Commission Country Work Strategy:
Supporting national policy action on the social determinants of health

Discussion paper for the Commission on Social Determinants of Health
DRAFT

COMMISSION ON
SOCIAL DETERMINANTS OF HEALTH

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This document has been prepared for the third Meeting of Commissioners taking place in India in September 2005.

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Contents

Summary

The Commission will work with countries to mainstream and strengthen actions to address the social determinants of health inequities. The country work, as a key component of the Commission's implementation strategy, will build understanding of how social determinants of health inequities can be tackled in practice, drawing on experiences across countries, with a view to creating the conditions for good health for future generations. A common objective across all country work will be to progress governmental policies and social agendas towards having health as a "cross-government" or "whole-of-government" priority.

The scope of country actions will range from: (a) strengthening interest in social determinants and developing a common vision and understanding of priorities among stakeholders; to (b) adapting, scaling up and mainstreaming existing circumscribed programmes, which have a proven positive impact on the social determinants of health inequities; to (c) implementing comprehensive reforms to frame health as a corporate priority in public policies and intersectoral action. The actions will aim for universal coverage with the purpose of addressing the health gradient across the full spectrum of socioeconomic positions.

By engaging a cross-section of actors within countries, the country work will demonstrate how an alliance across all levels of government, civil society, NGOs, technical institutions and global and regional partners, can strengthen leadership, systems of governance and upstream policy action on health inequities. The country work will organized around focal contact points or teams within countries. WHO (regional, country and headquarters offices) will play a key role in supporting the country work. Commissioners, the Secretariat, the Commission's knowledge networks, and experts from countries championing health equity will be involved at key points of the process to assist in coordinating, synchronizing, and catalyzing learning between countries, regionally and internationally.

Together, these mechanisms combined with other components of the Commission, will contribute to building a network of actors and institutions with the capacity necessary for sustaining longer-term action on social determinants of health globally.

I. Introduction

This document describes the latest thinking on the Commission's strategy for working with governments to support action on social determinants of health inequities in countries, and discusses the operational implications of the proposed approach. After initial discussion at the Meeting of Commissioners in Egypt, earlier drafts of this document were circulated for discussion in three regional consultations held with WHO and member states (Africa, America's and Eastern Mediterranean WHO regions). The current document has incorporated adaptations to respond to concerns raised in these meetings, and also includes the more recent comments received from Commissioners and the Chair in the run-up to the Third Meeting of Commissioners in India (see Appendix 1). It is intended as a stand alone piece as it is needed for consultation purposes, and for this reason repeats some of the information related to the Commission's overall strategy and conceptual and analytical framework, which are discussed in more detail elsewhere[1, 2](http://www.who.int/social_determinants/).

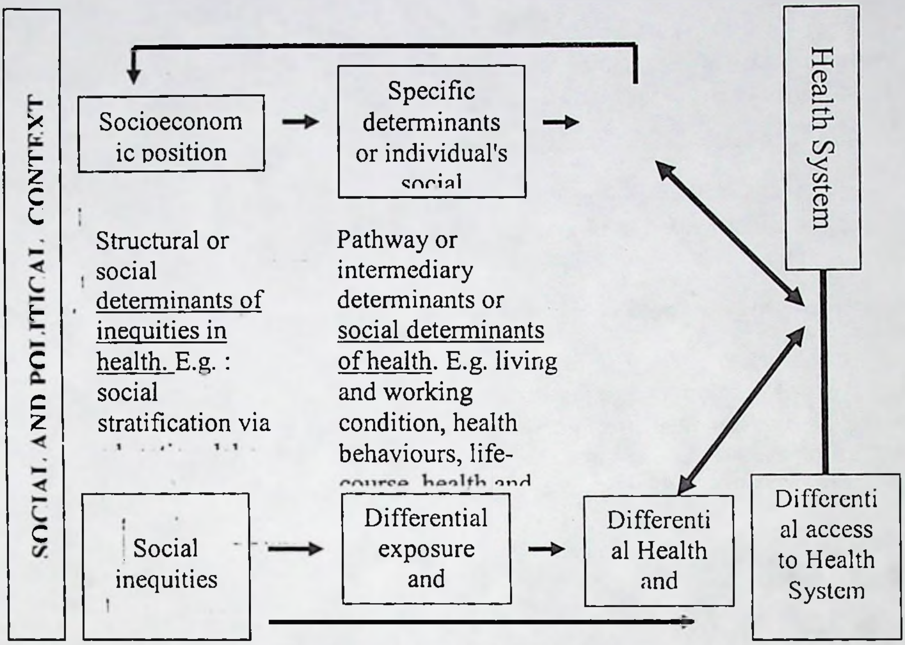
At the 2004 World Health Assembly, the Director-General announced the beginning of a process to act upon the social causes of ill health and inequities by calling for a global Commission on Social Determinants of Health (the Commission). The Commission over three years (2005-2008) will set the foundation for sustained processes to profile and integrate the social determinants of health within public policy and practice. The key insight underpinning the work of the Commission on Social Determinants of Health is that health care is only one of the influences on a population's health. Health is shaped by the social conditions in which people live and work. During its 3-year mandate, the Commission will begin a process of building the evidence, action, advocacy and leadership needed to sustain a global longer-term commitment to addressing the social determinants of health inequities (Edmonton Social Planning Council, 2005).

II. Why take action on social determinants?

The estimated impact of social determinants of health on the health status (average and gaps) of the population is large and yet inadequately addressed in contemporary policies and programmes. For example, in Canada, typical of several post industrialized nations, the impact of social and economic factors on health has been estimated at 50%, with health care systems responsible for 25%, the physical environment for 10% and biology/genetic endowment for 15%. Despite this pattern of attribution, reports from some provinces in Canada show that regional health authorities only spend 3% of their budgets on promotion, prevention and protection initiatives (Edmonton Social Planning Council, 2005) [3].

The diagram shown in Figure 1 identifies a number of potential points in the "social production" of health where governments and other national actors can intervene to reduce social and health inequities[4]. They may act upstream to develop policies and institutions that affect or mitigate the stratification of individuals in society (changing the social context); they may intervene on the **structural** determinants of health which shape where people live and work; they may intervene on **pathways** resulting in people's **differential exposure** and **vulnerability**; or they may intervene through health systems to influence **differential access** to health services and reduce the **differential consequences** of ill-health.

Figure 1: Potential Policy Entry Points in the Social Production of Health



In the context of this framework, the Commission understands that the health care sector is *only one* of the sectors that impacts on health. Improving health equity is a concern across the whole sphere of government and for all actors at country, regional and global level. Therefore, the Commission proposes to work with interested countries to promote political leadership, knowledge and action at national and sub-national government levels as well as with associated regional processes that strengthen country agendas on social determinants of health. To be in line with its core values and mission, such intersectoral actions would need to:

(a) Reflect shared values of health equity and a human centered orientation to development
(b) Support the notion of health as a social concern and an outcome of development
(c) Promote community and civil society involvement in decision-making
(d) Be effective and sustainable.

Furthermore, approaches to action and working with countries will need to be sensitive and responsive to the country's socio-political context and history, as well as its developmental conditions. For example, countries emerging from conflict will potentially require different modes of interaction and types of support.

III. Action at Country Level

Goal

As the ultimate purpose of establishing the Commission is for change, action at country level is key. One strategy for change, discussed here in this strategy, is working with governments to support work:

> *.. addresses health inequities as a mainstream, collective priority across government and society and reorients actions for health towards tackling the social determinants of health inequities.*

Reaching this goal will require: (a) dialogues to strengthen interest in health related inequities, social determinants and to develop a common vision and understanding of priorities among stakeholders; (b) adapting, scaling up and mainstreaming existing circumscribed programmes, which have a proven positive impact on the social determinants of health inequities; and (c) comprehensive strategic, planning and budgeting reforms to frame health as a cross-government priority (see more details in Appendix 2).

Why with governments? Strategic directions.

There are several reasons for the proposed focus on working with governments to support action. However, this will not be the exclusive engagement of the Commission at country-level. Other engagements will take place through civil society, for example. At this level of engagement with governments, several processes can be brought together to change the health policies affecting people's lives: government actions; civil society activism; knowledge institutions; public awareness and global initiative and regional agreements and agendas.

From a strategic point of view, working with governments to promote leadership in this area is seen as an opportunity for the Commission to start to help countries to take action on the social determinants of health inequities; the purpose of the Commission is for action, and this component of work will help the Commission to live up to this admirable aim from early on. In addition, involving countries in action early on will ensure that the Commission will have several real-life examples of what is it talking about, by the time of its presentation of its final report to WHO (May 2008). It will also enable the Commission to ensure that the knowledge network experts and products get referred to real life situations in countries to check their applicability at country-level. Furthermore, it is an opportunity to raise international political interest, at the smallest international unit, for acting on social determinants early on in the process; the nation state engages in global and regional processes (e.g. G8, NEPAD, ECLAC, EU), which can be used to amplify Commission messages.

Finally, and perhaps most importantly, the process of engaging governments is also an opportunity to ensure sustainability of the work on social determinants of health after the Commission has formally ended (August 2008) through:

- → the working mechanisms and channels created within WHO in 2006-2007;
- → through the lessons-learnt on WHO work of this nature at country level, discussed with the WHO Reference Group and WHO Technical Group;

→ through the pressure from WHO's Member States to provide more country assistance and global technical leadership in this sphere.
It is envisaged that a core of interested governments will be able to lead change in the future, and create the demand for new ways of working at WHO, which is envisaged as the *handover agency* for the Commission.

The strategic motivations outlined above for the Commission's country work can be summarized in short-hand. The suggested prioritization is as follows:
→ taking action on the determinants of health inequities
→ examples of good practice
→ developing pragmatic knowledge
→ WHO sustainability development
→ working through regional networks to scale up across countries.

Objectives

Taking the goal and the first four strategic considerations as key, the objectives below will be necessary for the Commission's country work. A more detailed review is needed to formulate a strategy for amplifying the Commission's message and work through regional networks.

1) facilitate direct assistance to countries, both technical and political, from: WHO, Commission knowledge networks, Commissioners, and other experts

2) facilitate between-country dialogue on the social determinants of health equity and the sharing of related experiences and skills

3) actively draw out learning gained from hands-on experiences of countries, nationally and sub-nationally, especially profiling and disseminating lessons for scaling up (within countries) and the role of different levels of government and different governmental mechanisms

4) support national and sub-national government leadership for promoting policies and actions on social determinants of health across their region (including through regional institutions) and share information on these experiences

5) facilitate dialogue with civil society and local and regional knowledge institutions, and develop a better understanding of the role of civil society and knowledge institutions in supporting countries' policies on social determinants of health

6) actively draw out the learning for WHO headquarter, regional and country offices in particular, on how best to support Member States to address the social determinants of health inequities in the future

7) actively draw out lessons for WHO's relationships with other UN and international organizations' when working to address the social determinants of health in order to ensure more efficient and sustained country performance in health policy-making in the future.

IV. How would governments benefit from being involved?

Taking action on the social determinants of health inequities will require determination and political commitment. By being part of an initiative that involves partners with shared goals, actions can be taken in the context of a larger global initiative and with the associated political and evidence-backed support to be provided through the Commission's knowledge networks and WHO. At the same time, the countries embarking on improving health equity as a cross-government goal will be supported in sharing their experiences with one another in an area which has not been the traditional focus of government activity. Many lessons will need to be discussed, shared and synthesized to gain a greater understanding of what this means for policy development, planning and budgeting decision. Sharing technical know-how and learning-by-doing will be and important part of building sustainable capacity in the future.

V. Implementation

Phases of work

The implementation of a stream of work to meet the abovementioned strategic objectives is complex and the strategic directions present competing challenges that will need to be managed. The ideal phasing of the work would seem to be to invest more time in several "exemplar" countries early on in the process, so that *in-depth* work can begin there, while at the same time expanding work and activities across countries as the resources and interests grow.

The challenge even this "ideal" approach presents is the issue of "selecting" countries whose processes are more likely to succeed and getting behind these countries in a more proactive way. The second challenge is to avoid creating a process that is perceived as too "exclusive", which may loose political currency and goodwill. Discussions with regional representatives have indicated that inclusion is important (indeed it is one of the determinants of health!). The third challenge is to manage with limited resources and institutional capacities at the same time in which these capacities are being developed (e.g. training materials, WHO technical assistance).

These challenges necessitate an organic approach, guided by clear strategic directions, which is flexible enough to take hold of new opportunities as they arise. The section below describes the envisaged phases of country work and proposed models of engagement and support in view of the abovementioned challenges.

Engagement opportunities

It is envisaged that engagement of countries can take place through different avenues. These include:

a) Commissioners
    a. personal and professional spheres of influence;
    b. the body of Commissioners as a collective influence, imbued with a special mandate by WHO, as they meet with governmental officials and discuss the Commission's work in front of other audiences;

b) WHO channels
    a. formal regional consultations
    b. technical programmes, existing work

    c. WHO country officer (WR) as a driving force [e.g. because of their own interest in the subject; through new tools in the Country Cooperation Strategic frameworks; responding to needs expressed for WHO to take health leadership in UN processes around the MDGs.]

c) Other streams of Commission work
    a. Knowledge networks as they may come across good practices and developments
    b. Civil society drivers as they map out opportunities
    c. Global initiatives as they identify synergies between protocols and objectives for country work.

Thus far, the use of personal spheres of influence, WHO World Health Assembly forums, WHO regional consultations and to some extent, liaison with global initiatives, have been the main channels of engagement tested so far. Each of these engagement platforms raises different issues with implication for the organization of the work. The implementation process proposed here is intended to be responsive to the different types of engagement.

Inclusiveness

The processes for engagement listed above are inclusive and should at least ensure that all countries have appropriate opportunities to work on social determinants of health. Further to the engagement phase, methods of support need to be developed to ensure that all countries are able to benefit from different streams of work in the Commission, including the knowledge products generated by the knowledge networks, documented and shared experiences of countries, and expert advice of Commissioners. These methods include ensuring a good website and system of information sharing across the Commission components, in particular between countries and with knowledge network products, and that WHO begins to support all countries wanting to tackle social determinants of health inequities through its technical programmes. For this to happen, clear signals would need to be sent from countries interested in the work, as well as from mechanisms created internally to WHO for the Commission, including the WHO Reference and Technical groups.

Sharing between countries

Sharing of experiences between countries is seen as key mechanism for spreading good practice and supporting technical assistance. Mechanisms for sharing knowledge experiences include:

→ use of any other appropriate Internet-based technologies and the effective means of information dissemination.
→ promotion of direct technical sharing between countries (through in-person visits)
→ focussed global inter-country meetings to discuss progress and themes of practical relevance across multiple countries.

While, exchanges using technologies and good dissemination practice on the part of the Commission will be most important for ensuring inclusiveness of a wide-range of countries, specific meetings of actors engaged in country work can be used to grow interest in the work and to share experiences of countries who have already started work or with a long track-record, with countries who are interested beginning work.

The Commission will need to coordinate its various mechanisms for bringing together countries to ensure the most effective use of resources. For example, training programmes may be timed appropriately with respect to critical points in progress updates taking place in the country work[5]. Other meeting-related strategies that can be used to promote interest and action across countries will be invite interested countries to attend meetings or workshops that form part of national dialogues in a particular country deeply engaged in the process.

Direct exchanges and technical assistance are the most limited type of sharing due to the financial implications relative to the small exposures (i.e. 1 to 1 versus 1 to many). For this reason, specific technical assistance exchanges overseen by the Commission process would need to be guided judiciously to maximize progress in the strategic directions outlined above.
Other forums, for example, like different Regional Economic Communities (REC), as they are dealing with proper implementation mechanisms of the overall NEPAD strategy and they can be instrumental in linking properly country/regional level strategies on SDH.

Support Model

The support model described below is based on the notion of strong support from the Commission, and WHO.

It is likely that the *WHO* will play an active role in coordinating support for the countries engaged early on in the Commission, and in particular for the countries the Commission wishes to show as examples of change by the end of its term (2008).

WHO will also play a key role in ensuring the inclusiveness of the process. As increased requests for technical assistance on social determinants work mount in a wide range of countries, WHO, through the WHO Reference and Technical Group it will need to ensure that clear signals are sent to support scaling up through headquarters and regional technical programmes, and country offices, thereby expanding the effective and existing WHO workforce on social determinants while at the same time reorienting health policy work to towards tackling social determinants of health inequities. The role that WHO plays in this component of the work, and the interaction between WHO and the Commission will ultimately work towards the Commission goal of developing more sustainable models of support as the number of countries demanding assistance in this area increases and in order to assist with the institutionalization of the work in WHO. By the later phase, 2007-2008, much of the country support would be expected to be mainstreamed into WHO's technical assistance to countries.

Commission Secretariat

With this in mind, the main functions of the WHO Commission Secretariat between 2005 and 2008 with respect to the Commission's country work will be:

i) to actively coordinate support for the advancement of Commission-related work for those countries identified by the Commission as having a high probability of providing "good examples" by 2008;

ii) to assist the WHO Reference Group and Technical Reference Group with the development of institutional changes within WHO, through supporting inputs to Organizational workplans and facilitating the Organization's technical assistance to countries for policies and programmes tackling the social determinants of health.

7. Assisting with the development of country implementation reports for countries involved in demonstrating and documenting actions.
8. Facilitating exchange on social determinants evidence and know-ho between countries in the region.
9. Engaging formal WHO governing bodies and regional political forums through presentations, discussions, and information sessions.

Commissioners

As processes of change in countries related to tackling the social determinants of health will have as much to do with evidence as with profiling the evidence and politics, the presence of Commissioners at critical phases in the country work (e.g. national dialogues, presentations to health select committees) will be an important part of their contribution to the Commission's country work. Further tools at their disposal will be to use the location, communication opportunities and deliberations of their meetings in a strategic way to consolidate or promote progress in countries. Furthermore, in their interactions with global and regional bodies, Commissioners can create opportunities or incentives for countries to progress in their work on tackling social determinants of health inequities. A small group of Commissioners can support progress review and feedback for country work in 2006 and 2007.

Knowledge networks and civil society

Knowledge networks and civil society form an essential axis of support for advancing the work in countries. Their assessments will be needed to ensure the quality and usefulness of:
→ inputs from the knowledge networks on the planned country work
→ evaluations of products from the country work
→ identification of experts to visit countries and attend global country meetings
→ support progress reviews and feedback to countries.

Dialogue in country work

The country level is a focal point of change where essential elements converge including knowledge institutions, health workers and organized representatives, different levels of government, other UN and other development institutions and civil society. Governments will be encouraged to involve these different constituencies in its national dialogues, in programme reform and policy development.

Successful engagements

Deciding in which countries to work in an *in-depth* fashion requires will entail some risk on the part of the Commission. The Commission cannot expect to hail successful change in all countries participating in its country work stream. Even the investment of resources by the Commission is no guarantor of success. For this reason, in addition to the strategic directions articulated above, it will be necessary to caste a wide net, be flexible, and sometimes opportunistic, and also ensure that the necessary back-up to the work is brought along in the process. Even in cases were success does not appear neatly after what is effectively, 2.5 years, the work may still yield fruit with more persistent guidance and assistance.

The critical ingredient for success at country level will be the issue of country leadership of the process. This means that steps should be put in place to ensure that the work is country-led, with the Commission and its agents playing a facilitating and coordinating role. With this in mind, the Secretariat proposes a set of steps for engaging with countries, that are framed by the recommendations for *country leadership*

WHO

It is proposed that WHO plays a key role in brokering and providing support the country work component of the Commission. WHO has a ready link to a pre-existing network of WHO and other UN institutions, which in turn have strong relationships with Member States. This link provides several opportunities, which can be used both to *identify* and *to support* countries in their work on tackling the social determinants of health inequities, reduce duplication of efforts, and make space on global agenda's to address social determinants of health. Also, the process of involving WHO in country work will help to identify new ways of working for WHO, with its counterparts at the country level and with its technical programmes in the future. This will ensure sustainability and transferal of the Commission recommendations into the practice of WHO country cooperation after the Commission formally ends in 2008.

WHO mechanisms for guiding budgets and country activities that will collaborate with the commission country work include:

(a) Country Cooperation Strategies (CSS): these are the reference for the majority of WHO's Country Office work in and with a particular country. The strategies combine assessments of country needs with WHO country and regional priorities, taking into account WHO's Corporate Strategy and Programme of Work. These strategies are revised periodically, every two or more years, depending on the needs of the government. Strategies of cooperation between countries and the Commission will be coordinated in the future revisions of Country Cooperation Strategies. Easy-to-use tools for strengthening the application of a social determinants lens when developing the CCS will also be developed with the CCS team and the Venice Office for Investment and Development Training Skills and Know-how development programme on social determinants of health.

(b) Country office agreements with governments: country agreements or bilateral cooperation agreements (BCAs) as they are known in the WHO EURO region, serve as the reference for WHO's work in countries. WHO regional offices also work with countries not in receipt of financial support from WHO. In these cases MOU's and Formal letters of technical support/cooperation are initiated. Revisions of these agreements are opportunities to align WHO work on health systems and health policies with the work on tackling social determinants of health inequities.

WHO Regional Offices, WHO Regional Committees

WHO regional and countries offices will play an important role in supporting the country work in their regions. The WHO Commission Secretariat and the Regional Offices will work closely to ensure an adequate support to the country work. Regional offices may take the lead in the following types of activities (though not limited to):

1. Identifying countries with strong political interest in tackling social determinants to act as sites of action in their region and supporting their work.
2. Supporting the development of country cooperation strategies and country office workplans.
3. Identifying experts to support regional action on social determinants (a roster needs to use the skills and professional mobility of the Diasporas where applicable).
4. Brokering mechanisms for sustainability and development of regional and country (WHO and in-country) capacities in addressing social determinants of health.
5. Coordination and advocacy with other regional agencies, inter-country regional organizations and regional networks.
6. Liaising with the WHO Reference Group, knowledge networks and reviewing Commission-related material to include regional perspectives.

of the work, discussed and developed by the Commissioners in Cairo. Countries participating in the country work should ideally:

1. Be self-selecting, in the knowledge that to act successfully on social determinants to reduce health inequities will require political commitment from the highest levels of government and at the highest level of other significant players in the country's political and health arena.
2. Recognize health as an indispensable component of development.
3. Have existing and future activities addressing the social determinants of health, and initiate and enhance activities with special attention to those with potential for scaling-up.
4. Become actively engaged in intersectoral cooperation and collaboration in health related issues, and develop alliances and partnerships; and demonstrate an interest in putting in place the necessary and management and institutional capacities needed to facilitate comprehensive intersectoral policy processes for health.
5. Perform monitoring and evaluation and be willing to exchange information related to social determinants of health.
6. Facilitate community participation and ownership in all health programmes and activities.
7. Designate the responsibility for the work at least to the ministerial level, which could be the Minister of Health.

For purposes of ensuring the development of "pragmatic knowledge and recommendations", the final group of participating countries should reflect the rainbow of realities facing countries around the world when trying to tackle social determinants of health and probably include at least 1 country from each of WHO's regions.

Steps for Engagement

To signal a serious intention to lead what will be a difficult process of change within a country, it is proposed that countries be requested to address formal letters from senior officials in their governments, expressing this interest. The exact nature of the country-level mechanism for taking forward the agenda will differ from country-to-country, but at least for purposes of engagement, a letter should be sent identifying a focal person(s) to work on developing a detailed workplan of activities. The workplan would be prepared in consultation with different directors in the health department and across different departments and inter-sectoral committees within government. Some prioritization of the different components of work would also need to be indicated.

The second step of the preparation would involve an *in-depth* period of working on the workplan or action plan with the Commission Secretariat, probably a period of 1 to 2 weeks, with a view to discussing the viability of the different proposed activities in the workplan, and the nature of support to be expected from the Commission. The finalized work/action plan would be presented back to Cabinet, the Planning or Health Committee for government approval. From the Commission's side, the process would be coordinated by the Commission Secretariat, with input from the relevant Commission components of work, including WHO. Appendix 3 and 4 outlines the steps and associated standardized documents to be sent to an interested country.

Workplan

It is proposed that WHO, support the initial development of the workplans and associated estimates of in-kind and actual financial assistance. It proposed that the WHO Secretariat assess the feasibility of the workplan activities using a small reference group that includes appointed knowledge network people, the WHO Secretariat and a small group of Commissioners, with opportunities for input ensured for the civil society stream and WHO health systems and policy experts. Once a guiding workplan is in place, progressive seed funding and technical assistance to countries would be contingent on satisfactory progress as reported in the progress review meetings planned for 2006 and 2007.

Reviewing progress

Progress will be monitored using *progress markers* and tools developed by the Knowledge Network for Measurement in collaboration with the Commission Secretariat and the countries concerned. It is important that a meeting with the early-starter countries be held early on to discuss progress markers with them with which they are comfortable. Some of these progress markers will be generic, others will be specific to the country's context. In this context, at least 2 progress meetings are envisaged taking place: 1 in 2006 and 1 in 2007. These meetings will also be linked to other objectives of the country work, such as expanding interest by inviting interested countries and by focusing on topics of interest (for example "the how to - for managing intersectoral processes in health"), with invited experts presenting.

Investing resources

Funds raised by the Commission will be used for working in countries. Assistance to countries will focus on technical and political assistance, with limited financial seed funding made available during implementation. Some donors have already earmarked spending for country work. Furthermore, it is expected that WHO will use its own resources to help strengthen its capacity to respond to the anticipated requests from countries for technical assistance in developing health policies and strengthening health systems to tackle the social determinants of health inequities. Seed funding decisions need to be made on the strength of the workplans (as approved by an agreed upon process in the Commission, see above, workplans) and progress.

Developing Capacities: guidelines and approaches

The countries involved in the Commission's country work will be invited to make use of existing tools and help to improve these tools based on their feedback and experiences of implementation. These tools will relate to the different approaches in which they are engaged and include:

- → Guidelines for conducting situation analyses on policies or policy-mapping[Commission's social determinants framework - to be adapted to a guideline by the Measurement Knowledge Network]
- → Approaches to analyzing and attributing inequities in health [Equity Team, WHO]
- → Guidelines for conducting historical case studies [Measurement Knowledge Network]
- → Guidelines for running national dialogues [existing, Venice Office]
- → Policy Process Evaluation guideline [existing, Venice Office] and Policy and Programme "Success" Evaluations [Measurement Knowledge Network]
- → Approaches for including the social determinants approach in health programmes [WHO Knowledge Network on Diseases of Public Importance]
- → Capacity Mapping for Social Investment [existing, Venice Office].

VI. Regional networks and strategies

The development of regional strategies needs to be a key component of the activities country sign on to in their workplans/plans of actions. The involvement of higher education institutions and academics in the process of country work is also very important; building on existing "poles d'excellence". Their involvement will provide a motivating force for scaling up action on social determinants of health.

Furthermore the development of regional strategies headed by WHO regional offices, needs to be seen as both a key component of capacity building within WHO for sustainability, as well as a mechanism for possibly engaging countries in action, providing demand from countries to WHO and for spreading the messages of acting on social determinants of health. Further work needs to be placed on the development of an understanding of the role of regional strategies within the Commission's strategic plan and how this impacts on the other components of work and their relation to oneanother.

VII. Outputs from country work

At country level, the work will be expected to have:

- Contributed to knowledge on the relative weights of the different social determinants of health inequities in the country, as well as any associated country-specific pathways.
- Identified policies and actions to most effectively address social determinants of health
- Improved the coherence and performance of mechanisms for policy integration & partnership within government (national through to local) and with other sectors in society, including community and civil society.
- Developed specific (multi-sectoral) health policies & strategies that address the most important social determinants of health.
- Directed resources and capacities to address social determinants of health.
- Contributed to wider knowledge on policies and practice for addressing, monitoring and evaluating the social determinants of health.
- Profiled and supported political leadership on the social determinants of health.

All participating countries will be expected to document their experiences related to tackling social determinants of health from a governmental perspective, and make these documents available to the Commission within the 3 year time-frame.

Across countries, the work will be expected to contribute to learning and leadership processes that will re-enforce actions taken to address social determinants of health in practice. In addition to changing practices within countries, it is expected that country work will:

- generate two types of knowledge: the more traditional kind in the form of case studies and policy reviews; and the less traditional kind related to know-how. Through these processes, the transferability of lessons learnt and appropriate means and technologies for transferability will be better understood. This type of knowledge will assist with developing strategies for sustainability and catalysing processes in other countries.
- the country work will provide an opportunity to test guidelines and approaches.
- the country work will contribute to scaling up interest in the work on social determinants of health through regional networks.

VIII. Next Steps

This current version of the Commission Country Work Strategy will be discussed at the India meeting of Commissioners alongside a report-back on progress in advancing some components of the country work. A useful target for the finalization of this strategy would be to have the broad strategic issues and parameters for implementation as well as the role of Commissioners finalized shortly after the India meeting.

Appendix 1: Developing the Country Work Strategy

The document is the result of an iterative process coordinated by the Commission Secretariat, incorporating input from the Chair (through the general strategic meetings), Commissioners and WHO. This process is described in more detail below.

Chile to Egypt

In the first meeting of Commissioners in Santiago Chile (15-16 March 2005), the Commissioners identified the promotion of "country leadership" for tackling the social determinants of health as an important component of the Commission's work. In response, the Secretariat, with input from a WHO task force, prepared a first draft of this document for discussion at the 2nd meeting of Commissioner (Egypt, May 2005). The meeting objectives identified the following aspects of country work for discussion with the Commissioners: a) selection criteria, b) next steps for setting up the country work, c) WHO linkages, and d) Commission linkages with respect to country work. The Commissioners' discussions focused on the selection criteria and the broad mandate of the work. It was agreed that the broad focus of the work would be:

i. Towards developing a national strategy for action on social determinants
ii. Explicit focus on countries in the south that are interested in/ able to implement practic programmes and policies, i.e.: real change - not just another report.
iii. Specific actions, which may include testing and learning from processes and mechanisms for social determinants of health policy and interventions; scaling-up or multiplying existing programs and positive deviants; introducing good practice initiatives in different country contexts.

Further to this, the Commissioner's developed an *internal note*, entitled "Guidelines for Country Involvement". The spirit of these guidelines was to ensure that the country work of the Commission could deliver several examples of action and change for the better by 2008. These guidelines were incorporated into subsequent revisions of the strategy document and used to shape the strategy.

WHO Consultations

Subsequent to the Egypt Meeting of Commissioners, a revised version of the document was circulated in three regional meetings of WHO technical staff and governmental representatives in the Eastern Mediterranean Region (May 2005), the Region of the Americas (July 2005) and the African Region (July 2005). In a parallel process, the document was also circulated to WHO headquarters, who advise countries on health policy. Formal comments were received from 3 WHO staff.

Appendix 2: Activities for Countries Participating in the Country Work Component

Commission on
Social Determinants of health

This note outlines the specific activities countries may wish to engage in as part of their involvement in the Country Work component of the Commission. It will be updated periodically to reflect new developments.

ACTIONS

Implementing national health strategies and plans for addressing social determinants of health equity

affecting policy making, planning and budgeting processes and covering:

- mechanisms for collaboration across sectors and levels of

National dialogues

Using the knowledge gathered in the exercises described below, run national dialogues involving different health sector and inter-ministerial stakeholders in national and sub-national levels of government, with civil society, health professionals, NGOs and other actors.

Implementing or Scaling up circumscribed Programmes

This activity refers to the implementation of a new programme or scaling-up of an existing one. This activity may be a subcomponent of a broader national strategy. A list of current recommended programmes will be compiled by the knowledge networks and regularly updated, e.g. School feeding programmes [partnered with the World Food Programme]; Access to ART

SUPPORTED BY EVIDENCE ON THE SITUATION AND AN UNDERSTANDING OF CONTEXT AND HISTORY

Historical Case Studies

On political, social and economic processes, including the impact of international and regional processes/expectations, influencing:

- national health agendas for tackling health inequities and investing in the social determinants of health
- public, government and professional perceptions of "health" , "populations health" /"public health".

Situation Analysis and Appraisals

- Identify issues, build commitment
- Diagnose problems and opportunities, including evidence on determinants of health, health inequities, and current policies
- Generate and test options
- Agree on priority actions

Policy Process Evaluations

Documenting the origins, context and process of specific strategies, initiatives and programmes aimed at tackling health inequities using a social determinants approach.

Demonstrating an understanding of the management and institutional capacities needed to manage comprehensive intersectoral policy processes for health.

SCALED UP AND SUPPORTED THROUGH:

- SHARING EXPERIENCES ACROSS COUNTRIES
- COMMISSION AND THE WORLD HEALTH ORGANIZATION, WITH

Appendix 3: Information sent to Interested Countries

Commission on
Social Determinants of health

Description of Documents
16 August 2005, version 1

Document title	**Description**
Planning steps.doc	Describes the steps involved in developing the country action or work plan
Example Letter 1 (English or French) - announcing intention.doc	Letter announcing the country's desire to be involved in the CSDH country work
Example Letter 2 (English or French) - final workplan.doc	Letter affirming agreement on the workplan activities
The Commission and its work.ppt	Presentation for the briefing of health departments and other ministries (requested from CSDH or WHO regional office)
Commission Country Work.ppt	Same as above (requested from CSDH or WHO regional office)

Appendix 4: Workplan Preparation Guide

16 August 2005, version 1

This note outlines the broad steps countries will embark on in preparing their workplan of activities.

1. The focal person for liaison with the Commission's country work is appointed and their appointment is approved by the Cabinet, or some other high level decision-making governmental authority.

2. Focal persons contact the Commission Secretariat and WHO regional counterparts to: inform them that they are proceeding with Phase 1 of the workplan development; obtain any further information, and discuss possible assistance in elaborating the Phase 1 process.

3. Phase 1: during this phase, the following needs to take place:
   - → a briefing with heads of department within the health ministry, describing the relationship between social determinants and health, and the Commission's goals
   - → briefing of other government ministries [Presentations provided by Secretariat, http://www.who.int/social_determinants/en/]
   - → heads of departments in the health and other ministry (ies) are approached to discuss their potential involvement and topics of mutual interest to pursue with the Commission's work on social determinants of health.
   - → this information is compiled into a preliminary draft workplan (see example in Box 1). sent to the WHO Secretariat, and the dates of the Phase II working visit is arranged with WHO.

Box 1: Example from Chile (first participating country)

Topics of Mutual Interest	No.	Project	Description	Contact	Possible Commission Support
Strengthen the social determinants approach within the national public health objectives	1	Matrix to follow-up on priority goals of the National Health Objectives for the Decade 2000 – 2010	Identify interventions introduced since the year 2000 to achieve the priority goals, in particular those incorporating a health determinants approach. The matrix will provide an overview of action taken and areas that need to be reinforced.	Cabinet, Undersecretary of Public Health	Provide evidence with respect to effective interventions, especially those that contribute to the reduction of health inequities.
	2	Mid-point Evaluation Achievement of National Health Objectives for the Decade 2000 - 2010	Analysis of action taken and measurement of health indicators to determine progress toward national health goals.	Ximena Aguilera, Head, División of Health Planning	Provide evidence with respect to effective interventions, especially those that contribute to the reduction of health inequities.
	3	Strengthen Capacities of Regional Health Authorities to Analyze Interventions in Public Health	PAHO – MOH project to design and execute a program of e-training for professionals of the Regional Ministry Secretaries (SEREMIs).	Fernando Muñoz, Undersecretary of Public Health	Provide information on successful experiences and technology transfer to develop e-learning modules to build capacity to address social determinants.
ntegration of social determinants of health into ational and regional public ealth work plans	4	Development of National and Regional Public Health Plans	During 2005 the Regional Health Authorities will formulate Public Health Plans with interventions in core areas: lifestyle and environmental risk factors, considering priorities identified in Regional health diagnosis, including local health equity indicators.	Ximena Aguilera, Head, Division of Health Planning	Methodological support to formulate interventions to improve health status of vulnerable groups.

4. Phase 2: the person appointed by the country will spend 1-2 weeks revising the preliminary draft workplan with WHO, supported by the different components of the Commission.

5. Phase 3: Once the revision of the workplan is completed, it will be presented to the government. Any requested modifications will be included and discussed with WHO and the Commission. Also at this stage it will be useful for the country to develop a clearer idea of the appropriate institutional mechanism for taking forward the work in the country. Finally, a letter should then be sent to WHO indicating broad agreement on the proposed set plan of activities and the institutional mechanisms overseeing operations at country level.

Endnotes

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[1] The strategic goals of the Commission will be operationalized through several components of the Commission, of which the country component is one of these. For details on the other components, please refer to the document "Imperatives and Opportunities for Change" on the Commission website (http://www.who.int/social_determinants/).

[2] WHO 2005. Towards a Conceptual Framework for Analysis and Action. Geneva: WHO. In process of publication. See www.who.int/social_determinants.

[3] O'Hara P 2005. Creating Social and Health Equity: adopting an Alberta Social Determinants of Health Framework. Discussion Paper. Edmonton Social Planning Council. Web-based: www.edmspc.com.

[4] WHO 2005. Towards a Conceptual Framework for Analysis and Action. Geneva: WHO. In process of publication. See www.who.int/social_determinants.

[5] One example of this is the work of the European Office of WHO (Venice)

COMMISSION ON
SOCIAL DETERMINANTS OF
HEALTH

Meeting Report

The First Meeting of CSDH Regional Civil Society Facilitators

WHO Geneva

8-10 August 2005

COMMISSION ON SOCIAL DETERMINANTS OF HEALTH

Report of the First Meeting of CSDH Regional Civil Society Facilitators
WHO Geneva, 8-10 August 2005

INTRODUCTION

The Commission on Social Determinants of Health (CSDH) aims to address the gross inequalities in health between countries and among social groups within countries through action on social determinants of health. The engagement of civil society is vital to this process. Civil society engagement with the Commission will: provide a global platform for civil society voice; advance civil society agendas relative to social determinants; strengthen capacities among participating civil society organizations; enhance learning from community level; promote country action shaped by civil society knowledge and concerns; broaden the political uptake of the Commission's messages; and improve the chances of sustainable impact for the CSDH.

Civil society engagement with the Commission must be guided by a comprehensive strategy that draws on the knowledge and experience present in civil society organizations and communities. This strategy must involve civil society in all major components of the Commission, including action in partner countries, Commission Knowledge Networks and the activities of the Commissioners. The strategy must reflect the diversity of civil society actors and the specificities of global regions. Most importantly, the strategy must be designed and led by civil society groups themselves.

To meet these requirements, the CSDH secretariat will work with civil society organizations from four global regions (Africa, Asia, the Eastern Mediterranean and Latin America) acting as CSDH Regional Civil Society Facilitators. The term Facilitator underscores that the role of these groups is to coordinate a consultative process. They will elicit inputs from a broad range of civil society actors in their respective regions and synthesize these inputs into a regional civil society strategy that reflects collective ownership. On 8-10 August 2005, delegates from the Regional Civil Society Facilitator organizations met for the first time to clarify principles, goals and methods for their work with the CSDH.

Topic of the meeting:

Civil society participation in the Commission on Social Determinants of Health and the role of Regional Civil Society Facilitators (CSFs)

Meeting objectives:

1. Ensure that CSFs are fully informed about all aspects of the Commission, including overall goals, deliverables, components and process

2. Achieve clear shared understanding on the purposes of civil society engagement with the CSDH

3. Identify entry points for civil society participation in key components of the CSDH, including Commissioner activities, Country Work and Knowledge Networks

4. Clarify criteria and methods to be used in regional civil society mapping exercises and in the creation of regional civil society data bases

5. Clarify CSF deliverables and participation in third meeting of CSDH Commissioners in India (Sept 05)

Meeting products:

1. CSF representatives informed about all aspects of the Commission
2. Entry points for CS participation in all components of CSDH identified
3. Criteria and methods for regional civil society mapping exercises defined and agreed
4. Civil society participation in CSDH India meeting specified

Mechanisms used for the identification of Regional Civil Society Facilitators:

Several convergent strategies were employed by the CSDH secretariat to identify organizations appropriate to act as CSDH regional CSFs. The mechanisms and criteria applied included: (1) identification of relevant groups through WHO Regional Consultations on the CSDH; (2) identification based on recommendations and contacts from CSDH Commissioners; (3) prioritization of organizations that have a network structure, to maximize outreach potential and convening capacity; (4) concern to include networks that bring together different types of civil society organizations within their respective regions; (5) concern to include groups that have strong connections with grassroots communities and the social "base".

COMMISSION ON
SOCIAL DETERMINANTS OF
HEALTH

EXECUTIVE SUMMARY:
KEY OUTCOMES AND LEARNING FROM THE FIRST MEETING OF CSFs

1. What do we mean by "civil society"?

1.1. **Definition:** General acceptance of WHO definition of civil society as "a social sphere separate from both the state and market" made up of "non-state, not-for-profit, voluntary organizations, ranging from formal organizations registered with authorities to informal social movements coming together around a common cause".

1.2. **The need to reduce fragmentation and the problem of representation.** The Commission should build on and strengthen existing regional civil society processes, rather than seeking to create new structures. Civil society actors from beyond the health sector need to be included (for example agriculture, labour movements). The media are crucial vectors of power, and Commissioners should make use of their celebrity status and capacity to intervene in media. Special channels of participation must be created for the traditionally voiceless, so they can express their realities and not just be spoken for by others.

1.3. **The relationship of civil society with governments: participation versus institutionalization.** The CSDH was called to promote social and political action that can improve the health chances of vulnerable people. While the primary responsibility for promoting health equity and human rights lies with governments, participation in decision-making processes by civil society groups and movements is "vital in ensuring people's power and control in policy development"[i]. Participation implies, most basically, people's being present (or adequately represented) and able to exert power or influence where policies affecting their health opportunities are weighed and decisions taken. Beyond simple presence and the opportunity to have their voices heard, genuine participation implies that people have the ability to effectively advocate for, guide, and have a discernable impact on processes in defense of their social interests. This is the perspective in which civil society participation in the CSDH is understood. CS partners are invited not simply to endorse programmes defined by others, but to contribute substantially to the processes through which the Commission's knowledge generation, action and leadership will be shaped. This means the opportunity to exercise real influence within key components of the Commission.

1.4. **Communication and media as a space for civil society.** People themselves must be informed participants in defining concrete objectives for the CSDH process, identifying feasible and appropriate strategies to achieve the objectives and implementing those strategies on the ground. This principle implies a particular effort to include groups and communities that have tended to suffer acute forms of marginalization, disempowerment and social exclusion.

2. What does civil society expect from the CSDH? (some key emerging messages)

2.1. Make the political nature and aims of the Commission more explicit.

2.2. Emphasize the hierarchical structure of health determinants (they are not all on the same level).

2.3. Affirm health as a human right. This assigns central responsibility for health to the State.

2.4. The CSDH process should strengthen civil society at country and regional levels, while placing SDH intervention on government agendas.

2.5. The CSDH can itself consitute a tool for positive change in civil society organizations, for example by enabling alliances among organizations and helping health-focused groups link with partners beyond the health sector.

3. Guiding principles for civil society " participation" in the Commission.

3.1 Autonomy of civil society with respect to the CSDH.

3.2 Participation must be real, not symbolic or tokenistic. That is, civil society must participate in decision-making. Participants in the Geneva CSFs meeting referred to *"the collective construction of public policies".*

3.3 Transparency in the processes and implementation of the CSDH, need for a code of ethics that will address conflicts of interest, resolution mechanisms and intellectual property issues regarding knowledge, among other matters. Participants argued that this can only be achieved by maintaining with civil society and other partners *"a direct, fluid and steady communication, not necessarily free of differences".*

3.4 Recover the spirit Alma Ata, and the political commitment that this implies.

3.5 Efficient and timely communication and sharing of information. Stress was placed on the need to *"put the CSDH into concrete political action, so that it doesn't stay closed-in in itself"*.

4. Entry points and critical themes around CSDH

4.2. *Entry points and critical themes around Commissioners*: Mechanisms should be created for disclosure of possible Commissioner conflicts of interest. CSFs should carry out a critical political "audit" of the Commissioners, as well as of the other Commission components. Some Commissioners have shown a strong interest in engaging with civil society, CSFs should nurture these connections. Commissioners should participate in regional civil society forums in order to link with relevant groups. With their experience and high profile, Commissioners will be able to play a significant leadership role in political and advocacy processes in regions and countries, as well as at the global level.

4.3. *Entry points and critical themes for KN process*: criticism of the Northern bias which is apparent in the selection of KN hubs. All North-based hubs should work with South-based institutions as equal partners. Explicit criteria should be developed for the selection of KN members to ensure North-South balance. Intellectual property rights issues need to be clarified. Who owns and controls the knowledge the networks generate? Meeting participants stressed the importance of community-based surveillance and community-based research on determinants, the results of which would be owned by communities themselves. Danger of "verticalization" or silo thinking in the respective KNs; need to focus on how to connect them, how to keep recommendations from adopting a silo structure. Criteria for the selection of KN members should be discussed and agreed with civil society, in order to ensure broad participation and the inclusion of diverse experiences and to guarantee that KN work translates into knowledge that can really be applied in developing country contexts.

4.4. *Entry points on Country Work*: During the Geneva meeting, the Anglophone group emphasized the need for the CSDH to develop explicit methods and strategies for engaging with countries where the government is not receptive to an equity-oriented SDH approach, but civil society is. The CSDH can take advantage of its independent status to reach out directly to civil society organizations and people's movements in such countries. CSFs can help identify opportunities, catalyze and implement strategies in these contexts. It is crucial that civil society be involved in the learning processes in countries to identify the key health determinants, then use their networks to drive implementation of interventions. Links with countries should not only happen through the national central government, but should also operate in provincial and local spaces. It may be possible to achieve a better initial reception in these spaces and, from there, to catalyze processes for national scale-up.

5. Main obstacles to civil society participation in the CSDH

5.1 Limited confidence and credibility regarding the spaces of real participation for civil society within the CSDH. This is reflected in the general weakness of channels of communication with civil society until now and in the absence of explicit mechanisms for civil society participation in decision-making within the CSDH.

5.2 There is a concern that the work of the CSDH could be perceived as limited to the activities of Commissioners, whereas the CSDH in fact comprises numerous actors. The Commission must not be allowed to turn inward on itself; Commissioners should build real and permanent connections with regions, countries and civil society. To achieve this, WHO's involvement in the orientation and implementation of Commission processes is fundamental, given the Organization's role of global health leadership.

5.3 The possibility that the Knowledge Networks may assume a primarily academic orientation is a source of concern for CSFs. If this occurs, the concrete experiences of civil society and communities in relation to the specific themes may be excluded. At the same time, CSF colleagues expressed worries about the powerful dominance of Northern countries among the KN Hubs; in this light, it is all the more vital to ensure strong representation of developing countries among the membership of the KNs and among the KN Chairs. Meanwhile, mechanisms must also be sought to avoid a vertical or compartmentalized mode of working in the KNs. Criteria for inclusion of KN members should be drawn up in collaboration and consensus with civil society.

5.4 CSDH Country Work requires a sophisticated contextualization of the relationship between government and civil society. Mechanisms must be put in place to ensure the participation of all sectors of civil society in each partner country in the elaboration of the country work plan and its implementation. The CSDH must play an active role in the meetings and discussions around these issues at national level. The Commission cannot have a neutral position.

5.5 The global process of the CSDH is above all a *political* process, and this challenge should be assumed as such. This implies that the Commission and in particular the Commissioners will take on tasks of advocacy and negotiation.

6. How do the CSFs define themselves, and what will they do?

6.1 The goal of the Facilitators is to develop and strengthen civil society participation in the CSDH. The CSFs do not "represent" civil society.

6.2 The work should call upon and strengthen relationships with civil society beyond the health sector, involving organizations and movements from sectors including education, environment, labour and others.

6.3 The Facilitators act as a link between the CSDH and civil society and community groups.

7. Civil society requirements from CSDH (in particular Commissioners)

7.1 Should express publicly the vision of the centrality of health and the importance of SDH in achieving it.

7.2 Should help to open space in countries for dialogue between State and civil society, with Commissioners using their political influence to facilitate this dialogue.

7.3 Commissioners should play a concrete role in CSDH Country Work, supporting countries and civil society to advance "powerful ideas" in relevant levels and settings.

7.4 The independence of the CSDH from WHO is favorable, but only up to a point. From the standpoint of civil society, the involvement and guidance of WHO in the process are seen as central, so that the Organization genuinely commits itself to an SDH agenda and assumes the global leadership role that should belong to it in this area. The WHO should be deeply involved and have clear responsibilities in the operational processes and leadership of the CSDH.

7.5 Should incorporate into their analysis the complex challenge of the representation of the voiceless and powerless. What is Commissioners' responsibility towards these excluded and vulnerable groups?

7.6 Mechanisms for decision-making within the CSDH need to be made explicit.

7.7 Commissioners need to have a direct and permanent relationship with civil society, for example via specific Commissioners responsible for each region, for particular countries, and/or for specific themes.

7.8 Civil society and CSDH should establish jointly a working agenda of advocacy visits by Commissioners to regions and countries. During these visits, Commissioners will act in already existing spaces and forums created by civil society, for example the upcoming Continental Health Forum in Caracas, Venezuela.

7.9 Capacity building and training on SDH for social leaders, along with tools to increase their capacity for political influence on relevant topics. In addition, CSDH training strategies should include capacity building for appropriate decision-making at intermediate government levels.

7.10 Communications aspects: It is vital that civil society partners participate in the development of the CSDH communications strategy, and that this strategy should make use of the particular spaces of civil society. Some communications messages strongly expressed during the first CSF meeting included: health is a human right; health is not limited to health care, but is about improving people's quality of life in a full sense; tackling the "causes of the causes".

8. Proposed work plan

From the point of view of civil society, the most relevant concern in the first phase of work with the CSDH is to identify the actors and sociopolitical contexts of countries and regions. To achieve this, an important tool will be the mapping of various areas: identification of government agendas that include SDH; typology of countries in terms of participation and democracy and of the relationship of government with civil society; identification of relevant actors and the roles they play (profiling/characterizing the various actors); identification of State organizations and other institutions of power in countries; inventory of key donor agencies working in the region; identification of civil society properly speaking; identification of regional or continental civil society organizations; mapping of the virtual networks that exist in every region; identification of relevant communications media, such as community radio stations and others; and the identification and characterization of spaces and events in which the CSDH can act in countries and regions.

A second process, parallel to the one just described, is to establish through consensus a joint working agenda for civil society and the CSDH, which will include visits and participation by the CSDH (especially Commissioners) in civil society meetings and spaces, as well as the monitoring of progress on agreed objectives, in line with the guiding principles presented above.

A third process is the social construction of public policies around SDH, from regional spaces and specifically at the level of CSDH Country Work. Civil society will also participate actively (as members) within the CSDH Knowledge Networks.

The strategies used will be based on regional specificities and participation. One of the immediate tasks for each CSF will be to hold a regional civil society meeting to discuss this aspect and to analyze, design and agree upon a regional work plan for civil society participation in the CSDH during 2006-2008. Following this, a second meeting of CSFs will take place.

COMMISSION ON
SOCIAL DETERMINANTS OF
HEALTH

MEETING NOTES

Attending:

CSF Delegates:
Fernando Borgia, Foro Social, *Uruguay*
Prem John, Asian Community Health Action Network, *India*
Bridget Lloyd, Health Civil Society Network, *Southern and Eastern Africa*
Mwajuma Masaiganah, Equinet / People's Health Movement, *Tanzania*
Alicia Munoz, Confederación Latinoamericana de Organizaciones del Campo, Asociación Nacional de Mujeres Rurales e Indígenas, *Chile*
Louis Reynolds, People Health Movement, *South Africa*
Amit Sen Gupta, People's Health Movement, *India*
Alaa Shukralla, Association for Health and Environmental Development, *Egypt*
Mauricio Torres, Asociación Latinoamericana de Medicina Social, *Colombia*
Walter Varillas, Red Salud y trabajo, *Peru*

CSDH Commissioner:
Professor Ndioro Ndiaye

CSDH Secretariat:
Alexandra Bambas Nolen
Hilary Brown (teleconference)
Tim Evans
Alec Irwin
Orielle Solar
Nicole Valentine
Jeanette Vega

WHO:
Eugenio Villar
Gerry Eijkemans
Gabrielle Ross

Facilitators: Alec Irwin and Orielle Solar

Organization and methodology:

The meeting took place over 2 ½ days and consisted of presentations by CSF delegates and members of the CSDH secretariat, plenary discussions and 4 small group sessions. For the small group sessions, participants divided into two working groups based on language facility (Spanish and English). Designated rapporteurs summarized the results of working group sessions for the plenary.

Location :

WHO Headquarters, Geneva (Salle B)

Day 1 (8 August):

1. Meeting introductions and presentations by CSF groups

The meeting was opened by Tim Evans on behalf of WHO. Alec Irwin summarized the structure and goals of the event. CSF groups presented their respective organizations and work. [For detailed content see meeting CD.]

2. The CSDH process

Jeanette Vega presented the overall structure of the CSDH and its milestones so far. Nicole Valentine presented the CSDH Knowledge Networks and Country Work.

Discussion: The political context (national, global) should itself be considered a social determinant of health. Politics seem strangely muted in the CSDH discourse. On the other hand, political battles do not all need to be fought frontally. Several participants stressed their desire to see the CSDH give clear emphasis to health as a human right. The core of the human rights approach is that it assigns central responsibility for health to the State. Jeanette Vega proposed that, instead of ostentatiously deploying human rights rhetoric, the CSDH will aim to be pragmatic in identifying policies that can actually help *operationalize* the right to health for marginalized groups.

