

Health Equity Programs of Action: An Implementation Framework



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Process of Developing This Guide

This guide has been spearheaded by a team at the O’Neill Institute for National and Global Health Law at the George University Law Center in Washington, DC, with support and input from a global Advisory Committee comprised of civil society, TB survivors, academics, present and former government officials, and officials at international agencies (see acknowledgments for Advisory Committee members). The process of drafting the guide began in September 2017. Once a draft version of this guide was completed, a web-based consultation began in April 2018 and lasted for several months, with anyone able to offer feedback on the guide directly or by filling out an online survey. Information on the consultation was shared with several listservs, through a publication on the Devex development news platform, an O’Neill Institute blog, and through Advisory Committee member assistance in sharing information on the guide with their networks. We are grateful for the feedback, which we considered and incorporated as appropriate. In addition, O’Neill Institute staff met with representatives of several civil society organizations to discuss the guide, as well as with representatives of UN agencies in Geneva, New York, and Washington, DC, including WHO, ILO, IOM, the Global Fund on AIDS, Tuberculosis and Malaria, UNDP, UNICEF, the Office of the UN High Commissioner for Human Rights, and PAHO.

Collectively, these inputs led to major changes in the guide, from improving its content to developing the idea of the framework that health equity programs of action embody, which could be incorporated into national health plans, development strategies, or social inclusion strategies, rather than focusing on a specific process for developing standalone national health equity strategies.

Overview

In countries around the world, life expectancies of residents in different neighborhoods – perhaps only miles apart – may differ by 10 years, 20 years, or even longer. Certain populations – such as indigenous peoples, ethnic minorities, people with disabilities, and people who are homeless, or simply very poor – often have immensely reduced opportunities to live long and healthy lives. To end this injustice, the world’s leaders placed at the heart of the 2030 Agenda for Sustainable Development the pledge “that no one will be left behind,” while promising that “we will endeavor to reach the furthest behind first.”¹ A focus on health equity could serve as the central organizing principle to fulfill these promises and to structure national action across the Sustainable Development Goals (SDGs), because all SDGs affect health.

We propose, therefore, that countries embark on a full-scale national mobilization against health inequities and the factors that underlie them, with dedicated, sustained, prioritized efforts to end health inequities by developing and implementing health equity programs of action. These would be based in, and help countries meet, their human rights obligations, and could be developed through national health plans or broader national development strategies. In the pages that follow, we describe a framework of seven principles to guide these health equity programs of action:

- *Empowering Participation and Inclusive Leadership:* People from marginalized and disadvantaged populations or those living in situations of vulnerability^a should be central to and part of the leadership for all processes and accountability mechanisms related to the health equity programs of action, which should reflect their realities and priorities and uphold their rights.
- *Maximizing Health Equity:* Programs of action should aim to maximize health equity, seeking to ultimately achieve true health equity, even as this may well take many years. Towards this end, the programs of action would need to address a broad spectrum of health issues, along with structural determinants of health inequities, such as systemic discrimination, political exclusion, and control over resources. Further, more research and data disaggregation are needed to better understand and respond to health inequities.
- *Health Systems and Beyond: All Social Determinants of Health:* The programs of action should address health laws, plans, policies, and programs, and the full array of other social, environmental, economic, and political determinants of health – even as

the programs of action may establish priorities among them – and require intersectoral collaboration.

- *Every Population Counts:* Programs of action would systematically and comprehensively address each population experiencing health inequities.^b Many factors driving health inequities are shared by numerous marginalized and disadvantaged populations, while others are unique to a single population, or common to only a few. The programs of action will need to respond to both shared and population-specific causes of health inequities.
- *Actions, Targets, and Timelines:* Programs of action should be action-oriented, with specific actions linked to timelines for carrying them out, along with measurable targets. Actions should be integrated into each sector’s plans and strategies.
- *Comprehensive Accountability:* Accountability is vital, including monitoring and evaluation, with progress reports drawing on many sources, including civil society and marginalized and disadvantaged populations. National Health Equity Dialogues could enable members of the public to directly engage policymakers. Programs of action should establish or strengthen health accountability mechanisms at national and sub-national levels, including communities, and should encompass executive, legislative, and judicial branches. People experiencing health inequities should be fully involved in all mechanisms.
- *Sustained High-Level Political Commitment:* Sustained high-level political leadership is needed for the necessary intersectoral action and coordination as well as successful implementation.

a We appreciate that different population views themselves differently with respect to these terms. Some may view themselves as marginalized, others as disadvantaged, others as living in situations of vulnerability – and others might use still different terminology. We do not intend any of these terms (or anything else in this guide) to give the impression of any such population being defined by these characteristics or lacking agency, or that they should view themselves in any ways other than as they in fact do view themselves and that they feel to be most empowering. For purposes of this guide, we generally use the terminology “marginalized and disadvantaged” to refer to all such populations. We hope that populations who are experiencing health inequities but use different terminology to describe their situations (such as living in situations of vulnerability) will recognize that we intend that they are fully included as populations referred to throughout this guide as among the populations who are experiencing health inequities, that should be full participants in developing health equity programs of action and included in associated leadership structures, and so forth.

b We use the terms “marginalized and disadvantaged populations” and “populations experiencing health inequities” interchangeably, given that populations experiencing health inequities will almost invariably be marginalized or otherwise disadvantaged in some way, or living in situations of vulnerability (see previous footnote), while marginalized and disadvantaged populations and populations living in situations of vulnerability generally experience some level of health inequity.

Introduction

The highest attainable standard of health is a universal human right. Social justice and human rights imperatives mandate health equity. Health equity is an indispensable element of the agenda for social solidarity, social trust, and social cohesion. The basic conviction of any social justice or human rights agenda is that people should have the possibility to live long and healthy lives regardless of the happenstance of their birth, or the struggles in life that those circumstances may generate. Yet a perverse reality that afflicts every country, rich and poor, undermines such foundations of a fair, just, and inclusive society: vast health inequities. Everyone holds the right to health, but many people do not experience it. People who have little education or money, or who are indigenous or live with a disability, are likely to live shorter, less healthy lives than those with more resources and who do not suffer from stigma, discrimination, and other disadvantages.

Health equity programs of action represent a viable and vital platform to facilitate health for all, and could be incorporated into national health plans, development strategies, SDG strategies, or social inclusion strategies. The framework for these programs of action that this guide presents could help countries move towards a state of health equity, where every person enjoys their human right to health, and where all people live in a fair, more just society, and where all people can prosper, benefitting local communities, countries, and the global community.

Key features of health equity programs of action

Health equity programs of action would be developed based on the following seven principles:

- *Empowering participation and inclusive leadership*, with people from marginalized and disadvantaged populations part of the leadership of all processes related to these programs of action;
- *Maximum health equity*, addressing all health issues and structural determinants of health inequities;
- *Health systems and beyond*, covering the health sector and the full array of social, environmental, economic, and political determinants of health, including through intersectoral actions;
- *Every population counts*, systematically and comprehensively addressing each population experiencing health inequities;
- *Actions, targets, and timelines*, with specific actions linked to timelines for carrying them out, along with measurable targets;
- *Comprehensive accountability*, encompassing but extending well beyond monitoring and evaluation to also include establishing or strengthening a comprehensive suite of health accountability mechanisms, and;
- *Sustained high-level political commitment*, necessary for ensuring sufficient resources and intersectoral action and coordination, as well as for successful implementation.

This guide will expand on these seven principles and how countries or

local jurisdictions could implement them through national health plans, development strategies – including SDG strategies – social inclusion strategies, relevant municipal plans, or other health and development plans and strategies. With this focus on locally- and nationally-owned processes, and an emphasis on empowering participatory processes, this guide does not detail specific strategies for improving health equity. Yet local, national, regional, and global evidence on specific approaches to improving health equity (successes and failures), overall and for specific segments of the population, is vital to consider. While information on this evidence base is largely outside the scope of this guide, we make brief reference to possible strategies in Annex 1 on social determinants of health, and provide selected references in Annex 3.

Since these programs of action would typically be created through existing processes, such as those to develop national health plans or development strategies, this guide is not a step-by-step manual on producing health equity programs of action. These principles would be incorporated as relevant into the different steps taken in developing the plans or strategies that would establish health equity programs of action – for example, how members of populations experiencing health inequities could participate in the structures developing health plans, ways in which health inequities would factor into assessments conducted as part of developing health plans, how perspectives of marginalized and disadvantaged populations would be taken into account in determining plans' priorities and actions, and so forth. Annex 2 offers key considerations on how national health plans could incorporate these principles. References in Annex 3 include tools that provide step-by-step approaches to health equity assessments and planning.

Understanding health equity

What precisely is the health equity that health equity programs of action would seek to achieve? Health equity merges the concepts of equality and of justice, demanding the elimination of all health disparities that are unfair, the result of injustices. This includes disparities in health outcomes (e.g., life expectancy, under-five mortality), access to quality health care (e.g., immunization levels), access to underlying determinants of health (e.g., safe housing, nutritious food, clean water, clean environments), and access to the broader contributors to health (e.g., good jobs, quality education). A sense of powerlessness is itself an obstacle to health equity,² as is any obstacle to people having the opportunity to be as healthy as possible resulting from discrimination. Achieving health equity will mean achieving a situation where all people have “a fair and just opportunity to be as healthy as possible”³ by eliminating all “systematic and potentially remediable differences in one or more aspects of health across socially, demographically, or geographically defined populations or population subgroups.”⁴ Health equity means that inequalities – differences – in health that are “unfair or stem[] from some form of injustice” will be eliminated.⁵

Intended audiences and uses

The following are among the main intended audiences of this implementation framework.

Policymakers (including political leaders, ministry officials, legislators, governors, and mayors): Health equity programs of action will help governments carry out their highest obligations, providing for the health and welfare of all of their people.

By focusing on the needs of marginalized and disadvantaged populations, they can help bring about more inclusive – and hence more stable and prosperous – societies, benefitting all. Health investments frequently have very high economic returns, including through increased productivity and greater economic growth.⁶ This should be especially true for marginalized and disadvantaged populations, for whom the potential gains for health and productivity are the greatest. By identifying priorities through an intersectoral, evidence-based approach, these programs of action should help governments direct their resources in ways that have the greatest impact on the health and well-being of their populations. They should help governments live up to their SDG promise to leave no one behind – and their commitment to universal health coverage – and bring coherence to the array of goals and targets in the SDGs. The programs of action should also contribute to other government priorities, whether in health, education, employment, or other areas, that require addressing marginalization and the people who are being left out.

Along with national action, we also encourage municipal, district, and provincial (state) authorities to initiate health equity programs of action for their jurisdictions. Besides advancing health equity locally, policy innovations often take place at these lower levels of government, and could serve as models for elsewhere.

Communities experiencing health inequities: The most direct benefits of health equity programs of action should flow to the people experiencing health inequities. They can be the most important advocates for developing them, and doing so in line with the seven-principle framework, including inclusive leadership.

The programs of action would move their health and well-being closer to the center of the policymaking agenda, and help lead to the tools, mechanisms, and information – such as new or strengthened structures for accountability, health equity impact assessments, and disaggregated data – that should help keep it there. These communities would have, perhaps for the first time, a central role in the policymaking process. Their realities, their perspectives, and their priorities would be the foundation of policies. They would have a full – and indeed, privileged – voice in developing the programs of action, and in accountability processes. They would have the proverbial seat at the table – and indeed, in partnership with government, at the head of the table.

Civil society: Civil society organizations that are committed to marginalized and disadvantaged populations – particularly with the range of marginalized and disadvantaged communities that health equity programs of action would address, along with their multisector nature – would see their missions advanced through these programs of action. The programs of action could lead to more resources and a more enabling environment for organizations working directly with these communities. They should also lead to clear commitments and targets that facilitate accountability, empowering civil society efforts in this area. Ensuring accountability for these programs of action would make use of civil society organizations' many capacities, as they contribute their expertise, help hold governments accountable, join in health equity programs of action development and follow-up accountability mechanisms and, where needed, facilitate the participation of

marginalized and disadvantaged populations. This role could include serving as mediators between policymakers and members of populations who do not feel free to participate openly. As with populations experiencing health inequities, civil society organizations can advocate with their governments to develop these programs of action.

Service providers: Health equity programs of action should contribute to the efforts of people who directly serve communities experiencing health inequities – as health workers, teachers, social workers, lawyers, and so forth. The programs of action are likely to provide them greater resources and create an enabling policy environment in which they can better serve the people with whom they work. Service providers may, as these programs of action are implemented, gain additional skills that enable them to more fully live up to the creeds of their professions, particularly regarding service to all. Further, service providers do not always have a voice in policymaking despite their skills and firsthand experiences; health equity programs of action would provide space for their participation.

Development partners: Development partners would likely participate in developing, and may support implementing, health equity programs of action. They would have many of their own goals and commitments advanced through these programs, whether for health or for other sectors. The comprehensiveness of health equity programs of action could assist development partners to more effectively prioritize their activities, including enabling their activities to be based on the priorities of marginalized and disadvantaged populations. The specific actions, targets, and timelines of the programs of action would contribute to mutual accountability. And through these programs of action, development partners may learn information – such as a greater understanding of the health inequities they are trying to redress and effective approaches to addressing them – to advance their missions.

Development partners could catalyze health equity programs of action by providing funding to lower-income countries to develop them, and offer financial support for their implementation. They could also encourage countries to develop these programs of action through their program and funding guidelines.

Advancing the SDGs and other national and global health priorities

Health equity programs of action would respond to the global commitment to leave no one behind in the 2030 Agenda for Sustainable Development, and to the rise of equity, including health equity, on regional and national agendas. They would provide a roadmap for equitably achieving universal health coverage and other SDG health targets – as well as the full range of SDGs, as each of the 17 goals is in some way connected to health equity.

Some SDGs, such as those on zero hunger (SDG 2) and clean water and sanitation (SDG 6), are integrally connected to people's health. SDG 1 is on ending poverty; reducing health inequities will help reduce poverty and economic inequalities, both through increased productivity due

to people's better health and through measures taken to reduce health inequities themselves, such as improving education for marginalized and disadvantaged populations. Equity throughout the social determinants of health is a prerequisite for health equity; SDGs 5 and 10 address, respectively, gender equality and equality more broadly. As this guide emphasizes, participation and accountability are central to reducing and ending health inequities; participation and accountability are also central to SDG 16. SDGs on climate change and other aspects of the environment will enable people to experience a healthy environment, something that marginalized and disadvantaged populations are particularly likely to be without. Even such seemingly distant SDGs as conserving ocean, sea, and marine resources (SDG 14) have a tight connection to health as, for example, the livelihoods and nutrition of millions of people depend on fishing. Such connections could be made between health equity and the rest of the SDGs as well.

Beyond the SDGs, the programs of action would contribute to national efforts to achieve targets in global health strategies^c and to implement international human rights treaties.^d Along with helping implement global (and regional) instruments, measures in health equity programs of action could strengthen and help implement national health and development plans, and other national plans and policies directly or indirectly connected to health equity and the right to health. Furthermore, by improving the health of people who would otherwise have lower levels of health, these programs of action should lead to greater productivity and economic growth.

Health inequities around the world

No country is immune from health inequities. Stark health inequalities exist throughout the world, from the richest country to the poorest.

- The average life expectancy of people who died while they were homeless in Los Angeles is in the upper 40s,⁷ similar (according to one source) to that of Native American men on South Dakota's Pine Ridge Indian Reservation (47 years), with a slightly higher (55 years) life expectancy for women.⁸ This compares to an average life expectancy in the United States of 79 years.⁹ Residents of one mostly white suburb of St. Louis, in the U.S. state of Missouri, have a life expectancy of over 91 years, compared to 56 years for residents of a mostly black St. Louis suburb.¹⁰ Across the United States, data collected from 2001

through 2014 found that across this period, the richest 1% of men lived 14.6 years longer than the poorest 1% of men, while the richest 1% of women lived 10.1 years longer than the poorest 1% of women. Gaps between rich and poor were only growing, especially for women. From 2001 to 2014, the men in the top 5% of the income distribution benefitted from a 2.34 year increase in life expectancy, while comparably high-income women were living 2.91 years longer at the end of this time period. By contrast, the growth in life expectancy for the bottom 5% was 0.32 years for men and only 0.04 years for women.¹¹

- In 2015, the life expectancy of black South Africans was 16 years lower than it was for white South Africans (56.4 years compared to 72.6 years).¹²
- Tuberculosis (TB) rates of prisoners around the world are far higher than those of people not imprisoned, reaching 1,000 times higher in HIV-positive inmates of a Mexican prison than the Mexico's overall population.^{13,14}
- The Aches people, an indigenous group in Paraguay, have a TB incidence 75 times that of the overall population,¹⁵ while the TB incidence in Canada's indigenous Inuit people is more than 300 times the TB incidence in non-native Canadians.¹⁶
- In South Asia, women in the top wealth quintile are nearly five times more likely to be attended by a skilled birth attendant than women in the poorest quintile (based on latest available data, 2003-9).¹⁷
- In 2014, 43% of Americans with only a high school degree or its equivalent smoked, compared to 5% of Americans with a graduate degree.¹⁸
- Europe's Roma population have a life expectancy about 10 years shorter than the non-Roma population (20 years shorter in Italy). While 99% of the majority population in Slovakia receive at least some vaccinations, little over half of Roma people do.¹⁹
- In 2015, the death rate from diabetes for Aboriginal and Torres Strait Islander people living in five Australian provinces was five times higher than for non-indigenous people.²⁰

c These include, among others, the WHO Global Health Sector Strategy on HIV, 2016-2021, the *WHO Mental Health Action Plan 2013-2020*, the *Stop TB Partnership's Global Plan to End TB 2016-2020*, the *WHO Global Plan of Action for the Prevention and Control of NCDs 2013-2020*, and the UN Standard Minimum Rules for the Treatment of Prisoners, all of which are focused on marginalized and disadvantaged populations or include equity among their central strategies and principles. Given the commitment of the Global Fund to Fight AIDS, Tuberculosis and Malaria to protect human rights and support key and vulnerable populations, the programs of action can also support – and could be supported by – Global Fund proposals. World Health Organization, *WHO Global Health Sector Strategy on HIV, 2016-2021: Towards Ending AIDS* (Geneva: WHO, June 2016). <http://apps.who.int/iris/bitstream/10665/246178/1/WHO-HIV-2016.05-eng.pdf>. World Health Organization, *Mental Health Action Plan 2013-2020* (Geneva: WHO, 2013). http://www.who.int/mental_health/publications/action_plan/en/. Stop TB Partnership, *Global Plan to End TB 2016-2020* (Stop TB Partnership and UNOPS, 2015). <http://www.stoptb.org/global-plan/plan2/>. World Health Organization, *Global Plan of Action for the Prevention and Control of NCDs 2013-2020* (Geneva: WHO, 2013). http://www.who.int/nmh/events/ncd_action_plan/en/. Standard Minimum Rules for the Treatment of Prisoners, adopted August 30, 1955 by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, U.N. Doc. A/CONF/611. <http://hrlibrary.umn.edu/instreet/g1smr.htm>.

d Along with the International Convention on Economic, Social and Cultural Rights, which contains the right to health, the health equity programs of action would contribute to meeting state obligations for treaties such as the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination Against Women, and the Convention of the Rights of Persons with Disabilities.

- In Guatemala, most non-indigenous women (70%) have access to a skilled birth attendant; most indigenous women (30%) do not. Guatemalan children in the lowest wealth quintile are five times more likely than children in the highest wealth quintile to have their growth stunted, primarily due to malnutrition.²¹
- Health workers throughout the world are massively inequitably distributed not only across countries, but also within them. For example the number of clinical workers per 1,000 population in two districts in Zambia (Chililabombwe and Livingstone) was recently calculated to be about 20 times greater than those in a marginalized, rural district (Chilubi).²² Even within a single province in South Africa (Limpopo Province), the number of doctors in public sector hospitals compared to the population varied by nearly a factor of four across districts – while the ratio of specialists to the population was 31 times higher in the district with the most specialists compared to the one with the fewest.²³

Extreme inequities in the social determinants of health, such as access to education and economic opportunities, greatly impede health equality. For example, research in Uganda found that only 5-10% of children with disabilities were in school, and 80% of working-age people with disabilities were unemployed.²⁴ Across 11 European countries, while 99% of non-Roma could read and write, only 77% of Roma women and less than 85% of Roma men could.²⁵

Yet these disparities are neither inevitable nor immutable.

Take efforts in Namibia, for example, where the government strengthened its public health system and sought to expand effective coverage, contributing to significant reductions in health disparities, even as they remain considerable. From 2000 to 2013, reproductive, maternal, newborn, and child health interventions coverage for the poorest sections of the population increased from 58.7% to 73.4%, even as coverage edged downward for the richest quintile, from 81.8% to 81.1%. During those years, antenatal coverage increased significantly for the poorest part of the population, from 81.0% to 95.1%, while changing little for the wealthiest, increasing from 96.7% to 96.9%. Also over that period, births attended by skilled health personnel significantly increased for the poorest quintile, from 56% to 75.7%, while increasing for the richest segment of the population from 96.3% to 98.4%.²⁶

An even more dramatic example in closing health disparities is in access to antiretroviral medication to treat HIV. South African Constitutional Court Justice Edwin Cameron captured the situation in Africa at the turn of the century: “Amidst the poverty of Africa, I stand before you because I am able to purchase health and vigour. I am here because I can pay for life itself.”²⁷ He could afford the cost; most people on the continent could not. In 2002, only 50,000 people were receiving antiretroviral medication in sub-Saharan Africa.²⁸ Yet after massive national and global efforts to enable everyone – including the poorest, and people living in far-flung areas – to access HIV treatment, such as by providing free treatment and through health system innovations such as community health workers and task-shifting, the number of people in sub-Saharan Africa receiving antiretroviral therapy had grown to nearly 14 million by 2016.²⁹ While

many millions in need remain without treatment, no longer could it be said that only those who could pay for life itself could access treatment; many who live in poverty now can as well. The effects were dramatic. In South Africa, life expectancy – which had plummeted by nearly a decade from the early 1990s until 2005, as HIV and AIDS took hold but few received medication – fully recovered (to 62 years) by 2015.³⁰

Situating health equity programs of action in the global context

A global commitment to health equity stretches at least as far back as the WHO Constitution and Universal Declaration of Human Rights, with their recognition of the right to health, and has deepened in recent years, particularly with the SDGs and a heightened priority at WHO. There have been milestones along the way, prominently the Alma-Ata Declaration on primary health care in 1978 and the Ottawa Charter for Health Promotion in 1986, along with subsequent international health promotion conferences. Human rights treaties over the years – from the International Covenant on Economic, Social and Cultural Rights to conventions on eliminating discrimination based on race and against women, and on the rights of persons with disabilities – would, if implemented, lead to enormous reductions in health inequities.

The focus on health equity accelerated from 2008 on. That year saw publication of the final report of the Commission on Social Determinants of Health,³¹ putting social determinants of health squarely on the global agenda. Also in 2008, with its *World Health Report 2008*, WHO renewed its focus on primary health care, while in 2009, a World Health Assembly resolution on equity and the social determinants of health urged states “to tackle...health inequities” and “to take into account health equity” through national policies (WHA 62.14).³² The following year’s *World Health Report* addressed universal health coverage, highlighting the importance of equitable approaches to financing.³³ An emphasis on equity pervaded the Rio Political Declaration on Social Determinants of Health in 2011,³⁴ followed by the UN Platform on Social Determinants of Health to support countries in implementing the Rio agenda,³⁵ and which highlighted the link between social determinants of health and health equity.³⁶ And the next year, the United Nations pointed to the need to reduce health inequities, institute equitable decision-making, and consider the needs of marginalized segments of the population in the UN General Assembly’s resolution on universal health coverage.³⁷

Yet for all of this, and even as the Millennium Development Goals (MDGs) contributed to significant overall health improvements, the MDG era saw little progress on reducing health inequities.^{38,39} The “inequitable distribution of power, money, and resources” that are the deepest drivers of these inequities persisted.⁴⁰ Health equity had not yet become a priority, globally or nationally. The MDG targets, powerful as they were, had focused on aggregate reductions in mortality and morbidity.

At the national level, some high-income countries have developed comprehensive national strategies on health equity, although only a few incorporate the full set of principles that health equity programs of action would entail, such as systematically addressing each population. Fewer still have developed such strategies through highly participatory processes, where diverse members of marginalized and disadvantaged populations are co-owners of these strategies.⁴¹

National health plans frequently and importantly address several key obstacles to health equity, such as reduced access to quality health care for people who are poor or who live in rural areas, or the discrimination and specific health risks that women continue to face, but not the full suite of obstacles to health equity. Some countries have separate health strategies for particular populations who experience health inequities, such as women⁴² and indigenous peoples.⁴³ Numerous countries have strategies for the inclusion of people with disabilities, including in health,⁴⁴ with the adoption of the Convention on the Rights of Persons with Disabilities an additional impetus for action. Countries have also developed strategies for particular health issues that disproportionately affect marginalized and disadvantaged populations, such as TB and HIV and AIDS, which often include specific measures regarding particularly at-risk populations.

The SDGs present an opportunity to move from the largely piecemeal approach of the past to systematic efforts, developed through inclusive leadership and with robust accountability, transforming health equity into a top national and global priority. WHO has increased its own focus on equity, developing a *Framework for Country Action Across Sectors for Health and Health Equity* (2016),⁴⁵ and pointing the way towards equitable universal health coverage through its Consultative Group on Equity and Universal Health Coverage.⁴⁶ WHO's focus on universal health coverage, which would contribute significantly to health equity – particularly if universal health coverage efforts incorporate a focus on equity and use an intersectoral lens – adds to the potential of the present moment.

