The report of the consultation recognizes the importance of addressing social determinants of health such as, individual risk factors, life-course approach, and structural determinants influenced by social, political and economic contexts of countries within South-East Asia. Academics were urged to generate evidence for multi-stakeholders to understand and operationalize the determinant factors leading to health inequity. It was acknowledged that data and measurement in most countries in South-East Asia were inadequate to bring about policy changes. Social participation at various levels of policy-making in the WHO South-East Asia Region was prominent. “Health equity in all policies” was recognized as the ultimate goal that needed strong support from all sectors through intersectoral actions. The movement towards decentralization and universal coverage could be an open opportunity for countries to strive for health equity and address the social determinants of health. The regional consultation was organized to follow up on the progress of implementation of various health programmes to address underlying causes of health. More importantly, health impact assessment, particularly for the vulnerable populations, needed to be carried out to raise concerns on health issues with other sectors. The need for capacity strengthening to address the structural determinants of health was highlighted.
Intersectoral actions for addressing social determinants of health

Report of a regional consultation
WHO-SEARO, New Delhi, 23-25 August 2011
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1. Introduction

1.1 Background

A series of regional consultations and activities to assess health inequity in the South-East Asia Region show significant realization in the Member States on the social determinants of health (SDH). A regional consultation on intersectoral actions for addressing social determinants of health was held in WHO-SEARO on 23-25 August 2011 to support Member States to assess the implementation of health-in-all policies and reduction of health inequity. It also reconfirmed the commitment of Member States to implement national policies addressing social determinants of health as called for in World Health Assembly resolution WHA 62.14.

In February 2007, WHO-SEARO and WHO-HQ conducted a joint mission with Sri Lanka to support its work on SDH. Sri Lanka took the lead in the Region to tackle social determinants of health through a series of activities with an intersectoral group comprising members from government, civil society, and donors.

In October 2007, the Regional Office organized a Regional Consultation on Social Determinants of Health in Sri Lanka sharing experiences on health inequities and social determinants which resulted in strategic recommendations to the Member States to establish a national institutional mechanism to coordinate and manage intersectoral action for health in order to mainstream SDH across sectors, to establish a regional working group to provide guidance in policies, planning, implementation and monitoring of efforts to reduce health inequities and address SDH, to revise the primary health care concepts in order to strengthen intersectoral action for addressing SDH at community level. The Regional Office also commissioned six country case studies to document the evidence on health and health care inequities in Bangladesh, India, Indonesia, Nepal, Sri Lanka, and Thailand.

In February 2009, a Regional Consultation on Social Determinants of Health: Addressing Health Inequities was organized in Colombo to assess
actions taken by Member States to reduce the equity gap. The actions included the contributory social security system for self-employed women in India, subsidized micro-credit to the poorest in Bangladesh, abolishment of bonded child labour in Nepal, provision of universal health care in Thailand, adoption of the Gross National Happiness Index in Bhutan, introduction of health insurance in Maldives, health insurance for the poor in Indonesia, and a progressive pattern of health financing in Sri Lanka. The consultation led to the “Colombo Call for Action” urging countries to mainstream health equity in all policies, empower individuals and communities and advocate good governance and corporate social responsibility.

In 2010, WHO-HQ, SEARO and Sri Lanka took another initiative to tackle different components of social determinants of health in the “Lighthouse Project” to address socio-economic and cultural factors in relation to tuberculosis control, healthy public policy, health and gender-based violence and other policy issues to highlight appropriate mechanisms to tackle the issues from a social justice and intersectoral coordination approach. The Maldives also conducted an analysis report on “Social Disparities in Health in the Maldives: an Assessment and Implications”, addressing inequality in NCDs and NCDs risk factors as well as in health system which called for strengthening health promotion and primary prevention to reduce NCDs and increase provision of facilities in urban areas to promote healthy activities, as well as strengthening the health-care system to manage long-term care for patients of NCDs. Progress has been made in Thailand and Indonesia to join the Asia and Pacific Health Global Action for Health Equity Network (HealthGAEN).

This regional consultation was another important step for Member States to share solutions to selected social, cultural, economic, and political factors determining the health of the population in the Region. It also provided an opportunity for sharing their innovative measurements, mechanisms, and solutions to address social determinants of health in the global platform of the World Conference on Social Determinants of Health in Rio de Janeiro, Brazil on 19-21 October 2011.

The regional consultation was aimed at sharing country experiences in addressing social determinants of health and lessons learnt. The Colombo Call for Action was one of the commitments that SEAR Member States made to address SDH, especially through intersectoral collaboration and coordination. The consultation discussed the following themes:
Regional Consultation on Intersectoral actions for addressing social determinants of health

- Addressing social determinants of health to prevent and control communicable diseases and noncommunicable diseases.
- Addressing social determinants of health in the area of maternal and child health.
- Addressing social determinants of health through the health system, health information, revitalization of primary health care, and advocating for health-in-all policies.
- Addressing social determinants of health through social participation.
- Mainstreaming SDH in all policies and intersectoral collaboration in the South-East Asia Region.

1.2 General objective

To develop a regional strategic framework for promoting intersectoral interventions to address social determinants of health.