Some participants objected that, as presented for example in the KN slides, the determinants lacked a clear, hierarchical order. Need to understand the causal connections among SDH, to see which are the "determinants of the determinants". Poverty should not be left out. The configuration of key SDH will be regionally specific. Meanwhile, regional networks such as Mercosur could be important political spaces for the Commission.

The CSDH places much emphasis on positive country examples, but how do we identify what is "positive"? What criteria will be used? The absence of poverty from the KN themes was criticized. Participants criticized a lack of adequate transparency in certain CSDH processes thus far and warned against a merely tokenistic inclusion of civil society.

3. Civil society involvement in the CSDH: initial proposals

Orielle Solar presented initial ideas on civil society involvement in the Commission process and the roles and products of regional CSFs.

Discussion: Participants agreed that the timelines originally proposed by the CSDH secretariat (with regional mapping exercises to be completed by September Commissioners meeting) are unrealistic. More time will be required for a genuinely consultative process. CSFs must in no way be seen as "representing" civil society in their regions. Their role is to facilitate a participatory process and to create linkages. The Commission should be prepared to come to and support civil society forums and processes that are ongoing in the various regions , e.g., upcoming social forums in Venezuela and Pakistan in January 2006. The CSDH should be ready in some cases to adapt to civil society calendars, rather than always the other way around. The proposal was made that, instead of a finished regional mapping exercise, the CSFs could bring to the India meetings the first draft of a document setting out the broad principles of civil society participation in the Commission along with some key entry points.

4. Results of Group Work session 1

General acceptance of WHO definition of civil society as "a social sphere separate from both the state and market" made up of "non-state, not-for-profit, voluntary organizations, ranging from formal organizations registered with authorities to informal social movements coming together around a common cause". In the Anglophone group, it was proposed that trade unions be explicitly included, but political parties actively contesting elections excluded. Discussion unresolved on the status of political parties.

Entry points and critical themes around Commissioners: Mechanisms should be created for disclosure of possible Commissioner conflicts of interest. CSFs should carry out a critical political "audit" of the Commissioners, as well as of the other Commission components. Some Commissioners have shown a strong interest in engaging with civil society, CSFs should nurture these connections. Commissioners should participate in regional civil society forums in order to link with relevant groups.

Entry points and critical themes for KN process: criticism of Northern bias apparent in selection of KN hubs. All North-based hubs should work with South-based institutions as equal partners. Explicit criteria should be developed for the selection of KN members to ensure North-South balance. Intellectual property rights issues need to be clarified. Who owns and controls the knowledge the networks generate? Importance of community-based surveillance, community-based research on determinants, the results of which would be owned by communities themselves. Danger of "verticalization" or silo thinking in the respective KNs; need to focus on how to connect them, how to keep recommendations from adopting a silo structure.

Entry points on Country Work: Anglophone group emphasized the need for the CSDH to develop explicit methods and strategies for engaging with countries where the government is not receptive to an equity-oriented SDH approach, but civil society is. The CSDH can take advantage of its independent status to reach out directly to civil society organizations and people's movements in such countries. CSFs can help identify opportunities, catalyze and implement strategies in these contexts. It is crucial that civil

society be involved in the learning processes in countries to identify the key health determinants, then use their networks to drive implementation of interventions.

<u>Day 2 (9 August):</u>

5. Plenary discussion with CSDH Commissioner Professor Ndioro Ndiaye

Representatives of the two Working Groups presented their main results in plenary. Professor Ndiaye responded.

Discussion: The previous WHO Commission (Commission on Macroeconomics and Health) made some valuable contributions, but was limited. Relationship of CSDH to CMH needs to be clarified. The CSDH is an essentially *political* process,

not just producing technical documents but attempting to influence public policy. This political focus should be made more explicit. The CSDH should have national visits, visit countries to exert political pressure and advocacy. Civil society groups, particularly in developing countries, need a direct relationship with Commissioners. On the other hand, catalysing appropriate contacts is difficult because much of the population is outside organized civil society.

Professor Ndiaye acknowledged the political character of the Commission's work and stressed the need to build concrete mechanisms for connecting government, civil society and Commissioners. She proposed the possibility of periodic thematic consultations among stakeholders and urged that the CSFs develop a concrete programme for this collaboration. A matrix of the key SDH in each region could be drawn up, then community-based, action-oriented research focused on the issues. The Commission should build on and strengthen existing regional civil society processes, rather than seeking to create new structures. Civil society actors from beyond the health sector need to be included (for example agriculture, labour movements). The media are crucial vectors of power, and Commissioners should make use of their celebrity status and capacity to intervene in media. Professor Ndiaye stressed the importance of tapping the resources of diaspora communities for the work of the CSDH and its interface with civil society.

6. Results of Group Work sessions 2 and 3

Discussions focused on: conceptual aspects of the proposed regional civil society mapping exercise; "social control" of CSDH processes and outputs; and potential barriers and facilitators for civil society in using the entry points identified within the Commission's components.

The mapping would not be simply a list of CS organizations, but instead a political mapping, a "power mapping" of actors, forces and processes in each region that can facilitate action on SDH or hamper progress. Suggestion that the mapping involve two parts:

1. First, a "situation analysis" of civil society and other actors in the region, including a list of key *categories* of relevant actors; need to identify facilitating and "blocking" actors, including State and for-profit private sector actors as appropriate to provide orientation for action;

2. Second part of mapping would enumerate organizations and actors related to possibilities for involvement in specific collaborative processes with the CSDH; initial inventory would be updated and expanded over time; image of concentric circles expanding outward as more and more groups are connected into the process, which should continue beyond the lifetime of the Commission.

The mapping must be crafted from the start as a *strategic* exercise. It should be seen as an open-ended process. A key part of CSFs' initial situation analysis would be identifying their own weaknesses and "blind spots", i.e., areas (geographical, social, political) where they will be especially challenged in gathering relevant information and contacts.

Training and capacity building around SDH for civil society should be oriented towards political influence and impact. Training modules oriented to political action could be developed for: government leaders and mid-level managers, also for civil society organizations and communities.

Areas of disagreement with the CSDH process thus far: process not transparent and genuinely inclusive; poverty neglected; insufficient emphasis on health as a human right; political context not seen as a major determinant.

Areas of agreement and approval: shift from biomedical to social model in health; health as a social value, not an economic input; efforts to address root causes rather than symptoms.

7. CSDH communications tools

Hilary Brown of the Commission secretariat and XX of PAHO explained by teleconference the uses of the CSDH Sharepoint communications tools and their relevance for CSFs.

Day 3 (10 August):

8. Results of Group Work session 4 and final plenary

Participants broke into working groups for a last session on expectations for the upcoming India meeting of the Commission, then joined in a closing plenary.

Discussion: Theme of potential Commissioner conflicts of interest must be put on the table explicitly during the CSDH meetings in India, as the Terms of Reference for Commissioners are debated. Hubs and members of KNs should also operate transparently and declare any conflicts of interest. Issue of intellectual property rights were again highlighted with respect to Knowledge Networks and other CSDH "products": who "owns" the knowledge of the KNs? Explicit criteria need to be defined for selecting membership of KNs, so as to ensure North-South and other forms of balance. More broadly, a "code of ethics" should be formulated for the CSDH and all its components -- including Commissioners and also CSFs. Health as a human right should be explicitly included in the Terms of Reference for all KNs. The Gujarat State government has a highly problematic civil rights record, and the failure to grasp the implications in time points to weaknesses in the Commission's strategic planning.

Participants stressed that contractual arrangements need to be finalized rapidly so that CSFs can get to work. Resources must be adequate to the effort demanded. Civil society relations with the Commission must be based on clear principles: collaboration but also autonomy. CSFs need to do a more thorough "profiling" of Commissioners in order to identify those who will be most useful partners. It was emphasized once more that CSFs are not "representatives" of civil society but engaged in supporting a process. A key challenge is to bring the Commission into relationship with "flesh and blood people", especially workers and marginalized communities. Special outreach and facilitation mechanisms will have to be put in place to secure the participation of grassroots organizations in the various regions.

Action points:

Secretariat

- Secure full participation for CSFs in the India meeting of Knowledge Network hubs, including dedicated time for presentation of civil society concerns with KN process and content.
- Secure maximum participation for CSFs in India Commissioners meeting, including dedicated time for CSF presentations and dialogue with Commissioners.
- Develop Terms of Reference for CSF participation in September CSDH meetings and circulate to CSFs for approval.
- Formulate revised Terms of Reference for CSF roles, timeframes and deliverables, reflecting input from first meeting of regional CSFs.

- Complete draft contracts (Agreement for Performance of Work) based on revised TOR and circulate in time for discussion and correction with CSFs in India.
- Prepare and circulate draft report of first meeting of regional CSFs.

CSFs

- Identify a delegate and confirm participation in India meetings of KN hubs and Commissioners, 9-14 September.
- Examine draft TOR for CSF participation in India meetings and approve or modify.
- Each CSF to develop a 10-minute presentation for Commissioners meeting in Ahmedebad; form and content to be defined and agreed with other CSFs.
- Proceed with draft regional civil society "political mapping"/situation analysis, along lines discussed in first meeting of CSFs.
- Begin political and ethical "audit" of the Commissioners and other components of the CSDH -- leading towards an eventual "code of ethics" for the Commission.
- Begin to identify dates on which to hold regional civil society meetings this fall.
- Identify possible regional civil society forums or events on which a second meeting of CSFs could "piggyback" in late October or November.

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[1] People's Health Charter

Briefing paper

NHS
Health Development Agency

Economic appraisal of public health interventions

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Introduction

The economic appraisal of public health interventions is both underdeveloped and intrinsically difficult. This paper considers some of the problems, and points towards potential solutions.

Problems to be solved

The problems of applying economic evaluation to public health interventions are considerable. The most important are outlined here.

Determinants of health and of inequalities in health

Over a long period, there has been an overall improvement in the aggregate health of the population. However, at the heart of public health is a conundrum – as the overall health of the population has improved, in the most recent past, inequalities in health have worsened. Despite a vast literature on the determinants of health, specific analysis of the determinants of inequalities in health is underdeveloped. And there is relatively little evidence of what interventions will work to reduce inequalities in health. Consequently the baseline for analysis of effectiveness is limited. The most comprehensive analysis is in the HDA's Evidence Briefings (Kelly, 2004; www.hda-online.org.uk/evidence).

Relationship between upstream and downstream interventions

Downstream interventions aim to change adverse health behaviours; upstream interventions target the circumstances that produce adverse health behaviours. The best evidence that exists tends to be about downstream rather than upstream interventions. While these interventions are important in themselves, from an evaluation point of view this presents a second important difficulty. For example, an approach that relies on specific downstream interventions, such as individual counselling to assist smoking cessation, will be mediated by broader social structural factors such as poverty, unemployment and social conditions. The analytical and evaluation problem is that upstream interventions to improve the circumstances in which people live may not be a **sufficient** condition to produce health improvements, but may be a **necessary** precondition for other downstream interventions to be effective. The importance of the socio-economic context has implications for how interventions are designed and evaluated. Evaluating single initiatives may fail to capture effects that rely on multiple interventions.

Mediating role of behaviour change

To be effective – and therefore cost effective – public health interventions (unlike many clinical interventions) often require a change in individual or population behaviour

WHO-CSDH Resource file for 24/8/a

patterns to ensure uptake of the intervention. The behaviour change is an intermediate or process event, necessary to achieve the desired final outcome. The behaviour change itself must be modelled into the economic analysis, but the modelling needs to account for the behaviour as more than the operation of a simple rational economic calculus in the mind of the individual. The traditional approach to economic evaluation has been to synthesise costs and final outcomes, such as life years gained, so intermediate process variables have often been ignored or dismissed as irrelevant. Yet understanding this behavioural process is crucial to determining why public health and health promotion programmes and interventions work (or fail), and at what cost. It can help in understanding the barriers to individual change, and how different approaches might be used to overcome such barriers. This will require some awareness of different socio-economic factors including income, employment, crime rates and educational attainment – especially important if the objective is not just to improve population health, but also to reduce inequalities in health, where the impact on specific subgroups is also required.

Separating cause and effect

Unlike drug-based or technological interventions, public health initiatives often use multi-faceted approaches, making it more difficult to identify which elements of a programme may lead to change. Some public health interventions occur outside the health domain, in transport, education, local authorities or the workplace. Even where interventions are well defined and tightly circumscribed within an obvious health domain, as in the delivery of smoking cessation via nicotine replacement therapy (NRT) in primary care, attributing cause to this intervention is difficult. Secular trends, and other anti-smoking activities to which the population is exposed, will also have effects, and interactive or synergistic effects between interventions need to be considered.

Study designs to help solve the problem of cause and effect may bring problems of their own. Randomised controlled trials, which are intended to eliminate bias, are often the preferred solution. However, it is important that these are pragmatic trials, carried out in real-world settings, in order to test effectiveness and not just efficacy. This may have implications for the scale and feasibility of the studies required. While the randomised controlled trial is the best way of eliminating bias and linking cause and effect, it is not without limitations. Other study designs have the potential to provide good quality evidence if they are rigorous in dealing with sources of bias. It should be noted that, in terms of reducing health inequalities, the potential sources of bias need to be identified and studied. The mediating or confounding factors at the point of implementation in real-world settings need to be considered from the point of view of effectiveness and cost effectiveness, and inequalities.

The variability in effectiveness and the likelihood of success of interventions are crucially filtered through two sets of mediating factors which are, to some extent, independent of the mechanics of the intervention itself. These are the enthusiasm, expertise and engagement of the staff carrying out the intervention; and the local delivery infrastructure. For example, sex education is much more effective when delivered by enthusiastic and motivated staff. In the absence of much in the form of intention to treat analysis in public health, the effects of the real world have to be disentangled when assessing study results. Statistical analysis of confounders can help here, but the confounders add a layer of complexity to the understanding of effectiveness and cost effectiveness. The most rigorous analysis of these confounders is to be found within the HDA's evidence into practice work (Kelly *et al.*, 2004).

Biological and social variation

Clinical treatments take place in the context of a relatively narrow, well defined span of biological variation in individual responses. Public health interventions take place within a very wide spectrum of social difference in the population which is not itself well defined (beyond usually blunt measures of socio-economic difference), and the variability in the population is not well mapped. Unsurprisingly, individuals respond in widely different ways to different public health interventions, so different interventions may work better than others with some individuals – the stubborn class differences in smoking rates are a testimony to this. There has been some limited attention to this effect in the literature. Better information is needed on tailoring interventions, and it may be efficient to have a range of interventions available. The HDA Evidence Base has consistently pointed to the need for tailored and targeted interventions, and the argument has repeatedly been made by the HDA for a much better understanding of the social differences in the population. Economic appraisal needs to embrace the diversity in the population and consequent variations in potential responses (Graham and Kelly, 2004).

Absence of 'D' in public health R&D

In contrast to drug trials, public health interventions are often implemented without much pretrial development. Thus public health interventions can change during their implementation, complicating interpretation of the results.

When should effectiveness be measured?

The impact of public health programmes is not short term. At what point is an intervention judged to have succeeded? – at some point immediately after the intervention has been completed; at three or six months, or a year, or longer? And what is the capacity for effects to atrophy or decay with time? In real time, the final outcomes of public health interventions may take many years to be realised, and thus may be difficult to attribute directly to any one intervention. Retrospective analysis may be possible, but only if steps were taken originally to ensure the appropriate data were collected. There may be potential for using secondary data to model longer-term impacts.

How should effectiveness be measured?

There are no standard methods to give common currency to the impact of public health interventions, other than the monetary valuation approaches used within CBA. The use of common currency outcome measures – estimates of cost per quality-adjusted life year (QALY) to evaluate public health interventions – needs careful assessment. Cost per QALY estimates already exist in the more clinical areas of public health evaluation, and there is much work in progress in terms of smoking cessation services. Many of the estimates produced to date show that public health interventions compare favourably with treatment interventions.

However, the QALY measure may not be sufficient to capture the complex impact and context of psychosocial treatments in public health and the wider range of relevant non-health outcomes. Past experience has shown that QALY outcome measures may not reflect sufficient differences between effects of interventions to decide priorities for public health practice. Attempts to draw comparisons of interventions across public health and healthcare interventions should be made in full knowledge of the limitations of the one-size-fits-all approach. Intense interventions of long duration cost more than their shorter, less intense counterparts, and there may be a non-linear association between intensity and duration of intervention and cumulative outcomes. This needs to be borne in mind when making cost per QALY comparisons of clinical and psychosocial public health interventions from the limited cost-effectiveness evidence.

Individual versus population measures

Should success be measured at an individual level or at a population level? Economists usually argue that the costs and benefits to individuals should be an integral part of economic evaluation. However, for pragmatic reasons appraisals of public health are frequently conducted from the viewpoint of the NHS and other public sector agencies. It can be argued that either costs and benefits are unlikely to vary significantly or systematically between individuals; or that individual costs and benefits are unlikely to vary significantly between treatments. Neither argument is necessarily sustainable in the area of health improvement. A better understanding of individual costs and benefits, and how these relate to individual outcomes, may help in understanding why certain interventions work better than others, and why they work differently with different groups. Where appropriate, this type of analysis needs to be integrated into the design of evaluation studies and may have implications for the size and cost of studies.

The solution: an analytical framework

The problems noted previously are not reasons not to undertake an economic analysis. They have to be acknowledged and then incorporated into the analysis by considering the existing information, building assumptions into the analysis, and making them explicit.

There are a number of different potential methods of evaluation available to the economist, although the emphasis in most thus far is on the evaluation of individual interventions rather than the complex programmes found in public health. Several types of economic evaluation are outlined briefly here, each of which has a different scope and suitability.

The simplest economic studies are concerned only with costs – not (usually) because they see outcomes as irrelevant, but because, in relation to the services under study, the health and quality-of-life outcomes have already been established from other research, or are currently not measurable because of conceptual difficulties or research funding limitations. One of these cost-only methods is the **cost-offset study**, which compares costs incurred with (other) costs saved. For instance, a new public health intervention might have higher start-up costs, but may reduce the need for in-patient admissions and thus lead to cost savings downstream. The limitation of such an approach, though, is that it does not look at alternative use of the resources elsewhere. **Cost-minimisation analysis** extends economic analysis further by considering alternative uses of resources, and proceeds in the knowledge that previous research has shown outcomes to be identical in the intervention or policy alternatives being evaluated. Well conducted cost-minimisation analysis can be thought of as a special type of cost-effectiveness analysis, but in most instances such evidence will not be available and more complex evaluation will be required.

Cost-effectiveness analysis is the most common approach used in economic evaluation, and synthesises single outcomes and costs (eg increase in life years gained) to health promotion intervention. An obvious weakness with the strict cost-effectiveness methodology is the enforced focus on a single outcome dimension (in order to compute ratios), when public health programmes can have multiple outcomes. Carrying multiple outcomes forward is less tractable analytically, but three options are available, associated with three other modes of economic evaluation. One option, **cost–consequence analysis** (CCA), is to retain all or most outcome dimensions using whatever appropriate measures are available. The other two options weight the outcomes, either in terms of money (cost–benefit) or in terms of utility (cost–utility).

Cost–utility analysis measures, then values, the impact of an intervention in terms of improvements in preference-weighted, health-related quality of life such as the QALY. Cost–utility analyses allow comparisons to be made across all areas of health intervention, aiding resource allocation decision making. But they do not capture the broader non-health consequences and opportunity costs of programmes.

Cost–benefit analysis (CBA) values all costs and benefits in the same (monetary) units. If benefits exceed costs, the evaluation would recommend investing in the programme, and *vice versa*. CBAs are thus intrinsically attractive, and theoretically an ideal approach, but conducting them can be problematic because of the difficulties associated with valuing outcomes in monetary terms (including public acceptability).

Given the nature of public health interventions and their impact across many other public sectors, there is a strong case, in this area in particular, for more attention to be placed on CBA. NICE guidance currently recommends only a health and personal social services perspective (although costs to patients and families may also be reported). CBA would theoretically adopt a complete societal perspective, but pragmatically, as a minimum from the policy-making perspective, the analysis could at least then be conducted from the perspective of the total public budget, which makes intuitive sense given the broad impact of these interventions. Valuation methods used by health economists in CBA studies have concentrated on direct valuations by either asking individuals to state the amount they would be prepared to pay (hypothetically) to achieve a given health state or health gain, or observing actual behaviour and imputing implicit values.

More recently, an approach first developed in marketing has been used to value health interventions. Commonly known as **discrete choice experiments**, this approach allows individuals to rank different real-world scenarios, which may consist of several dimensions. Although its use in health promotion and public health has been limited so far, this approach has the scope to explore some of the individual characteristics and environmental factors that may influence the uptake of interventions and changes in behaviour. By including cost as one of these dimensions, a monetary value can also be elicited. Although complex, in that the scenarios need to be devised carefully, this approach has the advantage of not specifically asking individuals to put a monetary value on health states or health gain, which can make the technique easier to administer than traditional willingness-to-pay studies, and also promote its acceptability to decision makers.

Cost–consequence analysis is similar to cost-effectiveness analysis in terms of the questions addressed, but is applied to evaluate interventions with more than one multi-dimensional outcome. In CCA, for each alternative the evaluation would compute total (and component) costs, and measure change along every one of the relevant outcome dimensions. The cost and outcome results would need to be reviewed by decision makers, and the different outcomes weighed up (informally and subjectively) and compared with costs. While this approach has theoretical problems, as it does not synthesise benefits and costs, it can be used to look at issues of changing behaviour that are so crucial to public health interventions. CCA does not attempt to combine measures of benefit into a single measure of effectiveness, so it cannot be used to rank interventions. Nevertheless it is a systematic technique that allows decision makers to weight and prioritise the outcomes of an evaluation. It is possible to produce cost-effectiveness comparisons for single outcomes within the CCA framework. The analysis involves focusing on a particular problem, for example teenage pregnancy, then considers two or more possibilities: to do something (one or more interventions); or to do nothing. Then, using either existing available data *post hoc*, or deriving new data, an appropriate method is established for an analysis of costs and outcomes in a common currency. The evidence collected needs to relate to four questions: what works to improve health; what works to reduce inequalities in health; what works in changing behaviour; and what works in promoting uptake of behaviour change interventions? The sources of evidence for these questions will be different. Outcomes can be measured in terms of QALYs, healthy year equivalents or disability-adjusted life years. Other outcomes might be in terms of teenage pregnancies or conceptions averted, awareness and take-up of contraception or avoiding adverse circumstances of teenage pregnancy, such as missed education and training opportunities. Comparisons between interventions would require capturing the wide range of consequences (good and bad) and the potential costs (to the initial provider, partner organisations and other services). A cost-effectiveness ratio for every intervention would compare cost (minus the saving in resources) with a unit of outcome such as a QALY, but the analysis can also show the trade-off between different outcomes across the alternative interventions.

Conclusions

In the longer run, the development of properly conducted, comprehensive CBA across all the interventions identified as capturing the broad, cross-sectoral impact of public health interventions should be a priority. CBA and CCA should be linked to data and evidence about effectiveness. Additionally, the links between measurable outcomes from policies, programmes and interventions and long-term health outcomes need to be modelled. There is a need for sophisticated economic and effectiveness models that can be used to evaluate the wider implications and impacts of different prevention strategies, and to encompass impacts on inequalities.

Approaches to economic assessment undertaken by economists, traditionally not considered to be 'economic evaluation', could also be conducted. For instance, econometric studies on the impact of taxation changes on consumption of alcohol and cigarettes are promising lines of investigation.

It is important to understand the context in which a public health intervention operates, and thus move beyond the 'black box' within which much traditional health economic evaluation sits. In particular there is a need to gather information on process outcomes and factors influencing changes in the behaviour of individuals and populations, as well as the institutional arrangements that may influence both the costs and effectiveness of interventions. Such information can help decision makers identify whether a successful (or unsuccessful) initiative undertaken in one locality might be generalisable to other settings.

There is presently insufficient economic evaluation evidence to knowledgeably inform public health policy making locally or nationally. This state of affairs can be changed, but will require strong direction to ensure the priorities for economic evaluation evidence become organised and coordinated at local, regional and national levels. Teams of economists working in isolation from the interventions and service-users they evaluate will not help to deliver the true scenario.

Key points

- The mechanisms of economic appraisal may, can and should be applied to public health interventions.
- Economic appraisal should be linked to the appraisal of effectiveness.
- Economic evaluations should be a routine and consistent part of all public health interventions.
- Economic evaluation should use a common economic framework. A common framework would facilitate and enhance a consistent and transparent basis for decision making.
- Such analysis should retain the shape and feel of a traditional economic framework, but will need enough flexibility to capture the multi-dimensional, complex and layered outcomes of public health policies and interventions.
- The economic analysis must be able to inform evaluations of the effectiveness of interventions that reduce inequalities in health.
- At the societal level, the ideal method in the long run is cost–benefit analysis (CBA), which would integrate outcomes into a single measure, allowing comparisons to be made between interventions. This would permit the resource trade-offs within and between government departments to be exposed.
- Given the practical difficulties in applying CBA, the use of cost–consequence analysis (CCA) within a pragmatic framework is suggested to capture the layered outcomes of public health interventions at the local level.
- CCA is similar to cost-effectiveness analysis in terms of the questions addressed, but is applied to evaluate interventions with more than one outcome, and where combining these outcomes in a full CBA is not feasible.
- CCA does not attempt to combine measures of benefit into a single measure of effectiveness, so it cannot be used to rank interventions.
- The full range of research methods should be used as an adjunct to CCA. This would include randomised controlled trials, quasi-experimental designs and qualitative methods.

Further reading and ongoing work

Standard texts that may usefully be consulted are Drummond *et al.* (1997) and Sefton *et al.* (2002). Recently several initiatives have been undertaken, both in the UK and elsewhere, to explore some of the issues in the economic evaluation of complex interventions (Hale *et al.*, 2005). The UK Health Promotion and Health Economics Forum has published a manual providing guidance on economic evaluation in the area of health promotion. Similar work has been undertaken on behalf of the Joseph Rowntree Foundation (www.jrf.org.uk) to look at how economic evaluation techniques traditionally used in the health arena can be applied to other areas of social welfare, and what can be learned by looking at how other branches of economics, and other disciplines, have approached evaluation. In the USA, the Centers for Disease Control and Prevention (www.cdc.gov) continues to build up an evidence base on the cost effectiveness of health promotion and public health interventions, and has developed a checklist and guidance to help improve the comparability of studies. Recognition is growing among health economists and others of the importance of qualitative approaches and the general challenges of evaluating complex multi-sectoral interventions. One positive step is the imminent creation of a joint Cochrane/Campbell Collaboration Economics Methods Group (www.med.uea.ac.uk/research/research_econ/cochrane/cochrane_home.htm) that will look at these issues in the fields of health, social welfare, education and crime.

Annex: Examples of economic evaluation

Introduction

In most potential priority areas for public health interventions, economic evidence can be identified in the literature. The US Centers for Disease Control has been building up a database of cost-effectiveness evidence, while a recent overview of evidence on the cost effectiveness of a wide range of policy and individual interventions to prevent/reduce smoking is available from the WHO Health Evidence Network (www.euro.who.int/HEN ; www.euro.who.int/document/e82993.pdf).

There are areas where evaluation is more limited, perhaps due to their complexity, or to a lack of demand and thus resources for such evaluations. For instance, recent reviews of the effectiveness of breastfeeding and of falls prevention by the NHS Centre for Reviews and Dissemination noted that only very limited evidence was available in these areas.

Where economic evaluations have been conducted, they have concentrated on individual interventions, similar to drug and technology evaluations, rather than those aimed at improving population health. The challenge in many respects is not about identifying studies providing evidence for the cost effectiveness of public health interventions, but rather about the difficulties in trying to compare the results of studies because of significant methodological differences and limitations, as well as poor reporting.

Few have looked beyond final outcomes to also consider the process by which those outcomes are achieved. Many public health/health promotion interventions will be successful only if individual and community behaviours can be altered. Without understanding these factors, it is difficult to determine the transferability of the results of any one successful intervention to a different setting. This is of particular importance given that much of the available literature derives from the USA, where the context can be very different. Rather than trying to come up with firm conclusions about the strength of cost-effective evidence, this section provides information from some examples of economic evaluations in this area, emphasising the types of intervention examined and methods used, as well as the public health issues addressed. An example is also provided of ongoing work seeking to incorporate contextual information into economic evaluation.

Example 1: Modification of diet through health promotion

The complexity of such studies can be seen by looking at a health promotion programme to modify the population's intake of salt. A simulation model was constructed that synthesised data on the effectiveness of various interventions. A range of health promotion interventions were considered, including information campaigns, requirements to declare the salt content in food, and taxes on salty food or subsidies for foodstuffs with less salt. Intermediate outcomes in terms of blood pressure reduction, and their subsequent impact on myocardial infarction and stroke rates, were estimated for an entire population. Overall, the model indicated that health promotion would be a cost-saving intervention as the direct costs associated with the programme, including the impact of taxation, would be less than future medical care costs avoided and lost productivity due to morbidity and premature mortality. By using a model it was possible to extrapolate the data to consider the consequences for the whole population and test for uncertainty in variable parameters, and to build a greater case for investment in this form of health promotion. A contextual analysis of the target subgroups might have helped inform decision makers as to which approach was most appropriate to those target groups of highest priority (Selmer *et al.*, 2000).

Another modelling study focused on estimating the costs and health consequences (reduced incidence of cancer) arising from increasing the dietary intake of fruit and vegetables to recommended levels. Demographic, health and healthcare cost data from 20% of the Danish population over a four-year period were included in the model. The model found that the strategy would be dominant over the current situation as daily life expectancy might be increased by between 0.8 and 1.3 years, and between 19 and 32% of all cancers might be prevented. Overall healthcare costs would remain unchanged – resources saved in cancer treatment would be required for additional lifetime healthcare costs for a longer-living population. This study, while useful, also demonstrates some of the limits of current economic evaluation in this area, as it does not take into account the costs and different mechanisms needed to promote behaviour change. Such models would also benefit from considering uptake rates, perhaps generating some of this information from additional qualitative and quantitative research (Gundgaard *et al.*, 2003).

Example 2: Evaluating the impact of financial incentives as a way of modifying behaviour

Although not fitting directly within the traditional mode of economic evaluation, econometric analyses have been used to estimate the impact of taxes (and subsidies) on the consumption of goods such as cigarettes, alcohol and healthy food options. An area less well explored has been the evaluation of direct financial incentives at an individual level as a way of modifying behaviour. One example is a Quit and Win campaign (www.quitandwin.net) that involved rewarding individuals with prizes as part of a mass media strategy. The intervention was found to be very much at the low end of the cost-effectiveness thresholds considered acceptable by NICE. Financial incentives in the form of lottery prizes being awarded have also been evaluated as a mechanism to help improve vaccination uptake rates, and again these appear to have an acceptable cost-effectiveness level compared with other funded interventions.

An additional example of the impact of modest financial incentives is a pilot study undertaken in Denmark comparing three different approaches intended to increase influenza vaccination rates in target population groups. The study compared several different interventions: personal invitations to family doctors; a letter from local authorities with user fees waived for vaccinations; personal invitations from family doctors; and user fees being waived. The latter method increased the uptake rate from 40 to 70%. More generally, there is a small but growing body of literature on the role of financial incentives paid to health and other sector professionals to promote screening and vaccination initiatives. Although ethically open to question, there may also be a case for looking at the use of direct financial incentives for populations to use healthy interventions – eg paying individuals a small fee to be vaccinated (Nexoe *et al.*, 1997).

Example 3: Evaluating the cost effectiveness of mass media campaigns on behaviour

Although there has been much written about the effectiveness of mass media campaigns in changing health behaviour, including a Cochrane review, much less has been done to evaluate their cost effectiveness, although some studies can be found. One study, for instance, evaluated a four-year television and radio campaign to deter teenagers from beginning smoking in four communities in the USA. Markov modelling was used to estimate the impact on life expectancy as a result of individuals not taking up smoking, and students were surveyed immediately at the end of the four-year campaign, then again two years later. The intervention was found to be cost effective, with a low cost per life year gained compared with many other interventions. Again, the difficulty with this analysis is that further information on the context is needed to determine whether the results are generalisable to other settings (Secker-Walker *et al.*, 1997).

Studies of mass media campaigns emphasising the dangers of alcohol and driving in the USA and Australia have also been reported to be cost-saving overall, with benefits far outweighing costs. Again, though, evaluation requires greater depth to determine what is actually working and how; one review of effective measures to reduce alcohol misuse in Scotland reported that the evidence for mass media interventions working was weak, and that they may influence knowledge and awareness rather than behaviour *per se*. It is also important to examine the impact of mass media and community public health campaigns on specific target groups. For instance, one recent study in London looking at the cost effectiveness of a smoking cessation campaign targeted at the Turkish community reported a favourable cost-effectiveness ratio of £105 per life-year saved (Stevens *et al.*, 2002).

Example 4: Brief interventions

Short-term interventions to promote public health have been subject to much evaluation, but only limited economic evaluation. Three economic studies have shown brief interventions to prevent alcohol misuse to be relatively cost effective due to fairly high levels of effectiveness and low costs. Modelling the results using UK cost data suggests that the cost per life saved is in the range £1,446–£2,628 if no savings in resource use are taken into account. If resource savings are considered, then the benefits exceed the costs of the intervention (www.scotland.gov.uk/health/alcoholproblems/docs/lire-00.asp). Brief interventions for smoking cessation have been estimated to cost around £73 per QALY (www.hta.nhsweb.nhs.uk/fullmono/mono616.pdf). However, this result should not be applied too simplistically. More intensive interventions for smoking cessation which have higher costs per QALY, such as buproprion, NRT and counselling at £487 per QALY, still represent good value for money and have a higher impact in terms of quit rates.

Example 5: Workplace health promotion

One area where a growing body of economic evidence exists is for workplace health promotion, in part because there have been greater demand and resources available to look at interventions seen to have a direct impact on productivity. There is good evidence, for instance, of the cost effectiveness of systematic, organisation-wide approaches to promote positive mental health at work and reduce work-related stress. These have recommended including staff support, two-way communication structures, enhanced job control, increased staff involvement, and an improved working environment in programmes (www.nelh.nhs.uk/nsf/mentalhealth/whatworks/knowhow/workplace-cfa.htm). In the USA, employee assistance programmes providing counselling services for employees and their families for a range of issues have been evaluated. These programmes have been found to be highly cost-saving, with improvements in productivity and reduction in absenteeism more than outweighing the direct costs. The analyses can generally also be considered to be conservative, as they do not take into account additional health and community benefits associated with maintaining employment (Alexander, 1990).

Example 6: Incorporating context into ongoing economic evaluation of a community health promotion programme

In addition to strengthening the quality and transparency of economic evaluations, there is much scope for augmenting the essential elements of economic evaluation with additional qualitative data to inform the context. This can be illustrated by looking at an ongoing randomised trial of an integrated programme of community-based and primary care strategies deigned to improve the emotional and physical health of women after childbirth. The scheme includes educational programmes for primary healthcare professionals; distribution of mothers' information kits; provision of befriending services; and coordination of services by a community development centre. The evaluation of the programme includes an 'ecological' economic evaluation. This incorporates all the standard elements of an economic evaluation, but also recognises that the programme itself is a dynamic entity that interacts with the local context, with important non-health-related outcomes. In order to capture some of this contextual information, a variety of research methods are being used. These include:

- Event logs documenting actions and impacts in each of the intervention communities
- Diaries kept by, and interviews with, community development officers on how the programme is evolving
- Interviews with other key stakeholders
- Documentation of resource costs and impact of changes in health outcomes on resource use
- Focus groups in non-study areas to ascertain what value other community groups place on changes in health status due to the intervention
- Community-based postal survey to elicit community values for project-related social outcomes
- Organisational survey before and after the PRISM intervention to document inter-organisational collaboration and the impact this has on the collaborations over time.

The aim is not only to help with interpretation of the success of the programme as it evolves, but also to build additional factors into models that might be used to consider the programme's transferability to other settings. Such approaches may increase the costs of studies considerably, and may not be appropriate for all public health interventions (Hawe *et al.*, 2004).

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International perspectives on Early Childhood Development

Prepared by the Knowledge Hub on Early Child Development for the WHO Commission of the Social Determinants of Health

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Executive Summary

The present work builds on the affirmed desire of the Commission on Social Determinants of Health (CSDH) to be judged on both its scientific rigor and the policy implications that the Commission's work will generate. In addition, we contribute to the general discussion on the social determinants of health by complementing the work of the Commission's other Knowledge Networks and by focusing on the fundamental conceptual issues relating to Early Childhood Development and Education (hereafter ECD). The scope of this review is to provide an international and global perspective on the determinants and life course implications of early child development.

There are important reasons for conducting this work. With advent of technologies that facilitate communication, connections among researchers and policy makers across the globe is increasingly taking place. This is occurring because of the recognized value of international collaborations in reciprocal learning and policy development. The importance of international co-operation to protect the fundamental rights of children is also acknowledged in the UN Convention of the Rights of Children that encourages State Parties to undertake measures at the legislative and administrative levels to implement the rights of children recognised in the Convention "within the framework of international co-operation" (Article 4).

While international co-operation is critically important, there are several challenges that limit the extent to which experiences, programs and research findings related to early childhood from one country can be applied to other countries and cultural realities. This includes cultural and language differences while others may be related to differences in the extent to which some countries have the adequate resources to ensure that children's rights are protected and appropriate policies implemented. Thus, there are a number of different issues about early childhood development that require a discussion at the global level so that not only knowledge-based principles can be applied universally across cultures and contexts but also implementation strategies can be readily adopted internationally to promote healthy child development.

The critical importance of the first years of life is well acknowledged. Three broad domains of early child development contribute to health, and have a role to play in health equity, across the life course: physical, social/emotional, and language/cognitive. The outcomes of early child development become life long determinants of health, but are, in turn, influenced by early life factors that are underlying social determinants of health. At the most intimate level the 'within family' environmental attributes of stimulation, support, and nurturance

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influence all three key domains of ECD mentioned above. There are a wealth of studies involving first world, immigrant, and developing country populations showing that nurturing qualities of family environments influence development and can be improved through intervention programs involving improved parenting skills, nutritional supplementation, and quality childcare arrangements. Although long-term follow-up has occurred on only a subset of these studies, the results are very promising when the initial ECD programme was of high quality.

At the next level of social aggregation, neighbourhoods/communities influence ECD. The key aspects here are safety, cohesion, and the avoidance of ghettoization of poor and marginalized families. The Bernard van Leer and Aga Khan Foundations have both demonstrated that community development approaches to improving child development are feasible and effective in developing country contexts. The challenges here are greater in urban environments than they are in village contexts, because city environments tend to create spatial separation among people from different walks of life and, thus, large differences in the qualities of the neighbourhood environments for children. Nonetheless, ECD is an important perspective to take when considering the urban aspects of SDH and their relationship to 'sustainable cities'.

At the broadest level of social aggregation, socioeconomic and programme delivery factors make a difference for ECD. Here, the programme delivery factors are much easier to modify than the socioeconomic context. The 'gold standard' for service delivery around the world would be the local neighbourhood 'hub' for ECD, through which families could access quality child care (emphasizing stimulation, nutrition, and quality play spaces); infant and family support programs; a conduit to pre and post-natal, primary, developmental health care services; family literacy programs; and a borrowing library of resources (books and toys) for young children. Examples of such hubs exist in many wealthy countries; in immigrant neighbourhoods; and among Aboriginal communities. Elements of the hub model also exist in many of the best developing country programs. *In principle, if a supportive community in a developing country has a well functioning hub, children should be able to reach school age at the same level of development as their counterparts in the wealthy world.* Thus, compared with many of the social determinants of health that are deeply embedded in economic processes, most of the social determinants of ECD are relatively easily modifiable.

The scope of this document is to integrate knowledge about the different levels of aggregation described above from an international perspective and to discuss the determinants and life course implications of early child development (ECD) at the global level. This review identifies general principles that can guide wealthy and developing countries in improving their children's developmental outcomes during the early years of life. It presents to the Commission a series of strategic considerations to assist it in planning a successful approach to early child development as a Social Determinant of Health. Over the course of the Commission's life, it is hoped that guidelines and recommendations will be promulgated that will apply in any place and cultural context to improve, globally, early child developmental outcomes.

The Social Determinants of Early Childhood Development

The social environment influences early child development (ECD) first. Later, as the life course unfolds, ECD emerges as the determinant of health most responsible for the fact that inequalities in health cut across virtually all causes of disease and disability. Inequalities in health appear at the beginning of the life course as 'social gradients' in ECD. Sensitive periods in brain and biological development start prenatally and continue into post-natal life, during which time the social environment plays a key role in determining outcomes. In particular, the extent to which early developmental processes lead to 'healthy' outcomes depends upon the qualities of stimulation, support, and nurturance in the environments where children grow up, live and learn. Early physical, social-emotional, and language-cognitive development, in turn, influence a wide range of subsequent health outcomes, as well as well-being and learning skills, across the balance of the life course. Thus, ECD is a social determinant of health in a special sense: at first, the early social environment is a determinant of ECD, but then ECD becomes a determinant of health across the balance of the life course.

By school age, development has been influenced by factors at three levels of society: family, neighbourhood/village, and the broader societal level.

Family-level Characteristics

Families are the first environments with which children interact from birth. They are critically important in providing children with stimulation, support and nurturance. These qualities, in turn, are influenced by the resources that families have to devote to child-raising (strongly influenced by income); to their style of parenting; and to their tendency to provide a rich and responsive language environment (strongly influenced by parental levels of education). Thus, family-level characteristics may influence children's development in both a positive and a negative manner, as risk and protective factors (Bronfenbrenner, 1986).

Over three decades ago North American researchers began observing that children who lived in families with very low income did not acquire the same level of verbal and cognitive skills as children who did not live in poor families (e.g., Birch, 1970). It was argued that poverty put children at risk because of the deficiencies in resources associated with poverty such as poor nutrition, including calcium, vitamins, and protein deficiencies, which are all essential elements for healthy physical development and cognitive growth. Recent studies have also documented that children from disadvantaged families tend to do worse in academic achievement, social skills and cognitive functioning than children who are not from economically disadvantaged families (Conger et al., 1992, 1994; Duncan, Brooks-Gunn, & Klebanov, 1994; Liaw, & Brooks-Gunn, 1994; McLoyd, 1990; Smith, Brooks-Gunn, & Klebanov, 1997). These same studies have identified other important social aspects of a child's environment that are associated with a healthy early childhood development. Factors such as adequate maternal nutrition, maternal mental and physical health, parental stress and depression, parenting styles, unemployment, limited or no income, housing conditions, and neighbourhood quality are some of the most important determinants of ECD identified in recent research—these family-level characteristics have important implications for optimal child health outcomes.

Living in family poverty has long been implicated in children's health and development (Engle, Castle, & Menon, 1996; Gissler, Rahkonen, & Hemminki, 1998; Wadsworth, 1997) and has also been linked to poor health in adulthood (Lundberg, 1993; Rahkonen, Lahelma, & Huuka, 1997; Wadsworth, 1997; West, 1997). Family poverty can affect the extent to which children's basic needs are met: needs such as safe housing, nutritious meals, and high-quality childcare (Brooks-Gunn, 1995). Brooks-Gunn studied the effects of family income on behaviour and IQ, and found that psychological resources such as family networks of support, high maternal education, and positive maternal mental health mediated children's scores. In addition, Brooks-Gunn, Berlin, and Fuligni (2000) have demonstrated that the home environment can either buffer or exacerbate the effect of low family income on children's cognitive ability.

Family-level factors, such as low maternal education, poor maternal mental health, and lack of family networks, have been demonstrated to pose risks to ECD (Brooks-Gunn, 1995; Hertzman, 2000). In the case of poor parental mental health, in situations of extreme poverty, or high levels of family stress (which could be associated with either of the preceding factors), important parent-child interactions may be impaired, resulting in fewer opportunities for learning experiences in the home (Bornstein, 1995; Willms, 2002). Single parenthood has also been shown to be more highly associated with depression, three times the level found in co-parenting individuals. When socioeconomic factors are considered, the rate of single-parent depression drops to only twice that of co-parenting individuals (Somers & Willms, 2002). As stated earlier, depression and adverse child outcomes are linked. For instance, the severity and chronicity of maternal depression are predictive of disturbances in child development (National Institute of Child Health and Human Development [NICHD] Early Child Care Research Network, 2004).

Parenting style is a fundamental influence on child development. Infancy/early childhood is the period during which interactions with parents provide the foundations for development of trust that is an essential element for children to 'know' that they can safely explore environments and learn from those explorations (Ainsworth, Blehar, Waters, & Wall, 1978; Bornstein & Tamis-LeMonda, 1989; Bruner, 1975). A 'responsive' parenting style is what allows children to safely explore environments and that responsive parenting consistently provided in the early years puts children on a positive developmental trajectory throughout childhood and adolescence (Landry et al., 1997). In turn, children who have successfully explored environments and have had positive learning experiences during their infancy and early childhood are more likely to develop cognitive abilities that are needed to assimilate information from one learning experience and apply it to other similar contexts (Rovee-Collier, 1995). Parental behaviours such as positive reinforcement, displays of warmth and affection, and consistent disciplinary strategies (known as authoritative parenting) result in fewer child behaviour problems and relate positively to academic competence and positive peer relations that, in turn, enhance a child's health (Brody & Flor, 1998; Conger, Elder, Lorenz, Simmons, & Whitbeck, 1994). The benefits of positive and responsive parenting have been widely documented and relate to the socio-emotional domain (Bornstein, 1995; Ainsworth et al., 1978; Sroufe, 1988) as well as to the development of cognitive abilities (Olson, Bates, & Bayles, 1984). While some literature associates negative parenting strategies with low income, Chao and Willms's (2002) study, using data from the Canadian National Longitudinal Survey of Children and Youth (NLSCY), demonstrated that both positive and negative parenting practices were found at all levels of socioeconomic status. Positive parenting strategies have also been shown to provide a buffer for poor child outcomes in families experiencing adverse circumstances. For instance, positive parenting has been found to buffer the expected effects of factors such as financial strain and parental divorce, through building children's coping resources (Armistead, Forehand, Brody, & Maguen, 2002; Hertzman, 2000).

The ability of parents to provide positive parenting can be hindered by socio-economic or personal circumstances such as unemployment, stress, and/or depression. Several studies have documented that women who live in poverty with young children are more likely to be depressed than non low-income women (Liaw & Brooks-Gunn, 1994; Kaplan, Roberts, Camacho, & Coyne, 1987; Radloff, 1975; Hall, Williams, & Greenberg, 1985). In turn maternal depression is associated with language and cognitive problems, poor social skills and behavioural problems in infancy and early childhood (Murray, Hipwell, & Hooper, 1996; Abrams, Field, & Scafidi, 1995; Murray, 1992; Cogill, Caplan, Alexandra, Robson, & Kumar, 1986). The effect of parental depression on the ability of children to engage in social interactions and object recognition are observable as early as two months of age (Campell and Cohn, 1991). In addition, infants of depressed mothers show a greater degree of 'stress' response as indicated by higher heart rate and cortisol levels than infants of non-depressed mothers (Field, 1995). Furthermore, mothers with depression have been found to have difficulties in providing their children with positive and responsive parenting, which is instead characterized as hostile, disengaged or intrusive, disorganised, and generally less competent (Gelfand & Teti, 1990; Goodman, 1992; Murray, 1997; Murray & Cooper, 1997; Webster-Stratton & Hammond, 1988; Burbach & Borduin, 1986).

Research on family and parental influences on ECD has produced some lessons that should apply world-wide. However, such research has also been primarily produced in developed western societies, limiting the extent to which our current knowledge applies to other cultures, especially those in developing countries. Yet, it is reasonable to conclude that fostering family environments that are stimulating, supportive, and nurturant will benefit all children regardless of geography, ethnicity, language or societal circumstances.

Neighbourhood-level Characteristics

At the level of the 'neighbourhood' (by which, we mean neighbourhood, village, or local community), children growing up in a safe area that is 'cohesive' in relation to children – where it mobilizes resources formally (creates programs) and informally (treats its children like they belong there) – are less likely to be vulnerable in their development than children from similar family backgrounds living in unsafe and non-cohesive neighbourhoods.

Neighbourhood characteristics influence children's development in a variety of ways (Beauvais and Jenson, 2003): through stresses (exposure to toxins, and social and psychological conditions such as high crime rates), through social organization (role models, collective efficacy, and shared values), through institutions (function of schools, police, neighbourhood services, etc.), and through 'epidemic' forces (power of peer influences). Neighbourhood safety, cohesion, and crowding are a few of the factors that may influence family practices, family psychological well-being, and thus children's development (Dunn & Hayes, 2000; Hertzman, 2000: Hertzman & Kohen, 2003; Kohen, Hertzman, & Brooks-Gunn, 1998; Sampson, 1991; Sampson, Raudenbush, & Earls, 1997: Shonkoff & Phillips, 2000; Wilson, 1987). For example, concerns regarding safety, for children as well as parents, might affect a child's opportunity to participate in physical activity in venues such as neighbourhood playgrounds; such limitations have a domino effect, inhibiting a child's social experiences. Research also shows that neighbourhood cohesion may act to diminish the effects brought on by safety issues, as social networks may provide supportive enclaves where families and children feel safe (Sampson et al., 1997).

Neighbourhood-level factors influence different child developmental outcomes to different degrees. Two recent reviews (Duncan & Raudenbush, 1999; Leventhal & Brooks-Gunn, 2003) have reported that the socioeconomic status of the neighbourhood demonstrates the most consistently powerful effects on children's health, but that research with school-age children provides the most consistent evidence of neighbourhood-level effects. Once children enter school, they have an immediate increase in their social networks and *potential* resources from which they can draw, as the influence of teachers and other professional, as well as school dynamics (positive or negative), shape children's lives at this age (Engle et al., 1996). School-aged children's[1] interaction with their environments increases at a time when they may not have the resources for dealing with challenging neighbourhood conditions such as high crime, lack of cohesion, dangerous roadways and more. These reviews showed that neighbourhood effects are stronger for cognitive and academic indicators than for behavioural and mental health measures (Duncan & Raudenbush, 1999; Leventhal & Brooks-Gunn, 2003).

Socio-political Context

Finally, at the level of society, access to 'quality' programs matters. This includes the full range of childcare, family support, and family strengthening programs; public health programs for high risk children; vision, hearing, and dental screening, etc.; and broader arrangements such as parental leave and housing programs. ECD is also influenced by broader societal conditions and policies that are far outside the traditional realm of child policy: the level of wealth of society, the political environment (e.g., rationalization of services and downsizing of health care), health and social services policy (e.g., welfare policy), and community and environmental programming (e.g., upkeep and presence of playgrounds and green space, presence of neighbourhood policing office, placement of public libraries). International studies comparing success in the acquisition of basic competencies (that is, reading and mathematics skills) by teenage and young adulthood

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[1] For instance, Hertzman, Brooks-Gunn, and Kohen (1999) found that family characteristics buffered the neighbourhood effects of school-readiness more for toddlers than for older children. These findings suggest that neighbourhood effects for school readiness measures may be stronger for children who have more interaction with their neighbourhoods.

demonstrate that societies that address all these areas achieve the best outcomes for children (OECD, 2001).

Societies have a crucial role to play in supporting initiatives that bring young children in contact with environments that have the following characteristics: exploration of all sorts (physical, auditory, tactile, musical, artistic) is encouraged; mentoring and development of new skills is provided; the child's developmental advances are celebrated; there is protection from inappropriate disapproval, teasing, or punishment; and the language environment is rich and responsive (Ramey and Ramey, 1998). These characteristics are important both within early learning and care settings, and also in family and neighbourhood environments. The fact that infants and young children are particularly receptive to responsive and interactive environments frames a very important challenge for ECD policy and programs. Influencing ECD globally requires that we take initiatives that are supported by the international community, but that must nonetheless penetrate to the most intimate realms of early life. Few other social determinants of health are of this character.

Society and ECD Programming -- ECD programs that provide children with high quality care, which incorporate some principles of responsiveness and positive learning experiences, may be able to compensate for the lack of such environments at home and better prepare children for entry into formal school programs. To be effective, however, these programs must start as young as possible; be of relatively long duration; and provide opportunities for care on a full-time basis (Hertzman & Wiens, 1996; Doherty, 2001).

A notable example of an ECD program that promotes development through interactions with a responsive and positive environment is the Reggio Emilia approach in the Emilia Romagna region of Italy. It is based on the principle that early consistent responsiveness which 'exploits' the children's natural curiosity to learn more about their environments, supports long term cognitive and socio-emotional development. What has made the Reggio Emilia approach appealing to early childhood educators worldwide is the dynamic nature of the pedagogical tools whereby the educator needs to quickly adapt their 'teaching' strategies to provide children with learning experiences that are relevant to the their fast changing abilities. What has made it appealing to the policy community is that it is widely understood to be a central, not a peripheral, element in the regional strategy for social and economic development. There is compelling evidence of the relationship that exists between the types and amounts of activities that young children engage with (e.g., family activities involving the child, books and toys for learning, opportunities for parent–child interactions) and performance on cognitive assessments in infancy and childhood (e.g., Aylward, 1997; Bee et al., 1982; Bradley et al., 1993; Longstreth et al., 1981; V. Molfese, DiLalla, & Bunce, 1997) The more they are offered opportunities for stimulating interactions with objects, physical environments, and responsive adults, the more likely children are to develop adequate physical, cognitive, language, and social skills.

