

SEA-HE-190  
Distribution: General

# Social Determinants of Health

*Report of a Regional Consultation  
Colombo, Sri Lanka, 2–4 October 2007*



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New Delhi, March 2008

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## Executive summary

Dramatic inequalities in health and healthcare exist worldwide. These inequalities are sharper in the developing world, including countries in the WHO's South-East Asia Region. There is concern about the double burden of disease faced by Member countries in the South-East Asia Region along with new health threats from avian influenza, climate change and natural disasters. A majority of health inequalities between and within countries are avoidable and, hence inequitable. There is a need to examine the embedded societal causes to understand the basic causes of the diseases and unhealthy behaviours. Disaggregating the prevailing morbidity and mortality patterns across the countries exhibits the social gradients for health outcomes and in the use of health systems. Member countries in the Region are not much different in this kind of social patterning of health. Technical solutions are not enough to tackle the growing disease burden. Realizing this hiatus, WHO established the Commission on Social Determinants of Health in 2005 to study this issue thoroughly through intensive campaigns, consultations, and by establishing knowledge networks to generate evidence from related good practices.

With the above background, the present Consultation on Social Determinants of Health was organized with the following objectives.

- (1) To present the work of the WHO Commission on Social Determinants;
- (2) To share experience on health inequities and social determinants from selected countries of the Region;
- (3) To make recommendations to Member countries and WHO for strengthening the work on addressing social determinants of health.

The consultation was held in Sri Lanka from October 2-4, 2007 and was attended by 42 participants and resource persons, including one Commissioner, two WHO staff members representing Headquarters and 29 participants from nine countries in the Region. After three days of exhaustive deliberations on the identified themes, it became clear from the country experiences, commissioned country studies, and group work that health inequities exist in the Member countries on social determinants like wealth, education of mother, health system access and utilization. Expanding coverage to the population tends to reduce

inequality. Income is not solely responsible for inequalities. Decomposition analysis reveals that other factors come into play as well. Health gaps are striking between rich and poor; between rural and urban and between the advantaged and marginalized groups of society. These need to be bridged by social actions. Partnerships with various stakeholders in health help to reduce health help the costs get reduced and also there is a sense of ownership of health interventions.

The participants were concerned over certain gaps in the interim statement. Knowledge networks have been organized in nine thematic areas and more region/country specific knowledge/experiences can be considered. The strengths/weaknesses of the interim statement need to be understood before final recommendations can be made. There is a strong need to explain the conceptual framework while describing and explaining relationships within and the pathways by which social determinants influence health outcomes.

Based on group work and other discussions, specific recommendations were made for consideration by Member countries, civil society and WHO. Also, key Elements (Strategic Directions) of a Regional Framework to address Social Determinants of Health were suggested.

# 1. Introduction

## 1.1 Background

During the World Health Assembly in 2004, the WHO Director-General announced the need for setting up a process to address the social causes of illness, health inequities and premature deaths and called for the establishment of a Commission on Social Determinants of Health (CSDH). The Commission was established in 2005 by the WHO Director-General to draw the attention of governments, civil society groups, international organizations and donors to address social conditions that affect health outcomes particularly among the world's most vulnerable populations. The specific goals of the Commission are:

- (1) To support health policy change in countries by assembling and promoting effective evidence-based models and practices that address the social determinants of health;
- (2) To support countries in placing health equity as a shared goal to which many government departments and sectors of society contribute;
- (3) To help build a sustainable global movement for action on health equity and social determinants, linking governments, international organizations, research institutions, civil society and communities.

The specific mandate of the CSDH from the WHO-Director General is to establish CSDH Country Stream Work intended to<sup>1</sup>:

- Organize knowledge to inform health policy and action on the social determinants of health (knowledge networks);
- Work with countries to promote, demonstrate and implement policies and programmes to tackle the social determinants of health in collaboration with country partners;

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<sup>1</sup> Strategy for the CSDH Country Stream of Work, WHO/EIP & CSDH, September, 2006.

- Work with civil society for social mobilization and long-term political sustainability of the social determinants of health agenda with its Regional Civil Society Representatives;
- Engage global institutions to include equity in health in their policies, increase investments towards action on social determinants of health;
- Develop the plan for institutional change at WHO so that it can also provide long-term support to countries in advancing the SDH agenda after the Commission has ended.

Addressing the World Health Assembly on 9 November 2006, Dr Margaret Chan, Director-General elect highlighted the need for WHO to lead a multi-pronged drive in addressing the social determinants of health, which are the root causes of health problems facing the world.<sup>2</sup>

Social determinants of health contribute significantly to premature death and diseases particularly among vulnerable groups such as women, children, the elderly and minority groups. Some of the critical factors that influence health include<sup>3</sup>:

- Increasing inequalities within and between countries;
- New patterns of consumption and communication;
- Commercialization;
- Global environmental change, and
- Urbanization.

The CSDH Commissioners held a meeting in the WHO Regional Office for South-East Asia (SEARO) on 15-16 September 2005 to introduce the work of the Commission and to request WHO/SEARO for its technical support under the country Stream Work. The Regional Director, South-East Asia Region (SEAR) appointed the Regional Adviser, Health Promotion and Education, as the focal point and the Department of Noncommunicable diseases and mental health (NMH) as the Secretariat. Since then, WHO/SEARO and CSDH have worked closely on planned activities at

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<sup>2</sup> WHO. Speech to the World Health Assembly. <http://www.who.int/dg/chan/speeches/2006/wha/en2006>

<sup>3</sup> WHO. The Bangkok Charter for Health Promotion, 2005.



country, regional and global levels to advocate for addressing social determinants of health. WHO/SEARO is collaborating with the WHO Kobe Centre (WKC), Japan, to address social determinants among urban populations. This work is being conducted under the Knowledge Network on Urban Slums (KNUS) under WKC, Japan. WHO/SEARO is also supporting the local Commissioner on SDH work in India. Sri Lanka has expressed interest in establishing a working group on SDH and WHO/SEARO has been providing technical support to this initiative. In February 2007, a joint SEARO/HQ mission was undertaken to Sri Lanka to support its work on SDH. This mission was able to develop a plan of action based on discussions and agreements with an inter-sectoral group comprising members from government, civil society and donors.

Countries in the South-East Asia Region have not been spared from the negative impact of socially determined health inequities due to exposure to health risks, social exclusion and broader determinants; and those associated with health risks including living conditions, work environment, unsafe sex and consumption patterns of food, water and information. A large proportion of the population in the Region also face social exclusion related to income, gender roles, education and ethnicity, among others. The broader social determinants of health include globalization, trade, intellectual property rights, air pollution. In summary, socially determined factors that influence health outcomes include rapid and often adverse social, economic and demographic changes that affect working conditions, learning environments, family patterns, as well as the culture and social fabric of communities.

Country and regional analysis is being undertaken through APWs with the Institute of Health Policy (IHP), Sri Lanka and the International Institute of Health Policy (IIHP), Thailand.

## **1.2 General objective**

To advocate placement of health equity as a shared goal of many government departments and sectors of society through an understanding of social determinants of health.

### **1.3 Specific objectives**

- (1) To present the work of the WHO Commission on Social Determinants;
- (2) To share experience on health inequities and social determinants from selected countries of the Region;
- (3) To make recommendations to Member countries and WHO for strengthening the work on addressing social determinants of health.

### **1.4 Expected outcome**

- (1) Commitment from representatives of other sectors of society and WHO; and
- (2) Salient recommendations to Member States and WHO for strengthening the work on addressing social determinants of health.

## **2. Business sessions**

### **2.1 Inaugural session**

Dr S.M. Samarage, Deputy Director-General (Planning) delivered the welcome address (see Annex 2 for full text) on behalf of the Secretary, Ministry of Healthcare and Nutrition, Sri Lanka.

The opening address of Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region was delivered by Dr S Puri, Acting WHO Representative, Sri Lanka. In his address, Dr Plianbangchang appreciated the vision and efforts of the former WHO Director-General, Dr Lee Jong-Wook, to set up the Commission on Social Determinants of Health (CSDH) with a specific mandate to promote a global agenda to address health and health equity through action on social determinants of health (SDH). This mandate was further affirmed by Dr Margaret Chan, the WHO Director-General, to continue supporting the work of the CSDH in order to address the social determinants of health which are the root causes of the disease burden and premature deaths across population groups.