1.3 Specific objectives

(1) To share countries' experiences and challenges in addressing social determinants of health to reduce health inequity;

(2) To discuss appropriate mechanisms and approaches to address social determinants of health through policy change and intersectoral interventions;

(3) To reach agreement on the Regional Strategy Framework for Intersectoral Interventions to address social determinants of health; and

(4) To identify and finalize the country experiences to be presented at the World Conference on Social Determinants of Health.
2. Business Session

2.1 Inaugural session

The message of Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia, was read out by Dr Jai P. Narain, Director, Department of Sustainable Development and Healthy Environments. The Regional Director observed that it is widely acknowledged that the causes of disease and ill health are very complex. This poses a tremendous challenge on how we organize and manage our health system to tackle them. These root causes are not only physical, environmental, but also include social, cultural, economic and political factors that are embedded in the way humans interact with the environment and in society, and the way we organize our health systems. It is well recognized that social disparities often determine the health status of people in the Region, particularly the poor and vulnerable living in remote areas who are socially excluded. The main driving forces of social determinants of health are globalization of information and trade, commercialization of commodities, urbanization and environmental changes. They influence equality of distribution and equity in access to resources and services. The health outcomes of people living in different social and economic environments reveal health inequities in respective countries.

WHO is committed to tackling the root causes of disease and premature death across populations, especially focusing on the growing inequities and inequalities in social and economic development affecting health.

The WHO Regional Office for South-East Asia and Member States in this Region have been making great efforts in addressing health inequity and social determinants in different ways. Following the “Colombo Call for Action” in 2009, Member States not only acknowledged the existence of inequalities but also inequities in health, particularly addressing the inequity issues using a social justice approach to health. The approach calls for the involvement of sectors outside the health domain. “We deliberated on how to improve health conditions, tackle unequal distribution of power, money and resources; and improve routine monitoring of health inequity. We hope these actions will close the health equity gap in our Region. We committed ourselves to mainstream health equity in all policies, empower individuals and communities, advocate good governance and corporate
social responsibility, as well as to establish a national task force, or similar mechanism, to address the social determinants of health”, the Regional Director said.

There is growing evidence to suggest that social determinants of health should be addressed by multiple stakeholders in the health and other sectors. It is very crucial for all Member States and WHO-SEARO to work together to reaffirm political commitment in closing the gap and tackle health inequities systematically.

“As we are aware, our Member States have made sustained efforts to improve the social and economic conditions of their people through activities such as the contributory social security system for self-employed women in India, subsidized micro-credit to the poorest in Bangladesh, abolition of bonded child labour in Nepal, provision of universal health care in Thailand, adoption of a Gross National Happiness Index as a measure of human development in Bhutan, introduction of health insurance in Maldives, health insurance for the poor in Indonesia, progressive health financing in Sri Lanka, and other initiatives”, the Regional Director added.

“These are good examples which we need to continue and expand. We need to give more emphasis on intersectoral and multisectoral approaches to tackle social, economic, and political factors that influence health of the people and structures of health systems in order to bring equity, or fairness, in health outcomes and service delivery. Without addressing the multidimensional root causes of illness and health, we will not be able to ensure equity in health” the Regional Director said.

“This consultation gives us the opportunity to share experiences on how social determinants of health are being addressed by our Member States from policy development to the grass-root interventions. We are here to reaffirm our commitment and assess our progress in mainstreaming social determinants of health, health-in-all policies, and collaboration within the health sector and across other sectors. We can learn from our Member States’ experiences to develop appropriate mechanisms, innovations and approaches to tackle social determinants of health in the Region.”

“As you are aware, WHO and the Government of Brazil have taken the issue of social determinants of health to the global platform by organizing the World Conference on Social Determinants of Health in
Regional Consultation on Intersectoral actions for addressing social determinants of health

Rio de Janeiro, from 19 to 21 October 2011. The Conference aims to bring Member States and concerned sectors together to mobilize high-level political support to address social determinants of health to reduce health inequities.”

“We, together as a Region, have made significant progress in areas of social determinants of health. We need to reaffirm our commitment and systematically address the new challenges including emerging threats from climate change, unplanned urbanization, an ever-increasing urban population, internal and international migration, international trade in food products and the information explosion. We can share our experiences, our achievements, challenges and lessons learnt during this consultation and establish our regional position and strategies to be presented at the World Conference in Rio de Janeiro.”

“I believe that this regional consultation will help in developing a future plan of action and further strengthen commitment to work together in the Region to tackle social determinants of health with the goal to achieve health in all policies in our respective countries”, the Regional Director concluded.

2.2 Addressing social determinants of health to prevent and control communicable diseases and noncommunicable diseases

In the area of prevention and control of communicable diseases, social determinants of health often address sociocultural and behavioural factors. The session highlighted significant examples that disease control and prevention need to address including social, political, and economic factors beyond the individual risk factors. Three examples were presented to stimulate discussion. Indonesia’s experience shows that control of pandemics such as avian influenza at the community level needs social participation and intersectoral action to reach the people in remote areas.

