



SDHE Implementation Discussion Paper Series

**Discussion Paper
Number 3**

**Health Equity at the Country Level: Building Capacities
and Momentum for Action**

**A Report on the Country Stream of Work in the
Commission on Social Determinants of Health**

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Executive Summary

The Commission on Social Determinants of Health (CSDH) included a stream of work focused on country action to address socially determined health inequities. Country Work engaged the «how-to» challenges countries face in turning evidence on the social determinants of health (SDH) and health equity (HE) into effective policies. The Country Work process has aimed to: (1) support countries in advancing action on SDH and HE in their specific contexts, while (2) enabling the CSDH to incorporate countries' experiences in its learning and recommendations.

Countries self-selected to use the opportunity of the Commission to jumpstart national action on SDH or pursue and strengthen existing efforts. A core group of interested governments have worked with the CSDH Secretariat to establish foundations for ongoing progress and identify ways WHO can support national action on SDH and HE. Country Partners whose efforts are described in this report include Brazil, Canada, Chile, England, Iran, Kenya, Mozambique, New Zealand, Sri Lanka, and Sweden. Country Partners' specific objectives and action plans shaped the Country Work agenda, while CSDH and WHO provided technical support and political leverage to Country Partners in strengthening demand for action on SDH and HE; identifying and implementing policy solutions; and documenting results.

This report describes how the Country Work has been conceptualized and organized; how countries joined the process and how their efforts have progressed; how success in the Country Work is being measured; the major questions and challenges Country Partners have faced; and the learning that has resulted. The concluding sections of the report outline a plan for sustaining the momentum that has been achieved through CSDH Country Partner action.

In tackling the «how-to» challenge of action on SDH and HE, Country Partners have taken their work forward in distinctive ways, reflecting their specific contexts and priorities. The CSDH has, however, highlighted five critical shared areas for national action on social determinants and health equity. Country Partners endorsed this approach. The five focus areas are: (1) assessing the national health equity situation (baseline analysis); (2) «getting the health sector right», i.e., identifying and using opportunities to strengthen health equity through policy and programme choices internal to the health sector; (3) spurring intersectoral action on SDH, including through a «whole-of-government» or «health in all policies» approach; (4) social participation in SDH action; and (5) building capacities and pursuing «how-to» knowledge to support implementation of SDH and HE policies.

Strong overall progress has been registered among Country Partners during their collaboration with the Commission. At this stage, gains are mostly measurable in terms of the political *processes* that have enabled Partners to jumpstart promising national action. Impacts on population health status and equity gaps will be measured over a longer timeframe. Within the short time allotted for formal CSDH Country Work, progress in advancing pro-equity and SDH policies has been demonstrated on several fronts, including: raising the political and public visibility of SDH/HE issues; improvements in the information environment for an SDH/HE agenda; development of incentive structures to increase accountability on SDH/HE issues; improvements in health sector programming with an SDH approach and capacity building for personnel; creation or strengthening of processes and structures to support intersectoral action for health; and increased incorporation of social participation into policy processes.

This report organizes learning from the Country Work process according to five major questions countries had to face as they advanced national SDH agendas. These questions, and the solutions found by Country Partners, will be relevant to other countries seeking to tackle SDH in the future.

1. How can countries catalyze action at the national level? Country Partners' experience shows that driving SDH action requires managing several processes, which have tended to unfold through three overlapping phases: (1) increasing the visibility of SDH and HE issues, for example by using data on existing health inequities to stir public concern and generate political will for action; (2) creating an institutional structure to take the SDH agenda forward, for example a national commission on SDH or a national reference group; for best results, such structures should incorporate spaces for dialogue between government and civil society on SDH/HE issues; (3) developing a national action plan - which need not be exhaustive, but can usefully highlight specific opportunities for action in a relatively short time frame (e.g., one year). Country Partners' action plans have given attention to short-term deliverables and potential «quick wins», while also looking towards more ambitious horizons of structural change to reduce social inequities. The perspective has generally been incremental and additive, based on the idea that smaller initiatives now will build momentum for systemic change.

2. What can the health sector do to promote an SDH and HE agenda internally? For countries embarking on SDH work, the health sector is a good place to start, even if their ultimate goal is to employ an approach that involves the whole of government. Country Partners found that «getting the health sector right» requires priority action in the following areas: (1) presenting information on the health equity situation strategically, to reinforce political commitment and highlight opportunities for intervention, for example by using statistical decomposition analysis to pinpoint the roots of specific health inequities, as has been done for under-five mortality in Iran; (2) ensuring that the health system's design and management contribute to reducing socially determined health inequities, and that health sector programmes are equity-sensitive, in particular focussing on the systems role in ensuring equity in access and prevention services; (3) establishing national health equity goals and plans to achieve them, as Chile and England did prior to beginning Country Work; (4) strengthening the national health information system to improve «health intelligence» and routine monitoring of social health inequities, as Sri Lanka is now doing through improvements to its national vital registration system and key survey tools, in collaboration with CSDH and WHO. In the follow-up to the CSDH, a group of countries are now actively engaged in taking forward national action to incorporate a social determinants and health equity approach into key national health programmes. This agenda builds on and extends the learning from the CSDH Priority Public Health Conditions Knowledge Network. It will incorporate mechanisms for «horizontal» knowledge-sharing among countries, as national action proceeds. WHO will support this process. An international meeting hosted in November 2008 by Chile's Ministry of Health clarified objectives and methods and strengthened momentum to advance the work.

3. What should the health sector be doing about cross-sectoral action on socially determined health inequalities? The health sector has responsibility to catalyze intersectoral action towards health equity goals. Intersectoral action has long been

recognized as an essential facet of primary health care (PHC). Historically, however, intersectoral work has been among the most challenging dimensions of PHC to implement. As part of its work with the CSDH, Canada, with WHO, sponsored a series of more than 20 country case studies on intersectoral action. These constitute a substantial new body of evidence to inform policy approaches in countries at all income levels. There are several levels of integration within intersectoral activities, ranging from cooperation to avoid overt programming and policy conflicts among sectors, to coordination, to integrated policy-making. Countries have found that beginning with relatively limited forms of cooperation can be a useful way to build skills, trust and a culture of collaboration, laying groundwork for more ambitious efforts. If ambitious collaborations involving multiple sectors are not immediately feasible, work can begin on priority objectives that may engage only one other ministry, as in Mozambique, where the Ministry of Health is planning to develop water and sanitation interventions with the Ministry of Public Works to reduce infant mortality.

Many CSDH Country Partners have recognized the goal of moving from a traditional model of intersectoral action towards more comprehensive, cross-sectoral strategies and ultimately a whole-of-government approach. Country Partners' experiences point to a series of key steps in advancing intersectoral agendas, including: (1) clearly define the role the Ministry of Health will play; (2) engage communication with other Ministries to identify shared concerns and potential areas of action; (3) to expand intersectoral buy-in, consider incorporating «social determinants of health» into a broader, more accessible vocabulary of social justice and wellbeing, as Chile is doing with its national social protection system; (4) use tools such as Health Equity Impact Analysis to evaluate policies outside the health sector and show why and how health concerns should be incorporated in these areas; (5) support innovative government management models and incentive structures that can encourage intersectoral cooperation, such as Chile's new public-sector Management Control System; (6) line up the support of government and administrative actors with broad mandates: for example the Office of the President, as in the case of Brazil's National Commission, or legislative actors, as when action by Canada's CSDH Reference Group led to a Senate Sub-Committee agreeing to study SDH policy options and report its findings to Parliament.

4. How can Ministries of Health improve social participation on SDH/HE? Civil society participation can strengthen political will around SDH and HE agendas and strengthen people's control over the factors that affect their health - an important social goal. Ministries of Health cannot create participation, but they can create spaces that enable and encourage participation. Social participation involving vulnerable and excluded groups should seek the empowerment of those groups, increasing their effective control over decisions that influence their health and life quality. All CSDH Country Partners explored ways to build social participation into SDH processes. However, political structures and institutional cultures often hamper substantive participation. Brazil's model of institutionalizing participatory management in health policy holds promise. Civil society organizations themselves have suggested strategies to strengthen social participation in the Primary Health Care agenda, including SDH and HE. These recommendations should be implemented. As part of their collaboration with the Commission, WHO Regional Offices, in particular AMRO/PAHO and EMRO, supported work to strengthen regional civil society

capacities on SDH. If the work is followed up and existing momentum reinforced, these processes will continue to build informed social demand on SDH/HE.

5. What kinds of capacities and skills need development to strengthen SDH/HE action, and how can the health sector build capacity? Workforces in many countries lack training in areas that are important for addressing SDH/HE. While basic skills can be taught relatively quickly, countries need mechanisms to institutionalize ongoing learning and foster the development of new skills. The aim must be to build a cadre of trained experts able not only to adopt and implement an SDH approach but also to develop new techniques and strategies. Many countries faced especially acute capacity gaps in the following areas: SDH monitoring and data analysis; capacity to plan and implement health sector programmes that take on board how the health system itself functions as a social determinant; capacities and mechanisms for cross-government action and social participation; and translating/communicating evidence to influence policy processes. In the course of the Country Work, countries made progress in diagnosing capacity needs and took action to remedy the most pressing gaps. Action in this area unfolded: (1) as part of ongoing national processes within countries; (2) through peer-to-peer knowledge sharing and collaborative processes among countries, enabled by the CSDH; and (3) through training and capacity-building provided or brokered by international agencies, including WHO. Several Country Partners provided or received forms of training during their CSDH work, including Brazil, Chile, Iran, Mozambique, and Sri Lanka. As countries advance their health equity agendas following the CSDH, WHO will encourage the development of tools guidance materials and platforms to facilitate capacity development and knowledge-sharing within and among countries. This will include capacity development networks that can translate the tacit, often fragmented knowledge on implementation that exists in countries into a more accessible, systematic knowledge base that can be shared and improved over time.

A key finding of the Country Work is that countries can make significant progress in political action to tackle the social determinants of health inequities in a short time, such as the three-year lifespan of the CSDH. Of course, the nature and scope of a given country's specific advances depend on its context and history. For countries with less experience in formally addressing SDH through intersectoral policy, including most countries in the AFRO region, the CSDH Country Work has generated political interest in SDH and in jumpstarting the process towards policy development by supporting baseline analysis of health equity and relevant social determinants. For countries with some experience, such as Brazil and Chile, the work has generated considerable political support for an SDH focus, and led to the creation of new mechanisms and institutional structures to promote intersectoral policy development, as well as pro-equity improvements within the health system. For countries building on an already long-established national tradition of analysis, debate and action on SDH and HE, such as England and Canada, the work has facilitated cross-national sharing of lessons and joint research initiatives. Joint research efforts have surfaced valuable experiences in intersectoral action and integrated policymaking. Collaborative research has also contributed to confirming the economic and equity benefits of tackling upstream health determinants.

Country Partners' experiences have encouraged the CSDH to challenge current «conventional wisdom» in areas such as welfare state policy and state-civil society collaboration. Notably, Partners have emphasized the importance of robust welfare state protections as an efficient,

effective means of improving health and strengthening health equity among social groups - at a time when welfare state mechanisms are under attack in some circles. Research from the Nordic countries has clarified and systematized relevant learning. While the public health effects of any specific redistributive welfare state policy may be modest, the combined effect of all such policies and institutions is likely to be substantial. This is especially true from a life-course perspective. People who enjoy access to resources provided by the welfare state, in addition to the resources of the market and the family, are likely to live longer.

Some CSDH Country Partners have adopted policy approaches that explicitly highlight social solidarity as a guiding value. Countries have explored different strategies for operationalizing this value in policy and programming. Such shared commitments among Country Partners make a powerful political statement on the global stage. At the same time, Partners' achievements to date necessarily raise additional questions. Areas of active inquiry include how universal health and social protection policy models relate to targeted strategies for the needs of special groups. Similarly, reconciling social participation and inclusiveness with the imperative for efficient, goal-driven government action is no simple matter. No uniform solutions exist, and a wide range of strategies may prove useful in specific contexts. These issues point out directions for continued learning in the years ahead.

Improving health equity is a long-term process. Unfair health differences among communities have deep historical roots and are anchored in social and political structures. Partner Countries have shown that change can happen fast; however, «levelling up» social determinants to substantially reduce inequities demands continuity of effort over time. A crucial objective for the coming years is to sustain and build on the momentum generated by the Country Work. A group of «path-finding countries», including the original CSDH Country Partners and others, will be leaders in this process. WHO will support their efforts.

Various models exist for understanding how evidence, such as that generated by the CSDH, is translated into political action. The Country Work process has confirmed the importance of negotiating the «non-linearity» of policy processes. Country Partners' experience highlights key ingredients for an active learning process to support further progress in the years ahead: (1) disseminating results and mobilizing demand around social determinants and health equity; (2) stimulating an increasingly inclusive, informed debate on these topics; (3) building mechanisms through which countries' still-pending questions on SDH and HE (as well as newly emerging issues) can be addressed; (4) implementing CSDH recommendations, evaluating progress, and sharing know-how («active learning»). In the coming years, while supporting countries already engaged through the Country Work, WHO will foster a «snowballing» model of country participation, so that global momentum for action on social determinants continues to build over time. The Organization will provide technical support to countries for policy translation, as well as tools for monitoring and evaluating impacts.

WHO's Medium-Term Strategic Plan for 2008-2013 establishes a strong organizational mandate for supporting country action on SDH and HE. WHO is reinforcing its institutional competencies to meet country demand in this area. WHO Regional Offices will be at the heart of this effort. As the architects of the Alma-Ata vision saw, delivering Primary Health Care effectively at country level requires an equity-oriented policy framework and cross-sectoral action on social determinants. Thirty years later, the evidence base has expanded; political and social contexts have evolved; the division of roles and responsibilities among key actors has shifted; and new strategies are required to achieve results. CSDH Country Partners have charted innovative paths in action on social determinants. These promising directions must

now be pursued to deliver on the promise of improved health for all and closing the gap through accelerated gains for vulnerable and disadvantaged communities.

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List of abbreviations

AFRO : African Regional Office of WHO
AMRO : Americas Regional Office of WHO
CBI : Community Based Initiatives
CW : Country Work
CNDSS : Brazilian National Commission on Social Determinants of Health
CSDH : Commission on Social Determinants of Health
CSO : Civil Society Organization
EC : European Community
EFHIA : Health Equity Impact Assessments
EMCONET : Employment Conditions Knowledge Network
EMRO : Eastern Mediterranean Regional Office of WHO
EU : European Union
EURO: European Regional Office of WHO
FIOCRUZ : Fundação Oswaldo Cruz
GPE : Government Program Evaluation
HE : Health Equity
HIA : Health Impact Assessment
HSKN : Health Systems Knowledge Network
IAH : intersectoral action for health
IHP : Institute for Health Policy (Sri Lanka)
IWG : Intersectoral Working Group
KN : Knowledge Network
MoH : Ministry of Health
MoHME : Ministry of Health and Medical Education
MoL : Ministry of Labour
MDGs : Millennium Development Goals
MIP : Management Improvement Program
MoU : Memorandum of Understanding
NGO : Nongovernmental organization
OAS : Organization of American States
OPT : Occupied Palestinian Territories
PAHO : Pan American Health Organization
PPHC : Priority Public Health Conditions Knowledge Network
RHAs : Regional Health Authorities
SDH : Social determinants of health
SDHI : Social determinants of health inequities
SEARO : South East Asia Regional Office of WHO
SMC : System of Management Control and Results-Based Budgeting
SWAps : Sector Wide Approaches
TB : Tuberculosis
UK : United Kingdom
WHA : World Health Assembly
WHO : World Health Organization
WPRO : Western Pacific Regional Office of WHO

Health Equity at the Country Level: Building Capacities and Momentum for Action

A Report on the Country Stream of Work in the CSDH

I. Introduction

At the 2004 World Health Assembly, WHO Director-General LEE Jong-wook announced the creation of a global Commission on Social Determinants of Health (CSDH). Its purpose was to produce knowledge and build political momentum to strengthen health equity through country-driven action. The creation of the CSDH expressed WHO's renewed commitment to equity as a central facet of global health leadership.

The architects of the CSDH knew that health inequities - unfair and avoidable health differences between population groups - have their roots in the social conditions in which people live and work. Strengthening health equity requires evidence-informed action on social factors. In its three-year mandate (2005-2008), the Commission's specific charge has been to show how countries can translate concern for health equity into effective policies and programmes.

From the beginning, connecting knowledge-generation to country action has defined the Commission's specificity and determined its process. Good science is vital to reduce health inequities - but it is not enough. The CSDH has emphasized a rigorous integration of research and policy processes, so that the knowledge produced by the Commission can both respond to countries' needs and reflect their innovative experiences. For this reason, the stream of work known as Country Work (CW) has been central to the CSDH process.

The aim of the Commission's Country Work was to promote, demonstrate and bridge knowledge to policy and implementation in order to address socially determined health inequities. This stream of work offered Member States interested in advancing their national health equity agendas an opportunity to use the CSDH infrastructure to accelerate national action while laying the foundations for longer-term change. The Country Work process also sought to identify ways WHO can most effectively support future national action on SDH and HE.

This report describes the CW process and summarizes the key achievements of Country Partners in their collaboration with the CSDH. The report explains:

- how the Country Work was conceptualized and organized;
- how countries joined the process and how their efforts have progressed;
- how success in the Country Work is being measured;
- the major questions and challenges Country Partners have faced and the learning that has resulted.

The concluding section of the report outlines elements of WHO's plan to strengthen capacities and sustain the momentum for action on social determinants and health equity generated through the CSDH Country Work.

II. Operationalizing the Country Work

II.1. Rationale and motivation behind the Country Work

The primary rationale for the CW was to create a mechanism to (1) support countries in advancing action on SDH and HE in their specific contexts, while (2) enabling the CSDH to incorporate countries' experiences in its learning and recommendations. Country Partners' specific objectives and action plans have shaped the CW agenda, while CSDH and WHO have provided technical support and political leverage to Country Partners in strengthening demand for action on SDH and HE; identifying and implementing policy solutions; and documenting results. The Country Work was also envisioned as contributing to the integration of an SDH for HE focus into the routine work of WHO at headquarters, regional and country levels. The core of Country Work has been about solving «how to» problems:

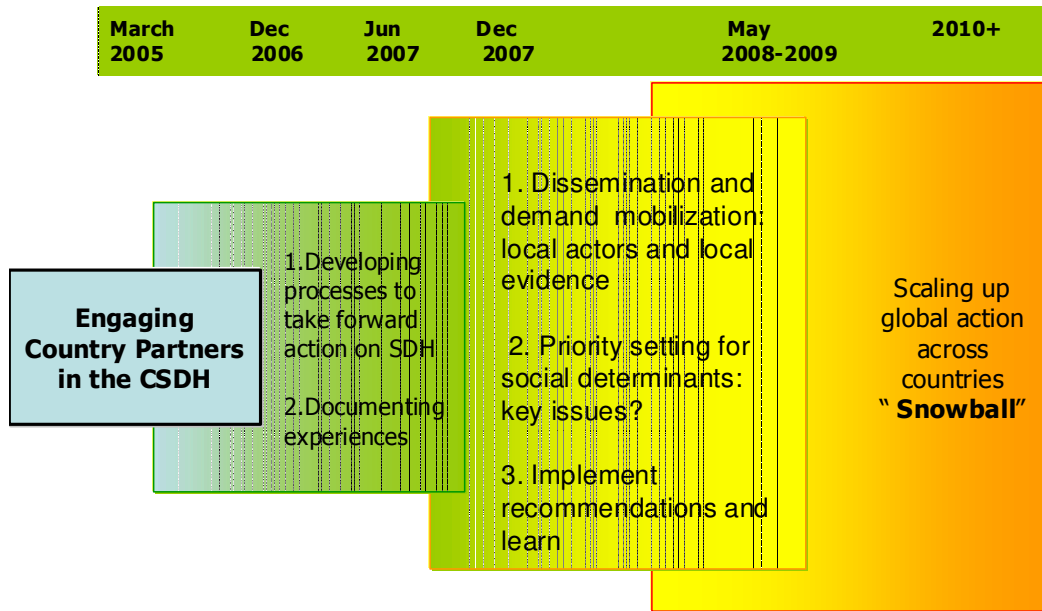
- how to build political momentum to tackle SDH in order to improve health equity at country level;
- how countries that want to improve health equity can design and implement policies that will work in their specific contexts;
- how to organize collaboration and partnerships so that external agencies can effectively support country efforts.

The CW timeline (Figure 1) reflects two concerns: (1) to maximize action and results within the lifetime of the CSDH itself (2005-2008); and (2) to lay foundations for sustained SDH and HE work beyond the timeframe of the CSDH: both in countries and in key supporting institutions, including WHO.

In its collaboration with Country Partners, the CSDH has worked to strengthen systematic action on SDH for HE across government, and to improve sustainability of SDH for HE work by building critical capability within and between countries to take forward the process beyond the life of the Commission. Country Work has aimed to explore some specific questions about implementing an SDH/HE agenda, and to learn what kinds of support and strategies work best to promote action on these issues, both short- and long-term.

In WHO, the CW stream supported the development of an increasingly important role for WHO Regional Offices to convene countries and to support development and dissemination of materials generated by the CSDH both between countries and within WHO. Contributions to the Medium-term Strategic Plan of the Organization was also used as a mechanisms to ensure sustainability within WHO post Commission.

Figure 1: Time frame for the CSDH Country Work process



II.2. The operational strategy

In order to bring the Country Work to fruition, an operational strategy needed to be developed, Country Partners had to be recruited, and ongoing support, cooperation and communication provided. Early in the process, CSDH Commissioners articulated grounding principles for collaboration with Country Partners. Through research and dialogue with countries, five main areas then emerged as foci for the CW operational strategy. These were the domains in which Country Partners were most interested in working with the Commission.

II.2.1. Grounding principles for Country Partners

The CW approach has been inclusive and pragmatic. There is no expectation of ideological uniformity across governments and stakeholders engaged in this work. At the same time, the Country Work, like the other processes associated with the CSDH, defines progress in health equity as its goal. The concept of equity presupposes an explicit reflection on values, emphasizing that values become meaningful through concrete action. With this in mind, in 2005, CSDH Commissioners developed a set of criteria that reflected the grounding principles of Country Work. These foundational concepts were agreed upon by the Commissioners in the course of their second meeting, in Cairo, Egypt, in May 2005. Commissioners resolved that Country Partners would:

1. Be self-selecting, in the knowledge that to act successfully on social determinants to reduce health inequities will require political commitment from the highest levels of

government and at the highest level of other significant players in the country's political and health arena.

2. Recognize health as an indispensable component of development and a human right.
3. Have existing and future activities addressing the social determinants of health, and initiate and enhance activities with special attention to those with potential for scaling-up.
4. Become actively engaged in intersectoral cooperation and collaboration in health-related issues, fostering appropriate alliances and partnerships; and demonstrate an interest in putting in place the management and institutional capacities necessary to facilitate comprehensive intersectoral policy processes for health.
5. Perform monitoring and evaluation and be willing to exchange information related to social determinants of health.
6. Facilitate community participation and ownership in all health programmes and activities.
7. Designate the responsibility for the work at least to the ministerial level, which could be the Minister of Health (CSDH, 2005c).

