AFR/RC60/3
16 June 2010

World Health Organization
REGIONAL OFFICE FOR Africa

REGIONAL COMMITTEE FOR AFRICA **ORIGINAL: ENGLISH**

Sixtieth session
Malabo, Equatorial Guinea, 30 August–3 September 2010

Provisional agenda item 7.1

A STRATEGY FOR ADDRESSING THE KEY DETERMINANTS OF HEALTH IN THE AFRICAN REGION

Report of the Regional Director

Executive summary

1. The past few decades have witnessed increased interest in commitment to greater equity in health through addressing the social determinants of health and their consequences. Health gaps exist in countries of the African Region and are widening in some cases. This document proposes a strategy for closing this health equity gap through action on the key determinants of health.

2. The strategy proposes priority interventions in line with the three overarching recommendations of the WHO Commission on the Social Determinants of Health, namely: (i) improving the daily conditions of living; (ii) tackling the inequitable distribution of power, money and resources; and, (iii) measuring and understanding the problem and assessing the impact of action. The interventions are divided into those that are within the immediate remit of the ministry of health, and those that come under other sectors or are cross-sectoral.

3. The proposed interventions take cognizance of the widening health equity gap within and among Member States. The strategy places emphasis on addressing the structural causes of ill-health and premature death associated with access, affordability and availability, and addresses issues even beyond the risk factors.

4. Member States are called upon to reduce the health equity gap through action on the social determinants of health. The prerequisite for success is political commitment to provide an enabling environment for all to contribute to reducing health inequities through action on the social determinants of health including measures to improve living conditions, tackling uneven distribution of power, money and resources, and routine monitoring of the health equity gap.

5. The WHO Regional Committee for Africa is invited to consider and adopt this strategy.

CONTENTS

ANNEX

INTRODUCTION

1. According to the Constitution of the World Health Organization, the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.[1] Health[2] is not just the outcome of genetic or biological processes. It is influenced by the social and economic conditions in which people are born, grow, live, work and age, and the systems put in place to deal with illness. These conditions, commonly referred to as the 'social determinants of health' (SDH), can help create or destroy peoples' health.

2. These conditions include income, wealth and their distribution, early childhood care, education, working conditions, job security, food security, gender, housing including access to safe water and sanitation, and social safety nets. Governance, and social and economic forces, in turn, shape these conditions.[3] For different social groups, unequal access to these social and economic conditions gives rise to unequal health outcomes.

3. Although health inequalities exist worldwide, between and within countries, the majority of them are avoidable. For many common indicators of socioeconomic status, people living in poverty face a higher risk of adverse health outcomes than those who are better off.[4]

4. The Final Report of the WHO Commission on Social Determinants of Health (CSDH) calls for a new global agenda for health improvement and health equity. It advocates an approach to health and human development in which equity is a fundamental objective of reform.[3]

5. The Sixty-second World Health Assembly passed a resolution calling for a reduction of health inequities through action on the social determinants of health as recommended by the CSDH report (see Resolution WHA62.14 annexed herewith). Similar calls have been made in the World Health Report 2008, [5] the Algiers Declaration, [6] the Libreville Declaration, [7] the Ouagadougou Declaration, [8] and the Nairobi Call to Action.[9]

6. This document proposes a strategy for reducing health inequities through action on the social determinants of health.

---

[1] World Health Organization, 1946 Constitution. Geneva. http://www.who.int/governance/eb/who_constitution_en.pdf (last accessed 02/03/2010 11:38).

[2] The Constitution of the World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". World Health Organization, 1946 Constitution. Geneva.

[3] WHO Commission on the Social Determinants of Health (CSDH) (2008) Closing the Gap in a Generation: Health equity through action on the social determinants of health. Final Report of the Commission. Geneva: World Health Organization. http://www.who.int/social_determinants/thecommission/finalreport/en/index.html (last accessed 3 April 2010).

[4] Mackenbach J.P. (2006), Health Inequalities: Europe in Profile, COI, London. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4121584.pdf - (last accessed 4 April 2010).

[5] WHO, Primary Health Care: Now more than ever. The World Health Report, 2008. Geneva, 2008, World Health Organization. http://www.who.int/whr/2008/en/index.html (last accessed 3 April 2010).

[6] WHO, (2008), The Algiers Declaration. Ministerial Conference on Research for Health in the African Region, a declaration by Member States of the WHO African Region, Algiers, 23–25 June 2008. http://www.afro.who.int/en/regional-declarations.html.