Addressing prevention of communicable diseases using the healthy market approach in Indonesia was mainstreamed through non-health sectors, local administration, municipalities, transportation, cooperatives, business, and other sectors. The Department of Communicable Disease Control, Ministry of Health, Indonesia, took the lead and was responsible for healthy market, healthy city, and other healthy settings in collaboration
with the Bureau of Health Promotion. The intersectoral actions also addressed strengthening community capacity to deal with disease control, particularly with street and market vendors.

Figure 1: **Intersectoral collaboration to increase awareness on avian flu control, Indonesia**

*A case-study of healthy market, Wonosari District, Indonesia*

Sri Lanka shared experiences in reducing health inequity by making health services available, accessible and affordable to people. The Government of Sri Lanka was striving to reduce inequities in areas of education, employment and income, housing and other infrastructure. A network of intersectoral collaboration in Sri Lanka addresses a number of diseases namely rabies, tuberculosis, leptospirosis, H1N1. There is strong commitment to the control of dengue by the Ministry of Health, through
legislation, the department of irrigation, and other sectors. The necessary legal framework was established for the public health workforce to take action in preventing and controlling dengue in Sri Lanka. For example, people are fined for harbouring a dengue breeding site at their residence or workplace. The measure was aimed to generate public awareness and for people to take responsibility.

TB control in South-East Asia was highlighted especially the six principal steps to address TB control among the poor and vulnerable population. The principal steps were adopted by national TB control programmes in a number of countries in South-East Asia. Provisions to support TB patients living below the poverty line such as pension, subsidies, monthly allowance, and free access to care and services through outreach workers were one of the main success stories in the Region addressing social determinants of health in TB control programmes. Involvement of other sectors such as the Ministry of Social Justice in Sri Lanka providing a monthly allowance for TB patients living below the poverty line, and private practitioner schemes in India providing free access for referral, diagnosis and DOT were also highlighted.

**Figure 2: Social determinants of health—perspectives from TB control programmes**

- Weak and inequitable economic, social and environmental policy
  - Globalization, migration, urbanization, demographic transition
  - Weak health system, poor access
  - Inappropriate health seeking

- Poverty, low socioeconomic status, low education
- Unhealthy behaviour

- High-intensity contact with infectious droplets
- Impaired host defence

- Active TB cases in community
  - Crowding, poor ventilation
  - Tobacco, smoke, air pollution
  - HIV, malnutrition, lung diseases, diabetes, alcoholism, etc

- Age, sex and genetic factors

- Exposure
- Infection
- Active Disease
- Consequences

- Focus of current Global Stop TB Strategy
- Entry-point for interventions outside health system
- Entry-point for NTP & other disease control programmes
Social determinants of health and noncommunicable diseases are increasingly intertwined due to a strong correlation between socio-economic, cultural and changing life-styles of populations in rapid social change, urbanization, and globalization. Gender, ageing, poverty and other social factors significantly affect the four major noncommunicable diseases in the Region. Prevention and control of NCDs needs a broad spectrum of actions from public policies that affect livelihood of population, employment, and life-style changes particularly in food consumption. Experiences from India and Indonesia were highlighted. Indonesia focused on intersectoral actions in health promotion and healthy public policy at municipal levels where tobacco control was given as an example of risk reduction.

The Government of India showed strong commitment to tackling NCDs along with social determinants of health particularly on the issue of urbanization, ageing and rural development. The government has included NCDs in the Twelfth National Plan which indicates the need to strengthen intersectoral coordination with non-health sectors, generate appropriate legislation to control tobacco, alcohol, and food labelling, upgrade health facilities in urban areas, improve surveillance systems and build political commitment to address social determinants of health in the control and prevention policy of NCDs.

Figure 3: Burden of common NCDs in India – estimates and projections

<table>
<thead>
<tr>
<th>Disease</th>
<th>Estimate (Year)</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>50.8 million</td>
<td>2010 IDF</td>
</tr>
<tr>
<td>Diabetes Projection</td>
<td>80.0 million</td>
<td>2030 IDF</td>
</tr>
<tr>
<td>CVD</td>
<td>2.9 crores</td>
<td>2000 NCMH</td>
</tr>
<tr>
<td>CVD Projection</td>
<td>6.4 Crores</td>
<td>2015 NCMH</td>
</tr>
<tr>
<td>Cancer</td>
<td>28.0 lakhs</td>
<td>2010 NCRP</td>
</tr>
<tr>
<td>Cancer Deaths</td>
<td>5.0 lakhs</td>
<td>2010 NCRP</td>
</tr>
</tbody>
</table>

Economic cost of tobacco linked diseases

= Rs. 27,760 crores per year
Ms Sujaya Krishnan, Joint Secretary, Ministry of Health & Family Welfare, India, said that the government’s response to the prevention and control of NCDs would address the primary risk factors, namely alcohol abuse, use of tobacco, poor diet and lack of exercise. Early detection through opportunistic screening is necessary for high blood pressure, diabetes and treatable cancers. The NCD prevention strategy recognized that prevention and control were best tackled at the primary level. The involvement of the community was critical in addressing lifestyle changes. Financial support to NGOs/civil society organizations would be introduced in all programmes. Policy change from all sectors was needed, for instance, agriculture in generating alternate crops to tobacco; women and child development in the matter of early and exclusive breastfeeding and nutrition security; food processing in promoting reduced salt content and reduced trans fats in processed foods and renewable energy sources for promoting safe cooking stoves.