Overview of International ECD Programs and Lessons Learned

While for the most part the studies reported above have been conducted in western societies, especially in North America, Australia and the UK, the review of the studies presented below would indicate that there are principles of effective ECD programs that may in fact apply to many different cultures, languages and contexts. The following section summarizes current knowledge of the fundamental principles associated with ECD. In order to review this knowledge from a global perspective several sources were consulted, especially reports from non-governmental sources including the European Commission Childcare Network; OECD PISA; UNESCO; the Consultative Group on Early Childhood Care and Development: UNICEF; World Bank; WHO; Bernard van Leer Foundation; Aga Khan Foundation.

As indicated in the previous section, the most important influences on early child development originate from within the family environment, the neighbourhood/village where children live, and the type of ECD programs that children are exposed to during their early years. One of the challenges in providing a global perspective of ECD is that, unlike the processes of brain, physical, and socio-emotional development which are common to all human beings, *there is great variability across cultures in the specific ways in which family environments, the neighbourhoods/villages and ECD programs may influence child development*. At the same time, studies conducted in developed as well as developing countries have been identifying a set of fundamental environmental conditions that are associated with healthy child development in different countries, and among different cultures, languages, and ethic backgrounds. For example, a wealth of studies involving first world, immigrant, and developing country populations show that the nurturing qualities of family environments that influence development can be ameliorated through intervention programs involving improved parenting skills, nutritional supplementation, and quality childcare arrangements. At the next level of social aggregation, neighbourhoods/communities influence ECD some key aspects are safety, neighbourhood/community cohesion, and the avoidance of ghettoization of poor and marginalized families. The Bernard van Leer and Aga Khan Foundations have both demonstrated that community development approaches to improving child development are feasible and effective in developing country contexts.

In order to 'measure' program effectiveness, specific criteria and procedures need to be put in place. In fact, programme evaluation is a discipline in and of itself that many wealthy societies rely upon to provide evidence of the extent to which programs are effective at the community level. However, for many countries struggling with a lack of resources, these forms of program evaluation may be neither feasible or affordable. Traditional programme evaluation can be expensive and often times inflexible. While there may be limited 'scientific' evidence of the effectiveness of ECD programs implemented in many developing countries there has been ample documentation of the effectiveness of these programs gathered according to different standards of evidence than those put forward by the western academic research community. Given the relevance of their findings these studies cannot be ignored and have to be included in the discussion of a global perspective such as that taken on by this Commission on the Social Determinant of Health.

In the words of Ruth N. Cohen of the Bernard van Leer Foundation: "...academic research is valuable but it is also expensive and, by its very nature, often long term and inflexible. We were looking for another form of research, one that would be more immediate, achievable by smaller programs that did not have access to vast resources, and adaptable to local needs and capacities. The point was to gain useful insights about actual impact – or the lack of it – on children, people, families and communities, and how this looked when considered in relation to the aspirations of the project. We recognized early on that these insights would often be personal and subjective rather than objective; would be hard to substantiate by, for example, statistical measures; and would need sympathetic sifting and consideration. In addition, we soon saw that some if the emerging data could be linked to something that is often underrated: intuition about what is happening. That doesn't mean that the data necessarily confirmed intuitions or feelings, rather that they helped us to see how accurate these were" (Early Childhood Matters, December, 2002 – No. 100).

The Effectiveness Initiative (EI) of the Bernard van Leer Foundation was created to conduct systematic evaluations of the effectiveness of community based programs promoting ECD. Ten projects were evaluated as part of this initiative each of these having at least a ten year track record, representing geographic diversity and illustrating a variety of different approaches. These ten projects are summarized in the Appendix.

The EI objective was not to examine *whether* a programme was effective or to measure to *what extent* it was effective by assembling evidence on the basis of 'quantitative' indicators but rather to learn *why* a program was effective. Below are reported some of the general lessons that were learned from this EI. Each of these lessons learned have important global and international implications for ECD programming and policy development.

The historical moment in which the program is implemented, and the receptivity (at the local and government level) of the environment are critical in determining the success of a program. The consciousness within the community of its problems and needs and an ability to recognise the long-term potential benefits of the program are also critical factors. The relationship between a program and whoever finances it should be properly defined at the outset. Such relationship should be characterised by a friendly spirit of collaboration. It should be based on a common view of desired outcomes and the donation of funds should not imply or legitimize authoritarian management practices.

One major component of program effectiveness is the consistency of contribution of those implementing the program in the community; those working in it; and those supporting the program with funds and other assistance. The commitment of the personnel can be more significant for program success than the programs' design was a theme that emerged repeatedly in the EI evaluations. "People who are intensely involved in the program, who are willing to work long hours and who confront barriers and the needs of a target community with vigour, enthusiasm and selfless dedication can be the difference between failure and success even of a poorly planned and poorly organised project. Being an effective community worker or organiser also means being reliable and lending a helping hand in good times and bad. Such sentiments, as well as a spirit of unity, hard work and community service, should be reinforced as much as possible among the personnel, but also among the other stakeholders" (Zimmermann, 2004; pg. 177).

Understanding the social conditions of the target community that could help refine a program was also found to be an important factor contributing to program success. The direction of the program should be shaped by the priorities and needs of the community. The program staff should be considerate of problems raised by stakeholders and beneficiaries, particularly if this occurs repeatedly, as signals that there may be unmet demands that require attention. Community workshops or discussion groups among parents, or other stakeholders can be reliable sources of information on community needs and priorities. These can also provide stakeholder with the opportunity to provide input and release tensions. The notion that the people constituting the target of the program may precisely understand what they need for self-actualization and advocacy cannot be overlooked.

The traditions and the culture of the community where the program is going to be implemented should not be ignored. Culture and tradition regulate several aspects of the relationship between parents and children, including feeding and eating routines, the behaviours that are tolerated and those that are punished, and the household economic arrangements. For programs promoting changes in the community, program approaches should be applied incorporating cultural and traditional practices as much as possible.

In several cases the implementation of the programs required that community 'insiders' as well as 'outsiders' be involved. This approach had the advantage of overcoming some of the limitations that are implicit in having only insiders or outsiders involved in the program. Some stakeholders have argued that insiders 'understand' the traditions and the needs of the target population better than outsiders and thus they could act as important mediators between the community and the programs. In addition, insiders may be more successful in communicating with other local stakeholders. Thus, the success of a program may as well depend to a great extent on the positive attitude among insiders towards that specific program. On the other hand, outsiders may be people who bring with them greater expertise thus addressing a lack in the community of qualified members. In addition, outsiders may be able to bring to the community a less biased perspective and they tend to be less motivated by personal interests. "If mothers find warmth and a caring attitude among the insiders who are their points of contact with a programs, or if they find competence and professionalism among the outsiders, then their relationship with the program is more likely to be positive even if their perceptions about the insiders and outsiders are due to bias. A model for the use of insiders and outsiders suggests itself. If the outsiders are resented by a community, then insiders should be encouraged to join the staff in some capacity. If the insiders are criticised because they are considered less skilled, then they should be offered more training, and outsiders might be brought in to supervise the technical aspects of their work" (Zimmerman, 2004)

For example, in Israel an Ethiopian paraprofessional (an 'insider' to the Beta Israel immigrant community) was paired with a local non-Ethiopian Israeli professional social worker (an 'outsider') to run some components of early childhood programs of Almaya. In this 'dyad' of insider-outsider, the Israeli professional was responsible for the technical aspects providing support to the Ethiopian insider that in turn provided the Israeli professional with expertise with respect to the culture and the values of the target community. The technical abilities that the outsider brought to the community combined with the insider's knowledge of the community culture and values enhanced to the benefit of the community and contributed to a more positive outcome of the program.

Community empowerment through training for local people is another critical element involved in the success of a program. People within the community can be trained to perform key functions in programs interventions which can have a pivotal role in enhancing the commitment of the target population to support and sustain the program. It also fulfills an added purpose which is that of increasing the human resources involved in the program delivery. By promoting capacity building through training, a given program will assign responsibility to community members and encourage their commitment in the solution of community problems. Assigning a more active role to community members can lead to a more proactive approach to problem solving and to greater continuity of the program after the outsiders leave.

Community mobilization is also an important factor that contributes specifically to the sustainability of programs. When assistance for program implementation arrives in a community in the form of external expertise community members become knowledgeable of the specific program and may take initiative to either create more programs or expand the program offered. Community mobilization is in fact another means of building local capacity and promotes program sustainability.

It has been documented that open communication is an important ingredient of program effectiveness. Such communication has to be open and there need to be different channels of dialogue between the program providers and the target community. Open communication promotes understanding and consensus between different members of the community and it helps linking community members socially; it encourages the recognition of accomplishments that in turn consolidates individual and collective achievement. When people have a chance to exchange experiences and to share experiences that worked or didn't work for them, motivation to continue participate in the program is enhanced as a result. Venues for open communication may include frequent and regular meetings within and across groups of mothers, ECD educators, and other members involved in the program. These opportunities for communication can take many different forms depending on each specific context and program.

It is important to have an appropriate management plan that allows quality control and assessment of the program progress. A program could promote a positive sense of competition among component activities which could act as an incentive to achievement but that also functions as a system of checks and balances. "Mutual support and accountability create a sense of responsibility towards the success of a program. Problems and progress should be discussed openly at frequent meetings among stakeholders. This would also help ensure that experiences and innovations are shared. Likewise, simple but comprehensive structures for research and for monitoring and evaluation should be put in place. These structures should take into consideration all the beneficiaries and stakeholders and provide pathways to receive stakeholder feedback. The capacity of staff to receive and properly assess this feedback must be built up. One measure of effectiveness may be the extent to which a program can make adjustments to take advantage of positive openings or turn crisis into opportunity." (Zimmerman, 2004)

The Early Childhood Development portfolio of the Aga Khan Foundation provides additional examples of successful ECD programs. In 2004 Syria began implementing a national programme of ECD that involves the participation of the Ministry of Education, other ministries, national and international agencies, and academic institutions. This extensive network of collaboration has lead to the design of a pilot community based early childhood programme implemented in existing nurseries and kindergartens. These nurseries and kindergartens function as 'hubs' or base for further outreach and services. At the local level, professionals and volunteers are trained in the areas of childhood care and education and participate in organizing six-week summer camps for children under 12 years of age. The pilot conducted in the village of Taltout has been completed successfully and will be implemented in other villages and communities.

The Consultative Group on Early Child Care and Development is another important hub where several ECD programs conducted around the world are documented, especially those implemented in developing countries. Within this consultative group a number of successful ECD programs and strategies have been identified.

The following are examples of the type of programs that have been found to be most associated with positive outcomes:

Programs that involve parent participation including parent education, parent support groups, and home visiting programs. One example is a mother-education project in Turkey that has shown that helping mothers develop greater parenting skills has long-term effects on children's development. This programme has also demonstrated effective use of an adult education network to house and disseminate the mother education model on a broad scale throughout the country, adding in elements of mother literacy and retraining of unoccupied adult educators to provide the services.

Programs that add an early childhood care and stimulation component to already existing health or community development efforts. For example, adding health and nutrition to a child care setting creates an integrated programme that meets the holistic needs of the child. Research has shown that care and nutrition enhance the potential for physical, mental, and emotional development. Experience in feeding programs in Guatemala have demonstrated that programs that emphasise the interaction between children and adults in feeding situations are more effective than just providing children with additional food. This type of programme is an example of the importance of holistic approaches that may be more appropriate for a wide range of cultures.

Programs that integrate traditional caregivers in the delivery of quality child care practices. Supporting traditional caregivers in their training and personal development involves building on care giving situations that are already provided in the community. An example comes from a programme in Mali where older women in the community serve as caregivers supported by the community youth. This group of caregivers receives additional training to enhance their role and their ability to respond to young children's needs.

Programs that use media such as the radio have been used to reach parents and caregivers and disseminate information about ECD and the needs of young children and their families. Radio is being used effectively as part of a parent education programme in the Philippines to provide hard-to-reach families with child development information.

Programs involving an active participation of older siblings who are often the primary caregivers in the households of many countries. These child-to-child programs aim at engaging both older and younger children in new behaviours and informational activities. For example, in Botswana, school children help younger children in the community make the transition into the primary school by bringing the younger children to the primary school and socialize them into school activities.

Programs that focus on facilitating the transition from ECD programs to primary school. These programs build on the concept of 'readiness for school' and envision training to primary teachers in exposing children to developmentally-appropriate learning experiences. In Kenya, preschool teachers and primary school teachers are provided joint training sessions aimed at enhancing understanding of child growth and development and appropriate methodologies to be used in teaching young children.

Programs that address the children's needs in conjunction with women's programs. An example of these programs is a family day care home programme developed in Vietnam and provides quality child while women are engaged in income-generating activities.

Programs that build on existing resources or networks. For example, in Nepal literacy programs have been in place for many years but new topics and materials for newly literate women were needed. A series on child development and parenting was thus created to meet women's need for more relevant reading material, while at the same time it provided them with useful information in their role as parents.

The Basis for Policy and Programs at the Regional, Country, and Global Level

Below are 10 strategic considerations for the Commission to consider when promoting ECD globally as a Social Determinant of Health.

1. *Early Child Development should be promoted as something occupying a policy/program space that complements current agendas for the 'rights of the child,' 'child survival,' and 'access to education'* -- At present, the principal foci of international development assistance are in these three areas. Although each of them either influences, or is influenced by, ECD, none of them lead directly to a global agenda to create environments/programs for young children that promote healthy child development across the three key developmental domains described in this report. Thus, a potential 'early win' for the Commission would be to achieve international agency agreement on the positioning and complementarity of ECD in relation to existing global child agendas.

2. *The long-term goal of a strategy for ECD should be to create global access to the conditions that support healthy child development, with the objective of 'raising and levelling the (developmental) bar'* -- ECD is influenced both by programs/services and by the nurturant qualities of the families, neighbourhoods/villages, and societies where children grow up, live and learn. This implies that we need a two-pronged strategy: one that deals with the quality of programs designed to provide early learning and care, and another that addresses families, neighbourhoods/villages, and societies from an environmental perspective. The overall criterion for success would be 'raising and levelling the developmental bar'; in other words, *both* improving child developmental outcomes, overall, within societies *and at the same time* reducing social inequalities such that developmental gradients become 'flatter'.

3. *The domain of social/emotional development must be given equal priority to physical and language/cognitive development* -- Until now, the principal domains of child development that have been addressed through global agencies have been the physical and the language/cognitive. This is because these domains are passively (though very partially) addressed through existing initiatives in child survival and schooling. The social-emotional domain ha been largely neglected until now. There are many reasons for claiming that this should be remedied. Just one will be stated here. A knowledge of brain and biological development leads to the conclusion that the social-emotional domain is a principal 'gate-keeper' for other domains. In other words, poor early social-emotional development undermines language/cognitive development (*in extremis* even physical growth is affected) and, as the life course unfolds, *limits the development of empathy necessary for global citizenship.*

4. *The Commission should build upon the work already done by the small family of international agencies that are currently in the ECD field, and on the lessons from their work that have been summarized in the previous section of this report* -- Positioning ECD as an internationally recognized 'Social Determinant of Health' has obvious potential advantages for advancing a successful agenda. Without 'health' the ECD

agenda tends to be an institutional orphan, in that there is no network of ministerial responsibility through which it can operate. By bringing in health, the global network of national Ministries of Health creates for ECD an institutional home. Although this is an opportunity, it also brings potential challenges. Until now, international ECD has largely operated as a series of community-based projects and *ad hoc* initiatives. Although these are low profile on the international stage, they have been very efficient in the sense that a high proportion of energy and resources have gone directly to communities and front-line training, rather than politicking and other high-level interchange. Bringing strong institutional partners, such as Ministries of Health, into ECD must be done in a way that expands upon this current strength and does not undermine it through bureaucratization. In this regard, building on the leadership of the small family of international agencies already doing ECD is essential.

5. *Countries should be encouraged to develop comprehensive intersectoral strategies for ECD; and to do so in ways that create a broad base of support* -- The determinants of healthy child development, and the opportunities for improvement, cut across many government ministries and exist at all levels of society, from the most intimate of family processes to the broadest realms of social policy. To date, those societies that have achieved the most in ECD are those that have developed and implemented a coherent intersectoral, multi-level policy that is broadly understood and supported. Although it may be too much to ask of a weak state, struggling to fulfill traditional government functions, to match countries like Sweden in this regard, it is not unrealistic to promote the idea that every society strives to create a credible framework of understanding and action around which national and international initiatives can be aligned. The action corollary to this is not a single new program initiative in a given society, but rather a basket of initiatives with a common rationale.

6. *The international lending and granting agencies should be encouraged to use an investment framework, rather than a welfare framework, in evaluating ECD program proposals* -- There is now a body of evidence, endorsed by internationally credible economists (such as van der Gaag and Heckman) showing that ECD programs that are effective in improving developmental trajectories are better seen as 'investments' than as 'expenditures'. There are two reasons for this. First, successful ECD programs pay for themselves many times over in reduced remedial education, juvenile delinquency, incarceration, and teen pregnancy expenses. Second, as adults, those who benefited from ECD programs as children have higher levels of successful participation in the economy than those who did not. In other words, the Commission is in a position to argue to the international lending agencies that ECD is *literally*, not just *rhetorically*, about investment, and proposals should be evaluated that way.

7. *There is need for an international program of monitoring progress in ECD at the population level* – At present, there are no internationally agreed-upon outcome indicators for ECD. Yet, without population level indicators that can parallel infant mortality and life expectancy, it will be impossible to monitor progress over time. At present, an opportunity comes from the fact that there are several indicators being implemented on an *ad hoc* basis in developing and wealthy societies. The danger is that,

like multi-attribute health status indicators, so many different instruments will proliferate globally that we will never achieve an international benchmark. An unambiguous success of the Commission process would be achieving consensus on a single indicator that stood for ECD the way life expectancy, GDP, and carbon dioxide emissions stand for mortality, economy, and sustainability, respectively.

8. *Despite many holes in our knowledge base, we know enough about the characteristics of social environments and interventions that support healthy child development to make intelligent choices about the sorts of initiatives that the international community should support* – Because ECD is about environments as well as programs, and because it is inherently inter-sectoral and multi-level in character, an ECD agenda is fundamentally one of social change. Thus it is difficult to apply, in a straightforward way, the rules of evidence that were developed for discrete health interventions unmediated by broader social processes. Put simply, a new basket of ECD initiatives (see point 5 above) should be implemented and evaluated according to three criteria: is the basket of proposed initiatives based upon principles that have succeeded in other societies with healthier child development? are the programs within the basket 'as evidence-based as possible under the circumstances', fully implementable, broadly supported, and sustainable in their new context? and, are the population-level indicators of ECD moving in a positive direction over time with the implementation of the new basket of initiatives?

9. *Modern communications technology should be exploited to create a global platform for local groups to share successes; learn from one another; and make progress even if/when senior governments are not supporting ECD* -- Although the Commission has a key role to play in raising the profile of ECD and institutionalizing it internationally, it also can and should play a leading role in creating a horizontal network of local and regional leaders in ECD through internet platforms. Unimaginable even 10 years ago, this technology can now allow individuals and groups working with children throughout the world to learn from one another, and receive support and encouragement in contexts that would otherwise be isolated. A lot of work is needed to make this happen, but it is relatively uncomplicated and feasible within the ambit of the Commission.

10. *Although the global trend for mothers to enter the formal economy is exacerbating the challenge of work-life/home-life conflict, it should also be seen as an opportunity to bring ECD out of the realm of exclusively private life, into the social sphere* -- The trend towards increased female participation in the formal economy has been gradual in many societies. Moreover, since the care of children is often seen as a mother's responsibility, systems are rarely put in place to ensure that quality child care is available for the children of working mothers. In some settlements around the world, this problem has led to a crisis where young children are swaddled to control them during working hours, or they are brought into dangerous working environments and cared for there. In neighbourhoods and villages where collective arrangements are worked out, there is the prospect of providing early learning and care programs of equal quality to the best in the wealthy world. The international community has shown that the training, housing, health/safety and equipment needs in this regard are feasible to address in receptive communities around the world. Championing a linkage between maternal labour force

participation and quality early learning and care is something that the Commission should closely consider.

Proposed Work Plan for the Knowledge Hub in ECD

A proposed work plan was described in two previous submissions. What follows below is a re-statement of that work plan, modified in light of Commission activities over the past several months.

1. Negotiating the priorities of the Knowledge Hub with the Commission – Although the proposed priorities of the Hub have been stated before, the focus of activities will depend upon the Commission's reaction to the ten strategic considerations presented above. Each consideration, if adopted, implies a program of work that would logically involve the Hub, the Secretariat, and the Commissioners themselves. Moreover, there is scope for the ECD Hub to work productively with other Hubs, especially those concerned with urban and gender issues. Thus, what follows below is preliminary to the Commission's deliberations.

2. Creating a global network of ECD researchers, policy makers, agencies that connect the developed and developing worlds -- The first activity of the Hub will be to work with the Commission to select the members of the Network. Membership will be on two tiers. The first tier, comprising not more than 20 people, will be the 'direct contact' group. This group will be asked to participate in conference calls and face-to-face meetings, as well as to respond in a timely fashion to written materials. The second, broader class of individuals will be 'corresponding members'. Their primary responsibility will be to respond to documents that the Network hopes will become subject of an international consensus. To date, a broad global list has been drawn up, but no decisions have been made as to membership composition.

3. Building a consensus that an international 'child survival' agenda and an ECD agenda are not in conflict -- The first product of the Network will be a short statement on why child survival and ECD are not in conflict as international priorities. The basic argument can be made in less than 2 pages. Thus, getting a disparate group of individuals around the world to concentrate on something like this should help us figure out what individuals' engagement styles are like and whether or not their level of commitment is adequate for the Network. Moreover, getting a 'quick win' in the form of a consensus statement will create a sense that this Network is not just another committee, but is actually going to make a difference.

4. Building an international consensus on the scope of early child development -- In practice this means expanding the concept of physical development beyond basic growth and nutrition; expanding beyond IQ in the language-cognitive domain; and bringing the social-emotional in as a domain of equal significance to the others. A second aspect of this work is to address the perceived dichotomy between 'rights talk' and 'development talk' to demonstrate that a broad notion of ECD is fully consonant with the International Convention on the Rights of the Child. Consensus statements need to be agreed to early in the process, in order to frame the balance of the work of the Network.

4. Review of literature appropriate to an international perspective on ECD – A thorough review of the subject would cover the following topics:

- social influences on early developmental biology;
- the influences of family, community, care arrangements and the state;
- how early development influences later health and well-being (why physical, social-emotional, and language/cognitive are all important);
- the economics of investment in early child development;
- the relationship between nutrition and stimulation in early development;
- the internationalization of work-life/home-life conflicts on family function;
- the development of 'resilience' in children from very difficult early environments.

This present document touches on each of these themes but, in order to stand as an independent review, would need to go into more detail in each area. We await the deliberations of the Commission as to whether or not it is a priority to pursue this.

5. Creating a single modifiable standard for assessing ECD around the world -- One of the most useful things that the Knowledge Network can do is to promulgate a method of assessing the state of early child development on a population basis and create a climate of receptivity to an understanding of why having a comparable approach throughout the world will be an advance on basic statistics like infant mortality and low birth weight. The method should be non-hierarchical, in that it should put the expectations of children from developing and wealthy countries on the same plane. It should be feasible to administer in countries with modest infrastructure; should tap the domains of development of interest to us; and be sensitive to change over time. Finally, it should modifiable in ways that allow for long and short versions; cultural modification; and refinement without losing its basic comparability over place and time.

6. Highlighting successes in the wealthy and developing worlds – Some of the world's successful ECD models have been described in this document, but this needs to be expanded to illustrate to a health-oriented global audience how the right mixture of social policies and inter-sectoral collaboration can work to support child development and health. This will involve highlighting both national successes and community success stories. The regional childcare model in Emilia Romagna, Italy, is thought to be the best in the wealthy world. The regional infrastructure established by the Aga Khan Foundation in the Gilgit region of northern Pakistan is a success story in the developing world. Success stories like these have been written up before, but primarily to highlight the work of a single agency; not to form part of a global consensus.

7. How to approach special global challenges in ECD -- The generic approach to ECD proposed here needs to be complemented by an emphasis on the unique ways that determinants of ECD play out in different societies. For instance, in many societies basic child survival, AIDS orphanage, child slavery, and/or warfare are the dominant challenges for ECD. In others it is something prosaic like work-life, home-life conflicts. The Knowledge Hub will articulate a strategy for maintaining a global unity of focus on ECD while emphasizing different major challenges in different places.

8. Sustaining global knowledge exchange -- One of the most useful potential outputs of this Network will be to advance the notion of a simple web-based system of access to the global knowledgebase on 'what works' to improve ECD. Because most ECD activity is carried out at the local level and the knowledge base is diffused across many disciplines, there is a singular lack of connectedness between the evidence as to what works and the people who are trying to make a difference for young children. Because of the relative ease of access to the Internet in this day and age it is expected that such a system might disproportionately benefit developing countries. The Network is the obvious forum for taking this idea from the talking stages to the point where a feasible plan is in place.

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APPENDIX A

Inventory of Relevant Initiatives

Effectiveness Initiatives

The EI project was started in 1999 when the Bernard van Leer Foundation partnered with the Consultative Group on Early Childhood Care and Development. This investigative project lasted three years. The goals of this project were to identify and examine the crucial aspects of an effective ECD program, and to create avenues for communication between nations to increase understanding of how to create effective ECD programs.

EI Columbia:
Partner Organisation: Centro Internacional de Educación y Desarrollo Humano (CINDE)
This community development project started in 1978 in the isolated villages of the Pacific coast of Colombia. This project is funded by CINDE (Centro Internacional de Educación y Desarrollo Humano or in English, "International Center for Education and Human Development") and carried out under PROMESA (Proyecto de Mejoramiento Educativo, de Salud y del Ambiente or in English "Program for the healthy physical, emotional and intellectual development of young children"). ECD and other activities are conducted by a community organisation. Local committees meet regularly and carry out activities. Local Promesa groups carry out systematic planning to design projects and are often asked by others outside the community to help design projects. A number of the programs that began as part of Promesa have been taken over by other institutions. Contributions and services to communities by Promesa include: operation of a community pharmacy, involvement in obtaining local land titles, management of a rotating loan fund, and a community library functioning in Nuqui. Also, many new habits have been incorporated into the culture through the work of Promesa; positive results achieved include the reduction of malaria through modification of local beliefs, attitudes and practices. In addition to these changes, most homes have sanitary facilities, there is a garbage collection system, nutrition has improved, children are less likely to be abused, conversation with children is more frequent, and continuing in school is accepted/encouraged.

EI Honduras
Partner Organisation: Madres Guiás-Guide Mothers
This is an ECD program with family, community and centre strategies. This project is funded by the Christian **Children's Fund Honduras** (CCFH) and run by the **Madres Guías** program. They effectively provide assistance and networking to communities affected by hurricane. The program was implemented in Honduras because of high poverty and low school enrolment. The CCFH seeks to improve child health and education through different venues, including: raising basic literacy, increasing access to clean water, providing medical care, implementing vocational training for youngsters and other training initiatives, and providing a training module for personnel. There are 55 local programs servicing 220 communities. CCFH ensure community responsibility for child welfare by requiring the local programs be run by a committee consisting of mothers and fathers in the area. Women who

show leadership are chosen to be "Madres Guias" (guide mothers), trained in proper child health care, nutrition, early childhood stimulation and educational practices and then put in charge of small groups of families. The results of this program have included: improved health care, controlled common childhood illnesses, reduced malnutrition among children, successful preparation for primary school, systematic responses to other childhood problems, favourable change in behaviours/ attitudes regarding child health/development, and noticeably enhanced self-esteem and confidence of mothers.

EI India

Partner Organisation: Self Employed Women's Association (SEWA)

The Self-Employed Women Association, SEWA, was founded to provide support to working women in India. Early childhood daily care was needed and consequently created as a social service for women. These care centres increased child health and development in multiple ways: mothers were able to make more money resulting in better nutrition for children, care centres provided immunizations for children, older siblings (most female) were freed of childcare responsibilities and therefore able to attend school, children with special needs were identified and referred to the appropriate services, and children in care centres were provided with a stimulating and enriched learning environment. SEWA ran several informational programs covering topics such as nutrition, child education, and disease prevention/control. Between 1998 and 2002 India experienced cyclones, drought, flooding, earthquakes, and communal violence. SEWA and childcare teams worked together to provide shelter, clothing, food, and medical supplies to affected communities in affected areas.

EI Israel

Partner Organisation: The Association for the Advancement of the Ethiopian Family and Child in Israel (ALMAYA)

This program, established in 1985, works with Ethiopian families that have migrated to Israel. It provides children with experiences that honour their traditional culture and prepares them to enter primary school. It is funded and run through ALMAYA (**The Association for the Advancement of the Ethiopian Family and Child in Israel**). Community based programs are run by Ethiopian madrichot (para-professionals), paired with a local Israeli professional educator or social worker. Madricha's are given training in various areas, including leadership, nutrition, and education. Almaya runs pre-school and after-school enrichment programs. Almaya also organizes for children a toy-lending library, a "big brother" program, and choral groups. The children who took part in the ECD program showed: increase in self-awareness, independent behaviour and decisiveness; a better developed capacity to express their feelings and their needs and to apply their talents; increase in communication skills; a greater tendency to show leadership; smaller tendency to be embarrassed by their Ethiopian heritage. These children also showed better organisation of activities and ideas, more initiative, positive perception of the importance of school, home and family, and the tendency to embrace positive social interactions. Parents of these children were more likely to be involved in school activities and see themselves as responsible for their children's future.

EI Kenya

Partner Organisation: Madrasa Resource Centre (MRC)
This program, funded by the Aga Khan Foundation (AKF), the Bernard van Leer Foundation and UNICEF, provides preschool services to Muslim families in Kenya through Madrasa (Qur'ānic schools). These preschools were implemented in response to a cycle of poor education leading to poor jobs, leading to poor education, as well as widespread malnutrition and disease. Teacher training/mentoring and community development are carried out at the Madrasa Resource Centre (MRC). The MRC is committed to encouraging and supporting communities in creating sustainable pre-schools, continuing teacher training and mentorship, implementing accepted pre-school curricula, creating a database for monitoring and evaluating clients, and exploring the long-term impacts of its own activities on its clients. The Madrasa program has been quite successful: in the last 5 years 150 new preschools have been constructed, hundreds of community members have received training in finance and organisation, over 1000 women have been trained as teachers, and almost 10,000 children have been exposed to early childhood education.

EI Mozambique
Partner Organisation: Assoçiação da Criança Familia e Desenvolvimento (CDF)
There is currently an EI in partnership with Assoçiação da Criança Familia e Desenvolvimento (CDF). This program evolved from an effort during the war to reunite children with their families. It now focuses on a variety of community based activities, one of which is ECD.

EI Netherlands
Partner Organisation: Stichting Samenspel Op Maat.
In 1999 the Stichting Samenspel Op Maat organization joined the Bernard van Leer EI. The Samenspel program provides a preschool/playgroup setting that helps integrate migrant (primarily Turkish and Moroccan) women and children into the Dutch culture.

EI Peru
Partner Organisation: Servicios Urbanos y Mujeres de Bajos Ingresos (SUMBI)
This program began in 1968 and then consisted of a nutrition education project and a non-formal preschool program among poor ethnic minorities in Puno state. The low-cost program was funded by Caritas Peru, Ministry of Education and UNICEF. The program was named Programas no Escolarizados de Educación Inicial (Non-Formal Early Education Programs), or 'PRONOEI' in the Spanish acronym. Teachers were trained in Piagetian theories to provide early education and paraprofessionals were trained to provide health, nutrition and early education activities. Currently there are over 17,000 PRONOEI preschools in Peru, providing education, nutrition, and health care to children. In 1999 PRONOEI was chosen to become part of the EI. Children who had the advantage of attending PRONOEI preschools were advanced cognitively and socially as compared to children who had not attended the preschools.

EI Philippines
Partner Organisation: Community of Learners Foundation
The Pinatubo Family Education Program in the Philippines came into being in 1992, shortly after Mt Pinatubo erupted in 1991 and almost 1,000,000 indigenous Aeta people were

displaced. The volcanic eruption resulted in ruination of farm lands, destruction of homes, death of livestock, and a plummet in health conditions. The German Agro Action, which was funding much of the disaster relief partnered with COLF (Community of Learners Foundation) to provide early childhood education to the disaster victims which gave rise to the Pinatubo Family Education Program. This program attended to many of the needs of these communities, including ECD, and focused on rebuilding cultural values, adaptation to new living environments, and increasing parent education about early childhood education. The program implemented preschool services and a Parent Education Program (PEP). As the years went on the program expanded to encompass the whole family, including activities for children ages 7-15 and adult literacy classes. The program has resulted in success academically and socially for children who participated. The program also resulted in improved parental attitudes towards play, education and health.

EI Portugal

Partner Organization: Ageuda Movement

In 1999 an EI was established in Portugal through the Agueda Movement (started in 1981), and funded by the Bernard van Leer Foundation. The EI allowed the Agueda Movement to analyze and reflect upon its role in the lives of Portuguese children and families. When the Agueda Movement was first started it provided resources and education for children with special needs. The program has grown to cover health education and services, identification of families at risk for having children with special needs, formation of community development groups, and training seminars for parents, teachers and community members.

Tracer Studies

The tracer studies were conducted under the Following Footsteps program. The goal of the tracer studies was to trace former participants of selected EI and other ECD programs and determine any lasting impacts these programs had on their lives.

Botswana

The challenges of change: a tracer study of San preschool children in Botswana

This study was carried out between 1993 and 1995. It traced children who had attended the Bokamoso Preschool Program. The San people were traditionally hunter-gatherers, but no longer have access to the natural resources they once relied upon. As a group, unemployment and alcoholism rates are high. San children have difficulty in the formal education system adapting to a different culture and language. A preschool program was implemented with goals of reducing the San drop-out rate, involving parents in their children's education, and exposing children to other languages. A lunch program was implemented to encourage students to attend. Most students who attended the preschool are still in school. These preschools are successful in exposing children to other languages while still using the native San language, a strategy the formal education system does not use. There is a chance however that the positive experiences San children have in preschools adapted especially for them will cause them to dislike even more the elementary schools they must later attend. The report stated that the main reasons San children leave the school system early are: the language gap, excessive use of corporal punishment, comparison of the school system to the preschool program, and lack of cultural understanding.

Colombia

Twenty years on: a report of the PROMESA programme, Colombia

This study was carried out in 2004. The purpose was to describe the activities and achievement of the program PROMESA. As a result of PROMESA (implemented in 1978), children tended to stay in school longer; on average their parents had 3.5 years of schooling, while the children had an average of 10 years of schooling. Children also had improved scores in math, language and critical thinking. Health and nutrition had improved; children were taller and heavier than their parents, and 95% had had vaccinations. Infant mortality rates dropped. State of the environment, community economics and use of technology had all improved which in turn improved health conditions. Adult literacy and self-concept of women had also improved which in turn helped the communities and families. Some important factors in the implementation of PROMESA include: utilization of community leaders, training of local peoples to run programs, and encouragement of cooperation between organizations.

Honduras

The future will be better: a tracer study of CCF's Early Stimulation Programme, Honduras

This study was carried out in 2004. It examined the effects of the Early Stimulation Program (ESP) run by the CCFH (Christian **Children's Fund Honduras**). The CCFH's preschool program resulted in beneficial emotional and social development, improved performance in difficult school subjects, and increased hygiene and health in children. The program also increased parental awareness of the importance of their children's wellbeing and what factors contributed to their child's wellbeing (e.g., love, respect, etc.). Parents involved in the ESP showed more respect towards their children and were less likely to use beatings as a way of training children. Children who participated in the ESP were more likely to form mixed-gender groups of playmates.

Ireland

Still going strong: a tracer study of the Community Mothers Programme, Dublin, Ireland

This study was carried out in 2002. The purpose of the study was to report on the progress of mothers and children who took part in a home visiting program during the child's first year of life. The Community Mothers Program (CMP, established in 1988) delivers this program. The goals of the program are to assist and sustain parenting skills to improve parent empowerment. Children who participated in this program were more likely to be up to date with immunizations and dental care. These children also were more likely to read to or be read to by their mothers, and more likely to enjoy school and achieve school success. Mothers who took part in the program were more likely to place value on playing games with their children and less likely to use physical punishment with their children. Mothers who took part in the program also reported more positive attitudes both towards themselves and towards motherhood.

Israel

A sense of belonging: A tracer study of ALMAYA's Parents Cooperative Kindergarten, Israel

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Jamaica

A new door opened: A tracer study of the Teenage Mothers Project, Jamaica

This study was carried out in 2001. It assessed the impacts of the Teenage Mothers Project (TMP) which operated between 1986 and 1996. This program had three main objectives: to decrease to rate of teenage pregnancy in the area, to facilitate training of teenage mothers, and to reduce the number of repeat teenage pregnancies. Participants of the program had higher employment rates and had pursued further education. The program was effective in decreasing the number of repeat teenage pregnancies. Mothers who took part in the program also had a greater sense of control over themselves and their situation and were more assertive. On average, children who had taken part in the program showed a greater success in school, including superior language and leadership abilities. The report suggests that should a project like the TMP be repeated, some important characteristics of this program successful program would include: involving fathers in the program, putting emphasis on bonding of the mother and child, the importance of nutrition, supportive/concerned/sensitive staff, and small group counselling.

Kenya

In the web of cultural transition: A tracer study of children in Embu District, Kenya

This study was carried out in 2001. It assessed the impacts of training the teachers who are employed by the preschool and the effect of that training on the children who attended. These training programs included information about the following: child development, the importance of play, child centered learning, community management and community organization. This training affected participating children in the following ways: better academic performance in the formal school system, children had a better learning environment (better learning tools, child-teacher relationships, etc.), and children were found to be more helpful, kind, and honest.

Trinidad

To handle life's challenges: a tracer study of Servol's Adolescent Development Programme in Trinidad

This study was carried out in 2002. It assessed the impacts of the Adolescent Development Program (ADP). Females who had taken part in the program showed a tendency to postpone having children (average age of first pregnancy in Trinidad is 16/17). Males did not show this tendency. Parents who had taken part in the training reported increased patience and attentiveness with their children as a direct result of the training. They also reported increased self esteem. The training equipped participants with the ability to express their feelings and emotions.

USA

Supporting families with young children, the High/Scope Parent-to-Parent dissemination project.

This study was carried out in 2002. The purpose of the study was to examine the Parent-to-Parent program that was active between the years of 1978 and 1984. The locally controlled program was originally designed to provide low-income parents with in-home visits by health professionals. These visits included information sessions for parents regarding child development and developmentally appropriate practices while utilizing pre-existing family strengths. Some deficits in the original program to be addressed in futures programs include: recognizing and dealing with hopelessness and dispair, providing easily accessible yet affordable health care, keeping the welfare of children in the forefront, establishing good relationships with parents, securing a stable source of funding, and increasing the emphasis on providing parenting skills.

APPENDIX B

Inventory of Institutions and Organizations Potentially Contributory to International Initiatives in Early Child Development

Governmental Organizations and Affiliates in Receiving Nations

Aga Khan Development Network
Geneva, Switzerland

The Aga Khan Development Network (AKDN) focuses on health, education, culture, rural development, institution-building and the promotion of economic development. It is dedicated to improving living conditions and opportunities for the poor in developing nations, without regard to their faith, origin or gender. (See also the Consultative Group).

Association for the Development of Education in Africa: ECD Working Group
Paris, France

The Working Group on Early Childhood Development was created in 1997 with UNICEF as the lead agency. In 1998 the leadership of the Group was moved to the Netherlands Ministry of Foreign Affairs. WGECD is guided by a consultative group composed of representatives of African countries who have demonstrated interest in ECD and international agencies and sub-regional organizations with strong commitment to ECD. The goal of WGECD is to encourage and support national governments in Africa that commit to and invest in ECD. The Working Group's activities cover areas of research, information dissemination, advocacy, networking and capacity building in order to enhance the capacity of policy makers to make informed decisions where it concerns the rights and development of children under eight years of age.

The Working Group initiated a policy-studies project aimed at getting a better insight in what would be required to enhance governments' commitment and involvement in ECD. Three countries, Ghana, Mauritius and Namibia, which have made steps toward a distinct and cross-sectoral ECD policy and which acknowledge the importance of holistic child development, carried out case studies analyzing the processes involved in the formulation and implementation of their ECD policies. WGECD and UNICEF provided financial and technical support. Concurrent with the case studies, the Working Group carried out a survey of ECD provision and policy in all African countries, through a questionnaire sent to ministers of education. On completion of the case studies and the survey, WGECD, together with the teams from each of the three countries, carried out a meta-analysis of the findings and produced a report that provides guidelines for African countries interested in developing their own ECD policies.

Bernard Van Leer Foundation
The Hague, Netherlands

This foundation is dedicated to funding research and related activities focused on early child development. Grants are provided for initiatives that are based in a variety of nations around the world. In particular, the interest of the foundation is to fund projects that meet the following criteria: 1) a holistic approach to early childhood development; 2) the enhancement of parents' capacity to support their children's development; 3) a development strategy that is rooted in the local context and is culturally, socially and economically appropriate; 4) the building of capacity, local ownership and working in partnership.

Caribbean Commission for Health and Development
Contact: George A.O. Alleyne

The goal of the CCHD is to give substance to the 2001 Nassau Declaration "The Health of the Region is the Wealth of the Region." In this regard, the Commission is responsible for providing the guidelines for action to increase investment in health in the Caribbean Community.

Consultative Group on Early Childhood Care and Development

This organization is co-directed by Kathy Bartlett of the Aga Khan Foundation, and Louise Zimanyi of Ryerson University (Canada). It is composed of a consortium of agencies, donors, NGOs and foundations that links with regional-based Early Childhood Care and Development networks comprising individuals and organizations involved in programming, research, policy-advocacy, monitoring and evaluation for young children (0-8) at risk in the Majority World. The term Majority World refers to those countries that are often referred to as South countries, developing or third world countries and serves to remind us that the majority of the world's children are at risk of delayed or debilitated development. One major goal of the organization is to strengthen regional networking, capacity-building, outreach and activities, as well as improving and/or establish more effective links with others working in health, social welfare, community development, adult literacy and basic education. In the next 5 years, key priorities of the organization include: development and use of indicators related to ECCD, HIV/AIDS and the impact on children, families, other caregivers, early literacy and family literacy efforts, conflict and post-conflict situations and the impact on young children and families, 0-3 year olds: their care and development, child rearing practices, early brain development, the Convention on the Rights of the Child: issues and follow-up for young children, training and Capacity Building of ECCD practitioners, programmers, researchers, organizations and policy makers, quality delivery in ECCD and sustainability (of programs, local ECCD organizations).

Early Childhood Development Virtual University
School of Child and Youth Care
University of Victoria
Victoria, Canada

The Early Childhood Development Virtual University (ECDVU) is a capacity building initiative designed to help meet the need for more leaders in early childhood development in Sub-Saharan Africa. It is an innovative and multi-faceted approach to addressing ECD leadership needs in Africa. It is a unique training and capacity building program using face-to-face and distance learning methods including seminars; computer assisted learning (CAL), the Internet, and video-conferencing. A key feature of the Program is those student cohorts continue to live and work in their own country while they study. The cohort will be able to apply what they are learning directly to their daily work; this will contribute to developing the Early Childhood capacity of their country on an ongoing basis. The ECDVU is based on a partnership model, which encourages partnerships among institutions, governments, NGOs, and learners and teachers. Some of the partners participate in advisory groups, which provide technological and pedagogical expertise to the program. Others are members of the 'Friends of the ECDVU' who are committed to the objectives of the capacity building initiative and are prepared to offer advice and support as needed. Organizations associated with the ECDVU include the World Bank, UNICEF, UNESCO, USAID, Bernard van Leer Foundation, Aga Khan Foundation, Save the Children Fund, Banyan Tree Foundation, The ECCD Consultative Group, ECDNA and others.

The Early Child Development Team/Human Development
World Bank
Washington, D.C.

The ECD team at the World Bank is administratively located in the Bank's Human Development Network (HDN) within the Children and Youth Group. The team's primary mission is to improve the Bank's staff and client's knowledge of ECD programming and to improve the quality of the Bank's lending for ECD. The team is lead by Mary Eming Young, a pediatrician and public health/child development specialist. As well, Marcelo Bortman is a Senior Public Health Specialist for Latin America and the Caribbean, in the Human Development section at the World Bank.

UNICEF Innocenti Research Centre
Florence, Italy

This centre works to strengthen the capacity of UNICEF and its cooperating institutions to respond to the evolving needs of children and to develop a new global ethic for children. It promotes the effective implementation of the Convention on the Rights of the Child, in both developing and industrialized countries, thereby reaffirming the universality of children's rights and of UNICEF's mandate. In particular, the centre works to ensure that its research supports the five priorities of the MTSP: girls' education; integrated early childhood development; immunization 'plus'; fighting HIV/AIDS; and increased protection of children from violence, abuse, exploitation and discrimination. In addition, UNICEF has an Integrated Early Childhood Development unit, in which **Dr. Patrice Engle** serves as a key consultant.

Project HOPE
Bethesda, Maryland

It is Project HOPE's mission to achieve sustainable advances in health care around the world by implementing health education programs, conducting health policy research, and providing humanitarian assistance in areas of need; thereby contributing to human dignity, promoting international understanding, and enhancing social and economic development. The essence of Project HOPE is teaching; the basis is partnership.

Governmental Organizations and Affiliates in Donor Nations

First Five California

This initiative stems from the California Children and Families Act of 1998, designed to provide, on a community-by-community basis, all children prenatal to five years of age with a comprehensive, integrated system of early childhood development services. Through the integration of health care, quality child care, parent education and effective intervention programs for families at risk, children and their parents and caregivers will be provided with the tools necessary to foster secure, healthy and loving attachments. These attachments will lay the emotional, physical and intellectual foundation for every child to enter school ready to learn and develop the potential to become productive, well-adjusted members of society. Programs supported by First Five include those that provide health and social services for children and their families, provide services for children with special needs, and improve administration and infrastructure that enable school readiness.

Non-Governmental Organizations with a Domestic Focus in Donor Nations

Annie E. Casey Foundation
Baltimore, MD

The mission of this foundation is to build better futures for disadvantaged children and their families in the United States. Their efforts are designed to foster public policies, human service reforms, and provide community supports. Their "Kids Count" research is designed to measure differences in child health and its determinants across the United States.

Innovation Philadelphia

Innovation Philadelphia is a public/private partnership created to grow the wealth and the workforce of the Greater Philadelphia Region's Innovation Economy by growing, attracting, retaining, and connecting technology-based businesses and workforce in the Region. Innovation Philadelphia accomplishes this mission by providing technology-based and early-stage businesses with traditional seed capital, access to alternative funding, skilled human capital, commercialization assistance, entrepreneurial resources, and intellectual capital.

Canadian Population Health Initiative
Director: Elizabeth Gyorfi-Dyke
Canadian Institute for Health Information

Center for Human Growth and Development
University of Michigan

This center, directed by Dr. Daniel Keating, furthers the understanding of the complex processes by which human beings grow and develop. With multidisciplinary collaborations among biomedical, behavioral, and social scientists, the long-range goal of research and training at the Center is to optimize children's physical, cognitive, and socioemotional development. Specifically, the center's objectives are to coordinate, integrate, and conduct research on normal and abnormal human growth and development, including its biological, intellectual, behavioral, and social aspects.

Centre for International Child Health
Institute of Child Health
University College London

This centre concentrates its research in four primary areas: 1) Nutrition - Epidemiology and nutritional factors contributing to subclinical mastitis and transmission of HIV, evaluation of micronutrient status and programs among refugees, nutritional status and health of school age children, molecular and microbiological diagnosis of non responsive pneumonia in young children, epidemiology and evaluation of factors responsible for low birthweight, perinatal transmission of Hep B, C and HIV, 2) Child Development - Assessment of impact of nutritional status and psychomotor interventions on indices of child development, evaluation of micronutrient supplementations during pregnancy on child development, evaluation of instruments for assessment of psychosocial, emotional and nutritional status of orphaned children, evaluation of health education programs on knowledge and practice in poor communities, 3) Disability - The disability research group at CICH focuses on finding ways to improve the quality of life of disabled children and their families in income poor countries of the world. This may be through prevention strategies, such as low-cost community based identification processes, for example, screening children for hearing impairment in Zimbabwe. Alternatively, it may be through community-based non-specialist interventions. for example, training health care workers in Uganda and Sri Lanka, parents of children with cerebral palsy in Bangladesh and Women's groups in Kenya. Current research areas include: Disability and HIV/AIDS, cerebral palsy and nutritional well being, community groups and CBR, and the impact of the health communication process on medical treatment of children with epilepsy, and 4) Children in difficult circumstances - The Children in Difficult Circumstances (CDC) group is new to CICH. Our main interests are in child labour, street children, refugees and HIV orphans. Faculty of note from this centre include Sally Grantham-McGregor, who focuses her work on issues of nutrition and development in Jamaica. And Christine Power, who is primarily concerned with the health and developmental effects of socioeconomic conditions experienced in early childhood.

Pennsylvania State University

Department of Human Development and Family Studies
College of Health and Human Development

Collectively, this department at Penn State University addresses a comprehensive range of issues related to early child development, from family factors to social policies. The department is also concerned with both cognitive and sociobehavioral development, and the interrelationships between these two developmental competencies. In addition, faculty members have expertise in research methodologies and psychometric approaches, as well as more applied perspectives, including intervention-oriented research.

Telethon Institute for Child Health Research
Perth, Australia

Director by Dr. Fiona Stanley, the primary research foci of this center include aboriginal children's health, epidemiology of infectious disease, developmental epidemiology, child nutrition and growth, childhood cancer epidemiology, social, economic, psychological and cultural determinants of health, adolescent development, suicide prevention, and capacity building. Projects in this center are based largely in Australia, as well as Papua New Guinea.

NHS

Health Development Agency

Grading evidence and recommendations for public health interventions: developing and piloting a framework

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This work was undertaken by SURE jointly with the Health Development Agency (HDA). SURE forms part of the Wales Collaborating Centre, one of two HDA Evidence and Guidance Collaborating Centres on Obesity.

From 1 April 2005, the functions of the HDA will transfer to the National Institute for Clinical Excellence. The new organisation will be the National Institute for Health and Clinical Excellence (to be known as NICE). It will be the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

Contents

Summary

The objective of this work was to develop a practical scale of grades of recommendation for public health interventions, adapted from the current National Institute for Clinical Excellence (NICE) methodology.

A literature review was carried out on the subject of incorporating research evidence into grades of recommendation for public health interventions. The literature search looked at publications from January 2000–May 2004 retrieved from 16 databases. The views of a range of public health experts were also sought for suggestions of other publications to be included in the literature review, and for their comments at various stages of the developing methodology.

The principles for development of the framework were that it should be:

- Adapted from, and clearly linked to, the current NICE methodology
- Based on detailed and transparent reporting and synthesis of *all* relevant supporting evidence (intervention and observation, quantitative and qualitative).

The literature review indicated general agreement that the randomised controlled trial (RCT) has the highest internal validity and, where feasible, is the research design of choice when evaluating effectiveness. However, many commentators felt the RCT may be too restrictive for some public health interventions, particularly community-based programmes. In addition, supplementing data from quantitative studies with the results of qualitative research is regarded as key to the successful replication and ultimate effectiveness of interventions.

Based on the literature review and consultation with experts, a framework was developed that derives grades of recommendation, incorporating

- Strength of evidence of efficacy based on the research design and the quality and quantity of evidence (the current NICE system)
- Corroborative evidence (from observational and qualitative studies) for the feasibility and likelihood of success of an intervention if implemented in the UK

The precise methods for combining the results from different types of corroborative evidence and for incorporating the size of effects, including (cost–)benefits and harms for the different outcomes measured, are still in development.

This provisional framework provides a practical and transparent method for deriving grades of recommendation for public health interventions, based on a synthesis of all relevant supporting evidence from research. The methodology is being piloted, alongside the current NICE methodology, within the development of the public health/prevention aspects of the HDA/NICE guidance on overweight and obesity. The lessons learned will help to inform the forthcoming work of the National Institute for Health and Clinical Excellence.

Introduction

In 2003 NICE and the HDA were commissioned by the Department of Health and the National Assembly for Wales to develop guidance on the prevention and management of obesity in children and adults. This was the first time NICE had been tasked to work in collaboration with an external body, and pre-empted the announcement that NICE will take on the functions of the HDA from April 2005. Crucially, it was also the first time that the applicability of existing NICE methodology to public health evidence and recommendations was to be fully considered.

Where possible, the development of the guidance was to adhere to procedures laid down by NICE. However, due to the nature of public health interventions and the associated evidence base, it became clear that further consideration would be needed in adapting the NICE methodology.

The NICE guidelines to date have been based on a well known hierarchy of research designs (NICE, 2004a,b; SIGN, 2001 and website), from which recommendations have been developed for clinical policy and practice. A parallel scale for grading evidence and recommendations for public health policy and practice does not exist at present. NICE is currently developing some broad principles for the methods used to assess evidence and prioritise recommendations that may be applied across all types of question, leading to both clinical and public health recommendations.

In some cases the 'gold standard' RCT cannot be performed in public health interventions for feasibility, cost and practical reasons (Wanless, 2004; Kelly *et al.*, 2005). Furthermore, RCTs tend to be limited to questions of efficacy or effectiveness; they are less useful, and hence less appropriate, when considering external validity and issues of implementation. For example, some public health interventions cannot readily be abstracted from their environment, making context very important. Thus reviews of evidence for public health interventions tend to be dominated by 'lower' levels of evidence, which will in turn receive lower grades of recommendation.

Clearly, a range of grades of recommendation is appropriate to provide guidance for policy makers in deciding which public health interventions might be considered for practice and/or further research. These grades should reflect the (theoretically) most appropriate evidence for the type of intervention, using a clear and transparent methodology.

