The First Meeting of Country Partners:
WHO Commission on Social Determinants of Health

MEETING REPORT

Convened by WHO and the Commission on Social Determinants of Health. Held in Geneva, Switzerland, 18-19 May 2006

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This report was prepared by Christine Brown with input from Jeanette Vega. It reflects the presentations and discussions at the First Meeting on Country Partners. Thanks are due to Bongiwe Peguillan and Amit Prasad for copy editing the document and to Elmira Adenova for formatting it. Any errors are solely the responsibility of the principal writers.

The views expressed in documents by named authors are solely the responsibility of those authors.
### ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>CCS</td>
<td>Country Cooperation Strategy</td>
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<tr>
<td>CMH</td>
<td>Commission on Macro-economics and Health</td>
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<td>CSDH</td>
<td>Commission on Social Determinants of Health</td>
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<td>CVD?</td>
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<td>EMCONET</td>
<td>Knowledge Network for Employment Conditions</td>
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<td>EMRO</td>
<td>WHO Eastern Mediterranean Regional Office</td>
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<td>HIS</td>
<td>Health Information System</td>
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<td>KN</td>
<td>Knowledge Network</td>
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<td>MDGs</td>
<td>(UN) Millennium Development Goals</td>
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<td>Mercosur</td>
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<td>NRHM</td>
<td>National Rural Health Mission</td>
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<td>PRS</td>
<td>Poverty Reduction Strategy</td>
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<td>SD</td>
<td>Social Determinants</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNDAF</td>
<td>United Nations Development Assistance Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>SDH</td>
<td>Social Determinants of Health (with a focus on health inequities)</td>
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### KEY TERMS

WHO; social determinants; health equity; country strategy; policy, Knowledge Network
Executive summary

The Commission on Social Determinants of Health (CSDH) supports countries and global health partners to address the social factors leading to ill health with a focus on health inequities. This report summarizes the main proceedings and outputs from the May 18 and 19 CSDH meeting with partner countries, civil society, knowledge institutions and WHO regional and country offices. The meeting was designed as a consultation workshop, whose objectives were:

1. To provide an update on progress and implementation of the Commission's strategies and plans, including expected products and planned activities involving governments, knowledge networks and civil society.

2. To identify and agree on mechanisms to link government policy makers with other streams of the Commission, specifically:
   - Explore ways for partner countries to inform the CSDH process of knowledge building (through knowledge networks) on social determinants (SD).
   - Develop strategies for the participation of civil society in CSDH work with governments and in the development of regional strategies on SD health;

3. To agree (with partner countries) on priorities for working collectively and advancing action on SDs.

The workshop brought together over 46 participants, representing 18 countries spanning all WHO regions. It was the first of its kind since the Commission was launched in March 2005. The participants represented a broad constituency of stakeholders. Presentations from Ministers of Health, senior policy makers, civil society organizations, and WHO regional and country offices focused on policies and strategies addressing the SD of health inequities. Research and development institutions contributed to a series of rich roundtable discussions on the emerging success factors and the institutionalisation of a health equity agenda across state and society.

The event provided a forum to share knowledge on lessons and actions taken to date. It also was used to formally consult on strategic objectives for the next phase of the CSDH work with countries (June 2006 - December 2007); and to agree about specific activities and products.

DAY 1

The first day focused on the necessary processes to develop equity and social determinants strategies and action plans from the perspective of government policy makers. Chile, Brazil and the Islamic Republic of Iran presented their respective action plans, which illustrated their different approaches, and targets and indicators devised to guide their implementation stages. England, Sweden and Norway, all well experienced in tackling the social determinants of health (SDH), shared their approaches and challenges. Despite the disparate levels of development among the countries, there were common challenges. Following the presentations, subsequent discussions debated two issues: the challenge to make health equity a priority across government and how to position action on social determinants at the heart of national health agenda.

Almost all the presenting countries expressed the need for strong realism regarding the timescale involved in developing and institutionalising frameworks on health equity and social determinants across government. At the same time many participants emphasized the need for the CSDH to document, synthesize and make easily available the knowledge on "what works" in different countries. Added to this was the view that the Commission should consider a range of entry points to build pressure, support and stimulate action. It was suggested that it could involve a wider range of stakeholders and institutions, particularly in countries undergoing war or where political will and mandate was fragile. A common theme across the various roundtable discussions was the need for clearer messages on SDH and a "more aggressive" communication strategy that positioned the CSDH
appropriately within and outside WHO. It was emphasized that the Commission needed to invest more support to accelerate the process and stimulate action in African countries. Specifically, it was pointed out that it should capture what was already working and facilitate an alliance of committed nations, civil society and knowledge institutions that could stimulate interest and generate pressure for action in the region. Dr Garrido, Minister of Health of Mozambique, who participated in the workshop, subsequently stressed the importance of systematically tackling the social determinants of health and health inequities in his address to the 57th World Health Assembly.

At the end of the first day there was an open discussion to draw out the emerging areas for collective country action and the type of support that should be provided by WHO/CSDH. Two key questions were raised to guide the discussion: “What is expected from the Commission”; and “What is expected from WHO?”.

To answers the first question, participants recommended CSDH:

✦ Builds an alliance of nations capable of drawing interest, exerting pressure and providing concrete examples of why and how to tackle the social determinants of health and improve health equity. The alliance should be in a position to accelerate the uptake of the SDH agenda.

✦ Addresses the fundamental areas which should pave the way for changes in health policy and programmes, that is, the economic arguments for investing in reducing health inequalities through actions on the social determinants; the costs of not doing so; and the rationale, examples and implications of investing in tackling the social gradient in health vs. targeting most disadvantaged groups vs. improving the average health status.

✦ Strengthens and influence global institutions and policies. The CSDH should lever the political conditions for equity and SDH, e.g. in health MDGs and PRSSs; demonstrate how the policies and actions of regional and global institutions positively or negatively impact the social determinants of health inequities.

✦ Increases its communication and visibility. The CSDH should clarify its key messages and use products, resources and sphere of influence more systematically and with a view to strengthening social debate and public awareness on social determinants of health.

To answer “What is expected from WHO”, three main priorities were raised:

✦ Institutionalise and sustain the Commission agenda on socially determined health inequities within global, regional and country level politics and within its strategic objectives; through the Department of Equity, Poverty and Social Determinants of Health; within country cooperation strategies - 2nd generation strategies and technical cooperation agreements; and integrate SDH into the UNDAF and into the monitoring of plans on MDGs and PRSs.

✦ Monitor and evaluate the SDH implications of WHO’s work in global and national policies, programs and normative work.

✦ Develop more consultative and participatory processes through the opening or enhancement of channels for civil society participation in the policy making process, action, evaluation and governance at WHO, and with governments partnering with the Commission.

These priorities set the backdrop for the presentations and roundtable discussions on the second day of the workshop.
DAY 2
Managing the process of knowledge generation and involving all of CSDH components in the process was the main focus of the day's events.

The first session looked at the synergies between knowledge building and country work. Participants were presented with examples of collaboration between country partners and Knowledge Networks (KNs). These highlighted opportunities, processes and mechanisms to accelerate national action and to ensure the Commission’s recommendations were relevant to policy and practice.

Setting the scene for a roundtable discussion, three stakeholder groups presented on their different roles within the CSDH process. Chile gave a government policy-maker perspective; WHO/EMRO presented their work in brokering knowledge generation and action on social determinants of health equity in their region; and the CSDH Knowledge Network for Employment Conditions (EMCONET) gave their perspective on building a participatory process in all phases from collecting to synthesizing evidence and supporting country partners to use participatory methods in their national action plans on health equity.

The presentations provided a rich foundation for a discussion on how to build synergies for action on SDH through the collaboration of governments policy makers with KNs and WHO. Incentives for collaboration emerged quickly. Opportunities to build national knowledge-base and institutional capacity on SDH were identified.

Participants pointed out that scientific evidence on its own was unlikely to produce change unless tailored to the reality of the country and international political environment. It was suggested that the KNs and WHO’s methodologies to generate practical knowledge be documented for future learning purposes. One proposal was for a mechanism for policy makers and civil society to input and review the KN products to ensure their “fitness for policy” and adequacy to proposed actions.

The roundtable discussion identified priority activities for the second phase of country work, including methodology and documentation of: a) baseline of health equity and social determinants in countries, including sources of information and inclusion in HIS; b) existing policies; c) existing mechanisms for inter-sectoral actions and participatory processes; d) and, case studies capturing successful initiatives and obstacles to progress.

The second session presented the rationale and proposed objectives of the Priority Public Health Conditions Knowledge Network (PPHC KN). The PPHC KN was set up to review the design and implementation of programs addressing priority health conditions and would identify key factors that affect the social distribution of health outcomes, such as:

a) risk behaviours;
b) access to services;
c) health status (morbidity and mortality); and
d) consequences of illness.

There was strong support for the PPHC proposal, particularly, of its expected outcomes. Many participants highlighted its potential to re-orientate WHO technical programs and make the SD perspective central in their design, implementation, monitoring and review. Overall feedback was that more work was necessary, particularly, around the type of PPH conditions that should be selected and developed in close collaboration with country partners and national priority programs.

The third session focused on what was a recurring theme on the importance and role of civil society as partners, and building a sustainable movement on the social determinants of health. Each of the CSDH Regional Civil Society Facilitators shared strategies and activities from within their regions. The multiple roles of civil society at different levels of the CSDH work were highlighted and included knowledge generation, public awareness, social debate on equity, training and capacity building for other CS organizations; and later monitoring the impact of policies on health equity. The open forum session called for the CSDH to undertake a synthesis of models that demonstrate effective
practices and impact of civil society participation in policy development, implementation and monitoring of health equity.

More examples of collaboration between civil society and governments of New Zealand, Brazil and India were presented. These highlighted opportunities and obstacles in addressing the root causes of health inequities. Discussions revealed that collaboration between the two actors needed a framework and mechanisms for accountability. Other important factors were capacity building for both government and civil society to create equal relations; and working together to capture and promote positive lessons. Participants reiterated the importance of documenting the collaborative work between the two stakeholders and of developing useful tools for future learning.

To conclude, a list of issues and priorities were identified for the Commission to offer better support within countries, regionally and internationally:

a) to support action on SDH in countries
   - Development of baseline health equity and social determinant analyses.
   - Development of national objectives and priorities to improve health equity.
   - Integrate different stakeholders and constituencies into institutional arrangements being developed to advance a health equity and social determinants agenda e.g. National Task Force; National Commission.
   - Enhance and publish current evidence on participation of civil society in country strategies to improve health equity.
   - Enhance and publish current evidence on intersectoral mechanisms and strategies to improve health equity.
   - Include Equity and social determinants into routine health information systems.

b) to support action on SDH across countries
   - Share priorities on SDH to synergise, commission and support work regionally.
   - Tap/invest in capacities and institutions in countries and regions.
   - Share horizontally across countries: visits, knowledge exchange, documentation, policy dialogue.
   - Systematize methodologies for wider application (research and practice).
   - Engage regionally in the global processes.
   - Country - Commission - WHO interactions.

c) for WHO to support action on SDH in country work and global advocacy
   - Examine the impacts of communicable and noncommunicable disease programs on socially determined health inequities and the resultant implications for program changes.
   - Explore how to integrate SDH beyond proximal determinants to upstream/distal causes in WHO policies and programs and reflect this in country and regional work and advocacy.
   - Institutionalize global monitoring on health equity and SDH.
Opening address: Sir Michael Marmot, Chair of the Commission on Social Determinants of Health

Prof. Sir Michael Marmot, Chair of the CSDH, opened the event and gave the rational behind the establishment of CSDH. He stated that it was no longer reasonable for those concerned with health to ignore crucial determinants such as the circumstances in which people lived and worked. Neither could the health sector continue to fail to address the social gradient in health which was reflected in the widening health gaps within and between population groups in a country and between countries, he added.

He stressed the importance of CSDH working with countries. Firstly, the work would provide detailed examples of the benefits of addressing the social determinants of health and health inequities. Secondly, documenting country actions would create a new body of knowledge on “how to” tackle the SDH. Thirdly, working with clusters of countries and regional stakeholders could mean committed nations and stakeholders with capacity to advance work on SDH sustain action beyond the commission’s lifespan.

General overview of CSDH and progress on implementation: Dr Alec Irwin, Secretariat of CSDH

Dr Irwin summarized the overall aims of the Commission and progress to date, reiterating the words of the late Director-General of WHO, Dr LEE Jong-wook 2004 that the “focus is on marshalling scientific evidence as a lever for policy change aiming towards practical uptake among policymakers and stakeholders in countries.”

He gave the rationale for the Commission’s organizational structure (Civil Society, Countries, Knowledge Networks, Global Institutions, WHO programmes and Regional and Country offices), stressing that the intention was to involve a wide range of stakeholders necessary to bring about real change in countries. He gave the following summary of actions under taken:

✧ Formal partnership with seven countries committed to developing, implementing and evaluating national SDH action plans. The first meeting of Global Country partners was also organised to share the initial learning from partner countries to date.
✧ Engagement of civil society, and elaboration of regional strategies through which to consult with and develop concrete activities and advance action on SDH. To partner with the Commission to raise public awareness and create pressure for addressing the social determinants of health inequities at the local, national and regional level.
✧ Establishment of eight global networks who had begun to synthesise existing evidence and develop a global inventory of effective polices and practices for tackling the SDH. It was explained how, seven of the knowledge networks (KNs) were focussed on collecting evidence on a priority determinant, known to be significant in explaining health inequities and amenable to intervention. The KNs
are Urban Settings, Early Childhood Development, Health Systems, Women and Gender Equity, Employment Conditions, Globalisation, and Social Exclusion. The work of the 8th KN was focussed on the measurement and evaluation of SD and was developing standards and guidelines for the synthesis of evidence related to SDH, which would be used by the other KNs in their collection and synthesis of evidence. A ninth network on priority public health conditions was in the process of being established.