Discussion and recommendations:

- Addressing social determinants of health in the prevention and control of diseases (communicable and noncommunicable) needs to be broadened to include the whole health system and development. Health services should be accessible and affordable by the poor and vulnerable population.

- Evidence on social determinants of health across risk factors and burden of disease need to be integrated in the surveillance system particularly for prevention of diseases.

- Community- or area-based approaches in designing health programmes to address marginalized and vulnerable populations for communicable and noncommunicable diseases control and prevention are needed. The area-based approach will be one solution to foster intersectoral action to address social, economic, and other cultural factors related to health and generate political commitment.

- Research and development should be strengthened to understand the complexity of social determinants of health in all sectors through public-private partnership. A regular analysis of the situation challenging health is needed in South-East Asia. Monitoring and evaluation of progress on development issues
using MDGs should be linked and analyzed along with the health status of the population.

- Political commitment to health and development should be part of the national agenda. Advocacy for policy development and actions to address social impacts on health of the population need to be generated.

### 2.3 Addressing social determinants of health and maternal and child health

Socio-cultural barriers in the area of maternal and child health are prominent in South-East Asia. Social exclusion comes in multiple dimensions particularly in terms of race, class, caste, and gender. Experience in India shows how the legal system and legislation could address culturally-embedded social exclusion, caste system etc. A rapid assessment of governmental and nongovernmental actions to address accessibility of women from scheduled tribes and scheduled castes to maternal and child health services was conducted and presented by Professor Dr K.R. Nayar from Jawaharlal Nehru University. The study showed that legislation significantly changed the response of health service providers to health care needs of poor women belonging to scheduled tribes or scheduled castes.

Broad policy frameworks in India such as Bharat Nirman and the flagship programme, the National Rural Health Mission, and the governance model in human development have helped in improving programmes on maternal and child health. A reduction in maternal and infant mortality rates was noted among women belonging to scheduled tribe and schedule castes. Accessibility to maternal and child health services increased, however, not only due to a legal provision, but also because of people’s awareness about their rights and collaboration between the public sector and nongovernmental agencies to reach out to the population in need.
Participants attending the consultation strongly agreed that socio-cultural factors are very important to address MDGs 4 and 5. However, this could not be achieved through government programmes alone but needed strong public-private actions to reach the most vulnerable groups. Legislation and health systems may make the services available but not necessarily make them accessible if socio-cultural barriers are not removed. Long-term and medium-term interventions are needed.

2.4 Addressing social determinants of health through the health system, health information, revitalization of primary health care, and advocacy for health in all policies

Measurement of social determinants of health in South-East Asia remains fragmented in most countries. Existing data and surveys in countries include demographic and health survey (DHS), multiple indicators cluster survey
(MICS), and MDGs progress reports. However, these national surveys are often not up-to-date and not adequately utilized to generate a comprehensive understanding of disparities and health equity. Various studies were conducted as stand-alone assessments. Thailand highlighted how the information and data was generated to develop evidence-based policies. A number of studies and surveys were used to generate advocacy to gain political commitment. An Institutionalized health information system was crucial to national policy change. The historic effort in Thailand to generate intersectoral participation at policy level is seen in the process of development of the National Health Act. The process involved participation of different sectors that held authoritative power, knowledge power, and power of social movement. The National Health Assembly was used as a public platform for the development of participatory healthy public policy.

Figure 5: Thailand’s Health Assembly addressing SDH and advocating for health in all policies

Health Assembly as a new public sphere for policy development

Health system reform in Thailand was highlighted in most case studies from Thailand because it created a new platform for a broad spectrum of intersectoral actions to tackle social determinants of health in various health activities. The example of addressing the needs of people with disability through health governance was presented. It showed how social exclusion, stigmatization, discrimination, and marginalization were addressed through provision of legal rights and social mobilization.
A series of actions occurred in Thailand to establish health governance for people with disabilities. Law enforcement and civil society collaborated to get public policy changed and to generate political commitment. Significant actions showing commitment included (a) establishment of governing bodies for law enforcement, rules, and mechanism to promote and develop quality of life of people with disability which resulted in “The Promotion and Development of the Quality of Life of PWD Act 1997; (b) budget allocation in the universal coverage expenditure for rehabilitation services and Medical Rehabilitation Fund; (c) initiative for the programme of health promotion for people with disability using the community health fund.

Figure 6: Thailand’s example of health governance addressing quality of life of the people living with disability

Governance to improve QoL of PWD
- De-stigmatization has internally empowered PWDs.
- Joining up the law enforcement by the PWD’s civil societies to make rights in Act to be real.
- Governing process turn more governance by involving of civil society: Political engagement, Joining public policy process, Social watching.
- Demolish the wall of government’s silo structure for improving QOL of PWDs.
- More and more engagement of civil societies in social services and welfare management, welfare societies, health in all policies.

Initiative (5)
- Rights and welfare assistance in which some principles are services to make adjustments to the environment to facilitate the handicapped, services in the form of home care in the case where no one is helping PWDs.

