Summary of proceedings: 5th meeting of Commissioners

Nairobi, Kenya: 26 – 30 June 2006

Social determinants of health are the conditions in which people live and work
Summary of proceedings: the 5th meeting of Commissioners

Nairobi, Kenya: 26–30 June 2006
Table of contents

Executive summary  page 1
About the Commission  page 3
Kenya meeting organization  page 4
Session summaries
  - Knowledge Networks  page 5
  - Additional key issues  page 13
  - Civil society  page 15
  - Country work  page 18
  - Working with global and regional actors  page 21
  - Commission reporting and advocacy  page 23
  - Strategies to advance on socially determined health inequities in Africa  page 23
  - Advancing the work on social determinants in Kenya  page 26
  - Special addresses  page 27
Summary and conclusions  page 31
Closing message from Sir Michael Marmot, Commission Chair  Page 32
Annex 1:  page 33
Annex 2  page 37
Annex 3  page 44
Annex 4  page 46
Annex 5  page 54

Glossary

Commission - Commission on Social Determinants of Health
CSDH - Commission on Social Determinants of Health
CS - civil society
AFRO - World Health Organization Regional Office for Africa
AMRO - World Health Organization Regional Office for the Americas
EMRO - World Health Organization Regional Office for the Eastern Mediterranean
EURO - World Health Organization Regional Office for Europe
KN - Knowledge Network
SEARO - World Health Organization Regional Office for South-East Asia
SDH - social determinants of health (with an implicit focus on health inequities)
WPRO - World Health Organization Regional Office for the Western Pacific
WHO - World Health Organization
Executive summary

Background

Action on the social determinants of health is the fairest and most effective way to improve health for all people and reduce health inequities. The best results are reached when health is seen as more than the absence of disease, and countries set health as a social goal relevant to policy decisions across all sectors of government and society.

At the 2004 World Health Assembly, the Director-General announced the beginning of a process to act upon the social causes of ill health and inequities by calling for a global Commission on Social Determinants of Health (CSDH, the Commission). The Commission was subsequently launched in March 2005. The Commission over three years will set the foundation for sustained processes to profile and integrate the social determinants of health within public policy and practice.

Commission on Social Determinants of Health

The vision of the CSDH is a world in which all people have equal opportunities over the life course to enjoy the highest attainable standard of health.

To achieve its vision, the Commission has set up five streams of work. These relate to:

I. setting up knowledge networks (KNs) to assemble information on effective interventions;
II. developing partnerships with countries who want to take a leading role in this area;
III. social mobilisation through working with civil society;
IV. including health equity on the agenda of major global and regional institutions; and
V. developing proposals for institutional and programmatic change at WHO.

Meeting in Kenya

CSDH held its 5th meeting of Commissioners in Nairobi, Kenya, from 26 - 30 June 2006. The meeting was funded by the Department for International Development of the UK Government department and hosted by the Kenyan Government.

The meeting in Kenya focussed on assessing progress in these streams, in addition to advancing the agenda of working to address socially determined health inequities in Kenya, and across the African continent.

Key discussion points and meeting outcomes

Several key messages emerged from the KN presentations of: Early Child Development, Globalization and Urban Settings. With respect to Early Child Development, the KN noted that early child development has an enormous influence on the health opportunities of future generations. Much is known about interventions to reduce child mortality, however, less is known about what to do with the living. The ECD KN will synthesize information on policies and interventions related to improving ECD. The are also actively involved in promoting more routine monitoring of ECD.

The Globalization KN reported that the KN was working with the notion of asymmetrical globalization and focussed on how globalization could be managed to be fairer and to provide healthier, nuanced, health equity related policy advice.

The Urban Settings KN spoke about efforts to engage stakeholders at different levels (global, national, local, municipal) in documenting linkages between action and policy on urbanization, health and development.

In general, the Commissioners approved the directions taken by the reporting Knowledge Networks. The overview of progress of all the KNs, provided by the KN coordinator, was also well received. Commissioners supported the suggested extension of KN membership and, or, mechanisms for involving larger constituencies to fill regional and policy expertise gaps.

Commissioners also welcomed the setting up of the Priority Public Health Conditions Network. This networks aims to advise on how the design and implementation of (national) policies and programs can be more effective in addressing priority health conditions by increasing their impact on disadvantaged, vulnerable or marginalized populations. This work not only applies to health promotion, but to health protection and curative care - the whole spectrum. Commissioners stressed the need for this KN to be explicit about its incorporation of a broader vision of health policy and programmes, which included intersectoral action for health and health stewardship.

Objective 2: Additional key issues

A list of additional key issues outside of the CSDH nine themes were discussed. Two "additional key issues" were added to the list, namely, indigenous people's health and man made disasters. Commissioners decided to address the additional key issues through a call for papers as part of a proposed Lancet series.

Objective 3: Country Partners

Countries partnering with the Commission increased between January and June 2006 from 6 (Brazil, Canada, England, Iran, Kenya, and Sweden) to 9 (Bolivia, Kyrgyzstan, and Peru). Discussions exploring partnership were in process with Sri Lanka and Mozambique. A list of core actions for Country Partners had been defined, in collaboration with countries, following the first meeting of Civil Society and Country Partners in May 2006. These actions ranged from baseline equity assessments to implementing equity targets, monitoring and a whole-of-government approach to health equity.

In reviewing the progress of the Country stream of work, the Commissioners welcomed the increased number of Country Partners added since January 2006. They stated the need for CSDH to articulate the type of actions expected from country partners. Commissioners supported the new list of priority actions that were proposed. Commissioners suggested that resources be focused on a small number of countries in the short-to-medium term in order to realize rapid progress.

Objective 4: Civil society

The Civil Society stream of work, through its civil society facilitator organizations, has concentrated action covering four regions Africa [Health Action International, EQUINET, Health Civil Society Network]; Asia [Asian Community Health Action Network, People's Health Movement India]; Eastern Mediterranean [Association for Health and Environmental Development]; Latin America and Caribbean [Latin American Confederation of Rural Organizations, Association of Rural and Indigenous Women, Latin American Association of Social Medicine; Network for Health and Work].

Progress markers for the stream of work as a whole since January 2006 were noted as including:
- CSDH will be featured in Global Health Watch II (now in preparation, publication 2008)

It was noted that the first stage of the regional work, which involved mapping civil society organizations in the different regions, was almost complete. The next stage of work would focus on knowledge collection and collaboration with CSDH Knowledge Networks.

Commissioners commended the advances made in the Civil Society stream of work. They supported the proposed strategic emphasis on linkages between civil society and knowledge generation in the next phase of the work of the Commission.

Objective 5: Global and regional institutions

Commissioners agreed to further clarify their core position statements and tailor their messages to different international and regional institutions prior to the launch of the Commission report in 2008. The proposal to test these messages at the World Social Forum (January 2007) was noted.

Objective 6: Commission reporting

The Commission confirmed its intention to release an interim statement for consultation with key communities and stakeholders as part of a continuous effort to mobilize champions and create demand for the final report.

Objective 7: Advancing the agenda in Africa

Commissioners affirmed their commitment to engage African Heads of State in the work of the CSDH, specifically targeting to do so before the Heads of State meeting scheduled for January 2007.

Objective 8: Advancing the agenda in Kenya

The Commissioners welcomed the commitment of the President of Kenya to establish a national Kenyan commission on social determinants of health and pledged to help support the commission.

Guest speakers on stewardship and human rights

With respect to the presentations made by the guest speakers, the Commissioners drew the following conclusions. The Commissioners supported the view that an essential function of health ministries was to act as stewards of population health. The Commissioners voiced support for a human rights approach to health but agreed to deliberate further on how to present their position on human rights in order to ensure that equity was maintained as a central principle in the CSDH approach.
The Commission on Social Determinants of Health (CSDH) was launched by the World Health Organization (WHO) to support countries and global health partners to act on social factors leading to ill health and health inequalities. The Commission has convened leading scientists and practitioners to assemble evidence and promote action on health inequities using policies that improve health by addressing the social conditions in which people live and work. The Commission has set up networks of experts, policy makers and advocates (referred to as Knowledge Networks) to collate thematically focussed evidence on the best practices and upstream interventions for addressing socially determined health inequalities. In addition, working with WHO, it is collaborating with over 10 countries and several global networks of civil society organizations to support policy change and monitor results. The Commission’s twenty Commissioners are outstanding innovators in science, public health, policymaking and social change.

The Commission’s focus is on improving health equity. Equity is the absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically, or geographically. Social determinants of health refer to both specific features of, and pathways by which, societal conditions affect health and that potentially can be altered by informed action, or more simply: "The social characteristics in which living takes place" (Tarlov A. Social determinants of health: the sociobiological translation. In Blane D, Brunner E, Wilkinson R (eds). Health and social organization. London: Routledge. 71-93, 1996). The social determinants cover a spectrum of characteristics that is captured in the acronym PROGRESS (Place of Residence, Occupation, Gender, Race-ethnicity, Education, and Socio-economic Status including income). A social determinants approach means to improve and take into account these characteristics in order to improve inequalities in health that are unfair and avoidable or remediable, referred to as socially determined health inequities.

The Commission was launched by WHO in March 2005, under the chairmanship of Professor Sir Michael Marmot, and will operate until May 2008. The Commissioners meet 3 times per year to review progress and advise on future directions for the different arms of the commission's work. Meetings take place in different countries around the world where country leaders have expressed interest in the work of the Commission. Organizing the meetings in this way provides an opportunity for the Commissioners to discuss the issue of socially determined health inequities with top decision-makers, as well as providing a conduit for the realities of different developmental contexts and cultures to inform the Commission's deliberations.

The CSDH has 5 streams of work:

1. The organization of knowledge to inform health policy proposals and action on the social determinants of health, which is being performed by 9 knowledge networks.

2. Demonstrating and highlighting the opportunities and possibilities of action, which is being formalized in country partnership agreements and action plans.

3. Social mobilization and long-term political sustainability of the social determinants agenda, which is being organized through an extensive civil society lead process.

4. Including action on social determinants of health and health equity in the policies and investment strategies of global institutions through engaging global institutions around key thematic issues of relevance to countries and emerging from KNs.

5. Developing proposals for institutional and programmatic change at WHO so that it can also provide long term support to countries in advancing the SDH agenda after the Commission has ended.

The Commission's final recommendations will be based on the collective work of these different streams.
Kenya meeting organisation

Kenya Commission meeting

The Commissioners’ meeting was preceded by two side meetings - the second meeting of the Knowledge Network Coordinating Hub representatives and the fourth meeting of Commission Regional Civil Society Facilitators. This report focuses on the deliberations of the Commissioners’ meeting. Summaries of the proceedings of the side meetings are included as Annex 1 and 2, along with the accompanying meeting agendas.

The Commissioners' meeting itself consisted of two parts. The first part (Monday and Tuesday) concentrated on meetings with Kenyan officials and the site visits, which were organized by the Kenyan hosts. The second part (Wednesday and Thursday) focused on the updates and deliberations on general progress of the Commission's work. See Annex 3 for the final Commissioners’ meeting agenda.

Meeting objectives

The objectives of the 5th Commissioners' meeting were:

Ø To inform and obtain Commissioners' feedback on the KN plans for collection and validation of knowledge for 3 knowledge networks: Globalization, Urban Settings, and Early Child Development; to discuss the newly created Priority Public Health Conditions KN, and to review KN progress in general.

Ø To assess and to approve the direction of knowledge collation relating to key determinants of health, falling outside of the CSDH’s KN themes.

Ø To review progress on country partner membership, provide feedback on the first meeting of country partners and civil society, and outline concrete country work priorities for action.

Ø To review civil society stream of work progress and clarify emerging opportunities for linkages between civil society activities, country work and knowledge networks in particular.

Ø To discuss developing a strategic position for the CSDH in the current global policy debate on health equity and social determinants and advance the strategy for engaging with global processes, agreeing Commissioners roles.

Ø To discuss the reporting of the Commission findings and the advocacy and communications process.

Ø To provide an opportunity for a focused discussion on opportunities for advancing the agenda for tackling socially determined health inequities in Africa.

Ø To advance the work on addressing socially determined health inequities in Kenya.

The detailed session summaries that follow were organized around these different objectives.

Participants

Meeting participants included the Commissioners, the CSDH Secretariat, WHO country and regional office representatives, experts from the CSDH knowledge networks, Kenya's focal point for the work on socially determined health inequities, the Commission civil society facilitators from 4 regions of the globe, local (Kenyan) civil society, and several special guests from partner countries and other institutions. The Minister of Health for Kenya, the honourable Charity Ngilu, also participated in the meeting in her capacity as Commissioner. Annex 4 provides a list of all the participants.

Funding acknowledgements

The meeting was made possible through the generous funding of the Department for International Development (DFID) of the UK Government department and the hospitality of the Kenyan Government.

Session summaries

Early Child Development Knowledge Network

Session structure and objectives
The session started with a presentation by Professor Clyde Hertzman of the Early Child Development (ECD) Knowledge Network. The presentation covered an update on progress of KN to date, key findings to date, and the next steps for the KN. Commissioner Denny Vågerö opened the discussion following the presentation with a short comment.

Presentation
The presentation highlighted the use of Early Child Development (ECD) as a central organizing principle for country policy. Efforts to measure ECD - especially the process of building consensus on an indicator similar to indicators used for childhood survival and childhood growth (e.g. stunting) - is particularly useful for advancing country policy. The knowledge network's proposed ECD Indicator will cover a child's social, emotional and cognitive development. The network is in the process of engaging international stakeholders in 15 countries (low to middle income) to develop this indicator. The procedure for calculating the ECD measure works best in societies where there is full attendance at school by 5 years of age but the network and its collaborators are now trying to adapt the indicator culturally and to develop methods for dealing with children who do not show up at school at 5 years of age. The ECD network have also taken advantage of other opportunities to advance work on early child development and health equity, for example, making inputs to the Committee on the Rights of the Child.

Key discussion points and outcomes
Commissioner Vågerö indicated that on the whole, the work of the ECD was impressive. He went on to raise certain problems he saw. Firstly, he raised the idea that early child development indicators may not mean the same thing across the world. The paradox of low birth weight (LBW) children was quoted, where LBW black children were more likely to survive than LBW white children. In response, the presenter admitted there were challenges, but insisted that as with the human development indicator, which also suffers from comparability problems, approximating comparability is better than its complete absence. UNICEF sponsored a study that looked at the domains of child development. Every country identified physical, social and emotional, cognitive and language domains. The question remained whether all countries understood the same things by these domains. On-going work in Egypt is underway to look at these issues of comparability, beginning with translation into Arabic and other languages, but there is empirical evidence on the common relevance of the three domains of ECD.

Some Commissioners expressed concern that the work of the ECD knowledge network appeared to be overly focussed on indicators and challenged the network to try to focus on successful policy and programme implementation to date. What makes these agendas successful or less successful in delivering in terms of mortality and survival? The presenter indicated that the relative amount of time spent on different issues in the presentation did not reflect the full spectrum of work the network is engaged in. Collecting evidence on successful
interventions is the primary focus of the network. This being said, the early child survival knowledge network was established on the premise that they were focusing on taking the agenda beyond survival, as already a huge amount of work has gone into child survival. The presenter pointed out that there is a huge gap with respect to what you do with the living. For example in slums of Nairobi 850 children per 1000 are surviving. What do you do with the living? The chair supported the presenter's comment, saying that the network had indeed been set up with this mandate.

Some Commissioners pointed out that the paper on early child development ECD was less sure-footed when it came to sociology about giving children agency. They pointed to the work in Europe and Australia, which was beginning to parallel the adult literature on control and agency. This may be important in Africa where children are taking on adult roles.

Commissioners were keen for the network to look at specific policy and programmatic options and the associated expenses. The Commission would like to be able to point to examples of successful policies and programmes in 3-5 countries. These points were noted by the presenter, who pointed out that there was a need to look at an investment argument - can we finance ECD programs out of the returns later on?

The point about the need to equip young women with ECD knowledge before they think of having children was raised, as was the question of how investments can be made in education systems so that in 10 to 15 years time there would be different children growing up, who understood the relevant issues for early child development as they become parents.

Commissioners pointed out that the second pillar of social development, emotional development, was extremely important here in Africa, where the health indicators were so negative. It would be particularly important to see what the emotional pillar contributes to the other physical and social pillars. They stressed the need for country cases in Western and Southern Africa.

Commissioners suggested that the ECD KN take on board the impact of rural-urban mobility within countries resulting from war or crisis, pointing out that Africa has the highest number of children soldiers of any continent.

Commissioners raised the issue of the over-medicalisation of child development. One example cited was depression and the EU discussion about whether or not to allow Prozac to be given to children. In response, the presenter indicated that the network was sticking to looking at children from a population health perspective versus looking at children from a screening perspective. The network's view was that while attention deficit hyperactive disorders were real, there was insufficient research on the contribution of the time pressures of adults to this situation, and a population and social determinants perspective needed to look at how the family economy contributes.

A speaker from the floor raised the issue of orphans, and what the Commission was going to say about this issue. The presenter indicated that the network was trying to find ways to highlight what is known and understood about coping strategies.
Globalization Knowledge Network

Session structure and objectives
The session started with a presentation by Professor Ron Labonte of the Globalization Knowledge Network. The presentation covered an update on progress of the KN and key findings to date, the relevance of the work to the work of the CSDH, and next steps for the KN. Commissioner Berlinguer opened the discussion with a short comment.

Presentation
The presenter highlighted several themes that the network was focussing on and related key questions. These key themes and questions are described below.

1. Evidence of globalization links with income, wealth and health
   **Key questions:** What does the evidence tell us about globalization and trends in economic inequalities and health outcomes? What does this mean for enhancing coherence in government’s foreign, trade, and donor policies?

2. Globalization and innovations in global governance for the social determinants of health
   **Key questions:** How do present global governance structures for health affect health equity via social determinants of health, and how can they be improved or new structures created?

3. Globalization and labour markets
   **Key questions:** How is globalization affecting income, poverty and economic insecurity through labour markets? And what policy responses are appropriate and effective?

4. Trade liberalization
   **Key questions:** How does trade liberalization and present trade rules affect the social determinants of health? And how can they be managed or improved to strengthen health equity in the SDH?

5. Financial liberalization and financial crises
   **Key questions:** How have financial crises affected health equity in differing national contexts, and what policy responses are appropriate and effective?

6. Policy space and globalization
   **Key questions:** How has globalization limited the "policy space" (flexibilities) available for governments to improve health equity via actions on social determinants of health, and how can that space be protected and expanded?

7. Globalization and health system change
   **Key questions:** How is globalization affecting national health systems and their ability to reduce health inequities through the Accessibility, Availability, Affordability and Quality (AAAAQ) of health services and support to actions on SDH?

8. Human resources for health
   **Key questions:** What are the different pathways by which the global flow of health human resources (primarily low- to high-income countries) affects health equity in both sending and receiving nations, and what policy responses can reduce the negative health impacts of this global flow?

9. Food/nutrition transitions
   **Key questions:** How is globalization affecting food security and nutrition as a key SDH, and what policy responses are needed to ensure more equitable access to healthy food?

10. Water/sanitation services
    **Key questions:** How is globalization affecting equitable access to water and sanitation, and what policy responses are necessary and appropriate?