[7] WHO, Libreville Declaration on Health and Environment in Africa. First Inter-ministerial Conference on Health and Environment in Africa: Health security through healthy environments, a declaration by Member States of the WHO African Region, Libreville, Gabon, 26–29 August 2008. http://www.afro.who.int/en/regional-declarations.html (last accessed 3 April 2010).

[8] WHO, (2008), Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium. A declaration by the Member States of the WHO African Region. International Conference on Primary Health Care and Health Systems in Africa, 28-30 April 2008, Ouagadougou, Burkina Faso. http://www.afro.who.int/en/regional-declarations.html (last accessed 3 April 2010).

[9] WHO (2009), "*The Nairobi Call to Action,"* The 7th Global Conference on Health Promotion on Closing the implementation gap," Nairobi, Kenya 27–30 October, 2009. http://www.who.int/healthpromotion/conferences/7gchp/documents/en/index.html (last accessed 3 April 2010).

SITUATION ANALYSIS AND JUSTIFICATION

Situation analysis

7. In the 1980s and 1990s, most parts of sub-Saharan Africa witnessed increasing economic deprivation and poverty, diminishing food security, devastation by the HIV/AIDS pandemic, environmental destruction, increasing unemployment, and general reversal of human development indicators.[10] Extreme poverty increased from 47% in 1990 to 50% in 2009.[11] Women, the elderly and displaced populations were the worst affected groups.

8. The African Region lags behind most other WHO regions in its overall health attainments. Life expectancy at birth was estimated at only 52 years in 2007. This contrasts with 64 and 65 years in the WHO regions of the Eastern Mediterranean and South East Asia, respectively and with the global average of 68 years.[12] Improvements in child survival in many countries in the Region have not reflected in higher life expectancy because these have been eroded by higher levels of adult mortality due to HIV/AIDS and conflict.

9. Progress towards achieving the Millennium Development Goals in the Region has been slow but perceptible.[13] Although reliable data on income poverty is lacking, available information suggests that progress towards reducing poverty is slow.[14] Only eight countries are on track to achieve the target of halving, between 1990 and 2015, the proportion of people who suffer from hunger.[15] Twenty countries in the Region have developed MDG-consistent (second-generation) poverty reduction strategies or national plans.

10. The Region made very little progress towards reducing under-five mortality. The vast majority of countries in the Region made only negligible improvements in reducing under-five mortality by about 2% between 1990 and 2005. Only six countries[16] are on track to achieve this target.[17] There was only a marginal improvement in infant mortality rates (from 110 to 99 per 1000 live births) between 1990 and 2005. However, Malawi and Mauritius recorded improvements exceeding 5%. The Region made virtually no progress towards achieving the MDG target of reducing maternal mortality, although there was a 30% increase in access to contraceptives among currently married women. In general, the prevalence of HIV/AIDS has stabilized but the challenge of providing support and treatment for cases remains.

---

10 Economic Commission for Africa, (2005). The Millennium Development Goals in Africa: Progress and Challenges. Addis Ababa: United Nations Economic Commission for Africa. http://www.uneca.org/mdgs/MDGs_in_Africa.pdf (last accessed 3 April 2010).

11 People living on less than US$1.25/day are said to be in extreme poverty. See World Bank MDGs website: http://web.worldbank.org/WBSITE/EXTERNAL/EXTABOUTUS/0,,contentMDK:20104132~menuPK:250991~pagePK:43912~piPK:44037~theSitePK:29708,00.html, (last accessed 12/29/2009).

12 WHO (2009), World Health Statistics, 2009. Geneva: Department of Health Statistics and Informatics of the Information, Evidence and Research Cluster. http://www.who.int/whosis/whostat/2009/en/index.html (last accessed 6 April 2010).

13 WHO, *Towards reaching the health-related Millennium Development Goals: Progress report and the way forward,* Brazzaville, World Health Organization, Regional Office for Africa, 2009 (AFR/RC59/3).

14 ECA, (2007). *Assessing Progress towards the Millennium Development Goals*. Report to the Conference of Ministers of Finance, Planning and Economic Development. Addis Ababa.

15 WHO, *Towards reaching the health-related Millennium Development Goals: Progress report and the way forward*, Brazzaville, World Health Organization, Regional Office for Africa, 2009 (AFR/RC59/3).

16 They include Algeria, Cape Verde, Eritrea, Malawi, Mauritius and Seychelles.

17 WHO, *Towards reaching the health-related Millennium Development Goals: Progress report and the way forward*, Brazzaville, World Health Organization, Regional Office for Africa, 2009 (AFR/RC59/3).