The role of the health system in improving health equity in Thailand has a long history with a series of evidence-based developments and political movement. Public financing systems and sources were analyzed to advocate with policy makers to make a commitment on universal coverage. Different models were initiated to fit the needs of different population groups with health equity in mind. The lessons from Thailand reveal that political commitment, a systematic analysis of feasible and practical solutions, and social movement are crucial for launching successful programmes and activities to address health inequity at different levels.
The incidence rate of ESRD patients in Thailand could range from 100 to 300 per million pop (PMP). If the government decides to provide universal access to RRT, assuming the incidence of 300 PMP, the number of ESRD patients will increase to more than 50,000 cases in the 5th year.

2. The estimate indicates that the government health budget for universal access to RRT would increase to 43,804 million Baht in the fifteenth year of implementation if the government plays a passive role in controlling costs for RRT and the incidence of ESRD patients.

The health information system and knowledge management of health information are part of Thailand’s success stories that were able to target a number of areas where health inequity needed to be addressed. Quality of data and strategic utilization of information are parts of the big picture where think-thanks in Thailand were able to draw political attention to mobilize resources and commitment for change in the health system. The model from Thailand is contextualized within the political and economic climate of the country.

Figure 8: Thailand’s health system approach to address health coverage
Health of the urban poor, particularly in India and in selected countries in South-East Asia, was discussed along with how the measurement of health and information can be utilized to foster intersectoral cooperation and partnership. Pro-poor policies and urban development need to be brought together to address health of the urban poor. However, measurement of health equity in urban areas in South-East Asia needed to be strengthened with road maps to address rapid growth of urbanization in the Region.

Intersectoral action through public-private partnership and community participation can increase access to health services among the urban poor. The Urban Health Resource Centre of India showed a significant link between building evidence, disaggregated data and measurement to address health of urban poor through multi-stakeholder mechanisms that encompassed governmental bodies, nongovernmental organizations, community-based organizations and all concerned agencies.

Figure 9: Multi-stakeholder coordination ensuring health of the urban poor
2.5 **Addressing social determinants of health through social participation**

An example of grass-root movement and participation in health in India was presented by the Voluntary Health Association of India (VHAI). A number of initiatives that began with community-based action such as the Khoj initiative involving local administrations to address the health and development agenda for the poor were described. The initiative had significantly improved the quality of life of rural and vulnerable populations in India. It had strengthened community response to poverty and health, helped in addressing health and rights of women and reproductive health, reduction of health expenditure and improvement in quality of health services. The Khoj initiative was an example that grass-root action could be sustained through the community and be mainstreamed in the National Rural Health Mission agenda.

*Figure 10: Social participation in community health: health impact of Khoj project, India*

- Increased health awareness
- Increased utilization of available govt health functionaries
- Significant improvement in antenatal care, natal care and postnatal care
- Reduction in mortality due to communicable diseases
- Effective disease surveillance leading to prevention of epidemics
- Reduction in health expenditure as quality health services made available at reasonable cost

The Society and Health Institute, Ministry of Public Health, Thailand shared experience on how social participation of people in the health system could be institutionalized. Thailand adopted a community-based, area-based, issue-based health assemblies approach and process to gather
health concerns initiated by the people. The process took community health agendas into public policy with suggested solutions initiated by the people in consultation with academics, practitioners, professionals, and policy makers. A series of actions were initiated till it reached national policy level.

Figure 11: Institutionalized social participation in the health assemblies, Thailand

A new paradigm shift in health system reform in Thailand was on actions towards addressing social health and well-being. Key components of discussions in health assemblies always encompassed social issues. Thus, a socially accepted process of discussion called, “deliberative democracy”, where people shared their concerns, needs, and agreed solutions to address their problems within the local contexts were adopted. Endorsement by the National Committee and National Health Assembly on people-initiated health issues were both political and social processes. It demanded intensive dialogue as well as political will from all sectors in taking action in all stages of development.

2.6 Mainstreaming social determinants of health in all policies and intersectoral collaboration in the SEA Region

Dr Narongsakdi Aungkasuvapala, Adviser to the National Health Commission Office and Chair of Social Inequity Reduction Network (SIRnet), presented an example of mainstreaming social determinants of health across sectors in Thailand. Learning from Thailand’s experience, health must be put at the heart of the whole health system with a holistic
approach. It must be generated from conceptual understanding that health encompasses physical, mental, social and spiritual well-being. A holistic health system includes health care services, individual conditions, and the whole social, political, economic, and natural environment. This holistic view of the health system is in line with the social determinants of health concept where the health of individuals is intertwined with biological attributes, health behaviours, belief system, socio-economic status and their interaction with the whole social, cultural, political, and economic systems. The health care system is part of the whole system that focuses on primary prevention, curative care and services that ensure accessibility, availability, and an equitable delivery system to promote and restore the health of the population.

Actions to address social determinants of health, thus, need multisectoral and multi-disciplinary approaches that engage numerous groups of actors, social networks, academics, and policy makers. Mainstreaming of social determinants of health must focus on advocacy to generate a common understanding and responsibility to act together.