The Network's main follow-up activities will include:
- continued outreach to various audiences (covering the Canadian Public Health Association (May 2006); the World Congress on Health in a Globalized World (August 2006); the Australian Public Health Association (September 2006); the Global Forum for Health Research (November 2006));
- a second network meeting, November 2006, jointly with a research network on Health in an Unequal World: Global Ethics and Policy Choices; and
- progressing towards the final network report.
Key discussion points and outcomes

Commissioners Berlinguer pointed out that MDGs and targets speak the language of charity, aid and philanthropy and not the language of rights. The language of rights calls on peoples to act, to struggle and meet the challenges. We should underline these things and not only talk to single diseases, not only to talk with experts. He commented on the new problem of international health security and two biases: (1) the over-emphasis on Avian flu, and (2) who is the focus of our efforts. The presenter responded that in terms of strategies related to the right to health, it is a struggle about ideas as much as about policies. Strategies need to be framed on evidence and ethics. Once there is clarity, we will see advocacy strategies arising and identify potential opponents. With respect to the citizenship task - more resources for civil society organizations are needed, as they are generally the strongest engines to shift policy ideas within health.

Commissioners pointed out that the network may want to look at strengthening the UN system as one response to globalization. They pointed out that multilaterals are not keeping pace with the pace of globalization - for example UN agencies were set up for a post World War II context but the context now is vastly different.

Commissioners pointed out that "globalization is here to stay" and that there are some positive impacts. The question is in what way should globalization be conducted and how can countries prepare for it. For this reason, it would be important also to establish correlations between globalization and its health equity impacts. The network needed to address the question of how to prepare policy makers at the global, regional and national levels for policy making within a globalized world. In response, the presenter pointed out that the network was not anti-globalization in its approach but it accepted the notion of asymmetrical globalization and focussed on how globalization could be managed to be fairer and to provide healthier, nuanced, health equity related policy advice.

Commissioners pointed out that additional issues important to look at included: women and globalization in terms of exploitation and trafficking; pharmaceuticals and patents; and how can developing countries take advantage of existing laws and regulations concerning globalization and trade to enhance health equity. The presenter pointed out that the knowledge network (KN) is doing a paper on policy space and as part of this paper they would be looking at the flexibilities and spaces that might be used by countries to take action on globalization specifically to address cases where governments are not using existing laws or regulations. In terms of pharmaceuticals, the KN is only looking at this issue in passing because there has been extensive work on this issue, most recently, the WHO work on pharmaceuticals and patents. The KN is using this available knowledge by distilling and consolidating it in a way that can add value to the field.

Commissioners queried how the network would deal with the overlaps with the Employment Conditions and Health Systems Knowledge Networks in particular. The presenter indicated that the globalization network has shared its paper outlines with other KNs and come to an agreement with these KNs about joint product(s) and, or, which aspects each KN would take forward.
Urban Settings Knowledge Network

Session structure and objectives
The session started with a presentation by Dr Susan Mercado of the Urban Settings Knowledge Network. The presentation covered an update on progress of the KN and key findings to date, the relevance of the KN to the work of CSDH, and next steps for the KN.

Presentation
The presenter pointed out that the network was going to look at urban settings as a whole and not only at slums. The network would aim to describe the overall causes of health inequities in urban settings but contain a substantive sub-focus on slums. The network would aim to show how structural drivers result in the loss of "control over one’s life" as an underlying factor of health inequity, particularly among slum dwellers and informal settlers. Certain assumptions guiding their work were that the knowledge synthesis would not be exhaustive given the time frame. The synthesis needed to be country specific and action-oriented. The network needed to establish a credible network of stakeholders and strategic partners to sustain action and to demonstrate that action through partnerships begins here and now.

Key sources of knowledge identified by the Network included the following:
Ø Slums: Brazil, Benin, Chile, Columbia, Egypt, Ethiopia, India, Kenya, Pakistan, Philippines, Tanzania, Thailand.
Ø Municipalities: Bangalore, Curitiba, Hong Kong, El Salvador, Kuala Lumpur, Marikina, Mumbai, Leon, Porto Alegre, Port Elizabeth, San Joaquin.
Ø Countries/regions: Albania, Brazil, Chile, China, Columbia, Cuba, Eastern Europe, Egypt, Singapore, Indonesia, Japan, Nepal, Nicaragua, Peru, Singapore, Tanzania, Thailand, Tunisia, Uganda, USA.
Ø Global: World Bank/Cities Alliance, MDG Task Force Reports: Improving the Lives of Slum Dwellers; UN HABITAT City development index.

Tools for promoting health equity in urban settings were being developed in 2006 in Chile, China, India, Japan and planned in 2007 for Tunisia and Kenya.

Key discussion points and outcomes
Commissioners queried whether the network was connected with the European Cities Against Drugs Movement? The presenter indicated that it was not connected to the European Cities Movement and noted the point for follow-up.

Commissioners pointed to the need to pay attention to urban settings while paying attention to villages and the constant movement between the two. The presenter indicated that two of the network papers would look at the issue of rural-urban migration.

Commissioners pointed to the need to look at what lessons on economic drivers can be exchanged between resource poor and resource rich countries, and the typology of urban economic growth patterns, including which interventions worked in different settings. Examples of Atlanta and Russia's experiences with migration and the consequent riots outside Moscow were quoted. The presenter indicated that different models, related to these contexts, were being studied.

Commissioners raised the question of the major driving forces of urbanization. They pointed out that big business capitalism and a concentration of resources and economic activity was leading people to live in ever bigger cities. In view of this momentum, the network should consider what could be done to keep people living in villages and smaller towns. If this was the question, then not only urbanization but also living conditions and housing everywhere needed to come under their purview. The speaker mentioned that the network would address “push and pull” factors that are creating “new urban settings” that have a bearing on policies that impact primarily on rural settings and result in growth of urban areas. Given the timeframe however, issues related to living conditions and housing are focused more on health in informal settlements in the urban setting.

A speaker from the floor commented that 20 years ago there was the Ottawa Charter and the associated healthy cities movement. They asked how different were things today, and to what extent these differences could be attributed to healthy cities. What could be learnt from that experience? The speaker pointed out the that Healthy Cities Movement had not anticipated the rate of growth of cities. 20 years ago the pace of change was not as rapid as today where literally overnight slums are springing up due to the rapid pace of urbanization. The movement successfully put public health on the agenda of local governments but there is not enough evidence to show that this has resulted in greater equity of health opportunities within cities.

The issue of citizenship was also raised. In many urban slum settings, people have no legal rights, for example, migrant workers who are brought in to work and have families and cannot return to their own country, but do not officially exist in the new country. The network was advised to consider how these individuals get their right to health.
Priority Public Health Conditions Knowledge Network

Session structure and objectives
The main objectives of the session were to present and agree on the proposed objectives of this new Knowledge Network - on the priority conditions and risks for inclusion; its proposed products; and concrete approaches to increase the network's impact. Dr Ritu Sadana of WHO made the presentation, which was based on a project proposal recently submitted to the Gates Foundation. Commissioner Satcher was asked to comment on the presentation and open the discussion.

Presentation
The presentation described how, as one of nine knowledge networks sponsored within the Commission on Social Determinants of Health, the Priority Public Health Conditions Knowledge Network would focus on the intersection of social determinants aspects of interventions aimed at redressing high burden diseases and risk factors.

The Network's objectives were:
- to review factors in the design and implementation of (national) policies and programs addressing priority health conditions, that increase or decrease access by disadvantaged, vulnerable or marginalized populations;
- to identify entry points to improve the "equity effectiveness" of policies and programs particularly for the benefit of populations in low- and middle-income countries; and
- to assess costs and cost-effectiveness of increasing equity (benefit) of these policies or programs.

Priority public health programs were defined as those addressing health conditions and proximal risks of greatest burden. Table 1 was presenting, giving a rough indication of burden of disease and related risk factors that are linked to social determinants. Criteria for inclusion of health conditions within the network included the burden of disease over the life course, and evidence of effective policies and programs addressing these priority public health conditions that were relevant to low- and middle-income countries. The Network would aim to draw on the wide-ranging capacities across the Commission on Social Determinants of Health, the World Health Organization, and its collaborators and partners at international, regional and national levels. Its main products would be:

- Evidence-based guidelines to improve the equity-effectiveness of national policies and programs addressing priority public health conditions, including synthesis and review of similar experiences addressing national programs and policies; technical guidelines on ways to assess equity effectiveness; and recommendations to programs on how to adopt social determinants approach and improve equity effectiveness.

<table>
<thead>
<tr>
<th>Health conditions - worst 12</th>
<th>Proximal risks - worst 12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 1: communicable, maternal/perinatal and nutritional</strong></td>
<td></td>
</tr>
<tr>
<td>- maternal/perinatal conditions</td>
<td>5.9 %</td>
</tr>
<tr>
<td>- lower respiratory infections</td>
<td>5.6 %</td>
</tr>
<tr>
<td>- HIV/AIDS</td>
<td>4.7 %</td>
</tr>
<tr>
<td>- diarrhoeal diseases</td>
<td>3.9 %</td>
</tr>
<tr>
<td>- malaria</td>
<td>2.6 %</td>
</tr>
<tr>
<td>- tuberculosis</td>
<td>2.3 %</td>
</tr>
<tr>
<td><strong>Group 2: Noncommunicable</strong></td>
<td></td>
</tr>
<tr>
<td>- ischemic heart disease</td>
<td>5.5 %</td>
</tr>
<tr>
<td>- cerebrovascular disease</td>
<td>4.7 %</td>
</tr>
<tr>
<td>- unipolar depressive disorders</td>
<td>3.4 %</td>
</tr>
<tr>
<td>- chronic obstructive pulmonary</td>
<td>2.5 %</td>
</tr>
<tr>
<td>- trachea, bronchus, lung cancer</td>
<td>1.0 % - 2.2 % deaths***</td>
</tr>
<tr>
<td><strong>Group 3: injuries</strong></td>
<td></td>
</tr>
<tr>
<td>- road traffic accidents</td>
<td>2.3 %</td>
</tr>
<tr>
<td><strong>Related but not only to group 1</strong></td>
<td></td>
</tr>
<tr>
<td>- childhood underweight</td>
<td>7.9 %</td>
</tr>
<tr>
<td>- unsafe sex</td>
<td>5.3 %</td>
</tr>
<tr>
<td>- unsafe water, sanitation, hygiene</td>
<td>3.4 %</td>
</tr>
<tr>
<td>- zinc deficiency</td>
<td>1.8 %</td>
</tr>
<tr>
<td><strong>Related but not only to group 2</strong></td>
<td></td>
</tr>
<tr>
<td>- high blood pressure</td>
<td>6.0 %</td>
</tr>
<tr>
<td>- smoking</td>
<td>4.7 %</td>
</tr>
<tr>
<td>- alcohol use ***</td>
<td>3.6 %</td>
</tr>
<tr>
<td>- high cholesterol</td>
<td>3.4 %</td>
</tr>
<tr>
<td>- overweight and obesity</td>
<td>2.8 %</td>
</tr>
<tr>
<td>- indoor smoke from solid fuels</td>
<td>2.7 %</td>
</tr>
<tr>
<td>- low fruit and vegetable intake</td>
<td>2.4 %</td>
</tr>
<tr>
<td>- physical inactivity</td>
<td>1.8 %</td>
</tr>
</tbody>
</table>

* Burden estimates based on 2001 global DALY 3% discount rate and equal age-weights (Lopez et al., 2006)
** Included due to high % of deaths even if % worldwide burden not ranked #12
*** Proximal risks by definition can contribute to a wide range of conditions in Groups 1, 2 & 3 - alcohol use for example contributes to maternal/perinatal conditions, non-communicable conditions and injuries.

*Table 1: Health conditions and risks with the highest burden of disease*
There was strong support for the topic of PPHC as a conditions. level are limited by social and environmental other words, the spectrum of choices at the individual people living in unsafe urban environments is that it is a difference but one of the first things observed about as another obvious example. Healthy lifestyles make when one is struggling to survive. Obesity was cited information, and the ability to change one's lifestyle social determinants, including education and likely to smoke during pregnancy. This is related to less than 11 years of education are 12 times more programmes and policies with a social determinants and equity lens were cited. For example, women with and the ability to change one’s lifestyle when one is struggling to survive. Obesity was cited as another obvious example. Healthy lifestyles make a difference but one of the first things observed about people living in unsafe urban environments is that it is unlikely that they will go out and jog or walk. In other words, the spectrum of choices at the individual level are limited by social and environmental conditions.

There was strong support for the topic of PPHC as a KN, and for it to address how programs targeting specific conditions may either reproduce poverty or reinforce mechanisms of inequality in access to effective promotive, preventive or curative services. There was a need for programs to be comprehensive (i.e., reshaped towards promotion/prevention), sensitive to equity in health, and to aim to achieve universal coverage.

It was noted that clarification of terms and the translation of the meanings of terms across languages is vital. For example, there was much discussion about what constitutes "public health programs". The definition may be more or less restrictive i.e. is the broader stewardship role across government implied? The meaning attributed to this term will depend upon the context of each country and their historical understanding of health programmes and systems. The Commission therefore needs to be explicit about the terms it uses.

The Commissioners debated the definition of health systems and their scope of influence. Some Commissioners commented that the they had initially thought the work would focus on identifying which upstream social determinants and factors were causally most responsible for which diseases and not on adjusting existing health programmes, whose scope may be too narrow. A speaker from the floor pointed out that the health system itself is a social determinant and that this work is trying to address this i.e. once you get people within the health system, what are you are doing? It is very important to address this. They felt that this KN really talked to the intersection and core business of the health system and the Ministries of Health. Commissioners then pointed out that the Commission has to differentiate between an intervention that is socially sensitive to individuals’ different backgrounds and an intervention that from an etiological point of view understands the root social causes. Both are important.

There was agreement that the PPHC KN would also address policies related to the stewardship role of the health sector and the broader government, i.e. that a broader social determinants approach is taken on by government. This means not only understanding the equity-effectiveness of public health programs that provide promotive, preventive or curative services, but also in terms of identifying, influencing and reviewing the equity-effectiveness of a comprehensive set of policies and mechanisms that together address priority health conditions. Two examples were provided: a) whether national taxes on alcohol or tobacco achieve their aims to moderate or reduce consumption and the degree to which these policies as implemented in a particular context are effective, progressive or regressive from an equity perspective; b) nutrition policies aiming to reduce obesity or hypertension that involve regulation of food content, such as sugar or salt, their implementation by private sector food manufactures, and the degree to which, as implemented, these policies were effective, progressive or regressive from an equity perspective.

Some points raised but not explored in detail were the following:
- the need to bring this approach together with a comprehensive primary health care approach;
- the specific partners or networks that would participate, outside of WHO and national programs;
- of the 24 conditions noted, if funding is limited, which ones should the KN pursue?
Progress Update on the Knowledge Networks Stream of Work

Session structure and objectives
The objectives of the session was to present an assessment and update of the progress of all the Knowledge Networks. The update covered outcomes of a hub meeting held on 24 - 25 June 2006 in Kenya. Sarah Simpson, the Commission Knowledge Network Coordinator, made a short presentation, which was followed by a discussion.

Presentation
Specific themes covered in the presentation on the progress assessment were related to answering the following questions:
- Are the Knowledge Networks on track to deliver their products in a timely fashion and with the necessary value-added in their field?
- What has been achieved so far?
- What are the strengths?
- What are the gaps?
- What could be strengthened?

Key findings were that, overall, KNs had made good progress and were responsive to requests from other parts of the Commission.

Some of the key markers of progress noted were:
- All first Knowledge Network meetings had been held.
- Strong networks were developing with active members.
- Innovative approaches had been developed within Knowledge Networks.
- Knowledge Networks were moving beyond papers and publications to action.
- Knowledge collection had commenced.

Some remaining challenges included: membership gaps; ensuring the networks kept their value-added (which relates to what can be said about which interventions work); testing and validating KN recommendations with real audiences; and maintaining a health equity focus.

Specific membership gaps noted were either in terms of countries represented, specific absences were noted from the Eastern Mediterranean (EMRO) and South East Asia regions (SEARO) of WHO. Within most WHO regions (Americas (AMRO), Europe (EURO), Africa (AFRO), Western Pacific (WPRO), and South-East Asia (SEARO), more practice and policy making organizations needed to be involved in the network, if not directly as members, at least as part of a second layer of reviewers and, or, informants.

More information on the Knowledge Network hub meeting and the conclusions regarding progress and future directions can be found in a summary meeting report contained in Annex 2.

Key discussion points and outcomes
Some Commissioners requested specific information on network membership and meetings. Specifically, Commissioner Rashad from the Eastern Mediterranean Region requested more detail on the membership gaps. Commissioner Rashad indicated that the joint workshop by WHO Eastern Mediterranean Regional Office on the social determinants of health provided a mechanism or means of identifying organizations within the region that Knowledge Networks could contact to get assistance in reviewing their products. This would ensure input from the region. The presenter noted these requests for follow-up.

Commissioners indicated that Knowledge Networks need to be developing knowledge for policy development. This was their first priority. Developing knowledge for advocacy was a second order priority.
Additional key issues

Session structure and objectives
The session objectives were to discuss the revised framework of the additional key issues (AKIs) identified by Commissioners, to update Commissioners on progress and obtain feedback on direction of specific AKIs, to identify gaps in AKI framework and to engage specific Commissioners in key AKIs. Dr Sharon Friel, Principal Researcher, CSDH Secretariat UCL, made a short presentation on the above issues, which was followed by a discussion.

Presentation
"Additional key issues" refers to a list of health equity and social determinants issues that Commissioners had flagged as potentially not being covered by the knowledge networks or other streams of work. The list of additional key issues identified up to the Kenya meeting, were time of the presentation are shown in Figure 1.

A classification system was used to assess to what extent existing streams of Commission work were covering these topics. This classification "framework" shown in Figure 1 identified whether or not the AKIs were:
- fully integrated into existing work streams;
- partly covered by KNs; or
- required stand alone treatment.

An analysis of the AKIs against this classification system revealed that 7 of the 14 AKIs would require stand alone treatment of some description. These AKIs were: ageing, environmental change, medical (or "health professional") education, natural disasters, psychosocial stress, rural settings, and violence.

<table>
<thead>
<tr>
<th>Additional key issue label</th>
<th>Fully integrated into existing work streams</th>
<th>Partly covered by KNs</th>
<th>Required stand alone treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>ageing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>aid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>alcohol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>environmental change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>food</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>medical/health professional education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mental health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>migration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>natural disasters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>psychosocial stress</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>religion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>rural settings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>violence</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Key discussion points and outcomes

Indigenous populations
The Commissioners identified the need for a paper on indigenous populations as another AKI. A suggestion was made that indigenous populations should be a focus of the Social Exclusion Network. Both approaches are possible. A Canadian Commissioner noted that aboriginal groups are set apart by history and are therefore different to ethnic groupings, which are constructed through current migration/population movements. Commissioners identified the opportunity to develop a paper using material from the forthcoming International Society for Equity in Health meeting in Adelaide, Australia in September, where there is a workshop dedicated to Aboriginal health issues.

Medical education
The importance of training health workers in social determinants of health was raised. Education on social determinants of health inequities was highlighted as especially important for physicians because of the influence of physicians on politicians. The term "health professional" education was preferred to medical education, in order to encompass all health workers, not only the medical professions. The presenter noted to change the label of this AKI.

