Summary of activities by Country Partners

Brazil

In March 2006, a Presidential Act created the Brazilian National Commission on Social Determinants of Health (CNDSS), with a two-year mandate. Created through the President’s Office, the CNDSS is supported by Fundação Oswaldo Cruz (FIOCRUZ) and the Ministry of Health, with the President of FIOCRUZ serving as Chair. The Commission includes 16 social, economic, cultural and academic leaders. This diversified composition underscores that health is a public good, constructed with the participation of all sectors of Brazilian society.

The CNDSS is organized around production and dissemination of knowledge, strengthening the SDH focus in policies and programs, mobilization of civil society, communication, and international cooperation. Capitalizing on its strong national capacity for research, Brazil has invested US$4 million to advance research on key questions related to SDH and health inequities. Commissioned research involves a special focus on health issues among specific key populations, including blacks, the handicapped, and males. Additionally, the CNDSS is conducting a review of all national systems related to SDH, and is developing a case study on health equity in occupational health systems to generate policy recommendations. The CNDSS has had discussions and developed joint policy and planning work with dozens of NGOs working in themes related to SDH. The Commission has produced television programs, magazine articles, and a website to facilitate access to information and encourage discussion on SDHI issues and activities. The CNDSS will publish its full final report in March 2008, with selected chapters released earlier, starting in mid-2007. The report will contain policy proposals and recommendations of structures and mechanisms to enable sustainable interventions on SDH. Specific recommendations will include:

- Recognition of Health Promotion, as conceived in Ottawa Charter, as the conceptual framework to articulate sectoral and intersectoral actions on SDH;
- Creation of an instance in the Ministry of Health with power and leadership to coordinate sectoral and intersectoral actions of Health Promotion;
- Institutionalization in the Presidential Cabinet of the current Intersectoral Working Group to coordinate and formulate intersectoral actions on SDH;
- Establishing a permanent research program on SDH and networks for exchange and collaboration between researchers and policy makers to follow-up research projects and to promote the early utilization of their results;
- Establishing a permanent information system for monitoring health inequities.
- Strengthening mechanisms of participatory management, through selective dissemination of information and training of community leaderships
- Strengthening the network of Healthy Municipalities, through dissemination of information, training of municipal managers and creation of opportunities and interactive spaces for exchange of experiences related to SDH.

CNDSS has also pursued regional political and technical activities to address SDH and equity issues, such as developing a joint Memorandum of Understanding with Chile to promote intersectoral action and participation in health, as well as supporting a regional civil society
meeting. Additionally, Brazil’s National Commission has been key in promoting regional initiatives to eliminate silicosis and tackle occupational health issues.

**Canada**

Primary responsibility for Country Partner work in Canada is with the Public Health Agency (PHAC) under the leadership of the Deputy Chief Public Health Officer, Health Promotion and Chronic Disease Prevention, Dr Sylvie Stachenko. A new group, the Strategic Initiatives and Innovations Directorate, has recently been established under the direction of Jim Ball, Director General, and will encompass the team responsible for orchestrating the response to the Commission. The team, now known as the Health Determinants and Global Initiatives Division, will lead action on the social determinants of health through global and national partnerships, strategic initiatives and informing policies in other sectors and levels of government. The team also provides analytical and secretariat support to the Canadian Reference Group on Social Determinants of Health (CRG). The CRG, chaired by the Deputy Chief Public Health Officer, includes Canada’s Commissioner, leads from two Knowledge Networks, representatives from federal government departments, provincial representatives, academics and NGO leaders. The mandate of the CRG is to inform Canada’s contribution to the Commission, to integrate lessons learned from the Commission into Canadian policy, and to mobilize action in Canada. Goals and objectives of the CRG, and Canada’s corresponding activities as a Country Partner, are summarized below.

**Goal: Expand the knowledge base**

**Objective A:** Improved knowledge on contexts, tools, mechanisms and approaches for intersectoral action for health and equity.