WHO has also developed valuable new resources to support countries in better addressing equity within their health programs and through intersectoral connections, many of which are included in Annex 3 and referenced in this guide. The entire UN system is orienting towards ending discrimination and reducing inequalities, including in health, as part of the SDG pledge to leave no one behind.⁴⁷ And in 2018, forty years after the Alma-Ata Declaration, the Declaration of Astana insisted that “it ethically, politically, socially and economically unacceptable that inequity in health and disparities in health outcomes persist.”⁴⁸ Following the adoption of the SDGs and with increased support through WHO and its resources, growing number of countries are striving to address health inequities.

The framework on health equity programs of action this guide presents, with its systematic approaches to empowerment, marginalized and disadvantaged populations, and health systems and all major determinants of health, aims to support countries in accelerating efforts towards achieving their commitments to health equity by taking their actions to the next level. It builds on well-recognized principles – participation and social engagement, the social determinants of health, and accountability, for example – and concepts and frameworks developed by WHO and others. It builds, too, on the understanding that health equity requires both equitable health systems and broader societal systems that are oriented towards better health and greater equity. At the same time, it seeks to extend several of these concepts beyond current guidance, particularly through an empowering process of development that itself is a central element of what it will take to achieve health equity, and through developing a comprehensive, multi-faceted suite of measures to facilitate accountability both to the program of action and to the precepts of health equity and the right to health more broadly.

As discussed elsewhere in this introduction, the health equity program of action framework could be used to guide action within the health system or even particular disease-focused or other more focused health strategies. Yet its greatest value may be when implemented in

full, such as through a national health plan, development strategy, or social inclusion strategy, and thus entail a national, comprehensive, actionable roadmap to health equity – though one to be continually improved with new evidence, and adapted to evolving circumstances.

Comprehensive and empowering: Key features of health equity programs of action

What would national efforts to end health inequities look like if countries developed health equity programs of action? These programs of action would ascribe to seven principles that, collectively, could be transformative. Brief descriptions of the seven principles follow. The remainder of this guide will examine each of these principles in more detail, offering further guidance on how they might be incorporated into health equity programs of action, the process of developing these programs of action, and accountability to them.

1. *A People's Plan: Empowering Participation & Inclusive Leadership:* Foundational to health equity programs of action is how they should be developed, with a leading role of people experiencing health inequities in every aspect of developing them, from establishing their priorities to monitoring and revising them. Indeed, such participation in health-related decision-making is their right.⁴⁹ The process must ensure an opportunity for marginalized and disadvantaged populations to make their voices heard and to be part of decision-making processes, participating as equals – and, indeed, to have their perspectives and priorities privileged, to be part of the leadership of all structures associated with the programs of action.
2. *Maximizing Health Equity:* Health equity programs of action would aim to achieve the maximum possible progress towards full national health equity. Health inequities are typically products of years, perhaps even centuries, of discrimination, and some of their effects may include lifelong impacts on today's children, so they cannot be speedily abolished in their entirety. It may take many years to achieve health justice, even with sincere national commitment.

Yet over time, health equity should be attainable. It entails reducing and ultimately eliminating all avoidable health disparities among different populations, including those related to the health system, to the social and other determinants of health, and to health outcomes. This requires addressing the injustices, past and present, intentional and inadvertent, that contribute to these inequities.

It is critical that true health equity is the goal; it is the one that social justice and human rights require. Towards this end, the programs of action will need to address the full gamut of health issues – health inequities in areas as diverse as violence, pollution, maternal mortality, cancer, and infectious diseases. They will also need to address deep structural determinants of health inequities, such as systemic discrimination, political exclusion, and control over resources.

Ending health inequities will require the fullest possible understanding of these inequities. Programs of action should include a robust agenda for gaining this understanding, including enhancing data disaggregation, building monitoring and evaluation into programs intended to reduce these inequities, and targeted research.

3. *Health Systems and Beyond: All Social Determinants of Health:* Health equity programs of action would incorporate actions to respond to the full range of factors leading to health inequities. It is vital to address inequities within the health system, such as a lack of health workers to serve marginalized communities, health financing policies that favor wealthier segments of the population, and inadequate access to health facilities for remote communities. It is critically important, too, to address the full range of determinants of health – social (including cultural), environmental, economic (including commercial), and political, including structural determinants. This inclusive scope adds greatly to the potential impact of health equity programs of action. Commitment from within and outside the government, with coordination and collaboration across sectors and stakeholders, will be necessary too. The agenda will be ambitious – prioritization will be necessary – but the comprehensive scope is required to achieve health equity, as well as to meet countries' human rights commitments. Resources and energy could be focused where most rapid and significant progress towards health equity is possible, inside and outside of the health sector, though without neglecting structural determinants. To help ensure sustained action, health equity could be incorporated into the mandates of each sector, relevant indicators established, and health equity impact assessments regularly conducted.
4. *Every Population Counts:* A defining feature of health equity programs of action would be that they are comprehensive, identifying and encompassing all populations who are marginalized and impacted by health inequities. They would include but go beyond addressing common metrics of inequity and marginalization, such as low income and little education, and populations who receive particular attention for other reasons, perhaps historical (e.g., indigenous populations) or based on specific international norms (e.g., people with disabilities, following the Convention on the Rights of Persons with Disabilities). Rather, they will focus on all populations suffering from health inequities, attentive to shared obstacles to health equity, such as social and political exclusion and low income, and to those particular to specific populations. Including groups that might otherwise be overlooked in planning processes is one of the motivating ideas behind health equity programs of action, which would seek to ensure that truly no one is left behind. Responding to the needs of each marginalized and disadvantaged population to achieve health equity is central to the core human rights principle of non-discrimination, whether intentional or the result of history, whether discrimination that is direct or an unintended result of apparently neutral policies, and whether it is in the public or private sphere.⁵⁰
5. *Actions, Targets, and Timelines:* Health equity programs of action would, as the name suggests, provide for specific actions to be taken, accompanied by timelines for these actions, as well as timebound, measurable targets. The programs of action should also be costed and integrated into budgets of each sector. And they should identify the parties responsible for the actions. The programs of action should also incorporate the priorities that marginalized and disadvantaged populations themselves have expressed.
6. *Comprehensive accountability:* Accountability for health equity programs of action must be robust. It would include monitoring and evaluation, including reports from both government and independent entities. These reports should draw on many sources of information, including input from civil society and marginalized and disadvantaged populations, and should include analyses of shortcomings, and recommendations where planned actions are not carried out, or benchmarks and targets are not being met. National Health Equity Dialogues could enable members of the public to directly engage policymakers. Further, programs of action should include a comprehensive suite of measures to strengthen health accountability at all levels of government, from communities to the national government, and encompass the executive, legislative, and judicial branches. These could include, for instance, operational village health committees, public health rights education, facilitated access to courts, parliamentary hearings, and health equity impact assessments. Measures should also include capacity building and support for civil society, and individuals and communities experiencing health inequities, to enable them to hold governments and other responsible actors accountable, both through their own advocacy and by being full participants in, and having leadership roles in, health accountability mechanisms. Capacity-building measures may also be needed to enhance the ability of government officials and others to implement measures to advance the right to health and address health equity. Actions included in the health equity programs of action should be integrated into each sector as relevant, along with related indicators, with those responsible for carrying out these actions made clear.
7. *Sustained High-Level Political Commitment:* The health equity programs of action should have high-level political commitment and leadership, from national to local levels. Only with such commitment will they successfully guide policymaking and resource allocation throughout the government. Political commitment could be based on factors as diverse as the promises of the SDGs and obligations of human rights, economic returns of health investments, and the fact that people's marginalization and disadvantage may place them at the highest risk for many infectious diseases, diseases that pose a health risk for the entire population. This level of political commitment will require key government actors and entities to be full participants in the process of driving and developing health equity programs of action.

HEALTH EQUITY PROGRAMS OF ACTION



Even though people overall are becoming healthier, many people are being left behind.



Black South Africans live 16 years less than white South Africans.*



56 years of life

73 years of life

In many countries, impoverished women are far less likely to be attended by a skilled birth attendant.**



Poorest 20%

Between 1 and 2 out of 10 women



Wealthiest 20%

Between 7 and 9 out of 10 women

Members of the Inuit people in Canada are over 300 times more likely to have tuberculosis than non-indigenous Canadians.



Inuit

Non-indigenous Canadians



HEALTH EQUITY PROGRAMS OF ACTION

Countries should develop comprehensive, inter-sectoral, human rights-based plans to reduce health inequities, possibly through national health plans or development strategies.

These health equity programs of action would follow 7 principles.

- 1 Empowering Participation and Inclusive Leadership:** Prioritizing perspectives of marginalized and disadvantaged populations and including these populations in leadership structures
- 2 Maximizing Health Equity:** Covering a broad range of health issues and addressing deeply-rooted structural determinants of health
- 3 Health Systems and Beyond:** Addressing the social (including cultural), environmental, economic (including commercial), and political determinants of health, with inter-sectoral approaches
- 4 Every Population Counts:** Systematically addressing each population experiencing health inequities
- 5 Actions, Targets, and Timelines:** Being action-oriented, with actions integrated into sector strategies
- 6 Comprehensive Accountability:** Encompassing a continuous process of monitoring progress and remedying shortcomings, and strengthening health accountability at national and sub-national levels
- 7 Sustained High-Level Political Commitment:** Enabling a long-term focus, sufficient resources, and inter-sectoral actions

SOCIAL, POLITICAL, AND ECONOMIC MOBILIZATION

Reduced disparities in life expectancy



73 years of life

73 years of life

Women, whatever their wealth, have access to skilled birth attendants



Poorest 20%

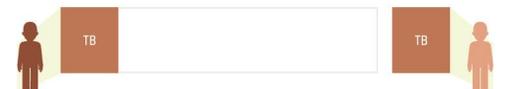
9 out of 10 women



Wealthiest 20%

9 out of 10 women

Marginalized and disadvantaged populations no longer have disproportionately high levels of disease



Inuit

Non-indigenous Canadians

EVERYONE HAS A FAIR AND JUST OPPORTUNITY TO LIVE A LONG, HEALTHY LIFE.

FOR MORE INFORMATION, PLEASE CONTACT ERIC FRIEDMAN (EAF74@LAW.GEORGETOWN.EDU) OR SEE ONEILLINSTITUTE.ORG

* Numbers do not add up due to rounding. ** In a number of countries, including Cameroon, Guinea, Haiti, Kenya, Madagascar, Nepal, Niger, Nigeria, Senegal, and Timor-Leste, only 10-20% of births to women in the poorest quintile are delivered with the assistance of a skilled birth attendant, compared with 70-90% of women in the wealthiest quintile.

Applying the framework to all health policies and programs, in all sectors, at all levels

National health plans and strategies present a prime opportunity for countries to develop health equity programs of action. The seven principles could, through these plans, be applied in their entirety. Particularly for countries that are already developing health plans based on the intersectoral approach that public health and the SDGs necessitate, the framework proposed here would reinforce current directions. Countries may have other comprehensive, multisector plans that they are developing and where health is a central component, such as national development strategies, social inclusion strategies, or SDG implementation strategies, to which they could apply this framework.

Alternatively, perhaps if national health plans are not intersectoral or if a new plan will not be developed for several years, countries may choose to organize a separate process to develop health equity programs of action. It may be preferable to incorporate health equity programs of action into national health plans or national strategies, such as a national development strategy, though, as this could help sustain national commitment across changes in government. For it is possible that when governments change after an election, a new administration less committed to health equity may see a separate program of action on health equity as a special project of the previous administration, rather than part of the regular functioning of government. Health equity programs of action incorporated into regular planning processes are less likely to face this risk.

Incorporating health equity programs of action into national health plans also has an additional logic: populations experiencing health inequities, often with relatively few resources, are more likely to use the public health system than people with enough resources to opt out of that system if public health services are not high quality. In general, then, the focus of national health plans, strengthening the public health system, will particularly benefit populations experiencing health inequities. Similarly, many deficits that the national health plan may seek to address, such as lack of access to clean water and sanitation, drug stock-outs, and inadequate numbers of health workers, are likely to disproportionately harm marginalized and disadvantaged populations.

At the same time, incorporating health equity programs of action into other plans and strategies creates some risk that their single-minded focus on equity might get lost in the larger plan, with the danger both that a less robust approach will be taken and that they will do less to advance a sustained national focus on health equity. Countries should guard against this approach, such as by including health equity as a central goal of the health plan and including mechanisms in the plan to sustain a national focus on and commitment to health equity, such as regular National Health Equity Dialogues (discussed later in this guide).

Whether incorporated as part of other plans or developed separately, health equity programs of action would feed into and build on existing strategies and policies, as well as those currently being developed. For instance, the health system components of the programs of action would be incorporated into health sector strategies, components on the disproportionate impact of pollution on some populations would be incorporated into environmental, industrial, energy, and urban policies, and so forth.

In addition – or, perhaps, in some countries as an initial step towards this more comprehensive approach – countries could, to a significant extent, apply the seven principles to other health plans and strategies, ones for specific diseases and health conditions and threats, for particular components of the health system, or even for non-health sector social determinants of health. While the principles could not be applied in their entirety – for example, their application to a particular disease would not cover all health issues – much of this approach would remain applicable. For example, disease-specific plans could still cover both health system and other determinants of health, specifically address each population experiencing health inequities with respect to that disease or health condition, engage each such population fully and as leaders in developing the actions to address these inequities, and include robust accountability.

***Innov8* – A WHO tool to help health programs reach marginalized and disadvantaged populations**

The World Health Organization has created a valuable tool that health ministries and health program managers can apply to individual health programs to help ensure that they reach and are effective in improving the health of marginalized and disadvantaged populations, including by engaging other sectors. More information on this tool, *Innov8*, is available through: <http://www.who.int/life-course/partners/innov8/>

This tool guides teams reviewing health programs through eight steps: 1) completing a diagnostic checklist; 2) understanding the program theory; 3) identifying who is being left out; 4) identifying the barriers and facilitating factors that sub-populations experience; 5) identifying mechanisms generating inequities; 6) considering intersectoral action and social participation as central elements; 7) developing a proposal to redesign the program to act on the review findings, and; 8) strengthening monitoring and evaluation.

Health programmers and others using *Innov8* could look to ways to ensure that the principles described in this guide – already in many ways emphasized in *Innov8*, which covers such areas as social engagement and intersectoral action – are incorporated into the process as fully as possible. This could include, for example, inclusive leadership by having diverse members of marginalized and disadvantaged populations on the team that is using this tool and building accountability measures into the health programs.

Individual ministries, too, can integrate equity throughout their work, whether or not an overall national health equity program of action has been developed. They can engage members of marginalized and disadvantaged communities, academics, civil society, service providers, and others to better understand how their ministry's actions affect health equity, and plan accordingly. Indeed, all sectors could apply, to the extent possible, the framework proposed here within their areas of authority.

In particular, they could:

- Make health equity a central goal;
- Undertake a comprehensive, systematic focus on each population

- experiencing health inequities;
- Engage each population, including in key decision-making roles;
- Identify obstacles to health inequity and actions to address them, and incorporate these actions into their sector plans;
- Conduct further research on how their mandate affects health equity, and improve collection and use of disaggregated data;
- Incorporate robust accountability, and;
- Advocate with other sectors to similarly prioritize health equity, working towards national health equity programs of action where they are not already being developed.

Health equity programs of action can also be – and we would encourage are – developed at the provincial (state), district, and municipal levels, following the same framework. They would have certain inherent limitations, as some funding and law and policy changes for health equity will be needed at the national level. However, while sub-national powers and funding will vary considerably across countries, in general these levels of government will have the authority and funding to make important progress towards reducing health inequities, and will be able to initiate innovative programs that could prove models for elsewhere in the country. Mayors, governors, and local officials can also be advocates for action in other municipalities and provinces (states). And, if action has not yet been taken nationally, these more local health equity programs of action could encompass advocacy for policy change, funding, and leadership at higher levels of government.

Modified approaches to health equity programs of action

While achieving health equity will require a comprehensive approach as proposed in the seven-principle framework – covering all populations experiencing health inequities and the full range of determinants of health and of diseases and other health conditions – if circumstances require it, countries might apply the basic approach proposed in this guide in narrower ways, along with incorporating its principles into other health-related planning, as suggested above. For example:

- Health systems only:* Countries could choose to limit health equity programs of action to health systems, systematically addressing equity within the health system for each population experiencing these inequities, fully engaging these populations in the process of developing the programs of action, identifying knowledge gaps and research priorities, and including accountability strategies. This approach, though, may not reach many of the deepest drivers of health inequities, and so would limit the potential impact of the health equity programs of action, though the impact could still be considerable.
- Health systems plus selected additional social determinants of health:* Health equity programs of action could cover both health systems and other selected social determinants of health, but not the full range of determinants of health that may contribute to health inequities. The selected determinants might be those agreed to nationally as being most important (perhaps identified after

an initial review or drawing on regional or international experience) or prioritized based on being both important and amenable to rapid, impactful action. They could also vary by population, depending on which are most significant in the context of the health inequities that each population experiences.

- “Top 10”:* Countries (or other levels of government developing health equity programs of action) could identify only the most significant ten – or any chosen number – of factors contributing to health inequities for a given population, and determine actions around these. As countries begin to take steps to address these issues, future versions of health equity programs of action could address other factors.

Additional entry points to health equity

In the absence of official health equity programs of action, a variety of actors could lay the groundwork for them, while also taking significant steps towards health equity. Civil society, community members, or particular government institutions, such as the ministry of health or the national human rights commission, may decide to develop health equity programs of action, even without a formal, national, intersectoral process. These could serve as roadmaps towards health equity that some of these entities may have the power to implement in part (in the case of the ministry of health) or to integrate into existing health and development processes (for example, through ministry of health participation in interagency bodies). They could also inform civil society advocacy efforts, stimulate political leaders to decide that their country (or sub-national jurisdiction) will develop official health equity programs of action, and catalyze national discussion around health equity.

Civil society organizations could also turn their attention to health equity. They could work with media organizations, members of the legislature and other policymakers concerned about health equity, other civil society organizations, health workers, and academics to highlight health inequities, working to place a national public spotlight on these inequities, and thus help build political will to act against them, including by developing a health equity program of action.

Data collection is another key entry point. Government officials who have input into or influence over what data is collected, both through national instruments like the Demographic and Health Survey and sector-specific data collection, such as health service and administration records, can use these opportunities to increase collection of disaggregated data relevant to health equity, regarding income and the many other markers of marginalization. Where such data already exists, policymakers and program directors can incorporate this information into their policies and programs and related monitoring and evaluation, and adjust programs accordingly to ensure that they are reaching marginalized and disadvantaged populations. They can also establish sector and programmatic targets that are based in equity, such as ensuring that the least wealthy 40% of the population experiences greater gains in their health than the wealthiest 20%, who are likely to be much healthier.

Addressing resource and information constraints

Resource or other constraints may mean that robust action to address health inequities affecting each population, or to cover all social determinants of health, may not be immediately possible. Health equity programs of action should be as comprehensive as possible, particularly with respect to addressing each population, and be developed through highly inclusive, participatory processes, with maximum possible participation of members of marginalized and disadvantaged communities, and with follow-on accountability that includes their full participation. If necessary, future health equity programs of action may be more thorough or even more participatory. Such a longer-term vision should be included in the initial program of action. Resource constraints (though raising resources should be part of the programs of action) may require initially prioritizing populations with the most severe levels of health inequities. If so, the longer-term goal of actions to address all health inequities should be clear, including the intended timeline for doing so, and with the actions included representing the maximum possible level of ambition.

A health equity program of action's comprehensiveness may be limited by insufficient information about obstacles to health equity and about the effects of programs and policies aimed at reducing health inequities. Countries can still use the information they do have, including information from members of marginalized and disadvantaged communities themselves, while strengthening data disaggregation capacity and conducting further research.

A note on national and location action

For simplicity, the discussion in this guide will largely treat health equity programs of action as national creations. We stress, however, as discussed above, leaders at more local levels can also follow this framework, applying references in this guide to national structures (e.g., countries, health ministries, and presidents) to their contexts (e.g., cities, health departments, and mayors).

A roadmap to this guide

The pages that follow offer a path to developing health equity programs of action, turning first to a background section describing two concepts central to them, the links between health and human rights, and particularly the right to health, and a further exploration of the meaning of health equity. The rest of the guide will be organized in separate chapters for each of the seven principles that are part of the health equity program of action framework. Finally, the annexes provide brief overviews of a number of social determinants of health, key considerations on incorporating the proposed framework into national health plans, and a set of annotated references to resources that may be useful.

Human Rights and Health Equity

Health, human rights, and the right to health: A brief overview

The human right to the highest attainable standard of physical and mental health – the right to health – is universal, applying to all people, in every country.⁵¹ The right emphasizes the importance of non-discrimination and equality, and of addressing the health needs of marginalized and disadvantaged populations, the driving motivation behind health equity programs of action. In an important sense, measurements of health inequity, with the underlying realities that they represent, capture in a few numbers the collective impact of a wide range of shortcomings in realizing the right to health and other rights affecting health. Collectively, these encompass inadequate health systems, people’s lack of access to underlying determinants of health, such as nutritious food and clean water, and insufficiencies and inequities across the broader set of social determinants of health, like education and political power.

Virtually all rights affect health. In the brief overview of health and human rights that follows, we turn first to the right to health itself, followed by the extensive links between health and other rights, and finally we examine several key concepts in the right to health and human rights more broadly, all applicable to health equity programs of action. The chapter then turns to a short discussion of health equity.

The right to health

The right to health is part of the International Bill of Rights, comprised of the Universal Declaration of Human Rights and the two formative human rights treaties that followed, the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). The Universal Declaration includes everyone’s “right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services” (article 25).⁵² And the ICESCR guarantees “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (article 12).⁵³

Several treaties addressing the rights of specific populations also include the right to health, including the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child, and the Convention on the Rights of Persons with Disabilities. Regional conventions and other instruments also guarantee the right to health, as do more than 130 national constitutions.⁵⁴

The right to health is intimately related to the right to life (ICCPR, article 6). Not only is there a strong conceptual relationship, but the Human Rights Committee has authoritatively interpreted the “inherent right to life” protected in the ICCPR (article 6) to require appropriate measures to protect life, including by addressing societal conditions that directly threaten life. Examples of conditions to address that the Human Rights Committee offers include life-threatening diseases, hunger and malnutrition, extensive substance misuse and excessive

use, and violence, with measures that states should take to protect the right to life including ones to ensure access to such essentials of life as food, water, sanitation, health care, and housing, among others, as well as to develop plans to address gender-based violence and maternal and infant mortality.⁵⁵ Even more significantly, national courts in a number of countries have recognized a constitutionally protected right to health that is based on a constitutionally guaranteed right to life,⁵⁶ even when the constitution does not specify the right to health itself. The Inter-American Court on Human Rights has taken a similar approach, recognizing the right to a dignified life (*viva dina*), which includes access to conditions – like water, sanitation, food, and health care – required for a dignified life.⁵⁷

The Committee on Economic, Social and Cultural Rights (ESCR Committee), responsible for monitoring ICESCR implementation, has issued an authoritative interpretation of the right to health. Its General Comment 14 explains that the right to health extends beyond health systems to also incorporate “underlying determinants of health,” including “access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health” (para. 11).⁵⁸ Along with being part of the right to health, most of these determinants – the rights to water and sanitation, as well as to food and to housing – are also human rights of their own right, stemming from the ICESCR and detailed in other reports of the ESCR Committee and of UN Special Rapporteurs. These are all among the areas that health equity programs of action would cover.

Other general comments of the ESCR Committee, which offer authoritative interpretations of other rights in the ICESCR (such as the rights water, nutritious food, and education), as well as of cross-cutting issues (such as state obligations in the context of business activities), are available through:⁵⁹ <https://www.ohchr.org/en/hrbodies/cescr/pages/cescrindex.aspx>

As General Comment 14 explains, all health goods, services, and facilities – including the underlying determinants of health – must be available, accessible, acceptable, and of good quality.⁶⁰ More particularly:

- They must be available in sufficient quantity in the country.
- They must be accessible to everyone, including being affordable (economically accessible) and geographically accessible, and accessible to everyone without discrimination.
 - Health information must also be accessible. People have a right to access and impart information concerning health issues, and to have their personal health information treated confidentially.
- They must be acceptable, respecting medical ethics and being culturally acceptable, including to different communities.
- They must be of good quality, including health systems with skilled health workers, scientifically approved and unexpired medications, and evidence-based health interventions.

Like all rights, the right to health includes core obligations, “minimum essential levels of each of the rights...[without which it] would be largely deprived of its *raison d’être*.”⁶¹ This includes the right to “essential primary health care.”⁶² General Comment 14 provides a non-exclusive set of these core obligations for health (para. 43), as well as obligations “of comparable priority” (para. 44).⁶³ These cover a selection of key health goods, services, and interventions, in particular: nutritious and safe food to ensure freedom from hunger; basic shelter, housing,

sanitation, and safe water; essential drugs; reproductive, maternal, and child health care; immunization against major diseases; measures to prevent, treat, and control epidemic and endemic diseases, and; information on major health problems in the community.⁶⁴ As the first UN Special Rapporteur on the right to health observed, because of varying health challenges across countries, the “minimum ‘basket’ of health services” will need to be nationally defined, and may vary across countries⁶⁵ – even as the core obligations and those of comparable priority applies to all countries.

The core (and comparable) obligations include four other elements particularly relevant to health equity programs of action. One is non-discrimination, “to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups” (para. 43(a)). Another is the “equitable distribution of all health facilities, goods and services” (para. 43(b)). A third, which would likely be a part of many health equity programs of action, is that health personnel need appropriate training – including health and human rights education.

And fourth, the core obligations include “adopt[ing] and implement[ing] a national public health strategy and plan of action,” which are to “be devised, and periodically reviewed, on the basis of a participatory and transparent process,” and include indicators and other methods to allow for close monitoring. Health equity programs of action would feed into this plan of action, and ensure that, as required through General Comment 14, the process by which the strategy and plan are devised, and their content, “shall give particular attention to all vulnerable or marginalized groups” (para. 43(f)).