Man made disasters
The Commissioners raised this issue as a separate AKI in the context of the importance of the issue in global governance and for raising awareness of social determinants (causes of the causes) within global fora (e.g. G8). A Commissioner pointed to the squandering of natural resources by developing countries in response to international forces as described in the book by Partha Dasgupta "Human Wellbeing and the Natural Environment".

BMJ and Lancet series
A series of Commission papers for BMJ was outlined by the presenter as a means for CSDH to be responsive to the questions raised by the AKIs (e.g. related to this point and the point raised above, there is a paper currently being prepared, led by Tony McMichael, on natural capital, its social distribution and impact on inequalities in health). The idea of the Lancet series of Commission papers was also outlined by the presenter. Commissioners suggested that the Commission use the Lancet opportunity to send out a call for papers on the additional key issues.
Session structure and objectives
The main objectives of this session were to:
⊙ Inform Commissioners on progress in the Civil Society work stream in the different regions.
⊙ Present the final results of the Civil Society mapping processes during Phase I of CSF activities.
⊙ Discuss gaps identified by Civil Society in Knowledge Networks and Country stream of work processes and present mechanisms proposed by Civil Society to overcome these problems.
⊙ Discuss next steps in Civil Society work and how the Commissioners can contribute.

Session presenters included Dr Alec Irwin, focal point for the Commission Civil Society Stream of Work, and the Regional Civil Society Facilitators (CSFs) (see list of participants, Annex 4). Commissioner Fran Baum was asked to make a short comment on the presentation before opening the discussion.

Presentations
The presentations were structured around two parts:
Part I: recap of principles and roles; update on regional Civil Society progress since January 2006; regional mapping exercise; civil society and country Work, questions for discussion.
Part II: civil society strategy for collaboration with Knowledge Networks, questions for discussion.

Part 1
The principles of civil society engagement in the CSDH were reiterated. They include the following:
- The Commission process needs a comprehensive strategy that draws on the knowledge and experience present in CS organizations and communities and that is led by civil society, thereby:
  - enhancing learning from community level
  - promoting country action shaped by civil society knowledge and concerns.
- The active participation of civil society (CS) organizations in the work of the Commission will strengthen civil society, and:
  - provide a global platform for CS voice
  - strengthen capacities among participating CS organizations;
  - advance CS agendas relative to social determinants
- The active participation of civil society (CS) organizations is crucial for CSDH success. It will:
  - broaden the political uptake of CSDH messages
  - improve the chances of sustainable impact.

The organizations acting as regional facilitators for the Commission’s work were listed. They are:
- Asia: Asian Community Health Action Network, People’s Health Movement India.
- Eastern Mediterranean: Association for Health and Environmental Development.
- Latin America and Caribbean: Latin American Confederation of Rural Organizations, Association of Rural and Indigenous Women, Latin American Association of Social Medicine; Network for Health and Work.

Progress markers since January 2006
- CSDH will be featured in Global Health Watch II (now in preparation, publication 2008)
The progress update, the following regional specific issues for advancing civil society action on social determinants of health equity were reported on. Key observations for each region are reported below.

AFRICA
- Special initiatives to involve francophone countries are underway, starting with Senegal.
- There are language barriers to accomplish national consultations in Francophone/ Lusophone regions.
- There are insufficient resources for civil society activities – too few CSO in the region have been involved.
- More involvement and interaction with the African and other Commissioners is needed.

Some people in communities and grassroots CSO are not comfortable with the use of English or other colonial languages—this becomes barrier to self-expression and participation.

ASIA
Challenges have included:
- The process of sensitisation of CS has been uneven across the region.
- Non-health sectors have been slower to respond.
- Communications between country focal points and the facilitating group have tended to be unidirectional.
- Facilitating mechanism would benefit from an additional focal point in WHO WPRO.
- Regional offices in SEARO and WPRO region need to be engaged in great depth.
- Commissioners have been supportive, but greater interaction was needed.

Looking ahead, the outlook showed:
- It is possible to build upon existing work of CSOs;
- There is a need for country-level coordinating mechanism that can "bridge" between national civil society groups and the CSDH;
- There is a need to develop the ability to share, communicate goals and work of CSDH with CSOs;
- Civil society needs a responsive information system to share knowledge.

Based on this awareness, civil society can join efforts for policy mobilization to influence government policy. The importance of building relationships with CSOs in other sectors (outside the traditional health sector) was emphasized.

LATIN AMERICA
Progress has included:
- 200 regional and national leaders and 100 social organizations engaged in 10 countries of the region.
- Advocacy with national governments (Venezuela, Bolivia and Uruguay) and local governments (Bogotá) has taken place.
- There are plans for discussion and dissemination of SDH information in major regional and global fora in coming months, including in: the 3rd National Health Conference in Peru; the World Public Health Congress in Brazil; and the National Convention of ALAMES in Mexico.

Challenges in the region include:
- Governments have been slow in joining the initiative. The Commission's adopted Country Work mechanism of voluntary expression of governments appears weak.
- It is unclear how AMRO-PAHO will drive the initiative in the region; mechanism for collaboration between PAHO and CSFs are still undefined.
- There is a need to strengthen the core group of facilitating organizations (operational and administrative capacities and resources). There is a need to bring in other organizations and existing continental actors.
- The voluntary nature of work complicates numerous tasks.
- Much remains to be done in the construction of a strong continental civil society movement for the right to health and equity, with a built-in capacity for political influence on states’ public policies.
The Regional Mapping Exercise was finalized in Asia, Eastern Mediterranean and Latin America. Each regional mapping includes:
- A description of the general regional context:
  - Analysis of trends in current legislation, policies, programs and institutions relevant to SDH
- The status of civil society in the region today:
  - A brief historical development of civil society in the region.
  - Factors affecting this development
  - Dominant trends (charity vs. human right based approaches)
- A database of key CS organizations. Example Eastern Mediterranean:
  - C.S Data base includes 140 questionnaires filled.
  - 8 Country meetings are held and 9 country profiles are documented
- A list of key stakeholders in the region.

Civil society contributions to Commission Country stream of work were identified around the following key themes:
- Relations between civil society and government: enabling civil society to collaborate effectively in plans and programmes addressing SDH.
- Broad participation of civil society, including grassroots organizations and social movements.
- Intersectorality: an aspect in which civil society can make major contributions.
- A major role necessarily falls to civil society in the monitoring and follow-up of policy processes.

Implementation of civil society proposals to some degree will depend on resource mobilization, as well as having the Commission Country Partners ensure their participation from the start in processes for advancing action on SDH.

Three models for civil society action with Country actors were identified, including:
- Civil society action with national governments of CSDH Partner Countries.
- Civil society action with local government in a country not affiliated with CSDH Country Work stream. This local government model was discussed in the context of the local government of Bogota and Colombia, where the national government had not expressed interest but the local government had. In November 2005, during visit of Commissioner G. Berlinguer to Colombia, Latin America CSF arranged for Dr Berlinguer to meet with Secretary of Health, Bogotá. In April 2006, following from CSF and Commissioner mediation, Bogotá submitted formal letter of interest in CSDH via PAHO Country Office.
- Civil society action through broad social mobilization.

Part 2
In light of the need to prioritize a limited set of potential CSF activities, and given the high importance being assigned to the knowledge dimension of CSDH work, it was decided that a viable approach would be to focus strongly for the moment on civil society and community knowledge around SDH and on civil society's potential contribution to the Commission's knowledge process.

Elaboration of a mechanism for civil society knowledge collection and collaboration with CSDH Knowledge Networks.
The discussion involved two main aspects:

Aspect 1: What do we mean by "knowledge from civil society regarding social determinants"? This issue was discussed at length among CSFs. The following key points were highlighted as part of the consensus reached:
1. A key dimension is knowledge rooted in daily collective experience which leads to collective empowerment.
2. Empowerment for what? For social and political change, strengthening equity and social justice.
3. Thus, knowledge from civil society includes experiences from communities and CSO interventions but not only this.
4. Civil society knowledge also includes political positions and successful strategies for influencing political processes.

Aspect 2: Discussion of mechanisms for civil society knowledge generation and collaboration with KNs
A functional structure was discussed and developed collectively by CSFs and discussed with CSDH Knowledge Networks hubs in the course of their meeting in Nairobi on 24-25 June. The proposed mechanism included 36 Regional Contact Points (RCP), one for each KN theme in each region. These collaborators will be identified by the CSFs. Each regional contact point will report to her/his reference group (see Figure 3) on a specific KN theme.

<table>
<thead>
<tr>
<th>Location of reference groups</th>
<th>Knowledge Network themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>Health Systems</td>
</tr>
<tr>
<td></td>
<td>Priority Public Health Conditions</td>
</tr>
<tr>
<td>America</td>
<td>Social Exclusion</td>
</tr>
<tr>
<td></td>
<td>Gender</td>
</tr>
<tr>
<td>Asia</td>
<td>Globalization</td>
</tr>
<tr>
<td></td>
<td>Employment Conditions</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>Early Child Development</td>
</tr>
<tr>
<td></td>
<td>Measurement</td>
</tr>
<tr>
<td></td>
<td>Urban Settings</td>
</tr>
</tbody>
</table>
With the support of the reference groups, RCPs will collect information for use by the respective KNs and in the CS report. The mechanisms also included four Reference Groups (RG) in total, one located in each of the four regions, with links to the CSFs. Each reference group has responsibility for interaction with 2-3 specific KNs.

**Key discussion points and outcomes**

Commissioners approved the strategy for civil society work with KNs, providing a green light to move this process ahead along the lines described in the presentation (creation of CS reference groups to coordinate knowledge gathering around specific KN themes; joint CS/KN generation and iteration of 'guideline' documents specific to each KN, indicating KN and CS concerns and needs and outlining the strategy for working together). The Commission Secretariat, CSFs and KNs will collaborate in moving this work forward, providing initial resources for civil society collaboration in the CSDH knowledge collection process.

Commissioners recognized the distinctive contribution of civil society in country-level action on SDH, through modalities including direct engagement with national governments and national SDH commissions (e.g., Kenya) and mass mobilizations such as the Indian People's Health Assembly.

The collaborative effort by Latin America CSFs and Commissioner Berlinguer to bring municipality of Bogota into CSDH process again raises wider questions around if and how the Commission will work with state and local jurisdictions. The chair and secretariat are requested to reach a decision about the response to be given to the specific request from Bogota. Further reflection is needed on broader question of how to engage with state and local governments, how and whether follow-up is possible with other municipal governments that have expressed interest in CSDH (e.g., London, New York).

Commissioners approved the initial progress made in outreach to civil society in Francophone Africa, urging that this process be pushed forward. Commissioners again expressed concern about geographical areas that have been left out of the CS process so far -- Eastern Europe and North America were particularly cited. The Commission Secretariat was requested to follow up with Commissioners Vagero and Beguin to develop list of possible organizational contacts in these regions and to initiate outreach, to the extent available resources permit.

Commissioners stressed the importance of involving labour organizations and trade unions in the CSDH civil society processes. CSFs are to put particular emphasis on outreach to workers’ organizations in the coming work phases.

**Session structure and objectives**

The objectives of the country work session were as follows:

- to provide an overview of activities related to advancing the SDH equity agenda in countries: Feb – June 2006
- to summarize main issues emerging from the 1st Meeting of Country Partners (and civil society)
- to summarize the main CSDH products being identified and finalized with country partners
- to highlight the importance of and opportunities for re-enforcing civil society participation in the action of country partners.

To achieve these objectives, the country work session was structured in two parts. The first part provided:

- a brief report on consultations with new countries expressing interest in partnering with the Commission since January 2006,
- a report on the first meeting of CSDH Country Partners and Civil Society
- a detailed exposé of the products expected by partner countries to be produced as part of the CSDH country stream of work over the next 12-18 months.

Dr Chris Brown and Nicole Valentine, the country stream work focal points, presented the updates provided for part 1 of the session. Commissioner Vagero, one of the two Commissioners to attend the Country Partner and Civil Society Meeting and the only one present for this session, was asked to comment on his impressions of the Country Partner and Civil Society meeting held in May 2006 in Geneva.

The second part of the meeting focused on providing a platform for nationally-based civil society and government representatives in Kenya to articulate their expectations for the national work on socially determined health inequities and the involvement of civil society in this work. The outcomes of this session are reported under point 8 (advancing the work on addressing socially determined health inequities in Kenya).
Presentation

Formal partnership in the Commission
A formal partner country is one which has requested to be a Country Partner by a formal letter to WHO and by so doing are signalling their commitment to advancing their national policy agenda to tackle the social determinants of health equity, and, or, to undertake specific activities to contribute to global learning in this area.

By January 2006, 9 months after the launch of the Commission, formal Country Partners included Brazil, Canada, England, Iran, Kenya, and Sweden. During the 2006 World Health Assembly, discussions were held with country delegations of Bolivia, Peru, Sri Lanka, Kyrgyzstan, Mongolia, Mozambique, and Norway. Additional countries to make formal representations since January included Bolivia, Kyrgyzstan, and Peru. (More recently, since the Kenya meeting, Sri Lanka and Mozambique have confirmed their interest). Figure 4 summarizes the country partnerships situation. All these countries are at different stages in terms of defining their priorities and contributions to shared global learning. The hope was expressed that most of the existing Partner Countries would have finalized their intended Commission-related action plans within the coming months.

Meeting of Country Partners and Priorities
The first meeting of Country Partners was successfully concluded in Geneva in May 2006. As a full meeting report was in the process of being drafted for distribution to the Commissioners, only a few key points emerging from the meeting were highlighted. These included the need for the CSDH to support:
- Capacity and methodology development
- Scope fundamental issues and questions
- Documenting learning and evaluating impact
- PPHC was thought by countries to be essential

And between nations:
- transfer of learning build a political alliance to build interest
- strengthening communication and advocacy strategy
- institutionalizing global monitoring on health equity and SDH.

One collective initiative that had emerged since the meeting of Country Partners and Civil Society in May 2006, was the formation of an alliance between several country partners (including Canada, Chile, and England), and the WHO Global Task Force on Health Care Financing, to explore how to take forward the development and documentation of the economic argument for investing upstream to tackle health inequities.
Country Work products
Concrete, priority products of the country stream of work that were presented to the Commissioners covered the following.

| Integration of health equity measures and indicators into existing national health information and planning systems. |
| Country case studies diagnosing socially determined health inequities and associated interventions. |
| Further development and documentation related to making the economic case for investments in "upstream" policies and initiatives to address inequalities in health. |
| The development of national health equity targets and integration of health equity targets and goals across different sectors. |
| Evaluating the impact of specific policies and programmes aimed at reducing health inequities by addressing social determinants, related to specific Knowledge Network themes. |
| Case studies evaluating how to improve the equity effectiveness of programmes aimed at addressing priority public health conditions by tackling the social determinants. |
| Policy case studies describing how countries have progressed the policy agenda for tackling socially determined health inequities. |
| A review of experiences in intersectoral action to identify issues, barriers, success factors/ best practices and recommendations for next steps in the development of tools and resources to support future country action. |
| A review of experiences in mechanisms for ensuring participation in health policy development and implementation. |

**Key discussion points and outcomes**

**Commissioner Vagero**, in his commentary on the Country Partners and Civil Society meeting, indicated that in looking at what was in common between these different countries - e.g. session where Chile, Iran and Kenya presented - one of the themes that emerged was that there are countries with broadly similar views on common problems but they are isolated. He was struck by how much scope there was in the WHO regions for countries to push forward together. Commissioner Vagero noted the lack of representation from the less developed countries of the former Soviet Union. He reported that the meeting showed that overall progress was being made in the country work, but that the Commission needed to work on making the country activities or Commission-related action plans more concrete.

Commissioners were pleased at the progress with further countries being added to the list of country partners. At the same time, commissioners expressed concern that the Secretariat is over-stretched, given the high amount of time required to involve countries given resources. High investments of time were required, especially at the initial stages of the work. This notwithstanding, Commissioners stressed the need to ensure francophone African countries were included. They welcomed the clearer articulation of the products. They commented that the list was a useful menu that would assist them to be more practical in their discussions with prospective country partners. A commissioner commented that it is worth having someone checking health equity results in relation to how much investment in social capital a country makes.

The commissioners indicated that it would be important to look at the implications of monitoring health equity for a country's health information systems.

Commissioner Hoda Rashad from the Eastern Mediterranean region drew the Commissioners' attention to the Regional Discussion Paper, developed by the WHO regional office (EMRO), which had been distributed to the Commissioners and the KNs at the Kenya meeting.

On the issue of economic arguments for investing upstream, Commissioner Vagero indicated that the aspect that made a difference in Sweden was linking equity to sustainable development. It made it possible for the health minister to go to the finance ministries with some clout related to what they were saying. Similarly, investing upstream in health is good for the economy and society - it is good message to have.
**Session structure and objectives**

The main objective of the session was to identify key global and regional actors and mechanisms with which the Commission should engage, up to and beyond May 2008, and to agree on global targets and strategies. Building on the presentation and strategy presented by Dr Rene Loewenson, consultant to the Commission Secretariat, in the Iran Meeting of Commissioners, the session aimed to:

- further review and target actors and institutions at global and regional levels
- give specific examples of institutions, CSDH objectives of, and strategies for engagement
- agree on the next steps for moving ahead the global and regional strategy.

The presentation was followed by a short series of commissioner-led roundtable discussions, starting with Commissioner Lagos, who focussed on the opportunities and strategies to engage with global actors to push forward core CSDH operating principles, described as:

- health equity as a whole-government responsibility; and
- health equity as key index of the success of a country’s general social policy.

Commissioner Lagos's commentary was followed by Commissioner Baum, who discussed the issue of finding common ground between civil society and global actors.

**Presentation**

Drawing on the CSDH meeting in Tehran, the presentation described a framework for targeting global and regional actors and institutions; and a preliminary framework for identifying thematic avenues for advancing the CSDH agenda with each of the different actors. Three stages were identified in the development of a global strategy for the CSDH:

- choosing the target;
- specifying what we wanted from them; and
- designing a target-specific strategy/approach.

Entry-points would need to be carefully mapped. Case studies for the World Bank and the G8 were used to illustrate the issues to be taken into consideration when approaching different actors.

**Commissioner Lagos**

Commissioner Lagos asked how the CSDH was going to define global public goods and global human rights. He stated that the Commission needed to define global public goods in connection with health equity and the determinants of health equity. For example the garbage in the slums of Nairobi is obviously linked to health, but the deterioration of environment is also related to this and the environment is increasingly an international public good and issue. He stated that the Commission should make these connections because at the international arena there are increasingly more public goods related to health.

He reported that, so far, the Commission had made a small amount of progress with ECOSOC. In the ECOSOC meeting in May - the summary report from the informal session mentioned the Commission. But follow up with institutions like ECOSOC need to be taken further.

In addition the CSDH needed to engage the financing institutions. The politics of these institutions need to be carefully navigated as their boards are dominated by the richer and more developed countries. Yet each of the developed countries have a voice on those boards and these governments are responsible for using their voice. If the CSDH has a good case, all these interest groups would need to be pressurized.

Apart from the financial institutions, there was the issue of TRIPS (trade-related aspects of intellectual property rights). The way this has been handled has been extremely uneven from point of view of developed countries. This is an area where the Commission can present very good, action-oriented examples.

