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HEALTH REPORTER: focus on social determinants of health 11 July 2006

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This is our monthly email bulletin, bringing together research to inform policy debates on health in developing countries. The Health Reporter aims to provide readers with a more in-depth look at a particular area of health policy. This month's theme is [social determinants health](#). The bulletin also features summaries of new documents and other additions to the [Health Resource Guide](#).

All documents listed below are available free on the web. If you are unable to access any of these materials online and would like to receive a copy of a document as an email attachment, please contact r.wolfe@ids.ac.uk.

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Feature: social determinants of health

The idea that the type of society we live in affects health is not new. Variation in health status can be explained by factors such as income and its distribution, quality of early childhood, employment and working conditions, at least as much as by improvements in health systems. Yet very few governments have coordinated policy responses that recognise the need to go beyond the health sector to improve population health.

In order to address this, the World Health Organization set up a new Commission on the Social Determinants of Health in March 2005. The Commission works with different government ministries, civil society and academics to draw attention to the role of social, political and economic factors on people's health. Its literature emphasises equal opportunities in accessing the resources required for good health. These resources include early child development, gender equality, high quality health systems, fair global policies, healthy urban settings, and decent employment and working conditions.

An important strand of the Commission's work is the involvement of civil society. It has declared that it will depart from 'standard practice in international organizations and previous global commissions, where civil society "participation" has often meant rubber-stamping decisions made by others' (see http://www.who.int/social_determinants/resources/cs_update.pdf). Instead, it is hoped that civil society organisations (CSOs) will be able to take an active role. Regional civil society networks such as (in Africa) Health Action International Africa and EQUINET, have been asked to facilitate a consultative process through which CSOs themselves will define their strategies for working with the Commission.

For more information see:

- [WHO Commission on Social Determinants of Health](#)
- [Health, poverty and vulnerability](#)
- [Strategies outside the health sector for meeting the health-related needs of the very poor](#)
- Search for documents on social determinants of health: www.eldis.org/health/docs/sdh

Recommended readings on social determinants of health

1. Action on the social determinants of health: learning from previous experiences

Authors: WHO Secretariat of the Commission on the Social Determinants of Health (2005)

This paper from the World Health Organization provides background information for the Commission on the Social Determinants of Health (CSDH), launched in March 2005. It recognises that the most powerful causes of disease and health inequalities are the social conditions in which people live and work (known as the social determinants of health or SDH). The paper includes a detailed historical survey of past efforts to promote health policies on social determinants. It stresses the importance of learning from these experiences, both positive and negative, to increase chances of future success.

The paper highlights four key areas the Commission needs to address: (1) evaluating both comprehensive and selective approaches to healthcare and identifying appropriate policy changes; (2) developing dialogue with international financial institutions and identifying quick gains for those taking up the SDH agenda; (3) forging alliances with the business community and civil society, and managing their competing interests; and (4) finding a compelling "story" to communicate the SDH message. The paper notes the opportunity for multisectoral action presented by the Millennium Development Goals, which link health with social factors. It concludes by stressing the key role of the Commission in tackling the root causes of ill-health. [adapted from author]

Available online at: <http://www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18115>

2. Global health watch 2005/06: an alternative world health report

Authors: People's Health Movement; Medact; Global Equity Gauge Alliance; Zed Books; Global Health Watch Secretariat
Produced by: Global Health Watch (2005)

Published by the Global Health Watch Secretariat, the Global Health Watch 2005/06 is the first "alternative world health report", written from the perspective of civil society. It challenges the world's major health institutions, addresses the causes of global inequality, and sets out measures for achieving adequate and equitable health for all. The report covers health and globalisation; health care services and systems; health of vulnerable groups; the wider health context; and the accountability of global institutions, including the World Health Organization (WHO), governments and corporations. In particular, it argues that the WHO is insufficiently resourced, and distracted from its core aims by internal management problems, the power games of rich nations, and too many uncoordinated initiatives.