Activities:

- Conducted 8 Canadian case studies to characterize contexts, approaches, and mechanisms used for intersectoral action for health and equity.
- Partnered with WHO Secretariat to lead a literature review on global experiences with intersectoral action on health and equity and coordinated the development of case studies involving ~ 20 low, middle and high income countries and the EU.
- Hosted a two-day dialogue to surface learnings from the case studies and suggest directions for future collaborative work.
- Plan to release report on intersectoral action in fall 2007.

**Objective B:** Increased knowledge of determinants of Aboriginal peoples’ health including self-determination as a determinant of health.

Activities:

- Convened roundtable dialogue among Aboriginal stakeholders in Canada.
- Commissioned 3 papers – one from each of the main groups of Aboriginal peoples in Canada (First Nations, Metis and Inuit) - detailing determinants of Aboriginal Peoples’ health and policy approaches for addressing health
inequalities. Distilled these into one Canadian synthesis paper for presentation in Adelaide.

- Participated in Indigenous Symposium in Adelaide and sponsored involvement of participants from 5 Latin American countries and China.
- Presented results/findings to WHO Commissioners in June 2007.

**Goal: Increase awareness and support among the public and decision-makers**

**Objective A:** Build an economic case for investment in SDH

Activities:

- Partnering with WHO, England, Sweden and Chile to explore this issue. Attended October 2006 exploratory meeting in London, followed up by an informal meeting in June 2007 in Vancouver.
- Examined existing evidence in Canada which contributes to an economic case for upstream investments and possible strategies for using these arguments within the Canadian political context.
- In addition to research and literature reviews, PHAC hosted an Expert Roundtable Discussion titled *Developing a Canadian Economic Case for financing the Social Determinants of Health.* Meeting included a wide range of health and economic experts and policy advisors from NGOs and federal government departments. A final report is currently being prepared which will inform PHAC’s next steps in this area.

**Objective B:** Improved collaborative engagement of civil society organizations to raise awareness of SDH among the public and decision makers.

Activities:

- Convened meeting of 50 national, regional and community organizations involved in addressing SDH to share information and discuss opportunities for collaborative work
- Developed a civil society engagement and communications plan
- Commissioner Monique Bégin and CRG raised awareness of SDH through participation in conferences and speaking engagements.

**Goal: Contribute to systemic change**

Activities:
The CRG’s vision included systemic change in policy processes and structures. For this reason, the CRG supported Commissioner Bégin’s efforts to solicit interest of a Senate sub-committee to undertake a study of this subject. A Senate Committee on Population Health has been established and is carrying out research and hearings. In December 2008 the Senate will make a recommendation to Parliament regarding appropriate approaches and investments to more effectively address determinants of health across departments of government.
The CSDH has served as an important catalyst to advance relevant knowledge development and policy analysis in Canada. A significant result has been increased focus and priority placed on the role of the health sector (especially public health) in leading cross-governmental action on SDH. A determinants and health inequalities focus has been included in the PHAC five year strategic plan and the agency’s past two annual reports on plans and priorities. An Action Framework is currently under development which outlines PHAC’s role in advancing action on SDH within the health sector and in collaboration with other sectors.

Chile

Chile's activities as a Country Partner have built upon previous SDH/HE work initiated during the Health Reform process begun in 1998. In working with the CSDH, Chile established a focal point within the Ministry of Health, in the Office of the Undersecretary of Public Health, to coordinate Country Partner activities and processes, and to spearhead a particular focus on issues of child health and workers' health. Country Partner activities also include strengthening equity and SDH information through monitoring and revision of National Health Equity Targets. In 2006, Chile conducted a decomposition analysis of the National Quality of Life Survey to better understand how various sectors can contribute to health, and developed the first National Quality of Life Survey focused on Workers' and Employment Conditions. Regional (sub-national) Health Authorities (RHAs) have been involved in integrating SDH and HE into health sector planning and monitoring following a detailed intersectoral analysis of health inequities. The Ministry of Health is also working with municipalities and RHAs to develop a new program to support citizen participation initiatives at regional and local levels. At the regional (supra-national) level in the Americas, Chile has signed a Memorandum of Understanding with Brazil and is supporting regional initiatives to eliminate silicosis and address occupational health issues.