The objective was therefore to develop a practical public health scale of grades of recommendation adapted from the current NICE methodology. The framework was to relate only to the grading of evidence and recommendations for public health *interventions*. (The types of evidence that are relevant to other (non-intervention) aspects of public health will be included in further developments of the methodology.) Development of the framework has incorporated an analysis of the published literature on deriving grades of evidence and recommendations for public health interventions, and consultation with public health and methodology experts.

Methodology and results

The methodology was designed to answer the following research questions:

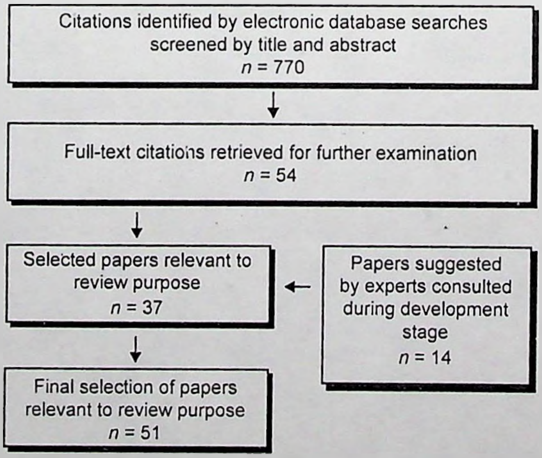
- What are the most appropriate research designs for determining the efficacy of public health interventions?
- How might qualitative research and data about implementation be used to assess whether an intervention is likely to work in the UK?
- How can these different types of evidence be combined to give a grading for public health evidence and help prioritise recommendations?

There were three elements to the development of the framework:

- Literature review
- Consultation with individuals and organisations with expertise in public health and/or grading methodology
- Piloting of the provisional framework.

The methodology and results for each are described below. This was an iterative process – for instance, the consultation with experts at various stages identified further publications for inclusion in the review and other experts to consult. Early versions of the framework formed part of the consultation with experts.

Figure 1 Selection stages for papers included in the review



Box 1 Search strategy

Databases searched

ASSIA, CareData, CINAHL, Cochrane Library, Current Contents, Educational Resources Information Center (ERIC), Embase, EPPI Centre, HDA Evidence Base, HDA HealthPromis, Health Management Information Consortium (HMIC), MEDLINE, PsycINFO, Sociological Abstracts, System for Information on Grey Literature (SIGLE), ZETOC.

Standard search terms

(public health OR health of the public OR health promotion) AND (grade* or level* or type*) AND ((guideline* or guidance or evidence or recommendation*).ti)

Additional search terms

Additional terms were used for the databases ASSIA, CareData, EPPI Centre, ERIC and SIGLE where complex search strategies were not feasible. These are available from the authors.

Website searches

Website searches were conducted for relevant organisations involved in searching and summarising evidence for public health, looking for methodologies for grading public health/health promotion recommendations and reviews/guidelines in the topic area. See Appendix 2 for organisations searched.

Search dates

2000–2004 plus follow-up of reference lists for other relevant publications. The searches were carried out in May 2004.

Literature review

An extended literature review was carried out on grading evidence and recommendations (see Box 1).

Selection and appraisal of relevant publications

Of the 770 abstracts/titles retrieved, 54 publications were examined in full and 37 were found to be relevant to the review question. Other papers were suggested by groups and individuals consulted during the development stages, and 14 additional papers were included, making a total of 51 (see Figure 1). They are marked ✓ in the References (page 17).

Publications were selected for full text review if the abstract (or title if no abstract was available) suggested that the paper included a discussion of the methodology for translating findings from public health research evidence into grades of recommendation for interventions. Papers were read and summarised by one reviewer to determine the authors' views on the most appropriate type(s) of public health evidence that should be taken into account when generating recommendations. Any areas of uncertainty were clarified through discussion with a second reviewer. The purpose was to assess areas of consensus and query. No formal evaluation of the publications included was carried out.

Results of the literature review

Type of evidence (research design)

An established evidence hierarchy of effectiveness is used by NICE, and this has a strong link to the grade of recommendation (NICE, 2004a,b).

The issue of the 'best' evidence for particular types of intervention (individual, group, community, society/socio-political) has been considered by Nutbeam (1998) and by the HDA (Ellis and Grey, 2004). There is general agreement that the RCT has the highest internal validity and, where feasible, is the research design of choice when evaluating effectiveness (Nutbeam, 1998; Kelly *et al.*, 1993; Sorensen *et al.*, 1998; Rimer *et al.*, 2001; Rychetnik *et al.*, 2002; Evans, 2003; Hawe *et al.*, 2004; Victora *et al.*, 2004).

However, RCTs are by nature narrowly defined and typically restricted to single/simple issues (Nutbeam, 1998; Tones, 2000; Truswell, 2001; Kroke *et al.*, 2004; Victora *et al.*, 2004). It is argued that, because of the complexity of interventions in real world settings, RCTs are subject to effect modification in different populations (Victora *et al.*, 2004) and in any event may be too restrictive for community-based programmes (Nutbeam, 1998). Many health promotion programmes draw on political systems and community networks as part of the intervention, rendering random allocation nearly impossible. However, in some circumstances, the design in which geographically isolated populations become the (randomly allocated) units of comparison (ie the cluster RCT) may be appropriate and feasible (Nutbeam, 1998; Sorensen *et al.*, 1998, Rychetnik *et al.*, 2002).

Other commentators are of the view that the RCT design can be appropriate for evaluating complex public health interventions by standardising the function and process of the intervention, but allowing local variations in the individual components. This allows the components to be tailored to local conditions and the needs of specific communities, without threatening the integrity of the intervention (Dane and Schneider, 1998; Hawe *et al.*, 2004).

The importance of supplementing data from quantitative studies with the results of qualitative research to provide depth and insight into people's experiences and social contexts is regarded as central by many commentators (Nutbeam, 1998; Sorensen *et al.*, 1998; Stephenson and Imrie, 1998; Rychetnik *et al.*, 2002; Pawson, 2003; Petticrew and Roberts, 2003; Dixon-Woods *et al.*, 2004; Harden *et al.*, 2004; Jackson and Waters, 2004; Kroke *et al.*, 2004; NSW Centre for Public Health Nutrition, 2004; Swinburn *et al.*, 2004; Thomas *et al.*, 2003, 2004), and of particular relevance to the successful replication and sustainability of interventions. Using each subsequent study to build on the inferences of the others, the likely effectiveness of social programme interventions can be assessed (Pawson, 2003). In one proposed decision-making framework for evidence-based obesity prevention, the RCT sits alongside other forms of evidence and each is judged equally on its ability to contribute to answering different questions (Swinburn *et al.*, 2004).

In a review of children and healthy eating (Thomas *et al.*, 2003) the EPPI Centre cross-matched the findings of qualitative and quantitative studies and looked at interventions based on components matching children's views. The reviewers found a relationship between what children regarded as important and the effectiveness of the intervention.

Petticrew and Roberts (2003) note that RCTs are best for questions of effectiveness (*does it work?*), safety and cost effectiveness; qualitative studies and surveys are best for questions of salience (*does it matter?*), appropriateness and satisfaction; and qualitative studies alone are best for questions concerning process (*how does it work?*) and acceptability. Of course a single study, particularly but not exclusively a systematic review, may provide evidence for several or all of the individual elements – effectiveness, salience, implementation and cost.

Some methodologies consider the type of evidence as one of many factors, and use a single quality assessment/critical appraisal tool for all studies to produce gradings, based on minimisation of potential biases, from poor/weak to good/strong (Millward *et al.*, 2003; EPHPP website).

Consistency

The consistency of study results contributes to the grades of recommendation used in the methodologies of NICE (2004a,b), the GRADE Working Group (2004) and others (Margetts *et al.*, 2001; Kelly *et al.*, 2004), and the importance of combining different study types is widely accepted.

Quality of evidence (critical appraisal)

Single critical appraisal forms are used by a number of public health groups (Briss *et al.*, 2000; Millward *et al.*, 2003; Øvretveit, 2003; EPHPP website), whereas clinical medicine review groups tend to use separate forms for each category of study type or research design (NICE, 2004a,b; Health Evidence Bulletins Wales 'Project methodology'; BMJ Publishing Group 'Clinical evidence'; SIGN 'Guidelines methodology'; Canadian Task Force for Preventive Health Care 'Evidence-based clinical prevention', Centre for Evidence-Based Medicine), other than the GATE method (University of Auckland (a)) which has a generic form for intervention studies.

The conclusions from a review of a large number of grading systems were that different appraisal forms are needed for different study types, and that a single evaluation framework could cause confusion and misleading conclusions (AHRQ, 2002).

Separate critical appraisal forms are used for different types of research study for NICE guidance. The overall assessment of study quality is graded within each study type using a code based on the extent to which the potential biases have been minimised (++, very low risk; +, low risk; –, high risk of confounding, bias or chance) (SIGN, 2001; NICE, 2004a,b). However, NICE does not currently have a critical appraisal form for non-randomised controlled studies, and specific enhancements and adjustments to NICE critical appraisal tools may be required for use with public health research evidence.

The Cochrane Effective Practice and Organisation of Care (EPOC) Review Group has developed critical appraisal forms for intervention studies that have not been adequately randomised and followed up in the randomised groups (EPOC Group, 2002). These are: (1) controlled clinical trials (sometimes called controlled non-randomised trials), (2) controlled before-and-after studies; (3) interrupted time-series studies. Another critical appraisal methodology for non-randomised trials is under development within the Cochrane Collaboration by the Health Promotion and Public Health Field (Jackson and Waters, 2004).

The TREND Group (Des Jarlais *et al.*, 2004) has also proposed a specific appraisal checklist for non-randomised evaluation studies as a companion to the CONSORT statement (Moher *et al.*, 2001) for RCTs.

Salience – does it matter?

Relevance of outcome

Several authors stress the importance of looking at a clearly defined and measured range of relevant health promotion and health outcomes in complex areas such as dietary behaviour and physical activity (for instance, Nutbeam, 1998; Lean, 2000). This includes an assessment of the relevant outcomes and most appropriate methods of evaluation for different types of intervention. Kelly *et al.* (1993) describe four levels of health promotion: environmental, social, organisational and individual, all of which have to be understood and integrated for successful health promotion interventions. It is emphasised that, from the outset of any health promotion project, these four levels should be used as a checklist to consider the likely consequences flowing from the desired intervention (Kelly *et al.*, 1993).

Ellis and Grey (2004) highlight that most reviews of effectiveness focus on health outcomes (eg incidence/prevalence) or intermediate health outcomes (eg behaviour), mainly because they are limited to RCTs and controlled trials which do likewise. These limitations in both the type of research included and the outcome mean that they are severely lacking in evidence about the effectiveness of community and socio-political interventions in addressing the personal and structural determinants of health and health behaviour (eg knowledge, social/peer norms, professional attitudes, discrimination, poverty, availability and accessibility of services). They are particularly unlikely to include any evidence about the effectiveness of 'upstream' (socio-political) interventions (Ellis and Grey, 2004).

Relevance to the UK population – demographic, personal and socio-economic factors

The context in which the intervention is implemented is clearly important. Relevance to the UK population contributes to the grades of recommendation used in the SIGN, NICE and GRADE methodologies (SIGN, 2001; NICE, 2004a,b; GRADE Working Group, 2004), but there is currently a lack of transparency in how this is derived. Specific consideration of socio-economic issues is recognised (Glasgow *et al.*, 1999; Kelly *et al.*, 2004; NSW Centre for Public Health Nutrition, 2004), as is the shortage of relevant evidence in this area (Aldrich *et al.*, 2003; Thomas *et al.*, 2003; Mulvihill and Quigley, 2003).

Implementation – will it work?

Consideration of issues such as feasibility, plausibility, acceptability, transferability and sustainability is suggested by the HDA (Ellis and Grey, 2004; Kelly *et al.*, 2004); the CDC Guide to Community Preventive Services (Briss *et al.*, 2000; Task Force on Community Preventive Services website); and other authors (Glasgow *et al.*, 1999; Evans, 2003; Jackson and Waters, 2004; Pawson *et al.*, 2004). It has previously been highlighted that an intervention should be based on firm theoretical principles using the knowledge of what is likely to work from previous research (Pawson, 2003; NSW Centre for Public Health Nutrition, 2004). In particular, reviewers should question whether the intervention is appropriate in relation to the views and preferences of the target population(s) (Thomas *et al.*, 2003; Pawson *et al.*, 2004).

As noted above, evidence from observational and qualitative research is considered central to informing the assessment of these issues (Nutbeam, 1998; Sorensen *et al*., 1998; Stephenson and Imrie, 1998; Tones, 2000; Rychetnik *et al*., 2002; Thomas *et al*., 2003; Pawson, 2003; Petticrew and Roberts, 2003; Dixon-Woods *et al*., 2004; NSW Centre for Public Health Nutrition, 2004; Pawson *et al*., 2004). While there is a need for a transparent and reproducible approach, there is currently a lack of consensus as to how to grade this type of evidence.

Implementation: cost

Estimated cost is considered by the GRADE Working Group (2004), the HDA (Kelly *et al*., 2004) and the Guide to Community Preventive Services (Briss *et al*., 2000). However, it is recognised that these data are seldom available from public health interventions undertaken to date.

Synthesis of different types of evidence

There is no consensus from the literature as to how different types of research study might be weighted in terms of their contribution to the overall summary of evidence and/or final grade of recommendation. Significant shortcomings were found in current approaches to grading levels of evidence when six prominent grading systems were critically appraised (GRADE Working Group, 2004). Some reviewers suggest that decisions about quality may require complex, contextualised judgements in combination with existing evaluation methodologies (Pawson *et al*., 2004). A review of the integrative approaches to qualitative and quantitative evidence concludes that more research is required to resolve the complex theoretical and methodological issues involved in developing the best method for synthesis, although a number of established methods exist, each with advantages and disadvantages (Aldrich *et al*., 2003). The aim should be to make judgements transparent and to try to protect against bias in the judgements that are made by being systematic and explicit (GRADE Working Group, 2004).

In a completely new model of research synthesis, a 'realist' approach to evaluative research has been suggested (Pawson *et al*., 2004), where complexity is acknowledged throughout in the task of searching the evidence base. The authors argue that the success of an intervention theory is not simply a question of the merit of its underlying ideas, but depends on the individuals, interpersonal relationships, institutions and infrastructures through which and in which an intervention is delivered.

In summary, a large number of factors should be taken into account in reaching a decision on the likely success of an intervention. The grade of evidence and recommendation should be based on a number of building blocks (individual studies within a topic) and clear, detailed guidance on the type and quality of each relevant study should be provided to steer this process.

Consultation with individuals and organisations with expertise in public health and/or grading methodology

At various stages of development, the findings from the literature review and the proposed framework were discussed with (or circulated for comment to) a large number of public health experts and expert groups within and outside the HDA, including (among others): the HDA Public Health Evidence Steering Group; the HDA Obesity Reference Group; the HDA Evidence and Guidance Collaborating Centres on Obesity; the GRADE Working Group, the Centers for Disease Control's Guide to Community Preventive Services, the EC 'Getting Evidence into Practice' project; the WHO Health Evidence Network; the Cochrane Health Promotion and Public Health Field; the EPPI Centre, the York Centre for Reviews and Dissemination; the Medical Research Council's Social and Public Health Sciences Unit (University of Glasgow); the London School of Hygiene and Tropical Medicine (Interventional Public Health Group), SIGN, and NICE (see Appendix 2 for list of respondents).

The questions posed at various stages are listed below with an indication of the consensus (if any) from those consulted.

- Is it appropriate to class interventions into individual, group, community/environmental and policy/socio-political, or are there other classes/groupings that should be considered?
  Response: Consensus that these are appropriate, however many interventions will cross these groupings.
- What are the 'most appropriate' types of evidence (of effectiveness) for different types of intervention (eg

individual, social structure, environment, organisation, group, community, society/socio-political interventions)?
Response: Narrow consensus to use RCTs whenever feasible, but accepted that this is unlikely to be the case for socio-political interventions.

- How and where do we capture the magnitude of findings for each component of evidence when formulating a grade of recommendation? Furthermore, is the magnitude of the effect size (and implied cost effectiveness) enough to support a recommendation, or should a cost effectiveness analysis be carried out when such evidence is not already available?
  Response: No consensus on how to capture magnitude of findings for each component, not least because outcome measures will vary. Cost effectiveness is difficult to estimate.
- In considering the factors that determine the relevance, generalisability and feasibility of an intervention to UK populations (corroboration), are some more critical than others, and how should they be weighted?
  Response: No consensus on how different aspects should be weighted, but inclusion of corroborative evidence is important.
- How should the combinations of evidence (qualitative and quantitative) be combined to obtain a balanced view of all the important aspects of a public health intervention (effectiveness, appropriateness, sustainability, etc)?
  Response: No consensus.
- In the final grading, is it more helpful to have: (i) an overall grading system (eg A, B) derived from a narrative summary of the different types of evidence; or (ii) a composite grading (eg A3, B1) that reflects the two components of (cost)-effectiveness and corroboration, but may lead to a lack of clarity (eg is B1 a stronger recommendation than A3?)
  Response: No consensus – some argue that a composite grading allows readers to make their own judgements, while others suggest this is too complex.

It is clear that a number of issues have yet to be resolved.

Comments and suggestions of respondents (Appendix 2) were, as far as possible, incorporated into this document and the proposed framework. This does not mean that respondents endorsed the framework – three respondents recommended existing alternative systems as more appropriate for public health evidence (GRADE – GRADE Working Group, 2004; CDC Guide to Community Preventive Services – Briss *et al.*, 2000; realist review – Pawson *et al.*, 2004). As our remit was to develop a system based on the NICE methodology, we have incorporated elements of these three very different systems where relevant and possible. The remainder of respondents were broadly supportive of the developing methodology, and of carrying out a pilot within a practical setting to explore the issues raised.

Developing and piloting the provisional framework

A pragmatic framework was developed, based on the findings from the literature review and the views of experts in the fields of public health and health promotion research. The framework included critical appraisal of individual studies and reviews to assess the strength of evidence, based on the quality and quantity of studies.

In assessing efficacy, the NICE/SIGN (level 1–4) evidence classification (SIGN, 2001; NICE, 2004a,b) was adapted to include non-randomised and quasi-experimental studies, as these are common public health research methods. However, the framework differs further from the NICE system in two significant respects:

- The 'most appropriate' (or highest level of) evidence for efficacy is not necessarily the RCT, in particular for socio-political interventions
- The issue of 'directly applicable to the target population' and 'extrapolated evidence' is separately assessed as 'corroborative evidence' and in so doing the framework draws on sources of evidence above and beyond that found in the studies of efficacy.

The system allows for the grade of recommendation to be promoted where the research design used to demonstrate efficacy is weakened by design or methods, but where there is consistent evidence from corroborative studies to suggest that the intervention is relevant, feasible and could be implemented for the population in question. This kind of approach is consistent with the GRADE methodology (GRADE Working Group, 2004).

Practical guidance was produced for those developing grades of recommendation from the available evidence on efficacy,

Table 1 Pilot public health evidence grading scheme: classification of recommendations

Class	**Basis for decision***
A [PH]	At least one 1++ study or consistent findings in a body of studies** principally rated as 1+ for efficacy***, with strong or moderate evidence of corroboration OR Consistent findings in a body of 2++ studies for efficacy, with strong evidence of corroboration
B [PH]	At least one 1++ study or consistent findings in a body of studies principally rated as 1+ for efficacy, with limited/no evidence of corroboration OR A single 1+ study for efficacy, with strong or moderate evidence of corroboration OR A single 2++ study or consistent findings in a body of studies principally rated as 2+ for efficacy, with strong evidence of corroboration OR Consistent findings in a body of studies principally rated as 2++ for efficacy, with moderate evidence of corroboration
C [PH]	Consistent findings in a body of studies principally rated as 2++ for efficacy, with limited/no evidence of corroboration OR A single 2++ study or consistent findings in a body of studies principally rated 2+ for efficacy, with moderate evidence of corroboration OR A single 2+ study for efficacy, with strong evidence of corroboration OR A body of level 3 or 4 evidence for efficacy, with strong evidence of corroboration
D [PH]	A single 2++ study or consistent findings in a body of studies principally rated 2+ for efficacy, with limited/no evidence of corroboration OR A single 2+ study for efficacy, with moderate evidence for corroboration OR A body of level 3 or 4 evidence of efficacy, with moderate/limited evidence of corroboration OR Formal consensus
D [GPP]	A recommendation based on experience of best practice by health professionals and expert groups

*See Tables 2 and 3 for key to study type, quality and strength of evidence.

**Body of studies = 3 or more, or a systematic review.

***For national environmental/socio-political interventions, a body of 2+ studies is acceptable.

[PH] public health; [GPP] Good Practice Point.

Source: adapted from SIGN (2001).

Table 2 Evidence of the efficacy of an intervention – did it work?

Level of evidence	Type of evidence
1++	High quality meta-analyses, systematic reviews of RCTs (including cluster RCTs), or RCTs with a very low risk of bias
1+	Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1–*	Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias
2++	High quality systematic reviews of, or individual high quality non-randomised intervention studies (controlled non-randomised trial, controlled before-and-after, interrupted time series), comparative cohort and correlation studies with a very low risk of confounding, bias or chance
2+	Well conducted, non-randomised intervention studies (controlled non-randomised trial, controlled before-and-after, interrupted time series), comparative cohort and correlation studies with a low risk of confounding, bias or chance
2–*	Non-randomised intervention studies (controlled non-randomised trial, controlled before-and-after, interrupted time series), comparative cohort and correlation studies with a high risk of confounding, bias or chance
3	Non-analytical studies (eg case reports, case series)
4	Expert opinion, formal consensus

*Studies with a level of evidence (–) should not be used as basis for making recommendations.
Source: adapted from SIGN (2001).

corroboration and cost effectiveness. Essentially, the evidence for the efficacy of an intervention (in a particular setting or with a particular population) is first assessed based on the research design, quality and quantity of studies, and a decision is made on the overall strength of the evidence of efficacy for each outcome (eg weight, diet, physical activity). This is then combined with an overall assessment of the strength of evidence of corroboration for the intervention in question, based on evidence from the efficacy studies and from elsewhere.

The framework is being piloted alongside the current NICE system within rapid reviews being carried out for the public health/prevention aspects of the HDA/NICE guidance on overweight and obesity. As a consequence of the initial piloting, it has been further amended as summarised in Tables 1–3. The methods by which the building blocks of evidence from different study types might be appraised and combined to guide an overall grade of recommendation are summarised in Figure 2 on page 12.

Table 3 Evidence for corroboration – will it work? (evidence to support implementation in the UK today) and does it matter? (evidence of salience and relevant outcomes for UK populations today)

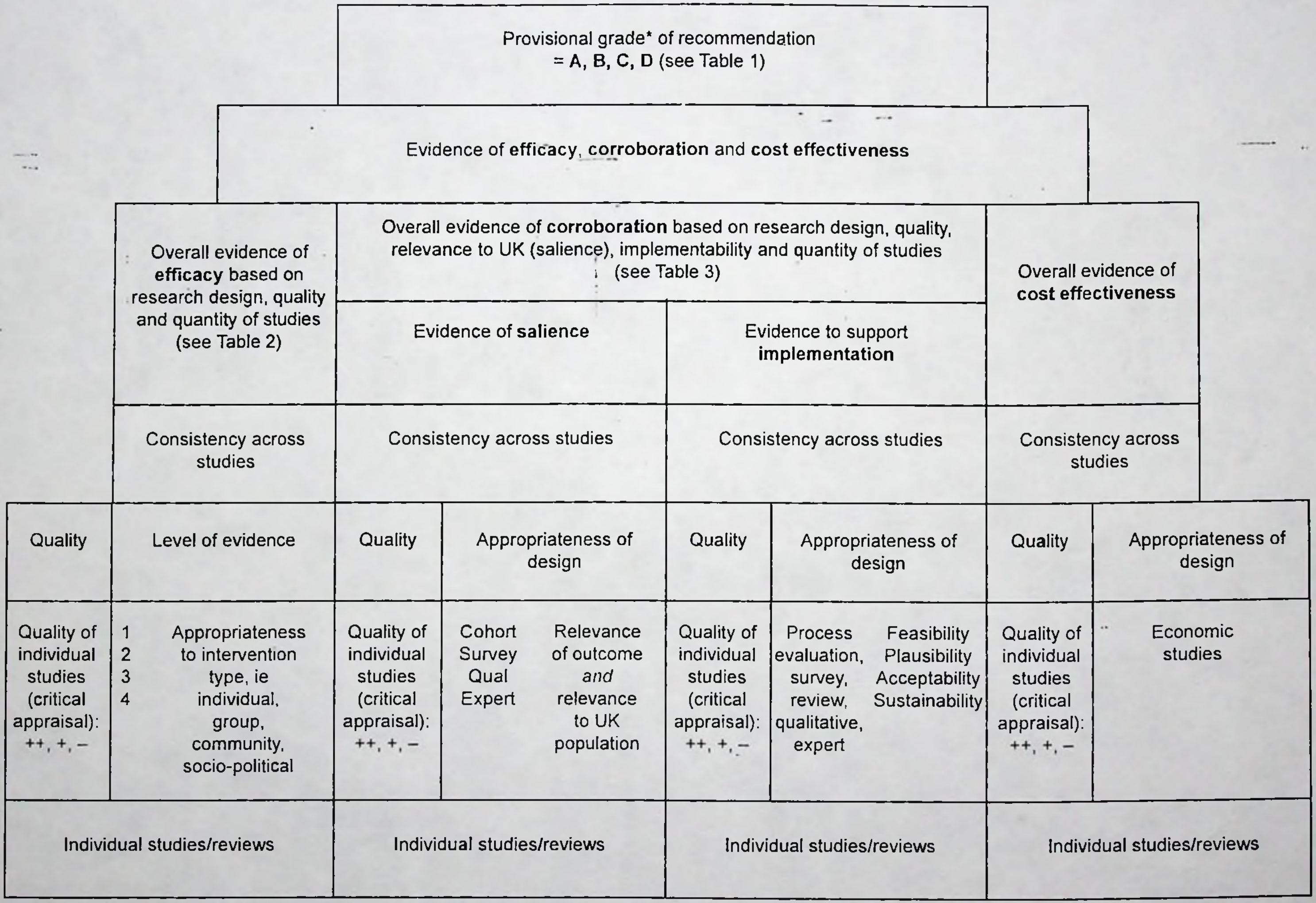
Strength of evidence	**Type of evidence**
Strong	Consistent findings in two or more studies of ++ quality carried out within the UK and applicable* to the target population, providing evidence on salience and implementation
Moderate	One ++ study or consistent findings in two or more studies of + quality carried out within the UK and applicable to the target population OR Two or more ++ studies from outside the UK but applicable to the target population, providing evidence on salience and implementation
Limited	Only one + study from the UK, two or more studies with inconsistent findings (on balance providing evidence of benefit or harm) or studies of + quality from outside the UK
No evidence	No study of acceptable quality, inconsistent findings (on balance providing no useful evidence) or no relevant research available

*Applicable – in general terms of age, socio-economic status, ethnicity, gender and cultural/religious practices.
Note: there is no established evidence hierarchy for corroborative studies.
Key to quality: ++, very low risk; +, low risk; –, high risk of confounding, bias or chance.

A number of issues were highlighted when the proposed framework was piloted.

- The presentation of corroborative evidence provides valuable information to the developers of recommendations, and aids transparency. There is, as yet, no agreed hierarchy for corroborative evidence (often a combination of observational studies and qualitative evidence), nor is it clear whether corroborative evidence for one outcome, such as diet, can be extrapolated to another outcome, such as physical activity.
- Weighting a body of evidence of efficacy is still under discussion, in particular, how can the evidence be balanced when there is not complete consistency of findings?
- The framework does not, as yet, incorporate the size of the effects including (cost–)benefits and harms for the different outcomes measured.

Figure 2 Pyramid of evidence building blocks on which grades of recommendations may be based



*The final grade would take into account magnitude/effect size(s) (+ve or –ve)

Key to quality: ++, very low risk; +, low risk; –, high risk of confounding, bias or chance.

Discussion and conclusions

This project set out to answer the research questions listed on page 3. While the literature review and consultation with experts suggest that the RCT design is usually the best method to demonstrate the effectiveness of individual and group interventions (and cluster RCTs for many community interventions), there is a dominant (if not universal) view that it may not lend itself to evaluating the effectiveness of many complex public health interventions, such as those involving communities and socio-political (including organisational) 'interventions'. In these cases a non-randomised design may be more appropriate.

In addition, evidence from observational and qualitative research is central to providing the depth and insight required for implementing/replicating appropriate and sustainable interventions. A combination of different study types (quantitative and qualitative) is required to build up a picture of the likely success of an intervention when implemented in a specified context, as is the consistency of research results (where each subsequent study supports the results of the previous studies).

Responses from the expert consultation confirm that this is a complicated area. Various grading systems are already in place, and some respondents did not feel that another system was required. Despite this, the majority of respondents supported this work and its emphasis on the inclusion of corroborative evidence.

The provisional framework presented here aims to provide a practical, but detailed and transparent, method for deriving grades of recommendation for public health interventions, based on a synthesis of all relevant supporting evidence from research. Decisions on the strength of the evidence for efficacy within the framework are, where possible, in line with existing methodologies.

The literature review demonstrates that there is no consensus concerning natural hierarchies for studies looking at corroborative evidence based on salience and implementation. We have proposed a simple, transparent system for assessing the strength of such evidence, while recognising that this results in a considerable increase in the amount of data to be considered within a literature review. However, it is conceded that the appropriateness and ease with which these types of evidence can be combined would benefit from some further clarification.

While the existing NICE methodology does not assess corroborative evidence explicitly, it does consider whether evidence is 'extrapolated' and/or 'directly applicable' (SIGN, 2001; NICE, 2004a,b). Essentially, 'directly applicable' evidence is from studies carried out on populations that are so similar to the target population that applying the same interventions can be expected to have the same effects. Thus evidence from UK studies would normally be considered directly applicable; studies from elsewhere may also be judged directly applicable (Robin Harbour, SIGN, personal communication). The definition of such terms remains open to interpretation and may lead to inconsistencies in the range of issues considered and their implementation. We have therefore attempted to ensure that there is clarity and rigour in the assessment of applicability. This includes taking into account whether the study was conducted in the UK, although it is recognised that this is only a proxy indicator of generalisability: there may be interventions implemented abroad that are more pertinent to some UK populations than those implemented in the UK. This part of the framework would benefit from some further development.

At present the framework does not formally take effect size into consideration as part of the grading. An intervention may have a body of high quality evidence to indicate that it has been effective in changing some outcome, and there may be strong evidence to suggest it would be implementable in the UK, yet its effect on the population may be negligible. Further work will need to be undertaken so that the final grading and prioritisation of the recommendation will be based on size of effect (including any differential impact on health inequalities), as well as the strength of the underlying evidence, and our confidence in being able to replicate the intervention successfully in a UK setting today.

This framework is being piloted and compared alongside the existing NICE system, within the development of the public health/prevention aspects of the HDA/NICE guidance on overweight and obesity. The lessons learned will help to inform the forthcoming work of the National Institute for Health and Clinical Excellence.

Appendix 1 Organisations involved in searching and summarising evidence for public health

- Campbell Collaboration
  www.campbellcollaboration.org
- Centre for Knowledge Transfer
  www.ckt-ctc.ca/English/Links.htm
- Centre for Reviews and Dissemination – particularly the Wider Public Health project
  www.york.ac.uk/inst/crd/wph.htm
- Centers for Disease Control and Prevention
  www.cdc.gov and www.thecommunityguide.org/default.htm
- Effective Practice and Organisation of Care (EPOC) Group
  www.epoc.uottawa.ca/aboutus.htm
- European Project, Getting Evidence into Practice
  www.nigz.nl/gettingevidence
- Hamilton Public Health & Community Services, Effective Public Health Practice Project (EPHPP)
  www.city.hamilton.on.ca/PHCS/EPHPP/default.asp
- Health Evidence Network
  www.euro.who.int/HEN
- International Obesity Taskforce
  www.iotf.org
- National Coordinating Centre for Health Technology Assessment
  www.ncchta.org
- National Institutes of Health
  www.nih.gov
- New Zealand Health Technology Assessment
  http://nzhta.chmeds.ac.nz
- Public Health Association of Australia
  www.phaa.net.au

Appendix 2 Those consulted on the developing framework

The literature review was conducted by SURE and the draft methodology was developed in collaboration with the HDA. In addition, many groups and individuals were consulted during the developmental stages of the methodology and have made contributions during the process. Their participation and contributions are gratefully acknowledged, although their inclusion in the list below in no way signifies their support or endorsement.

- HDA Obesity and Evidence and Guidance teams, including Mike Kelly, Caroline Mulvihill, Hugo Crombie and Daniel Warm
- HDA Obesity Reference Group, including Andrew J. Hill (University of Leeds), Penny Gibson (Royal College of Paediatrics & Child Health), Ken Fox (Bristol University) and Mike Lean (University of Glasgow)
- NICE, including Francoise Cluzeau and Jeremy Wyatt
- Public Health Evidence Steering Group Methodology Subgroup, including Josephine Kavanagh and Sandy Oliver (on behalf of the EPPI Centre) and Ray Pawson (University of Leeds)
- Public Health/Prevention Subgroup of the NICE/HDA Obesity Guideline Development Group
- UK and Ireland Public Health Evidence Steering Group
- Wales HDA Obesity Collaborating Centre, including Eddie Coyle (Wales Centre for Health); Chris Roberts and Nina Parry-Langdon (Health Promotion Division, Welsh Assembly Government)

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- Robin Harbour, SIGN
- Nicki Jackson, Cochrane Health Promotion and Public Health Field
- Sue Lloyd, Wales Centre for Health
- Anne Ludbrook, Health Economics Research Unit, University of Aberdeen
- Andrew Oxman and the GRADE working group
- Mike Rayner, British Heart Foundation Health Promotion Research Group
- Mary Renfrew, Mother and Infant Research Unit, University of Leeds
- Tim Stokes, National Collaborating Centre for Primary Care
- Carolyn Summerbell, Teesside University (HDA Obesity Collaborating Centre)
- Malcolm Ward, National Public Health Service for Wales

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Notes

Social Exclusion Knowledge Network
Analytic and Strategic Review Paper

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WHO-CSDH resource file

I. Focus and Conceptual Framework

Conceptual Definition of Social Exclusion

Discussions of social exclusion center on the following ideas:

1. Social exclusion is related to inadequacy at systematic levels, such as inadequacy in policy developments on social protection, employment, education and training, health and housing policies. (Lisbon Strategy of the European Union)
2. social exclusion is linked to connectedness and participation. It is characterized by geographic isolation, a lack of means and opportunities to participate in normal activities of citizens in a given society and the barriers preventing individuals from participating due to factors beyond their control. (Center for the Analysis of Social Exclusion, London School of Economics and Political Science, http://www.lse.ac.uk/; see also Burchardt et al. 1999)
3. social exclusion has to do with particular social characteristics and related labeling of the individuals with those characteristics , which generate negative consequences for these groups (see related discussions in "Exclusion en Salud: en paises de America Latina y el Caribe, 2004, PAHO).
4. Social exclusion involves the process marginalization and related lack of rights protection. It "refers not only to the economic hardship of relative economic poverty but also incorporates the notion of the process of marginalization." The process often generates cumulative effects. (See Shaw, Dorling, and Davey Smith, 1999; Davey Smith, 1998).
5. Social exclusion generates multiple effects, which in isolation or in combination affects health through various pathways. (See WHO Commission on Social Determinants of Health, May 5, 2005).
6. Possible benefits of exclusion and burdens of inclusion. Voluntary social exclusion can have potential benefits (See, for example, Goodin, 1996). These include: protecting cultural or social identities and continuities, empowering in-group members, or gathering support for a cause beneficial to in-group members. The empowerment. movement of the Native Americans in the United States actively resisted inclusion or integration. The burden of inclusion can be negative when it is forced upon the will of vulnerable populations. For example, the forced adoption of native American children in the United States and aborigine children in Australia generated negative social consequences on the native communities. (See Kreisher, March 2002; Stone, November 10, 1999)

To sum up, ***social exclusion is a multi-faceted phenomenon generated by such factors as geography, group or individual characteristics, access to opportunities and resources, and barriers to voluntary participation in community activities***. The health inequities entailed by social exclusion are related to the structures and dynamic processes through which individuals, proceeding through their lives, become excluded and unable to access social, economic, political and cultural resources to address their health issues.

There are multiple dimensions to the concept of exclusion and the relationships among these dimensions are mutually reinforcing. In general, it encompasses economic, social, political, and temporal dimensions. (See Shaw, Dorling, Smith, and Davey Smith (Eds.), 1999; White,1998; "Wiley, 2004).

Forms of Exclusion: Burchardt et al. (1998) provides a widely used conceptual framework in discussing social exclusion. This framework suggests that it is important for individuals to participate in "production, consumption, wealth, political and social" dimensions of activity. (See also Sparkes, November, 1999, p. 1) These discussions point to the following forms of exclusion that can affect population health:

- exclusion from economic opportunities. It has to do with lacking access to the "normal perquisites, routines, and experiences of everyday life," such as a lack of access to employment, inheritance, land, or other economic resources. It was suggested that in some communities, certain groups are routinely excluded from the labor market, e.g., women, the elderly, minorities, the disabled, migrants, and are routinely discriminated against in employment. (See Galabuzi, 2002, p. 1; Shaw, Dorling, Smith, and Davey Smith, 1999)
- exclusion from educational resources. For example, the children in remote rural areas, where transportation is difficult and resources are scarce, are likely to be excluded from educational opportunities. (See UNICEF, 2004, "State of the world's children 2004"; Brown, Socially stigmatized children due to certain conditions (e.g., those infected with HIV/AIDS) have been routinely excluded from schools. A related point is that exclusion from information resources or tools to access information has contributed to the digital divide phenomenon. As a result, the benefit of information technology has not evenly spread to all population and the divide between "information-rich" and "information-poor" occurs. Exclusion from information resources generates other forms of disadvantages, such as access to job market or professional skills updates. (See DiMaggio and Hargittai, 2001)
- exclusion from civil society due to legal constraint or regulation. Examples of affected populations include migrants, specifically illegal immigrants, or children of legal immigrants. For example, legal migrant farm workers in the US are not entitled to social security and health care benefits.
- exclusion from social discourse and political participation. This refers to exclusion from voicing one's opinion or representation in the media or in other political processes .
- exclusion from accessing social goods. Individuals with certain social characteristics, such as the disabled, mentally ill or immigrants find it difficult to access the health systems due to the lack of accommodation or limited language skills in health care settings.
- exclusion from social production and participation. Some groups may be labeled as "undesirable, unacceptable, or in need of control, such as gypsies and nomadic travelers. Or some minorities, who are stereotyped as lazy or lacking the mental acuity to be constructive members of society, are excluded or limited in their participation in economic activities.
- exclusion from public policy and intervention. The larger social and policy context plays a critical role in exclusion. (See Melville, Nov. 14, 2002; also Hong. 2000; Heredia and Purcell, 1995; and Bouillon and Buvinic, 2003; Hall, 2005; Lipietz and Saint-Alary; 2003; "From social exclusion and social cohesion: Towards a policy agenda," 1995; Maxwell, 1999; Olukoshi, 2003; Shah, 2005; Thomas and Wint, 2002;). Some examples are: social and economic development policies, globalization and mutli-lateral or bilateral trade agreements, especially those proposed by the World Trade Organization, macroeconomic stabilization policies, such as structural adjustment, poverty reduction, and related conditionaliies (i.e., economic shock treatment). For example, the measures for structural adjustment, a policy tool for the World Bank and IMF, multilateral development banks (MDBs), and bilateral aid agencies, routinely require tightening of credit, suppression of wages, privatization of state-owned agencies, reduction of government expenditures, and

liberalization of trade regimes and financial markets. Despite the achievements in containing inflation and inducing economic growth in some cases, these measures have produced some unintended social outcomes, especially in increasing unemployment, declining wages, increasing poverty and wealth gap, and reduction of public investment in education and health services, as illustrated by the cases of Peru, Somalia, Vietnam, Nicaragua, Mexico, Argentina, and Brazil. (See Hong, 2000; Heredia & Purcell, 1995.) For example, price controls and wage reductions have forced rural farmers to migrate to urban settings for better employment. The debt servicing requirements have led to growing debt burden on the third world countries. Some third world countries fell into a vicious debt servicing cycle by borrowing even more to pay for the interest and amortization. This leads to further reduction of public investment in health care and education. (See Hong, 2000). It was estimated that in 1990, Africa owed 46% of their export earnings on debt servicing along, while at the same time there was a drastic decrease in overall aid to the region. The other force related to this discussion is the impact of globalization and free trade initiatives on the communities, especially in employment and population migration (See Beall, 2002; Hong, 2000). Overall, our review suggests that these macroeconomic policies often contribute to social dislocations, which have a major impact on social determinants of health. The consequent erosion of social capital, due to reduced access to social resources and networks needed, to address health-related issues, has contributed to exclusion and generates serious implications on population health.

Excluded people

These forms of exclusion generate the following individuals: 1. guest workers, refugees, migrants, ethnic and linguistic minorities, who are excluded from the benefits of full participation in civil society; 2. the disabled, chronically ill, mentally ill, and emotionally vulnerable, such as residents of children's homes, orphans or neglected elderly; 3. the poor, homeless, unemployed, and abandoned children; 4. those already marked by disadvantaged social status, with additional stigmatizing health conditions i.e. HIV/AIDS, leprosy, physical and mental disabilities; 5. socially disadvantaged women, and sexual minorities.

The manifestations of exclusion vary across communities, country contexts, or regions. There are universal factors as well as factors unique to a particular community.

Cross-national Continuities

Evidence suggests that besides the global factors of exclusion, there are local factors unique to regions or country contexts. Nevertheless, the global factors, especially poverty and employment, have a robust interaction with the local factors. For example, in the United States, racial/ethnic affiliations and immigration status are a major exclusionary factor (Institute of Medicine, 2003). In the Caribbean, Central America and Andean countries in South America, such as Haiti, Puerto Rico, and Dominican Republic, Mexico, Ecuador, Colombia, Peru, and Bolivia, poverty is the common denominator for exclusion while a more nuanced analysis indicates that ethnic/racial and linguistic differences (in some instances due to the indigenous status) are often relevant factors to poverty. The indigenous, according to the World Bank, are the poorest of the poor. (See Griffith, 2000) Yet, there are factors unique to a particular country. For example, in Dominican Republic, migration status (being Haitian immigrants) is an exclusionary factor, while urban-rural divide contributes to exclusion in Guatemala and Honduras (Wang, 2004; PAHO, 2004). In North America, racial/ethnic racial affiliations is a major exclusionary factor. Yet, more distinction is necessary in examining this factor: in the United States, skin color explains racial/ethnic exclusion, while in Canada, the aborigine status accounts for racial exclusion In Southeast Asia, gender, education, urban-rural disparity, and poverty-related issues are critical exclusionary factors in India, Bangladesh, Pakistan, Thailand, Indonesia, and Cambodia. However, there are different factors unique to each country. For example, in Thailand, it is the combination of gender, geography, and ethnic affiliations that is a critical determinant for health inequities. Within these countries, there are factors unique to particular social and geographical milieus. For example, gender disparity is more likely to be a critical factor in the rural areas than in urban settings in India. In East Asia, poverty is a common exclusion factor while this factor interacts with other factors in very different manners. For example, In China, rural and urban divide, migration status, linguistic differences, and religion are critical exclusion factors while in Japan, ethnic distinction and national origin account for exclusion. Even within the same country, there are regional variations. In China, ethnic differences account for marginalization in Northwest region while in Central, Eastern and Southern region, urban-rural divide, which is closely associated with migration status, is a major exclusionary factor. In the Middle-East, religion, which is closely related to other social, cultural and political factors, is an important social exclusionary factor. However, there are also unique local factors. For example, in Iran, rural to urban migration is a key poverty and exclusionary factor. (See Sheykhi, 2000). In India, religion-related exclusion is often linked to caste/class, ethnic differences, and rural-urban divide. Overall, these factors point to the importance to examine the power dimension in involuntary social exclusion. In addition, to avoid being entrapped in the conceptual pitfalls of stereotyping and over-generalizing, it is necessary to examine the interaction between these local factors and global factors across populations in producing social exclusion.

Definition of Inequities

Summarizing discussions on health and equity, inequities refer to a subset of inequalities that are deemed unfair. (Evans, Whitehead, Diderichsen, Bhuiya, and Wirth, 2001; Marmot, 1999). Health inequities are disparities in health outcomes due to unequal health opportunities that are unfair and avoidable, such as disparities in infant mortality, life expectancies (that are not natural), morbidity, etc. (See Commission of Social Determinants of Health, 2005; Evans, Whitehead, Diderichsen, Bhuiya, and Wirth, 2001; Marmot, 1999)

Major Conceptual Issues in a Model of Social Exclusion and Health Inequities

Major issues in conceptualizing the pathways between social exclusion and health inequities:

Dynamics within and between dimensions of social exclusion. Social exclusion is a complex construct that involves multiple dimensions. Each of them can be further examined at micro- and macro-levels. Major considerations include: 1. the dynamic between the micro- and macro- factors within the same dimension. 2. the interaction among different dimensions. For example, education interacts with other social determinants, which in turn affect health in the course of a life time. Education also affects literacy, health literacy, or language and communication skills that are related to social interaction and discrimination, access to health resources, and quality of treatment in the health care settings.

The continuum of social exclusion. Social exclusion is not always a dichotomous variable. In many cases, it is a continuous variable. For example, on gender and educational opportunities, the issue is not that girls are excluded from education and boys are not. A more sophisticated approach would be to examine the ways in which access to different lengths, types, and depths of education affects men and women differently in their health outcomes due to different cultural and social backgrounds.

The dynamics between exclusion and other structural determinants, and between structural determinants and intermediary determinants. The pathways between social exclusion, intermediary determinants and health inequities are often multi-directional and mutually reinforcing. There are direct and indirect pathways between social exclusion and health inequities. Thus, it is important that we do not examine social exclusion in isolation. For example, as Galabuzi (2002) pointed out, attention should be paid to how the combined effects of poverty, gender inequity, unemployment, and neighborhood selection mediate the relationship between social exclusion and health inequities. Our research also suggests that exclusion from educational opportunities is not the only predictor of ill health. Moreover, exclusion from education, which characterizes the experience of some minorities or migrants, interacting with discrimination and hazardous working conditions, might be a powerful predictor of ill health. In measurement, it is necessary to identify the independent effect from combined effects of social exclusion on health inequities.

The reverse feedback in the causal relationship between social exclusion and health inequities. The pathways between social exclusion and ill health are not necessarily unidirectional or linear. They also work in reverse direction in the causal path. For example, poverty has a negative effect on health. Yet, the pathway is not unidirectional. Ill health also aggravates poverty. This negative feedback loop moves in spirals that subject the poor and less healthy population to worse health and economic situation. The poverty conditions might also interact with other structural (such as class or cast) or intermediary determinants that create even a larger gap in health disparities.

Generalizability and unique cases of social exclusion. Since the goal of this project is to generate global evidence of social determinants of health, it is then necessary to examine those social exclusion dimensions that can be generalized across all communities. However, it is equally important to examine the dimensions unique only to a particular population or community context. They might reveal important information about a specific social/institutional structure that produces a particular health outcome in that population and the related need to address it.

The interaction between social exclusion and CSDH themes. Social exclusion is not an isolated phenomenon particular to a community. Understanding the interaction between social exclusion and other macro forces and micro factors provide a more accurate explanation about the correlates and combined effects of these interactions on health inequities. For example, social exclusion might be further aggravated by such prevailing systemic forces as globalization and trade-related issues. Several issues are relevant: 1. At the country level, in what way public policies in social sectors, especially in health, poverty reduction, education, and social protection and solidarity, can be used as an effective instrument to dilute the possible negative effects of globalization, such as by increasing resource allocation to address social exclusion. The model practiced by the Scandinavian countries might be instructive. 2. At the regional and global levels, it is relevant to discuss how trade-related globalization initiatives, especially those spearheaded by WTO rules and bilateral trade agreements, affect exclusion. 3. In addition, it is important to examine the effectiveness of global interventions, such as debt relief initiatives, poverty reduction strategies, and Millennium Development Goals. 4. Social exclusion also has significant interaction with other themes, such as urban settings, gender, employment conditions, and health systems. These other factors, as focus of other Knowledge Network themes, impact and are affected by social exclusion. Investigating these links is integral to the work for the Social Exclusion Knowledge Network.

The need for a comprehensive model to generate interventions to address and health inequities due to social exclusion. Social exclusion plays a central role in health inequities. Several issues need major considerations: First, the macro forces at the systemic level that affect social exclusion need scrutiny, especially in public policies and interventions and rights protection at global, regional, country, and community levels. Second, the micro-level factors, such as communications at the interpersonal level, labor conditions, housing segregation, etc., need to be examined. Third, health inequities are not the end result of the path. They also act as a starting point that further aggravates the social positions of those excluded population, such as their access to the health system, socioeconomic opportunities, etc.

II. Literature Review

A. Existing evidence. The aforementioned framework is used to critically and systematically review evidence on the robustness and associations between social exclusion and health/health equity across different country contexts. A preliminary review of existing evidence shows:

On poverty

As an important socioeconomic status indicator, poverty has long been recognized as a major cause and outcome of social exclusion (see for example, Pan American Health Organization, 2004).

1. Poverty has economic and social dimensions and does not necessarily imply exclusion and vice versa. The underlying factors of poverty are inadequacy in macro-level policies, systems and context that creates such outcomes as unemployment, wealth gap and marginalization, etc. (Bessis, 1995; Bhallla and LaPeyre, 1999; see also PAHO, 2004.)

2. Among all sub-dimensions of poverty, unemployment or under-employment-related poverty generate particularly serious effects on health due to exclusion from the labor market and social benefits of accessing consumption, maintaining identity, and obtaining recognition that comes with income-generating activities. Specifically, poverty affects health via the following **pathways**:

- deprivation of material conditions affects fulfillment of basic health needs, such as balanced nutrition.
- the poor are deprived of financial resources to engage in normal social activities
- poverty due to social discrimination excludes access to social capital, such as to health systems.
- lack of access to health resources (such as disposable income for health care, access to private and public insurance, health information, etc.) to address one's health care issues. (Dain, 2004; Davey Smith, 1998; see also "An introduction to social policy: Social need." By Center for Public Policy Management. Aberdeen Business School. The Robert Gordon University).
- the psychological burden on the poor also makes it more likely for them to indulge in less healthy life styles, such as excessive alcoholic consumption and smoking (Shaw, Dorling, and Smith, 1999).

Inter-American Development Bank (IADB) noted that there is a high correlation between poverty and social exclusion and the excluded typically constitute the poorest. These excluded often suffer serious health consequences. (See "About Social Exclusion." By Inter-American Development Bank, May 4, 2004; Wilkinson et al, 1989; Wilkinson, 1996; Wilkinson and Marmot, 1998; Kawachi, Wilkinson and Kennedy, 1999; Raphael, 1999; 2001; Kawachi, I., Wilkinson, and Kennedy, 1999; Wilkinson, et al., 1989; Wilkinson, 1996; Wilkinson and Marmot, 1998).

3. Discussions of poverty require an examination of *how poverty is determined*. Several major approaches are: A. an absolute index approach: The World Bank uses the indicator of $31 a month income. B. budget standards: The US demarcates poverty by identifying income levels based on the food basket cost, below which is the poverty line. C. relative measures: The European Union uses a comparative measure that sets a poverty line at 50%. D. others: subjective opinion or a consensual method. (See "An introduction to social policy: Social need." By Center for Public Policy Management. Aberdeen Business School. The

Robert Gordon University). Poverty defined as relative deprivation is a useful concept that can be further modified in different contexts when discussing population health (Townsend, et al. 1988). For example, Townsend index of deprivation is a composite indicator of unemployment, percentage of households with no car, the extent of overcrowding, and housing tenure. (Townsend, 1988).

4. The **cumulative effects of poverty** during the course of life make it important to look into its relationship with other determinants. Discussions on the impact of poverty on health inequities require a more comprehensive understanding of the complex relationship between education, employment, income inequality, discrimination, deficit of social capital and health inequities. For example, education interacts with poverty in affecting health inequities. As will be discussed in the following section, educational attainment is "strongly correlated with" unemployment and earnings, which determines poverty levels, in developed countries. (See Sparks, November, 1999, p. 2). Poverty also has a bi-directional relationship with education in that poverty can pose as a barrier to access to educational opportunities. The interaction effect between poverty and education then contributes to reduced access to social resources, such as networks. Together, they subject individuals to higher risk to ill health in the short term as well as in a life course.

Entry points for discussing social exclusion and poverty: 1. The precursory conditions that aggravate poverty of the excluded and that produce ill health outcomes. 2. Exclusion from employment, poverty, and health inequities. 3. The causal relationships between poverty, exclusion and health inequities. 4. How social exclusion affects the poor in accessing balanced nutritional resources. 5. How poverty interacts with other determinants to further aggravate social exclusion. 6. How social capital affects the social position of the poor and produces health inequities.

