

This is the Commission on Social Determinants of Health's Interim Statement. It sets out the Commission's vision and goals, the problems it seeks to ameliorate, and the intellectual foundation for a social determinants approach. In doing so, the Interim Statement is a resource for stakeholders concerned with social determinants of health and health equity, as they build towards a global movement. Recommendations for action, based on the evidence gathered across all the Commission's work streams, will be made in the Final Report in May 2008. The Interim Statement will be disseminated widely among the Commission's many stakeholder communities. These range from partner countries and policy-makers, including ministries of health and finance, to civil society actors, political alliances, trade unions, clinicians and health sector workers more broadly, and the private sector. A targeted stakeholder consultation will contribute to the completion of the comprehensive evidence base and recommendations for action in the Final Report.

The Commission on Social Determinants of Health (CSDH) was set up in March 2005 by the late Dr Lee Jong-Wook, then Director-General of the World Health Organization (WHO). The endorsement of WHO has been carried forward with the support of the present Director-General, Dr Margaret Chan. Valuable financial assistance has been received from partner countries including Brazil, Canada, Chile, China, Egypt, India, the Islamic Republic of Iran, Japan, Kenya, Sweden, and the United Kingdom.

If you would like to receive updates relating to the Commission please register online through the web site http://www.who.int/social_determinants/en



Building a global movement for health equity

Health is a universal human aspiration and a basic human need. The development of society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health. Health equity is central to this premise and to the work of the Commission on Social Determinants of Health.

Strengthening health equity – globally and within countries – means going beyond contemporary concentration on the immediate causes of disease. More than any other global health endeavour, the Commission focuses on the “causes of the causes” – the fundamental structures of social hierarchy and the socially determined conditions these structures create in which people grow, live, work and age – the social determinants of health.

The time for action is now: not just because better health makes economic sense, but because it is right and just. The outcry against inequity has been intensifying for many years from country to country around the world. These cries are forming a global movement. The Commission on Social Determinants of Health places action to ensure fair health at the head and the heart of that movement.

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THE COMMISSION ON SOCIAL DETERMINANTS OF HEALTH

Dramatic inequalities dominate global health today. These health inequalities involve us all, rich and poor countries alike. In response to this, the Commission on Social Determinants of Health (CSDH) was set up in 2005 by former Director-General of the World Health Organization, the late Dr Lee Jong-Wook.

The conditions in which people grow, live, work and age have a powerful influence on health. Inequalities in these conditions lead to inequalities in health. The Commission's vision is a world in which all people have the freedom to lead lives they have reason to value. This is a matter of social justice. Health and its key determinants are an issue of human rights. Politically, it is vital, as success of a society can be judged from the quality and fair distribution of its population's health. Good health enables people to participate in society, with potentially positive consequences for economic performance.

The vast majority of inequalities in health, between and within countries, are avoidable and, hence, inequitable. Our success in improving health and reducing these inequities depends on serious attention to the underlying societal causes. Technical solutions within the health sector are important, but are not sufficient. Dealing with the social determinants of health may yield greater and sustainable returns. Action on social determinants of health empowers people,

communities and countries. Empowerment is a powerful route to changing both social structure and conditions, and it is through such changes that people are empowered.

In an endeavour to realize its vision, the Commission is building a global movement for change to improve global health and reduce health inequity. It is building partnerships with governments, civil society, and international organizations. It is reviewing the global evidence base on health inequity, harnessing national and local knowledge for action, and advocating for change. The CSDH is ultimately concerned with action to tackle the range of health determinants – from structural conditions of society to the more immediate influences, at all levels from global to local, across government and inclusive of all stakeholders from civil society and the private sector. Recommendations for action will be made in the Final Report in 2008.

Leading the Commission are influential global and national level policy-makers, scientists, practitioners and civil society leaders from all over the world, united by their concern about health inequity, and their conviction that societal action is needed to respond to it. The diversity of their backgrounds demonstrates compellingly how health is a concern for all, not just those involved in health care. Commissioners bring their experience as former heads of

government, as ministers (of education, foreign affairs, public works, and health), as national-level policy-makers and advisers, as members of national task forces, advisory councils, regional councils and parliaments, as heads of United Nations and intergovernmental organizations, as world-renowned academics, and as leaders and representatives from within civil society.

The expertise of the Commissioners is complemented by that of the Commission's global partners. Leading academic institutions in the North and the South have formed networks of research, policy and practice around specific thematic areas. These Knowledge Networks are assessing existing global knowledge in each of the theme areas, with an emphasis on evidence for action. The Commission is learning from the experience of countries, learning from policy-makers and practitioners, and working with them as they spearhead change. The Commission is engaging with key global and regional players – from finance institutions such as the World Bank to United Nations agencies, from international nongovernmental organizations to the global institutions of Member States. In addition, the Commission is learning from and working with civil society organizations – engaging with groups that commissions often do not talk to. Commission meetings take place across the world. These meetings

engage all the way from discussion with heads of state and national-level policy-makers to site visits and interaction with communities.

The devastating health inequities we see globally are man-made. The causes are social – so must be the solutions. A global society in which millions of children and adults are unable to lead flourishing lives is not sustainable. Never before have we been so interconnected globally. Never before has a global movement for health equity been more necessary or more possible.

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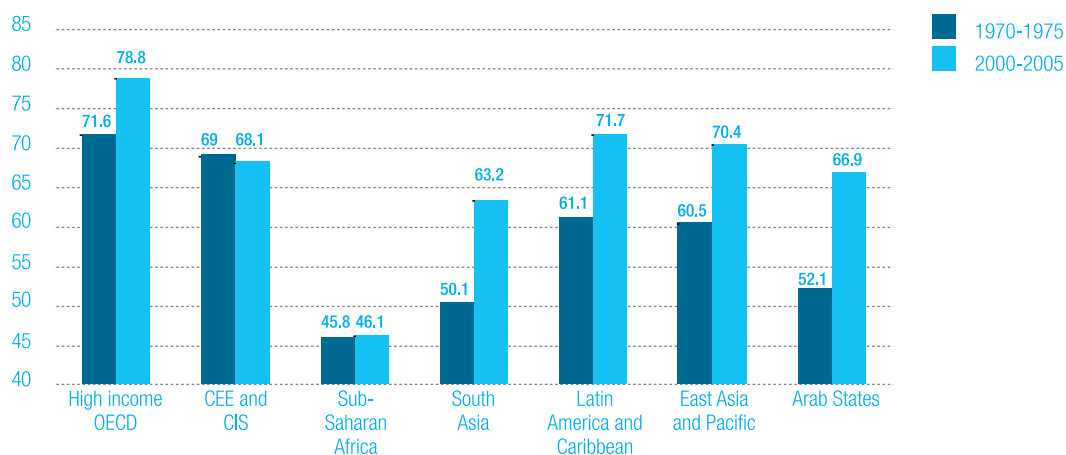
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Global health improvements but still major inequalities between countries

Consider three children: one African, one South Asian, and one European. At birth each one, representing the country average, has life expectancy of less than 50 years. The African and South Asian figures come from 1970, the European figure from 1901. Over the last century, life expectancy for the European child increased by about 30 years, and is still rising (Willets et al., 2004). Between 1970 and 2000, the South Asian's life expectancy rose by 13 years, while for the child in sub-Saharan Africa, during the same period, life expectancy rose by four months (UNDP, 2005).

The improvement in health in 20th-century Europe, North America, and the other countries that now make up the Organisation for Economic Co-operation and Development (OECD), is a major societal achievement. While there is no certainty as to what accounted for the improvement in Europe, it is highly likely it was the result of a combination of improvement in the conditions in which people live and work and, latterly, advances in medical care.

Figure 1: Life expectancy at birth by region, 1970–1975 and 2000–2005



Source: UNDP, 2005.

We start from the proposition that Africa should not be condemned to its ill-health any more than South Asia was in 1970 or Europe was in 1900. The health achievements that Europe has enjoyed have already started happening in South Asia and other regions (Figure 1) – but have considerable distance still to go – and could happen in sub-Saharan Africa. No country or region should have to live with levels of ill-health that are avoidable. The lack of improvement in health in the countries of central and eastern Europe and the former Soviet Union is of concern just as are the other differences shown in Figure 1. Improvements in living and working conditions, and finding a way to deliver known medical solutions, would lead to dramatic reductions in these global inequalities in health.

These inequalities in health need not exist. Look at the experience of women giving birth. In many poor countries, maternal mortality ratios exceed 500 per 100 000 live births. In Sweden the ratio is 2 per 100 000.

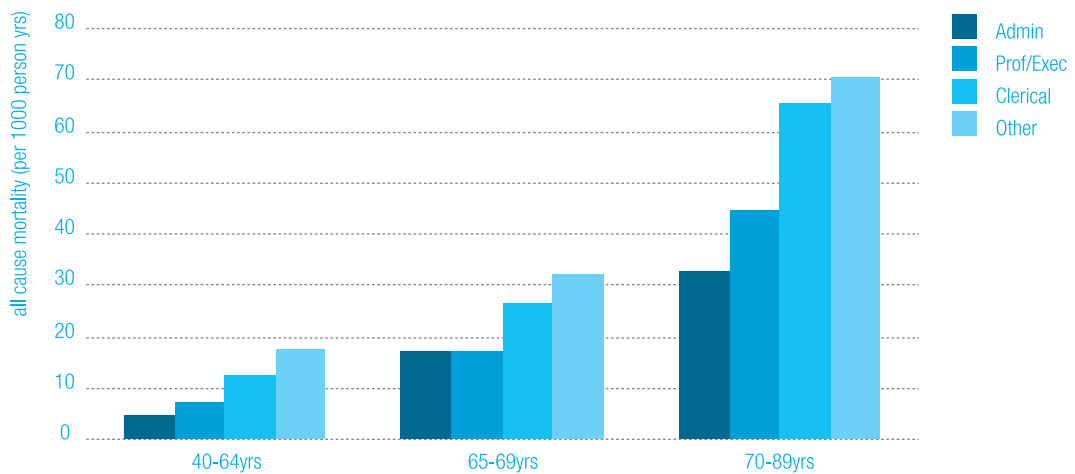
Health inequalities within countries and the social gradient

There is a second problem of inequalities in health: the dramatic differences within countries. These differences in health occur along a number of axes of social stratification including socioeconomic, political, and cultural. One way of describing the magnitude of inequalities is the gap between top and bottom socioeconomic groups. In El Salvador, for example, if mothers have no education their babies have 100 chances in 1000 of dying in the first year of life; if mothers have at least secondary education the infant death rate is a quarter of that (World Bank, 2006b).

Such dramatic inequalities in health within countries are seen in rich as well as poorer countries. In the Scottish city of Glasgow, life expectancy of men in one of the most deprived areas was 54 years, compared with 82 years in the most affluent (Hanlon, Walsh & Whyte, 2006). This means that the poorest men in Glasgow have lower life expectancy than the Indian average. Men with the lowest life expectancy in the United States of America, 1997–2001 (Murray et al., 2006) had lower life expectancy than the Pakistan average, 1995–2000 (UNDESA, 2006b). In every instance, indigenous peoples of the world have life expectancies lower than the national average (CSDH, 2007).