### Issues and Challenges

Participants pointed out that while most people agreed with the concept of SDs, the practice of addressing the determinants was sporadic and had limited impact on mainstream health policy and programmes. The Commission was urged to capture the main obstacles as well as to document successes. The common obstacles were stated as follows:

1) A general perception in many nations (within government and society as a whole) that the goals of reducing inequities (in health) were utopian and therefore not attainable in practice.

2) A lack of realistic assessment of obstacles when embarking on actions to reduce health inequities and failure to put in place appropriate counter-strategies at the planning stages. One example given was what lay behind smoking behaviour were market forces to push tobacco into the Third World, e.g. China, India.

3) A tendency to develop broad goals for reducing health inequities without incorporating specific objectives and indicators that could be pursued, monitored and revised. These were thought to be some of the fundamental issues that the Commission could help address during its term.

The CSDH was asked to explain how it selected partner countries. Some participants felt that all countries should be involved in its process. Commissioner Vågerö responded that during the life of the Commission the decision had been made to partner with countries that were committed, willing to undertake comprehensive national action and build pressure and interest in their respective regions and globally. Additional responses from CSDH Civil Society Facilitators and from the CSDH Secretariat and Commissioners, referred to the design of the Commission, which aimed at becoming a “groundswell” of actors capable of building pressure, drawing interest and sustaining action on the social determinants of health.
Summary

- The Commission should address fundamental questions that have blocked “real” action to address health inequities.
- The Commission should give specific support necessary to strengthen capacity, produce methodologies and examples of how action on the social determinants and its impact on health inequities could be monitored.

The CSDH Country Strategy: objectives, products and progress to date

Chris Brown, Focal Point for Country Work, CSDH Secretariat

The country work strategy was presented outlining the overall purpose of country work within the Commission as “promoting, demonstrating and bridging the knowledge gap between policy and action to address socially determined health inequities”.

The CSDH aimed to involve an initial core of interested governments that would enable knowledge generation and application of evidence during the life of the CSDH. Additionally, it would allow WHO to evaluate its own strategies on health equity and social determinants across a range of countries. It could also provide a platform to analyse and produce concrete examples demonstrating how global/international institutions enable or disable country action on the social determinants of health inequalities. An overview of countries currently partnering with the Commission was included as represented in the Table A below.

Table A. Overview of status of CSDH partner countries (18 May 2006)

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<tr>
<th>Expressions of interest to collaborate</th>
<th>Discussing focus of collaboration</th>
<th>Formalized collaboration</th>
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<tr>
<td>Sri Lanka</td>
<td>Peru</td>
<td>Brazil</td>
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<td>India</td>
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<td>Chile</td>
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<td>Mozambique</td>
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<td>Kenya</td>
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<td>Senegal</td>
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<td>Islamic Republic of Iran</td>
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<td>Bolivia</td>
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<td>Canada</td>
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<td>Mongolia</td>
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<td>England</td>
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<tr>
<td>Vietnam</td>
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<td>Sweden</td>
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<td>Kyrgyzstan</td>
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The progress made with implementation highlighted how the CSDH had so far managed to support work within countries and to facilitate exchange between countries. The work on how global and regional institutions impact on national action on health inequities had only just begun and the intention was to further develop it in
the next phase of partnership with countries. Specific areas of work with country partners included:

i) Creating space for dialogue to build a common framework for action on health equity.

ii) Brokering people and institutional mechanisms in support of intersectoral action and evidence building on health equity, for example, as in Kyrgyzstan, Kenya, and a cluster of countries in the EMRO Region.

iii) Efforts to put social determinants and equity at the centre of the government’s policy agenda was illustrated with reference to the national action plans and institutional arrangements for cross government working that had been developed with Brazil and Chile.

iv) Work to support and distill learning from experiences of target setting to reduce health inequities though action on social determinants had begun in partnership with Chile, Brazil, Canada and England.

A number of common issues had begun to emerge from the work across countries, indicating priorities to be implemented in the next phase of the Commission’s country work (June 2006-December 2007). The main ones included a) more support to improve the quality of data collected to facilitate the analysis and monitoring of social inequities in health; b) capacity building to engage health and other government sectors in the development of public policies, programs and interventions that emphasize equity in health c) and, brokering evidence, tools and examples that work to incorporate actions that reduce inequities in health into the budgets of different sectors and levels of government. A fundamental issue in many countries was to mobilize civil society to advocate for health equity in public policies.

In response to these emerging issues, the Commission elaborated a set of collective products and activities to advance its work. The products are summarized in Table B.
### Table B Priority CSDH country work products

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<th>STRATEGIC OBJECTIVES</th>
<th>PROPOSED PRODUCTS</th>
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<tr>
<td>1. To contribute to the identification, development, testing and integration into routine Health Information Systems (HIS) of tools, methods and norms to support the analysis and monitoring of health equity and social determinants of health inequities.</td>
<td>✦ Diagnosis of the existing and potential use of health equity measures in national health information systems ✦ Integration of health equity measures into existing national health information systems</td>
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<td>2. To contribute to the development and testing of tools to evaluate: (a) the economic consequences of health inequities; (b) the cost effectiveness of priority interventions; and (c) the economic impact of investing in policies to tackle health inequities and social determinants.</td>
<td>✦ Development of a methodology for evaluating the cost-effectiveness of upstream versus downstream interventions to improve health equity ✦ Have applied this methodology to test the case in several partner countries</td>
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<td>3. To increase the evidence base on the extent of socially determined health inequities and to have evaluated selected policies and programs aimed at addressing socially determined health inequities.</td>
<td>✦ Country case studies: ✦ Diagnosing the baseline situation on health equity and linkages to social determinants ✦ Evaluating the impact of selected policies and programmes that have aimed to reduce health inequities by addressing specific social determinants or groups of social determinants</td>
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<td>4. To support the process of the development of commission inspired national health policies to systematically prioritize and address socially determinants of health and health inequities in partner countries</td>
<td>✦ In-depth, prospective country case studies describing how countries have progressed the agenda on tackling socially determined health inequities, covering the following steps: ✦ Identification of priorities for action, national objectives, targets, and indicators for action on SDH ✦ Identification, strengthening and development of sectoral and multisectoral mechanisms for action on SDH ✦ Development of a medium-term national plan of action for action on SDH ✦ Development and implementation of monitoring strategies for action on SDH.</td>
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<td>STRATEGIC OBJECTIVES</td>
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<td>5. To contribute to the identifying and answering key questions requiring further</td>
<td>✦ A systematic literature review of mechanisms for encouraging civil society participation in the</td>
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<td>research and better analytical and monitoring tools, methods and norms, in order to</td>
<td>development of policies tackling health inequities</td>
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<td>advance the agenda of incorporating action on socially determined health inequities</td>
<td>✦ A systematic literature review of mechanisms for supporting intersectoral action on socially determined</td>
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<td>in country health and development policies, programs and systems</td>
<td>determined health inequities</td>
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<td>✦ A conceptual framework to guide future research on the relationship between psycho-social factors</td>
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<td>and health inequities</td>
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<td></td>
<td>✦ A task force report on other priority research issues relevant to countries trying to tackle socially</td>
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<td>determined health inequities</td>
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<td>6. To contribute to ensuring the relevance of knowledge network products to country</td>
<td>✦ Participation in a peer review process to comment on specific KN products</td>
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<td>action</td>
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<td>7. To contribute to the final CSDH and World Health Reports</td>
<td>✦ A country work report (stand alone)</td>
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**Issues and challenges**

The country work strategy was seen as a good framework for guiding the Commission in its engagement with countries and there was overall support for its rationale and strategic goals. At the same time, there were some concerns expressed that it set out a very ambitious agenda, especially within the time frame of the Commission. The involvement to date of WHO country and regional offices as strategic partners in the process of facilitating interest and supporting implementation of action on social determinants was welcomed. At the same time, WHO's involvement in a systematic manner could add value, and so would mechanisms such as the Millennium Development Goals (MDGs), and Poverty Reduction Strategies (PRS). Such a move would increase the capacity available to deliver the strategic objectives within and beyond the life of the Commission and strengthen the institutionalisation of social determinants within WHO.

The principle of developing a social determinants approach to the design implementation, monitoring and review of priority public health conditions was strongly supported. The Commission was urged to look for partnership with former CMH countries and use specific issues such as malaria to demonstrate the importance of social determinants. It was pointed out that there had to be a careful selection of issues to promote understanding and demonstrate the role of social determinants in health outcomes.
The proposed strategic objective 2, which focused on advancing work to address the economic arguments for investing in tackling health inequities, drew several comments. There was general support for the CSDH, in partnership with countries and other stakeholders (e.g., task force for health financing), to advance this work, as currently there was a critical “gap” in information for policy and decision-making, at country level. Participants said that it should show the added benefits of investing in social determinants beyond cost-effectiveness; it should recognize that health and the economy sometimes work against each other (the example of Russia was given), and its products should show the cost of not investing in reducing health inequalities as well the value of investing in reducing health inequalities. Additionally, it should produce new methodologies. In support of the later point, a participant noted how a “recent massive report on looking at cost-effectiveness of public health interventions mentioned that the methodology ended up eliminating good interventions”.

The CSDH was encouraged to make the documentation of country examples a priority and transform it into applicable tools. Participants said the CSDH should distil “what works” to institutionalize SD and health equity into government priorities and policies. It was felt that given the time frame of the CSDH, this needed to be done prospectively with new partner countries, and retrospectively, using examples from countries with more experience, e.g., Sweden, Canada, England. This indicated support for the proposed country case studies products, presented under “strategic objective 4” of the country products (see table B).

Participants suggested that a process should be set up for CSDH civil society networks to review and contribute to the collection of practical lessons from countries. A re-emerging issue from the discussions in the previous session was how country stakeholders could get involved where there was no official government support or commitment. Respondents from civil society stated that they and community-based initiatives could play a key role in this process, by creating pressure and a number of examples were given.

Despite progress, a number of areas were identified for special attention. First, the Commission was asked to invest more time and resources in African countries to accelerate the process and promote action. Specifically, it was asked to capture what was already working, and to facilitate an alliance of committed nations, civil society, and knowledge institutions able to drive the process, stimulate interest, and generate pressure for action in the region. Second, it should strengthen its work with global institutions and look at how global mechanisms have a specific impact on health equity at country level. Linked to this was the view that the CSDH should use its mandate to have higher visibility, give stronger messages and have more influence on global institutions and policies.

Summary

There was support for the approach, strategic objectives and proposed products outlined in the CSDH country work strategy. However, it was felt to be an ambitious agenda to implement within the time frame of the commission, which may warrant a subsequent reprioritisation exercise of activities and products during the next phase of implementation.
Country case studies should include learning which clearly showed what health strategies, polices or systems looked like, and how they performed when they were orientated to health equity through addressing SDH.

Documenting, synthesising and making accessible the learning on ‘what works’ from experiences in countries to integrate health equity and social determinants as core business in government health policy was crucial. Learning should be translated into application products to ensure accelerated uptake and support innovation in and between countries, globally on tackling the social determinants of health.

Fundamental areas which should pave the way for changes in health policy and programmes, are, the economic arguments for investing in reducing health inequalities through actions on the social determinants; the costs of not doing so; and the rationale, examples and implications of investing in tackling the social gradient in health vs. targeting most disadvantaged groups vs. improving the average health status.

Processes and tools needed to be developed for better integrating social determinants and the learning from the Commission into WHO policies, technical programs and its normative role, at global, regional and country levels.

A range of entry points should be considered, for building pressure, support and stimulating action to reduce health inequalities, through involvement of a wider range of stakeholders and institutions, particularly in countries where the political will and mandate is fragile.

Clearer messages were needed on social determinants of health inequities. The commission should strengthen its communication strategy and specifically the positioning of messages, externally and within WHO.
Roundtable 1 - Progress, mechanisms and future priorities in advancing national health equity action plans - feedback from CSDH Partner Countries

Chair
Ndioro Ndiaye, Deputy Regional Director, International Organisation for Migration, Geneva, Switzerland

Presentations
- Mr Alberto Pellegrini, Executive Secretary for the National Commission on Social determinants of Health, Brasil (Brazilian National Commission on Social Determinants of Health).
- Dr G. Heideri, National Focal Point on SDH, Ministry of Health and Medical Education, Islamic Republic of Iran (Iranian National Action Plan on Social Determinants of Health).

Overview: Chile

There were good improvements in the health status of the population and a major decline in infant and maternal mortality rates over the last 40 years. Average life expectancy at birth stood at 77.9 years, adult literacy rate was 95.7 %, and combined school enrolment stood at 81%, with the percentage of the population living below US$1 dia (0) and below US$2 dia 9.6%. Additionally, the country had witnessed a decline in infectious diseases, in 96% of population.

Successes were attributed to a history of social progress and investments in broad-based social protection measures, including the maintenance of long standing policies since the 1950s. These policies involved a number of initiatives at the primary and then secondary, and tertiary levels. Despite the success, inequities in health
persisted between population groups, for example the gradient in infant mortality and in the risk of diabetes and hypertension was strongly correlated to level of education (mother’s education level, in the case of infant mortality).

The Government, under the leadership of the new President Michelle Bachelet was advancing a new agenda to tackle the social determinants of inequities, building on the foundations set by her predecessors, such as President Ricardo Lagos. The key priorities for the period 2006-2010 involved the strengthening of the social protection network; creation of conditions for equitable development; and focusing on combating discrimination and exclusion. The corresponding strategic map for health in Chile had multiple strands, including targeted policies and programs to improve the health of the most disadvantaged groups; broader policy interventions designed to prolong the number of illness free years; and targets to reduce health inequities through better focus and coverage of universal social protection measures, such as the protection system for children and equity in workers’ health systems.

Challenges to delivering the above health agenda fell in three categories:
- Building new institutional processes for strengthening intersectoral planning;
- strengthening evidence and know-how to advance universal policies with a social rights agenda;
- and, building networks of social promotion and protection that involve all sectors of government and civil society.