Figure 12: **Mainstreaming social determinants of health through network of networks**
SIRnet is a network of academics, policy makers, and civil groups who are working together to address health issues of vulnerable groups such as people living with disability, elderly persons, farmers, labourers, women and others. The network started with core technical individuals who saw health as the broad responsibility of all sectors. They work together to produce evidence and advocate for policy change. It is also a network of networks.

Research in different areas was conducted through networks with support from governmental organizations and partners in the country. The network synergized individuals and networks of people through their existing commitment on the issues. Public platforms were organized and brought evidence for social communication and advocacy for policy change. The power to change used by this network is considered a soft power, using positive arguments and deliberations that led to further cooperation and partnerships.

Globally, another example of networking is the Global Action for Health Equity Network (HealthGAEN) which was established through networks of academics who take the agenda and recommendations of the Commission on Social Determinants of Health forward with WHO partnership. In Asia and the Pacific, AP-HealthGAEN is chaired by the Australian National University with membership across countries of WHO South-East Asia and the Western Pacific Regions.
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SIRnet, Thailand and institutes in Sri Lanka are members of the AP-HealthGAEN. The network published a series of evidence synthesis, reports, textbooks, and provided modules for capacity development to promote health equity. The network is also used as a mechanism to develop strategic advocacy and gain attention from the media. AP-HealthGAEN produced a significant report for the WHO World Conference on the Social Determinants of Health, in October 2011, in Brazil, namely “An Asia Pacific Spotlight on Health Inequity: Taking Action to Address the Social and Environmental Determinants of Health Inequity in Asia Pacific.”

3. Group Work

Recognizing that social determinants of health are cross-cutting, group discussions led to recommendations to address social determinants of health to control and prevent communicable and noncommunicable diseases, as well as a strategic framework on intersectoral actions addressing social determinants of health in South-East Asia.

Regional positions on SDH to tackle communicable and noncommunicable diseases included:

- The health care system should focus on accessibility and quality of services more than coverage, especially when it applies to vulnerable groups. There should be no financial barrier to access services.
- Political commitment for health development should be a national agenda with cooperation from other sectors.
- Community-based initiatives should cover the marginalized population.
- The disease surveillance system should be integrated and geared towards prevention, as well as inclusive of agendas from other sectors to be able to utilize and share data.
- School health curriculum and life-skill training are optimal entry points to ensure life-long prevention and control of diseases.
- Programme management for health should be strengthened to cover health equity issues, methods addressing social determinants of health, and result-based management.
Monitoring of process and progress of health status should be analyzed in relation to other development indicators (MDGs) to tackle underlying causes.

Recognizing emerging challenges in addressing noncommunicable diseases, multisectoral partners involved in social determinants of health must be included in programme planning and strategies to prevent and control NCDs.

Mechanisms to address the needs of the poor and vulnerable populations to access long-term care and treatment of NCDs along with life-course prevention must be considered.

Area-based interventions should be identified and settings approach used for most vulnerable and at-risk population groups to encourage integrated intersectoral actions where resources and manpower can be shared.

Capacity of individuals, families, and communities on prevention and control of communicable and noncommunicable diseases should be strengthened through behavioural change communication, health literacy activities, media, as well as advocacy for addressing the needs of people.

4. **Regional Strategic Framework**

Social determinants of health is a complex issue influencing the health of populations particularly in lower- and middle-income countries. The Commission on Social Determinants of Health (CSDH) reiterated WHO’s constitutional commitments to health equity and social justice and re-emphasized the values of health for all. In May 2009 the World Health Assembly adopted resolution WHA 62.14 entitled, “Reducing Health Inequities through action on the social determinants of health”, urging Member States, the WHO Secretariat and the international community to implement the recommendations of the Commission, highlighting areas such as measurement of health inequities, implementing the social determinants approach in public health programmes, adopting a health-in-all policies approach by government, and aligning work on social determinants with the renewal of primary health care.
With increasing challenges in addressing social determinants of health in South-East Asia, intersectoral actions require rigorous participation of partners and a coordination mechanism to address issues beyond public health. The current dynamics of change include the demographic structure where a large percentage of the population is ageing with a high proportion needing long-term care; rapid urbanization is putting pressure on the environment and a demand for housing; migration, both within and across national boundaries is creating pockets of marginalized population and social exclusion; changing health behaviours due to life-style changes; disappearance of traditional social relations; emergence of new social networks; and other issues are influencing health such as financial crises, political conflict, post-conflict social environment, domestic violence, safety and injury issues which demand a link with the health and social justice systems as well as to have appropriate social protection.

In the light of the “Colombo Call for Action” and recommendations from the regional consultation on Social Determinants of Health: Addressing Health Inequities, 2009, the Member States, civil society, academia, development partners, the private sector, WHO and other relevant stakeholders were urged to take several steps related to intersectoral actions as follows:

(a) Tackle health inequities within and across Member States in the Region through political commitment on “closing the gap in a generation” as a national agenda in Member States.

(b) Advocate actions on social determinants of health and apply the overarching recommendations of the Commission on Social Determinants of Health to the country context in order to mainstream ‘health equity in all policies.’