Institutions within the UN system, including WHO, are also important. Right now you have a high level panel to introduce reforms into the UN system but there was little opportunity to impact on that given its timeframe (September 2006). The question for the CSDH is how do we manage not to repeat in many of these UN institutions similar problems and models we observe at the national level with respect to action on social determinants and health? Each of these different organizations think that the different social determinants of health are their own. They need to work together. Before May 2008, the Commission should talk to these different institutions.
**Commissioner Baum**

Commissioner Baum raised the following issues with respect to finding common ground between civil society and global actors:

- The nature of civil society, like with many other institutions, is changing quite rapidly. It is very fuzzy and contested. One good example of this is the People's Health Movement (PHM), a network using the email with a long and varied list of organizations affiliated with it. We need to start thinking about the different ways in which CS is organizing itself.
- The Commission needs to think about the ways to work with the newly formed PHM and networked CS organizations. Some of the issues are: What are the roles that CS can play that would benefit the work of the CSDH?

(a) grassroots flag waving role for us within the institutions;
(b) putting issues on the agenda and at present CS provides a strong constituency for equity as a global good;
(c) social determinants issues are political and they challenge the idea that all options are realistic and practical which is usually the argument used not to change the status quo; and
(d) playing a role in challenging the orthodoxy and keeping Alma-Ata alive.

Another role of CS is as critics, and increasingly the role of gathering knowledge and monitoring government and the private for-profit sector is being taken up to support this role. At the end of the day, the CSDH has to work in a space between the global institutions and the civil society groups. It will be difficult for the CSDH to reconcile those two areas. The idea of having a G8 summit where these dialogues could occur is promising.

**Key discussion points and outcomes**

The Chair indicated that they were looking to the KNs in terms of giving concrete proposals for taking action. All the KNs are at a relatively early stage of their operations and this is a dilemma.

The Commissioners indicated the need for that action-oriented messages to key organizations and cautioned that the Commission should not suggest that the health sector is fine.

A speaker from the floor suggested that when thinking about global institutions, the Commission needed to come up with messages that have a comparative advantage for being addressed at the global level and not at the national level. Five suggestions were made:

1. The knowledge enterprise for health, inclusive of intellectual property, should go beyond averages to looking at distribution. How many institutions have that capability currently and exercise it regularly?
2. The whole area of social determinants and health equity research is underfunded - suggestions could be made here.
3. How can the CSDH take advantage of natural social experiments in which efforts are being made to improve social determinants?
4. How does the CSDH align itself with existing initiatives? For example, should the CSDH align itself with the Commissioner who is calling for a dedicated UN institution on women? How do we have the conversation at the global level such that all of us who are interested in promoting the health of the poor do it in a way that is much more efficient and sensitive - e.g. part of the redistribution of money might be to road traffic and calming devices.
5. What about the barrier of scale, which relates to the inability of some nations to have sufficient size to tackle problems on their own. Perhaps there is a need for regional pooling of efforts and this might relate to agreements across countries (e.g. with education on social determinants and equity).

Another speaker from the floor suggested thinking about the CSDH messages to global institutions in terms of arguments: ethical arguments, global public goods arguments, rights-based arguments, and efficiency arguments. The speaker stressed the need to be clear on the definition of equity used in each case. The speaker suggested that the next KN hub meeting may be used to start working on recommendations to the Commission. These could be tested at the World Social Forum (January 2007). They agreed on the priority of advancing the CSDH work on the key position statements by the time of the Brazil meeting in September 2006.

The Commission invites the ongoing, pro-active contributions of multiple partners turning knowledge into action.
Session structure and objectives

The session consisted of two formal presentations, one by Dr Ruth Bell, CSDH Secretariat (UCL), and another by the WHO Communication Officer, Dr Mandelbaum-Schmidt. The purpose of the session was to stimulate discussion among the Commissioners on how to increase the likelihood that their final report and recommendations would lead to results.

Presentations

The presentation by Dr Ruth Bell, CSDH Secretariat (UCL), outlined revised timelines for the interim and final Commission reports, a proposal for ‘road testing’ and consultation process on the interim report, and an overview of the possible types of reports the Commission could come out with, using examples from other Commissions. The envisaged timeline was outlined as follows:

- "Road Test": inviting individuals and representatives of key organisations (supporters and critics) to review the Consultation Document and to participate in the Commission meeting to engage in debate in June 2007 (Vancouver) followed by a revision of the consultation/interim document
- Consultation process: July - October 2007
- August 2007 paper by CSDH Chair published in the Lancet reflecting key issues
- August 2007 Lancet will put out a call for papers, to be submitted by Dec 20.

The Lancet collaboration (for publication in April 2008) was identified as consisting of the following components:

- A series of papers based on key issues from the CSDH would be published online alongside papers which responded to the Lancet call in August 07.
- The Lancet would be a partner in the launch of the Commission final report.
- Mini-series of papers, based on the Final Report conclusions and recommendations, would be published in the Lancet to coincide with the Final Report launch.
- Media launch of final report.

Dr Mandelbaum-Schmidt, noted the importance of defining the specific target audiences and desired changes early on in order to shape advocacy and communications, including key messages/recommendations. She advised the report should be clear, crisp, professionally written, and contain a few straightforward recommendations.

Key discussion points and outcomes

As the streams of work mature and produce more substance on which the Commission may develop positions, the Chair judged that the Commission should shift its attention to intellectual consensus building and articulating their major propositions. This issue was picked up again by Commissioners who presented a strong argument for mobilizing key champions and reaching out to a broad base of civil society to create demand, which would also help to ensure continuity of action after the life of the Commission. Commission

The Commission confirmed its intention to release an interim statement for consultation with key communities and stakeholders as part of a continuous effort to mobilize champions and create demand for the final report. In addition, the consultation would provide the Commission with an opportunity to test its propositions, highlight problems, surface potential adverse reactions, and guide the further development of recommendations.

Strategies to Advance on Socially Determined Health Inequities in Africa

Session structure and objectives

The session aimed to present the rationale, approaches, opportunities and challenges for developing a framework for coordinated action to address the social determinants of health in the African Region by presenting the different perspectives of different stakeholders for discussion of possible ways forward. The three types of stakeholders represented were a minister of health’s perspective (Chair Ngilu, Minister of Health, Kenya); a regional perspective from WHO (Dr Benjamin Nganda, AFRO), and a regional perspective from civil society (Patrick Mubangizi, CSDH Civil Society Facilitator, Africa region).

Presentations

A Minister of Health’s Perspective was presented by Commissioner Charity Ngilu, Minister of Health, Kenya, who reflected on priorities and next steps agreed from the Meeting of African Health Ministers, held in February 2006.

Kenya has been engaged in building support and interest among other African Nations to address the SDH, as it was felt that achieving an impact on socially determined health inequities in the region requires a strong nucleus of countries to lead the process and would need to involve the following activities:

a) strengthen the evidence on SDH equity;

b) demonstrate concrete action to be taken by ministries of health, other sectors and groups in society; and

c) influence the policies and priorities of key health and development bodies towards addressing socially determined health inequities, specifically the policies and priorities of the African Union and the Southern African Development Community (SADC).
A conference of Eastern and Southern African Ministers, held in Nairobi in February 2006, chaired by MOH Kenya, focused on socially determined health inequities. (Report of the conference is available from MOH, Kenya). The dialogue started at the conference was continued when the same group of Ministers met in a closed session during the 57th WHA, May 2006 (Geneva). The group reaffirmed the importance of action on socially determined health inequities, drawing on the strong direction set by MOH Mozambique in his address on the first day of WHA, that action on socially determined health inequities was the single most important priority that countries (and Ministers of Health) should have on their agenda.

Commissioner Ngilu stated that it was important to move from words and good intentions to action and results. The proposed Kenyan Commission could be a vector for action demonstrating how to tackle SDH equity in a country, but she cautioned that the following are areas where countries need further support to advance the regional health equity agenda:

- All countries and especially CSDH ‘spearhead’ countries need support to implementing a new architecture of governance of health equity (across government and in public health) to deliver such an agenda;
- Community leadership needs support to be real partners in planning and decision-making; and
- Research capacity on socially determined health inequities needs to be strengthened within and between countries.

The second presentation was a WHO/ Regional Office perspective on advancing SDH in the region, presented by Dr Benjamin Nganda, from the WHO African Regional Office. Dr Nganda’s presentation outlined the contextual challenges for a strategy for tackling social determinants of health inequities in Africa, listing the region’s poor economic performance, where most countries were showing stagnation or deterioration, poverty (it is the only region where poverty has been rising and is forecast to continue to rise in the next decade or two), and the increasing ‘double burden of disease’, civil strife, natural and man-made disasters. In spite of these trends, he outlined several reasons for optimism for acting on socially determined health inequities, including: the increased commitment of political leaders; increased support from global partners for improving health; the United Nations Millennium declaration and MDGs; which give prominence to health; and the international consensus on the importance of health for socioeconomic development and poverty reduction. Other opportunities were offered by the global partnerships for HIV/AIDS, malaria, tuberculosis, immunisation, making pregnancy safer, etc.

He identified existing frameworks and mechanisms, several of which were related to WHO’s efforts to give priority to this work. These could be used to advance action on SDH equity and included: the 2020 vision for Africa, MDGs, and the International Consensus on importance of health for socioeconomic development and poverty reduction. Related to WHO, there was the Regional Strategy on Poverty and Health approved in 2002, WHO/AFRO 2005-2009 Regional office priorities - Priority 5 (To enhances awareness and response to key determinants of health), and WHO/AFRO Regional Committee 2005 where African ministers called for a multi-stakeholder regional strategy on SDH equity. Dr Nganda stressed the need for a unifying framework for action on SDH equity in the region. The Regional Office of WHO has been working with CSDH Secretariat, Civil Society Facilitators and Knowledge Networks to draft such a framework.

Dr Nganda then presented data on health inequalities and inequalities in social determinants for the African region, showing how health inequalities (mortality/ morbidity) varied between countries and between population groups in the same country depending on factors such as mothers level of education, residence in either rural or urban areas, household income and household assets.

The priorities Dr Nganda identified for addressing socially determined health inequities in the African region were as follows:

- a more substantive situation analysis that would seek to increase the long-term research capacity and evidence base on SDH in the region;
- country case studies to demonstrate different approaches that government can take to reduce socially determined health inequities (including different entry points for action, target setting and indicators to monitor implementation of national actions);
- development of an effective regional framework needs African states to speak out on the importance of SDH equity and involvement in defining priorities for action;
- a clear advocacy strategy to involve committed nations, WHO/AFRO, civil society, and donors; and
- the CSDH Priority Public Health Conditions Knowledge Network is a strong potential entry point for action on health inequities arising through the failure of TB, malaria and HIV programmes to take into account the differential impacts of social factors.

Finally, the Civil Society perspective’s on a regional strategy was presented by the Regional Civil Society Strategy Facilitator for Africa, Patrick Mubangizi, who highlighted how good governance is the basis of health equity. He stressed that the strategy of Civil Society was in its early stages, but to date had focussed on the following issues:

- building capacity on understanding the concept of socially determined health inequities with communities and NGOs/CBOs; and
- training for community leaders.

The next stage of the strategy would focus on:

- documenting and identifying programs that start with bottom-up planning and also involve participatory approaches to priority setting, budgets etc, as these have good potential;
- slum areas – civil society role is to challenge government policies and decisions and also too be partners in planning and delivery; and
- civil society plan to hold parliamentarian meetings to advance common agendas.
Key discussion points and outcomes

African Commissioners were invited to comment first. Commissioner Ndiaye

Commissioner Ndiaye reported being impressed by the meeting with the President that day and his Excellency’s commitment to have Kenya play a role among the eastern African economic community (involving Kenya, Uganda and Tanzania) and beyond this, to the African Union. The next step was certainly to help the Commission to be linked to the President of the African Union. Commissioner Ndiaye indicated that the CSDH needed to consider other partners beyond Kenya, including Senegal, maybe Mozambique, and Mauritania. Commissioner Ndiaye indicated that a huge part of Africa was left behind in this process of CSDH because francophone Africa was not involved and stressed that it was important to have the same movement across the continent.

Commissioner Mocumbi

Commissioner Mocumbi expressed support for the words of Commissioner Ndiaye, indicating the need to include health as a component of the strategy that the African Union had already adopted. He pointed out that the health component of the NEPAD strategy could be improved. He stressed the need for the approach of the CSDH in Africa to be at the community level. The needs of people living with ill health could be substantially addressed at the community level by adopting actions that went beyond disease to address water supply, and better communication between urban and rural centres.

Regarding the health sector in Africa, he stressed the need for it to reform towards prevention and promotion. He indicated that what was still lacking was how to organize people in Africa, taking into account Africa’s own traditions and knowledge. Also most African leaders have not looked at how they could take advantage of community infrastructure. While the lack of resources in Africa remained an issue, they could be mobilised from the national deficit when foreign payments were reduced.

He pointed out that it was known that there is commitment by the Health Ministers to using a primary health care approach at the level of the African Union but this was a vision and still not a strategy. It would be important for the region that partner countries in Africa participated in the African Union deliberations on how to take the SDH approach. This should be addressed the next time the heads of state met (January 2007) and the CSDH should ensure a presence there.

Commissioner Ngilu

Commissioner Ngilu commented that there would never be enough money to deal with health sector when all other infrastructures for health were broken down e.g. education, shelter, sanitation, available clean and safe water. All the money in the world would still not be enough to deal with problems that other ministries have not dealt with. For this reason Commissioner Ngilu applauded the President’s proposed national commission for Kenya.

Commissioner Ngilu reported that during the meeting in eastern, central and southern Africa in February 2006, her government put the social determinants of health on the agenda. Kenya is now the chair and they are meeting again in November 06. Commissioner Ngilu suggested that if by that time Kenya had set up their Commission, it would be possible to encourage other countries in the region to set up their own commissions or to develop shared activities which would result in economies of scale.

Open discussion

In commenting on the presentation of health inequities in the region, the Chair reminded the Commissioners that in Sub-Saharan Africa, the burden of communicable disease is the same as the burden of non-communicable disease and the action that needs to be taken on the latter is not so manifestly obvious.

Commissioner Lagos commented that the essential condition in the short term was to have the political will. Heads of state needed to be interested in SDH before the January 2007 meeting of the African Union. Also, from his experience as president in Chile, it was also important to start with a message of hope - that it is possible to do something. For example, having commitment not to accept garbage on the streets. The younger kids seen earlier that day in Kibera were not so ill that they did not have hope. But perhaps the older ones had lost hope. Either tackling the social conditions or having good primary health care was not going to perform the work that the CSDH required. But the two approaches needed to reinforce each other. For example, if primary health care centres that included prevention and promotion increased access to the population, then people would have hope for change. While engaging the communities in these types of approaches was a very difficult undertaking, it was the only way forward.

The Commissioners praised the commitment of the Kenyan President to use the work on SDH in Kenya for the good of the region. They suggested that the global Commission should help to set up terms of reference for the commission in Kenya, and that the commission in Kenya should consist of people from the grassroots and from the top, representing different fields of interests, and definitely not be constituted of just governmental ministries.
Meeting the President of Kenya, His Excellency, President Mwai Kibaki
A significant outcome of the meeting with the President of Mwai Kibaki was his announcement that he wanted to establish a National Commission on Social Determinants of Health in Kenya. The president said that the focus of the Commission would be on an intersectoral approach and accepted that Kenya would play a role among the East African economic community that exists between Kenya, Uganda and Tanzania and beyond this to the African Union.

Site visits
During their visit, Commissioners were taken to Kibera, Africa’s biggest and poorest slum according to UN/HABITAT. While in Kibera, the Commissioners also visited a programme on HIV/AIDS run by Medecins Sans Frontier (MSF, Belgium). Close to a million people live in Kibera in corrugated iron shacks and without basic sanitary facilities. Minister of Health, Charity Ngilu, took the Commissioner to an under-resourced local clinic and to two primary schools, one said to be the best performing school in the country, in spite of its limited resources. The objective of the visit was for Commissioners to witness, first hand, some of the social determinants of health that challenge Kenya's government. The Kibera visit tied in with Dr Mercado's Knowledge Network for Urban Settings presentation. Dr Mercado held specific meetings, to discuss collaboration of the knowledge network with local Kenyan's and UN/HABITAT, who are working to improve the situation in Kibera.

Invited national speakers
Martha Karua, Minister of Justice and Constitutional Affairs, Kenya
Dr Karua described her government commitment to the rights of poor people and the disadvantaged, and how this was an integral part of developing the renewed sense of justice and community solidarity in Kenya. Dr Karua indicated that progress that had been made in this regard over the recent years and that during her office she was committed to maintaining the improved track record.

Dr Angnyong, Kenya
Dr Angnyong shared with the Commission his experience of urban planning in Kenya. He outlined the proposal for the sale of Kibera land, which, being close to the centre of town, was commercially valuable. This value provided a potential source of revenue for the government to improve housing conditions for the Kibera slum dwellers. He outlined the proposal to use the revenue to house the Kibera squatters further out of town on cheaper land.

Commissioners expressed concern with this proposal. Evidence from other countries had shown how important it was to ensure close proximity of richer and poorer neighbours, both in order to sustain the life of cities for the health of the population, as well as to encourage social solidarity. Commissioners cited examples from Chile and India. Participation of slum dwellers in defining their solution for healthier housing was an imperative for finding a solution that promoted health equity.

Better civil society – government collaboration
National civil society organizations in Kenya had held a meeting on 21 June to discuss the country’s progress on taking forward the agenda for tackling socially determined health inequities. Following the meeting, a statement was prepared. This statement was sent to the government before the Commissioner meeting session and both prepared their presentation of their respective statements described below. In the session on the Country stream of work, the agenda provided a platform for civil society and government in Kenya to discuss their position on advancing the SDH agenda.

Patrick Mubangizi, Health Action International Africa
Mr Mubangizi, who had organized the national civil society meeting in Kenya, presented the statement from civil society. Within the framework of the health sector strategic plan and the sector wide approaches to health and the newly established commission on social determinants of health, it called for leadership and accountability, the establishment of a cross sectoral commission that was adequately resourced, the establishment of independent oversight mechanisms with strong participation of CSOs to monitor the utilization of devolved resources, and the recognition of the importance of building and maintaining partnerships with all stakeholders within civil society including the community based groups, young people, the media, parliamentarians, faith based organizations, and trade unions. Civil society made a request to the government for greater participation in the process of developing Kenya's agenda for tackling socially determined health inequities.
Mr Stephen Muchiri
The Kenyan government representative and official CSDH Country Partner focal point Mr Stephen Muchiri, Chief Economist, Ministry of Health, Kenya, also read out a statement that had been prepared in advance by the government. His statement outlined the progress that had been made by the Kenyan government in taking forward the agenda on the social determinants of health equity. His statement referred to the leadership the government had shown by signing on as a Country Partner early on in 2005. He described how the government had begun to identify key social determinants to address but progress had been hindered in 2005 by the lack of a formal mechanisms for taking the work forward. He expressed confidence that now that the President had announced the launch of a formal mechanism for taking forward action in the form of a national commission, it would be easier to move forward. The government emphasized their commitment to ensuring cross-sectoral, and in particular, civil society participation in the process of advancing Kenya's agenda for tackling socially determined health inequities through a national Kenyan commission.