Focusing on the gap between top and bottom, however, fails to draw attention to a pervasive phenomenon: the social gradient in health (Marmot, 2004), see Figure 2. With few exceptions, the evidence shows that the lower an individual's socioeconomic position the worse their health. There is a social gradient in health that runs from top to bottom of the socioeconomic spectrum. The effects of the gradient can be dramatically obvious and they can be quite subtle. In general, people second from the bottom have worse health than those above them but better health than those below. In Sweden, adults with a Ph.D have lower mortality than those with a professional qualification or Master's degree (Erikson, 2001). This is a global phenomenon, seen in low, middle and high income countries (Victora et al., 2003). The gradient in health should not deflect attention from the plight of people at the bottom of the gradient, the poorest of the poor. Rather, the social gradient in health means that we are all implicated.

Figure 2: Mortality over 25 years according to level in the occupational hierarchy, Whitehall study

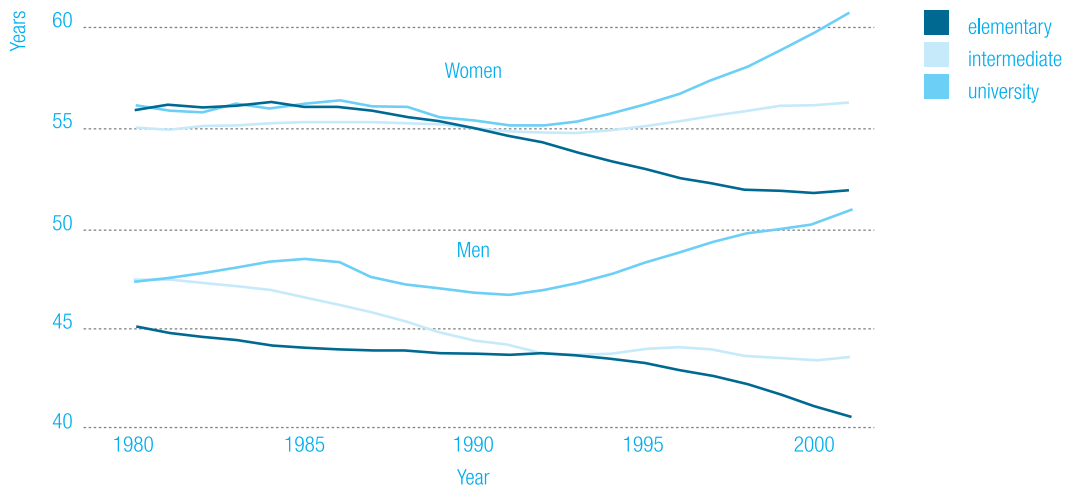


Source: Marmot & Shipley, 1996.

Inequalities in health within and between countries arise from inequalities within and between societies: inequalities in social and economic conditions and their effects on people's lives that determine their risk of illness and the actions taken to prevent or treat illness when it occurs. Such inequalities are not inevitable or fixed. There are ample instances of widening inequalities. For example, we see increasing differences in the Russian Federation in life expectancy by level

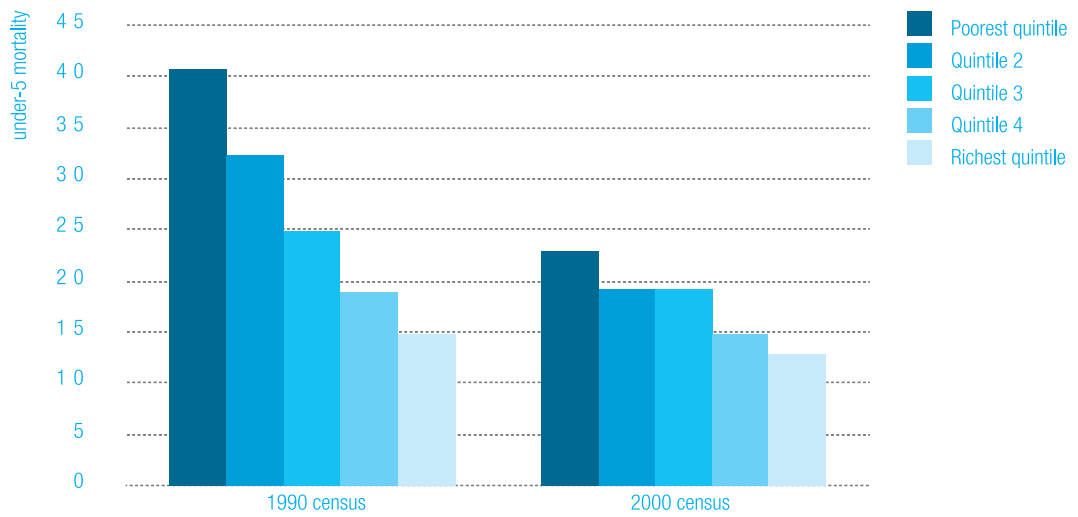
of education among both men and women (Figure 3). There is also good evidence that conditions can be changed for the better (Figure 4). A central aim of the CSDH is to assemble the evidence, particularly of what will make a difference, in order to lay the basis for action to reduce inequalities in health within and between countries. Where such evidence is lacking the Commission will make recommendations on how to redress the gaps.

Figure 3: Trends in male and female life expectancy at age 20, by educational attainment, Russian Federation



Note: Reproduced with permission from the American Public Health Association.
 Source: Murphy et al., 2006.

Figure 4: Under-5 mortality rates by wealth quintile, 1990 and 2000, Thailand



Source: Vapattanawong et al., 2007.

Justice, inequality and inequity

All societies have social hierarchies in which economic and social resources, including power and prestige, are distributed unequally. The unequal distribution of resources impacts on people's freedom to lead lives they have reason to value (Sen, 1999). This in turn has a powerful impact on health and its distribution in society. The Commission takes issue with the unequal distribution of social conditions when health suffers as a consequence.

Not all health inequalities are unjust or inequitable. If good health were simply unattainable, this would be unfortunate but not unjust. Where inequalities in health are avoidable, yet are not avoided, they are inequitable. This can be illustrated by the difference in men's and women's health. Women, in general, live longer than men. This is likely to be a consequence of biological sex differences, and is not, therefore, inequitable. However, in cases where women have the same or lower life expectancy as men – that is, where social conditions act to reduce the “natural” longevity advantage of women – this inequality is a mark of gross inequity (Sen, 2003). The injustice that the Commission seeks to redress comes from failure to achieve levels of health that, but for lack of action, should be attainable.

The right to the highest attainable level of health is enshrined in the Constitution of the World Health Organization and numerous international treaties (UN, 2000a). This right obliges governments and others to act – to take steps that increase all individuals' chances of obtaining good health. The realization of this right, however, will take not just access to health care but action on the social determinants of health.

While we see health as having intrinsic value – health as an end in itself – the Commission also recognizes its instrumentality. Good health enables people to participate in society, with potentially positive consequences for economic performance (CMH, 2001; Mackenbach, Meerding & Kunst, unpublished). Addressing the social determinants of health will yield greater, and sustainable, returns to existing efforts to improve global health.

Empowerment and freedom – dealing with poverty and the gradient

At the heart of the concern with social determinants of health, and health inequity, is concern for people without the freedom to lead flourishing lives (Sen, 1999). To make a fundamental improvement in health equity, technical and medical solutions such as disease control and medical care are, without doubt, necessary – but they are insufficient. There will need to be empowerment of individuals, communities, and whole countries.

We see empowerment operating along three interconnected dimensions: material, psychosocial, and political. People need the basic material requisites for a decent life, they need to have control over their lives, and they need political voice and participation in decision-making processes. Although individuals are at the heart of empowerment, achieving a better distribution of power requires collective social action – the empowerment of nations, institutions, and communities.

The differential status of men and women in almost every society across the globe is perhaps the single most pervasive and entrenched inequity. As such, the relation between the genders represents as pressing a societal issue for health as the social gradient itself. Indeed the feminization of the catastrophic AIDS epidemic in southern Africa is a clear demonstration of the lack of power of women to enjoy fundamental social

freedoms (Lewis, 2005). This marked health inequity encapsulates disempowerment at many levels – government and institutional incapacity to act on evidence of gendered impact, and the unequal participation of women in political institutions from village to international levels; unequal access to and control over property, economic assets and inheritance; unequal restrictions on physical mobility, reproduction and sexuality; sanctioned violation of women's and girls' bodily integrity and accepted codes of social conduct that condone and even reward sexual violence against women. It is not enough to focus on delivering antiretrovirals to women with AIDS in southern Africa if little is done to deal with their profound disempowerment.

The impact of these processes of disempowerment is shown dramatically among indigenous peoples, who are among the most marginalized and disenfranchised peoples in the world, experiencing profound dispossession of land and erosion of culture. It is argued that their crisis situation is “most clearly reflected in the health status of indigenous peoples around the world, with wide disparities between the health status of indigenous peoples and non-indigenous peoples within the same country” (Nettleton, Napolitano & Stephens, 2007).

In emphasizing the need for both empowerment and technical solutions, we draw the parallel with contemporary

models of development (Marmot, 2006). It is now recognized that an increase in national income, by itself, does not capture development in its fullest sense. At the least, education and health should be included (UNDP, 2005). To achieve development in this fuller sense, economic growth is insufficient – it needs to proceed hand in hand with empowerment (Stern, Dethier & Rogers, 2004).

A social determinants of health approach has several advantages. It bridges the artificial distinction between technical and social interventions, and demonstrates how both are necessary aspects of action. It seeks to redress the imbalance between curative and preventive action and individualized and population-based interventions. Also, by acting on structural conditions in society, a social determinants approach offers a better hope for sustainable and equitable outcomes (Baum, 2002).

SOCIAL DETERMINANTS OF HEALTH AND HEALTH EQUITY: “THE CAUSES OF THE CAUSES”

There is not a great deal of mystery as to why poor people in low income countries suffer from high rates of illness, particularly infectious disease and malnutrition: little food, unclean water, low levels of sanitation and shelter, failure to deal with the environments that lead to high exposure to infectious agents, and lack of appropriate medical care. Similarly, we have a great deal of knowledge of the causes of noncommunicable disease that represent the major burden of disease for people at the lower end of the social gradient in middle and high income countries. The WHO/World Bank Global Burden of Disease study identified underweight, overweight, smoking, alcohol consumption, hypertension, and sexual behaviour as major causes of morbidity and mortality (Lopez et al., 2006). In both situations the question is how these causes, and their inequitable distribution, come about. That is, what are the causes of the causes? This brings us to the social determinants of health and health equity.

Conceptualizing the causes

The question that the Commission is ultimately seeking to answer is what would social action to tackle these inequities look like? Recommendations to this end will be made in the Commission’s Final Report in 2008. In order to answer that question we first seek to understand and articulate the causes of health inequities. The Commission believes that these health inequities are the result of a complex system operating at global, national, and local levels.

The global context affects how societies prosper through its impact on international relations and domestic norms and policies. These in turn shape the way society, at national and local levels, organizes its affairs, giving rise to forms of social position and hierarchy. Where people are on the social hierarchy affects the conditions in which they grow, learn, live, work and age, their vulnerability to ill-health, and the consequences of ill-health.