Assessment of Evidence. Among all dimensions of social exclusion, the most discussed association is between poverty, unemployment, and poor health outcomes. The majority of evidence suggests that poverty and unemployment affect physical and mental health. (See, for example, Davey Smith et al. 1994; Davey Smith, Blane, and Bartley, 1994; on mental health, see Evans, and Repper, 2000) Most of the evidence on income inequality and population health focus on developed countries. For example, Adler et al. (June, 23, 1993) examined how socioeconomic status as a whole affects morbidity. Some specific evidence on exclusion, poverty, and health outcomes has also focused on the populations in developed countries, e.g., in UK. For example, some epidemiological studies have explored the relationship between unemployment, exclusion and housing, poor physical health and mental health outcomes. Most global comparisons on poverty and excluded populations were produced by inter-governmental agencies and NGOs. For example, the World Bank 2000 Global Poverty Report and poverty reduction strategy papers discuss poverty and its impact at a broad and general level. The Poverty Center of UNDP has produced more focused research on poverty and some excluded populations, such as on poverty and children. (See Children on the Brink of 2004: A joint report of new orphan estimates and a framework for action. (www.undp-povertycentre-org); Gordon, Nandy, Pantazis, Pemberton, and Townsend, funded by UNICEF). Pan American Health Organization has also generated research that examines some impact of poverty and exclusion (See Dain, 2004, for PAHO). Some government reports, such as by UK and Australia, have examined the relationship between low SES and health outcomes. For example, Australia's report presented detailed comparative analyses and measures of health status, such as nutrition intake, morbidity, etc., among different social classes. (http://www.undispatch.com/archives/world_health/) "Health Status of South Australians by Socio-economic Status.") In general, 1. there has not been consistent, focused, and detailed studies on the relationship between poverty and ill health for specific excluded populations. 2. it is necessary to generate a standardized measure of poverty that accounts for diverse experiences of the excluded in different country contexts. 3. groups-desegregate data are also needed to analyze the effects of exclusion on health.

On education.
1. Education is a multiplier and gateway to other social gains, such as employment opportunities, income, gender equality, participation in civil society, political processes, and access to social capital. It is an effective instrument for integration and maintaining social cohesion. The major **underlying factors** of exclusion from education are: inadequacy in social resources and deficiency in policy interventions and rights protection. 2. The **pathways** between education and health outcomes are. A. the socioeconomic gains afforded by opportunities associated with education have long-term implications for health. B. health literacy that is associated with normal school education can promote positive health behavior. C. exclusion from educational opportunities reduces access to social and psychological sources and increases social isolation and affects access to social support. D. As a common experience, education creates stronger communities. (Brehm and Rahn, 1997). This bond between individuals and society established in the educational process directly and indirectly affects population health. 3. The relationship between education, other structural determinants (such as SES, ethnic/racial status, gender, access to political power), and intermediary determinants (labor conditions of child labor) is complex and multi-directional. The effect of one determinant feeds into others and the combined effects multiply health inequities. For example, the combined effects of lacking access to education opportunities and gender inequities have a strong correlation with infant mortality. 4. The macro-level issues also interact with micro-level issues in enlarging health inequities. These micro issues include: different content, types, and range of education received by children of different social characteristics (such as rural vs. urban, boys vs. girls, racial/ethnic/linguistic subgroups, etc.), the different types of health education needed at the primary versus secondary levels. For example, primary education might emphasize comprehensive preparation in basic skills, formation of positive health habits and practices, nutrition, and prevention of child abuse. In contrast, at the secondary level, besides reinforcing those basic skills, the content of education might include the teaching of professional skills and reproductive and sexual health.

Major issues on education and social exclusion.

- Exclusion from well-rounded education, such as science and health, excludes the cognitive sources that one can use to gain health literacy, information for disease prevention and intervention, and health maintenance.
- Exclusion from languages that are major sources of information, access to power and social capital. Language barriers and the lack of resources to address this problem is a recurring issue across different countries. Education affects the ability to use officially sanctioned language in a given society and has major implications on access social sources and health resources. Of special concern are the consequences when the language of education differs from the language of an excluded or marginalized group. Several issues are relevant: A. For those who do not use the official language, there are questions about translation and the attitudes of the dominant language group toward minorities' or toward ethnic languages in health settings? B. For those who use the official language, there are questions about society's attitudes toward and services for those individuals. C. Education also determines one's access to technology or the language of science and technology that has major implications for health inequities. The phenomenon of digital divide affects access to health-related information and solutions.

- Exclusion from education is a continuous variable. For example, even when rural children receive some education, the types, content, and range of education received might not be the same as those by urban children. This puts them at a disadvantage point in terms of employment, earnings and occupational status during the course of their lives. Similarly, when girls receive education, the questions remain: whether the content, especially in math, science and health, and expectations for girls are the same as those for boys; if the educational system makes specific attempts to address gender-specific health needs. The fact that educational levels of women are a reliable predictor of infant mortality point to the need for examining the complex interaction between macro- and micro-level factors and dynamic pathways between education and health inequities. The same point can be made about specific educational needs of cultural, racial, ethnic, social minorities.
- Education also affects health inequities by addressing justice and human rights-related issues in the curricula and communication in social forum. For example, the most effective way to address prejudice and discrimination against socially marginalized groups is through education, especially at the early stages of life in school and social settings. Health education has also been noted as being highly effective in tackling public health concerns such as HIV and STDs.

Assessment of Evidence: Most studies, such as Desai and Alva (1989), articulate a possible strong association between education and population health, especially from the life course approach. Many innovative programs and policies have been implemented to address the encompassing implications for exclusion from education. Nevertheless, there still lacks focused and consistent research on the relationship between education and the health outcomes of excluded groups in the short term and in the long-term. There has been some documentation of successful educational programs addressing quality of education, retention of children in general, gender-sensitive education, and those including health literacy and service in school-based education, such as Bolsa in Brazil, Progresa Opportunidades in Mexico, Balochistan Primary Education Project in Pakistan. Evidence suggests that a long-term, comprehensive evaluation and assessment component in this discussion is still lacking.

Gender

According to WHO (1998), gender "is related to how we are perceived and expected to think and act as women and men because of the way society is organized, not because of our biological difference." As such, gender is a multiple dimensional construct that encompasses biological components but also has social, cultural and psychological implications. For example, perspectives about gender roles and functions can range from simple/restrictive (such as reproduction and nurturing) to complex/flexible (biological, social and political). The major **underlying factor** that contributes to gender exclusion is: discriminatory social, cultural, economic, and political practices against men or women who do not have resources or recourse to address the consequences of those practices. (Ostlin, George, and Sen, G., 2001). Gender-related exclusion often determines unequal access to resources and networks, unequal opportunities in public representation, and unequal participation in the making of institutional policies. Gender-related exclusion is reflected in all aspects of social life and its manifestations vary from society to society. These can be different levels and types of education for boys and girls, access to the range and amount of health care received, and division of labor and related occupational status. These practices affect economic rewards conferred within and outside the household, the range and types of liberties one is permitted to exercise, and possibilities for social and political representation. (See Sen, A. 1992). Gender interacts with other intermediary factors, such as education, class, employment, to produce health inequities. The relationships between gender and health inequities can proceed through the following **pathways**: 1. biologically defined health needs in different life stages that are not recognized and accommodated. For example, nutritional needs for women at pre-partum stage are different from other stages of the life course or from men. The risk factors in morbidity and mortality, such as in mental health, reproductive health, cardiovascular diseases, and possibly in musculoskeletal system, are different for men and women. (Danielsson and Lindberg, 2001) 2. inequalities in health outcomes and health care that go beyond biological differences in sexes, which, as mentioned earlier, are affected by unequal, social, cultural practices in gender relations. For example, women's advantage in life expectancy is a widely recognized natural biological difference in gender. Yet, this advantage disappeared in deprived communities in developing countries. And for males, excess male mortality is largest in former Russian Republics and Eastern European countries due to non-biological factors, especially homicide among the young and war. The variation of this biological-survival advantage across different countries underscores the importance of examining non-biological factors in addressing gender-related health inequities. One possible pathway is that women and men are excluded from equal participation in certain aspects of social life and that exerts negative health impact on women.

Major issues: 1. whether excluding women from education or certain types of education leads to their decreased access to economic resources and employment. This form of exclusion determines women's social status, their power relation with men in the household, their possession of health care resources (such as health literacy), and their participation in society, social discourse, and political process. It further determines women's influence over allocations of social resources to protect their health. It is a complex cycle of feedback that enlarges health inequities. Like some other structural determinants, such as SES and marginalization, the seriousness of gender inequity has its intergenerational implications. Exclusion of women leads to socially disadvantaged children and the vicious cycle leads to increased health vulnerabilities and risks that further excluded them from upward social mobility. 2. whether cultural and social norms have contributed to the exclusion of men and women who do not fit in traditional definitions of gender roles and result in violence against men and women. These multiple interactions can exert very negative effects on the population. In this sense, gender-related social exclusion has a circular, multi-international effect with other structural determinants. 3. how differences in cultural and social experiences among women and men of different socioeconomic status account for different health outcomes.

Assessment of Evidence: 1.most scientific evidence on gender and health inequities was based on studies on developed societies. (See Doyal, 1995; Green and Rafflin, 1993; Heston and Lewis, 1992; Krieger, 1995; Lerner and Kanel,1986; Verbrugge, 1985;). 2. These studies indicated strong associations between gender and health inequities in general and in specific areas, such as heart diseases in developed countries. 3. There were much fewer studies on gender exclusion and health outcomes on developing countries. 4. The few studies on gender and health inequities in developing countries discussed gender and health in such areas as malnutrition, mortality, morbidity, pregnancy-related issues and mental health. (See for example, Evans, et al. Eds, 2001; Bhuiya and Ansary, 1998; OKojie, 1994; Paltiel, 1987; Paolissio, and Leslie, 1995; Rahman, et al. 1994; Santow, 1995; Vlassof, 1994). 5. As a whole, there lacks sex-desegregate data on health outcomes. Data on the relationship between gender, exclusion, and health outcomes are lacking. Most of the global comparisons were generated by intergovernmental agencies or NGOs. For example, WHO pointed to the high mortality rate of pregnancy in developing countries. WHO's 1998's technical paper on gender and health, WHO report on gender and health (2003) and PAHO's report on gender and health (2003) presented a strong association between gender and health inequities in developing countries. However, few studies specifically examine the interaction between gender, social exclusion and health outcomes. Even fewer studies have examined the interaction between gender and other exclusion dimensions or factors, such as age, poverty, racial/ethnic backgrounds, and health outcomes at the global level. One study by the World Bank did make an attempt to address the social dilemmas of one excluded population, albeit with peripheral mentioning of health. In this report, World Bank presented comprehensive evidence in gender differences in access to opportunities, resources and participation across the range of civil services and social and economic life chances. This report specifically pointed out that there have not been detailed studies and data on rural women's health. (See Grieco, 2002).

On marginalization and discrimination

Marginalization encompasses several interrelated dimensions, such as ethnic/racial, cultural, geographical, sexual, physical and mental capacity, social stigma, linguistic, residential/housing status, and migration status. Discrimination against marginalized groups is often wrought in explicit or implicit forms that lead to exclusion. This phenomenon is often more prevalent than what individual communities recognize or are willing to recognize. 1. **Underlying factors**: The distinction between "in-group" and "out-group" by the use of various criteria, such as skin color, cultural differences, sexual orientations, physical capacities, housing conditions, and migration status often leads to the generation of unequal social, political, cultural policies and rules that discriminate against marginalized groups. 2. However, the process is not dichotomous. It is a more nuanced process and environment of differentiation and inequity that produce corresponding degrees and types of health inequities. Even within the in-group, certain social/cultural factors produce various forms and degrees of discrimination. 3. The interaction between global (i.e., race/ethnicity) and local factors (such as class) produces gradients of health inequities. For example, when compared to Caucasians, African Americans as a group have shown a statistically significant difference in major health indicators. Yet, within the same population, the low-income African American men have an even more pronounced difference from middle-class African American men or women. (Institute of Medicine, 2003). 4. **The pathways** from marginalization to ill health are through •lack of secure sources for food, shelter and stable employment, •stress due to loss of social support networks, need for social adjustment in a new environment or changing environments, •the risks of working in hazardous environments, with few or no mechanisms for self-protection or organized protection (i.e., such as through unions), •fear for harassment, •exposure to environmental toxins, e.g., the pesticides) (Wang, 2004, case studies in Cambodia, US, Thailand; see also Drever and Whitehead, 1997; Toole and Waldman, 1997; Corvalan et al., 1994). Degree of marginalization often interacts with employment, occupational status, political participation, access to health resources, working conditions, and living conditions to produce negative health outcomes. It is then important to examine these structural mechanisms and intermediary pathways through which exclusion of social groups lead to health disparities.

Forms and Range of Prejudice and Discrimination

- On social characteristics: The minority health research in the United States has systematically documented the differences among African Americans, Native Americans, Hispanics, Asian Pacific Islanders and Caucasians in various health outcomes, such as in infant mortality and life expectancy, cancer morbidity, and differential treatment of health care. However, as mentioned earlier, the interaction between race and other SES factors differentiates health outcomes of the subgroups in a given racial/ethnic group.
- On physical disabilities: the physically disabled and mentally challenged are more likely to experience discrimination in social settings and their needs are often not accommodated. Poor, ignored elderly are more likely to experience negative health consequences than those who are of a higher SES status. Income and employment would produce further gradients of health inequities in this group.

- On migration status: These groups include: refugees (who flee from countries in conflict), displaced persons (due to natural disasters, such as the recent Tsunami in Southeast Asia), immigrants who experienced hardships and discrimination (such as those in Europe, America, the Middle East), migrant workers (the Mexican guest farm workers in the US or Southeast Asian house workers in Hong Kong and Singapore), trafficked persons (trafficked commercial sex workers in Thailand, India, Cambodia, Holland, etc.) These groups are at higher risks of mortality and morbidity, such as in physical injuries, communicable diseases, neonatal problems, malnutrition, mental, psychological, and emotional problems. In addition, SES factors and other social characteristics, such as skin color, further differentiates the health outcomes of this group. For example, Cubans as an immigrant group have shown better health outcomes than other groups in the Hispanic population.
- Residential/housing status: It has a more complex, bi-direction, causal relationship to social exclusion. It involves the discussion of: 1. urban-rural divide in developing countries. Rural residents are invested with much fewer resources, which affect all aspects of social life (See, for example, Hovenga, 1998). The rural residents have less access to health facilities. There are fewer health providers available. The quality of care is inferior. Even when well-equipped health care infrastructure is available, other inefficiencies, such as transportation or good roads prevent the residents from accessing the health care. 2. housing status. The distinction between having a shelter and not having a shelter, which characterizes the homeless and street people, has pronounced effects on health status. 3. The kind of housing that one has, in a slum or a regular residential area, also affects health. 4. Neighborhood. Questions raised here are: the kinds of neighborhood one lives in, i.e., the kinds of infrastructure, access to services, and community cohesion and safety. These issues are closely related to access to healthy food, clean water, exposure to violence, environmental hazards, community bond and support, good roads and convenient transportation, access to health care, etc. (See Hovenga, 1998) Poverty, class, and gender can be a major factor of differentiation in exclusion in this case. For example, rural-urban divide is a major exclusionary factor in China; however, well-off rural farmers have little difficulty accessing health care or improved housing. (Wang, 2005)
- On religious affiliations. Religion also interacts with other social determinants, such as gender, class/cast, political affiliations and race, in producing graduations of health inequities. For example, in South Asia, the strong interaction between religion and cast is a major exclusionary factor. (See detailed discussions in the section on religion).
- On gender. Gender discrimination entails discussions of biology, sexuality, and socialization experiences. As mentioned earlier, differences in male and female biology and gradients in social/political/economic experiences contribute to social exclusion. It is worth noting that the gradients in socialization experiences, such as SES backgrounds, generate different health outcomes. For example, in Africa, poor women in rural areas of Africa are more likely to be infected with HIV than those well-off in urban settings. (UNAIDS report, 2005). Gender discrimination also needs to focus on the discussion of male exclusion. Homosexual men or men of lower SES or cast, ethnic origins face various degrees of discrimination. For example, in some countries, homosexuality is illegal. (See Wang, 2005)

Assessment of Evidence: Most of the evidence on marginalization and discrimination has been produced in developed countries. For example, minority health research in the US has produced a large number of studies on health disparities among ethnic minorities, especially among Native Americans and African Americans, and Caucasians due to discrimination. (See

"Unequal Treatment." 2003). So far, these studies presented the strongest scientific evidence on discrimination as an exclusionary factor for ill health. Other reports made similar attempts to address the negative effects of social exclusion, albeit with little mention of health outcomes. For example, the Scottish government produced a report on the effects of social exclusion on some marginalized groups, with little analysis of health effects. This research, which provides new empirical evidence based on detailed surveys in 3 urban areas of Scotland, found that: women, the unemployed, elderly, people with health problems and those in low income groups are more likely to experience transport related social exclusion. ("The Role of transport in social exclusion in urban Scotland." Scottish Exclusive. http://www.scotland.gov. uk/cru/kd01/ blue/rtseuc_03.htm). One attempt by the UK's Exclusion Unit Report Breaking the Cycle (2004) did produce general evidence that the excluded elderly suffered specific physical and mental health issues, such as mortality and loneliness. It also pointed out that exclusion itself aggravates ill health. The Joint NGO report in response to New Zealand government's Second Periodic Report to the Committee on Economic, Social, and Cultural Rights pointed to the need to improve housing for the excluded populations, without addressing health effects. In general, most of the global comparisons are produced by inter-governmental agencies, such as UN and its affiliates. For example, UN High Commission for Refugees regularly reports on the status of displaced populations. The 2003 report from the "Permanent Forum on Indigenous Issues" (May 12, 2003) pointed out that the indigenous were displaced from lands and are more likely to suffer extreme poverty. PAHO's report on "Exclusion in Health" (2004) was a comprehensive attempt to investigate the exclusion factors as barriers to access to health care. In a 6-country study, this report concluded that exclusion in health seemed to be related to poverty, marginality, racial discrimination, cultural patterns (such as language), informal structures in employment, underemployment and unemployment, geographical isolation, lack of basic services, such as electricity, drinkable water and basic sanitation and a low level of education or information on the part of service users. Despite the rigorous methodology and quality of the data, this study focused specifically on exclusion from health care instead of social exclusion as a whole.

On religion

First, the **underlying factors** that account for religion-related exclusion and health inequities are as follows: Religion can be considered as a unique cause of marginalization. When there is a clear case of a community composed of "religious majority" and "religious minority," the majority, in many cases, tends to have more power to define the rules for institutional or informal, social sanctions that affect many aspects of social lives of the minorities, such as in education, economic opportunities, health resources, gender relations, health practices, etc. In this case, the dominant or "state-sanctioned" religious group defines what is normative and important in health priorities and therefore apportions government and social resources to support those priorities, with the intended and unintended effects on "non-dominant" religious groups. As is obvious in this case, the minorities generally lack power to negotiate and ameliorate their social positions. The major **pathway** between religion-related exclusion and health inequities is through discrimination. Discrimination occurs in overt and covert forms. Overtly, this can lead to reduced denial of access by minorities to resources, including health care. This power imbalance is also likely to lead to wars, massive migration, genocide, violence against women and children in extreme cases. In most cases, discrimination takes other less violent forms, such as contempt and harassment that perpetuates discrimination. For example, some communities allocate fewer public resources to the religious "out-groups." Some religious groups are forced to concentrate in less desirable neighborhoods, areas, or environments. They might be subject to blatant or less obvious forms of oppression, such as interpersonal verbal abuse, neglect in cultural and media representation, discrimination in employment and education, exclusion from community and political participation, which can result in negative physical outcomes and mental or emotional distress.

Second, religious institutions can be an important component of social capital. They can be potent vehicles of inclusion. It can play and in some cases has played a positive role in improving access to health care. Religious organizations and affilated charities are often effective channels through which access to health care is provided or facilitated. Religious institutions provide elaborate networks and a range of services that influence health: such as services for disaster response, reproductive health, disease outbreaks (such as HIV), and other initiatives that have positively improved health disparities. They are often effective in reaching socially and geographically excluded populations, such as the indigenous, homeless, slum dwellers, abandoned children, abused women, and elderly, etc. In this sense, they can be effective in filling the void of government action in addressing health disparities.

Third, religious-related teachings and practices can have both positive and negative or positive effects in improving population health. The use of Islamic teaching to preach monogamous relationship to reduce HIV prevalence is an example. The Mormon teachings against use of tobacco and alcohol consumption have long been noted as a protective factor for this group. (Koenig, McCullough, and Larson, 2001). Nevertheless, it must be noted that religious teachings or practices can serve to suppress the exercise of rights of certain social groups, such as women, and can incur negative health consequences at the population level. Assessment of Evidence: There are few studies examining the interaction between religion as an exclusionary factor and health outcomes. 1. Most studies examine the role of religion in healing and in supporting positive health behavior. 2. Most studies were conducted in the context of developed countries, primarily in the Untied States. 3. The methodological rigor of these studies needs to be evaluated. For example, religiosity is found to help coping behavior for kidney disease (Baldree et al., 1982). O'Brien (1982) found that 52.4 patients indicated that religion was "usually" or "always" associated with their adjustment to hemodialysis. It was said to have a positive effect on the patients undergoing coronary artery bypass graft (Saudia et al.,1991) Harris et al. (1995) found that beliefs and practices predicted better physical functioning, lower anxiety, higher self-esteem, fewer health worries, and less difficulty with the transplant medical regimen and better compliance. A study on 100 HIV or AIDS patients showed that prayer or other spiritual activities played a major role in their life. (See Carson, 1993) Similar findings can be found among diabetic patients. (Landis, 1996). An interview on 51 seniors in Rhode Island showed that out of 66 coping strategies, prayer was most used. (See Manfredi and Pickett, 1987) Overall, similar results were generated from informal research (See, for example, Koenig, McCullough, and Larson, 2001, p. 86). In 1980s, a Gallup poll on 1.485 adults indicated that almost 80 percent of the US population receives comfort and support from religious beliefs.

On the role of religion in affecting health behavior, some studies suggested that religious persons are more likely to engage in healthier life styles and less likely to smoke, abuse alcohol, use illicit drugs, and engage in risky sexual practices or other hazardous behaviors. They eat more healthily, have lower serum cholesterol levels, and may exercise more. (see Koenig, McCullough, and Larson, 2001, p. 3). Still, there are studies, such as by Riley et al. (2001), indicating the negative health outcome of religious practices. Overall, in terms of the relationship between social exclusion, religion and health outcomes, there needs research to examine: 1. the role of religion as a macro-level force in social exclusion or inclusion and its impact on health outcomes. 2. effectiveness of religion as a positive tool to broaden access for excluded populations. 3. effectiveness of religion in promoting positive health behavior. As we will discuss in the following sections, there have been a large number of health programs applying faith-based approaches and teachings, such as CORE supported by USAID and ACP or "HIV in Uganda" program in Uganda. Yet, the outcome assessment and evaluation component of these programs needs further research, especially in addressing the health outcomes of the excluded.

Elements of Social Capital

The role of social capital in integrating communities has aroused some contentious debates among social scientists and community practitioners. The debates center on: 1. the connotations of "social" and "capital" in the building of community. One major issue is: how "social networks" and "economic capital affect the community. 2. definitions of social capital. Among different types of capital, the tension between bonding and bridging capital has been subject to close scrutiny. In Putman's (2000) original definition, bonding (exclusive) social capital refers to relationships that are inward-looking and tend to strengthen in-group loyalty and cohesion (i.e., family, ethnic, fraternal, and religious organizations). Bridging (inclusive) social capital refers to relationships that are outward-looking and embrace diverse social groups (e.g., youth groups, civil rights groups, etc.) 3. if it is always beneficial. For example, bonding social capital can generate negative impact on population health by, for example, upholding a potentially harmful health practice, such as the group ritual of heroine injection in Southwest region of China that has contributed to very high HIV prevalence . 4. the need to include discussions of power, especially in relation to economic capital, in evaluating the social capital in communities. 5. macro-level factors, such as policies and interventions that contribute to the strengthening or incurring the deficit of social capital. (Crombie, et al., March, 2005). Most discussions on social capital originated from sociology or economics. In this section, we will focus on elements of capital relevant to the discussion of health inequities. In population health, social capital refers to "collective characteristics of communities and societies that determine population health status." (Kawachi, and Berkman, 2000). It is generally agreed that the key elements of social capital are: social networks (the tangibles), trust, and norms (the intangibles). (See Productivity Commission, July, 2003, "Social capital: Reviewing the concept and its policy implications." Australian Government; Bourdieu and Wacquant, 1992; Coleman, 1988; Coleman, 1990; Loury, 1992; Putnam, 1993; see also Kawachi and Berkman, 2000, p. 175).

1. social networks: A network is an interconnected group of individuals that have an attribute in common. (See Productivity Commission, June, 1993). Examples of networks that affect the operation of population health are: families, kinships, neighborhoods, employment affiliations, community organizations, and institutions.

Social networks have generated major discussions in population health. Among social networks, civil societies, communities and public institutions (such as health care agencies) are relevant to health inequities. Measures of social networks include: A. measures of characteristics of networks, mainly the structural measures: size, density (extent to which members are connected to each other), boundedness and homogeneity; B. measures of individual social ties: frequency of contact, multiplexity (number of transactions flowing through a set of ties), duration, and reciprocity (extent to which exchanges and transactions are reciprocal). Civil society, as an important element of social networks, is "that zone between the individual and the state which is occupied by a crisscrossing network of voluntary associations." (Kawachi and Berkman, 2000, p. 179). The activities of civil society are usually not part of the formal political system, commerce, or government. (See Baum, and Ziersch, 2003). The other important element of social networks is community, which refers to a group of people who "share a sense of identity or have common concerns." (Baum and Ziersch, 2003, p. 322; Berkman, and Glass, 2000). Participation and volunteering are major mechanisms for social networks to generate strong social cohesion. The services provided by social networks, especially in health and educational services, are instrumental in strengthening health-related social capital. Social networks foster emotional, mental/psychological support, material support, rights and policy support, and increasing participation. (See Putman, 1993; Kawachi and Berkman, 2000). What sustains social networks is participation, which is a central element to WHO Health for All Strategy. This program ranges from "consultation to structural participation in which lay people are the driving force of initiatives. (Baum, and Ziersch, 2003, p. 323). There have been several pronounced cases in which civil societies and community mobilization have made a difference in population health. The mobilization for increasing access to HIV medicine for the poor populations in developing countries by NGOs was an often cited case in point. (Loewenson, R. (Civil society influence on global health policy. See WHO Training and Research Support Center. http://www.tarsc.org/WHOCSI/globalhealth.php)

2. trust: Trust affects population health in a major way. For example, minority health literature in the US shows that If the health care system functions in discriminatory manner, the marginalized groups would be mistreated (See Institute of Medicine, 2000; see case studies in Lima, 2005). Lack of trust can make marginalized groups underutilize beneficial health resources. Mistrust due to the Tuskegee Syphilis Study (REF) continues to influence interactions with the health system of African Americans in parts of the United States. This mistrust is likely to start the vicious cycle of decreased participation by those groups in mainstream health care institutions or their resorting to the use of emergency services as a "last-minute" solution.

3. norms. Social norms that affect health are: "honesty, law abidingness, the work ethic, respect for elders, tolerance, and acceptance of diversity, and helping people in need. (Putman, 2000). For example, unequal gender norms can expose women to higher risks of STDs. The recent increase in HIV prevalence among married women in Cambodia is related to husbands' refusal to use protection in marital relationships while extramarital sex is a common practice among those married men. (Wang, 2004).

These elements of social capital can affect human capacities, both physical, emotional, and intellectual, and human capital also impacts social capital. (Brehm and Rahn, 1997). The bi-directional pathway between social capital and exclusion has implications on health. On the macro-level, the **underlying factors** of the deficit of social capital are multiple social forces, among which social and political context factors, such as globalization, labor markets and organizations, economic pressures, and organizational links, have the most impact. These forces at the macro level impact job stability, food security, migration patterns, land ownership and related issues that expose certain populations to major health risks. (See Berkman, and Glass, 2000; Granoveter, 1973; Marsden and Friedkin, 1994; Morris, 1994).

Exclusion from social capital affects health inequities through the **pathways** of lacking "support, social influence, social engagement, access to jobs and material resources, access to health resources." (Baum, and Ziersch, 2003, p. 323). These pathways then exert direct consequences on physical and mental health, such as exclusion from health systems, elevated risks to physiological stress and responses, vulnerabilities to health-damaging behaviors (such as substance addiction), problems with medical adherence, and exposure to infectious diseases, such as HIV and STDs.

A large number of studies in social epidemiology have investigated the relationship between social support and health outcomes. World Bank reports specifically pointed out that social capital can be an effective tool for poverty reduction. (2004 World Bank report. http://www1.worldbank.org/prem/poverty/scapital/home.htm) (See for example Macinko & Starfield, 2001; Kawachi & Berkman, 2000; Narayan 1999; Kahssay, Oakley 1999; World Bank Social Capital. http://www.worldbank.org/poverty/scapital/index.html; World Health Organization. The Ottawa Charter for Health Promotion, Health Promotion 1986;1:i-iv.; Baum, 2002; Cox; 1997; Muntaner, 2000; Ziersch, 2002. Campbell, 1999. Macintyre & Ellaway.

2000; Baum 2002;; Cattell, 2001; Ashton & Alvarez-Dardet; 2003; Alvarez-Dardet & Ruiz, 2004; Berkman & Kawachi, 2000; Lynch, Due, Muntaner, & Davey Smith, 2000; Muntaner, Lynch, Davey Smith, 2000; Lynch, 2000; Kawachi & Berkman, 2000; Kawachi. Kennedy, Lochner, 1997; Kawachi, Kennedy, & Glass, 1999; Wilkinson, 1996; House J, Landis & Umberson, 1988; Wilkinson, 1999; Wilkinson R. 1997; Lynch et al., 2001; Ross 2000; Brodsky, 1996; Daniels, Kennedy, Kawachi, 2000; Davey Smith, Frankel, & Ebrahim, 2000). These studies demonstrate that social support is central for improving population health. Similar conclusions were derived from reports by inter-governmental agencies, governments, or NGOs. For example, *Health Survey for England, 2000, found " . . . a strong relationship between perceived social support and mental health . . . Among men, those with some lack of perceived support were 1.53 times as likely to report poor health as men with no lack of support." (Baum and Ziersch, 2003). 1. Most of these studies focused on developed societies. 2. There lacked consistent and rigorous evaluation of programs that have strengthened social capital and have generate positive health outcomes. 3. Even fewer studies examined these issues in developing countries or that focused on the relationship between social capital, excluded groups, and health outcomes in global context.

Existing Gaps: An Overall Assessment

- Most of the existing research on social exclusion and health has been conducted in developed countries, such as United Kingdom, Australia, Canada, Sweden, and United States. There is a lack of data examining the social exclusion and health inequities in resource-poor populations. Additionally, even the research in developed countries has not been systematic and did not target excluded groups specifically.
- Lack of coherent, comprehensive, and systematic research and related studies, especially rigorous scientific studies on various dimensions of social exclusion, internal dynamic of each dimension, and on interactions among various dimensions, and their relationship to health inequities. Existing data examine certain excluded groups in isolation, i.e. focusing only on one dimension or one characteristic of exclusion without taking into account inter-group and/or intra-group differences or combined effects. E.g, when discussing health issues of indigenous, the focus on poverty or material conditions provides only a partial picture of causal relationships. Understanding the interaction of multiple causes is critical to our understanding of the SD and to the search for solutions. There also needs reliable and valid measures of various dimensions of social exclusion.
- Lack of consistent and systematic research on combined effects between structural and intermediary determinants on health inequities, such as between exclusion dimensions, discrimination, and working/housing conditions or access to health care.
- Lack of information on social exclusion and its links to other cross-cutting WHO themes, such as globalization, early child development, in producing ill health.
- Lack of large-scale, comparative, population-level research examining the similarities and differences of social exclusion in global context.
- Lack of a systematic framework of evaluation of existing programs in different dimensions of social exclusion.
- There is little discussion on global-level, inter-sector, and public policies and interventions in development and social sectors to link exclusion, health outcomes, and to long-term social change. It is necessary to examine how macroeconomic policies, especially structure adjustment and debt servicing related issues, have affected resource allocation for social development and related health outcomes. This will point to the need to render population health a central focus in development policies and programs at bilateral and multilateral levels.

B. **Prioritize the Associations between Social Exclusion and Health Inequities.** We have identified and prioritized associations that can be acted upon and used as the basis upon which to outline policies and programs on social exclusion at country, regional and global level.

Overall Commentary on Polices and Interventions. Our review of interventions shows that there are short-term solutions for every dimension of social exclusion. Nevertheless, sustainable solutions require coordination between policy, programs, and expenditures commitments with an overarching goal of social reform. For example, there needs policies that break the cycle of poverty and that utilizes the asset of the excluded and "public expenditures and institutions that provide equitable access to education, health care, and other social services." (See related discussions from Sheykhi, 2000).

- On policy environment, interventions require a supportive "enabling environment," "fiscal space," "policy space" and "social space" to address social exclusion. Political will with an internationally supported and harmonized policy platform is likely to create momentum and viability for interventions. The work on exclusion by the European Union and Iran are relevant cases in point. The Lisbon Strategy proposed by the European Union was designed to generate a comprehensive policy platform to tackle social exclusion at the systemic level. 1. It promotes a better understanding of social exclusion through continued dialogue and exchanges of information and best practice, on the basis of commonly agreed indicators. 2. It is integrated into existing budgetary framework at central and local levels by mainstreaming inclusion in Member States' employment, education and training, health and housing policies, such as through the use of Structural Funds at the community levels. 3. It develops priority actions targeting specific groups (for example minority groups, children, the elderly and the disabled) by Member States with flexibility within each state due to their unique situations and circumstances. Certainly, given the expansiveness of the framework, the effectiveness of this policy platform remains to be seen. Nevertheless, political will at a collective, cross-national level is necessary to generate large-scale changes. The case of Iran is relevant to this point. Since 1990s, Iran has stepped up its integrated interventions (policies, programs, and cultural change) in poverty alleviation, family planning, support for the elderly (with monthly cash allowance), strengthening universal health care systems, and empowerment of women in reproductive health issues. Similar legislative initiatives can also be found in Quebec, Canada, Belgium, and France, which links poverty reduction to education, employment, health, social services, and housing. (See Eliadis, and Ledue, October 7, 2003, Canada Policy Research Initiative, http://policyreearch.gc.ca/page.asp?pagenm=v6n2_art_11)
- On program effectiveness, integrated intervention programs are likely to break the vicious cycle of exclusion. For example, the Bolsa program in Brazil is an effective case in point. Bolsa Escola, which covers approximately 99% of municipalities in Brazil, aims to break the vicious cycle of poverty and exclusion by targeting school retention through the use of a multi-pronged strategy. The thrust of the program is to provide cash incentives for poor families to make their children stay in school. It has the following features: 1. it is supported from the highest levels of the government. The program was passed by the Congress and sanctioned by President Fernando Enrique Cardoso. 2. it is extensive but it has a clearly identified target population. 3. the policy framework coordinates with and is supported by other legal instruments, such as the child labor law that prohibits children to work under sixteen. 4. it has clear stipulations of enforcement criteria. 5. the administrative, financial and regulatory responsibilities were distributed vertically and horizontally between different levels of central and local government. 6. it has an effective

evaluation mechanism. A Council of Social Control was established to evaluate the program, monitor fiscal integrity and execution. The outcomes in education retention, reduction of child labor, decrease in street children, and income increase in the poorest population were assessed. Similar initiatives include: "Progresa" in Mexico, the "Programa de Asignacion Familiar" (PRAF) in Honduras, the "Red de Proteccion Social" in Nicaragua, and the "Beca Escolar" in Ecuador. (World Bank. "Brazil: An assessment of the Bolsa Escola Programs." 2001). 7. it has a clear transparency component. To avoid misuse of funds, the implementation personnel were prohibited to be affiliated with local governments. 8. it has a sustainable component: Brazil government has made a legislative commitment in fiscal allocation in educational programs. 9. It synergizes with other programs, such as training teachers in poor areas and incentives for families to avoid sending children to hazardous working conditions. The other program that demonstrates the need for program integration to intervene the vicious cycle is World Bank's Indigenous Peoples and Afro-Ecuadorian Peoples Development Project (PRODEPINE). It was designed to achieve the combined goals of poverty reduction, ethnodevelopment, capacity building, and land regulation that can impact health. It has channeled resources directly to areas in which over 50% of the population are indigenous or Afro-Ecuadorian in South America. By 2000, it had achieved tangible success: the grassroots organizations had gained 22,700 hectares of land; paralegals received training in land regulation; about 2,328 students won scholarships in higher education, 77 completed intensive courses in irrigations, social conservation and agro-forestry, 500 Men and women interned in a agro-ecology program, and 459 locally managed business projects were approved.

- The need for a "bottom-up," "culture-sensitive" and "self-development" framework for policy and program interventions. The aforementioned PRODEPINE program also demonstrates that major input for effective interventions should derive from individuals who are closest to the problems. The major goal of PRODEPINE is to improve the quality of life of the indigenous, under which it also aims to strengthen cultural and ethnic identity, self-determination and territoriality, and self-management. In this framework, culture is seen as positive source of development. Unlike other Bank projects for indigenous in the period 1992-1997, of which only half involved active consultation with the indigenous, PRODEPINE took an "ethnodevelopment" approach and actively included the indigenous representatives in every state of the project. It has channeled resources directly to areas in which over 50% of the population are indigenous or Afro-Ecuadorian in South America. These culturally sensitive measures have shown tangible positive outcomes on overall social development, as mentioned earlier. The importance of addressing precursors of gender inequity.
- Our review shows that gender has cross-cutting implications. The intersection between gender and other social determinants suggests that interventions should target those precursors of gender inequity, such as poverty and education, to generate gender-related solutions. One possible model is to integrate gender components in existing successful education-centered programs, such as Bolsa Escola.
- Use existing social capital in the communities through forming a wide range of coalition, including public-private partnership. The experiences of tackling the care of HIV/AIDS patients in Thailand and Cambodia showed that communities and social networks can play an important role in providing care in areas in which local governments are inadequate. (Wang, 2004; Interviews with personnel at CARE, Cambodia, such as Masaya Kato, project manager, 2004, Cambodia.) In Thailand, local communities, who worked with Buddhist organizations and NGOs, shared the care of HIV/AIDS infected and affected. In Cambodia, the orphans of the HIV infected have been cared for by NGOs, such as CARE, Family Health International, faith-based organizations, etc., and the communities. The

Islington Project in Britain illustrated the possibility to use public-private partnership to address social development goals of improving poverty, education, housing, etc. (See Power and Wilson, February, 2000). Thus, it is important to support the strengthening of social networks in macroeconomic development policies as well as to correct those macroeconomic measures that have contributed to the deficit of social capital.

In specific: There exists programs that can be modified or scaled up at global, regional, country, and community levels. (See Appendix A for a more detailed list of programs).

Education.

1. Existing global initiatives that can be modified by integrating health-related goals include: UNESCO's Education for All Campaign and related Fast Track Initiatives, Dakar Framework for Action, WHO Global Education initiative, Effort to implement Millennium Development Goals 1-7, Global Campaign for Education, ICTs for Educational Capacity Building, micro-banking and micro-lending programs, Global Fund financed programs, World Bank's poverty reduction strategy programs, Global Fund for AIDS, TB and Malaria, G-8's African initiative.
2. Government initiatives that have used a comprehensive framework of intervention and that have shown some effectiveness: Mexico's Programa de Educación, Salud y Alimentación (PROGRESA), Bolsa Escola Programme of Brazil, the Balochistan Primary Education Project in Pakistan, Food for Education in Bangladesh, Red de Proteccion Social (cash incentives for poor households), PACES vouchers program for the urban poor, BESO universal education program in Ethiopia, elimination of school fees in Uganda, school waivers for girls in Malawi. Mexico's Telesecundaria is an innovate TV education program that specivically aims to reach excluded population in the remote areas. 3. Programs by NGOs: programs that have a specific focus, such as ActionAid International's "Reflect" program to address adult literacy or programs that have a comprehensive nature, such as BRAC in Bangladesh that combines income generation and women's empowerment. 4. Comprehensive programs by intergovernmental agencies: The World Bank's Project Population et Lutte contre le SIDA (PPLS) develops a comprehensive information, education, and communication (IEC) strategy and campaign to address HIV/AIDS and other reproductive health issues.

Major policy and program implications:

•Access to affordable education in school-based programs; retention of children of excluded populations in basic education. •Quality and quantity of education deemed sufficient for positive health outcomes. •Gender and health-sensitive education. •Education and health education for excluded illiterate adults. •Use of language in schools for culturally and linguistically diverse children. •Using schools as health centers for socially excluded. •Educational opportunities or health education in the refugee camps or trafficked victims. •Diversity education for health professionals emphasizing dignity and respect for culturally diverse and excluded groups. •Promoting access to education through innovative information technology and bridging digital divide. •Policies for inclusion in institutions of higher learning.

Gender

1. global initiatives: UN Girls Education Initiative, 25x2005- Accelerating Progress in Girls Education Initiative; Girls Education Movement in Africa. 2. Government programs to support education for girls: Pakistan's Balochistan's Primary Education Program (to increase girl's enrollment), Food for Education in Bangladesh (support poor girls), African Girls Education Initiative, District Primary Education Program in India (gender equity). 3. programs by intergovernmental agencies: WHO's "Safe Motherhood" and "Family Planning." 4. NGOs: Women's Agenda for Change by Oxfam to support health of the commercial sex workers, Botswana's Diphalana Initiative to keep pregnant girls in schools. Couples in the Know Program by CARE, Cambodia. (focusing on education on sexually transmitted infections, HIV transmission and self-protection, reproductive health, domestic violence, sexuality,

discrimination against HIV as a social stigma, care and support, alcohol and drug use), anti-FGM campaign in Burkina Faso, the educational project in Côte d'Ivoire, CEDPA, CEOSS Projects in Egypt, CPTAFE in Guinea, Project Video in Guinea, MYWO in Kenya, similar projects in Nigeria, Senegal, Tanzania, Uganda, etc.

Major policy and program implications:

- Enrollment and retention of girls. •child labor and exclusion. •Prevention and intervention in exclusion of socially marginalized men. •Health literacy, nutrition education and school meals for excluded girls and poor pregnant women. •Prenatal health education that also involves men for excluded pregnant women. •Prevention and intervention on violence against women. Involving men in gender education issues. •Employable skills and protection of rights for excluded men and women. •Increasing network support for the excluded women and men.

Poverty

1. global: Global effort to improve MDGs 1-8, The Heavily Indebted Poor Countries Initiative (HIPC) has to date provided $31 billion in debt reduction to 27 countries pursuing economic reform programs, 23 of them in Africa, G-8 Africa poverty reduction initiative, micro-banking and micro-lending programs. Current negotiations of NGOs with World Trade Organization that addresses poverty and improving health access for the poor. UK Prime Minister's Commission for Africa initiative and related development efforts. 2. government-initiated programs: Haiti's National Council for Popular Finance to give credit to small farms. China's anti-poverty campaign. 3. programs by inter-governmental agencies: World Bank's PRSP programs. 4. programs by NGOs: the International Labor Organization's programs to promote non-discriminatory employment policies with regard to HIV status and programs in the work place. On-the-Job HIV/AIDS program by Family Health International. BRAC on micro-financing in Bangladesh.

Major policy and program implications:

•Addressing macro and micro issues of poverty and health through education and employment. •Provide channels and networks of employment information for the excluded through creative means of communication. •Provide incentives for employers and governments to recruit and retain the excluded. •Provide information and regulation on occupational health and safe work environment (e.g., use gloves and masks in pesticide-related field work) •Provide rights protection for the health of the excluded. •Assessing existing resources in public and private sectors in meeting the needs of the excluded to address inadequacy and redundancy. •Generating global platform to protect the economic means of the excluded, e.g. through the commitment of G8 leaders. •Use employment as a conduit for access to health care system and for improving health literacy (prevention and intervention), such as through job-based health insurance; integrating health education into employment training; using employment network as a conduit to transmit health information and provide network support. •Upgrade transportation for the excluded to access health care in urban dwellings and in rural areas.

Marginalization

Given the complexity of marginalization, tackling this dimension of social exclusion is challenging but it deserves most attention and effort. The groups that will benefit from immediate action: abandoned children, displaced populations (such as refugees and trafficked populations), diverse linguistic and cultural groups (such as the indigenous), disabled, and individuals with stigmatized diseases and their children. (We will possibly work with other networks to address the urban neglected populations, such as the street people and slum dwellers).

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1. global level: ICTs Intercultural Dialogue and Diversity project,' for indigenous peoples, UN Habitat's Housing Policy and Development Section, its Housing Rights Programme, and its Global Campaign for Secure Tenure, addressing homelessness, land, and urban-related exclusion. United Nations High Commission for Refugees' Evaluation and Policy Analysis Unit, addressing, via analysis, the welfare of displaced people. UN's Economic and Social Council's (ECOSOC) Permanent Forum on Indigenous Issues and its Commission on Social Development. International Disability and Development Consortium and International Association of Homes and Services for the Ageing (IAHSA) which have a global reach and address concerns of specific excluded populations. New Partnership for Africa's Development (NEPAD) priority area of health. 2. programs by intergovernmental agencies: Indigenous Knowledge Program by World Bank. 3. programs by NGOs: . "No Home too Far" program by PATH help isolated Cambodian migrants in Thailand to maintain close communications with homes to avoid risky situations and behaviors. (maintain a social support system by mail). YouthBuild, based in the US, is an innovative, comprehensive program that integrates school, work, social action, leadership development, and personal transformation. The program targets unemployed, socially-excluded youth who build houses for homeless and low-income families, while studying to complete secondary school, and learning empowerment and leadership skills. Work by International Rescue Committee (providing health education and services for the refugees in Congo) supported by UN High Commissioner for the Refugees,
<u>Major Policy and Program Implications</u>:
•Promote communication with and understanding of the marginalized groups and of their health needs in schools. •Promote egalitarian legislations, such as in addressing the health needs, Title VII of the Federal Civil Rights Act in the US, and communication, such as anti-discrimination messages in the media, and representation in the media and social discourse. •Establish and strengthen the community associations, such as through civil societies/NGOs, to serve the health needs of the marginalized. •Provide access to linguistically and culturally sensitive materials in social and health settings. •Find creative means of communication, such as through mobile clinics and theatres, to promote health literacy and access to health care for the geographically isolated. •Equip the health professionals with intercultural communication skills to interact with the marginalized. And integrate culturally appropriate care for the marginalized.

Elements of Social capital. Social capital, such as the health and education services provided by civil societies or institutions, can provide most cost-effectiveness means of addressing the health needs of the excluded. This is also the area that integration of effort within multiple sectors can make the largest difference in the short term.

Most of the programs are supported by national governments or NGOs: 1. Humana People to People in Soweto, South Africa, door-to-door effort to reach the excluded about HIV health literacy. Similar programs "Door-to-Door Outreach" in Brazil. Mobile Counseling Services in India. "Magnet Theatre" by PATH: a regular interactive theatre program that communicates sensitive issues about HIV in Kenya. "Community theatre in Benin" on family and reproductive health by PATH. Home Care Program for People with HIV/AIDS in Cambodia
2. government-initiated programs: In UK, the Social Exclusion Unit generated the innovative project "time bank," a co-operation project where the sick, elderly and other excluded groups support each other's daily needs. 3. inter-governmental agencies have a potential to further strengthen social capital, through such initiative as the Healthy Cities by UN-Habitat.
<u>Major Policy and Program Implications:</u>

•Interventions in causes for the deficit of social capital. •Interventions in the negative elements of social capital, such as the bonding capital that causes "honor killing" in Pakistan. •Rights protection and social interventions on the network needs of the excluded. •Health needs assessment of the excluded. •Evaluation on the effectiveness of current social support programs. •Assessing resources allocation to serve the health needs of the excluded. •Integrate and coordinate different social support services among inter-governmental, national and local agencies and among public and private sectors.

Religion

Religion itself has multiple interactions to social exclusion. Applied properly, religious connections can be a potential positive public health tool to address the health needs of the excluded. According to Walkup, (See Walkup, 2004), faith-based organizations fund and provide much of the 40% of health services in developing countries not provided by national governments. Faith-based health organizations often serve the most needy, most vulnerable, and hardest-to-reach populations (due to geography, social and political unrest, etc.) in the developing world. In some cases, governments actively have enlisted the support of religious organizations to address HIV, such as in Uganda and Thailand. In specific,

- The ACP in Uganda, a multisectoral program enlisting the support of religious leaders to address HIV.
- The use of Buddhist temples as community centers for the care of HIV infected.
- SANRU, Public-private partnership by faith-based organizations and government to ensure access to health services in the former Zaire.
- CORE initiative by USAID to fund faith-based programs for HIV/AIDS, including African Network of Religious Leaders, American Jewish World Service [AJWS] (Kenya), Asia Network of People Living with HIV/AIDS, Catholic Relief Services [CRS] (Global), Church World Service (Armenia, India, Indonesia, and Sierra Leone), Christian Conference of Asia [CCA] (Asia-wide), Ecumenical Advocacy Alliance (Global), Global Network of People Living with HIV/AIDS (GNP+) (Global), International Community of Women Living with HIV/AIDS (Southern and East Africa), Islamic Relief (Global), Adventist Health International (AHI), Lott Carey International (Uganda), Lutheran World Relief [LWR] (East and West Africa), The Organization of African Instituted Churches [OAIC] (Kenya and Uganda), Pan-African Christian AIDS Network [PACANet] (Africa-wide), Ponleur Komar (Cambodia), Positive Muslims (South Africa), Samaritan's Purse (Mozambique), Women's AIDS Run (Africa-wide), World Alliance of YMCAs/ World YWCA (Sierra Leone and Angola), World Conference of Religions for Peace (Africa-wide). Sangha Metta Project, a program in which Buddhist monks offering care and spiritual help for the sick.

Major policy and program implications:
•Interventions on the negative aspects of religion that can affect the health of the excluded. •Use religious networks to reach the excluded populations and increase their access to health care. •Integrate religious resources to increase education and strengthen social capital for the excluded. •Use religious teachings as guidance for positive inter-group communication and health. •Use religious opinion leadership to promote public health prevention and intervention.

C. **Inventory of Operationalization Framework**. key stakeholders who are researching, implementing and evaluating interventions and policies on social exclusion in the government, academe, inter-governmental agencies, and in the field. (Please see Appendix B for the list)

III.Priority Areas of Social Exclusion Work for 2005-06

A. **Mapping the framework for a knowledge network**: 1. guided and assisted by the CSDH, we will identify the stakeholders. 2. based on existing international academic collaborations between USP, and other stakeholders, such as CUBES/UNESCO, Innovation Philadelphia, we will examine the potential contribution of our partners in South Africa, Cambodia, and Haiti to the knowledge network. As whole, we will generate an exhaustive inventory of all stakeholders who conduct research, and implement policies and programs in addressing issues related to social exclusion and health outcomes. These are actors/participants/stakeholders who have already demonstrated expertise in examining and generating solutions to issues related to social exclusions and health.

B. **Establish operational mechanisms for data collection**:

- Identify work priorities. We will follow the Commission's guidance to set up a task agenda. We will make every attempt to engage in broad-based consultations to generate knowledge that vertically, integrate actions at local, national, and international levels to increase social participation, community support, and policy interventions.
- Set up a communication framework and Initiate communication with potential collaborators.
- Obtain agreements from potential collaborators to include their data in the knowledge networks and establish framework for assigning work and communicating, monitoring, and receiving research output.
- Set up collaboration mechanisms for data collection: propose joint research proposals, assistance to leverage fundraising to private and public foundations, assisting policy analyses and program evaluations (such as for community organizations, country agencies, and inter-governmental agencies), assistance in information/ communication/technology management and support, and possible support for program implementation.
- Plan meeting schedules: At least 3 KN in-person meetings will be held in Haiti, Philadelphia and possibly a third member site (depending on geographic distribution of members) over the duration of this project.

C. **Data analysis**:

- Assess and evaluate evidence based on criteria established by WHO experts. Based on WHO criteria, we will generate a comprehensive evaluation and assessment protocol to be applied to the analysis of scientific evidence, existing programs, and policies.
- Synthesize and identify results that can be generalized in universal contexts vs. results that have specific country implications.
- Identify knowledge gaps that need systematic, consistent, and long-term effort to fill at multi-level and multi-sector effort.
- Produce recommendations that link scientific evidence, program implementation and policy actions. Particular attention will be paid to generating a global policy platform to address social exclusion and health inequities that take into account the differences in individual countries' contexts and experiences at a multi-level, stakeholder-inclusive, culturally sensitive, collaborative, cross-sector effort.

Example of Policy and Program Mapping:

1 Address health needs of socially excluded.

2 Integrate population health objectives into macroeconomic policy and development programs to create a "fiscal space" and "policy space" to address health inequities. Relevant to this point is the need of dialogue and collaboration among all stakeholders at

the multi-levels, such as between World Bank, IMF, and WHO or among governments, civil societies, WHO, and other UN agencies.

3 Integrate health in social programs in education, gender skills, anti-stigma, anti-discrimination.

4 Increase social network capacities to address the health needs of the excluded by strengthening the collaboration between the public and private sectors.

5 Incorporate health services into social services for the excluded.

6 Increasing rights protection for the excluded in social space, health care system, work place, and community activities.