In the ensuring discussion following the presentation of these two statements, Commissioners queried whether the government's proposed national Kenyan commission would include a broad cross-section of stakeholders, or whether it would only involve government officials. The government confirmed that the proposed Kenyan commission would involve a broader group of stakeholders. The government confirmed that representatives from civil society would be included as national commissioners. Commissioners emphasized that it was important to have civil society, policymakers, WHO regional offices, academics and government all around the table from the beginning.

Bridging the Divide: Comprehensive Reform to Improve Health in Mexico

Dr Julio Frenk, Minister of Health, of Mexico
Dr Frenk's address was entitled "Bridging the Divide: Comprehensive Reform to Improve Health in Mexico". His speech focused on the role of health ministers as stewards and on particular programmes in Mexico that were successfully tackling the social determinants of health inequities. Dr Frenk stressed the point that the role of ministers of health was not to run the health system, but to improve the health of people and this included being active on road safety, fiscally to raise the taxes on tobacco and so on. Dr Frenk described how the government in Mexico had aimed to use a comprehensive integrated approach when tackling the plight of the health of the poor and less advantaged, citing in particular the Mexican program, Oportunidades, which is presently benefiting 5 million families, which comprise 25 million persons or one quarter of the total Mexican population. He indicated that by taking a comprehensive approach, the Commission is placing health at the center of a broader social agenda and is therefore underscoring its larger value to the national and global goals of equitable development. A copy of the full speech is contained in Annex 5.

A Human Rights Approach to Health

Session structure and objectives
The objectives of the session were to discuss what health as a human right means in practice, and to discuss the implications (positive and negative) of adopting the right to health framework in the CSDH. Helena Nygren-Krug, WHO's human rights adviser, made a 30-minute presentation. Commissioner Berlinguer opened the discussion with a short comment on the presentation.

Presentation
The presentation discussed what human rights were, what was meant by the term "right to health" and how it was governed, and what was the value-added to the Commission of adopting a rights-based approach. Ms Nygren-Krug described human rights as being standards generated by governments that indicated what governments can do, cannot do, and should do to or for their populations. These rights should apply universally, to the whole population and rights are interrelated and indivisible. Furthermore, rights provide a framework for interaction or relationships between governments and individuals or groups in

Human rights, furthermore, are very broad, allowing for diversity within cultures. They are enshrined and monitored at international levels (e.g. human rights

President of Kenya Mwai Kibaki with Commissioners Ndioro Ndiaye and Charity Ngilu
relevant to children are enshrined in the Convention of the Rights of the Child, and monitored by the Committee of the Rights of the Child set up under the Convention), regional levels (e.g. the African Charter on Human & Peoples’ Rights enshrines rights of people in Africa and is monitored by the African Commission on Human and People’s Rights and the African Court on Human and People’s Rights), and at national levels (e.g. the Constitution of South Africa enshrines rights of people in South Africa and is monitored by the South African Human Rights Commission).

The norms underpinning health-related human rights (including those addressing underlying determinants of health), including the right to health, and the work on health and human rights has undergone a tremendous evolution in the last century. The term, "right to health" is shortened from “the right to the highest attainable standard of health”, which was first reflected in the WHO Constitution in 1946 at international level. Two years later, following the end of the Second World War, the Universal Declaration of Human Rights was adopted. This set out the right to an adequate standard of living, adequate to health and well being. When it came to codifying the declaration into a binding treaty law, the cold war had dichotomised and politicized human rights into two categories – economic, social and cultural on the one hand, and civil and political on the other. With the end of the cold war and the endorsement by the international community of the inter-dependence and indivisibility of all human rights, there has been renewed attention to the right to health.

In 2000, WHO worked with the Committee on Economic, Social and Cultural Rights to develop a General Comment on the Right to Health (the General Comment No. 14 adopted by the Committee on Economic, Social and Cultural Rights was distributed as a handout). This served to clarify the normative content of the right to health and set out States’ obligations and individuals’ freedoms and entitlements. In 2002, the Special Rapporteur on the right to health, who is an independent expert tasked with reporting on how the right to health is being respected around the world, was appointed by the UN Commission on Human Rights (now replaced with the UN Human Rights Council). The mechanisms for overseeing the implementation of the right to the highest attainable standard of health within the UN human rights system are summarized in the Figure 5.

The right to health is not a right to be healthy, but a claim to a set of social arrangements – norms, institutions, laws, an enabling environment – that can best secure the enjoyment of this right. The right to health is an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. The core contents of this right include: freedom from discrimination in ensuring access; access to essential food, basic shelter, housing and sanitation, and safe and potable water, access to essential drugs as defined under the WHO Action Programme on Essential Drugs; equitable distribution of all health facilities, goods and services; a national public health strategy and plan of action with particular attention to all vulnerable groups. International human rights standards relevant to economic, social and cultural rights, including the right to health, acknowledges the constraints due to the limits of available resources and do not require these rights to be fully realized overnight. Instead, they require States to use the maximum of their available resources; take deliberate, concrete and targeted steps individually and through international assistance and cooperation; use indicators (structural, process and outcome) and benchmarks to measure progress. In realization of the right to health, it is important to distinguish government incapacity vs. unwillingness.

In summarizing the added value to the Commission of using a human rights approach to health equity, the following points were made.

The right to health:
- provides an explicit and common value system universally recognized;
- is enshrined in law: national and international;
- has clear definitions, solid and robust long-term framework;
- focuses on root causes and power structures;
- people as actors, agents, rather than objects or passive recipients → empowering;
- changes paradigm from needs and charity to rights and obligations;
- heightens accountability: monitoring mechanisms in place; and
- connects a broad range of actors.

![Figure 5: UN Mechanisms overseeing human rights and the right to health](image-url)
Key discussion points and outcomes

Commissioner Berlinguer opened the discussion with a short commentary. He said the presentation was useful. His only criticism was that the presentation had been oversimplified. He opened the discussion with a short commentary. The presenter responded that this was true, and that the shortening of the evolutionary time frame was made in the interests of time.

The Chair addressed the Commissioners with the questions, "what are the upsides and downsides of our Commission embracing health as a human right?" and "what are the outcomes if we do not come out explicitly embracing health as a HR?".

A speaker from the floor argued strongly for the connection between health as a human right and the CSDH work on addressing socially determined health inequities, indicating that civil society groups were already using this approach to monitor the realization of health for different populations.

Commissioners expressed the idea that to ensure that the right is exercised, services need to be built, and in so doing, society needs to accept rationing because it cannot provide all care to everybody all the time. The presenter agreed and pointed out that said that this was where the legal notion of progressive (gradual) realization is extremely important. What was equally important was the process through which the rationing was decided. For example, were the vulnerable and affected groups involved in making the decisions about rationing?

Some Commissioners indicated that the rights movement had sometimes been represented flippantly in the press. The presenter indicated that in terms of rights, it is not possible to be flippant. The examples from the press cited by the Commissioners were not actual rights enshrined in law nor were they part of any international legal framework. What has crystallised at the international level in human rights was an agreement about the very basic things, e.g. every child has a right to an identity, the right to an education - which are in fact minimalistic. As people become more aware of their rights they are taking governments to court and WHO is mapping this development. For the health sector and for the government, it is worrying because courts are judging whether health should be available on issues such as ART. In general, the litigation that WHO has mapped so far has proved to be very empowering for health equity eg. indigenous peoples taking their government to court for what they allowed a multinational (Shell Oil) do to their people.
**Key discussion points and outcomes**

**Commissioner Berlinguer** opened the discussion with a short commentary. He said the presentation was useful. His only criticism was that the presentation had been oversimplified the origins of the ideas related to human rights, which could be traced down through the centuries. The presenter responded that this was true, and that the shortening of the evolutionary time frame was made in the interests of time.

The Chair addressed the Commissioners with the questions, "what are the upsides and downsides of our Commission embracing health as a human right?" and "what are the outcomes if we do not come out explicitly embracing health as a HR?".

A speaker from the floor argued strongly for the connection between health as a human right and the CSDH work on addressing socially determined health inequities, indicating that civil society groups were already using this approach to monitor the realization of health for different populations.

Commissioners expressed the idea that to ensure that the right is exercised, services need to be built, and in so doing, society needs to accept rationing because it cannot provide all care to everybody all the time. The presenter agreed and pointed out that this was where the legal notion of progressive (gradual) realization is extremely important. What was equally important was the process through which the rationing was decided. For example, were the vulnerable and affected groups involved in making the decisions about rationing?

Some Commissioners indicated that the rights movement had sometimes been represented flippantly in the press. The presenter indicated that in terms of rights, it is not possible to be flippant. The examples from the press cited by the Commissioners were not actual rights enshrined in law nor were they part of any international legal framework. What has crystallised at the international level in human rights was an agreement about the very basic things, e.g. every child has a right to an identity, the right to an education - the rights are in fact pretty minimalistic. As people become more aware of their rights they are taking governments to court and WHO is mapping this development. For the health sector and for the government, it is worrying because courts are judging whether health should be available on issues such as ART. In general, the litigation that we have mapped is very empowering for health equity eg. indigenous peoples taking their government to court for what they allowed a multinational (Shell Oil) do to their people.

Commissioners expressed concern at the tension between social equity and individuals claiming individual rights, noting that the General Comment contained a paragraph referring to indigenous groups who may value social equity over individualistic rights. They felt that this statement could be applied to the whole right to health. Individual rights should come second to considerations of social equity.

In summary, the Commissioners supported the adoption of a rights-based approach but one that ensured that equity was very much at the centre. This meant that while adopting the rights-based approach, equity would trump any challenge between an individual's right if their right threatens fairness. The Commissioners agreed to deliberate further on how to present this position on the right to health.
Summary and Conclusions

The Commissioners concluded four fruitful days of high level meetings, sites visits and general Commission business in Kenya. With respect to the particular objectives set for the meeting, they made substantial progress and reached several important conclusions, as summarized below.

With respect to the work of the CSDH Knowledge Networks, they approved the progress made by the presenting knowledge networks of Early Child Development, Globalization and Urban Settings. They also welcomed the setting up of the Priority Public Health Conditions Knowledge Network. They stressed the need for this KN to be explicit about its incorporation of a broader vision of health policy and the intersectoral nature of the health and the stewardship role of ministries of health. In the review of overall progress with KNs, the Commissioners supported the proposed mechanisms to fill the identified regional and policy-oriented expertise gaps in KN membership, including extension of KN membership either by adding new primary members or enlisting the involvement of a secondary tier of members.

A range of additional key issues not being addressed by the Commission's streams of work were discussed. Two others were added to this list, namely, indigenous people's health and man-made disasters. The Commissioners supported the idea of addressing the additional key issues through a call for papers as part of a possible Lancet series.

In reviewing the progress of the Country stream of work, the Commissioners welcomed the increased number of Country Partners added since January 2006. Commissioners emphasized the need to be concrete with respect to what activities or actions were required of Country Partners. They supported the new list of priority actions that were proposed, in particular the work on strengthening routine information systems for health equity, and suggested focusing resources on a small number of countries in the short-to medium term in order to realize progress more rapidly, while not forgetting to include French-speaking Africa.

Commissioners commended the advances made in the Civil Society stream of work. They supported the proposed strategic emphasis on linkages between civil society and knowledge generation in the next phase of the Commission's work.

Commissioners identified the need to tailor messages to different global and regional financial and UN institutions prior to the launch of the Commission report in 2008. The identified the need to develop the messages in light of the comparative advantage of global and regional, versus national, action. They agreed to have advanced the CSDH work on the key position statements by the time of the Brazil meeting in September.

Regarding its report, the Commission confirmed its intention to release an interim report or statement for consultation with key communities and stakeholders by June 2007, which would be road-tested as part of a continuous effort to mobilize champions and to create demand for the final report.


The Commission welcomed the commitment of the President of Kenya to establish a national Kenyan commission on social determinants of health and pledged to help support the commission in developing its terms of reference.

With respect to the special addresses by the guest speakers, the Commissioners commented on the importance of the stewardship role for health ministries, as outlined in the speech by the Minister of Health for Mexico, Dr Julio Frenk. With respect to the presentation on a human rights approach to health, the Commissioners supported the adoption of a rights-based approach but one that ensured that equity was very much at the centre. They agreed to deliberate further on how to present this position on the right to health.

In summary, the Chair, Sir Michael Marmot said that the Commission on Social Determinants of Health has to be relevant to the problem of health inequity in all countries whether rich, intermediate or low income. He said that this point was put to the Commission powerfully during their time in Kenya. Poverty in Kenya was an order of magnitude different from social and economic disadvantage in Europe, North America or Australasia. In addition to the double burden of disease emerging in countries like Kenya, poor people in Kenya have the double burden of poverty of material conditions and basic services, and disadvantage or lack of empowerment that is a powerful driver of socially determined health inequities in all countries. He indicated that the Commission was greatly encouraged by President Kibaki’s commitment, made in person to Commissioners, to set up a Kenyan Commission on Social Determinants of Health. The Commission looked forward to Kenya being a partner.
The Commission on Social Determinants of Health has to be relevant to the problem of health inequity in all countries whether rich, intermediate or low income. The point was put to us powerfully that poverty in Kenya is an order of magnitude different from social and economic disadvantage in Europe, North America or Australasia. Observers speak often of the double burden of disease suffered by countries such as Kenya. In addition, poor people in Kenya have the double burden of poverty of material conditions and basic services, and disadvantage or lack of empowerment that is a powerful driver of socially determined health inequities in all countries.

The meeting in Kenya was a good example of how the Commission is working to meet the challenge of health inequalities within and between countries. The meeting brought all the streams of work together and, importantly, we had extensive time for meeting with Kenyan colleagues. The site visits that gave us a glimpse of the scale of the problems to be addressed and the meetings with government ministers were both important in furthering the Commission’s work. We were greatly encouraged by President Mwai Kibaki’s commitment, made in person to Commissioners, to set up a Kenyan Commission on Social Determinants of Health. We look forward to Kenya being a partner of the Commission.

Not a Commissioner left Kenya without a strong desire to return.

Closing message from Sir Michael Marmot Chair of the Commission

The Commission on Social Determinants of Health has to be relevant to the problem of health inequity in all countries whether rich, intermediate or low income.
ANNEX 1: SUMMARY OF MEETING PROCEEDINGS

Fourth meeting of Commission on Social Determinants of Health
Regional Civil Society Facilitators (CSFs)
Nairobi, Kenya, 26-27 June 2006

Meeting objectives
- Discuss mechanisms for implementation of the proposed regional civil society strategies for action on SDH: analyse potential impact on civil society process of changes at WHO following death of Director-General J.W. Lee; reach agreement on which forms of civil society collaboration with the CSDH should be prioritized in the current context (short and medium term); define specific action areas and next steps; inventory project proposals that might be submitted to outside donors to secure additional funding for civil society activities.
- Discuss the generation and collection of knowledge of social determinants that exists in civil society and communities and develop a concrete mechanism for advancing civil society's work with the CSDH in knowledge collection.
- Discuss and agree upon strategies for the participation of civil society in CSDH Country Work.
- Discuss mechanisms to develop regional and global civil society advocacy on SDH in coordination with partners.

Key meeting outcomes and action points

1. The situation of the CSDH following the unexpected death of WHO Director-General Lee was discussed frankly by Civil society facilitators (CSFs) and secretariat. The potential implications for CSDH financing and for the civil society work stream were analysed. Full implementation of the proposed regional civil society strategies for action on SDH is not possible until greater clarity emerges on the political and resource situation at WHO and CSDH. A limited set of priority areas for short term action was defined. It was decided to focus civil society collaboration with the Commission in the short term particularly on knowledge generation, in order to ensure civil society voice and input in the CSDH Knowledge Network process and products (see Outcome 2 below).

Action points/next steps
- CSFs and CSDH secretariat to focus their joint work heavily in the area of knowledge generation through end 2006 and probably until March 2007 (date when CSDH Knowledge Networks submit their final reports to the Commission).
- Secretariat and WHO/EQH advocacy team to identify and explore options with outside donors for funding other portions of the CSDH civil society work.
- CSFs to seek funding from their own sources as appropriate to carry forward aspects of their work on SDH in light of reduced short-term support from WHO.
2. A mechanism for collecting knowledge about SDH from civil society and communities in all global regions was developed and refined through discussions among CSFs and secretariat, based on a draft model presented by CSFs to CSDH Knowledge Network Hubs. Conceptual and operational issues around the collection of knowledge from civil society were clarified. A draft budget for civil society knowledge collection work was developed jointly by CSF and secretariat. The secretariat agreed to fund the civil society knowledge work in line with the budget proposed.

**Action points/next steps**
- Secretariat focal points to summarize agreements on the knowledge collection mechanism and circulate to CSDH civil society partners for final input.
- Secretariat focal points to review budget with secretariat leadership and define final amounts available.
- Secretariat focal points to generate WHO Agreement for the Performance of Work (APW) contracts with the regional CSF organizations to fund the initial phases of knowledge collection and coordination of Reference Groups.
- CSFs to establish civil society knowledge Reference Groups in their respective regions and to identify a coordinator for each Reference Group. In collaboration with CSDH Knowledge Networks, civil society Reference Groups will be responsible for coordinating the global collection of civil society and community knowledge on the specific thematic areas assigned.
- Each CSF organization, in consultation with civil society partners, to propose 9 Regional Contact Points who will link with and channel regional evidence to the 9 CSDH Knowledge Networks.

3. Modalities and entry points for civil society involvement in CSDH Country Work processes were discussed, in light of the creative action of Kenyan civil society in developing a joint Position Paper on SDH and government response, and using the opportunity of the CSDH meetings in Kenya to press for greater inclusion of civil society in the national policy process relative to SDH.

**Action points/next steps**
- CSFs for Africa and Kenyan national civil society partners to follow up Government of Kenya promise that participatory space will be provided to civil society within the Kenyan National Commission on Social Determinants of Health whose creation was announced at the Kenya meeting of the CSDH.
- CSFs to advocate for the creation of national SDH commissions in other countries, based on the particular advantages that this model provides for civil society involvement, advocacy and monitoring of policy processes.
- Civil society to continue its action in country-level political processes related to SDH through mechanisms including: formal engagement with national governments in countries whose political leaders have established a relationship with the CSDH (e.g., Kenya); efforts where appropriate to engage municipal, state or local authorities who are interested in action on SDH and health equity, even if the national government is not (e.g., Colombia); participation in national grassroots movements and mobilizations on health, bringing an SDH perspective to these processes (e.g., national People's Health Assembly process in India).

4. Potential advocacy products and activities by civil society—and the relationship of civil society advocacy to the 'official' products of the CSDH—were discussed. On this point, important clarifications emerged concerning the goals of civil society knowledge generation and the factors that can strengthen civil society uptake of CSDH reports and other products for advocacy purposes. The discussions highlighted the importance of independent civil society reports on SDH as a contribution to advancing understanding and spurring action on SDH and health equity.

**Action points/next steps**
- Civil society thematic reports and position papers to be prepared with awareness of Knowledge Network timelines, in time to be incorporated into KN final reports.
- Draft final civil society report will be completed in time to be integrated into the CSDH final report.
- Civil society knowledge gathering activities will also feed an independent civil society knowledge process and political analysis on SDH; this will be reflected in an independent civil society SDH report which will constitute a distinctive contribution to global debates and action.
ANNEX 1, APPENDIX A: MEETING AGENDA

Kenya pre-meeting of Regional Civil Society Facilitators
Commission on Social Determinants of Health
Nairobi, Kenya, 26-27 June 2006

Topic of the meeting
Ensure and strengthen civil society participation in the global strategy of the Commission on Social Determinants of Health (CSDH).