Political will was recognized as essential to generating the rapid action necessary to demonstrate the impact of Country Work, while advocacy processes to build political momentum where it does not exist can take years to develop. Considering these factors and the Commission's own time-limited character, the CSDH committed to work with self-selecting countries; to include all countries that wished to participate; and to have countries choose their own processes and activities, with the Commission playing a facilitating and coordinating role.

II.2.2. Five areas of focus

Through WHO, the Commission endeavoured to provide guidance regarding the expected content of Country Work, while allowing for differing levels of intensity and variations in the scope of work that countries might undertake. The Commission's discussions with Country Partners and analysis of previous country experiences identified five main areas of focus for a programme of action. These areas provided the basis for structuring the work with Country Partners and were endorsed at the first meeting of Country Partners in May 2006. The five areas are described briefly below and explored in detail in the core section of this report (Part IV).

(1). Assessing the health equity situation (baseline analysis) refers to the assessment of existing socially determined health inequities in the country. This includes assembly and analysis of relevant population health and socioeconomic data, using appropriate forms of disaggregation and statistical methods to enable comparison of health status and outcomes among population groups. In addition to accurate baseline description of existing health differences among social groups, the health equity situation assessment should also include analysis of the specific causal mechanisms that produce health inequities in the country, using both quantitative and qualitative methods.

(2). Getting the health system right involves understanding the health sector's own specific role in generating or reducing health inequities and then taking action to reinforce equity through the health

system. «Getting the health system right» in equity terms has two main dimensions: (1) strengthening equity in access to health services for all groups in society, particularly those that have suffered systematic disadvantage or exclusion; (2) fully realizing the health sector's opportunity to catalyze, guide and contribute to intersectoral action for health equity, including cross-government approaches. The following actions can accelerate the alignment of the health system with SDH and HE goals: (a) presenting information on the health equity situation strategically, to reinforce political commitment and highlight opportunities for intervention, for example by using statistical decomposition analysis to pinpoint the roots of specific health inequities; (b) ensuring that the health system's design and management contribute to reducing socially determined health inequities, and that health sector programmes are equity-sensitive, in particular with reference to equity in access and prevention services or programmes; (c) establishing national health equity goals and plans to achieve them; (d) strengthening the national health information system to improve «health intelligence» and routine monitoring of social health inequities.

(3). Intersectoral action building towards a «whole-of-government» approach. Social determinants and health equity interventions naturally engage the responsibilities of sectors and actors outside the health sector. An intersectoral approach is essential to tackling social determinants at the policy level. A key concern for the CSDH Country Work has been identifying practical strategies to strengthen systematic action for health equity across government ministries and agencies.

The 1978 Alma-Ata Declaration on Primary Health Care highlighted the importance of intersectoral action to advance health and health equity. In practice, intersectoral action has been one of the most challenging components of the Primary Health Care agenda to implement. Through documentation of existing experiences and analysis of new options for country action, the CSDH process has strengthened the evidence base on intersectoral work and created platforms for knowledge-sharing and collaboration among countries working to advance the health equity agenda.

Precise definitions of «intersectoral action» have sparked debate. The CSDH adopted a broad and fluid understanding of intersectoral action in order to capture the widest possible set of relevant country experiences. These include cases in which government ministries or departments work together in explicit, structured collaboration towards a shared objective connected with health equity or SDH. But relevant country experiences also include instances in which sectors have worked in a synchronistic way (i.e., each working on determinants that affect health, but not necessarily working in explicit collaboration) (PHAC, 2008: 2). Linked to an inclusive understanding of intersectoral action for health is the idea that the explicit goal of such action need not always be formulated strictly in health terms. Country experience shows that framing complex health issues broadly (and, in some cases, with reference to a social indicator rather than a health indicator) may allow multiple sectors to more easily define their roles and contribute to solutions.

While a broad understanding of intersectoral action is helpful, the evidence assembled by the CSDH also clearly suggests that best results will be obtained when action for health equity is pursued in a coordinated manner across multiple government sectors or departments within a jurisdiction. Some CSDH Partner Countries have adopted the term «cross-sectoral action», which may more effectively capture the idea of coordinated strategies engaging a range of government departments and tending towards a full-fledged «whole-of-government model» (PHAC and WHO, 2007).

A «whole-of-government» and «health in all policies» approach implies an integrated effort to impact on health and health equity through the work of other sectors of government, either through approaches that promote leadership from highest levels of government or through more collaborative processes of supporting other sectors to reach their objectives. More limited forms of intersectoral action occurring across fewer government sectors may build momentum for a more comprehensive approach.

(4). Social participation leading to empowerment. As stated in the Commission’s Conceptual Framework, a central point of public policy «should be the configuration of cooperative relationships between citizens and institutions» (CSDH, 2005c). The state has a responsibility to develop flexible systems that facilitate access and enable participation by citizens, including strengthening of local or regional governments so that they can constitute concrete spaces of participation.

The CSDH has aimed to incorporate civil society participation into its own processes and to engage Country Partners committed to social participation as a fundamental component of national action for health equity. CSDH leaders understood, however, that «participation» can be interpreted in many ways. The Commission’s Regional Civil Society Facilitators defined authentic participation as implying a change in power relationships, whereby historically oppressed and marginalized groups claim greater control over their own health and lives. The Civil Society Facilitators observed:

Civil society views its role [in the CSDH process] not as that of an instrument of advocacy, but as a significant partner that brings in fresh, people- and community-centred perspectives.... It is important that civil society organisations drawn into the process do not feel that they are being “co-opted”, i.e. they are being asked to implement or advocate for policies and processes they do not play a part in shaping (CSDHa, 2007).

Box 1. Key events to engage Country Partners

2005

- March: Launch of the CSDH and 1st Commissioners' Meeting, Chile
- May: Eastern Mediterranean Regional Office Meeting, Egypt
- May: 58th World Health Assembly, including special session on ‘Supporting National Policy Action on Social Determinants of Health’, WHO HQ
- July: Americas Regional Office Meeting, USA
- July: African Regional Office Meeting, Republic of Congo
- August: CSDH Regional Civil Society Facilitators Meeting, WHO HQ
- September: South East Asia Regional Office Meeting, India

2006

- March: Western Pacific Regional Office Meeting, China
- March: Launch of the Brazilian National Commission on Social Determinants of Health, Brazil
- May: 59th World Health Assembly, including "Managing the Politics of Equity" Seminar, WHO HQ
- May: 1st Meeting of Country Partners, including Civil Society, WHO HQ
- December: Africa Civil Society Meeting, Senegal

2007

- February: 2nd Regional Civil Society Meeting, Brazil
- March: European Regional Office meeting, Denmark
- October: Meeting of Technical Advisory Group of Policymakers on policy translation of CSDH findings, UK

2008

- August: Launch of the CSDH report: WHO HQ
- November: Meeting on ‘Integrating SDH and HE into national health programmes,’ Chile

Social participation, whether in country-level processes or international deliberations, requires spaces in which communities can actively contribute to decision-making and so gain greater power over policies and processes that affect their lives. Stakeholders in Partner Countries have worked to create and expand such spaces at country level and to negotiate the tensions that inevitably arise as participatory processes unfold. Countries and CSDH leadership alike have recognized that civil society engagement is essential to the sustainability of SDH and HE agendas.

(5). Building national capacities and expanding knowledge. Capacity strengthening is a priority and prerequisite for sustaining national action on SDH for HE, while at the same time it is important to stretch the boundaries of the existing knowledge base. This particularly includes practice-oriented knowledge on how to build political momentum around SDH; how to design, implement and manage effective policies, especially using intersectoral mechanisms; and how to expand social participation to tackle SDH and HE.

II.2.3. Engaging countries in the process

Engagement of Country Partners in the CSDH focused on identifying a limited number of countries with which specific work aimed at advancing the SDH agenda could be implemented during the life of the Commission, attempting to include at least one country in each WHO region. A call for Country Partners was issued through discussions with countries around the launch of the Commission in Chile in March 2005, and then subsequently through a variety of mechanisms (Box 1), including special sessions at World Health Assemblies; a series of WHO Regional Office Meetings involving WHO staff, Member States and regional stakeholders; Commissioners' personal spheres of influence; dialogue with countries hosting Commissioner meetings; and civil society lobbying.

By December 2007, fifteen countries had made formal expressions of interest from their national governments to become

Box 2. Almost 100 Countries participating in the CSDH process

Country experiences have been brought into the CSDH process in flexible ways that have not always implied full, formal engagement as Country Partners. In the end, close to one hundred countries were covered by the CSDH work through the production of case studies or reports and conducting research or hosting CSDH meetings (see Annex A for details on the products generated by countries in their work with the CSDH).

Core Partners stimulated interest and initiated work in cooperation with other countries. Canada, with WHO, for example, engaged more than 20 countries through an initiative to collect lessons about intersectoral action on health and health equity. The process began with a literature review and evolved into a series of case studies from high-, middle-, and low-income countries. Similarly, Sri Lanka engaged China (Hong Kong) and Malaysia to provide a comparative case study on countries with successful low-cost primary health care systems financed by taxes.

WHO Regional Offices supported baseline analysis of equity information (AFRO, EMRO, and SEARO) and working directly with countries to develop tools and promote SDH policy (EURO and AMRO) raised awareness of many additional countries.

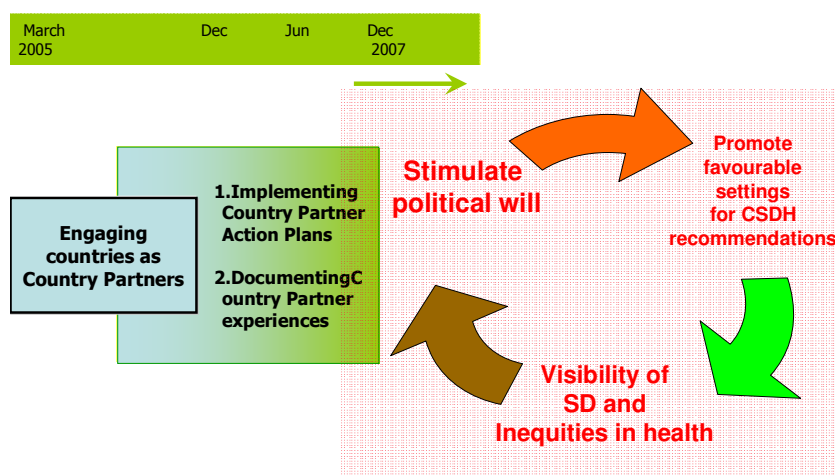
The CSDH Knowledge Networks collected case studies from dozens of countries on specific topics. This process has likely increased interest in and attention to the SDH agenda in many countries.

Civil Society initiatives also stimulated on-the-ground action in countries. The CSDH Civil Society Stream of Work included Civil Society Facilitators from each region, who enabled the engagement of scores of national groups, in jurisdictions formally affiliated with the CSDH and others. In Latin America, for example, Civil Society advocated in support of expanded SDH action with the national governments of Venezuela, Bolivia, and Uruguay as well as the municipal government of Bogotá, Colombia.

Country Partners. The group initially included Brazil, Canada, Chile, England, Iran, Kenya, Mozambique, Sri Lanka and Sweden, later joined by Bolivia, Mauritania, New Zealand, Peru, Poland and Thailand. The first nine countries had also developed Action Plans in consultation with the CSDH Secretariat, and their activities and experiences are related in this report.

The Commission intended for the momentum and interest generated by the core countries to result in a «snowballing» effect that would incorporate a much broader set of countries as time went on. The core phase of the Country Work process and some of the crucial objectives pursued are illustrated below in Figure 2. The figure reminds us that action on SDH for HE involves interwoven social and political processes that, together, determine what practical use is made of scientific evidence on health determinants. A fundamental requirement is to increase the social and political visibility of SDH and health inequities. This involves making the evidence on existing inequities, trends and proposed solutions available in an intelligible and compelling form to decision-makers and civil society groups. Raising the profile of the issues will assist, in turn, in stimulating political will for action. Documentation of specific experiences and strategies for catalyzing political commitment in different contexts is an important piece of the Country Work learning.

Figure 2: Process of building momentum for action on SDH and HE during the Country Work.



As political pressure for action on health inequities and social determinants builds, a more favourable climate is created for the reception and implementation of the policy recommendations emanating from expert bodies like the CSDH. Discussions around the Commission’s recommendations and countries’ efforts to put them into practice will again raise the public visibility of health equity issues and social determinants. Figure 2 depicts the potential for this «virtuous circle». There is evidence that such a process has moved forward among CSDH partner countries, though these cycles always remain fragile, underscoring the need to engage multiple constituencies to support SDH for HE. Grassroots civil society groups and international agencies like WHO have an important role, because they can

maintain focus on these themes, even when governments and political fashions change. These cyclical processes can also be strengthened by including from the start mechanisms for dialogue and action across government sectors, so that the HE agenda is «owned» collectively and not seen as the concern only of one department or ministry.

III. Country Partner Action

Each Country Partner has determined how best to take advantage of the opportunity represented by the CSDH to build political momentum and technical capacities for national action on SDH. Each Partner has designed an Action Plan and taken significant steps to advance an equity agenda in its national context while working with the CSDH.

Of course, some countries brought to their work with the Commission a substantial previous history of national efforts to document, analyze and address socially-determined health inequities. Other countries have come relatively freshly to the topic of health inequities through the CSDH process, and have therefore focused their work on building the basic foundations of an equity-relevant knowledge base, raising awareness, and mobilizing political will. All Partners, regardless of their starting points, made significant progress during their collaboration with the Commission and have generated important learning. The remainder of this chapter describes the actions undertaken by each Country Partner. The next chapter (Part IV) draws together and analyzes the key lessons emerging from these experiences.

Highlights of work by Country Partners

A brief summary of each Partner's Action Plan, including major initiatives, structures, and activities, is presented below. Action Plans used multi-faceted strategies to identify and address priority health equity issues, create synergies among key players, take advantage of political opportunities and technical strengths, and contribute to a longer-term agenda for tackling SDH, incorporating contextual specificities. More detailed descriptions of Country Partners' activities are available on the CSDH website, at http://www.who.int/social_determinants/country_action/partners/en/index.html.

Brazil. Building on the momentum of the global CSDH, Brazil launched its own National Commission on Social Determinants of Health (CNDSS) in March 2006. The CNDSS was created by a Presidential Act and is supported by Fundação Oswaldo Cruz (FIOCRUZ) and the Ministry of Health. The CNDSS has a high profile within the country. Commissioners include personalities from the academic and political spheres, social leaders, and media and business personalities, with the President of FIOCRUZ serving as Chair. The CNDSS is organized around production and dissemination of knowledge; strengthening the SDH focus in policies and programmes; mobilization of civil society; communication; and international cooperation.

In the area of knowledge generation, capitalizing on its strong capacity for scientific research, Brazil has invested US\$4 million to advance research on key questions related to SDH and health inequities. The research programme includes a focus on health determinants among key population groups, including the country's Black population. In the policy field, the CNDSS is conducting a review of all national systems related to SDH, and is developing a case study on health equity in occupational health systems to generate policy recommendations.

Committed to strengthening social participation in action on health determinants, the CNDSS has conducted discussions and developed joint policy and planning with dozens of NGOs working on themes related to SDH.

The National Commission has produced television programmes, magazine articles, and a website to facilitate access to information and encourage discussion on SDHI issues and activities. It has also pursued regional political and technical activities to address SDH and equity challenges, such as developing a joint Memorandum of Understanding with Chile on intersectoral action and participation in health, as well as supporting a regional meeting of civil society. Additionally, Brazil's National Commission has played a prominent role in promoting regional initiatives to eliminate silicosis and address occupational health issues.

Canada set up a Reference Group in 2005 to provide liaison and advisory support to its two CSDH Commissioners, and to develop a Country Partner Action Plan. The Canadian Reference Group (CRG) is comprised of experts in science and policy development in the area of social determinants of health, including the Commissioners and Canadian Knowledge Network leads, representatives of selected federal government departments, provincial/territorial health officials, Aboriginal health experts, academics and public health NGOs. The Deputy Chief Public Health Officer at the Public Health Agency of Canada has championed this work. The CRG has identified several priority areas of work, including improving the health of Aboriginal groups in Canada.

The Reference Group is particularly investigating how Canada can use a whole-of-government approach to address health inequities. The CRG's vision included systemic change in policy processes and structures. For this reason, the CRG supported Commissioner Monique Bégin's efforts to elicit interest from a Canadian Senate sub-committee to undertake a study of this subject. A Senate Committee on Population Health has been established and is carrying out research and hearings. The Senate Committee is scheduled to make a recommendation to Parliament in December 2008 regarding appropriate approaches and investments to more effectively address SDH across departments of government.

Canada has initiated three major cross-national activities as part of its Action Plan. First, Canada led the development of an ambitious international literature review on intersectoral action for health and health equity, convening a dialogue to surface learnings from case studies on intersectoral action in 22 countries and the European Union. Outputs of the literature review have been posted on the Public Health Agency of Canada's website. Canada's second international project is an effort to coordinate multi-country research focused on health determinants among Aboriginal peoples. A successful roundtable brought together Aboriginal leaders and researchers to discuss the issues and identify priorities for action; plans are underway to drive action on the recommendations at national levels. Third, Canada has worked with several other Country Partners to strengthen the economic case for investment in SDH.

Chile's activities have built on previous SDH/HE work initiated during the Health Reform process that began in 1998. Chile established a focal point within the Ministry of Health in the Office of the Undersecretary of Public Health, to coordinate Country Partner activities and processes, and to spearhead a particular focus on issues of child health and workers' health. Country Partner activities have also included strengthening equity and SDH information through monitoring and revision of National Health Equity Targets. In 2006, Chile conducted

a decomposition analysis of the National Quality of Life Survey to better understand how various sectors can contribute to health, and developed the first National Quality of Life Survey focused on Workers' and Employment Conditions. Regional (sub-national) Health Authorities (RHAs) have been involved in integrating SDH for HE into health sector planning and monitoring, following a detailed intersectoral analysis of health inequities. The Ministry of Health is also working with municipalities and RHAs to develop a new programme to support citizen participation initiatives at the regional and local levels.

The Chilean model of SDH action involves integrating SDH policies and programmes as part of the construction of a broader social protection system. When complete, the system will provide universal coverage for the whole population throughout the life cycle, with a comprehensive network of services based on a human rights framework. Strengthening regional ties within the Americas, Chile has signed a Memorandum of Understanding with Brazil to promote intersectoral approaches and social participation in SDH action, and is supporting multi-country initiatives to eliminate silicosis and address occupational health challenges.

Building on the results of the CSDH, Chile has taken bold action to begin realigning national public health programmes to improve equity. In May 2008, the Sub-Secretariat of Public Health established an Executive Secretariat for Social Determinants of Health. Its aim is to «position a social determinants and health equity framework on the agenda of the Ministry of Health and of other sectors» (Solar, 2008). In September 2008, the Sub-Secretariat of Public Health announced a programme of seven objectives and 13 concrete steps to achieve this aim, under the title: «Social determinants of health: 13 steps towards health equity». The plan outlines actions for the period 2008-2010, including a rigorous review of key national health programmes from an SDH for HE perspective, and the progressive reconfiguring of these programmes to incorporate determinants and equity in their goals and strategies. Even as it enacts innovations in national policy, Chile is taking leadership in an international knowledge-sharing process to facilitate similar progress elsewhere. In collaboration with WHO, Chile's Ministry of Health hosted a major international consultation on incorporating SDH for HE into public health programmes in Santiago in November 2008. Participating countries included Brazil, Canada, Cuba, Ecuador, Norway, Peru, Sri Lanka and the United Kingdom. Regular follow-up consultations are planned through 2010.

England established its focal point for the CSDH as the Deputy Chief Medical Officer, a position within the Department of Health responsible for health inequalities. England's national health inequalities strategy provides targets for cross-government actions. England aims, by 2010, to reduce inequalities in health outcomes by 10%, as measured by infant mortality and life expectancy at birth. The national strategy gives priority to the health of families with young children and to major causes of premature mortality. It emphasises variations between social groups and differing settings/geographical areas. Given that monitoring towards 2010 targets is in place, it was decided that it would be inappropriate to develop a separate action plan for the SDH for England or the UK at this time. Instead, England has focused its Country Partner activities on stimulating regional processes within the European Union (EU) and working to support the agenda in other countries. England proactively supported EU policy analysis and development on SDH issues, especially during the UK's exercise of the EU Presidency in 2005. England is also taking a leadership role in the multi-country effort to make the case for investing in SDH, using economic arguments.

I.R. Iran's Country Partner work builds on a five-year plan to improve social justice and ensure basic needs in the population. The focal point is the Director General for Network Development and Health Promotion within the Ministry of Health and Medical Education (MoHME). With high level political support, a Reference Group was established in the MoHME in the Office of the Undersecretary for Health, and includes WHO. Iran's activities have focused on producing an SDH situation analysis in coordination with WHO and the MoHME and a case study on intersectoral action through the Canadian project. I.R. Iran is working to refine its Action Plan based on the situation analysis, recognizing the breadth of initiatives within the country that could be brought under the umbrella of an SDH agenda and better aligned to improve coordination and efficiency. Iran's health leaders emphasize the role of social participation in promoting a national effort to address SDH. Finally, Iran has been instrumental in working with WHO's Eastern Mediterranean Regional Office to support a regional movement to address SDH.

In the short time they have been Partners, Kenya and Mozambique, the representative countries from the AFRO region, have focused largely on galvanizing political commitment, setting up institutional support and structures, and developing their Action Plans.

Kenya developed an Action Plan in 2006. The Minister of Health, who also served as a CSDH Commissioner, served as focal point for the national process. Kenya's Action Plan includes a focus on improving maternal mortality in a particularly disadvantaged province; urban planning and health to address the conditions of Kenya's slums; and how to introduce equity monitoring into the Medium Term Expenditure Framework (possibly expanding to other planning processes such as SWAps, the health sector's Annual Operational Planning, and the National Health Insurance Fund). Kenya hosted a regional civil society consultation on SDH and the fifth meeting of CSDH Commissioners in June 2006. Underscoring these meetings' catalytic importance for SDH action nationally and across the African region, President Mwai Kibaki endorsed the creation of a Kenyan National Commission on SDH to spearhead the eradication of health inequalities in the country.

Mozambique pursued formal status as a CSDH Country Partner in June 2006, and then worked quickly to establish a focal point in the Ministry of Health, the Director of National Planning and Cooperation, working directly with the Minister. In late 2006, a baseline analysis was carried out with support from WHO, which resulted in identification of priorities to be incorporated into the Action Plan, including the link between maternal mortality and maternal education as well as issues of child malnutrition, malaria, and source of drinking water. In connection with this plan, Mozambique's national health leaders recognize the need to improve the health information system. Efforts will also be made to achieve better alignment of priorities and establish coordination mechanisms, both within the Ministry of Health and among key Ministries.