D. **Communication mechanisms**:

- Internal and external Communication: 1. We will regularly report to the Commission about all issues governing the operation, data collection and dissemination, coordination, administration and communication issues. 2. We will communicate with other knowledge networks through an internal WHO-established framework, including CSDH's Share Point website. 3. There will be continuous telephone contact and conferences between the two co-hubs and respective KN members. Between members, the primary mode of communication will be via internet and email as well as through CSDH's Share Point website, depending on member-site technological capability. 4. Externally, we will set up a central communication command, such as through a web site that serves as a major venue for external communication for information on social exclusion and health inequities.
- Disseminate research results: With the guidance of the Commission, 1. we will regularly communicate our results to other KNs, major stakeholders among NGOs/civil societies, local and country governments, inter-governmental agencies, etc, in the form of research summaries or newsletters. 2. We will initiate consultations and meetings with members in the network and we will convene conferences for stakeholders and outside interested parties. Through the access channels of the CSDH, our work and corresponding results will reach the following global agencies. If permitted, we will publicize our results in all major community, regional, global health meetings, academic publications, and other leadership summits where our information can be of utility to global leaders and policy makers. These include: 1. Global, Intergovernmental, regional, country-level development-related (e.g., poverty, gender skills, employment, etc.) meetings. 2. specialized meetings in health at global, regional, and country levels. These may include but are not limited to: UN meetings, G-8, APEC, African, WTO conferences, World Health Assembly, WHO regional consultation meetings, international AIDS Conference, People's Health Assembly, Global Leaders Forum, World Conference on Health Promotion and Health Education, etc.

E. **Establish a framework for sustainable solutions to social exclusion and health inequities in data collection and global action**:

Overall: In the long-term, and after the work and mandate of the CSDH have expired, it is hoped that these contacts and the established Network on social exclusion could continue to serve as a clearing house, research partnership and knowledge pool from which the global community can draw. The hub-leaders in Philadelphia and Haiti will:

- Establishing a central network of data collection, policy planning, program implementation and community action on health consequences of social exclusion in the long term.
- Linking private and public effort in allocating the resources to address the health impact of social exclusion.
- Implementing a comprehensive monitoring and evaluation system on the policy interventions and program outcomes.

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Appendix A

A list of References of Intervention Programs to Dimensions of Social Exclusion

Education: Useful references:

- Global initiatives: UNESCO's Education for All Campaign and related Fast Track Initiatives, Dakar Framework for Action, WHO Global Education initiative, Effort to implement Millennium Development Goals 1-7, Global Campaign for Education, UNICEF's education programs in Iran and China, ICTs for Educational Capacity Building, micro-banking and micro-lending programs, Global Fund financed programs, World Bank's poverty reduction strategy programs, its disease-specific programs like the Bank's multi-country AIDS program and its soon to be launched global strategy for malaria, several bilateral poverty reduction programs, Global Fund for AIDS, TB and Malaria, G-8's African initiative.
- Mexico's Programa de Educación, Salud y Alimentación (PROGRESA), Bolsa Escola Programme of Brazil, the Balochistan Primary Education Project in Pakistan, Food for Education in Bangladesh, Red de Proteccion Social (cash incentives for poor households), PRAF household allowance program in Honduras, PACES vouchers program for the urban poor, BESO universal education program in Ethiopia, elimination of school fees in Uganda, school waivers for girls in Malawi, and free universal primary education in low-income in Kenya.
- Improving educational quality: Government initiatives: SIMCE in Chile (also "Extension Jornada Escola," i.e., Full School Day Initiative in Chile), Money Straight to School program in Brazil,
- Successful models to support families in retaining children in schools by governements: the experiences of Mexico's Programa de Educación, Salud y Alimentación (PROGRESA), Bolsa Escola Programme of Brazil, the Balochistan Primary Education Project in Pakistan, Food for Education in Bangladesh, Red de Proteccion Social (cash incentives for poor households), PRAF household allowance program in Honduras, PACES vouchers program for the urban poor, BESO universal education program in Ethiopia, elimination of school fees in Uganda, school waivers for girls in Malawi.
- Integrate health in education: Primary School De-worming Program in Kenya, PIDI Integrated Child Development Project (nutrition, health, and education), Integrated Early Childhood Development in Eriterea, School meals program in Kenya, Sesame Street Goes to Egypt (including health, education and gender skills). LoveLife, South Africa's largest national HIV prevention initiative, is a bold and ambitious attempt to reduce HIV infection among South African adolescents by promoting sexual health and healthy futures for young people.
- Comprehensive approach: The World Bank's Project Population et Lutte contre le SIDA (PPLS) develops a comprehensive information, education, and communication (IEC) strategy and campaign to address HIV/AIDS and other reproductive health issues. The President of Burkina Faso launched a multimedia adolescent health campaign, including a rural radio program, radio drama series, radio and television spots, pamphlets, posters, a comic-style booklet, two dramas, and youth-friendly training for service providers that disseminated HIV/AIDS messages. Other similar programs (mainly by NGOs): "Journey for Life" in Ethiopia, "Stop AIDS, Love Life" in Ghana, PRISM Project in Guinea, youth lifestyle radio show in Namibia, mass communication campaigns in Nigeria, KUBA (Life Force) campaign in Rwanda, Maternal Health/Family Planning Project in Senegal, HIV/AIDS campaign in Sierra Leone, Lifeline in South Africa, Behavior Change Communication Program in Tanzania, Then Zambia Integrated Health Package Communication and Community Partnership (ZIHPCOMM) program with CARE, AFRIcare, and Manoff Group with HEART Campaign in Zambia, Sports for Life (promoting positive health behaviors in reproductive health and prevention by youth leaders), and

Sante Faimilale et Prevention du SIDA (SFPS), a regional practice involving Ivory Coast, Cameroon, Togo, Burkina Faso, Mauritania, and Niger.

- On bridging technological divide, Telesecundaria (Mexico), Telecurso (Brazil), Enlaces (Chile), and SHOMA for rural and urban students (South Africa)
- To support excluded children (children who have dropped out or have never been in school), COBET in Tananzia, COPE in Uganda (finishing 5 grades in 3 years), EDUCO in El Salvador (provide household incentives for children in remote area), BRAC to support children in rural areas in Bangladesh, Nueva Escuela Unitaria in Guatemala (innovative program to support children in rural areas).
- To support adult literacy: ActionAid International's "Reflect" program.

Gender

Useful references:

- UN Girls Education Initiative, 25x2005- Accelerating Progress in Girls Education Initiative; Girls Education Movement in Africa.
- Local programs to support education for girls: Pakistan's Balochistan's Primary Education Program (to increase girl's enrollment), Food for Education in Bangladesh (support poor girls), African Girls Education Initiative, projects in Kavango, Namibia to increase girls' enrollment, Hamlet Girls' Schools Project in Yemen, District Primary Education Program in India (gender equity)
- Integrating health in education: Initial Education in Mexico (teaching mothers about child-rearing practices); Gendering Adolescent AIDS Project in South Africa. "Safe Motherhood" and "Family Planning" programs by WHO.
- Addressing excluded women: Schools for pregnant women in Bosnia and Herzegovina, Women's Agenda for Change by Oxfam to support health of the commercial sex workers, Botswana's Diphalana Initiative to keep pregnant girls in schools.
- Gender skills, health, and communication: Couples in the Know Program by CARE, Cambodia. (including education on sexually transmitted infections, HIV transmission and self-protection, reproductive health, domestic violence, sexuality, discrimination against HIV as a social stigma, care and support, alcohol and drug use); Sesame Street Goes to Egypt (including health, education and gender skills).The African Women's Media Center Program, with special emphasis on reporting on HIV/AIDS in African and women. "Community theatre in Benin" on family and reproductive health by PATH and China's adolescent health program by PATH on gender and health literacy. Entre Amigas by PATH in Nicaragua on gender and health, targeting women in poor areas.

Other programs that have a special emphasis, such as female genital mutilation: anti-FGM campaign in Burkina Faso, the educational project in Côte d'Ivoire, CEDPA, CEOSS Projects in Egypt, CPTAFE in Guinea, Project Video in Guinea, MYWO in Kenya, similar projects in Nigeria, Senegal, Tanzania, Uganda, etc.

Poverty

Useful references:

- Global: Global effort to improve MDGs 1-8, The Heavily Indebted Poor Countries Initiative (HIPC) has to date provided $31 billion in debt reduction to 27 countries pursuing economic reform programs, 23 of them in Africa, G-8 Africa poverty reduction initiative, micro-banking and micro-lending programs. Current negotiations of NGOs with World Trade Organization that addresses poverty and improving health access for the poor. UK Prime Minister's Commission for Africa initiative and related development efforts, Global Business coalition of companies against HIV/AIDS (a model for British Petroleum's on-the-job HIV/AIDS program), Poverty Reduction Strategy Program (PRSP) by World Bank, Global Coalition for AIDS, the Global Fund's co-investment programs, the International Labor Organization's programs to promote non-discriminatory employment policies with regard to HIV status and programs in the work place.

- Specific programs: European-Haiti Coordination Network and the National Council for Popular Finance in Haiti, On-the-Job HIV/AIDS program by Family Health International, Haiti's National Council for Popular Finance to give credit to small farms.
- Notable examples to address poverty and exclusion: The World Bank's Indigenous and Afro-Ecuadorian Peoples Development Project (PRODEPINE) channels resources directly to areas in which over 50% of the population are indigenous or Afro-Ecuadorian. By 2000, it had achieved tangible success in land acquisition, regulation, access to education, conservation, employment and business opportunities, etc. The other: World Bank's Indigenous Capacity-Building Program. It helps locals indigenous groups to identify needs, prioritize development goals, and maximize their own resources. Indigenous peoples design most of each country's program. Several capacity building projects focus on conservation by Afro-Latin communities. For example, Sustainable Development of Belize River Valley Communities provided 3 communities with training in natural resource management, ecotourism and organizational skills in the Pacific Coast region of Colombia.

Marginalization

Useful references:

- Special-emphasis projects: Work by International Rescue Committee (providing health education and services for the refugees in Congo) supported by UN High Commissioner for the Refugees. Indigenous Knowledge Program by World Bank, Incorporating indigenous knowledge (IK), customs, and values into projects. "No Home too Far" program by PATH help isolated Cambodian migrants in Thailand to maintain close communications with homes to avoid risky situations and behaviors. (maintain a social support system by mail). MOST (Management of Social Transformations program) and Social Exclusion and Integration Best Practice cases. YouthBuild, based in the US, is a comprehensive program that integrates school, work, social action, leadership development, and personal transformation. The program targets unemployed, socially-excluded youth who build houses for homeless and low-income families, while studying to complete secondary school, and learning empowerment and leadership skills. Croatian Association for HIV sponsored programs that focused on anti-discrimination in HIV campaigns.

- Global effort: ICTs Intercultural Dialogue and Diversity project,' for indigenous peoples, UN Habitat's Housing Policy and Development Section, its Housing Rights Programme, and its Global Campaign for Secure Tenure, addressing homelessness, land, and urban-related exclusion. United Nations High Commission for Refugees' Evaluation and Policy Analysis Unit, addressing, via analysis, the welfare of displaced people. UN's Economic and Social Council's (ECOSOC) Permanent Forum on Indigenous Issues and its Commission on Social Development. International Disability and Development Consortium and International Association of Homes and Services for the Ageing (IAHSA) which have a global reach and address concerns of specific excluded populations. New Partnership for Africa's Development (NEPAD) priority area of health.

Social Capital

Some useful references:

- In UK, the Social Exclusion Unit generated the innovative project "time bank," a co-operation project where the sick, elderly and other excluded groups support each other's daily needs.

- Humana People to People in Soweto, South Africa, door-to-door effort to reach the excluded about HIV health literacy. Similar programs "Door-to-Door Outreach" in Brazil. Mobile Counseling Services in India.
- "Magnet Theatre" by PATH: a regular interactive theatre program that communicates sensitive issues about HIV in Kenya.
- LINC (US), a program that sets up a virtual world of health literacy, that can be modified in different community contexts.
- MAYA community ownership in education in India, a program that involves community to promote youth awareness.
- "Community theatre in Benin" on family and reproductive health by PATH.
- Home Care Programme for People with HIV/AIDS in Cambodia.
- Projects by Community Arts Networks that can include health messages in art.
- Rural Advancement committee in Bangladesh support village workers to implement programs. And Women's microfinance program in Bangladesh supports women to be self-reliant.
- Aga Khan Rural Support Program facilitates villagers to strengthen networks.
- Center for Social and Economic Development in Bolivia supports economic building and community solidarity.
- Orangi Pilot Project in Pakistan supports poor settlers to implement community projects.

Religion

<u>Useful references</u>:

- The ACP in Uganda, a multisectoral program enlisting the support of religious leaders.
- The use of Buddhist temples as community centers for the care of HIV infected.
- SANRU, Public-private partnership by faith-based organizations and government to ensure access to health services in the former Zaire.
- CORE initiative by USAID to fund faith-based programs for HIV/AIDS, including African Network of Religious Leaders, American Jewish World Service [AJWS] (Kenya), Asia Network of People Living with HIV/AIDS, Catholic Relief Services [CRS] (Global), Church World Service (Armenia, India, Indonesia, and Sierra Leone), Christian Conference of Asia [CCA] (Asia-wide), Ecumenical Advocacy Alliance (Global), Global Network of People Living with HIV/AIDS (GNP+) (Global), International Community of Women Living with HIV/AIDS (Southern and East Africa), Islamic Relief (Global), Adventist Health International (AHI), Lott Carey International (Uganda), Lutheran World Relief [LWR] (East and West Africa), The Organization of African Instituted Churches [OAIC] (Kenya and Uganda), Pan-African Christian AIDS Network [PACANet] (Africa-wide), Ponleur Komar (Cambodia), Positive Muslims (South Africa), Samaritan's Purse (Mozambique), Women's AIDS Run (Africa-wide), World Alliance of YMCAs/ World YWCA (Sierra Leone and Angola), World Conference of Religions for Peace (Africa-wide). Sangha Metta Project, a program in which Buddhist monks offering care and spiritual help for the sick.

Appendix B

Inventory of Operationalization Framework

Individuals.

- Experts recommended by the Commission of Social Determinants of Health.
- Dr. Sulamis Dain, Professor of Economics, Institute of Social Medicine, State University of Rio de Janeiro.
- Dr. Pascual Gerstenfeld, Division of Statistics and Economic Projection, Economic Commission for Latin America and Caribbean Region.
- Dr. Daniel Lopez-Acuna. Director of Program Management. Pan American Health Organization.
- Dr. José Arnoldo Sermeño Lima, Dirección de Integración Social, Secretaría General del Sistema de la Integración Centroamericana (Central America)
- Dr. Micky Chopra, University of Western Cape, South Africa, EQUINET.
- Dr. Elisabeth Carmen Duarte, Direcora, Esplanada dos Ministerios, Ministerio Da Saude, Secretaria de Vigilancia em Saude, Departamento de Analise de Situacao de Saude-DASIS, Brasil. (Especially the Program of Bolsa)
- Dr. Rocio Rojas, MD, MPH. Technical officer, Health of the Indigenous Peoples Initiative, Technical and Health Services delivery. PAHO.
- Rodolfo Guzman Garcia, Secretario Tecnico, Coordinacion Nacional, Opportunidades, Mexico.
- Dr. Elenora Dal Grande, Department of Health, Government of South Australia.
- Dr. Sok Pun, CARE, Cambodia. And Masaya Kato, CARE, Cambodia.
- Ms. Pry Phallay Phuong, Women's Agenda for Change, Cambodia.
- Dr. ING Kantha Phavi, Minister of Women's Affairs, Cambodia.
- Dr. Trevor Peter, Clinton Foundation. Caborone, Bostwana.
- Dr. Kaoru Ishikawa, Ambassador, Director, Multicultural Cooperation Department, Ministry of Foreign Affairs, Japan.
- Dr. Dennis Raphael, York University, Toronto, Canada.
- Hua Hsu, Deputy Director, China AIDS Foundation.
- Rifqah Kahn, Bush Radio, South Africa.
- Nguyen Quynh Trang, Policy Project Vietnam.
- Rosanna Barbero, Oxfam, Cambodia.
- Martin Khor Kok Peng, Third World Network, Malaysia.
- Manuel Carballo, Executive Director, International Center for Migration and Health, Vernier, Switzerland; Professor, Columbia University, USA.
- Pulin Nayak: School of Economics, University of Delhi.
- Pierre Chauvin, MD, Ph.D, DSc, Equipe Avenir, National Institute of Health and Medical Research, France.
- Prof. Dave Gordon, Townsend Centre for International Poverty Research, U. of Bristol.
- Dr. Kevin O'Reilly, WHO.
- Glenys Parry and Patrice Van Cleemput, School of Health and Related Research, University of Sheffield, UK.
- Mrs. Elaine Squires, Poverty and Social Exclusion Division, Dept. of Work and Pensions.
- Dr. Neil Williams, medical director, Safety Surveillance, Santa Fe Aventis.
- Helene Gayle, Global Health Leader. President of International AIDS Conference, 2006.
- Mr. Alberto Minujin, Senior Officer, UNICEF.
- Dr. Julie Evans, Department of Public Health, University of Oxford.
- Mr. Aranthan Jones, Senior Staffer to Congresswoman Donna Christiansen, US Congress.

Institutions

- African Medical and Research Foundation.
- Cape Town Refugee Center
- McGill Centre for Teaching and Research on Women, Montreal.
- Department of Health, Government of South Australia.
- Centre for Research on Social Inclusion: Macquarie U., Australia.
- University of Bristol, UK. Townsend Centre for international Poverty Research.
- Institute of Fiscal Studies. (Britain's leading independent microeconomic research institute)
- Institute of Public Policy Research. *Network of Gender and Development, UK.
- Poverty and Social Exclusion Division, Department of Work and Pensions, UK.
- Salisbury Centre for Mental Health, UK.
- Social Exclusion Unit, Office of the Deputy Prime Minister. National Assembly of Weles.
- Chronic Poverty Research Centre. Ghana.
- Centre for the Analysis of Social Exclusion.
- The African Women's Media Center Program.
- Global Health Council.
- Minority Health Office, USA.
- Canada`s International Development Research Centre (IDRC)
- Danish International Development Agency (DANIDA)
- Danish Refugee Council
- Swedish International Development Agency
- European Community Humanitarian Office (ECHO).
- Academy for Educational Development.
- Canadian International Development Agencies: poverty reduction projects in Asia.
- US Department of State, Bureau of Population, Refugees and Migration.
- World Bank Post Conflict Unit.
- Children and Armed Conflict, Social Science Research Council.
- Australian Housing and Urban Research Institute, Southern Research Center.
- UK's Department for International Development (DFID).
- Chronic Poverty Research Centre, Centre for Policy Analysis, Accra-North, Africa

National and Local Governments: National governments: Haiti, Brazil, Honduras, Guatemala, Mexico, Uganda, Kenya, South Africa, Nigeria, Tanzania, China, India, St. Lucia, Cambodia. Local governments: Cape Town, Phnom Penn, Shanghai, Port-au-Prince, Nairobi..

NGOs/Civil Societies.

- Gender-related: Self-Employed Women's Association, India. UK Gender and Development Network. Women's Global Network for Reproductive Rights (WGNRR). European Women's Lobby. the International Federation of Family Planning Associations (IPPF). Population Council (Men and Reproductive Health). International Center of Research on Women. Women's Agenda for Change in Phnom Penh Cambodia. Oxfam International: education and gender diversity. UNRISD (Reproductive Issues and Social Development), Europe.
- Refugees and displaced populations: The International Committee of the Red Cross (ICRC). United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA)Medicines sans Frontiere, The International Rescue Committee. Women's Commission for Refugee Women and Children (supported by IRC). The Norwegian

Refugee Council. European Council for Refugees and Exiles. The Foundation for the Refugee Education. Amnesty International. Action contre la Faim. Interagency Network for Education in Emergencies.

- On education: Basic Education Coalition. Community Organization Development Institute (Thailand), Education Action Aid India. World Education and World Learning (Southeast Asia). ActionAid International with Global Campaign on Education and One World South Asia to promote access to education.
- Disability: Acting Through Ukubuyiselwa (ATU) in Johannesburg South Africa that works with disabled, chronically-ill or violence-afflicted populations.
- Cross-cutting themes: HOPE Worldwide. Social Watch. Family Health International. AIDC (alternative information and development center) focuses on globalization, employment, and health.
- Health-specific: Regional Network for Equity in Health in Southern Africa (EQUINET). Africa Alive: a multi-national network of nearly 100 public and private sector youth and AIDS organizations in 6 African countries (Nigeria, Kenya, S. Africa, TAnzaiia, Uganda, Zambia, and Zimbabwe. China AIDS Foundation: addressing excluded populations in rural areas. Alliance. PATH.
- On Children: The Coalition to Stop the Use of Child Soldier. Enfants Refugies du Monde. Consortium for Street Children. Defense for Children International. Childwatch International Research Network. Save the Children. Middle East Children's Association. Young Lives (international NGO) (addressing children's poverty in all continents. Partners: Center for Economic and Social Studies (CESS) India. Dept of economics of addis Ababa, Ethiopia. Ethiopian Dev. Res. Institute, Addis Ababa, Ethiopia. General Statistical Office, Gov. of Vietnam. Grupo De Analisis Para El Desarrollo (GRADE), Peru. Institute of devel. Studies, U. of Sussex, UK. London School of Hygiene and Tropical Medicine, UK, Medical Research Council of South Africa, RAU University, Johannesburg, S. A. Research and Training Centre for Community Dev. Vietnam, Save the Children, UK, South Bank U., UK, Statistical Services Centre, U of Reading, UK.
- Faith Based organizations: American Jewish World Service, Corpus Haiti, All Africa Council of Churches, Asia Network of People Living with HIV/AIDS, Catholic Relief Services [CRS] (Global), International Community of Women Living with HIV/AIDS (Southern and East Africa), Islamic Relief (Global), Lutheran World Relief [LWR] (East and West Africa), Pan-African Christian AIDS Network [PACANet] (Africa-wide), Ponleur Komar (Cambodia), Positive Muslims (South Africa), Samaritan's Purse (Mozambique), World Conference of Religions for Peace (Africa-wide), AIDS Interfaith Network, Jesuit Refugee Service, World Vision International (for the poor and oppressed); Tzu-Chi Foundation, a Buddhist organization that supports displaced populations. FRED DE SAM LAZARO in Thailand, Buddhists supporting the care of the sick, especially poor HIV patients.
- Anti-discrimination, egalitarian communication: Australian Anti-Racism Advocacy Coalition. Network against Racism (ENAR) in Europe.
- Other themes: Friends of the Earth: working on transport-related issues to improve exclusion.

International Organizations
WHO's Commission of Social Determinants of Health, WHO and its regional affiliates (such as PAHO), Special Rapporteur on the Right to Education, UN-HABITAT, Special Representative for Children and Armed Conflict , Commission on Human Rights. UNDP, United Nations Development Programme Post Conflict Division, UNESCO, UNFEMM, UNICEF (and its affiliates, such as NGO Working Group on Girls), United Nations High Commission for

Refugees, United Nations Office for the Coordination of Humanitarian Affairs, United Nations Human Settlements Program, United Nations Development Fund for Women, UN Commission of Social Development, United Nations Children's Fund, World Bank, World Food Program, G8, Asian Development Bank, African Development Bank, African Union, International Labor Organization, and Economic Commission for Latin American and then Caribbean, USAID, United Nations Relief for Palestine Refugees (UNRPR).

Regional Bodies. Comision Economica para America Latina y el Caribe in Latin America, Programa de Promocion de la Reforma Educativa in America Latina y el Caribe, Inter-American Development Bank, African Development Bank.

Related Processes: (some were mentioned earlier)
UN-Related initiatives: WHO's Global School Health Initiative, Education for All, CUBES, Health, Nutrition, and Population Team (HDNHE), World Bank, STEP of International Labor Organization, UNDP, UNIFEM and UNICEF programs for aging, indigenous, youth, displaced populations, and trafficked victims, MOST (Management of Social Transformations program), Social Exclusion and Integration Best Practice cases, 'ICTs Intercultural Dialogue and Diversity project,' "ICTs for Educational Capacity Building," UN Girls Education Initiative, 25x2005- Accelerating Progress in Girls Education Initiative. Global effort associated with promoting Millennium Development Goals in "education and gender equality," "hunger," "child health and maternal health," slum dwellers," "access to essential medicines," and "science, technology and innovation," G8. the Africa initiative and related development effort.

ANALYTIC AND STRATEGIC REVIEW PAPER:

HEALTH SYSTEMS KNOWLEDGE NETWORK

Jane Doherty,[1] *Lucy Gilson,*[1,2]

Second draft
26 August 2005

Submitted to the Commission on Social Determinants of Health, World Health Organisation

by

The Health Systems Knowledge Network Hub

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WHO-CSDH
Resource file
Jn

EXECUTIVE SUMMARY

This review scans and summarises the international literature related to health systems and equity, focusing on *existing reviews* and articles that document *new lines of evidence and thinking.*

We note that the available literature covers a wide range of issues, but provides limited detailed or rigorous evidence, particularly with respect to the actions and interventions that promote equity.

In reviewing this literature we address the following three questions:
1. How can the social factors influencing access to and uptake of population/public health interventions, health promotion and personal health services, be addressed, particularly where these have an impact on equity in the opportunities for health?
2. How do key policies and organisational dimensions of health systems impact on access to population health interventions, health promotion and personal health care services, social differentials in heath outcomes, and other social determinants of health?
3. How can the policy space for health systems based on equity values be developed and maintained?

The health system as a social determinant

Using the health care system as an entry point, the review begins by presenting data that illustrate that health services tend to be used proportionately more by richer than poorer social groups. Existing patterns of health system inequity, thus, clearly demonstrate how the opportunities to benefit from health care are themselves socially differentiated.

It then analyses the social factors affecting access to, and uptake of, health services and shows how these engage with features of the health care system. Overall, it argues that the interaction between household health-seeking behaviour and experience of the health system generates differential health and economic consequences across social groups. The long-term costs to households of seeking care sometimes lead to impoverishment for poorer households.

The review then applies this analysis to the Commission's conceptual framework, showing that the health (care) system acts as a social determinant of health, interacting with other social determinants as well as the social and political context. Adding to the Commission's framework, we note that the health system can, moreover, itself interact with the social and political context. This highlights the potential for policy change within and by the health system to influence that context. In other words, health systems both reflect existing patterns of social inequality and provide a site in and from which to contest them.

Addressing policy and organisation in the health system to promote equity

The review examines aspects of the health care system that contribute to, or mitigate, inequity. These include:
- priority-setting;
- resource allocation;
- financing (covering various mechanisms of cost recovery, development aid and, pre-eminently important, tax-based funding; as well as the disbursement of conditional grants and vouchers to support use of health care interventions)

- organisation of the health system (including decentralisation and community participation, integration of services, re-orienting health care to primary care delivery, targeted versus universal approaches, and public-private interactions);
- human resources; and
- management and regulation.

The review concludes that national health systems founded on values of equity, solidarity and redistributive justice may reflect normative values, and value and entitle citizens, in ways that differ from other national and trans-national systems operating within wider economic contexts, including market-oriented macroeconomic policies, conflict and globalisation. Health systems may provide an entry point for broader societal transformation in the interests of poor and marginalised people, both through structural and cultural or value-driven change. However, this potential is often under-developed. Developing health systems of this nature is not simply a technical process structured around evidence. Instead, as there are likely to be competing interests, it demands political, health sector and social leadership.

Building health systems based on equity and social justice: maintaining the policy space
The literature on how policy-makers can maintain the space – at global, national and local levels - to build health systems based on values of equity and social justice in the face of broader forces such as market reforms, conflict and globalization, is scant but growing. The review notes the importance of:

1. Developing strong political support for the notions of equity and social justice, both within Ministries of Health and across government;
2. Promoting inter-sectoral action for health;
3. Strengthening the voice of the poor to make claims, and government legitimacy;
4. Constructing values-based health care systems and preventing excessive fragmentation within them;
5. Strengthening the ability to implement new policies and interventions that promote-equity.

Gaps in the literature
From the work that we have been available to do so far, we note several areas of weakness in this review that could be addressed through the knowledge network. These are:

- the role and nature of state action in promoting health equity in different contexts;
- the potential of particular health system strategies to promote equity, including health promotion and broader public health interventions;
- how to support and sustain policy implementation;
- differential household experiences of health systems, and variation within households;
- limited geographic coverage.

Priority interventions
Despite these gaps, a number of lessons and potential areas of action emerge from the review. Case study analyses of examples of these actions could add to the knowledge base in this field.

1) Leveraging policy action:

- The health system needs to use its leverage with other sectors and spheres of government to promote healthy public policy.
- Good governance and accountability are a prerequisite for equity-focused priority-setting and decision-making within health systems.

- Equity cannot be improved without strengthening the health system, especially the public sector. To this end, any policy change needs to be assessed as to its potential overall impact on the health system.

2) Achieving equity-promoting health system interventions:
- Build the health workforce to ensure the equitable distribution of appropriately skilled and adequately motivated staff across the health system and country.
- Re-orient health systems towards the provision of primary health care within a District Health System.

3) Financing health care and allocating health care resources:
- A comprehensive approach to financing, founded on the ideals of solidarity and cross-subsidisation, is vital to guard against the differential consequences of health care use and promote equity.
- Increase the proportion of government spending that is dedicated to health, along with increased donor aid and debt relief.
- Reduce out of pocket spending as a proportion of total spending on health care, including the removal of user fees through a properly planned and appropriately implemented strategy.
- Contain the development of private insurance mechanisms and where they exist take steps to prevent risk-rating by, and promote risk equalisation across, insurance schemes.
- Overall resource allocation should be needs-based, taking account of inter- and intra-regional disparities.

4) Strengthening management and implementation capacity:
- Develop the skills of public managers as stewards of the health system.
- Pay attention to transforming the organisational culture of the public sector to enable better management and implementation.
- Develop effective regulation of, and wise interaction with, the private sector to harmonise the efforts of public and private providers.
- Information is vital in developing and implementing policies that support equity. This information needs both to be sensitive to measuring inequity, and dynamic in its engagement with issues of process and outcome.

Areas of synergy or overlap with other knowledge networks

Finally, there are a number of areas where this network would benefit from engagement with other networks. Likewise, there are a number of areas where some clarity is needed on which network will take prime responsibility for investigating issues. These areas of potential synergy and overlap are:
- Community-based interventions, health promotion and implementation lessons (Priority Public Health Interventions);
- The impact of gender and on access and power relations between providers and patients, and between providers themselves (Gender, Social Exclusion);
- Global influences over health systems including health worker migration, trade in health, commercialisation and the role of the state (Globalisation);
- Community-participation and accountability (Social Exclusion);
- Health care for the urban poor, inter-sectoral action for health (Urban Settings).

TABLE OF CONTENTS

1 OBJECTIVES OF THIS REVIEW

The Commission on Social Determinants of Health has requested knowledge network hubs to provide:

1. an in-depth review and analysis of what is known about:
   (a) the priority associations between social determinants of health/health equity (with special emphasis on inequities in health);
   (b) the policies, programmes and institutional arrangements that positively enhance opportunities for greater health equity and;
   (c) the priority areas that the knowledge network will undertake.

2. an in-depth mapping of the country, regional, and global institutions and individuals currently doing work in the thematic area of the knowledge network.

This paper seeks to address these objectives for the health systems knowledge network within the limits of the time frames and resources provided. The concluding section of this paper, **Section 8**, comments, amongst other things, on the extent to which the paper has been able to meet the objectives.

2 APPROACH TO THE LITERATURE SEARCH

The review is based on literature sourced from within the consortium managing the hub as well as from institutions networked with the consortium members. Some key references from existing materials have also been followed up. Given the wide scope of work on health systems, it has not been feasible to conduct a general electronic search. Nor has it been possible to access substantial quantities of grey literature, given the difficulties associated with identifying and locating copies of this type of literature. It is anticipated that wider literature, including grey literature, will be fed into the review once the knowledge network has been initiated.

Because of time constraints, the focus of the review is on providing an overview of the full range of relevant topics and issues rather than a more detailed assessment of a limited set of topics. The paper focuses on *reviews* of international experience and articles documenting *new lines of investigation*. We have specifically sought out reviews that are in press or forthcoming to ensure as up-to-date an evidence base as possible.

3 STRUCTURE OF THE PAPER

In its work, the health systems knowledge network will consider three main questions:

1. How can one address the social factors influencing access to, and uptake of, population or public health interventions, health promotion and personal health services, particularly where these have an impact on equity in opportunities for health?;
2. How do key policies and organisational dimensions of health systems impact on access to population health interventions, health promotion and personal health care services, social differentials in heath outcomes, and other social determinants of health?

3. How can the policy space for health systems based on equity values be developed and maintained?

Section 5 draws on an analysis of the social factors affecting access to and uptake of services to provide an overview of the role of the health system as a social determinant of health, relating this to the Commission's conceptual framework. In so doing, it talks to question (1) above, although **Section 6** explores the answers to question (1) more fully, whilst at the same time addressing question (2). **Section 7** tackles question (3).

These sections are preceded by **Section 4** which provides some definitions. The concluding section, **Section 8**, highlights what appear to be the major areas of action required to improve equity and, in responding to objective (c) above, begins to identify priority areas that the knowledge network might want to undertake (finalising these areas requires further consultation with the Commission and the knowledge network itself).

Our overall aim is to outline the available evidence briefly and to draw conclusions based on that evidence. However, we recognise that at times we may err towards the more instrumental approach of apparently using literature to justify our argument. Where this occurs it reflects partly a degree of consensus across a range of reviews with which we concur, and partly the limits of the available evidence base.

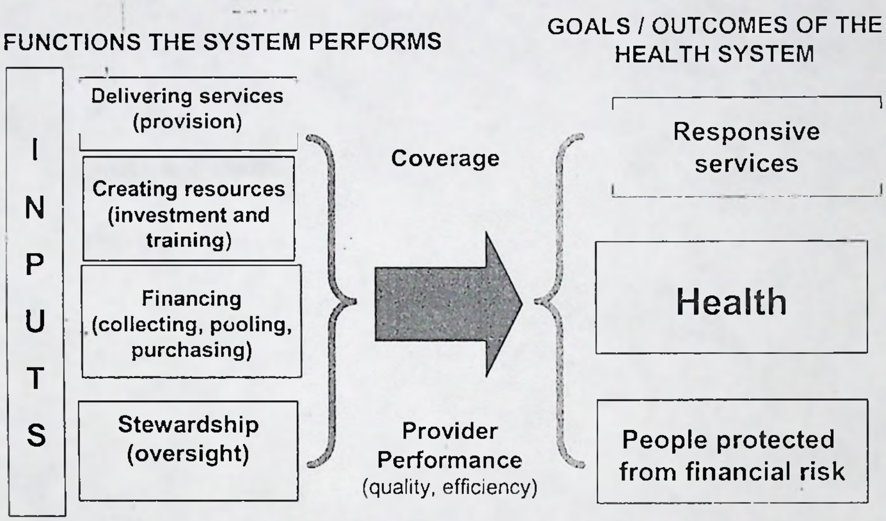
With respect to the in-depth mapping of institutions and individuals working in the thematic area of this paper, **Annex 1** provides a first draft of principles and approaches that could be used to guide the selection of knowledge network members. Further consultation with the Commission and others is required before the mapping can be finalised.

4 KEY DEFINITIONS

A ***health system*** includes all the actors, institutions and resources that undertake health actions, with ***health actions*** being all those interventions whose primary intent is to improve health. This covers promotive, preventive and curative actions. Although the defining goal of a health system is to improve population health, the World Health Organisation (2004) notes that health systems also have other intrinsic goals: they seek to be responsive to the population they serve and to ensure that the financial burden of paying for health is fairly distributed across households (see boxes in right-hand column of **Figure 1**). Thus, a health system is central to ensuring social responsibility for health and health care, bringing benefits to society that transcend individual gain. This role of the health system as an element of the social fabric of any country (Gilson 2003) is a particularly important feature in later discussions on the role of health systems in promoting equity.

A health system includes numerous elements, amongst them governance structures, different sources of finance, a range of financing intermediaries, different levels of care and different types of providers across the public and private (for-profit and not-for-profit) sectors, institutions in other sectors (especially water, sanitation and education), users and citizens. The World Health Organisation (2004) outlines four key functions that determine the way health systems transform inputs into the outcomes that society values (see boxes in left-hand column of **Figure 1**): the generation of resources, financing, service provision and the leadership or stewardship that organises other elements, reflecting and promoting social values and rights. The last function is the task of government as it has the ultimate responsibility for the performance of all national health systems (whatever the combination of public and private providers and financing intermediaries). This explains the importance attributed in later sections of this paper to issues of governance, accountability and power relations.

Figure .1: Functions and goals of health systems



Source WHO (2004)

An array of factors - including the broader socioeconomic environment as well as powerful actors and even those working within the health system - influence how these elements interact in practice to promote health (or ill-health) and health equity (or health inequity). Consequently, health systems are made up not simply of a set of technical processes and interventions. On the contrary, they are often the domain of political engagement and allow the expression of the interests of global, national and local elites. They are also shaped by the practices of those who work within them. As discussed later, this has implications for understanding how to encourage health systems to accept equity and social justice as the basis for achieving health and, consequently, as principles guiding their organization and operation.

Turning then to the concept of ***health equity***, this review uses the definition applied in the Commission's conceptual framework, namely, 'Health equity can be defined as the absence of unfair and avoidable or remediable differences in health among populations or groups defined socially, economically, demographically or geographically' (Commission on Social Determinants 2005c). Health equity is therefore more than just 'health equality:' it implies that the opportunity to benefit from health services is distributed according to need rather than according to factors such as income, insurance status, geographical location, gender or age.

High levels of existing inequity imply that interventions under focus in this review must primarily seek to allocate resources preferentially to those with the worst health status (***vertical equity***): until relatively recently, this concept has received less attention in the literature than horizontal equity, which refers to equal treatment for equivalent needs (Mooney and Jan 1997). As discussed below, this implies understanding and influencing the redistribution of social and economic resources for equity-oriented interventions in the health system, and understanding and influencing the power and ability people (and social groups) have to make choices over health inputs as well as their capacity to use these choices towards health' (EQUINET Steering Committee 1998).

As the Commission's conceptual framework shows, health equity is affected by a number of social determinants, only one of which is the health system (the concept of the health system as a social determinant is developed in a later section). Consequently, this paper is concerned with the degree to which the health system could, and does, address the causes of health inequity that are within its control. In doing so, it refers to examples of the 'health disadvantage,' 'gaps' and 'gradients' approaches to redressing inequity referred to in the Commission's conceptual framework (Commission on Social Determinants 2005c) whilst preferring, as discussed later, the 'gradients' approach.

Finally, in referring to those who typically have limited opportunities to utilise services within the health system, this document often uses the term '*the poor*.' Noting that this term is not intended to be used to label or stigmatise people experiencing different forms of deprivation, in defining this category, Goudge, Khumalo and Gilson (2003) include the following:

1. those on the margins of formal employment, who could be included within formal systems of employment;
2. those outside the formal sector, either self-employed or working in the informal sector, who are able to contribute towards their health care costs;
3. poor people who are not able to contribute to their own health care costs; and
4. the poorest groups who are not only not able to pay but also, due to social exclusion, exist on the margins of society where they are very difficult to reach (especially women and children, particularly in rural areas).

The review will integrate and explore these and other individual, family and social dimensions of poverty that impact on the opportunity to access and utilise services and resources within the health system.

5. HEALTH INEQUITY AND THE ROLE OF THE HEALTH SYSTEM AS A SOCIAL DETERMINANT

In this section we first review the available evidence on who benefits from health care services and what factors influence access to, and uptake of, these services. This perspective provides an entry point for considering the role of the health system as a social determinant and relating this understanding to the Commission's conceptual framework. Recognising the wider dimensions of health systems, as outlined in the definitions of the previous section, the paper will subsequently explore their service, resourcing and governance dimensions. Nonetheless, the focus of this section and indeed the paper, is on preventive and curative care provided through facilities, rather than on broader population health interventions, such as health promotion. This is partly because of time constraints and partly because of uncertainty with respect to the scope of this knowledge network viz-a-viz the knowledge network on public health interventions.

5.1 Who benefits from health care services?

Existing patterns of health system inequity clearly demonstrate how the opportunities to benefit from health care are themselves socially differentiated. Generated mostly quite recently, the available evidence from developing countries clearly documents the inequities of curative care provision.[3] A recent benefit-incidence analysis by Castro-Leal *et al.* (2000), for example, estimates the monetary value of curative services, and how that monetary value was distributed across the population, for seven African countries. They find that the share of spending that went to the poorest quintile of households was significantly less than that to the richest twenty percent. Gwatkin, Bhuiya and Victora (2004) quote a study of 21 countries across the developing world as confirming this trend: 'the top 20% of the population gained on average over 26% of total financial subsidies provided through government health expenditures [on curative services], compared with less than 16% in the lowest 20% of the population.' Schellenberg *et al.* (2003) show that, even within a rural Tanzania community that could have been assumed to be uniformly poor, utilisation was lower amongst the poorest families. Much less information is available on preventive or population health interventions, although some analyses of immunisation coverage suggest that it is also regressive (Gwatkin, Bhuiya and Victora 2004). While data are poor, it seems that there are considerably greater inequities in relation to private as opposed to government services even, in some cases, within the not-for-profit sector (Gwatkin, Bhuiya and Victora 2004).

One of the reasons for the distribution patterns discussed above is the predominance of spending on hospital-based, often urban services, which the poor generally do not use. Castro-Leal *et al.* (2000) make the point that 'budget re-allocations towards primary care would in themselves improve the targeting of spending to the poor,' an argument which is made convincingly by Starfield, Shi and others in work in developed and developing countries (see, for example, Starfield 2001, 2002 and 2005, Starfield and Shi 2004, Shi, Green and Kazakova 2004). Gwatkin, Bhuiya and Victora (2004) comment that all levels of care tend to be regressive but that 'poor-rich differences seem much larger for higher-level than for primary care.' Implicit in the thinking of later sections, therefore, is the assumption that district health systems development, and especially the development of capacity to deliver primary health care, is a necessary strategy for the promotion of equity.

Unfortunately, much of the literature that examines the impact of interventions on the poor does not differentiate the impact on women, nor look at the intra-household allocation of resources. However, Castro-Leal *et al.* (2000) were able to determine that women in the poorest quintile use health services less relative to their male counterparts than do women in rich quintiles. Thus, poverty and gender inequality combine to aggravate the health inequity experienced by women. Women are represented disproportionately in vulnerable population groups, are subject more to cultural and ideological influences that affect access to, and utilisation of, health services, and are confronted with higher opportunity costs in seeking care (Standing 1997). These problems persist despite extensive health sector reforms in the 1990s which, although having sometimes included improved equity as one of their objectives, in fact appear to have increased the cost of, and constrained access to, care for poor women (Ravindran and de Pinho forthcoming).

The available findings suggest that health care provision tends to reinforce social differentials, and so appears to support Tudor-Hart's 'inverse care law' which states that the availability of good medical care tends to vary inversely with the need for it in the population served (Hart 1971). This problem persists, even where interventions intended to benefit the poor are

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[3] See, for example : Schellenberg *et al.* 2003; Victora, Barros and Vaughan 2000.

introduced. Thus, whereas Victora, Barros and Vaughan (2000) found that the considerable gap between the poor and the wealthy in Brazil in the early 1980s was diminished after interventions were introduced a decade later, this only occurred where reduction in mortality was no longer possible for wealthier groups. In addition, they comment that their study of the Brazilian health system over more than twenty years suggests that most interventions reach the private sector (and therefore the wealthy) years before they are made available to the general population through government services. 'This has been the case for vaccines, antibiotics, surfactant therapy, neonatal intensive care, antenatal screening, and many other technologies … [I]n the rare event when new interventions are delivered through the governmental system but are not available commercially, the wealthy are also entitled to use them, and – being better informed – will acquire access to these technologies before the poor.'

While persistent health inequities appear to be the norm in many countries, there are instances where good improvements in life expectancy and child mortality have been achieved, including amongst the poor, even within the context of low per capita income. The most well-known of these are the three countries China, Costa Rica and Sri Lanka, and the Indian state, Kerala (Halstead, Walsh and Warren 1985, Commission on Social Determinants 2005a). The factors underlying these success stories are discussed in later sections.

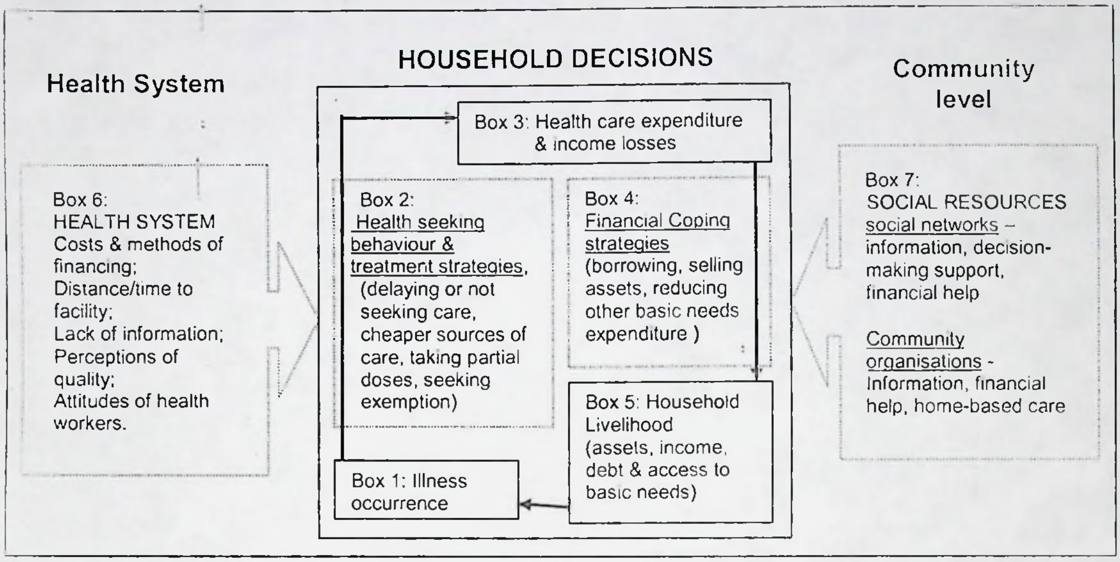
5.2 What affects access and influences differential consequences?

This section draws on a synthesised account of relevant literature, rather than providing a detailed review of the wide range of studies that exist in this field. It is important to note that health-seeking behaviour is very complex, as demonstrated by the different models that exist to understand it and the critiques of such models (Hausmann-Muela, Ribera and Nyamongo 2003).

The paragraphs below look, first, at barriers to accessing and utilising health care from the perspective of the household, and give some idea of how structural determinants combine with features of the health system to affect access and utilisation. Second, they consider some of the consequences of health care use in order to show how the health system may itself lead to differential consequences that reinforce pre-existing social stratification. This section draws on a guiding framework (**Figure 2**) that has been developed and applied in a series of studies investigating how poor households cope with the costs of ill-health (Russell 2001).

A variety of factors influence access to health services. When there is illness in a household (Box 1 in **Figure 2**), a number of decisions are made. ***First, is treatment of one sort or another needed for this condition and person?*** (Here, the term 'need' refers to the household's assessment of need, rather than the 'objective' assessment of need by a clinical expert.) If the household decides that it does need treatment, ***should the household self-treat, seek traditional or alternative treatment, or visit a Western provider, or use some combination of these providers?*** If care in the Western health system is needed, ***should the household seek care in the public or private sectors?*** The response to these decisions and the factors and environments underlying this response influence the differentials in access to, and benefit from, health services noted earlier.

Figure 2: Conceptual framework for understanding how households cope with illness-related costs



Source: Russell (2001)

A range of social factors, first, influence decisions about health-seeking behaviour (Box 2 in **Figure 2**), including some social determinants: :

1. Household livelihood (Box 5): It is a well-known phenomenon that the poor tend to self-rate their health status higher in relation to self-ratings by the more affluent, despite tending to suffer from more ill-health (for example, Castro-Leal *et al.* 2000 and McIntyre and Thiede forthcoming). Differential ratings may lead poorer households to refrain from seeking care when higher income households do, simply because poorer households cannot afford to be ill, that is, to take time away from income-earning activities. The household livelihood set encompasses not only the security, sources, levels and distribution of income but also the assets and endowments that households have individually and draw from social groups (such as extended families, community networks and formal collectives).

2. Cultural beliefs about disease and healing (linked to Box 2). These shape how households understand illness and may prevent households from identifying illness or suggest that, as illness has social causes, it cannot be effectively treated by providers operating within the Western medical paradigm. Interestingly, Russell (2004) notes that widespread public confidence by Sri Lankans in the effectiveness of Western medicine as a system of treatment – and the explicit role taken on by the state in ensuring that this care is universally available - contributes to the willingness of households to contemplate using Western providers, despite a tradition of using Ayurvedic medicine.

3. Power relations within the household (underlying all household decision-making). As mentioned earlier, there is little literature looking at the intra-household allocation of resources (Standing 1997). However, it is known that women are represented

disproportionately amongst the most vulnerable and that their access to health services is often curtailed by socio-cultural factors. Power relations within the household are likely to determine who is allowed to seek health care (and what sort of health care). This, together with greater opportunity costs, may account in large part for low utilisation rates amongst poor women (see, for example, Castro-Leal 2000, Standing 1997).

Further, social norms, such as the emphasis on 'innocence' in young women in some societies prevents them from seeking information about sex or services relating to their sexual health. Social stereotypes about sexual behaviours, including the acceptability of older men 'marrying' much younger women, increases the risk of HIV infection in the next generation (Rivers and Aggleton 2003).

Unfortunately, social and cultural norms cannot be easily characterised: they have been caught in the rapid transition of cultures over the past 100 years, influenced by colonialism, migrant labour systems, traditional values and urbanisation (Voluntary Services Overseas 2003). Nor are they always amenable to simple assessment. The weakness in current levels of understanding of the role of stigma in HIV transmission, for example, is evident in inequity in the uptake of health services for prevention and control of AIDS.

Stigma is, for example, not simply a psychological response. It may be a means to respond to disease without challenging the conditions that cause it (Bond 2002). Society needs to explain or control disease, and blaming the victim is one response used as people seek to isolate and distance themselves from the problem. The negative impact of such a response is to make stigmatised people responsible for taking action on their affliction, rather than society as a whole (Bond 2002). This can leave the underlying structural causes of the disease untouched, as has been the case with females or adolescents. Stigma is thus a way of sustaining power relations. Groups already 'scapegoated' for other reasons, including migrants, commercial sex workers and poor women, are more vulnerable to such stigma. AIDS-related stigma plays into, and reinforces, class, gender, sexual and racial inequalities in society (Bond 2002, Jenkins 2000).

4. Knowledge about illness and appropriate treatment options (linked to Box 2). The poor tend to be less educated, have less access to information, and less knowledge about health and health care issues (Bennett forthcoming). Hence, they are less likely to identify correctly when treatment is needed or to know where to access such treatment. This underlines the importance of health promotion.

5. Access to social networks and resources (Box 7): The social networks and resources available to households may provide information used in determining whether and where to seek care, or may be a source of cash used to purchase care or pay for transport costs (see below). However, the limited available evidence suggests that these resources may be distributed differentially across households according to their income level (Russell 2004).

   Interestingly, in South Asia, despite a rapidly growing HIV epidemic, there is a prevailing silence about violence against women and girls (including domestic violence, abuse in the working environment, sexual abuse and other forms of exploitation that they experience in the process of earning a living). While there are reported to be high levels of social cohesion in these societies, this has not broken the silence and enabled the societal acknowledgement of behaviours that increase risk of HIV infection, which leaves individuals susceptible to risk and impedes individual and social prevention efforts (Shah *et al* 2002).

Young people face similar dissonance between social norms and reality, undermining the support they get from adult society. In many societies, the family and immediate community traditionally provided young people with information and guidance about sex and sexuality. In many parts of the world, however, recent and rapid urbanisation and migration have dispersed and weakened family and community networks, leading to the youth using other sources of information (Rivers and Aggleton 2003). In Zimbabwe, for example, surveys have found that sexual information tends to be obtained not from family members, but from the media, school and friends

A second set of factors influencing access, namely health system features, interact with broader social factors, as shown on the left-hand side of **Figure 2:**

1. <u>Geographic barriers</u>. The poor – whether they live in rural or peri-urban settings – tend to have worse geographic access than urban dwellers, as historically health care facilities tend to have been located in urban settings (Bennett forthcoming). This acts as a deterrent to seeking care.

2. <u>Drug availability</u>. The availability of drugs has a specific influence over health-seeking behaviour and limited availability can be enough by itself to lead patients to use alternative providers. Indeed, the expectation of drug availability at private providers is one factor underlying the use of these providers even by the poor.

3. <u>Financial barriers</u>. These act in numerous ways to prevent access to health care. User fees, which represent *the immediate and direct* costs of health care, tend to be widespread, even in low-income countries and even for public services and, as discussed later under financing mechanisms, have a history of deterring the poor from seeking care. Apart from official user fees, there may also be unofficial fees charged by health workers unhappy with their government salaries, either because the amount is too low or because payment is irregular. Unofficial fees may be monetary or paid in kind, and may be paid to professional health workers, other types of staff or even to the facility itself (Goudge, Khumalo and Gilson 2003).

   The immediate but indirect costs of accessing health care are also a deterrent, and many exceed direct costs considerably (McIntyre and Thiede forthcoming). These may include travel costs and the opportunity cost of missing work and neglecting other duties (for example, Castro-Leal *et al.* 2000, Bennett forthcoming).