The Regional Director expressed concern about the double burden of disease faced by the Member countries along with new health threats from avian influenza, climate change and earthquakes (see Annex 2 for full text). Such health concerns can be better addressed and tackled by the SDH approach as health inequities persist in the Region. SEARO has initiated several activities as part of follow-up action in order to advance the agenda of the Commission in the Region. These include (a) identification of a technical focal point in the area of Social Determinants of Health in the Regional Office, (b) establishment of a SEARO Working Group on SDH to provide guidance to the WHO Regional Office and countries in addressing issues related to social determinants of health, (c) establishment of a National Task Force on Social Determinants of Health in Sri Lanka, (d) the Bangalore Health Urbanization Project, (e) six country studies to analyze health inequities and (f) a case study on the Self-Employed Women's Association (SEWA) to examine and document the empowerment process and community action on addressing social and health inequities and inequalities among poor women.

The Regional Director also hoped that during the consultation, adequate time will be devoted to examining the experiences gained from following the Primary Health Care (PHC) approach and how it could be adapted to the current efforts to address the social determinants of health.

Dr Davison Munodawafa, Regional Adviser, Health Promotion and Education, WHO/SEARO, thanked the distinguished guests and introduced the participants (see Annex 4 for full list of participants). Dr Than Sein, Director, Noncommunicable Diseases and Mental Health, proposed the nominations for Chair, Deputy Chair and the Rapporteur. Dr Samarage was nominated as Chairperson and Dr Dorji Wangchuk, Director-General Health, Bhutan as Co-Chairperson. Dr Nilar Tin, Key Rapporteur, was assisted by Ms Rossukon Kangvallert and Dr Saroj Jayasinghe with the support of the WHO secretariat.

The agenda and the programme of the consultation were formally adopted.

## 2.2 WHO Commission on Social Determinants of Health (CSDH)

### *An overview of the work of the Commission*

Dr Michel Thieren, Senior Scientist IER/EQH, provided the update on the work of the Commission. His emphasis was on the recent progress in the Commission's work rather than a critique on the interim statement. The focus of the presentation was on the main five components of the Commission's work.

The Commission was established in 2005 for a three-year term to gather evidence, harness national and local efforts, detail what effective social action must entail in order to maintain, promote, and provide better health for all, advocate for change and engage with those responsible for health-related decision making.

While reviewing the work of the Commission, he observed that there is a strong social gradient when we relate health indicators like level of mothers' education and under-five mortality and likewise childhood stunting with household wealth and source of drinking water. Averages mask the gaps. There is a strong rationale for the social determinants approach to address and take social actions that reduce health inequities in large vulnerable population groups across countries.

He briefly elaborated the rationale, progress and accomplishments of the nine knowledge networks (KNWs) established by the Commission. These were on: Globalization; Women and Gender Equity; Social Exclusion; Employment Conditions; Early Child Development; Urban Settings; Health Systems; Priority Public Health Conditions; and Evidence and Measurement. The larger objective of knowledge networks was to generate evidence on the linkages between SDH and health outcomes. Macro recommendations of the KNWs are being finalized for the Beijing meeting. Dr Thieren also raised three questions that emerge from the conceptual framework for SDH.

- (1) Where do health differences among social groups originate, if we trace them back to their deepest roots?
- (2) What pathways lead from the root causes to the stark differences in health status observed at the population level?

- (3) Where and how should we intervene to reduce health inequities?

There is a strong need to add theoretical conceptual thinking behind describing and explaining relationships within, and pathways by which social determinants influence health outcomes. Looking at the health and SDH equation, it is obvious that health and health equity is a function of social determinants.

***CSDH interim statement: Overview and critique***

An overview of the key messages from the Interim Statement (IS) of the Commission was presented by Commissioner, Ms Mirai Chatterjee, Ahmedabad, India. The Commissioner noted the following:

- (1) There is significant improvement in health status indicators across the countries. However, inequalities and inequities in health and healthcare exist even with knowledge and technology gains. The dilemma as to why such gains are not translated in reducing social gradients in health remains a major challenge.
- (2) Health gaps are striking between rich and poor; rural and urban and advantaged and marginalized groups of society. These need to be bridged by social actions.
- (3) Various forms of injustice exist in society and these become the underlying causes of the health gaps. The Commission reinforces the thinking that we must look into the causes of such health gaps and only then inequities and disparities in health and healthcare can be reduced and mitigated across social and cultural groups. To produce evidence on such causes, the knowledge networks were commissioned and their findings are being incorporated in SDH.
- (4) How actions at various levels can implement the recommendations is being worked out. This forms one of the most important strategies to translate social theory into health results.
- (5) Empowerment of marginalized communities becomes crucial in this direction. Mahtama Gandhi's approach of "Anatodaya"

(development of all ) happens to be more relevant today while we address the question of equity in health towards the empowerment of the underprivileged.

- (6) Partnerships with various stakeholders in health are noticed to reduce health inequities as the costs are reduced and also there is a sense of ownership of health interventions.

### ***A critique on the CSDH interim statement***

Dr Saroj Jayasinghe (Sri Lanka) presented the critical analysis of the Interim Statement that formed the basis of the discussions that resulted in the recommendations from the WHO SEAR countries. There was unanimity regarding the positive contributions of the Interim Statement in the following areas:

- (1) The Interim Statement was found to express the vision and goals of the CSDH effectively and succinctly.
- (2) The Interim Statement was deemed a resource for stakeholders in terms of its provision of an intellectual foundation for the SDH approach.
- (3) The call for action “now” embraces the need for a global movement to tackle the root causes of inequities which is considered appropriate and essential.

However, the following weaknesses of the Interim Statement were identified:

- (1) There are several references and figures which illustrate that social stratification leads to gross inequalities in health outcomes. However, the examples used could have confounding variables and it is necessary to state that these variables have been taken into consideration.
- (2) The linkage between empowerment, SDH and inequalities is not clear. In fact, the conceptual framework presented by the Commission (and referenced in the text) does not have empowerment as an item to address. It is not even a part of the section on ‘Building a global movement for health equity’. Based on this omission, the plausible conclusion is that the

empowerment process is less understood within the CSDH. The recommendation would be to identify experts in empowerment discourse who are outside the health sector and have them provide the much-needed guidance.

Recommendations to CSDH on the Interim Statement:

- (1) Since most SEAR countries have a dominant private sector, the specific contribution and integration of this sector in addressing social determinants of health needs to be considered.
- (2) Addressing family structure and parenting as part of a social determinants approach is essential given the changes due to globalization, migration, changes in cultural values and working patterns among parents.
- (3) Social capital and/or social networks are not mentioned in the Interim Report and yet these are very critical for countries in the South-East Asia Region. There is a need to address the “causes of the causes” associated with the production of “socially determined” health outcomes which result from changes in cultural values and beliefs, patterns of food consumption, communication, and local and global relations among others . The Interim Statement appears to focus more on health equity issues and not much on the social aspects and their effects on health.
- (4) Individual and community empowerment is considered a key component to address social determinants of health. However, the Interim Statement’s contribution in this area is very weak. In fact, it is silent on the subject. The CSDH should identify experts in this area in order to strengthen the Interim Statement’s contribution.
- (5) War and conflict, and religion play a major role in health outcomes in SEAR countries and therefore, the Interim Statement should endeavour to address this aspect. There are associated sensitivities but that should not prevent the Interim Statement to recognize its importance.

### **2.3 Health inequities: Country and regional experiences (Presenters: Mr Amit Prasad and Ms Fazana Saleem-Ismail)**

Five studies were commissioned by WHO-SEARO to document the evidence on health and healthcare inequities in five selected Member countries (Bangladesh, India, Indonesia, Nepal, and Sri Lanka). Comprehensive findings of the studies were presented by Mr Amit Prasad from the WHO/Hq and Ms Fazana from the Institute of Health Policy, Sri Lanka. Summaries of the evidence-based Country Reports (Annex 1) and regional decomposition and discussion points from the presentations are stated below.

The comprehensive regional aspects based on five studies were presented in two parts. Ms Fazana presented a “Situation Analysis of Health Equity and Social Determinants of Health in the South-East Asian Region” and Mr Prasad presented the “Determinants of inequities in health indicators in the South-East Asia Region”.