(c) Use the current global concerns such as food and energy security, water availability, economic crisis, and climate change, as an opportunity for action on the social determinants of health and prioritize investment in effective intersectoral actions to reduce the burden of diseases among the vulnerable population, in particular, prevention of low birth weight and child marriage, develop and expand early child development programmes, improve work conditions, strengthen social security systems and empower vulnerable groups.
(d) Develop national strategies and plans of action to assess the scope and magnitude, causes and profile of health inequities, establish or strengthen where appropriate, intersectoral mechanisms and build and sustain capacity to implement the national plans of action and monitor progress.

(e) Establish national institutional mechanisms to coordinate and manage intersectoral action for health in order to mainstream health equity in all policies, and where appropriate, by using health and health equity impact tools.

Figure 14: Regional strategic framework on intersectoral actions addressing social determinants of health

The consultation agreed that this framework clearly expresses the goal of health equity which needs to be strengthened throughout other policies. An intersectoral mechanism needs to be established similar to that of the National Commission on Social Determinants of Health in Sri Lanka, or establish a Social Inequity Reduction Network as in Thailand, and other modalities. However, it is recognized that countries in South-East Asia Region urgently need to build evidence with appropriate measurements on social determinants of health.
Measurement of health equity in various areas of health still needs to be accomplished. Beyond health, other sectors would be able to address underlying determinants of health via health impact assessment that would enable policy change as well as response and measures to prevent or control impacts of programmes and development policies. A social protection platform and intersectoral mechanisms are needed to address social determinants of health which may be designed based on social, political, and economic contexts that are specific to population- or geographical-based interventions. Policies and interventions should be directed toward reducing exposure to health-damaging factors and vulnerabilities of population groups. Intersectoral collaboration, governance, and social participation are prime movers for ensuring health equity in all policies. Various platforms that respective countries in South-East Asia could initiate were discussed and identified, for example, UNDAF, UNPAF, WHO-CCS, parliamentary, and other inter-agency platforms.

5. **World Conference on Social Determinants of Health (WCSDH), 19-20 October, Rio de Janeiro, Brazil - Preparation, Procedure, Participation and Declaration**

Dr Kumanan Rasanathan gave a briefing on the background and objectives of the World Conference on Social Determinants of Health to be held in Brazil, in October 2011. The conference was initiated as part of WHO commitments in accordance with World Health Assembly resolution WHA 62.14 (2009) to provide a global platform for dialogue on “how-to” address social determinants of health. The resolution strongly called for a “health in all policies” approach and a renewed commitment to intersectoral action (ISA) to reduce health inequities, as well as the implementation of a social determinants approach across public health programmes and improved capacity to measure health inequities and monitor the impact of policies on social determinants. The resolution also requested the WHO Director-General "to convene a global event before 2012 to discuss renewed plans for addressing the alarming trends of health inequities through addressing social determinants of health". The Government of Brazil is hosting this WHO global conference bringing together global leaders to discuss how to implement the recommendations of the Commission to reduce health inequities.
It was essential to collect country experiences, to be presented by Member States at the WCSDH, which show that work on SDH to reduce health inequities is feasible through concrete measures, rather than just abstract or rhetoric. This regional consultation was an important process to share country experiences. The best experiences were collected through collaboration between WHO country and regional offices and headquarters and also with other departments of WHO. The representative from WHO-HQ explained that the aim should be to have senior country representatives present these experiences, with perhaps discussion from civil society or international agencies. In addition, Member States should be encouraged to produce short papers detailing these experiences prior to the Conference, with the assistance of WHO offices.

The country experiences would be presented during the parallel sessions of the Conference. There would be five parallel sessions of four hours each, covering the six themes of the Conference, namely:

1. Health systems, public health programmes and SDH.
2. Joined-up government/health in all policies/intersectoral action at country level.
3. Measurement, analysis and evidence for policies on SDH.
4. International cooperation for development and health (i.e. action on SDH at global level, including achieving MDGs).
5. Social participation.

Experiences from South-East Asia presented in this meeting were proposed to the World Conference of Social Determinants of Health. The three areas of action addressing social determinants of health highlighted were:

(a) institutionalized social participation in health policies and services (Bangladesh, India, Thailand).
(b) Changing the role of the health sector (Thailand).
(c) Health system reforms and universal health coverage (India and Thailand).

The draft of the Rio Political Declaration would be distributed and the updated programme could be accessed via the website. The representative
from WHO-HQ provided the timeframe of the conference’s processes and urged participants as well as partners from other sectors in the countries to attend the conference. Interventions for the drafting process of the Declaration through online participation was provided during the World Conference on Social Determinants of Health.

6. Conclusions and Recommendations

Conclusions

Recognizing the importance of addressing social determinants of health from individual risk factors, life-course approach, and structural determinants influenced by social, political, and economic contexts of countries within South-East Asia, the participants agreed that the issues must be addressed as part of the national and regional agenda where intersectoral action could be achieved through political commitments. Academics were urged to generate evidence for multi-stakeholders to understand and operationalize determinant factors leading to health inequity. Most of the social determinants of health are in sectors other than health which require significant inputs to build strategic communication for advocacy. It was admitted that data and measurement in most countries in South-East Asia were inadequate to bring about policy changes. At country levels, policy advocacy skills needed to be strengthened for the health sector in order to lead the issues.