Regarding intersectoral action for health (IAH), Mozambique's health leaders have found that there is willingness to cooperate but that clear mechanisms must still be established. Key government actors in developing IAH will be the Ministries of Education and Culture; Public Works; Labour; and Women and Social Action. Perceived opportunities and priorities for intersectoral action include: integration of school health and nutrition programmes; interventions related to water and sanitation to reduce infant mortality by increasing coverage and access among the most disadvantaged communities; a needs assessments of health equity in the workforce; improved social and health protection for people working in the informal

sector; and prevention and control of violence against disadvantaged and vulnerable people, especially women.

New Zealand. While New Zealand did not seek a formal Country Partner relationship with the CSDH, the country played a prominent and constructive role in the Commission process, building on a substantial history of national efforts to understand and address the social roots of health inequities. New Zealand contributed an important case study on intersectoral action to the research programme Canada coordinated on this topic. New Zealand has also taken a leading role in highlighting the determinants of Aboriginal health and effective policy responses within the CSDH framework. This work draws on the innovative policy and programming efforts undertaken in New Zealand to improve health among the country's Maori community. In addition, New Zealand contributed to the Commission's work on indicators for measuring SDH and evaluating policy impacts.

Sri Lanka became a Country Partner late in 2006 and set up a focal point in the Ministry of Health. A Working Group on Health Inequalities was appointed to develop plans for collaboration with the CSDH and sustained national action on health equity. On the basis of its experience as a Country Partner, Sri Lanka is committed to taking forward a «health in all policies» approach to governance and is fostering interest and joint action on comprehensive health equity strategies among countries in the region. The country's history of successful health action at low levels of per capita healthcare expenditure makes documenting Sri Lanka's experience particularly important.

Sri Lanka's SDH-focused learning as a Country Partner included three major case studies. First, a historical case study reviewed Sri Lanka's experience in achieving «good health at low cost». Second, the MoH partnered with the Marga Institute on a study of intersectoral action, including: (a) description and assessment of existing formal mechanisms for IAH; (b) description and assessment of existing informal mechanisms, including collection of best experiences; and (c) recommendations. Third, in partnership with the International Labour Organization (ILO), Sri Lanka undertook a case study on equity in occupational health.

Additional activities included an SDH equity analysis on why malnutrition has remained an enduring problem in Sri Lanka despite the country's other impressive health achievements. Sri Lanka is also updating and improving its information systems to better understand social health inequities and facilitate country comparisons across the region. Working with WHO, Sri Lanka is taking a lead role in a regional initiative to provide a baseline equity analysis for policy discussion with Ministers of Health. In October 2007, Sri Lanka and WHO-SEARO hosted a major regional meeting on implementing CSDH recommendations to tackle health inequities. The event brought together health sector leaders and multi-sectoral stakeholders from 11 countries, in Colombo.

Building on the momentum achieved, Sri Lanka is considering the creation of its own National Commission, along with a range of other options to further strengthen awareness and action on SDH for HE beyond the lifetime of the CSDH. Sri Lanka participates actively in global implementation and learning partnerships that have emerged through the CSDH, and continues to play a leadership role in regional work. Sri Lanka presented its experience in

intersectoral action for health equity at the November 2008 meeting hosted by Chile, «Integrating social determinants of health and health equity into national health programmes». In February 2009, Sri Lanka will host a regional follow-up consultation on translating CSDH recommendations. Under the title «Closing the equity gap through action on the social determinants of health», the meeting will engage policymakers, implementers and civil society leaders. Connecting decision-makers from SEARO countries with counterparts from other regions and CSDH Commissioners, the event will place emphasis on a «health in all policies» approach and its regional relevance.

Sweden. Sweden has a long history of attention to health equity and SDH issues. In its role as a CSDH Country Partner, Sweden has been active on multiple fronts. Sweden co-ordinated and provided start-up funds to establish a Nordic Reference Group on SDH, a research and policy development alliance that includes Iceland, Denmark, Finland, Norway and Sweden. The reference group supported Commissioner Professor Denny Vågerö from the Center for Health Equity Studies (CHESS) in Stockholm, who represented the Nordic countries. The purpose of the Nordic Reference Group was to discuss and convey the Nordic experiences of working with the SDH to the CSDH via Commissioner Vågerö and to share learning with other countries via the platform of the CSDH. Sweden was also represented in three of the Commission's nine scientific Knowledge Networks (Globalization, Women and Gender Equity, and Urban Settings). The universalistic Nordic welfare policy and its effects on people's health have attracted interest from the Commission. A report, *The Nordic Experience: Welfare States and Public Health (NEWS)*, was presented to the Chair of the Commission by researchers at CHESS in Stockholm.

Together with England, Canada and Chile, Sweden explored the issue of building an economic case for investment in SDH. Following participation in the CSDH meeting in June 2007 in Vancouver, Sweden presented four cost-effectiveness studies to the Commission: «Health, economics, and feminism: on judging fairness and reform»; «Preventive home visits postpone mortality – a controlled trial with time-limited results»; «Cost-effectiveness of the promotion of physical activity»; and «A cost-effectiveness analysis of alcohol prevention targeting licensed premises». The economic case for investing in health is also underlined as an important task by two working groups within the European Union, of which Sweden is a member; the EU Expert Group on Social Determinants and Health Inequalities, and Determine - An economic consortium for action on socio-economic determinants on health.

IV. Learning from Country Partners on how to support a social determinants and health equity agenda

The preceding section described the action undertaken by Country Partners in the CW process. The present chapter summarizes the main lessons from country action. Learning from Country Partner experiences will be valuable to the Partners themselves as they pursue their national agendas. Equally important, this learning will serve a growing number of countries initiating action on SDH for HE in the coming years. Below, the results of Country Partner learning are organized as responses to a series of questions that Country Partner governments, especially Ministries of Health, faced in their work with the CSDH.

The key questions are the following:

1. How can countries catalyze initial action on SDH/HE at the national level?
2. What can be done to promote an SDH/HE agenda within the health sector itself?
3. What should the health sector be doing about cross-sectoral action on socially determined health inequities?
4. How can the health sector create space to develop or improve social participation in SDH/HE?
5. What kinds of capacities and skills need development to strengthen SDH/HE action, and how can the health sector build capacity?

IV.1. How can countries catalyze action at the national level?

The first question countries confronted was basically «How can we stimulate action?» Depending on existing levels of public and political support, countries may need to start with increasing the visibility of SDH/HE issues in various ways. As Benach and Muntaner (2005) have argued, a process of learning to «see» social inequities and how they affect people's health is required to spur action on SDH for HE. As the issues gain profile among the public and decision-makers, various types of time-limited structures and alliances can be established opportunistically to push the agenda.

IV.1.1. Learning to see inequities and how they affect health

Bringing attention to the facts can be an effective first step in generating interest in SDH and health equity issues. Countries with histories of successful policy agendas on SDH have often made use of documentation on inequities to mobilize concern and stimulate action. Policymakers, the public, and even health professionals are often surprised at how strongly social determinants affect health outcomes in a population, and at the actual measured levels of inequalities in health between social groups. As such knowledge becomes more widely disseminated, pressures for action may grow. England's history of tracking health inequalities among occupational groups since the 19th century has been a factor in spurring awareness and political action, not only domestically, but ultimately in many other countries. In Chile, data showing a stark gradient in infant mortality rates among women with different levels of educational attainment helped spur national health reform with an explicit equity focus (Nolen et al., 2005). On the other hand, the mere existence of information on health inequities is not sufficient to catalyze action, as England's experience with the celebrated Black Report shows.

This is why enabling social actors and policymakers to truly «see» and act upon health inequities requires both data and a strategy for communicating the data's political relevance so as to enable action.

Numbers are crucial - but they must be selected and framed for maximum impact. It is important to present evidence in a way that demonstrates policy implications, suggesting actions that could be taken to improve the situation; if projections to estimate the level of improvement are possible, all the better. Comparisons between countries, or over time within one country, can raise alarm bells and signal a need for change. But sophisticated comparative presentations, while valuable, are not indispensable in the first instance. Country Partners found that even simple overviews of the health equity situation (baseline analyses) using DHS and other information sources found in virtually every country increased the visibility of issues and spurred some response.

Baseline health equity analyses have also proven useful in countries that did not wish to seek formal Country Partner status, but where there was a desire to work with the Commission in other ways. For this reason, the CSDH prioritized development of baseline national equity assessments in countries, with special focus on sub-Saharan Africa, South East Asia, and the Eastern Mediterranean. Baseline analyses have been undertaken for virtually every country in these regions. Countries often chose to highlight issues that touched on common social justice and health concerns or high-profile political issues, which caught the attention not only of policy makers but also of the public.

IV.1.2. Create national dialogue and debate

As the facts on SDH and HE came into clearer visibility, Country Partners created national forums for deliberation on these issues. Creating national dialogues can be an effective way to stimulate public interest and enhance political momentum. Country Partners chose a range of different mechanisms and channels to promote national debate, depending on their contexts. Some examples:

Seizing a political opportunity to open national debate. The leaders of Brazil's National Commission on Social Determinants of Health (CNDSS) focused strategically on the country's election campaign during the second semester of 2006. A series of activities were organized to promote public debate around governmental policies and programmes related to SDH. A seminar was held with representatives of political parties to discuss SDH approaches in their respective governmental programmes. Members of the CNDSS also published an open letter directed to political parties. Systematic efforts were undertaken to include questions related to SDH in debates among the candidates and in media interviews. Materials were prepared to inform and orient voters by providing analyses of government programmes related to SDH. This is a suggestive example of how SDH/HE leaders can seize an opportunity linked to the national political calendar to insert health equity forcefully into policy debates.

Using the media. Brazil's National Commission has made effective use of mass media and communication to disseminate information on SDH and health inequities. Activities include production of a series of television programmes; production of media materials; publication of a print and electronic newsletter about the CNDSS and its activities; preparation of a monthly magazine article about SDH; and creation of the «Media Observatory on SDH» in the SDH

web portal in order to collect, organize, analyze, and circulate materials and reports about SDH to researchers and the public.

Generating dialogue from and with civil society. A key aspect of national dialogue around SDH and HE concerns communication and collaboration between government, in particular the Ministry of Health, and civil society. Working with civil society and creating fora in which the voices of affected communities can be better heard are important ways to raise the visibility of health equity issues and stimulate demand for policy action. Several Country Partners have hosted national and regional meetings of civil society organizations as a means of generating support for SDH and health equity issues and enabling coordination of agendas and approaches.

Regional civil society initiatives can be especially effective in creating political momentum. The Governments of Brazil and Chile, working with the Pan American Health Organization and the Summits of the Americas Secretariat of the Organization of American States (OAS), facilitated a consultation focused on SDH with 30 civil society organizations in the Americas in April 2007. Goals included: to define strategic actions for civil society with respect to SDH, especially in relationship to governments; to create broad networks mobilized around the SDH; to expand the number of countries that have National SDH Commissions; and to identify civil society contributions to the global debate and action of the CSDH. One output of that meeting was the Letter of Brasilia, a call to action for the region's governments and international organizations to commit themselves to the processes initiated by the CSDH (see Annex C).

IV.1.3. Set up a structure to take the SDH and HE agenda forward

Assuming there is political support for addressing SDH for HE, there needs to be a structure to take the agenda forward. Each Country Partner had some form of administrative structure responsible for promoting and developing the agenda and strategy, generally falling into one of three categories: (1) setting up a high profile structure, such as a National Commission; (2) creating a more technical or administrative advisory group, such as a Reference Group; or (3) establishing a focal point with a more limited mandate, such as those found within a Ministry of Health department or a public health agency. Some examples:

- a. Brazil set up a National Commission on Social Determinants of Health, an option available due to a high level of political support for the agenda that also provided a high level of visibility to the issues and a strong advocacy platform. Interestingly, civil society organizations working with the CSDH felt that National Commissions offered valuable opportunities for social participation in policy design and implementation.
- b. Another strategy, employed by Canada, was to create a Reference Group, chaired by the Deputy Chief Public Health Officer at the Public Health Agency of Canada and comprised of experts in science and policy development in the area of social determinants of health, including CSDH Commissioners and Canadian Knowledge Network leads, federal government departments, provincial health officials, academia and non-governmental organizations. The Reference Group helped to orchestrate Canada's contribution to the work of the Commission; translate Commission findings into policy; and mobilize SDH action in Canada.

- c. Some countries, such as England and Chile, have established a focal point within the Ministry, ministerial departments or public health agencies to be responsible for promoting the SDH agenda. England established the Health Inequalities Unit within the Office of the Deputy Chief Medical Officer. In Chile, a special unit within the Ministry of Health, including both technical and policy expertise, was established to develop the Country Partner Action Plan and to guide collaborative work on social determinants within the country.

Regional structures or other international partnerships can also be drawn upon to reinforce awareness of health inequities and political commitment at country level. Countries can more rapidly build national support for an SDH/HE approach if regional governance structures support this agenda. Reciprocally, CSDH Partners have demonstrated that countries taking forward vigorous national-level action on SDH/HE issues can also influence regional processes and priorities. Spurred by CSDH Partner Countries and others, some influential regional bodies have now begun to establish dedicated structures and policy avenues for SDH work (Box 3).

Box 3: Regional action to strengthen health equity: innovation in the European Union

The UK Presidency of the European Union (EU) in 2005 focused on health equity. Networks and structures were created to enhance information sharing and align policies across Member States. In October 2005, the UK Presidency Summit, 'Tackling Health Inequalities: Governing for Health', provided an assessment of socio-economic health inequalities in EU Member States and the range of actions underway to address them. The UK Presidency also ensured ongoing support to promote the SDH/HE agenda in EU policy on a range of issues including: narrowing health equity gaps between Member States; agriculture and rural development (to narrow gaps between rural and urban areas within Member States); social policy; employment and equal opportunities; and health inequalities research. An Expert Working Group on socially determined health inequalities established during the UK Presidency will assist Member States in exchanging information and good practice, and will feed into the public health programme and European Commission policy proposals. Expected outputs include collection and analysis of national policies; evaluation and health inequalities impact assessment of policies; recommendations on good practice; input into the development of indicators for assessing health inequalities; and integration into thematic strategies or population groups.

Source: UK Department of Health (2005).

Bilateral partnerships or linkages between smaller groups of countries can also help provide momentum for national action. Brazil and Chile have pioneered innovative approaches to partnership around SDH/HE. The countries' strong bilateral relationship includes joint commitments to regional integration and increased civil society participation in health policymaking (see Box 4). A further effect of the collaboration is that Chile is now considering development of a National Commission similar to Brazil's.

Box 4. Chile and Brazil Ministries of Health unite in collaboration

When Brazilian President Luis Ignacio da Silva visited Chile in April of 2007, Chilean Minister of Health Soledad Barría signed a memorandum of understanding with her Brazilian counterpart, one of eight such memoranda signed between the two countries during the visit. The memoranda reflect Chile's and Brazil's similar views on a range of social, political and economic issues, underpinned by similar values and principles, including a shared sense of responsibility for promoting regional cooperation and integration in health and other key fields. The President of Brazil affirmed that «South American integration is not an academic word game. Without integration, we cannot discover the true potential of Latin America».



In discussions, both Ministries of Health focused on promoting and developing cooperation, taking account of their collective potential to influence other countries. Areas where plans for specific cooperative activities emerged included social participation and participative management in health, as well as building human resources, education and capacity. Other areas will be health information and communication management, health financing, regulation of health systems and the elaboration of specific policies on gender and other social determinants. The memorandum is intended to stimulate participation in international meetings and seminars as well as planning and implementation of health projects.

IV.1.4. Develop an Action Plan linked to equity goals

Once a country has begun to organize its baseline information on SDH/HE and has defined a mechanism for spearheading the agenda, an action plan will prove useful to organize and coordinate efforts towards clear objectives. Country Partners' diverse experiences suggest that such plans can adopt different forms and may have quite different levels of long-range ambition. Depending on context and needs, either a comprehensive, holistic and long-term plan for promoting SDH agendas and policies, or more modest, short-term strategies may be preferred. An important concern is to be practical and realistic with regard to what steps can be accomplished in a short time frame (for example, within one year).

The CSDH has consistently emphasized that policy action on underlying structural determinants is the most effective way to reduce health inequities, while also acknowledging the political challenges involved. The advantage of a structural approach is that it attacks health inequities at their roots. The disadvantage is that enacting far-reaching structural measures generally requires a mobilization of political commitment over a long period, supported by a sustained social consensus in favour of redistributing power, resources and opportunities towards disadvantaged communities.

In the near term, more modest interventions may be the option available to those in government, particularly in the health sector, seeking to catalyse action on health determinants. The consensus among Country Partners has been that it is preferable to initiate concrete action that can begin to raise awareness and generate some results, even modest, rather than to put action on hold until the conditions are aligned for sweeping structural change or the adoption of a comprehensive national SDH/HE framework.

The experience of Country Partners suggests that it is not necessary to wait for a comprehensive, long-term Action Plan to initiate efforts, and that there *is* an important role for supporting discrete activities within the broader goals of promoting structural approaches. Especially in countries with less experience in addressing health equity and SDH issues, fewer resources to support new work, or weaker intersectoral mechanisms for advancing SDH policy, it may be a better strategy to identify a few key pieces of work and move these forward quickly, rather than to develop a comprehensive Action Plan and integrated structure before implementing any action.

Ambitious efforts not only can take significant time to develop, but can face barriers if paths have not already been traced to prove the worth of the approach, create shared goals and establish effective mechanisms for planning and implementation. Significant pro-equity action can be undertaken within the health sector itself, even before a cross-sectoral or whole-of-government approach becomes a realistic option. Indeed, cultivating relevant experience and appropriate skills within the health sector may be a pre-condition for developing a comprehensive cross-sectoral strategy, getting buy-in from non-health sectors, and securing resources to advance and sustain intersectoral action

Accordingly, Country Partners' action plans have given attention to short-term deliverables and potential «quick wins», while also looking towards more ambitious horizons of structural change to reduce social inequities.

Box 4: Rapid action to advance health equity: the case of Norway

In only a few years, Norway's policy environment has developed into a system of comprehensive, intersectoral policy to reduce social inequalities in health. The initial stages of Norway's work were outlined in an action plan which stressed the fact that social inequalities in health is a gradient challenge, implying that (1) there is a need for population strategies (not only high-risk groups) and (2) measures should be directed towards the whole causal chain, including the social determinants or structures. Building on this, an Intervention Map was developed which tried in a simple way to map out entry points for policies. These tools, backed by the political will of a new government, were utilized to set targets, plans, and policies for income redistribution, kindergarten coverage, work and the working environment, social inclusion, and health services.

The perspective has generally been incremental and additive, based on the idea that smaller initiatives and the resulting SDH/HE gains now will build momentum for more comprehensive changes later. However, voices within and beyond the CSDH, notably from civil society, have also questioned this incremental approach. Critics have emphasized that modest, short-term interventions on intermediary determinants, originally presented as a transitional step, tend to become ends in themselves, and may function in practice as substitutes for structural action, rather than a means to achieve it.

IV.2. What can be done to promote an SDH/HE agenda within the health sector itself?

In countries that have been successful in addressing health inequities, health systems themselves have considered equity or related values such as social welfare to be an important part of their responsibility in delivering care to the population. For countries embarking on SDH/HE work, the health sector is a good place to start even if their ultimate goal is to employ a whole-of-government approach.

Understanding how the health system functions as a social determinant of health is a key step for national health leaders who want to advance policymaking and programming on SDH. Many SDH analytic frameworks have failed to acknowledge sufficiently the role of the health system itself as a health determinant. The CSDH analysis has shown that the health system should be understood as an intermediary determinant (CSDH, 2005). While a less powerful shaper of health outcomes and differentials than underlying structural forces, the health system nonetheless offers a distinctive space for pro-equity policies and interventions. Many Country Partners have incorporated this aspect into their action in collaboration with the Commission and WHO.

The primary entry point for health system action on SDH/HE is *equity in access* to health services. This encompasses the organization and delivery of personal and non-personal health services. The health system can directly address differences in exposure and vulnerability to health-damaging conditions among population groups by improving equitable access to care. In addition, the health sector has a key role in intersectoral action to improve health status (see next section). A further aspect of great importance is the role the health system plays in mediating the differential consequences of illness in people's lives. The health system is capable of ensuring that health problems do not lead to a further deterioration of people's social status. Properly framed health sector policies and programmes can facilitate sick people's social reintegration. Examples include programmes for the chronically ill to support their reinsertion in the workforce, as well as appropriate models of health financing that can prevent people from being forced into (deeper) poverty by the costs of medical care (CSDH, 2005c).

The Country Work area entitled «Getting the health sector right» focused on a number of specific actions that the health sector can take, including:

- a. Communicating available information on SDH effectively
- b. Ensuring the health system's design and management contribute to reducing socially determined health inequities, and that health sector programmes are equity-sensitive
- c. Setting health equity goals or targets for the country and developing plans to achieve them
- d. Strengthening information systems to improve «health intelligence» and routine monitoring of social health inequities

These areas of country action can be seen in relation to the recommendations for health sector policy formulated in the Commission's final report, which were informed by the learning from the Country Work (CSDH, 2008).

A. Communicate available information on SDH effectively

A robust evidence base on SDH and health inequities in the national context can accelerate policy action and serve as a key resource for programme design and implementation. In countries that have taken a systematic approach to tackling SDH and equity issues, such as England, Sweden and, in recent years, Chile, documentation of the national health equity and SDH situation has been critical to informed policymaking. However, as previously stressed, data must be «framed» strategically and communicated skilfully to achieve full impact. This is an area where the health sector can often make substantial progress. CSDH Country Partners achieved significant gains in this respect during the active phase of the Country Work.

There is a common conception that countries do not have sufficient data to perform equity analyses and demonstrate the pathways and impact of social determinants of health. However, it is important to note that data and information on equity and SDH that can be found in most countries, such as in Demographic and Health Surveys, is still underutilized. Country Partners found that the presentation of information could often be improved to facilitate understanding of the core issues at stake, particularly when data are presented to busy decision-makers.

Country Partners' experience highlights six fundamental principles for presenting health equity information. These are:

- Know the health equity situation as fully as possible;
- Address health equity issues that relate to widely shared social justice concerns;
- Show evidence that demonstrates the impact of other sectors;
- Show evidence that has policy implications;
- Provide comparisons within regions (i.e., among countries) and within countries; and
- Show trends in health equity over time.

While many of these ideas boil down to common sense, by applying them consistently, health leaders in some Partner Countries have been able to lay foundations for innovative policy action on SDH/HE. These principles are explored in more detail in Annex B.

B. Address the impact of the health system's design and management on health inequities

The work of the Commission's Health Systems Knowledge Networks stressed how health can provide a site in and from which to contest social inequity. The network stated in its final report:

Overall, the evidence demonstrates that, when appropriately designed and managed, health systems can address health equity. They do this when they specifically address the circumstances of socially disadvantaged and marginalized populations, including women, the poor and other groups excluded through stigma and discrimination. They also generate wider benefits: a sense of life security, well-being, social cohesion and confident expectation of care in times of illness; and they may be influential in building societal and political support for governments that promote health equity (Gilson et al., 2007).