**Brazilian National Commission on Social Determinants of Health**

Brazilian National Commission on Social Determinants (BNCSDH) was launched in March 2006. One of its biggest challenges was the indifference to extensive inequities in health which existed across regions, income groups and races in Brasil. The BNCSDH, had been set up to make specific recommendations of policies to combat health inequities based on scientific evidence, strong political support and wide awareness of the social determinants of health.

Composed of 17 members, the BNCSDH’s leading figures are from the scientific, cultural, economic and social spheres of life in Brasil. In addition to the Commission, an intersectoral working group with representatives of several ministries
was created. The group would work in close collaboration with the Commission, facilitating the implementation of its recommendations.

The Brazil strategy had the following main points:

1. **Production and dissemination of knowledge and information**: including funding for a call for research proposals; methodological seminars; review, evaluation and dissemination of all information systems related to SDH; and knowledge generation to focus on relationships between social determinants and health situation, particularly health inequities, in order to support policies and programs.

2. **Policies and programs to support work of an intersectoral group**: the forum would identify, promote, coordinate and evaluate governmental actions on SDH; also support members of Health Councils at all levels, through selective information dissemination and creation of opportunities for interaction to analyse experiences in SDH interventions.

3. **Mobilization of civil society for advocacy on action**: partnerships with NGOs, interest groups and associations to create awareness about the importance of the relationships between health and living conditions, and show that it was possible to take actions that promoted health equity.

4. **Web portal on SDH**: disseminate information, publish documents and provide space for strategic debate among decision makers, researchers, media professionals and others.

5. **International projection**: In partnership with CSDH and PAHO, to participate in technical cooperation activities with Latin America and Portuguese speaking African countries, to promote the SDH approach in health policies.
WHO and the Iranian National Action Plan on Social Determinants of Health

A strong reduction in child mortality, marks Iran’s experience since the setting up a comprehensive and free to the user primary health care system. However, social inequities have persisted particularly on gender gaps in employment and in certain destabilised geographical areas are affected by migration, mainly from neighbouring countries in conflict, under economic hardship, or destabilised by natural disasters.

New trends such as the rise in the urban population; leading to unplanned growth of peri-urban areas, increased levels of social isolation, increased rates of injuries and deaths from road accidents is challenging the public health system largely designed to cater for a stable rural population. A recent analysis of inequities in infant mortality revealed that low household economic status, low level of mother’s literacy and residency in a rural area were the three most significant predictors of infant mortality in the country.

A consultation and review of the draft national action plan to reduce socially determined inequities is currently under-way. The plan was drawn up in December 2005, followed up in January 2006 with the government playing host to the 4th meeting of CSDH Commissioners. The meeting was used as an opportunity to engage other government line ministries and civil society in a more consolidated debate on health inequities and their role in addressing these in their core policies programs and plans. The Supreme Leader committed to the agenda and the SDH was placed high in the Health High Council’s agenda. A multi-disciplinary team was established to coordinate the elaboration of a national action plan on SDH. Between January and April the team has held a series of workshops and meetings to build better understanding and commitment to joint- models of working and shape a new equity orientated public health agenda.

Current challenges included knowledge gaps on appropriate policy responses to reduce health inequities particularly between urban and rural populations; understanding of causal pathways from social determinants to health outcomes within Ministry of Health departments, across government and other institutions; and
mechanism and tools to strengthen intersectoral collaboration and ensure implementation of equity targets across government.

**Issues and Challenges**

A suggestion was made that the Commission and country partners, together with WHO country and regional offices, should map and define how to engage with influential regional networks such as Mercosur.

The equity performance of some countries, e.g. Chile was impressive and questions were raised regarding if and how they had been evaluated. The Commission was requested to make available methods and examples of any evaluations of equity performance that had been documented. There was an offer from WHO/EMRO to share work that was being undertaken in their region to look at causal pathways for functioning of programs, which could be used by other regions.

The role of knowledge for policy was a strong theme in the presentations and led to proposals from knowledge networks participants that there could be more interaction between countries and KNs to debate the policy ‘acceptability’ of evidence emerging from KN. Real synergy could come from such a process whereby a country and a KN, were both working on a shared theme e.g. urban setting, early childhood development. This would facilitate country stakeholders in an engaged debate on policies related to the relevant KN report and help to advance country thinking and action, while providing concrete examples for KN reports, as part of the global evidence being synthesised by the CSDH.

Intersectoral mechanisms was a key theme in the presentations and the discussions indicated it was an area for CSDH to synthesise effective practice appropriate to a variety of country contexts.

**SUMMARY**

- The Commission should consider including “intersectoral action on health equity” as fundamental and additional work on the issue should be scoped and advanced.

- Specific examples, methodologies and tools were needed for measuring the equity performance of policies and programs
Roundtable 2: Challenges to put Health Equity as a Policy Priority across Government, "Lesson Learned"

Chair
Dr Erio Ziglio, Focal Point for SDH, WHO/EURO

Presenters
- Dr Øyvind Giaever, Senior Adviser, Directorate for Health and Social Affairs, Norway: The Challenge of the Health Gradient - experiences of shaping the national health agenda in Norway.

The session presented the experiences and lessons from three countries, Sweden, England and Norway. The presentations focused on sharing knowledge on specific institutional mechanisms, process and systems that have contributed to putting health equity as a whole of government policy responsibility.

Inequalities as a Corporate Government Responsibility: The Experience in England

The name of the national health inequities strategy for England ‘Tackling Health, Reducing Inequalities’ highlights the dual aim of improving overall levels of health in the population and reducing the gradient in health inequalities between population groups. Data was presented showing that average life expectancy in England had increased, while the rate of improvement varied across population groups and geographical areas. As a result, the actual gap in health inequities had increased, with differences in mortality following a strong socio-economic gradient. Political will had been the single most important factor in building policy commitment to tackle health inequalities. The Acheson inquiry (1997) was a watershed-report, which reviewed latest available evidence. It created context and focus for national debate on what factors affected health and how these manifested themselves over the life course to shape health experience. The inquiry also set out priority areas for future policy development such as priority to families with children and reduction of income inequalities, including targeted improvement of living standards for impoverished households. The report was significant in highlighting how the policies of all sectors had an impact on the determinants of health.

Preparation for whole of government strategy development and implementation of an equity agenda required initial and ongoing work to review the role and contributions of different sectors and society. Significant work included a cross-cutting treasury review on health inequalities (2002) and development and testing of different scenarios for improving health & reducing inequalities (e.g. Wanless Report, Programme for Action on Health Inequalities 2003). A ‘spearhead group’ was established recently to build a focus for integrated action and successful delivery in the most deprived areas.
In summing up Dr. Adshead stressed that the process took time and required ongoing commitment and investment. The need for targets was crucial for ensuring momentum and to direct resources, policies and programs. The National inequalities strategy for England had set a number of targets within a specified timeframe e.g. by 2010 to reduce inequalities in life expectancy and infant mortality by 10%. The regular reporting on progress to a cross government committee was important to keep momentum and ensure government commitments.

**National Equity Orientated Public Health Strategy for Sweden**

The goal of the national equity-oriented public health strategy for Sweden was ‘*The creation of social conditions to ensure good health, on equal terms, for the entire population*’. Public health policy in Sweden was a process which had involved many stakeholders with composition from four pillars: political representatives from each party; the scientific community; civil society and all line ministries and departments. Key principles of the Swedish strategy included equal opportunities to good health as an overarching aim of public (health) policy. Monitoring and evaluation was a priority because “what is monitored is more likely to be implemented and maintained over time”.

Most health determinants fall under the responsibility of other policy areas than health and medical care which required convincing other Ministries to apply a public health perspective in their respective policy areas. Experiences of tough negotiations with minister of finance on allocation of resources for achieving objectives of the public health policy were a key part of moving the policy forward. There was a need to understand the priorities of other sectors and to identify the ‘equity synergies’ which led to an analysis of the health objectives in existing policy areas and enabled more focused dialogue and actions to put them in a public health context. The process required ‘tactics’ as well as evidence.

Institutionalising health equity had been advanced through a number of different mechanisms, including the appointment a special Minister of Public Health to give visibility and an institutional mandate of the policy, backed up by mechanisms to strengthen inter-ministerial action. For instance, a national steering group for public health was established in which the most relevant national agencies were represented by their respective director-generals; governmental directives were given to all concerned state agencies to take action on equity objectives under their sectoral responsibility, designated support to sectoral agencies on implementation was given to the National Institute of Public Health, which also had the responsibility to monitor the national strategy and publish a Public Health Policy Report (published every 4 years) and evaluate progress towards achieving targets. The public reports were used to maintain visibility, interest and ‘relevance’ of the issue in government and were formally presented and discussed in parliament.

In summing up Ms Nilsson cautioned that it took time to get government to act. In Sweden, it took 2 years for the strategy to be formally adopted, from the time it was drafted. Given the time investment required, a strong and ongoing political commitment was necessary. External agencies and the influence of other countries could play a critical role in ensuring ongoing political commitment. For example, when the case for SDH and equity was made by other countries, it lended weight to the...
Swedish public health strategy and allowed “space” to develop. It was pointed out that WHO, the CSDH country partners and products from the commission had a strong role to play as prime advocates of social determinants and in engendering political commitment. Other areas of work within WHO e.g. Health Promotion, (which have been a foundation to the Swedish equity policy), were also a main avenue through which to advocate for and put in place actions to decrease health inequities. Therefore, WHO should coordinate its programs and activities in the area of health equity and maximise the use of these resources in working with countries in the long term to secure the health equity agenda. In summing up, MS. Nilsson highlighted the importance of making the connection between sustainable development, social determinants and health in securing whole of government commitment to health equity. She summed up the point in her concluding remark: “When the goals of sustainability and country planning have a visible presence within the organization, this opens up opportunities for effective follow-up at the level where policies and actions are needed the most, i.e. the country level.”

**The Challenge of the Health Gradient – experiences of shaping the national health agenda in Norway**

Norway presented an analysis of the causes of health inequities. It showed how social inequalities in health began early in life, compounded by negative causal factors that tended to accumulate over the life course and with the same population groups more susceptible to different risk factors of illness. In outlining the principle of the national plan to reduce the social gradient in health, the types of measures that were at the heart of success were outlined. The main ones included measures directed towards the entire population (not only high-risk groups) and measures directed towards social structures (not only towards individual behaviour).

The recognition that more evidence on causal pathways and specifically policy interventions to break negative pathways was needed. However the lack of full causal knowledge should not prevent action. The national action plan included a range of policy entry points directed at universal measures across the population and selective measures divided across upstream, midstream and downstream determinants, as outlined in Table C.
The first global meeting of country partners: WHO Commission on Social Determinants of Health

Table C: Universal and Selective Measures for tackling SDH.

<table>
<thead>
<tr>
<th>Universal measures</th>
<th>Midstream</th>
<th>Downstream</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Upstream</strong></td>
<td><strong>Midstream</strong></td>
<td><strong>Downstream</strong></td>
</tr>
<tr>
<td>education, taxes, labour market policies, housing</td>
<td>working environment, living environment</td>
<td>health service reform</td>
</tr>
<tr>
<td><strong>Selective measures</strong></td>
<td><strong>Selective measures</strong></td>
<td><strong>Selective measures</strong></td>
</tr>
<tr>
<td>social security, child welfare</td>
<td>targeted lifestyle measures</td>
<td>targeted health services</td>
</tr>
</tbody>
</table>

The next steps for Norway were to use the draft framework and background evidence to develop a strategy with a focus on leveraging the involvement and actions of all branches of government.

**Issues and challenges**

The experiences of countries indicated that there were a core set of critical success factors for institutionalising health equity as a priority for the whole of government. Included in this core were:

a) Political will and pressure plus the incentives to sustain it over time;
b) Targets and formal institutional processes for monitoring and reporting on implementation (to government and the public);
c) Evidence was important, but bargaining and negotiation were equally important;
d) Understanding the priorities of other sectors, with a view to identifying where health objectives feature in existing policy areas and how to put them in a public health context; and,
e) High level intersectoral steering mechanisms, backed up by a clear plan of action and capacity support for implementation.

Particular challenges to sustaining a political agenda were put on the table, highlighting a conflict between short term political lifecycles and the high proliferation of ‘new political initiatives’, while action on social determinants required time to show results.

The role of WHO in advocating for social determinants and health equity was crucial to keeping social determinants on the agenda in partner countries (reference to CSDH country partners) and to create receptivity and commitment to act in other countries. WHO also had a role in bringing together evidence, monitoring the impacts of development on health and health inequities, and in appraising the capacity and response of policy and health systems. Additionally, WHO should strengthen technical assistance to Member States in the form of training and know-how development to address the social determinants of health inequities.

The issue of building and sustaining political pressure was raised by a number of participants. It was pointed out that committed countries should play a part in shaping global health policy through leveraging their government actors and international policies. In this way, mechanisms which have had an impact on distal
determinants of health in other nations such as global trade pricing, which affect livelihoods and livelihood opportunities nationally, could be challenged.

The CSDH should capture the interface between global policies and national determinants of health, showing how global factors have an impact on health equity and then follow-up with the generation of policy and institutional restructuring that addresses the negative effects on health equity.

As in the earlier roundtable, the use of multiple policy and program interventions to impact a range of determinants seemed the preferred option of choice when tackling health inequities, indicating support for the approach of working across the whole gradient. There were questions about the feasibility of this in countries with less stable governance systems, more fragile economies and development status and/or higher burden of poverty and disease. This led to a number of comments about effectiveness of different approaches to tackling health inequities in different country contexts needing to be further explored and communicated. Some of the comments made were:

- *With regards to comparisons of health inequities between Sweden and UK in the last 20 years, to what extent were these effects a result of different intervention approaches?*
- *Both types of approach (targeting, vs. work across the gradient) were essential and were not necessarily contradictory. Differences in developing and developed countries should be taken into account in how they determined what approach (or combination of approaches) was most feasible and effective.*
- *How successful were targeted policies in bridging the gradient in health?*
- *If absolute differences decreased then it should be seen as an achievement.*

Many participants felt that the experiences of countries on ‘how to develop and sustain intersectoral approaches and capacity’ was a fundamental question that the commission should seek to answer.

