Consultation on Social Determinants of Health in the Western Pacific Region

Beijing, People’s Republic of China
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REPORT

CONSULTATION ON SOCIAL DETERMINANTS OF HEALTH
IN THE WESTERN PACIFIC REGION

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NOTE

The views expressed in this report are those of the participants in the Consultation on Social Determinants of Health in the Western Pacific Region and do not necessarily reflect the policy of the World Health Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Members States in the Region and for those who participated in the Consultation on Social Determinants of Health in the Western Pacific Region held in Beijing, China from 22 to 24 March 2006.
CONTENTS

SUMMARY

1. INTRODUCTION ................................................................................................................. 1
   1.1 Objectives ..................................................................................................................... 1
   1.2 Organization ............................................................................................................... 2

2. PROCEEDINGS .................................................................................................................. 2
   2.1 Opening session ............................................................................................................ 2
   2.2 Introduction to the Commission's work ........................................................................ 3
   2.3 Country actions to address social determinants of health........................................... 9
   2.4 The role of civil society in addressing social determinants of health ....................... 21
   2.5 The role of knowledge networks in addressing social determinants of health ............ 27
   2.6 Addressing social determinants of health in urban settings ..................................... 29
   2.7 Follow-up action to address social determinants of health ...................................... 31
   2.8 Workshop: Addressing social determinants of health in urban settings .................. 32

3. CONCLUSIONS ............................................................................................................... 40
   3.1 Concluding remarks .................................................................................................... 40

ANNEXES:

ANNEX 1 - TIMETABLE
ANNEX 2 - LIST OF PARTICIPANTS, TEMPORARY ADVISERS,
          REPRESENTATIVES/OBSERVERS, AND SECRETARIAT
ANNEX 3 - OPENING REMARKS OF DR SHIGERU OMI,
          REGIONAL DIRECTOR, WHO WESTERN PACIFIC
ANNEX 4 - OPENING SESSION SPEECH OF DR WANG LONGDE,
          VICE MINISTER OF HEALTH OF THE PEOPLE'S
          REPUBLIC OF CHINA
SUMMARY

Although aggregate global health indicators have improved in recent decades, health inequalities between and within countries have widened and are growing. The key to reversing this trend is action on the social determinants of health, which account for the bulk of these disparities. Social determinants include all factors influencing health that are shaped by people’s different positions in society. Several important factors have slowed progress on tackling these determinants. Making substantial headway requires integrating priority targeted programmes, strengthening health systems, and taking pragmatic steps to address the social determinants of health.

The Commission on Social Determinants of Health (CSDH), launched in March 2005, aims to:

1. Compile evidence on successful interventions and formulate policies that address key social determinants, particularly in low-income countries;

2. Raise societal debate and advocate for implementation—by Member States, civil society, and global health actors—of policies that address social determinants; and

3. Define a medium- and long-term action agenda for incorporating social determinants of health interventions/approaches into planning, policy, and technical work within WHO.

The Consultation on Social Determinants of Health in the Western Pacific Region, held in Beijing from 22 to 24 March 2006, was the fifth in a series of regional consultations held so far. The four others were held in the Pan American Health Organization/Regional Office for the Americas, the Regional Office for Africa, the Regional Office for the Eastern Mediterranean and the Regional Office for South-East Asia, respectively. The Consultation afforded its participants an opportunity to discuss progress to date, exchange views, and identify ways to take forward the work on social determinants of health.

The objectives of the Consultation were:

1. To share information about the Commission, its streams of work, and planned activities at the national, regional and global levels and ongoing work in countries on social determinants of health; and

2. To identify opportunities at the regional level and among Member States for addressing the social determinants of health.

The meeting was attended by 68 participants and observers, including three Commissioners, 18 country participants from nine countries in the Region, 30 representatives from international, governmental and nongovernmental organizations and 20 WHO staff representing Headquarters, the Western Pacific Regional Office and the WHO Kobe Centre.

The impressive level of commitment and engagement in the Region on social determinants of health were noted in the meeting’s concluding remarks. The next steps would be to take this commitment forward, building on existing experiences, taking them to scale, and undertaking advocacy to increase policy action across sectors. Strengthening health system performance, it was emphasized, needs to be a key dimension of this work. The Commission will need to develop capacity-building tools for various levels and partners. The Knowledge Network on urban settings can contribute by mapping trends, documenting and sharing good practices, and analyzing the process of scaling up within specific contexts. At the country, regional and global levels, WHO stands ready to help in these efforts.
1. INTRODUCTION

Although aggregate global health indicators have improved in recent decades, health inequalities between and within countries have widened, and are growing. The key to reversing this trend is action on the social determinants of health, which account for the bulk of these disparities. Social determinants include all factors influencing health that are shaped by people's different positions in society. Several important factors have slowed progress on tackling the social determinants of health. These include: a lack of clear, usable evidence of the specific pathways of social determinants; difficulty in managing intersectoral action for health; a lack of policy guidance and documentation of successful interventions; and an absence of clear leadership, commitment and technical support from global health actors. Making substantial headway requires integrating priority targeted programmes, broad health systems strengthening, and implementing pragmatic steps to address the social determinants of health.

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1. compile evidence on successful interventions and formulate policies that address key social determinants, particularly in low-income countries;

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1.1 Objectives

The objectives of the Consultation were:

1. to share information about the Commission, its streams of work, and planned activities at the national, regional and global levels and ongoing work in countries on social determinants of health; and

2. to identify opportunities at the regional level and among Member States for addressing the social determinants of health.
1.2 **Organization**

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Annex 1 shows the timetable of the meeting and Annex 2 contains the list of participants.

2. **PROCEEDINGS**

2.1 **Opening session**

Dr Shigeru Omi, WHO Regional Director for the Western Pacific, officially opened the Consultation on Social Determinants of Health in the Western Pacific Region (see Annex 3 for his opening remarks). Dr Omi noted with concern the widening health inequalities between and within countries, despite recent overall progress in health, and urged action on its social determinants to reverse this trend. The 1948 WHO Constitution, the 1978 Alma-Ata conference and Health for All movement recognized the social dimensions of health as central. In the 1980s, with shrinking states and free markets, more upstream issues were given less emphasis. He observed that, today, health stands higher than ever on the international development agenda and cited the need for stronger multisectoral collaboration, strengthening health systems, and developing policy guidance for effective interventions. To that end, he called for a fundamental change in philosophy and for bold and innovative thinking. He hoped the consultation would mark a turning point in efforts to address social determinants and achieve health for all in the Western Pacific Region. Dr Omi concluded by expressing his gratitude to the Government of China for hosting this important meeting and to all representatives of partner organizations and institutes present for their participation.

In his opening speech (Annex 4), Dr Wang Longde, Vice-Minister of Health, People's Republic of China, welcomed participants and stressed the goal of health as a basic human right. He expressed hope that the Commission on the Social Determinants of Health would assist countries in identifying social barriers to health development and sharing experiences gained from practice to improve health equity globally. He reviewed China's progress in socioeconomic development, as well as health outcomes, in the last 50 years, stating that these resulted from government's prioritization of human health and security. However, rapid economic development has brought new challenges, such as inadequacies in the public health system, irrational distribution of health resources, inaccessibility and lack of affordability of health care, and disparities between urban and rural areas and between different regions. The Government emphasizes people-centred and equitable development. He also noted that the 10th National People's Congress has prioritized issues such as accessibility and affordability of health, by: increasing government-led investment in health; strengthening national capacity to respond to public health emergencies; improving the prevention and control of major illnesses (with a focus on HIV/AIDS, hepatitis, tuberculosis and schistosomiasis and human avian influenza); intensifying rural health work; strongly promoting urban community-based health services; and completing the development of the health security system for both urban and rural populations.
In closing, Dr Wang noted that governments are also responsible for protecting global health, since neither disease nor the social determinants of health respect national borders. He stressed that protecting the health of the people is a critical responsibility of any government. This needs cross-sectoral collaboration. Diseases do not respect country borders; neither do the social determinants of health. Therefore, governments are also responsible for protecting global health, through strengthened international collaboration. He wished participants a successful meeting.

2.2 Introduction to the Commission’s work

2.2.1 Introduction to Commission and objectives of consultation

Ms Sarah Simpson, Technical Officer, Evidence and Information for Policy Cluster, which houses the Secretariat of the Commission at WHO Headquarters, provided a brief introduction to the Commission and the objectives of the Consultation.

The term "social determinants of health" refers to the social conditions in which people live and work. These conditions, in turn, reflect how the general public interacts with hierarchies of power, prestige and resources. The outcomes of these interactions directly affect their health. In the words of Dr J.W. Lee, WHO Director-General, "The (Commission's) goal is not an academic exercise, but to marshal scientific evidence as a lever for policy change—aiming towards practical uptake among policymakers and stakeholders in countries". The mechanisms of the Commission are designed to begin action now and put in place strategies and approaches to make this work sustainable. The purpose of gathering knowledge is not to develop the final report, but to use knowledge as a lever to influence policies. Accordingly, the Commission's structure is driven by its goals (Figure 1).

Figure 1. Goal-driven structure of the CSDH

The cornerstone of the Commission’s work is promoting health equity, or "the absence of unfair and avoidable or remediable differences in health among groups defined socially, economically, demographically or geographically." Health inequities reflect social stratification. Equity is not the same as equality. Health equity is concerned with both opportunities and health outcomes.
The Commission will have several phases (Figure 2). However, several milestones have already been reached. Six Knowledge Networks (KNs) have been established and have held their first meetings. Up to 16 countries have been identified as partners. Civil Society Facilitators (CSFs) have been named and are developing frameworks for regional strategies.

Figure 2. CSDH Phases of Work

![CSDH Phases of work](image)

The Commission has several streams of work, including:

1. work by the Commissioners themselves, who are engaged across streams and undertake advocacy in action;
2. work at the level of countries;
3. work with civil society; and
4. work by specific Knowledge Networks.

The theme of the Commission's work is integration across these streams, a challenging task but one with significant potential gains. This approach will help build sustainable communities of practice now, as well as foster consensus on how to strengthen health equity.

Recapping the stated objectives of the Consultation, Ms Simpson pointed out that its real purpose was exchange and collaboration. In practice, the Consultation marked the beginning of a dialogue on the added value of a social-determinants approach, including identifying opportunities and incentives to partner with the Commission, such as working with Knowledge Networks, as country partners or by setting up a regional reference group. It would be important to focus the Consultation and consider how the Commission’s mechanisms fit with regional incentives, opportunities and challenges.
2.2.2 Presentations by Commissioners

In his presentation, Commissioner Dr. Kiyoshi Kurokawa, Adjunct Professor at the Research Center for Advanced Science and Technology, University of Tokyo, provided a historical overview of trends in demographic and medical progress over the millennia. The human population has grown from an estimated 100 million in the year 1 AD to over 6 billion today and a projected 9 billion by 2050. At the same time, life expectancy has increased from 25 years in 1 AD to 40–45 years in 1900 and 80 years in the industrialized world today.

From facing the challenges of the 14th century plague in Europe, medical science has achieved many victories through the centuries. Science and technology have changed our way of life. Today’s challenges include urbanization, lifestyle-related diseases, ageing, climate change and the environment, and widening disparities between industrialized and developing countries. Recent initiatives to address these challenges include the Millennium Development Goals (MDGs), the Commission, and the G8 summits, among others. We cannot change the past, but we must learn from it and shape our future so that all stakeholders and policy-makers renew and expand their historic collaboration to achieve the goal of health for all.

Commissioner Dr. Guo Yan, Vice Dean, Institute for Advanced Study, School of Public Health, Peking University Health Sciences Center, spoke about the relevance of social determinants in the Region. Large population, rapid economic growth overall with wide variations between areas, rapid transitions, and the emergence of public health challenges are some of the health and development characteristics of the region. Infant mortality rates illustrate the public health disparities in the region. Several countries—including China, Mongolia, the Marshall Islands, the Philippines, Samoa, and Viet Nam—have achieved at least a 60% reduction in infant mortality rates and appear to be on track in meeting the MDG target. However, the infant mortality rate has worsened in some countries since 1990. A two-thirds reduction in the infant mortality rate requires an average reduction of 4.2%. The Western Pacific Region appears to be off-track in meeting this target. Unlike other regions, it also faces a simultaneously high burden of noncommunicable diseases.

Addressing the social determinants of health—or the “causes of the causes”—is crucial for improving health outcomes. The social determinants across the spectrum of health inequity include: risks to ill-health (exposure, vulnerability); restricted access to health services, in terms of their location, appropriateness and affordability; and the negative consequences of ill-health, including work-related loss of income and the costs associated with providing care.

There are several challenges to addressing these social determinants. The first is skewed economic development, which leads to increasing disparities, such as those between urban and rural areas: for example, the health care needs of the rural poor in Viet Nam are three to four times greater than the needs of those in the more developed urban areas. Similarly, maternal mortality rates vary widely by level of development across sub-areas in China. Another challenge is lack of access to education, especially for girls. Mothers’ illiteracy and lack of schooling directly disadvantage their young children. Lack of schooling translates into poor quality of care for children and higher infant and child mortality rates and malnutrition. Mothers with more education are more likely to adopt appropriate health-promoting behaviours, such as having young children immunized. A third challenge is lack of access to safe water and adequate sanitation. For example, evidence shows that rural residents in China face greater risk from unsafe water than do urban residents. A fourth
challenge is migration. Floating populations tend to work harder for lower incomes, experience poorer living conditions, lack basic health knowledge, face more severe health conditions and have lower access to timely health services. A low level of access to health services, especially for the poor, is a fifth challenge. Several countries show large inequalities in health-service use across income groups. For example, while significant progress has been made in China’s maternal health services, considerable regional disparities exist. Analysis shows that financial reasons account for 35% of women who do not have deliveries in hospital and transport or cultural constraints account for the remainder. Other challenges are inadequate investments in health, weak health systems, and lack of mechanisms for intersectoral collaboration on health.

The MDGs have motivated policy-makers to enhance activities that address the social determinants of health. In tackling these determinants, efforts are needed both at national and regional levels. At the national level, governments should assess public health equity as an indicator of development objectives. Within the health sector, health reform should result in better geographical and financial accessibility to health services. Efforts need to focus on improving the quality and relevance of services and improving efficiency and equity in the performance of the health system, by promoting public health and primary health care. Action across sectors should focus on: promoting economic development and increasing investments in health; increasing education, especially for girls and women; popularizing knowledge of health and hygiene through appropriate education and promotion; and improving sanitation and environmental conditions. At the regional level, mechanisms are needed to coordinate activities related to the Commission and set up Knowledge Networks for sharing knowledge and experiences.