Two of the Network's most significant final recommendations called for ministries of health to pay attention to the design of health systems in specific areas by supporting:

- health care financing and provision arrangements that aim at universal coverage and redistribute resources towards poorer groups with greater health needs; and
- the revitalization of the comprehensive primary health care approach as a strategy that reinforces and integrates other health equity-promoting features (Gilson et al., 2007).

The health sector's own core programmes offer entry points for assess the system's impact on health equity and taking action to reduce equity gaps. As a fundamental step to strengthen health equity, health sector leaders and programme implementers can ensure that health sector programmes are equity-sensitive and monitor equity impacts. Beginning in the health sector provides a strategy for Ministries of Health to initiate work that builds skills and confidence, demonstrates sectoral expertise, and then may progressively engage other sectors.

As part of maximizing policy-relevant learning from the CSDH, WHO formed a Knowledge Network on Priority Public Health Conditions (PPHC). Its primary aim was to advance «how-to» knowledge on improving the equity impact of major health sector programmes. The PPHC KN analysed inequities in health outcomes for 18 public health conditions (see Box 5). Its work has encompassed three broad emphases:

1. Analysis of programmes from a health equity perspective;
2. Identifying entry points for interventions and developing interventions; and
3. Developing measures to steer and implement public health programmes that are sensitive to the social determinants of health equity.

Equity in access to health services is significant not only for its impact on health outcomes, but is itself a key measure of the performance of health systems. In addition to equity in access, health systems may also tackle the following issues relevant to reducing health equity gaps: strengthening preventive care (extending beyond behavioural models to more upstream determinants); quality of care; financing; human and financial resource allocations; and implementation practices that (often unintentionally) produce inequities in access or outcomes.

Box 5. Public health conditions being addressed by the PPHC, and WHO HQ departments involved

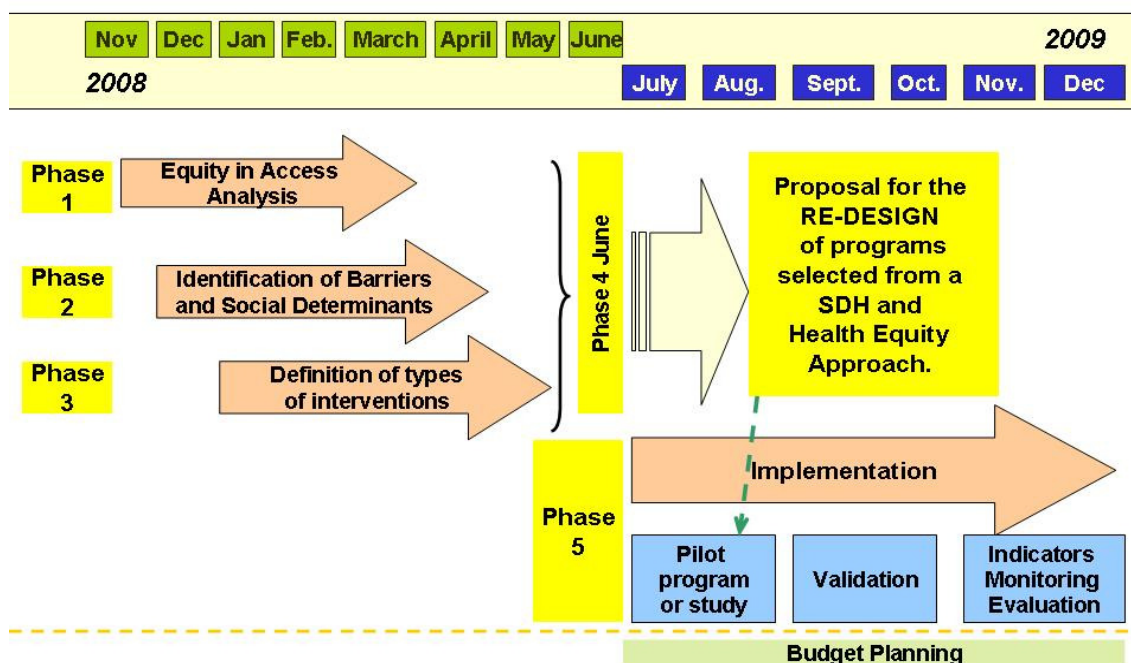
<u>HQ Department</u>	<u>Public Health Condition</u>
Control of Neglected Tropical Diseases	Cluster of neglected diseases
Child and Adolescent Health and Development	Child health
Immunization , Vaccines and Biologicals	Vaccine preventable diseases
Making Pregnancy Safer	Maternal health
Reproductive Health and Research	Reproductive health
Recovery and Transition Programme	Health in recovery
Global Malaria Programme	Malaria
HIV Department	HIV/AIDS
Stop TB	TB
Chronic Diseases and Health Promotion	Diabetes
Chronic Diseases and Health Promotion	Cardiovascular
Chronic Diseases and Health Promotion	Oral health
Tobacco Free Initiative	Tobacco related health
Mental Health and Substance Abuse	Mental health
Mental Health and Substance Abuse	Alcohol related health
Nutrition for Health and Development	Child malnutrition
Injuries and Violence Prevention	Injuries
Food Safety	Food-borne diseases

Addressing structural and architectural issues within health systems, such as universal access to care, financing mechanisms, and health workforce employment policies, can make a dramatic impact; however, changes in these areas require significant political commitment. Therefore, in the short time of the CSDH work, most of the Country Partners focused more on programme improvement and less on structural changes.

With the completion of the formal CSDH process and the opening of a new phase of work, several countries, including formal Country Partners and others, are now looking to undertake more ambitious and far-reaching national action. This new effort builds on the momentum generated through the Country Work. Drawing on its experience as a Country Partner, Chile has formulated a Plan of Action for the period 2008-2010 entitled «Social Determinants of Health: 13 Steps towards Health Equity». A key thrust of the strategy is to realign national public health programmes by incorporating SDH for HEalth equity into their goals and strategies. The analysis of key health programmes from an SDH/HE perspective will be carried out by «nodes» of experts: flexible, multi-disciplinary teams including professionals from across the health sector, as well as technical experts from other sectors and representatives of organized civil society. These «nodal» groups will analyze each selected programme through an SDH/HE lens and develop recommendations for redesigning the programme to incorporate a determinants perspective and strengthen equity. The proposed sequence of activities and timeline for the effort are illustrated in Figure 3, below. The plan includes five main phases for each major health programme addressed: (1) an analysis of equity in access to the service under consideration; (2) identification of barriers to access and social determinants related to those barriers; (3) definition of the types of interventions that

might be adopted; (4) development of a proposal for redesign of the programme, with an SDH/HE focus; and (5) implementation of the planned changes, including the selection of appropriate performance indicators and monitoring and evaluation of results (Solar, 2008).

Figure 3: Phases in the planned integration of a social determinants and health equity framework into key health programmes in Chile. Source: Solar (2008)



Phases for the Adoption of a SDH and Equity approach in Public Health Programs

Chile, other CSDH Partner Countries, and several new countries are consolidating an international partnership to accelerate action and share ongoing learning in the incorporation of an SDH/HE framework into key health programmes. In November 2008, the Chilean Ministry of Health, in collaboration with WHO, convened an international meeting in Santiago to explore: «Integrating social determinants of health and health equity into national health programmes». The meeting brought together policymakers, technical experts and civil society representatives from 10 countries. It pursued the following objectives:

1. Discuss the need for using a social determinants and health equity lens on national health programmes, based on experience from Brazil, Canada, Chile, Norway and Sri Lanka.
2. Review existing evidence regarding the need for adjusting interventions based on the Priority Public Health Conditions and others CSDH Knowledge Network research.

3. Review existing mechanisms for incorporating social participation and intersectoral work in the programme review process, based on the experience from Brazil, Canada, Cuba and Sri Lanka.
4. Identify mechanisms for transferring available evidence on how to improve programmes using the SDH and HE lens and mainstreaming with respect to key stakeholders from the public health sector and other sectors.
5. Identify monitoring and evaluation methodologies for programmes that include social determinants of health and health equity in their design and implementation.

The Santiago meeting marked the beginning of a major country-led effort to apply and extend the results of the CSDH process in national policy.

In taking forward these agendas, it is especially important that the health sector make efforts to ensure that the SDH approach permeates all levels of planning, from national to local. While some countries have been effective in decentralizing their health care systems, effectively supporting an SDH approach at multiple levels within the health care system will likely require special attention to ensuring capacity and accountability for planning and implementation.

The Brazilian National Commission, in partnership with the Secretary of Participatory Management of the Ministry of Health, is facilitating decision-making processes throughout the health sector by supporting managers and members of Municipal and State Health Councils in Brazil's 6000 municipalities in defining policies, programmes and interventions related to SDH. Activities include dissemination of information about SDH and creation of a dedicated space for managers on the SDH web portal, providing data, description and analysis of relevant experiences, as well as discussion groups.

Chile's national and regional-level systems are being given greater responsibility for mainstreaming an SDH/HE approach in planning, setting regional priorities for SDH/HE, monitoring the impact of interventions, and increasing social participation and intersectoral action on health equity. In 2006, 13 new sub-national health authorities, called Regional Health Authorities, were created and given responsibility for local public health planning. Each region developed its own health outcomes evaluations, priorities and targets, and strategic plans. Areas of focus identified include the environment, health promotion, occupational health, surveillance systems, and preventive programs (including vaccines, TB control, HIV-AIDS, tobacco, obesity, nutritional support and zoonotic disease prevention). Regions will be expected to restructure their priorities based on the experiences and findings from pilot projects, and to initiate scale-up to ensure universal coverage within regions.

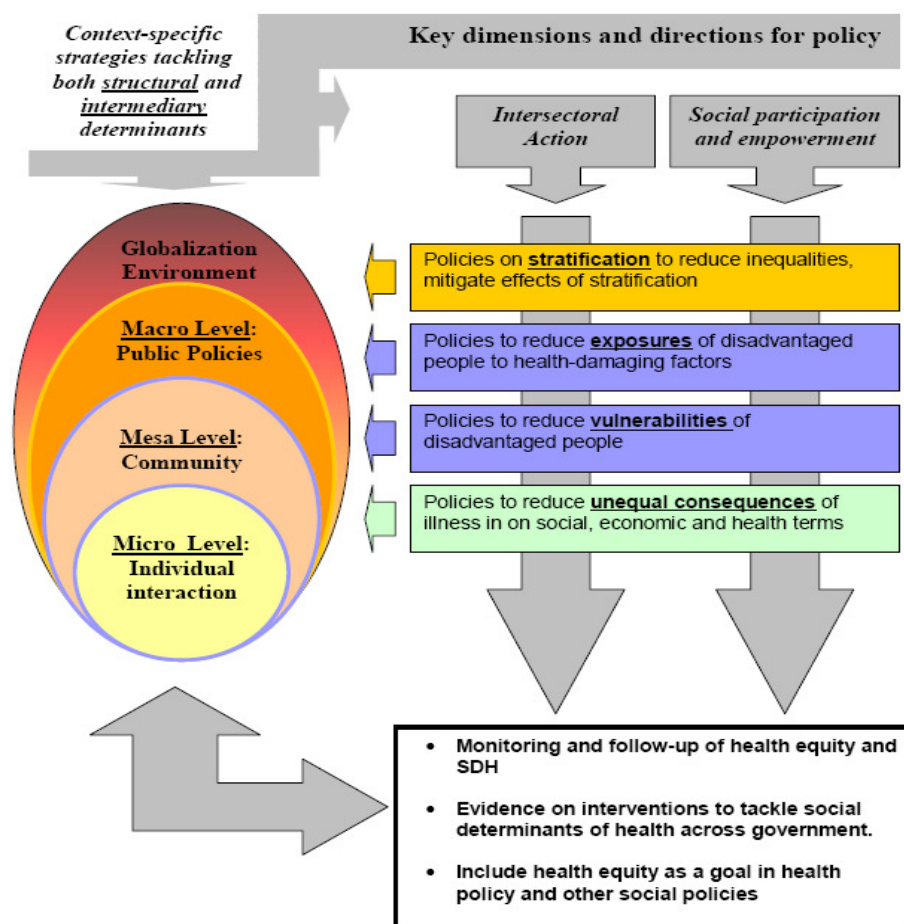
In Mozambique, equity in access has been identified as a priority health sector issue. Mozambique is working with civil society partners from the region and members of the former CSDH Health Systems Knowledge Network to advance the incorporation of equity into health systems. During Mozambique's engagement with the CSDH Country Work programme, inequities with respect to women at childbirth were analyzed and discussed. Nationally, of the 800,000 births each year, only 47% of women who need care during delivery receive skilled assistance. Representatives from the maternal health programme in Mozambique attended an international expert meeting, convened by the WHO Department of Ethics, Equity, Trade and Human Rights, to discuss barriers and facilitators to health care.

C. Set health equity goals or targets for the country and develop plans to achieve them

To help accelerate action on health equity, the health sector can develop national targets or goals for health and health equity. This process not only sets out standards, but also creates a mechanism for generating advocacy, increasing political support, engaging other sectors in relation to addressing SDH, and increasing accountability for improving health equity. Setting national goals for health and health equity can be a time-consuming process, often taking several years. Several Country Partners had already established such goals before beginning work with the Commission. They include England, Sweden, Canada and Chile, the last of which established health objectives in 2002 within the context of a health reform process.

Laying out a plan of action for achieving goals will enable an efficient and effective approach. In particular, the action should, as much as possible, address the roles and responsibilities of various sectors, develop multi-sector and cross-sector interventions, and establish regular monitoring and evaluation mechanisms to track progress. To enable long-term improvement, plans should propose various policy entry points via both structural and intermediary determinants of health, as analyzed in the Commission’s conceptual framework (Figure 4).

Figure 4: A framework for policy action to tackle social determinants to improve health equity. Developed by the CSDH secretariat (CSDH, 2005).



In some instances, countries have decided to harness existing high-profile global health and development targets as opportunities to evaluate national progress on health and health equity and highlight the contributions of different sectors. Through the Ministry of Plan Implementation, and in cooperation with WHO and UNDP, Sri Lanka is planning to develop a scorecard to determine the performance of ministries on progress to address the health-focused Millennium Development Goals (MDGs). This work will incorporate the WHO core equity indicators and will help align WHO and UNDP indicators.

D. Strengthen information systems to incorporate health equity

A key part of «getting the health sector right» in SDH/HE terms is strengthening the health information system. Country Partners have recognized the need to bolster «health intelligence», in order to incorporate routine information on equity-related aspects of population health into health and development planning. Currently, most countries' health information systems do not support a high level of disaggregation of data according to a broad range of socioeconomic stratifiers, such as income, education, and geographic location, making it difficult to comprehensively document inequalities. Further, very few health information systems are structured to link health information with social determinants information from databases of other sectors within countries. Many countries, especially in Africa, still lack reliable vital registration systems, a basic component of the health information system, and therefore rely on survey data for most of their information. These shortfalls inhibit effective documentation, priority setting, and interventions centred on upstream (structural and intermediate) determinants of health (Nolen et al., 2005).

In an effort to improve both national monitoring of health and health inequalities and regional comparability, the Sri Lanka Department of Census and Statistics has worked with the CSDH Secretariat and WHO to align the Sri Lankan vital registration forms with those of other countries in the region, using automated coding software. WHO is also providing support to improve the health section of the Consumer Finances and Socio-economic Survey, which includes data on growth, economic development, and social issues.

The Chilean health sector has placed a strong focus recently on linking sectoral systems in order to have more comprehensive information on determinants, while improving the ability to disaggregate information according to socioeconomic groups. Another ambitious initiative is the Brazilian health system's focus on

Box 6. Norway's national strategy to reduce social inequalities in health

In 2007, Norway presented a ten-year national strategy to reduce social inequalities in health as part of the Government's comprehensive policy for reduction of social inequalities, inclusion and combating poverty.

The primary objective of the health strategy is to reduce social inequalities in health by leveling up. The four priority areas of work are to

- reduce social inequalities that contribute to inequalities in health;
- reduce social inequalities in health behaviour and use of the health services
- targeted initiatives to promote social inclusion
- develop knowledge and cross-sectoral tools.

The strategy is intended to govern annual budgets; management dialogues with subordinate agencies, regional health enterprises, etc.; legislation, regulations and other guidelines; and interministerial collaboration, organizational measures and other available policy instruments.

Goals are linked to areas including income, childhood conditions, employment and working environment, health behaviour, health services and social inclusion, although time limits for achieving them have not been laid out at this point. Rather, the strategy includes development of progress assessment indicators for each objective to allow annual policy review.

identification, review and analysis of health information systems. The objective of this work is to facilitate and rationalize access to data, information and indicators related to SDH. Activities include: identifying nationwide information systems and collections of data related to SDH produced in Brazil by different sources; describing the methodology of data and information collection and processing available in each system; organizing the identified resources in order to facilitate access for the non-specialized public; analyzing the potential uses of data, information and systems from the standpoint of SDH; making relevant data and analyses available through the SDH web portal; and keeping the portal continuously updated, following up and incorporating any changes in the information systems and their data.

IV.3. What should the health sector be doing about cross-sectoral action on socially determined health inequities?

While substantive action to advance health equity can be taken within the health sector itself, the roots of health inequities lie largely outside the direct reach of the health care system. For this reason, cross-sectoral action is vital for an effective policy response to health inequities. In addition to getting its own house in order, the health sector has a responsibility to provide leadership in cross-sectoral collaboration to tackle social determinants and promote equity.

IV.3.1. Intersectoral and cross-sectoral action for health: definitions

Health leaders have long acknowledged the need to address health and health equity challenges through coordinated action across multiple spheres of government responsibility. The phrase «intersectoral action for health» (IAH) was widely adopted following the 1978 Alma-Ata declaration to describe such forms of activity. WHO's often-cited definition of IAH is as follows:

A recognised relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone (WHO, 1997; cited in PHAC, 2007: 2).

While acknowledging the usefulness of the established WHO definition, the CSDH and Country Partners have taken a broader view that has the potential to capture a wider range of country experiences. The CSDH has wished to consider situations in which government ministries or departments work together in explicit collaboration to address SDH. But researchers linked to the Commission have also sought to derive lessons from cases of «synchronistic» action by government bodies that were *not* linked by formal collaborative relationships or intersectoral structures. Sri Lanka's successful action on SDH through much the 20th century illustrates this pattern (PHAC and WHO, 2008).

While synchronistic, non-formalized modes of work have proven successful in some cases, there was general agreement among Partners that more systematic, coordinated approaches across government will accelerate health equity gains: when the political context makes such approaches feasible. Some CSDH Partner Countries have moved towards a vocabulary of «cross-sectoral action». This term may more effectively capture the emerging emphasis on inclusive forms of integrated goal-setting, planning and policymaking that span a range of

government sectors, ultimately tending towards a «whole-of-government» or «Health in All Policies» model. The term cross-sectoral action highlights the dimension of broadly coordinated state action on the determinants of health and health equity.

In practice, as Sihto, Ollila and Koivusalo (2006) point out, «intersectoral action», «multisectoral action», «cross-sectoral action» and related terms such as «Health in All Policies» are used somewhat interchangeably. While they reflect distinct nuances, these terms «share the core message of the need to integrate health considerations into other policies and sectors beyond the health sector».

IV.3.2. Historical background on intersectoral action

The concept of IAH gained prominence following the International Conference on Primary Health Care in Alma-Ata, Kazakhstan, in 1978. The primary health care model outlined in the Declaration of Alma-Ata affirmed the need to address underlying social, economic and political causes of poor health by coordinating action across sectors (PHAC, 2007: 4). In the 1980s, high-level conferences related to IAH, along with the growing international health promotion movement, further underscored the need to work between sectors to realise health gains (WHO, 1986). A formal commitment to IAH became part of many countries' official health policy frameworks during this period. However, the track record of actual results from national implementation of IAH was uneven. IAH to address social and environmental health determinants «generally proved, in practice, to be the weakest component of the strategies associated with Health for All» (WHO, 2005: 15).

In the 1990s, evidence emerged that existing health policies had failed to reduce health equity gaps. At the same time, knowledge on determinants of health was also advancing, consolidating the scientific arguments for intersectoral approaches. In this context, a renewed focus on IAH emerged, symbolized by a major international conference on IAH sponsored by WHO in 1997. In the late 90s, some countries, notably including Sweden and the United Kingdom, placed equity issues at the forefront of their national health policy agendas and undertook innovative intersectoral policies designed to reduce health equity gaps (PHAC, 2007).

In recent years, regional and global institutions and partnerships, including the CSDH, have strengthened momentum for cross-sectoral action on health equity. In 2006, the European Union (EU) introduced «Health in All Policies», a far-reaching directive with implications for intersectoral policy development, implementation and evaluation. The EU organized a milestone conference on the topic in September 2006, and momentum for the «Health in All Policies» approach has continued to build (PHAC, 2007: 4)

Today, amidst renewed recognition of the importance of working across sectors to strengthen population health and promote equity, the full promise of IAH remains to be fulfilled. While many countries have established platforms and administrative structures intended to support intersectoral action for health, especially in response to Alma Ata's vision of comprehensive primary health care, very few countries actually use those structures to effectively plan and implement change. CSDH Partner Countries have undertaken ambitious learning processes and generated important new insights in this area.

IV.3.3. Preliminary lessons from the Country Work

Country Partners' direct experiences with cross-sectoral action during the Country Work have been complemented by important new research on IAH, co-sponsored by WHO-CSDH and the Public Health Agency of Canada (PHAC). WHO and PHAC have undertaken an unprecedented multi-phase initiative to learn more about the use of intersectoral action for health and health equity as it is implemented internationally. The research initiative involved the preparation of a literature review, *Crossing Sectors – Experiences in Intersectoral Action, Public Policy and Health* (PHAC, 2007), followed by the joint commissioning of a set of IAH case studies from high, middle, and low income countries and from a mix of social and political contexts. The case studies “outline countries’ diverse experiences with the use of intersectoral action for health and health equity” (PHAC and WHO, 2008: 1). A final synthesis report was completed in February 2008. While the individual case studies and the final synthesis do not resolve all questions connected with the effective implementation of IAH or distil simple, easy-to-follow recipes for success, the cumulative learning from Country Partner experiences and these richly documented studies provide substantial new insights into how cross-sectoral action works or fails in practice. Some of the emerging lessons include:

Diversity of goals and approaches in IAH. The concept of IAH or cross-sectoral action embraces a wide range of different strategies in practice. Country Partners and countries contributing case studies defined the goals of intersectoral action in different ways. Some IAH processes aimed explicitly to reduce inequities in health among population groups. Others conceptualized their goal as improving health among a particular disadvantaged group. In other cases, the goal of cross-sectoral was not set in terms of health indicators, but defined in terms of impact on one or more key determinants of health. “How the issue was framed had an impact on the strategies implemented, the partners invited to the table, and the ways in which outcomes were defined” (PHAC and WHO, 2008: i).