Beyond these areas and cross-cutting principles described below, General Comment 14 highlights the right to health of certain populations, namely, women, children and adolescents, older people, people with disabilities, and indigenous peoples. States are to develop strategies on women’s health, including to ensure access to a full range of sexual and reproductive health services, reduce maternal mortality, address gender-based violence, and protect against harmful cultural practices,⁶⁶ elements that may well be incorporated into health equity programs of action. States should also take a gender-sensitive approach, including by disaggregating health and socioeconomic data by sex to identify and remedy health inequities.⁶⁷

The right to health has continued to evolve following General Comment 14, including through the work of UN Special Rapporteurs on the right to health and Special Rapporteurs addressing its underlying determinants,⁶⁸ and through national and regional court decisions and regional commissions.

Health, human rights, and the social determinants of health

Beyond the health system and the underlying determinants of health are other social determinants of health, ranging from spheres of life such as work and education to society-wide issues of how power and other resources are distributed. The landmark 2008 report of the Commission on Social Determinants of Health identified two broad baskets of action (along with better measuring and understanding health inequity and its drivers, and evaluating the equity impact of policies and actions): improving daily living conditions and redistributing power, money, and resources.⁶⁹ True health equity can only be achieved through actions that respond to all factors that contribute to health inequities, within the health system and through the social determinants of health.

Some determinants that affect daily living conditions are directly addressed by particular rights, such as the right to education and the right to work. Many other rights directly or indirectly affect the distribution of power, money, and resources. The rights to be free from slavery and torture protect people from conditions of an extreme level of powerlessness. Rights related to political participation, expression, and assembly enable people to work for systematic change from outside the halls of power and to enter those halls themselves, and to use the levers of power to achieve a fairer distribution of power, money, and resources. The right to form a union can redistribute power within the workplace and increase people’s safety and resources, and the right to social security redistributes resources to those in need.

The right to benefit from scientific progress assumes a special importance for health, as its realization – or violation – directly affects people’s ability to benefit from advances in medical technologies and public health knowledge. This right requires, for example, that new medicines and diagnostics be available to all people who need them. And like other rights, this right does not stop at national borders. A person’s ability to access a medicine should not depend on whether that medicine was developed in their country or another country, whether that person lives in a rich or a poor country, or whether she is herself rich or poor. As for so many rights, international cooperation is vital.

Key human rights concepts

Equality and non-discrimination: If there is one core bedrock principle throughout the entire body of human rights law, it may be that of equality and non-discrimination, basic principles underlying health equity programs of action. As explained more below, the substantive equality that human rights law requires is equivalent to equity, the term that we have been deploying. All people are equally entitled to fully exercise all of their human rights. The ICCPR provide that states undertake to respect and ensure rights “without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status” (article 2(1));⁷⁰ the ICESCR contains a similar command.⁷¹

As the next section details, equality not only requires that state and non-state actors refrain from treating people differently in ways that undermine the rights of one or multiple groups, but also requires active measures to enable people who are unable to fully realize their rights because of discrimination, past or present, to fully realize their rights. These measures may include affirmative action.

Participation: Participation as a human rights principle entails the right to active, informed engagement in decisions that affect people’s rights, such as decisions affecting their health⁷² and in selecting measures needed to end discrimination.⁷³ Participation under the right to health will be further discussed in the next chapter, on empowering participation and inclusive leadership.

Accountability: Accountability is a fundamental demand of human rights. It is not enough that states assert that they are conforming to human rights obligations; they must in fact do so, with measures to ensure that states are properly discharging their obligations, and corrective measures where they are not.

Accountability is primarily forward-looking, an ongoing obligation to monitor, review, act, and remedy, with remedies that are primarily aimed at improving the realization of rights in the future. It is not centrally about assigning blame and punishing those who fail to meet

their obligations – though where state officials or other agents of the state violate people’s rights, they must be held responsible, and people’s whose rights have been violated duly compensated.

Accountability also entails monitoring progress in aligning legal and policy frameworks with human rights obligations, developing rights-based budgets, and creating systems to understand disparities among populations in their rights (such as differing levels of access to health services and health outcomes), and reviewing how these frameworks and budgets are being implemented, including their effects on health inequities. Mechanisms might include health (and other) sector assessments, financial audits, and parliamentary inquiries, and should include mechanisms independent of government. Based on the findings, states must bring their actions in line with their human rights obligations. Remedies should principally involve systematic measures to ensure future respect for rights.⁷⁴ Accountability is not a state exercise alone. In line with the principle of participation, people should have opportunities to participate in accountability processes.

The final chapter of this guide explains how this principle can be incorporated into health equity programs of action.

Respect, protect, and fulfill: States have an obligation to respect, protect, and fulfill people’s human rights, including the right to health. Respecting rights means that the state must not itself violate a person’s rights, such as by enacting a discriminatory law. Protecting rights entails protecting people from violations of their rights by third parties, whether corporations that fail to provide safe and healthy working conditions, private sector health actors, or even family members, such as in the context of domestic violence. And states must take proactive measures to fulfill people’s rights, such as by developing policies and allocating resources to develop available, accessible, and acceptable quality health services.⁷⁵

Maximum available resources and progressive realization: The ICESCR obliges states to act “to the maximum of [their] available resources, with a view to achieving progressively the full realization of” people’s rights (article 2(1)).⁷⁶ The “resources” to which “the maximum of [a state’s] available resources” refers are not limited to financial resources, but rather encompass all forms of resources, including human resources, information resources, technological resources, and natural resources.⁷⁷

Funding to implement health equity programs of action should be consistent with this principle. Given that the programs of action would be rooted in the central obligations of the right to health, and would benefit many rights beyond health, states should give high priority to implementing health equity programs of action in their resource allocations. These programs of action will have another benefit from the perspective of resources. Advancing health equity will contribute to some of the least healthy people having far better health, enabling them to be more productive. They will contribute more to the economy as well as to tax revenue, and thus increase a country’s resource base – increasing the level of its available resources that states can use to advance all rights.

Progressive realization requires constant progress towards fully realizing people’s economic, social, and cultural rights, rather than realizing them in their entirety immediately. This is a nod to the reality that these rights require resources (as do civil and political rights), including funding, that states might not have. As state resources expand and states gain understanding of the measures that will be most effective in fulfilling people’s rights, they will be able to more fully ensure people’s rights.

The progressive realization requirement is not an excuse to delay. While full realization will take time – and in some respects, be an ongoing process – states should take steps immediately towards better realizing people’s rights, using “all appropriate means, including particularly the adoption of legislative measures.”⁷⁸ Meanwhile, some aspects of human rights are immediate – including, particularly critically for our purposes, non-discrimination and developing strategies to promote rights’ realization.⁷⁹

International cooperation and assistance: The ICESCR requires states “to take steps, individually and through international assistance and co-operation,” to realize rights. The references to international assistance and cooperation have a dual implication. One, states that lack sufficient internal resources should seek international assistance in order to maximize the resources they can devote to human rights⁸⁰ – including to health equity programs of action. Two, states in a position to assist are obliged to provide assistance, which is necessary if all people are to fully secure their rights. As the ESCR Committee states, “international cooperation for development and thus for the realization of economic, social and cultural rights is an obligation of all States. It is particularly incumbent upon those States which are in a position to assist others in this regard.”⁸¹ It is also “particularly incumbent” on states in a position to assist to help enable states to fulfill their core and comparable human rights obligations. As we have seen, health equity programs of action will contribute to realizing these obligations. States should make funding them a high priority for international funding.

Along with the ICESCR, the requirement for international cooperation and assistance derives from the UN Charter itself. Article 55 commits the United Nations to promoting “universal respect for, and observance of, human rights,” while through Article 56, UN “Members pledge themselves to take joint and separate action in co-operation with the Organization for the achievement of the purposes set forth in Article 55.”⁸² Universal observance of human rights will only be possible if this cooperation includes states providing assistance if they are able to do so.

The Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights further explain, “Each State must separately and, where necessary, jointly contribute to the fulfilment of economic, social and cultural rights extraterritorially, commensurate with, inter alia, its economic, technical and technological capacities, available resources, and influence in international decision-making processes.”⁸³

Understanding health equity⁸⁴

As described earlier, health equity entails eliminating systematic, remediable differences in health – outcomes and access to health services and other underlying and social determinants of health across populations – and thus ending health inequalities that stem from injustices. Health inequities are fundamentally the result of discrimination which, as the ESCR Committee explains, may be intentional or the result of “historical or persistent prejudice.” Discrimination may be direct – treating people differently because they are members of a disfavored group – or indirect, the result of “laws, policies or practices which appear neutral at face value, but have a disproportionate impact on the exercise of [people’s] rights as distinguished by prohibited grounds of discrimination” (such as disproportionately harming women or migrants).⁸⁵ Health equity requires addressing both direct and indirect discrimination, and discrimination in the public and private spheres, such as within the home or a private workplace.⁸⁶

The term equity is synonymous with substantive equality, the term frequently deployed in the human rights context. Substantive equality requires that a person's ability to enjoy their rights is not "influenced by whether [that] person is a member of a group characterized by [a] prohibited grounds of discrimination."⁸⁷ This should be the goal of health equity programs of actions.

Health equity can be measured by comparing the health and the determinants of health of a marginalized or disadvantaged group – a group that had suffered or suffers from discrimination – with populations who lack that marker of marginalization. The aim is to reduce and ultimately eliminate disparities that preclude members of any group, based on membership in that group, from being able to be as healthy as possible. So, for example, people from the lowest wealth quintile should not have a shorter life expectancy or less access to skilled birth attendants than people in the highest wealth quintile. Health measures for indigenous peoples should be no worse than those for non-indigenous people.

One valuable perspective regarding health equity is that of "proportionate universalism," which recognizes that health inequities need to be addressed throughout the socioeconomic gradient, but with more intense actions for more disadvantaged populations.⁸⁸ A mix of universally oriented strategies with broad effect and targeted measures for disadvantaged populations will be necessary.⁸⁹

Health equity does not necessitate eliminating every health disparity. There are some that society cannot change, ones that are not the result of discrimination or injustice, and not subject to effective interventions. For example, treatments might not exist to enable someone with a certain severe disability to live as long as someone without that disability. Biological factors may lead men and women to experience a given disease at different levels, and certain illnesses are more prevalent in particular ethnic groups. Yet what is socially modifiable – what is subject to societal intervention – may change over time.

It is necessary, too, to interrogate why effective interventions do not exist. For example, the lack of any effective treatments raises the question of whether treatments do not exist because of the limits of medical science or because of inadequate investment in research and development of the needs of a marginalized or disadvantaged population. The latter would point to a health inequity, though one that may require international cooperation to resolve; a resource-poor country may not be able to invest significant levels of its own resources into medical research, and may have limited sway in the international patent system, which provides little incentive for private investment in medical research not likely to yield profitable medicine. Creative approaches, like an advanced market commitment (an agreement by a certain party to purchase a product that is not yet available, such as a vaccine, at a given price once it becomes available), can help overcome this obstacle. It may also be that the treatment exists but is not available in a given country, suggesting a violation of people's right to "the benefits of scientific progress and its applications."⁹⁰ International cooperation is particularly important to facilitate this right.

Within the context of limited resources, determining what fairness requires will not always be a straightforward matter. For instance, in the above example of a person with a severe disability, what if the new therapy is extraordinarily expensive? Particularly in a low-resource setting (if the country is unable to secure a lower price), what trade-offs might providing the therapy entail? Would it necessarily be unjust not to provide it? Does it matter whether the condition affects very few people or many people, with the larger strain on resources the latter

situation would entail? And why is the new therapy so expensive? Is a country making every effort to make the therapy affordable, such as through compulsory licensing (meaning the government issues a license to produce a product without permission of the patent-holder, as countries may do under international law) or parallel importation (importing a product without the consent of the patent-holder, also permitted under international law),⁹¹ negotiations with the manufacturer, or public subsidies?

Questions of this nature extend to other areas. Rural populations may be marginalized and have less access to health care. Yet the distance people live from health facilities may result not only from marginalization, but also from practicalities borne of very low population densities. Even a genuine commitment to the full equality of rural populations may leave people living in remote areas farther from hospitals than people in urban centers. Yet even then, countries can – and to ensure equitable access, should – take measures to enable accessible, quality health care, with approaches that might include telemedicine, well-trained community health workers, a well-developed transportation system including for medical emergencies, and incentives for health workers to serve in rural areas. These issues are part of the larger challenge of resource prioritization, addressed later in this guide.

In some cases, eliminating health inequities will require addressing the defining determinant of a population's marginalization. For example, while specific strategies will be needed to reach people with little education, who may be illiterate or otherwise lack information and thus the opportunities that may come with that information, increasing their levels of education will also be necessary to achieve health equity. Similarly, people who are homeless need homes; they will never realize health equity otherwise. While income disparities will remain – there will continue to be a bottom and a top wealth quintile – poverty itself will need to be addressed to achieve health equity across income levels.

Global health equity

Even maximal levels of health equity at the national level will not abolish global health inequities, though it would narrow them significantly. Ending global health inequities will also require global actions (e.g., development assistance, reformed international law and cooperation frameworks on patents on medicines and health worker migration). As *The Lancet*-University of Oslo Commission on Global Governance for Health put it, "some of the root causes of health inequity must be addressed within global governance processes... global governance processes outside the health arena must be made to work better for health."⁹²

While focused on national action, this guide will touch on ways in which health equity programs of action can begin to address transnational considerations, both with respect to how global dynamics affect health equity within the country and how national actions can contribute positively to global health equity. Global health equity will also require addressing national issues (though often with global counterparts) that reduce the health of the country's entire population and vary considerably by country, such as corruption, mismanagement, and inadequate overall levels of health system investment.

Principle 1: Empowering Participation and Inclusive Leadership

People’s right to participate in the decisions that affect their health is a core value that all aspects of health equity programs of action and associated processes should incorporate. This means that people experiencing health inequities – members of marginalized and disadvantaged populations – should be part of, and have the opportunity to have leadership positions in, these processes. Their priorities and perspectives should receive privileged consideration. Along with the value of their input, the centrality of marginalized and disadvantaged populations to health-related policymaking itself stands to be empowering, an affirmation of the dignity of marginalized and disadvantaged populations, a response to the political and social exclusion that is often an underlying factor in health inequities. Empowering participation will build populations’ capacities to engage in political and policymaking processes, to know their rights, and to enhance their confidence to engage in policymaking and insist upon their rights and that policymakers be held accountable.⁹³

As even particular communities are not homogenous, diverse members of the community should be able to participate. Migrants, for example, include men and women of all ages, those who are legally present and those who lack proper documentation, refugees and asylum seekers (who receive special protections under international law, and are thus sometimes referred to as a distinct population from other migrants^e), and people from different countries, among other sub-groups. Where possible, all community members should have opportunities to express their views during the process of developing health equity programs of action.

Here, we further explain the importance of people’s participation and leadership in structures and processes related to health equity program of action, what that participation might look like, and several ways to facilitate it.

The importance and features of empowering and effective participation

Centrality of community participation

Participation is a human right, central to the concept of human dignity in that through participation, people have the ability to have a say in the decisions that affect their lives, and those of their families and communities. From a human rights perspective, participation has a particular meaning: being part of decision-making processes. The ESCR Committee, which is responsible for interpreting the foundational treaty on economic, social, and cultural rights, including the right to health, has affirmed that the right to health includes people’s right to participate “in all health-related decision-making at the community, national and international levels.”⁹⁴ Because the decisions taken in

forming the health equity programs of action should have dramatic effects on people’s health, people have a right to participate in developing these programs of action. And as the ESCR Committee indicates, this right extends beyond being part of a consultative process during which they provide information, and thus have their views considered by others who are making the decisions. People also have the right to themselves be part of decision-making processes, to be part of power structures. Participation with this decision-making emphasis is also an overarching principle of the SDGs, which include a target (16.7) to “[e]nsure responsive, inclusive, participatory and representative decision-making at all levels.”⁹⁵

Along with being required by human rights law and a core commitment of the SDGs, participation and related principles, such as the right to information, are constitutionally or legislatively guaranteed rights in a number of countries. The process of developing health equity programs of action, along with their accountability processes and structures, should be fully consistent with these laws – and may even provide models for effectively implementing these laws in other realms.

The right to participation assumes extra importance for people who are most likely to be excluded from decision-making processes and from opportunities for political influence – in general, people who are poor, poorly educated, and otherwise marginalized and disadvantaged, and who are also the most likely to suffer from health inequities. Including them in decision-making processes for health equity programs of action will often represent a significant change from how these populations are typically treated. This approach will not only enhance the potential effectiveness of health equity programs of action, for reasons noted below, but should also help counteract the sense of powerlessness that has itself been identified as contributing to health inequities. As WHO has rightly noted, “empowerment and meaningful participation constitute one of the mechanisms for the redistribution of power.”⁹⁶

The potential impact of health equity programs of action could be greater still if they begin to change expectations among marginalized and disadvantaged populations of their role in political processes. If they both understand their right to participate and see that they can meaningfully engage political processes, they may be empowered to better advocate for being included in decision-making processes in other realms. Likewise, health equity program of action processes may serve as models, helping to create space for inclusive participation in other national decision-making processes. Participation in decision-making processes also has great practical benefits, for communities know their own needs and what solutions might work best for them.^{97,98} Ensuring extensive and meaningful participation will thus improve health equity programs of action, enabling them to best target priorities and to incorporate the most impactful solutions.

People, particularly marginalized and disadvantaged populations, may have priorities not readily identified from standard approaches to setting priorities, such as cost-effectiveness based on the cost of gaining an additional disability-adjusted life year (DALY) or quality-adjusted life year (QALY). A less measurable but vitally important metric – dignity – could be central to these populations’ own priorities. An emphasis on dignity may lead to a focus on issues that could receive less priority otherwise, such as preventing discrimination and

e For purposes of this guide, we include refugees and asylum seekers as part of the population we refer to as “migrants,” but recognize this distinction, with migrants having left their country for any reason, and refugees and asylum seekers having fled persecution or similar circumstances, requiring international protection. UN Refugees and Migrants, <https://refugeesmigrants.un.org>, accessed November 7, 2018.

mistreatment in health facilities. Or people may place higher priority on palliative care, including for children – even in cases where it would not extend life – because of the physical, emotional, and spiritual suffering this could avoid, both for the individual who is ill and for their family.

Views from the people and communities who will be directly affected by health equity programs of action are vital, and go hand-in-hand with input from academics, who can provide evidence-based input. Through a successful partnership where both perspectives inform policy, the programs of action will encompass the most appropriate priorities, based on comprehensive understandings of obstacles and solutions. Incorporating the priorities and values of communities, their on-the-ground knowledge, and evidence-based recommendations should lead to stronger policies that can be effectively implemented, as well as a broad sense of ownership of these policies.⁹⁹ This becomes particularly important when the decision are not ones people agree with, for actions around priorities and resource allocations may require difficult choices. People may support the decisions nonetheless if they know that they had input that was seriously considered, even if their views did not carry the day.

Further, by being among the decision-makers in health equity program of action processes, people from marginalized and disadvantaged populations will more likely be seen by other people, including policymakers, as partners – as equals. This potential for a transformed relationship will be critical for the long-term success of health equity programs of action, which will require members of marginalized and disadvantaged populations and policymakers to work in partnership, continuing to find and implement solutions to health inequities. And this change in relationship may quickly yield health benefits. If people trust that the government and health workers are taking measures to build respectful and inclusive health services, people may be more likely to use these services.

Principles of rights-based participation¹⁰⁰

Participation should be:

- *Informed*, meaning that participants have the information they need to effectively participate. Information should cover the right to health and other rights, disease prevalence (including across different populations), current health policies, costs of interventions, and evidence of how different policies and determinants affect health. This information should be presented in an accessible way, provided in the language, form (such as oral or written), and degree of complexity that people will best comprehend. Different levels of information may be appropriate for different stakeholders, including based on the ways in which and the extent to which they are involved in developing the health equity program of action.
- *Fair*, meaning that the rules for participation are clear, including how to proceed when there are disagreements. Participants should have the opportunity to provide items for the agenda (for example, regarding meetings or other forums related to developing a health equity program of action), and all participants should have the opportunity to be heard.
- *Transparent*, meaning that participants understand the purpose of the process in which they are engaged, the topics for discussion,

how the information they provide may be used, and their own role in the process. Participants should also be informed on how the information they provided was in fact used, in this case for the health equity program of action.

- *Respectful and nonjudgmental*, meaning that all participants and their views are treated with respect, even where there are disagreements. Participants should not be judged for who they are or for the views that they express.
- *Attentive to power dynamics*, ensuring that power differences within a group do not preclude certain views from being represented or some participants from honestly expressing their views. For example, recognized community leaders might not adequately represent all members or all segments of the community.

Safe spaces for participation

The success of health equity programs of action will depend, in part, on the ability of people from marginalized and disadvantaged populations to honestly express their experiences, perspectives, and preferences. Yet some people in these groups might feel that they are unable to express themselves honestly. Perhaps their experiences with the government officials or other people of authority – including health workers – may have been negative, where they have felt disrespected and looked down upon. They may belong to a criminalized population, such as people who use drugs and, in some countries, members of the LGBTI community.^f Power and cultural dynamics within a community may also preclude people from expressing themselves. Perhaps only a recognized community leader speaks for that community, even if that person does not truly represent everyone – and may even discriminate against some segments of that community. Along with (potentially) community leaders, other people in marginalized communities sometimes discriminate against others in their community. This, in addition to community power dynamics and cultural norms, may have an impact on the ability of individuals to participate. For example, women may feel constrained in what they can say in the presence of men.

Therefore, the process of developing health equity programs of action should include safe spaces, places where people feel comfortable expressing themselves honestly, where their views will be respected and they do not fear being judged or that expressing their views will result in negative consequences. Such spaces may be ones where participation is limited to members of the discrete population or set of populations concerned, such as women-only focus groups, or focus groups of members of the LGBTI community. These are places where they can be confident that they will not be subject to abuse by other social groups or by the authorities. The physical spaces will be spaces that do not evince a feeling of powerlessness, as a government office might, for example. They might instead meet at the office of a community-based organization, a religious institution, or a regular meeting space within a community.

Both to facilitate participation and to ensure safe spaces, the processes of developing health equity programs of actions may be spread across a country. Some discussions could take place within geographically defined marginalized or disadvantaged communities, such as those of indigenous populations, or communities with high levels of poverty. These forums may also provide opportunities to train people on their health-related and other human rights.

^f This population also encompasses any other orientations or gender identities not otherwise listed (including questioning and asexual individuals).

To identify these spaces, those who are spearheading the health equity programs of action should approach civil society organizations that work with a community or recognized community leaders, who will be central to building trust that might otherwise be absent. This outreach should include assurances of safety and security where such concerns may be present. Community members and civil society organizations working with marginalized and disadvantaged communities could also reach out to health equity programs of action organizers to offer safe spaces. Empowered members of the community and civil society organizations that partner with them could serve as intermediaries with policymakers, feeding the information from the safe spaces into other aspects of the health equity program of action development processes.

Enabling members of marginalized and disadvantaged communities to participate may require more than ensuring safe spaces. It may also be necessary to provide lunch and transportation costs (which, in some regions, participants are likely to expect), or a small stipend for participation to compensate for time that people might have otherwise spent working.

Health equity programs of action might also use other methods to gather the perspectives of and seek feedback from members of marginalized and disadvantaged populations. These could include online methods, surveys, written instruments, and one-on-one discussions. Whatever the methods, people should have the option to express their views anonymously.

Accountable representation¹⁰¹

Even with a mix of methodologies to enable many members of marginalized and disadvantaged communities to participate, not everyone will be part of the structures that develop the health equity programs of action. Community members who are part of these structures therefore have a responsibility to endeavor to be accountable to the broader community. This means genuinely representing the community and being answerable to them, with an obligation to report and explain their decisions.

As a core principle of accountable representation, members of the community should select their own representatives on decision-making structures. There is no single method for choosing these representatives. There may be a community-run electoral process. There may already be widely recognized and respected community leaders – possibly themselves chosen through an electoral process (such as members of governing councils of indigenous populations) – community networks, or community-led civil society organizations that regularly and effectively represent a population. Or community leaders or civil society might organize an application process. Approaches for choosing representatives may evolve for updated versions of the health equity program of action.

Accountable representation is part of an ongoing process of accountability. This may include:

- *Two-way communication mechanisms*, where community representatives inform the broader community of the questions under consideration and decisions to be made, seek feedback, and share decisions with the broader community. Other community members should be able to offer feedback, raise their concerns, and offer their views.
- *Making information available to the community*, providing documents and other relevant information to the community

in forms that are readily accessible to community members, including people with disabilities and who cannot read. This may mean, to the extent possible, translation into local languages or providing summaries of lengthy documents.

- *Establishing delegations*, where those who are formally part of decision-making structures in the health equity program of action development processes are supported by a broader delegation of community members. This can enable more diverse input, including representing different segments within a population, and support communications with the broader community.
- *Active outreach*, reaching out to different segments of the population to enable them to provide their perspectives and otherwise participate in developing the health equity program of action.
- *Rotation among community members*, where different people have the opportunity to represent the community at different times, and which may be a possibility, such as for ongoing participatory processes that the programs of action establish as part of their accountability mechanisms.
- *Terms of reference*, providing clear expectations for how community member will effectively and accountably represent the community.
- *Evaluations of the effectiveness of measures to ensure accountable representation*, such as communications between community representatives and the broader community and the ability of representatives to effectively represent all segments of the community. This may happen while developing the program of action, afterwards in order to inform work on later versions of the program of action, or as part of ongoing accountability processes.

Ensuring accountable representation will require time and resources, particularly as many of these communities may be resource constrained. Funding for developing health equity programs of action should incorporate sufficient funding to facilitate accountable representation.

Joint and inclusive governance

To ensure the most effective health equity programs of action and the broadest sense of ownership, a wide variety of stakeholders should participate in developing the health equity program of action. Structures associated with these programs of action would operate according to principles of joint and inclusive governance. That is, members of the government and other stakeholders – as we have emphasized, most significantly people from populations experiencing health inequities, but also other stakeholders as well – would make decisions jointly. Such joint and inclusive governance will also facilitate enabling experiences, perspectives, and priorities of members of populations experiencing health inequities to be combined with more traditional scientific evidence, so that health equity programs of action can be true to both.