Commissioner Professor Frances Baum, Professor and Head of Department of Public Health, Flinders University, spoke about the Commission’s vision for change. The Commission aims to put the social determinants of health on the international health agenda and encourage action on them, to improve health globally, and to reduce health inequities within and between countries. The goals of the Commission are:

1. to support policy change in countries by promoting models and practices that effectively address the social determinants of health;

2. to support countries in positioning health as a shared goal to which many government departments and sectors of society contribute; and

3. to help build a sustainable global movement for action on health equity and social determinants that links governments, international organizations, research institutions, civil society and communities.

Social determinants are important because they have a direct impact on health and because they structure other causes of health. Since the 19th century, modern public health has stressed their significance. Agreements such as Alma Ata and the Ottawa Charter emphasise that health service intervention is only a minor determinant of population health. As Nelson Mandela said, “...the very right to be human is every day denied to hundreds of millions of people as a result of poverty.... [This is] not a preordained result of the forces of nature or the product of a curse of the deities, but the consequence of decisions which men and women take or refuse to take.” This message, however, is not yet enshrined in policy and action.
The Commission was launched in Santiago, Chile in March 2005 and has a three-year life, from 2005 to 2008. In the global environment, the Commission acts as a champion of social causes of ill health and inequity, seeking to influence global institutions (including WHO) and national governments by using evidence, and on-the-ground initiatives, and working with powerful global institutions and grass roots civil society. The Commissioners include academics, politicians, civil society representatives, and senior public health bureaucrats. They will help translate knowledge gained from other work streams into levers for policy change and action on health, and mobilize financial and human resources, as well as and political support for the Commission.

At the global level, the Commission engages institutions in several ways, including through:

1. identifying meetings where global or regional institutions are present to include its key messages;
2. engagement of Commissioners with global and regional institutions and policymaking processes;
3. supporting engagement by global and national leaders on social determinants of health;
4. supporting WHO’s agenda on social determinants of health; and
5. raising its agenda within mechanisms for inter-agency collaboration.

A modest national-level approach would mainstream the strategy for engaging government institutions into the Commission’s areas of work, especially through the country teams. This would promote continuity at the national level, beyond the life of the Commission. Key government agencies would need to be identified during the country work scoping exercise and involved in the process, in order to gain their support, learn from their experiences and build on existing networks, such as the Millennium Villages (where applicable) and the People’s Health Movement, etc.

Recent trends—including rapid globalisation, trade liberalization, financial deregulation, the growing influence of the international financial institutions (such as the World Bank and International Monetary Funds), and the emergence of new global funds focusing on vertical disease eradication and control—pose challenges for WHO’s leadership in global health. Countries are concerned about terrorism and biosecurity. Encouragingly, forces for social justice are stronger because of global campaigns such as Make Poverty History. Social justice has appeared on government agendas in many countries and global civil society is increasingly vocal at gatherings such as the World Social Forum. The growing People’s Health Movement can help contribute to and monitor the work of the Commission and increase its sustainability.

The Commission will work to institutionalize capacities and approaches that act on social determinants of health within WHO policies and programmes, by integrating WHO staff at country, regional and global levels in all its activities.

Success could be achieved in multiple ways. Structural redistribution would involve redistributing power and wealth and increasing educational opportunities, especially for the currently excluded. Alternatively, environments for poor people could be improved, through better housing conditions, social security and public housing. Healthy choices could be promoted through health education, adopting healthy settings initiatives (e.g. Healthy Cities) and providing protective
measures such as condoms, bednets, and safe injecting rooms. Improving the quality, accessibility and equitability of health services is also critical. Comprehensive primary health care should form the basis of the health system and emphasize rehabilitation and prevention as well as treatment.

Successful outcomes will involve increased global knowledge, awareness and advocacy on social determinants of health and health equity with many champions. Best practices on social determinants of health that identify opportunities, diagnose obstacles, inform policy, implement action and measure results will be widely accepted and put into practice. The Commission’s report will form a blueprint for national and global action. WHO and other global and national institutions will adopt a social determinants model and comprehensive approach to promoting health and reducing health inequities. Widespread evidence of policy and institutional change to underpin action across sectors will be available.

2.2.3 Short overview of mechanisms and structure of the Commission on Social Determinants of Health

Ms Sarah Simpson presented a brief overview of the mechanisms and structures of the Commission. The Commissioners give a profile and voice to the Commission, use their experience and knowledge to shape its learning activities, propose mechanisms for translating recommendations into action, integrate the Commission’s message into their respective policy platforms, and seek opportunities to leverage policy change.

The country work stream intends to strengthen action across government to systematically tackle the social determinants of health inequities. The stream consists of three strands: work within countries, such as creating a space for dialogue, brokering people and institutional mechanisms and collecting information on country situations; work between countries, including facilitating networking, exchange and sharing of know-how and training support; and global work, including identifying how to act upstream on global policies, multi-country and regional alliances and reinforcing change within WHO. Under the civil society stream of work, civil society itself defines the strategy and leads implementation. Civil society organizations in four regions, acting as Civil Society Facilitators, initiate a consultative process in countries and regions and link the Commission’s agenda with ongoing civil society action. The Knowledge Networks’ stream of work aims to collect and synthesize global knowledge, across several priority themes (Figure 3) on the links between social determinants and action to improve health equity, including those that can be scaled up.

Figure 3. Knowledge Networks priority themes
Integration across these streams of work will be achieved in various ways. For example, country work can support Knowledge Networks by documenting processes that reduce health inequalities or by undertaking case studies that identify entry points and pathways in the health system as a social determinant of health. Knowledge Networks can enhance country work by supporting the development of national approaches that address the health system as a social determinant of health, from diagnostic aspects to policy evaluation. These Networks can also aid country work by communicating their reports to countries to help develop and implement national actions. Similarly, the civil society stream can support Knowledge Network actions though peer review or by collecting alternative forms of information from communities, such as ethnographic or qualitative research. Knowledge Networks can aid civil society initiatives by validating the knowledge and experiences of civil society, or by providing evidence on the health system as a social determinant of health that can be used for advocacy and dissemination of messages in communities.

Through an iterative and interactive process, the Commission will produce interim and final reports that integrate knowledge and evidence on substantive issues from its work streams. The Knowledge Networks’ tasks will be harmonized by: using standardized points of reference; signalling gaps, cross-cutting issues and synergies across Knowledge Networks; developing models to address them; negotiating the application of minimum standards and guidelines across Knowledge Networks; and setting up external scientific peer reviews.

2.3 Country actions to address social determinants of health

2.3.1 Cambodia

Dr Loun Mondol, Vice-Chief, Planning, Policy Development and Health Sector Reform Bureau, Ministry of Health, presented an overview of Cambodia’s actions to address the social determinants of health.

Of Cambodia’s population of 13.5 million, 85% live in rural areas and 38% are less than 15 years of age. Economic growth has averaged 7% over the past 10 years, with the informal sector employing over 85% of the population. Only 4% of the labour force have secondary education levels or higher. Almost 50% of children are malnourished. Per capita expenditure on health averages US$32. However, 70 to 80% of this comprises out-of-pocket expenditures by households at the time of illness. Evidence shows that catastrophic expenditures contribute to impoverishment. Health and poverty are correlated. For example, the likelihood of smoking is inversely related to per capita consumption and schooling.

Recent years have seen much progress, with the infant mortality rate estimated to have fallen from 95 in 2000 to 66 in 2004, the under five mortality rate from 124 to 82, the total fertility rate from 4 to 3.3, the HIV infection rate from 2.8% to 1.9%, and poverty from 47% to 35% in the same period. However, disparities persist, by income, sex and other indicators of social exclusion. For example, the literacy rate for men is 85%, while for women, it is 64%. Literacy among the richest income quintile is 61%, while, among the poorest, it is only 29%. Only 9% of the poor population live in urban areas, whereas 91% live in rural areas. In urban areas, 72% of households have safe drinking water, although the proportion for rural households is only 40%. The proportions of urban and rural households with adequate sanitation are 55% and 16%, respectively.
A 2006 World Bank poverty assessment recommended secure property rights, greater emphasis on smallholder agriculture, equitable access to common property resources, increased investments in infrastructure, and improved human development and human capital through pro-poor delivery of basic health and education services. The National Strategic Development Plan (NSDP) 2006-2010 accords top priority to improving the lives of the rural poor by raising agricultural productivity and incomes, developing a standardized approach to identifying the poor, and targeting the most needy and least-served. Gender equity concerns permeate all activities under the plan, especially in agriculture, health and education. The plan aims to ensure equitable access to quality education and expand the availability and accessibility of health facilities for poor.

Cambodia’s initiatives to address disparities include education improvement, secure land tenure, and contracting for health service provision in poor, remote and rural areas. It also involves scaling up equity funds to protect the poor from catastrophic health care costs, widening the scope of health insurance, expanding the achieved 3 by 5 targets for HIV/AIDS care and deworming 80% of school children. The Government will support action on social determinants of health in the National Strategic Development Plan 2006-10, through the Technical Working Group on Health and in the Health Sector Strategic Plan 2007-10. It intends to establish an Inter-sectoral Technical Advisory Group and adapt the Commission’s knowledge to the Cambodian situation.

2.3.2 China

Dr Haichao Lei, Deputy Director, Department of Health Policy and Regulation, Ministry of Health, began his presentation by outlining some social determinants of health in China. Despite overall social stability following peace and development, this process seems to have been unbalanced across regions and provinces, leaving the coastal areas better off than other provinces. About 26 million of the rural population lived in poverty in 2004. Urban/rural disparities are a concern (Figure 4). Although about 57% of the population lives in rural areas, urban health is better than that in rural areas. In 2005, only 5.2% of the population had an education of college level or above, and 31.1% of junior school level. Overall, girls have fewer opportunities for education. With industrialization, environmental factors such as ensuring clean air and water, adequate waste disposal and occupational safety and working conditions are increasing concerns. The floating population, estimated at 147.4 million in 2005 and rising, is a serious issue. Globalization has brought home the importance of new and emerging diseases—especially communicable ones—that can cause public health emergencies.

Figure 4: Life expectancy in selected provinces in China (2000)
Numerous steps have been taken to address these issues, based on the concept of the xiao kiaung or harmonious society and scientific development. These include the new socialist, new rural campaign, the poverty reduction project and urban support to rural areas. Ensuring equal access to essential public services, including health and environmental protection, are priorities. In the area of legislation, laws on compulsory education and primary health care have been initiated. Mechanisms are being set up to coordinate the line ministries.

In the future, an in-depth and systematic review of China’s social determinants of health will need to be undertaken. With international collaboration, appropriate public policies and programmes will need to be developed to address issues arising out of the analysis. Social networks will be required to ensure coordination and collaboration across government agencies, NGOs and academia and the private sector.

2.3.3 Japan

Dr Hideki Hashimoto, Adjunctive Professor in Health Management and Policy, University of Tokyo Graduate School of Medicine, presented Japan’s experience. Japan has enjoyed health improvement over the past five decades. As in other industrialized countries, life expectancy has steadily increased. This success may be attributed to the health care and welfare system. Participation in the National Medical Insurance System, implemented by the Government since 1961, is mandatory and premiums are proportional to income, not based on risks such as comorbidity or age. The inclusion of all citizens over 40 is also mandated under the Long-Term Care Insurance System, run by municipal governments since 2000, and premiums are fixed irrespective of income levels, with exemptions for the poor. The Preventive Medicine and Public Health policy provides free annual health check-ups for workers, students, and community residents, and a registry system for neonatal care by every municipal health centre. Social safety nets are ensured by the welfare system, which covers the physically and mentally disabled, mothers and children, the fragile elderly and the unemployed.

Overall, when compared to other developed countries, Japan’s national expenditure on health is efficient. However, the reasons for Japan’s success have not been clearly identified, its sustainability is under question, and inequities remain. For example, all-cause mortality is correlated to income inequality across prefectures. The rapidly ageing population poses an emerging challenge. Evidence shows that household income differentiates the risk of elderly disability (Figure 5). Similarly, national survey data show that the burden of elderly care negatively affects the self-reported health status of women caregivers (Figure 6).

Figure 5. Household income and elderly disability
Figure 6. Caring and health of caregivers
There is a need to address social determinants of health through health policy research and practice in the Asian context—including by considering economic, gender, and ageing issues; family; traditional and transformed functions; and the roles of the state, community, and the individual. Regional networking can facilitate mutual learning.

2.3.4 Lao People’s Democratic Republic

In his presentation, Dr Bounfeng Phoummalaysith, Deputy Director of Cabinet, Ministry of Health, emphasized that health in the Lao People’s Democratic Republic is linked to social determinants such as heredity, income, access to services, lifestyle, education, demographic and village characteristics, and environment. Health care spending and income are strongly linked, with households in the two richest income quintiles spending nearly 100 to 140% more on medical care than those from the poorest, probably reflecting greater access to better services by the non-poor. Physical access is also important. Households in villages, that remain accessible during the rainy season, report higher medical expenditures than those in less accessible villages. The presence of a pharmacy or trained nurse in the village is also associated with higher spending. Education, occupation, and demography also have an impact. Education of the household head increases incomes and reduces poverty by 2% and 3% respectively and has a positive impact on health expenditures. Households headed by farmers show lower levels of health care spending than other groups. Demographic characteristics have a significant impact. Households with elderly people and children have higher per capita expenditures, while those with more women have lower expenditures, reflecting a possible gender bias in household allocation of health expenditures.

The policy for narrowing the gaps is articulated in the government’s poverty reduction framework. Social assistance schemes, such as health insurance for enterprises, community-based health insurance and insurance for civil servants, can reduce inequity. In parallel, health equity funds can assist the poor.

The National Growth and Poverty Eradication Strategy prioritizes 12 health programmes to reduce poverty and improve health outcomes. Those directly related to health include: maternal and child health, immunization, health education, health network expansion, water and sanitation, communicable disease control, control of HIV/AIDS and sexually transmitted infections (STI), expansion of revolving fund drugs, improved food and drug safety, and traditional medicine. Those indirectly related to health include: human resource development and strengthened financing. The strategy aims to improve the quality and coverage of rural infrastructure, as well as health and education services. Analysis identified a clear need to improve the quality and coverage of key public services in health, education, and infrastructure. However, without information regarding the link between public spending and outputs, increased spending alone may not result in improved services. For this reason, emphasis is given to devoting more resources to lower income households, improving sector-wide coordination, and monitoring outcomes to better understand their links to policy variables, such as public expenditures. This should be done as part of an overall effort to improve budget management and governance in the public sector.