Contextualizing all of these levels is the natural environment, and the macro/micro-level impacts of environmental change. Risks to health include the impacts of heatwaves and other extreme weather events, changes in infectious disease patterns, effects on local food yields and freshwater supplies, impaired vitality of ecosystems, and loss of livelihoods. If present trends continue, the adverse health impacts from human-induced environmental changes will be distributed unequally. The poor, the geographically vulnerable, the politically weak and other disadvantaged groups will be most affected. Addressing the intersection between social determinants of environmental change and the impact of environmental change on health inequities will benefit sustainable ecology and population health alike (McMichael et al., in preparation). A background paper on the conceptualization of social determinants of health can be found in Solar & Irwin, 2007.

Thematic determinants

In order to translate this conceptual understanding into action on the social determinants of health, the Commission convened nine thematic Knowledge Networks: Globalization, Health Systems, Urban Settings, Employment Conditions, Early Child Development, Social Exclusion, Women and Gender Equity, Measurement and Evidence, and Priority Public Health Conditions. Each network is reviewing evidence of what we know, what is likely to work, and why. In addition other key factors such as violence and conflict, food and nutrition, and the environment were investigated. The full range of issues investigated within the knowledge work stream is listed in the Annex. Recommendations based on a comprehensive analysis of this work will be reported in the Commission's Final Report in 2008.

The discussion that follows outlines what the Commission believes to be major social determinants of health and health equity. It draws on work from the above thematic areas and is organized around key groups of social determinants of health, working from intermediate factors towards more structural determinants.

Panels 1 to 3 illustrate case-studies from low, middle and high income countries. The examples not only embody the range of social determinants of health – the causes of the causes – but, perhaps more importantly, illustrate types of action that can be taken. Action is needed that tackles the range of health determinants – from structural conditions of society to the more immediate influences, at all levels from global to local, across government. It should be emphasized that the Commission sees action as a truly multi-stakeholder process, including government and non-government actors, civil society more broadly (including trades unions, political parties, popular movements and alliances), private sector organizations and, critically, health practitioners themselves. Crucial to multilevel, multisectoral action is coherence. None of the three case-studies captures all elements of the ideal comprehensive strategy necessary to tackle health inequities. Rather, the case-studies illustrate a variety of approaches currently used to prevent and redress the unequal distribution of health within these countries.

Panel 1: The Self-Employed Women's Association (SEWA), India

Many Indians, both urban and rural dwellers, experience severe disadvantage as a result of low social status, the combined effect of caste, education and income. They have poor housing, with limited access to clean water and sanitary facilities. They have little in the way of financial resources and experience difficulty pursuing their rightful livelihoods. Their children have had little opportunity for development and education, especially where they forego schooling to work with their parents. When ill, they have little access to health care, which is frequently only available for a fee.

In Ahmedabad, there are around 100 000 street vendors, forming a sizeable proportion of the informal employment sector in the city. They sell fruit, vegetables, flowers, fish, clothes, vessels, toys, footwear, and many other items for daily and household use. Most vendors have been selling in the city's markets and streets for generations.

Like other poor self-employed women, the vegetable sellers of Ahmedabad live in poor parts of the city. They start work at dawn, buying their wares from merchants in the wholesale markets. They frequently need to borrow money, incurring very high rates of interest, and routinely face harassment and eviction from their vending sites by local authorities. The Self-Employed Women's Association (SEWA), a union of almost one million workers, is a striking example of collective action by these women and others like them, to challenge and change these conditions.

To strengthen control over their livelihoods, vegetable sellers and growers (all SEWA members) linked together to set up their own wholesale vegetable shop, cutting out exploitative middlemen. As a result, both growers and sellers have seen improved incomes through better prices for their produce. SEWA also organizes child care, running centres for infants and young children, and

campaigns at the state and national level for child care as an entitlement for all women workers. Further, SEWA members are improving their living conditions through slum upgrading programmes to provide basic infrastructure such as water and sanitation. This happens in partnerships with government, people's organizations and the corporate sector.

In order to solve the problem of access to credit, the SEWA Bank provides small loans and banking facilities to poor self-employed women, such as the vegetable sellers, avoiding the huge interest rates demanded by private loan agents. The Bank is owned by its members, and its policies are formulated by an elected Board of women workers.

In times of health crisis, poor families not only lose work and income, but often also have to sell assets to secure the wherewithal to pay for treatment: poor informal sector workers and their families are pushed further into the cycle of poverty and indebtedness. With SEWA, however, when the vegetable sellers or their family members fall ill, collectively organized health insurance can be used to pay for health-care costs. SEWA has started an integrated insurance scheme for women in times of crisis.

Frequently harassed by local authorities, the vegetable sellers campaigned with SEWA to strengthen their status, through formal recognition in the form of licences and identity cards, and representation on the urban Boards that govern market activities and urban development. That campaign, started within Gujarat, subsequently went all the way to the India Supreme Court, and inspired international attention and alliances.

*SEWA web site:
<http://www.sewa.org/services/bank.asp>*

Panel 2: Conditional income transfer (Bolsa Familia), Brazil

In many ways, Brazil in recent years is a good example of managed growth and commitment to poverty reduction. However, even though the government of President Lula Da Silva has set a course to redress the high rates of inequality in the country, chronic poverty in parts of Brazil means that the poorest households continue to suffer from multiple forms of disadvantage. Such households are frequently unable to secure adequate nutrition for the family, and in rural areas can be highly vulnerable to environmental hazards such as drought and flood. The poorest urban households are not connected to either water or sewage systems, and poor communities have no waste collection services. Poor access to education leads to relatively high rates of illiteracy, compromising employment opportunities for young men and women.

The period of “re-democratization” from the mid-1980s brought with it significant changes in Brazil’s approach to governance, social policies, and poverty reduction. A key component of this new policy environment is the Family Stipend Programme, or Bolsa Familia, a form of conditional cash transfer targeted at poor and extremely poor families to mitigate key aspects of extreme poverty and reduce inequality.

Bolsa Familia, launched in October 2003, unified four federal programmes designed to deal with key aspects of household wellbeing among the poorest families. These were: the School Stipend, Food Stipend, Food Card, and Fuel Support Programmes. Conditionalties stipulated that children between seven and 15 years of age should regularly be attending school, and that growth, nutrition, development and immunization status of children from birth to six years of age should be monitored regularly. The programme also included pre-natal care for pregnant women.

Complementary interventions, designed to safeguard household income and promote further poverty reduction, included adult literacy classes, aid to family-based agriculture, access to microcredit, and professional/vocational training. At the federal level, the programme was coordinated through an Inter-Ministerial Management Committee. Originally, the Bolsa Familia secretariat was directly linked to the President’s office. While municipalities were responsible for registering eligible families, the legislation enacting Bolsa Familia established local councils, including the participation of civil society organizations, to monitor interventions (Magalhaes et al., 2007).

Bolsa Familia represents a holistic approach to social welfare, reduction of poverty, and the interconnected conditions that lead to poor and inequitable health. Coordinated across sectors through interministerial management, the programme acts on key aspects of wellbeing at the family and household level – from child development through stimulating uptake of health and education services, through nutrition for children and mothers, to living conditions with the fuel subsidy, and employment through vocational training, support to family agriculture, and microcredit facilities.

Although the share of total income represented by the conditional income transfers has been relatively small, the programme’s outstanding targeting (using a unified registry) has resulted in an impressive equalizing impact, responsible for about 21% of the fall in the Brazilian Gini index (Soares et al., 2007).

Panel 3: Multilevel intersectoral action for health, Sweden

Sweden is, in general, a healthy place to live; life expectancy is among the highest in the world and infant mortality among the lowest (National Board of Health and Welfare, 2006). Comparing absolute levels of mortality for manual and non-manual workers, Sweden has lower health inequities than other European countries (Vågerö & Erikson, 1997). Health in Sweden is contextualized by a stable, wealthy democracy with strongly developed social welfare policies broadly based on equal treatment (Navarro et al., 2006). The changing global context, in combination with an economic recession in the early 1990s, is, however, affecting the way work and life are organized. Although health is improving for all groups, health inequalities are growing.

Structural intervention

Norrbottnen, an area in the north of Sweden, is characterized by traditional livelihoods in logging and mining. The region has started to see effects of globalization in the increasing segmentation of traditional sectors, and increasingly precarious forms of employment – reflected in high and rising rates of sickness absence. The region has among the lowest rates of disposable income per person in the country. There are higher rates of death from cardiovascular diseases, suicide and alcohol-related diseases, particularly among men. Norrbotten's unemployment rates are higher and education levels are lower than the national averages. The FRISK Initiative by the governor of Norrbotten is aimed at structural drivers in the field of employment and working conditions. While concerned initially with sickness absence it now takes an integrated

approach to: (i) management training with a focus on positive health effects and health promotion; (ii) improving the work environment and increasing worker safety; (iii) providing information resources for the expansion of professional networks; and (iv) supporting the rehabilitation of individuals who have been long-term unemployed (http://www.euro.who.int/socialdeterminants/socmarketing/20070220_3).

Community intervention

A more disease-oriented approach, combining individual and population-level efforts involving multiple sectors, is the Västerbotten Intervention Programme. Västerbotten, a county in northern Sweden, had the highest cardiovascular mortality in the country. A long-term prevention programme was initiated in 1985 to work towards solving this problem. In particular, the community intervention in Norsjö has been followed carefully and offers valuable experience for other communities. Contrary to other models, the health sector and its primary health-care providers took an active role in the work, including health counselling and food labelling. In the 10-year evaluation, the intervention area had a significantly larger decline in cholesterol, systolic blood pressure and predicted coronary disease mortality (Weinehall et al., 1999, 2001). People with lower education seemed to benefit the most from the prevention programme, suggesting that the reduction of health inequity is possible through this type of approach.

Growing, living and working

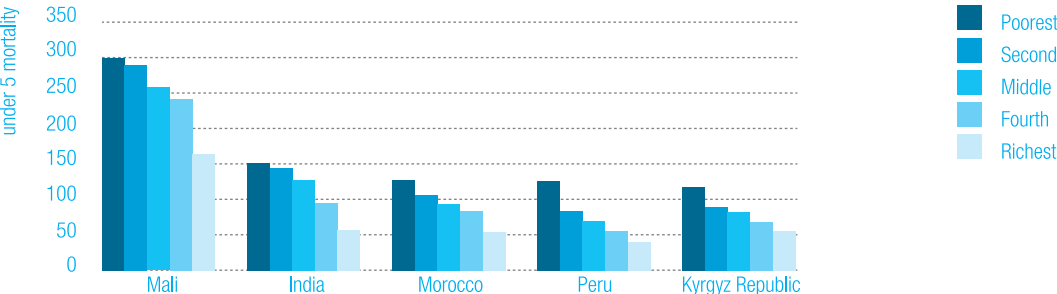
The three panels demonstrate how a combination of environments – home, school, work, neighbourhood, and the health-care system – can unequally expose different groups to health damaging factors; but they also show how action on the conditions within the environments can improve people’s material conditions, psychosocial resources, and behavioural opportunities.

Each year, 4 million babies die within the first four weeks of life; 450 babies every hour (Lawn, Cousens & Zupan, 2005).

The growing environment: child survival, early child development and education

The tragedy of infant and child deaths in poor countries is that the majority are preventable. Child mortality shows a clear social gradient (Figure 5) (Gwatkin et al., 2000). There is no necessary biological reason why this should be so. In the ideal situation that inequalities in under-5 mortality were eliminated, under-5 mortality would be reduced by 30–60% in most low and middle income countries (Houweling, 2007).