Currently, Chile finds itself in favourable conditions to make the case for financing SDH interventions. Under the leadership of President Bachelet, the Chilean government is strongly committed to establish a rights-based social protection system. At the same time, it is recognized that the country’s current strong economic growth will require progress in equality of opportunities and comprehensive social protection to be sustainable. Following this understanding, the government is taking robust action in relevant areas of social policy. Fully 68% of the country’s public sector budget for 2007 will be oriented to social expenditure, an 11.2% increase compared to 2006. However, driving effective action on SDH poses several challenges. Among them, the most relevant is to trigger a process whereby actors from inside and outside the health adopt an SDH approach to improve health status. To succeed in this, SDH should be integrated into more comprehensive goals, such as social protection or quality of life, which may be linked to strategic goals and products of different Ministries and agencies. Attaining SDH and health equity goals will require proving and quantifying the influence of diverse government programmes on SDH, and in turn of SDH on the more comprehensive social goals. Chile’s approach is based on the idea that health leaders should abandon health-centered language and instead develop a vocabulary with a more universal appeal, which may encourage actors outside the health community to accept an SDH agenda.

The Chilean model of SDH action thus involves integrating SDH policies and programmes as part of the construction of a broader social protection system. Fortunately, various components
of such a system are already in place in Chile and provide useful lessons about agenda setting and the implementation process. Among those, Health Care Reform offers an interesting example of a rights-based approach to public policy. For a list of 40 diseases, the GES (Explicit Health Guarantees) system grants Chileans the right to access care within a certain period of time; defines maximum co-payments; and sets quality standards. It also creates the institutions and mechanisms to provide redress when guaranteed standards fail to be met. The diseases included under GES are the main causes of morbidity and mortality in Chile.

Meanwhile, the social support and integration programme ‘Chile Solidario’ is the first intersectoral program with a systemic approach to social protection. This programme aims to effectively coordinate different social sectors in order to target families in extreme poverty and ensure access to interventions designed to enable social re-integration. Both, Chile Solidario and GES provide valuable insights about the critical requirement of a comprehensive integrated information system, to ensure that social programmes reach those who need them most, and to prevent the social protection system from falling prey to abuse.

Using Chile Solidario as a model, President Bachelet has prioritized a social protection system with universal coverage for the whole population throughout the life cycle, with a comprehensive network of services based on a human rights framework. Because of the large scope of work and resources required, the network is being built in a progressive manner, starting with young children and the elderly. The Social Protection for Young Children component, known as “Chile Crece Contigo” (Chile grows along with you) was launched in 2007.

England

Fiona Adshead, the Director General for Health Improvement and Deputy Chief Medical Officer for England, is the UK lead for work with the CSDH. As such, Dr Adshead has instituted mechanisms to understand the needs and interests of her colleagues in the UK countries, as well as identifying partners in other countries where synergies of interest suggest joint working.

England has an established body of cross-government work to address Health Inequalities which are encompassed in an Action Plan with related targets. This work is overseen and progress is monitored by a scientific committee which is chaired by Sir Michael Marmot. As this group is a pool of expertise in the area of SDH, it was decided to grow it and add representation from Northern Ireland, Scotland and Wales to form a reference group for work with the CSDH. This group is chaired by Dr Adshead. The group has initiated work in specific areas where it considers that knowledge and evidence is under-developed. These include:

- Future scanning and SDH
- Making the economic case and SDH
- Peer learning on SDH

Secretariat support for the group is provided by senior staff of the Health Inequalities Unit of the Department of Health for England.

The Tackling Health Inequalities Strategy and corresponding Action Plan for England cover fundamental areas of the social determinants of health. Work on these and toward targets will
continue until 2010. Connections between this national agenda and the work of the CSDH are made through the scientific and reference groups.

England’s national health inequalities strategy provides targets for cross-government actions. England aims, by 2010, to reduce inequalities in health outcomes by 10%, as measured by infant mortality and life expectancy at birth. The national strategy gives priority to the health of families with young children and to major causes of premature mortality. It emphasises variations between social groups and differing settings/geographical areas.