**SUMMARY**

- The role of WHO in advocating for social determinants and health equity was crucial to keeping social determinants on the agenda in partner countries (reference to CSDH country partners) and to creating receptivity and commitment to act in other countries. The strategy and mechanisms for doing so needed to be further elaborated and implemented during the life of the commission.
- Country work should seek to develop mechanisms for strengthening in-country and between country capacity-building to share skills expertise and know how among policy makers, practitioners and interested stakeholders, to advance a health equity agenda through action on social determinants.
- Build an alliance of nations capable of generating interest, pressure and concrete examples of how and why to tackle SDH - through facilitation of action and exchange within and across countries and regions and to accelerate uptake and interest of other countries and institutions in tackling SDH as part of “core business”.
- Address fundamental questions which would pave the way for changes in health policy and programmes. Specifically i) how to develop and sustain intersectoral approaches and ii) the rationale, examples and implications of investing in tackling
the social gradient in health vs. targeted interventions. And relevance to different country contexts.

Knowledge Networks - Strengthening the Evidence base for action on SD's - current progress and Expected Knowledge products

Sarah Simpson, Focal Point for Knowledge Networks, Secretariat of CSDH

The Coordinator of knowledge networks outlined how a number of the CSDH’s streams of work were involved in building the knowledge base on tackling social determinant and health inequities. She outlined the organization and focus of 8 of the Knowledge Networks (KNs). Most of the networks had begun collection and synthesis of existing evidence, documenting new learning and all were developing a global inventory of effective polices and practices for tackling the SDH. Seven of the KNs were focussed on collecting evidence on a priority determinant, known to be significant in explaining health inequities and amenable to intervention (Urban Settings, Early Childhood Development, Health Systems, Gender, Employment Conditions, Globalization, Social Inclusion). The work of the 8th KN is focussed on the measurement and evaluation of SD and in developing standards and guidelines for the synthesis of evidence related to SDH which would be used by the other KNs in their collection and synthesis of evidence.

The key deliverable for each KN was a final report (due 31st March 2007) that synthesized global knowledge on the theme area and included key findings and gaps in knowledge on associations; an inventory of successful sectoral and intersectoral policies and programs; in-depth country case studies demonstrating government action on SDH; and recommendations for action - globally, regionally and nationally. In addition, each knowledge network would produce a number of specific and separate products on its specific theme area to support the application of findings to policy and practice. Products would include published papers1, discussion reports, and consensus statements (e.g. Early Childhood Development statement on survival & development), case studies and glossaries.

There was a short summary of different entry points through which country partners and other stakeholders could participate in and draw upon the expertise of the work of Knowledge Networks during the life of the commission, including a) Jointly working with KN members to produce in-depth country case studies which would be used by the country to advance a national agenda on health equity, while at the same time constitute a case study as part of the global knowledge being collected by the KNs; b) participation of policy makers in specific knowledge networks to give a practitioner perspective; c) Participation of policy makers in a proposed peer review of knowledge products to ensure relevance to policy and practice. Input to future knowledge network meetings through which to scope the type of questions countries might want answered and around which future knowledge products could be developed. It was made clear that the process for involvement of countries also

1 Types of papers as exemplified by the early childhood development (ECD) KN include; "Experienced based brain & biological development"; "Structural determinants & social inequality in ECD"; "Review of effective ECD interventions globally".
involved WHO Regional Offices and was currently being discussed with the Regional Offices.

Finally, relevant milestones for the work of Knowledge Networks was shared including progress reporting to the Commissioner meetings (June 2006, Kenya; September 2006, Brazil;), inter-network hub events planned for October 2006; and the final reports of each KN, due by 31st March 2007.

**Issues and challenges**

The rationale for the choice of knowledge network themes was understood and generally accepted but the question arose on how other issues with a regional and or country specific relevance could be picked up. Participants felt that more evidence and examples were needed on issues such a war, trade sanctions, migration and governance (reference here was to governments that are non democratic) globalization, market forces and the impact of the neo-liberal paradigm on health equity at the country level. It was explained that additional key issues were being addressed, an example was WHO’s Eastern Mediterranean Office (EMRO) regional case studies and how these were taken forward with support from the Commission. Also, discussed was how the knowledge and evidence would be shared with other regions and countries with similar evidence and priorities. The Commission was then requested to put together knowledge institutions and countries/regions sharing common priority social determinants, presently outside the formal KN themes. It was recommended that a key selection criterion should be the ability of the countries/regions to resonate with a number of program areas, which WHO or other UN agencies were running.

The point that people identified by the country and civil society streams of work should review the KN products was well received. This way, the evidence would be more credible to “end-users” and could create room for introducing new evidence into policy dialogue on health equity and social determinants. There was a general discussion on linkages between the different KNs and between KNs and other streams of the CSDH. From the perspective of collaboration between KNs and civil society, the view was the CSDH regional facilitators should take the responsibility to be in contact with all the different networks. Additionally, access to ‘Sharepoint’ was strongly requested by many participants, with the secretariat agreeing but adding a caveat that access would need to be capped, sending it to the whole world could cause a number of problems related to the integration of knowledge.

There were some questions about whether alliances were being forged with other bodies involved in knowledge development with a focus on equity and social determinants. The example was given of the Global Forum for Health Research which could offer a complimentary global platform for the CSDH to work with. The response came that a scoping exercise could be undertaken to explore mutual knowledge development alliances.
SUMMARY

- Evidence on issues such as war and migration, which cut across a range of countries and were key in determining health outcomes, were important to capture in the evidence synthesis and should also be reflected in knowledge products across all the KN themes.
- Criteria for global country case studies should be developed to ensure the final contents and products resonate with institutions and bodies whom the commission was trying to influence and partner with, to advance a global agenda on health equity.
- The proposed peer review of synthesized evidence and knowledge products, by civil society, country policy makers and WHO programs country and regional offices was important and well supported. The process and mechanisms now needed to be put in place.
- A scoping of further global knowledge development alliances between the CSDH knowledge networks and other knowledge institutions e.g. The Global Forum for Health Research, was recommended.
- Access to the knowledge network portal ‘Sharepoint’ was requested by country partners and other stakeholders.

Day 1 Summing up of country experiences of tackling health inequities through action on the social determinants

Chair Dr Marie André Romisch-Diouf, Director CCO, WHO, Geneva
Facilitator Dr Rene Lowenson, EQUINET, Harare, Zimbabwe

At the end of the first day there was an open discussion, which began with a synthesis of key lessons from tackling health inequities in countries.

Overview

Country partners consistently stressed that the process took time and built on existing history, values, rights, political leadership (and consensus). Success depended as much on work to strengthen institutional processes as it did on evidence, technical work and policy development. Political support and mandated accountability were crucial. The comment by one senior health official succinctly expressed this: “political will is the single most important factor in tackling inequities.”

Policy required the involvement of multiple stakeholders working a different levels within and outside of government, to create pressure for action and to participate in the implementation, monitoring and review of policies plans and targets to reduce health inequities.

The existence of unified health and social protection systems, guaranteeing basic rights and elements for health and social justice were repeatedly shown as the cornerstones of societies capable of producing and sustaining better equity in health. The choice of the approach to reduce health inequities, with the case for acting across the gradient vs. focussing on specific disadvantage was keenly discussed. The
experience across most countries was to take a combined approach, but with the overarching aim to act across the gradient.

Other factors commonly identified as important to establishing and implementing a national health agenda on tackling health inequities included:

- A national intersectoral forum, with profile, authority and leadership, inclusive of stakeholders and with clear roles (with formal institutional accountability, e.g. to parliament);
- fed by evidence, information, analysis, dialogue and debate;
- translating into concrete workplans, programmes, tools, goals and measurable outcomes;
- using, strengthening and re-orientating existing institutional resources for delivery;
- and, mindful to move from ‘initiative’ to policy and institutional change-scaling up and integration of learning and responsibilities for tackling health inequities.

The second part of the roundup session looked at the type of support needed from WHO and the CSDH to advance action on social determinants and health equity in countries. With the experiences of countries fresh in the minds of participants, two questions were put forward:

Question 1: What is expected from the Commission?
Question 2: What is expected from WHO?

Responses to question 1:

- **Build an alliance of nations capable of drawing interest, exerting pressure and providing concrete examples of why and how to tackle the social determinants of health and improve health equity. The alliance should be in a position to accelerate the uptake of the SDH agenda.**

- **Address the fundamental areas which should pave the way for changes in health policy and programmes, that is, the economic arguments for investing in reducing health inequalities through actions on the social determinants; the costs of not doing so; and the rationale, examples and implications of investing in tackling the social gradient in health vs. targeting most disadvantaged groups vs. improving the average health status.**

- **Strengthen and influence global institutions and policies. CSDH should lever the political conditions for equity and SDH, e.g. SD in Health MDGs and PRS; demonstrate how the policies and actions of regional and global institutions positively or negatively impact the social determinants of health inequities.**

- **Increase communication and visibility of the Commission; clarify key messages, and use products, resources and sphere of influence more systematically and with a view to strengthening social debate and public awareness on social determinants and health.**

Answer to question 2:
Institutionalise and sustain the Commission agenda on socially determined health inequities within global, regional and country level politics and within its strategic objectives; through the Department of Equity, Poverty and Social Determinants of Health; within country cooperation strategies - 2nd generation strategies and technical cooperation agreements; and integrate SDH into the UNDAF and into the monitoring of plans on MDGs and PRS.

Monitor and evaluate the SDH implications of WHO’s work in global and national policies, programs and normative work.

Develop more consultative and participatory processes through the opening or enhancement of channels for civil society participation in the policy making process, action, evaluation and governance at WHO, and with governments partnering with the Commission.

These priorities set the backdrop for the presentations and roundtable discussions on the second day of the workshop.

Day 2: Friday 19th May

Roundtable 3  Collaboration between Country Partners and Knowledge Network: opportunities, process and mechanisms to accelerate national action and ensure knowledge generation is relevant to policy and practice?

Chair - Dr Sylvie Stachenko, Public Health Agency, Canada

Presentations

Dr Patricia Frenz, Coordinating Directors of SDH, Ministry of Health, Chile: A country perspective: knowledge needs for national action and opportunities for collaboration with KNs

Dr Susan Watts, WHO, Eastern Mediterranean Office: The role of the WHO Regional office in brokering knowledge generation and Regional Action on Social Determinants of Health Equity

Professor Vilma Sousa Santana, Co-hub leader, CSDH Employment Conditions Knowledge Network, University of Bahia, Brazil: The Employment Conditions KN: proposed topics and approaches for knowledge generation

A country perspective: knowledge needs for national action and opportunities for collaboration with KNs

From the view of a policy maker successful policy making and implementation of policies, requires the involvement of academics or experts from specialist institutions and from communities in ascertaining a consolidated view of priorities to be addressed and in generating the questions that policy responses should answer.

A key challenges for KNs in meeting government or country partner needs was therefore to come up with answers not only to what should be done, but also options on how to do it. It involved understanding the policy-making process, particularly, why action wasn’t taken even when knowledge was available. Issues such as capturing and
having ‘knowledge tools’ were capable of supporting policy makers to overcome lack of political will were as important as actual evidence on what works.

The implications were that KNs would need to develop products with utility in the highly politicized context of government decision-making, which was characterized by multiple agendas, competing interest and time and resource constraints.

Therefore the process of knowledge generation was key and needed to be done in such way that the questions were right in terms of the scope and areas covered, ensuring a policy perspective (and civil society perspective) in the sourcing of and synthesis of evidence; providing case examples which include detailed analysis of the content, process and context of action/change on SDH, extracting key elements for application and policy transfer and understanding the validity of different types and sources of knowledge.

Moving on to outline the mechanisms for country collaboration, six areas of collaboration were presented, through which synergy between KNs and country partners could be mutually reinforced and advanced a SDH policy agenda in a country. Firstly, KNs could work with country partners to ensure policy makers perspectives and common issues across countries were incorporated into the scope and products of KNs. Secondly, the countries could develop national KNs with back up support from CSDH KNs as a means of address knowledge gaps on country specific challenges and thus strengthen the capacity of national knowledge institutional on SDH. Thirdly, countries could undertake work jointly with KNs on documenting case studies. Fourth, interaction on ongoing basis between CSDH partner countries and KNs via access to intermediary products: Share Point. In respect to disseminating knowledge products to increase national awareness and commitment, it was felt that joint events could be organized to share experiences and learning. This latter point was also expressed as an activity that the CSDH secretariat should take up, specifically to broker and catalyze exchange and debate on emerging findings between KNs and Country partners in the regions and globally.

The role of the WHO Regional office in brokering knowledge generation and Regional Action on Social Determinants of Health Equity

The presentation gave an overview of the initial work within the EMRO region, to catalyse and bring together knowledge, knowledge institutions and countries to create a foundation for developing strategies for advocacy and action on SDH in the region.

It was first pointed out that the knowledge base on SDH and Health equity (including appropriate policy and program responses) in the Eastern Mediterranean Region (EMR) were scarce and scattered. The work to broker development of a more robust knowledge base (actual evidence and institutional capacity) across the region required intensive support to networking with colleagues in EMRO, country offices, Civil Society and academic partners. However, networking was focused on turning knowledge into action and to date a variety of meetings, dialogue events and consensus building workshops on SDH and health equity had taken place. These have led to the production of regional discussion papers on SDH and commissioned position papers on SDH in 7 EMR countries including: Egypt, Islamic Republic of Iran, Jordan,
Morocco, Oman, Pakistan and Palestine. Joint initiatives with WHD/EMRO programs such as the Community Based Initiatives (CBI) had resulted in new alliances to share experiences, produced case examples and strengthened learning that could be extracted and shared from the work. There had been a special Collaboration established with the Social Research Center, AUC, Cairo and Regional Civil Society Organizations, and a planned workshop in June 2006 would formalize the collaboration and lead to an action plan.