Making the case for intersectoral action. Because action across sectors is challenging and often resource-intensive, a compelling case for employing a cross-sectoral approach is vital to engage participants and sustain their commitment. Countries have strengthened the case for intersectoral work through strategies including the following:

- Building on public concern for the health and well-being of a particular disadvantaged group;
- Using high-profile political champions to advocate for intersectoral action;
- Making careful use of «framing» language to present the issue in terms all sectors could relate to and «own»;
- Building on international leadership, for example momentum generated by WHO or by regional consortia and processes;
- Building on concerns about the need to use scarce resources more efficiently, making an economic case for «upstream» action on SDH;
- Acknowledging the limitations of previous approaches, especially those that involved sectors working alone;
- Taking advantage of political transitions to reassess roles and begin to work better together; and,
- Building consensus via shared gatherings, such as conferences or community meetings.

Additionally, some countries have strengthened the concrete incentives for IAH by setting up shared decision-making structures among partner agencies and through the provision of specific funding dedicated to intersectoral work (PHAC and WHO, 2008: ii).

Linking national policy initiatives with local, participatory processes. IAH initiatives undertaken by Country Partners or reported upon in the case studies ranged from small local initiatives substantially driven by community voices to ambitious whole-of-government approaches at the national level. An important lesson from the case studies is the importance of integrating high-level policy mechanisms with community processes. A high-level, cross-government approach and grassroots participatory engagement complement each other and, together, strengthen results. The authors of the concluding analytic paper comment:

Whole of government approaches that originate at the national level may be limited in their capacity to influence social determinants of health if such initiatives are not supported by comprehensive, ground-up initiatives at local levels. This local level work, that often facilitates active public participation in community planning and program development, appears vital to addressing health inequities. Ideally, such initiatives are supported by a funding mechanism and accountability structure that allow the initiative to ebb and flow as necessary, based on the changing needs of the community (PHAC and WHO, 2008: i-ii).

In the IAH case studies, substantive cooperation in planning, implementation and evaluation was facilitated when vertical integration reaching down to community level accompanied «horizontal» linkages among government departments.

Varied models and structures to organize intersectoral action. To handle the complexity of a «whole-of-government» approach, all countries that have implemented such approaches have developed formal models to guide their intersectoral work (PHAC and WHO, 2008: ii). In addition to such theoretical frameworks, countries have chosen a wide variety of concrete ways to organize their work. «A common structure was one in which inter-ministerial committees were formed. In some cases, countries built an elaborate system of committees and other structures to solidify intersectoral action». However, while putting in place new structures can «lend credibility to ... a cooperative approach to addressing health inequities», the mere creation of additional structures does not ensure good work or meaningful results. Similarly, while «bringing people from diverse sectors together to discuss issues and come up with common goals is necessary», meetings and discussions are not sufficient in themselves to foster effective intersectoral action (PHAC and WHO, 2008: ii-iii). For this reason, when Norway embarked on an ambitious whole-of-government approach to action for health equity, it explicitly chose *not* to create new administrative apparatus, but to implement the new approach through existing government structures.

The challenge of monitoring. The relative dearth of systematic evaluations of intersectoral action in the WHO-PHAC case studies «reflected a lack of standardized measurement tools and methods». Countries faced major challenges in monitoring processes and results of IAH. «At the same time, almost all of the case studies reported some positive outcomes that were thought to be attributable to intersectoral collaboration. It is premature to draw conclusions about the overall effectiveness of intersectoral action for health and health equity as many initiatives have been implemented quite recently and there has not been sufficient time for effects to accrue and be evaluated» (PHAC and WHO, 2008: iii).

Flexibility in defining the role of the health sector. Country Partners and those contributing case studies report considerable variation in the part played by the health sector in cross-sectoral action. Rather than a single, uniform approach, the evidence argues for flexibility in defining the health sector's position and role. However, some lessons are applicable across a wide range of IAH processes and context. This topic is discussed at length below.

Box 7. Conditions for success in IAH

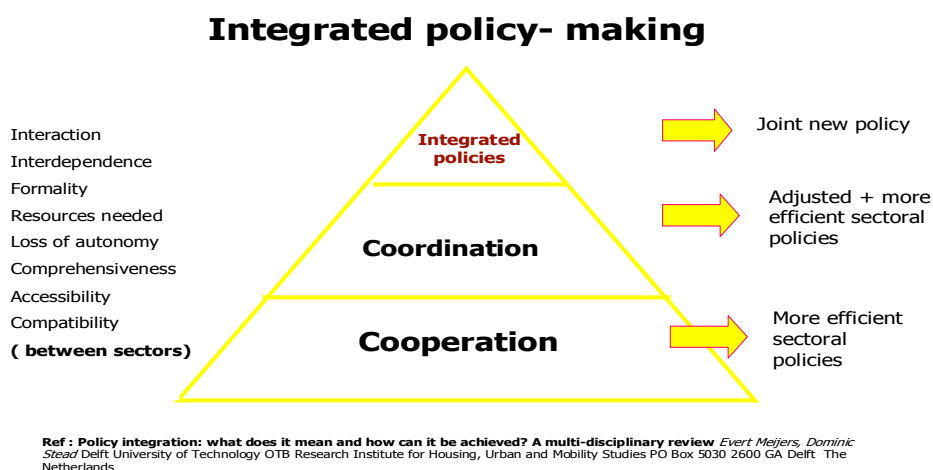
1. Create a philosophical framework and approach to health that is conducive to IA.
2. Emphasize shared values, interests, and objectives among partners and potential partners.
3. Ensure political support; build on positive factors in the policy environment.
4. Engage key partners at the very beginning: be inclusive.
5. Ensure appropriate horizontal linking across sectors, as well as vertical linking of levels within sectors.
6. Invest in the alliance-building process by working toward consensus at the planning stage.
7. Focus on concrete objectives and visible results.
8. Ensure leadership, accountability and rewards are shared among partners.
9. Build stable teams of people who work well together, with appropriate support systems.
10. Develop practical models, tools and mechanisms to support the implementation of intersectoral action.
11. Ensure public participation; educate the public and raise awareness about health determinants and intersectoral action.

Source: PHAC, 2007.

IV.3.4. Degrees of integration in intersectoral action: from cooperation to integrated policy-making

There are several levels of integration within intersectoral activities, ranging from cooperation to avoid overt programming and policy conflicts among sectors, to coordination, to integrated policy-making, aimed at increased levels of harmonization and synergies. These levels, shown below in Figure 5, require increasing technical competence, management skills, and shared values between sectors to be successful. In fact, integrated policy-making is more of an aspirational objective than one that countries have actually achieved.

Figure 5: Co-operation, co-ordination and integrated policy-making



Source: Meijers and Stead, 2004, p. 5.

This model presents a hierarchy, in which each of the steps depends on the previous steps having already been secured. Especially for Ministries of Health without significant intersectoral experience, the best strategy may be to begin with limited forms of cooperative planning and action across Ministries, rather than leaping immediately into complex agendas requiring high degrees of integration. More modest cooperation and coordination may strengthen trust between sectors; refine management and knowledge-sharing mechanisms; and provide chances to test innovations on a limited scale, building progressively towards more ambitious integrated work.

It is also important to recognize that, for certain types of policy objectives, less demanding models of cooperation and coordination are sufficient to generate the desired results. Full-scale policy integration will not be necessary in all cases where countries embark on action on SDH and HE involving multiple sectors. In considering forms of intersectoral action, policymakers will want to weigh the complete range of options and determine which is best suited for the specific objectives they have decided to prioritize.

IV.3.5. Specifying the role of the Ministry of Health in intersectoral and cross-sectoral action on SDH

A fundamental step for Country Partners and others seeking to advance cross-sectoral action is to define the role the Ministry of Health will play. Country Partner experience and the lessons derived from IAH case studies confirm that Ministries of Health are crucial in successful intersectoral action, but that how they define their roles and responsibilities varies greatly. Canada's *Crossing sectors* study provides a valuable discussion on the multifaceted role of the health sector «as leader, partner, supporter and defender» of health issues. Acknowledging variations in MoH capacities as well as possible tensions between sectors, it notes that Ministries of Health need to use a flexible approach to defining their role, taking into account their level of political influence and that of the agenda they are espousing, existing relationships with other sectors, and the timing of opportunities (PHAC, 2007).

Box 8. Norway's concept of the health sector's role in IAH

Norway describes five responsibilities of the health sector:

- Describe social inequalities in health and make the link to their determinants
- Make visible the impact of other sector policies on health
- Support intersectoral collaboration and advocate for action in other sectors
- Strengthen preventive health service
- Ensure equity of health systems

The Norwegian experience is that the extent to which the health sector itself can take the leading policy role depends on the issue at hand. *First* there are issues where the health sector both have the knowledge about effective measures *and* control those means, like preventive services and measures to make health systems more equitable. Here the health sector has a natural leading role.

Second, there are issues where the health sector have knowledge about effective measures but do not control the arena or means for implementing the measures. Examples may be health promoting schools with physical activity, healthy school meals and, mental health programmes, smoking prevention programmes etc. In the development of policy in this field the health sector may take a lead role in promoting solutions but have to ensure close cooperation and ownership of the problem and solutions by the other sector.

Third, there are the determinants of health where the health sector have knowledge about the adverse health impacts of other sector policies, but where the health sector itself neither control the means for implementation nor has exact knowledge about how measures should be framed. Examples are inclusion to the labour market, reducing social inequalities in learning in schools etc. In the process of developing policies within these very up-stream policy areas the health sector may only play the role of a policy partner that on equal terms may inform the policy process with the health inequalities perspectives.

--From Norway's Intersectoral Action Case Study

While flexibility is key and standardized models unlikely to be successful, Country Partner experiences do suggest a number of recommendations that can guide MoH engagement in intersectoral action across a range of contexts:

A. Reinforce communication with other sectors.

Because intersectoral action for health can be a complex process and especially difficult if previous lines of communication have not been established, brokering communication with priority ministries is a useful way to initiate intersectoral processes. As part of the Country Work strategy, initial conversations with Partners on potential Action Plans almost always involved introductory discussions with non-health ministries, sometimes with as many as a dozen or more. Often, these conversations led to identification of shared concerns and potential areas for joint action. Sri Lanka, for instance, is brokering communication with the Ministry of Labour (MoL) to identify priorities and joint strategies for addressing occupational hygiene and work safety. Although the Ministry of Labour is, in theory, in charge of planning and monitoring activities related to the issue, and is responsible jointly with the MoH for conducting surveys of occupational diseases and injuries, it does not have the human resources to carry this out. A lack of formal mechanisms to coordinate with other sectors such as the MoH, environment and food administration also impedes progress. Consequently, the MoH and MoL have worked to develop a case study on employment conditions and workers' health (through the CSDH EMCONET Knowledge Network), which

is expected to bring attention to the issues and challenges and to jumpstart work to improve the situation.

B. Develop a «common language» that can be used to support a shared agenda.

Once dialogue with other sectors has been initiated, and substantive discussions are underway, it can be helpful for sectors to adopt a shared vocabulary through which to articulate the emerging common agenda. In the first instance, health authorities often tend to conceptualize the IAH process as «getting others to buy into the health agenda», rather than seeking priorities and responsibilities of mutual interest. The health sector will generally find greater responsiveness and cooperation if it is able to use a discourse familiar to various sectors and in alignment with their goals. A shared agenda is most useful when it is not sector-specific but relates to higher social values that can encompass the specific mandates of different sectors, such as social welfare, human development, etc. Admittedly, creating a shared agenda may still require sectors to «buy into» each others' agendas at times in order to support specific initiatives. But if adequate management mechanisms are established, and if the shared agenda is well thought through, such trade-offs should not pose a problem for sustainability or inordinately threaten the interests of any particular sector.

Box 9. Chile's commitment to a comprehensive social welfare system

'The coming years will be decisive. This will be about consolidating a society that not only acknowledges freedoms, but also defends and promotes them. The State must not only outline rights; it must guarantee them to all its citizens.'

We intend to achieve a decent social welfare system that will accompany people throughout their cycle of life, protecting them in their first steps, ensuring them access to educational and work opportunities, covering them in case of illness or disability, and guaranteeing an adequate retirement.

The construction of this system - with employment, educational, healthcare, housing and pension components - is a priority objective for my administration. This will be possible thanks to progress made in this country over the years.'

--Chilean President Michelle Bachelet, 2006

Chile is encouraging adoption of the language of «quality of life» and «human development» while promoting use of health indicators as indicators of social welfare. The Chilean government has identified the major challenge to operationalising and institutionalizing an SDH/HE approach across sectors as *how to trigger a process where actors both inside and outside the health sector get involved in the SDH approach in order to improve health status*. Their strategy to address this challenge is to integrate SDH into more comprehensive goals, such as social protection or quality of life, in order to link the work to strategic goals and products of a range of other Ministries and agencies. Specifically,

Health leaders should also abandon health-centred language but develop one with a more universal appeal, which may encourage actors outside the health community to engage in a SDH approach. [SDH arguments need to be rephrased] in terms of quality of life and human development, where the health sector plays a role that can be seen as equivalent with other social sector priorities (Government of Chile, 2006a).

At the same time, the Chilean MoH is lobbying the Social Cabinet that there should be a fundamental shift to adopt health indicators as the primary impact measure for success of the social protection system. This two-way approach is effectively working to strengthen the links between health and social welfare both conceptually and technically, creating a more holistic and integrated approach to health not only within discourse but also in policymaking and planning.

C. Demonstrate why and how health concerns can be incorporated into non-health sector public policies.

Evaluating the health and health equity impact of non-health sector public policies is an extension of the health sector's own responsibility to ensure that health policies are pro-equity. Health equity impacts (both short- and longer-term) of all government policies need to be evaluated and given important consideration when weighing policy decisions in all sectors. Specific challenges to this vision include moving from concepts of stewardship based on cost-effectiveness to those based on equity; from quantitative evaluation to evaluation incorporating qualitative elements; from decontextualized models to those incorporating contextual and historical analysis; and from a sense of responsibility for health as limited to the health care sector to one in which other sectors acknowledge the health and health equity impacts of their specific sectoral activities - and implement policies accordingly.

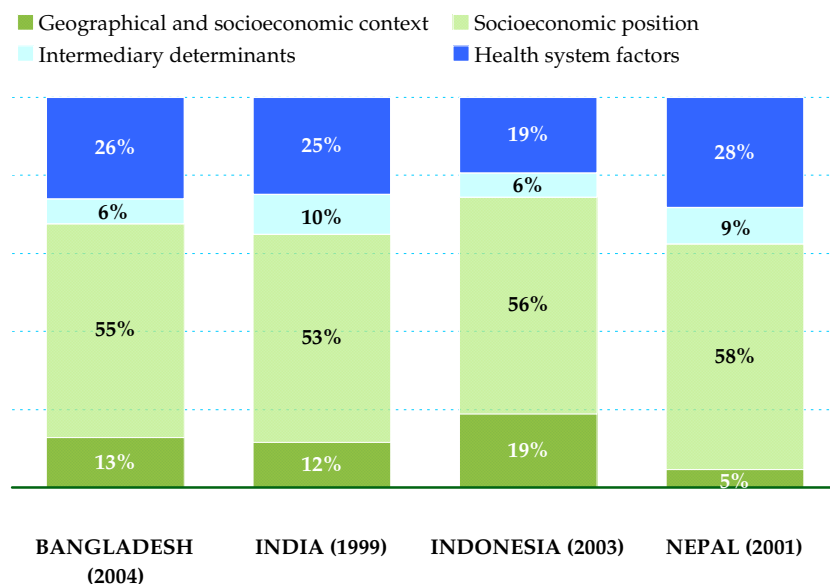
Although development of evaluation frameworks for such analyses is still in its early stages, some countries have begun assessing existing policies and/or conducting evaluations of prospective policies as a precondition for their approval. Moving towards a more pro-active approach, evaluations of prospective policies offer the chance for integrated policymaking during the development phase and improve the chances of non-health sector policies' actually contributing positively to health equity goals.

Current tools for evaluating existing policies include Health Impact Assessments (HIAs) as well as Health Equity Impact Assessments (EFHIA). These tools provide a practical framework for identifying (positive and negative) health impacts of social, economic and environmental policies, programmes and projects and ways of addressing them. In the case of EFHIA, the approach allows policymakers to focus specifically on the differing needs of population groups. HIAs are intended to go beyond the traditional aims of environmental impact assessments, which have often served primarily as a monitoring and evaluation tool, to encompass a stronger prescriptive dimension, pointing to changes in policy proposals that would produce more favourable health outcomes (Scott-Samuel et al., 2001; Mahoney et al., 2004).

Results such as those in Figure 6 below suggest other ways Ministries of Health can use data to show how policies in other sectors are affecting health and health equity, and so to make a strong case for intersectoral collaboration. The graph reflects a decomposition analysis conducted by the WHO Department of Ethics, Equity, Trade and Human Rights on the factors influencing inequities in skilled birth attendance in selected countries. The results reveal that health system factors account for only a small portion of such inequities (28% or less in all four countries). Determinants that fall under other policy sectors, notably women's socioeconomic position, account for much larger portions of the observed inequities in this key maternal health indicator. Drawing on data such as these, health sector leaders can

develop powerful arguments for mandating the incorporation of health and health equity components into policy deliberations in non-health sectors.

Figure 6: The contribution of different types of determinants to inequities in access to skilled birth attendance, 4 countries.



Source: WHO Department of Ethics, Equity, Trade and Human Rights

Even when a whole-of-government approach is untenable for political or other reasons, creating small teams of non-health sector allies to address specific SDH can be an effective step in building capacity for IAH, addressing priority issues, and building a process that can be expanded later. The MoH can prepare the way for such alliances by assessing the relative health and health equity impacts of specific SDH, then reaching out to ministries whose remits include determinants with especially powerful effects on vulnerable populations. As mentioned previously, decomposition analysis in Mozambique shows that the source of drinking water accounts for 19% of poor growth in children. Consequently, the MoH has identified water availability as a major priority for intersectoral action, and plans to develop interventions with the Ministry of Public Works related to water and sanitation to reduce infant mortality by increasing coverage and access to those most in need.

Box 10. Good practices: Chile's governmental management environment

Chile's Ministry of Finance has set up a System of Management Control and Results-Based Budgeting (SMC), which is aimed at making public resource allocation to programmes, projects and agencies more efficient and results-oriented. SMC consists of several tools, including two that could incorporate SDH indicators: Government Programme Evaluation (GPE) and the Management Improvement Program (MIP).

The *Programme Evaluation* tool is comprised of three types of evaluation: GPE, Impact Evaluation, and Comprehensive Spending Reviews. Governmental Programme Evaluation and Impact Evaluation may be particularly useful to engage the whole public sector on a SDH policy approach, by including dimensions such as programme consistency with or impact on population health. In all three types, there is an Inter-Ministry Committee in charge of providing policy orientations and coordination, and commitment to the evaluation process. The National Budget Office, dependent of the Ministry of Finance, is responsible for carrying on the process, for integrating the evaluation results into the budget cycle, and for establishing Institutional Commitments for the improvement of the programmes so evaluated. Members of Congress can propose programmes to be evaluated, and can use this to discuss programmatic and budgetary decisions with the Executive.

Management Improvement Program: The MIP links the level of attainment in certain indicators to a performance bonus for government employees. Compliance with the management objectives in an annual MIP gives employees the right to a salary increase, provided the agency has met annual objectives. The MIP includes goals related to improve human resources management, intersectoral planning, customer services, financial management and gender equity. These goals are set according to each Agency's or Ministry's Mission, strategic goals and strategic products. If pertinent, SDH objectives and indicators could be included in the MIP Framework.

Source: Government of Chile (2006a).

In Chile, the MoH has developed intersectoral partnerships with the Ministries of Labour and Planning on two regional initiatives in the area of workers' health. The first initiative, launched through regional consultations, defined criteria for evaluating equity in workers' health systems; these criteria will be applied in a series of case studies of occupational health systems across Latin America, including a study in Chile itself. The second initiative concerns advancing a regional plan to eliminate silicosis by 2030, identifying strategies, priorities and mechanisms. The Chilean government and the United States National Institute of Occupational Safety and Health are in the final stages of signing a letter of agreement for cooperation in support of Chile's national efforts. Under the agreement, Chile will in turn extend technical and scientific support to other countries of the Americas for formulation and implementation of their own plans (Government of Chile, 2006b).

D. Support development of management agreements, financing mechanisms and incentive structures to encourage cooperation

A number of mechanisms can effectively support intersectoral action, but are too rarely used. These tools include management agreements, financing mechanisms and incentive structures designed to facilitate cooperation among sectors. Canada's intersectoral action case study initiative explored existing mechanisms in countries and possible new tools. Chile has recently had success in reconfiguring the public sector management environment through a series of innovations, including new programme evaluation and management improvement procedures. This change signals promising opportunities to enable intersectoral working through more rational, transparent management structures (Box 10).

E. Enlist the support of administrative structures and ministries with broader mandates.

Support from the highest levels of government, as well as from state institutions with a broad «horizontal» reach, can be useful in promoting an SDH and HE agenda across sectors and ensuring cross-sector accountability for health. The examples below highlight the need for flexibility in tailoring strategies, structures and mechanisms to take advantage of national opportunities.

1. Executive structures

Broad executive branch structures, such as Cabinets, National Commissions, and other structures established under the President's Office, are useful to ensure commitment by sectors because they set the agenda for government. More specifically, the Executive oversees sectoral management and has the authority to create intersectoral structures and responsibilities, allocate resources, and demand accountability for performance by sectors. This authority can be used to align goals and strategies, delineate areas of work, and foster integrated policy approaches. Without Executive support, the Ministry of Health may face an uphill struggle in persuading other sectors to prioritize health issues, due in part to MoH's limited ability to influence resource flows.

Brazil's National Commission (CNDSS) is a joint partnership of the Ministry of Health and FIOCRUZ, and is based in the President's Cabinet. In connection with the CNDSS, an Intersectoral Working Group (IWG) was established by Presidential Decree in 2006. The IWG is a formal structure to ensure shared responsibility and accountability among sectors for improving social determinants of health. The CNDSS acts as secretariat of the IWG, providing technical and operational support to the group's activities. The IWG includes representatives of several levels of public administration, ministers related to SDH, and representatives of the National Councils of State and Municipal Health Secretaries (CONASS and CONASEMS). The IWG promotes information exchange and coordination of actions among its member institutions. The group works as an instrument for the implementation of CNDSS policy and programme recommendations.

The CNDSS has also used other mechanisms to inform decision-making processes in health, for example through its partnership with the Secretary of Participative Management of the Ministry of Health. The National Commission and Secretary of Participative Management

collaborate to support Municipal and State Health Councils in defining policies, programmes and interventions related to SDH. The CNDSS and IWG have produced recommendations for rapid action on SDH/HE and formulated strategies to sustain action beyond the life of the National Commission.

2. Legislative structures

Legislative structures that take up the SDH/HE agenda can have important convening and oversight powers, potentially lending support to the MoH, especially in relation to: advocacy and priority- setting for SDH; budgeting issues (including intersectoral budgeting mechanisms); and accountability. Interestingly, regional parliamentary structures are beginning to take up SDH and HE issues. African Parliamentary Portfolio Committees on Health have joined together, and with the support of Ministries of Health and civil society they are building an agenda for coordinated action at national as well as regional levels (Box 11).