Given that monitoring towards 2010 targets is in place, it was decided that it would be inappropriate to develop a separate action plan for the SDH for England or the UK at this time. The reference group, set up to steer work in the context of CSDH, developed a different approach. This involved identifying actions that would:

- Help to develop a supportive international environment for the national agenda of addressing health inequalities and the SDH.
- Work with international organisations and partners in other member states to develop evidence and learning in specific areas of mutual interest.
- Develop mechanisms to share learning from current practice with other national policymakers.

To facilitate the development of a supportive environment, the Department of Health (DH) took the following actions:

- Hosted a high level international meeting on behalf of WHO European Region on the work of the CSDH and to consult on the development a related programme of work.
- Ensured representation of CSDH at meetings on a HP Global Framework and European NCD strategy development hosted by DH on behalf of WHO.

In relation to the working with international partners and international organisations, the DH has:

- Hosted an international scope meeting in liaison with the WHO Finance Task Group on the issue of making the economic case to address SDH.
- Participated in a meeting with Country Partners in Canada on these issues and defined a longer term programme of work.

To develop shared learning, the DH:

- Participated in international meetings in Chile, Copenhagen, Russia, Geneva, Hungary and Canada.
- Organized a Country Partner meeting in London that included participation from Canada, Chile and Sweden. Participants discussed possible peer approaches to policy learning. Follow-up has been in the form of a ‘think tank’ held in Canada and a visit by infant mortality leads from the DH to Canada. A meeting on this theme will take place with international partners in September 2007.

A lesson from the English experience is that it takes time both to get SDH and health inequalities on the agenda and to develop mechanisms to address them. Results are often only seen in the longer term, and it takes serious commitment from politicians to invest in a process
that may not show benefits within their term of office. Congruence between SDH priorities and the political agenda in a country is, therefore, crucial for long-term investment in the area of health determinants.

I.R. Iran

In addition to high-level commitment from policymakers and authorities, Iran’s legal system and national policy framework support action on SDH and provide many opportunities for tackling determinants at national, provincial, district, and local levels. The IRI ‘Vision 2025’, the fourth national development plan and various articles of the national constitution are aligned with an SDH approach. The country’s Supreme Leader and current president support the concepts of SDH and equity publicly announced during the fourth CSDH meeting, held in Iran in January 2006.

The Ministry of Health and Medical Education (MoHME) functions as the focal point for SDH work in Iran and collaborates with WHO through the SDH secretariat, under the supervision of the Deputy Minister of Health. The secretariat coordinates with the other departments of MoHME, related sectors, civil society organizations and partners in order to integrate SDH in their plans and action. A multidisciplinary team has been established to accelerate SDH processes.

SDH action in I.R. Iran is guided by the following vision: Health, as central to multi-sectoral development, should be accessible to all people as a universal human right, with a special focus on deprived and marginalized groups; SDH should be incorporated into intersectoral mechanisms and actions, enhancing investment for health and creating an enabling environment to maximize health gains. The goal of SDH activities is achieving equitable health for all by promoting integration of a social determinants of health approach in all health programmes, relevant sectors and allies' strategies and action plans. In pursuit of this goal, Iran has conducted or supported a wide range of activities connected with its status as a CSDH Country Partner:

- Hosted 4th CSDH Commissioners meeting in Tehran (January 2006)
- Conducted informational and consultative meetings for different ministries, MoHME departments and civil society organizations
- Conducting bi-monthly meetings for technical subcommittee
- Hosted WHO missions to develop situation analysis and policy documents
- Produced in-depth assessments of SDH and health inequities in Iran
- Contributed to situation analysis of SDH in Iran by WHO missions
- Included SDH in the community-based initiative (CBI) training of programme managers and community representatives
- Training of MPH students in SDH
- Conducted trainings on SDH for municipal health staff; Ministry of Welfare and Social Security (MOWSS); State Welfare Organization (SWO); and civil society organizations, including Imam Khomeini Relief Foundation (IKRF)
- Consultative meetings with health program managers, MOWSS, Municipality, SWO, and others to put SDH on their agenda
• Advocacy to parliamentary MDG Theme Group and Women’s Faction of Parliament to consider SDH for next national plan

These actions have created an environment in the country in which the SDH concept has been understood and accepted by health partners and multisectoral allies. Many are interested in incorporating an SDH approach into their plans and actions. However, efforts have remained substantially tied to individuals, and much work is still required to develop sound mechanisms and processes for integrated joint actions. That may only be possible if a comprehensive situation analysis clarifies linkages between the work of related sectors and the health sector, and identifies appropriate roles and responsibilities, along with a set of evidence-based policies that can be pursued collaboratively by different sectors and allies.