2.3.5 Mongolia

Dr Batseredene Byambaa, State Secretary of the Ministry of Health, identified some key social determinants of health in Mongolia, including income disparities, employment, nutrition and food security, water, sanitation and hygiene, rising rates of STI and HIV/AIDS, and alcohol consumption.
The urban poverty rate is 30%, while rural poverty is 43%, and as high as 51% in the western region. Income disparities between the rich and poor and between urban and rural areas are widening. The depth of poverty and inequality among the poor is substantial, with the poverty gap standing at 11% and the severity of poverty at 4.7%. The number of women-headed households is increasing due to various social factors (Table 1). Unemployment in Mongolia is estimated at about 15%. At over 30%, unemployment is three times higher among the poor than among the non-poor.

Table 1. Sex of poor household heads, by location, 1998

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<tr>
<th></th>
<th>Capital city</th>
<th>Aimag centre</th>
<th>Soum</th>
<th>Rural area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men household heads</td>
<td>21.4</td>
<td>39.1</td>
<td>28.5</td>
<td>25.2</td>
</tr>
<tr>
<td>Women household heads</td>
<td>43.8</td>
<td>53.2</td>
<td>51.7</td>
<td>23.6</td>
</tr>
</tbody>
</table>

The Mongolian diet suffers from poor variety, with a lack of fruits and vegetables. Imports of low quality food are increasing. Over 6% of children below the age of five are underweight and 19.2% are stunted. Anemia is prevalent at 14.4% among pregnant women and 21.8% among children below age five. Lifestyle factors, including tobacco and alcohol consumption, are increasing the incidence of noncommunicable diseases. Only half the population has access to safe drinking water, while only one third has access to adequate sanitation facilities (Figure 7). Sexually transmitted infections are the most common among communicable diseases. Their incidence has been increasing rapidly. Although Mongolia had only 16 reported cases of HIV/AIDS by January 2006, the rapid epidemic in neighbouring countries and high-risk behaviours of young people pose potential threats.

Figure 7. Access to water, sanitation and hygiene in Mongolia

The Government has been trying to create a supportive policy and legal environment through policy documents such as the State Public Health Policy, 2001-2015, the Mongolia MDG Strategy, 2000-2015, and the Health Sector Strategic Master Plan, 2006-2015. These documents emphasize the right to health, well-being and equity, as well as pro-poor, client-centred and gender-sensitive approaches. By an amendment of the health law in 2006, primary health care is provided free of charge for all.
Among the principal activities undertaken to address social determinants of health is the establishment of the intersectoral National Public Health Council in 2002. The Council, headed by the Prime Minister, is responsible for coordinating and ensuring intersectoral cooperation in implementing the public health policy and developing partnerships between government, nongovernmental organizations, the private sector and international organizations. Other activities include the setting up of a risk factor surveillance system for noncommunicable diseases, protection and upgrading of 29 springs in 21 provinces under the “healthy springs” project, improvement of two soum hospital water supply and sanitation facilities, and revision of the national standards on drinking-water quality, based on WHO guidelines.

However, these small-scale activities have not resulted in significant impact on the social determinants of health. The social determinants are still not central in the policy agenda and major stakeholders are inadequately sensitized. In the future, the government intends to strengthen the National Public Health Council to become a more effective tool for addressing the social determinants of health and increasing intersectoral collaboration. There is also a need to reach the rural population with basic primary health services, reduce the incidence of STI, HIV/AIDS, and the rising epidemic of noncommunicable diseases through health promotion, increase access to safe water and improved sanitation, and increase community participation in health policy, planning and service delivery.

2.3.6 Papua New Guinea

Dr Angelica Braun, National Health Planner, Department of Health, explained that Papua New Guinea has a population of approximately 5.7 million and a per capita income of $565, making it a low-income country. At 3.1% per year, between 1990 and 2000, the population growth rate is higher than expected. A Human Development Index of 0.552 places the country in the bottom third of all nations. Only 9% of the working age population has paid employment. On average, those aged 15 years and above have only 2.9 years of schooling. There are also large gender inequities. The illiteracy rate is 37% for men and 49% for women. The female/male enrolment ratio is 0.9 at the primary level and 0.77 at the secondary level. The proportion of women in paid employment is 35.4%. A combination of internal and external factors—including a sharp decline in mining, weak domestic demand and low commodity prices, resulting in continued recession—have led to a 3.3% decline in GDP in the past five years. Lawlessness and corruption are other factors retarding development. HIV/AIDS is a serious, nationwide problem.

Decentralization was initiated through the Organic Law of 1998. A large public sector reform process to improve management and accountability in the provinces, led by the Office of the Prime Minister, is ongoing, with support from the Asian Development Bank and AusAID. The overarching principles of the reforms are integration, decentralization, partnership and ownership. The Public Sector Reform Advisory Group (PSRAG) ensures that the process has practical application to service delivery and alleviation of poverty. Other governance initiatives focus on: restoring integrity and independence in the hiring and firing of public service members; strengthening the capacity to investigate and prosecute corruption; activating the Public Accounts Committee; undertaking comprehensive budgetary review and reforms; and building financial management capacity. A Roads Authority and a Maritime Authority have been set up to improve infrastructure. A Prime Ministerial taskforce has been set up to improve the climate for business by identifying and addressing investment barriers.
Analysis suggests that funding for health will continue to decrease in the next five years. Provinces have been obliged to contribute 6% of their social sector funding to the health sector, but more affluent provinces are encouraged to increase their health sector budgets from internal revenue. It is hoped that the public sector reform will improve the delivery of public and health services.

2.3.7 Philippines

Ms Erinda Capones, Director, National Economic and Development Authority, discussed the key social determinants of health in the Philippines and the steps taken to address them. These determinants include income, employment, housing, food security, education, social exclusion (by gender, age, etc.) and the social and health policy.

Poverty incidence is high, with about 30.4% living below the poverty line, 11.3% unemployed and 21% underemployed in 2005. In 2002, the number of families living in slums was estimated at nearly 600,000. Almost 14% of Filipinos faced food insecurity in 2003. There is a need to achieve universal access to elementary education. Although the participation rate in 2002-03 was over 90%, the completion rate was less than 67%. There are also wide regional disparities in health status. Health insurance coverage stands at 64% and needs to be extended, especially to poor families. The overall level of investment in health is low, while the prices of medicines are very high. There is a need to improve the quality of health services as well as the management of national and local health systems. There is a need to address disparities based on age, sex and culture. Children, mothers, the youth and the elderly are particularly vulnerable.

Initiatives to address these challenges include poverty alleviation programmes, job creation initiatives, asset reform (in agrarian and urban land) and micro-enterprise development. The Government has introduced socialized housing programmes for slum dwellers. It is addressing food insecurity through nutrition programmes and the development of agribusiness. About 13,500 classrooms were built in 2005. Distance learning and school-based health and nutrition programmes have also been introduced. The KALAHI programme aims to reduce socioeconomic disparities. Specific programmes target vulnerable groups. Gender mainstreaming is a cross-cutting activity. PhilHealth is currently expanding its insurance coverage and improving the benefit package. Efforts are ongoing to reduce the prices of essential medicines through parallel drug imports, the use of generics and improving the distribution system. Ongoing health reforms aim to improve health service delivery, regulation, financing, and governance. Measures are needed to ensure the sustainability of these initiatives.

Mechanisms for intersectoral collaboration include the Social Development Committee, the Investment Coordination Committee, the Philippine National AIDS Council, etc. Consultations are held periodically with key stakeholders, including government agencies, local government units, civil society groups, the private sector, donors and local communities. Further support is needed to increase investment in the health sector and strengthen capacities in policy development, research and training.

2.3.8 Solomon Islands

Dr Cedric Alependava, Undersecretary, Health Care, Ministry of Health and Medical Services, presented the situation in the Solomon Islands. A prime social determinant is the low literacy rate, with wide variations across the provinces and between sexes. About 84% of the population lives in the provinces, mostly in traditional housing and without access to adequate water and sanitation. The high rate of population growth (2.8% per annum) outstrips the rate of economic growth. An
estimated 42% of the population is under 15 years of age. The sex ratio is imbalanced, at 107 men per 100 women. Both male and female labour force participation are high (over 70%), but most people are engaged in the subsistence sector, with only 23% being in paid employment. Economic incentives and opportunities need to be created in rural areas to reduce rural to urban migration. It is important to create economic and decision-making opportunities for women, so that they can contribute to economic growth and development. Other primary social determinants include geographical constraints, lack of infrastructure and high transportation costs, which make the delivery of basic goods and services difficult, especially to very rural and remote locations where the majority of the population lives. Infrastructure and social services are exhausted. Quality infrastructure and transport services are thus the most critical in ensuring access to basic health and medical services. Ethnic conflict has retarded development efforts and disrupted the delivery of basic health services.

Several government initiatives attempt to address these issues. The Department of National Development Planning aims to increase economic growth and create economic incentives and opportunities in rural areas. Ensuring quality infrastructures (roads, shipping, and bridges) and accessible market outlets are accorded high priority in both the current and next National Economic Development Plans. The Regional Assistance Mission for the Solomon Islands (RAMSI) has normalized law and order and the financial situation. The Ministry of Health and Medical Services implements a reproductive health programme. The Social Sector Division of the Department of National Planning and Aid Coordination also supports population and development planning activities. The Population Geographical Information System (POPGIS), a low-tech, user-friendly system developed by the Secretariat of the Pacific Community (SPC) with the United Nations Population Fund (UNFPA) support, aims to map population and development issues by geographical areas to facilitate development planning.

Partnerships are promoted and transparency fostered, through memorandums of understanding (MOUs) with churches and nongovernmental organizations, to help deliver basic health services. Development partners have provided assistance to help keep clinics, schools and other infrastructure and services running in the post-conflict period. However, the proliferation of donors has raised challenges, including: setting up of parallel operations, rather than working within government rules and procedures; donor-led rather than country-owned development; lack of monitoring, evaluation and accountability; and waste of resources. Though external assistance in health is currently extensive, priorities need to be defined clearly, coordination improved, local systems used, local capacities enhanced for sustainability and quality ensured.

With support from the World Bank and AusAID, the Ministry of Health and Medical Services is currently undertaking a national health review and situational analysis, which will form the basis of the national health strategic plan. Following the successful development of a Sector Wide Approach (SWAP) in education, a similar approach is being explored in health.

The future challenge for national planners is to develop opportunities to allow youth, women, the rural population and the illiterate to participate fully in development. Equally, the health sector needs to ensure the delivery of basic health goods and services at the local level. This will need more investment in quality infrastructure and service delivery, in population strategies, in public health strategies, and in evidence-based approaches. Appropriate monitoring and evaluation of health programmes at the lowest level of delivery and better alignment of donor assistance with government procedures will also be needed.
2.3.9 Viet Nam

Dr Duong Huy Lieu, Director, Planning and Finance Department, Ministry of Health, gave an overview of the social determinants of health in Viet Nam. The poor, ethnic minorities and those living in remote areas are among the most vulnerable populations in the country. Key health indicators show clear disparities by income level (Figure 8). Access to health services also shows variation by socioeconomic status or area of residence (Figure 9). The poor face a higher financial burden of seeking care and use lower cost inpatient care.

Figure 8. Differential mortality

Several underlying trends are a cause for concern. The rise in living standards, including those among the poor, is accompanied by increased use of tobacco, alcohol and overeating. Increasing environmental pollution, as well as poor enforcement of occupational health and safety and traffic safety standards, poses threats to health. With the decentralization of health financing, it is harder for poorer provinces to fund basic health care. Rising costs of curative care make such care unaffordable for the poor and near-poor. There is political pressure to invest in high-tech curative care services.

Poverty reduction and ensuring access to health for the poor are high priorities for the Government. Policies to reduce health gaps include free health insurance or exemptions for target groups, investments in infrastructure, training at the grassroots level, and preventive health programmes focused on maternal and child health and infectious diseases.

There have been attempts at intersectoral involvement in developing policies. For example, consultations are held with provincial, district and lower level authorities during policy development. Large international donors, UN agencies and nongovernmental organizations are also actively involved in policy dialogue. However, problems have been faced in intersectoral implementation, due to shared accountability and barriers to sharing resources. Lack of funds and effective monitoring are also constraints to successful implementation at the provincial level. Although the principle of community involvement for implementation of policies exists, actual community participation varies considerably by policy and by the effectiveness of community level institutions.

The Health Partnership group between the Ministry of Health, donors, UN agencies and NGOs is quite active and constitutes a potential mechanism for cooperation on social determinants of health. The Comprehensive Poverty Reduction and Growth Strategy and the MDG process also help keep health equity high on the agenda. However, challenges are faced in coordination, identification of problem areas, implementation of policies, and monitoring and evaluation.
The Commission can help by providing advice on measures to counter the negative effects of ongoing reforms—including decentralization, autonomization of hospitals, private sector development, and other market-oriented reforms—on social equity. It can help in continuing to push for basic quality health care in remote and poor areas, where maternal and infant mortality remain high and clean water and sanitation are still inadequate. Assistance is also needed with reform of the grassroots primary health care system to deal with changing disease patterns (noncommunicable diseases and accidents) in a low-cost manner. Measures and institutions are needed to control the rising costs of health care, especially for the treatment of noncommunicable diseases. The Commission can share international experience in:

- measures to counteract negative impact of WTO accession and globalization on health and health care (especially in the area of pharmaceuticals)
- planning to ensure healthy urban settings, especially in the technical and management aspects of sewage treatment and garbage disposal that are affordable and feasible in a low-income country setting
- development of a gender approach that focuses on men’s lifestyles affecting their own health and that of their families
- prevention of health problems among unemployed youth, including drugs, prostitution, crime, and mental health conditions

2.3.10 Global progress: update on CSDH country work

Dr Chris Brown, Senior Advisor for Country Work in the CSDH Secretariat, presented an update on the global progress in country action, which plays a strategic role within the Commission. Countries are the place of convergence for actions in all the Commission’s streams of work. The country level is where the impact of its actions will be felt and measured. It is therefore important to build capability in countries to take forward the process beyond the life of the Commission. The Commission partners with countries wanting to strengthen the performance of health policy and improve health equity by addressing the social determinants in addition to downstream risk factors or service issues.