The purpose of Ms Fazana’s presentation was to: (a) assess inequities in health and access to health services at the country level and (b) analyze trends in population averages and wealth inequities of health status and health systems indicators. She used an analytical approach to analyze trends in population averages and wealth inequities and conduct a comparative analysis of health outcomes in the Region. Health systems indicators like DPT3 vaccination coverage, skilled birth attendance coverage and contraceptive prevalence rate (for all married women) were used. For health outcome analysis, infant mortality rate, under-five mortality rate, stunting in children under five years of age, prevalence of underweight in women and prevalence of overweight in women were considered. Stratifies to assess differential outcomes included (i) sex of the child for IMR and U5R only, (ii) urban/rural residence (iii) mother’s educational attainment and (iv) household wealth quintile. The same parameters were used in the second presentation by Mr Amit Prasad. Averages and concentration index were used to exhibit country-specific inequalities against health system and health outcome indicators for various stratifiers. The major findings are as follows:

- Health disparities are seen among various social determinants.
- Disparities by income level are larger than disparities by urban/rural residence and educational level.
- Expanding coverage to the population tends to reduce inequality.



- Income is not solely responsible for inequalities. Other factors come into play as well. Decomposition analysis sheds light on these determinants.

Decomposition analysis on the above parameters by Mr Prasad was taken up due to the critical concerns like half of all 500,000 maternal deaths per year occur in South and South-East Asia. The countries in the Region contribute two thirds of the global burden of malnutrition. By using the CSDH framework a decomposition analysis was applied on health outcome and health systems indicators primarily to analyse skilled birth attendance and child malnutrition across selected countries. The analysis on skilled birth attendance revealed that:

- Socioeconomic position contributes to more than 50% of inequities in skilled birth attendance in all countries.
- Health systems factors (access and quality) had an important but smaller influence; accounting for 19-26% of inequities.
- Socioeconomic factors act as significant barriers preventing many or most mothers making use of provided services.
- Cost and distance affects the access to services.

Likewise, a discussion on inequities in childhood malnutrition revealed that:

- The key factor determining malnutrition is household wealth (in 3/4 countries), while the healthcare system plays a limited role.
- The contribution of socioeconomic factors to inequities is largely related to poverty and food insecurity.
- Healthcare behaviours and child care practices have an impact on inequities; though these are significantly lower than that of socioeconomic factors.
- Mother's education and presence of adequate sanitation facilities are the other important specific factors.

He further outlined the policy implications for the Region. Intersectoral action for health will be a key in addressing health inequities given the prominence of social and economic factors. Improving overall

access to health services and moving towards universal coverage is likely to reduce socioeconomic disparities. Improving food and income security is essential in those countries where child malnutrition inequities are high across socioeconomic groups.

#### *Key messages from discussants*

- Access to health care system cuts across most social groups and geographic locations and hence needs to be strengthened.
- Considering regional influences in social determinants, the regional disparities approach should be also considered to capture physical variation and the backward regions of a country.
- Data comparability, reliability, replaceability and desegregation are essential for producing scientific evidence in health policy related actions.
- Country-specific analysis is better than regional analysis for policy-related interventions. Contextual situations vary by countries' size, population composition, level of development and socio-cultural preferences.
- There is a need for revisiting the community-based health system, despite weaknesses of the past. In Bangladesh, the community referral system helped to reduce mortality.
- Socioeconomic determinants do not explain much about mass stunting in Sri Lanka, whereas for DPT coverage, infant mortality rate (IMR) and child mortality rate (CMR) reductions these mattered. Socioeconomic determinants do not have uniform impacts on health conditions.

## **2.4 Scaling-up actions on health inequity and SDH: Sharing of country experiences**

### ***Bangladesh (Presenter: Dr A.H. Munshi)***

In his presentation, Dr A.H. Munshi, provided information on some basic indicators of the country related to vital statistics, health status, health facilities, human resources and health budget. He identified 12 social

determinants of health including food security, reproductive health, prevalence of communicable and noncommunicable diseases, malnutrition among children, child and maternal health, provision of safe drinking water and sanitation, health and gender, access to healthcare, superstition and religious constraints and road traffic accidents. For each SDH, the strategic goal and implementation status were presented in brief. It was stated that health status and health care delivery in Bangladesh has improved over the last few years. Bangladesh is doing well on most health-related MDG goals, including nutrition. Areas where serious action is required include maternal mortality and neo-natal mortality. Health achievements could be enhanced using innovative approaches and strategies with a bearing on SDH and these could be considered by other countries and also by the Commission. These include:

- Advocacy for cleanliness and personal hygiene.
- Health-seeking behaviour change through active participation of NGOs in improved access to government hospitals and NGO-run clinics.
- Affect on smoking behaviour through legislative changes, taxation on tobacco and strong advocacy campaigns.
- Improved equity in health access due to introduction of health insurance, demand-led financing for maternal health and user-co-payment leading to reduction in misuse of facilities and medicines.
- Improvement in environmental health through legal ban on plastic bags, piped water supply to slums and commissioning of more deep tube wells.
- Women-friendly hospitals for antenatal care and treatment of complicated delivery cases.
- Revised National Drug Policy to keep vigilance and price control.
- Alternative health financing schemes for the poor, such as a micro-credit scheme.
- Enhanced budgetary allocation for health.

***Bhutan (Presenter : Dr Dorji Wangchuk)***

In his presentation, Dr Wangchuk described the uniqueness of Bhutan among Member countries with its geographical location, small size and population, land-locked location and homogeneous hill communities. The development philosophy of Bhutan is based on the “Gross National Happiness Index”. Even with its qualitative and abstract nature to measure performance, the index incorporates all elements of quality of life including health. Other countries have begun to appreciate the concept and are trying to incorporate its basic elements in their own health and other social policies. He further elaborated on the performance of certain fundamental health indicators. The country is now almost fully (90 %) covered with provision of safe drinking water which has helped in the eradication of anaemia among women by helping to reduce the hardships faced by them in collection of water. The government has charted a “Health Vision” policy framework wherein health equity concerns are adequately raised and are addressed by free health care to all and by decentralization of health services. The Government is using an innovative approach to help meet health needs of poor communities by raising a “Health Trust Fund” through donor support and contributions of civil society. The Fund is matched by contributions from the government on a 50-50 basis and the money is invested in bonds to ensure constant returns.

***India (Presenter: Ms Ganga Murthy)***

Ms Murthy stated that there has been overall improvement in the critical health status indicators in India. However, the healthcare system is plagued by inequities related to access, health spending and health outcomes. Inequities in health outcomes and healthcare access are still prominent on a rural-urban, regional, provincial, and wealth basis. She identified reasons for limited access to public healthcare services primarily as being non-availability of human resources, vertical disease-centric approach, and a fragmented approach to healthcare, low funding (maintenance), lack of regional priorities and widening inequalities. Ms Murthy informed about the paradigm shift in healthcare planning and delivery with the recent launch of the National Rural Health Mission. She further elaborated the key objectives, main approaches and core and supplementary strategies to achieve improved health outcomes.

The Mission has been launched with a view to bring about dramatic improvement in the health system and the health status of the people, especially those who live in the rural areas of the country. The Mission seeks to provide universal access to equitable, affordable and quality health care which is responsive to the needs of the people. The overall objective is to help India achieve goals set under the National Health Policy and the Millennium Development Goals. The objectives are to be achieved through the approach of community engagement, flexible financing, improved management, innovation in human resource management and by monitoring progress against established standards. There is scope within the Mission strategy to integrate other government programmes which seek to address socioeconomic determinants of ill health.

The discussants observed that by considering intense inequities in rural healthcare, the Government of India has launched the National Rural Health Mission with an intersectoral approach. The challenge is how to bring various sectors and existing health programmes together. It was also questioned that while the resources are not major constraints, governance needs to be strengthened for efficient delivery in public healthcare systems. Promotion of medical education is another important intervention along with other structural changes in healthcare systems.

***Indonesia (Presenters: Mr Naydial Roesdal and Mr Abdurachman)***

After a brief introduction about the country and its health infrastructure, Mr Roesdal identified the prevailing health inequities in Indonesia. These emanate from the geographical, economic, cultural and information gaps due to the isolated and scattered nature of the multi-island country. The challenge is how to bridge these gaps. Actions to increase equity include:

- Posting doctors and midwives in backward areas with special incentives.
- Special aid for construction of health facilities, medical equipment, mobile health centres or ambulances.
- Implementing a poor people health insurance scheme (as a subsystem of Social Health Insurance).
- Introducing a programme of cheap drugs for people.

- Developing a partnership between midwives and traditional birth attendants for the MCH programme. Shifting the role of TBA to neonatal care.
- Providing electricity, public TV or radio, newspapers (by other ministries).

These actions have resulted in much improved utilization of health services by the poor.