In summing up, the presented showed how WHO Regional offices could play a key role in brokering knowledge for action through activities such as collecting and sharing knowledge from and between countries; use this to build the case for and direct the focus of regional and country level strategies on SDH and health equity; identify and support research and action on themes of special relevance to the Region; provide and facilitate capacity building on research into SDH and health equity; and act as an agent for partnership building by using its sphere of influence and channels of communication to engage and support interaction between regional Office, WHO Geneva, Country offices, Civil Society, Academia and KNs. vi)To build up these networks for advocacy and action.

The Employment Conditions KN: proposed topics and approaches for knowledge generation

The session looked at the synergies between the knowledge building and policy and program development activities of the Commission and how these could be realized. To provide a context to the roundtable discussion, three separate presentations were made, each giving the perspective of a different stakeholder group with a critical role to play in the process of supporting action on SD and health equity in countries and regions. Chile presented from a country policy-makers perspective on the type of knowledge needed to generate and support national action on SDH; WHO/EMRO presented their work in brokering knowledge generation and action on social determinants of health equity in their region and the CSDH Knowledge Network for Employment Conditions gave the perspective of a specialist knowledge development institution on how the process being used by KNs to collect & synthesize evidence on SD of health inequities could also be used to support country partners to advance national action plans on health equity.

Overview - CSDH KN HUB Employment Conditions

The key objectives of the KN Hub, called EMCONET, were shared which highlighted its intention:
- To develop models and measures to improve the understanding of the links between employment conditions and social determinants of health,
- To develop pathways to translate knowledge into public and occupational health policy recommendations,
- To collect data and evidence on the effectiveness of different health-related interventions (policies and programs)
- To improve employment conditions at the level of comprehensive policy in appropriate country-specific context and for different vulnerable and high-risk groups,
To identify programs which include workers’ participation in developing interventions

To enhance and to promote social consensus towards the need to act upon health inequities as a politically avoidable and harmful reality for individual and social development and well-being

EMCONET had just begun to develop its activities and its strategies to generate knowledge were still under development and would be discussed during the KN meeting in June. It was highlighted that member recruitment was guided by principles of inclusivity of regions and in collaboration with some civil society facilitators. It was also stressed that because of its focus on action, the knowledge generated needed to go beyond the academic frame, be problem-oriented, and take into consideration relevant questions posed by policy-makers and stakeholders, such as labor unions and social organizations. The process of gathering evidences for learning would be participatory in all phases and would include not only academic documents but also grey literature. The knowledge would be designed to contribute at country level and within institutions. Therefore, further work on the knowledge generation side of the HUB’s activities would include helping to identifying local relevant experiences (grass root initiatives) developed out of the academic environment and creating space for inaccessible grey literature.

With respect to translating knowledge into practice a participative process of defining appropriate political guidelines (priorities) supported by empirical evidences and ethical principles had been devised and work was being planned to identify opportunities for action in each particular context.

Particular collaboration with countries would involve putting in place and using existing mechanisms to promote enhanced discussions of papers and reports on issues such as social and labor policy makers, social movements, labor unions. On the other hand, country involvement in KN knowledge generation processes would help to ensure that contents and language of knowledge products were tailored to target audiences. To ensure sustainability of actions on SDH it was also important to keep in mind the strategic role of collaboration with local research institutions the KN, which could help in the building capacity for their own sustained knowledge generation on SDH.

Collaboration between the KN and countries in the area of translating knowledge into practice has included mapping social actors (civil society leaders, labor unions, workers’ associations, institutions, organizations, movements, etc.) relevant for political mobilization and action. This type of mapping activity had also led to analysis of existing (and helping to create new) opportunities for action (social policies/programs and budget re-orientation), answering a commonly expressed concern from country partners that the impact of KNs would not be felt until after the life of the Commission. Further work in this regard would involve: i) promoting workshops with social actors to disseminate knowledge and generate ties of solidarity and agreement concerning actions; ii) Support the creation of in-country knowledge networks (to share and disseminate information); iii) and, brokering engagement of the KN and health- and labor-related education programs (graduate and specialization courses for professional teams), to ensure that new evidence was institutionalized into common national and local education and training programs.
Issues and Challenges

The presentations provided a rich foundation for a productive discussion on how to build and realize synergies for action on SDH through the collaboration of Countries with KNs and WHO. Incentives for collaboration emerged quickly and included opportunity to build a national knowledge base and institutional capacity on SDH, capable of creating pressure and generating change in health policy and practice in countries. There were suggestions that the methodologies being used by CSDH KNs and WHO to generate knowledge and use this to affect change in countries should be documented, so that they could be replicated in the future, by others.

A number of countries supported the generation of evidence that resonated with key ‘gatekeepers’ to policy change in the policy arena. The example of needing economic and cost effectiveness arguments for tackling health inequities, so as to negotiate with Ministries of Finance and Planning Commissions, reinforced the message in the presentation from Chile, that scientific evidence on its own is unlikely to produce change unless it is tailored to the reality of the policy environment. Additional comments to a similar effect included how there are competing interests: on one hand there is a need have the best information available while on the other hand people in government make decisions every day that are not based on having the desirable information. This requires knowledge development and sharing on equal terms with civil society, so they can be informed and able to call on governments when they make mistakes.

Related to the collaboration of civil society as partners in knowledge generation and as a vehicle for translating knowledge into pressure for change, the view was expressed by some participants, that in spite of the efforts to date, participation of civil society in CSDH KNs and country work was low. A call was made for the CSDH to strengthen and extend its participation of civil society in these vital processes, and to ensure that what emerges from the CSDH work can be sustained in the future.

There was recognition of the many players involved in ensuring real change at the country level, but prime responsibility lies with government. As such there were questions put on the table asking how governments can better ferment the participation of civil society particularly in identifying priorities for action and in generating knowledge to address these issues. This led to a discussion on the type of knowledge that the KNs are collecting and the degree of significance being given to lay knowledge and evidence vs. traditional sources of data and scientific evidence. The response from KNs highlighted that they were not anticipating divergences and strong controversies between what will emerge from the civil society and scientists. All types of evidence are considered relevant and necessary to get a strong argument to convince decision makers. Some KNs explained how they were taking a pragmatic approach to evidence in order to avoid being too prescriptive and also because there are limitations from taking only published evidence that would bias evidence towards developed countries. As such KNs were taking a plurality of evidence into account and involving a diversity of opinion to ensure robust and democratic approach to the generating and defining of knowledge on SDH. The role of CSDH Civil Society Facilitators was flagged in respect of ensuring connection with country partners and KNs, likewise it was agreed that KNs and country partners would share action plans,
institutional arrangements and membership list with CSFs. The CSDH was requested to broker this sharing of information and the active engagement of different stakeholders in knowledge generation and country action.

There was then a series of commentaries on the involvement of WHO in knowledge generation and its sustainability for example through linkage with existing WHO/Regional Collaborating Centres into appropriate i.e. regionally relevant, knowledge generation and application activities. WHO could also engaged in ensuring access to the CSDH Sharepoint, a request made by country and civil society partners.

A keen discussion took place on the challenges facing countries in generating and using knowledge for action on SDH, which had implications for the type and extent collaboration with KNs. Firstly, there was a need to capture why good policies may exist but remain unimplemented. This indicated collaboration could be focussed on capturing and synthesizing the learning from countries on factors inhibiting implementation. This is essential knowledge for policy makers to draw on when devising strategies to ensure that action goes beyond policy making and into policy implementation.

Countries stated very strongly that they needed strong evidence and bold recommendations from KNs, ones that would be strong enough to 'show us the way to go if we are to put in place medium term agendas for change that are credible and robust enough to transit political changes. At the same time country partners stated how installing institutional capacity to build the process for change is important: 'but we also need quick wins in order to keep the forward momentum and have a chance of achieving the medium and longer term agenda for change within national and local government and society as a whole.'

Support for strengthening monitoring and evaluation in countries was recommended on the basis that it can make a valuable contribution to keeping issues such as health equity on an 'overcrowded policy agenda'. There was a call for CSDH, through collaboration with countries, civil society, and KN partners to develop and synthesis examples of a) equity indicators which could be included in routine information systems and b) recommendations for monitoring national and global programmes on health equity.

**SUMMARY**

† Scientific evidence on its own is unlikely to produce change unless it is tailored to the reality of the policy environment. Peer review of knowledge being generated by KNs is recommended to ensure it is fit for ‘policy’.

† The process of knowledge collection and synthesis can in itself be used to generate awareness as incentives for action, if they are designed to include a range of country stakeholders and institutions in the approach.

† There is a need to capture and explain why good policies exist but remain unimplemented. This indicated collaboration could be focussed on capturing and synthesizing the learning from countries on factors inhibiting implementation, as well as documenting successes. This is essential knowledge for policy makers to
draw on when devising strategies to ensure that action goes beyond policy making and into policy implementation.

Despite good efforts to date, the participation of civil society in CSDH KNs and country work appears low. A call was made for the CSDH to strengthen and extend its participation of civil society in these vital processes, to ensure that what emerges from the CSDH work can be sustained in the future.

The Proposal and Design of the Knowledge Network for Public Health Conditions - A Social Determinants Approach to Priority Public Health Programs

Dr Ritu Sadana, Senior Scientist, WHO/ GENEVA
Chair- Dr Peter Eriki, WR, Kenya

Overview

It was the first time Priority Public Health Conditions Knowledge Network (PPHC KN) presented its proposals for public discussion. The session was used as a mechanism to test the acceptability and relevance of the proposed work content with stakeholders working in public health, globally.

The PPHC Knowledge Network was presented as one of the Commission's nine knowledge networks with the purpose to review the design and implementation of programs addressing priority health conditions. PPHC worked towards identifying key factors that affect the social distribution of outcomes such as risk behaviours; access to services; health status (morbidity and mortality); and consequences of illness. It would identify a range of entry points to redress social inequalities in these outcomes with a view to improving the “equity effectiveness” of interventions associated with priority public health conditions. The costs and benefits of these modified interventions would be evaluated.

The project would draw on a range of capacities across the CSDH, the World Health Organization, its collaborators and partners at international, regional and national levels. The products of the priority public health conditions knowledge network, would enable the Commission to provide recommendations on the most cost-effective interventions to improve health in low income countries that go beyond the description of social inequalities to specific opportunities to redress these; and provide a legacy to instil an equity effectiveness criteria within WHO guidelines, covering a wide range of programs and concrete approaches to measure the equity effectiveness of programs.

2 The purpose of Equity effectiveness and the use of equity effectiveness loop as a core part of the approach to implementation and for each of the conditions it addresses, was put forward, highlighting how it is an analytic approach with quality assurance feedback, drawing on the clinical epidemiological concept of effectiveness which provides information on the distribution of both “risk” and “response” across social groups (Tugwell et al. 2006). The equity effectiveness loop entails going beyond mere measurement or assessment of social inequalities in health interventions to the design of strategies to improve health equity.
The presented main objectives of the PPH KN were:
1. To review factors in the design and implementation of programs addressing priority health conditions that increase or decrease access to disadvantaged, vulnerable or marginalized populations.
2) To identify entry points to improve the “equity effectiveness” of priority public health control programs particularly for the benefit of populations in low and middle income countries.
3) To assess the costs and cost-effectiveness of increasing equity within priority public health control programs.

It was explained that the products from the PPH KN would facilitate a range of priority public health programs to go beyond mere recognition of inequity in process and outcome and move towards strategies that decrease inequity and unfair differences, i.e. prevent, expand access, increase case detection & cure rates.

The criteria for priority public health programs would include a mix of important diseases in terms of mortality, morbidity, disability and other consequences of disease in low and middle income countries; a selection from communicable and non-communicable diseases, with important risks or social determinants over the life course; and in areas with successful experience.

The network’s proposed products were:
(1) An edited volume: improving the equity effectiveness of programs for priority public health conditions, including policy briefs as stand-alone resources for policy makers and planners.
(2) Country case studies addressing the extent to which national priority public health control programs are ‘equity effective’? Case studies describing and analysing priority public health programs and health system wide resources that would be most relevant given the context.
(3) WHO Technical Guidelines on assessing equity effectiveness. A WHO technical guidelines report would be issued on the indicators and methods to monitor and evaluate equity effectiveness of priority public health control programs.

**Issues and Challenges**

Most of the feedback, following the presentation, indicated that CSDH should give priority to developing this work. There were high expectations about what its proposed objectives and products could deliver. One participant noted ‘its potential as a powerful tool for delivering the reorientation of WHO that has been promised through the CSDH’. There were comments that the PPHC KN should also push for a resource shift, within WHO and in the ways it worked at country level. One measure of the impact of CSDH and of the PPHC KN could be through monitoring future resource allocations across WHO, specifically the rate and type of increased focus on SDs and more programmatic work linked to social pattern of disease.

Related comments also backed up the potential of the PPHC KN to influence vertical programs to improve current efforts (detect, treat, cure) but also to push for prevention to figure more prominently in WHO. WHO country, regional and technical
program staff were amenable and indicated that PPHC KNs approach was a pragmatic way to draw on expertise and experiences from across WHO.

There was support for the utility of looking critically at key WHO programmes such as TB and HIV and at how they contributed or undermined the new focus on SDH. It was suggested that it would be useful to engage with these programmes and assess how they supported or blocked the process of improving action on equity. It was pointed out that it was necessary to establish why some well designed and good policies were not actually implemented at country level. These comments provoked a call for CSDH through the PPHC KN and more generally “to put in place rigorous designs in developing countries” to enable the evaluation of programmes, a significant weakness in developing countries. Participants proposed that that the PPHC KN should ask ‘how the public health programs can engage better with issues of SDH’. ‘With 40 years experience of tensions between delivery of specific disease programmes and the entry points for action on social factors, there is already a huge amount of knowledge on how disease-specific programmes ought to engage with health promotion and SDH. The question we need to ask is whether these programmes are using this existing knowledge, and if not, why not, a participant added.’