Figure 5: Under-5 mortality (per 1000 live births) by wealth group

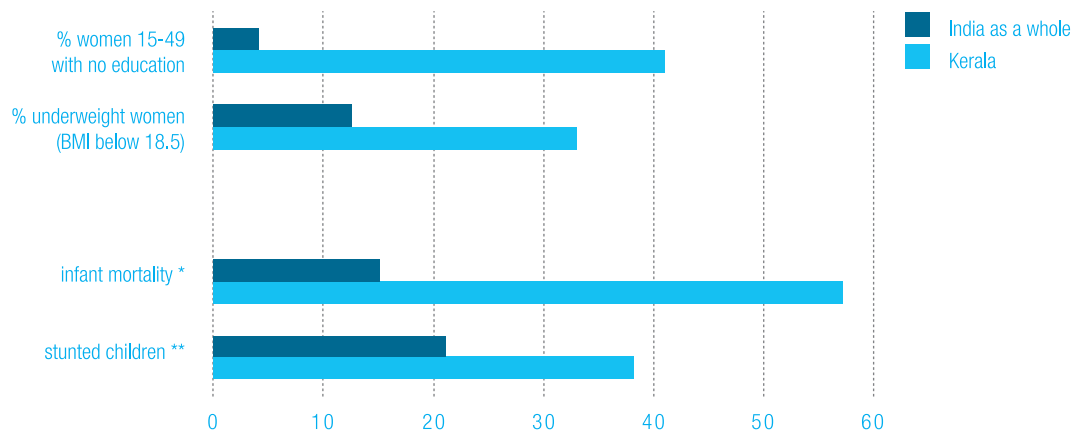


Source: Gwatkin et al., 2000.

A comparison of the Indian state of Kerala with the rest of India (Figure 6) shows how a combination of technical and social interventions is necessary. Women in Kerala are better nourished and better educated than the average in India. It is a reasonable speculation that the better survival and lesser stunting of their children is a direct result of maternal education and better nutrition

for mothers and children. Bolsa Familia in Brazil (Panel 2), like many other cash transfer programmes around the world, takes maternal and child nutrition as one of its key areas for intervention. There is a body of evidence that points to the importance of education of women for child survival (Cleland & van Ginneken, 1988).

Figure 6: Impact of better education and nutrition for women on nutrition and health for families, Kerala, India



* Infant mortality per 1000 live births in the previous five years.

** Percentage of children under the age of three years who are stunted (too short for age).

Source: Ministry of Health and Family Welfare, Government of India (n.d.), National Family Health Survey 2005–2006.

Child survival is essential – but so is the quality of children’s development. The seeds of adult health and health inequity are sown in early childhood. Over 200 million children worldwide are not reaching their development potential (Grantham-McGregor et al., 2007). There are four major preventable risk factors, each directly connected with poverty: stunting, iodine deficiency, iron-deficiency anaemia, and inadequate cognitive stimulation. The figure of 200 million children not achieving their development potential is based on defining poverty at \$2 a day. If poverty is bad for children’s development it is likely to be a graded phenomenon just as is child survival: hence the likelihood of many more than 200 million children who are being harmed by omission. The Commission’s Early Child Development Knowledge Network stresses the need for a balanced approach to children’s development, comprising physical, cognitive/language, and social/emotional components.

In addition to economic circumstance, each component of child development is dependent on the nature of the environments in which children exist. A child’s early environment has a vital impact on the way the brain develops. The more stimulating

the environment, the more connections are formed in the brain and the better the child thrives in all aspects of life: physical development, emotional and social development, and the ability to express himself or herself and acquire knowledge. While physical health and nutrition are important, a young child needs to spend its time in caring, responsive environments that protect from inappropriate disapproval and punishment. Children need opportunities to explore their world, to play, and to learn how to speak and listen to others.

In Brazil, the Bolsa Familia programme clearly illustrates a central concern with supporting and improving the development of children and the household conditions that contextualize that development. Although originating in a relatively top-down policy-driven approach, the conditional income transfer model focuses centrally on the empowerment of households to break intergenerational poverty through enhanced and more equitable support to childhood as a critical goal.

Education and the life-course

While vitally important for childhood health, early child development has far reaching societal impact, accumulating over the life-course with implications for health inequities in adult life. One key factor that may mitigate adverse child development is education. Education and the associated high social standing in adult life may protect against health-damaging early life exposures (Barker et al., 2001).

Universal primary education is one of the Millennium Development Goals. It is likely that inadequate education plays a key causal role in generating health inequities (Smith, 2005), at least in part, because it has a profound influence on income, employment status and living conditions in adulthood. Removing the numerous barriers to achievement of primary education will

be a crucial part of action on the social determinants of health. Prominent among these will be removing the financial barriers that prevent the poorest children from attending school, as in the recent removal of user fees in primary education in Kenya.

The importance of education is not limited to primary education nor to low income countries. A key measure of social stratification in countries rich and poor is education – at a fundamental level, this raises the central role of literacy in health equity. The influence of education on health is seen not only as a difference between those with some and those with none but it is a gradient that runs to the highest level (Erikson, 2001).

Over 121 million primary school-age children are out of school (UNICEF 2004).

Female adult literacy varies from 12% in Mali and 13% in Afghanistan to 100% in Cuba, Estonia, Latvia, Lithuania, and Slovakia (World Bank, 2006a).

The urban living environment

Of the 3 billion people who live in urban settings, about a billion live in slums (UN-HABITAT, 2005).

In 2007, more than half the world's population lives in urban areas. Urban dwelling has long been a way of life in high income countries where nearly 100% of the urban population have access to improved sanitation facilities. In low income countries only 61% of urban dwellers do (World Bank, 2006a). In most African countries the majority of the urban population lives in slums. In Kenya, for example, 71% of the urban population are slum dwellers.

Both the physical environment and social conditions can influence health and lead to health inequities. To create decent living conditions in the rapidly growing urban areas is a major challenge for government

Only 38% of the population in low income countries have access to improved sanitation facilities, whereas the figure is 100% in high income countries (World Bank, 2006a).

authorities at all levels: local, regional and national. Better housing and living conditions, access to safe water and good sanitation, efficient waste management systems, safer neighbourhoods, food security, and access to services such as education, health, welfare, public transport, and child care are examples of social determinants of health that can be addressed through good urban local governance.

The scale of the urban problem may seem vast and unmanageable. However, urban areas can provide a healthy living environment; indeed, they can improve health via their various material, service provision, cultural and aesthetic attributes (Kirdar, 1997). The improvements over the last 50 years in mortality and morbidity in highly urbanized countries such as Japan, the Netherlands, Singapore and Sweden give testimony to the potentially health-promoting features of modern cities.

Over 60% of children in South Asia and sub-Saharan Africa are deprived of reasonable shelter (UNICEF, 2004).

The working environment

For most people in the world, living conditions are largely determined by economic opportunity afforded through the labour market. A major challenge to health is the working environment: working conditions, the nature of employment contracts, and the availability of work itself. In high income countries, much action has been taken on physical and chemical hazards in the workplace. Now, however, the labour market is mainly segmented and precarious employment has become more prevalent. These labour market changes pose major health risks from the psychosocial and economic hazards associated with less job control, insecurity, lack of worktime flexibility and access to paid family leave, and unemployment (Benach & Muntaner, 2007; Bartley, Ferrie & Montgomery, 2006; Marmot, Siegrist & Theorell, 2006). The example

Around 126 million children aged 5–17 years are working in hazardous conditions. Around 5.7 million children are trapped in bonded labour (UNICEF, n.d.).

from Sweden (Panel 3) shows how changing employment conditions towards less job security and control are influencing people's wellbeing and health in a high income country. The example also shows how joined-up governmental action at the regional level, supported by national intersectoral action, can be designed to mitigate such adverse impacts, providing protection against globalization's downsides.

In low income countries these risks are in addition to major persisting physical and chemical hazards. Employment conditions provide a fertile area for major improvements in conditions of the physical and social environment with real opportunities for change. In many countries, the majority of workers are excluded from labour protection. These include workers in cottage industries, agricultural workers (except for

Unemployment rates in France are about twice as high among its immigrant population (ILO, 1998).

plantations), local vendors and workers in small enterprises, domestic workers and homeworkers. Other workers are deprived of effective protection because of weaknesses in labour law enforcement.

A key issue for SEWA is that its members, like more than 80% of workers in India and the majority of people in developing countries, are outside the formal employment sector. They are usually excluded both from the protection afforded by labour standards and from whatever social security provisions are linked to formal employment. Producing goods for export, for example in textiles and clothing, provides employment for people in low income countries. This benefit should not be at the cost of substandard employment conditions that damage health. The price of “cheap” consumer goods for people in high income countries should not be poor health in low income countries.

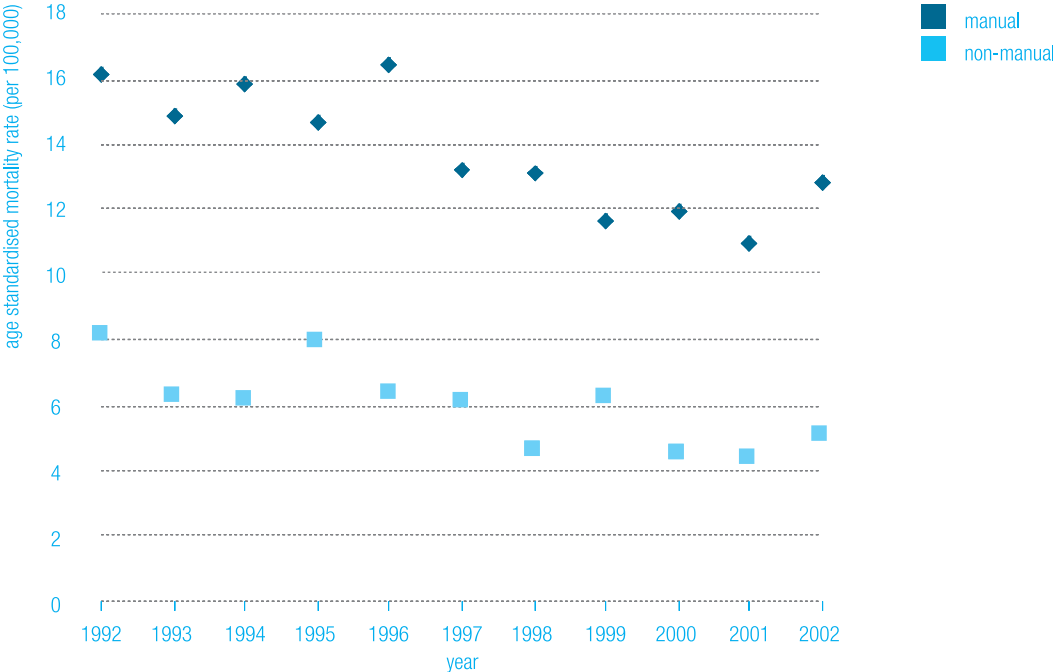
In India 86% of women and 83% of men employed in areas outside the agricultural sector are in informal employment (ILO, 2002); in China, there are now between 100 and 200 million migrant labourers, mostly moving from rural to urban areas (Reuters 2007).