***Maldives (Presenter: Mr Hassan Akhtar)***

Mr Akhtar described the unique nature of the country as it comprised over 2 000 islands and a population of 300 000. Agriculture is practiced only on 1% of the total land area and imports predominate in the share of the national economy. Culturally and ethnically it is most homogeneous as Islam is the predominant religion and Muslims constitute 100% of the population. He further stated that the cost of living is very high and social services like healthcare are largely provided by the government. The budget allocation for health sector at 11% is perhaps among the highest in the South-East Asia Region. To ensure effective healthcare delivery and improvements in health, a Health Master Plan (2006-15) is in place.

The homogeneous nature of the country leaves less scope for social gradients on health outcomes. In Maldives economic determinants are more important than social as inequalities and disparities exist only on the basis of income. Despite the isolated location of islands, access to health services is not a serious issue as speedboats connect the islands with frequent service. Sustainability of health service is a problem due to the high cost of healthcare infrastructure. This is being compensated by the involvement of the community (community activism) in primary health care. Educating mothers in basic health needs has been a successful initiative of community involvement. The common people suffer from food insecurity which is affecting their nutritional status. Environmental health issues related to water scarcity are increasing. Tourism has not affected the quality of health services for the islanders as tourists generally stay at health resorts.

**Myanmar (Presenter: Dr Nilar Tin)**

Despite the success stories of leprosy elimination and wide coverage of water and sanitation, the country faces epidemiologic, demographic, economic and privatization transition. The country has made several innovative strides as follows to improve health and healthcare of the people:

- Introduction of user charges and since then direct out-of-pocket payments by households have been a major source of financing health in Myanmar.
- Mechanisms for protection of the poor have been looked through exemptions and establishment of trust funds in all hospitals.
- Exploring the need for community health insurance scheme for the long run.
- The success of the malaria control programme is due to the partnership approach with UN agencies, bilateral partners, national and international NGOs and local communities.
- Development of micro-finance projects to generate income for women of reproductive age group.
- Anti-poverty programmes are oriented towards improving health of women and children.
- For early childhood development, the expanded programme for immunization has been given a special boost.
- Advocacy for adding iodine to salt was started in 1996.

**Nepal (Dr Babu Ram Marasini)**

Dr Marasini highlighted the inequities in health and healthcare associated with gradients in social conditions and geographical location. The high death rate among women and children, vast differentials in child mortality related to geographical location, caste and income status attest to the social and geographical gradients in health and healthcare. Nepal has initiated health sector reforms since 2000 to bring equity, efficiency and effectiveness in the health sector. The reforms are also linked to the poverty

reduction strategy and to the Millennium Development Goals. The major objectives are to (a) increase coverage of essential health care services with a safety net for the poor and vulnerable population, (b) decentralized management of health services and (c) build public-private-partnership. The reforms were related to both health and non- health sectors ensuring intersectorality in health care. Non-health sector reforms include empowerment of women, incentive to parents and girls for joining school and formation of local health facility management committees, with predominance of women members. The reforms have demonstrated the following health achievements in the last five years:

- Contraceptive prevalence rate increased from 39% in 2001 to 48% in 2006
- DPT3 immunization increased from 72% in 2001 to 85% in 2006
- Anaemia in pregnancy reduced from 78% in 2001 to 36% in 2006
- Stunting in under-five children reduced from 58% in 2001 to 48% in 2006, though wasting increased from 8% in 2001 to 12% in 2006
- Maternal mortality ratio reduced from 539 (1996) to 281 (2006)/100,000 live births
- Infant mortality rate reduced from 64 in 2001 to 48 in 2006
- Child mortality reduced 79 (2001) to 61 (2006)/1000 live births
- Life expectancy increased to (62.5 years) and the average life expectancy of Nepalese women became equal to Nepalese men.

Nepal has identified health sector reform at the national level and local self-governance and decentralization at the local level as the major strategy to overcome the intersectoral and cross-cutting issues in delivering health services.

***Sri Lanka (Presenter: Dr Saroj Jayasinghe)***

In the presentation Dr Jayasinghe conceptualized development or scaling-up of sustainable action to address health inequities using a SDH approach



and a combination of primary health care (PHC) and intersectoral action (ISA) within this framework. Assumptions behind the framework include (a) Equity as an explicit and key objective of policy, (b) SDH as an approach to narrow inequities and (c) PHC and intersectoral action as strategies. He further tried to develop the framework for SDH with clear goals, objectives and targets. To achieve results, these concepts should be clearly defined. The framework should specify strategies (of PHC and ISA) which are linked with policies and plans and monitoring and evaluation mechanisms. He concluded that to scale-up sustainable action on health inequities using a SDH approach we need: Several prerequisites before this happens; PHC and intersectoral action as two strategies within the health sector to address SDH; and SDH approach to look beyond the health sector.

***Thailand (Presenter: Mr Supon Limwattananon, supported by Ms Phandhipaya Dharmasaroja and Mrs Rossukon Kangvallert)***

Empirical evidence on achievement of equity in health in Thailand during recent years was presented. Four dimensions of health systems including health status, health risk behaviour, health care utilization, and health financing were covered. Indicators of the population health focused on under-five mortality rate, infant mortality rate, and prevalence of child illnesses (diarrhoea and suspected pneumonia) and malnutrition (underweight, wasting, and stunting). For health risk, the selected indicators included prevalence of smoking and alcohol drinking. Healthcare utilization measures covered ambulatory visits and hospital admissions specific to types of health care facilities. Health financing was monitored by the direct payment for health of households as compared with the government expenditures or 'who pays'. The analyses focused on distribution or concentration of the measures in each health dimension with respect to four groups of equity stratifiers, including geographic, demographic, social, and economic characteristics of the population or households. Since Thailand has achieved a universal health care coverage for over 90% of the population through three major public health insurance schemes, disparity in certain health dimensions, for example, health resource utilization in selected disease conditions across the insurance schemes was also demonstrated.

Two lessons can be drawn from the Thai experience on health equity achievement. To monitor and evaluate the health systems, two major sources of data have contributed to the equity analysis. The first group

includes the primary survey of nationally representative households. These include (1) Population Census which is conducted every 10 years for [under-5 mortality rate (U5MR) and infant mortality rate (IMR) monitoring]; (2) Maternal, infant and child survey (MICS) for maternal and child health and health care accessibility; (3) Socio-Economic Survey (SES) (to monitor equity in health financing, catastrophic and poverty impacts of health payments, and public subsidy of health expenditure); and (4) Health and Welfare Survey (HWS) (for health care utilization, health risk behaviour. With a major contribution by the National Statistical Office (NSO), all these survey data are regularly produced for health equity analysis. The second group is facility-based reports and records. They have been used mostly when the equity analysis focused on certain specific health conditions and diseases. Achievement of equity in healthcare utilization and financing in Thailand can be traced as a consequence of two major milestones: A nation-wide establishment of fully functional district hospitals with competent health professionals (medical doctors (MDs) and regional nurses (RNs), in particular) at the district health level in 1977, and the universal coverage (UC) implementation in 2001.

#### *Key messages from discussants*

- Community-based health data can be generated by committed organizations and can supplement data from other sources.
- Health equity can be influenced and addressed by quality of health infrastructure and committed health manpower. Committed young doctors in Thailand have made the difference to develop a kind of universal health care coverage.
- The public sector is mostly used by the poor and has reduced health inequity.
- Investment in health care can reduce inequity in health financing.

#### **Field visit**

On the second day, the participants visited “The Sarvodaya”, an NGO whose social activities are largely spread over Sri Lanka. The Sarvodaya Sharamdan Movement (awakening of all through shared labour) is a unique people’s self-help organization that takes integrated an, holistic approach to

development, peace and spiritual awakening. From its early beginnings in a rural village it has grown to cover more than 13,000 villages throughout the island, with supporters around the world. The movement promotes human-centred development to improve the quality of life, including health, of the poorest people in the country. Its methods are designed to preserve traditional Sri Lankan values. Believing that development should focus on uplifting all people in society, Sarvodaya has a history of promoting self-reliance rather than dependency. It enables and empowers people to take responsibilities for planning their own future.

Sarvodaya has identified 10 basic needs including basic health care, a balanced diet, clean and adequate supply of water, a simple house to live in and well rounded education to empower village communities for overall development. The participants were introduced to the work of the movement through two presentations and were shown various institutions where work is carried out.