11. Most countries are likely to achieve gender parity by 2015. Ten countries achieved gender parity in primary education in 2005.[18] Seventeen countries had a gender parity of over 0.90[19] while six others achieved net rates of enrolment in primary education in excess of 80%.[20] Between 2004 and 2005 Ethiopia, Kenya, Mozambique and Zambia recorded increased enrolments in primary education in excess of 4%. Ethiopia, Ghana and Tanzania maintained the momentum of high enrolment achieved in previous years, posting growth rates in enrolment of 6.5%, 4.2% and 17.3% respectively between 2005 and 2006.

12. Despite the progress noted in some of the MDG indicators as set out above, most MDG targets are not likely to be met. Even in those countries that are making some progress, although improvements in national averages for the health and other MDG indicators are likely, the situation of the poor and vulnerable groups is not likely to change. Consequently, there is need to address the social determinants of health in countries in order to ensure that as countries strive to achieve the MDGs targets, the poor are not left behind.

13. Widespread health inequalities exist in various health outcome measures such as infant and child mortality, maternal mortality and stunting, and in access to health services indicators.[21] The health system, itself a determinant of health, has not been adequately prepared to address the "causes of the causes" as regards the major communicable diseases, maternal and child health problems and the increasing prevalence of chronic diseases.

14. There are wide inequities, within and between countries, in health services coverage, safe water supply and sanitation, and health outcomes.[21] In the majority of countries some common patterns are observed as regards urban/rural location, education and gender. The patterns are: urban dwellers generally live longer than rural inhabitants; higher education results in higher life expectancy; and females live longer than males. In some countries, there are major disparities in health status between the rich and the poor while for others the difference is insignificant. Disparities across households are also increasing.[21]

15. Globalization, trade, urbanization, climate change, information technology, and civil conflicts are among the major external drivers that have an impact on social, cultural and behavioural practices and ultimately on health outcomes across population groups. These factors, which are structural and intermediate, are beyond the remit of the health sector apart from environmental issues related to water supply and sanitation traditionally linked with public health. However, they have a huge cumulative impact on health due to their influence on lifestyle-related factors such as food consumption, use of tobacco, alcohol, drugs and other psychoactive substances, physical activity, violence, sanitation and hygiene, unsafe sex, health information seeking and high-risk behaviours, among others.

16. Climate change is threatening to erode the gains made in economic growth and poverty reduction. Sub-Saharan Africa suffers from natural fragility, with two-thirds of its surface area being a desert land or arid land. In addition, it is exposed to spells of drought and flooding predicted to intensify due to climate change.[22] Malaria, one of the major killer diseases in the

---

18 These include Gambia, Gabon, Lesotho, Malawi, Mauritius, Mauritania, Namibia, Rwanda, Seychelles and Uganda.

19 They were Algeria, Botswana, Cape Verde, Congo, Equatorial Guinea, Ghana, Kenya, Madagascar, Sao Tome and Principe, Senegal, South Africa, Tanzania, Zambia and Zimbabwe.

20 Algeria, Benin, Botswana, Cape Verde, Mauritius and Tanzania.

21 WHO, Health Inequities in the WHO African Region: *magnitudes, trends and sources*. World Health Organization, Regional Office for Africa, Brazzaville 2010.

22 World Bank, Regional Vulnerability to Climate Change. World Development Report 2010: Development and Climate Change – *http://econ.worldbank.org/WBSITE/EXTERNAL/EXTDEC/EXTRESEARCH/EXTWDRS/EXTWDR2010/0,,contentMDK:22303545~pagePK:64167689~piPK:64167673~theSitePK:5287741,00.html#AFR* last accessed 10/29/2009.

Region, is spreading to previously non-endemic areas usually of high altitude.[22] In addition, the global economic crisis threatens to worsen the current health situation if the limited resources available are diverted from health to other areas accorded greater priority.

Justification

17. The health inequities that exist within and between countries of the African Region are hampering progress in attaining the Millennium Development Goals (MDGs).[23] In order to improve health outcomes and attain the MDGs countries should promote sectoral policies that address the key determinants of health, the upstream factors and the fundamental 'causes of causes'.[24]

18. The responsibility for tackling many of the key determinants of health rests with ministries other than the ministry of health. The challenge therefore is how the ministry of health can influence actions by these other ministries. Although WHO and Member States are already addressing these challenges through various initiatives,[25] there is urgent need for a more coherent approach. This strategy should be seen also as an opportunity to streamline and implement World Health Assembly Resolution WHA62.12 which strongly reaffirms the values and principles of primary health care including equity, solidarity, social justice, universal access to services, multisectoral action, decentralization and community participation as the basis for health systems strengthening.