Kenya

Kenya developed an Action Plan and obtained commitment from the President’s Office to establish a National Commission in 2006. The focal point is the Minister of Health, who also serves as a CSDH Commissioner. The Action Plan developed to date includes: a focus on improving maternal mortality in a particularly disadvantaged province; linking urban planning and health action to improve conditions in Kenya's slums; and work to introduce equity monitoring into the Medium Term Expenditure Framework (possibly expanding to other planning processes such as SWAps, the health sector's Annual Operational Planning, and the National Health Insurance Fund).

Kenya hosted a regional civil society consultation on SDH and the fifth meeting of CSDH Commissioners in June 2006. Underscoring these meetings catalytic importance for SDH action nationally and across the African region, President Mwai Kibaki endorsed the creation of a Kenyan National Commission on SDH to spearhead the eradication of health inequalities in the country. Activities of the national commission could include:

• Production and dissemination of evidence, knowledge and information, including a baseline diagnosis of equity in health and SDH, and a review of cost-effective approaches to improving population health

• Review and make recommendations on policies, programmes and development frameworks in terms of impact on SDH and HE, including cross-cabinet inquiry into health inequities and development of National Objectives and Targets on Health Equity and Social Determinants

• Provide recommendations to Government on: (1) how spending in other sectors and in macro-level development policies and financing frameworks can reduce health inequities; and (2) how to ensure than spending decisions can be taken as cost-effectively and consistently as possible

• Strengthening institutional mechanisms to adopt a whole of government approach, including introduction of equity indicators into routine health information systems and into monitoring of development plans

• Mobilizing civil society for advocacy and action, including a meeting of national and regional stakeholders and development of a national advocacy strategy on health equity and SDH
• Support regional and international work in cooperation with the WHO Regional Office for Africa, especially focused on major African institutions, including the African Union Council for African Health Ministers; Southern African Development Forum; and the East African Development Forum.

The commission would be supported by an intersectoral technical working group on SDH (to coordinate and manage commission activities and products) and a Cabinet Committee on SDHE (charged with institutionalizing processes within government). The Ministry of Health would function as the secretariat.

Additional specific activities under examination as part of national action on SDH and HE include:

• Reviewing the resource allocation criteria for the government’s grant system to assess how these criteria relate to key social determinants of health and health inequities
• Reviewing current MOH expenditure and health outcomes using a social determinants lens
• Developing a national process of workshops with key stakeholder groups involved in Health Facility Committees to sensitize the Committees to the social determinants of health and health equity issues
• Evaluating the impact of reducing user fees on poverty and health status among vulnerable groups

Mozambique

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

The MOH has defined strategic objectives for 2006-2009:

• Increase coverage of health services
• Decrease inequities in budget allocation
• Increase efficiency in the use of resources
• Improve quality of non personal and personal service provision
• Develop a clear strategic health plan for the sector

SDH priorities include maternal education, water availability and malnutrition. In terms of intersectoral action, health leaders note that there is willingness to cooperate but as yet a lack
of clear mechanisms. Key government actors in developing IAH will be the Ministries of Education and Culture, Public Works, Labour, and Women and Social Action. Perceived opportunities and priorities for intersectoral action include:

- **Ministry of Education and Culture**: improve collaboration in areas of clear synergy related to health and education; establish concrete mechanisms for integration of school health and nutrition programmes
- **Ministry of Public Works**: interventions related to water and sanitation to reduce infant mortality by increasing coverage and access among the most disadvantaged communities
- **Ministry of Labour**: needs assessments of health equity in the workforce, for tackling child labor, and to improve social and health protection for people working in the informal sector
- **Ministry of Women and Social Action**: prevention and control of violence against the most disadvantaged