These participants could include:¹⁰²

- Members, networks, and representatives of marginalized and disadvantaged populations
- Government ministries/departments, including from

regions/states/provinces, municipalities, and other sub-national jurisdictions

- Civil society organizations (including those working on health and on human rights, or are part of relevant sectors)
- Patients' groups and networks of people with particular diseases or health conditions
- Health professional organizations and frontline health workers
- Parliamentarians, mayors, and members of the judiciary
- Academic and research institutions
- Human rights statutory bodies (e.g., human rights commissions, law commissions, ombudspersons)
- Faith-based organizations and leaders
- Traditional authorities
- UN agencies, international organizations, and bilateral agencies
- Foundations
- Private sector representatives

Caution will be needed with respect to the participation of certain actors. Corporations often have considerable power to affect policies in ways that harm health (see commercial determinants of health entry in Annex I), such as by dissuading governments from enacting laws or issuing regulations, or convincing governments to weaken them. Yet forceful regulations may be required to advance health equity. To mitigate this risk, certain private sector actors should not participate in developing health equity programs of action, such as industries that profit from unhealthy products (e.g., tobacco, alcohol, and unhealthy foods and beverages) or otherwise profit from activities that undermine health and health equity (e.g., private prison operators).

Inclusive participation and leadership in action: Incorporating these features and principles into processes for developing health equity programs of action

Getting started

Depending on how countries go about developing health equity programs of action – for example, through national health plans

or separately – they may initiate the process of developing such programs of action in different ways. If sufficiently empowered, the minister of health may make the decision to develop this program of action, incorporating it and its processes into the national health plan. Support at the highest levels of government would still be important, including to help drive, coordinate, and ensure intersectoral action, as well as to enable resource allocation across the government that is consistent with the needs of the program of action. A minister in another area closely connected to health equity – for example, a minister of social development, perhaps in coordination with the minister of health – might initiate the process. So could a minister that regularly works across sectors, such as a minister of planning, or a deputy prime minister.

The decision to develop the health equity program of action could also come directly from the highest levels of government – the president, the prime minister, the cabinet. Given the intersectoral, whole-of-government (and indeed, whole-of-society) approach that these programs of action entail, those driving the process will also want to ensure early, significant, and continued high-level engagement of other members of government in influential positions, such as high-level officials in other ministries, chairs of relevant parliamentary committees, and senior officials in the president's or prime minister's office.

If countries incorporate the health equity program of action framework into their national health plan, development strategy, or social inclusion strategy, they may already have structures in place that drive the processes of developing that plan or strategy – though those structures may need to be modified to ascribe to the principles of empowering participation and inclusive leadership and covering health systems and other social determinants of health. Otherwise, countries could create a steering committee or task force to direct the process.⁹ This might be accompanied by a National Health Equity Dialogue.

Steering committee: Whether based on an existing structure or newly developed, the steering committee that organizes the program of action should include a mix of stakeholders, including significant representation of diverse marginalized and disadvantaged groups and human rights organizations (such as NGOs, international partners, and national human rights institutions), along with government officials. Other key stakeholders to be part of the steering committee could include civil society organizations, international organizations (such as UNDP, WHO, and the Office of the UN High Commissioner on Human Rights) and bilateral agencies, health workers and other service providers, and academics. Its leadership should include people from populations experiencing health inequities. For example, it might be co-chaired by a leader from a marginalized or otherwise disadvantaged population and a government official.

The steering committee could make initial decisions on the nature of the program of action, such as whether it will be the full version or a modified version, the process and timeline for developing the program of action, the social determinants of health to cover, and an initial decision of the populations to include. However, these decisions may be refined during the course of developing the health equity program of action. Some of these decisions, such as the timeline, may be based on existing plans, such as the timeline for developing a national health plan. The steering committee could also organize a National Health Equity Dialogue.

⁹ For simplicity, we will refer throughout to the structure that is driving the process of developing the health equity program of action as the steering committee.

As we will see, even with a commitment to include all populations experiencing health inequities, which these populations are is not self-apparent, as detailed in the chapter on every population counts. Since some of these populations may not be very visible (perhaps because of the stigma that they face), and because of internal political and social dynamics in some countries that might otherwise lead certain populations to be excluded, we advise closely collaborating with international actors familiar with the country (such as at WHO, UNDP, or the Office of the UN High Commissioner for Human Rights) in this process, as well as human rights and community-based civil society organizations and members of marginalized and disadvantaged populations.

National Health Equity Dialogue: We recommend holding a National Health Equity Dialogue, which the steering committee could help organize, to build widespread awareness of the initiative to develop a health equity program of action and to affirm – or recommend changes to – the overall parameters that the steering committee proposes. The dialogue’s broad participation would also provide a good opportunity to strengthen political will and gather an overall sense of people’s priorities, including the biggest obstacles to health equity that the country faces and the most urgently needed steps.

The dialogue would also be an opportunity for marginalized and disadvantaged populations and civil society to prepare for the health equity program of action development process, possibly even determining individuals and organizations that should be part of the process. Participants in the dialogue could make decisions regarding the steering committee’s proposed parameters of the health equity program of action, or offer recommendations for the steering committee to consider regarding these parameters. More generally, the perspectives expressed at and the discussions during the National Health Equity Dialogue should be captured as one input into the programs of action.

It may be desirable to hold several National Health Equity Dialogues, in different locations in the country, open to members of the public, to enable more people to offer their views early in the process. These public forums may be similar to town halls or community assemblies. The dialogue could also include social media and other online activities, further enabling public participation.

The media should be invited to participate in the dialogue so that the whole population is aware of this initiative and to raise national awareness on health inequities. Media outlets can also share information on how members of the public can participate in developing the program of action. For example, some countries might provide an online (Internet and mobile phone) platform where people can share their views and priorities. Or it may be possible for members of marginalized and disadvantaged populations to become more directly involved in addition to those proposed below.

National Health Equity Dialogue¹⁰³

- *Participants:* In accord with the principle of inclusive participation, and the need to have political support, the steering committee should seek to maximize the number and diversity of those participating from marginalized and disadvantaged populations and other stakeholders. Community leaders and people influential within their respective constituencies (such as different ministries of government, professional bodies, and academia) will be

particularly important to invite.

- *Preparation:* Participants could receive background information on health equity, the plan for developing the health equity program of action, including any initial decisions about its parameters to be discussed as part of the National Health Equity Dialogue, and opportunities for people to participate in developing it, along with the agenda for the National Health Equity Dialogue and their role in it.
- *Moderation:* The Steering Committee should select a skilled and well-prepared moderator (or several moderators) who can be trusted by all participants. The moderator should be prepared to navigate controversies that may arise in ways that retain trust and lead to productive conversations, and enable everyone to be heard in a forum with complicated power dynamics, with participants including members of marginalized and disadvantaged populations and government officials.
- *Format:* One possibility for the format of the National Health Equity Dialogue would be to divide it into three parts. It could begin with an orientation for all participants on the health equity program of action and its planned processes and parameters. Next, different stakeholders – such as members of marginalized and disadvantaged populations, civil society organizations, government officials, and academics – could meet separately to discuss their views on and expectations for the health equity program of action, including how they would like to engage in the processes of developing it. They might also offer initial thoughts on what they consider priorities in terms of obstacles to health equity and key actions to address them. It could be desirable to have members of marginalized and disadvantaged populations meet both separately and together with members of other communities. In the final part of the National Health Equity Dialogue, everyone could come back together into a single forum to share and discuss views that emerged from the separate stakeholder discussions and make any required decisions. These might include affirming or modifying, or recommending changes to, the steering committee’s initial decisions on the parameters of the program of action.
- *Safe space:* It is critical for all participants to feel that they can speak openly and that their safety and confidentiality will not be put at risk. If the presence of government officials would make certain participants feel at risk if they express their views openly, regardless of any assurances, a trusted civil society organization could represent their views. This might be based on a private dialogue arranged for marginalized and disadvantaged populations at which they can openly express their views.
- *Venue:* A setting that encourages interaction among participants is desirable.

Inclusive leadership in developing the health equity program of action

Inclusive leadership, with a particular concern for empowering leadership roles of people from populations experiencing health inequities, might be accomplished in various ways. Some possibilities would more thoroughly engage and empower marginalized and disadvantaged populations than other approaches. The steering committee and participants in the National Health Equity Dialogue could address and decide upon which approach to use. Several possibilities follow.

Health equity program of action task team: One possibility would be to have the steering committee, or another entity (“health equity program of action task team”) – perhaps one that is already developing the national health plan or development strategy, for example – lead the process of developing the health equity program of action. This could encompass the research required to understand obstacles to health equity and decisions on the strategies and specific actions required to address them. The task team would heavily engage members of populations experiencing health inequities in this process to get their perspectives and priorities. This task team should, like the steering committee, include a diverse mix of stakeholders, and be comprised, in significant part, of members of populations experiencing health inequities. As suggested for the steering committee, leaders from these populations should have a leadership role in this group, such as being the chair, or one of the co-chairs.

Population teams: Another approach would be to have members of populations experiencing health inequities take full charge of developing the parts of the health equity programs of action that relates to their group – for example, analyses of the reasons for the health inequities that they face, actions to address them, and their priorities among these actions. Countries could establish “population teams” that would be comprised primarily or entirely of members of different marginalized and disadvantaged populations. They would still engage other stakeholders – through interviews, focus groups, and other methods (see below) – to ensure that their analyses, knowledge, and perspectives are fully taken into account. These population teams might also reach out to other members of their own populations for additional insights and to enable more people to participate in developing the health equity program of action.

Such teams could be in addition to the health equity program of action task force discussed above. That task force would likely still have important roles, such as harmonizing the actions proposed by these teams into a single health equity program of action and developing an accountability strategy, as well as other work that cuts across many different populations. For example, it could analyze obstacles to health equity and actions to respond to these obstacles from the overall national perspective for each social determinant of health (see discussion in the chapter on health systems and social determinants of health). Such functions might also be performed by the steering committee.

If countries develop teams of marginalized and disadvantaged populations, the steering committee might develop material and arrange trainings to orient these teams to health equity programs of action, providing guidance as warranted, and equipping them with any skills or information that could be of benefit. Members of marginalized and disadvantaged populations might organize their own teams, possibly beginning to organize them during the National Health Equity Dialogue.

Or, where populations do not have the current structures or leadership in

place that would enable this self-organization, the steering committee could facilitate their organizing, such as by reaching out to prominent members of these populations and civil society organizations that could assist. UN agencies that work with marginalized and disadvantaged populations (for example, UNDP or the Office of the UN High Commissioner for Human Rights) and bilateral development agencies might also be able help.

Civil society organizations working with these populations, or potentially other stakeholders focused on their health and rights, may also join these teams. If they do, these teams may still want to create the space for separate discussions or other activities that are only for members of the marginalized and disadvantaged populations themselves if they are unable to speak candidly when government officials or other people outside of their population are present.

Population teams of this sort might be established for each population addressed in the health equity program of action. If it is not possible to organization population teams for any group – for example, groups representing LGBTI communities in countries where they face significant risk of violence or of being imprisoned, or groups that do not have any identifiable leaders or structures – the task team could carry out the roles of population teams for these groups.

Various other approaches would be possible as well, perhaps reflecting resource or other practical constraints:

- Multiple population teams could be established, each with its membership drawn from several populations. Perhaps populations who encompass large numbers of people could have separate teams working on the health equity program of action, while populations with fewer members could join together – and possibly even forge new relationships and alliances in the process. Or, populations sharing certain characteristics or causes of marginalization or disadvantage, or that already have strong alliances, could join together.
- To work alongside the steering committee and task team (if one is established), a single population team could be established. Its members could be drawn entirely from populations experiencing health inequities, and perhaps also civil society organizations working closely with them. Since this approach would limit the number of members of each population included in this team, additional outreach to members of these populations (through interviews, focus group discuss, and meetings, for example) would be particularly important. This approach may be seen as logistically simple, while still maintaining the centrality of members of marginalized and disadvantaged populations in developing the health equity program of action.
- One, several, or many population teams could be established, but with a more limited role, such as determining the actions to be taken with respect to their populations, and the priorities among different actions. Or their role might be to work alongside the steering committee or task team in all population-specific aspects of the health equity program of action (such as analyses of obstacles to health equity, actions to address these, and priorities among these actions).
- Since members of marginalized and disadvantaged populations are also in government (though in some countries, discrimination, population size, or other factors may limit the presence of some or many of these populations in the government, or among other stakeholders), and are academics, members of civil society

organizations, health workers, and so forth, the task team, if established – or, indeed, the steering committee itself – could be comprised primarily or entirely of members of populations experiencing health inequities. Given the limited number, and possibly limited diversity of members of these populations who would be part of the task team (or steering committee), additional outreach to members of these populations would still be necessary. Additional outreach to government officials and other stakeholders would be needed as well.

Building shared understandings

Whatever the exact structures and processes that countries utilize, one critical result of the proposed approaches is that policymakers, civil society, and people from populations experiencing health inequities will be working closely together, and thus have the opportunity to learn from one another and better understand one another's realities. Policymakers involved in the process should come to better understand the lives of people who experience health inequities. This may help erode stereotypes and strengthen policymakers' commitment to act. It could enable them to better appreciate the particular factors underlying health inequities for a specific community, realize why certain policies that sound promising in theory are ineffective in practice, learn the priorities of marginalized and disadvantaged populations, and appreciate the importance of listening to and incorporating the perspectives of marginalized and disadvantaged populations.

Similarly, interacting with policymakers will enable civil society and members of marginalized and disadvantaged populations to understand the environment in which policymakers operate, including their constraints, from difficult decisions on trade-offs within inadequate budgets to limited capacity and the need to prioritize their actions. This will enable the processes of developing health equity programs of action to contribute to an informed empowerment. This, in turn, will help ensure that the actions, targets, and timelines that are part of the health equity plan of action are, while ambitious, also realistic, avoiding commitments that are likely to go unfulfilled.

Such interactions can also help create sustained relationships between policymakers, civil society, and members of marginalized and disadvantaged populations that are based on mutual respect and understanding. These relations can form the basis for collaborative governance that extends into other realms, well beyond developing health equity programs of action.

The processes of developing a health equity program of action and the resulting interactions among stakeholders can also contribute to a greater shared understanding between members of marginalized and disadvantaged populations and health workers and other services providers. They may have different understandings of some of the barriers to access, for example, related to how health workers treat patients or how patients comply with directions from health providers. Perhaps interactions when developing health equity programs of actions could contribute to separate efforts – or actions within the program of action – to bridge these gaps

in understanding and to move towards solutions and towards understanding and responding to underlying causes.

Gaining the views of members of populations experiencing health inequities and other stakeholders

Central to developing the health equity programs of action will be the views of people from marginalized and disadvantaged communities, supplemented by other stakeholders. A mix of approaches is possible, including interviews, such as with community leaders, people in key government positions, and civil society leaders; focus groups of members of marginalized and disadvantaged populations; community meetings of members of marginalized and disadvantaged populations, and; meetings that bring together a mix of stakeholders. Online or in-person surveys could collect views from any member of the population who wants to participate. Mobile phone technology might also be used to capture people's perspectives.

It may be useful to have focus groups and meetings that address marginalized and disadvantaged populations individually and ones that bring together multiple populations to understand common experiences and needs, providing insights into where obstacles to health equities and the responses needed to address them are distinct for particular populations experiencing health inequities and where they are shared. Meetings bringing together several populations may also be opportunities to build or strengthen alliances between them. They could also be forums to address people's overlapping identities and challenges.

Outreach to members of marginalized and disadvantaged populations will need to be well planned, including to engender trust and a sense of empowerment, including believing that contributing to the health equity program of action is truly an opportunity to have their views listened to and taken seriously, with a real chance of affecting policies and programs, and ultimately their own lives. Otherwise, particularly if trust in the government and other institutions is low, people may be reluctant to participate. They may, for instance, believe that they cannot effect change, so it is not worth their time. Similarly, it will be important to be honest about what their participation can change – such as laws and policies, programs, practices, and resource allocation – but (unless other measures are built into the health equity program of action development process) will not immediately change their individual circumstances.¹⁰⁴

Participatory action research

Where possible, focus group discussions could follow the participatory action research method, through which the discussions would be aimed not only at contributing critical information to the health equity program of action, but also at catalyzing action to create change for that community. Participatory action research involves a cycle of reflection and action. In the case of gathering perspectives related to health equity programs of action, views on priorities and actions that members of marginalized and disadvantaged populations identify could inform immediate action to address their concerns. Members of these populations might act themselves or together with other communities sharing similar concerns, perhaps geographically nearby communities (such as where indigenous people are concentrated in a region),

communities that share identities (different migrant communities, for example), or different communities with shared concerns (for example, migrants and people experiencing homelessness, both concerned about a lack of affordable housing, or migrants, indigenous peoples, and people with disability, all who may need interpretation services in health facilities). After they act, the communities would reflect on the results, identify further actions, act, and reflect again. The cycle could continue to repeat, with participants feeding the lessons of these actions into health equity programs of action.

Community leaders or civil society organizations could guide these processes, which will likely require additional funding. Budgets might be built into overall budgets for developing health equity programs of action, or separate sources of funding might be found. It might not always be possible to incorporate the participatory action research approach into the process of developing health equity programs of action, or might be possible to only a limited extent.

Wide and open process for finalizing health equity programs of action

Whatever approaches countries take to developing health equity programs of action, before being finalized, the program of action and the analyses underlying it could be shared with members of each of the identified marginalized and disadvantaged populations addressed, and with other key stakeholders, including individuals and entities that provided information that contributed to the development of the program of action. They would then have the opportunity to provide feedback, with the steering committee and, depending on the approach the country has taken, task team and possibly population teams, revising the program of action accordingly. If this process led to significant revisions, the revised program of action may itself then be subjected to this process of feedback and revision.

A final step could be to validate the health equity program of action to ensure that it meets the understandings, expectations, and priorities of all stakeholders, particularly members of marginalized and disadvantaged populations. A second National Health Equity Dialogue could be held for this purpose. Any last revisions to the health equity program of action could also be made at this time, based on views expressed in this dialogue.

This National Health Equity Dialogue could also be an opportunity to begin to organize the steps required to implement the program of action. For example, representatives of different ministries, legislators, civil society, and marginalized groups could meet to discuss changes in laws and policies that are part of programs of action. Members of marginalized and disadvantaged populations and civil society could develop advocacy strategies, and government officials, development partners, civil society, and marginalized groups could meet to discuss funding the program of action. The National Health Equity Dialogue could also be a forum, where needed, for rights and sensitivity training of and education for attendees on non-discrimination, or to train health workers or other populations to be able to themselves train colleagues in their communities on non-discrimination and other aspects of health and human rights.

As with the first dialogue, the media should be invited to this National Health Equity Dialogue so that they, and indeed all participants, can

share with the broader population information on the health equity programs of action. And again, the dialogue could include social media and other online components. Ensuring this public awareness is itself an important form of accountability.

Laying the groundwork: Empowering marginalized and disadvantaged populations to effectively participate

Often, marginalized communities will be well-positioned to participate in these processes, and already organized and aware of their rights, such as through networks of people living with HIV and AIDS, organizations of people living with disabilities, women's rights organizations, and indigenous population governing structures.

Other communities might not be aware of their rights or might face other challenges with participation. They may feel neglected and disempowered, and thus believe that their input and participation will not lead to meaningful change. The possibility of engaging with policymakers may be intimidating. Some communities might not be organized to stand up for their rights. Such communities will be better positioned to participate in the health equity program of action development process if targeted capacity-building measures precede their participation. Civil society organizations could educate people on their rights and offer skills-building workshops and other experiences to help people gain confidence in their ability to participate. More empowered members of the community may be able to serve this role. Another possibility is community-to-community empowerment, where more organized or empowered communities of marginalized and disadvantaged populations assume a leading capacity-building role.

Capacity building will be an ongoing process. Feelings of disempowerment resulting from a lifetime of experiences will not be quickly undone, nor will fears of discrimination, which may lead people in some stigmatized populations (e.g., people living with HIV or LGBTI persons) to hide their status or identity. Capacity building will often also be an important component of the health equity programs of action themselves. Empowerment and people's ongoing engagement in political and policymaking processes will be critical to achieving health equity.

Along with this capacity building, solutions will be needed to very practical barriers to participation. Special measures may be needed to enable members of marginalized and disadvantaged communities to overcome such obstacles, such as the cost of transportation or missed work, low levels of education and illiteracy, lack of connection to the Internet and other information technology, gender or cultural norms, and living in remote or otherwise hard-to-reach areas.^{105,106} And as noted earlier, special measures may be necessary to enable populations whose behaviors are criminalized, who may face violence, or who fear for their privacy to participate.

Principle 2: Maximizing Health Equity

Health inequities are, by definition, unjust. Countries ought, therefore, to seek to make maximum progress towards eliminating them entirely, with the aim of ultimately achieving full health equity. Such inequities surface across a wide range of health areas; comprehensive health equity programs of action would not be limited to a single disease and they will need to address the social determinants of health, this framework's next principle. Some causes of health inequities have deep roots, such as discrimination that may go back centuries, and attitudes – for example, regarding women or people with disabilities – that are deeply entrenched. These and other structural determinants of health are embedded in foundational aspects of society, such as who owns economic resources, who controls social institutions, and who holds political power. It will take time and considerable political will to create change in these areas, but health equity cannot be achieved without these changes.

Along with the necessity of an intersectoral approach, a commitment to maximize health equity and to work towards full health equity has several implications for the nature of health equity programs of action. They would: 1) encompass the full spectrum of health issues; 2) encompass structural and societal determinants of health; 3) mobilize political will and empower populations experiencing health inequities, and; 4) be based in evidence. We address each of these in turn.

The full spectrum of health issues

Health inequities will often be reflected in many or even virtually all diseases and other causes of death and disability, though in different ways and to different extents for different populations. Often, this is because underlying causes, such as poverty, inadequate nutrition, and limited education, will affect people's vulnerability to many illnesses. To accord with the principle of maximum health equity, health equity programs of action should cover the full range of health conditions and threats to people's health, ensuring due attention to both these underlying causes and targeted intervention that may be needed for particular diseases and health conditions.

It would be possible, though, for most of this health equity program of action framework to be applied on a narrower basis, to particular diseases or health conditions. In some cases, focusing on a particular disease may necessitate addressing many of the factors underlying health inequities more broadly, as well as numerous marginalized and disadvantaged populations. Tuberculosis stands out in this regard. For example, poor nutrition, poor housing, and poverty are among the underlying causes of tuberculosis – with societal drivers of marginalization, in turn, underlying these. Addressing TB also necessitates addressing other diseases that are themselves TB risk factors, including HIV and diabetes, as well as addressing smoking and indoor air pollution.¹⁰⁷ And an extensive set of people experiencing health inequities and marginalization are considered “key populations” for TB, based on various factors that make them more prone to the disease.^{108,109}

Yet any focus on only a single disease will be incomplete, neglecting other diseases and health conditions and, most likely, not including a comprehensive set of actions to redress inequities in social determinants of health. Such a focus might also suggest a different set of

priorities than would emerge from considering the inequities across the entire national burden of disease. And a focus on a single disease may also be insufficient to create the political will to respond to the inequitable distribution of power and resources, despite these being fundamental to health inequities.

Structural and societal determinants of health

A distinction is sometimes made between social determinants of health and structural, or societal, determinants of health. The former may be considered the “the immediate, visible circumstances of people's lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities,”¹¹⁰ “access to...economic and social resources,”¹¹¹ or “social and community influences, living and working conditions and broad socioeconomic, cultural and environmental conditions...[such as a] clean and safe environment, adequate income, meaningful roles in society, good housing, population-based services and utilities, affordable nutritious food, education and social support within communities.”¹¹² Underlying these, though, are “the unequal distribution of power, income, goods, and services, globally and nationally,”¹¹³ “the political, economic, social, and cultural structures that shape health and health patterns,” and “control and ownership over [social and economic] resources.”¹¹⁴ The latter set of health determinants are sometimes referred to as societal, or structural, determinants of health. The Commission on Social Determinants of Health rightly includes both aspects in its definition of social determinants of health, people's immediate conditions and the deeper power and economic factors that shape them.¹¹⁵

Actions in the health and other sectors – the subject of the next principle that this guide discusses – will need to address immediate issues of access and the circumstances that people experience in the institutions around which these sectors are organized. They will also need to respond to the deeper structural issues within these sectors, such as who holds power within them. For example, with respect to access to food and income in agricultural regions, who owns the land? Are some populations who receive lower quality or less education fully represented among school principals and district superintendents? Who are the judges, prosecutors, and lawyers in the judicial system? And what are the underlying economic dynamics of these institutions? Are prisons run by the state, accountable to the people and meant to act in the public interest, or run by private companies, accountable to their shareholders? Is water treated as a public good to which people have a right, or a commodity, controlled by private water companies that are seeking a profit?

Addressing the full range of social determinants of health, including the societal and structural determinants, will require actions across sectors to address foundational political, economic, and social systems and institutions. Does the tax system contribute to or undermine a fair distribution of income? Do rules on unionization and workers' rights contribute or undermine the ability of populations who experience health inequities to work in safe and health conditions and earn fair wages?

Elected and appointed politicians, along with civil servants, establish the policies that affect all social determinants of health. The political will necessary to address these drivers of health inequities is, ultimately, the will of these individuals within the government. Does everyone have an equal voice in the political system and equal access to people in policymaking positions? Or are wealthy corporations and wealthy

individuals able to convince politicians to prioritize their interests?

Societal institutions – social, political, economic – may systematically exclude certain populations – such as women, indigenous populations, or in some countries, people of a certain ethnicity or religion – from positions of power and control. Exclusion may even extend to participation in these institutions altogether, rendering certain populations, such as people with disabilities, virtually invisible in society. Often, such exclusion has deep roots and has long existed. Yet health equity will not be achieved without transforming exclusion into inclusion.