## 2.5 Civil society experiences

### ***Building community action to address social determinants through women's Empowerment-SEWA Study (Dr Surinder Aggarwal and Ms Sapna Desai)***

The Self-employed Women Organization (SEWA), with a membership of close to one million across India empowers self-employed poor women to gain social (health, education and housing) and economic (employment, banking, marketing) security. Health security was found to be fundamental to economic security and SEWA, through various health activities attempts to empower women for work and income security. Members' ability to work was found to be impaired by their own ill health or the poor health of family members. Health care services were found to be lacking and SEWA stepped in to provide and strengthen preventive and curative health care. Preventive health care primarily includes health education and awareness, immunization and micronutrient supplements to expectant mothers and health insurance. Curative care includes improved physical and financial access to health care provided by trained health workers (barefoot doctors and other paramedics) and the sale of low-cost, western and indigenous medicines. VIMOSEWA, a health insurance cooperative, offered health collective insurance packages to SEWA members and their families at an affordable cost to meet primarily emergency health needs. Likewise, the

Mahila Housing Trust offers loans to purchase a house or for expansion and improvement of an existing house. It also partners other organizations to improve the quality of life and enhance the income generating capacity of slum dwellers through assured provision of drinking water, sanitation and power.

The secret of SEWA's success lies in its organizational structure and its strategy of networking and forging partnerships with other like-minded agencies. Its organizational strength comes not only from its large membership but also from the fact that most of its leadership is derived from among its grassroots members. Its partnership with governmental and nongovernmental agencies has worked to its own advantage and also to the advantage of its partners and their beneficiaries. It has also networked successfully with other organizations working in similar areas to advocate the cause of its members and lobby for favourable policies and legislation at national and international levels. It has adopted an intersectoral approach to produce synergy among its various wings to benefit members in an integrated manner.

The study clearly establishes that access to micro-finance, secured full employment; improved housing with access to water and sanitation; preventive and low cost curative health care at the doorstep can empower the weaker sections of society and, in turn, improve the health of all community members. These emerge as the best determinants of health from the SEWA study. Capacity building, partnership, networking and self-reliance remain the primary instruments of change.

#### *Key messages from discussants*

- Replaceability of an experience like SEWA is possible only in a few components, not in totality
- Cost effectiveness of health interventions should be done on the basis of scientific study
- Sustainability of the social movement in sectors like health is through commitment and ownership of the members
- Community organization is central to the success.

## 2.6 Experiences from the knowledge networks of the CSDH

### *Early child development (Dr Frank Oberklaid)*

An estimated 200 million children fail to reach their full potential. They are 'stunted' physically, cognitively, or social-emotionally because they do not receive adequate nutrition, consistent loving care and opportunities to learn. Early intervention efforts for disadvantaged children can lead to improvements in children's survival, health, growth and social-emotional development. The health care system has an important leadership role in addressing the social determinants of health as they affect young children. Early childhood is a strategic place to begin the broader agenda of social determinants. There is a strong research base, sound economic case and it is non-ideological by nature. Dr Oberklaid elaborated on aspects such as brain development, research findings and the importance of environmental factors in influencing outcomes. What happens in early childhood has life-long implications and consequences. Two sets of environmental and proximal factors affect the growth and mental development in early childhood. This is where the interventions are required for policy and action levels. Some recommendations at global, structural and implementation levels from the Report on Knowledge Network on Early Childhood Development are as follows:

- Global Alliance for ECD – WHO, UNICEF, World Bank, Consultative Group on ECD, Bernard Leer
- Foundation, Soros Foundation, Aga Khan Foundation etc
- WHO has been important advocacy role in early childhood development (ECD)
- WHO recognizes that ECD is critical for achieving the Millennium Development Goals
- WHO should provide technical support to regions, countries and partners for integration of ECD interventions (e.g. IMCI-CDI) into health services
- WHO should gather data about ECD and the effectiveness of interventions

- Local, regional and national governments should incorporate the 'science of early child development' into policy – an inter-ministerial framework that clearly articulates the role of each sector
- Child and family friendly policies – employment, food security, financial support, child care
- Create opportunities for professional training and research in ECD
- Incorporate ECD into existing child survival and health programmes
- Develop strategies for 'scaling up' effective programmes
- Ensure all children are enrolled in school, that gender inequalities in schooling are eliminated, and that schooling is free and compulsory.

*Key messages from discussants*

- Notwithstanding the long-term impact of early childhood development intervention, where should we intervene with respect to SDH.
- Cost-effectiveness of investment after five years of childhood if maximum brain development happens during the first five years of life.
- How to integrate ECD in health systems in Member countries, considering its neglect in many health policies?
- How to address the issue of ECD when teenage and un-wed pregnancies are increasing?
- Consider cultural differences in child development.
- Impact of maternity leave on ECD needs to be emphasized and encouraged.
- Childcare by family and community members for working mothers needs to be acknowledged in SDH

- Health care investments during ECD pay long-term, life and economic returns and therefore ECD can be a politically acceptable social determinant.
- In developing societies, technological evidence on health impacts needs to be tackled carefully.

***Promoting health equity through healthy urbanization***  
***(Dr Jostacio M. Lapitan, WKC, Japan)***

The goal of the project was to reduce health inequity in urban settings by developing and demonstrating the applicability of strategies and by building capacity. Interim results and key messages of the Knowledge Network on Urban Settings (KNUS) in Chile, China, Japan, India, Kenya and Tunisia were presented.

- (1) Urbanization can and should be beneficial for health. Health outcomes are better when city government leaders and policies address the key social determinants of health. In developing countries the best local governance can help produce 75 years or more of life expectancy; with bad urban governance, life expectancy can be as low as 35 years.
- (2) Better housing and living conditions, access to safe water and good sanitation, efficient waste management systems, safer working environments and neighbourhoods, food security, and access to services like education, health, welfare, public transportation and child care are examples of social determinants of health that can be addressed through good urban governance.
- (3) Failure of governance in today's cities has resulted in the growth of informal settlements and slums that constitute an unhealthy living and working environment for a billion people. National and local governments have a role to play in 'healthy urban governance'. A credible health agenda is one that benefits all people in cities, especially the urban poor who live in informal settlements.
- (4) International agreements calling for urgent action to reduce poverty such as the Millennium Development Goals can only be

met through national urban development strategies that involve local governments and the urban poor themselves.

- (5) Health inequalities in urban areas need to be addressed in countries at all income levels. Urban development and town planning are keys to ensuring health equity in cities. The health sector needs to work with other sectors and civil society to undertake bold and urgent measures to improve urban health.
- (6) Half of the world's population lives in urban settings. Achieving healthy urbanization in all countries is a global and shared responsibility. The elimination of deprived urban living conditions will require resources – aid, loans, and private investments – from more affluent countries. The funding required is in the order of \$200 billion per year, which is no more than 20% of the annual growth of the GDP in the high income countries.

Finally, the entry points for responses include slum-upgrading, urban primary health care, healthy cities/settings, local government and urban/metropolitan planning and national policy and decision-making.

### ***The Bangalore healthy urbanization project (Dr P.S. Thandava Murthy)***

The highlights and various components of the project were presented by Dr Murthy. Globally, the project is known as 'optimizing the impact of social determinants of health on exposed populations in urban settings for 2006-2007". Six healthy urbanization field research sites selected in San Joaquin (Chile), Kobe/Hyogo (Japan), Suzhou (China), Ariana, (Tunisia) and Nakuru, (Kenya) also includes Bangalore (India). The project is partnered by Bengaluru Mahangar Palike (BMP)-WKC-WHO/SEARO, civic society and academia. Bangalore was chosen as it had initiated programmes towards wellness and established healthy life style centres in collaboration with WHO, India office, Commonwealth Association for Mental Handicap and Development Disabilities (CAMHADD) and other partners and the city already has a sound health promotion policy.

According to a study, the key social determinants responsible for health inequities in exposed populations of Bangalore were found to be low income levels and poverty; low educational and employment opportunities; lack of housing (along with individual and public toilets);



water supply and sanitation and safety and security of women, children and the elderly. The project working strategy is through seven Healthy Urbanization Learning Circles (HULC). HULCs are networks of multi-sectoral and interdisciplinary teams that undertake action research projects on selected SDH. The meaning of SDH is difficult for partners to understand, however through training they have begun to appreciate the benefits of this approach of low cost interventions for long-term health gains.