The report calls on the world community to go further than the G8 summit in addressing debt, aid and trade. It calls for an end to the imposition of trade liberalisation on developing countries; and the establishing of an international tax authority to prevent corporate tax avoidance and fund health and development. It advocates a stronger voice for indigenous, disabled and other marginalised people in health and development decision-making. A ten-point action plan for effective health services includes abolishing user fees, reversing the commercialisation of health, and improving donor assistance within the health sector. [adapted from author]

Available online at: <http://www.eldis.org/cf/rdr/rdr.cfm?doc=DOC19018>

3. Child survival 4: Applying an equity lens to child health and mortality: more of the same is not enough

Authors: Victoria, C.G.; Wagstaff, A.; Schellenberg, J.A.; Gwatkin, D.; et al

Produced by: The Lancet (2003)

Gaps in child mortality between rich and poor countries are unacceptably wide and in some areas are becoming wider, as are the gaps between wealthy and poor children within most countries. They exist despite the availability of an impressive array of effective interventions and initiatives. This article, the fourth in The Lancet child survival series, examines why poor children die earlier and asks how policymakers can reduce child survival gaps.

The gaps in child mortality might have been even greater in the absence of existing interventions, but it is clear that present initiatives have come nowhere close to eliminating them. Inequities are generally reinforced by initiatives reaching upper-income children more effectively than disadvantaged ones. The article argues that the huge mortality reductions that might be expected to occur if inequities were eliminated are far greater than could be achieved with new technology.

Key findings include the following:

- In high income countries, six of every 1000 children die before their fifth birthday; in the developing world, the rate is 88 per 1000; and in the poorest countries, the rate is 120 per 1000.
- Poorer children are more exposed to risks for disease in the form of inadequate water and sanitation, crowding, and high exposure to disease vectors amongst other factors. They are also more likely to have lower resistance to infectious diseases because they are undernourished.
- The health of poorer children is further compromised by low coverage levels for prevention interventions. Once sick, they are not as likely to be taken to a health care facility; if they are, they are less likely to receive proper care.
- Approaches that have been used for improving child health services in poor populations include: improving knowledge and changing behaviour in poor mothers (such as nutrition counselling), improving access to water and sanitation, commercial-sector marketing (such as for mosquito nets), and making health care more affordable and accessible (fee-waiver schemes).

Conclusions include the following:

- Enough is known now to move ahead to reduce health inequalities in children. Implementation of poverty orientated approaches on a large scale is the next challenge.
- Two basic approaches can raise coverage in poor population groups. One approach focuses on particular programmes or interventions that mainly benefit poor people, usually referred to as targeting. The other approach achieves universal coverage with programmes or interventions that address conditions that are especially important for disadvantaged groups. Both have strengths and weaknesses and the decision of which strategy to use must be made on a case-by-case

basis.

- Providing programme managers and policymakers with accurate information about health inequities is key. Documenting inequities will make it possible to hold decision-makers to account for failing to take the necessary action.
- International agencies must build on present efforts to address equity by advising governments on what they can do to tackle child health inequities. Special efforts based on the approaches in this article must be made to reach the poorest populations, and progress towards the millennium development goal of reducing child mortality should be monitored across the socioeconomic groups.

NB: To access this paper, you will first be asked to register with The Lancet. This process and access to the paper is free of charge.

Available online at: <http://www.thelancet.com/journals/lancet/article/PIIS0140673603139177/fulltext>

4. Analytic and strategic review paper: international perspectives on early child development

Authors: WHO Commission on the Social Determinants of Health (2005)

This paper, published by the World Health Organization Commission on the Social Determinants of Health, focuses on early child development and education (ECD) as a determinant of health. It describes three sets of factors that influence ECD. The first set, factors within the family, includes stimulation, support, and nurture. These can be enhanced through interventions involving improved parenting skills, nutritional supplementation, and quality childcare arrangements. Second, neighbourhoods and communities influence ECD, and community development approaches have been shown to be feasible and effective in improving child development in developing countries. The third set consists of socio-political factors such as national wealth, income distribution, employment, migration, and attitudes to mothers and children.