Issues of governance and corruption, too, cannot be outside the scope of health equity programs of action. Corruption within the health and other sectors tends to disproportionately affect poor and other marginalized and disadvantaged populations.¹¹⁶ For example, absenteeism at public health facilities or schools affects people and children who cannot afford higher quality, private options, while informal user fees most affect people who have the fewest resources. More broadly, corruption drains the government of resources needed to create equitable health and education systems, a strong social protection system, adequate levels of affordable housing, and so forth. Communities with the least political power may be most vulnerable to consequences of corruption, such as poorly constructed housing that is unsafe, or government contracts with companies that fail to ensure the health and safety of their workers.

Steps to counter societal and structural health determinants that contribute to health inequities may be the most challenging aspect of health equity programs of action, with respect both to agreeing to these steps and to successfully implementing them. The programs of action – at least in their first iterations – may not be able to take on all of these determinants at once. And even when implemented, it may take some time before these fundamental changes lead to changes in people’s circumstances and their access to their health needs. Timelines in health equity program of actions will need to recognize this reality. Programs of action should address both these longer-term structural changes and “quick wins” that will quickly begin to transform people’s lives, and health.

Political will and empowerment

Given that achieving full health equity will likely require addressing long-standing structural drivers of a country’s political, social, and economic dynamics, the needed changes in these structural determinants of health will not happen without creating and harnessing political will. Directly empowering populations experiencing health inequities is central to creating this will. The global response to HIV and AIDS stands out as a prime example, where some of the most marginalized of populations – including gay men, injecting drug users, and sex workers – organized, and turned a political blind eye into, ultimately, a global response of unprecedented, if still not sufficient, proportions. A commitment to health equity and to human rights requires such empowerment to change current dynamics surrounding control of power and resources. We will address some possibilities for empowerment in this guide’s chapter on accountability.

Relatedly, strong and lasting political commitment will be necessary, as changing the deepest factors causing exclusion will require a sustained process over many years. We will touch on the subject of helping to maintain political commitment to address health inequities in the final chapter.

Evidence

What actions will in fact contribute to health equity, and how and by how much? How can these changes be sustained? To maximize health equity, successful strategies must be deployed, requiring a strong evidence base. Much evidence already exists of actions and approaches that will contribute to health equity, both to improve equity in the health sector and to improve equity in other domains in ways that will contribute to health equity. Still, more evidence will typically be valuable. We will turn to the importance of health equity research at the end of the chapter on the principle that every population counts. It will also be important for countries to learn from experiences elsewhere, while countries should themselves share their experiences and evidence of successful approaches to addressing health equity (as well as what has not worked), including how to make changes across the deep, structural determinants of health.

Principle 3: Health Systems and Beyond: Addressing All Social Determinants of Health

Health systems and inequities

Health systems themselves are a major source of health inequity. Contributing to health inequities are, among many other factors, the inequitable distribution of health workers, facilities, and financing; lack of affordability of health services and medicines; under-developed community systems; discrimination within the health sector; lack of diversity within the health workforce, and; the lack of programs of particular importance to the health of marginalized communities, such as peer-led support systems. Addressing these factors must be an integral part of health equity programs of action, so that the priority of health equity is thoroughly incorporated into all health laws, regulations, policies, plans, and programs. For many countries, acting in these and other areas will also be necessary to achieve universal health coverage.

Importance and scope of social determinants of health

At the same time, the environment in which people live and work affects their health even more than the clinical health services they receive – vital though these are.¹¹⁷ Actions across sectors, therefore, are necessary to achieve health equity. Addressing these determinants – enabling people to live in good housing, to have clean water and sanitation, to breathe clean air, to have safe transportation and opportunities to exercise, to have a solid education and good job – will help protect people from disease. Along with the critical role of health systems in prevention – such as through vaccinations and health screenings, and helping people access underlying determinants of health – addressing social determinants of health is central to preventing ill health and health inequities in the first place. Adding to not only the necessity of but also the power of this approach, actions involving other determinants of health can also contribute to improvements across many health conditions. Similarly, in what has been dubbed synergistic epidemics, or “syndemics,” adversely interacting disease states may have at their root several mutually reinforcing risk factors – which, if addressed, can mitigate this collection of illnesses.¹¹⁸

Some of these social determinants of health – such as our natural and built environments, water and sanitation, food and nutrition, housing, violence, and working conditions – operate directly, spreading harmful bacteria (or not), damaging our lungs (or not), introducing toxins into our body (or not), injuring us (or not), affecting our body’s basic nourishment, and affecting our susceptibility to illness. Our built environment and housing, and other determinants such as transportation, can affect our ability to engage in healthy behaviors, such as exercise, and our proximity to pollution and violence, but also to employment and health care. Commercial determinants of health, when companies’ profit motives conflict with health, lead to unhealthy

behaviors such as tobacco and alcohol use and consuming too much sugar. Some of the most significant determinants have a less direct but immense impact on our health, such as income and education, affecting access to health care, nutritious food, safe and clean environments, health information, and more, while being closely linked to health-promoting and health-damaging behaviors. Beyond affecting income, the nature of people’s work – as well as unemployment – can also affect people’s stress, contributing to cardiovascular diseases, and affect the amount of sleep people get. The amount of sleep we get has a number of health implications. The criminal justice system, too, may affect people’s access to many determinants of health, including both during and after incarceration for those imprisoned. Many of these factors operate with particular power in early life – nutritional status, water pollution, and education, for example – and have lifelong consequences.

Discriminatory laws and practices contribute to societal exclusion that leads populations to have negative interactions with the social determinants of health, such as reduced access to nutrition, sanitation, and employment, and living in communities that experience high levels of violence and pollution. Women in almost every country, though to greatly varying degrees, experience discrimination that creates barriers to employment and political participation, and sometimes such basic needs as health care, sanitation, and nutrition, while they experience high rates of sexual and domestic violence.

In different country contexts, the significance of some of the determinants will vary greatly. For example, clean water and adequate sanitation remains a large barrier to health in many low-income countries, but not in most high-income countries. Violence is relative rare in some countries (though violence against women stands out as comparatively common virtually everywhere), but a daily danger in others.

In short, to begin to reach their full potential, health equity programs of action must address the full range of social determinants of health, including yet extending beyond health care. Resource or other practical constraints may lead countries to focus on only certain determinants deemed priorities in their contexts, but the more that are addressed, the more that health programs of action stand to contribute to full health equity.

The health equity programs of action would encompass the determinants of health that are most important in the national context. Here we offer 27, including health systems themselves, that should receive serious consideration for inclusion. Even this list is not complete. Countries may choose to include others as well. It may also be appropriate to include others for specific populations for whom they may be particularly important – just as for a given population, some determinants might not contribute to health inequities.

Meanwhile, there are certain key determinants of health, such as the use of law and civil society advocacy and activism, that cut across many of the other determinants. These may also be considered separately. For example, while advocacy may affect how the government (or other actors) responds to particular social determinants of health, the overall degree of respect for freedoms, including those of expression, association, and peaceful assembly, will affect the effectiveness of civil society advocacy that is possible across determinants.

These determinants are further explained in Annex 1, both their connections to health and health equity and very brief surveys of policies to address them.

27 social, environmental, economic, and political determinants of health

1. Health systems
2. Food and nutrition
3. Water and sanitation
4. Housing
5. Early life
6. Education
7. Working conditions
8. Employment and job security
9. Income and income distribution (including poverty)
10. Social safety net
11. Social support systems and community networks/social capital
12. Natural environment
13. Built environment
14. Agricultural land use and ownership
15. Transportation
16. Recreation and physical activity
17. Commercial determinants of health
18. Electricity and technology
19. Safety/violence
20. Criminal justice system
21. Gender
22. Migration
23. Indigenous status
24. Disability
25. Social, economic, political, and legal exclusion and discrimination
26. Control over resources, institutions, and decision-making
27. Political engagement and empowerment

People of adequate financial means can generally access certain positive determinants that people require for health, such as nutritious

food, adequate housing, clean water, adequate sanitation, and health care itself. Lack of these basic needs will directly contribute to ill health – malnutrition, infectious diseases, and respiratory illnesses, for example. People who cannot access them will most often be poor, often with other markers of marginalization as well. In some cases, such as adequate housing, even people of modest means but well above the poverty level may also have trouble accessing essential needs, or cultural factors may be at play, as with adequate sanitation in India. Generally, though, for determinants of health, where universal coverage is necessary and achievable, the people with the least access will be from populations experiencing health inequities, and that lack of access will contribute to these inequities. In other words, as long as parts of the population cannot access these essential needs, health inequities will persist. Therefore, lack of effective universal access will inevitably contribute to health inequities.

Still, there will be more or less equitable ways to achieve that universal access, as with universal health coverage. The principle of progressive universalism proposes “that more disadvantaged subpopulations benefit at least as much as more advantaged subpopulations in reforms towards universal health coverage.”¹¹⁹ It would be inequitable to leave out certain populations along the path towards universality (perhaps because it is politically convenient to do so, or those populations are particularly hard to reach), waiting until other populations have already achieved access. It would, in general, also be inequitable to enhance access for people who had some access – for example, to some level of health services – while some people had no access at all.¹²⁰ The focus here, then, would be both achieving universal access to the determinant – taking into account quality, as there is a world of difference between high and low quality education, good quality and poor quality health care – and doing so in an equitable manner. As noted in the chapter on human rights and health equity, the principle of proportionate universalism – addressing health inequities throughout the socioeconomic gradient, with increasingly intense actions for increasingly disadvantaged, marginalized, and vulnerable populations – provides valuable guidance as well.

At the same time, as also discussed in the chapter on human rights and health equity, sometimes a balance will be needed between reaching hard-to-reach populations and having the greatest overall health gains. Reaching these populations may require extra resources, which could produce a greater aggregate benefit if concentrated on easier-to-reach populations. With no single best approach, the balance a country (or sub-national region) chooses should be found through inclusive, participatory approaches.

Tanahashi framework and barriers to health services

WHO points to the Tanahashi framework as a valuable way of thinking about barriers to accessing health services that different populations may face.¹²¹ The framework covers five dimensions and tracks closely to the right to health framework of availability, accessibility, acceptability, and quality:

1. *Available coverage*, whether there are enough health resources (e.g., workers, facilities) in the country (or sub-national area under consideration).
2. *Accessible coverage*, whether people can physically access health services, including with respect to time, distance, and the location of the services, and the affordability of the services.

3. *Acceptable coverage*, whether the services are acceptable in terms of dimensions including people's culture, gender, religion, age, and so forth. Acceptable coverage also includes whether the quality is acceptable, including whether it is worth the cost and whether people are treated fairly.
4. *Contact coverage*, which is the proportion of the population that not only can access acceptable health services, but also in fact do access (come into contact with) those services.
5. *Effective coverage*, which is the proportion of people who receive successful interventions, including an accurate diagnosis and proper treatment, and adhere to that treatment.

Looking particularly to universal health coverage, WHO has identified barriers across six domains:

1. Socioeconomic constraints
2. Demographic (biological) and jurisdictional constraints (e.g., rights associated with residency)
3. Political and institutional constraints
4. Knowledge and education constraints
5. Social norms
6. Physical constraints

More detail is offered in WHO's scoping review of intersectoral factors influencing equity-oriented progress towards universal health coverage:¹²² <http://apps.who.int/iris/bitstream/handle/10665/255607/9789241512329-eng.pdf>

In areas where universal coverage is not the central goal, the main concern with respect to health inequities will be the inequities within the determinants, though coverage (or access) may still be an important issue. In no country does everyone looking for a job have one at a given point, but unemployment and underemployment rates may vary considerably by population, in turn contributing to health inequities. Polluting infrastructure may need to be placed somewhere – though often pollution levels can be reduced, or alternatives could be found – but may be disproportionately located near marginalized and disadvantaged populations. Public transportation, facilitating access to employment, nutritious food, and education, may be less accessible for some populations (such as people with disabilities) or in some areas (such as poorer neighborhoods). People rich and poor may both find themselves imprisoned, but poorer people in far higher proportion and in far worse conditions, with health harms caused by poor prison conditions, reduced post-employment prospects, and possibly other consequences of imprisonment.

Meanwhile, as discussed under the previous principle, it will be necessary to address the societal and structural determinants of health – issues such as long-standing discrimination, the distribution of power, and who owns and controls resources, for example – that underlie why certain populations are poor and lack access to nutritious food and clean water, why some populations have lower employment

and levels of education, and more exposure to violence and pollution, and so forth. Countries will need to implement new laws and reform existing ones, and take other measures, to regulate powerful actors, such as transnational corporations and other businesses that prioritize their profits over people's rights and health.

A two-way street

Just as people's experience with the social determinants of health can negatively affect health, ill health can have negative ramifications for social determinants of health.¹²³ For example, ill health may cause people to miss work or even be unable to work. This could, in turn, lead to people having less access to health care, nutritious food, and education, which can lead to still worse health. Since groups experiencing health inequities by definition have worse health to begin with, they are at greatest risk of experiencing this downward spiral.

Health equity programs of action will need to account for the consequences that poor health can have for social determinants of health, and the risk of exacerbating the causes of health inequities, thus deepening and further entrenching health inequities.

Systematic reviews

The necessity of addressing social determinants of health to achieve health equity means that health equity programs of action would be based on systematic assessments of these determinants and how they are contributing to health inequities. As discussed in the next chapter, health equity programs of action would be based on assessments of how, for each population experiencing health inequities, different determinants of health contribute to health inequities.

Countries might also undertake and develop responses based on a systematic review of each major determinant of health and its contribution to health inequities at a national level. For instance, is nutritious food unaffordable for some populations, or hard to find in some neighborhoods? Do populations with less education have difficulty understanding information on nutrition labels?

A comprehensive assessment would encompass laws, policies, strategies, and programs aimed at increasing equity, both in general and for particular populations, and both those addressing a single determinant and those addressing multiple determinants. It would include overarching initiatives aimed at improving health equity, such as Health in All Policy approaches. If possible, the assessment would also include information on implementation and enforcement.

In addition, the assessment would cover the nature and quality of governance, in particular features that are most related to health equity.¹²⁴ Seven broad areas that could be addressed are:

1. Governance and corruption
2. Participatory and accountable government structures
3. Structured intersectoral collaboration mechanisms

4. Disaggregated data and health equity monitoring, evaluation, and research
5. Civil society and media enabling environment
6. Vital (civil) registration system
7. Adequacy of, and equitable mobilization and distribution of, financial resources

As with the social, environmental, economic, and political determinants of health listed earlier, these are also described in more detail in Annex 1.

Transnational considerations

In considering the role of different determinants of health on health equity, it is important to consider the effect of transnational factors and their dynamics. Examples of such factors include climate change, international migration, regional air pollution, conflicts, and international property protections and other international legal frameworks. *The Lancet-University of Oslo Commission on Global Governance for Health* emphasized seven areas where improving health equity requires global action and cooperation: internationally-driven economic austerity measures, knowledge and intellectual property, investment treaties, food security, the conduct of transnational corporations, irregular migration, and armed conflict.¹²⁵ Many of these factors disproportionately impact people already experiencing health inequities. For example, smallholder farmers may find that already low incomes fall as rains become uncertain due to climate change, or fresh water turns salty, killing their crops. Higher drug prices due to the effect of international patent law on drug prices will have the largest effect on poorer people, who may be unable to afford these medicines.

Beyond considering how regional and global issues affect health equity domestically, we encourage countries to consider how their actions contribute to health equity abroad. How are their policies contributing to climate change? Does air pollution from forest burning affect health and health equity in other countries in the region? Do the trade treaties they are negotiating risk impeding access to medicines, or causing economic dislocation (reducing job security and employment, important social determinants of health) in other countries with which they are seeking to enter these agreements? At the same time, are there ways that national actions do or could contribute to health equity abroad, such as through development cooperation or improving access to high quality, affordable medicines?

Multisectoral engagement

Addressing these social determinants of health will require that virtually all sectors be engaged in developing health equity programs of action, and to understand their roles in advancing health equity. Along with the health sector itself, and a leading role that it would assume, relevant sectors include:

- Education (addressing, e.g., disparities in educational attainment; health and human rights literacy)
- Justice (addressing, e.g., policies to reduce violence; whether a criminal or public health approach is used to address substance use

disorders; law enforcement policies that may drive marginalized populations underground; health care in prisons; discrimination in the criminal justice system; connections between health and criminalizing certain behaviors; violence against women)

- Gender (addressing, e.g., health gender inequities; discrimination against and the health of gender and sexual minorities; violence against women)
- Social welfare (addressing, e.g., social safety net programs)
- Commerce (addressing, e.g., intellectual property laws and trade policies with implications for access to medicine; marketing of unhealthy products)
- Environment (addressing, e.g., water and air pollution that disproportionately affects marginalized and disadvantaged populations)
- Housing (addressing, e.g., housing policies that affect the safety and availability of housing for marginalized and disadvantaged populations; homelessness)
- Food and agriculture (addressing, e.g., nutrition policies; farm-worker health and safety risks that may disproportionately affect marginalized and disadvantaged populations)
- Immigration (addressing, e.g., migrant health; migration policies that affect migrants' health)
- Finance (addressing, e.g., equity in health and related financing; overall financing for efforts to improve national health equity)
- Energy/electricity (addressing, e.g., ensuring uninterrupted electricity supplies for health facilities; expanding access to electricity)
- Local governments (ensuring that sub-national jurisdictions integrate health equity throughout their departments and services)
- Sports and recreation (addressing, e.g., physical activity; youth-related interventions; safety in places of recreation)

While all sectors bear responsibility for health equity, the health sector could spearhead efforts. WHO has developed a short step-by-step guide on how the health sector can engage other sectors to implement intersectoral action on health:¹²⁶ http://www.who.int/nmh/publications/ncds_policy_makers_to_implement_intersectoral_action.pdf

Health sector actions could include assessing evidence, initiating dialogue across sectors, advocating for addressing social determinants of health in public discourse and policies, promoting synergies across sectors and partners, and assessing evidence and generating an evidence base for action.¹²⁷ Collaborations for intersectoral action include joint budgeting and workforce development, cross-cutting information and evaluation systems, and cross-sector action teams.¹²⁸

Past initiatives aimed at intersectoral action for health point to additional lessons on successful intersectoral action. These include the importance of building trust and strong working relationships across sectors, developing champions both inside and outside of government, demonstrating how intersectoral actions can lead to more efficient uses of resources, framing health issues in ways that different sectors can relate to (with non-health sectors understanding their roles), engaging researchers, enabling civil society and public

engagement, recognizing the limits of past and current approaches, building capacity across sectors and partners, developing permanent intersectoral structures, and using data and media attention to build public demand, as well as using data to inform opportunities for collaboration. In certain instances, even where collaboration with a particular sector proves difficult, that sector could agree to avoid interfering with health-related efforts. It will also be important to monitor and evaluate how intersectoral actions are working in practice to identify and overcome barriers (e.g., bureaucratic regulations, staff turnover, and different cultures across agencies and partners).^{129,130}

Engaging officials in sectors outside of health not only on their sector's role in health equity but also on how their priorities might be advanced as health equity improves, and through the measures required to improve health equity, could also help build political will within other sectors to work towards health equity. Such benefits are as diverse as reduced crime and healthier children, enabling children to be more effective in school. And increased productivity of people presently experiencing health inequities, and the resulting increased economic growth and government revenue, stands to enlarge the budgetary possibilities across government entities.

Specific measures that countries can take to enhance the capacity of non-health sectors to contribute to health equity and to enhance their responsibility for health equity are discussed in the chapter on comprehensive accountability.

Principle 4: Every Population Counts

Health equity can only be achieved by understanding and addressing both causes of health inequities that many marginalized, disadvantaged, and vulnerable populations share and factors specific to one or several populations. To be sure, many reasons for health inequities are shared by populations who experience these inequities, such as low income, less education, and higher unemployment. Underlying these commonalities will typically be shared drivers of health inequity, including the structural determinants of health discussed earlier, such as discrimination and the inequitable distribution of political power across a society. Health equity programs of action would address these shared experiences and underlying factors.

Yet many reasons for health inequities are related to the particular characteristics and historical experiences of different populations. For example, people with physical disabilities face unique issues related to accessing health facilities and other buildings, migrants may face unique law-based discrimination regarding access to health care if they are not citizens, children who are homeless, with no place to study and a very unstable environment, face challenges at school that even other children from families with very little income do not, women may need to contend with cultural acceptance of child marriage and domestic abuse, and so forth. Health equity programs of action would also systematically address these population-specific factors.

Countries may already have strategies to address particular health needs of some populations, but not others. Health equity programs of action can help ensure that no population is neglected. They can also provide an opportunity to review current approaches, and where appropriate, chart a new course of action, such as developing robust systems of community-based, rather than institution-based, living and support for people with disabilities.

Accordingly, health equity programs of action should systematically examine health inequities for each population that is experiencing them, and develop actions to address them. In this section of the guide, we address the practical challenge of answering the seemingly straightforward question of which populations are experiencing health inequities and offer points to consider as countries endeavor to address the causes of and solutions to health inequities for each population. We also offer several frameworks for population-by-population assessments of health inequities, and point to sources of information as well as the importance of further research.

Identifying populations to include in the health equity programs of action

Which populations to include in the health equity program of action will be an early, fundamental decision, though one that might be refined during the process of developing these programs of action. Conceptually, every group experiencing health inequities should be included. But how to identify and define these groups?

We first consider the overarching question of which groups to include – people with disabilities, ethnic minorities, and indigenous peoples, for example. Second, we will look into two complexities within and among groups. One is that of sub-groups, as many marginalized,

disadvantaged, and vulnerable populations are themselves comprised of a number of different groups. A country may have dozens of different ethnic minorities and numerous indigenous peoples. People with disabilities may have mental or physical disabilities (or both), and may include people who are deaf, blind, physically disabled, autistic, schizophrenic, and suffering from depression, among many forms of physical and mental disability. And so forth. The other complexity is that everyone has multiple identities and belongs to multiple groups. These different identifies may interact in complex ways, and contribute to different forms and degrees of discrimination.

Deciding what groups to include in the health equity program of action: Macro-level decisions

We discuss six non-mutually exclusive possibilities for identifying the populations to be included in health equity programs of action:

- Using existing data;
- Using marginalized and disadvantaged populations identified in existing laws, strategies, and policies;
- Using key populations and those of heightened risk of disease as delineated by international bodies;
- Using the list of categories in General Comment 20 on freedom from discrimination from the Committee on Economic, Social and Cultural Rights and those identified by WHO;
- Using participatory processes, and;
- Adapting populations used in other countries' health equity programs of action.

Countries may choose to – and to be comprehensive, would be well advised to – combine different approaches.

1. Using existing data

Health ministries may have disaggregated data for some segments of the population (such as ethnicity) that reveal populations experiencing health inequities. Other ministries may also have disaggregated data on social determinants of health – levels of education or employment, for example, or rates of malnutrition – that indicate populations likely experiencing health inequities. In countries that conduct it, the Demographic and Health Survey will be a key source of data. Sub-national data on health inequities, including regarding social determinants of health, may also be available, whether collected through the government or independent researchers. Particularly where national data is lacking for some populations, countries may look to data in neighboring countries or any data that may exist in the region or subregion, which may provide insights on health inequities in their own countries. Countries in certain region may share similar economic, social, or other conditions that could contribute to health inequities.

Importantly, the data can be used in the health equity program of action in ways other than determining which populations to address. For example, data might identify disparities regarding particular health issues that may require population-specific responses, and help to determine priorities, based on the extent of the disparities.

Data may exist for only a limited set of indicators. For example, a country may have data demonstrating that rates of tuberculosis are far higher for people in prison than in the population overall, yet other data on prisoners' health, including long-term health effects of imprisonment, may be sparse.

Even limited data may provide a good indication of the need to include a given population in a health equity program of action. Rapid assessments and sampling methods, discussed briefly in the chapter on comprehensive accountability, can also be used to gather supplemental data.

When should marginalization be a proxy for health inequities?

Data for many marginalized and disadvantaged populations on the health inequities that they suffer may be sparse or lacking entirely. How should health equity programs of action address populations for which there is little or no direct evidence of the level and nature of health inequities – or whether they are subject to health inequities at all?

For some populations, discrimination and health inequities remain challenges in virtually every country in the world. These populations should be included in health equity programs of action. These include, for example, people with disabilities, women, sexual and gender minorities, people who are homeless, undocumented migrants, stateless people, indigenous peoples, people living in poverty (see box below), and people living with illnesses that may be stigmatized, such as people living with HIV. These populations may be referred to using different terminology in some countries, and some, such as stateless and indigenous peoples, have little or no presence in many countries. Meanwhile, racial and ethnic identities are relevant to health inequities in virtually all countries.

In other cases, countries may look to proxies that are indicative of likely health inequities. In all probability, if a group is subject to discrimination, it will experience health inequities. If a population is disproportionately poor or less educated, its members will very likely experience a range of health inequities. Likewise, evidence with respect to other social determinants of health, such as safe housing and employment, may suggest health inequities. Indeed, inequitable access to some determinants – for instance, safe housing and clean water – will itself be a form of health inequity.

Anecdotal evidence of health inequities based on individual experiences and general understandings in the country may also be informative. Participatory processes, including the National Health Equity Dialogue, may be particularly important in these cases.

Uncertainties will also indicate the need for further research.

2. Using marginalized and disadvantaged populations identified in existing laws, strategies, and policies

Countries may already have delineated marginalized and

disadvantaged populations for other purposes. Some might be specified in health or other development strategies. Laws prohibiting discrimination will include classifications upon which marginalized and disadvantaged populations may be based, or may identify specific populations. Judicial decisions could also provide guidance on groups that are entitled to protection against discrimination. For example, prohibitions on discrimination based on ethnicity provide a category of a person's identity within which populations experiencing health inequities may be found, in this case, certain ethnic groups. In developing their health equity programs of action, countries might then delineate specific groups within these categories that are (or are likely) experiencing health inequities based on census or other data (e.g., ethnic groups with poor health indicators) or other evidence. Anti-discrimination laws could cover, and thus identify, certain marginalized and disadvantaged populations, such as people with disabilities and people living with HIV and AIDS.