THE REGIONAL STRATEGY

Aim and Objective

19. The aim of this strategy is to assist Member States to promote actions to reduce health inequities through intersectoral policies and plans in order to effectively address the key determinants of health. The objective is to provide Member States with a structured approach to implementing the CSDH recommendations in line with World Health Assembly Resolution 62.14[26] and to promote their uptake in countries. The overall goal is to ensure that all countries in the Region address the social determinants of health using a "whole-of-government" approach.

Guiding Principles

20. In this regard, there is a need to adhere to the following general guiding principles:[27]

(a) levelling up i.e., health equity policies should strive to raise the health status of individuals and groups at the bottom of the ladder;

(b) equity for all i.e., the health system should be built on principles of fairness;

---

23 WHO, Towards reaching the health-related Millennium Development Goals: Progress report and the way forward, Brazzaville, World Health Organization, Regional Office for Africa, 2009 (AFR/RC59/3). http://www.afro.who.int/en/fifty-ninth-session.html - last accessed 4 April 2010.

24 WHO, Achieving Health Equity: from root causes to fair outcomes, Interim Statement, Commission on Social Determinants of Health. World Health Organization, Geneva, 2007. http://whqlibdoc.who.int/publications/2007/interim_statement_eng.pdf - last accessed 4 April 2010.

25 For example, through work emanating from the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium, the Libreville Declaration on Health and Environment, and the Algiers Declaration on Health Research for Health in the African Region, the Regional Strategy on Poverty and Health, and "Agenda 2020" on Health for All in the African Region by the Year 2020.

26 WHO, World Health Assembly Resolution WHA 62.14 on "Reducing health inequities through action on the social determinants of health", World Health Organization, Geneva, May 2009. http://apps.who.int/gb/ebwha/pdf_files/A62/A62_R14-en.pdf – last accessed 4 April 2010.

27 Whitehead, M. and Dahlgren, G. (2006) Levelling Up (part 1) Concepts and Principles for Tackling Social Inequities in Health. Discussion Paper. WHO Europe. http://test.cp.euro.who.int/document/e89383.pdf - accessed 4 April 2010.

(c) universal participation i.e., all voices, including those of marginal groups should be heard;

(d) partnerships i.e., implementation should be based on partnership between the country and all development partners;

(e) multisectorality i.e., implementation should be the responsibility of all sectors;

(f) ownership i.e., there should be a sense of ownership by country and relevant stakeholders.

Priority Interventions

21. The priority interventions presented below emanate from the overarching recommendations of the CSDH:

(a) improve day-to-day living conditions by improving the circumstances in which people are born, grow, live and age;

(b) address the inequitable distribution of power, money and resources; and

(c) measure and understand the problem and assess the impact of action.

22. The proposed interventions are grouped into two broad categories, namely: interventions specific to the health sector; and interventions in sectors other than health including cross-sectoral actions.

(A) Interventions specific to the health sector

23. **Strengthen the stewardship and leadership role of the ministry of health** to coordinate and advocate for multisectoral and multidisciplinary interventions to reduce the health equity gap through addressing SDH. The responsibility for action on health and health equity should itself be assigned to the highest level of government.

24. **Build capacity for policy development, leadership and advocacy to address SDH**. There is need to build the capacity of the staff of the ministry of health to provide leadership in developing policies and programmes for improving health literacy, knowledge transfer and research on social determinants of health using multisectoral and multidisciplinary approaches.

25. **Advocate for legislations and regulations to ensure a high level of protection of the general population** from harm and from the impact of some social and economic determinants of health e. g., globalization, commercialization, urbanization.

26. **Create health systems based on universal and quality health care.** Health systems in the Region should be built on the basis of the principles of equity, disease prevention, and health promotion. Quality health care services should be aimed at universal coverage of primary health care. Leadership of the public sector in equitable health care should be strengthened. The health workforce should be developed or strengthened and their capabilities to act on SDH should be strengthened.

27. **Enhance fairness in health financing and resource allocation.** The role of the ministry of health should be to advocate for fair allocation of financial and technical resources. Countries should strengthen or mobilize public finance for action on SDH by building capacity for progressive taxation. They should consider establishing mechanisms to finance cross-government actions on SDH and allocate funds fairly between geographical regions and social groups.

(B) Interventions in sectors other than health including cross-sectoral actions

28. **Ensure social protection throughout the life-course.** Countries should establish and strengthen comprehensive universal social protection policies that support a level of income sufficient for a healthy living for all.