Objectives
- Discuss the mechanism for implementation of the proposed regional civil society strategies for action on social determinants of health.
- Proposed activities during the intermediate phase: Eastern Mediterranean, Africa, Asia, America Latina. TOR for the public call for bids to be issued by WHO for the coordination of Phase 2 (implementation of regional civil society strategies). Ideas of project proposals that might be submitted to outside donors to secure additional funding for civil society activities.
- Identify the capacities that need to be strengthened within civil society and among social leaders for the implementation of proposed CSDH civil society strategies.
- Discuss the generation and collection of knowledge of social determinants that exists in civil society and communities.
- Discuss and agree strategies for the participation of civil society in Country Work and the CSDH/WHO regional strategies.
- Discuss mechanisms to develop regional and global advocacy from Civil Society and coordination with other partners.

Monday, 26 June 2006

09:00 - 09:10  Objectives and structure of the meeting: Alex Irwin, CSDH Secretariat

09:10 - 10:00  Ideas of project proposals that might be submitted to outside donors
First topic of discussion: Capacities that must be strengthened within civil society organizations and among social leaders in order to develop and implement the proposed regional strategies and to support work on social determinants in regions and countries.
Presentation: Mwajuma.
Discussion, comments and main agreements.

10:00 - 11:10  Second topic of discussion  Knowledge of social determinants
Main issues to be presented in the Commissioners meeting.
Presentation : Amit Gupta.
Discussion, comments and main agreements regarding the generation and collection of knowledge of social determinants that exists in civil society and grassroots communities Next step and timeline.

11:10 - 11:30  Coffee/tea

11:30 - 12:00  (continued ) Second topic of discussion : Knowledge of social determinants.
Preparing presentation for Commissioners Meeting.

12:00 - 12:20  TOR for WHO's public call for bids for Phase 2 coordination.

12:20 - 13:00  Discussion, comments and agreements.

13:00 - 14:00  Lunch
14:15 - 15:00  Summary the proposal activities in the intermediary phase: America Latina, Asia, Africa, Eastern Mediterranean.  
Presentation: Secretary of CSDH.  
Discussion and comments.

15:00 - 16:00  Topic of discussion: Positioning the CSDH in the regional and global environment  
What are the regional or subregional strategies, programs and/or activities where there is an opportunity to harness synergy with the CSDH and which should be included in the global and regional strategies of the CSDH?  
With whom and within what areas of policy synergy can the Commission work globally to generate policy and political momentum?  
With whom and through what forms of new or existing institutional action at global level will the Commission lever the institutional environment for sustained follow up after it is dissolved?  
Presentation: Secretary of the CSDH.  
Main issues to be presented in the Commissioners meeting.

16:00 - 16:20  Break

16:20 - 18:20  Preparing the presentation for the Civil Society session in the CSDH meeting of Commissioners.  
We make four working groups, one hour and plenary for agreements.

16:20 - 17:20  Group 1: General keys, update on regional CS activities, one general , and one for each region summary of the mapping.  
Group 2: GAPS in Country Work from CS perspective and proposed solutions (local/national, participation).  
Group 3: Main concept of the paper CS link CW and advocacy.

17:20 - 18:20  Plenary and agreements

18:20 - 19:00  Discussion: Next steps.  
Coordination: Secretary of the CSDH.

**Tuesday, 27 June 2006**

08:30 - 10:00  Africa working on socially determined health inequities.

10:30 - 12:30  Meeting with Knowledge Networks.

12:30 - 13:30  Lunch

14:30 - 18:30  Site visits. The informal settlement (shantytown) of Kibera.
ANNEX 2:
SUMMARY OF MEETING PROCEEDINGS

Second meeting of the Commission on Social Determinants of Health
Knowledge Network Hubs
Nairobi, Kenya, 24-25 June 2006

The following is a summary of the key issues and main outcomes from the second meeting of Knowledge Network (KN) hubs in Kenya on 24th-25th June 2006. The focus of this summary is on the following key issues: strengthening the knowledge collection process in KNs; Final product(s) of KNs including mechanisms for validation of knowledge and bringing the final report together. More detailed minutes from the meeting will be made available. The agenda for the meeting including aims and objectives is at Annex A.

Participants
Participants included one or more representatives from seven of the eight established KNs, Civil Society Facilitators from the four regions, CSDH Secretariat staff (WHO and UCL), representatives from Kenyan civil society organizations and the WHO office in Kenya. The Women and Gender Equity KN were unable to participate in the meeting.

Background
The second Knowledge Networks (KN) hubs meeting in Kenya (24-25th June 2006) provided an important opportunity (the mid point for most KNs) to review the progress to date of KNs; identify and consolidate strengths and achievements; identify where KNs need to be in order to meet the key deliverable(s) of KNs by March 2007; and develop agreed strategies for ensuring KNs build on current strengths and can meet key deliverable(s).

A midpoint assessment was undertaken using: the KN interim reports; first meeting reports; key presentations; other documents developed by KN (eg. Health Systems approach to measurement); minutes of KN hub teleconferences (March and May 2006); network membership lists (by region and organizational type); and other documents such as specific feedback from Commissioners and other stakeholders. The ninth KN on priority public health conditions was not included in the assessment as the KN has not yet been established.

Key issues discussed

<table>
<thead>
<tr>
<th>Strengthening the knowledge collection process</th>
</tr>
</thead>
<tbody>
<tr>
<td>The midpoint assessment was presented at the meeting and options for addressing gaps or strengthening particular aspects were discussed. The overall progress with the KNs is good and there are some real strengths and achievements to build on. There are however some real gaps in membership coverage across the KNs and it will be important to keep the 'value add' of the KNs in focus as time pressures increase in the lead up to March 2007.</td>
</tr>
</tbody>
</table>

Some key strengths and achievements include: all of the KNs have held their first meetings, this is particularly important given the delays in funding and contracts for three of the KNs; there a strong networks developing with active members; there are innovative approaches developing within KNs to the collection and generation of knowledge; some of the KNs are moving beyond the generation of knowledge through papers and publications to the strengthening or establishment of new partnerships to generate knowledge; and at least half of the KNs have commenced knowledge collection.

In terms of ensuring adequate geographical and contextual coverage for collection of global knowledge, the assessment identified specific membership gaps: across WHO regions namely the Eastern Mediterranean and South East Asian regions; and uneven coverage within regions. There is over-representation of two of the WHO regions across the KNs - these are AMRO (37 members) and EURO (26 members). Numbers for other regions are as follows AFRO (18), WPRO (12), SEARO (8) and EMRO (4).
There is over-representation of countries within the regions and as follows - within AMRO there 12 from the USA and 9 members from Canada; within EURO, there are 10 from the UK; within AFRO 7 members are from South Africa; within WPRO 5 of the members are from China and 5 from Australia; and within SEARO 6 of the 7 members are from India. The KN members located in EMRO are from Lebanon, Pakistan and Egypt.

The issue of over-representation across and within WHO regions is not shared equally across the KNs.

In terms of ensuring collection of knowledge for action - knowledge that is policy and advocacy relevant - the assessment identified that: researchers and academics dominate the membership across KNs - however there is an imbalance on some KNs in that they do not have enough members from other organizational types, particularly government practitioners; and government practitioners - 5 of the 6 KNs have one or more governmental practitioners on the KN, however to ensure validity of knowledge for action it is important that there is more than one on each KN. Therefore 4 of the 6 KNs really need to look at strengthening the government practitioner representation in their network.

Areas for strengthening within KNs included: getting focused on final products and qualitative dimensions of the KNs work; topics for knowledge collection - this is not well articulated across all KNs; ensuring geographic & contextual diversity; identifying processes for validating that knowledge is policy and advocacy relevant; and ensuring that those KNs that have not commenced knowledge collection begin to do so as soon as possible.

In addition, there is a lack of detailed plans for knowledge generation – therefore potential gaps in quality of knowledge not known. It is important to have some mechanism for ensuring the 'value-add' or qualitative dimensions of KN products such as global coverage of knowledge (both geographically and contextually representative) and policy and advocacy relevance of knowledge, so that the knowledge can be used for taking action.

It has been difficult for KNs to establish linkages with the other streams of the Commission's work (civil society and country work streams) due to different timeframes for these two workstreams. However the time is now right and a key outcome of the hubs meeting should be on developing specific linkages with country partners and the civil society stream of work.

The options for discussion at the meeting for strengthening knowledge collection included: addressing membership gaps by (1) identifying new members for gaps, (2) replacing 'non performing' members with new members and/or (3) establishing secondary network circles for consultation and/or validation; increasing collection of knowledge from non-English sources by using members on own KNs and other KNs as well as from the civil society stream to translate or identify if published sources of knowledge should be translated; developing specific linkages with civil society and country partners; developing a detailed action plan – one document that can also inform country partners, civil society and other stakeholders.

**Final product(s) from Knowledge Networks**

With regard to the final report from each KN, it was agreed that the final report is the key deliverable for KNs, that the audience is the Commission which includes the civil society, Commissioners and country partners work streams and that the final report needs to be more than the sum of the KN products. While the report of individual KNs can be made public, it may be an issue of timing and impact and this needs to be clarified. The guidelines developed by the Measurement and Evidence KN together with the Secretariat are considered a useful starting point for KNs and should be seen enabling rather than a regulatory framework.

In terms of 'collective' or second-order products from KNs (ie. products developed jointly by KNs and/or by KNs with other parts of the Commission), KNs considered that they would be in a better position to identify the types of products in October 2006, when they are scheduled to have the third KN hubs meeting and again in March 2007, when KN final reports are available. This discussion however highlighted the need to identify what will happen after 31st March 2007 and commence the development of proposals for building on the knowledge generation process and creation of KNs.

The issue of mechanisms and processes for validating knowledge collected by the KNs for policy and advocacy relevance, was discussed during the meeting. The standardised points of reference developed as part of the Harmonised Review Process, were seen as providing one mechanism for KNs to check or validate their knowledge collection. Beyond this and existing mechanisms (eg. policy maker participation on KNs, civil society review of KN products) however, KN hubs considered that they did not have the time nor resources to undertake separate processes for validating knowledge for policy and advocacy relevance.
Key outcomes

**Strengthening the knowledge collection process**

Membership gaps:
- For advanced KNs – review information and where gaps, seek input from organizations within regions not well represented esp. Eastern Mediterranean.
- Secretariat to liaise with EMRO to obtain list of potential organizations.
- Specific gaps for follow up separately with KNs where membership less well established.

Ensuring ‘global’ & action focused knowledge collection:
- Hub instructions/TORs to authors etc to reflect requirement for geographic representativeness, etc.
- Process agreed for civil society linkage - meeting with CSFs and four of the KNs to agree on progressing the proposal for linkages.
- Direct follow up between KNs and country partners.
- Use of Standardised Points of Reference to ensure the global and action focus.
- Third Hubs meeting provides a chance for KNs and Secretariat to review progress.
- Second Interim Reports - Secretariat to ensure format seeks information on the global and action focus and KNs to ensure they use the format to respond to these questions.
- KNs to also use second meeting of their KNs to review this aspect of progress.

**KN final product(s)**

Final report of KNs (31st March 2007):
- Clarification of audience - agreed that it is Commission stakeholders including Commissioners, country partners and civil society organizations.
- The final report of KNs can be published.
- An extension is required for final reports of the Social Exclusion (SEKN) and Employment Conditions KN (EMCONET) given they have only just been able to commence work in the last month or so due to selection process, funding and contractual delays.

Validation process (policy & advocacy relevance) - needs additional resources for KNs to do during the knowledge collection process. This may be something that has to be done as part of the ‘road testing’ of KN and Commission products in 2007 rather than during the knowledge generation process.

Collective products – better idea by October 2006 and dependent on outcomes of proposals to provide funding and or resources after 31st March 2007.
Meeting Agenda

Knowledge Network hubs, Nairobi, Kenya, 24 - 25 June 2006

Objectives
- Assess where KNs are right now - strengths and key issues to address in the next 12 months.
- Discuss the generation of knowledge through KNs including: a. providing an overview of the different structures that KNs are using to ensure global coverage of knowledge collected; b. identifying and agreeing on specific mechanisms to support linkages between KNs and between KNs and other streams of the Commission's work; c. discussing the different dimensions of context and agreeing on general principles for ensuring that the different dimensions of context are recorded in KN products.
- Clarify and discuss the primary task and focus of the Measurement and Evidence KN.
- Discuss the final product(s) from KNs including: the final content of final report for each KN and process for ensuring synthesis of individual KN products into final report; identifying the collective products of the KNs.
- Identifying the different target audiences for knowledge collected; the processes for validating and disseminating this collection of knowledge for action.
- Discuss and provide feedback on the proposed harmonized review process developed by the Secretariat located at UCL.

Outcomes
- Agreement on priority issues that need to be addressed in the next 12 months to achieve KN objective(s).
- Agreement on the generation of knowledge including: the process and format for each KN to consolidate and clearly demonstrate how the KN is collecting global knowledge to ensure adequate geographical coverage and diversity of knowledge; how specific gaps in geographical coverage and diversity of knowledge will be monitored and addressed; some precise mechanisms and entry points for linking between the KNs and between the KNs and other streams of the Commission's work; shared and agreed working definition of context and classifications of the dimensions to be included in KN products.
- Shared understanding about the primary task and focus of the MEKN.
- Agreement about the final products of the KNs, the audiences and dissemination mechanisms for these final products including the final report and agreed priority collective products.
- Agreement on purpose and scope of proposed harmonized review process, and identification of roles and responsibilities.

Saturday, 24 June 2006

8:30 - 8:45 Welcome and introductions: Dr Peter Eriki, WHO Representative, Kenya
Aims and objectives of meeting: Sarah Simpson, Coordinator, Knowledge Networks, CSDH Secretariat, WHO

8:45 - 9:30 From knowledge to action: an assessment of Knowledge Network progress at June 2006.
Session objectives: to assess where KNs are right now - strengths and key issues to address in the next 12 months

Session outcomes: shared understanding of the issues that need to be addressed in the next 12 months to achieve KN objective(s)

Plenary discussion: discussion of current KN strengths and agreement on issues to be addressed over next 12 months. Chair: Nicole Valentine, CSDH Secretariat, WHO.
9:30 - 10:30  Proposed KN strategies and mechanisms for ensuring global reach of Knowledge Networks
Session objectives: to provide an overview of the different ways of structuring their work being
implemented by KNs to ensure global coverage of knowledge collected.

Session outcomes: identification of the required elements in the structure and the processes of
the KN to ensure adequate geographical coverage and diversity of knowledge sources.

Session agenda: Early Child Development KN: structuring a KN to enable collection of
knowledge about what works in low to middle income settings: Clyde Hertzman.

Employment Conditions KN: structuring a KN to collect knowledge within a diverse field:
EMCONET hub.

Roundtable discussion: strengths of different KN approaches and learning from them across
KNs. Chair: Sharon Friel, CSDH Secretariat, UCL.

10:30 - 11:00  Break

11:00-12:30  Mechanisms and entry points for linkages between KNs and the Commission
Session objectives: to identify and agree on mechanisms to support linkages between KNs and
other streams of the Commission's work.

Session outcomes: improved awareness of mechanisms and entry points for linking with other
streams of Commission's work; agreement about specific action that KNs and the Secretariat
will take to implement linkages.

Session agenda: regional entry points for Knowledge Networks: Nicole Valentine, Orielle
Solar. Country work stream: entry points and mechanisms for linking with global country
partners: Nicole Valentine.

Civil Society knowledge needs and contribution to KNs: proposed CSF approach - Amit Sen
Gupta CSF, SEARO) (TBC).

Roundtable discussion: discussion of proposed mechanisms and entry points and agreement
about how each KN is going to act on these linkages. Chair: Lucy Gilson, Health Systems KN.

12:30 - 13:30  Lunch

13:30 - 15:15  The relevance of context: developing a shared understanding and approach
Session objectives: to discuss the different dimensions of context and agree on general
principles for ensuring that the different dimensions of context are recorded in KN products.

Session outcomes: shared and agreed working definition of context and classifications of the
dimensions to be included in KN products; specific mechanisms identified for ensuring that
context is captured according to the agreed dimensions in KN products.

Session agenda: developing a typology: proposed approach of Employment Conditions KN:
EMCONET hub; capturing context in a cross-cutting network: important dimensions of context

Roundtable discussion: What are the different dimensions of context? Which of these
dimensions of context need to be captured by KNs in collecting knowledge? What are the
principles for ensuring that KNs do this? Chair: Jennie Popay, Social Exclusion KN.

15:15 - 15:45  Break
Clarifying the work of the measurement and evidence Knowledge Network
Session objectives: to clarify and discuss the primary task and focus of the Measurement and Evidence KN.

Session outcomes: shared understanding about the primary task and focus of the MEKN.

Session agenda: presentation on the work of the MEKN including its focus, how the MEKN is taking its work forward and the relationship of the MEKN to other KNs: Josiane Bonnefoy, Measurement and Evidence KN.

Plenary discussion. Chair: Ritu Sadana, EIP, WHO

Bringing the Knowledge Network products together: final report of KNs
Session objectives: to clarify content and audience(s) of the final report for each KN and process for ensuring synthesis of individual KN products into final report.

Session outcomes: shared understanding about the purpose and audience(s) of the final report and what it should look like; identified strategies for synthesis of KN products into KN final reports.

Session agenda: brief overview of KN final reports: key elements, content, using the writers group and three different views on synthesis: Sarah Simpson.

Plenary discussion: Reflection on planning for final report including KN hubs identifying the mechanisms or processes by which they plan to bring the final report together. Chair: Gabrielle Ross, CSDH Secretariat, WHO.

Meeting close

Sunday, 25 June 2006

Feedback on outcomes of Day 1
Session agenda: presentation summarizing key outcomes from Day 1: Lucy Gilson, Health Systems KN).

Plenary discussion. Chair: Susy Mercado, KN on Urban Settings.

Collective contribution of Knowledge Networks to the Commission's work
Session objectives: to discuss and identify the collective products of the KNs; to identify the themes and spaces that could be synergistic.

Session outcomes: agreement about specific global products arising from KNs. Identification of mechanisms to: address overlap between KNs and; synergize knowledge from different KNs.

Session agenda: mapping of specific areas of: synergies, overlaps and gaps between KNs, to achieve identified products: Orielle Solar, Sarah Simpson; two working groups: Identification of X number of collective products to be produced by the KN stream of work; reporting back and plenary discussion. Chair: Bongiwe Peguillan, CSDH Secretariat, WHO.

Break
Validating the process of knowledge generation: advocacy and dissemination

Session objectives: to discuss proposed processes for validating this collection of knowledge for action; to discuss mechanisms for advocacy and dissemination.

Session outcomes: shared understanding of the mechanisms that KNs need to have in place in order to validate knowledge for action process and products.

Session agenda: three circles of the KN on Urban Settings: a mechanism for validating the process of knowledge generation: KNUS hub; ensuring knowledge for advocacy and action: a civil society perspective: Patrick Mubangizi, CSF AFRO; two working groups: (1) specific processes for validation of knowledge for action; (2) specific mechanisms for dissemination; reporting back and plenary discussion. Chair: Ritu Sadana, EIP, WHO.