The goal of country work is to strengthen action across government to tackle systematically the socially determined causes of health and health inequities. The Commission hopes to show that, although there are various entry points for this process (Figure 10), all stakeholders must eventually be involved, if positive change is to be sustained. Several countries have expressed interest in collaboration, while others are discussing the focus of such a partnership. Still others have already formalized their collaboration (Figure 11).
There are three strands of country action. The first is within country action, which takes various forms, such as: creating space for dialogue (e.g. Iran); brokering people and institutional mechanisms (e.g. Kyrgyzstan, Lithuania, and the Regional Office for the Eastern Mediterranean case studies); putting social determinants and inequities on the policy agenda (e.g. Brazil, Kenya); identifying priorities and setting targets and indicators to monitor concrete actions (e.g. Chile, Brazil); influencing national resources and investments (e.g. England, Canada); and collecting information on the country situation.

As an example, the entry point for the country work in Iran was the government's new development policy, which aims at balanced growth and development, with an increased emphasis on equity and contribution from all sectors. The challenge lay in operationalizing this policy. Decomposition analysis of socioeconomic inequality in infant mortality was done, using data from the Iran Demographic and Health Surveys (DHS) of 2000 and 2006. It showed that inequalities in infant mortality are determined by factors beyond the health sector. For example, educational status explains 21% of inequities, while lack of sanitation explains 12%, especially in rural areas. The Ministry of Health thus recognized the need to work more closely with other ministries—education, labour and welfare, trade, regional development—to achieve health targets and contribute to the balanced growth and development policy agenda.

Iran is now conducting an equity impact assessment of the development policy to identify priorities and strengthen policy coherence across government. Strengthened data analysis and interpretation have aided in the articulation of social determinants in decision-making for investment. A High Level Steering Group on Social Determinants reporting to the President's office and an intersectional technical steering group based in the Ministry of Health have been set up. This will help the government move from pilots to mainstreaming the social determinant agenda into policy, legislation and organizational behaviour.

Similarly, the entry point in Chile was a major reform of health policy and the social protection systems, launched to address persistent inequalities, despite overall improvement in health and development indicators (Figure 12). Measuring the health inequalities and identifying the best cross-sectoral responses posed a challenge. Analysis showed that 88% of socioeconomic inequalities in infant mortality are explained mainly by factors like mothers' education and occupation and 30% by conditions originating in the perinatal period. This illustrated the importance of intersectoral action.
Chile is using a range of tools and techniques to measure equity gaps and related social determinants. A mid-term evaluation of national health targets was conducted in 2005. A study measuring the financial impact of health care was also done, using WHO methodology on catastrophic expenditures and impoverishment (CEI). A technical workshop was held and a national team established to develop the survey and indicators for mainstreaming the CEI methodology. In future, the government will strengthen the mechanisms for multisectoral priority setting and action, such as through the Chilean Health Equity Initiative. A process of public debate will help develop a framework to determine priorities and coordinate action across sectors. The Minister of Health, who is responsible for equity, liaises with the Commission and national actors through the Cabinet. A special unit has been set up in the health ministry for coordination. The national and regional levels are to translate knowledge into action and monitor the impact of these changes.

The second strand of country work involves action between countries, or bilateral and multi-country action. This comprises the exchange of know-how through: tools, technologies and tactics; documentation and sharing of information through global and regional policy dialogue events, as well as peer review and strategy exchange workshops; in-country capacity building to manage the political and technical aspects of mainstreaming the social determinants approach; and the development of regional strategies, such as that developed in the Eastern Mediterranean region.

The objectives of this regional strategy are to: raise awareness of social determinants of health in the Region, develop a regional perspective, and identify ways stakeholders can work together to develop a solid evidence base in the Region to facilitate further work, advocate for the inclusion of social determinants of health in national policies, and build a cadre of committed policymakers. A regional Task Force is being formed, with members from WHO’s Eastern Mediterranean Regional Office staff, civil society representatives, knowledge institutions, and WHO Headquarters’ equity team from Geneva. The task force will provide guidance on how to position the social determinants of health with respect to regional activities related to the MDGs, sector-wide approaches and Poverty
Reduction Strategy Papers. It will review country papers and develop a regional paper on the social determinants of health. It will encourage country offices to undertake related activities and strengthen advocacy in the Region. Country papers are being developed for Egypt, Iran, Jordan, Lebanon, Morocco, Oman, Pakistan and Palestine. These countries have been selected to capture the variety in health status and social determinants of health found in the Region. They will provide a basis for strengthening attention on social determinants and identifying regional priorities for action.

The third strand of country work is the global or international strand. This involves identifying how international institutions may enable country action, collecting concrete experience on how to act upstream on global policies (e.g., the MDGs), forming multi-country and regional alliances and reinforcing change within WHO. The primary focus is currently on the first two strands.

Following Sen, Anand argues that health cannot be treated like other human goods. Health is the foundation of all other human capabilities. It is the basis for people’s ability to act as agents. Thus governments have a special responsibility for ensuring equal access to this fundamental good. What is to be equalized is health opportunity, not health status. Making substantial progress on health equity requires action on the social determinants of health. These ideas are meant to give initial groundwork for the “values” work of the Commission, which will continue. Commissioners with a special interest in this area will take the lead, with support from the Secretariat. Clarifying the relationships between health equity, social determinants, political power and individual agency will be an important conceptual contribution of the Commission.

2.4 The role of civil society in addressing social determinants of health

Dr Guo Yan, Commissioner, chaired this session, which examined the role and activities of civil society in partnering with the Commission to address the social determinants of health.

2.4.1 Global progress: update on CSDH-civil society participation

Dr Orielle Solar from the CSDH Secretariat at WHO Headquarters presented an update on global progress in civil society participation in CSDH activities. In the words of Commissioner Ndoro Ndiaye at the first meeting of Commission’s regional civil society facilitators, "The presence, advice and testimony of civil-society actors is essential to the work of the Commission and will be decisive to the general awakening we wish to promote."

This strand of work provides the Commission with a comprehensive strategy that draws on the knowledge and experience of civil society organizations and communities and is led by civil society. Social participation and empowerment can potentially provide ethical legitimacy, checks and balances through social monitoring, and sustainability. The active participation of civil society organizations in the work of the Commission will provide a global platform for their voice, strengthen their capacities, and advance their agendas on social determinants. Participation from civil-society groups is crucial for the Commission's success as it will broaden the political uptake of the Commission's messages and improve the chances of sustainable impact.

The process for identifying Civil Society Facilitators included Secretariat research, CSDH regional consultations and recommendations from Commissioners. Criteria for prioritization included organizations possessing network structures, links to different types of groups within their regions, connections at the grassroots level, and diversity of actors, as well as those working on
issues specific to the regions. Civil society organizations in four regions currently act as Facilitators (Figure 13). Led by the Facilitators, civil society itself will define strategy and lead implementation through a consultative process in countries and regions and will link the Commission’s agenda with ongoing civil society action.

Figure 13. Regional Civil Society Facilitators

Regional CSFs:
- **Africa**: Health Action International; Equinet; Health Civil Society Network
- **Asia**: Asian Community Health Action Network; People’s Health Movement India
- **Eastern Mediterranean**: Association for Health and Environmental Development
- **Latin America and Caribbean**: Latin American Confederation of Rural organizations; Association of Rural and Indigenous Women; Latin American Association of Social Medicine; Network for Health and Work

Two phases of civil society activities are planned. The phase from September 2005 to March 2006 is for the design of regional civil society strategies and implementation plans with measurable targets, through regional and national civil society consultations and political mapping. The mapping is a situation analysis for the region and involves assessment of opportunities, barriers, potential allies, donors, national policies and events on relevant themes. The implementation phase starts in May 2006, with the third meeting of the Facilitators.

The red markers in Figure 14 indicate regional civil society meetings in connection with the Commission. The blue crosses identify countries that have sent participants to these meetings. Past national civil society meetings are indicated in green and planned meetings in yellow. In Asia, national meetings have been held in India (two), Chira, Indonesia, Bangladesh, Sri Lanka, Nepal, Thailand, Malaysia, Philippines, and Viet Nam, and one is planned in Cambodia.

Figure 14. Recent Civil Society meetings
Participants at the Second Global Meeting of Civil Society Facilitators in Uruguay in December 2005 worked out the links between the civil society strand and other strands of the Commissions' work. Civil society actors can ensure that the Knowledge Networks incorporate knowledge from civil society and communities, while the Knowledge Networks can validate civil society knowledge, strengthen civil-society advocacy and provide tools for community-based research. Country work can promote empowerment of civil-society actors, their involvement in government decision-making processes, intersectoral action, and social monitoring and follow-up.

2.4.2 Progress in the development of civil society action with the Commission

Dr Prem Chandran John of the Asian Community Health Action Network and People's Health Movement spoke about civil society partnerships with the Commission in Asia.

The need to involve communities in planning, implementation, monitoring and evaluation of health programmes has been recognized since Alma Ata. Civil society organizations (CSOs) offer several advantages in that they often work at the grassroots level and are able to articulate the needs and aspirations of communities, especially the poor. Civil society engagement with the Commission can increase clarity on the political and economic dimensions of health and affirmation of health as a fundamental human right.

The civil society stream of work envisages the joint formulation of plans, policies and strategies with the Commission, based on the analysis of CSOs themselves. Civil society groups face various barriers in acting on social determinants, including lack of information, lack of expertise and resources, and differences in approaches. The varying strengths and weaknesses of CSOs in countries will determine the specific nature of civil society partnerships on social determinants. Where civil society is strong and has links with government, country work—linked to the work of the Knowledge Networks—is possible. Where civil society is strong but has weak links with government, civil society action will focus on working with the Knowledge Networks. Where civil society is weak, the emphasis will be on capacity building. In countries where civil society is strong, but their links with the Commission are weak, advocacy on the Commission and on social determinants of health will be needed.

As part of a regional situational analysis, the mapping of CSOs, other actors, donors, opportunities, events, anticipated obstacles, and entry points for policy discussion on social determinants of health has been a primary focus of work in Phase I. Criteria for identifying civil society partners include: their interest or expertise in social determinants; their ability to advocate with government and the public; their ability to promote these issues with civil society constituencies; their capacity to contribute to analysis, policy development and implementation; and their ability to link communities' voices to country work.

Civil society action on social determinants can take many forms. One area of work could be bringing participatory research on par with institution-based research, consolidating the fragmented research findings of CSOs to feed into policies, and building the capacity of CSOs to conduct such research with more rigor. A second is lobbying and advocacy, while a third is service delivery. CSOs are often better able to reach communities and can educate communities, increase the demand for services, and even provide certain services.
Civil society organizations have various entry points for such work. They can initiate dialogue with Commissioners at country level, work with WHO and the Secretariat, get involved in country work, contribute to the outputs of Knowledge Networks, or work with communities. They can create regional and country groups to document civil-society work on specific determinants to feed into the work efforts of the Knowledge Networks. They can prepare civil society reports on the social determinants of health. Civil society can link local communities to policymakers. Civil society organizations working on health can develop models of intervention. The increasing global focus on health creates important funding opportunities. Areas of focus of such work could include: food security, access to basic needs (water, sanitation or housing), access to health services and medicines, healthy environment, gender equity and health policies. Strategies for Civil society organizations can include: research, public campaigns, networking, advocacy, social mobilization, service delivery, and networking with related groups. WHO and the Commission should facilitate regional and national meetings of civil society to identify areas of country work, in partnership with governments or independently.

Civil Society Facilitators function as a non-hierarchical enabling mechanism for exchange and sharing. Regional CSO meetings are intended to provide civil society partners with clear directions. CSOs from 11 countries participated in the Asian Regional CSO Meeting held in Bangkok in November 2005. Country consultations are intended to deepen civil society engagement with the Commission. National meetings have been held in India, Nepal, Bangladesh, Sri Lanka, Indonesia, China and Viet Nam, and are planned in Cambodia and the Philippines. In Thailand, CSOs are undertaking a country study of social determinants of health. Regional and sub-regional meetings are envisaged as workshops to produce and disseminate materials, and set up working groups on specific determinants to interact with the Knowledge Networks.

The regional CSO strategy will result in sensitization and capacity-building of a range of CSOs on social determinants of health and documentation of civil society work on social determinants to complement the work of the Knowledge Networks. It will also allow for the identification of a civil society perspective on social determinants, the development of frameworks and plans for country work—in partnership with governments where possible—and a civil society report on social determinants of health to complement the Commission’s work. The expected outcomes from the strategy-development phase include: a coordination mechanism for the region and countries; mapping of important civil society organizations and of the sociopolitical situation with respect to key determinants; prioritization of specific social determinants of health; and identification of modes of action and entry points for civil society.

2.4.3 Update from China

Professor Gong You Long, Department of Social Medicine and Health Statistics, School of Public Health, Fudan University, provided an update on actions on social determinants of health in China by the Chinese Preventive Medicine Association Social Medicine Sub-Branch (CSMA). Established in 1982, the CSMA has 500 members, 80 participating universities or colleges, 12 PhD training courses with 45 candidates, and 30 master degree programmes with 120 students. The social medicine programme covers issues such as population health status, social determinants of health, and social health strategies to improve health status.

Health status indicators have traditionally included birth and death rates, life expectancy, morbidity and mortality patterns—particularly those for infants and mothers—and low birth weight. The new development indicators that social medicine currently looks at include: potential years of
life lost, life expectancy free of disability, active life expectancy and disability-adjusted life years (DALYs). Important areas of study in social medicine include health economics, urbanization and health, immunization, tuberculosis control, health insurance coverage, maternal health, the life cycle approach and gender and health.

For example, economic analysis of health shows that a one year increase in life expectancy is associated with a 4.3% increase in GDP, or that a 1% increase in health investment is associated with a 0.78% gain in GDP. Analysis also shows gender inequities in health expenditure by region. For example, the male/female ratio in health expenditure is 1.26 M/F in the eastern region, 1.14 M/F in the central region and 1.12 M/F in the western region. The overall annual health expenditure is 2898/2510, M/F. Women have been found to be disadvantaged in access to care and delays in diagnosis. A TB social assessment finds that poverty is related with low levels of education. Current analysis of equity and health focuses on: the health care transition in urban China; an assessment of factors related to health insecurity in the eastern, central and western regions; and a performance assessment on the responsiveness of the Chinese health system. Behavioural studies include a surveillance system for behavioural risk factors in China and the prevention of drug abuse, teenage pregnancies, STI, and accidents and injuries. Other areas being explored include population and health, employment and health, poverty and health, education and health and social development and health.