4. <u>The responsiveness of the health sector</u>. There is considerable evidence to show that even poor households make use of the private sector (Bennett forthcoming), partly because private providers may be physically more accessible, especially in remote areas, and also because of the better responsiveness of the private sector compared to the public sector (supporting evidence is provided in **Annex** 4 under point (i). The features that ensure that influence the responsiveness of health care providers include:

i. *The availability of an appropriate range of services.* This is discussed under the section on priority-setting.

ii. *Convenient services* in terms of:
   - <u>Opening hours</u>. The opening hours of public services – and the time taken waiting in queues - deter access, especially for daily wage earners who are reluctant to lose earnings (Russell 2005, Bennett forthcoming).

- The integration of services. Integrated services allow patients to receive a number of services at one visit. This helps to minimize the time taken up by seeking health care.

iii. *Respectful treatment* including (Gilson, Palmer and Schneider 2005):

- Positive, courteous attitudes and behaviour, including listening to, and taking time with the patient. There is evidence from many settings that poor health worker attitudes undermine the performance of public services (for example, Russell 2005, Freedman *et al.* 2005, Bennett forthcoming). One example is recounted by a South African study where public sector staff were characterized as being rude, showing favouritism and ignoring the needs of patients (for example, by taking tea breaks while patients are waiting and sending them away without being seen at the end of the day). Health workers tend to treat poorer patients more dismissively which can act as a deterrent to accessing public health care, and contribute to the diversion of patients to the private sector.
- Thoroughness. In public settings high workloads mean that clinicians cannot perform proper consultations and rush through their encounters with patients (for example, Gilson, Palmer and Schneider 2005).
- Good communication which allows a reciprocal relationship between providers and patients.
- Technical competence. While this may be perceived to be superior in the private sector, in reality the clinical quality of care provided by private providers is often indifferent and sometimes poor, either due to lack of knowledge or due to distorted incentives, especially arising from payment mechanisms (Bennett forthcoming). In addition, private providers seldom provide public health services (such as immunisation, antenatal care and TB care).
- Continuity of care. This is valued by patients, even poor patients, and tends to be a feature more of private than public providers.
- Privacy and confidentiality, including to reduce stimgatisation. As noted in the earlier discussion stigma as a social phenomenon may deter people from accessing services of a sensitive nature, particularly where their past experience of health care providers has shown a lack of respectful or courteous behaviour or where using such services will have wider social repercussions. The lack of privacy in many public sector settings drives even poor people to use the private sector (with consequent economic implications)(see, for example, Gilson, Palmer and Schneider 2005).

Several of these features of responsiveness combine to create patient 'trust' in the provider, and wider health system (Gilson, 2003). Russell (2005) defines trust as, 'user confidence that the health worker, and the system which they represent, works for the best interests of the patient and has the technical and personal competencies to do so.' Patient trust is important because it allows patients to have confidence in the motives and decisions of the provider, given that they are in the vulnerable position of experiencing uncertainty around their condition and have little medical knowledge. In addition, it facilitates communication, patient focus, patient disclosure and adherence, and ultimately enhances the utilization of health services (Russell 2005, for example). Inherent in the definition of patient trust in the provider is acknowledgement of the fact that trust can be invested at both the personal and institutional levels (see **Box 1**). As mentioned in an earlier section, the state can promote trust through commitments to equity (as is the case in Sri Lanka).

Box 1: Features of patient trust in the individual health worker and the health system

Personal level trust

- Develops through face-to-face encounters with providers (both medical and non-medical);
- Needs time to develop;
- Is influenced by levels of trust in wider society; and
- Can bolster or undermine institutional level trust.

Institutional level trust

- Allows patients to trust the system without personal knowledge of the health workers representing the system; and
- Is based on an awareness that, for example:
    - the health system has a track record of being able to perform expected delivery functions such as ensuring the availability of staff, pharmaceuticals and equipment;
    - the system is based on norms, procedures and other institutions that support fair treatment;
    - health worker remuneration systems that support professional practice;
    - there are professional training systems in place to ensure high standards;
    - there is institutional oversight such as licensing, ethical codes, quality controls, and disciplinary procedures to maintain standards;
    - there are procedures in place that ensure health worker accountability.

Source: Adapted from Russell (2005), Gilson, Palmer and Schneider (2005)

Finally, **Figure 2** shows that the interaction between household health-seeking behaviour and experience of the health system generates important health and economic consequences (Boxes 4 and 5). The long-term costs to households of seeking care may consume a significant share of poor household's income (McIntyre and Thiede forthcoming). In part, these costs are generated by the geographic availability of care, the price of care and the nature of the care provided. For example, inappropriate drug consumption as a result of inappropriate prescribing of drugs by providers or irrational use of drugs by households (such as not purchasing or using the full regimen, using several drugs, demanding unnecessary injections) adds to the costs of accessing care, as well as possibly generating negative health outcomes with longer-term costs (Homedes and Ugalde 2001, Goudge, Khumalo and Gilson 2003). Similarly, poor referral systems and poor chronic disease care may increase the costs of accessing care, as well as generating poor health outcomes. Also important to the long-term costs of care are the indirect costs resulting from loss of income.

The literature currently suggests that total cost burden levels of 10% of total household income or 40% of non-food income are catastrophic for household livelihoods (Xu *et al.* 2003). However, even lower levels of cost burden may be too much for poor households to bear (Russell 2002). Impoverishment may result from the use of savings, sale of assets and increased indebtedness as a result of having to finance care out-of-pocket, especially in the case of long-term chronic illness, such as AIDS. Impoverishment can be aggravated when financial barriers lead to the decision not to seek treatment, resulting in severe or chronic illness and even death (McIntyre and Thiede forthcoming). As Russell (2005) found in Sri Lanka, the urban poor are particularly vulnerable to further impoverishment because they tend to be unskilled and, if they are in the formal sector, earn daily wages; they also tend to have less access to the social resources that could help them to cope with illness and the related costs. In contrast, higher income groups are more likely to have financial protection against health care costs, access to sick leave benefits and access to social resources (McIntyre and Thiede forthcoming).

Overall, therefore, the differential opportunities to access care and the differential consequences of accessing care feed back into the production of social differentials in the opportunities for health. Indeed, the way in which the social and health system factors influencing patterns of health care access and use across population groups are managed demonstrates the extent to which the system reproduces the dominant social and economic patterns.

5.3 A framework for understanding the health system as a social determinant

Drawing on the experience presented in **Sections 5.1** and **5.2**, **Figure 3** presents this paper's application of the Commission's conceptual framework to the health systems domain. The boxes in the upper section of the Figure describe the 'vicious cycle' set up by inequity, with social stratification leading to differential exposure and vulnerability to ill-health, leading to health inequity and then on to differential consequences of ill-health, which in turn reinforce and perpetuate social stratification.

The boxes in the lower section of the Figure show how social determinants influence this cycle. Structural determinants (such as income, education, gender, ethnicity and social cohesion) set up social stratification. The dotted arrow above this box symbolises policies and interventions that may influence structural determinants so that they worsen social stratification, leave social stratification untouched, or confront social stratification so that the 'vicious cycle' becomes less intense or disappears (much of the rest of this paper is concerned with identifying policies that achieve the latter). Negative or neutral impacts on equity may reflect a failure to respond to equity concerns (deliberately, unwillingly or inadvertently) or problems with implementation.

Intermediary determinants ensure that social stratification is carried forward into the next steps of the cycle (again, policies and interventions may influence these determinants in a negative, neutral or positive way, and may reflect either a failure to develop policy or a failure to implement).[4] Amongst these intermediary determinants, living conditions, working conditions and food availability have primarily been seen to influence the generation of differential exposure and vulnerability (but may have impacts further along the cycle as well, as shown by the Figure). The health system has primarily been seen to influence the translation of differential exposure and vulnerability into health inequity through providing access to health care. However, it also has prior impact through contributing to the barriers to adopting health-related behaviour, and subsequent impact through the creation of differential consequences (for example, by leading to the impoverishment of households due to high user charges).

Importantly, structural and intermediary determinants influence one another (as shown by the double-lined arrows between the two grey boxes). Thus, gender inequalities in society at large may translate into power relations within the health system that favour men and lead to decisions within the health system that reinforce patterns of gender-based access to resources. Conversely,

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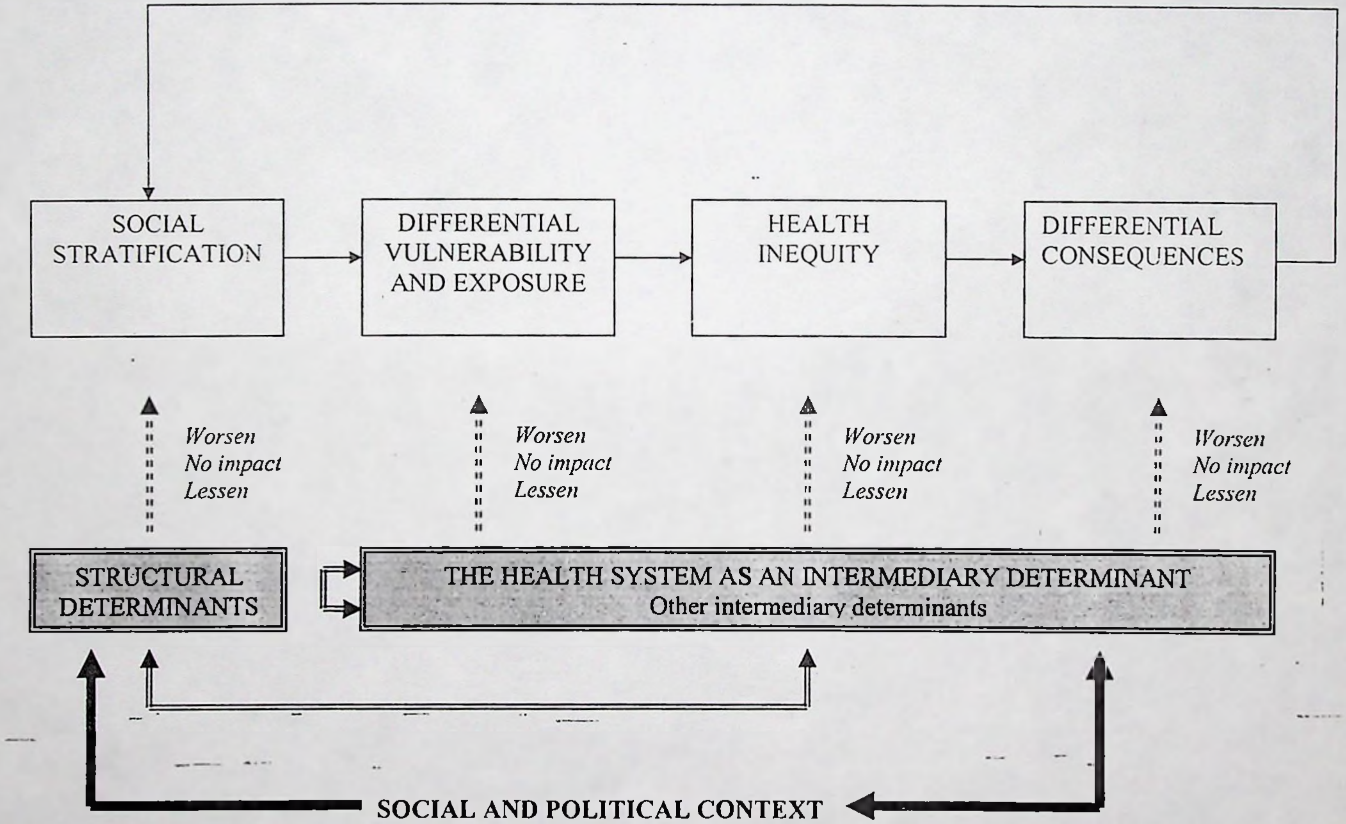
[4] For example, the health system can a) fail to identify or mount a response to an existing inequity (for example, by failing to include reproductive health services in an essential package), b) aggravate an existing inequity and its differential consequences (by imposing retrogressive user fees which lead to impoverishment) or c) fail in its implementation of an intervention (for example, by failing to target the poor appropriately through an exemption mechanism for user fees).

health system features that reduce social exclusion within communities, for example, could elevate the status of marginalised communities, improving their access to resources in general. These features might include participatory decision-making structures or mechanisms for ensuring health system accountability to the population. Likewise, there is interaction between the various sorts of intermediate determinants (as shown by the double-lined arrow that loops back on itself just to the left of the intermediary determinants box), with health policy literature paying particular attention to the potential for the health sector to influence policies around social welfare, education, nutrition, water and sanitation, in the interests of good health. This implies that policies to reduce health inequity must of necessity be multifactoral.

As the dark arrows at the bottom of the Figure show, the social determinants of health arise within a wider global, national and local context of values, rights and macro-level policies that influence health. The impact of globalisation is pertinent here. For Mackintosh (2001), then, 'health care systems, as social institutions, are built out of the existing social structure, and carry its unique inequalities within them.' As a result 'unequal legitimate claims upon a health care system, and unequal experiences of seeking care, are important elements of poverty and social inequality in people's experience.' This is echoed by the UN Millenium Project's Task Force on Child Health and Maternal Health which states that 'as core social institutions, dysfunctional and abusive health systems intensify exclusion, voicelessness, and inequity, while simultaneously defaulting on their potential – and obligation – to fulfill individuals' rights and contribute affirmatively to the building of equitable, democratic societies' (Freedman *et al.* 2005).

The bi-directional nature of the arrow between 'context' and the health system adds a new element to the Commission's framework, pointing to the potential for policy change within and by the health system to influence that context. Indeed, following Mackintosh (2001), we suggest that health systems are 'a key site for contestation of existing inequality.' For example, health systems can play a role in addressing social inequalities through redistribution. Health systems in many developed – and a few upper-middle income countries such as South Korea and Costa Rica – have performed this role as a basis for addressing social inequality and exclusion (Koivusalo and Mackintosh 2004). The welfare state in Western European countries such as the United Kingdom, Scandinavia and Germany also highlight the redistributive role that health systems may play. They tackle inequalities through applying the policy principles of inclusion, universality and solidarity. This arena for policy action – that is, the policy space associated with the health system's efforts to tackle inequities - is the focus of **Section 8**.

Figure 3: Framework demonstrating the role played by the health system as a social determinant of health



6. ADDRESSING POLICY AND ORGANISATION IN THE HEALTH SYSTEM TO PROMOTE EQUITY

This section looks at aspects of the health system that have the potential to undermine or generate equity-promoting interventions.

6.1 Priority-setting

There is increasing evidence that health services – particularly those provided by the public sector - tend to fail to match the needs of the poor in terms of the range of services provided. This is partly because, as discussed in a later section, the poor tend not to have a voice in determining priorities (Bennett forthcoming).

Indeed, for much of the 1990s, priority-setting in the public sector has been associated with the implementation of 'essential packages of care' determined at a national, and even global, level. The concept of a 'package' was promoted by the 1993 World Bank Report, *Investing in Health*, which developed an illustrative package based on estimations of the main causes of the burden of disease, and cost-effectiveness analyses of interventions targeted at these main causes (World Bank 1993). For thinkers in the World Bank, this process of prioritizing services was intended to benefit the poor enormously, as it would supposedly deliver highly cost-effective interventions against conditions that disproportionately affect the poor.

As summarised by Doherty and Govender (2004), the World Bank approach to determining service packages has been critiqued for several reasons. These include methodological problems in the calculation of the burden of disease and cost-effectiveness, which raise questions around the appropriateness of interventions included in the package. Another critique centres around the dominance of efficiency concerns, rather than equity, in the construction of the package. Paalman *et al.* (1998) note that 'the fact that the most efficient interventions ... tend to specifically benefit the poor is more a result of coincidence than of principle.' Musgrove (2000) quotes Gwatkin and Guillot (1998) as substantiating this finding more fully. Thus, the cost-effectiveness approach does not intrinsically protect equity. Indeed, cost-effectiveness principles might argue against the extension of services to populations in remote areas, as the cost of delivery increases in such circumstances.

Consequently, World Bank (1993), Bobadilla *et al.* (1994) and Musgrove (2000) all emphasize that governments need to make explicit choices between equity and efficiency concerns when prioritizing services (implying that a political decision could be made to prioritise equity at the expense of efficiency). Nonetheless, Rannan-Eliya (2001) rejects the cost-effectiveness approach outright, stating that 'cost-effectiveness of interventions and a disease-focused approach to allocational efficiency are irrational and inefficient guides to resource allocation and may lead to erroneous use of resources.' He states on the basis of the Sri Lankan experience that 'unless equity of access is the highest priority, choices about rationing will be made which inevitably hurt the poor' (Rannan-Eliya 2001). These sentiments are shared by Alvarez-Castillo, Ravindran and de Pinho (forthcoming), who argue that this priority-setting approach is intrinsically unfair, especially to poor women, as many of their health care needs are under-estimated and hence excluded from the package of government-financed services.

The critique of the dominance of the World Bank approach to priority-setting in the 1990s is part of a broader discomfort with the role of 'global policy elites' in the determination of developing country policies and programmes (as expressed, for example, by a book – Ravindran and de Pinho (forthcoming) - produced by the Initiative for Sexual and Reproductive Rights in Health Reforms). Apart from distorting national priorities and encouraging the development of vertical programmes, this has contributed to the fact that 'health systems have been too readily reimagined as a collection of cost-effective interventions and strategic purchasing' (Mackintosh and Koivusale 2005). Thus, for example, Gwatkin (2000) cautions that there is a danger that the current drive to meet international targets will result in coverage being extended amongst easier-to-reach, and therefore wealthier, sub-populations.

Another weakness of past international health care initiatives has been that, whilst focusing on services that, in theory, would disproportionately benefit the poor, they have seldom addressed the enormous problems associated with ensuring that these services reach the poor on the ground (Bennett forthcoming). Thus, for example, a pro-poor essential package in Bangladesh was undermined by other barriers to access facing the poor (Ensor *et al.* 2002). While recently popularised Poverty Reduction Strategy Papers for governments are potentially a valuable tool for ensuring that the health care needs of the poorest are prioritised, focussing as they do on mechanisms for poverty alleviation, including the reduction of geographic and financial barriers to health care, they tend also not to address the enormous challenges of effective implementation (Bennett forthcoming) (the inherent and continuing weaknesses in developing country health systems are discussed in more detail later).

In trying to understand the impact of essential packages, it is noteworthy that, while many countries have adopted the approach, these have seldom been evaluated. However, a recent experiment which has attempted to use evidence on burden of disease and cost-effectiveness to prioritise and deliver services at the district level in Tanzania is TEHIP or the Tanzania Essential Health Interventions Project (see point (ii) in **Annex 4** for a description of some of TEHIP's activities). In TEHIP, priority-setting was driven more by the shares of the burden of disease that cost-effective interventions could address, and cost-effectiveness knowledge was used only to eliminate interventions known to be grossly cost-*in*effective.

The net effect of decentralized basket funding plus the health system inputs described in point (ii) in **Annex 3** was a relative and absolute increase in resources for the delivery of prioritized, cost-effective interventions addressing the largest shares of the local burden of disease, an increase in the utilization of government health services, and a decrease in mortality in infants, children under five, adolescents and adults. This was achieved with relatively limited resources. The district health systems received health-basket incremental funding of about US $0.92 per capita per year additional to conventional district health budgets that covered salaries, supplies, drugs and vaccines (personal communication with Don de Savigny, former TEHIP research manager). TEHIP shows that, as seen in the Bamako Initiative, a dynamic process of using local (rather than national) information coupled with local problem-solving, planning and ownership is vital for appropriate decision-making and consequent implementation.

The importance of combining local decision-making with co-ordinated efforts to improve the functioning of the local health system is expressed within a new concept called 'MESH', which is based on the experience of resource allocation for Aboriginal health care in Australia and being proposed in South Africa (Thomas *et al.* 2005). It is based on Mooney's proposals for using capacity to benefit as a key principle in resource allocation (Mooney 2003), which involve four steps: establish the good to be achieved, in collaboration with those who will benefit; see how that good can be made better with the resources available; where regions need help creating the infrastructure needed to do better, adjust the allocation formula to allocate funds for this purpose; and make due allowance in the allocations for variations in the cost of access across regions. The infrastructure of relevance is encapsulated in MESH, referring to the Management, Economic, Social and Human infrastructure necessary to create a sustainable and effective foundation for primary health care. Here, management capability refers to the management of finances and service provision as well as leadership, the process of eliciting community preferences and health care needs, and planning infrastructural improvement. Building economic infrastructure relates to improving geographic access to health facilities and the development of other amenities, services and employment. Social cohesion includes unity and organization within communities, as well as interaction between communities and government and between the different spheres and sectors of government. Human infrastructure includes the effective deployment of human resources and the development of appropriate skills. The concept of MESH locates priority-setting firmly within a comprehensive approach to local health system development, drawing together many of the concepts that are discussed later in this paper.

6.2 Resource allocation

Resource allocation processes tend to favour better-off areas and communities (Bennett forthcoming). To counter this, needs-based formulae are a mechanism that has emerged in the 1990s to re-direct financial (and hence other) resources to more needy areas, especially rural areas with less-developed health services. At their simplest, these formulae depend entirely on estimates of relative population size and EQUINET Resource Allocation Theme Group (2005) have shown that such formulae may be perfectly adequate in estimating the direction and size of resource re-allocations in low-income contexts. More complex formulae adjust population figures according to age and sex breakdowns and standardised mortality ratios. In countries with sophisticated data, like the United Kingdom, deprivation indices are also included. In fact, McIntyre, Muirhead and Gilson (2002), using data from South Africa and deploying small area analyses, were able to develop a general index of deprivation in a data scarce context, and show that, because of its close correlation with ill-health, it would successfully lead to more equitable resource allocation among provinces if included in the current, less sophisticated formula. The index also has the potential to be useful for intra-provincial resource allocation, in order to deal with the problem of identifying pockets of deprivation within better-off provinces.

Different forms of decentralisation can work together with resource allocation formulae to shift expenditure patterns at the local level. Bossert *et al.* (2003b), in a study in Colombia and Chile, found that equitable levels of per capita financial allocations were achieved at the municipal level, with local funding choices and, in the case of Chile, a horizontal equity fund, adding to the impact of a formula. Importantly, the equity fund partially re-allocated resources raised by wealthier municipalities to more disadvantaged ones. Although resource re-allocation is more likely to succeed under devolved systems (for reasons discussed further in the section on decentralisation), Bossert, Chitah and Bowser (2003a) found that, under the Zambian system of more limited decentralisation, equitable resource allocation between districts was achieved by means of a formula. Equally, though, there have been several instances where decentralisation and/or formulae have not led to a reduction in the overall level of inequity (Goudge, Khumalo and Gilson 2003).

Resource re-allocation is not simply about the technical process of deciding on relative need. Green *et al.* (2000), Okorafor *et al.* (2005) and EQUINET Resource Allocation Theme Group (2005) all comment on the strong political interests that are challenged by such formulae. These are likely to block change (as was the case when decentralisation reforms were introduced into an area in Pakistan (Green *et al.* 2000), especially when the capacity of technicians can be called into question. An exception may be where re-allocation formulae focus simply on allocating new funds to poor areas, rather than re-distributing existing funds (as was the case in Colombia (Bossert *et al.* 2003)). In addition, the process of shifting resources needs to be well-paced and managed, to ensure that new funds are absorbed and utilised effectively. The MESH approach described above is partly a mechanism to build the capacity to use resources into the resource allocation formula itself (Thomas *et al.* 2005). Essentially, the aim is to complement the redistribution of operating costs with the addressing of MESH infrastructural needs, especially in cases where there are backlogs. In South Africa, this is especially important at the primary health care and district level, as these services are being eroded by resource allocation mechanisms under a system of fiscal federalism (Okorafor *et al.* 2005).

6.3 Financing health care and health

This section deals both with some of the major sources of finance (including household sources such as out-of-pocket payments and insurance premiums, development aid and government allocations of tax funding) as well as some pertinent pro-equity mechanisms for targeting funds, namely vouchers and conditional cash payments.

6.3.1 Cost-recovery mechanisms

A number of cost-recovery mechanisms have emerged since the late 1970s to deal with chronic resource shortages faced by the tax-funded public health sector. In attempting to assess the evidence generated since 1995 on the impact of these mechanisms on access in low-income settings, Palmer *et al.* (2004) comment that, despite the diversity of the literature, hard evidence is limited and is seldom generalisable. The methodological weaknesses faced by the studies that they reviewed are summarized in **Box 2**, and are illustrative of the problems generally experienced with the literature on health systems and equity.

Box 2: Weaknesses of studies that investigate the impact of financing mechanisms on access in low-income settings

- Studies tend to be descriptive.
- They are on a small scale.
- They have limited socio-economic data, including because studies tend to use data initially intended for other purposes.
- Baseline data are limited.
- Controls are absent, including because studies tend to make use of natural experiments.
- There are sampling problems.
- Effects are measured over only a short timeframe.
- The desired outcome of the intervention is not clearly defined.
- More than one intervention is implemented at a time, making it difficult to disentangle effects and control for confounding variables.
- Except for three studies, in Columbia, Mexico and Niger (see below), evaluations are not set up prior to, and alongside, implementation.
- They do not examine the reasons that explain why implementation occurred as it did.

Source: Palmer *et al* (2004)

Nonetheless, it is possible to draw some conclusions from the international literature. Different mechanisms for cost recovery are discussed below, in order of the increasing degrees of cross-subsidy that they achieve. The evidence presented below makes it clear that, in order to promote equity, governments need to take a comprehensive approach to financing arrangements that is based on the principle of solidarity, that ensures that sufficient cross-subsidies between the rich and the poor are achieved through one or other mechanism, and that financial protection is afforded in the face of catastrophic illness (McIntyre and Gilson 2005). There is overwhelming evidence that private financing does not fulfil these criteria and, on the contrary, worsens inequity (see **Section 7.4**).

1. <u>User fees</u>.[5] Although often justified on the grounds that the increased revenue generated will improve the quality and quantity of services, as well as put an end to informal charging, user fees tend to create a financial barrier to accessing care, and to preventive care in particular. User fees represent a greater burden for poor households (van Doorslaer *et al.* 1999, McIntyre and Thiede forthcoming), contributing to exclusion and self-exclusion from health care.[6] This is confirmed by, amongst others, Gilson *et al.* (2002), Ravindran and Maceira (forthcoming) and Bennett (forthcoming). Conversely, in South Africa in the mid-1990s, when user fees were removed for primary care services in the public sector, utilization increased. Utilization also increased more recently in Uganda with the abolition of user fees (see, for example, Laterveer, Munga and Schwerzel 2004). However, the extent to which user fees deter utilization – and for what kinds of services – is not clear, especially when quality improvements are introduced simultaneously. In addition, indications are that the extra revenue generated for public services by user fees is relatively limited, especially when collection costs are taken into account (for example, Bossert, Chitah and Bowser 2003, Laterveer, Munga and Schwerzel 2004).

   The equity impact of user fees has led to calls for their abolition in developing countries. While Gilson and McInytre (forthcoming) support this notion, they caution that fee removal is not a simple exercise. In particular, additional resources need to be made available to the health system so that it can deal with the increased utilisation that follows on fee removal, while health workers need to be consulted and supported to avoid problems with morale as workloads increase (see also **Section 7**). If user fees are retained, it is critical that exemption mechanisms for the poorest are simple and effective: currently, the poor tend not to benefit from exemptions (Palmer *et al.* 2004, Ravindran and Maceira forthcoming). Those eligible for exemption should be identified *prior* to needing health care, as it is ineffective and unfair for health workers to make this decision. A variety of means is available to identify the poorest (for example, Ravindran and Maceira forthcoming). Mechanisms also need to be put in place to avoid regional inequities arising from the differential ability of public facilities to raise user fees (as was found, for example, by Bossert, Chitah and Bowser 2003 and Ravindran and Maceira forthcoming). This might include an 'equity fund' which re-distributes a proportion of user fee proceeds to worse-off districts (Bossert, Chitah and Bowser 2003).

2. <u>Community-based insurance</u>. Such schemes have potential for improving access because of their ability to pool risks and protect the poor against catastrophic costs (McIntyre and Thiede

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[5] Most of the research on user fees derives from Africa, although there is also some evidence from Brazil and China.

[6] Except in a Ugandan study in which some rural facilities saw a rise in utilization.

forthcoming). Indeed, evidence quoted in Palmer *et al.* (2004) and Ravindran and Maceira (forthcoming) shows that community-based insurance has a greater equity impact than user fees. For example, utilization increased for the insured versus the uninsured (who had to pay user fees) in a Rwandan study, and the probability of utilization within the insured group was similar for different socioeconomic groups, whereas amongst the uninsured it was higher for the better off. Likewise, a study in Niger showed a significant increase in uptake by the poor, women and children in a district imposing a local tax plus a small user fee, versus a district simply using a higher user fee (Palmer *et al.* 2004).

However, while numerous community pre-payment schemes have been set up (across Africa and Asia, in the main), they tend to be small in size and suffer from low levels of enrolment. The data for such schemes tend to be weak, and Palmer *et al.* (2004) comment that analyses over-emphasise the value of achieving higher levels of enrolment and improving the financial health of schemes, and under-emphasise the real benefits to enrolees and communities, including equity gains. There is little evidence on how to scale up successful schemes, or explanation of what makes some schemes fail.

One exception is the increasingly detailed information that is emerging from Vimo SEWA[7] in India (see, for example, Ranson 2002, Ranson, Sinha and Chatterjee forthcoming). Apart from life and assets insurance, Vimo SEWA has provided voluntary insurance for hospitalisation to informal sector workers in Gujurat since 1992. Data suggest that the scheme does provide beneficiaries with *financial protection*, but that this protection is less for those with more expensive hospitalisations. Factors limiting the degree of financial protection include capping of benefits, the lag time between discharge from hospital and reimbursement, the high rejection rate of claims, and the difficulties and costs beneficiaries face in compiling supporting documentation for claims. Data with respect to *increased access* were inconclusive because of data deficiencies. Ranson, Sinha and Chatterjee (forthcoming) note that the rural poor face long distances and high transportation costs in accessing care, problems which an insurance scheme cannot address and which require government investment in infrastructure. With respect to *giving the poor a voice to shape health care services*, the scheme has been very successful. Nonetheless, there are a number of shortfalls with respect to influencing provider behaviour, some of which relate to the lack of a regulatory framework.

In discussing the limitations of community-based financing schemes, McIntyre and Thiede (forthcoming) note that community-based insurance is really only a mechanism for the poor to pool their risk, and does not achieve what would be more important cross-subsidies, namely from the rich to the poor. As prepayment is voluntary, it is likely that it is the very poorest who are not able to join these schemes, or who default soon after enrolment (Ravindran and Maceira forthcoming). Especially as the coverage by such schemes tends to be low, community financing arrangements should therefore be seen as complementary to, and not as substitutes for, other financing arrangements that achieve greater cross-subsidisation (Ekman 2004).

3. National and social health insurance. This form of insurance is mandatory for the population it targets, and engineers income cross-subsidies from the more affluent to the poor. It therefore has the potential to impact considerably on equity. However, Palmer *et al* (2004) note that most studies investigating national and social health insurance are descriptive in nature. What data there are (for example, from Columbia and Costa Rica) tend to be

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[7] Self employed Women's Association.

inconclusive. However, a recent article from Thailand (which, in recent years, has achieved universal coverage) shows that it has been able to demonstrate a reduction in the incidence of catastrophic expenditure and the number of households that were impoverished as a result of out-of-pocket health care payments (Limwattananon, Tangcharoensathien and Prakongsai 2005).

There is some indication, though, that, where insurance does not have universal coverage, it can lead to widening inequity between those belonging to a scheme (typically those employed within the formal sector) and those who do not (typically those employed within the informal sector) (Ravindran and Maceira forthcoming)). In addition, health insurance premiums can be inequitable when there are insufficient cross-subsidies between income and risk groups: there is some evidence from Latin America, for example, that women are charged higher premiums (because of the costs associated with reproduction) (Weller *et al.* forthcoming). An innovative solution to such problems may be a system which is being proposed in Ghana. This seeks to combine social health insurance for formal sector workers with district-wide community-based pre-payment schemes. Contributions for low-income households will be subsidised by government and donor funds, while there will be risk-equalisation between all the individual schemes that make up, in effect, a universal national health insurance system (McIntyre and Gilson 2005).

6.3.2 Development aid and government allocations of tax funding

The WHO Commission for Macroeconomics and Health demonstrated that the health systems of poor countries are chronically under-funded and called for massive investment in health systems, including a doubling of development aid over time to fund an essential package of adequate coverage. While additional aid is sorely needed, development aid has a history of being tied to programmes that are not necessarily national priorities or are vertical in nature (with damaging effects on the broader health system).

Sector-wide Approaches (SWAps) have been introduced in many African and some Asian countries to pool government and donor funds in order to replace many donor-funded projects with one, sector-wide programme. Under this system, national leadership needs to be strengthened in order for governments to play a proper role in determining priorities (Walt *et al.* 1999) while aspects of SWAps that impact negatively on health care equity should be limited (for example, the lack of ear-marking of pooled funds for priority services, the predominance of financial accounting mechanisms over service delivery and quality, and the reduction of the financing stream to non-governmental organisations, many of which service the poor (Ravindran and Maceira forthcoming). Of some concern is the recent move away from SWAps by some donors who favour general budget support through allocation of donor funds to Treasuries. The ability of Ministries of Health to influence how money is spent will probably weaken under this arrangement (McIntyre and Gilson 2005).

Increased donor interest in developing country public sectors should be matched by increased commitment by country governments to funding the health sector out of the tax base. For example, in the Abuja Declaration of 2001, African Heads of State committed their governments to working towards spending 15% of government funds on the health sector (Organisation of African Unity 2001). This is especially important given the range of problems experienced with many other forms of financing, especially with respect to promoting equity.

As van Doorslaer *et al* (1999) showed in OECD countries, and is widely accepted in developing countries (McIntyre and Gilson 2005), tax-based funding generally tends to be pro-poor in its overall redistributive effects. However, greatly improved debt relief and cancellation is required to enable governments in developing countries to improve the amount of tax funding available to social services (McIntyre and Gilson 2005).

6.3.3 Vouchers and conditional cash payments

Two new and unusual forms of financing health care interventions, for which there is still only limited evidence, include vouchers and conditional cash payments.

Vouchers provide an entitlement to a specific good or service, with the recipient usually free to choose between a number of providers. Vouchers effectively represent a cash transfer to the recipient and allow targeting of this transfer, usually along the lines of biological vulnerability (Hanson, Worrall and Wiseman forthcoming). Vouchers have been used, with some success, for insecticide-treated bed-nets for pregnant women in Tanzania (pilot experiences) and for reproductive health services for sex workers in Nicaragua. A voucher system needs to be able to identify needy recipients and be reasonably certain that the vouchers will not be transferred to non-needy persons, and represents a reasonably limited intervention as far as fair financing mechanisms are concerned.

Conditional grants, in contrast, involve payments made to households, conditional on attendance at certain priority services, including preventive services and nutritional support, as well as education attendance. The evidence on such payments currently derives solely from Latin America: conditional cash payments would be inappropriate in countries where there are insufficient resources to provide free, quality services (Palmer *et al.* 2004). Conditional payments do appear to have the potential to improve the uptake of interventions (as was found, for example, in the PROGRESA scheme in Mexico, and in Honduras and Nicaragua (Hanson, Worrall and Wiseman forthcoming). Gertler (2004), for example, also found a significant improvement in the health of children as a result of PROGRESA, showing that the effect of the programme increased the longer the children stayed on the programme. A benefit incidence analysis across the three Latin American countries further found that all three programmes were relatively well-targeted at the poor (Hanson, Worrall and Wiseman forthcoming). However, the perverse incentives that could be generated by such programmes (such as encouraging families to have more children) are not well understood.

The relative value of conditional grants versus other forms of social grant, in terms of health gain and health care uptake, has also not yet been assessed. Yet, as evidence from South Africa shows that social grants do generate household level health gains (Case 2001), this inter-sectoral policy intervention may represent an equity and health promoting action that is not dependent on health care provision and use.

6.4 Organisation of health systems

6.4.1 Decentralisation and community participation

As argued earlier, primary care, organised through the district health system, is a key strategy for delivering care to the poor. Decentralisation to the district level has been promoted as an organisational change that can allow local-level decision-making to enhance the responsiveness, efficiency and equity of the health system. Peckham *et al.* (2005) comment on the limitations of frameworks for analysing decentralisation and concur with Bennet (forthcoming) and Kawonga, Nunn and Maceira (forthcoming) that the evidence on the impact of decentralisation on equity is mixed, inconclusive and context-specific. For example, Peckham *et al.* (2005) find that 'there is a lack of any real definitive evidence to support the key assumptions that have been made about decentralisation leading to improvements and benefits in process including co-ordination, accountability, responsibility and cost.'

Decentralisation has been somewhat successful in promoting responsiveness, however (Peckham *et al.* 2005). Decentralisation may enable citizens to acquire control over the disposal of resources and the shaping of services, by participating in decision-making processes so that politicians truly reflect their interests. Gwatkin, Bhuiya and Victora (2004) note that the focus should be on 'creating an effective demand and pressure for relevant health services on the part of poor people, to counterbalance the influence of well-off groups that traditionally define priorities and design programmes.' There is however some caution that efforts to strengthen voice and demand from poor people and communities need to be complementary , and not a substitute for, health care systems that provide the procedural systems and are organised to respond to the needs of poor communities (Loewenson forthcoming, EQUINET Steering Committee 2004).

Community participation can vary in its scope, with lower orders of community participation tending simply to seek to achieve greater outreach of health services and more efficient management of local health services, and higher orders seeking to influence policy-making, resource allocation and health services administration. 'It is the higher order of community participation, wherein community participation is seen as a citizenship right, that can strengthen accountability to communities,' note Murthy *et al.* (forthcoming). They find that 'the nature of accountability promoted through the participation of community as part of health sector reforms is more administrative in nature than political or strategic in nature and more in implementation than during design. They mainly promote accountability of health workers and providers pertaining to inputs and outputs, than of health managers and policy makers with respect to social relevance and impact of policies.'

Indeed, as many community participation strategies are lower order and are limited to consultation, it is often questionable whether the poor, especially the poorest of the poor, benefit from these strategies. Weaknesses in community participation mean that, for example, in the field of sexual and reproductive health services, community involvement tends less to influence the introduction of contested, new or low priority services (such as abortion) than services belonging to 'the conventional wisdom,' such as antenatal care (Murthy *et al.* forthcoming).

This could be explained by the fact that, in many communities, the poor have little time to participate in activities without compensation, community structures are often controlled by powerful elites, and there are asymmetrical relations, in terms of power and information, between community members and health workers. Standing (1997) notes that local health committees are often set up solely to mobilise centrally determined programmes, that participation is low (especially amongst women), that often the interests of the most vulnerable are not represented, and that equity considerations are sacrificed when services are confronted by other pressures, especially rising costs. Loewenson (forthcoming) comments that it cannot be assumed that the mere presence of participatory mechanisms like councils and boards will yield the benefits of community participation.

Thus, although in theory decision-making by local bodies should best represent local interests, this only occurs when power is truly devolved to the local level and certain conditions to promote the voice of the marginalised prevail. Murthy *et al.* (forthcoming) include in these conditions: the transfer of resources; free and fair elections to local bodies, with quotas for representation by marginalised groups; provision for elected bodies at lower levels to be represented at higher levels of decision-making, so as to influence policy; and the transfer of adequate information and powers to elected representatives so that they may adequately assume their roles. Many of these provisos relate to the problem of ensuring that local elites do not capture or distort the representativeness and outcome of community participation initiatives. Given the weaknesses and lack of sustainability of past health system policies to organise for effective involvement of communities and civil society in health, this is an area where community knowledge and experience and a significantly more systematic assessment is needed. This should be located within the context of different types of political economies and health systems.

6.4.2 Integration

Since the 1980s, debate has raged around the relative merits of horizontal versus vertical services. Currently, vertical approaches, whilst sometimes logistically simple and necessary in the short-term, are viewed as inefficient in the long-run (see, for example, Freedman *et al.* 2005). Mills *et al.* (forthcoming) show how much more comprehensive and long-term are health system responses to the usual constraints faced by low- and middle-income countries, as opposed to those provided by disease-specific programmes (see **Table 1**).

Integration of services for a specific population group (such as children in the case of the Integrated Management of Childhood Illness) has gained popularity (although Briggs *et al.* (2003) note that there are too few studies to conclude that integration has a positive impact). Doherty and Govender (2004) describe this form of integration as 'the bundling of services across several diseases using a common delivery technology and point of contact with the beneficiary. In doing so, it addresses more of the burden of disease at less cost than would individual interventions separately, improving efficiency. It also facilitates the training of health workers in dedicated skills.' Integration also has the potential to enhance the responsiveness of the health system, an issue which has already been discussed.

In a review of the impact of integration initiatives around sexual and reproductive health services in developing countries (before the advent of anti-retrovirals), de Pinho *et al.*(forthcoming) conclude that, while there is a policy shift towards integration in all countries (and particularly amongst donors), integration has been poorly implemented. Obstacles to implementation include the lack of political will to allocate sufficient resources, failure to achieve administrative integration, and socio-cultural barriers such as the stigmatisation of certain services.

Unger, de Paepe and Green (2003) propose strategies for implementing disease control programmes – and a 'code of best practice' – so that they strengthen existing health systems. This is especially important following the introduction of anti-retroviral programmes which, unless well-integrated into the general health system, pose a threat to its sustainability by diverting resources.

Table 1: Typical health system constraints and possible disease-specific and health system responses

Constraint	Disease-specific response	Health system response
Financial inaccessibility: inability to pay, informal fees	Allowing exemptions or reducing prices for focal diseases	Developing risk-pooling strategies
Physical inaccessibility: distance to facility	Providing outreach for focal diseases	Reconsidering long-term plans for capital investment and siting of facilities
Inappropriately skilled staff	Organizing in-service training workshops to develop skills in focal diseases	Reviewing basic medical and nursing curricula to ensure that basic training includes appropriate skills
Poorly motivated staff	Offering financial incentives for the delivery of particular priority services	Instituting performance review systems, creating greater clarity about roles and expectations, reviewing salary structures and promotion procedures
Weak planning and management	Providing ongoing education and training workshops to develop planning and management skills	Restructuring ministries of health, recruiting and developing a cadre of dedicated managers
Lack of intersectoral action and partnership	Creating disease-focused, cross-sectoral committees and task forces at the national level	Building systems of local government that incorporate representatives from health, education, and agriculture and promoting the accountability of local governance structures to the people
Poor quality care among private sector providers	Offering training for private sector providers	Developing accreditation and regulation systems

Source: Mills *et al.* (forthcoming)

6.4.3 Re-orienting health care delivery towards primary care

As already noted, there is widespread evidence to show the equity gains that result from budget re-allocations towards primary care (see, for example, Starfield 2001, 2002 and 2005, Starfield and Shi 2004, Shi, Green and Kazakova 2004).

In a review of relevant literature Tollman et al. (forthcoming) explain that primary care services act as a fulcrum of a comprehensive care and support system – providing a link to programmes working in the wider community as well as facilitating patient access to district referral services. They identify the equity-enhancing aspects of primary care to include: physical, financial and cultural accessibility; the provision of comprehensive, integrated, personalised and continuous care; responsiveness to patients' non-health needs (such as courteous and respectful care); the role of primary care facilities as a community resource use and their focus on the the elements of the disease burden that disproportionately affects poor people. Well-functioning primary care level services, thus, represent the face of the health system for many and have the potential to inspire trust in the system as a whole. However, such gains do require the provision of good quality and responsive care, as discussed in **Section 5**.

6.4.4 Targeted versus universal approaches

In discussing ways of providing services, it is helpful to make a distinction between *targeted* and *universal* approaches. Bennett (forthcoming) provides a useful summary of the features of these different approaches (see **Box 3**). Hanson, Worrall and Wiseman (forthcoming) review the experience of a number of targeting approaches, including resource allocation formulae, contracting NGOs to provide health services in rural areas, user fee exemptions, conditional payments, vouchers and market segmentation using self-selection. They find that programme design and implementation issues were key to explaining observed outcomes. Additional important factors were the incentive effects and the costs of the mechanisms.

Mills (forthcoming) uses the example of Sri Lanka to emphasise, though, that improvements in health outcomes through targeted interventions are optimised if they operate off a basic 'platform' of functioning health services. Indeed, Freedman *et al.* 2005 argue that 'the crux of the problem is not just how to use resources to target a needed intervention to a population that has low access or utilisation (what is often labelled a 'pro-poor' intervention.) Rather, the core issue is how to create a system that encourages, supports and sustains increasing inclusion, that is, redistribution.' This coincides with our view that, although pro-poor interventions (such as exemptions mechanisms or targeted provision of bednets), may sometimes be appropriate in redressing inequities, these interventions will only contribute to that goal if they occur within a health system characterised by the 'gradients approach' as described in the Commission's framework document.

Box 3: The differences between targeted and universal approaches

Targeted approaches

- Direct resources at specific sub-communities.
- Have the advantage that they:
  - Use limited resources carefully.
  - Disrupt local economies less (e.g. the targeting of subsidized condoms or insecticide-treated nets at poor communities avoids crowding out private retailers).
- Have the disadvantage that they:
  - Have higher administrative costs because poor households need to be identified.
  - May fail to identify the poorest households and to prevent leakage of resources to non-poor households (particularly when the programme is neither accountable nor transparent).

Universal approaches

- Improve the functioning of the health system altogether (in the process also benefiting the poor).
- Have the advantage that they:
  - Avoid the costs of identifying the poor.
  - Secure political support more easily as they also benefit the non-poor.
- Have the disadvantage that they:
  - Tend to be captured by the non-poor.

Source: adapted from Bennett (forthcoming)

6.4.5 Public-private interactions

Private providers clearly play a significant role in many low- and middle-income countries with respect to the provision of primary care services (Berman and Rose 1996, Palmer *et al.* 2003). Private sector providers have thus come to be seen by governments as additional resources that can alleviate the burden on public services and allow an extension of health system coverage. As mentioned earlier, patients often prefer the private sector for a number of reasons (Khe *et al.* 2002, Mills *et al.* 2002, Palmer *et al.* 2003). Such reasons include geographic accessibility and convenient opening hours, more favourable staff attitudes towards patients and perceived better quality in terms of shorter queuing times, greater privacy, and quality of diagnosis, treatment and counseling. With the introduction of user fees in public facilities, poorer sections of communities sometimes turn to self-medication and private practitioners (see, for example, Khe *et al.* 2002). Whilst private providers are often thought of in terms of curative care, there is growing interest in the role that they could play in meeting public health objectives especially with respect to rolling out primary care services (Mills *et al.* 2002). In some contexts, private sector provision of health care is sought because the costs of public sector care are high. One of the reasons that private providers are often able to provide cheaper services is because they are adjusted to the purchasing power of the client, such as when partial doses of drugs are sold (Mills *et al.* 2002).

While the private sector is sometimes thought of as 'homogenous and financially self-sustaining', in reality this sector is highly heterogeneous (Giusti *et al.*1997). Not-for-profit private providers have often been instrumental in bringing primary care to poor communities. In Uganda, for instance, the non-governmental sector pioneered the development of primary health care initiatives which now account for about 65 percent of the current primary health care delivery in the country (Berman and Rose 1996). A recent review of contracting arrangements with non-governmental organizations suggests that this can be a very effective approach in rapidly extending care to marginalised groups at low cost (Loevinsohn and Harding 2005), with many of the anticipated difficulties of contracting not materialising.

The potential for for-profit providers to contribute to care of the poor is less obvious, however, especially with respect to its ability to meet public health objectives. Palmer *et al* (2003) note, for example, that whereas there appears to be a general perception in South Africa that the quality of care is good (or better than at public facilities), there is evidence that suggests that 'general practitioners often deliver care of questionable technical quality, especially with respect to the quality of diagnosis and use of appropriate drugs'. In an international review, Weller *et al.* (forthcoming) make a similar comment about the quality of sexual and reproductive health services. Mills *et al.* (2002), in reflecting on the role of the private sector in low-income countries, find that consumers of private sector primary care in these countries are often unable to assess the technical quality of services, tending to place more weight on aspects of perceived quality, such as interpersonal skills of providers and the comfort of the environment in which treatment occurs, both of which may be unrelated to technical competence.

Mills *et al.* (2002) argue that the effectiveness of private services is by and large also rather low: 'poor treatment practices have been reported for diseases such as tuberculosis, and sexually transmitted infections, with implications not only for the individuals treated but also for disease transmission and the development of drug resistance.' For example, Chabikuli *et al.* (2002), in a study of urban private practitioners in South Africa, found that 'knowledge of recent developments in STD syndromic management and effectiveness of prescribed drugs was poor … and less than half the prescriptions overall were judged as effective.'

Furthermore, while public-private interactions may expand coverage and improve services for some, there is evidence that they may contribute to worsening inequity, especially where they involve for-profit partners (see **Box 4**).

Box 4: Ways in which public-private interactions may impact negatively on equity

- PPPs tend to be based in commercial centres, and do not reach remote communities. This is even true of social marketing projects, and means that public and donor subsidies are 'captured' by more urban people in higher income groups.
- Many forms of PPP, including some that involve not-for-profit providers, only serve those who are able to pay. Out-of-pocket payments are particularly inequitable in that they require lower-income groups to pay proportionately more than high-income earners. Because of the financial burden they place on poor families, they also delay visits to health services.
- PPPs can reduce – rather than free up - resources available for providing essential care to the indigent. At the national level, this is evident when donor funds are diverted to PPPs. At the international level, it is evident with the current focus on infectious disease programmes, rather than other components of sexual and reproductive health services.
- Differentials in care are experienced between paying and non-paying patients, such as in hospitals with private wards, and in cases where fees are charged for diagnostic services and drugs.
- The presence of an active private sector contributes to the 'brain drain' of personnel from the public sector.

Source: Ravindran and de Pinho (forthcoming).

Given such problems with quality, effectiveness and equity, as well as the financial incentives that operate in the for-profit sector, governments need to be cautious about setting up public-private partnerships for health care provision to the under-served, especially in the case of the for-profit sector and where government's capacity to manage contractual arrangements is weak (this is discussed further in a later section looking at management and regulation). Private providers (including the for-profit sector) may be able to make valuable contributions in specific contexts. Positive examples relate to the distribution of bednets for malaria (Hanson, Worrall and Wiseman forthcoming) and management by general practitioners of conditions of public health significance (such as sexually transmitted infections and tuberculosis). However, public-private interactions should preferably occur within the context of strong over-arching government policies on engagement with the private health sector and strong regulatory frameworks. It is important that, where public health systems are weak, the private sector does not gain ground at the expense of the public sector, with potentially serious consequences for costs and equity.

6.5 *Human resources*

The Joint Learning Initiative (2004) provides an extensive analysis of the human resource situation in the health sector in developing countries, and the challenges that need to be overcome in ensuring that service provision is sustainable. The report notes that all the countries reviewed 'suffer from numeric, skill and geographic imbalances' and that 'improving within-country equity requires attracting health workers to rural and marginal communities – and retaining them.' Health workers are also distributed inequitably between the public and private sectors, while international inequity is worsened by 'unplanned international migration, with the loss of nurses and doctors crippling health systems in many poor sending countries.'

Improving the human resource situation in low- and middle-income countries is clearly an urgent priority if their health systems are not to be further undermined and inequity worsened. This is particularly so given the HIV/AIDS epidemic and mounting international efforts to deal with this and other diseases: while these efforts provide an opportunity to improve human resources for health, they also threaten to overburden the health systems of developing countries (Gilson and Erasmus 2005, Freedman *et al.* 2005).

The host of pertinent human resource strategies is not reviewed here. Instead, four specific strategies are singled out because they relate directly to equity (acknowledging that many other factors affect equity indirectly). Specific emphasis is given to public health systems as these continue preferentially to serve the poorest communities in any country (despite some use of private care providers). The strategies considered are: tackling the absolute shortages of human resources experienced in the public sector; reviewing the appropriate mix of cadres and skills; addressing the factors encouraging international migration; and tacking action to promote the retention and productivity of health workers particularly in rural areas. These responses need to be shaped in ways that neither punish workers nor leave poor communities unfairly underserved. Work in east and southern Africa signals that, while generic approaches may be outlined, these need to be configured into different policy mixes in different countries, together with measures to strengthen institutions and capacities for policy implementation (Padrath *et al.* 2003, Gilson and Erasmus 2005).

Given the existing problems, one clear requirement is to increase the number of health workers in the public sector and their distribution to levels of the health system where demand and workloads are highest. Recently, Kurowski *et al.* (2004) investigated the human resources required at the district level to implement the package of services recommended by the Commission for Macro-economics and Health (CMH) in Tanzania and Chad, both currently and in 2015. Their model was based on need for health care, adequate service coverage, intervention-specific tasks and staff productivity and, for future human resource availability, included current human resource availability, training capacity and attrition. They found that 'future human resource availability was grossly insufficient to meet the human resource requirements necessary to scale up priority interventions to the scale recommended by the CMH.' The largest gaps existed in staff with nursing and midwifery skills. This severe shortage of human resources is likely to be the pattern in many Sub-Saharan countries, which means that there needs to be a massive programme to train appropriate cadres in order to be able to deliver the basic package in future.