*Key messages from discussants*

- Failure of governance in cities has led to the growth of slums and unhealthy conditions.
- It is difficult to convey the meaning and merits of SDH to other related sectors and partners.
- Cost sharing by budgetary allocations among partners can bring sustainability to major urban projects.
- Intersectorality, leadership qualities and good governance are essential parameters in selecting an urban project to achieve health equity in disadvantaged urban settings.

***Employment conditions (Dr Charles Muntaner)***

Dr Muntaner elaborated the importance and relevance of “Employment Conditions” Knowledge Network in understanding the health implications of workers in their working environments. He stated that more evidence exists on this dimension in the Western developed world as early industrialization impacts were experienced there. The developing economies like India and China and many transition economies are undergoing big socio-economic transformation and must learn from the experience of the West. He has used the welfare and social movement approach in his larger study to understand the cause’s approach of SDH. He concluded that power relations are important to understand the employment conditions at workplaces. Employment conditions lead to working conditions which, in return, translate into health inequities. There is sufficient evidence that justifies interventions at the workplace level to improve health at least of the low paid workers.

*Key messages from discussants*

- Social relations between the employer and the employee need to be understood in a systematic manner.
- Health needs of home-based workers need to be addressed in the developing countries in the same manner as for those in formal employment.
- There is a need to understand labour market relations in the case of home-based workers vis-à-vis formal workers. Understanding of such relations is important if this were to contribute towards health interventions; and
- How can informal workers realize health benefits since they contribute to the economy?

## **2.7 Group work: Strategic directions and recommendations**

Group work discussions focused on identifying actions necessary for addressing factors outside the jurisdiction of the Ministry of Health so that there could be tackled effectively in order to achieve desired outcomes. Each group identified specific action-oriented recommendations for Member States, civil society and WHO. A summary of the strategic directions and final recommendations are presented below:

***Strategic directions for addressing social determinants of health***

- Placing SDH high on the agenda of all government departments and not limited to MoH alone;
- Establishing mechanisms for assessment, planning, implementation and monitoring of health inequities and SDH at all levels, and across sectors and public health issues;
- Empowerment of communities and individuals to initiate and sustain local action in addressing SDH. The Primary Health Care approach shall guide all community-based activities;
- Consensus building at regional and country levels regarding the priority social factors that are essential for health and health equity, and the strategies required;

- Instituting pilot models for generating evidence regarding the impact of health inequities and SDH across population groups, and the effectiveness of interventions.
- Establishing partnerships to address health inequity and SDH through alliances and networks. Countries in the Region could consider setting up either a Working Group or National Commission on SDH;
- Innovative financing and resource mobilization for activities addressing health inequity and SDH;
- Greater coordination within WHO to achieve coherence of messages and actions as a follow-up to the recommendations of the Commission on Social Determinants of Health (CSDH).

### ***Recommendations***

#### *Member States*

- Establish national institutional mechanisms to coordinate and manage inter-sectoral action for health in order to mainstream SDH and health inequities across sectors.
- Establish a Regional Working Group within and between the countries of SEA Region to provide guidance in policies, planning, implementation and monitoring of efforts to reduce health inequities and address SDH;
- Generate and report disaggregated national data on health inequities routinely and to apply the data in making policy and programme changes;
- Build national capacity to address advocacy, intersectoral action and evidence gathering for health equity and SDH across sectors including priority public health issues e. g., MCH, NCD, CDS and new health threats;
- The ministries of health should sensitize their respective governments on the utility and relevance of addressing health inequities and SDH;
- Revisiting the primary health care (PHC) concepts in order to strengthen inter-sectoral action for addressing SDH at community level.

### *Civil society*

- Set up a regional SDH network to exchange local, regional and global experiences about health equity and social justice resulting from SDH;
- Integrating experiences of civil society groups in advocacy and community mobilization into national and local community actions to address SDH;
- Develop and publicize innovative models to address health inequity and SDH at community level involving sectors outside the Ministry of Health.

### *WHO*

- Integration of the SDH approach in the work of WHO with primary focus on strengthening intersectoral action at national and community level;
- Facilitate and provide an enabling environment for governments and civil society to achieve their goals related to addressing SDH across sectors;
- Strengthen capabilities of MoH to provide leadership toward establishing and sustaining intersectoral action to address factors that contribute to health outcomes but exist outside the jurisdiction of MoH;
- Bring SDH into the agenda of other UN agencies and other international organizations in order to mobilize financial and technical resources;
- Greater coordination within WHO to achieve coherence of messages and actions as a follow-up to the recommendations of the Commission on Social Determinants of Health (CSDH).

## **3. Closing session**

Dr S.M. Samarage, Deputy Director-General (Planning), Ministry of Healthcare and Nutrition Sri Lanka thanked WHO-SEARO for its support in organizing this event, Ms Mirai Chatterjee, Commissioner, CSDH for her presence and sharing views on the Interim Statement and interventions,

officials from WHO-HQ for their observations on the interim statement and presentation of country studies, and Dr Borra , WR Sri Lanka for logistic and other technical support. Dr Samarage was happy that the objectives of the consultation were achieved through exhaustive deliberations over three days.

Dr Michel Thieren, Senior Scientist, IER/EQH from WHO-HQ was appreciative of the focused recommendations. He thanked the Commissioner for her presence and for sharing views on the Interim Statement and the work of the CSDH. He underlined the importance of the consultation in this Region due to the prevailing social gradients in health and health care that emerged from various country studies. From that perspective, it is important to understand and act on SDH. Due to fast economic growth in many countries of the Region, wealth and disparities are growing and that strengthens the relevance of the SDH approach here.

Dr Davison Munodawafa thanked the officials and staff from the Ministry of Healthcare and Nutrition Sri Lanka, the Commissioner CSDH, the participants representing SEARO Member countries, officials and staff from WHO and resource persons for their cooperation and support towards achieving the objectives of the consultation.

On behalf of the participants, Dr Dorji Wangchuk thanked the organizers for giving them the opportunity to share their experiences and views on such an important theme on equity in health issues in the Member countries and for a comfortable stay in Colombo.

Dr Puri, Acting WHO Representative, Sri Lanka, thanked the Government of Sri Lanka, Member States, participants and the WHO secretariat for their respective contributions in ensuring a successful consultation.

## **Annex 1**

# **Welcome Message from the Secretary Ministry of Healthcare and Nutrition, Sri Lanka**

Distinguished Participants, Ladies and Gentlemen,

I am indeed privileged to deliver the welcome speech at the inauguration of this Regional Consultation on Social Determinants of Health. This is the second WHO South East Asia Regional Consultation on this subject and I am very thankful to the organizers for selecting Sri Lanka to host this important event. On behalf of the Ministry of Healthcare & Nutrition of Sri Lanka, I wish to extend a warm welcome to each and every one of you the resource persons, participants and organizers for this important consultation. A very special welcome to the WHO staff from headquarters and the Regional Office, and all the foreign participants and resource persons from the regional countries.

The Global Commission on Social Determinants of Health, supported by the World Health Organization, was launched in March 2005. The broad objectives of the Commission were to source and collate evidence across countries globally on the impact of social conditions on health, and to recommended interventions and policies to improve health and narrow inequalities through action on social determinants.

As we all know, we, the Member States in the South-East Asia Region are faced with the double burden of diseases and demographic transitions. We have to face disaster situations like earthquakes, tidal waves and conflict situations which will have a serious impact on the health of our populations. We are facing the challenges of providing the optimal healthcare especially to members among vulnerable population groups. Most of these challenges we face today are determined and influenced by a number of socioeconomic factors such as globalization, urbanization, environmental changes etc. They have caused inequalities within the countries and even between countries. The change of lifestyle, shift of cultural values, norms and beliefs and advancement of communication techniques all have added to the social determinants of health. Hence, the social determinants of health will have to be paid enough attention.

The Ministry of Healthcare and Nutrition expects this regional consultation would give an opportunity for participants to develop a better understanding on social determinants of health , share the experiences of and make the recommendations to Member countries and WHO for strengthening the work on addressing the social determinants of health.

I wish the deliberations all success and a very pleasant stay in Sri Lanka for our overseas delegates.

## **Annex 2**

### **Message from Regional Director WHO South-East Asia Region (delivered by Dr S. Puri, Acting WHO Representative, Sri Lanka)**

Distinguished participants, ladies and gentlemen,

I have great pleasure in conveying warm greetings from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, who is unable to attend this consultation due to prior commitments. I have the privilege to deliver his inaugural address. I quote:

WHO, together with its partners, is determined to identify the causes leading to the rise in disease burden and premature death in Member countries of the South-East Asia Region. This meeting, organized by WHO, seeks to:

- (1) Present the work of WHO's Commission on Social Determinants of Health;
- (2) Share experience on health inequities and social determinants from selected countries of the Region;
- (3) Make recommendations to Member countries and WHO for strengthening the work on addressing social determinants of health.