Lunch

Knowledge Networks and the proposed harmonised review process

Session objectives: to discuss and provide feedback on the proposed harmonized review process developed by the Secretariat located at UCL.

Session outcomes: agreement on purpose and scope of proposed harmonized review process, and identification of roles and responsibilities.

Session agenda: proposal to develop an harmonized review process and timing of key deliverables from KNs: Sharon Friel, CSDH Secretariat, UCL; ensuring gender as a cross-cutting concern: Ruth Bell, CSDH Secretariat, UCL; response and comment - Employment Conditions KN: EMCONET hub; response and comment - Globalization KN: Ron Labonte; roundtable discussion - progressing and implementing the HRP approach, identifying what needs to be done and by whom. Chair: Jeanette Vega, CSDH Secretariat, WHO.

Break

Feedback on outcomes of Days 1 and 2

Session objectives: to identify and summaries how the key issues, objectives and outcomes from the meeting have been advanced.

Session outcomes: shared understanding of how we move forward from here; agreement about how KNs will include the agreed outcomes (processes, mechanisms etc) in their workplans; agreed milestones for monitoring and assessing process; identification of next steps including key meetings and activities.

Session agenda: presentation summarizing key outcomes from both days and including proposed processes for inclusion in KN plans, proposed milestones and proposed next steps: Sarah Simpson, CSDH Secretariat, WHO.

Plenary discussion. Chair: Jeanette Vega, CSDH Secretariat, WHO. Work to progress and arrangements for KNs remaining for Commissioners meeting.

Meeting close.

Individual preparatory meetings with hub leaders, CSDH Secretariat and Commissioners for Early Child Development KN (17:00-17:30)
Measurement & Evidence KN (update) (18:00-19:00)
Globalization KN (19:00-20:00)
Urban Settings (TBA - likely to be 26th June)
Monday, 26 June 2006

09:00 - 10:30 Welcome and briefing on program of site visits and official meetings  
Commissioner Ngilu, Minister of Health, Kenya

10:30 - 11:30 Early Child Development KN: presentation of findings to date  
Dr Clyde Hertzman, Early Child Development KN Hub

11:30 - 12:30 Closed session: attended only by Commissioners and Dr Jeanette VEGA, Head of the CSDH Secretariat, World Health Organization.

12:30 - 13:30 Lunch

13:30 - 14:00 Transit

14:00 - 17:30 Ministry meetings: hosted at the Ministry of Finance Offices, includes meetings with Ministry of Planning, Ministry of Finance, Ministry of Home Affairs, Ministry of Education, Chairmen of Constituency Development Fund.

19:00 - 20:00 Cocktail hosted by Ministry of Health of Kenya: at the Palm Atrium.

Tuesday, 27 June 2006

10:15 - 11:00 Transit

11:00 - 12:00 Meeting with the President of Kenya, H.E. Mwai Kibaki

12:15 - 12:30 Transit

12:30 - 13:30 Lunch

14:30 - 18:00 Site visits: the informal settlement (shantytown) of Kibera

18:00 - 19:00 Africa - working on socially determined health inequities: Invited speakers - Commissioner Charity Ngilu, Benjamin Nganda, WHO Africa Regional Office Representative, Patrick Mubangizi, CSDH Civil Society Facilitator for Africa. Chair: Prof. Sir Michael Marmot

Wednesday, 28 June 2006

8:45 - 9:15 Governance of Kenya:  
Martha Karua, Minister for Justice and Constitutional Affairs

9:15 - 10:00 Social inequalities and health inequities in Kenya:  
Dr Angnyong

10:00 - 10:30 Break
10:30 - 12:30 Progress update for knowledge networks: urban settings, globalization, and measurement: Sarah Simpson, CSDH Secretariat, World Health Organization Ron Labonte, University of Ottawa hub, Globalization Knowledge Network Susy Mercado, Kobe Centre hub, Urban Settings Knowledge Network Dr Josiane Bonnefoy, Measurement and Evidence, Universidad del Desarrollo co-hub, Measurement and Evidence Knowledge Network.

12:30 - 13:15 Progress update: additional key issues: Dr Sharon Friel, CSDH Secretariat, University College London

13:15 - 14:15 Lunch


15:15 - 15:45 Break

15:45 - 17:30 Progress update - country work: Commissioner Denny Vågerö Dr Chris Brown, CSDH Secretariat, World Health Organization Nicole Valentine, CSDH Secretariat, World Health Organization Stephen Muchiri, Country partner Kenya, focal point Patrick Mubangizi, CSDH Civil Society Facilitator for Africa

Thursday, 29 June 2006

9:00 - 11:00 Progress update - civil society: Dr Alec Irwin, CSDH Secretariat, World Health Organization Civil society regional focal points: Dr Mwajuma Masaigahan, Patrick Mubangizi (Africa region) Dr Alaa Shokralla (Eastern Mediterranean region) Dr Amit Sen Gupta (Asia region) Dr Mauricio Torres (Latin Americas region)

11:00 - 11:30 Break

11:30 - 12:30 Closed session of the Commissioners

12:30 - 14:00 Lunch

14:00 - 15:00 Keynote address: Dr Julio Frenk, Minister of Health of Mexico

15:00 - 16:00 Global stream of work - working with global and regional actors to advance the SDH agenda: Commissioners: Ricardo Lagos, Tibaijuka, Fran Baum Dr Sebastian Taylor, CSHD Secretariat, University College London

16:00 - 16:30 Break

16:00 - 17:00 Advocacy and communications strategy for the CSDH report: Sir Michael Marmot

17:00 - 18:00 A human rights approach to health: Dr Helena Nygren-Krug, Health and Human Rights Adviser, World Health Organization

18:00 - 18:15 Wrap up and closing: Sir Michael Marmot
ANNEX 4

LIST OF PARTICIPANTS

Commissioners

Chair
Prof Sir Michael Marmot
Head of Department
Department of Epidemiology and Public Health
University College London
1-19 Torrington Place
London WC1E 6BT
United Kingdom
Tel: 44 20 7679 1717. Fax: 44 20 7813 0242. Email: m.marmot@ucl.ac.uk

Other Commissioners
Prof Frances Baum
Professor of Public Health
South Australian Community Health
Flinders University of South Australia
GPO Box 2100
SA 5001
Australia
Tel: 61 8 8205 5983. Fax: 61 8 8374 0230. Email: fran.baum@flinders.edu.au

Dr Monique Bégin
Dean
Faculty of Health Services
University of Ottawa School of Management
Room (VNR): 255D
136 Jean-Jacques Lussier Ottawa
Ontario
Canada
Tel: 1 613 562 5800. Email: begin@management.uottawa.ca

Dr Giovanni Berlinguer
MP European Parliament
Via di San Giacomo 4
00187 Rome
Italy
Tel: 39 06 69 19 06 76. Email: gberlinguer@europarl.eu.int

Ms Mirai Chatterjee
General Secretary
Self Employed Women's Association
SEWA Reception Centre
Bhadra, Ahmedabad 380 001
India
Tel: 91 79 25 506 444. Fax: 91 79 25 506 446. Email: social@sewass.org

Mrs Charity Kaluki Ngilu
Minister of Health
Ministry of Public Health
P.O. Box 30016
Nairobi
Kenya
Tel: 254 20 248 551. Fax: 254 20 248 552. Email: ckngilu@iconnect.co.ke
Prof Kiyoshi Kurokawa  
Adjunct Professor  
The Research Center for Advanced Science  
The University of Tokyo  
#102, Bldg.14  
4-6-1, Komaba, Meguro-ku Tokyo, 153-8904  
Japan  
Tel: 81 3 5452 5090. Fax: 81 3 5452 5091. Email: kurokawa@is.icc.u-tokai.ac.jp

Dr Ricardo Lagos  
Santiago  
Chile  
Email: cbudnik@terra.cl

Dr Alireza Marandi  
Professor of Pediatrics  
Shaheed Beheshti University  
13 Kamali-Sharghi Street, Saboori Street  
Pour-Ebtehaj Street  
Tehran 19789-75654  
Iran, Islamic Republic  
Tel: 98 21 2800736. Email: alirezamarandi_md@yahoo.com

Dr Pascoal Mocumbi  
Higher Representative  
European Developing Countries  
Clinical Trials Partnership (EDCTP)  
334 Laan van Nieuw Oost Indië  
P.O. Box 93015  
The Hague, 2509 AA  
Netherlands  
Tel: 31 70 344 0883. Fax: +31 70 3440 899. Email: mocumbi@edctp.org

Mrs Ndioro Ndiaye  
Deputy Director  
International Organizaton for Migration (IOM)  
17 Route de Morillons  
P.O. Box 71  
CH-1211 Geneva 119  
Switzerland  
Tel: 41 22 717 9380. Fax: 41 22 717 9440. Email: nndiaye@iom.int

Dr Hoda Rashad  
Research Professor and Director  
Social Research Center  
American University in Cairo  
113 Kasr El Aini Street  
P.O. Box 2511  
Cairo 11511  
Egypt  
Tel: 202 797 6940. Fax: 202 795 7298. Email: hrashad@auc.acs.eun.eg

Dr David Satcher  
Interim President  
Morehouse School of Medicine  
National Center for Primary Care  
720 Westview Drive SW  
Atlanta, GA 30310-1495  
USA  
Tel: 1 404 756 5740. Email: bmoore@ msm.edu
Dr Anna Tibajuka
Executive Director
UN/HABITAT
PO Box 30030
Nairobi 00100
Kenya
Tel: 254 20 623 120. Email: execdir.habitat@unhabitat.org

Dr Denny Vågerö
Director
Centre for Health Equity Studies (CHESS)
Stockholm Univ./Karolinska Institute
SE-10691 Stockholm
Sweden
Tel: 46 8 162313. Email: denny.vagero@chess.su.se

Dr Gail R. Wilensky
HOPE Project
7500 Old Georgetown Road, suite 600
Bethesda MB 20814
USA
Tel: 1 301 347 3902. Email: gwilensky@projecthope.org

Invited speakers

Prof. Anyang Nyongo

Dr Julio Frenck Mora
Minister of Health
Ministry of Health
Lieja 7, Col. Juárez
México DF 06696
Mexico
Tel: 52 5 553 0758. Fax: 52 5 553 7917. Email: jfrenk@mail.ssa.gob.mx

Ms Helena Nygren-Krug
Human Rights Adviser
World Health Organization
20, Avenue Appia
CH-1211 Geneva
Switzerland
Tel: 41 22 7912523. Email: nygrenkrugh@who.int

Dr Martha Karua
Minister for Justice and Constitutional Affairs
Ministry for Justice and Constitutional Affairs
The Government of Kenya
P.O. Box 56057-00100
Nairobi
Kenya
Tel: 224029/55/82. Email: mercy.muthuuri@justice.go.ke
DFID

Dr Anthony Daly
Kenya Health Advisor
Department for International Development (DFID)
British High Commission
Upper Hill Road
P.O. Box 30465
Nairobi
Kenya
Tel: 254 20 284 4000. Fax: 254 20 284 4102. Email: a-daly@dfid.gov.uk

Kenyan delegation

Mr Stephen Muchiri
Chief Economist
Ministry of Health
Ministry of Health Planning Division
Kenya
Tel: 254 202 713710. Email: health@nbnet.co.ke

Mr Annah Wamae
Head
Ministry of Health of Kenya
Div. of Child Health
P.O Box 2681 KNH 00202
Nairobi
Kenya
Tel: 254-020-2725105. Fax: 254-020-2725694

Knowledge Network Coordinating Hub representatives

Dr Joan Benach
Unitat de Recerca en Salut Laboral
Dep.de Ciències Experimentals i de la Salut
Universitat Pompeu Fabra
c/Dr. Aigüader, 80
08003 Barcelona
Spain
Tel: 34 93 5421396. Email: joan.benach@upf.edu

Ms Josiane Bonnefoy
Co-hub leader
Measurement and Evidence
Universidad de Desarrollo
1 Santiago
Chile
Telephone No. : +56 2 218 7735/7903 Email address : josiane.bonnefoy@gmail.com

Dr Etheline Enoch
Honorary Research Fellow
Lancaster University
London
United Kingdom
Tel: 44 20 7 267 3384. Email: enochuk@yahoo.com

Prof Lucy Gilson
Deputy Director, Centre for Health Policy
National Health Laboratory Services
Braamfontein
Johannesburg
South Africa
Tel: 27 11 489 9941. Email: lucy.gilson@nhls.ac.za
Mr Amit Sen Gupta  
Peoples Health Movement  
India D158 Lower Ground Floor  
Saket New Delhi 110-017  
India  
Tel: 919 810 611425. Fax: 911 126 862716. Email: ctddsf@vsnl.com

Dr Clyde Hertzman  
Human early Learning Partnership  
Library Processing Centre  
320-2206 East mall  
Vancouver BC V6E3Z9  
Canada  
Tel: 1 604 8221278. Fax: 1 604 2880640. Email: clyde.hertzman@ubc.ca

Dr Heidi Johnston  
Senior Social Scientist  
Centre for Health and Population Research  
GPO Box 128  
Dhaka-1000  
Bangladesh  
Tel: 880 171 3030537. Email: heidi_johnston@mindspring.com

Dr Ronald Labonte  
Director  
Saskatchewan Pop. H. and Evaluation  
University of Saskatchewan  
107, Wiggins Road  
Saskatoon, Saskatchewan  
Canada  
Tel: 1 306 966 23 49. Fax: 1 306 966 79 20. Email: ronald.labonte@usask.ca

Dr Susan Mercado  
Programme Coordinator  
Cities and Health Programme  
WHO Centre for Health Development (WHO Kobe Centre - WKC)  
Kobe  
Japan  
Tel: 81 78 230 3157. Fax: 81 78 230 3178. Email: mercados@who.or.jp

Prof Jennie Popay  
Professor, Sociology & Public Health  
Institute for Health Research  
Lancaster University  
Alexandra Square  
Lancaster LA1 4YG  
United Kingdom  
Tel: 44 1524 592 493. Fax: 44 1524 592 401. Email: j.popay@lancaster.ac.uk

Dr Laetitia Rispel  
Executive Director  
Human Science Research Council  
134 Pretorius Street  
Pretoria  
South Africa  
Tel: 27 12 302 2602. Email: lrospel@hsrc.ac.za
Dr Theodore Schrecker  
Scientist  
Department of Epidemiology and Community Medicine  
Institute of Population Health  
University of Ottawa  
1 Stewart Street  
Ontario K1N 6N5  
Canada  
Tel: 1 613 562 5800. Fax: 1 613 562 5659. Email: tschreck@uottawa.ca

Ms Vilma Sousa Santana  
Instituto de Saude Coletiva/UFBA  
Campus Universitario do Canela  
Rua Augusto Vianna S/N 2o. Andar  
Salvador, Bahia 40110-040  
Brazil  
Tel: 55 71 3336 0034. Fax: 55 71 3263 7420. Email: vilma@ufba.br

**Regional Civil Society Facilitators**

Mr Amit Sen Gupta  
People's Health Movement  
India D158 Lower Ground Floor  
Saket New Delhi 110-017  
India  
Tel: 919 810 611425. Fax: 911 126 862716. Email: cttddf@vsnl.com

Dr Mwajuma Saidy Masaiganaan  
PHM Focal Point  
East Africa Region  
Mwasama Pre and Primary School  
P.O. Box No. 240  
Bagamoyo  
Coast Region  
United Republic of Tanzania  
Tel: 255 2440062. Fax: 255 2440154. Email: masaigana@africaonline.co.tz

Mr Patrick Mubangizi  
Health Action International Africa  
P.O. Box 66054-00800  
Nairobi  
Kenya  
Tel: 254 20 3860434. Fax: 254 20 3860437. Email: pmubangizi@haiafrica.org

Mr Hani Serag  
Association for Health and Environmental Development (AHED)  
17 Beirut St. Apt #501  
Heliopolis  
Cairo  
Egypt  
Tel: 20 2 2565613. Fax: 20 2 2565612. Email: hpsp@ahedegypt.org

Dr Ibrahim Shokralla  
Association for Health and Environmental  
5 Khan Younis Street Mohandessin  
Cairo  
Egypt  
Tel: 20 2 2565613. Fax: 20 2 2565612. Email: alaashuk@yahoo.com

Mr Mauricio Torres  
Asociacion Lationamericana de Medicina Social  
Alames Kr. 25 No. 28-37  
Bogota  
Colombia  
Tel: 57 4539657. Fax: 57 3400784. Email: coordinadorgeneralalames@yahoo.es
CSDH Secretariat - University College London

Dr Ruth Bell
Department of Epidemiology and Public Health
University College London
1-19 Torrington Place
London WC1E 6BT
United Kingdom
Tel: 44 20 7679 1717. Fax: 44 20 7813 0242. Email: r.bell@public-health.ucl.ac.uk

Dr Sharon Friel
Department of Epidemiology and Public Health
University College of London
1-19 Torrington
London WC1E 6BT
United Kingdom
Tel: 44 207 679 1684. Fax: 44 207 813 0242. Email: s.friel@ucl.ac.uk

Dr Antonia Houweling
Department of Epidemiology and Public Health
University College London
1-19 Torrington
London WC1E 6BT
United Kingdom
Tel: 44 207 6791684. Fax: 44 207 813 0242. Email: t.houweling@ucl.ac.uk

Dr Sebastian Taylor
Department of Epidemiology and Public Health
University College London
1-19 Torrington Place
London WC1E 6BT
United Kingdom
Tel: 44 207 679 1684. Fax: 44 207 813 0242. Email address : s.taylor@ucl.ac.uk

CSDH Secretariat - World Health Organization/Geneva

Dr Chris Brown
Programme Manager
Tel: 41 22 7915581. Email: chb@ihd.euro.who.int

Dr Timothy Evans
Assistant Director-General
Evidence and Information for Policy
Tel: 41 22 7912752. Email: evanst@who.int

Mr Alexander Irwin
Technical Officer
Tel: 41 22 7911960. Email: irwina@who.int

Mrs Sarah Simpson
Technical Officer
Tel: 41 22 7911217. Email: simpsons@who.int

Dr Orielle Solar
Health Systems Adviser
Tel: 41 22 7915531. Email: solaro@who.int

Mrs Bongiwe Peguillan
Communications Officer
Tel: 41 22 7912658. Email: peguillanb@who.int

Mr Richard Poe
Technical Assistant
Tel: 41 22 791 3476. Email: poerw@who.int

Dr Ritu Sadana
Senior scientist
Office of the Assistant Director-General
Evidence and Information for Policy
Tel: +41 22 7913250. Email: sadanar@who.int

Ms Nicole Valentine
Technical Officer
Tel: 41 22 7913217. Email: valentinen@who.int

Dr Jeannette Vega
Director, ai
Tel: 41 22 7911998. Email: vegaj@who.int
World Health Organization Regional and Country Offices

Dr Peter Eriki
World Health Representative
Kenya Country Office
4th floor ACK Garden House
1st Ngong Av./off Bishops Rd.
P.O. Box 45335
Nairobi GPN 35003
Kenya
Tel: 254 20 271 7902. Fax: +254 202719141. Email: wrkenya@ke.afro.who.int

Dr Humphrey Karamagi
Health Economics and Systems Advisor
Kenya Country Office
4th floor ACK Garden House
1st Ngong Av./off Bishops Rd.
P.O. Box 45335
Nairobi GPN 35003
Kenya
Tel: 254 20 271 7902. Fax: +254 202719141. Email: karamagih@ke.afro.who.int

Dr Assumpta Muriithi
National Professional Officer
Kenya Country Office
4th floor ACK Garden House
1st Ngong Av./off Bishops Rd.
P.O. Box 45335
Nairobi GPN 35003
Kenya
Tel: 254 20 35022. Fax: +254 202719141. Email: murithia@ke.afro.who.int

Mrs Eulalia Namai
National Professional Officer
Kenya Country Office
4th floor ACK Garden House
1st Ngong Av./off Bishops Rd.
P.O. Box 45335
Nairobi GPN 35003
Kenya
Tel: 254 20 723069. Fax: +254 202719141. Email: Namaie@ke.afro.who.int

Dr Benjamin Nganda
Regional Advisor
Poverty and Ill Health Programme
Health in Sustainable Development
Division of Healthy Environments and Sustainable Development
World Health Organization Regional Office for Africa
BP 06 Brazzaville
Republic of Congo
Tel: 47 241 39943. Fax: +47 241 39501. Email: ngandab@afro.who.int

Country partner representatives

Dr Jim Ball
Director
Public Health Agency of Canada
130 Colonnade Road
A.L. 6501H
Ottawa, Ontario K1A 0K9
Canada
Tel: 1 613 941 6572. Fax: 1613 952 7223.
First of all, I would like to express my gratitude to Sir Michael Marmot for the invitation to address this distinguished audience. Thanks to Tim Evans, I had the privilege of witnessing the launch of the Commission on Social Determinants of Health in Chile, under the auspices of President Ricardo Lagos. The Commission is a timely initiative that seeks to systematize our understanding of the broader factors which determine the level and distribution of health in a population. Such an understanding will help support the application of interventions to improve social conditions that affect health.