There was a discussion on the range of ‘PPHC topics’ that would be selected and many requests that the work should be carried out in countries where the Commission on Macro-economics and Health (CMH) had been successfully implemented. The rationale being that this would build on prior WHO work in partnership with countries already sensitized to and with existing capacity in the area of analysing the cost and impact of the burden of disease.

There were questions as to whether the PPHC KN would focus on diseases or determinants? If diseases are the focus, then there was a clear need to include cardiovascular diseases (CVD), given its contribution to the global disease burden and how it was disproportionately affecting the most disadvantaged groups in society. If the focus is on determinants, then the network may need to think about the invention of new programmes that have not yet been implemented by WHO, for example, alcohol may be an issue in the Russian Federation, where 500 deaths per day were attributed to it, a challenge WHO had not systematically addressed.

Spontaneous suggestions for topics to be included in work of the PPHC KN included: malaria; cardiovascular disease; access to drinking water; training and orientation of health professionals; alcohol; waterborne diseases; access to medicines/essential drugs; human rights and status of migrants; reproductive health; preventive medicine; access to treatment in general and not only for specific diseases.

Useful suggestions on how to manage the decision process included generating a long list and then noting which ones are included in the KN given various constraints; or that each country draws up its own list, even if KN pragmatically focuses on a few. However no clear consensus was reached on whether there should be a list of determinants or of diseases.

Some concerns were expressed pertaining to listing of diseases and if this would compromise and or set back the growing dialogue and focus on a comprehensive, total approach to health. Specifically some participants felt that while
the work was important, if the CSDH were to look at diseases through an SDH lens, it would lose the focus on distal determinants such as safe water, secure employment conditions etc. There was a clear request for the Commission to keep the focus on the social production of disease and the influence of global and political factors, not only service and individual factors. The example was given of TB control in Russia, which worked well before the collapse of the socialist government and the transition to a market based model.

In response, Dr Ritu Sadana suggested a need for clarity about the added value of the activities and products of the PPHC KN. She went further, highlighting the issue of priority PH programmes was not just about WHO, but about national programmes in all countries and whether they were working or not. She shared how “there are virtually no guidelines on how to bring an equity focus to big, important disease programmes, a situation which clearly demands attention”. She noted that there was possibly a demand from participants for a conceptual shift in the focus of the work in WHO and in what WHO as an organization should be promoting. She stressed that both were long-standing concerns both within and outside the organization, which were also partially a rationale behind the establishment of the CSDH.

**SUMMARY**

✧ The PPHC KN was very important within the CSDH because of its potential to identify and explain key factors that affect the social distribution of outcomes such as risk behaviours; access to services; health status (morbidity and mortality); and consequences of illness. This knowledge would have significant impact upon levels of awareness, commitment and activity within countries to address SDH and also could significantly reorient WHO technical programs to incorporate a SD perspective as central in their design, implementation, monitoring and review.

✧ More work needed to be done to build consensus on the type of PPH conditions that would be selected and also in the choice of country partners who would be involved. Further clarification was required on whether the work focused on diseases or determinants.

✧ There was a need to understand why existing well designed PH policies and programs were not being implemented and to capture the institutional, political and other reasons for poor uptake. Findings should be used to inform the design and roll-out of the PPHC KN.

✧ The PPHC KN should develop tools and standards to enable evaluation of programmes that were going to be instituted, especially with respect to strengthening PH program evaluation in developing countries.
Civil Society - Partners for Action in Building a Sustainable Movement on CSDH - Introduction and progress and emerging priorities - CSDH Regional Civil Society Facilitators

Chair - Chris Brown, Focal Point for Country Work, CSDH Secretariat

Presenters

Dr Alec Irwin, CSDH Secretariat, World Health Organization, Geneva
Dr Amit Sen Gupta, Asia Civil Society Facilitator
Mr Patrick MUBANGIZI, Africa Civil Society Facilitator
Dr Mauricio Torres, Latin America & the Caribbean Civil Society Facilitator
Dr Alaa Ibrahim Shokralla, Eastern Mediterranean Civil Society Facilitator

Alec Irwin
Dr Irwin, one of the focal points for the Civil Society area of work within the secretariat of the CSDH, presented the rationale for the civil society stream of work within the CSDH and gave a brief overview of progress to date.

The rationale for the strong civil society stream of work within the CSDH was presented as contributing to building an advocacy base through which to catalyse lasting change, which is part of the overall mission of the CSDH. The presentation highlighted how the Commission process will be sustainable to the extent that it is recognized and valued by society and that affected groups see themselves represented in the proposals elaborated by the CSDH and are encouraged to demand political action on social determinants of health at local, national and regional levels.

This approach to working with civil society was discussed and approved by CSDH Commissioners during their September 2005 meeting in Ahmedabad, India. Commissioners approved the strategy and reaffirmed the importance of civil society participation in the key dimensions of the CSDH: learning, advocacy, action and leadership. Commissioners emphasized the importance of a political approach to social determinants action that operates simultaneously “top-down” (engaging the highest levels of political leadership) and “bottom-up” (drawing on community knowledge and leadership capacities and nurturing the demand for action at the social base).

To advance this agenda, leading regional civil society networks have been asked to facilitate a consultative process through which civil society groups will collectively define their strategies for working with the CSDH. The organizations responsible for guiding this consultative process in four regions (Africa, Asia, Eastern Mediterranean, Latin America/Caribbean) are known as CSDH regional Civil Society Facilitators (CSFs).

The progress to date has resulted in:

1. Formalizing the Commission’s relationship with regional Civil Society Facilitators (CSFs) - contractual relationships with regional CSF organizations have been formalized in four regions via WHO Agreements for the Performance of Work (APWs). The contracted partner organizations are: i) Asia: People’s Health Movement, India (in alliance with Asian Community Health Action Network), ii) Eastern Mediterranean: Association for Health and Environmental Development, Egypt, iii) Latin America/Caribbean: Asociacion Latinoamericana...
de Medicina Social (in alliance with Coordinadora Latinoamericana de Organizaciones del Campo and Red de Salud y Seguridad en el Trabajo), and iv) Africa: Health Action International Africa, in alliance with EQUINET, People’s Health Movement, South Africa, and the Health Civil Society Network.


There were then short inputs from each of the four CSDH regional Civil Society Facilitators summarizing the main actions within their region to develop a regional civil society strategy.

Overview: Development of African Regional Civil Society Strategy

Nairobi, 10-11 January 2006. The meeting was organized and hosted by Health Action International Africa and EQUINET and brought together 24 participants from diverse organizations representing nine countries (Democratic Republic of Congo, Kenya, Malawi, Mozambique, South Africa, Tanzania, Uganda, Zambia, Zimbabwe). Participants included representatives of the Ministries of Health from Kenya and Tanzania, delegates from international organizations, and WHO personnel from the Regional Office for Africa (WHO/AFRO) and Country Offices (COs). The meeting unfolded successfully and provided an opportunity for mapping, network building and shared strategies among organizations concerned with action on the social determinants of health. However, participants were concerned by the absence of representation from the CSDH secretariat and the fact that no CSDH Commissioners were able to attend in person.

In support of the civil society strategy on SDH for the African region, the following activities have been undertaken: i) Training CSO leaders, ii) National, regional, district meetings and mapping, iii) Campaign issues relevant to SDH, iv) Public discussion foras, v) Fact sheets, internet portals, participatory media, press briefings, vi) Collaboration with MOHs, WHO Parliamentarians, other ministries, vii) Linkages with other CSOs outside the sector of health, viii) Analysis and influencing of policies on SDH, and ix) Monitoring and evaluation.

The process to date has generated strong consensus on the concept of formalizing a reference group on social determinants of health and health equity, drawn from across a range of civil society organizations in the region. Some challenges persist as the work moves into more substantive implementation. The key challenges are: a) Organizational: administrative support needs to be institutionalized to manage all logistics, b) Financial resources; poor communications infrastructure, high cost of transport due to the size, and geography of the region, c) Capacity building: besides individual capacity building needs there is a need for exchange visits among CSFs globally, (IPHU, EURO) d) Managing language barriers (Francophone, Anglophone).
Overview: Development of Asia Regional Civil Society Strategy

Bangkok, 14-15 November 2005: The meeting was hosted by the Asian Community Health Action Network and the People's Health Movement, India, and benefited from the active participation of Commissioner Yan Guo. Alec Irwin represented the CSDH secretariat. The meeting brought together representatives from civil society organizations in 13 countries. Significant progress was made during the meeting to disseminate the goals and strategies of the CSDH, advance the regional mapping/situation analysis of social determinants and civil society action, and gain consensus on the key elements of the regional civil society strategy for collaboration with the Commission. Dates were fixed for national meetings which will be held through February in many of the participating countries.

In addition to the regional meetings, situational analysis work, and mapping of progress, the focus of further elaboration of the civil society strategy on SDH for the Asian region has been upon consultations at country level under the umbrella of the CSDH. The aim being to bring together government and civil society with the aim of identifying modes of partnership and collective action and identifying specific initiatives in countries (ongoing or new) for scaling-up. This work will continue in the next stage, and also include work positions on terms of engagement with global institutions and mechanisms, viz. the WTO, introduce experiences from other countries, and develop indicators and targets for public sector led interventions on SDH.

Further, work is planned to (continue to) bring onboard diverse civil society partners, and sensitizing them to the Commission's work, as well as encourage them to participate in the CS initiatives. This will also involve development of communication strategies, and material and tools to disseminate information about the concept of Social Determinants. An example for India was used to highlight this type of work: *e.g. in India, a process to develop material that address issues related to key determinants .. campaign strategy planned for nationwide dissemination of this material using various communication forms such as cultural forms (skits, songs, etc.), public hearings, policy dialogues involving government officials, exhibitions, slide shows, etc.*

Overview: Development of Eastern Mediterranean Regional Civil Society Strategy

Cyprus, 3-5 December 2005. The meeting was hosted by the Association for Health and Environmental Development. The organizers received 28 confirmations from 10 countries, though last-minute complications reduced participation to 16 representatives of 7 countries (Egypt, Iran, Iraq, Lebanon, Palestine, Tunisia, Bahrain). The meeting was enriched by the participation of Commissioner Prof. Ndioro Ndlaye. Alec Irwin represented the secretariat. Over 3 days, participants met to share experiences, discuss and work together. The sessions laid foundations for a regional strategy and work plan addressing the social determinants of health in the Eastern Mediterranean space, taking account of the economic, cultural and political diversity among the region's countries. A second regional meeting for the Eastern Mediterranean was held in Cairo on 11-12 May 2006, in order to finalize the proposed regional civil society strategy.
Overview: Development of Latin America/Caribbean Regional Civil Society Strategy

Lima, 9-10 January 2006. The meeting was hosted by Asociacion Latinoamericana de Medicina Social, the Coordinadora Latinoamericana de Organizaciones del Campo and the Red de Salud y Seguridad en el Trabajo, with additional support from the Health Forum of Peru. Orielle Solar represented the CSDH secretariat. No CSDH Commissioner was available to participate. The meeting brought together representatives from civil society organizations in 11 countries and ten regions within Peru and resulted in substantial advances in the development of the regional strategy. At the close of the meeting, a social dialogue on the CSDH was held, in which 150 people from numerous institutions and organizations in Peru took part.

In addition to the regional strategy development meeting and dialogue events the next phase of implementation will focus on four pillars of work: i) Organizational and leadership strengthening among civil society in the region in relation to health as a right, the construction of equitable health systems, and action on SDH, ii) Generation, systematization and dissemination of accumulated experiences and knowledge with the goals of influencing the design, execution and evaluation of public policies from the standpoint of SDH and health, iii) Exigency and advocacy, and iv) Education and communication e.g. carrying out training and preparing material for dissemination and training on the SDH perspective, the right to health and health equality, as well as developing a web of the Latin American region and establishing an electronic communication network and electronic newsletter on SDH and health equity, actions, priorities and events.

Issues and Challenges

Across all of the 4 regional Civil Society Strategies on social determinants of health, common issues emerged. With regards to emerging priorities for cooperation between civil society and government in the CSDH country work the following points were made:

✦ Civil society would identify possible areas of country work with justification and evidence.
✦ Document/identify existing CS initiatives for scaling-up or links to country work.
✦ Build on existing work of civil society and take advantage of civil society experience even if at micro-level.
✦ Advocate social determinants uptake across government.
✦ Civil society should be considered an implementer or a partner in the implementation of programs and interventions to address SDH.
✦ Open space for debate to develop appropriate policies and strategies to address SDH, particularly, the root causes for health inequities.
✦ Provide genuine space for CS cooperation in debates, planning and implementation of interventions.
✦ Strengthen cooperation with CS while providing space for independent roles.
✦ Open space and support cooperation between CS organizations and local authorities.

Another strong theme was the role of civil society organizations in knowledge generation. Comments on the effective interface and collaboration between KNs and civil society included: i) The need to ensure that KNs incorporate knowledge from civil
society and communities in what they document and synthesize, ii) KNs to provide tools for community-based research and validate the knowledge generated by civil society thus strengthening CS advocacy, and iii) Knowledge must flow back from official networks an the Commission as a whole to communities, enabling action.

Through partnerships with the KNs and the Commission, CS can promote and mainstream participatory monitoring that go beyond traditional health surveillance. Such mechanisms can observe indicators, health goals and the fulfillment of policy commitments.

SUMMARY

* Civil society has multiple roles and can support action on social determinants of health at national and local levels, as well as in regions and globally. The strength of civil society was in their ability to contribute to knowledge generation, public awareness, social debate on equity, and monitor the impact of policy on determinants affecting health outcomes at local levels.