29. **Develop or promote policies for healthy places and healthy people.** Health equity between rural and urban areas should be promoted. There is need for investment in rural development and for addressing the exclusionary policies and processes that lead to rural poverty, landlessness, and displacement of people from their habitats. For urban areas, there is need to place health and health equity at the heart of urban governance and planning. There is need also to ensure economic and social policy responses to climate change and environmental degradation, taking into account health equity. Countries will need to take measures for increased resilience and for protection against adverse changes in the climate.

30. **Ensure health equity in all policies.** Countries should place the responsibility for action on health and health equity at the highest level of government and ensure its coherent consideration across all policies. Health and health equity should be the corporate business of the entire government, supported by the head of state and should be a marker of government performance.

31. **Assess and mitigate the adverse effects of international trade and globalisation.** Countries should institutionalise health impact assessments of major global, regional and bilateral trade agreements and ensure and strengthen the representation of public health in domestic and international economic policy negotiations.

32. **Enhance good governance for health and health equity.** Countries and development partners including civil society should make health equity a shared developmental goal as part of ensuring social corporate responsibility e. g., in the areas of trade, urbanization and climate change, among others. There is need for a framework with appropriate indicators for monitoring progress, taking into consideration country contexts.

33. **Invest in early childhood development to ensure equity from the start.** Countries should commit themselves to implementing a comprehensive approach to early life, building on existing child survival programmes and expanding interventions in early life to include social, emotional, language and cognitive development. Depending on the availability of resources, quality compulsory primary and secondary education should be provided for all children.

34. **Promote fair employment and decent work.** Full and fair employment and decent work should be a central goal of national social and economic policy making. Decent work should be a shared objective of national institutions and a central part of national policy agendas and development strategies with strengthened representation of workers in the creation of policy, legislation and programmes relating to employment and work including occupational health.

35. **Mainstream health promotion.** Priority should be given to mainstreaming health promotion in all policies and programmes to reduce the equity gap through community empowerment. Priority actions should be implemented within the primary health care (PHC) approach to advocate for health; invest in sustainable policies and infrastructure; build capacity for policy development and leadership; ensure high level protection from harm through adequate regulation and legislation; and build partnerships with various players to create sustainable intersectoral action.

36. **Mainstream and promote gender equity.** Countries should address gender biases in the structure of society: gender-based cultural and social biases; biases in national and local government laws and their enforcement; biases in the way organizations are run, how interventions are designed, how economic performance is measured. Policies and programmes aimed at bridging the gaps in education and skills and supporting female economic participation need to be developed and adequately financed. There is need to expand investments in sexual and reproductive health services and programmes geared towards universal coverage and respect for human rights.

37. **Address social exclusion and discrimination.** Addressing social exclusion, promoting social inclusion and respecting diversity should be key public policy priorities. Public service delivery should be equitable, culturally sensitive, appropriate to diverse needs and accessible to people with disabilities and other vulnerable groups and communities. If appropriate, information about health and welfare entitlements and public services should be made available in a broad range of formats and languages. Data collection strategies should ensure that adequate information about the social and geographical patterns of health of the population is routinely available.

38. **Enhance political empowerment.** All groups in society should be empowered through fair representation in decision-making about how society operates, particularly in relation to its effect on health equity and the creation and maintenance of a socially inclusive framework for policy making. Civil society should be empowered to organise and act in a manner that promotes and realizes the political and social rights in regard to health equity.

39. **Protect/improve SDH in conflicts.** Countries need to improve SDH and promote human rights through building health care systems that promote health equity and community participation in conflict situations.

40. **Ensure routine monitoring, research and training.** There is urgent need:

(a) to ensure that routine monitoring systems for health equity and SDH are in place and to strengthen vital statistics and health equity surveillance systems to collect routine data on SDH and health equity.

(b) to conduct social, cultural and behavioural studies applying social science research methodologies to determine social factors likely to hinder or promote the bridging of the equity gap through action on social determinants of health that have an impact on priority public health issues such as control of communicable and noncommunicable diseases. This will complement the action of countries in implementing and monitoring the Algiers Declaration, the Libreville Declaration and the Ouagadougou Declaration.

(c) to provide training on the social determinants of health for policy actors, stakeholders and practitioners, and invest in raising public awareness.

Roles and Responsibilities of Member States, WHO and Partners

Member States

41. In addition to the actions requested of Member States in World Health Assembly Resolution WHA62.14, countries should:

(a) In the short term:

(i) strengthen the stewardship role of the ministry of health to coordinate and advocate for intersectoral action to reduce health inequities through action on social determinants of health;

(ii) institutionalize mechanisms for advocacy, evidence gathering and dissemination in order to act on socially-determined health inequities both within and outside the health sector;

(iii) cooperate with training and research institutions in order to document the situation with respect to the distribution of the key determinants of health. This analysis would further consolidate the evidence-base on the impact of SDH in order to inform policy making and establish a baseline for evaluation of the outcomes of these policies;

(iv) build national capacity to advocate for reducing the health equity gap through addressing SDH in all priority public health concerns such as HIV/AIDS, NCD, mental illness and TB.