This is an enlightening perspective that can empower national policy makers as we strive to build better health systems. After almost six years as minister of health, I am convinced that a key component of the stewardship role is to mobilize all the tools of public policy to improve health. Indeed, health cannot be seen simply as a specific sector of public administration, but must be understood as a social objective. Therefore, it is not enough to develop health policies in the strict sectoral sense; we also need healthy policies that mobilize interventions from other sectors in order to pursue the social objective of better health.

Such a comprehensive perspective has become even more necessary today, as most developing countries undergo a protracted and unequal health transition that is adding new layers of complexity to the patterns of disease, disability, and death. Through a web of multiple causation, those countries are facing a triple burden of ill health: first, the unfinished agenda of infections, malnutrition, and reproductive health problems; second, the emerging challenge of noncommunicable diseases and their associated risk factors like smoking and obesity; third, the growing scourge of injury and violence.

The complexity in health conditions is mirrored by the complexity in the social arrangements to respond to those conditions through health systems. Indeed, we must strive to understand the interactions between the broad social determinants of health and the set of institutions that constitute the health care system. We know today that there is huge variation across countries in the performance of health systems, even at the same level of income and health expenditure. Depending on such performance, a society may face either a virtuous or a vicious cycle between its level of development and the workings of its health system. The conclusion is clear: health policy does matter in determining which of those cycles occurs in a given country.

One area of special concern is the relationship between poverty and health financing. We have known for a long time that poverty is a major determinant of health conditions and also of health systems. More recently, we are becoming aware that the relationship may also operate in the opposite direction. In particular, many developing countries are facing today an unacceptable paradox: even though better health is one of the most effective ways of fighting poverty, medical care can itself become an impoverishing factor for families when a country does not have the social mechanisms to assure fair financing that protects the entire population. In fact, WHO has recently estimated that every year close to 100 million persons in developing countries face catastrophic health expenditures.

As we can see, countries all over the world are facing a growing degree of complexity both in their health conditions and in the social response to those conditions through the health system. The only way to deal with the challenges deriving from this complexity will be to adopt a comprehensive strategy. In particular, we must bridge the divide among three intellectual and programmatic traditions in public health. The first one has focused precisely on the mandate of your Commission, namely, the social determinants of health, with the conviction that the way to achieve sustained improvement in health is through long-term transformations of the structures and relationships of a society. The second tradition has focused on specific interventions for specific disease categories. This has been the so-called “vertical” approach to public health. Lastly, the third tradition has taken a systemic or “horizontal” approach, seeking to modify the general structure and functioning of the set of organizations constituting the health system.
What we need today is to integrate these three traditions into a coherent policy framework. If we extend the geometry metaphor, we must bring together the vertical and horizontal approaches to search for what Jaime Sepúlveda has called the “diagonal,” that is to say, a strategy in which we use explicit priorities to drive the required improvements into the health system, dealing with such generic issues as human resource development, financing, facility planning, drug supply, rational prescription, and quality assurance. In turn, diagonal health policy must be placed in the framework of a broader healthy policy, as I mentioned earlier. In this presentation, I would like to share with you the main insights deriving from an intense reform experience in my country aimed at bridging the divide in order to implement a comprehensive strategy. In particular, I would like to point out the way in which a number of knowledge-related global public goods were influential in shaping policies that are transforming the health system in Mexico. Since such global public goods are the main product from commissions such as yours, I believe that concrete country experiences may reaffirm the enormous value of your work.

Knowledge is not only the product but also part of the substance of this Commission’s remit. Indeed, one of the social determinants of health is the creation and diffusion of knowledge. There is a growing body of evidence showing that knowledge represents one of the major driving forces for health progress. We all agree that research is a value in itself, an essential part of culture. At the same time, knowledge has an instrumental value as a means to improve health. This is achieved through three mechanisms. First, knowledge gets translated into new and better technologies, such as drugs, vaccines, and diagnostic methods. This is the best-known mechanism through which it improves health. But, second, knowledge is also internalized by individuals, who use it to structure their everyday behavior in key domains like personal hygiene, feeding habits, sexuality, and child-rearing practices. In this way, knowledge can empower people to modify their lifestyles in order to promote their own health. The power derived from knowledge also allows individuals to become informed users of services and citizens conscious of their rights. Third, knowledge becomes translated into evidence that provides a scientific foundation for decision-making both in the delivery of health services and in the formulation of public policies.

Recent developments in my country illustrate this last point. In the mid-1990s a review of research findings and an extensive consultation with local and international specialists guided the design and implementation of an ambitious initiative intended to enhance basic capabilities of families living in extreme poverty. Initially called PROGRESA and later renamed Oportunidades, this program is an early example of the comprehensive approach aimed at bridging the divide among the three traditions mentioned earlier. First, Oportunidades acts on several social determinants by creating incentives for families to invest in their children’s human capital through cash transfers that are conditioned on the fulfillment of certain elements of co-responsibility, most notably school attendance and improved nutrition--two major determinants of health. Further, the program is guided by a gender perspective, since scholarships are higher for girls in order to prevent discrimination. In addition, cash transfers are received and managed by women, something that empowers them within the household. Evidence also shows that mothers are more likely than fathers to spend additional resources on their children’s health and welfare.

Another element of co-responsibility is attendance to a health clinic. In a case of revitalized primary care through the diagonal approach, the program has fostered a major expansion and strengthening of local health systems, achieved through an explicitly defined package of health promotion and disease prevention interventions, including basic sanitation, reproductive health, nutritional and growth surveillance, and specific prevention measures mostly for communicable diseases, but increasingly also for high blood pressure, diabetes, and injury. As can be seen, Oportunidades utilizes concurrent improvements in income, education, nutrition, and health care to create a synergy that has been hypothesized to help families break the cycle of chronic poverty. From its inception, the program has had an evaluation component that has been robust enough to attribute substantial improvements to the various interventions and has also generated evidence to fine-tune implementation.

In addition to its technical aspects, rigorous evaluation has had an enormous political value to assure the continuity of the program through a change in administration. Indeed, scientific evidence persuaded the present government not only to continue with the program, but to greatly expand its geographical coverage to cover also the urban poor and to add new productive opportunities for youngsters and a pension scheme for senior citizens. Oportunidades is presently benefiting 5 million families, which comprise 25 million persons, one quarter of the total Mexican population.
But in health we are always victims of our own success. The improvement itself in basic health conditions fuels the epidemiological transition by enhancing the survival of children to reach ages where expensive noncommuncable diseases are more prevalent. It is this dynamic that makes health a never-ending challenge. Even as Oportunidades was proving its value in reducing poverty and improving health, the beneficiaries were experiencing new disease burdens, while their expectations for higher quality of care were growing. Ironically, a considerable proportion of the cash transfer received by poor families from Oportunidades was being used to finance care not included in the initial basic package of interventions which, as mentioned before, was mostly focused on the pre-transitional pattern of disease burden. Yet a reality often overlooked in the search for equity is that problems only of the poor, like many common infections and undernutrition, are no longer the only problems of the poor, who also suffer higher rates of many noncommuncable diseases, mental disorders, injury, violence, smoking, obesity, and other risk factors.

On the basis of the successful platform provided by Oportunidades, it was therefore necessary to expand social protection for all families that had hitherto been excluded from such benefits. With this purpose in mind, a major structural transformation was launched by the present administration. The reform of the Mexican health system is probably a textbook case of evidence-based policy. Indeed, sound analysis made decision makers and the public aware of critical realities that required solution. Thus, the careful calculation of national health accounts revealed that more than half of total expenditure in Mexico was out-of-pocket. This proved to be a direct result of the fact that approximately half of the population lacked health insurance. Furthermore, out-of-pocket expenditures were shown to be highly regressive, since they represented a higher proportion of income in poor households than in nonpoor ones.

These findings were unexpected as it was generally believed that the Mexican health system was based on public funding. Instead, the analysis revealed the unacceptable paradox of which I spoke earlier: far from being a key factor in the fight against poverty, health care itself was a direct cause of impoverishment since the economic consequences of illnes generated a poverty trap. The realization that millions of households had been paying catastrophic out-of-pocket sums generated a different perspective on the operation of the health system. Policy makers extended their focus to include financial issues that proved to have a great impact on the provision of health care and on levels of poverty among Mexican households.

Another global public good that helped to make the local case for reform was the WHO framework for the assessment of health systems performance. This framework highlighted fairness of financing as one of the intrinsic goals of health systems. As a result of its high levels of out-of-pocket spending, Mexico performed very poorly on the international comparative analysis of fair financing. Instead of generating a defensive reaction, this poor result spurred detailed country-level analysis in 2001 that showed that catastrophic expenditures were concentrated among poor and uninsured households. The country-level analysis was based on data from the national income and expenditure surveys for Mexico, yet another global public good. These surveys are produced by many countries in the world and provide homogenous data sets that are key for cross-national comparisons.

The careful interplay between national and international analyses generated the advocacy tools to promote a major legislative reform establishing a system of social protection in health, which was approved by a large majority of the Mexican Congress in 2003. This system is reorganizing and increasing public funding by a full percentage point of GDP over seven years, mostly from federal general taxes supplemented by state-level contributions. This growth in funding is affordable, since the starting point for total health expenditure was a mere 5.7% of GDP in the year 2000, a level that was insufficient to deal with the pressures posed by the triple burden of disease. The new financial scheme will make it possible to provide universal health insurance, including the 50 million Mexicans, most of them poor, who had been excluded until now from formal social insurance schemes because they are self-employed, are out of the labor market or work in the informal sector of the economy.

The increased funding is spearheading a major effort to realign incentives throughout the health system. Poor families can now enroll in a new scheme called "Popular Health Insurance," or Seguro Popular, which is the basis for allocating federal funds to states. The old model of "bureaucratic budgeting," which subsidized providers without regard to performance, is being replaced by "democratic budgeting," whereby money follows people in order to assure an optimal balance between quality and efficiency.
To achieve this aim, the macro-level financial reform is being complemented by a micro-level management reform, which is strengthening delivery capacity through a series of specific interventions on critical areas like human resource development, long-term facility planning, efficient schemes for drug supply and rational prescription practices, quality assurance, and outcome-oriented information systems. The element that articulates the financial and the managerial reforms is an explicit package of benefits, which has been designed using cost, effectiveness, and social acceptability as the guiding criteria. Apart from serving as a priority-setting tool, the package is a means of empowering people by making them aware of their entitlements and is also a key instrument for accountability on the part of providers.

By the way, Chile has been a pioneer in this approach, through the innovative AUGE plan promoted by President Lagos. AUGE is a Spanish acronym for the notion of universal access with guaranteed benefits. Making the rights of people explicit is a powerful tool for improving the performance of health systems. Mexico certainly has learned a lot from the Chilean experience. The net result has been a dramatic increase in the number of entitlements. From the original Oportunidades basic package of only 13 interventions, the Seguro Popular encompasses now over 250, which include all interventions at the primary and secondary levels of care. Even within this comprehensive package, there are opportunities to implement the diagonal approach by strengthening overall health system capacity through clearly identified priorities. Having already achieved over 95% coverage with one of the most complete immunization schedules in the world, the next frontier for equity was to reduce maternal mortality, which is actually the Millennium Development Goal where Mexico needs to improve. The various financial and managerial measures adopted as part of the reform are being focused on a special initiative to address this top priority.

In addition, the seven-year transition period stipulated in the new law to achieve universal coverage of families is accompanied by the coverage of an expanding set of high-cost interventions. Through a transparent and collective priority-setting mechanism, the new insurance scheme is already providing universal coverage for AIDS treatment, childhood cancer (which is the second cause of death among school-age children), uterine cancer (the first cause of death among women over 25 years), and cataract extraction (the main cause of preventable blindness), among other interventions. Each of them provides yet another opportunity to enhance health system performance through the attainment of explicit priorities. But the benefits of the new system are not restricted to curative actions. For the first time in Mexico, the new system has created a separate Fund for Community Health Services, which protects the budget for health promotion and disease prevention interventions. As a result, a recent survey shows a significant increase in the utilization of early detection services, aided by an accompanying scheme of health cards with a gender and life-course perspective.

The reform has also included an unprecedented effort to strengthen health-related public goods, such as epidemiological surveillance, environmental health services, regulatory actions to protect the public, and more generally the set of intersectoral interventions that define a healthy policy capable of modifying the social determinants of disease. In this way, we have made an explicit attempt at bridging the divide among the three public health traditions identified at the beginning of this paper. The evaluation experience gathered through Oportunidades is being applied to the current structural reform. Rigorous monitoring and evaluation is also being applied at the state level to benchmark health system performance and measure the impacts of the reform. The encouraging results shown by the ongoing evaluation will hopefully serve once again to preserve the continuity of the reform through the change of government scheduled for the end of 2006.

As can be seen, a hallmark of the Mexican experience has been a substantial investment in research to design the reform, monitor progress towards its implementation, and evaluate its results. This is a clear example of the possibility of using science to promote social change by harmonizing two core values of research: scientific excellence and relevance to decision-making. The need for sound research to enlighten decision-making is underscored by the worldwide search for better ways of strengthening health systems. Because of the gaps in our current knowledge, every reform initiative should be seen as an experiment, the effects of which must be documented for the benefit of every other initiative, both present and future. This requires a solid investment in research on health systems. Each innovation constitutes a learning opportunity. Not to take advantage of it condemns us to rediscover at great cost what is already known or to repeat past mistakes. To reform it is necessary to inform, or else one is likely to deform.
The Mexican case also shows that the dilemma between local and global research is a false one. As we have seen, the process of globalization can turn knowledge into an international public good that can then be brought to the center of the domestic policy agenda in order to address a local problem. Such application, in turn, feeds back into the global pool of experience, thus generating a process of shared learning among countries. Finally, the Mexican reform illustrates the way in which knowledge public goods can empower local decision makers to advance the health agenda amidst the competition for attention and public resources. Especially in their interaction with ministers of finance, health officials can make use of global evidence showing that, in addition to its intrinsic value, a well-performing health system contributes to the overall welfare of society by relieving poverty, improving productivity, increasing educational abilities, developing human capital, generating employment, protecting savings and assets, enhancing competitiveness, and directly stimulating economic growth with a fairer distribution of wealth.

These arguments have been a powerful tool to convince decision makers to mobilize more money for health. But, in the words of the legendary Professor Ramalingaswami, we must also assure that we achieve more health for the money. The experience I have shared with you illustrates the growing consensus around the notion that the pace of diffusion of knowledge into a country is one of the major social determinants of the pace of health improvement. In turn, the spread of knowledge-related public goods will depend on a renewal of international cooperation in health. In closing, let me suggest three key elements for such a renewal, three “e’s”: exchange, evidence, and empathy. First, the communications revolution provides the opportunity to exchange experiences about the ways to deal with the common challenges being faced by health systems all over the world. I am certain that the work of the Commission on Social Determinants of Health will be play a crucial role in speeding the dissemination of policy-relevant knowledge, for the benefit of ministries of health, other arenas of public action, and civil society organizations.

To be informative, such exchange should be based on sound evidence about alternatives, so that we may build a solid knowledge base of what really works and may be transferred across countries when it is culturally, politically, and financially reasonable. The path is clear: scientifically derived evidence must be the guiding light for designing, implementing, and evaluating programs in national governments, bilateral aid agencies, and multilateral organizations.

But there is another value. The British philosopher Sir Isaiah Berlin has proposed the comparative study of other cultures as an antidote against intolerance, stereotypes, and the dangerous delusion by individuals, tribes, states, ideologies or religions of being the sole possessors of truth. And this leads us to the third element, empathy, that human characteristic which allows us to emotionally participate in a foreign reality, understand it, relate to it and, in the end, value the core elements that make us all members of the human race. The work of your Commission is an excellent example of what global health requires today: global partnerships for the creation of global public goods that will foster global understanding to help us address common global problems.

By taking a comprehensive approach, the Commission is placing health at the center of a broader social agenda and is therefore underscoring its larger value to the national and global goals of equitable development. In our turbulent world, health remains as one of the few truly universal aspirations. It therefore offers a concrete opportunity to reconcile national self-interest with international mutual interest. More today than ever, health is a bridge to peace, a source of shared security, a way to give globalization a human face. It is this kind of interconnection that lies at the heart of the Commission’s mandate. Such a comprehensive perspective was reflected in the words of a universal person, Dr. Martin Luther King Jr., who wrote in 1968: “It really boils down to this: that all life is interrelated. We are all caught in an inescapable network of mutuality, tied into a single garment of destiny. Whatever affects one directly, affects all indirectly.” I am certain that in your exciting work you will contribute to weave the destiny of better health for all the inhabitants of our common world.

Dr. Julio Frenk
Publication Contributors

Publication Coordination and Editing
Nicole Valentine

Copy Editing
Nicole Valentine
Bongiwe Peguillan

Contributors from the Secretariat of the Commission:
Sir Michael Marmot, the Commission Chair
Jeanette Vega

Ruth Bell
Chris Brown
Sharon Friel
Alec Irwin
Bongiwe Peguillan
Gabrielle Ross
Ritu Sadana
Sarah Simpson
Orielle Solar
Sebastian Taylor

Other contributors:
Civil Society Facilitators
Julio Frenk
Helena Nygren-Krug
Asako Hattori

Photographs:
Frances Baum
Bongiwe Peguillan
Orielle Solar

Layout:
Elmira Adenova

The views presented in this draft publication represent the editing staff’s interpretations of notes taken during the meeting and reviews of the presentation materials submitted by the presenters. Any errors or misrepresentations of opinions or facts are wholly the responsibility of the editors.