Contextualizing behaviour

Contemporary public health interventions have often given primary emphasis to the role of individuals and their behaviours. The Commission recognizes the important role of these factors, but sets them in the wider social context in order to illustrate that behaviour and its social patterning, as shown in Figures

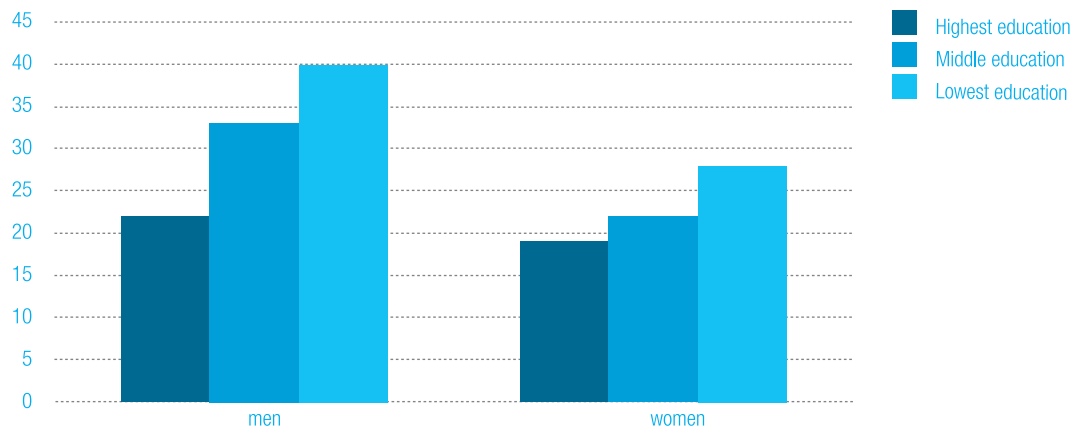
7 and 8, is largely determined by social factors. Cirrhosis mortality shows that the harm associated with heavy drinking is more common in lower socioeconomic groups. We believe that unless action also takes account of the structural drivers of inequity in behaviour, it will not tackle health inequities.

Figure 7: Socioeconomic inequalities in male cirrhosis of the liver mortality, manual and non-manual workers, Australia



Source: Najman, Williams & Room, 2007.

Figure 8: Smoking prevalence (%) and inequalities in smoking by educational level, Europe



Source: Huisman, Kunst & Mackenbach, 2005.

National tobacco control efforts demonstrate the responsiveness of health-damaging behaviours to intersectoral action. Globally, the WHO Framework Convention on Tobacco Control (WHO, 2005b) embraces a social determinants approach to tobacco control that encompasses multilevel, intersectoral action. Countries with more restrictive alcohol policies tend to have lower levels of alcohol consumption, lower levels of liver cirrhosis mortality, lower levels of other alcohol-related mortality, and fewer social problems caused by alcohol use (Room, Babor & Rehm, 2005). There is growing evidence that alcohol would lend itself to a control model similar to that of the tobacco framework.

A relatively new global phenomenon is the “nutrition transition” (Popkin, 1993) – increasing consumption of fats, sweeteners, energy-dense foods, and highly processed foods. The world now faces a double burden of malnutrition – under- and over-nutrition – both of which are socially patterned (Hawkes et al., 2007). Community-based approaches to tackle household food insecurity such as SEWA’s are important parts of the solution. Similarly, the knowledge, attitudes and behaviour focus of the community health promotion intervention in Sweden (Panel 3) demonstrated positive changes in the cardiovascular risk profile of the population, using approaches that required no additional

costs. However, addressing nutrition inequities in a sustainable manner also requires action on the structural drivers of food availability, accessibility and acceptability at the global and national levels (Friel, Chopra & Satcher, in preparation).

Childhood malnutrition is an underlying factor in more than 50% of under-5 deaths (Black, Morris & Bryce, 2003).

In a rich country like Ireland, single parent households with one child would have to spend 80% of their weekly household income in order to purchase a food basket that is compliant with national dietary guidelines (Friel, Walsh & McCarthy, 2006).

Health systems

We have made the point that inequities in health result from the social conditions that lead to illness. That said, given the high burden of illness particularly among the socially disadvantaged, it is urgent to make health systems more responsive to population needs. International, national and local systems of disease control and health services provision are both a determinant of health inequities and a powerful mechanism for empowerment. Central within these systems is the role of primary health care (PHC), as illustrated in the community-based programme in Sweden (Panel 3).

In some instances, health systems actively perpetuate injustice and social stratification. In low and middle income countries, public money for health care tends to go to services that are used more by the rich than by the poor (Gwatkin, Bhuiya & Victora, 2004). Reforms that lead to charging at the point of use are a disincentive to use of health care. Out-of-pocket expenditures for health care tend to deter poorer people from using services, leading to untreated morbidity (Palmer et al., 2004). Such expenditures can also lead to further impoverishment (Whitehead, Dahlgren & Evans, 2001) or bankruptcy (Gottlieb, 2000). The larger the proportion of health care that is paid out of pocket, the larger the proportion of households that is faced with catastrophic health expenditures (Xu et al., 2007).

The conditional cash transfer model of Bolsa Familia, for example, stimulates uptake of health services that typically do not get to poor communities. While financial support to improve access to and use of health services among the poor is vital in the short term, the underlying issue for policy intervention is the need to reduce and remove financial barriers to such services. National health systems are pivotal in tackling health inequities; in order to do so effectively they need to be adequately resourced, function well, and be accessible to all. Appropriately configured and managed health systems provide a vehicle to improve people's lives, protecting them from the vulnerability of sickness, generating a sense of life security, and building common purpose within society; they can ensure that all population groups are included in the processes and benefits of socioeconomic development and they can generate the political support needed to sustain them over time. Current efforts to revitalize primary health care globally (PAHO, 2007) should go hand in hand with attention to the social determinants of health.

Just as a social determinants approach to improving health equity must involve health care, so must programmes to control priority public health conditions include attention to the social determinants of health. Such action has to involve multiple sectors in addition to the health-care sector. It is not sufficient,

for example, to provide treatment for people with diabetes in middle income countries and not deal with the drivers of the obesity epidemic; to be concerned with childhood illness and not education of women who will become mothers; to deliver health education to individuals and not be concerned with their poverty; or to deal with stress-related illness and ignore the conditions in which people live and work that gave rise to it.

The Commission has convened a network on Priority Public Health Conditions at WHO headquarters in Geneva, working with a number of disease control programmes to bring these approaches together. For example, work by the WHO Stop TB programme notes that tuberculosis is associated with patterns of social and economic development that include rapid urbanization, inequitable economic growth and presence of large pockets of social deprivation. Lasting control of tuberculosis requires the combination of treatment and preventive action, taking into account biological and health behavioural factors, health service responsiveness, and socioeconomic conditions.

Over half a million women die each year during pregnancy, delivery or shortly thereafter, virtually all in developing countries (WHO, 2005a)

In the USA, health-care use is lower among the uninsured (Hadley, 2007), more than 40 million people.

More than 100 million individuals globally are impoverished through direct health-care expenditure (Xu et al., 2007).

The shape of society

Health inequities reflect the unequal distribution of power, prestige and resources among groups in society. All societies are stratified along lines of ethnicity, race, gender, education, occupation, income and class. We see this very clearly in each of the case-studies from India, Brazil and Sweden described in the panels. Although at very different stages of economic development, the differentiation of certain groups – be it by gender, caste, education, place, or income – is key to the way health inequity is generated.

Stratification creates advantage and disadvantage across social groups. Progressive disadvantage can lead to marginalization and disproportionate vulnerability among those excluded from societal benefits. These processes of disempowerment can operate not only at the level of individuals, households, groups, and communities, but also among countries and global regions.

Gender is perhaps one of the most powerful illustrations of imbalance in societal power, prestige and status, and its effects in the unequal health experiences of men and women worldwide. At the core of gendered health inequity are social norms and structures that support and perpetuate bias.

In sub-Saharan Africa, women undertake more than 75% of agricultural work, yet they own less than 10% of the land (UN Millennium Project, 2005).

In Mexico, 35.2% of young women aged 15–24 years are not in the labour force and not in education, compared with 5.3% of young men in that age group (World Bank, 2007).

Gender bias affects almost every aspect of social organization and consequent conditions of life and work, from unequal access to and control over property, economic assets and inheritance; division of labour within and outside the home; unequal participation in political institutions from village to international level; to restrictions on physical mobility, reproduction and sexuality, and sanctioned violence against women and girls.

The marginalization of working women in India is dramatic and clear from SEWA's account. The emphasis in conditional cash transfer programmes – such as that in Brazil – on channelling resources via female household members demonstrates the importance that the policy of such programmes places on supporting women's role in protecting children's development and promoting family health. The Swedish example, too, shows how global and national changes in the organization of production can have disproportionate effects on women. The response of the regional government to focus on gender equity as a core objective reflects the concern for this pervasive phenomenon.

SEWA's range of actions shows the importance of a multilevel approach to addressing gender inequity. While supporting its members' material circumstances and working arrangements, SEWA also takes action to challenge the Indian legal system, taking the local experience of empowered SEWA women to the national level of equity-related governance.

Because of the numbers of people involved and the magnitude of the problems, taking action to improve gender equity in health and to ensure women's rights to health care is one of the most direct and potent ways to reduce global health inequities and ensure effective use of health resources.

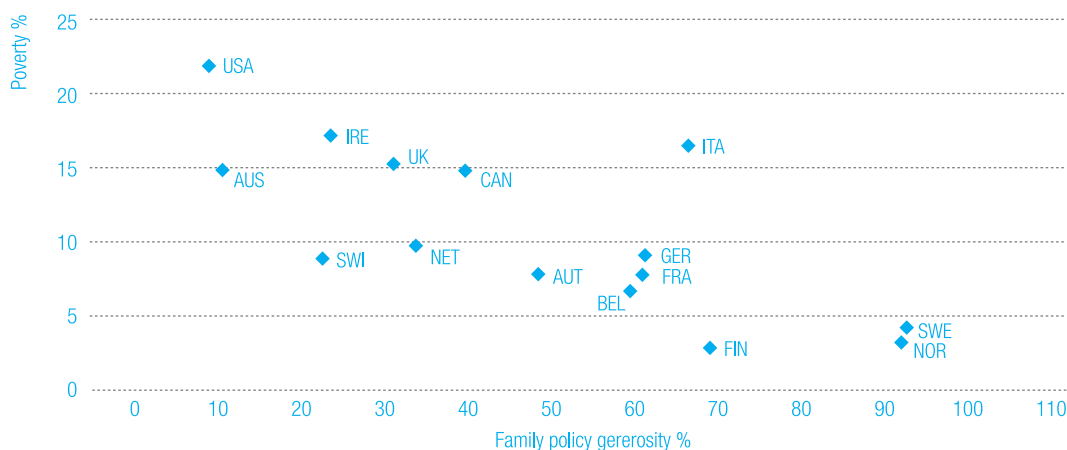
150 million girls under the age of 18 years experienced forced sexual intercourse or other forms of physical and sexual violence in 2002 (Pinheiro, 2006).

The social context

Economic and social policies affect the distribution of the social determinants of health, including resources for education, health, and financial security. It is clear, therefore, why the relationship between ministries of health and ministries of finance is so vital to a social determinants view of health. Recognition of the importance of social determinants of health means that government social policy, not just health policy, is vitally important for health equity. This taps deep into the value system of society. The promotion of health equity relies on values but it also requires the strengthening of evidence in policy formation.