The CSMA intends to hold a workshop on social determinants of health in Beijing this year and looks forward to further cooperation and support from WHO.

2.4.4 Update from Viet Nam

Dr Phan Vu Diem Hang of the Viet Nam Medical Association discussed civil society initiatives on social determinants of health in Viet Nam.

Primary social determinants of health in Viet Nam include environmental issues (deforestation, urbanization, pollution, chemical misuse, housing, water supply and sanitation), lifestyle issues (traffic safety, poultry breeding, injection drug use, and dietary and sexual practices), and health systems issues, especially the quality and prices of medical services and medicines. Viet Nam has had some important success in addressing social determinants of health. For example, polio was eliminated in 2000 and neonatal tetanus in 2003. Immunization rates are very high, with no 'EPI blank' commune. Other successes include SARS and avian flu control, the Healthy and Cultural Village movement and guidelines on the socialization of health care.

Addressing social determinants of health is an important but new notion in Viet Nam. It requires new ways of thinking among decision makers and society as a whole, and new methodologies, including revision of training curricula. This is extremely challenging.

The process of civil society engagement on social determinants of health in Viet Nam began after the Asian civil society workshop in Bangkok, in November 2005. After discussions with Ministries and civil society, the Viet Nam Medical Association organized a national workshop in March 2006. The workshop objectives were to share understanding of the Commission and of social determinants in Viet Nam, and to establish a social-determinants network and develop a plan of action. Participants, numbering over 50, included the Ministry of Health, the Institute for Health
Policies and Strategies, the School of Public Health, the Food Safety Administration, the Viet Nam Medical Association and its member associations, international and local NGOs, the National Academy of Administration, ecologists, the mass media, and UN agencies including WHO and UNFPA. The workshop resulted in a clear understanding of the initiative, a strong commitment to take leadership, and the formation of an initial network, complete with vision, goal and objectives up to 2008, membership and regulations, a Chairperson, and a Secretariat. The preliminary plan of action includes expansion of the network, communication and advocacy, future meetings and research by network members.

The expectations of Vietnamese civil society from the Commission include advocacy at the global level with UN agencies and other international partners, regular sharing of knowledge and lessons between countries and assistance with fundraising to support country activities.

2.4.5. Update from Cambodia

Dr Sok Sovannarith presented the experience of Medicam, a membership organization in the health sector with 111 members including nongovernmental and donors, as well as bilateral and multilateral agencies. A prime mandate of Medicam is representing the voice of nongovernmental organizations in the health sector. It has done this by preparing a position paper to the Consultative Group Meeting and by participating in the Joint Annual Performance Review and in technical working groups for health and HIV/AIDS, in addition to the Country Coordinating Mechanism of the Global Fund to fight AIDS, tuberculosis and malaria. Medicam also shares information in various ways, including its monthly meeting, newsletters, library, database and website. To facilitate advocacy, Medicam works with working groups on child survival and reproductive health promotion, especially on male involvement. The links between NGOs-Civil Society Working Group and the national steering committee for Child Survival are shown in Figure 15. Medicam’s capacity-building activities include training and coaching under the Provincial Network and Capacity Building Project.

Figure 15. Medicam links with stakeholders
The network is a focal point in assisting the government to communicate and coordinate with the nongovernmental organizations community health matters. It is a safe forum where NGOs can strategically debate and generate internal consensus before advocating for policy change. It is marked by inclusiveness, leverage and credibility, especially for smaller, voiceless NGOs and community-based organizations. It aims for alignment and harmonization of policies through the technical working groups. However, Medicam faces several challenges. It lacks enforcement power and faces a huge diversity among stakeholders in the sector. Sometimes, the network is unpopular with government, donors and NGOs, while quality information sharing and mapping efforts of the NGO community on health, alignment and harmonization are also key challenges. Nevertheless, the Medicam experience shows the value of creating a network in each sector for alignment and harmonization with government and donors and for successful advocacy. The network is currently revising its membership criteria and trying to close the gaps between community-based organizations, nongovernmental organizations, policymakers and donors.

In discussions following these presentations, the issue of a potential relationship between the brain drain and General Agreement on Trade and Tariffs was raised. Although GATT apparently contains no specific provision on human resources and services, it is perceived as facilitating brain drain, mainly from South-East Asia to the USA, the United Kingdom and Middle Eastern countries. Governments considering human resources as a commodity may contribute to brain drain and may be at odds with the health sector that wants to retain trained staff. On the other hand, governments often do not have the financial resources to counterbalance the brain drain or cannot impede the fundamental human right of freedom of movement. This global phenomenon needs to be analysed, in combination with urban-rural, and public-private sector brain drain within countries. Another trade issue is the increase of medical tourism, which involves the establishment of health facilities and specific training of health staff to provide services for rich foreigners, at the expense of less well-off local populations. Civil society organizations can address these issues by advocacy, knowledge sharing, and capacity building: for example, by calling attention to the Right to Health Campaign and making their voices better heard at the national level. To address these civil society concerns, the Commission could identify the characteristics of health workers who choose jobs in a public health environment or in rural areas, compared to those that opt for specialized careers in for-profit institutions.

2.5 The role of Knowledge Networks in addressing social determinants of health

Professor Frances Baum, Commissioner, chaired this session, which examined the role and activities of the Knowledge Networks in partnering with the Commission to address the social determinants of health. Ms Sarah Simpson began the session by providing an update on global progress with regard to the Knowledge Networks.

Figure 16 provides an idea of how the Knowledge Networks are placed within the Commission’s conceptual framework. The nine Network themes were selected because they represent major social determinants with respect to which significant work is needed to further political support. It would not have been possible to address all the social determinants. Decisions for prioritizing the areas of work were based on the greatest likelihood of efforts resulting new policy recommendations, political support, and impact on health equity. For instance, while water and sanitation are important health determinants, other initiatives have already dedicated significant effort to them. The Commission would certainly support appropriate policy recommendations, but did not feel that its resources were best spent on reproducing work already done on water and sanitation.
Each network comprises a global group of experts, working together virtually. Each is coordinated by a hub institution and includes 10 to 12 member institutions that demonstrate geographic, north/south, and disciplinary diversity, as well as country partners and representatives from civil-society groups, Commissioners and WHO at global, regional and country levels. The Commission Secretariat, both at WHO and at the University College London, provides support and input. The organizational hubs are located as follows: early child development in Canada; urban settings in Kobe; health systems in South Africa; globalization in Canada; measurement and evidence in the United Kingdom and Chile; women and gender equity in Sweden and India; social exclusion in the United Kingdom and regional offices; employment conditions in Barcelona and Brazil; and priority public health conditions at WHO.

The objectives of the Knowledge Networks are to identify priority associations across different country contexts and actions that can be taken, as well as to inform and stimulate public debate on opportunities for possible action on social determinants of health. They also include evaluating the application of proposed policies and programmes and identifying their implications for global policy and practice. The Networks are asked to include a diversity of views, information and knowledge sources and make gender equity a cross-cutting theme, in addition to integrating their work with the other streams of CSDH work, and focusing on action. Their key deliverable is a synthesis of global knowledge on the priority association of the theme across different country contexts. The Knowledge Networks will make an inventory of possible actions, policies and programmes to address health inequities arising from social determinants of health, bring out position papers and statements, and develop indicators. The Networks are a resource to support the learning track and will learn from and provides expertise to the country and civil society streams of work.

The first meetings of the globalization and urban settings Networks were held in February 2006 and that for health systems in March 2006, while those for the Knowledge Networks on measurement and evidence, early child development and women and gender equity will be held in April 2006. Key challenges for the Networks include: retaining a focus on policy and programme actions and the upstream determinants; synthesizing common themes and issues across Networks; measuring and gathering evidence for action at the upstream level; and working across the Commission's streams of work.
The following are some examples of how country work can support the Knowledge Networks: identify and document key processes to reduce inequalities in health; conduct case studies to deepen knowledge on specific aspects, e.g., certain entry points and pathways of health system as a social determinant of health; or set up a regional network to review experiences, develop a regional typology of health systems, or characterize the context in which systems operate and information is gathered. Examples of how Knowledge Networks can support country work include supporting countries diagnostics and policy evaluation on the health system as a social determinant of health and communicate Network progress for partner countries to use in developing and implementing national actions. A series of meetings and missions have been held or are planned to make these links operational: for example, the Regional Social Determinants Planning Meeting for the Americas region (March 2006); national scoping missions to Senegal, Nigeria and Mozambique (April 2006); Global Meeting of Commission on Social Determinants of Health Country Partners (May 2006) and Regional Strategy Workshops in the Regional Offices for Africa (June 2006) and Europe and the Pan-American Health Organization (September 2006).

The second Civil Society Facilitators Meeting about Knowledge Networks in December 2005 developed the following examples of how Knowledge Networks can support civil society work. They can ensure that they incorporate knowledge from civil society groups and communities; strengthen civil society advocacy; provide tools for community-based research; promote mechanisms for participatory monitoring beyond traditional health surveillance; and develop and use indicators to monitor the fulfilment of policy commitments and health goals. These objectives can be achieved by including civil society representatives as members of Knowledge Networks and by building links with the reference groups established by regional civil society organizations to work with the Networks. Examples of how civil society actors can support Network activities include conducting peer reviews and collecting new types of information from communities, e.g. ethnographic or qualitative research. A series of meetings and missions have been held or are planned to operationalize these links: for example, the Third Meeting of CSFs (April 2006), and meetings of Knowledge Networks, civil society groups and countries (October 2006).

The discussion following this presentation focused on questions such as: how Knowledge Networks can advance work on the social determinants of health within the region, potential links between country work and Networks, the key factors, actors, incentives and opportunities to do so, how to ensure local relevance, and how to identify gaps in knowledge that the Networks might contribute to filling.

2.6 Addressing social determinants of health in urban settings

Dr S. Iwao, Director, WHO Centre for Health Development in Kobe (WKC), Japan, chaired this session. Three presentations were made, including an introduction to the work of the Knowledge Network on Urban Settings, and two reports from cities addressing some aspects of social determinants of health in their cities.

Dr Susan Mercado, Focal Point, Knowledge Network on Urban Settings, WKC, gave an introduction to the Knowledge Network on Urban Settings. New urban settings, characterized by radical social and political change, greater environmental impacts, the expansion of metropolitan areas and the proliferation of slums and informal settlements, pose threats and risks to health that most cities are unprepared for. In this context, a wide range of health determinants converge in
cities: poverty, gender, social exclusion, access to health care, access to transportation, food security, and living and working conditions, among others. The most vulnerable people in a country may be living in urban settings and their health status and needs may be masked. Of the three billion people who live in urban areas, one billion reside in slums and informal settlements.

The framework for local policy and action to address social determinants of health in urban settings is embodied in several WHO initiatives in the areas of environmental health, health promotion and primary health care.

The Knowledge Network on Urban Settings is currently reviewing tools, methods and interventions to enhance understanding of how social determinants can be addressed. The DPSEEA model (driving forces, pressures, state, exposures, effects and action) provides a useful starting point for analysis of social and environmental factors, as well as interventions. The Healthy Cities approach is a relevant model for multisectoral action for social determinants through healthy urban governance.

Dr D. Enkhbayar, Head of Social Development Department, Ulaanbaatar City Governor’s Office presented the issue associated with housing and shelter in his city. The population in the city has recently increased to over 900,000, or 37% of the total population of the country, mainly due to the migration of people into the peri-urban settlements called, ger districts. Those residents living in apartments fully supplied with public utilities are only 41.5% of the total city population, while the remaining 58.5% live in the ger districts. These areas have no water distribution system, no sewage system and no regular solid waste collection system. Indoor smoke from burning coal and fire wood is very common. Unemployment, low family income and other social and economic factors also affect the residents of these districts.

To address these issues, the city started to implement two projects: one on improving density and conditions of housing in a ger district, and the other on improving public services in Ulaanbaatar City. At this early stage of project implementation, the focus is more on the infrastructure development of the city. However, the improvement of the physical infrastructure is expected to advance the health of city dwellers.

Ms Tang Ying, Vice Mayor, Suzhou City, presented her city’s Healthy Cities programme as an attempt for healthy urban governance. Suzhou City has focused on four areas of strategic development of the city: enhancing capacity in science, technology and education; making urban economic development more international; making development sustainable; and managing urbanization effectively.

In practice, the Healthy Cities programme in Suzhou is geared towards improving health services for the general public, as well as “greening” and cleaning the urban environment. It also focuses on building citizens’ social relations and the capacity of communities, as well as institutionalizing an urban culture of health promotion. Nongovernmental organizations, citizens and private companies can help implement these activities with the city government facilitating and leading the overall Healthy Cities movement.
2.7 Follow-up actions to address social determinants of health

At this stage in the Consultation, participants divided into two groups to consider regional and national level actions to address the social determinants of health.

The group that discussed national level actions noted that work on social determinants is not new, but already existing within governments and civil society groups. Perhaps the term "social determinants" is what is new. Much of this work is motivated by social justice, rather than health considerations. What is needed now is the creation of an evidence base through further analysis of continuing work, successes and failures, and how successful experiences can be applied elsewhere or taken to scale. Available evidence often comes from the developed world and is not applicable to situations in developing countries. New methodologies are often needed, as well as the capacity to respond to the local demand for evidence for decision-making. Evidence on specific, emerging issues is lacking. For example, in Mongolia, these issues include burns resulting from unsafe household heating, the rise of alcoholism, urban unemployment caused by the shift from nomadic to settled lifestyles and rural-to-urban migration. In Cambodia, user fees have become a barrier to accessing health services. Analysing the new Demographic and Health Survey data in terms of equity would help prioritize the structuring of the next socioeconomic development plan.

Such knowledge also needs to be documented and widely disseminated through the development of simple materials, from policy-makers, right up to local communities. Translation of publications from English to local languages is needed, as well as tools and findings from the Knowledge Networks that can be used in ongoing multisectoral training workshops.

Health is a cross-sectoral issue. Action to address its social determinants is therefore needed across sectors. In addition, better coordination is necessary between various stakeholders on policies and actions. Such coordination needs to occur across ministries engaged in health, as well as between government and civil society. Sometimes, the links between national and local counterparts are weak. In the Solomon Islands, for example, some stakeholders, such as church leaders, women’s groups, community leaders and youth, are still not eligible to participate in the tribal (chieftain) system at the community level.