In 2006, at the urging of Commissioner Monique Bégin and the Canadian Public Health Association, the Canadian Standing Senate Committee on Social Affairs, Science and Technology prioritized the topic of SDH. The Committee was authorized to:

- examine and report on the impact of the multiple factors and conditions that contribute to the health of Canada's population - known collectively as the social determinants of health
- examine government policies, programmes and practices that regulate or influence the impact of SDH on health outcomes across the different segments of the Canadian population, with the understanding that the Committee would investigate ways in which governments could better coordinate their activities in order to improve these health outcomes; and
- study international examples of population health initiatives undertaken either by individual countries, or by multilateral international bodies such as (but not limited to) the World Health Organization

The Committee began its work in early 2007 and is now (December 2008) poised to submit its final report to the Senate.

Box 11. Parliamentary committees and health action in Eastern and Southern Africa: results of a CSDH case study

Parliament and parliamentarians in East and Southern Africa are taking new approaches to coordinate activities on health policy and implementation. Parliamentary Committees on Health can be particularly effective in networking at both the national and regional level, which can help remove obstacles and facilitate continuous pressure on authorities for sustainable health policies. In particular, networking at a regional level is one of the checks and balances on governance and health. However, parliamentary networking cannot succeed in isolation: parliamentarians need to collaborate with civil society and health professionals for technical and other inputs.

Lessons of these efforts to date include: (1) to be effective and overcome a fragmented, ad hoc character, regional parliamentary networks need to have a permanent secretariat; (2) a particular emphasis in regional networks must be placed on influencing and creating clearly-defined budget processes for health; and (3) networks for parliamentary committees and civil society organisations should work towards the development of resources allocation formulae that could be agreed to, with the Ministry of Health, and used consistently to address equity in health.

--From CSDH Health Systems Knowledge Network final report, summarizing the case study by Chebundo (2007).

3. Partnering with Ministries that have a cross-sector responsibility and authority

Partnering on specific initiatives with Ministries that have cross-sector responsibility and authority can be effective in both drawing additional sectors into SDH/HE work and utilizing existing and tested mechanisms for generating cooperation. Ministries of Planning and Development, for instance, often have significant intersectoral experience simply due to the nature of their work. Conscious of this, Sri Lanka took early steps to engage the Ministry of Finance and Planning in the Working Group created in 2006 to map strategies for sustainable national action on SDH and HE. Chile's strategy for strengthening IAH has also included regular discussions with the Ministry of Planning (MIDEPLAN), aimed at identifying opportunities for collaboration at national, regional and local levels. The Sub-Secretariat for Public Health within the MoH is now developing concrete proposals for harnessing Ministry of Planning expertise in implementing pro-equity policies and measuring results. These proposals for joint action with MIDEPLAN will be presented by the Minister of Health for consideration in the Social Cabinet.

IV.4. How can the health sector create space to develop and improve social participation in SDH/HE ?

All CSDH Partner Countries have embraced social participation as a fundamental aspect of action for health equity. Despite broad theoretical agreement, however, in practice, participation has posed challenges for country action on SDH/HE, as for other areas of health action and public policy. Surfacing and analyzing the challenges associated with social participation within the CSDH process has enabled important learning that constitutes a valuable contribution of the Country Work.

The CSDH created space for social participation within its own processes through a civil society workstream supported by Civil Society Facilitators from four global regions, who coordinated inputs and action among scores of regional, national and local organizations. In their report to the Commission, the Civil Society Facilitators identified factors that explain some of the challenges associated with social participation:

- Different stakeholders define «participation» in different ways and set different standards for what constitutes an acceptable level of social participation in decision-making processes.
- Authentic participation involves a change in power relationships in favour of groups that have previously experienced marginalization and exclusion. Such changes in the distribution of power are rarely easy.
- From the standpoint of civil society, it is vital that «participation» not become «co-optation». Civil society and community groups participating in policy processes retain their independence and must be able to assess these processes critically, even as they work within them. This stance of simultaneous engagement and independence can be difficult for governments and other partners to accept. However, it is a necessary condition for civil society groups to bring their distinctive «value-added» to policy processes (CSDH, 2007a).

- Civil society itself is internally complex and diverse. While international organizations and governments sometimes look to a few selected representatives to «speak for» civil society as a whole, such expectations do scant justice to the complexity of the social fields to which the term «civil society» points. «In reality, civil society is extremely heterogeneous and represents the different and often antagonistic currents in society. But within this heterogeneity also lies its potential to build unities that have the potential to challenge established ethical and ideological norms and practices. Thus, civil society is an arena where, through social interaction and struggles, excluded, marginalized, exploited and dominated social groups and individuals, are empowered to participate in decision making processes ...» (CSDH, 2007a: 11-12).

These factors complicate the dynamics of social participation within global processes such as the CSDH and in national policy debates. Stakeholders should not expect social participation to «come easy» in any of these settings. But participation remains a critical factor for successful outcomes. In particular in SDH/HE, where success ultimately depends not on the delivery of a technological intervention but on complex social processes sustained over time, participation and ownership of policy agendas by communities is vital.

Ministries of health and other government authorities cannot «create» social participation in SDH/HE. But they can establish enabling spaces in which such participation can flourish. In the course of the Country Work, many countries have taken steps in this direction, and valuable lessons have been learnt.

IV.4.1. Historical context: social participation and the revitalization of the Primary Health Care agenda

The CSDH Civil Society Facilitators have argued that the question of social participation in national SDH/HE processes must be situated within a historical framework. The history of modern public health action has been marked by a persistent tension between (1) approaches that tend to rely on technological solutions delivered by experts and (2) approaches that foreground the need to act on the social roots of disease and that place a strong emphasis on community participation in health action. The high point of this more socially grounded, participatory approach came with the 1978 Alma-Ata Declaration and the Primary Health Care movement that emerged from Alma-Ata (CSDH, 2007a).

The CSDH Civil Society Facilitators argue that current efforts to develop an agenda for effective country-level health action need not «reinvent the wheel», but should instead focus on (1) understanding why the promise of the original Primary Health Care movement remained unfulfilled and (2) recovering for the contemporary context the core elements of the Alma-Ata agenda, including: health equity as the overarching goal; health as a human right, not a commodity; action on the social and economic determinants of health; and the participation of people, especially marginalized and vulnerable communities, in health policymaking and action (CSDH, 2007a). The current high-profile effort to revitalize Primary Health Care may provide an opportunity for progress, if these key aspects of the Alma-Ata agenda are maintained in global norm-setting and country action. The momentum emerging from the CSDH Country Work may contribute to this goal.

IV.4.2. From social participation to empowerment

At national level, governmental support for social participation can include a range of activities that translate into qualitatively different forms of engagement. These include:

- **Informing:** To provide people with balanced and objective information to assist them in understanding problems, alternatives, opportunities and solutions
- **Consulting:** To obtain feedback from affected communities on analysis, alternatives and decisions
- **Involving:** To work directly with communities throughout the process to ensure that public concerns and aspirations are consistently understood and considered
- **Collaborating:** To partner with affected communities in each aspect of the decision including the development of alternatives and the identification of the preferred solution
- **Empowering:** To ensure that communities have «the last word» - ultimate control over the key decisions that affect their wellbeing (CSDH, 2005c).

The CSDH Civil Society Facilitators observe: «People's health can be ensured in the long term only if people have control over their lives. While there needs to be little or no debate to establish that empowerment is a desired goal, there is room for debate on what we mean by empowerment and what are the processes that lead to this desired objective» (CSDH, 2007a). To have meaning for policy, discussions of «empowerment» require a clear definition of terms. A framework originally developed by Longwe (1991) provides a useful way of distinguishing among different levels of empowerment, while also suggesting the step-wise, progressive nature of empowerment processes. The framework describes the following levels:

1. The welfare level: where basic needs are satisfied. This does not necessarily require structural causes to be addressed and tends to assume that those involved are passive recipients.
2. The access level: where equal access to education, land and credit is assured.
3. The conscientisation and awareness-raising level: where structural and institutional discrimination is addressed.
4. The participation and mobilization level: where the equal taking of decisions is enabled.
5. The control level: where individuals can make decisions and are recognized and rewarded.

It is important to be aware of certain specific ambiguities and debates surrounding recent uses of the term «empowerment». The term was originally strongly associated with grassroots movements and progressive politics. However, as Luttrell and Quiroz (2007) and others have argued, during the 1990s, the association between empowerment and progressive political agendas tended to break down. In the context of neoliberal economic and social policies, with their emphasis on a reduced role for the state, «notions of participation and empowerment, previously reserved to social movements and NGOs, were reformulated and became a central part of the mainstream discourse» (Luttrell and Quiroz, 2007, 2). A substantially depoliticized model of empowerment emerged. During this same period, the vocabulary of empowerment

was being adopted by mainstream international development agencies, including the World Bank. Today, some critics argue that the widespread, often vague use of the word «empowerment» allows some development organisations and governments «to say they are tackling injustice without having to back any political or structural change, or the redistribution of resources» (Luttrell and Quiroz, 2007, citing Fiedrich et al., 2003). Such critiques underscore the need for clarity on what we mean by «empowerment», and in particular for insistence on the aspects of communities' effective control over processes and decisions that affect their health and quality of life.

IV.4.3. Strategies to create space for social participation

All CSDH Country Partners found ways to involve civil society in their Action Plans, and a number also demonstrated strategies for improving social participation in general. This section highlights some of the approaches used and issues addressed in Partner Countries and other countries where CSDH Civil Society Facilitators have been engaged.

Acknowledging and enabling civil society leadership: A basic principle in successful participatory processes is that agency and leadership come from affected communities themselves. The CSDH process as a whole fostered the creation and expansion of multiple platforms for participation, in which national civil society groups and the Commission's Civil Society Facilitators took leadership. Civil society partners developed collaborative links with national policymakers from health and other sectors; regional bodies, such as the Organization of American States (OAS); and international agencies, including WHO.

Participatory action on specific issues: Governments and civil society groups in Partner Countries used the opportunity of the CSDH to advance collaborative work on specific health equity issues affecting vulnerable communities of special concern in their jurisdictions. Some examples:

- **Indigenous health:** As part of its Action Plan, Canada convened a roundtable of Aboriginal stakeholders to explore determinants of Aboriginal peoples' health and define strategies for action. Canada's work connected to a wider process within the CSDH of surfacing knowledge on the determinants of health inequities affecting indigenous peoples, and developing strategies to respond. An international symposium on the determinants of indigenous people's health was convened under the auspices of the CSDH in Adelaide, Australia, in April 2007. It brought together government, representatives of indigenous communities, and researchers. Results and recommendations from the symposium and from Canada's national consultations have fed into Canadian national policy processes and also into the evidence and recommendations of the CSDH. This is an example of how affected communities' voice in deliberations and decision-making about SDH policy was strengthened through the Country Work.
- **Refugee populations:** The CSDH Civil Society Facilitators for the Eastern Mediterranean Region, working closely with the Regional Office of WHO, developed a case study on the health challenges facing Sudanese refugees living in Egypt. The study detailed the specific determinants of health inequities suffered by this population and explored options for response. The study used a focus-group discussion methodology to elicit insights into health issues and underlying social and

political determinants from members of the Sudanese refugee community themselves. The focus group discussions brought out stark details of the refugees' housing, sanitation, nutrition and employment conditions, as well as the forms of social discrimination they confront. The study provides a picture of health status and determinants within the refugee community that can be used to strengthen advocacy within Egypt and regionally, notably to promote the full application of existing bilateral agreements between Egypt and Sudan on the treatment of their respective nationals.

- **Rights-based approaches to improve health care in excluded communities:** An important example of new strategies to improve health for vulnerable and excluded populations, especially the rural poor, has emerged in India. Spearheaded by the People's Health Movement, India (Jan Swasthya Abhiyan), in collaboration with the Indian National Human Rights Commission, the Right to Health Care Campaign seeks to define a new relationship between NGOs, communities, and public sector health authorities, based on a systematic effort to document the state of health care in disadvantaged areas and support collaboration among stakeholders to fulfil the right to health. CSDH Civil Society Facilitators have been involved in this process and documented it as a case study of participatory action for the CSDH. For civil society, the objective of the campaign is «not to find faults and point out the inefficiency of the public health care delivery system, but to work in close partnership with State Governments, State Human Rights Commissions, the National Human Rights Commission, Health Departments» and other branches of state and national government (CSDH, 2007a). The campaign aims to cement collaborative relationships among these partners that can accelerate constructive, evidence-based action to fulfil the right to health in communities that have suffered exclusion. Key facets of the campaign include:
 - Participatory surveys of public health facilities from village to district levels
 - Collection of cases of denial of health care, systematised on the basis of a detailed protocol that identifies different forms of denial
 - Public hearings at sub-district, district, state, regional and national levels
 - Follow-up with joint monitoring of recommendations and actions taken

The success of the campaign within India has led to a decision by the global People's Health Movement to launch a similar effort at global scale (CSDH, 2007a).

Strengthening national action through regional processes: In several instances, national action to expand social participation was reinforced through regional processes engaging multiple stakeholders. WHO Regional Offices played an important facilitating role. In the Eastern Mediterranean Region (EMRO), CSDH regional Civil Society Facilitators and country-based groups developed a strong working relationship with the WHO Regional Office, which sponsored a series of national SDH case studies in countries throughout the region and supported civil society efforts to identify platforms and strategies for increased participation in national processes. In EMRO countries, the Community-Based Initiatives approach (CBI) has long been a focus of regional health action and a fundamental expression of Primary Health Care, in which community voice and participation are central. The WHO

Regional Office used the opportunity of the CSDH to engage civil society groups and national authorities in further exploration of how the CBI method can be applied in different settings to empower communities and strengthen health outcomes (Assai, Siddiqi and Watts, 2006). Civil society leadership in the EMRO region drew attention to complex SDH/HE issues that require a participatory approach for effective solution: these include violence and conflict as major regional health determinants; health among refugee populations; and extreme forms of gender discrimination that result in female gender mutilation. Under CSDH auspices, civil society developed detailed documentation and case studies on these issues, with recommendations for action by national governments, regional bodies, and other stakeholders (CSDH, 2007a).

In the region of the Americas, Country Partners and civil society groups also used cross-national and regional platforms to share experiences and strategies on social participation and to lend additional momentum to national processes. Brazil and Chile included a commitment to strengthened social participation in health action as part of their bilateral accord on joint action for health equity. Regional civil society meetings furthered the dialogue, as did forums convening civil society, national policymakers, and regional governance institutions. One key example came in April, 2007, when civil society representatives from across the region assembled in Brasilia for a consultation on SDH and HE convened by the Governments of Brazil and Chile, civil society organizations, the Organization of American States (OAS), the Pan-American Health Organization (PAHO), and WHO. The consultation generated a shared agenda of action to reduce health inequities across the region, set forth in the «Letter of Brasilia» (see Annex C).

IV.4.4. Institutionalizing social participation: the example of Brazil

An important part of developing social participation in action for health equity involves securing stable mechanisms and platforms for such participation within governance institutions. Creating such an institutional basis can change patterns in which participation is seen as an optional addition to governance processes and establish participation as central to the way effective government works.

Before and during their work with the CSDH, partner countries have explored different ways of anchoring social participation in health action within national and sub-national institutions. One of the most ambitious and promising models comes from Brazil, which has a longstanding national commitment to social participation in national policy processes. The effort to ensure civil society engagement in the production and use of knowledge about SDH is consistent with Brazil's wider efforts to support and institutionalize social participation in health.

As one part of its work to strengthen social participation around SDH, Brazil is supporting managers and members of municipal and state health councils in the country's 6,000 municipalities in defining policies, programmes, and interventions related to SDH. Fifty percent of health councils' membership is drawn from civil society, with the remaining 50% made up health professionals and government representatives. The health councils mobilize approximately 100,000 people every month, and the national health council, which meets every 2 years, mobilizes 2 million. The council system provides an institutional mechanism for ensuring that the voices of affected communities are heard in deliberations on policies to address health challenges. By harnessing this system to support institutionalization of social participation in the SDH agenda, Brazil is establishing a vital space for sustainable social

participation in policymaking and implementation on SDH/HE that can help ensure that policy responses match communities' real needs, while strengthening the agency and autonomy of vulnerable social groups.

IV.4.5. Challenges and opportunities in expanding space for social participation on SDH/HE

Examples such as Brazil's municipal and national health councils may not be immediately replicable in all settings, but they show what can be achieved. They encourage other countries taking action on SDH to recognize the importance of participatory processes and to seek solutions appropriate for their national contexts to anchor participation institutionally.

The challenges inherent in advancing an agenda of social participation in SDH should not be underestimated. As the Commission's Civil Society Facilitators have repeatedly stressed, participation inevitably involves tensions because, when conducted seriously, it implies a shift in power relationships in favour of population groups have historically experienced exclusion and marginalization.

On the other hand, the focus on SDH and HE offers a promising opportunity to advance participation and the empowerment of socially disadvantaged groups using new, pragmatic arguments. Reducing health equity gaps requires action on social factors, and CSDH evidence has confirmed countries' experience that policy action on the determinants of health inequities in turn demands the active engagement of affected communities to maximize success. Social participation and community voice in decision-making on health are necessary means to achieve the objective of reducing health inequities. But they are also already part of the end goal itself: greater well-being, dignity and quality of life for all members of society. By making this relationship clearer, the CSDH process has given new focus and impetus to global and national agendas to improve social participation in health action.

IV.5 What kinds of capacities and skills need development to strengthen SDH/HE action, and how can the health sector build capacity?

Institutionalizing, implementing, and managing a «health in all policies» or cross-government SDH and HE approach while «getting the health sector right» requires skills that are rarely taught in public health, management, and policy institutions. Consequently, workforces in many countries lack training in areas that are important for addressing SDH/HE, such as: understanding the social pathways of disease; technical and data analysis; translation of knowledge to action and policy; joint (intersectoral) planning, management processes, and policy making; and monitoring/evaluation related to health sector action on SDH/HE and to intersectoral interventions. Few countries have experience in developing economic and political arguments for tackling SDH; in supporting consensus and common agendas among sectors; and in managing interests and processes across sectors. While basic skills can be taught relatively quickly, countries need mechanisms to institutionalize ongoing learning and foster the development of new skills relevant to addressing SDH and HE. The aim must be to

build a cadre of trained experts able not only to adopt and implement an SDH approach but also to develop new techniques and strategies.

IV.5.1.-What capacities do countries need?

Country Partner experience has identified a set of specific capacities that are particularly critical for rapidly advancing action to improve health equity. These include both individual skill sets and systems capacities.

A. Capacity to monitor and analyse SDH and HE

Countries found that the capacity to reliably measure and analyse SDH and HE conditions and processes is fundamental to generate momentum for action on health equity and to design evidence-based policies. Countries found value in strengthening capacities for the systematic application of statistical decomposition techniques to document the roots of health inequities and identify appropriate areas for intervention. Several working meetings were held on this subject during the CW process. Several Country Partners provided or received forms of training on data analysis techniques in the course of their CSDH work, including Brazil, Chile, Iran, Mozambique, and Sri Lanka.

Brazil took wide-ranging action to identify capacity needs in monitoring and data analysis and to strengthen relevant capacities as the Country Work advanced. Brazilian authorities developed a methodological seminar on evaluation of SDH interventions for the country's intersectoral working group (IWG). The Brazilian NCDSS also developed courses for community leaders and municipal managers pursuant to its goals to strengthen mechanisms of participatory management and reinforce the network of Healthy Municipalities.

Alongside the other, perhaps more familiar technical capacities countries have identified as requiring reinforcement to strengthen results, an additional facet that must not be neglected concerns the strategic ability to translate and communicate evidence on SDH and HE effectively to different constituencies and to use this evidence to influence policy processes. Without the ability to make the science of SDH intelligible to policymakers and the general public, and to manage the political processes needed to translate evidence into political action, technical expertise on health determinants will not yield its full benefits. To see action on SDH/HE as a political challenge, as much as a technical public health problem, expands the set of capacities that must be mobilized to generate results. Countries have found that recognizing these additional factors clearly «raises the bar» in terms of the demands placed on existing system capacities by a commitment to tackle health inequities. But this more politically strategic, multi-dimensional approach also raises the probability that the actions undertaken will ultimately yield results. This point was emphasized during the October 2007 meeting of a Technical Advisory Group of policymakers providing guidance to the CSDH on how its recommendations can be most effectively translated into policy and action at the country level (CSDH, 2007b).

B. Capacity to plan and implement health sector programmes that take on board how the health system functions as a social determinant of health

In order to «get the health sector right» and maximize the potential of health systems to contribute to health equity, countries need to develop a new generation of policy and

implementation skills for health sector action. The work of health policymakers, programme planners and implementers needs to be informed by a detailed understanding of how the health system itself operates as a social determinant of health. The health system's role as a determinant is one of the key messages emerging from CSDH research and Country Partner experience.

Health systems architecture and individual health sector programmes that fully incorporate this understanding may depart significantly from established models, requiring fresh approaches to planning, delivery and management. Countries engaged with the CSDH saw the need for both short- and long-term strategies to expand individual skill sets and reinforce capacities within national systems. Short-term approaches are required to ensure that country-level work begins sooner rather than later and that those in senior positions can quickly provide leadership on SDH/HE. At the same time, longer-term strategies are clearly necessary to build a broad base of expertise within a larger workforce population and ensure the sustainability of equity-oriented values and practices.

In the near and medium terms, opportunities for capacity strengthening and knowledge sharing among countries will emerge through collaborative work that several Country Partners are pursuing to integrate SDH and HE into national public health programmes. This promising development on the formal Country Work has gained momentum through a strategy meeting hosted by Chile's Ministry of Health in Santiago in November 2008. The process builds on learning from the CSDH Priority Public Health Conditions Knowledge Network, as well as Country Partners' experiences. It is establishing a global network of countries pursuing innovative programmes to strengthen health equity; sharing strategies and results; and supporting each other to put in place the needed capacities and tools for continued action.

In the long term, a fundamental requirement is training a cadre of health workers and planners with SDH/HE competencies regularly taught in tertiary education institutions; this need remains largely unmet in countries.

C. Capacities and mechanisms to develop cross-government action and social participation

Some of the greatest capacity challenges for countries seeking to improve health equity come in the management of cross-sectoral processes and in fostering social participation in health action. While countries recognize the promise of intersectoral action and a cross-government or «health in all policies» approach, the identification and consolidation of the specific skills and governance mechanisms needed to make these approaches work has proceeded much more slowly. Likewise, as noted in the previous section, the value of social participation is acknowledged, but systematic learning on the practical mechanisms that can optimize participation is still in its early stages.

The country case studies of intersectoral action sponsored by Canada as an input to the CSDH learning process helped shed light on the capacities and structures countries have found useful in advancing intersectoral processes on health and health equity. These studies also highlighted the unmet capacity needs and persisting gaps in knowledge identified by national actors. Background research for the case studies highlighted how IAH requires the health sector to reach beyond its traditional set of core technical and management competencies. In

IAH, «fulfilment of the health sector roles of leadership, partnership, support and defence requires knowledge and skills that extend beyond health issues» (PHAC, 2007: 31).