From countries’ experiences, a number of areas can be addressed through existing mechanisms such as in the MDG platforms where all the indicators could be considered as social determinants of health. Health and human rights needed to be integrated in the health systems. Social participation at various levels of policy making in the South-East Asia Region was prominent, yet active participation in health was varied due to the level of education and political atmosphere of the respective countries. The movement towards decentralization and universal coverage could be an open opportunity for countries to strive for health equity and address social determinants of health. Health Equity in all Policies was recognized as the ultimate goal which needs strong support from all sectors and intersectoral action.
This regional consultation was called to follow up on progress of implementation of various health programmes to address underlying causes. More importantly, health impact assessment, particularly for the vulnerable populations, needed to be carried out to raise concerns on health issues with other sectors. Capacity strengthening on how to address structural determinants of health was highlighted.

Following extensive deliberations, the participants made the following recommendations:

**Recommendations**

**WHO**

The meeting calls upon WHO to:

1. Provide analysis on health inequities in the Region, documentation of best practices and sharing of experiences.

2. Facilitate capacity building of Member States for implementation, research, monitoring and evaluation, and advocacy.

3. Provide guidelines and a framework for action to advocate for intra- and inter-sectoral coordination to address social determinants of health.

Facilitate dialogue among Member States, UN agencies and relevant stakeholders to move forward the agenda for intersectoral actions addressing social determinants and reducing health inequities.

**Member States**

The meeting calls upon the Member States to:

1. Address health as a development issue to synergize intersectoral actions at all levels.

2. Generate evidence to understand health inequity in South-East Asia, measurement of social determinants of health – underlining health risks, accessibility, affordability of health services, and other policy implications on the health of populations. Utilize
data and indicators from existing frameworks and methodologies such as MDG, DHS, MICS, etc. to understand the social determinants of health within different segments of society (such as urban areas, socially excluded groups) and inform policy and raise awareness among health and other sectors.

(3) Institutionalize equity in health care services and programmes, health finance, and governance in health systems to ensure availability, accessibility, affordability, and quality of services for vulnerable groups in society.

(4) Establish collaborative networks to consolidate and strengthen capacities of countries through intersectoral partnership, coordination, and pooling of resources to address the needs of vulnerable groups.

(5) Ensure social inclusion through people’s empowerment and participation in information sharing, and decision making on policies influencing health.

(6) Develop strategic agendas including innovative multisectoral and area-based approaches to mobilize resources to address social determinants of health.

**Follow-up actions**

- Building evidence on health equities.
- Mainstreaming social determinants of health (beyond gender mainstreaming).
- Addressing health of urban poor in South-East Asia as the priority for the next biennium in the Region.
- Strengthening intersectoral coordination and generate sustainable actions.
- Organizing Regional Conference on Health in All Policies, in 2012.
7. Closing

The Director of the Department of Sustainable Development and Healthy Environment, Dr J.P. Narain, gave the closing remarks and thanked the participants for their fruitful deliberations. Recognizing the complexity of social determinants of health, intersectoral action became even more important. Rigorous research in this area will be important to provide a clearer understanding for all sectors. Dr Narain endorsed that the regional conference on health in all policies would be very important to move the social determinants agenda forward. A step-wise approach to address SDH could be taken from the country level with technical support from the WHO Regional Office and the existing network.
Annex 1

Agenda

(1) Inaugural session

(2) Addressing social determinants of health to prevent and control communicable diseases and noncommunicable diseases

(3) Addressing social determinants of health and maternal and child health

(4) Addressing social determinants of health through the health system, health information, revitalization of primary health care and advocacy for health-in-all policies

(5) Addressing social determinants of health through social participation

(6) Mainstreaming social determinants of health-in-all policies and intersectoral collaboration in the SEA Region

(7) Group work

(8) Regional Strategic Framework

(9) World Conference on Social Determinants of Health (WCSDH), 19-20 October, Rio de Janeiro, Brazil - Preparation, Procedure, Participation and Declaration

(10) Conclusions and Recommendations

(11) Closing
Annex 2

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Regional Consultation on Intersectoral actions for addressing social determinants of health

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The report of the consultation recognizes the importance of addressing social determinants of health such as, individual risk factors, life-course approach, and structural determinants influenced by social, political and economic contexts of countries within South-East Asia. Academics were urged to generate evidence for multi-stakeholders to understand and operationalize the determinant factors leading to health inequity. It was acknowledged that data and measurement in most countries in South-East Asia were inadequate to bring about policy changes. Social participation at various levels of policy-making in the WHO South-East Asia Region was prominent. “Health equity in all policies” was recognized as the ultimate goal that needed strong support from all sectors through intersectoral actions. The movement towards decentralization and universal coverage could be an open opportunity for countries to strive for health equity and address the social determinants of health. The regional consultation was organized to follow up on the progress of implementation of various health programmes to address underlying causes of health. More importantly, health impact assessment, particularly for the vulnerable populations, needed to be carried out to raise concerns on health issues with other sectors. The need for capacity strengthening to address the structural determinants of health was highlighted.