The former WHO Director-General Dr Lee Jong-wook set up the WHO Commission on Social Determinants of Health (CSDH) in March 2005 with a specific global mandate to promote a global agenda to address health and health equity through action on social determinants of health. This followed the realization of the growing inequities and inequalities between and within countries resulting in poor health outcomes particularly among vulnerable population groups such as women, children, the elderly and displaced persons or minority groups. In a speech to the World Health Assembly in November 2006, Dr Margaret Chan, Director-General (elect) pledged to continue supporting the work of the CSDH in order to address the social determinants of health which are the root causes of the disease burden and premature deaths across population groups.



The specific goals of the Commission are:

- (1) To support health policy change in countries by assembling and promoting effective evidence-based models and practices that addresses the social determinants of health;
- (2) To support countries in placing health equity as a shared goal to which many government departments and sectors of society contribute;
- (3) To help build a sustainable global movement for action on health equity and social determinants, linking governments, international organizations, research institutions, civil society and communities.

As you may be aware, the Commission was given a three-year term to achieve its objectives. It has 18 Commissioners and is headed by Dr Michael Marmot. From the WHO South-East Asia Region, we have Ms Mirai Chatterjee, Coordinator of Self-Employed Women's Association (SEWA) as a Commissioner and I wish to take this opportunity to acknowledge and recognize her presence in this meeting.

Distinguished Ladies and Gentlemen,

Some members of the Commission visited the WHO Regional Office for South-East Asia on 15 and 16 September, 2005. Since then, the Regional Office has initiated several activities as part of follow-up action in order to advance the agenda of the Commission in the Region. In this context, I wish to highlight that a technical focal point in the area of Social Determinants of Health has been identified in the Regional Office. The Director, Noncommunicable Diseases Department (NMH) has been designated as the Coordinator with Health Promotion and Education (HPE) Unit as the Secretariat. Further, a SEARO Working Group on Social Determinants of Health has been established to provide guidance to the WHO Regional Office and countries in addressing issues related to social determinants of health.

Several other specific activities have been undertaken such as the Joint Mission to Sri Lanka in February 2007 resulting in the establishment of a National Task Force on Social Determinants of Health. In October 2006, the city of Bangalore was selected as one of the six cities in the world to implement the Healthy Urbanization Project to address social determinants of health in urban settings. The Bangalore Health Urbanization Project has been jointly undertaken by the Regional Office for South-East Asia, the WHO India country office, the WHO Kobe Centre, Japan, and Bangalore Municipality and its partners.

Recently, WHO commissioned country studies to analyze health inequities in six countries of the South-East Asia Region using the Demographic Household Survey and Population Census data. Also, a case study on Self-Employed Women's Association (SEWA), was conducted to examine and document the empowerment process and community action on addressing social and health inequities and inequalities among poor women.

Distinguished participants,

The Commission on Social Determinants of Health has been the major driver of this initiative and recently released its Interim Statement highlighting the key preliminary findings. The Interim Statement attempts to set the stage for the recommendations and finalization of the Commission's work and its final Report which will be released in January 2008. This Regional Consultation will discuss the Interim Statement and arrive at a common understanding as to what the Commission considers to be the essential issues. I have no doubt that you will give the Interim Statement a fair amount of time and attention, and most importantly arrive at a consensus regarding aspects of the statement which are relevant to our Region in terms of opportunities and lessons for addressing social determinants of health.

While we examine strategies for addressing the social determinants of health, I hope that in this Consultation, adequate time will be devoted to examining the experiences gained from following the Primary Health Care (PHC) approach and how it could be adapted to the current efforts to address the social determinants of health.

As is the case in most developing countries, we are experiencing a dramatic change in lifestyle with regard to food consumption patterns; a shift in cultural values and beliefs among societies; changes in communication and health information-seeking behaviour patterns; an alarming increase in childhood and adult malnutrition which combines both under-nutrition, obesity and overweight; an increase in unsafe sex resulting in a rise in HIV infections cases; consumption of alcohol, tobacco and other drugs, and an increase in suicides, depression and violence. In addition, countries in the Region are also reporting a huge disease burden e.g., diabetes, hypertension and cancer as well as the new threats to health due to avian influenza and climate change.

The main driving forces of social determinants of health include globalization, trade (commercialization), urbanization and environmental changes which have resulted in increasing inequalities within and between countries. The need for practical approaches to address these challenges becomes a priority and this consultation, I feel, should help in providing some solutions.

Distinguished participants, Ladies and Gentlemen,

Opportunities exist in our Region and also across the globe to address the social determinants of health. However, the challenge is to clearly delineate the approaches that would yield the greatest benefits for our communities. I would agree that, in addition to re-examining the Primary Health Care approach and its outcomes, the work of the nine Knowledge Networks established by the Commission should be the platform on which our knowledge base and future actions are built.

The Commission set out to establish how social action could be used for tackling inequities and other social determinants of health. This consultation should also pose the same question in relation to the Region and establish how factors operating outside the jurisdiction of the Ministry of Health could be tackled effectively. There is, therefore, a need to:

- Examine the stewardship role of the government in addressing social determinants of health in a globalized world. This should include policy coherence and coordination between related departments working outside the Ministry of Health and efforts to place social determinants of health on the national, regional and global agenda;
- Understand the stewardship role of the health systems as a driver for addressing social determinants of health;
- Contextualize human behaviour as it relates to disease burden and premature deaths. There is a need to invoke a socio-behavioural analysis approach in order to guide all health promotion interventions seeking to address social determinants of health e.g., food consumption patterns, health seeking behaviours and harm reduction among others;
- Gather and document the evidence related to the impact of social determinants of health using disaggregated data and other variations such as rural versus urban; children, adults and the elderly.

The South-East Asia Region has expertise in countries in the form of individuals, research and academic institutions, and nongovernmental organizations to take forward the challenge of addressing the social determinants of health at all levels of society. WHO remains committed to support Member States in addressing the negative health outcomes caused by social determinants of health.

### **Annex 3**

## **Summary of country studies**

### **Bangladesh**

The data for this report was obtained from Bangladesh's Demographic and Health Survey, 2004. The Health indicators assessed are infant and under-5 mortality, prevalence of stunting in children and percentage of underweight and overweight women. Health system indicators include coverage of DPT vaccination, skilled birth attendance and current use of modern contraceptives.

All health indicators and health services indicators showed improvement during the period 1996-2004 period. There was also a general reduction in inequality. The gap between the rich and poor families was narrowing in the case of all indicators barring stunting in children and the percentage of underweight women. The use of decomposition technique to find the factors contributing to inequities in the presence of skilled attendants at the time of birth shows that health system factors are the most important contributors to inequity. The most important among them is receiving valid antenatal care and the quality of antenatal care. Socioeconomic status also accounts for inequities in use of skilled birth attendants, the major factor being the education level of parents.

The major determinant of inequities in stunting was the socioeconomic status determined largely by household wealth, parents' education, partner's occupation and exposure to newspaper and television. Health system factors such as quality of antenatal care, use of a skilled birth attendant and availability of valid antenatal care also contributed significantly to inequities in stunting.

### **India**

The analysis of inequities in health and access to health services in India is based on data obtained from the National Family Health Survey 1998-99. The indicators selected for analysis are infant and under-5 mortality, prevalence of stunting in children below 5 years, and the percentage of underweight and overweight women. The efficiency of the health system is assessed on the basis of the

percentage of children administered the DPT3 vaccine, percentage of births attended by trained personnel and the current use of modern contraception.

Infant mortality in India was reported at 73 per 1 000 live births while under-5 mortality stood at 101 per 1 000 live births in 1998-99. The gaps in health status on the above indicators showed clear social and location gradients with respect to high education of mother, general literacy levels and urban settings. Likewise, prevalence of stunting among children was twice as high in the poorest households and also in children of illiterate mothers. Rural-urban differences were also high. On other parameters of health status, underweight and overweight women also exhibited a strong linkage with their education and income levels and location.