As Figure 9 illustrates, pro-health equity policies appear to rely in many cases on the state in providing an adequate degree of security – via welfare programmes and the provision of a universal social safety net. Such policies may include: housing, health and safety standards, family-friendly labour policies; active employment policies involving training and support; the provision of social safety nets, including those for income and nutrition; and the universal provision of good quality health, education, and other social services.

Figure 9: Total family policy generosity and child poverty in 15 countries, 2000 or nearest



Notes: Net benefit generosity of transfers as a percentage of an average net production workers' wage. Poverty line 50% of median equivalized disposable income.

Source: Lundberg et al., 2007, based on Luxembourg Income study data.

Sweden has, for much of the post-Second World War period, maintained very strong state-led welfare policies. The political support for this policy orientation has much deeper roots in the way in which Sweden, and to a degree other Nordic countries, developed over several centuries. Following three decades of military dictatorships, Brazil has emerged into a period of democratization. With this, a strong commitment to tackle both poverty and inequity has taken centre-stage in the political sphere. In India, the material conditions of the vegetable sellers of Ahmedabad can be improved in the short term through local forms of collective action and empowerment; but a more sustained empowerment for workers comes from action at the structural level: action through the state and national legislature, and improved access to credit.

Women account for only 17% of parliamentarians worldwide (IPU database).

Many countries spend more on the military than on health. Eritrea, an extreme example, spends 24% of GDP on military and only 3% on health. Pakistan spends less on health and education combined than on military (World Bank, 2006a)

The global arena

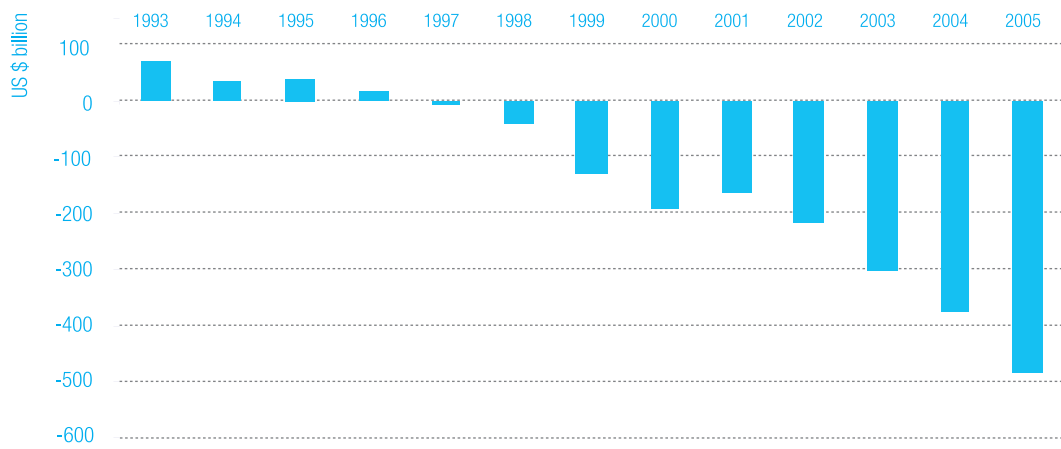
While action by countries and local communities is of profound importance to the social determinants of health, so too is the global context. The global level exercises an increasingly powerful influence on relations between countries and conditions within them. Globalization, with its remarkable acceleration of trade and knowledge and resource flow, offers unprecedented promise for improving human health. Yet, to date, many feel that this promise has been unfulfilled.

The emphasis placed on globalization as an engine of economic growth on a new global scale has overlooked or underestimated the initial conditions of inequality between rich and poor countries, and within them. Where the social institutions through which people share resources are relatively strong and fair, moderate inequality can be “constructive”, driving the efforts and risk-taking at the micro level that underpin economic success. But where institutions governing the distribution of societal resources are weak, corrupted, or structurally inequitable, as they are both within many countries and between the rich and poor regions, inequality can act

destructively, suppressing local enterprise and perpetuating impoverishment (Birdsall, 2007). So far, the benefits of globalization have been largely asymmetrical, creating among countries and within populations winners and losers, with knock-on effects on health.

There is great benefit to be had from increased trade openness, increasing interdependence among nations, and an expanded policy space at the global level to deal with the major issues – environment, health, security – common to all countries (Cline, 2004). Nevertheless there is something profoundly wrong in the assumption that all countries come to these new global fora equally equipped (Birdsall, 2006). Long historical trajectories bring countries together under globalization at dramatically differing levels of institutional capacity and strength. A globalization that does not provide for institutional building among the developing nations is liable to foster and even increase inequity, and to continue to disappoint both its supporters and its critics.

Figure 10: Net financial flows in developing economies, 1993–2005



Source: UNDESA, 2006.

The poorest countries of the world, notably in sub-Saharan Africa, receive only small portions of global financial flows. In fact, net flows are increasingly from developing economies to high income countries, as shown in Figure 10. As a result, developing countries rely heavily on official development assistance to finance critical public expenditure, including health. Such assistance continues to be important as a source of financing, complemented by more extensive forms of debt cancellation. Aid has the potential to lift as many as 30 million people out of absolute poverty each year, although its effectiveness is undoubtedly affected by issues relating to delivery. Strengthened social security systems would in the longer term act as a buffer against detrimental health effects of those benefiting less from trade liberalization (OECD, 2002).

The expansion and liberalization of trade globally has had both positive and negative impacts on health in rich and poor countries. Increased global trade in food products, for example, is associated with the nutrition transition described earlier. The growth of transnational supermarkets has led to changes in food availability, accessibility, price and, through global marketing, desirability. Unregulated, these changes can have very negative health consequences. Trade negotiations that take a balanced view of health and commercial considerations can be beneficial for all in society.

While the Commission recognizes the contribution that economic growth can make to the availability of resources for improving access to social determinants of health and reducing health inequities, it asserts that growth per se is not a sufficient prescription for equitable improvements in population health – nor is growth with inequality a simple or automatic trade-off. Rather, action within and between countries to mitigate and remove structural, destructive inequality is the necessary counterpart to global growth itself and the policies that aim to support it.

Over 60% of the total increase in official development assistance between 2001 and 2004 went to Afghanistan, the Democratic Republic of Congo, and Iraq – in spite of the fact that the three countries account for less than 3% of the developing world's poor (World Bank, 2006)

THE TIME FOR ACTION

We are at a turning point in history. Sixty years ago, in 1948, the establishment of the World Health Organization embodied a new global vision, emerging from the ashes of conflict, of universal health at the highest attainable level. Thirty years later, in 1978, the community of nations came together again in Alma-Ata to call for a new approach to health, one founded in a holistic understanding of local primary health-care needs, across the social determinants, and of people-centred action (WHO, 1978). In 2008, the end of the Commission as a formal entity will, we believe, be the launch of a global movement, one that perceives equitable health as a societal good, at the heart of which lies social action, and a field in which countries and people, rich and poor, can unite in common cause.

Proponents of health for all have been numerous and vocal around the world. The primary health-care movement, though sometimes overshadowed by disease-specific concerns, never died. Indeed primary health care, once again, plays a central role in WHO's current agenda. The 1986 Ottawa Charter on Health Promotion, and its renewal in Bangkok, embraced a truly global vision of public health action and the importance of a social determinants approach (WHO, 1986; Catford, 2005). The Latin American social medicine movement and the People's Health Movement, the General Comment on the Right to Health, and the broad social vision of the Millennium Development Goals all reaffirm the central importance of health, the need for social and participatory action on health, and the core human value of equity in health (Tajer, 2003; PHM, 2000; UN, 2000a; UN, 2000b).

Building on these efforts, the Commission represents a unique opportunity for action – action taken by the wide spectrum of actors interested in better, fairer health. Where in the past efforts have been fragmented, the Commission for the first time brings together at a global scale actors, experiences and evidence concerned with social determinants of health and health equity. At the global level, we now understand, better than at any moment in history, how social factors affect health and health equity. While the need for better evidence remains, we now have the knowledge to guide effective action. By linking our understanding of poverty and the social gradient, we now assert the common issues underlying health inequity. By recognizing the nature and scale of both noncommunicable and communicable diseases, we demonstrate the inextricable linkages between countries rich and poor. Action is needed on the determinants of health – from structural conditions of society to the more immediate influences, at all levels from global to local, across government and inclusive of all stakeholders from civil society and the private sector. Key to multilevel action is coherence.

As processes of globalization bring us closer together as peoples and nations, we begin to see the interdependence of our aspirations – aspirations for human security, including protection against poverty and exclusion; and aspirations for human freedom, not just to grow and flourish as individuals but to grow and flourish together. In these aspirations, we recognize the interconnectedness of the causes of health inequity, and the imperative of action that is global, social and collective.

The goals

The Commission on Social Determinants of Health (CSDH) seeks to create a global movement for health equity, rooted in shared beliefs in social justice and human rights. Realizing the Commission's vision of a world in which people have the freedom to lead the life they have reason to value, requires action on the social determinants of health. The goal of the Commission is to gather evidence, harness national and local efforts, detail what effective social action must entail in order to maintain, promote, and provide better health for all, advocate for change and engage with those responsible for health-related decision-making. The goals of the CSDH are pursued

through a number of work streams operating in parallel: Knowledge Networks, Partner Countries, Civil Society Organizations, and Global Initiatives. Within the various work streams, efforts have been made globally to expand the evidence base on social determinants of health, and in particular on effective action to understand and deal with these determinants. The Commission is supported by a secretariat based in the Department of Equity, Poverty and Social Determinants of Health, WHO, Geneva, Switzerland, and the International Institute of Society and Health, University College London, England.

Commissioners

Leading the CSDH are 19 Commissioners, who are global and national leaders from politics, government, civil society, and academic fields. Through their meetings they steer the Commission in all its processes: from conceptual formulations, through evidence gathering, appraisal, and synthesis to the

formulation of recommendations. Drawing on their expertise and experience, Commissioners communicate the key messages and recommendations of the Commission in policy arenas and focus political attention on the social factors that lead to ill-health.

Knowledge Networks

The Commission has set up nine Knowledge Networks (KNs), arranged around the themes of Globalization, Health Systems, Urban Settings, Employment and Working Conditions, Early Child Development, Social Exclusion, Women and Gender Equity, Measurement and Evidence, and Priority Public Health Conditions. These KNs were established to collect, collate and synthesize a diverse range of evidence on: (i) plausible causal relations; (ii) key areas in which action should take place; and (iii) effective practices and interventions for addressing socially determined health inequities globally.

The KNs comprise one or more coordinating hubs with members drawn from academic, policy, practice and advocacy arenas across low, middle, and high income countries throughout the world. Understanding how social determinants lead to health inequities, and identifying effective responses to address them, requires drawing upon evidence often found outside the biomedical discourse, in a plurality of disciplines such as social policy, urban development, political science, social epidemiology, and gender studies. Knowledge was gathered from diverse sources including peer reviewed literature, grey literature, expert opinion, case-studies, and narratives. The deliberate two-way flow of information to and from KNs to the Commission's other work streams was designed to facilitate the

progressive input from country and civil society experiences and uptake of evidence by countries, institutions, and advocacy groups.