Canadian researchers' review of previous policy processes identified some cases where new intersectoral approaches and the required competencies have been successfully introduced, implying a fundamental reframing of the way partners tackle problems. For example, environment and health collaborations have «demonstrated success in moving away from theoretical approaches toward problem-based approaches to learning». Actors in this area built capacity through mechanisms such as workshops drawing on multiple perspectives to address complex policy challenges in a pragmatic, results-focused manner. «The shift from discipline- and sector-specific theoretical approaches to problem-based learning has had a positive influence on IAH professional development and training programs» in the environment and health area (PHAC, 2007: 32). The concluding analysis of the case studies pointed to a range of areas fundamental for successful IAH, and in which countries will need to progressively strengthen capacities. These include:

- Analytic and communications skills to build the case for intersectoral action;
- Outreach, partnership-building and collaborative skills to engage other sectors of government and foster participation by multiple stakeholders, including communities;
- Planning and management capacities to organize work across sectoral boundaries that have traditionally demarcated administrative responsibility and budget flows;
- Monitoring and evaluation capacities to track the process and outcomes of intersectoral work (PHAC and WHO, 2008)

The IAH analysis also emphasized the importance of complementing capacity development at the level of national government with an effort to nurture local capacities related to cross-sectoral action and social participation. The authors note that some successful models have involved convening a multi-sector community-based group or forum to advise on local health priorities. «The recommendations of these groups were then considered by health planners in the setting of system-wide priorities and financial allocations». This approach has been adopted in Brazil, Cuba, and Iran, for example. In these instances, «Public participation, empowerment of marginalized groups at the local level, and a significant partnership role for non-government organizations are strong drivers, possibly because these groups are less likely to bring a sectoral-based perspective to the problem. Their participation consequently facilitates intersectoral collaboration» (PHCA and WHO, 2008: 21).

IV.5.2. Action to build capacity through the Country Work - and beyond

Clearly, many of the capacity challenges just discussed are not amenable to «quick-fix» solutions, particularly in countries where existing capacities are very constrained and experience in designing and implementing policies on SDH/HE is limited. A long-range agenda, coordinated at national, regional and global levels, will be required to meet the demands and build a solid, sustainable foundation of skills and tools for effective action on SDH/HE.

Again, however, countries' experience with the CSDH has confirmed that meaningful progress can be achieved rapidly. Modest but strategic action can jumpstart a developmental

process and create enabling conditions for more ambitious agendas later. Many Partner Countries had already been reinforcing relevant capacities even before joining the CSDH, and have used the Country Work as an opportunity to accelerate those processes while learning from other countries engaged in similar efforts. In the course of the CW, countries made progress in diagnosing capacity needs and took action to remedy the most pressing gaps. Action in this area unfolded: (1) as part of ongoing national processes within countries; (2) through peer-to-peer knowledge sharing and collaborative processes among countries, enabled by the CSDH; and (3) through training and capacity-building provided or brokered by international agencies, including WHO.

Some countries had already been advancing with national capacity-strengthening in relevant areas and continued to do so in collaboration with the CSDH. Brazil, Chile and Iran offer instructive examples. The CSDH analysis of national IAH processes documented how Iran has developed training programmes for key service staff on the practice of intersectoral planning and action. A significant portion of resources for Iran's Community Based Initiatives (CBI) programmes has consistently been spent on training and capacity building. Since 2001, the CBI Secretariat has held approximately 50 workshops with more than 1500 participants in 25 districts across the country. Workshops were designed to enhance participants' skills in community development and intersectoral collaboration. Participants have included members of district intersectoral teams, as well as community members. «In some cases, participants have been supported to share their new learning by training others in subsequent workshops» (PHAC and WHO, 2008: 19).

While encouraging and seeking to accelerate such national processes, the CSDH also created opportunities to reinforce partnership, knowledge-sharing and «horizontal» capacity strengthening mechanisms among countries working on SDH/HE. The Nordic Countries Reference Group was an important example. The group created a forum for discussion and shared learning among countries and generated substantive scientific inputs to the CSDH process. Other examples of horizontal partnerships for joint learning and capacity-strengthening included the visit of a team of Iranian health leaders and technical experts to Chile in December 2007, to study the institutional and technical solutions that have enabled Chile's rapid action on SDH/HE. The four-day intensive session yielded significant learning on both sides; bolstered actors' understanding of SDH challenges and options for institutional response; and cemented foundations for further bilateral collaboration. Such horizontal networks for collaboration among countries will be critical to reinforcing SDH/HE capacities in the years ahead.

In many instances during the Country Work, WHO Regional Offices, Country Offices, and Headquarters technical staff provided or brokered capacity-building support to countries on topics relevant to SDH/HE. Support to a large number of countries to establish their national health equity baseline analyses is just one example. Bolstering its own organizational capacity to respond to demand from Member States' in key areas related to action on SDH/HE will be an important feature of WHO's agenda to carry forward the achievements of the CSDH. As countries advance action on SDH/HE, WHO will develop a range of tools and platforms to facilitate capacity development and knowledge-sharing within and among countries. These will include capacity development networks that can translate the tacit, often disjointed knowledge on implementation that exists in countries into a more accessible, systematic knowledge base that can be shared and improved over time.

V. The way forward: sustaining and expanding country action on SDH/HE

Improving health equity is a long-term challenge. Unfair health differences among communities have deep historical roots and are anchored in social and political structures. Partner Countries have shown that change can happen fast; however, «leveling up» social determinants to substantially reduce inequities demands continuity of effort over time. A crucial objective for the coming years is to sustain and build on the momentum generated by the Country Work.

Accordingly, Country Partners' work to expand evidence-informed action on health equity, and WHO's support for country efforts, will not stop here. WHO's Medium-Term Strategic Plan (MTSP) for 2008-2013 establishes a strong organizational mandate for supporting country action on SDH and HE. WHO is reinforcing its institutional competencies to meet country demand in this area. WHO Regional Offices will be at the heart of the effort, taking forward their engagement in the Country Work to date.

V.1. A new phase of action

Country Partners have indicated to WHO that a new phase of collaborative action is needed to consolidate the learning and capitalize on the political momentum generated by the CSDH. This new phase will be built on the larger political, scientific, and institutional landscape emerging around the SDH/HE agenda. Many constituencies have contributed to the momentum for SDH/HE action now observed within and among countries. Working at global, regional and country level, WHO will support this emerging movement.

WHO's role, while already broadly mandated in the programme of work that flows from the MTSP, will be elaborated and brought to the appropriate scale once Member States have issued a resolution on how to respond to the CSDH Final Report. The details of WHO's comprehensive organizational strategy to support a global movement for action on SDH/HE are being developed in this context. The plans will reflect broad consultation with Member States and international partners, as well as close collaboration among WHO Regional Offices, Country Offices and Headquarters.

Looking to the future on what is needed to expand uptake of the SDH/HE agenda, a set of activities can be identified that are both urgent and feasible to implement in the coming biennium, if the budget support for SDH work outlined in WHO's programme of work is received. Even under budget constraints, a range of initial activities must be implemented to maintain the momentum achieved to date, stimulate fresh efforts, and bridge towards the development of a more comprehensive programme to advance SDH/HE agendas at country level and globally.

The immediate objectives for action are: (1) to reinforce awareness and interest in SDH and HE issues among national policymakers and programme planners, within WHO, and in civil society in the wake of the CSDH; and (2) to strengthen the «how-to» knowledge base on SDH/HE. Activities have been grouped into four main strategic lines of work for WHO and Country Partners:

FOCUS	WHO value-added
<p>1. DISSEMINATION AND DEBATE</p> <p>Disseminating CSDH findings and the results of Country Partner learning; stimulating informed debate on these topics in countries and globally; continuing to mobilize demand around SDH and HE.</p>	<ul style="list-style-type: none"> • Organize, translate, synthesize and present knowledge from Country Partners and other CSDH streams of work (e.g., Knowledge Networks) in WHO’s new and existing web platforms, in formats useful for policy makers and their advisers/technical staff • Enable exchange of country experiences via live debates and panels • Global and regional scientific and policy discussion forums and publications • Reinforce institutional coherence in policy discourse on SDH/HE with other global health and development partners; strengthen international partnerships • Technical collaboration with Member States
<p>2. SHARING AND LEARNING</p> <p>Building mechanisms through which countries’ still-pending questions on SDH/HE (as well as newly emerging issues) can be addressed, strengthening the evidence base for action.</p>	<ul style="list-style-type: none"> • Training courses • WHO web-based platform interactive features • Support research on interventions to address SDH • Evaluation framework and baselines for alliance of “pathfinding” countries advancing action on SDH/HE
<p>3. ACTION LEARNING</p> <p>Implementing CSDH recommendations, evaluating progress, and sharing the resulting know-how («active learning»).</p>	<ul style="list-style-type: none"> • Coordinate alliance of SDH/HE pathfinder countries • Implementation guidelines and expertise • Inter-country exchanges • Regional training and technical dialogues and exchanges
<p>THROUGH ALL THESE ACTIVITIES, it will be key to ensure «snowballing» - including more countries in the work and building global momentum over time.</p> <ul style="list-style-type: none"> • Alliance of SDH/HE “pathfinding” countries • Inter-country practice exchanges • Global and regional policy dialogue and recurring forums • Global movement network with University College London and other academic institutions 	

Dissemination. Various models exist for understanding how evidence, such as that generated by the CSDH, is translated into political action. The Country Work process has confirmed the importance of negotiating the «non-linearity» of policy processes (Lawrence, 2006). Country Partner experiences provide valuable lessons on pathways and entry points for generating political momentum and for understanding the contextual factors that encourage or discourage uptake of evidence by policymakers. Results from the Country Work have shown the

importance of horizontal knowledge-sharing and «peer-to-peer» linkages among countries pursuing similar policy goals. Accordingly, in the new phase of country work, Country «pathfinders» themselves will be key vectors of the learning generated. WHO will facilitate this process.

Building knowledge on the «how-to». In the coming years, the knowledge already produced by Partner Countries will prove valuable to an expanding group of national and global stakeholders concerned with health equity. So, too, will the questions countries were *not* able to resolve fully during the period of their work with the CSDH. These questions will continue to guide research, policy innovation and exchanges of experience between countries. Countries have expressed a desire to pursue the following questions, among others:

- How can countries move from theoretical recognition of the value of cross-sectoral policymaking to concrete implementation? What specific steps should be prioritized? What coordinating structures are most effective?
- How did countries that have implemented cross-sectoral approaches secure buy-in from other sectors and high-level political leaders? How have budget flows for cross-sectoral work been handled?
- How can countries with limited resources best strengthen capacity to measure SDH and HE, and in particular to assess the impact of interventions?
- What approaches and mechanisms will work best to further strengthen civil society participation in country action on SDH and HE?
- What strategies might be effective in bringing untapped constituencies, e.g., the business sector, into national action on SDH/HE?
- How can a more robust economic / «return on investment» case be developed for action on SDH and HE?

Together, these issues map the beginnings of an ambitious agenda for action research on the «how-to» dimension of SDH/HE policymaking and programme implementation.

Implementing CSDH recommendations. In the years ahead, a growing number of countries will take steps to implement the policy and programming recommendations developed by the CSDH. WHO is committed to support country efforts through a range of mechanisms, including: publication and dissemination of guidelines, case studies and other tools for translating CSDH recommendations into national policy; supporting global and regional dialogues and collaboration among countries implementing CSDH recommendations; regional training and technical dialogues for policymakers and implementers; and technical collaboration with countries on a range of issues central to tackling implementation challenges in SDH/HE policy. Key areas for technical collaboration will be defined by country demand and may include: supporting processes for developing cross-sectoral policies and implementation mechanisms (e.g., «Health in All Policies»); incorporating the SDH/HE lens into specific health programmes; strengthening social participation in health policymaking; and in all cases, finding ways to monitor the effects of policy interventions. WHO Regional Offices will be central in brokering support for country action and working with countries to adapt CSDH recommendations to regional and national contexts.

«Snowballing» action. A key objective expressed by many Country Partners is to use the global momentum generated by the CSDH to «snowball» action, so that an increasing number of countries are brought into the process and the collective momentum for tackling health equity challenges continues to build over time. The snowball effect has already been felt during the lifetime of the Commission, with a steadily expanding group of countries seeking engagement with the CSDH process at various levels (see above, Section II.2.3). Regional leadership and communications platforms will be crucial in expanding this movement. WHO is positioned to support country networking and knowledge-sharing by facilitating inter-country practice exchanges and global and regional policy dialogues. WHO will work with University College London and other leading academic institutions, regional bodies and civil society organizations to maintain and expand a global action network on SDH and HE.

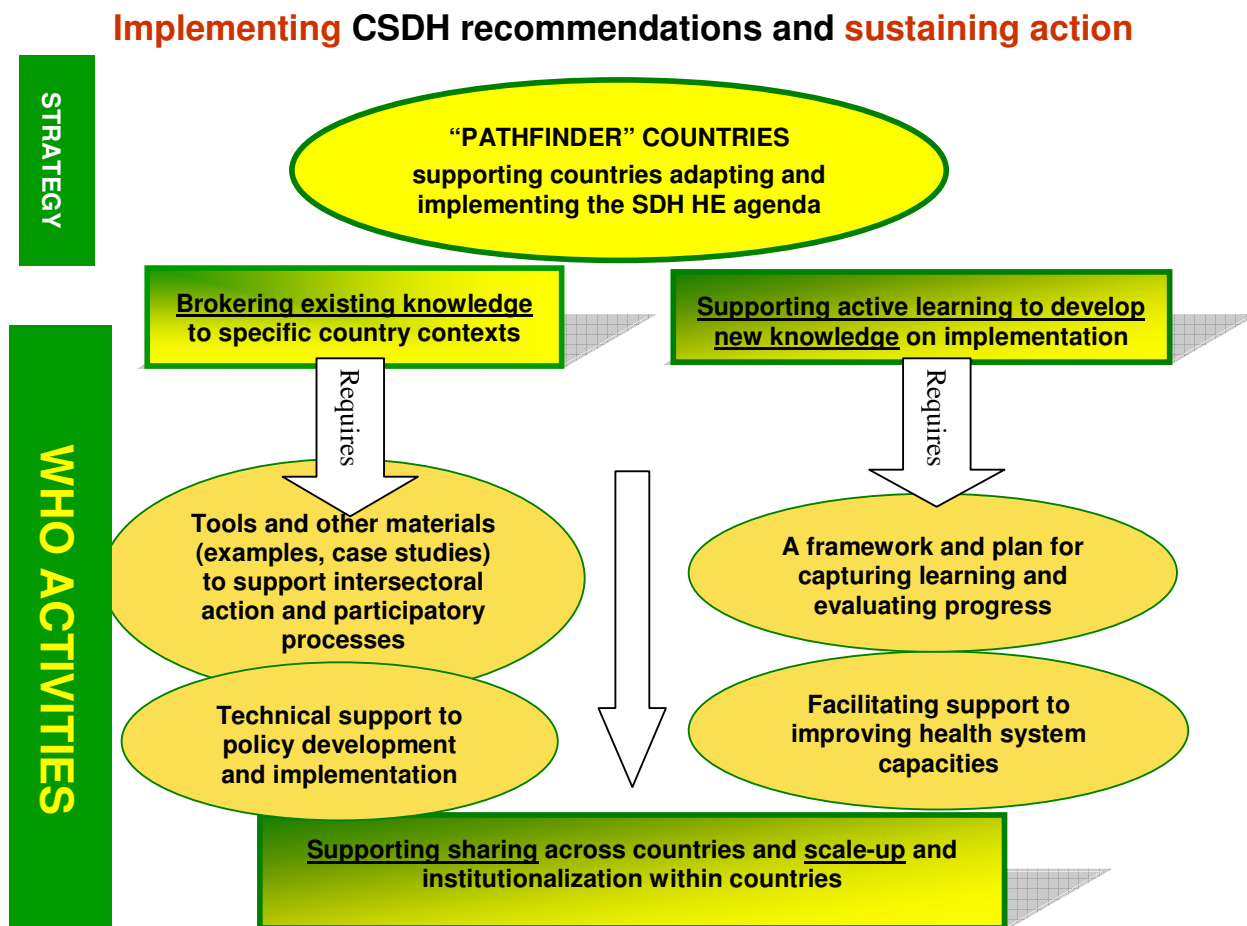
V.2. «Pathfinder» countries for health equity

Crucial to the next phase of action on SDH and HE will be strategic action to forge a new, results-focused alliance of countries working to improve health for vulnerable and marginalized groups in their societies (see Figure 6, below, which outlines key elements of the emerging strategy). As countries take up various avenues of the SDH/HE agenda, WHO will connect them to one another and identify further interested countries. The aim is to build a group of countries from all regions committed to accelerating evidence-informed action on SDH and HE. This network will amplify global leadership on health equity. Supporting this alliance will be a key part of WHO's agenda to enable country action on SDH and HE in the coming years.

Active learning. Given the need for innovation in policymaking in this area, an “active learning” approach will be required. This approach will focus especially on documenting and sharing knowledge about how intersectoral policies are developed, implemented and monitored in different settings. Learning will focus on implementation, as well as strategies to develop the appropriate capacities in the health sector. WHO will support these critical knowledge generation and dissemination processes within and among countries. A key need and opportunity for countries is to surface tacit knowledge about policy and implementation and make that knowledge explicit, systematic and available to be shared. This requires tools and strategies for effectively documenting policy and delivery processes and synthesizing results in a transferable, «living» format. In this way, learning can feed directly back into implementation work and improve it, and lessons can also be more widely shared.

Country leadership. Progress is feasible even in budget-constrained conditions by building opportunistically on interest from a core group of countries committed to action on SDH and HE in their national contexts. Countries that have been engaged as Partners in the CSDH process are positioned to take leadership in this approach, but the process can include other countries that have worked in these areas for some time but were not formally involved in the CSDH, as well as countries where momentum for tackling SDH is more recent.

Figure 6: Building on the CSDH: Supporting and expanding country action on social determinants and health equity.



Specific plans to advance this agenda are being refined through dialogue among countries and WHO. As currently envisioned, the work will focus on supporting countries’ efforts in the following areas:

- Integrate specific social determinants and health equity strategies into health policies and programmes, cross-sectoral strategies, and other national policy and planning instruments;
- Document the policy development and implementation process and evaluate the impacts of policies and programmes aiming to strengthen health equity;
- Share results and experiences with other countries.

Countries joining forces in this effort will take action on the social determinants of health inequities and at the same time, through operational learning, systematically reinforce the how-to knowledge base on cross-sectoral and «joined-up-government» policymaking in health.

Implementation experts resource group. WHO will convene an expert resource group to advise on supporting country implementation. These experts will include: leaders in national and international policy (in particular from countries actively engaged in advancing SDH/HE work); business and civil society leaders; and researchers with recognized expertise in analyzing and supporting policy processes. The implementation resource group will feature expertise in intersectoral policymaking for health; significant past experience in translating new concepts into policy agendas that lead to action; and skills in policy learning and evaluation.

The experts group will advise WHO on strategies to optimize dissemination of evidence on SDH and HE to countries, including the development of tools, training materials and other resources for country learning and policy translation. In addition, the group will serve to anchor and reinforce WHO's own commitment to SDH/HE action over time.

Tools and materials to support country action. To date, consultations with countries have suggested tools and support WHO can usefully provide to the group of implementing or «pathfinder» countries. These resources will also contribute to the wider process of disseminating SDH/HE knowledge and stimulating country-level action:

- Website on learnings from the CSDH Country Partner work, in particular on intersectoral action (from the PHAC-WHO collaborative case study and synthesis project)
- SDH and HE knowledge synthesis, in the form of policy briefs
 - on social determinants themes that can work as entry points across countries (e.g., social security, indigenous health)
 - presenting examples of the translation of CSDH recommendations to the national policy level, given different development scenarios
- Training course on intersectoral action
- Planning tools and guidelines to support intersectoral work and integrated policymaking
- Case studies and models on social participation in health decision making
- Guidance in measurement, monitoring and evaluation for countries seeking to document SDH/HE learning and implementation processes and to evaluate results
- Materials, events and process support to facilitate ongoing partnership and «peer-to-peer» knowledge sharing among countries implementing action on SDH/HE. The nature of these supports will be agreed upon in discussions among countries and WHO as the joint work progresses.

Details of WHO's comprehensive strategy to support country action will be determined in the coming months, in line with Members States' formal response to the recommendations of the CSDH through WHO's Governing Bodies. In the meantime, country-driven processes to consolidate and build on the achievements of the Country Work are already underway. In the short timeframe of the CSDH, Country Partners have expanded the knowledge base on SDH and HE; mobilized multiple constituencies at country level; cemented expanding regional alliances; and built unprecedented global political momentum to drive future action for health equity.

VI. Conclusion

This report has summarized the progress made by Country Partners in tackling SDH and HE during the three-year lifetime of the Commission. At present, gains are still mostly measurable in terms of the political processes that have enabled Partners to jumpstart promising national action. Impacts on population health status and equity gaps will be measured over a longer timeframe. Within the short period allotted for formal CSDH Country Work, progress in advancing pro-equity and SDH policies has been demonstrated on several fronts, including: raising the political and public visibility of SDH/HE issues; improvements in the information environment for an SDH/HE agenda; development of incentive structures to increase accountability on SDH/HE issues; improvements in health sector programming with an SDH approach and capacity building for personnel; creation or strengthening of processes and structures to support intersectoral action for health; and increased incorporation of social participation into policy processes.

Country Partners' experiences have encouraged the CSDH to challenge current «conventional wisdom» in areas such as welfare state policy and state-civil society collaboration. Notably, Partners have emphasized the importance of robust welfare state protections as an efficient, effective means of improving health and strengthening health equity among social groups - at a time when welfare state mechanisms are under attack in some circles. Research from the Nordic countries, in particular, has clarified and systematized relevant learning. While the public health effects of any specific redistributive welfare state policy may be modest, the combined effect of all such policies and institutions is likely to be substantial. This is especially true from a life-course perspective. People who enjoy access to resources provided by the welfare state, in addition to the resources of the market and the family, are likely to live longer.

Some CSDH Country Partners have adopted policy approaches that explicitly highlight social solidarity as a guiding value. Countries have explored different strategies for operationalizing this value in policy and programming. Such shared commitments among Country Partners make a powerful political statement on the global stage.

At the same time, Partners' achievements to date necessarily raise additional questions. Areas of active inquiry include how universal health and social protection policy models relate to targeted strategies for the needs of special groups. Similarly, reconciling social participation and inclusiveness with the imperative for efficient, goal-driven government action is no simple matter. No uniform solutions exist, and a wide range of strategies may prove useful in specific contexts. These issues point out directions for continued learning in the years ahead.

As the architects of the Alma-Ata vision saw, delivering Primary Health Care effectively at country level requires an equity-oriented policy framework and cross-sectoral action on social determinants. Thirty years later, the evidence base has expanded; political and social contexts have evolved; the division of roles and responsibilities among key actors has shifted; and new strategies are required to achieve results. CSDH Country Partners have charted innovative paths in action on social determinants. These promising directions must now be pursued to deliver on the promise of improved health for all with accelerated gains for vulnerable and disadvantaged communities.