(v) adapt a "whole-of government" approach to health promotion through multisectoral and multidisciplinary collaboration by establishing a "Social Determinants of Health Task Force" to, among others, identify and build support for health in all policies, at all levels of government and across all sectors;

(b) In the long term:

(i) ensure that health policies, plans and programmes are oriented to addressing the key SDH;[28]

(ii) review health and other training curricula to ensure that linkages between health and SDH are included in all training and in research funding criteria;

(iii) provide the financial resources required to support activities for implementing these actions;

(iv) advocate for good governance and corporate social responsibility at local and global levels since the widening health equity gap results from structural forces such as globalization, trade and urbanization.

The World Health Organization and Partners

42. In addition to the actions requested of WHO in Resolution WHA62.14, WHO and partners should:

(a) hold consultations and discussions on priorities and add them to already identified areas of collaboration;

(b) establish a mechanism for annual monitoring of the progress that countries are making in addressing SDH and reducing health inequities;

[28] Evidence from the final report of the WHO-CSDH Knowledge Network on priority public health conditions can help inform this process.

(c) ensure greater coordination within WHO in order to provide the necessary technical support and guidance to countries in reducing the health equity gap through action on SDH.

Resource Implications

43. Implementing this strategy will require new and additional resources. Countries, WHO and partners are called upon to mobilise resources for implementation of this strategy.

Monitoring and Evaluation

44. The following three elements of monitoring and evaluation are crucial to the implementation of this strategy: (a) monitoring the overall implementation of the strategy over the next 3–5 years; (b) monitoring country progress in implementing the recommendations; (c) tracking and documenting health equity trends for intercountry comparisons.

CONCLUSION

45. This regional strategy proposes interventions for addressing SDH. The priority interventions outlined fall into three key areas of action contained in the CSDH Report. They are: (a) improving the conditions of peoples' daily life; (b) tackling the inequitable distribution of power, money and resources – the structural drivers of the conditions of daily life; and (c) measuring and understanding the problem.

46. The strategic interventions are grouped into two areas namely (a) those that are specific to, or driven by, the health sector; and (b) those that are driven by sectors other than health including cross-sectoral actions.

47. Reducing health inequities through action on SDH requires committed leadership and bold action at all levels. It requires strong partnerships between Member States, WHO and other development partners, communities, and individuals.

48. Member States are encouraged to implement the proposed interventions, integrate SDH across sectors and settings, and provide an enabling environment for all stakeholders to contribute to the reduction of health inequities.

49. The Regional Committee is requested to consider and adopt this strategy.

ANNEX 1

SIXTY-SECOND WORLD HEALTH ASSEMBLY **WHA62.14**

Agenda item 12.5 **May 2009**

Reducing health inequities through action on the social determinants of health

The Sixty-second World Health Assembly,

Having considered the report on the Commission on Social Determinants of Health,[29]

Noting the three overarching recommendations of the Commission on Social Determinants of Health: to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action;

Noting the 60th anniversary of the establishment of WHO in 1948, and its Constitution, which affirms that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Noting the thirtieth anniversary of the International Conference on Primary Health Care at Alma-Ata in 1978, which reaffirmed the essential value of equity in health and launched the global strategy of primary health care to achieve health for all;

Recalling the principles of "Health for All", notably the need for intersectoral action (Resolution WHA30.43);

Confirming the importance of addressing the wider determinants of health and considering the actions and recommendations set out in the series of international health promotion conferences, from the Ottawa Charter on Health Promotion to the Bangkok Charter for Health Promotion in a Globalized World, making the promotion of health central to the global development agenda as a core responsibility of all governments (resolution WHA60.24);

Noting the global consensus of the United Nations Millennium Declaration to achieve the Millennium Development Goals by 2015 and the concern at the lack of sufficient progress towards many of these goals in some regions at the half-way point;

Welcoming in this regard resolution WHA61.18, which initiates annual monitoring by the Health Assembly of the achievement of health-related Millennium Development Goals;

Noting *The world health report 2008*[30] on primary health care and its focus on ways to improve health equity by reforming health and other societal systems;

Mindful about the fact that responses to environmental degradation and climate change include health equity issues and noting that the impact of climate change is expected to negatively affect the health of vulnerable and disadvantaged populations (resolution WHA61.19);

---

[29] Document A62/9.