Data for equity analysis are available in Mozambique, but have not been adequately used, so priority action to support Mozambique’s Country Work has involved planning a baseline study on inequities in health, including trends based on existing data, and strengthening national capacities for equity analysis. The objective is for Mozambique to conduct a baseline assessment of inequities in health and then follow up with continuous monitoring based on existing data sources (e.g. DHS surveys). Improving the country’s vital registration system is seen as a priority with respect to evidence needs. A necessary first step is to better integrate the cooperation between MOH and the National Institute of Statistics (NIS).

Equity in access to health services is another key theme for Mozambique, as was confirmed during a mission involving representatives of the CSDH secretariat and the WHO HQ Department of Equity, Poverty and Social Determinants of Health to the country in August 2006. Ensuring equity of access is significant not only for its impact on health outcomes, but also is itself a key measure of the performance of health systems and of equity in health more broadly. Measuring that a population accesses and utilizes a service does not guarantee that it does so according to its real needs, and certainly does not prove that the population that did not utilize the system did not need to do so. It is necessary to include specific tools and mechanisms to follow up equity in access and the intersectoral action link with promotive, preventive and curative activities in specific programmes. WHO has proposed to incorporate Mozambique into a multicountry study on barriers to care that is being led by the HQ Department of Equity, Poverty and Social Determinants. Specifically it is proposed to explore barriers and facilitators for access to care in relation to two of the country’s most prevalent health problems: maternal mortality and malaria.

An additional area of health equity action emerging in Mozambique’s work as a Country Partner concerns equity in occupational health systems and employment conditions, building on work spearheaded by the CSDH Employment Conditions Knowledge Network (EMCONET). Opportunities in this area of work include:

- To develop a case study of employment conditions in Mozambique in coordination with EMCONET;
• To share expediencies and be part of a network with Brazil and Chile, which are also developing case studies on employment conditions;
• To support the uptake of recommendations for action arising from the case studies, including the development of intersectoral action with the Ministry of Labour and others to improve health and employment conditions in Mozambique.

Sri Lanka

A delegation from Sri Lanka attended the Regional Consultation on Social Determinants of Health in New Delhi, 15-16 September 2005. Subsequently the Ministry of Healthcare and Nutrition Sri Lanka initiated action to follow up this WHO initiative. A Working Group was appointed in May 2006 to explore strategy and develop a Plan of Action to pursue this initiative, with the Management Development & Planning Unit of the Ministry of Healthcare and Nutrition (MOH) functioning as the focal point. Working Group members included officials from the MOH, Ministry of Finance and Planning, Ministry of Labour Relations, Marga Institute, academics and WHO. The Working Group met periodically and consulted with national stakeholders and international partners. Dr. Davison Munodawafa from WHO SEARO visited WHO Sri Lanka and MOH officials in October 2006 in order to take forward the proposal and Sri Lanka’s participation as a Country Partner. Shortly thereafter, the MOH formalized its interest in partnering with the Commission in a letter to WHO. A CSDH focal point has been recruited in the MOH under the supervision of Dr. Sarath Samarage from June 2007.

The Working Group has proposed to focus Sri Lanka’s action as a CSDH Country Partner on interventions to reduce inequalities in health. This is based on the following reasons:
• Reducing inequalities is consistent with core values of society and the current and past Governments of Sri Lanka have repeatedly committed towards equitable health development.
• Tackling inequalities helps to improve stagnating health indices and counter the increasing prevalence of NCDs and injuries.
• The theme is closely related to the broad policy objectives of the government and is likely to be acceptable to politicians.

The country’s history of successful health action at low levels of per capita healthcare expenditure makes documenting Sri Lanka’s experience particularly important. Sri Lanka’s SDH-focused learning as a Country Partner includes three major case studies.
1. A historical case study will review Sri Lanka’s history of ‘good health at low cost’ and develop the political argument for (a) structural changes in the organization of primary health care; (b) greater investment in health; and (c) focus of increased investments to deliver non-communicable disease care at relatively low cost.
2. MOH and university-based researchers will partner with the Marga Institute on a case study on intersectoral action for health (IAH) that focuses on (a) description and assessment of all formal existing mechanisms for IAH; (b) description and assessment of informal existing mechanisms for IAH, including
collection of best experiences in the country; and (c) based on the above
develop recommendations to discuss with the government.