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Annex A. Engagement of Country Partners and other country participants in specific work areas of the CSDH

Area of work of CSDH	List of countries		
Early Child Development Knowledge Network	<ul style="list-style-type: none"> Eritrea 	<ul style="list-style-type: none"> Kenya 	
Employment Conditions Knowledge Network	<ul style="list-style-type: none"> Chile China Ethiopia Jordan Liberia 	<ul style="list-style-type: none"> Nigeria Peru Senegal Sweden 	<ul style="list-style-type: none"> Turkey United States of America
Globalization Knowledge Network	<ul style="list-style-type: none"> Argentina Bangladesh Brazil Cambodia <i>Caribbean</i> Cuba <i>Eastern Europe</i> 	<ul style="list-style-type: none"> Finland FSU India (2) Italy Mexico <i>South Asia</i> 	<ul style="list-style-type: none"> <i>Southern Africa</i> Philippines Russia Thailand
Health Systems Knowledge Network	<ul style="list-style-type: none"> Australia <i>CEE/FSU</i> Chile China Cuba <i>"Conflict-affected fragile" states</i> 	<ul style="list-style-type: none"> Guatemala Kenya Mexico South Africa Sri Lanka 	<ul style="list-style-type: none"> Sweden Thailand United Kingdom United States of America Zimbabwe
Intersectoral Action for Health	<ul style="list-style-type: none"> Australia Belgium Brazil Canada Chile Colombia Cuba 	<ul style="list-style-type: none"> EC Ecuador El Salvador England India (2) Iran Malaysia 	<ul style="list-style-type: none"> Morocco Norway New Zealand Sri Lanka Uganda Viet Nam
Measurement and Evidence Knowledge Network	<ul style="list-style-type: none"> Brazil Bolivia Canada Kenya 	<ul style="list-style-type: none"> Mexico (2) Netherlands Peru Slovenia 	<ul style="list-style-type: none"> Tanzania Thailand (2) Uganda United Kingdom (2)
Priority Public Health Conditions Knowledge Network	<ul style="list-style-type: none"> Bangladesh Canada Chile China 	<ul style="list-style-type: none"> Indonesia Iran Nigeria 	<ul style="list-style-type: none"> South Africa Tanzania Vanuatu

Area of work of CSDH	List of countries		
Role of Civil Society	<ul style="list-style-type: none"> • Chile • Cuba • Eastern and Southern Africa 	<ul style="list-style-type: none"> • Guatemala • Mexico 	<ul style="list-style-type: none"> • South Africa • Zimbabwe
Role of parliamentarians	<ul style="list-style-type: none"> • Eastern and Southern Africa 	<ul style="list-style-type: none"> • Kenya 	<ul style="list-style-type: none"> • South Africa • Zimbabwe
Situation analysis of health inequities and its determinants	<ul style="list-style-type: none"> • Benin • Burkina Faso • Cameroon • Central African Republic • Chad • Comoros • Congo • Cote d'Ivoire • Ethiopia • Gabon 	<ul style="list-style-type: none"> • Ghana • Guinea • Kenya • Lesotho • Madagascar • Malawi • Mali • Mauritania • Mozambique • Namibia • Niger 	<ul style="list-style-type: none"> • Nigeria • Rwanda • Senegal • South Africa • Tanzania • Togo • Uganda • Zambia • Zimbabwe
	<ul style="list-style-type: none"> • Bangladesh • India • Indonesia 	<ul style="list-style-type: none"> • Iran • Maldives • Nepal 	<ul style="list-style-type: none"> • Sri Lanka • Thailand
Social Exclusion Knowledge Network	<ul style="list-style-type: none"> • Australia • Bangladesh • Botswana (2) • Brazil • Colombia • England 	<ul style="list-style-type: none"> • Ghana • Mozambique • Peru • Venezuela • Senegal • South Africa 	<ul style="list-style-type: none"> • EU countries incl. Portugal, France, Slovenia and Hungary
Urban Settings Knowledge Network	<ul style="list-style-type: none"> • Australia • Bangladesh • Brazil (3) 	<ul style="list-style-type: none"> • Hong Kong, SAR, People's Republic of China • India • Japan 	<ul style="list-style-type: none"> • Philippines • Singapore • South Africa • Tanzania • Thailand
Women and Gender Equity Knowledge Network	<ul style="list-style-type: none"> • Argentina • Bangladesh • Bolivia • Brazil • Chile • China • Colombia • Egypt 	<ul style="list-style-type: none"> • India • Indonesia • Kenya • Malawi • Nepal • Mexico • Pakistan • Peru • Poland • Rwanda 	<ul style="list-style-type: none"> • South Africa • Sweden • Tunisia • Uganda • United Kingdom • Uruguay • Zambia

Annex B. Principles for presenting information on health equity

1: Know the health equity situation as thoroughly as possible.

Every Country Partner either already had a well-developed baseline analysis, or incorporated an analysis into its Action Plan. In addition to increasing the visibility of the issues, these analyses provided an overview of the health and health equity situation in the countries, identified priority problems, contributed to planning for policy and interventions, and established a baseline for tracking changes over time.

Baseline analyses often took the form of quantitative analyses that disaggregated health issues along various socioeconomic dimensions. This was a particularly useful approach when a large amount of data was available. Baseline analyses also took the form of qualitative studies, especially when a specific topic was identified (e.g., barriers in access to care for maternal health), when quantitative data was weak or sparse, or when particular types of information related to the topic were not available as data but were seen to be useful (e.g., user perspectives on barriers to care).

2: Address health equity issues that relate to widely shared social justice concerns.

Addressing health equity issues that relate to common social justice concerns not only catches the eye of politicians--it is also a fundamental aspect of appropriate priority setting, often exposes information gaps, and can be an effective way to move planning forward.

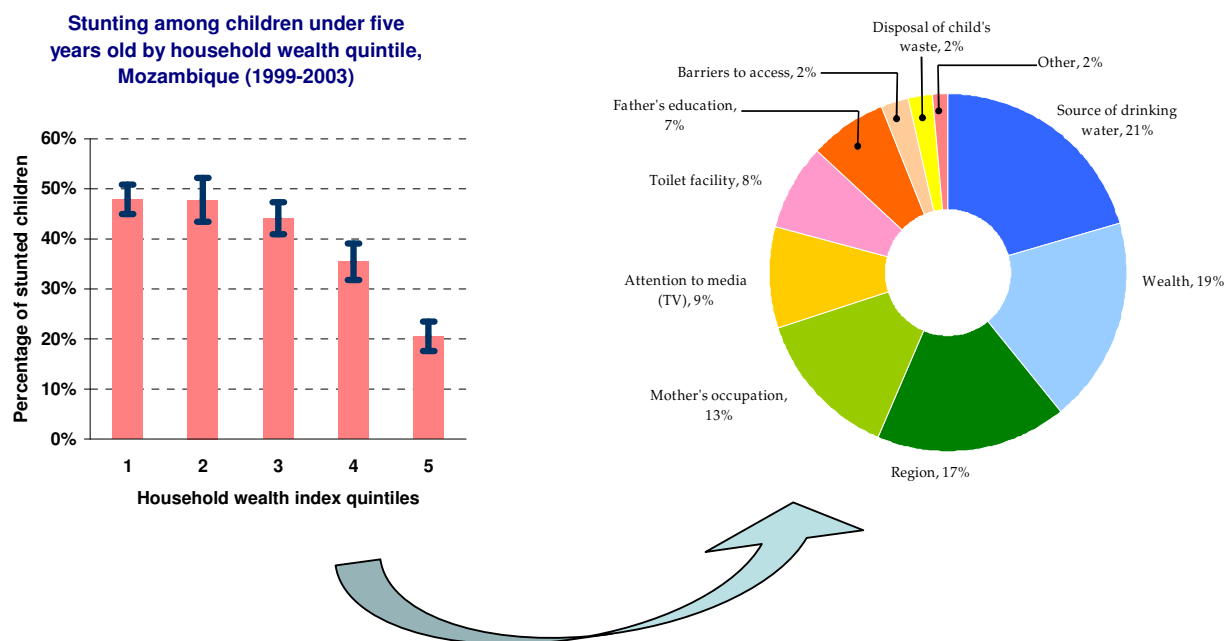
In Sri Lanka, the high levels of child malnutrition have long been a source of concern and a mystery, especially given Sri Lanka's generally high health achievements. Initial discussions with the Ministry of Healthcare and Nutrition focused on the improving the evidence base for the issue and understanding the mechanisms causing the problems. Iran's baseline analysis report emphasized the need to document and further explore gender dimensions of SDH and health equity, noting that gendered lifestyle and behavioral differences appear to create significant inequities in disease risks found for males and females. The gender dimension of other social determinants of health requires careful investigation - for example, the employment rate, especially access to high level jobs. Brazil's research agenda places special emphasis on three equity dimensions, including the health of the black population, health of handicapped and health of male population. Racial inequities in particular are not only a major socioeconomic divider in that society, but also represent an important social justice issue for the country.

3: Show evidence that demonstrates the impact of other sectors.

A significant barrier in advancing SDH policy in the past has been inattention to the relative contribution of specific SDH to illness and health inequalities and how non-health sectors play a role. More effective use of statistical methods can help address this gap. Decomposition analysis, for instance, demonstrates pathways of SDH, showing the importance of non-health sectors in both generating and addressing health concerns and drawing them into an SDH agenda. Decomposition analyses often suggest that collaborative, intersectoral strategies are needed. The Commission has encouraged the use of decomposition analysis by Country Partners, and supported capacity building for such analysis in order to improve sustainability and institutionalization of the approach, and spur policy responses across relevant sectors. In addition to decomposition analysis, other tools for highlighting the need for IAH include health and health equity impact evaluations of public policies, discussed further in section III.F, below.

Decomposition analysis using data from the 2003 Demographic and Health Survey in Mozambique shows that the four biggest contributors to poor growth in children (defined as height-for-age falling two standard deviations below the median of the reference population), stratified by household wealth, are: source of drinking water (19%), household wealth itself (17%), geographical differences (16%) and mother's occupation (13%).¹ An additional 10 factors identified in the survey together contribute 35%. This analysis has helped Mozambique to focus its Action Plan.

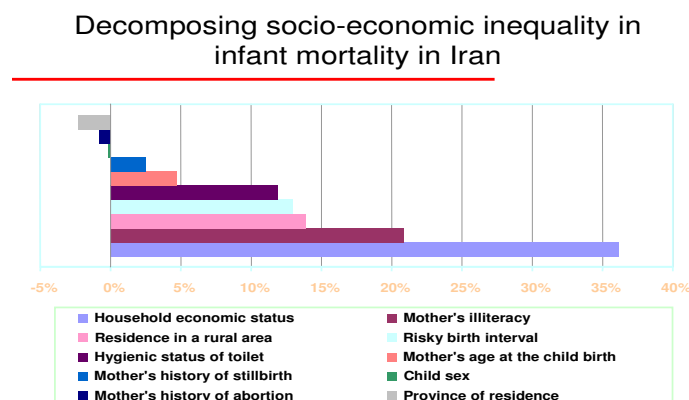
Figure 7. Decomposition analysis of malnutrition in Mozambique, 1999-2003.



Establishing baseline information in Iran on health inequities and their social determinants was a major component of cooperation with the CSDH, using DHS information from 2000, updated in 2006. Decomposition analysis shows that SDH other than healthcare play a major role in inequalities in infant mortality, e.g., education inequalities explain 21% of inequities, and lack of sanitation explains 12% of inequities, especially in rural areas.

¹ Household wealth index constructed using durable goods, type of materials used in housing floor, and number of rooms divided by the number of household members. Wealth quintile 1 indicates the poorest and wealth quintile 5 the least poor.

Figure 8. Decomposition analysis of infant mortality in IR Iran , 2001.



4: Show evidence that has policy implications.

Evidence that has clear implications for policy and action makes a stronger statement to decision-makers than descriptive analyses. For instance, it may be useful to show that a particular district has higher rates of a disease, but when we can show *who is affected, why, and what could be changed*, the argument for action strengthens. This can often be accomplished through simple analyses using existing information and ensuring disaggregation of socioeconomic groups.

While decomposition analysis can be quite useful for directing policy development, it is worthwhile to note that decomposition of SDH and of SDHI can have very different policy implications, even using the same data. Consider the two charts below. The first shows the contribution of various determinants of health to Chile's national (averaged) infant mortality rate, and reveals that behavioral and biological factors (shown in orange) account for the largest share of the country's infant mortality. The second chart, though, indicates that factors related to socioeconomic position (shown in blue) by far contribute the most to the *inequalities* in infant mortality.

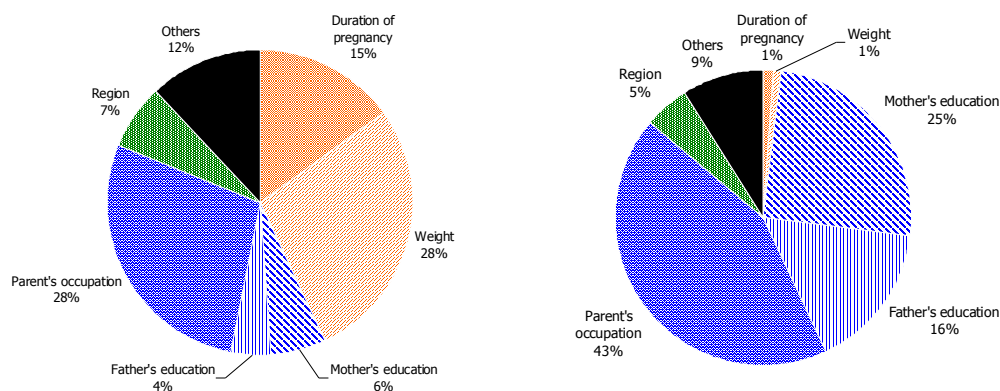


Figure 9. Factors contributing to average health indicators and health inequalities are often different.

Therefore, having a sense of the specific goals one is interested in prioritizing, such as increasing average health vs. reducing inequalities between the best-off and worst-off, can affect choices on how to present data; if goals are not clearly defined, the way data is presented can end up driving the identification of priorities.

5: Regional and country comparisons are also useful.

Comparisons of health inequities among countries can serve a number of functions, including: raising visibility, helping countries understand where they stand in terms of health, drawing out common problems within a region that might be addressed jointly, or pointing to societies that have been more or less successful in addressing equity issues.

Quantitative analysis. In a joint effort between WHO Headquarters, Regional Offices, Ministries, and national research institutes, SDH baseline analyses are being produced for countries in sub-Saharan Africa and South East Asia. AFRO's Regional Committee Meeting of Ministries of Health called for WHO to provide decomposition analyses for each of the countries in the region. These analyses are expected to accompany a recommendation to WHO on prioritizing an SDH approach at the August 2007 WHO Regional Committee Meeting. SEARO, in cooperation with Sri Lanka, is also stimulating SDH work at the national level by supporting baseline analyses for countries in the region. Findings will be presented at an October 2007 regional inter-ministerial meeting, in which representatives of 11 countries will take part. Thirty-three participants from Ministries of Health, Economic Planning and Labour, NGOs, universities, and international organizations will discuss the findings and develop strategies to place health equity as a shared goal across government departments and sectors.

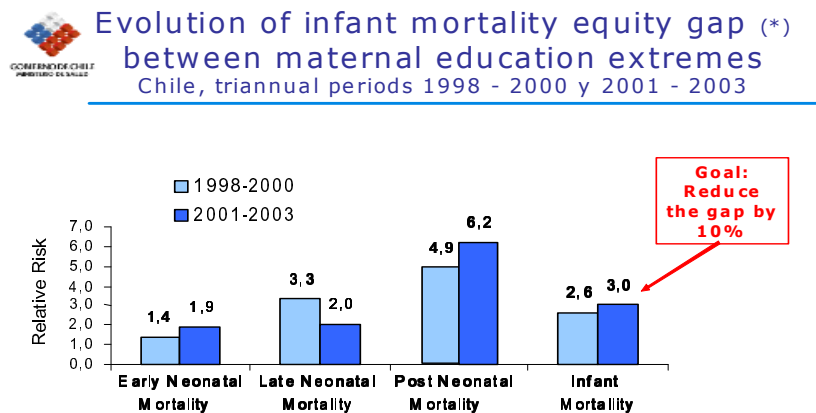
Case studies. WHO's Eastern Mediterranean Regional Office (EMRO) supported a diversity of approaches to increase the visibility of relevant issues by documenting the SDH and HE situation in countries in the region. As part of this effort, EMRO commissioned SDH review papers by social scientists in seven high-, middle- and low-income countries: Egypt, Iran, Jordan, Morocco, Occupied Palestinian Territories (OPT), Oman, Pakistan. Case studies explore not only the health situation but also relevant aspects of countries' socio-political contexts; major national policies tackling SDHs; and key policy entry points for action, including mechanisms for community participation in decisions, mechanisms to facilitate intersectoral action, and any available evidence on the effectiveness of interventions. The case studies were also intended to discuss policy impacts on equity in terms of: (1) improving health (in absolute terms) for those social groups that suffer the poorest health; (2) reducing absolute differences between groups; and (3) reducing relative differences between groups. Additionally, EMRO has developed a paper on conflict and SDH in EMR, focused on Afghanistan, Iraq, Lebanon, Occupied Palestinian Territories, Somalia and Sudan (Darfur). The paper is intended to be a guideline for work in affected countries, where feasible.

6: Show trends in health equity over time.

Trend information can contribute politically and technically to planning, goal setting and monitoring progress. Tracking health equity over time can support development or revision of national health equity goals and help guide action to achieve those goals. Comparisons can create a sense of progress or a sense of urgency, pinpoint specific issues or areas that are improving or worsening, and inform evaluations of the effectiveness of interventions.

In 2005, Chile assessed trends among the three key equity indicators chosen for the 10-year Health Objectives (2000-2010), including gaps in infant mortality and temporary life expectancy between education extremes, and the gap in Years of Potential Life Lost between municipal extremes. These indicators were chosen based on their relevance to health equity in Chile, international comparability, potential to strengthen existing health equity measurement, and national policy relevance. Although overall health indicators appeared good, findings showed that a social gradient persists and equity gaps have widened for some groups (see Figure 6 for an example).

Figure 10: Chile's equity gap in infant mortality



(*) Expressed in relative risk, or the number of times the mortality risk of infants of mothers with less than 3 years of schooling increases in relation to the mortality risk of infants of mothers with 13 or more years of schooling.

Annex C. Letter of Brasilia



REGIONAL MEETING OF CONSULTATION WITH CIVIL SOCIETY ON SOCIAL DETERMINANTS OF HEALTH

Brasilia, Brazil, April 12-14, 2007

LETTER OF BRASILIA

Minga to reduce health inequity in the Americas*

We are a coalition of social and popular movements and organizations of women, rural people, peoples of the forest, indigenous peoples and nations, communities of African descent, Roma and other nomadic peoples, gender identity and sexual orientation (GLBT) groups, territorial neighborhood organizations, union movements of workers, academics, housing activists, health service users, patients' leagues, professional guilds, and NGOs of various parts of the Americas, from Canada to Chile, through Central America and the Caribbean, gathering in Brasilia for the regional meeting of consultation on social determinants of health, convened by the Governments of Brazil and Chile, civil society organizations of the Americas, the OAS, PAHO, and the WHO, to discuss the multiple health-related issues we face and the need and importance of recognizing social determinants of health in order to overcome them.

This meeting reaffirms profound dissatisfaction with the prevailing approach to social and economic development in the Americas, an approach that, in recent decades, has gained strength through a set of neoliberal policies associated with globalization, and that must be replaced. Based on market logic, it privatizes and medicates health to the detriment of the right to health, heightens human rights violations and inequalities that lead to health inequity, weakens and impairs health and living conditions, and is entirely avoidable and unfair.

We also reaffirm that this development approach reduces the role of the state as a promoter of health, fragmenting and privatizing health systems, shrinking public health resources, emphasizing a curative approach to individual diseases.

The growth of this approach in the Americas heightens inequalities and social exclusion, as evidenced by the concentration of wealth, land, and income and the improper use of natural resources. At the

* Word used by indigenous peoples and nations of the Andean region, referring to a social practice of collaboration, solidarity, and cooperation in which each person, according to ability, contributes resources for the benefit of the community as a whole.

same time it heightens gender inequality and discrimination for reasons of ethnicity, race, religion, and sexual orientation and gender identity (GLBT), and increases all forms of violence in both rural and urban areas, both public and private places.

It is clear to the civil society movements and organizations present at the meeting that health is a universal human right, a duty of the state, which requires a set of factors like food safety and security; decent work and recognition of the value of childbearing; adequate income; land access, use, and tenancy; sustainable management of natural and renewable resources; decent housing in a healthy environment; democratic civic participation; universal access to education and health services that are timely, humanized, of quality, and culturally appropriate; inclusive government social policies; social relations that are neither sexist nor racist; and cultural and religious tolerance. This means that health factors and the right to health are indivisible and interdependent.

It is clear that, in order to make progress in overcoming health inequities, it is essential to devise sustainable approaches to social and economic development that safeguard human, civil, political, economic, social, cultural, environmental, sexual, and reproductive rights; that government adopt an approach that guarantees those rights; to promote sovereignty and food security to eradicate hunger from the Hemisphere, promoting agrarian reform that ensures land access, use, and tenancy, makes possible sustainable agriculture, and preserves ownership of heritage seeds, in a context of rural family farming appropriate to the climatic diversity of the region; to have urban reform that promotes better distribution of urban land and the building of socially just and environmentally sustainable cities; to democratize human cultural capital through universal access to education; to bring about participatory democracy; and to develop government policies that are intersectoral, universal, integrated, equitable, and participatory.

Accordingly, we civil society organizations meeting in Brasilia believe it is advisable to promote a common agenda concerning determinants of health that strengthens and broadens activism, autonomy, and social mobilization—at the national and hemispheric levels—to orient government and public policies toward this integrated perspective on health factors.

Therefore, we call for a civil society alliance based on the ancestral principles and knowledge of indigenous peoples and traditional communities (Minga), to restore a social practice in which we all will feel invited and committed to contribute our experience so as to strengthen action to transform determinants of health and enforce demands for health-related rights. At the same time we call upon national governments and international organizations to respect the autonomy of social organizations -according to those same principles – and to commit their initiative, action, and resources to this transformation.

As organizations present in multiple social sectors, we pledge to publicize this discussion among popular organizations and social movements in the Hemisphere, to broaden it to include their viewpoints and contributions, and to enlist their active participation in the debate and in realizing the shared agenda, building a hemispheric movement that will continue to grow.

We also call upon the region's governments and the international organizations to commit themselves to this process, which began with the establishment of the Commission on Social Determinants of Health, in 2005, and to move forward, together with civil society, in firming up policies and programs that will affect and transform those determinants. The WHO, PAHO, and the OAS, along with the region's governments, must continue to support and broaden this process, facilitating broad and influential participation by the region's civil society organizations.

Brasilia, April 14, 2007