Governments might have laws and policies directed at, or government offices devoted to, populations who are marginalized and therefore require particular attention, such as people with disabilities, indigenous people, women, and people who are homeless. Similarly, certain populations may be eligible for affirmative action, an indication of marginalized status, and thus be populations likely experiencing health inequities.

Addressing children, youth, and the elderly in health equity program of action

Unlike other statuses of marginalization, which apply to many people for all of their lives (such as their gender, ethnicity, or religion), or to some people for part of their lives (such as a disability acquired or that manifests itself later in life, or experiencing homelessness), all of us begin our lives as children, become adolescents and youths and, if we are lucky, will end our lives as elderly people. Much data that is central to assessing health inequities, such as life expectancy and maternal mortality, cannot be used to assess inequities among these populations. Changing disease prevalence and vulnerabilities across people's life course will inevitably skew other data. For example, levels of obesity will likely be lower among children than for adults, while dementia will be higher for the elderly than for younger adults. Still, a sense of the efforts and effectiveness of national responses to health conditions specific to, or more prevalent in, children or the elderly could be gathered through international comparisons, especially of comparable countries, such as countries in the region and countries with a similar level of per capita income.

In other respects, though, children and the elderly, as well as youth, are comparable to other marginalized and disadvantaged populations. They, too, might suffer from stigma and discrimination, particularly the elderly and girls. They, too, have particular health concerns – like dementia for the elderly, or undernutrition, malaria, and lead poisoning for children. Some health issues may manifest themselves in specific ways in older or younger people, like depression in the elderly. Health conditions as they manifest in the young and the old may be insufficiently studied, or medical technologies less developed than for adults, as is frequently the case for children, such as for tuberculosis.¹³¹ Conditions may also be particularly neglected for younger and older people, like HIV and, especially for children, palliative care. Girls

and young women may face heightened discrimination with respect to sexual and reproductive health services. In other words, children, adolescents and youths, and the elderly also have health concerns that require targeted approaches – population-specific strategies that fit well with the health equity program of action approach.

Given all of this, countries will need to decide whether to include the young and elderly as distinct populations to be included in health equity programs of action. If they do, the nature of their participation may be distinct. Children, for example, may need assistance in their role in developing health equity programs of action. Whether or not they are included as their own populations, children and the elderly, as well as adolescents and other youths, can be treated as sub-populations of other groups, an issue discussed below. Countries could also choose to address specific groups of children, adolescents and other youths, or elderly people, such as orphans.

3. Using key populations and those of heightened risk of disease as delineated by international bodies

UN agencies, multi-stakeholder partnerships, WHO, or other health bodies may recognize certain populations as being at heightened risk of disease. UNAIDS considers five groups to be key populations – gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and prisoners and other incarcerated people – due to their heightened risk of contracting HIV.¹³² The Stop TB Partnership identifies many more key populations for tuberculosis: prisoners, indigenous peoples, health workers, sex workers, miners, migrants workers, undocumented migrants, refugees and internally displaced persons, women in settings of gender disparity, hospital visitors, and people with other health conditions or behavioral factors, including with HIV and diabetes, and people who are undernourished, inject drugs, use tobacco, or suffer from alcohol use disorder.¹³³ TB key populations are identified as such because of increased exposure to TB, increased risk of contracting TB if exposed, or limited access to TB services. Note that not all (such as health workers) necessarily experience health inequities even if they are at heightened risk for a particular disease.

When should a health disparity lead to being included in the health equity program of action?

It will not be necessary or perhaps even feasible to develop a set of actions in the health equity program of action for every population suffering any health disparity or heightened risk. Some populations may face heightened risks only briefly or not be a cohesive group, such as hospital visitors. Yet they face an increased risk of contracting TB.¹³⁴ Tay-Sachs disease, a rare genetic disease, is most common among several groups including people of Ashkenazi Jewish descent (whose ancestors come from Eastern Europe), but this heightened incidence is biological and not subject to societal remedy.

It may also be that a population holding heightened political, economic, and social power, and is not marginalized, experiences worse health outcomes. For example, in virtually every country, men have shorter life expectancies than women.

Some of this difference relates to factors (such as higher rates of smoking or alcohol use among men) that can and should be addressed. But are health equity programs of action the place to address them? That will be for each country to decide.

Meanwhile, while women have longer life expectancies, they will often nonetheless face systematic, remediable barriers to good health linked to discrimination – perhaps higher rates of malnutrition, lower rates of employment and less income, disproportionately few resources to maternal health services, mistreatment when accessing health services, and so forth – indicating the importance of specifically including women in health equity programs of action.

4. Using the list of categories in General Comment 20 on freedom from discrimination from the Committee on Economic, Social and Cultural Rights and the categories identified by WHO

The ESCR Committee has issued General Comment 20 on the right to be free from discrimination.¹³⁵ It describes the grounds of discrimination expressly prohibited in the ICESCR: race, colour, sex, language, religion, political or other opinion, national or social origin, property, and birth.¹³⁶

Along with the ICESCR's express prohibition on these grounds, the treaty prohibits discrimination based on "other status." General Comment 20 provides a non-exhaustive set of forms of "other status" upon which discrimination is prohibited. This list is based on earlier general comments from the Committee, as well as its concluding observations, which are its responses to periodic state reports on their implementation of the ICESCR. The forms of "other status" that are also forbidden grounds of discrimination under the ICESCR that the Committee identifies are: disability, age, nationality, marital and family status, sexual orientation and gender identity, health status, place of residence, and economic or social situation.¹³⁷

Like national anti-discrimination laws, the classifications described in General Comment 20 may be helpful in identifying marginalized and disadvantaged populations.

General Comment 20 also lists specific populations as examples within the difference categories, including women; linguistic and religious minorities; people living in informal settlements; people born out of wedlock or of stateless parents; people with disabilities; older people and young people; refugees, asylum seekers, stateless persons, migrant workers, and victims of international trafficking, regardless of legal status and documentation; people living in a family relationship not recognized by law or who have been divorced or widowed; people who are transgender, transsexual, or intersex; people with HIV and AIDS, people with mental illness, people with leprosy, and women who have suffered obstetric fistula, and; people living in poverty or who are homeless.

As a general matter, where such populations make up identifiable and cohesive groups within a country (which will not be the case for some populations, such as people born out of wedlock), and there is evidence of discrimination against the group (which, for example, may be the case with people who are divorced in some countries but not in many other countries), countries should strongly consider including them among the populations addressed in health equity programs of action.

Also possibly helpful, and overlapping many categories in the ICESCR and General Comment 20, is a list that WHO offers of commonly used categories for monitoring health inequities: income or wealth, place of residence (rural, urban, or other), race or ethnicity, occupation (workers/employed or unemployed), sex, religion, education, socioeconomic status, social class, age, and other characteristics particularly important for a program of interest and in the country context (e.g. migrant status, caste, gender identity, and sexual orientation).¹³⁸

5. Using participatory processes

People know the realities of their communities and countries. Participatory processes – focus groups in different regions and settings, for example, or surveys – may be used to identify populations likely to be experiencing health inequities. The proposed National Health Equity Dialogue would be an important forum for providing input into the groups that will be the subject of the country's health equity program of action. Participatory processes will provide an important supplement to the more data- and document-driven other methods, and may also reveal populations and sub-populations who, perhaps because of a high level of stigma and discrimination, are not found in other sources of information.

6. Adapting populations used in other countries' health equity programs of action

While each country will need to identify marginalized and disadvantaged populations who experience health inequities through its own processes, countries can still learn from one another. What populations other countries include in their health equity programs of action may be informative. This may particularly be the case for neighboring countries that share similarities in the composition of their population, such as their ethnic groups.

Beyond populations: Geographic inequities

Inequities surface not only across populations, but also across districts, provinces (states), and other sub-national jurisdictions. People living in different parts of the country may differ significantly in health status and access to health care and other determinants of health. These differences are often markers of the nature of the populations living in these areas. For example, regions with high proportion of people living in rural areas, with high levels of poverty, or with large indigenous population, may well have worse health indicators than other regions. Accordingly, addressing the barriers to health equity that these populations face should lead to significant health improvements in the region – and addressing health in certain regions should contribute to greater health equity for the people who live in them.

It may be appropriate, then, to incorporate region-specific actions into health equity programs of action. For example, under a policy introduced in Brazil in 2012, the level of funding that the federal government transfers to municipalities to support the country's Primary Care Strategy, which is at the heart of its universal health system program, depends on factors including the municipality's per capita GDP and the share of the municipality's population living in extreme poverty or participating in the national conditional cash transfer program.¹³⁹ In the United States, at a still more local level, under a policy that began in 2014, free school lunches

are available not only to individual children from low-income households, but also to all students in schools with a high proportion of low-income students. In particular, individual schools or school districts where at least 40% of the children are eligible for free school lunches may participate in a federal program that enables all students in those schools to receive free lunches. This eliminates the risk of stigmatizing students who receive free lunches, ensures that the program reaches all students in need in these schools, and reduces administrative costs. In Norway, where parents must pay a fee for their children to attend kindergarten (though a 2015 scheme provides 20 hours of free kindergarten for children in low-income households¹⁴⁰), a pilot program provided free kindergarten to children living in multi-ethnic or disadvantaged areas.¹⁴¹

Addressing sub-populations and layered marginalization

Sub-populations within groups

Many marginalized and disadvantaged populations are themselves comprised of numerous sub-populations. For example, along with examples noted earlier of people with disabilities, ethnic groups, and indigenous peoples, migrants include refugees and asylum seekers (though their special legal status leads them to often be distinguished from other migrants), internally displaced persons, undocumented migrants, migrants with various forms of residency status, seasonal migrants, and internal migrants. Obstacles to health equity may vary across these groups. And within these categories are migrants from different regions and countries, people who are newly arrived and people who have been present for decades (and may even include citizens), and those who speak the country's official language and those who do not. Adding to the complexity, many of these groups of migrants may experience health inequities, but some might not. Similarly, some ethnic or religious minorities may be marginalized and experience health inequities, while other minorities have better health outcomes than the overall population.

Likewise, people with some health conditions – people living with HIV and AIDS or with leprosy, for example – may experience discrimination that impedes their health care or otherwise shortens their lives. At the same time, people with many other chronic health conditions, also populations who could be defined by their disease status, might not experience discrimination – though still have reduced health outcomes due to their conditions. People with some diseases that are not chronic conditions, like TB, may experience discrimination in the health system and other discrimination that reduces their access to conditions of good health (employment discrimination, for example), but chiefly during the time they have the disease (though in some cases, even after being cured), which in the case of TB, if properly treated and not drug resistant, will be about six months once treatment begins.

It would be appropriate, then, within these broader categories of health inequity and marginalization (such as migrants and ethnic minorities) whose sub-populations experience different degrees and possibly types of discrimination and inequities (and possibly none at all), for health equity programs of action to focus on the sub-populations who are experiencing health inequities.

Further, as noted in the box on children, adolescents and youth, and the elderly, for some populations, one's stage in life is particularly important for strategies to enhance health equity. For example, addressing homelessness for youth may require different strategies than addressing homelessness for people who are homeless further into adulthood.

Thus, the number of populations that a country could potentially address in its health equity program of action is immense. How should countries respond to such complexities? There is no single right answer. As with many aspects of health equity programs of action, countries will make their own decisions, while learning from elsewhere as experience with health equity programs of action grows. It will be necessary to balance the need to be pragmatic with the real differences across sub-populations that need to be addressed for a health equity program of action to be comprehensive with respect to populations covered.

One possible approach is to address populations both at the overall level – migrants and people with disability, for example – and at the sub-population level. Actions, and analyses upon which they are based, could be included that address broader populations who face shared obstacles to health equity and, where additional actions for specific sub-populations may be required to enable them to achieve health equity, that address these sub-populations as well.

If this is too many sub-populations to be feasible, considerations of which groups to include could be those who face the largest health inequities, the largest sub-groups who face health inequities based on their population size, and those who face the most distinct obstacles to health inequities, requiring particularly tailored responses. Where health equity programs of action cannot adequately address all sub-groups of a given population, a follow-up action that programs of action include could be to develop a specific national strategy on the health of that population (e.g., people with disabilities or migrants) that does cover all sub-populations who have specific health needs or who experience health inequities.

Depending on national circumstances, if most members of the larger population category do not experience health inequities but one or several sub-populations do – a single ethnic group, for example – the health equity program of action could address those sub-populations only, rather than the overall population group.

How members of a population participate in developing health equity programs of action could mirror this approach. Countries should ensure that the processes and structures – such as the steering committee, the National Health Equity Dialogue, and population teams, if developed – are inclusive not only in terms of broader population groups (like people with disabilities), but also, to the extent possible, of sub-populations. It may be appropriate to create working groups addressing different sub-populations. Focus groups should be diverse with respect to sub-populations they represent or be developed for specific sub-populations, and interviews could aim to gather broader population as well as sub-population-specific information and perspectives.

Persistent and transient marginalization

Some populations include people who are part of them for a significant period of time, such as people who are chronically homeless or people imprisoned or in other forms of custodial

custody for many years, as well as people who are part of a marginalized and disadvantaged population only briefly, experiencing a single instance of homelessness or imprisoned or in other forms of custodial custody once for a very brief period, for example. These differences should, where possible and relevant, be taken into account as countries develop health equity programs of action. For example, health disparity data for short-term members of these populations may be particularly difficult to collect.

In some cases, the obstacles to conditions required for good health may exist for all members of these populations. People who are imprisoned or in other forms of custodial custody for one month or one decade may similarly face the crowded conditions, poor health care, and inadequate nutrition that fuels the spread of TB and other infectious diseases during their time in confinement. People who experience a month of homelessness or years cycling between living on streets, in shelters, and on friends' couches are likely to face barriers to good health such as discrimination, disrupted health care, stress, inadequate nutrition, and other features of the homeless experience.

Strategies may be similar or vary across these groups. Creating prison conditions conducive to good health will help all in prison, as will education and programs to facilitate re-entry into communities. By contrast, people who are chronically homeless may be experiencing very different life circumstances than someone temporarily without a home because of an unexpected expense, such as a medical bill, that forced them to miss rent payments.

People's many identities and layered discrimination

We all have multiple identities. The member of a racial or ethnic minority subject to health inequities might also be a woman who is homeless. The undocumented immigrant might also be a member of the LGBTI community and living in a remote area, without a social support system. The health disparities that people experience will often be the compounded effects of these multiple identities, with discrimination or other obstacles to good health emerging from each aspect of their identity. The obstacles to health inequity that a person faces may be more complex still, as different forms of marginalization interact to create a unique set of health challenges for a discrete sub-population comprised of its members multiple identities.

As with the question of sub-populations within a single population group, there is no single approach for how health equity programs of action should address these human realities. Countries might take different approaches; so might different populations teams, if these teams are developed as part of the process of creating health equity programs of action. In general, it will make sense to specifically address a sub-population whose members share a layered identity when addressing health inequities they face will require additional actions that might not otherwise be included.

If population teams are developed, their diversity and inclusiveness is critical, and will require capturing as many as these overlapping identities as possible. Coordination and interaction among different populations will be necessary as well.

Addressing people who are poor in health equity programs of action

How should strategies address people who are poor? In all countries, people who are poor suffer health inequities. Yet given that members of many marginalized and disadvantaged groups are disproportionately poor, poverty's effects on health are sure to be addressed through actions items for many other populations. Likewise, the diversity of people who are poor may lead to quite a large number of issues that are specific to different sub-groups of people who are poor. Addressing people who are poor as a distinct population may thus be particularly complex.

At the same time, though, a focus on people who are poor as their own population will ensure that some issues of poverty and their link to health inequities are not inadvertently neglected if other populations focus primarily on the more distinct issues that they face. It is important to ensure that issues that cut across a range of people who are poor are incorporated into health equity strategies – while also not neglecting people who might not be below the country's official poverty line, yet whose low income still leads them to experience health inequities.

If people who are poor are included as a distinct population in health equity programs of action, countries may take a different approach than for other populations. For example, they might choose not to address sub-populations as they might for other groups, with the more specific concerns that would arise to be addressed when assessing and planning actions to respond to the health inequities that other population face. Or, countries might specifically address only sub-populations of people who are poor whose specific needs would not be addressed elsewhere in the health equity program of action. For example, in the United States, from the late 1990s to the present, life expectancy has uniquely fallen among middle-age white Americans with the least education (high school or less).¹⁴² Suicides, drug use, and alcohol poisoning largely drive this change in life expectancy.¹⁴³ White, middle-aged Americans, in general, however, would be considered relatively privileged, not marginalized.

Also, as this example illustrates, people with lower education tend to have worse health. Should countries address people with low education as a specific population? Countries might take a similar approach to addressing low education in health equity programs of action as they do for poverty, allowing the ways in which low education is addressed through actions related to other populations to suffice, or looking separately only to sub-populations with low education who are not otherwise included in the health equity program of action.

Another approach to addressing both poverty and education would be one suggested in the chapter on health systems and other social determinants of health. Along with population-specific analyses and strategies, health equity programs of action could separately evaluate, at the level of the country's whole population, how different social determinants of health contribute to health inequities. These determinants would include education and income. Countries choosing this approach, then, would address issues of insufficient income and poverty, and inequitable access to quality education,

both through this nationwide approach and within the actions related to other marginalized, disadvantaged, and vulnerable populations whom the program of action covers.

Factors to consider when analyzing health inequities for each population

The actions incorporated in the health equity program of action would be based on evidence for and analysis of the causes of health inequities for each population covered. The evidence and analysis could cover several dimensions. One framework for analyzing health inequities, drawing in part on the Stop TB Partnership framework of analyzing risks that key populations in the TB context face,¹⁴⁴ would be to analyze, for each population, 1) social determinants of health; 2) particular diseases and health conditions; 3) behavioral factors; 4) biological factors, and; 5) research and knowledge.

- *Determinants of health:* How do different social, environmental, economic, and political determinants of health contribute to the health inequities that members of a population experience? The determinants considered could include those listed in the chapter on health systems and the social determinants of health, as well as others that may be relevant to that population. This analysis would also include existing laws, policies, and practices that undermine equity in that domain, such as laws that, as written or applied, discriminate against women, or that otherwise restrict the rights of a certain group, or that exclude a population from the social safety net.
- *Diseases and health conditions:* What is the evidence of increased levels of particular diseases and other health conditions for members of the population? What causes this? Causes may be linked to the determinants of health overall (such as reduced access to health care or adequate nutrition) or to more specific disease- or condition-related factors. These might include, for instance, a lack of accurate information about the disease, like a mistaken belief among health workers that a population is less at risk of certain diseases or not understanding different ways that a disease presents itself in a particular population (such as differences in presentation of cardiovascular diseases for men and women), leading to inadequate prevention or treatment.
- *Behavioral factors:* Behaviors such as smoking, alcohol and other substance use, and lack of exercise significantly increase the risk of numerous diseases and are associated with overall poor health outcomes. These behaviors are often linked to social determinants of health, and require interventions both that affect these determinants and that are specific to the behaviors, such as targeted smoking cessation and substance use disorder treatment programs. What is the evidence for a population of a high prevalence of unhealthy behaviors and low prevalence of healthy behaviors, and the factors underlying these behaviors in that population?
- *Biological factors:* Biological factors may cause health disparities, such as disabilities that reduce lifespans and increased prevalence of certain diseases among populations based on genetic characteristics. However, despite the biological roots of these disparities, these may be amenable to medical or other interventions, and represent inequities to the extent that, because of discrimination or a population's lack of economic, social, and political power, the government has not taken the necessary steps to

ensure that these populations can receive available interventions (such as early intervention for children with development disabilities). Likewise, if medicines or other interventions have not been developed, it may be because the country (or other countries with higher levels of academic, government, and industry-based medical research) has not invested public resources or designed national systems of research and development to address these health conditions. In both cases, the lack of prioritization may be discriminatory and create or perpetuate health inequities.

- *Research and knowledge:* Information might not exist about how particular diseases differentially affect a population or make a population particularly vulnerable to a disease. Or the information might be available but not incorporated into government policies and health care practices. Along with gaps in information or how it is used, there might be gaps in medical technologies that are developed and available. A lack of diagnostics or treatments that a certain population requires when the commonly used diagnostics or treatments do not meet their particular needs might be because the medical technologies have not been developed. Or they might exist, but be unavailable in the country or to members of that population (perhaps because they are unaffordable), contributing to health inequities. Private actors, such as manufacturers or university research centers, may hold relevant information. If so, measures should be implemented to ensure the information is accessible to the government and the public.

Another way to analyze the factors contributing to health inequities is through a different five factor framework, one developed by the Priority Public Health Conditions Knowledge Network. The Commission on Social Determinants of Health established the Network, and WHO has been a major contributor.¹⁴⁵ Its framework analyzes health inequities based on socioeconomic position and four health and other vulnerabilities and consequences that result from a person's socioeconomic status:

1. *Socioeconomic context and position*, recognizing that addressing differences among populations' level of control of power and resources "is critical to reducing health inequity." The factors determining this socioeconomic context "include[] governance, social policies, macroeconomic policies, public policies, culture and societal values."¹⁴⁶
2. *Differential exposure*, with different populations exposed to different levels of health risks, such as pollution, violence, unsafe housing, dangerous working conditions, and insufficient food and nutrition.
3. *Differential vulnerability*, where "[t]he same level of exposure may have different effects on different socioeconomic groups, depending on their social, cultural and economic environments and cumulative life course factors."¹⁴⁷ For example, HIV increases the risk of developing TB, lack of social support and poverty can worsen the effects of alcohol use, and low income can reduce a family's ability to escape from unsafe housing.
4. *Differential health outcomes*, where access to fewer or lower quality health services, or discrimination within the health system, may lead people in some populations to have worse health outcomes than people in other populations with the same health condition. In this way, the effects of a person's socioeconomic position and the resulting differential exposure and vulnerability "may be further amplified by health systems."¹⁴⁸

5. *Different consequences*, as even the same health outcomes can lead to worse consequences for some populations than others. For example, populations with lower levels of health insurance coverage due to less formal employment and more poverty may face higher economic costs of illness, and people in some populations may be in more precarious employment situations and more likely to lose their jobs as a result of illness.

Frameworks such as these could provide a detailed, evidence-based understanding of reasons that a population is experiencing health inequities. This evidence would then serve as a basis for determining the strategies and actions needed to respond to these inequities, including (particularly for the framework from the Stop TB Partnership) additional research needs. To inform the program of action that will be developed based on this information, analyses based on these frameworks could also identify what appear to be the most significant obstacles to health equity for different populations, requiring the most urgent responses.

Following analysis of each population experiencing health inequities, it would be advisable to synthesize these findings to understand the most significant obstacles to health equity for each population and across populations. This prioritization would inform the priorities within the programs of action.

In addition to these population-specific analyses, as noted in the chapter on health systems and other social determinants of health, countries could also assess how each social determinant of health is contributing to health inequities. This would counter the risk that population-specific analyses may pose of not adequately addressing causes of health inequity that are common to many populations, as these population-specific approaches may lead to analyses that highlight differences rather than similarities across populations.

Sources of information

The information for these analyses could come from a variety of sources, including:

- *A review of existing health and demographic data to understand existing health inequities.* Sources could include national surveys, government reports and other published data, academic studies, and NGO reports. This information may be supplemented by interviews with government officials who may have access to data that is not publicly or readily available, as well as others who may hold data not readily available, including academics and members of civil society organizations.

International organizations will likely have relevant information, particularly WHO, and possibly UN and specialized agencies working with specific populations, such as UN Women, UNICEF, UNAIDS, UN Enable (people with disabilities), and the International Organization for Migration. For low- and middle-income countries, proposals to and analyses from the Global Fund to Fight AIDS, Tuberculosis and Malaria, other global and bilateral funding agencies (e.g., USAID, DFID), and the World Bank and other development banks may also have relevant information.

- *A review of laws, policies, and regulations to understand the legal and policy basis of existing health inequities.* What needs to be changed? What are positive aspects of laws and policies that require improved implementation and enforcement, that could serve as models in other areas, or that could be strengthened? Analyses could also identify legal and policy gaps that, if filled,

would reduce health inequities.

- *A review of written analyses.* These may address the nature and causes of health inequities within a country, how laws and policies that may exacerbate or reduce health inequities are being implemented (including where implementation is falling short), and proposed solutions. These might be documents from NGOs, government, academics, the United Nations or UN agencies, and journal publications. The review of written analyses could extend to other countries and to general international experiences.
- *Gathering people's perspectives.* Central to understanding health inequities and the most effective actions to respond to them will be the views of people from marginalized and disadvantaged communities, supplemented by other stakeholders. A mix of approaches is possible, including interviews, such as with community leaders, people in key government positions, and civil society leaders; focus groups of members of the marginalized and disadvantaged populations; community meetings of members of the marginalized and disadvantaged populations, and; meetings that bring together a mix of stakeholders. Online or in-person surveys could collect views from any member of the population who wants to participate. It may also be possible to use mobile phone technology.

It might be useful to have focus groups and meetings that address marginalized and disadvantaged populations individually and ones that bring together multiple populations to understand common experiences and needs, and where obstacles and needed responses to health inequities are distinct and where they are shared. Meetings bringing together several populations could also be opportunities to build or strengthen alliances among them. They would also be forums to address people's overlapping identities and the implications of multiple identities and layered discrimination.

The need for further research

Much about health inequities may be unknown, from the degree to which (or even whether) some populations are experiencing health inequities to the key factors behind health inequities and the best approaches to addressing them. How are the different determinants of health contributing to health inequities? How do current laws, policies, and practices affect health inequities? What are the most effective approaches, with the greatest promise for reducing health inequities? What lessons might there be in strategies in other countries? What are the most cost-effective actions?