The paper identifies general principles that can guide both wealthy and developing countries in improving children's developmental outcomes. It suggests that the "gold standard" for service delivery in ECD is the local neighbourhood "hub," through which families can access quality child care, infant and family support programmes, health care services, family literacy programmes, and a borrowing library of resources for young children. It argues that this can enable children in developing countries to reach school age at the same level of development as those in wealthy countries, and improve their chances of succeeding at school.

Available online at: <http://www.eldis.org/cf/rdr/rdr.cfm?doc=DOC22310>

5. Health inequities in Brazil: our most serious disease

Authors: Brazilian National Commission on Social Determinants of Health (2006)

This document, presented at the launch of the Brazilian National Commission on Social Determinants of Health (NCS DH), outlines the relationships between social factors and health in Brazil, and explains how the new Commission intends to combat inequality in health. The document notes that, once a certain level of economic growth has been obtained, additional increases in wealth are not necessarily translated into improved health. Instead, the way wealth is distributed may be more important. The document argues that, although relationships between poverty, income distribution and health are recognised in the research literature, this knowledge has not been used in the formation of health policy.

The document argues that the relationship between health research and policy, and the democratic process used for determining health policy, both need to be strengthened. It explains the lines of action through which the NCS DH intends to achieve these goals. These include: improving the quality and comprehensiveness of social and demographic data collected by health information systems; incorporating social determinants of health into training of health professionals; mobilising civil society around the principle of equity; disseminating knowledge on social determinants of health and related rights; and financing new research.

Available online at: <http://www.eldis.org/cf/rdr/rdr.cfm?doc=DOC22119>

6. A billion voices: listening and responding to the health needs of slum dwellers and informal settlers in new urban settings

Authors: WHO Commission on Social Determinants of Health Knowledge Network on Urban Settings (2005)

This paper, published by the World Health Organization Commission on Social Determinants of Health, examines the ways in which living in an urban slum, combined with poverty, can lead to ill health. It reports that women are particularly affected by health problems in slums, as they tend to stay home more, and are more vulnerable to violence and crime. Low levels of education also play a role: health literacy depends on basic literacy, and plays a crucial role in reducing vulnerability to health problems in slums and informal settlements. Other determinants of health in slums include living and working conditions, social and political exclusion, access to quality health care, violence and crime, transportation and the environment.

The paper argues that, in order to address the conditions that create poor health for slum dwellers and informal settlers, the political relationship between government and all citizens, particularly the urban poor, may need to be redefined. Strategic actions for improving health in slums include: upgrading slums by improving security of tenure, improving infrastructure and providing basic services; improving access to quality health care; targeted health promotion for specific risks to health; integration of health, welfare and education services; and using the principles of sustainable development to improve environmental health.

Available online at: <http://www.eldis.org/cf/rdr/rdr.cfm?doc=DOC22204>

Search for more documents on social determinants of health: www.eldis.org/docs/sdh

Other recommended readings

1. How does progress towards the child mortality millennium development goal affect inequalities between the poorest and least poor?: analysis of demographic and health survey data

Authors: Moser, K.A.; Leon, D.A.; Gwatkin, D.R.

Produced by: British Medical Journal (BMJ) (2005)

This paper, published in the British Medical Journal, examines how inequality in the under-five mortality rates of the poorest and least poor groups changes as progress is made towards the Millennium Development Goals (MDGs), in 22 countries of Africa, Latin America and the Caribbean, and Asia. For most of the countries, under-five mortality rates were between 1.5 and 3 times higher amongst the poorest one-fifth of the population than amongst the richest one-fifth. In thirteen of the countries, there were declines in the overall level of under-five mortality. But none of the countries saw any statistically significant change in the gap between the mortality rate for the richest and that for the poorest.

The paper concludes that there are large and persistent inequalities in under-five mortality within many low and lower middle income countries, and that improvements in national under-five mortality, in line with the MDGs, do not necessarily bring about decreasing inequalities. The authors argue that this indicates the importance of monitoring under-five mortality among different socioeconomic groups. They also suggest that the child mortality MDG could be reformulated to incorporate an equity dimension, in order to provide an impetus for policies that tackle health inequalities.