3. In partnership with the International Labour Organization (ILO), Sri Lanka will undertake a case study on equity in occupational health focusing on a comprehensive review of the situation based on all existing studies. The study will produce recommendations on how to incorporate promotion, protection and services to address the specific health needs of workers in Sri Lanka.

Additional key activities and products include conducting studies on the causes of persistent child malnutrition in Sri Lanka, despite the country’s significant health progress in other areas. Sri Lanka is also updating and improving information systems to better understand social health inequities. Specifically, with technical support from WHO, Sri Lanka is revising two major instruments:

- Vital registration forms (Department of Census and Statistics)
- Consumer Finances and Socioeconomic Survey’s health component; including ICD-10 training (Central Bank of Sri Lanka)

Regional leadership in action on SDH and HE is part of Sri Lanka’s role as a Country Partner. In October 2007, Sri Lanka and WHO-SEARO will host a major regional meeting on implementing CSDH recommendations to tackle health inequities. The event will bring together health sector leaders and multi-sectoral stakeholders from 11 countries, in Colombo.

**Sweden**

Sweden has a long history of attention to health equity and SDH issues. Based on the work of the Swedish National Committee for Public Health, a comprehensive Swedish public health policy was adopted by the Swedish Parliament, the Riksdag, in April 2003. It pushes health up on the political agenda and affords equity in health high priority. The overall aim of the policy is to “create societal conditions for good health on equal terms for the whole population”. To help achieve this aim through multisectoral efforts, the Government has established eleven “domains of objectives” with connections to SDH.

Many actors on all levels of society have responsibility for the implementation of the public health policy. Central government agencies, whose tasks and activities have a direct impact on public health, are obliged to consider the effects and to monitor their work. For municipalities and county councils the domains of objectives, according to the Government, “show how their activities can be incorporated to help achieve the overall national public health aim”. A national steering committee, under the leadership of the Minister of Public Health and Directors-General of concerned agencies, has been established to improve coordination on the national, regional and local level. The Swedish National Institute of Public Health (SNIPH) coordinates the national monitoring and evaluation of the policy.

In its role as a Country Partner, Sweden has been involved in the project in several ways. Sweden has co-ordinated and provided start-up funds to establish a Nordic Reference Group on SDH, a research and policy development alliance that includes Iceland, Norway, Denmark, Finland and Sweden. The reference group is supporting the Commissioner professor Denny
Vågerö from the Center for Health Equity Studies (CHESS) in Stockholm who is representing the Nordic countries. The purpose of the Nordic Reference Group is to discuss and convey the Nordic experiences of working with the SDH to the CSDH via Commissioner Vågerö and to share such work within the group. Sweden is also represented in three of the Commission’s nine Knowledge Networks (Globalization KN, Women and Gender Equity KN and Urban Settings KN). The universalistic Nordic welfare policy and its effects on people’s health have attracted interest from the Commission. A report, *The Nordic Experience: Welfare States and Public Health (NEWS)*, has been presented to the chair of the Commission by researchers at CHESS in Stockholm.

Together with WHO, England, Canada and Chile, Sweden has explored the issue of building an economic case for investment in SDH. In October 2006 Sweden attended a meeting in London followed by another meeting in June 2007 in Vancouver. Since the second meeting Sweden has presented four Swedish cost-effectiveness studies to the Commission: Health, economics, and feminism: on judging fairness and reform; Preventive home visits postpone mortality – a controlled trial with time-limited results; Cost-effectiveness of the promotion of physical activity; A cost-effectiveness analysis of alcohol prevention targeting licensed premises. The economic case for investing in health is also underlined as an important task by two working groups within the European Union, of which Sweden is a member; the EU Expert Group on Social Determinants and Health Inequalities, and Determine – An economic consortium for action on socio-economic determinants on health.