Knowledge Networks: organizational hubs

1. Globalization KN hub

University of Ottawa: Professor Ron Labonte, Hub Leader (rlabonte@uottawa.ca); Professor Ted Schreckler, Hub Coordinator (tschreck@uottawa.ca).

2. Women and Gender Equity KN co-hubs

Karolinska Institute, Sweden, and Indian Institute of Management: Dr Pirooska Ostlin (piroska.ostlin@ki.se) and Professor Gita Sen (gita@iimb.ernet.in).

3. Social Exclusion KN co-hubs

Human Sciences Research Council, South Africa; ICDDR,B and BRAC, Bangladesh; National University and Javeriana University, Colombia; National School of Public Health Sergio Arouca, Oswaldo Cruz Foundation, Brasil; Lancaster University, UK: Dr Laetitia Rispel (LRispel@hsrc.ac.za); Dr Heidi Johnston (hjohnston@icddr.org); Dr Mario Esteban Hernández Alvarez (mehernadesza@unal.edu.co); Dr Sarah Escorel (sescorel@ensp.fiocruz.br); Professor Jennie Popay (j.popay@lancaster.ac.uk).

4. Employment Conditions KN co-hubs

Pompeu Fabra University, Spain, and Federal University of Bahia: Dr Joan Benach (joan.benach@upf.edu & joan.benach@utoronto.ca), Professor Vilma Sousa Santana) and Dr Carles Muntaner (Carles_Muntaner@camh.net).

5. Early Child Development KN hub

Human Early Learning Partnership and the Centre of Excellence in Early Childhood Development: Professor Clyde Hertzman, Hub Leader (clyde.hertzman@ubc.ca); Dr Lori Irwin, Hub Coordinator (lori.irwin@ubc.ca).

6. Urban Settings KN hub

WHO Kobe Centre, Japan: Dr Susy Mercado (mercados@who.or.jp); and Dr Kirsten Havemann (havemannk@wkc.who.int).

7. H Health Systems KN hub

University of Witterasand: Professor Lucy Gilson, Hub Leader (lgilson@iafrica.com); Dr Jane Doherty, Hub Coordinator (jane.doherty@nhls.ac.za).

8. Priority Public Health Conditions KN hub

Department of Equity, Poverty and Social Determinants of Health, WHO, Geneva: Dr Erik Blas, Hub Leader (blase@who.int).

9. Measurement and Evidence KN co-hubs

University del Desarrollo and National Institute for Health Clinical Excellence: Dr Josiane Bonnefoy (josiane.bonnefoy@gmail.com), Professor Mike Kelly (mike.kelly@nice.org.uk) and Mr Antony Morgan (antony.morgan@nice.org.uk).

Knowledge Networks: reports and background documents (as of June 2007)

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- Packer C, Labonté R, Spitzer D, Murphy S, Bhushan A, Warren B (2007). *Globalization and health worker migration*. Background document of the Globalization Knowledge Network of the Commission on Social Determinants of Health.
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- Breilh J (2007). *Globalization and social determinants of health – lessons from the Latin American experience*. Background document of the Globalization Knowledge Network of the Commission on Social Determinants of Health.

- Rowson M (2007). *Globalization, debt and poverty reduction strategies*. Background document of the Globalization Knowledge Network of the Commission on Social Determinants of Health.

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- Bond P (2007). *Trends in global political economy and geopolitics post-1980*. Background document of the Globalization Knowledge Network of the Commission on Social Determinants of Health.

Women and Gender Equity

- Knowledge Network on Women and Gender Equity (2007). *Unequal, unfair, ineffective and inefficient - gender inequity in health: Why it exists and how we can change it*. Final report

- Sen G, Östlin P, Iyer A (in preparation). *Intersectionality in health and health care: a review of research and policy*. Background document of the Women and Gender Equity Knowledge Network of the Commission on Social Determinants of Health.

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- Newman L, Biedrzycki K, Patterson J, Baum F (2007). *South Australia's Social Inclusion Initiative: A Rapid Appraisal Case Study*. SEKN Background Paper 10

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Background case-studies

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 - Barten F, Mitlin D, Mulholland C, Hardoy A, Stern R (2007). Integrated approaches to address the social determinants of health for reducing health inequity. *Journal of Urban Health*, 84:164–173.

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- Knowledge Network on Health Systems (2007). Final report. Final report of the Health Systems Knowledge Network of the Commission on Social Determinants of Health.

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- De Maeseneer J, Willems S, De Sutter A, Van de Geuchte I, Billings M (2007). Primary health care as a strategy for achieving equitable care.
- George A (2007). Human resources for health: a gender analysis.
- Gilson L (2007). What sort of stewardship and health system management is needed to tackle health inequity, and how can it be developed and sustained?
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- Hanefeld J, Spicer N, Brugha R, Walt G (2007). How have global health initiatives impacted on health equity? What strategies can be put in place to enhance their positive impact and mitigate against negative impacts?
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- Public Health Agency of Canada and Health Systems KN (2007). Crossing sectors: experiences in intersectoral action, public policy and health.

- Vega-Romero R, Torres-Tovar M (2007). The role of civil society in building an equitable health system.

Country and regional case-studies

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- Dubowitz T, Anthony R, Bird C, Cohen D, Lurie N (2007). The experience of the USA: health inequity within a high-income setting.
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- Laurell AC (2007). Granting universal access to health care. The experience of the Mexico City government.
- Meng Q (2007). Developing and implementing equity-promoting health care policies in China.
- Perera MALR (2007). Intersectoral action for health in Sri Lanka.

- Ranson K, Poletti T, Bornemisza O, Sondorp E (2007). Promoting health equity in conflict-affected fragile states.

- Tangcharoensathien V, Prakongsai P, Limwattananon S, Patcharanarumol W, Jongudomsuk P (2007). Achieving universal coverage in Thailand: what lessons do we learn?

Case-studies on the role of parliamentarians in promoting health equity

- Chebundo B (2007). The Zimbabwe re-engineered budget process and the impact of its all-stakeholder inclusiveness approach, and how the involvement of EQUINET and other stakeholders contributes towards achieving equitable distribution of health resources.

- Chebundo B (2007). The way parliamentary committees on health have overcome obstacles in creating sustained and coordinated pressures for health through regional networking in Southern and Eastern Africa.

- Health Systems Trust (2007). Manner in which parliamentarians have been able to use the budget process to make visible inequalities in health and to promote equitable distribution in South Africa.

- Mugisha F (2007). The Nairobi Equity Gauge work with parliaments.

Priority Public Health Conditions

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Measurement and Evidence

- Kelly MP, Bonnefoy J, Morgan A, Florenzano F, Friel S, Houweling TAJ, Bell R, Taylor S, Simpson S (2006). *Guide for the Knowledge Networks for the presentation of reports and evidence about the social determinants of health*. Background document of the Measurement and Evidence Knowledge Network of the Commission on Social Determinants of Health.
- Kelly MP, Bonnefoy J, Morgan A, Florenzano F (2006). *The development of the evidence base on the social determinants of health*. Background document of the Measurement and Evidence Knowledge Network of the Commission on Social Determinants of Health.
- Measurement and Evidence Knowledge Network (in preparation). *Promoting standards in the use of measurement and evidence to develop policies and programmes to address the social determinants of health – guidelines and recommendations from the Measurement and Evidence Network (MEKN)*. Background document of the Measurement and Evidence Knowledge Network of the Commission on Social Determinants of Health.

Additional key issues

In addition to the central thematic areas investigated by the Knowledge Networks, key additional factors known to contribute to health and health inequities were investigated, albeit less extensively, and discussion papers and peer-reviewed journal articles were prepared based on a synthesis of existing evidence on a particular topic. These additional key issues include migration, education, aid, ageing, mental health, medical education, indigenous peoples, food and nutrition, violence and conflict, alcohol and tobacco, rural settings, and the environment.

- McMichael AJ, Friel S, Nyong A, Corvalan C (in preparation). Global environmental change and human health: implications for health inequalities, social policy and the health professions. Paper commissioned by the *British Medical Journal*.

- Friel S, Chopra M, Satcher D (in preparation). Unequal weight: equitable policy responses to the global obesity epidemic. Paper commissioned by the *British Medical Journal*.

- Gwatkin D, Taylor S, Marandi SA (in preparation). The social determinants of health and the design of health programmes for the poor. Paper commissioned by the *British Medical Journal*.

- McCoy D (in preparation). Beyond the microbe – the social determinants of infectious diseases calls for social action. Paper commissioned by the *British Medical Journal*.

- Taylor S (2006). *Working paper on violence and injury*. Commission on Social Determinants of Health, University College London.

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- Nettleton C, Napolitano DA, Stephens C (2007). *An overview of current knowledge of the social determinants of indigenous health*. Working Paper for the Commission on Social Determinants of Health.

- Watts S, Siddiqi S, Shukurullah A, Karim K, Serag H (2007). *Social determinants of health in countries in conflict: the Eastern Mediterranean perspective*. Background paper for the Commission on Social Determinants of Health.

- Butler R, Cohen B (2006). *Ageing open letter* from the Panel on the Social Determinants of Adult Health and Mortality, USA.

- Satcher D, Friel S, Bell R (in preparation). The mental health impact of disasters: natural and man-made. Paper submitted to *JAMA*.

- Golkari A, Forde I (2007). *Social determinant of health interventions. The direct financial cost*. A background paper prepared for the Commission on Social Determinants of Health.

- De Maeseneer J, Boelen C, Sewankambo N, Marandi SA, Luboga S (in preparation). How can curricula for health-care workers address the social determinants of health? Paper submitted to *PLoS Medicine*.

Understanding how contextual factors contribute to health and health equity is being explored specifically through two regional networks: Nordic and Asia.

Since 2005, a multicountry project has been undertaken as a contribution to the CSDH. The work, entitled *The Nordic experience – Welfare states and public health*, has been led from the Centre for Health Equity Studies (CHESS), Stockholm University and Karolinska Institute. The cross-country collaboration includes Denmark, Finland, Iceland, Norway, and Sweden and brings together collaborating researchers from Social Medicine, University of Copenhagen, the Danish Institute for Social Research, Copenhagen; STAKES, Helsinki, Department of Public Health, University of Helsinki; Research Centre for Occupational Health and Working Life, Reykjavik; Oslo University College, NOVA, Oslo; and Institute for Futures Studies, Stockholm. The NEWS

Project attempts to bring together “historical and sociological knowledge on welfare state development and cross-national variation” with “public health knowledge on social determinants of health, population health and health inequalities”.

The Asian network is being led from the University of Tokyo Graduate School of Medicine, Japan. The cross-country collaboration includes China, China (Hong Kong Special Administrative Region), China (Province of Taiwan), Japan, and the Republic of Korea. The network aims to share understanding about how each of the following may have contributed to the health experience of these societies: the rapid demographic change (Japan, followed by China and the Republic of Korea), the drastic economic change and related social and environmental issues, a legend of relatively good health status in macro, but questionable sustainability, common but distinctive cultures, and historical, political, and health-care system heterogeneity.

Country work stream

The main goal of the CSDH country stream of work is to promote, demonstrate, implement and institutionalize policies and programmes of action on social determinants. The work aims to improve the stewardship role of government to take action on the social factors influencing health and health equity.

Action at country level will be one of the primary vehicles for using the Commission's vast evidence base, implementing the recommendations of the Commission, and sustaining awareness and understanding of social determinants of health among political leaders and stakeholders worldwide after the Commission formally ends in May 2008.