Available online at: <http://www.eldis.org/cf/rdr/rdr.cfm?doc=DOC19164>

2. What evidence is there about the effects of health care reforms on gender equity, particularly in health?

Authors: Östlin, P.

Produced by: Health Evidence Network, WHO (2005)

This review article, published by the World Health Organization, assesses the impact of four key health care reforms - decentralisation, financing, privatisation and priority setting - on gender equity in health. It reports that, in many low income countries, rapid decentralisation has led to difficulties in providing affordable, accessible and equitable health services, and may also inadvertently support a more conservative reproductive health agenda. Other findings include that: taxes and social insurance schemes provide the most equitable basis for health care financing; privatisation may worsen gender equity; and some

priority setting methods incorporate gender biases, and so underestimate the burden of disease on women.

The article argues that gender equity in health requires that men and women will be treated equally where they have common needs, and that their differences will be addressed in an equitable manner. This should be a consideration particularly in the planning and delivery of services at national, regional and local levels. Decentralisation should be accompanied by a corresponding devolution of authority and adequate human, institutional and financial resources. When health insurance schemes are introduced, they must adequately cover vulnerable and marginalised groups. Other recommendations include protecting the working conditions of health personnel - the majority of whom are female.

Available online at: <http://www.eldis.org/cf/rdr/rdr.cfm?doc=DOC21570>

3. Cost effectiveness analysis of strategies for tuberculosis control in developing countries

Authors: Baltussen, R.; Floyd, K.; Dye, C.

Produced by: British Medical Journal (2005)

This article, published in the British Medical Journal, assesses the costs and health effects of tuberculosis control interventions in Africa and south east Asia. It focuses on DOTS (directly observed treatment, short- course), the internationally recommended tuberculosis control strategy. It considers both "minimal" DOTS - treatment of cases which are detectable by a relatively simple smear test and "full DOTS" - treatment of all cases whether they are detected by this test or not. Comparison is also made between programmes which include, or do not include, multi-drug resistant cases (cases where the initial line of treatment fails). The article reports that minimal DOTS without treating resistant cases is the most cost-effective strategy. However, the other strategies are also highly cost-effective compared to commonly used benchmarks.

Considering the policy implications of this analysis, the authors argue that treatment of smear-positive cases in DOTS programmes must be the basis of any tuberculosis control strategy, as has become standard practice. There is also a strong economic case for treating smear-negative cases in DOTS programmes and for treating multi-drug resistant cases. The authors recommend that substantial scaling up of all three interventions is needed in order to meet the international targets for tuberculosis control, and in particular that detection rates need to be improved.

Available online at: <http://www.eldis.org/cf/rdr/rdr.cfm?doc=DOC22347>

4. Global tuberculosis control - surveillance, planning, financing: WHO report 2006

Authors: World Health Organization (WHO) (2006)

This World Health Organization annual report provides an update on the results of national tuberculosis (TB) control programmes, focusing on 22 countries where the burden of TB is high. Although both the prevalence of TB and mortality rates due to TB have fallen globally between 1990 and 2004, TB incidence has continued to rise in Africa, following the spread of HIV. 53 per cent of cases were detected in 2004, and this rate is likely to fall short of the 70 per cent target set by the World Health Assembly for 2005. The treatment of drug-resistant TB is also still inadequate in many countries.

The report argues that, although laboratory networks have expanded, services need to be improved in many countries. Areas requiring special attention include national reference laboratories, external quality assurance for all laboratories, and the development of capacity and infrastructure for culture and for drug susceptibility testing. It also suggests that implementing new WHO guidelines will improve the programmatic management of drug-resistant TB cases. It notes that, whilst wealthier high-burden countries provide most of the funding needed for TB control in their countries, others rely on grants from donors. For 2006, the high-burden countries reported a funding gap of US\$141 million in paying for their TB programmes.

Available online at: <http://www.eldis.org/cf/rdr/rdr.cfm?doc=DOC22371>

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