* A synthesis of effective practice and models of participation of civil society in policy development, implementation and monitoring of actions to improve health equity is needed to strengthen the case.

Roundtable 4:- Collaboration between civil society and government on SDH: Opportunities, obstacles and examples

Chair : Dr Juan Manuel Sotelo, WR, Chile

Presentations
Dr Janice Wilson, Deputy Director General of Mental Health, New Zealand: Health improvement and community empowerment: addressing Maori health challenges in New Zealand.

Dr Narendra Gupta, Peoples Health Movement, India: An example of civil society-government collaboration in India.

Dr Ana Costa, Ministry of Health, Brazil/ABRASCO: Expanding civil society participation in health action: lessons from Brazil.

Overview

This session focused on three diverse experiences of partnership in India, New Zealand and Brazil. Each presentation covered the background, rationale, ongoing factors that facilitate and inhibit collaboration between civil society and government on SDH.
Health improvement and community empowerment: addressing Maori health challenges in New Zealand

The presenter gave an overview of an initiative between the government of New Zealand and the Maori to protect and improve the health of Māori people. As a launch pad, the ‘Treaty of Waitangi’ was used. The treaty set out rights and responsibilities of the government to the Maoris. The massive economic and social change in the 1980s and 1990s had a negative impact on the Maori health and welfare. The widening inequalities in socioeconomic resources between the Maori and non-Maori during the 1980s and 1990s, explained the mortality disparities between these groups. Since 2001, there has been a political mandate across sector policies to reduce inequalities, through policy that aim to improve health, education, housing, and employment of Maori. This is coupled with a strategy to involve civil society, particularly Maori NGOs in health and welfare service planning and development.

The strategy to address inequalities involved addressing the human rights and status of Maori as equal citizens, through legislative means including the Treaty of Waitangi settlements (repairs); and offering Maori owned education e.g. preschool, universities and the resurgence of Maori language as an official language in New Zealand. The strategy presented also referred to included Maori membership in Health Boards, target setting service design and delivery, for example, leading to Health Board partnerships with Maori and increase in Maori health delivery through NGOs.

The presenter said in terms of genuine empowerment, there was an increase of Maori owned businesses. The increase in the economic and political force of Maori was attributed to its own education system and establishment of a Maori Political Party in 2004. At the same time there was still a need to target actions to reduce inequities, for example, in increasing the number of Maori seats in the House of Parliament and increasing political commitment to really advance their agenda.

Critical barriers to real partnership and tackling of inequities included the lack of capacity in leadership and governance to work in new ways with civil society and some perverse “backlash” to perceived race-based approaches and from economic or global influences.

The factors for success in fostering sustainable collaboration between government and civil society in the area of tackling inequities were summarized as: i) Building political leadership and maintaining it over time, ii) Having a mandated framework to use to push for action e.g. The Treaty of Waitangi, iii) Strong Civil Society (Maori) leadership and capacity to lead and shape the process, iv) Documenting and sharing broadly the impact and successes serve to maintain commitment to act both within civil society and government, and v) Mechanisms to capture and ensure regular feedback from civil society/NGOs on policy impacts, services and situation analysis.

An example of civil society–government collaboration in India

The presentation gave an overview of the rationale, aims, and learning to date on the National Rural Health Mission (NRHM) which is a new Government of India initiative
designed to augment rural health services, which had been set up for an initial life span of 7 years (2005-2012).

The aims of the program were: i) Increase public spending in health currently from 0.9% of GDP to 2% in five years, ii) Carry out architectural corrections in the health care delivery mechanism, iii) Initiate a process of bottom up planning, iv) Guarantee certain health services, v) Converge different vertical health programmes, and vi) Create inter-sectoral coordination with other departments to improve service and engagement of civil society in NRHM in development of community based monitoring mechanisms and representation in different NRHM national committees.

Factors which enabled setting up of the NRHM included a strong civil society critique and mobilization, for example, through the National Health Assembly in 2000 and through major policies such as the Indian Health Charter. Increased political support for more public spending in health and for the reorganization of health services was also a factor. This led to the incorporation of the agenda of health care reorganization in the common minimum programme in 2004, which was a significant structural adjustment in funding flows and priorities. Global agencies through international covenants such as the MDGs, and global donors added to the creation of an enabling environment for NRHM.

Civil society critiqued the ambivalence of the program on the ground that while it was aimed at strengthening public health it had elements of liberalization and privatization. Also, while the national mission incorporated a participatory process, external forces were still influencing its content and focus. The third criticism was that despite the goal of integration of health programmes, the population control agenda had significant influence. In response, civil society planned to strengthen engagement with NRHM by: i) deepening and supporting all positive aspects and follow-up on actions and impacts, ii) airing differences on the adverse aspects of the initiative, particularly, on the introduction of user fees in public funded health facilities - known to be a strong barrier to accessing health care, and iii) devising alternatives and demanding more community based orientation.

**Expanding civil society participation in health action: lessons from Brazil**

The presentation highlighted how participatory management was standard practice in Brazil, covering a range of domains traditionally under the control/responsibility of government including:

- Social control
- Health councils
- Conferences
- Participative management councils
- Equity promotion
- Committees
- Other mechanisms

The process was institutionalized and formally reinforced, for example, within health councils with formal regulations related to the composition; character; attributions
and operating mechanisms to ensure strong participation of service users and community based organizations as illustrated in the following diagram:

Based on the Brazil experience, successful participatory management raised the following key issues and challenges: i) To obtain consistent representatives requires an understanding of the dynamics of the local community and its networks as well as a range of different mechanisms spanning time and place to enable diverse participation, ii) Intervention capacity requires government bodies and civil society with the capacity to work in a participatory manner, iii) Political decision requires formal commitment and mandate, accountability, and mechanisms to show that participatory management is being implemented, and iv) Corporatism - to ensure that legislative power is given to civic assemblies allowing them a more critical role in the decision-making process and ensuring higher degree of accountability and transparency in design and delivery of health systems at the local level.

SUMMARY

The three presentations highlighted common element critical to building and sustaining collaboration between civil society and government in tackling the root causes of health inequities. Stressed was the importance of a formal and mandated framework for collaboration, and mechanisms for accountability during implementation.
The first global meeting of country partners: WHO Commission on Social Determinants of Health

The need to ensure capacity building in civil society and within government for equal relations to develop in their collaborative work.

The need to capture and promote the positive lessons and impact of collaboration e.g. decrease in inequity gap in Maori and non Maori Health outcomes; empowerment of Maori in government and commerce.

Sharing good practices as a contribution to establish better collaboration between civil society and governments was regarded a powerful mechanism to support work on SDH.

Closing Session - Priorities for collective action and work plan for country action
Co Chairs
- Dr Timothy Evans, ADG WHO, Geneva
- Dr Denny Vågerö

Facilitator
- Dr Rene Lowensen

Overview

At the end of the second day, facilitator Rene Lowensen led an open session, summarising the main issues from the roundtable discussions. Unsurprisingly, the following recurring themes from the previous day were made: i) CSDH should engage globally and lever the political conditions for proposals and action at the country level on equity and SDH, ii) CSDH should use its various streams of work and spheres of influence (including through WHO) to raise the political profile, public awareness and social debate on equity and SDH, iii) CSDH should strengthen support and work more closely with and through WHO programs at country and regional offices, and iv) CSDH should facilitate action and exchange within and across countries and between different stakeholder groups in countries and regions, and v) Monitor the impact of its work in countries and regions.

To generate feedback to the commission on its current work and how it could better support action on SDH within countries, regionally and internationally, a discussion on issues and priorities followed. The participants suggested the following:

a) Issues and Priorities for CSDH to support action on SDH within countries

- Country priority setting and analysis on equity and SDH.
- Country level ‘Commissions’ integrating different streams, constituencies.
- Intensified participation of civil society in country work (empowerment, involvement in plans, stimulating action across sectors, using social knowledge, monitoring).
- Review information input to KN work.
- Involvement in framing and informing work on PPH.
- Establishing country level knowledge networks on key areas of priority and ‘additional key issues’.
- Country hearings on evidence and policy options to review and debate policy uptake and action.
- Monitoring and routine information systems in equity/SDH.
- Promote country - Commission - WHO interactions.

b) Issues and Priorities for CSDH to support action on SDH across countries
- Share priorities on SDH to synergise, commission and support work regionally.
- Tap/ invest in capacities and institutions in countries in regions.
- Share horizontally across countries: visits, knowledge exchange, documentation, policy dialogue.
- Systematise methodologies for wider application (research and practice).
- Engage regionally in the global processes.
- Promote country - Commission - WHO interactions.

c) Issues and Priorities for CSDH to support action on SDH globally/internationally
- Work on PPH to comprehensively examine equity and SDH implications: explore equity impacts of ‘programme’ approaches and the implications for WHO; explore how to integrate SDH beyond proximal determinants to upstream and distal causes; reflect and work with regional/country priorities.
- Institutionalise global monitoring on equity and SDH.
- Explore how knowledge translates to policy and policy to action, identifying blocks and facilitators and use this to support wider institutional and policy change.

Following the open discussion on issues and priorities, two final questions were put forward for debate:

**Question 1:** What will we now do to advance and institutionalise action within countries (political action, roles, processes, learning), the Commission (all streams of work) and WHO?

**Question 2:** What can be presently done collectively across countries, the Commission (all streams of work) and WHO?

**SUMMARY**

- Decentralize the process and institutionalise regional, country and local mechanisms for taking the work forward, e.g. through national and regional “commissions” or “task forces” reflecting the state, civil society, knowledge institutional composition.
- WHO regional offices can more proactively coordinate country work with this role reflected in the Global Programme of Work.
- Strengthen communication of country experiences across all constituencies, especially on strategies that work, supporting environments, tools and capacity building opportunities.
- Prepare effectively for the phase of proposals to action in 2007 for countries to take up recommendations, evaluate approaches, assess economic implications and give feedback.
Involve countries (state, civil society) working with the Commission in shaping a holistic and practical approach to the KN work on priority public health conditions (see earlier points discussed).

Have face-to-face meetings between representatives of country, civil society and knowledge institutions, commissioners, etc. are useful points of exchange of experience, analysis, and to build a shared identity of the Commission as a whole of its different components.
Appendices

1. OVERVIEW OF STRATEGIC OBJECTIVES AND PROPOSED PRODUCTS OF CSDH COUNTRY WORK
2. SUMMARY OF ACTIVITIES AND RECOMMENDED OUTCOMES
3. MEETING AGENDA - COUNTRY PARTNER WORKSHOP
4. LIST OF PARTICIPANTS
### APPENDIX 1

**OVERVIEW OF STRATEGIC OBJECTIVES AND PROPOSED PRODUCTS OF CSDH COUNTRY WORK**

<table>
<thead>
<tr>
<th>STRATEGIC OBJECTIVES</th>
<th>PROPOSED PRODUCTS</th>
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<tbody>
<tr>
<td>1. To contribute to the identification, development, testing and integration of tools, methods and norms into routine Health Information Systems (HIS) so as to support the analysis and monitoring of health equity and social determinants of health inequities.</td>
<td>• Diagnosis of the existing and potential use of health equity measures in national health information systems. • Integration of health equity measures into existing national health information systems.</td>
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<tr>
<td>2. To contribute to the development and testing of tools to evaluate: (a) the economic consequences of health inequities; (b) the cost effectiveness of priority interventions; (c) and, the economic impact of investing in policies to tackle health inequities and social determinants.</td>
<td>• Development of a methodology for evaluating the cost-effectiveness of upstream versus downstream interventions to improve health equity. • Have applied this methodology to test the case in several partner countries.</td>
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<tr>
<td>3. To increase the evidence base on the extent of socially determined health inequities and to have evaluated selected policies and programs aimed at addressing socially determined health inequities.</td>
<td>• Country case studies: (a) diagnosing the baseline situation on health equity and linkages to social determinants. (b) evaluating the impact of selected policies and programmes that have aimed to reduce health inequities by addressing specific social determinants or groups of social determinants.</td>
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<tr>
<td>4. To support the process of the development of commission-inspired national health policies to systematically prioritize and address social determinants of health and health inequities in partner countries.</td>
<td>• In-depth, prospective country case studies describing how countries have progressed the agenda on tackling socially determined health inequities, covering the following steps: (a) identification of priorities for action, national objectives, targets and indicators. (b) identification, strengthening and development of sectoral and multisectoral mechanisms for levering policy actions on SDH and Health Equity. (c) development of a medium-term national plan of action. (d) development and implementation of monitoring strategies.</td>
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<td>5. To contribute to identifying and answering key questions requiring further research and better analytical and monitoring tools, methods and norms, in order to advance the agenda of incorporating action on socially determined health inequities in country health and development policies, programs and systems</td>
<td>• A systematic literature review of mechanisms for encouraging civil society participation in the development of policies tackling health inequities. • A systematic literature review of mechanisms for supporting intersectoral action on socially determined health inequities. • A conceptual framework to guide future research on the relationship between psycho-social factors and health inequities. • A task force report on other priority research issues relevant to countries trying to tackle socially determined health inequities.</td>
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<td>6. To contribute to ensuring the relevance of knowledge network products to country action.</td>
<td>• Participation in a peer review process to comment on specific KN products.</td>
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<td>7. To contribute to the final CSDH and World Health Reports.</td>
<td>• A country work report (stand alone).</td>
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<tr>
<td>SESSION TITLE</td>
<td>SUMMARY</td>
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<tr>
<td><strong>Overview of the CSDH progress on implementation</strong></td>
<td>✷ Support for capacity building in countries to advance action on SD and health equity.</td>
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<tr>
<td><strong>The CSDH Country Work Strategy</strong></td>
<td>✷ The Strategy is a useful framework for guiding CSDH activities with countries; however the strategic goals and products are ambitious within the time frame and despite good efforts impact in Africa and on Global initiatives has been limited. ✷ Learning on “what works” should be documented, synthesised and be publicly accessible. It should cover country the crucial experiences in integrating health equity and social determinants as core business of government health policy. ✷ Address the fundamental areas which should pave the way for changes in health policy and programmes, that is, the economic arguments for investing in reducing health inequalities through actions on the social determinants; the costs of not doing so; and the rationale, examples and implications of investing in tackling the social gradient in health vs. targeting most disadvantaged groups vs. improving the average health status. ✷ Processes and tools need to be developed for better integration of social</td>
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</table>
### Roundtable 1: CSDH Country Partner Action Plans

- The equity performance of some countries, e.g. Chile is impressive and would be a valuable resource for other countries if they were evaluated and documented. The health care system implemented in Brazil was also acknowledged as a relevant and innovative experience that needs to be described and evaluated concerning its impact on SDH and equity.
- The importance of an intersectoral frame for action was a key theme in the presentations and the discussions indicated that this is an area where the CSDH need to synthesise effective practices appropriate to a variety of country contexts.