The CSDH is collaborating with a small number of Partner Countries (listed below) to support the development of national policies aimed at reducing health inequities through cross-governmental action on the social determinants of health.

WHO region	Partner Countries
Africa	Kenya Mozambique
Americas	Bolivia Brazil Canada Chile
South-East Asia	Sri Lanka
Europe	Sweden United Kingdom
Eastern Mediterranean	Islamic Republic of Iran

A clear commitment from the head of state to improving health and reducing health inequities within a country is crucial to developing a national agenda on health and health equity. Four key steps in this process have been identified and endorsed by countries and define the basis for structuring work with Partner Countries: (i) diagnosis and assessment of the health equity situation; (ii) getting the health system right, that is correcting health inequities being generated by the health system itself, developing national targets or goals for health and health equity, and strengthening health information systems; (iii) intersectoral action across government to address social determinants of health; and (iv) frontier knowledge, or breaking new paths in our understanding of social determinants of health and health equity.

A number of other countries are also working cooperatively with the Commission, though with a less formally structured approach than the Partner Countries. WHO regional offices have also initiated important work, starting with the establishment of a regional focal point for social determinants of health. The regional offices are involved in a variety of social determinants of health activity such as supporting baseline analysis of equity information (Regional Office for Africa (AFRO), Regional Office for South-East Asia (SEARO), Regional Office for the Eastern Mediterranean (EMRO), and Regional Office

for the Western Pacific (WPRO) or working directly with countries to develop tools and promote social determinants of health policy (Regional Office for the Americas (AMRO) and Regional Office for Europe (EURO)).

Preliminary analysis of the country stream of work indicates impact in the following general areas.

- For countries with less experience in formally addressing social determinants of health through intersectoral policy, such as most countries in the African Region, the CSDH country stream of work has generated political interest in social determinants of health and in jumpstarting the process towards policy development, by supporting baseline analysis of health equity and the relevant social determinants of health for the country.
- For countries with some prior experience of highlighting health equity, such as Brazil and Chile, the work has generated considerable political support for a social determinants of health approach, and has led to the creation of new mechanisms and institutional structures to promote intersectoral policy development and improvements within the health system.

Ministries of Health of Brazil and Chile collaborate

Following the meeting on Latin American Civil Society's work with the Commission, in April 2007, the President of Brazil Luis Ignacio da Silva visited Chile. During the visit, the ministers of health of both countries signed a memorandum of understanding underpinned by their countries' similar views on health and its social, political and economic determinants – and on how they should link with the rest of world. The President of Brazil affirmed: "South American integration is not an academic word game. Without integration, we cannot discover the true potential of Latin America." In discussions, both ministries focused on promoting and developing cooperation in relation to policies on gender and social determinants, citizen participation and participative management in health.

- For countries with significant experience in this area, such as Canada, Sweden and the United Kingdom, the work has facilitated cross-country sharing of lessons as well as joint research initiatives, such as investigating international experiences in intersectoral action and integrated policy-making for health, incorporating over 20 high, medium and low income countries. They are also advancing frontier knowledge in the understanding of social determinants of health and health equity, for example by assessing the economic and equity effectiveness of addressing upstream determinants of health.

Intersectoral action and integrated policy to promote health and health equity

The social determinants of health cut across the whole of government and therefore require integrated intersectoral action. Health is a responsibility of the whole of government, not solely ministers of health. This premise carries undoubted challenges. The Canadian Country Partner, led by the Public Health Agency of Canada, has embarked on an initiative to collect lessons on more and less successful efforts to engender cross-government action on health and health equity. Using case-studies, the initiative will reveal the nature of policy challenges being met by intersectoral action in different countries; significant contextual factors; mechanisms used to support intersectoral action; the roles of various actors; the subsequent health and broader social outcomes; and lessons learned. The initiative will identify mechanisms, tools, and strategies that are needed or that have proven useful in intersectoral planning as well as integrated policy-making for health.

The report from the country work stream will play a crucial role in informing the Commission's recommendations, specifically in relation to how to instigate and develop intersectoral policy processes on social determinants of health; how WHO can best structure member support for promoting a social determinants of health approach; how to build sustainable action on social determinants of health; and how new knowledge on social determinants of health and health equity can stimulate action.

Civil society organizations

The Commission's Civil Society stream of work is central to building and using the evidence on action relating to health equity. The active participation of civil society organizations in the work of the Commission aims to provide a global platform for civil society voice, strengthen capacities among participating civil society organizations, and advance civil society agendas in relation to the social determinants of health. Civil society is doing this by engaging with ongoing activities at the grassroots level that focus on the social determinants of health. Civil society is also building further momentum in support of the social determinants of health approach by helping to ensure that a strong voice advocates and agitates for a social determinants approach to health equity, using the CSDH evidence base and recommendations.

Specifically through the efforts of this stream of work, the Commission is positioned in several countries worldwide and has enabled previously unconnected social movements to establish common working agendas, strengthening their advocacy and lobbying capacities. This work stream also contributes to the development of the evidence base through case-studies in the Knowledge Network theme areas and also by contributing learning from civil society on how to effect social change through community engagement, advocacy, and other aspects of civil society movements.

The CSDH Civil Society strategies have been developed through consultative processes led by civil society groups in four global regions (Africa, Asia, the Eastern Mediterranean and Latin America/Caribbean). The civil society organizations that participate in the CSDH lead a process drawing on the knowledge and experience in their organizations and communities to learn from the community level and promote country action shaped by civil society knowledge and concerns.

Civil Society Facilitators

African Region

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Some of the key issues emerging from the civil society work to date:

1. Current development models (at both national and international levels) are inherently and exponentially generating inequities.
2. Including the excluded, using a “right to health” approach to participatory public policies, is essential if new policies to address the social determinants of health are to be ethically and politically legitimate and effective.
3. What is new and encouraging in the Commission is its emphasis, specifically, where the CSDH is playing a role: in collecting evidence on what has worked.
4. Both states and civil society are key and indispensable actors along with development agencies, academia, and mass media among others. Joint action is necessary to make an impact on the structural social determinants and consequently on reducing health inequities.

Civil Society reports and background documents (as of June 2007)

- CSDH Civil Society (2007). Civil society report. Prepared for the Commission on Social Determinants of Health.
- Case-studies (prepared under the auspices of the Health Systems Knowledge Network of the Commission on Social Determinants of Health)
 - Cuevas JH (2007). Health and autonomy: the case of Chiapas (in Mexico).
 - Mbombo N (2007). Building and maintaining the capacity, representativeness, legitimacy, diversity and voice of civil society in order to allow for authentic, bottom-up, effective and informed engagement: the case-study of a community-based organization (CBO) at a Black informal settlement area, South Africa. Case-study commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health.
 - Musuka G, Chingombe I (2007). Civil society participation in programme implementation for intersectoral action on health equity and intersectoral action for health: a case-study of the Health Civil Society Network in East and Southern Africa. Case-study commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health.
 - Nazarit PS (2007). The contribution made by women's and feminist movements to equity in health: the Chilean experience. Case-study commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health.
 - Ochoa FR, Visbal LA (2007). Civil society and health system in Cuba. Case-study commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health.
 - Peren HI (2007). Revival of Maya medicine and impact for its social and political recognition (in Guatemala).
 - Rusike I (2007). Civil society promotion of equity and the social determinants of health through involvement in the governance of health systems: the case of the Community Working Group on Health in Zimbabwe. Case-study commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health.

Global initiatives

Given that what happens within countries is increasingly influenced by the policy prescriptions of global institutions, the Commission is strongly committed to engaging with those actors. Fair and inclusive multilateralism offers the best hope, both for effective governance in shared global concerns – including global health and health equity– and the strongest basis for countries to benefit from globalization while protecting domestic policy flexibility.

The Commission’s approach to global institutions aims to establish dialogue, learn from experiences, engage in policy debates and develop shared approaches around social determinants of health. Opportunities for engagement with global institutions are pursued around areas of common interest arising from the knowledge generated by the work streams through the affiliations of Commissioners and members of the Knowledge Networks. The Commission works to build knowledge and understanding of how the actions of global institutions impact on health and health inequities within and between countries.

The Commission has been working with civil society partners, WHO, and G8 country representatives to engage with the 2007 presidency and its interest in gender, HIV/AIDS, Africa, growth and health systems. United Nations agencies are crucial partners, individually, through the leadership of WHO, and looking forward to increasing cross-sectoral coherence under the reform agenda. Equally, the international finance institutions, in particular the World Bank, have much to offer the Commission and, we believe, much to gain. Here, early discussions have set the ground for future cooperation as the World Bank engages a new health strategy.

Bilateral aid donors, private philanthropic organizations, and international and global nongovernmental agencies and social movements are all directly invested in the production of better health. The Commission seeks to provide such actors with the evidence base for the value and effectiveness of upstream action on determinants of health, underpinned not simply by economic arguments but by the principle of equity inherent in their mandates. The Commission recognizes the significant and increasing role of regional institutions, both the development banks and the policy fora. In addition, the Commission recognizes the major influence of the business sector on the social determinants of health.

Working with WHO

At the 7th Commissioners' meeting in Geneva in January 2007, the newly appointed Director-General of WHO, Dr Margaret Chan, met the Commissioners and signalled her strong support for the Commission's work. WHO is mandated to be the foremost global voice advocating for global health and has a vital role in working with governments and civil society, building alliances across global institutions, and speaking out with a frank and fearless voice to position health equity unequivocally as a global public good and societal goal. While the goal of achieving more equitable health outcomes within and between countries requires action at global, regional, country, local, household and individual level, WHO is uniquely positioned to champion new approaches to global governance for health. At the same time the Commission acts as a springboard to re-establish the vision of Alma-Ata within WHO as a basis for health system development in the 21st century. The participation of civil society in developing, implementing and evaluating the global health agenda is vital.

The Commission works within WHO to integrate social determinants of health into policy and programmes at regional and country level as outlined above. This work intensified early in 2007 with the creation of the Priority Public Health Conditions (PPHC) Knowledge Network. The PPHC is a large network extending across departments, regional and country offices of WHO as well as involving national programme managers and academia. The public health conditions prioritized by this network are shown below.

The work of the PPHC is divided into three broad phases:

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

Throughout its work the PPHC KN will make use of the evidence base built by other knowledge networks and areas of work of the Commission.

WHO/HQ department	Public health condition
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 Europe	Malaria
HIV Department	HIV/AIDS
Stop TB	Tuberculosis
Chronic Diseases and Health Promotion	Diabetes
Chronic Diseases and Health Promotion	Cardiovascular diseases
Chronic Diseases and Health Promotion	Oral health
Tobacco Free Initiative	Tobacco-related disorders
Mental Health and Substance Abuse	Mental health
Mental Health and Substance Abuse	Alcohol-related disorders
Nutrition for Health and Development	Child malnutrition
Injuries and Violence Prevention	Injuries
Food Safety	Food-borne diseases

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- CSDH (2007). *Social determinants and indigenous health: the international experience and its policy implications*. Report on specially prepared documents, presentations and discussion at the International Symposium on the Social Determinants of Indigenous Health, Adelaide, 29–30 April 2007. Geneva, World Health Organization (Commission on Social Determinants of Health).
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