Efficiency of health system coverage (DPT3 vaccine, presence of trained personnel at the time of birth, contraceptives use) is again noticed to be influenced by the gradients in socio-economic status (education level, economic status) and location of the users of health services. Major conclusions from the above studies and presentations include:

- Health disparities are seen across various social determinants
- Disparities by income level are larger than disparities by urban/rural residence and educational level
- Expanding coverage to the population tends to reduce inequality
- Income is not solely responsible for inequalities. Decomposition analysis reveals that other factors come into play as well.

## **Indonesia**

The present analysis is based on data obtained from Indonesia's Demographic and Health Survey 2002-2003. Infant mortality and under-5 mortality have been used to assess health while the extent of DPT vaccination coverage, presence of skilled personnel at the time of birth and use of modern contraceptives has been used to assess the health system.

Both infant mortality and under-5 mortality decreased during 1997-2003. However, while the poorest to richest ratio fell from 3.7 to 3.5 in the case of under-5 mortality, it increased from 3.4 to 3.6 in the case of infant mortality. There was a slight decline in immunization coverage and the poorest to richest ratio in this case increased from 1.6 to 1.8. There was a six-fold increase in the number of births

under trained supervision, accompanied by a steep fall in the poorest to richest ratio from 4.2 to 2.6. There was not much change in the use of contraceptives by women and the poorest to richest ratio also remained constant at 1.2.

A decomposition analysis shows that socioeconomic status and health systems factors together account for 97% of inequities in Indonesia. The major determinants of socioeconomic status that contribute to inequities are mother's education, partner's education and exposure to newspapers. The major health systems factors that contribute to inequities are: location (accessibility) of antenatal care, receiving valid antenatal care and the quality of antenatal care.

## **Nepal**

Nepal's Demographic and Health Survey, 2001 was the source of data for the analysis of inequities in health and access to health services in Nepal. The indicators chosen for the purpose are infant and under-5 mortality, incidence of stunting among children and the presence of underweight and overweight women as well as the percentage coverage of DPT3 vaccination, percentage of births attended by trained personnel and current use of modern contraception by women.

Between 1996 and 2001, there was a positive change in all indicators of health status except in the incidence of stunting in children. However, the poorest to richest ratio was either constant or showed an increase, indicating an increase in disparity between the poor and the rich. Again, while there was improvement in immunization coverage and contraceptive use (and a decrease in disparity), the percentage of births attended by trained personnel decreased from an already low of 10.1 in 1996 to a mere 6.7 in 2001 and the poorest to richest ratio increased from 11.6 to 12.5.

Health system factors accounted for more than 50% of inequities in skilled birth attendance, the most important of them being receiving valid antenatal care and the quality of such care. Socioeconomic factors like mother's education, partner's education and exposure to television are also important. The main socioeconomic determinants of inequity in stunting were the literacy status of the mother, source of drinking water, type of toilet facility and father's education. The most important health systems factor was the receiving valid antenatal care.

## **Thailand**

The report was based on a survey of 40,511 households in Bangkok and 75 other provinces in the country. Child health was assessed through mortality, common illnesses and the nutritional status of children less than five years of age and immunization coverage of children aged 12-23 months. The indicators chosen to assess women's health were maternal care for mothers who had children in the past two years and the use of family planning devices by married and non-pregnant women.

Babies with low birth weight were more common when mothers were less than 20 years or more than 39 years. They were less common among women who had completed secondary education but no definite relationship with economic status could be established. Geographically, more low-birth-weight babies were born to mothers in the south. Male children were more likely to be only breastfed up to the age of six months as compared to girls who were also given other nutrition. There was a strong gradient of breast-fed children with the education of mothers. The percentage of children who were only breastfed also varied with income, the highest being among those belonging to the second quintile and the least among the third quintile.

Prevalence of low-grade malnutrition among children is more common outside Bangkok metropolitan region and particularly high in the north-east and southern regions. The prevalence of stunting showed a similar pattern though wasting did not show as distinct a pattern. The incidence of all three degrees of malnutrition decreased with an increase in the education of mothers and an increase in economic status. The pattern of childhood immunization was quite uniform within the country. Two common childhood illnesses, diarrhoea and suspected pneumonia were found to be more frequent among boys than among girls. Both were less common if the mother was highly educated, if the household income was high and if the family lived in an urban area. Teenage pregnancy was found to be most prevalent among girls with no education, those in the poorest quintile, particularly in the rural areas.

Most pregnant women were taken care of by trained personnel. The proportion of women whose babies were delivered by skilled personnel increased with an increase in education and economic levels and was also higher in urban locations. While 75% of married women who were not pregnant were using some modern method of contraception, a relatively higher percentage of the more

educated and economically better off women preferred to use natural methods of birth control.

It was found that health disparities in Thailand were lower than economic disparities. The gap in women's health was less than in the case of child health. In the case of women's health, education played a major role in causing health disparity. Education of mothers or care givers, together with the economic status of the household, also played a major role in child health disparity.



## Annex 4

# Programme

### Tuesday, 2 Oct 2007: Day One

- 08:30 – 09:00      **Registration of participants**
- 09:00 – 10:00      **Agenda 1 – Inaugural session**
- Welcome Message from the Secretary, Ministry of Healthcare and Nutrition
  - Message from Regional Director, (WHO Representative)
  - Introduction of participants, and Nomination of Chairperson and Rapporteur – Dr Davison Munodawafa, Regional Adviser, HPE/SEARO
- 10:00 – 10:30      *Group Photo/Tea Break*
- 10:30 – 12:00      **Agenda 2 – Overview of WHO Work on Social Determinants of Health.**
- Interim Statement of the Commission on Social Determinants of Health – Dr Michel Thieran, WHO/HQ
  - Discussions on the Interim Statement of the Commission on Social Determinants of Health
  - Dr Michel Thieren (Moderator)
  - Ms Mirai Chatterjee (India) – Discussant
  - SRL National Task Force (SRL) – Discussant
- 12:00 – 13:30      *Lunch*
- 13:30 – 14:30      **Agenda 3 – Health Inequities (Regional and Country experiences)**
- (a) Regional Overview of Health Inequity and Social Determinants of Health – IHP, Sri Lanka
- 14:30 – 15:30      (b) Country Experiences
- Evidence on determinants of health inequities in child malnutrition and skilled birth attendance – WHO/HQ

- 15:30 – 16:00      *Tea Break*
- 16:00 – 16:30      ➤ Building community action to address social determinants through women empowerment: – SEWA (India) Case Study – Dr Surinder Aggrawal and SEWA Representative.
- 16:30 – 17:00      ➤ Thailand Health inequities and social determinants – IHHP
- 18:30 – 20:30      *High Tea / Reception – MoH&N and WHO*

### **Wednesday, 3 Oct 2007: Day Two**

- 08:30 – 09:00      Day Two – Recap (*Chair to recap*)
- 09:00 – 10:30      **Agenda 4 – Application of the Commission’s findings to critical themes in the Region (Experiences of meetings of Knowledge Networks on Social Determinants of Health)**
- 4.1 Early Child Development – Dr Frank Oberklaid
- 4.2 Health Systems (India Experience) – Dr Ganga Murthy
- 10:30 – 11:00      *Tea Break*
- 11:00 – 12:30      4.3 Urban settings –  
(WKC, Japan / Bangalore Municipality / SEARO / WRO India)
- 12:30 – 13:30      *Lunch*
- 13:30 – 17:30      Field Trip

### **Thursday, 4 Oct 2007: Day Three**

- 08:30 – 09:00      Recap (*Chair to recap*)
- 09:00 – 10:30      **Agenda 5 – Scaling up action on health equity and social determinants of health.**
- a. **Round Table:** Social determinants of Health and the Primary Health Care agenda
- Bangladesh / Bhutan / India / Indonesia / Maldives / Myanmar / Nepal / Sri Lanka / Thailand

- 10:30 – 11:00      *Tea Break*
- 11:00 – 12:30      b. Working Groups to develop a Regional FRAMEWORK for ACTION  
on Health equity and Social Determinants (Identifying the Key  
Elements)  
  
                              (3-4 Groups )
- 12:30 – 14:00      *Lunch*
- 14:00 – 16:00      **Agenda 6 – Report on Group Work**  
➤ Plenary discussion on key issues and way forward
- 16:00 – 16:15      *Tea Break*
- 16:15 – 16:45      **Agenda 7 – Conclusion**  
➤ Summary and Recommendations.
- 16:45 – 17:00      **Agenda 8 – Closing**

## Annex 2

### List of participants

#### Bangladesh

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Joint Secretary and Joint Chief and  
Head, Health Economics Unit  
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