### Roundtable 2: Implementing Whole of Government approaches to health inequities

- The role of WHO as a whole in advocating for social determinants and health equity is crucial to keeping social determinants on the agenda in partner countries, and to create receptivity

- **Determinants and the learning from the Commission into WHO policies, technical programs and normative role, at global, regional and country level.**

- **A range of entry points to build pressure, support and stimulate action are needed.** It was suggested that CSDH could involve a wider range of stakeholders and institutions, particularly in countries undergoing war or where political will and mandate was fragile. Related, clearer messages are needed on social determinants of health inequities.

- **Specific examples, methodologies and tools for measuring the equity performance of policies and programs should be synthesised and a WHO statement on critical importance and use made.**

- **The Commission should consider including the issue of ‘intersectoral action on health equity’ as a fundamental question and on which additional work should be scoped and advanced.**
| and commitment to act in other countries. | generating interest, pressure and concrete examples of how and why to tackle SDH through facilitation of action and exchange within and across countries, regions and institutions as part of their 'core business'. |
| Country work should develop mechanisms for strengthening in-country and between country capacity-building, skills exchange and “know- how” transfer among policy makers, practitioners and interested stakeholders, to advance a health equity agenda through action on social determinants. | 11. CSDH to consider options for organising and delivering capacity development support on SD and health equity covering technical knowledge and know-how on managing a health equity agenda across government. |
| Address fundamental questions which would pave the way for changes in health policy and programmes. Specifically i) how to develop and sustain intersectoral approaches and ii) the rationale, examples and implications of investing in tackling the social gradient in health vs. targeted interventions, and relevance to different country contexts | 12. Commission to produce detailed case studies documenting experiences from partner countries on implementing national action plans on SDH. |

| There is a need to ensure that the knowledge is ‘fit for policy & practice’ and to facilitate a higher degree of ‘transfers’ of perspectives between country policy makers, civil society organisations and KNs in the generation and review of knowledge/evidence, taking into consideration that a model not necessarily fits all social realities and political contexts. | 13i The proposed framework and mechanisms for peer review of KN products should be put in place. |
| Evidence on issues such as war, refugees and migration, which cut across a range of countries and are key issues in determining health outcomes, are important to capture in the evidence synthesis and should also be reflected in Commission knowledge products. | 13ii Access to the knowledge network portal “Sharepoint” needs to be improved for country partners, civil society and WHO stakeholders. |
| The proposed peer review of synthesized evidence and | 14. The process for identifying and managing ‘additional key issues’ in the knowledge generation work of Commission should be more clearly articulated. |
| CSDH Knowledge Networks Update and Progress | 15. CSDH should actively broker alliances with other global and national knowledge institutions to support and advance a global research and know-how agenda on SD and |
knowledge products, by civil society, country policy makers and WHO programs country and regional offices is important and well supported.

✦ A scoping of global knowledge development alliances between the CSDH knowledge networks and other knowledge institutions e.g. The Global Forum for Health Research was recommended.

– Roundtable 3: Collaboration between Country PARTNERS and Knowledge Networks

✦ Scientific evidence on its own is unlikely to produce change unless it is tailored to the reality of the political environment. Peer review of knowledge being generated by KNs with the participation of civil society facilitators is recommended to ensure that it reflects distinct social actors perspectives and that is appropriate for ‘political action’.

✦ The process of knowledge collection and synthesis can itself be used to generate awareness and incentives for action, if it is designed to include a range of country stakeholders and institutions.

✦ A range of distinct methodological approaches need to be considered, i.e., qualitative and quantitative, and special attention need to be paid to grassroots knowledge that is not easily accessible and should be identified and acknowledged.

✦ There is a need to map and to understand why good policies and effective programs exist, are feasible, but remain unimplemented. This indicated that country collaboration needs to focus on capturing and

16. The proposed framework and mechanisms for policy maker & civil society review of evidence generated by KNs evidence should be put in place. i.e. establish and implement mechanisms to policy proof knowledge generated by KNs.

17. CSDH should synthesis good practice in participatory methods of knowledge generation.

18. Country case studies should include detailed analysis of factors which inhibit implementation of good policies and programs as well as known strategies for reducing inhibiting factors and maximising facilitating factors to policy change.

19. CSDH should identify actions and mechanisms at the country and global levels that will facilitate a country “uptake” of KN recommendations.
| Proposed Knowledge Network for Priority Public health Conditions | synthesizing the learning on factors inhibiting implementation, as well as documenting successful experiences. This is an essential knowledge for policy makers to devise strategies to ensure that action goes beyond policy making to effective implementation.  
- Despite good efforts to date, the participation of civil society in CSDH KNs and country work appears to be low. A call was made for the CSDH to strengthen and extend its participation of civil society in these vital processes, to ensure that what emerges from the CSDH work is appropriate, effective and can be sustained in the future. | The PPH KN is a critically important activity within the CSDH, because of the potential of the work in identifying and explaining key factors that affect the social distribution of outcomes such as a) risk behaviours; b) access to services; c) health status (morbidity and mortality); and d) consequences of illness.  
- This knowledge would have significant impact upon levels of awareness, commitment and activity within countries to address SDH and also make a significant contribution to re-orientating WHO technical programs so as to incorporate a SD perspective as central in their design, implementation, monitoring and review. | 20. More work needs to be done to build consensus on the type of PPH that will be selected and also in the choice of country partners, which will be involved.  
21. The PPH KN should develop tools and standards to enable equity evaluation of programs that are going to be instituted. |
<table>
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<tr>
<th>Civil Society - Partners for Action on SDH</th>
<th>22. Synthesis of effective practice and models of civil society participation in policy development, implementation and monitoring of actions to improve health equity. (<em>Links to recommendations 17 and 23</em>).</th>
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<tr>
<td>Roundtable 4: Collaboration between civil society and government on SDH.</td>
<td>23. The need to capture and promote the positive lessons and impact of collaboration e.g. direct and indirect benefits e.g. decrease in inequity gap in Maori-Non-Maori Health; empowerment of Maori in government and commerce. (<em>Links to recommendations 17 &amp; 22.</em>).</td>
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<tr>
<td>✧ Civil Society have a multiplicity of roles in relation to supporting action on SDH at the national and local level, as a collective effort, in regions and globally. Contribution to knowledge generation, public awareness, social debate on equity and to the monitoring of the policy impact on determinants that strongly affects health outcomes at the local level.</td>
<td>✧ The common elements which are critical to build and sustain collaboration between civil society and government in tackling root causes of health inequities were identified as i) the importance of a formal and mandated framework for collaboration, ii) mechanisms of accountability to collaborate on implementation, and iii) the need to ensure capacity building in civil society and within government for collaborative working.</td>
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APPENDIX 3: MEETING AGENDA - COUNTRY PARTNER WORKSHOP

GLOBAL PARTNER COUNTRY CONSULTATION WORKSHOP
Geneva, Switzerland

The overall purpose of the consultation workshop is to bring together countries who are partnering with CSDH to tackle the social determinants of health and systematically reduce health inequities. The specific aims of event are to:

Objectives

1. Update & discuss with partner countries the overall progress and implementation of the Commissions work including action and expected products from country work, knowledge networks and civil society.

2. Identify and agree on mechanisms for linkage between Country Work and the other streams of Commission’s work, specifically:
   a. how the CSDH process of knowledge building (through knowledge networks) on SD can be informed by partner countries as well as used to advance country agendas; and
   b. strategies for the participation of civil society in Country Work and in the development of regional strategies on SD health

3. Discuss and agreed with partner countries on priorities for working collectively and the next steps to progress action on SDs.

Expected results

1. Countries and WHO regional & country partners informed about the current status of CSDH work.
2. Agreed linkages and priorities between: Country Work partners and Knowledge Networks; and Country Work partners and Civil Society.
3. Clearly defined priorities and timeframes for global country action within the CSDH.
DAY ONE:   Thursday 18 MAY

08:15 - 08:30  Registration

08:30 - 08:50  Welcome, Opening Remarks and Aims of the meeting
- Sir Michael Marmot, Chair - Commission on Social Determinants of Health (CSDH).

8:50 - 09:10  General Overview of CSDH, Progress on Implementation
- Emerging issues for discussion with Country Partners, Civil Society, and Regional Offices
- Dr Alec Irwin, CSDH, WHO Geneva.

09:10 - 9:40  Comments & Questions

9:40 - 10:00  The CSDH Country Strategy
- Presentation of the overall purpose of Country Work within the framework of the CSDH, objectives, products and progress to date.
- Dr Chris Brown - Focal Point for Country Work, CSDH Secretariat

10:00-10:45  Feedback & Discussion

10:45-11:00  Break

Thematic Focus Day 1
Sharing Experiences & Lessons Learned on Developing National Health Equity Strategies & Action Plans
- A Government & Policy Makers’ Perspective

Roundtable 1
Progress, Mechanisms and Future Priorities in advancing National Health Equity Action Plans - Feedback from CSDH Partner Countries’
Chair: Ms Ndioro Ndiaye, CSDH Commissioner

11:00 - 12:00  Presentations

National Action Plan for Chile
Dr Lidia Amarales Osorio, Undersecretary of Public Health
Ministry of Health Chile
Brazilian National Commission on Social Determinants of Health
Mr Alberto Pellegrini, Executive Secretary for the National Commission on Social determinants of Health, Brasil.

Iranian National Action Plan on Social Determinants of Health
Dr G. Heideri, National Focal Point on SDH, Ministry of Health and Medical Education, Islamic Republic of Iran

12:00 - 12:40 Discussion
12:40 - 13:30 Lunch
14:30 - 15.15 Comments and discussion
15:15 - 15:35 Break
15:35 - 16.20 Knowledge Networks - Strengthening the Evidence base for action on SD’s - current progress and Expected Knowledge products.
Ms Sarah Simpson, CSDH - KN Coordinator
Questions and Discussion
Chair: Dr Marie André Romisch-Diouf, Director CCO, WHO, Geneva
Facilitator: Dr Rene Loewenson.
Open Discussion to identify:
• What type of support and products should be provided by CSDH to support country action?
• What are the emerging areas for collective country action?
17.40 - 17.50 Round Up and Closing Remarks from Day 1.
- Dr Marie André Romisch-Diouf.
DAY TWO: 19th May

Thematic Focus Day 2

Contribution of the CSDH in support to Countries tackling Social Determinants and Health Inequities

Roundtable 3

'Collaboration between Country Partners and Knowledge Network'

What are the opportunities, process and mechanisms to accelerate national action and ensure knowledge generation is relevant to policy and practice?

Chair - Dr Sylvie Stachenko, Public Health Agency, Canada

08.30 - 09.15 Presentations

The Employment Conditions KN: proposed topics and approaches for knowledge generation
Professor Vilma Sousa Santana, Co-hub leader, CSDH Employment Conditions Knowledge Network, University of Bahia, Brazil

A country perspective: knowledge needs for national action and opportunities for collaboration with KNs
Dra Patricia Frenz, Coordinating Directors of SDH, Ministry of Health, Chile

The role of the WHO Regional office in brokering knowledge generation and Regional Action on Social Determinants of Health Equity
Dr Susan Watts, WHO, Eastern Mediterranean Office.

09:15 - 10:00 Questions and Discussion

10:00 - 10:30 The Proposal and Design of the Knowledge Network for Public Health Conditions - A Social Determinants Approach to Priority Public Health Programs
Dr Ritu Sadana, Senior Scientist, WHO/ GENEVA

10:30 - 11:15 Discussion and comments

11:15 - 11:30 Break

11.30 - 12.15 Civil Society - Partners for Action in Building a Sustainable Movement on CSDH - Introduction and progress and emerging priorities - CSDH Regional Civil Society Facilitator's.
Roundtable 4

“Collaboration between civil society and government on SDH: Opportunities, obstacles, examples

Chair: Dr Juan Manuel Sotelo,

14.10 - 15:00 Presentations

An example of civil society-government collaboration in India
Dr Narendra Gupta, Peoples Health Movement, India:

Expanding civil society participation in health action: lessons from Brazil
Dr Ana Costa, Ministry of Health, Brazil/ABRASCO:

Health improvement and community empowerment: addressing Maori health challenges in New Zealand
Dr Janice Wilson, Deputy Director General of Mental Health New Zealand

15.00 - 15.45 Discussion

15.45 - 16.00 Coffee

16:00 - 16.45 Discussion and comments
16.45 - 17.30
Priorities for collective action and work plan for country action
Chair Dr Timothy Evans, ADG WHO, Geneva
Facilitator Dr Rene Loewenson

17:30 - 17:40
Closing remarks
Dr Denny Vagero, Commissioner CSDH
APPENDIX 4

COMMISSION ON
SOCIAL DETERMINANTS
OF HEALTH

Commission on Social Determinants of Health
Civil Society Facilitators Meeting & Country Partners Meeting
16 to 19 May 2006, Geneva, Switzerland

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