[30] World Health Organization. *The world health report 2008: primary health care – now more than ever*. Geneva, World Health Organization, 2008.

Mindful about the facts concerning widening gaps in life expectancy worldwide;

Attaching utmost importance to the elimination of gender-related health inequities;

Recognizing that millions of children globally are not reaching their full potential and that investing in comprehensive supports for early child development that are accessible to all children is a fundamental step in achieving health equity across the lifespan;

Acknowledging that improvement of unfavourable social conditions is primarily a social policy issue;

Noting the need to improve coordination among global, national and subnational efforts in tackling social determinants of health through work across sectors, while simultaneously promoting social and economic development, with the understanding that such action requires the collaboration of many partners, including civil society and private sector;

Mindful of the important role of existing global governance[31] mechanisms to support Member States in provision of basic services essential to health and the regulation of goods and services with a major impact on health, and the need for corporate responsibility,

1. EXPRESSES its appreciation for the work done by the Commission on Social Determinants of Health;

2. CALLS UPON the international community, including United Nations agencies, intergovernmental bodies, civil society and the private sector:

(1) to take note of the final report of the Commission on Social Determinants of Health and its recommendations;[32]

(2) to take action in collaboration with WHO's Member States and the WHO Secretariat on assessing the impacts of policies and programmes on health inequities and on addressing the social determinants of health;

(3) to work closely with WHO's Member States and the WHO Secretariat on measures to enhance health equity in all policies in order to improve health for the entire population and reduce inequities;

(4) to consider health equity in working towards achievement of the core global development goals and to develop indicators to monitor progress, and to consider strengthening international collaboration in addressing the social determinants of health and in reducing health inequities;

3. URGES Member States:

(1) to tackle the health inequities within and across countries through political commitment on the main principles of "closing the gap in a generation" as a national concern, as is appropriate, and to coordinate and manage intersectoral action for health in order to mainstream health equity in all policies, where appropriate, by using health and health equity impact assessment tools;

---

31 In *Basic Documents*, 46th edition, Geneva, World Health Organization, 2007.

32 Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health*. Geneva, World Health Organization, 2008.

(2) to develop and implement goals and strategies to improve public health with a focus on health inequities;

(3) to take into account health equity in all national policies that address social determinants of health, and to consider developing and strengthening universal comprehensive social protection policies, including health promotion, disease prevention and health care, and promoting availability of and access to goods and services essential to health and well-being;

(4) to ensure dialogue and cooperation among relevant sectors with the aim of integrating a consideration of health into relevant public policies and enhancing intersectoral action;

(5) to increase awareness among public and private health providers on how to take account of social determinants when delivering care to their patients;

(6) to contribute to the improvement of the daily living conditions contributing to health and social well-being across the lifespan by involving all relevant partners, including civil society and the private sector;

(7) to contribute to the empowerment of individuals and groups, especially those who are marginalized, and take steps to improve the societal conditions that affect their health;

(8) to generate new, or make use of existing, methods and evidence, tailored to national contexts in order to address the social determinants and social gradients of health and health inequities;

(9) to develop, make use of, and if necessary, improve health information systems and research capacity in order to monitor and measure the health of national populations, with disaggregated data such as age, gender, ethnicity, race, caste, occupation, education, income and employment where national law and context permits so that health inequities can be detected and the impact of policies on health equity measured;

4. REQUESTS the Director-General:

(1) to work closely with partner agencies in the multilateral system on appropriate measures that address the social determinants of health and promote policy coherence in order to minimize health inequities; and to advocate for this topic to be high on global development and research agendas;

(2) to strengthen capacity within the Organization with the purpose of giving sufficient priority to relevant tasks related to addressing the social determinants of health in order to reduce health inequities;

(3) to make social determinants of health a guiding principle for the implementation of measures, including objective indicators for the monitoring of social determinants of health, across relevant areas of work and promote addressing social determinants of health to reduce health inequities as an objective of all areas of the Organization's work, especially priority public health programmes;

(4) to support the primary role of Member States in promoting access to basic services essential to health and the regulation, as appropriate, of goods and services with a major impact on health;

(5) to ensure that ongoing work on the revitalization of primary health care addressing the social determinants of health is aligned with this, as recommended by The world health report 2008;

(6) to provide support to Member States in implementing a health-in-all-policies approach to tackling inequities in health;

(7) to provide support to Member States, upon request, in implementing measures with the aim of integrating a focus on social determinants of health across relevant sectors and in designing, or if necessary redesigning, their health sectors to address this appropriately;