Given all of these questions, health equity programs of action should incorporate the need for research into health inequities. It may be impractical for the health equity program of action to itself include a comprehensive health equity research agenda and measures required to carry out this research. Additional time might be required to identify institutions and researchers who could lead different components of research, to determine how best to organize the research (e.g., through a competitive grants program), and to determine what aspects of the research are the highest priorities.

Instead, the program of action could set into motion a national health equity research plan. For instance, a government agency (such as a national public health research institute) or an academic institution might be charged with stewardship of the research plan, though the actual research would likely be conducted by a number of different researchers, including, and with a special effort to include, researchers from populations experiencing health inequities.

The health equity program of action could catalyze a health equity research plan by identifying:

- One or several lead organizations to develop the research plan, or a set of actors responsible for either finding a lead organization or organizing a multisector, multi-stakeholder research committee that could take charge of developing (and possibly oversee implementation of) the research plan.
- Key research questions or issues that the plan should address, and possibly the priorities among them.
- Target dates for developing the research plan and for beginning the research.
- An estimate of costs associated with developing the plan and, if possible, where the funding will come from.
- Principles that the plan should incorporate, such as maximizing the role of researchers who are members of marginalized and disadvantaged populations. The principles could include, where possible, using participatory action research methods (discussed in the chapter on empowering participation and inclusive leadership). Another principle should be transparency and open access, both so that a country's own population can be informed of (and if they feel necessary, also be able to challenge) evidence that can influence policies and so that people in other countries can also benefit from this research.

Principle 5: Actions, Targets, and Timelines

With an understanding of how health inequities are affecting different populations in hand, and how the many social, environmental, economic, and political determinants of health are contributing to health inequities, countries are prepared to develop the program of action required to mitigate and ultimately end these inequities. This will require determining the actions needed across populations and determinants, and consolidating them into a single program of action, accompanied by targets and timelines.

This chapter provides some general considerations about formulating and prioritizing the actions. It will then address linking actions to timelines, responsible actors, targets, benchmarks, and indicators to set the stage for implementation and accountability.

Formulating the actions

Actions could be developed for each factor contributing to health inequities for each population, based on the frameworks of analysis discussed earlier.

Actions will often address several areas of analysis simultaneously. For example, poor housing conditions may contribute to high incidence of asthma among children of populations disproportionately experiencing these conditions. Considering the Stop TB Partnership framework, actions to address these housing conditions would address a determinant of health (housing) and a specific health condition (asthma, among others). And considering the Priority Public Health Conditions Knowledge Network framework, actions to address the housing conditions would address the populations' heightened vulnerability as well as perhaps worse outcomes (children who receive treatment for their asthma may return to the same poor housing conditions) and worse consequences (perhaps the children's parents risk losing their jobs if they need to stay home from work to take their child to a health center).

Actions will also often encompass several determinants of health. For example, increasing the supply of supportive housing for people experiencing homelessness could also improve their access to nutritious food and jobs skills training and reduce their exposure to violence. An initiative to improve women's safety on public transport, along with addressing gender, safety, and transportation, could facilitate women's ability to access jobs and, through increased income, enable them to purchase sufficient quantities of nutritious food.

Actions may also build on one another. Human rights training could be one action to address discrimination by health workers against members of certain populations. Meanwhile, some populations may receive lower quality health care because health workers are unaware of how certain diseases present themselves differently in those populations, or of those populations' increased vulnerability to certain diseases. An action to address these contributors to health inequity may be to update health worker education curricula to address both human rights, including non-discrimination, and how those populations experience the diseases at issue.

Many actions will address health inequities with respect to multiple populations. In the above examples, children part of several

disproportionately poor populations may benefit from actions to remedy poor quality housing (e.g., migrant workers, marginalized racial or ethnic groups), and multiple marginalized and disadvantaged populations may benefit from the human rights and other reforms to health worker education curricula (e.g., women, people with disabilities). Given that many actions will respond to health inequities that multiple populations are experiencing, it will be important to harmonize and combine actions to address different populations into a single set of actions.

Five perspectives

The Norwegian Directorate of Health offers five perspectives to consider when deciding upon strategies and actions to reduce health inequities: 1) the risk perspective (where actions might be aimed at promoting a healthier diet); 2) the protection/good health perspectives (where actions might seek to strengthen social networks); 3) the disease perspective (where actions might be targeted to particular diseases, such as cardiovascular diseases); 4) the target group perspective (with actions specific to certain populations), and; 5) the arena (place) perspective (where actions might be implemented in schools or at the workplace).¹⁴⁹

Much as it may be valuable for countries to systematically review each social determinant of health to ensure that some causes of health inequity are not missed because they are common to many populations experiencing health inequities, as discussed earlier, a similar approach could be valuable with respect to actions to address health inequities. Actions proposed in response to the factors underlying health inequities that each marginalized or disadvantaged population is experiencing may miss certain actions needed to address obstacles to health equity that are not specific to any population but instead shared by many, and thus are at risk of being neglected in population-based approaches to identifying needed actions, even as these actions could reduce health inequities for many different populations. For example, perhaps due to many more salient factors, populations have not addressed the need for early childhood education. Yet by contributing to children's cognitive, emotional, and social development, such education can have a wide range of long-term health benefits.¹⁵⁰ Actions to increase access to quality early childhood education, therefore, would contribute to health equity.

Therefore, if countries have separately assessed how each major determinant of health contributes to health inequities overall, along with conducting population-specific analyses, these assessments should be reviewed to ensure that all issues they have identified have been covered in the sets of actions identified through population-specific approaches. If any of these issues are not adequately addressed, actions to respond to them should be developed and included among the actions that will comprise the health equity program of action.

39 recommendations from the Commission on Social Determinants of Health

The report of the Commission on Social Determinants of Health provided 39 intersectoral recommendations,¹⁵¹ which WHO and others classified into three set of interventions: governance, socioeconomic, and environment.¹⁵² Countries are encouraged to consider how specific actions linked to these recommended set of interventions may be useful in their contexts. This box reproduces a box in the article in the *Bulletin of the World Health Organization* that made this three-part classification.¹⁵³ That article's own language is drawn from the Commission's report.

Intersectoral governance interventions

- Local government and civil society, backed by national government, establish local participatory governance mechanisms that enable communities and local government to partner in building healthier and safer cities.
- Parliament and equivalent oversight bodies adopt a goal of improving health equity through action on the social determinants of health as a measure of government performance.
- National government establish a whole-of-government mechanism that is accountable to parliament, chaired at the highest political level possible.
- The monitoring of social determinants and health equity indicators be institutionalized and health equity impact assessment of all government policies, including finance, be used.
- National and local governments and civil society establish a cross-government mechanism to allocate budget to action on social determinants of health.
- Public resources be equitably allocated and monitored between regions and social groups, for example, using an equity gauge.
- Government policy-setting bodies ensure and strengthen representation of public health in domestic and international economic policy negotiations.
- Governments create and enforce legislation that promotes gender equity and makes discrimination on the basis of sex illegal.
- Governments set up within the central administration and provide adequate and long-term funding for a gender equity unit that is mandated to analyse and to act on the gender equity implications of policies, programmes, and institutional arrangements.
- National government strengthens the political and legal systems to ensure they promote the equal inclusion of all.
- National government acknowledges, legitimizes, and supports marginalized groups, in particular Indigenous Peoples in policy, legislation, and programmes that

empower people to represent their needs, claims, and right.

- National- and local-level government ensure the fair representation of all groups and communities in decision-making that affects health, and in subsequent programme and service delivery and evaluation.
- Support for civil society to develop, strengthen, and implement health equity-oriented initiatives.
- Governments ensure that all children are registered at birth without financial cost to the household.
- National governments establish a national health equity surveillance system, with routine collection of data on social determinants of health and health inequity.
- Governments build capacity for health equity impact assessment among policy-makers and planners across government departments.
- Governments include the economic contribution of household work, care work, and voluntary work in national accounts and strengthen the inclusion of informal work.

Intersectoral socioeconomic interventions

- Build comprehensive package of quality early child development programmes and services for children, mothers, and other caregivers, regardless of ability to pay.
- Provide quality education that pays attention to children's physical, social/emotional, and language/cognitive development, starting in pre-primary school.
- Provide quality compulsory primary and secondary education for all boys and girls, regardless of ability to pay, identify and address the barriers to girls and boys enrolling and staying in school.
- Develop and implement economic and social policies that provide secure work and a living wage that takes into account the real and current cost of living for health.
- Build universal social protection systems and increase their generosity towards a level that is sufficient for healthy living.
- Use targeting only as back up for those who slip through the net of universal systems.
- Ensure that social protection systems extend to include those who are in precarious work, including informal work and household or care work.
- Invest in expanding girls' and women's capabilities through investment in formal and vocational education and training.
- Support women in their economic roles by guaranteeing pay-equity by law, ensuring equal opportunity for employment at all levels, and by setting up family-friendly policies that ensure that women and men can take on

care responsibilities in an equal manner.

- Research funding bodies create a dedicated budget for generation and global sharing of evidence on social determinants of health and health equity, including health equity intervention research.
- Educational institutions and relevant ministries make the social determinants of health a standard and compulsory part of training of medical and health professionals.
- Educational institutions and relevant ministries act to increase understanding of the social determinants of health among non-medical professionals and the general public.
- Reduce insecurity among people in precarious work arrangements including informal work, temporary work, and part-time work through policy and legislation to ensure that wages are based on the real cost of living, social security, and support for parents.
- Develop and implement economic and social policies that provide secure work and a living wage that takes into account the real and current cost of living for health.
- Build and strengthen national capacity for progressive taxation.
- New national and global public finance mechanisms be developed, including special health taxes and global tax options.

Intersectoral environmental interventions

- Manage urban development to ensure greater availability of affordable quality housing; invest in urban slum upgrading including, as a priority, provision of water and sanitation, electricity, and paved streets for all.
- Plan and design urban areas to promote physical activity through investment in active transport; encourage healthy eating through retail planning to manage the availability of and access to food; and reduce violence and crime through good environmental design and regulatory controls.
- Develop and implement policies and programmes that focus on: issues of rural land tenure and rights; year-round rural job opportunities; agricultural development and fairness in international trade arrangements; rural infrastructure including health, education, roads, and services; and policies that protect the health of rural-to-urban migrants.
- Occupational health and safety policy and programmes be applied to all workers – formal and informal – and that the range be expanded to include work-related stressors and behaviours as well as exposure to material hazards.
- Strengthen public sector leadership in the provision of essential health-related goods/services and control of health-damaging commodities.

- Public capacity be strengthened to implement regulatory mechanisms to promote and enforce fair employment and decent work standards for all workers.

Transnational considerations and actions

Countries will be more or less able to directly affect transnational factors that have an effect on health equity within their own countries, though all should do what they can. For example, all countries should abide by and strengthen their Paris Agreement commitments and seek to minimize their contributions to climate change, though the direct effect that mitigation efforts of small countries have on climate change may be negligible (though the same measures taken to reduce contributions to climate change may have direct, significant effects on local air pollution and other health determinants). Countries may also be able influence transnational factors indirectly, such as by exerting international leadership, as Pacific island nations have on climate change, or through capacity-building measures to affect multilateral agreements. For example, countries could ensure that their trade negotiators have public health knowledge and could include public health experts in their trade delegations and negotiation teams, helping protect or even advance health equity domestically while also contributing to health equity internationally.

Meanwhile, health equity programs of action should incorporate measures to protect against the effects that transnational factors will have on health equity. These might include, for example, climate change adaptation measures, making full use of the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), or directing extra funds to towns or regions hosting large numbers of refugees. Actions may also include seeking additional international financing where it may be needed, such as from the Green Climate Fund and global health funds.

We encourage countries to include in their health equity programs of action measures to mitigate any harms their actions may have on health and health equity in other countries, whether through their domestic actions and policies (such as in energy production or immigration policies) or through how they engage in international forums, and furthermore, to proactively contribute to health equity in other countries. This would protect the health and lives of marginalized and disadvantaged populations abroad, contribute to global goodwill, solidarity, and social justice, and give effect to their right to health obligations to respect, protect, and fulfill this right not only domestically, but also to respect, protect, and contribute to its fulfillment extraterritorially.¹⁵⁴ Such measures may include international financial and technical assistance, including with a specific focus on enhancing health equity. Indeed, health equity programs of action may include support for other countries in developing and implementing health equity programs of action.

Local actions

The program of action cannot realistically encompass every action that could contribute to health equity, particularly those developed and carried out at the provincial (state), district, or municipal level. Yet sub-national actions can substantially affect health equity. Health equity programs of action developed at the national level may, however, catalyze these actions. They could include, for example:

- National funding or mandates for provincial (state), district, or municipal authorities to develop their own health equity programs

of action;

- Targets on the number of sub-national jurisdictions that develop sub-national health equity programs of action, whether or not there is national funding or mandates;
- Developing local health equity targets that fit local circumstances, whether these are incorporated into a national health equity program of action or developed as part of its implementation;
- Legal mandates for provincial (state), district, or municipal authorities to take specified actions to advance health equity;
- National funding to incentivize sub-national jurisdictions to develop programs in certain areas related to health equity;
- Technical support to localities to address health equity;
- Recommendations on actions in different sectors that sub-national jurisdictions could take to enhance health equity;
- Funding for pilot programs in certain localities, and;
- Establishing national networks of local leaders to share actions and lessons on health equity.

Pilot programs

Actions do not have to be nationwide. They may include pilot programs to test approaches that could improve health equity. While monitoring and evaluation should be a regular feature of programs in general, careful assessment of pilot programs, including factors in their success or failure, is particularly important to form a basis for deciding whether to end such programs, conduct further pilots, modify programs, or significantly scale them up.

Research

The program of action would include key steps needed to develop a national plan on health equity research if one is being developed, as discussed in the chapter on every population counts.

Accountability

The program of action would also include actions related to accountability. These will be discussed in the chapter on accountability.

Prioritization

Resource and institutional constraints, capacity limitations, political realities, and other factors will almost surely preclude countries from immediately and fully undertaking all of the actions determined necessary to address health equity. It will be necessary to prioritize them, with the decisions on priorities affecting the timelines for undertaking different actions and the targets included in the health equity program of action.

It may be desirable to include among the priorities “best buys” and

“early wins” – actions that are affordable and can be rapidly implemented – to create change in the near-term, which can build momentum for further, possibly more difficult, actions. At the same time, as discussed under the principle on maximizing health equity, we recommend also including actions required to address deep, structural determinants of health. These determinants will often take a long time to change, so it will important to begin to address them soon, and not put off beginning to make these changes for a future date. Including actions of this sort will also demonstrate a true commitment to full health equity.

[T]he great French Marshal [Louis-Hubert-Gonzalve] Lyautey once said to his gardener: “Plant a tree tomorrow.” And the gardener said, “It won't bear fruit for a hundred years.” “In that case,” Lyautey said to the gardener, “plant it this afternoon.”

— John F. Kennedy, Address at the Anniversary Convocation of the National Academy of Sciences, October 22, 1963¹⁵⁵

Like the tree that will take 100 years to bear fruit, undoing the structural determinants of health that frequently underlie health inequities will often be a long and difficult process, and results might not be immediate. But the only way to begin to changes these dynamics is to begin.

Participation during prioritization

As with all other aspects of developing health equity programs of action, the perspectives of people in populations experiencing health inequities should be central to determining priority actions. Their perspectives may be influenced by considerations not directly related to health equity. Particularly for determinants of health outside the health system, actions may contribute to well-being in ways that extend beyond their health effects (such as employment or housing), leading populations to view these actions with added importance. Or they may view other actions as priorities because of their centrality not only to their health but also to their dignity, such as measures to reduce discriminatory treatment.

Different populations may place very different levels of priority on similar actions. Whatever a country's process for developing health equity programs of action, it would be desirable to establish forums where members of these populations can discuss their views and the reasons behind differing levels of priority. Engaging one another on these reasons – and not only on which actions people view as priorities – is a critical part of a fair framework for ethical decision-making.¹⁵⁶ Through such engagement, different populations might be able to offer shared recommendations on the level of priority an action should receive (even as other factors, such as resource constraints, will also need to be considered). If their views continue to differ, the experience of sharing them and understanding these differences could still usefully inform how the action is prioritized within the program of action, while enabling the different populations to better understand the reasoning underlying the ultimate decisions. Transparency in the

decision-making process, including to enable widespread agreement on the reasonableness of the decisions, is another necessary part of ethical decision-making.¹⁵⁷

Factors to consider during prioritization

Factors countries may use in deciding the priority interventions include: 1) the priorities that populations experiencing health inequities identify as their priorities; 2) the populations (and sub-populations within them) experiencing the most severe health inequities; 3) the actions most likely to have the greatest impact on reducing health inequities (for the worst off groups specifically, as well as throughout the spectrum of marginalization, disadvantage, and vulnerability); 4) actions that are most likely to be feasible, effective, and efficient; 5) the most cost-effective interventions; 6) actions that are achievable within currently available and potentially available resources; 7) actions that are acceptable to affected communities and other key actors (e.g., those in non-health sectors, where relevant); 8) actions that can be implemented within an acceptable timeframe; 9) actions that are consistent with local and national priorities, and; 10) actions that, in addition to contributing to health equity, also significantly contribute to other dimensions of people's well-being.¹⁵⁸

Determining priorities may be one of the most challenging, even contentious, areas of developing health equity programs of action. It will involve difficult trade-offs in the face of finite resources – even if the program of action will include measures to increase revenue – and could mean acknowledging difficult political realities. While transparency is necessary throughout the process of developing health equity programs of action, transparency and being thorough in explaining the decision-making process and rationales for the decisions taken on prioritization will be especially important.

While national-level priority setting will be necessary and valuable for many actions (for health equity programs of action that are national), there may be value in leaving priority setting for other actions to sub-national levels. A review of efforts to integrate equity into health programming in Indonesia “concluded that prioritization of these was better done at sub-national level, given the decentralized context, variations in system capacity, and differing barriers to services across the country.”¹⁵⁹ For example, the program of action could include allocating funds to sub-national jurisdictions to spend on reducing local barriers to accessing health services, or to addressing other determinants of health such as education and employment, for populations experiencing health inequities. Such allocations might come with national oversight (e.g., with national authorities approving the use of funds based on consistency with the health equity program of action). Or programs of action could include allocating funds to sub-national jurisdictions that could be used (again with national oversight, and perhaps requirements on participatory processes in determining how the funds are used) however localities see fit to reduce health inequities, in general or for specific populations.

Making health equity programs of action SMART

Health equity programs of action should be “SMART,” that is:

* *Specific*: Actions and what they seek to achieve should be specific, such as specific laws and policies to be reformed or introduced to create a certain outcome, programs to be expanded, particular changes in benefits in a universal health coverage scheme or in the

process of determining these benefits, or an increase in financing and a certain level of additional staff in the relevant office within the Ministry of Justice to effectively enforce anti-discrimination legislation. Making actions specific means that, for example, rather than providing that national laws should be reformed to remove discriminatory provisions, the action should name the particular law(s) that should be reformed and the types of changes required. Rather than identifying the need to reduce polluting infrastructure in low-income neighborhoods, the action could be that a certain piece of legislation should be enacted (or regulations promulgated) to prohibit specified types of polluting infrastructure (e.g., bus depots) from being placed in areas with high incidence of respiratory illness (possibly specifying the level of incidence or how it should be determined). Or, to take one more example, rather than an action to train health workers on human rights, the action could be to incorporate human rights training into pre-service education curricula for health workers and to update regulations on continuing education for health professionals to include a requirement for human rights education.

* *Measurable*: It should be possible to determine whether or not the action has been taken and whether it is meeting its objective. If an action is specific enough, it will generally be measurable. It is possible to determine whether a law has been passed or a new program established, how much funding has been allocated to a particular initiative, or how many health workers have received a human rights education. It should also be possible to track progress towards the action.

The effects of these actions should also be measurable. For example, surveys could track how people's perceptions of whether they are being discriminated against or treated respectfully change after health workers have received human rights education, and whether any progress is sustained. If the aim of better resourcing an office within the Ministry of Justice is to more effectively enforce anti-discrimination legislation, it would be possible to judge the effects of the new resources by, for example, monitoring the number and success of prosecutions to enforce the legislation.

* *Achievable*: Actions and what they seek to achieve should be ambitious; health equity requires it. Yet they should also be achievable, within the realm of possibility. For example, doubling the number of doctors and nurses might not be possible within a given time period because of current limitations on health worker training capacity and the time required for health worker training; even rapidly scaling up training capacity might not lead to many new health workers (particularly those requiring longer periods of training) right away.

* *Realistic*: Along with being possible, actions and the timelines that accompany them should be realistic. This requires considering such factors as political will and the available financial and human resources. For example, it may be feasible for the government to build (or incentivize private developers to build) a sufficient amount of affordable housing within several years, but if this were to consume half the government's budget, it would not be realistic.

Countries could look to historical trends to inform what is realistic. It is critical not to be bound by these trends; a central motivation behind health equity programs of action is the need to greatly accelerate past progress. Yet historical trends and the factors behind them – why, for example, progress on equity in various areas at various times was slow (or non-existent), or why it was rapid – may provide one useful input in considering what is realistic, and over what time period.

What is not realistic in the short-term may be realistic in the medium- or longer-term. Over a period of some years, housing for all is achievable.

And short-term actions could include the government developing its own SMART plan to ensure sufficient housing over a certain period of time, an immediate increase in the budget for affordable housing, and immediate actions to, in the words of the South African Constitutional Court, provide immediate relief to those in “desperate need,” those who have “no access to land, no roof over their heads, for people who are living in intolerable conditions and for people who are in crisis because of natural disasters such as floods and fires, or because their homes are under threat of demolition.”¹⁶⁰

Other constraints at present might not be constraints over time. If political will is insufficient now, advocacy, education, and other measures can change the political environment. If the health budget or overall national revenue is too low, the level can be increased through advocacy, policy reforms, and other approaches including, in some countries, seeking international resources.

Available resources should be considered in the context not only of current budgets and their potential for growth, but also in the context of the entire set of actions. Some actions could generate new resources or lead to cost savings. For example, housing people who are homeless can reduce health care and possibly criminal justice system expenditures that may be associated with homelessness.¹⁶¹

* *Timebound*: Actions should have a specific timeframe in which they should be taken, with the timelines informed by and consistent with the prioritization process discussed above. Should actions occur within the next year? Two years? What is the target date? Actions may be broken into short-, medium-, and longer-term actions. Placing meaningful specific target dates could be difficult for longer-term actions. The program of action could instead provide specific target dates for near-term actions while, for other actions, indicating which are for the medium- or the longer-term, along with approximate timeframes for medium- and longer-term actions (e.g., medium-term actions within the next 4-6 years, and longer-term actions within the next 7-10 years). Actions not expected to take place well into the future might be less precise than those with a near-term timeframe.

Responsible actors: Each action should be associated with an actor that is responsible for taking or overseeing that action. Responsible actors would include the legislature and specific government agencies, whether in the health sector or outside of it, or at national or more local levels. In some cases, they may be outside the government (e.g., health professional associations). The actor should be identified as specifically as possible to avoid inaction because of a lack of clarity of exactly who needs to act. Lack of adequate specificity creates the risk that no one will assume responsibility, and the action will not be taken.

Costing

To the extent possible, actions should include cost estimates and where the funding would come from (e.g., ministry of health, provincial [state] governments). This will facilitate including them in relevant budgets. It will also help judge how realistic the actions are, including whether certain actions may need to be spread over a longer time period. Some actions may have no or only minimal additional costs, such as passing legislation. Even these actions may have a future cost, though. For example, there may be costs associated with effectively enforcing a new law banning discrimination, or the law might require funding to implement.

Not all costs will be new. To the extent actions in the program of action overlap with ones already being planned, associated costs will already

be accounted for in health and other budgets and plans.

Costs in one sector may lead to cost savings in another. Policies and practices in non-health sectors that contribute to ill health, for example, which might or might not save costs in the non-health sectors, impose costs on the health sector. Using toxic chemicals and inadequately protecting agricultural workers, for instance, will lead to health sector costs to treat the workers for resulting diseases. Poor ventilation, overcrowding, unhygienic conditions, and food that lacks proper nutrition in prisons all contribute to the spread of TB and other diseases, again imposing health system costs. Prison visitors and prison staff may become infected, and if people are released from prison and into the community with TB that is not being effectively treated and remains infectious, not only will they require effective treatment, but other people in the community will be at risk of infection as well.

At the same time, investments in health will lead to cost savings or economic benefits in other areas. Improved health will lead to improved worker productivity, benefiting the economy and, through resulting higher tax revenue, the finance ministry. Similarly, investments in the health workforce in economies not at full employment can have a multiplier effect on the economy by increasing demand.¹⁶² Meanwhile, health improvements that enable people to more productive may reduce their need for social welfare payments, while increasing the pool of workers throughout the economy.

Importantly, while health sector financing is critical, so too is funding for other sectors in ways that will contribute positively to the social determinants of health – improving access to nutritious food, affordable housing, quality education, and so forth. A balance will be needed across sectors – along with additional revenue-raising issues that may be necessary – to ensure that health and other sectors contributing to health are all adequately resourced.

Targets and indicators

The program of action should have measurable targets. Targets should be timebound, consistent with the timelines for specific actions and related considerations (such as resources), and may apply to a single action, a collection of related actions (for example, all actions aimed at reducing the disproportionate effects of pollution on a population), or to the entire program of action. They can fall into at least five categories:

- *Structural targets*: These targets would relate to structural changes required within the government or elsewhere that would contribute to sustained advances in health equity. These might include, for example, establishing a legal requirement on engaging marginalized and disadvantaged populations in decisions that may affect their health or creating and fully resourcing structures (such as village health committees) that create spaces for marginalized and disadvantaged populations to have a role in health-related decision-making. Health equity could be made a priority area for a national human rights institution, and participatory health equity impact assessments could be required for all planned laws, policies, programs, and projects that may substantially affect health equity. Mechanisms to improve intersectoral collaboration could be established.
- *Input targets*: Input targets relate to the resources required for an action or set of actions, such as funding. For example, inputs into a law against domestic violence might include a certain sum of money to effectively implement and enforce the law (e.g., building shelters for survivors of domestic violence, and ensuring sufficient

funds to investigate and prosecute cases of domestic violence and to carry out educational and norm-changing campaigns). Human resources are another significant input. An action on developing a community health worker program might include hiring a certain number of trainers.