Often, mechanisms exist and can be used or strengthened. For example, there are good regional and international networks in the Pacific, which can be used. The Lao People’s Democratic Republic has set up a sector-wide coordination body. To achieve the goal of poverty reduction, Cambodia’s four-corner strategy spans education, health agriculture and capacity building. Its health coordination body is government-led and partners with WHO, international agencies and civil society groups. In Viet Nam, too, the Ministry of Health is bringing together other ministries and stakeholders such as academics. In the Philippines, there are strong civil society networks which are organizing and empowering communities.

Ultimately, the group agreed that a change in attitudes is needed, through awareness-raising among policymakers and opinion leaders on social determinants of health. Political negotiation is vital to shift the focus from downstream to upstream factors. Understandably, expectations from the Commission are high. WHO can also provide support for research and documentation, translation of publications and organization of meetings on the social determinants of health.
Like its national level counterpart, the group that discussed regional level actions agreed, that a stock-taking of current work at the country level is a priority, since much action is ongoing in parallel. Group participants noted that the Western Pacific is a large and diverse region and that there is a need to embrace its diversity. WPRO countries have many issues in common, such as nutrition or lifestyle-related health determinants, but they also possess many country-specific problems owing to varying levels of development.

Mechanisms are needed to identify specific determinants and share information, as well as to identify the best country-specific approaches and support countries as they address the social determinants of health. Participants noted the presence of strong civil society networks in the region, which can play a role in making a real change in the political environment. Other issues included how countries will process information-rich Knowledge Network products. Some participants suggested country focal points were necessary. Ideas such as local or national commissioners (as has been proposed in Brazil) or a subregional commission for the Pacific were raised. Some participants questioned the added value of the Commission’s work and suggested it may be better to integrate this work with the MDG or Poverty Reduction Strategy Papers processes.

2.8 Workshop: Addressing social determinants of health in urban settings

The whole of the third day of the meeting was devoted to a workshop, chaired by Dr Linda Milan, Director, Building Health Communities and Populations, WHO Western Pacific Regional Office, on the issue of addressing social determinants of health in urban settings.

Dr Keiko Nakamura, Head, Secretariat of the Alliance for Healthy Cities, and Head, International Health and Medicine, Graduate School of Tokyo Medical and Dental University (a WHO Collaborating Centre for Healthy Cities and Urban Policy Research), began the first session of the day with an update on the organization and work of the Alliance for Healthy Cities (AFHC).

The AFHC grew out of earlier initiatives, including WHO Healthy Cities. WHO held a Regional Consultation on Healthy Cities in October 2003. The First Organizational Meeting of the Alliance for Healthy Cities was also held in October 2003. The Inaugural General Assembly and Conference of the Alliance for Healthy Cities was held in October 2004 in Kuching, Malaysia, on the theme “Bringing Healthy Cities to Greater Heights through Stronger Networking and Community Empowerment”. The theme of the Second General Assembly and Conference of the Alliance for Healthy Cities, planned for October 2006 in Suzhou, China, will be “Healthy Cities in the Globalizing World”. Sub-themes will include: creative developments to tackle urban issues; harmonious developments of healthy settings and healthy cities; and evaluation of Healthy Cities and indicators.

Full membership of the AFHC is open to governing units of cities and municipalities (Figure 17). Associate membership is available to individuals, NGOs, national government agencies, private organizations, international agencies and academic institutions. Its organizational structure is given in Figure 18.
The AFHC represents an institutionalized mechanism for a “whole-of-government” approach to promoting health. Political commitment is expressed through a charter or statement for a Healthy City. An intersectoral steering committee is set up for development and sharing of the vision at the international and local levels. A health profile analysis is conducted and incorporated into the city’s master plan. Awareness among policymakers and the public is raised with civil society involvement. Workshops and study tours help build capacity. The leadership of city mayors and governors is crucial.

The goal of evidence-based healthy cities is achieved through health profile and indicator analysis. Such analysis has revealed the effectiveness of integration or an intersectoral approach. Participatory research and its reflection in policies also contribute to evidence-based healthy cities. For example, a study conducted with over 900 households living on river boats under fragile living conditions in Hue, Viet Nam, revealed a complex association between their health and socioeconomic conditions.

Dr Hisashi Ogawa, Regional Adviser, Healthy Settings and Environment, WHO Western Pacific Regional Office, provided an overview of the Healthy Cities movement in the Western Pacific Region. Regional networking had been happening since 1995 through several meetings on Healthy Cities. As a result, the concept and approach of Healthy Cities became more popular, through the production of regional guidelines, case study documentation of model projects, and the organization of regional meetings, training courses and study tours. The process has generated a body of regional resources, including training programmes, experts, and city and national coordinators. Cities were looking for opportunities to exchange experiences among themselves and for recognition. The birth of the AFHC represented the chance to scale up this approach.

The Alliance for Healthy Cities was created to allow wider participation of cities and other stakeholders (nongovernmental organizations, national coordinators, international support agencies, and the private sector); facilitate more effective communication and mutual support among cities; and provide cities and other stakeholders with recognition of good practices and incentives for
innovative projects. The AFHC’s vision is to “build […] cities and communities of peace where citizens of all ages live in harmony, committed to sustainable development, respectful of diversity, reaching for the highest quality of life, by promoting and protecting health in all settings.”

The Alliance is organizationally independent of WHO. WHO is not a member, but serves as Adviser to the Steering Committee. WHO gives annual Good Practice and Best Proposal Awards to Alliance members to promote WHO’s agenda in cities. Awards were given in 2004 in the areas of integrating diet and physical activity in urban planning, healthy environments for children, health promotion investment planning, and making cities safe through emergency preparedness planning. Awards in 2005 included those for building a drug-free community, clearing the air: tobacco-free/smoke-free cities, community-based rehabilitation, financial protection of the poor, mother-friendly initiatives, and pro-poor or equity enhancing Healthy Cities initiatives. Awards are proposed for 2006 in the following categories: addressing social determinants of health in Healthy Cities; financing health promotion activities; gender-based violence prevention; health emergency planning; mother-friendly hospitals; promoting and supporting breastfeeding; and promoting healthy diets and physical activity. In addition, Regional Director’s awards are given at the Alliance General Assembly for long-standing and exceptional efforts to promote Healthy Cities.

Dr Susan Mercado, Coordinator, Urbanization and Health at the WHO Kobe Centre, provided her updates on the work of the Knowledge Network on Urban Settings (KNUS) by presenting a framework for the work of the Knowledge Network (Figure 19). In this framework, urbanization (including slum formation and suburbanization) and health and its determinants in the urban setting are driven by the forces of industrialization, globalization, population growth and demographic change, population ageing, and other factors. In some parts of the world, such as Africa, however, urbanization and industrialization are decoupled. These driving forces and factors converge in urban settings through rural-urban migration, marginalization and poverty. The key pathway for addressing the social determinants of health in urban settings would be “healthy urban governance,” which involves managing these forces and seeking balanced development so as to create the conditions for health for all, and in particular, to reduce inequities in health and its determinants. The balance should be achieved simultaneously in the social, natural, economic and built environment.

Figure 19. Framework for building urban community capital
The Network’s activities will take shape through three operational circles, including a core circle of experts, a synergy circle of agencies, academics and donor organizations that can scale up activities, and a breakthrough circle of cities and municipalities that will work closely with the six Regions of WHO. The starting points for deriving new knowledge under the Network could be located at global, national, municipal or slum levels. Table 2 represents the key questions guiding the Knowledge Network’s various operational areas of work.

Table 2. KNUS’ operational areas of work and key guiding questions

<table>
<thead>
<tr>
<th>OPERATIONAL AREA</th>
<th>KEY QUESTION</th>
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<tr>
<td>Delineating good practice</td>
<td>What approaches and methodologies are effectively influencing social processes to enhance health and well-being?</td>
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<tr>
<td>Identifying challenges and opportunities</td>
<td>What are the organizational and institutional barriers that limit the effective application of these approaches and methodologies? How might these be overcome?</td>
</tr>
<tr>
<td>Developing an interdisciplinary framework for collecting evidence</td>
<td>What is the evidence that these approaches and methodologies work?</td>
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<tr>
<td>Validation and measurement</td>
<td>What comprises evidence in relation to social processes?</td>
</tr>
<tr>
<td>Delineating action-research options and alternatives</td>
<td>What types of research are needed to drive public health-related policy and practice in ways that enhance health and well-being?</td>
</tr>
<tr>
<td>Moving from knowledge to action</td>
<td>What priority actions might WHO undertake, in partnership with others, to ensure effective scaling up of current initiatives and to maximize the health benefits for a critical mass of people living in new urban settings?</td>
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During 2006-2007, deliverables for the Knowledge Network on Urban Settings include reports on 11 thematic areas and the creation of a KNUS secretariat, a network of champions and advocates, and a knowledge-base of existing and new knowledge, as well as a communication system for networking, and a global platform for action on urbanization and health. The thematic areas identified include: the state of health and its determinants in urban settings; the urbanization process and the formation of slums and informal settlements; healthy urban governance; improving health and building human capital; building social capital; improving the living environment; communications and advocacy for healthy urbanization; urbanization and the future; crises and vulnerability; housing and shelter; and integrated approaches to achieving health equity in the urban setting.

Opportunities for collaboration with the this Network include working to produce vignettes, stories and “voices” from urban settings, mapping of urban champions, advocates and stakeholders, and developing proposals for scaling up interventions to address social determinants of health in urban settings.
The Knowledge Network on Urban Settings is also considering opportunities for action beyond the life of the Commission. A critical future challenge for the Kobe Centre will be to become a key research centre on global health policy. Toward this end, a global platform for action on urbanization and health has been conceptualized and will be the result of research findings in the urban field-health research sites and the KNUS. As this is work in progress, the evolving global platform for action is summarized in the phrase ‘healthy urbanization’. Five Es characterize the platform for action—initiatives will be tested to ensure that they: engage all sectors; are environmentally sustainable; deliver equity-based health systems; are energy efficient; empower individuals and communities; and eliminate extreme urban poverty.

2.8.1 Group work: Promoting local actions to address social determinants of health

A significant portion of the day was devoted to working in four groups to discuss various specific aspects of addressing social determinants in urban settings and then reporting and discussing their conclusions in the plenary session.

Group A discussed the economics of urban settings and slums, and focused on: the challenges cities face in trying to balance the need for employment and while ensuring that various forms of work do not pose hazards to slums and general communities; how cities can promote the desirable influences of employment and work conditions on health and reduce the undesirable ones; opportunities to improve employment opportunities and conditions of work for those working outside the formal sector; sectors that need to work together on these issues; and the role of stakeholders such as national authorities, local governments, communities and civil society groups.

People living in urban settings are subject to a range of environmental, social and economic factors that influence their health. Those who are disadvantaged by virtue of their ethnicity, caste, gender, lack of education or other social factors are likely to experience a constellation of adverse conditions that result in poor health. These include poor quality housing, vulnerable land tenure, and inadequate water and sanitation. They also involve weak or non-existent health, education, and social services, environmental pollution, unemployment or dangerous work, and poor public transport. The one billion people living in informal settlements and slums in the developing world experience the worst conditions and their health is the most adversely affected. Their needs, therefore, should be prioritized.

Participants noted that people live in slums because of economic pressures, including the negative impacts of globalization and trade on local industries, employment and economic well-being. The unfair global economic order is thus a "cause of the causes" or an over-arching social determinant leading to unhealthy slum communities. The hardships of slum communities can be exacerbated by the structural reform programmes introduced by the international financial institutions. Appropriate economic policies can stimulate rural growth and job creation to stem the flow of rural to urban migration. Empowerment of poor workers can be promoted through minimum wage laws. Civil society groups can monitor working conditions, undertake advocacy to place the rights of local workers before corporate needs, and improve education and awareness among slum communities.
Governments have a key role to play in providing policy support and developing ways to provide land and basic services. Services are usually not provided in slums. However, services must come with responsibility and the community needs to participate from the beginning. Local slum communities can be empowered through the organization of groups to establish services. Another strategy is to set up decentralized zones, with low-cost housing and subsidized arrangements for facilities and basic utilities. Using the healthy settings approach, health promotion activities can be started through Healthy Workplaces programmes. Taxation policies can also play a significant role, through tax havens or heavy taxation of undesirable activities, such as pollution.

Group B discussed healthy urban governance, the definition of which can depend on its context. Governance is understood to include, but to extend beyond local government. It involves as partners groups from all sectors, including public, private and civil society, whose choices and decisions influence the health of the population. Health-focused urban governance aims to manage industrialization and urbanization so as to create the conditions for health for all and reduce inequity.

Participants noted that governance can result in unsafe or healthy behaviour. Sometimes, issues other than health are prioritized in policymaking. Advocacy is needed, therefore, to place health higher on the agenda. Agenda 21 is a useful framework within which governments can formulate national laws and policies.

Even where policies are good, their poor implementation may result in unhealthy outcomes. This happens because of government's relatively weaker capacity for change, as compared to that of the private sector. Public policies should be implemented in a transparent manner. Living in large urban settings can result in social isolation or alienation, making people individualistic and uncaring about governance or the environment. Good implementation involves overcoming such anomic or apathy and promoting community participation in culturally sensitive ways, for example, by celebrating religious festivals to promote harmony.

Political will and transparency are key characteristics of healthy urban governance. Health, which includes economic, social, physical and religious dimensions, comprises a common political agenda across communities. A sector-wide approach is useful in developing policies to provide public amenities, such as shops, roads and schools, keeping mind the different needs and capacities of various communities.

The felt needs, challenges, opportunities and appropriate policy response vary from the local to the national, regional and international level. Pressing needs at the local level usually include water, sanitation services and employment. The governance challenges are sustainability, operation and maintenance of urban facilities, enhancing skills, and facilitating transport, a living wage and markets. Community-led and managed action, as well as labour surpluses, comprise good opportunities. Laws to guarantee working conditions or minimum wages, zoning to increase the visibility of slums, and tax incentives for employment are important policy options. Organizing and empowering communities are also necessary.

Policy challenges at the national level include rural to urban migration, resulting from scarcity of land in rural areas and vested interests over land use, as well as limited rural employment opportunities, and low rural wages. The policy response involves land reform and rural growth and employment policies. At the regional level, reform may lead to competition for jobs across countries and increased vulnerability resulting from macroeconomic reforms. In response, a regional
consensus on employment standards needs to be developed. At the global level, a primary challenge is reducing the negative impact of globalization without losing its benefits. Policy responses include promoting fair terms of trade, subsidies targeted to poor, and development of employment standards.