(8) to provide support to Member States, upon request, in strengthening existing efforts on measurement and evaluation of the social determinants of health and the causes of health inequities and in developing and monitoring targets on health equity;

(9) to support research on effective policies and interventions to improve health by addressing the social determinants of health that also serve to strengthen research capacities and collaborations;

(10) to provide support to the regional directors in developing a regional focus on issues related to the social determinants of health and in engaging a broader range of countries in this issue, in accordance with the conditions and challenges of each region;

(11) to convene a global event, with the assistance of Member States, before the Sixty-fifth World Health Assembly in order to discuss renewed plans for addressing the alarming trends of health inequities through addressing social determinants of health;

(12) to assess the performance of existing global governance mechanisms to address the social determinants of health and reducing health inequities;

(13) to report on progress in implementing this resolution to the Sixty-fifth World Health Assembly through the Executive Board.

Eighth plenary meeting, 22 May 2009
A62/VR/8

= = =

AFR/RC60/WP/1
10 June 2010

DRAFT RESOLUTION

A STRATEGY FOR ADDRESSING KEY DETERMINANTS OF HEALTH IN THE AFRICAN REGION

The Regional Committee,

Having examined the document entitled "A strategy for addressing the key determinants of health in the African Region";

Recalling the report and recommendations of the WHO Commission on Social Determinants of Health (CSDH);

Noting global and regional calls and commitments to reduce the health equity gap by addressing the risk factors and their determinants namely, the Bangkok Charter for Health Promotion in a Globalized World (2005); and the Nairobi Call to Action for closing the implementation gap (2009); the Ouagadougou Declaration and the Libreville Declaration;

Noting the global consensus through United Nations to achieve the Millennium Development Goals by 2015 and the concern about inadequate progress in many countries of the African Region to achieve these goals to date;

Welcoming, in this regard, Resolution WHA61.18 which requires annual monitoring by the Health Assembly of the achievement of health-related Millennium Development Goals;

Taking note of Resolution WHA62.14 on "Reducing health inequities through action on the social determinants of health" adopted by the 62nd Session of the World Health Assembly 2009;

Acknowledging that health inequities and inequalities exist within and between countries of the African Region and that the structural drivers include education, trade, globalization, employment and working conditions, food security, water and sanitation, health care services, housing, income and its distribution, unplanned urbanization and social exclusion;

Noting that most of these key determinants of health are rooted in political, economic, social and environmental contexts and are therefore linked to good governance and social justice for all particularly the poor, women, children and the elderly;

Concerned that growing poverty, the global financial crisis, climate change, pandemic influenza, globalization and urbanization could further widen the health equity gap by differentially impacting on population groups and result in increased premature deaths, disability and illness from preventable causes;

Acknowledging the efforts by individual Member States of the African Region to reduce the health equity gap and the progress made by some of the Member States;

Recognizing the growing evidence suggesting that action on the equity gap and its determinants is possible;

Noting the need for Member States to integrate health equity in all policies and programmes, advocate for reduction of the equity gap through action on determinants of health, and document the evidence;

1. ENDORSES the Regional Strategy for addressing the key determinants of health in the African Region as contained in Document AFR/RC60/3 and expresses its appreciation for the work done by the WHO Secretariat and the Commission on Social Determinants of Health;

2. URGES Member States:

(a) to deliberate on the recommendations of the CSDH Report and identify recommendations that are relevant to the contexts of countries;

(b) to establish sustainable national leadership, policies and structures to coordinate intersectoral action to address the determinants of health across population groups and priority public health conditions;

(c) to monitor the health equity trends and document and disseminate the findings to strengthen policy and programme implementation across priority public health conditions;

(d) to promote both quantitative and qualitative research in order to understand factors influencing the health equity trends including the role of cultural beliefs and values;

(e) to establish or strengthen national institutional mechanisms for monitoring the implementation of the regional strategy and document the findings;

3. REQUESTS the Regional Director:

(a) to strengthen the leadership role of WHO and the ministries of health to advocate and coordinate intrasectoral and intersectoral actions by providing guidelines, policies and strategies to address social determinants of health across sectors and priority public health conditions;

(b) to support countries to establish routine monitoring systems that include the collection of disaggregated data and health equity analysis;

(c) to support national and regional research on social, cultural and behavioural risk factors and the determinants likely to influence health outcomes;

(d) to strengthen the capacity of Member States to empower individuals, families and communities through increased literacy in determinants of health within the context of revitalizing primary health care;

(e) to report to the Sixty-second session of the Regional Committee (2012) on the progress made in the implementation of this resolution.