Clearly it will be important to examine alternatives to doctors and professional nurses: mid-level and auxiliary workers are likely to be less expensive to train, produced more quickly and able to deal with many conditions adequately, and may be more likely to stay in the public health sector, especially when they are recruited from the local community and have qualifications that are not recognised internationally (Freedman *et al.* 2005, Hongoro and McPake 2004). Although there is some experience of such cadres, for example in Tanzania, very little detailed evaluation of their potential in an equity-promoting strategy is available. Skilled birth attendants are particularly important to develop (Freedman et al. 2005), as are community health workers, especially with the emergence of chronic diseases, and both have particular roles to play in reaching marginalised communities. Both sets of cadres are essential in ensuring the re-orientation of health systems towards primary care that has already been noted as a key strategy in tackling inequity. However, past experience of birth attendants and community health workers indicates the importance of ensuring that they are given tasks for which they are appropriately skilled, well supervised and managed, and appropriately remunerated. Sustainability of community health worker programmes is also linked to adequate resourcing of the entire programme in which they work (Freedman *et al.* 2005, Walt 1990). In some cultures, such workers are also essential to overcoming the cultural barriers faced by women in accessing care (in some Muslim societies, for example, women cannot easily travel alone, mix with men or visit male health workers). Finally, expanding the number and skills mix of lower level cadres (who are mainly women) could improve gender equity in employment, although government should avoid shifting responsibilities onto unpaid community health workers and women carers in the home (Standing 1997).

There is a growing literature on international migration, including Martineau, Decker and Bundred (2002), Buchan, Parkin and Sochalski (2003), Padarath *et al.* (2003), Physicians for Human Rights (2004), Freedman *et al.* 2005, and Global Health Watch 2005-2006. These analyse a variety of 'push' and 'pull' factors that impact on the movement of healthcare workers, arising both within and beyond the health system. Factors endogenous to the health care system (push factors) are low remuneration levels, work-associated risks including diseases like HIV/AIDS and TB, inadequate human resource planning with consequent unrealistic work loads, poor infrastructure and sub-optimal conditions of work. Exogenous 'push' factors are also noted, including political insecurity, crime, taxation levels, repressive political environments and falling service standards. Movement is also influenced by pull factors, including aggressive recruitment by recipient countries, improved quality of life, study and specialisation opportunities, and improved pay. These push and pull factors are mitigated by 'stick' factors in source countries, which lead to greater personnel retention, including family ties, psychological links with home, migration costs, language and other social and cultural factors. 'Stay' factors influence decisions to remain in recipient countries and influence rates of return of personnel. These include reluctance to disrupt family life and schooling, lack of employment opportunities in the host country and a higher standard of living in the recipient country (Padrath .*et al.* 2003).

A second set of urgent actions, therefore, revolve around reducing 'pull' factors for migration, essentially through international agreements to limit recruitment from developing countries. The effectiveness of such action is, however, not yet clear. One linked set of discussions focuses on the possibility of reparations to compensate developing countries for their human resource loss, reparations which could then be used for expanding domestic training, for example. A second set of linked discussions focus on encouraging the return to their home countries of those currently working in the North. Such a return might be encouraged on patriotic or personal grounds and could be facilitated by financial support or revisions to human resource systems that allow migrant workers to freeze their pensions during periods abroad and then renew payments into them on their return.

The third set of urgent actions in the human resources field focus on addressing the 'push' factors that encourage migration and are linked to the actions needed to improve staff recruitment, retention and productivity in the public sector (Hongoro and McPake 2004). Essentially policies in this area need to focus on valuing health workers (Freedman *et al.* 2005; Global Health Watch 2005-6). Many of the policies relate to providing incentives, including some combination of both financial and non-financial incentives. The latter range from improvements in working environments and better access to housing and other living conditions improvements, to the feelings of being recognised, appreciated and cared for that result from strong human resource management procedures and positive interactions with community members and patients. Little evidence is yet available about the impact of different incentives on health worker motivation and performance (Gilson and Erasmus 2005).

However, the notion of 'workplace trust' allows specific investigation of the influence of the non-financial incentives arising from personal relationships over health worker motivation (Gilson, Palmer and Schneider 2005). This workplace trust is built up through trusting relationships between: colleagues (which is rooted in shared experiences and values, and enhanced by effective teamwork); health workers and their supervisors (which is linked to personal behaviours and is inter-linked with trust in the employer); and between health workers and their employer (which is based on the style of organisational leadership and the nature of human resources management, especially procedural justice in decision-making and constancy).

There is some evidence from the developed world, that such trust may contribute to motivation and, in turn, to improved health worker performance. There is also some suggestion that workplace trust can contribute to the development of a strong client orientation in worker behaviour and improved trust between health workers and patients (Gilson, Palmer and Schneider 2005). It may, therefore, be possible to build a virtuous cycle of workplace trust and patient-provider trust, enhancing the responsiveness of the health system to all patients and so tackling the inequities that result from, for example, poor health worker attitudes and behaviours towards, in particular, patients from poor and marginalized groups. This adds a new dimension to understanding how human resources may impact on equity, and acknowledges the importance of focusing on the human rights and livelihoods of health care workers in building equitable health systems (Freedman *et al.* 2005, Global Health Watch 2005-06).

It is also important to consider the gender-based experience of health workers and, as reflected within its own institutional character, the health system's influence on health system inequities. Standing (1997) notes 'the interlinking and reinforcing nature of gender, class and professional status' within the health system, leading to the dominance of senior positions by men. Mumtaz *et al.* (2003) identified, in a study of women community health workers in Pakistan, that female health workers face 'abusive hierarchical management structures, disrespect from male colleagues, lack of sensitivity to women's gender-based cultural constraints, conflict between domestic and work responsibilities, and poor infrastructural support.' The implication for this is that the health system needs to develop a more supportive style of management that encourages women health workers to exercise their 'voice,' develops career paths for women, takes account of gender-based constraints in organisational issues, and expects respect for women health workers from male colleagues. Such actions, together with measures to enhance dialogue between communities and health workers may, then, create environments that facilitate fairer treatment of patients.

A final set of human resource policy actions to consider focus on the role of private sector providers. Given the absolute human resource shortages being faced in the public sector, one approach to improving human resource availability might be to contract private providers to work within public facilities or to provide care to poorer patients. Few studies have examined this option in any detail. One from South Africa, reflecting the discussion in an earlier section, identifies problems in the quality of private provider care and highlights the difficulties of managing such contracts effectively (Mills *et al.* 2004).

Two final important points to note in relation to tackling human resource problems are, first, that such action will require strong governmental leadership and multi-sectoral action: the health sector cannot address the problems by itself (Gilson and Erasmus 2005, Freedman *et al.* 2005). Second, national action must be supported by international action to address the factors pulling health workers to migrate, including addressing the influence of trade and health policies such as the General Agreement on Trade and Services.

6.6 Public sector management and regulatory capacity

Public sector management capacity tends to be weak across the developing world. This contributes to inefficiencies, to the malaise felt by front-line health workers, and to difficulties in implementing change. Gilson (2003) notes that reforms in the 1990s to improve management, termed 'the New Public Management,' have been criticised 'for endangering the trust and long-term co-operation between client/patient and provider critical to the effective delivery of health and welfare services, by replacing high trust relationships between employees and managers with low trust ones.' Khaleghian and Das Gupta (2004) describe a wider number of the features of the New Public Management and show how these are not always applicable to essential public health functions. They suggest that government bureaucracies should rather concentrate on building management capacity, improving accountability (both hierarchically within government and externally to the public), and improving the organisational climate. This last point is echoed by Blaauw *et al.* (2003) who assert that too little attention has been paid to what they call the 'software' of health systems, namely their organisational cultures, as opposed to the hardware (such as physical infrastructure, number of personnel and drugs).

It is important to note that management transformation is key to the process of strengthening the capacity and the legitimacy of the state. This means that, apart from equipping managers with technical skills backed by operating systems, it is important to equip them with skills that help them to build trust, shift the organisational culture, develop organisational relationships and networks and strengthen engagement with the public (Blaauw *et al.* 2003, Gilson 2003). This includes redressing inequities that afflict the workforce itself, including gender issues. The aim would be to encourage a values-based style of management that is particularly committed to serving the needs of the poor and marginalised. The form of management required in the public sector generally has, thus, considerable differences from that required in the private sector.

However, few of the plethora of management training and strengthening approaches that have been undertaken in developing countries have taken this issue seriously. Neither have they been effective in developing the more technical skills of resource and service planning and management. Often funded by external sources they are generally too limited in scope and too short-lived to have much effect (Global Health Watch 2005-06).

Apart from improving management within its own ranks, government needs to strengthen its stewardship role: this was one of the strong messages in the World Health Report of 2004 (World Health Organisation 2004). In this capacity, and given the existence of multiple private providers, governments must specifically build their capacity to regulate the private sector to ensure that societal goals are not jeopardised – but are preferably enhanced - by its actions. Such regulation may partly occur through contractual arrangements. However, governments also need to build their capacity to manage such arrangements as governments tend to perform this function badly. Indeed, given existing capacity constraints, Mills *et al.* (2001) suggest that the radical and wide-ranging reforms envisaged by the New Public Management are not an appropriate strategy for low income countries. They propose, instead, more gradual reform processes that encourage necessary improvements in capacity to be built over time.

7. BUILDING HEALTH SYSTEMS BASED ON EQUITY AND SOCIAL JUSTICE: MAINTAINING THE POLICY SPACE

National health systems founded on values of equity, solidarity and redistributive justice may reflect normative values, and value and entitle citizens, in ways that differ from other national and transnational systems operating within wider economic contexts, including market-oriented macroeconomic policies, conflict and globalisation. Indeed, health systems may provide an entry point for broader societal transformation in the interests of poor and marginalised people, both through structural and cultural or value-drive change (Freedman *et al.* 2005). This section focuses on how to realize this potential of health systems. We note that this is not simply a technical process structured around evidence. It is one based on values, where there are likely to be competing interests, and that demands political, health sector and social leadership.

The literature on how policy-makers can maintain the space – at global, national and local levels - to build health systems based on values of equity and social justice in the face of broader forces such as market reforms, conflict and globalization, is scant but growing. Much of it has emerged as a result of critiques of health sector reforms in the 1990s which are characterized as largely technocratic in character and founded on a neoliberal ideology that elevates the role of the private sector (see, for example, Global Health Watch 2005-6, Ravindran and de Pinho forthcoming). This body of literature suggests a number of strategies that re-assert the importance of the state in securing health, and emphasize the importance of values and community views in shaping the health system.

7.1 Strong political support for the notions of equity and social justice

In many countries during the last decade of the last century, the notions of equity and social justice appeared to be in abeyance as governments grappled with the problem of resource shortages (through introducing user fees, for example, at the expense of equity). Experience has shown that the principles of equity and social justice need to be brought to the fore and to be made a concern across the whole of government to ensure that government policies do not, even inadvertently, aggravate inequity further. This will require leadership from the health system to manage actors inside government, across different sectors, and outside government to create support for, and take advantage of, windows of opportunity to introduce change. It also requires that political leadership at higher levels enable and reinforce these processes. Some examples that signal the critical importance of political factors in achieving equity-promoting change are discussed below.

Sri Lanka is an example of a country that, for many decades, has explicitly upheld equity as a key driver of its policies, resulting in excellent health outcomes relative to its GDP. In Sri Lanka, the government has assumed the responsibility of providing universal health care free at the point of entry, has established an extensive network of public health services, and ensured that hospital care is available for catastrophic illness. The reasons for Sri Lanka's success include (McNay, Keith and Penrose 2004): cultural, social and historical reasons (such as relative gender equality, democracy, consensus on national priorities); synergies between health and other policies (including free education, subsidization of food, improvements in water and sanitation); and policy decisions in health which, in many ways, ran counter to the received wisdom of the international community (including an emphasis on public financing of inpatient rather than outpatient care, the creation of a motivated and trained workforce, and the rejection of cost recovery as a financing policy).

Like Sri Lanka, China, Costa Rica, Cuba and the Indian state of Kerala have also achieved remarkable improvements in health outcomes. With Sri Lanka, they shared five common social and political factors: historical commitment to health as a social goal; a social welfare orientation to development; community participation in decision-making processes relative to health; universal coverage of health services for all social groups; and intersectoral linkages for health (Halstead, Walsh and Warren 1985, Commission on Social Determinants 2005a). However, all of these countries' health systems have proved vulnerable to external shocks and domestic political change (Commission on Social Determinants 2005a).

The Brazilian Government has underpinned its policies aimed at universal comprehensive and redistributive health services with a constitutional provision of the right to health, as a means of enabling social and legal processes to secure the principles of the system against encroachment from contrary political influence and economic policies.

Mexico City is an example of a city which recently embraced notions of equity and experienced considerable success in providing free health care and drugs to the poor, and food support to the elderly (Laurell, Zepeda and Mussot forthcoming). The free health care programme covered 65 percent of the target population after only three years. Unfortunately, the literature does not yet analyse what facilitated the introduction of these new policies by the new city council when prior governments had focused on pro-market policies and small-scale, targeted programmes, although the election of a new political party was certainly a critical factor. The paper by Laurell *et al* (forthcoming) signal that many of the initial gains were made by a redistribution of available resources within the public social welfare system, and that the mobilisation of new resources from economic activities was more difficult to lever. Interestingly, the successful experience of Mexico City occurred within a health system which in general had little impact on fair financing, quality of care and democratic governance, although had instituted reforms in the late 1990s that had some impact on access by the poor to health care (Gomez-Dantes, Gomez-Jauregui and Inclan 2004).

Unfortunately the available health literature about these experiences suffers from four key weaknesses. First, there is limited attention to constructing a 'typology' of states in terms of governing principles and the organisation of power, that would be useful in explaining why some countries are able to carry forward equity-promoting change while others are not. Second, although some literature is emerging, there remains little understanding of how to build, organise and consolidate the political support for equity and social justice where states are weak, particularly in the many conflict and post-conflict settings of Africa. Third, there is little examination of the particular strategies used in managing the powerful national and local level actors influencing health systems that are commonly resistant to equity-promoting change (such as medical professional organisations, the pharmaceutical industry and, even, locally powerful leaders). Fourth, little connection is generally made to the wider literature examining how states have managed socio-economic development more generally. Yet such literature has important lessons for the health sector. For example, from analysis of ten countries' experience in eliminating hunger and deprivation, Dreze and Sen (1989) conclude that across two very different development strategies (growth-led vs. support-led security) the two common features of positive experience were the extensive use of public provisioning to enhance living conditions, and marshalling the diverse sections of the population in the process of social and economic transformation (see the next section on this last issue).

However, it is possible to identify two major challenges to establishing the policy space required to implement pro-equity policies. The first derives from international public policies that weaken or distort the national long-term measures needed to make and secure universal systems. For example the New Public Management approach, referred to earlier, was introduced through health care reform proposals in the 1990s and emphasised a greater role for private provision and finance with the state merely providing the safety-net for the poorest (Koivusalo and Mackintosh, 2004, Mills *et al* 2001). These policies were actively promoted and supported with aid resources despite knowledge that tiering or segmenting services according to ability-to-pay reinforces existing inequalities, and undermines the ability of the health system to promote inclusive and universal access to health care according to need.

The increased commercialisation of health services initiated through some of these reforms is reinforced by a second policy pressure that further narrows the space for national policy-making. This is the increasing role of the World Trade Organisation agreements in services and health-related policy. For example, a country that has opened its market to financial services, including foreign insurance firms providing health insurance, may find it more difficult to implement a redistributive, universal social health insurance scheme, reinforcing societal segmentation. Thus, there are debates as to whether, in practice, there is the policy space and capacity for states to ensure that in any conflict between limits posed by trade agreements and public health obligations, the latter are respected and honoured. The impacts on health of new trade agreements such as the General Agreement on Trade in Services (GATS) is still relatively unaudited and unknown: it is understood that these pressures will be more thoroughly discussed in the knowledge network on globalisation and health.

7.2 Inter-sectoral action in support of health equity

The adoption of the Health for All strategy in 1978 marked a forceful re-emergence of social determinants as a major public health concern, explicitly stating 'the need for a comprehensive health strategy that not only provided health services but also addressed the underlying *social, economic and political causes of poor health'* (original emphasis). The PHC philosophy incorporated: a commitment to shift health resources from urban hospitals to meeting the basic needs of rural and disadvantaged populations; confronted 'medical elitism,' or reliance on highly specialized doctors and nurses; and made an explicit linkage between health and social development. PHC included among its pillars intersectoral action to address social and environmental health determinants. The Alma-Ata declaration specified that PHC 'involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communication, and other sectors; and demands the coordinated efforts of all these sectors.'

During the 1980s, the concept of intersectoral action for health (IAH) took on increasing prominence, with 39th World Health Assembly discussions including working groups on: health inequalities; agriculture, food and nutrition; education, culture, information and lifestyles; and the environment, including water and sanitation, habitat and industry. The 1986 Ottawa Charter on Health Promotion then identified eight key determinants ("prerequisites") of health: peace, shelter, education, food, income, a stable eco-system. sustainable resources, social justice, and equity. It was understood that this broad range of fundamental enabling factors could not be addressed by the health sector alone, but would require coordinated action among different government departments, as well as among nongovernmental and voluntary organizations, the private sector and the media.

According to the Commission's background paper, while a formal commitment to IAH became part of many countries' official health policy frameworks in the 1980s, the track record of actual results from national implementation of IAH was poor (Commission on Social Determinants 2005a). The paper attributes this to countries attempting to implement IAH in isolation from the other relevant social and political factors supporting this framework, namely: broad commitment to health as a collective social and political goal; the crafting of economic development policies to promote social welfare; community empowerment and participation; and equity in health services coverage. Further, IAH was weakly supported by decision-makers in other sectors who complained that health experts were often unable to provide quantitative evidence on the specific health impacts attributable to activities in non-health sectors such as housing, transport, education, food policy or industrial policy, particularly given the complexity of causal networks and time lags in producing these effects. This was compounded by institutional factors such as: vertical boundaries between sections in government: integrated programmes often seen as threatening to sector-specific budgets, direct access of sectors to donors, and sectors' functional autonomy; the weak position of health and environment sectors within many governments; few economic incentives to support intersectorality and integrated initiatives; and government priorities often defined by political expediency, rather than rational analysis.

In recent years in the developed world, however, integrated planning by different sectors in the interests of health has gained ground. Sweden and Britain under the Labour government stand out as countries that have taken a social determinants of health approach to government policy (Canada is another example although, more recently, the strength of this approach may be declining) (Commission on Social Determinants 2005a). In Sweden, policy is based on a culture of solidarity that makes equity a central and explicit aim. National health objectives are targeted at determinants rather than health status, and a variety of sectors is involved in the process of health policy development from the early stages. The British approach is distinctive for 'simultaneous emphasis on broad redistributive efforts coordinated at national level and on locally managed area-based initiatives' (Commission on Social Determinants 2005a). For example, income, employment, education, early childhood development, and regeneration initiatives are combined in disadvantaged areas through 'Health Action Zones' involving partnerships between government, the private sector and communities that develop innovative ways to reduce health inequalities, breaking through organisational boundaries.

The growing emphasis on the inter-linkages between health and economic development at a macro-level (Commission for Macroeconomics and Health 2001) may also provide an entry point for renewed intersectoral action in developing countries. In addition, the integration of health across sectors has increasingly come to be seen as part and parcel of sustainable development (see, for example, Harrison, Flynn and Brown 2004, who provide a list of the capacities – in terms of infrastructure, processes and tools – required to achieve this integration effectively).

However, as the Commission's background paper (Commission on Social Determinants 2005a) notes, one of the biggest problems in achieving intersectoral action for health in developing countries is achieving sustainable co-ordination across different government sectors (and even across different sections in health ministries), especially in the local government sphere.

Blaauw *et al.* (2004), in looking at governmental relationships and HIV/AIDS service delivery in South Africa, note that 'there is a tension between achieving short term delivery objectives – through mechanisms such as centralization and verticalisation – and broader, more long term developmental goals – such as the strengthening of the local sphere of government.' They emphasise, too, the importance of 'coordination of coordination' mechanisms and activities, including the development of shared values between different parts of government. Gilson and Erasmus (2005) meanwhile highlight the barriers to achieving the coordination resulting from the different mindsets of different sectors of government. From experience in Africa, they argue that Ministries of Health generally play a weak role in encouraging the intersectoral action necessary to underpin health human resource policy implementation. This weakness reflects the different mindsets and language of, say, health and finance ministries, the weak capacity for human resource planning and management within Ministries of Health and the generally complex nature of health system governance in any country that have themselves been subject to massive reform over the last ten to twenty years.

In general, the literature on inter-sectoral action remains primarily descriptive with few clear conclusions on how to bring about effective action. A central task of this knowledge network will be to document positive experiences of how the health system has been able to encourage and lever action on health across the whole of government so that we are able to draw stronger conclusions about the actions necessary to initiate and sustain such action. We would also seek to understand the political environments and health sector actions that have facilitated and sustained such actions across government. Examples of this include:

1. making health a priority across government: examining examples of high level political leadership (that is, at the level of the executive), levels and patterns of national resource allocation and earmarked funding mechanisms for health such as the President's Special Intitiave on Human Resources for Health in Zambia and Brazilian taxes on finance transactions allocated to health;
2. integrating health in other sectors or joint service provisioning (for example, health impact assessment and management in investment and trade programmes, sectoral co-operation in environmental and occupational health; work on integration of actions on HIV and AIDS across sectors); and
3. political processes and institutions that build integration, such as parliamentary roles in budgeting and policy oversight.

7.3 Strengthening the voice of the poor to make claims and government legitimacy

Health sector reforms in the 1990s encouraged bigger roles for the private sector in providing health care services. This was partly in response to perceived inefficiencies and poor quality care in the public sector. However, the disappointing performance of the private sector has redirected focus on the central role of the state not only in regulating care, but also providing services (for example, Freedman *et al.* 2005). The state will be most effective in carrying out this role when it is viewed as legitimate and is trusted by its citizenry, and when its autonomy is protected in the face of powerful international interests, including those of aid agencies and multinational corporations. This last point – the preservation of government autonomy – was referred to briefly in earlier sections on priority-setting and stemming the brain drain. However, full treatment of the topic is not possible here, given the vast literature on donor aid, as well as the influence of multi-nationals (little of which is linked directly with issues of health system equity). This is also a potential overlap area with the knowledge network on globalisation.

Going back to the issue of state legitimacy, Gilson (2003) proposes that trust – within the management structures of the health system, between providers, between providers and patients, and between patients and the system as a whole –plays an important part in conferring legitimacy on the state. Russell (2005) also notes that in Sri Lanka, for example, the fact that the state has clearly taken on the responsibility of making universally available health care free at the point of delivery has built the foundation for public trust in the state, and contributed to the success of, for example, public financing arrangements. Recognising 'the still slim but growing body of multidisciplinary research and literature in this area,' Freedman *et al.* (2005) specifically suggest that public trust and government legitimacy can be enhanced by policy actions that improve access to health care, reinforce the commitment to health as a right and improve health resource allocation to under-served areas.

At the same time, they emphasise that in order to promote equity, such actions must be complemented by steps to strengthen the voice of the poor and marginalized to make claims of entitlements. Such entitlements reflect commitments made by the state to its citizens in terms of, for example, access to and quality of care. As an entitlement, health care access is a right of all citizens, not a gift given by those who are powerful. Claims to health rights are asserted through social action, through formal legal or regulatory mechanisms and through procedural systems that build relationships between citizens and the state and through which mutual obligations of entitlement and accountability are expressed (Freedman *et al.* 2005). London (2004) has pointed out that the social rights to health of poor communities are more likely to be claimed through collective political and social action, given the weak access such groups have to legal and procedural mechanisms.

To strengthen the claims of poorer communities states and non-government organisations have taken, sometimes complementary, action including documenting and publicising inequities in health and health care between population groups; acting as watchdogs overhealth service performance; overseeing policy implementation; developing and promoting patients charters; seeking legal redress through court action; establishing essential health care entitlements; promoting consumers' rights movements; and establishing effective mechanisms for including public participation and involvement in health facility management.

Many of these actions can also be considered mechanisms of accountability. As such they also confer state legitimacy (and, of course, a prerequisite for accountability is the proper functioning of democratic institutions). Accountability includes two elements, 'answerability' of those who hold power to citizens and 'enforceability' of penalties in the event of failure to do so (Murthy *et al.* forthcoming), and can be applied to the political, financial and administrative domains. Accountability can also either be horizontal (that is, between sections of government) or vertical (that is, between government and the community).

Accountability and community participation strategies that have been attempted, both by governments and by civil society, across the developing world, include a diverse range of activities (Murthy *et al.* forthcoming): constitution of permanent or time-bound stakeholder fora for policy formulation and monitoring of implementation; holding of consultations with stakeholders on policy; decentralisation of health management; promotion of community financing; formation of community health structures for managing local health clinics and hospitals; client regulation through patients' rights charters; self-regulation by professional associations; health superintendency (oversight) by government; placing of advertisements in media and holding of public hearings around public inputs on proposed policies; creation of task forces to strengthen health service accountability; pressure from below on health policies, legislation and their implementation; consumer protection acts, consumer forums, and public interest litigation; ombudsmen centres; audits into, for example, mortality; right-to-information campaigns; and citizen monitoring of health expenditure and quality.

While field studies have found these mechanisms to enhance public involvement in health systems, they also report a number of factors constraining their representativeness, performance and power. These include: weak participation from the poorest groups, limited access to resources, information and training, resistance from health professionals who perceive them as interfering in primarily technical decisions and weak formal authority (Loewenson *et al* 2004, Ngulube *et al* 2004). The same problems have been found to affect participatory mechanisms (such as committees and boards) in a range of studies (Kahassy and Baum 1996, Rifkin 2003, Bennett *et al* 1995, Gilson *et al* 1994, Mubyazi *et al* 2003, Macwangi *et al* 2004). Programmes that aim to build participation thus explicitly recognize and deal with such barriers, and do so in a sustainable and consistent manner to build more meaningful forms of participation, particularly for poor communities (Rifkin 2003).

Such problems indicate that accountability mechanisms and forms of participation are located within the wider framework of relationships and interactions between the state and society, and the wider context of how power is exercised. Sen (1990) proposes that such public action should be seen in a broad perspective to include not only what is done *for* the public by the state, but also what is done *by* the public for itself by demanding state action and through making governments accountable. Such action is argued to promote the political incentive for governments to be responsive, caring and prompt. Thus, the public is both beneficiary and primary instrument.

However, these relationships between citizen and state are changing, as are the values that inform them. They are differently expressed and organised in state-driven welfare systems organised around principles of solidarity, universality and equity, than in systems built on flexible labour and liberalised markets (Navarro *et al.* 2003). For example, trends towards commercialisation of health services through fee charges and privatisation of essential health-related services like water supplies is reported to have changed the status of communities - from citizens with public rights and responsibilities into consumers with market power, or lack of it. This weakened the ability of poor communities to demand and access such services (Municipal Services Project 2004, Van Rensburg and Fourie 1994). In these circumstances there is evidence that it is the more powerful medical interest groups, or the wealthier urban elites, who have been able to exact concessions under these reforms, sometimes at the cost of poorer, less organised rural health workers, or the urban and rural poor (Van Rensburg and Fourie 1994, Bennett *et al* 1995).

This has raised new debates around how to strengthen the voice of poor communities in health. While the primary focus for communities is at national level, marginalized communities now also need to gain a voice in systems where decisions affecting health and livelihoods are made beyond the national level in global institutions and exchanges, and within the boardrooms of foundations and multinational companies. What forms of state-citizen interaction and what vehicles of state authority can speak with, rather than only speak for, such communities, and in so doing strengthen the accountability and authority of states? What forms and rules of fair process are needed to give voice and weight to the health claims of poor communities within this environment? (Kalumba 1997, Lafond 1991, Storey 1989).

7.4 Constructing values-based health care systems and preventing excessive fragmentation

While much of the equity-focused health system literature focuses on how to improve access for the poor, especially through government services, a parallel body of literature focuses on how to expand the size and use of the private sector, partly to relieve government services from the burden of providing for the rich, and partly to provide alternatives to government services for the poor, especially where there is poor access to state services or where the quality of public sector services is low. Indeed, as mentioned in an earlier section, poor populations are accustomed to dealing with a pluralistic pattern of health providers, choosing to use private providers for selected conditions.

However, in a new book, Mackintosh and Koivusalo (2005) present evidence on the relationship between healthy life expectancy and private and public health care expenditure as a percentage of total expenditure. This evidence indicates that healthy life expectancy is significantly higher, and child mortality is significantly lower, in countries with lower levels of private health expenditure relative to public expenditure, after allowing for level of economic development and the influence of AIDS in sub-Saharan Africa. In addition, countries that spend proportionately more of their GDP through public expenditure or social health insurance have significantly better health outcomes in terms of healthy life expectancy and child mortality. Higher income countries have better health outcomes both because of their higher incomes and because they have higher levels of public health expenditure. In contrast, countries that devote a higher proportion of their GDP to private health expenditure do not display better health outcomes in these terms even after allowing for the effect of higher incomes on health outcomes. Finally, they present other analyses of Demographic and Health Survey data across 44 low and middle income countries which show that greater levels of government health expenditure as a percent of GDP are associated with better access to care for the population.

The latter findings echo earlier analyses of financing systems in OECD countries which concluded that countries with health care systems funded largely through private financing intermediaries have particularly regressive systems, whereas those funded primarily by social insurance were moderately regressive and those from taxes, were either progressive or mildly regressive (van Doorslaer, Wagstaff and Rutten 1993).

Drawing on a wide range of country experiences, Mackintosh and Koivusalo (2005) go on to raise strong concerns about the commercialisation of health care systems that has resulted from the growing role of private sector financing mechanisms. They analyse commercialisation as occurring through three main pathways, depending on the economic development of a country:

1. Informal commercialisation in low-income primary care. This is the pre-dominant form in most low-income countries in Sub-Saharan Africa and South Asia, and in the Asian transitional economics. It is represented by private, small-scale, largely unregulated provision, especially for the poor and lower middle-income groups living in urban areas. It includes the unlicensed and off-prescription sale of drugs. This type of care is usually financed by out-of-pocket payments (which are regressive), and generates incentives for unethical practice.
2. Corporatisation and segmentation in middle-income hospital care. This is occurring to a lesser extent than suggested by the high profile accorded to these developments. Corporations tend to be reluctant to sustain ownership and provision of hospital care, and recently there has been extensive profit-taking, risk-shedding and corporate exit from this sector. These markets therefore tend to be financially fragile, with firms continually looking towards opportunities for public contracting and subsidies.
3. Globalisation in input supply and labour markets in the health sector. In contrast to the hospital sector, this is strong and increasingly dominant in medical technology and pharmaceuticals. Multi-national corporations have had a strong influence on international policies on trade in goods and intellectual property rights, with a view to protecting corporate interests (and in many cases strengthening monopolies), with negative implications for access to drugs in developing countries. Recent increases in the migration of health workers from developing countries is undermining both the staffing and the financial sustainability of developing country health systems.

They identify the pressures towards increasing commercialisation as including: at a global level, international market integration, new incentives for international investment and international, regional and national regulatory changes that encourage corporate restructuring; economic crises in many developing countries; at a national level, the encouragement of public-private partnerships, partly as a result of international health policy and partly as a result of commercialisation of national health systems; the legitimisation of high levels of out-of-pocket spending (even by the poor) as a result of health sector reforms in the 1990s; and the rapid integration and commercialisation of the international labour market.

Yet, the argument that market failures experienced in the health sector justify public provision and strong regulation, are well-established. Market failures result from asymmetrical power relations and access to information, as well as fee-for-service reimbursement systems that incentivise over-servicing. Indeed, 'neither the public sector nor the private sector work in the idealized way that market-based approaches theorise. Instead, both rich and poor face a pluralistic market with a wide and chaotic array of services of wildly varying quality' (Freedman *et al.* 2005).

The consequences of commercialisation include not only regressive financing patterns but also a reinforced segmentation of the health system into different financing and provision systems for the rich and poor. Although some argue that such systems can better serve the poor by allowing public resources to be devoted to them, others suggest that there is a dual danger. On the one hand, fragmented financing and provision prevents the rich from cross-subsidising the poor and the healthy the sick, and obstructs equity-promoting policy (see **Section 6.3.1**). On the other hand, fragmented systems hold the political danger of undermining support for equitable systems by allowing the development of different interests and concerns across more and less powerful social groups (Nelson 1989). As a result, the legitimacy of the state's stewardship role across the whole health system may also be undermined, leaving it unable to implement its governance and regulatory functions.

From the Latin American experience of fragmentation, Londono and Frenk (1997) have thus argued that health care systems should be founded on a universal entitlement to services, rooted in citizenship, and that entitlement should be funded through financing approaches which enable and promote cross-subsidy and met through a range of providers. This reflects the emerging universal financing approach of Thailand, for example, as well as the experience of countries like Canada. Such an approach represents a different understanding of health systems than that currently prevailing within international health policy debates. The UN Millennium Project's Task Force on Child Health and Maternal Health summarises this new understanding in **Table 2**.

Table 2: Task Force approach to health systems

Item	Conventional approach	Task Force approach
Primary unit of analysis	Specific diseases or health conditions, with focus on individual risk factors	Health system as core social institution
Driving rationale in structuring the health system	Commercialization and creation of markets, seeking financial sustainability and efficiency through the private sector	Inclusion and equity, through cross-subsidization and redistribution across the system
Patients/users	Consumers with preferences	Citizens with entitlements and rights
Role of the state	Gap-filler where market occurs	Duty-bearer obligated to ensure redistribution and social solidarity rather than segmentation that legitimates exclusion and equity
Equity strategy	Pro-poor targeting	Structural change to promote inclusion

Source: Freedman *et al.* (2005)

Within this framework, government may take action to encourage appropriate collaboration with private providers (see **Section 6.4.5**). However, to fulfil its stewardship role it will also need to develop its capacity to regulate private providers to provide comprehensive and good quality care (see **Section 6.6**). One strategy to enhance this capacity includes encouraging patients to act as a watchdog over private providers – for example, by providing information about quality or probity that patients then use when deciding where to go for care (Freedman *et al.* 2005). However, as noted, there remains limited evidence on how to strengthen regulatory capacity and only patchy evidence on the potential impact of informal regulation.

7.5 Strengthening policy implementation

Many equity-promoting policies flounder because of problems in implementation: this makes it difficult to sustain progressive initiatives and erodes the legitimacy of the state. Such policies are almost always subject to contestation as, in seeking to benefit powerless groups, they challenge the status quo and the associated vested interests (for example, Reich, 1996, Nelson 1989, Williams and Satoto 1983).

In addition, as health systems themselves reflect the wider patterns of social inequality in any society (Mackintosh 2001), such policies challenge the norms, traditions and hierarchies within health systems. These institutions shape health professional practice, influencing who gets access to health services, as well as the treatment and nature of care offered to different social groups. Recent experience in Tanzania, for example, demonstrates how poor people's experience of abuse at the hands of providers is a key facet of their experience of their social exclusion (Tibandebage and Mackintosh 2005). In South Africa, meanwhile, nurses' critical attitudes towards groups such as pregnant teenagers, teenage mothers, patients with HIV/AIDS and poor patients judgements have been shown to be rooted in their own values which, in turn, reflect the class and other divisions in the society as a whole (Jewkes *et al.* 1998).

Resistance to policies from within health systems is illustrated by health worker responses to the removal of fees in South Africa, which included greater rudeness towards patients (Walker and Gilson 2004). These problems also reflected the increased workloads that resulted from the policy change, weak preparation for its implementation and the limited communication with health workers about it. Other experiences of implementing equity-promoting policies in Africa also show the types of conflict that can arise between the driving beliefs and views underpinning implementors' behaviour and the equity goals of policies (Gilson 2005).

Unfortunately, with some exceptions, the literature seldom analyzes the reasons why interventions fail (or even succeed), making it difficult for policy-makers and planners to learn from past experience. However, Gilson *et al.* (1999), drawing on an evaluation of financing reforms in two African countries, provide a detailed analysis of strategies that can support implementation, including the incorporation of implementation concerns into the policy-making process. The broad principles behind these strategies are summarised in **Box 5**. One of these principles, around securing better policies through monitoring and evaluation, relates not so much to measuring progress towards targets, but to instituting 'early learning' mechanisms that allow the process, as much as the design, of interventions to be adapted as implementation proceeds. Nolen *et al.* (2005) provide a range of recommendations with respect to strengthening health information systems to health equity challenges.

Box 5: Strategies to improve implementation

1. **Strengthen policy formulation as a foundation for implementation:**
   - Support leadership by providing technical analysis;
   - Strengthen the strategic skills and awareness of technicians; and
   - Build implementation concerns into design development.
2. **Strengthen implementation processes:**
   - Accept the need to work within a changing policy environment;
   - Enable implementation through leadership;
   - Plan for implementation; and
   - Secure better policies through monitoring and evaluation.

Source: Gilson *et al.* (1999)

Looking specifically at strategies to enhance economic access by poor households to health care, Goudge, Khumalo and Gilson (2003) also draw out lessons from experience across the developing world (see **Box 6**). These lessons highlight the multi-factoral nature of intervention, the need for implementation to be carefully managed, and the importance of adaptability to changing circumstances.

Box 6: Lessons for implementing strategies to enhance economic access

1. Taking the views of the poor into account in policy design (whether it be resource allocation, community financing, drug use interventions or exemptions);
2. Enabling implementation and management to be flexible in order to meet the unforeseen needs of the poor;
3. Creating a sense of ownership and control by communities to ensure commitment to a policy;
4. Rooting policy design and implementation on an adequate understanding of the characteristics of poverty – the mobility, lack of participation in formal systems, differing needs to due vulnerability and insecurity of income, the stigma associated with being poor, and greater reluctance to take risks;
5. The need to ensure that the non-poor accept that the poor should be beneficiaries, including politicians and bureaucrats;
6. Ensuring the commitment and motivation of health staff, responsible for implementation is crucial for success;
7. To recognize the importance of solidarity and the willingness to share risks, particularly in success of community financing schemes, where to some extent the wealthier groups will subsidize the poorer groups

Source: Goudge *et al.* (2003)

As noted, part of successful implementation is overcoming resistance to equity-promoting policy changes, even from within the health system itself. Experience in Africa suggests that a core obstacle is the practice of power within health systems, linked to the hierarchical and quite authoritarian nature of public sector bureaucracy (Gilson 2005). Gilson and Erasmus (2004), thus suggest that equity-promoting policy implementation is likely to require changes in organisational culture based on shared values and objectives, respect and open communication, both in relation to patients but also to those who work within the health system. These sorts of developments to the organisational software of health systems also serve to complement and strengthen developments in the hardware of structure, financing mechanisms, and legal frameworks separately identified as necessary to the health system's promotion of equity.

8. CONCLUSION

This review reaffirms the role of the health system as a social determinant of health equity which interacts with other social determinants as well as the broader social and political context. The health system often contributes to inequity and is not the sole promoter of health equity, but nonetheless has enormous potential to act as a driver of change towards health equity across the whole of government.

A comment on the evidence surveyed in this review

In terms of answering point (a) set out in the objectives for this paper (see **Section 1**), the health system literature consistently comments on the limited evidence linking interventions with equity impacts (for example, Palmer *et al.* 2004 and Bennett forthcoming). Many studies are descriptive, and only a handful use robust study designs to measure causal relationships. In addition, proving clear causal links between intervention and impact is difficult given that health system change tends to be multi-causal, slow and strongly shaped by local contexts. However, where the case study designs that could investigate such complex phenomenon are used, they rarely apply the explicit theoretical frameworks that would permit analytical generalisation.

This review has also been limited by the time available to conduct it. As mentioned earlier, we seek to provide an overview of the full range of relevant topics and issues rather than a more detailed assessment of a limited set of topics, and our approach has involved a particular focus on reviews of relevant experience and articles documenting new lines of investigation. Many of the preliminary findings of this paper are therefore based on knowledge that has emerged consistently from different articles, with the caveat that such knowledge is not strictly tested. We have also been able to draw on two parallel international processes and reports focussing on health system and equity issues – the Report of the UN Millennium Project's Task Force on Child Health and Maternal Health (Freedman *et al.* 2005) and the Global Health Watch Report 2005-2006.

Qualitative information that is built on sound methodologies makes an important contribution to this body of knowledge, particularly in understanding the contexts, values, processes and actors influencing health systems (Commission on Social Determinants of Health 2005b). Theory also has a role to play, especially where empirical evidence is thin. The paper seeks to draw on available theoretical perspectives to clarify causal pathways. Beyond causal explanation, the paper also seeks to place emphasis on understanding successful strategies for policy implementation, particularly those that create synergies between different interventions (within and outside the health care sector).

Data and time limitations have also meant that we have not, in attempting to answer point (b) of the objectives, been able systematically to sift policy and implementation recommendations according to the criteria of 1) likelihood of equity-promoting impacts, 2) likelihood of sufficient evidence (of sufficient robustness), 3) high potential for policy uptake, or 4) contribution to existing efforts. Nonetheless, we do identify some possible priority actions drawn from the available evidence, and as reflected in the conclusions of other recent reviews of health system and equity needs.

Gaps in knowledge

Given the literature that we have been able to review, we specifically note the following gaps in this paper. Following further reflection, we propose that filling some of these gaps through focussed literature searches and assessment of existing experience form one element of the knowledge network's future work. The weaknesses of current studies already noted and the gaps around these issues in the international literature indicate a clear need for longer-term research in this field. We hope that the work of the knowledge network can begin to address some of these gaps in the short-term.

The gaps are five-fold:

1) Weak understanding of the role and nature of state action in promoting health equity in different contexts, which necessitates further work around:

- Assessing the influence and potential of state action in relation to equity-promoting policy comparing experience across political, social, economic and health systems (with reference to factors such as the way power is organised, state legitimacy, the level of technical and administrative efficiency, relationships between the state and citizens, for example, as well as exploration of the nature of a 'developmental state');
- Considering how to preserve and restore equity in conflict and post-conflict situations where states are weak and communities disrupted;
- Considering how to protect equity under conditions of market reform, liberalised trade and commercialisation;
- Investigating how health systems can leverage national and local level inter-sectoral action on health, integrate health across all spheres of government including levering resources for health across all sectors; and
- Investigating the mechanisms and procedures by which citizens exert influence on the health sector to enhance equity and understanding how participatory mechanisms can contribute to the development of national commitment to principles such as solidarity.

2) Weak understanding of the potential of particular health system strategies to promote equity, which include further assessment of:

- how to produce and manage the health workforce in ways that promote equity (including, for example, the role of the manager in changing organisational cultures and building employee trust, and the relative balance between non-financial and financial incentives in motivating and retaining health workers);
- what mechanisms can encourage the private sector to support equity within a universal financing system;
- how to devise health promotion efforts that are equity-enhancing and create synergies with other aspects of health system reorientation towards equity; and
- consideration of the role of traditional and alternative sectors in promoting health system equity.

3) Weak understanding of implementation needs, which necessitates further work around:

- how to encourage a 'gradients' approach to redressing inequity;
- strategies that can promote successful implementation of new policy interventions intended to promote equity (that is, a focus on *how* to implement change, including scaling up of successful experiences);
- strategies for the sustained development of public sector leadership and management capacity;

- strategies for building the organisational software necessary to sustain equity-promoting health systems; and
- approaches to building information and monitoring systems that are well-used by policy makers and planners.

4) Weak understanding of differential household experiences of health systems, to be addressed by analysis of available secondary data, such as:

- analysis of longitudinal data from Demographic and Health Surveillance Sites in order to understand health service utilisation patterns by the poor (dis-aggregated into different sub-populations, especially women);
- synthesis of available experiences from in-depth studies (including some longitudinal ones) investigating the factors influencing how households cope with the costs of ill-health, covering the role played by social networks and resources as well as the health system (there are five to six such studies known to the authors, review of which would add to the conceptual frameworks and understandings outlined in **Section 5**); and
- evidence on the value of cash transfers and other social grants in promoting access to care.

5) Limited geographic coverage, requiring additional evidence from other regions, especially Eastern Europe.

Priority areas for action

The gaps identified above notwithstanding, the following areas appear to be key lessons and potential areas of action emerging from the review. Case study analyses of specific examples of these actions could add to the knowledge base in this field. In highlighting these lessons we draw attention to their similarity with those of the two other reviews of health system and equity issues recently conducted (see **Annex** 3).

1) Leveraging policy action:

- The health system needs to use its leverage with other sectors and spheres of government to promote healthy public policy.
- Good governance and accountability are a prerequisite for equity-focused priority-setting and decision-making within health systems.
- Equity cannot be improved without strengthening the health system, especially the public sector. To this end, any policy change needs to be assessed as to its potential overall impact on the health system

2) Achieving equity-promoting health system interventions:

- Build the health workforce to ensure the equitable distribution of appropriately skilled and adequately motivated staff across the health system and country.
- Re-orient health systems towards the provision of primary health care within a District Health System.

3) Financing health care and allocating health care resources:

- A comprehensive approach to financing, founded on the ideals of solidarity and cross-subsidisation, is vital to guard against the differential consequences of health care use and promote equity.
- Increase the proportion of government spending that is dedicated to health, along with increased donor aid and debt relief.

- Reduce out of pocket spending as a proportion of total spending on health care, including the removal of user fees through a properly planned and appropriately implemented strategy.
- Contain the development of private insurance mechanisms and where they exist take steps to prevent risk-rating by, and promote risk equalisation across, insurance schemes.
- Overall resource allocation should be needs-based, taking account of inter- and intra-regional disparities.

4) Strengthening management and implementation capacity:

- Develop the skills of public managers as stewards of the health system.
- Pay attention to transforming the organisational culture of the public sector to enable better management and implementation.
- Develop effective regulation of, and wise interaction with, the private sector to harmonise the efforts of public and private providers.
- Information is vital in developing and implementing policies that support equity. This information needs both to be sensitive to measuring inequity, and dynamic in its engagement with issues of process and outcome.

Areas of synergy or overlap with other knowledge networks

Finally, there are a number of areas where this network would benefit from engagement with other networks. Likewise, there are a number of areas where some clarity is needed on which network will take prime responsibility for investigating issues. These areas of potential synergy and overlap are:

- Community-based interventions, health promotion and implementation lessons (Priority Public Health Interventions);
- The impact of gender and on access and power relations between providers and patients, and between providers themselves (Gender, Social Exclusion);
- Global influences over health systems including health worker migration, trade in health, commercialisation and the role of the state (Globalisation);
- Community-participation and accountability (Social Exclusion); and
- Health care for the urban poor, intersectoral action for health (Urban Settings).

ANNEX 1: IDENTIFYING THE KNOWLEDGE NETWORK MEMBERSHIP

Membership definition

1) Core members invited to attend meetings and guide development of network, as well as to provide inputs as appropriate and possible (10-12 people)
2) Other people and groups involved in aspects of network's programme e.g. by reviewing documents, conducting country-level work etc.

Principles for selection of core members - to strive for balance in membership across:

- Geographical areas, with particular focus on low and middle income country and transitional country membership and allowing for different language groups
- Country, regional and global level initiatives
- Knowledge sources in global initiatives, country governments, civil society, research and academic organistions
- Expertise in different dimensions of health systems
- Different disciplinary perspectives

Proposed process for finalising selection of core members:

- Initial ideas on selection grid (se below) discussed within hub and with Commission (Sept 05)
- Try to fill gaps
- Ask for inputs from wider circle of connected people
- Approach potential members – and snowball additional ideas through them

Acronyms used in grid below:

ALPS Affordability Ladder Programme (Margaret Whitehead, Liverpool University)
CHP Centre for Health Policy
CREHS Consortium for Research on Equitable Health Systems (Anne Mills, London School of Hygiene and Tropical medicine + 7 national partners, including Viroj Tangcharoensathien, Thailand)
EQUINET Regional Network on Equity in Health in Southern Africa
EQUITAP Asia Equity Network (Ravi Rannan-Eliya, Sri Lanka)
GEGA Global Equity Gauge Alliance
HSAN Health Systems Action Network (developing from Montreux meeting)
PHM People's Health Movement
RHSRHS Reproductive health and sexual rights and health system reform project
UN Millennium Project Task Force on Child health and Maternal Health (Columbia University)

Initial grid, as a stimulus to discussion:

Geographic area	**Initiative level**	**Knowledge source**	**Specific expertise**	**Disciplinary perspectives**
Africa: EQUINET; W Africa equity network; NEPAD; WHO Afro *Asia:* EQUITAP; RHSRHS project; CREHS, ALPS *Lat America* Social Medicine Association [gap] Pacific/M East/ Transitional Countries [gap] *High Income Countries*: e.g. Gavin Mooney Margaret Whitehead	*Country/Regional* EQUINET EQUITAP Lat Am Social Medicine Association West Africa equity network WHO Afro NEPAD *International* UN Mill Project Task Force RHSRHS: ALPS CREHS HSAN GEGA	*NGO/social groups:* GEGA; PHM; RHSRHS *Global* HSAN WHO Afro *Governmental:* NEPAD *Research:* ALPS CREHS EQUINET	*Equity experts:* Starfield Mackintosh Mooney Whitehead *Gap filling:* Conflict; Dvelopment; Accountability	*Health Economics:* Mooney EQUINET CREHS EQUITAP Development economics: Mackintosh *Pub Health/Epi:* Starfield Whitehead LatAm Social Medicine Association EQUINET *Law/human rights:* EQUINET UN Mill Project Task Force *Social science:* [gap] *Policy analysis* CHP/EQUINET

ANNEX 2: BIBLIOGRAPHY

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ANNEX 3: SUMMARY OF THE FINDINGS OF OTHER REVIEWS

Millennium Project's Task Force on Child Health and Maternal Health proposals for strengthening health systems to support achievement of MDG 4 and 5 (Freedman et al. 2005)

Health systems, particularly at district level, must be strengthened and prioritized:

- they are key to sustainable, equitable delivery of technical interventions
- they should be understood as core social institutions indispensable for reducing poverty and advancing democratic development and human rights
- to increase equity, policies should strengthen the legitimacy of well governed states, prevent excessive segmentation of the health system , and enhance the power of the poor and marginalized to make claims for care

Financing:

- bilateral and international financing institutions should substantially increase aid
- countries should increase allocations to the health sector
- user fees for basic health services should be abolished

Human resources:

- the health workforce must be developed according to the goals of the health system, with the rights and livelihoods of the workers addressed

Information systems:

- indicators of health system functioning must be developed and integrated into policy and budget cycles
- health information systems must provide appropriate, accurate and timely information to inform management and policy decisions
- countries must take steps to improve vital registration systems

(There are also proposals on sexual and reproductive health and rights, child mortality, maternal mortality and global mechanisms)

Global health Watch 10-point agenda to repair and develop health systems

Alternative World Health Report launched in Cuenca and London by David McCoy and Mike Rowson (http://www.equinetafrica.org)

1. Provide adequate funding for health care systems
2. Take better care of health sector'workers
3. Ensure that public financing and provision underpin health care systems
4. Abolish user fees that put people into poverty
5. Adopt new health system indicators and targets that incentivize countries to improve the health system rather than simply tackle specific diseases
6. Reverse the commercialisation of health care systems by using regulatory and legislative instruments; and search for ways in which the private sector's resources can be harnessed for the public good
7. Strengthen health management and adopt the District Health System as the model for organising health systems
8. Improve donor assistance within the health sector
9. Promote community empowerment to improve the accountability of the health system
10. Promote trust and ethical behaviour to combat the corrosive effects of commercialization.

ANNEX 4: SUPPORTING EVIDENCE FOR STATEMENTS CONTAINED IN THE TEXT

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[i] Lack of trust in the public sector can drive patients – and even the very poor – to use the private sector. For example, Russell (2004) found that, in two poor communities in Sri Lanka, people tended to use the private sector for moderate, acute illnesses: 48% of the study population (95% confidence interval) who sought treatment outside of the home for acute illness went to the private sector – this included 26% of patients from the poorest income quartile (these were households that struggled to meet daily food and fuel needs and, in incurring medical costs, would have had to sell assets etc.) – and most would have preferred to use private. This was because it was much quicker getting access to a private doctor, private doctors spent more time on the consultation and listened carefully to the patients' complaints, and because patients – and their families – were able to build a strong relationship with their doctors over time (resulting in the notion of a 'family' doctor). By way of contrast, at the public facilities there was overcrowding, long queues, cursory consultations and, in the hospitals, high occupancy rates. Russell (2004) concludes that, *'despite the strengths of Sri Lanka's public health sector, poor relationships act as an access barrier and push a range of income groups [including the very poor] to the private sector.'*

[ii] The following was written by Don de Savigny, TEHIP Research Manager, 2004, and extracted from Doherty and Govender (2004):

'The emphasis on decentralization and SWAp health-basket funding in the mid-1990s quickly illuminated the challenge of how district-level health systems could do evidence-based health planning that would improve the technical and allocative efficiency of local choices with respect to resource allocation and service provision. In Tanzania this was taken up by a large-scale demonstration project run by the Ministry of Health, called the Tanzania Essential Health Interventions Project (TEHIP) (Finlay *et al.* 1995). This study ran from 1997 to 2004 involving districts with a combined population of over 700,000 people.

TEHIP benefited from a parallel health research program that followed health system changes, health-seeking behaviour trends, and health impacts. It also had a research and development component tasked with inventing practical tools for decentralized planning that would address needs arising during district health planning and priority-setting. The latter added a number of tools and processes into the district-planning toolkit including:

1) an annual **District Health Intervention Profile** that provided a graphical display of the regional burden of disease in terms of intervention-addressable DALY shares from sentinel demographic surveillance systems;
2) a computer-based **District Health Accounts** tool that allowed districts to do budget and expenditure mapping in terms of allocation of health resources;
3) a computer-based **Health Mapping** tool that could be used at a district level to visualize Health Management Information System data from community and health facility levels;

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4) a **District Integrated Management Cascade** process that improved the efficiency of supportive supervision of health services;

5) a **Community Ownership of Health Facilities Strategy** that freed up resources to renovate physical infrastructure; and

6) a number of capacity building processes for strengthening **District Health Management and Administration** (de Savigny *et al.* 2002). www.idrc.ca/tehip'