Group C discussed the concept and definition of social capital, as well as how best to build it. It also looked at some examples of success, the main sectors that need to work together, and the role of national authorities in this area. The group also discussed the key challenges, opportunities, felt needs and recommended actions in building social capital.

Participants agreed that social capital includes not just economical capital, but also bonding and people's support of each other. It can have both positive and negative implications. For example, the social capital of urban elites can exclude the poor. It would be good to analyze whether and how social capital has played any significant role in improving health outcomes in China, Kerala or Japan. For example, despite improvements in life expectancy in China from 35 to 65 between the 1950s and early 1980s, life expectancy has not improved after the reforms, and disparities are increasing.

Challenges in building social capital include poverty, low health and education status, lack of employment opportunities, lack of infrastructure, linguistic and cultural diversity, urban violence, and limited interaction between urban residents. Another challenge is scaling up from small successes. There are some successful examples of addressing new migrant populations. In Japan, for example, nongovernmental organizations run self help groups for men, which also raise awareness on various issues. In Korea Kyong Rodang is an NGO-led programme that supports migrant population. Papua New Guinea has several examples of nongovernmental organizations running homes for displaced young people, safe houses, or education and health services, especially for young people in cities. Community-based approaches against gender-based violence include neighbourhood women 'ringing the bell' when one of them is abused in the home. In the Solomon Islands, churches and extended families provide support to young people in urban areas. In the Philippines, social workers employed by municipal authorities provide support and counselling to young people. In Kerala, India, library movements from early in the last century continue till today. The Government provides opportunities for people (especially young men) to come together and discuss social and political issues. The Government's Department of Non-Resident Keralites Affairs (NORKA) has offices across big cities in India and in the Middle East to address issues of the large number of migrant Keralites.

Participants recommended comprehensive approaches at the city level to address migrant's issues. Various stakeholders, sectors and government departments need to work together to foster social capital, but especially those involved with urban development, social welfare, health, education, rural employment, nongovernmental organizations and community groups. National authorities can help by regularly assessing and monitor the situation of migrant populations on a regular basis. They can also introduce appropriate policy initiatives to support the migrant population at its source, as well as at its destination, by stimulating rural employment generation, developing infrastructure to accommodate the migrant population and improving intersectoral collaboration and coordination. Networking and information sharing are important at the regional level.
Group D discussed housing and shelter, which need to be addressed through an integrated and holistic approach. There is an influx of migrants from rural to urban areas in search of employment, better services and better standards of living. However, they may only be able to get low-income, insecure jobs with poor working conditions. Moreover, the best land is already occupied by companies and funding for affordable housing is difficult to find. These factors make housing and shelter a critical urban challenge.

Poor planning, weak governance and low revenues are among the pivotal challenges that cities face in trying to improve the condition of shelter and housing in slums and other informal settlements. Class-based inequalities result in unaffordable or poor quality housing for low-income groups. Governments refrain from investing their resources in improved water and sanitation in informal settlements so as to discourage such settlements from becoming permanent or more numerous. Lack of political will is another challenge. Laws and policies to protect workers’ rights, safeguard their wages and help them find employment can help. In the long term, rural growth and development can prevent rural to urban migration. In cities, low-cost housing can be developed through public-private partnerships.

Churches, nongovernmental organizations, the private sector and national and local government agencies are all primary stakeholders in addressing these challenges. National government agencies should invest in transport and communication, education, and rural development. Provincial governments need to develop policies to create marketing opportunities, provide subsidized inputs for farmers, generate employment, and provide social services in rural areas. Local governments need to develop policies to relocate those without shelter to safer environments. Nongovernmental organizations can organize slum-dwellers and local communities so they have a voice in policymaking.

3. CONCLUSIONS

3.1 Concluding remarks

Discussions about next steps and concluding remarks were made in two wrap-up sessions, one at the end of the first two days of the Consultation and the other after the workshop on the third day.

The first wrap-up session was chaired by Dr Timothy Evans, Assistant Director-General, Evidence and Information for Policy Cluster, WHO Headquarters. He appreciated the diversity of the group and congratulated participants on their fruitful deliberations.

Commissioner Professor Frances Baum noted the impressive level of engagement in the Region and observed that capacity building tools will be needed for each of these levels and types of partners—civil society organizations, cities, countries, and the Region as a whole. Social determinants are both obvious and obscure, and understanding the connections between them and health is difficult. She felt that the Commission should change institutions by winning the hearts and minds of their stakeholders, including the World Bank, ministries of health and finance in various countries and training institutions. Commissioner Professor Guo Yan expressed the hope that the Commission would unite stakeholders in action at a higher level of insight.
Dr Soe Nyunt U, Director, Health Sector Development, WHO Western Pacific Regional Office, observed that a good beginning had been made and there was a need to sustain these efforts. He urged countries and partners to undertake advocacy to convince ministries of health and other important policymakers, right up to heads of state, about the need to address the social determinants of health. He assured participants that WHO, at the country, regional and global level, stands ready to help in these efforts.

Dr Chris Brown recognized the Region’s strong commitment to addressing the social determinants of health. The next step is to take this commitment forward by building on existing experiences and lessons learned and taking them to scale. Strengthening the performance of health system performance needs to be a significant dimension of this work. As a first step, she advised interested Member States to send a formal expression of interest to the Commission and WHO Regional Office. This would also contribute to the Commission’s efforts to better tailor the next stage of development of its various streams of work.

In the second wrap-up session, chaired by Dr Soe Nyunt U, Dr Susy Mercado of the WHO Kobe Centre pointed out the need for better insights regarding how to scale up successful local experiences to a national scale. National actions are needed to enable local actions. The most critical issues in addressing social determinants of health in urban settings include land rights, the intersection between public health and law, and the tension between opportunities for urban development versus those for rural development, in the face of rural deterioration or degradation. The Knowledge Network on Urban Settings can contribute by mapping trends in land ownership and their associations with health. It can also document and share the huge range of good practices existing at the local level. Finally, this Knowledge Network could analyze the process of scaling up within specific political, organizational and structural contexts.

Dr Keiko Nakamura of the Alliance for Healthy Cities observed that cities are facing health inequities. There are many ideas for addressing these issues, which need to be shared across and outside the Alliance, perhaps through the Knowledge Network or Urban Settings and the Commission itself. A significant challenge is identifying how to build on the positive aspects of globalization while minimizing its negative impacts. This raises issues at the national and global level, necessitating the need for partnership development. She informed participants that the AFHC would discuss possible actions to address the social determinants of health during its three day Steering Committee Meeting in late March.

Ms Sarah Simpson observed that cities need to address health inequities. One way to begin this task is to start collecting and analyzing information that is disaggregated by various social stratifiers. There is also need for advocacy to change prevailing negative perceptions among policymakers about slum dwellers and identifying possible, government-led solutions.

Dr Soe Nyunt U stressed the need for public-private partnerships, and for corporate social responsibility, especially at the local level. He thanked participants for their active participation in the Consultation and expressed the hope for more sustained actions to address the social determinants of health in the Region.
<table>
<thead>
<tr>
<th>Time</th>
<th>Wednesday, 22 March</th>
<th>Thursday, 23 March</th>
<th>Friday, 24 March</th>
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<tbody>
<tr>
<td>08:30</td>
<td>Registration</td>
<td>IV. The role of civil society in addressing social determinants of health <em>(Chair: Prof. Guo Yan)</em></td>
<td>IX. Workshop: addressing social determinants of health in urban settings</td>
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<tr>
<td>09:00</td>
<td><strong>I. Opening session</strong></td>
<td>• Global progress: update on CSDH civil society participation <em>(Dr. O. Solar)</em></td>
<td>A. Global and regional updates <em>(Chair: Dr. L. Milan)</em></td>
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<tr>
<td>09:30</td>
<td>• Vice Minister, Ministry of Health, China</td>
<td>• Progress in the development of civil society action with the CSDH <em>(Dr Prem Chandran John)</em></td>
<td>• Update on organization and work of the Alliance for Healthy Cities <em>(Dr K. Nakamura)</em></td>
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<td></td>
<td>• Dr Shigeru Omi, Regional Director for the Western Pacific</td>
<td>• Update from China <em>(Prof. Gong You-Long)</em></td>
<td>• Update on WHO support to the Alliance: <em>(Dr. H. Ogawa)</em></td>
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<td></td>
<td><strong>Introduction of participants</strong></td>
<td>• Update from Viet Nam <em>(Dr. Phan Vu Diem Hang)</em></td>
<td>• Update on focuses of the urban settings Knowledge Network <em>(Dr. Susan Mercado)</em></td>
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<td><strong>Group photo</strong></td>
<td>• Update from Cambodia: <em>(Dr. S. Sovannarath)</em></td>
<td>• Discussions</td>
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<td>10:00</td>
<td><strong>BREAK</strong></td>
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<tr>
<td>10:30</td>
<td><strong>II. Introduction to Commission’s work</strong> <em>(Chair: Head of Chinese delegation)</em></td>
<td>V. The role of Knowledge Networks in addressing social determinants of health <em>(Chair: Dr. Frances Baum)</em></td>
<td>B. Group work: promoting local actions to address social determinants of health</td>
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<td></td>
<td>• Introduction to Commission and objectives of Consultation <em>(Dr. S. Simpson)</em></td>
<td>• Global progress: update on CSDH Knowledge Networks <em>(Dr S. Simpson)</em></td>
<td>• Instructions for group work and discussions</td>
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<td></td>
<td>• The relevance of social determinants in the Region <em>(Commissioner Dr Guo Yan)</em></td>
<td>• Discussion: Ensuring local relevance</td>
<td>• Group work</td>
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<tr>
<td></td>
<td>• Presentation <em>(Commissioner Dr K. Kurokawa)</em></td>
<td>• Learning from previous experience in addressing the social determinants and identifying mechanisms so that relevant regional/local experiences are included in the development of global knowledge by the Knowledge Networks</td>
<td>Group A: Economics of urban settings and slums</td>
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<tr>
<td></td>
<td>• Presentation <em>(Commissioner F. Baum)</em></td>
<td>• Identifying the gaps in regional/country knowledge and how the Knowledge Networks might contribute to building regional/local knowledge on the issues</td>
<td>Group B: Healthy urban governance</td>
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<td></td>
<td>• Short overview of mechanisms and structure of CSDH <em>(Dr Sarah Simpson)</em></td>
<td>• Summary: taking this forward</td>
<td>Group C: Building social capital</td>
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<td>• Discussions</td>
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<td>Group D: Housing and shelter</td>
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<td>12:00</td>
<td><strong>LUNCH</strong></td>
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<td>13:30</td>
<td><strong>III. Country actions to address social determinants of health (Chair: Head of Chinese delegation)</strong></td>
<td><strong>VI. Addressing social determinants of health in urban settings (Chair: Dr Soichiro Iwao)</strong></td>
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<td></td>
<td>• Country presentations (Japan, Cambodia, China, Lao PDR, Mongolia, Papua New Guinea)</td>
<td>• Urban setting Knowledge Network Hub (Dr S. Mercado)</td>
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<td></td>
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<td>• Ulaanbaatar: Housing and shelter (Mr Enkhbayar Dondog)</td>
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<td>• Hue: Economics of urban settings and slums (Hon Mr Le Quang Dung)</td>
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<td>• Suzhou: Healthy urban governance (Mr Tan Ying)</td>
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<td>• Discussions</td>
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<td>15:00</td>
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<tr>
<td>15:30</td>
<td><strong>Country actions to address social determinants of health (Chair: Head of Chinese delegation)</strong></td>
<td><strong>VII. Follow-up actions to address social determinants of health</strong></td>
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<td>17:15</td>
<td>• Country presentations (Philippines, Solomon Islands, Viet Nam)</td>
<td>• Group work:</td>
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<td></td>
<td>• Global progress: update on CSDH country work (Dr C. Brown)</td>
<td>Group 1: Actions at regional level</td>
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<td>• Discussions</td>
<td>Group 2: Actions at national level</td>
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<td><strong>VIII. Next steps (Chair: Dr Timothy Evans)</strong></td>
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<tr>
<td>18:00</td>
<td><strong>Reception (hosted by Dr S. Omi, WHO Regional Director for the Western Pacific)</strong></td>
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<td>Dr C. Brown, CSDH Secretariat</td>
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<td>**C. Plenary presentations and discussions (Chair: Dr Soe Nyn-U)</td>
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<td><strong>D. Next steps and wrap-up (Chair: Dr Soe Nyn-U)</strong></td>
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<td>WHO Kobe Centre (Dr S. Mercado)</td>
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<td>Healthy Cities Alliance (Dr K. Nakamura)</td>
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<td>CSDH Secretariat (Dr S. Simpson)</td>
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<td>Final discussions and closure</td>
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# Annex 2

## List of Participants, Temporary Advisers, Representatives/Observers, and Secretariat

### 1. Participants

<table>
<thead>
<tr>
<th>Country</th>
<th>Name and Position</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
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<td>Cambodia</td>
<td>Dr. Loun Mondol, Vice-Chief, Planning, Policy Development and Health Sector Reform Bureau, Ministry of Health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ms Thavary Khout, Deputy Director, Budget and Finance Department, Ministry of Health</td>
<td></td>
</tr>
<tr>
<td>China</td>
<td>Dr. Haichao Lei, Deputy Director, Department of Health Policy and Legislation, Ministry of Health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr. Ren Wei, Director, National Commission of Development and Reform Center</td>
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</tr>
<tr>
<td>Japan</td>
<td>Dr. Hideki Hashimoto, Adjunctive Professor in Health Management and Policy, University of Tokyo</td>
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<tr>
<td></td>
<td>Dr. Katsunori Kondo, Professor, Faculty of Social Welfare, Nihon Fukushi University</td>
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<td>Dr. Boungfeng Phoum Malaysith, Deputy Director of Cabinet</td>
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<td>Mongolia</td>
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<td></td>
</tr>
</tbody>
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<table>
<thead>
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<th>Annex 2</th>
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</table>
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### Annex 2

<table>
<thead>
<tr>
<th>Country</th>
<th>Contact Person</th>
<th>Position/Role</th>
<th>Address/Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
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</tr>
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<td>Malaysia</td>
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<td>Mr Enkhbayar Dondog, Head of the Special Development Department, Office of the Capital Governor, Sukhbaatar Square-11, Ulaanbaatar 46, Mongolia</td>
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</tr>
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<td>Ms Anjanette E. Dimaculangan, City Administrator</td>
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<td></td>
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<tr>
<td></td>
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</table>
Annex 2

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<table>
<thead>
<tr>
<th>WHO REGIONAL OFFICE FOR THE WESTERN PACIFIC</th>
<th>Who</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
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### Annex 2

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OPENING REMARKS OF DR SHIGERU OMI, REGIONAL DIRECTOR,
WHO WESTERN PACIFIC AT THE CONSULTATION
ON SOCIAL DETERMINANTS OF HEALTH IN THE WESTERN PACIFIC REGION
22-24 March 2006
Beijing, China

Honourable Minister, commissioners, distinguished guests, ladies and gentlemen, thank you very much for the opportunity to speak on this important occasion. I would like to express my sincere appreciation to the Government of China for hosting this important meeting. I would also like to thank our esteemed participants from various countries across the Region, both for your participation in this meeting and for the progress you have made so far in addressing the social determinants of health. I am particularly happy to welcome the mayors from various cities in the Region. We look forward to working with you in addressing common issues related to social determinants—such as slums and clean air and water.

One of the most disturbing realities is that although aggregate global health indicators have improved in recent decades, health inequalities between and within countries have widened and are continuing to grow. These trends make this meeting all the more timely. These health inequities are both avoidable and unfair. The key reason we are here today is that across Asia and the Pacific—even in this age of the Internet, globalization and rapid economic growth—700 million people live in extreme poverty. They struggle to survive—on a daily basis—on incomes of $1 or less a day. They often go to bed hungry, suffer without treatment when they are sick, and do not have safe water to drink.

The gap between the rich and the poor is unacceptably wide. For example, the poorest 20% of the world's population are roughly 10 times more likely to die before the age of 14 than the richest 20%. Similarly, in many developing countries, women have very limited access to reproductive health services. Nearly 40% of all births worldwide are not attended by a skilled health worker. Because of a lack of health prepayment schemes, the poor often pay out of their pockets for health care, pushing their families further into the vicious cycle of poverty. Environmental health hazards often take a higher toll on the poor. While global warming is largely due to energy consumption in large and more industrialized countries, its consequences affect the lives of everyone, particularly people in poorer countries. Similarly, the health impacts of globalization have been, at best, mixed—particularly on more vulnerable population groups.

One of the keys to reversing this trend is action on the social determinants of health. In using the term "social determinants", I refer to all factors influencing health that are shaped by people's different positions in society. In fact, social determinants account for the bulk of the health disparities we see today.

Historically, the social dimensions of health were strongly affirmed in the 1948 WHO Constitution and in the Health for All movement, following the 1978 Alma-Ata conference. Intersectoral action on social determinants was central to the model of comprehensive primary health care proposed for achieving Health for All.

Soon, however, the concept of "selective primary health care" gained influence. This focused on a few cost-effective interventions and downplayed the social dimension. For example, interventions such as immunization, breastfeeding and oral rehydration therapy were promoted, while more upstream issues, such as environmental health or water and sanitation, were given less emphasis. Action on determinants—meaning action to address the upstream causes of health—was further weakened by the economic paradigm that emerged in the 1980s characterized by privatization, deregulation, shrinking states and free markets.
Annex 3

Nevertheless, important advances were made in understanding the relationship between health and other social factors. In the late 1990s, several countries, particularly in Europe, began to introduce various innovative policies to improve health through action on social determinants.

Today, health stands higher than ever on the international development agenda. For example, the Millennium Development Goals have created a favourable climate for multisectoral action and underscored connections between health and social factors. This is the context in which the Commission on Social Determinants of Health was launched a year ago.

Fortunately, there is renewed commitment on the need to address the social determinants of health. This meeting illustrates the increasing recognition of the importance of social determinants.

However, I cannot say that we have been successful in turning this recognition into effective action. Of course, we know that changing social determinants for better health requires stronger multisectoral collaboration, strengthening health systems, and developing policy guidance for effective interventions. In fact, almost 30 years ago when the Alma Ata Conference took place, we already recognized the importance of upstream approaches—meaning, addressing the root causes of ill health. But, that recognition has not been transformed into action. So, intellectual understanding is not enough. In my view, the more important need is to fundamentally change our philosophy, our way of thinking, and our mind-sets.

Too often, we tend to be more interested in short-term solutions. Political leaders may be looking for results before their next election. Emphasis on market-driven solutions, with an eye on profits, can also reduce focus on more fundamental solutions. What is more, there is a sort of false assumption that it takes many years before the results of upstream approaches are realized.

Global warming is a good example of the need to change our mind-sets. We have already seen that global warming has resulted in more floods and more droughts. Global warming may even lead to the desertification of the Amazon forest. We know that the solution lies in the reduction of greenhouse gases, such as carbon dioxide. The Kyoto Protocol provides an international instrument to reduce greenhouse gases. But some of us seek short-term gain, instead of achieving the long-term goal and global benefit.

Changing people’s mind-sets and values is, of course, a daunting task. I do not have immediate answers as to how it will be achieved. However, one thing for sure is that we need to be bold and innovative in our thinking. We can no longer afford to engage in business as usual. I hope that during this meeting we will put our heads together and come up with some innovative thinking and approaches. We can try to be innovative in coming up with incentives to promote private sector action on social determinants of health. For example—although this idea does not reflect WHO’s official position, but my thinking—companies could receive tax breaks. Or companies could be given non-financial recognition, such as extending ISO certification for good work in this area.

Today, we have the unprecedented opportunity to improve health in the poorest and most vulnerable communities by tackling the root causes of disease and health inequalities. If we do not act now, we may be endangering not only global public health, but even Planet Earth itself. I hope that this meeting will mark a turning point in our efforts to take effective action to address social determinants and achieve health for all in the Western Pacific Region. Finally, I would like to thank the Government of China for agreeing to host this very important meeting. I wish you success and productive discussions. With these words, I would like to officially announce this Consultation on Social Determinants of Health in the Western Pacific Region open.

Thank you.
OPENING SESSION SPEECH OF DR WANG LONGDE, VICE MINISTER OF HEALTH OF THE PEOPLE'S REPUBLIC OF CHINA
AT THE CONSULTATION ON SOCIAL DETERMINANTS OF HEALTH IN THE WESTERN PACIFIC REGION
22-24 March 2006
Beijing, China

Respected WHO/WPRO Regional Director Dr Omi, ladies and gentlemen, on the occasion of the opening ceremony of this WHO Consultation Meeting on Social Determinants of Health in the Western Pacific Region, please allow me, on behalf of the Ministry of Health China, to express our sincere congratulations as well as our warm welcome to all international visitors from far and national participants.

Health is one of the basic human rights and the common goal to pursue. To study and improve the social determinants of health would have significant impact on the achievement of this goal. Human has to live and conduct productive activities within the overall social environment, in which all social factors would have either favourable or unfavourable impact on his/her health. The MDGs of the United Nations and the commitment to achieve the goals made by the governments of the countries reflect the consensus of nations with different beliefs and countries with different political systems around the world on this issue. WHO formed the Social Determinants of Health Commission in March 2005, and also established the research network covering the nine social determinants of health to provide knowledge and technical support to the Commission, aiming at achieving the MDGs, reducing poverty and its related social problems, and promoting health equity. This will assist the countries to identify social problems in the way of health development and the obstacles in solving these problems. It will also help the countries in sharing experiences gained from practice in this area so as to improve health equity globally.

As different countries may be at different stages of economic development and faced with different problems, they may choose different health systems and have different ways to solve their health problems. This leads to an extensive range of ways to respond to different problems. It is also why it is so important for the countries to share information and experiences.

China is a large populous developing country with many. Over the past 50 years, especially after the opening policy in 1978, China has witnessed continuous rapid economic growth. From 1979 to 2005, Chinese GDP increased from 403.8 billion yuan to 18,232.1 trillion yuan with an average annual increment of over 9%. In general, the living of the Chinese people has been significantly improved, and has preliminarily reached the level of “Xiao Kang” Society. During the process of social and economic development, the Chinese government has always put the health and life safety of the people in the first place, by emphasizing the development of health, strengthening the build up of health infrastructure and health human resources, setting up basically the health care systems and health inspection and enforcement system. As a result, the health status of the people has significantly improved. Let’s take a look at the three major health indicators: the average life expectancy has increased from 35 years in 1949 to 72 years in 2004; the infantile mortality rate has dropped from 200‰ to 21.5‰; the maternal mortality rate has decreased from 1500 per 100,000 to currently 48.3 per 100,000. These changes indicate that China has reached the higher level among the developing countries in terms of people’s health status.

Although China has made achievement in health reform and development, the rapid economic development and improvement of living standards have also brought with them new problems and challenges. The outbreaks of SARS in 2003 uncovered the hidden problems such as the insufficient Chinese public health system, incomplete emergency response mechanisms, irrational distribution of health resources, disparities between urban and rural areas and between different regions. We understand
very well the challenging situation and the significant responsibilities we are shouldering. We also well recognize the unsolved problems with the accessibility to and affordability of health care by the people.

The Government has proposed the scientific development concept that emphasizes people-centred and coordinated development with good balances between urban and rural areas, between different regions, between economic and social development, and between domestic and international development. The Government also prioritizes the problems that are most closely related to the very interests of the people; emphasizes the harmony between economic development and social development; focuses on social equity so that all members of the society could benefit from the achievement in reform and development.

The "Report on the Work of the Government", ratified by the just finished 4th session of the 10th National People's Congress, has sent a clear message that priorities should be given to problems that are most closely related to the very interests of people, especially focusing on health work to gradually solve the problem with accessibility to and affordability of health care by the public. We are now making efforts for changes in the following aspects:

First, to increase government-led investment into health. The Government will continue to increase its input into public health, community-based medicine, rural health and basic healthcare services, meanwhile to encourage inputs from other sources to enrich health resources so as to meet needs at different levels of the public.

Second, to build up the capacity to respond to public health emergencies. Recently in the world, natural disasters occur frequently; terrorism threats increases; major accidents happen from time to time; as a result, being capable of responding competently to emergencies has become an important indicator of the ruling capacity of the governments. The Government has learnt lessons from the fight against SARS, and taken actions to set up and improve the public health emergency response systems at all levels, as well as the prevention and control system for major diseases, medical rescue and treatment system, and health inspection and enforcement system. Now the public health emergency systems have been preliminarily established and have played an important role in responding effectively to major public health events like SARS and bird flu.

Third, to strengthen the prevention and control of major illnesses with focus on HIV/AIDS, hepatitis, tuberculosis and schistosomiasis, and with special attention to the prevention and control of human avian influenza. The Government believes the epidemic of HIV/AIDS has a significant impact on the prosperity of the Chinese nation and the national safety. Therefore, strong and effective measures must be taken to contain its epidemics. We have made and implemented special policies targeting the people living with HIV/AIDS among the rural population and the poor in urban areas, to provide free treatment, free testing, free services to block mother-to-child transmission, free education for HIV/AIDS related orphans, and financial assistance to people infected with HIV/AIDS. All these policies have significant impact both domestically and abroad.

Fourth, to strengthen rural health work. Rural health work is the priority of health work for China, and an integral part of the new socialist countryside. It is one of the important responsibilities of the Government to ensure the basic health needs of the farmers to be met. We will launch the "Plan for Building up and Developing the Rural Health Care System", complete the county-township-village three-tier network, and step by step improve the quality of rural health care. Fifth, to strongly promote the development of urban community-based health services. We will speed up the establishment of the community-based new urban health care network and provide convenient and cost-effective services to the people, by reallocating urban health resources, increasing government's input, strengthening the training of health personnel, optimizing the functions of the providers and encouraging innovative ideas.
Sixth, to complete the health security systems for both urban and rural populations. For the urban population, we will speed up the establishment of urban social health insurance scheme and expand the coverage. We will also set up complementary health insurance, medical financial assistance system and commercial health insurance system. For the rural population, we will proactively promote the establishment of the new rural cooperative medical system. From 2006, the assistance from the central and local budget to each participant farmer of the cooperative medical system will be increased from 20 yuan to 40 yuan. By 2008, the new rural cooperative medical system and the medical financial assistance system will be established in all rural areas in China.

Ladies and gentlemen, the disparities between countries and regions are most significant in health development. Most countries are faced with challenges to reform and improve their existing health system, and to improve the health status of their people. We would like to share with you the following experiences:

Firstly, it is one of the critical responsibilities of any government to protect the health of the people. The government must put the health and safety of the people as the top priority of their work. In the process of health reform, the Chinese government is taking more and more responsibilities. Nearly half of the MDGs of the United Nations are directly or indirectly related to health. Although some of the goals are extremely challenging, the Chinese government is making all efforts to fulfill its promises.

Secondly, health development needs the joint contribution of all social sectors. In the 21st century, human beings are faced with more complicated economic and social problems with more diversified determinants of health. This leads to the involvement of more sectors in the efforts to improve the health of people. In the process of economic globalization, we are faced with new public health problems; human safety is being threatened by emerging communicable diseases like bird flu, AIDS and Ebola infections; environmental pollution, social-economic transition, ageing of population, and the migration of rural population into cities are bringing unprecedented challenges to human health. The health issues of a country need to be addressed by joint efforts of all relevant sectors. In doing so, the Chinese government has formed cross-sectoral leading groups such as the National Patriotic Health Campaign Committee, the State Council HIV/AIDS Prevention and Treatment Committee, the State Council Joint Committee on New Rural Cooperative Medical System, all of which have played extremely important role in promoting the reform in different areas.

Thirdly, diseases don’t respect country borders; neither do the social determinants of health. Therefore, the government of a country is not only responsible for protecting its own people’s health, but also responsible for protecting the health of the people of the world by strengthening the cooperation between governments and with the international organizations. I notice that Health Determinant Commission has set up a research network covering areas such as globalization and health reform, health systems, public health problems, urban poverty, employment and occupational health, early child development, gender issues and monitoring and evaluation. These areas may have not included all social determinants of health, however, the network provides a mechanism for the governmental workers, scholars and non-governmental organization workers around the world to exchange information, and to work closely as to make joint contributions to improving the social environment, preventing diseases from transmission, and to promoting progress, peace and harmony of the human world. I am in full favour and support of this action.

Ladies and gentlemen, let us work together and make our contributions to the improvement of health of the people of the world. I wish all the success of this meeting!

Thank you.