- *Output targets:* Output targets measure the immediate result of an action. For example, if the action is to hire more health workers from a certain population, the target might be the number hired. If the action is to train health workers on human rights, the target could be the number trained. If the action is to enact legislation, the output target could simply be that the legislation has indeed been passed and enacted into law. If several actions involve a set of measures to reduce violence against women, one target might be the number of perpetrators arrested and successfully prosecuted.
- *Outcome targets:* Outcome targets measure the direct effect of the action. If actions involve introducing cultural mediators and interpretation services for migrants at health facilities, the target could be a specified increase in how often migrants are utilizing health services. If there were a set of actions to reduce homelessness, the target could be a reduced number or percentage of people experiencing homelessness.
- *Impact targets:* Impact targets measure the effect that, in our case, actions are having on health equity. For example, for a population suffering disproportionately from a disease, the impact target might be reducing the level of the disparity or eliminating it entirely. Other targets might be reducing the child mortality rate for a given population to the national average, or increasing the life expectancy of a population by a certain number of years.

Particularly in setting impact targets and developing associated timeframes within which to achieve them, it is worth bearing in mind that it may take years for the impacts of some interventions to manifest themselves. For example, improving children's nutritional status may reduce obesity-related mortality that would not occur for decades. Or it may lead to better education, and in turn better employment and higher income, again with health impacts that appear many decades after successful actions to improve children's nutrition.

Different measures of health equity

Measuring the impact that actions have on health equity could take at least three forms. Consider a country where the under-five mortality is 80 per 1,000 for the poorest households and 20 per 1,000 for the wealthiest. First, impact targets might relate to relative health equity. This is the ratio between the different groups being considered. In this case, the under-five mortality level is four times higher for the poorest households compared to the wealthiest. A target over a given timeframe might be to reduce the gap from being four times higher for children in the poorest households to being two times higher for children in the poorest households, with further reductions over time.

Second, impact targets might be to reduce the absolute level of health inequity, which is the numerical difference between different populations, in this case, 60 deaths per 1,000 children. The target might be to reduce the difference to 20

deaths per 1,000 children (and ultimately, to zero).

It is possible to reduce absolute health inequities even while relative inequities grow. For example, if child mortality fell by 20 deaths per 1,000 children for children in the poor households and 10 deaths per 1,000 children in wealthy households, the under-five mortality will now be 60 per 1,000 for children in poor households and 10 per 1,000 children in rich households. In this example, the absolute level of health inequity is lower (an additional 50 deaths per 1,000 children in the poorest households instead of an additional 60 deaths), and the absolute level of reduction is greater for the poorest households (a reduction of 20 deaths compared to a reduction of 10 deaths), but the relative inequity has grown, with children in poor households now dying at six times the levels of children in wealthy households.

Third, impact targets might relate only to a marginalized and disadvantaged population, without comparison to another population. In this case, it might be to reduce the under-five mortality for the poorest households to 40 deaths per 1,000 children.

There is no one right approach to take. A mix of approaches may be appropriate. Absolute health inequities may be most important from the perspective of overall health of all populations concerned, including maximizing the health improvements among marginalized and disadvantaged populations. At the same time, though, unless progress is made towards reducing and ultimately ending relative health inequities, a deeply unjust situation will persist, where progress among better-off populations demonstrates the level of health that is possible, yet some in society would remain excluded from these possibilities for better health.

While other indicators would be needed, including ones that address dimensions of health inequities other than wealth as well as even deeper levels of poverty, one valuable set of indicators, with accompanying targets, would focus on the poorest 40% of households. These indicators could measure the rate of progress on various health-related dimensions for these households compared to the national rate or that of the wealthiest 60%. This would build on an SDG target focused on the poorest 40% of households. The first target of SDG 10 is that the rate of income growth (or expenditure) per capita for the bottom 40% of households should exceed the national average. Similarly, targets could seek faster progress on health improvements for the poorest 40% compared to the national average or to the wealthiest 60%.

Targets will be measurable at different stages of the action. Output targets judge whether or not an action has been taken (e.g., passing legislation), or could measure its immediate effect. Outcome and impact targets will measure actions' longer-term effects.

Each of these targets may have benchmarks, that is, steps along the way. If a target is to deploy a certain number of health workers to an underserved community in five years, there might be a three-year benchmark. For a target to increase by 50% the number of people in rural areas who have access to a functioning health facility in five years, a benchmark could be a 30% increase in three years. If a target is to enact a piece of legislation, benchmarks might include having

the bill introduced into the legislature and having the bill considered in committee. As with targets, benchmarks should have dates or time-frames attached to them, with the recognition that it may take a period of time before policies can be fully implemented and begin to demonstrate results.

The targets and benchmarks would, in turn, be measured by indicators that monitor progress towards the benchmarks and targets. To take the example of deploying health workers to underserved areas, indicators might include the number of health workers who have been newly deployed to underserved areas, and the proportion of the population in these areas that now has access to a skilled, motivated health worker. Looking to impact, what is the maternal mortality ratio in these areas (though reducing maternal mortality will relate to a number of other factors as well)? Indicators and targets should all be accompanied by baseline measurements.

To the extent possible, the indicators selected should be ones for which data exists or where measurement is straightforward (such as the number of units of supportive housing constructed); otherwise, tracking progress will be difficult. Yet this may be a challenge. Disaggregated data might not exist, however necessary for tracking progress. The next chapter, on accountability, addresses strengthening health and other information systems to collect the necessary disaggregated data, as well as supplementary approaches to data collection where data is unavailable. Countries will need to find a balance, selecting the relevant indicators while not creating such a need for additional data collection that most resources and efforts are spent collecting data rather than taking actions to improve health equity.

Similarly, while the programs of action could potentially have very many targets, benchmarks, and indicators, caution is needed to protect against a proliferation of metrics that creates such an administrative burden that government ministries focus their energies on assessing and reporting on these metrics rather than on carrying out the actions. Too many metrics could also lead those developing progress reports to spend all of their time assembling data rather than also considering factors behind the numbers – why there is progress or a lack of it – as discussed more in the chapter on comprehensive accountability. Targets, benchmarks, and indicators should be carefully chosen to measure what needs to be measured, but not more.

Also, it is important not to set short-term targets that may disincentivize investments in or policy and political focus on structural issues that might not bring immediate results, however necessary for significant and sustained progress. Similarly, it is important that short-term targets are not set in ways that could prevent or limit the participation of marginalized and disadvantaged populations, even as such participation may require additional time.

Principle 6: Comprehensive Accountability

A comprehensive, robust approach towards accountability for health equity programs of action is vital to ensuring they are successfully implemented. We begin here with the importance of disseminating the program of action and broad input into its accountability components, following this with the importance of integrating health equity programs of action into national health, development, and other relevant strategies and plans. We will then discuss the process of monitoring and evaluating the program of action, including collecting data and data disaggregation. After that, we will suggest capacity-building measures to improve implementation and further measures to strengthen accountability for health equity, measures that can themselves be incorporated into the health equity program of action. Finally, we will discuss how the health equity program of action could be regularly updated.

Dissemination

The health equity program of action should be widely disseminated to the public, including being posted online, and made available in local languages. Beyond that, to facilitate access, summary and other easily digestible versions of the health equity program of action should be developed so that people, particularly those who are marginalized and disadvantaged, understand the actions that are being taken to improve their health and enhance health equity, including as they relate to particular populations. Understanding these measures is key to their ability to engage with efforts to improve accountability. People should also be informed of any opportunities they may have to provide feedback and to participate in evaluations and other accountability processes.

Creating and disseminating this information will likely require collaboration between the government, civil society organizations, and the media. Information may be disseminated outside of written formats – videos explaining the programs of action and what people should expect, or skits, for example. Ideally, even the hardest-to-reach populations – illiterate people in remote areas, for example – would be aware of and understand health equity programs of action.

Input into and the process of developing the accountability strategy

As with other aspects of the program of action, multi-stakeholder participation, including the central role of members of populations experiencing health inequities, is critical in determining accountability measures for the health equity program of action. People might, for instance, propose new local or national mechanisms for accountability to health equity, or offer their views on existing mechanisms, such as how they are functioning and how to improve them.

It may also be desirable to reach out to stakeholders who might not otherwise be part of developing health equity programs of action to contribute to this aspect of the health equity program of action. These

could include NGOs working on accountability (though they may be participating in any case), community members currently engaged in accountability processes (for example, members of village health committees), local academics with expertise in accountability, health workers with firsthand understandings of accountability in the health system, international academic or other experts, and people at international agencies (such as bilateral aid agencies, UNDP, and the World Bank) who work on accountability.

Integrating health equity programs of action into other national and sub- national plans and strategies

The health equity program of action would feed into the work – including the strategies, plans, policies, budgets, and targets, indicators, and other monitoring and evaluation processes – of many different ministries. Incorporating relevant actions into their plans and policies will be a key step in implementing the program of action. These actions for health equity should be seen not as additional tasks for ministries to address, but as a core part of their mandate and major contributions to a national priority.

Countries can take different approaches to how they might revise sectoral plans to incorporate elements of the health equity program of action. And if it is developed as part of the national health plan, development strategy, or social inclusion strategy, and possibly otherwise, there may already be processes in place for this incorporation.

Approaches across ministries and regulatory bodies may vary as well. Some ministries – depending, for instance, on the number of actions in the health equity program of action that fall within their responsibilities, where they are in their own planning cycle, whether their strategic plans include detailed action plans, and their capacity – may update their current strategic planning documents to fully incorporate relevant elements of the health equity program of action; develop an addendum to their current plan that includes the relevant health equity actions, or; act upon the actions in the program of action that are within their mandates without formally updating existing plans.

Whatever the initial approach, the health equity program of action should be integrated into future planning documents. Governments may want to delineate a clear process to incorporate relevant aspects of these programs of action (including later versions of them) into ministry plans – as well as relevant intersectoral plans – as they are updated. And in countries where the programs of action are not already developed as part of the national health plan or development strategy, it may be possible to coordinate timing of future iterations of health equity programs of action with the timing and processes of updating one of these strategies.

Ministries are not the only organs of government that will need to conform their actions to those that are part of the health equity program of action. For example, the legislature's agenda may need to be revised to reflect legislative elements of the action plan.

Very likely, actions in the health equity program of action will include ones that pertain to provincial (state) and more local levels of government. Their executive and legislative branches should similarly update their plans and agendas based on the health equity program of action. Non-governmental entities would also need to incorporate certain aspects of the health equity program of action. These entities could include, among others, health professional associations, health

worker training institutions, corporations (for example, related to hiring processes), and universities (for example, related to admission practices or health equity research).

Annual plans and budgets that government ministries develop represent one key opportunity to quickly incorporate elements of the program of action. Whether or not longer-term planning documents are revised, these annual action plans and budgets, which may also be the basis of legislative budget allocations, should incorporate relevant actions and costs in the program of action.

Government plans could incorporate actions that require more funding than presently available, and explore how to secure the additional needed funds. Governments may also find ways to raise additional revenue (such as a dedicated, progressive tax surcharge to help fund the action plan), and some will also be able to seek external resources.

The steering committee should plan for the necessary outreach to all relevant entities, within and outside of government, to ensure that they understand the health equity program of action and how it may relate to them. While the steering committee should itself be comprised of people from different sectors, it is unlikely to include all entities that will need to act on elements in program of action, given how numerous these entities would be. It may be useful, therefore, to have targeted outreach to people from all entities charged with actions.

The initial National Health Equity Dialogue could set the stage for incorporating actions from the health equity program of action into the plans and policies of different ministries and other entities, highlighting the importance of this integration, while ensuring that different stakeholders are aware that the health equity program of action may have implications for their plans. In addition, representatives of all entities that have responsibilities under the health equity program of action could be invited to participate in the second National Health Equity Dialogue, where the health equity program of action may be launched.

Integrating health equity into sector plans and actions

Along with directly incorporating the health equity program of action, governments should, more generally, incorporate the goal of health equity into the mission of each of the many sectors whose actions affect health equity, beyond the specific directions that come from the health equity program of action and any policies and actions different ministries may already have in place or be undertaking. For different sectors' goal of health equity to have the best chance of significant impact, governments could:

- Incorporate health equity into the formal mandate of different sectors.
- Train staff of different ministries on the connections their jobs have to health equity and build staff competencies to address health equity. Skills-building workshops could cover such areas as public health, human rights, casual pathways and key intervention points for different determinants of health, and diplomacy and negotiations skills for working across sectors.¹⁶³
- Develop sector-specific targets and indicators related to health equity, collecting additional data as needed, and upgrading information systems to incorporate this data.
- Establish annual reviews assessing how each sector is contributing to or undermining health equity, including for specific

populations, and including identifying obstacles and steps to overcome them.

- Require health equity impact assessments (see below).

In addition, each sector could establish a formal agreement on collaboration with the health ministry and, as relevant, other ministries.¹⁶⁴ And the government could establish an intersectoral committee and other processes and communication mechanisms to ensure coordination among ministries to collectively advance health equity and maintain health equity as a priority for each sector.

Integrating health equity into sub-national actions

Many pieces of the health equity program of action, and actions for health equity in general, will require measures at the sub-national level. Provincial (state), district, and municipal governments typically have varying degrees of authority over and funding for such areas as housing, education, the environment, criminal justice, nutrition, health services, water and sanitation, and more – all affecting health equity.

The health equity program of action would very likely include actions that relate to sub-national jurisdictions' budgets, legal codes, regulations, policies, strategies, and programs. These actions should be incorporated accordingly. In addition, sub-national governments can, like the national government, take steps – like those recommended above to ensure that health equity is a focus in all relevant sectors at national level – to ensure a consistent and high-priority focus on health equity throughout their policies and actions.

Monitoring and evaluation

Monitoring and evaluation is a central part of any accountability regime. Effective monitoring and evaluation of the health equity program of action requires solid information, and would be greatly facilitated if quality, disaggregated data and evaluations of individual policies and programs are available. Data and other information should be analyzed and made public through regular reports. Civil society and members of populations experiencing health inequities should have the opportunity to be fully involved in processes and mechanisms for monitoring and evaluating progress in implementing health equity programs of action. Relevant political structures, such as parliamentary committees and interagency task forces, can also be forums for monitoring the programs of action.

Disaggregated data

Disaggregated data offers critical information. We discussed earlier how disaggregated data is a key source of understanding which populations are experiencing health inequities, in what ways, and to what extent. Data can also provide clues and insights into the causes of these inequities, and the relative significance of different causes.

Good data and the capacity for real-time monitoring of health inequities, revealing how these inequities are changing over time, are also critically important to understanding whether and to what extent actions intended to eliminate health inequities are or are not working. Quality, timely, disaggregated data, along with qualitative information, will enable monitoring progress towards redressing these inequities, and understanding why efforts to remove them are or are not succeeding. Yet disaggregated data across populations may be lacking.

Collecting quality disaggregated data

Sometimes, countries will already have the relevant data disaggregated for at least some of the populations included in health equity programs of action. National health information systems will be important sources of data, as will their equivalents in other sectors that relate to the determinants of health. Other sources may include household data (e.g., from Demographic and Health Survey and Multiple Indicator Cluster Surveys), census data (though limited by the infrequency with which censuses are conducted), health (and other, e.g., school) facility and administrative data, vital registration systems, and surveillance systems, among others.¹⁶⁵ Enhanced disaggregated data should be accompanied by ensuring, and as needed expanding, the capacity to effectively analyze, understand, and make use of the data. This analytical capacity should encompass the ability to assess multiple levels of disaggregation across several dimensions of inequality to capture layered discrimination and people's multiple identities. WHO has developed a step-by-step manual on monitoring health inequities that provides further guidance:¹⁶⁶ <http://apps.who.int/iris/bitstream/10665/255652/1/9789241512183-eng.pdf>

Health data collection will need to go hand-in-hand with ensuring that the data is protected, including through personal identification protection measures and safe storage, to prevent misuse. Equity should become a central focus of national health information strategies, as well as of reviews of national health programs.¹⁶⁷

In addition, it will be critical to collect data on health financing. This can be used to monitor whether health financing disparities between or within regions (e.g., if poorer and more rural regions, or those with high proportions of marginalized and disadvantaged populations, receive less funding) are decreasing, whether funding for primary care and health issues that disproportionately affect populations experiencing health inequities is increasing, and whether funding is being allocated to priorities and actions identified in the health equity program of action.

In many countries, sufficient disaggregated data will not be available at present, making it necessary to use supplemental methods of quantitative and qualitative data collection until the relevant data is collected systematically. And even for populations and measures for which disaggregated data exists, it will likely be useful to collect additional qualitative information to provide context and an understanding behind the quantitative data and the progress or lack of progress it reflects.

Where data is unavailable, it may be possible to find proxy indicators – indicators that can stand in for the originally selected or preferred indicators that are still able to measure that which was originally to be monitored – for which data is available. Sometimes, though, proxy indicators that have sufficient data may not exist, necessitating supplemental data collection.

A guide on identifying and monitoring key populations at heightened risk for TB, the Stop TB Partnership's *Data for Action for Tuberculosis Key, Vulnerable and Underserved Populations*, explains two complementary approaches for supplementary data collection. While set in the tuberculosis context, the guide's general approaches and principles are more broadly applicable. These methods are non-representative rapid assessments using qualitative methods and sampling methods to collect quantitative data locally and extrapolate this information to the national level (see chapter on comprehensive accountability). Qualitative methods for rapid assessments – and for supplementary data collection in general – include unstructured

interviews, structured interviews, group interviews, and focus group discussions.¹⁶⁸ Including in these interviews and discussions people who have better and worse health status within a given marginalized or disadvantaged population can help identify measures that can improve health equity for a particular population. Supplemental data collection methods may combine research with action through the participatory action research methods (discussed in the chapter on empowering participation and inclusive leadership).

Local sampling methods will often be necessary, even in countries with well-developed systems for collecting health information (including for non-health sector determinants of health), for highly marginalized populations, such as sexual and gender minorities and undocumented immigrants, who may keep their status hidden because of the discrimination they experience.¹⁶⁹ This may make it difficult (though not impossible¹⁷⁰) to collect information nationally or to incorporate information into regular data collection systems, which would require people to reveal their status to authorities.

All data collection should abide by human rights and ethical considerations, including voluntary and informed consent, ensuring that people whose data is collected understand and agree to how the data will be used, protecting people's privacy and confidentiality, and ensuring safe storage of all data. Any national or institutional ethical protocols for research should be followed.¹⁷¹

Improving data on health equity monitoring

Over time, rather than relying on supplemental data collection, countries will want to improve their ability to collect disaggregated data relevant to health equity, in line with the Sustainable Development Goals (target 17.18).¹⁷² This will require strengthening national health information systems so that the sources of data incorporate information from different populations. This would enable data on many dimensions of health inequities to be routinely and systematically collected and reported for health status, health services, and health outcomes. Health and other data systems should be open and transparent.

Sources of data will include ones specific to the health system and population-based sources, along with government records on health budgets and health expenditures.¹⁷³

Health sector specific data sources include:

- health administrative records, such as information on the location and density of health facilities and health workers and availability of key health services, and information on health spending;
- health services records, such as information on patients' health service utilization and use of medicines, and;
- health and disease records, produced by health workers and disease-specific programs, and covering information such as disease prevalence and health outcomes.

Population-based data sources include:

- census information;
- the vital registration system, including information on births and deaths and cause[s] of death, and;
- population-based surveys, such as the Demographic and Health Survey.

While some of these data sources, such as population-based surveys and the census, will provide information that is outside of the health sector, it will also be necessary to work with other sectors to strengthen their capacity to collect disaggregated data (e.g., training on collection and use of data, designing and modifying data collection instruments, quality control, software development). For example, students' records from school districts and information on how teachers' performance varies across more and less advantaged districts would be key sources of information regarding equity in education, with immense implications for health equity.

Along with national coordinating committees on health information that some countries have established, key actors to engage include health information units of the ministry of health (other units or parts of the ministry may also be involved in data collection and reporting) and information units in other ministries, the national statistics office, other ministries (including those responsible for the vital statistics registers), health and other researchers (including those involved with household surveys), public health institutions, and international partners and civil society engaged in collecting health information and strengthening the national health information system, as well as information systems in other areas.¹⁷⁴

It will be important to train health workers and other responsible individuals on data collection, and to emphasize the importance of collecting disaggregated data and to demonstrate how it will be used. It will also be important to ensure that as data from health facilities is transferred to district, provincial, and national levels, disaggregated data is not aggregated back together,¹⁷⁵ and to ensure consistency on the definitions and types of disaggregation.

Policy and program monitoring and evaluation

Individual policies and programs that are developed and implemented as part of the health equity programs of action should themselves be designed to include careful monitoring and evaluation. The resulting information will form an evidence base of how different policies and programs affect health equity, helping to identify ones that should be expanded because of their success, those that should be reformed to enable them to better advance health equity, and ones that are less successful and might be discontinued or need to be significantly reworked. This information can also inform the development of other programs and policies aimed at improving health equity.

Annual reports and analyses

Governments should report regularly, preferably annually, on progress implementing the action plan, including reporting on indicators and progress towards targets and benchmarks.^h This reporting could encompass, where possible, sub-national actions and initiatives. The report should be publicly available, including on the Internet, and should be translated into local languages to make it as accessible as possible.

While government should be responsible for developing annual reports, civil society organizations, members of marginalized communities, professional associations, and other stakeholders should be welcomed to contribute to them. This will help ensure accuracy and, particularly in countries where the government might not be fully trusted, that the information is viewed as being legitimate. The report might be overseen by both a government official or governmental

entity (such as the office of the minister of health) and a member of a marginalized or disadvantaged population or an NGO. Civil society organizations should also be encouraged to develop their own reports or other assessments of progress.

To the extent possible, the annual reports should explain why progress is or is not being made across action items and targets. Understanding reasons for progress is useful for drawing lessons, while understanding shortcomings is necessary to determine appropriate corrective action and how to act more effectively going forward. For example, was the necessary funding not available? Did human resource limitations – in numbers or in skills – within an agency impede action? Was a lack of political will a factor, or did a ministry not incorporate actions into its own plans, and if not, why not? Did an action proceed in accordance with the program of action, but without having the expected effect?

Building on this analysis, the annual reports should offer recommendations on how the government and other actors can overcome these obstacles to progress. The reports could even go a step further, providing steps the government plans to take to address shortcomings regarding actions for which it is responsible. These steps could then be incorporated into the health equity programs of action.

Civil society, members of populations experiencing health inequities, and structured monitoring and evaluation of health equity programs of action

Civil society and members of populations experiencing health inequities should have the opportunity to participate in structured mechanisms for reviewing progress on implementing the health equity program of action and acting on recommendations from annual reports and other reviews and forums. There are multiple approaches that countries may take. These include:

* *Annual National Health Equity Dialogues*: Countries could hold annual National Health Equity Dialogues, encompassing as wide a range of stakeholders as possible, especially members of populations experiencing health inequities. These dialogues would assess progress in implementing the health equity program of action. Any available data and information on progress could be shared (such as the above-mentioned reports), while participants who are from marginalized, disadvantaged, and vulnerable populations could offer their own views of whether they are experiencing changes. Do they perceive that they are experiencing less discrimination? Are health facilities more accessible? Are health workers more culturally sensitive, or more likely to be drawn from their own communities? Have they gained access to clean water for the first time? Are government messages discouraging child marriage making a difference? And so forth.

People should also have the opportunity to offer their views on why their circumstances are changing, or not. Their insights into reasons behind shortcomings in and barriers to implementing the program of action will be especially important. For example, are policies not being implemented locally, despite having been developed at the national level? Has corruption impeded policy implementation? Are officials at the local level not prioritizing health equity? Are health messages targeting a particular population not culturally sensitive?

The National Health Equity Dialogues would also be a forum for

^h Some data might not be available annually; for example, Demographic Health Surveys are typically conducted only once every five years.

accountability. Participants should have ample opportunity to question public officials, who should recognize their duty to respond candidly. The media's presence will be critical, enabling the content of the National Health Equity Dialogues, including public officials' responses, to be part of a genuine national dialogue, and not be limited to the people physically present. This could contribute significantly to public accountability. To further increase broader public engagement, accompanying social media and other online activities could be a regular feature of the dialogues.

Meanwhile, civil society and populations experiencing health inequities may want to organize before, during, and after the National Health Equity Dialogue to plan the areas that they want to focus on during the dialogue and to follow-up with advocacy or other actions.

As discussed earlier, National Health Equity Dialogues or other similar forums could regularly be held across the country. Thailand, for example, has a National Health Assembly along with Provincial Health Assemblies.¹⁷⁶

* *Continuing with the steering committee:* The steering committee developed to oversee developing the health equity program of action could become a standing committee, with its role shifting from developing the program of action to overseeing its implementation and helping to keep it on track. Alternatively, a similarly intersectoral, multi-stakeholder new steering committee could be established, again with significant representation of people from populations experiencing health equity, who would also be part of its leadership.

Based on the national progress report and any supplemental information that the steering committee seeks, the committee could, if deemed useful and not simply an unnecessary proliferation of reports, issue its own analysis of progress and recommendations for improving implementation or for taking other steps to accelerate progress on health equity. For example, it might recommend re-ordering the priorities in the program of action based on lessons learned or changing circumstances. After the initial review, these reviews would also include analysis of how its earlier recommendations have been implemented.

The value of separate reviews from the steering committee may depend in part on the nature of the government-led national report, including its comprehensiveness, its perceived accuracy, whether it proposes actions to enhance program of action implementation, and how it is being used. It is also possible that the steering committee itself, with its multi-stakeholder representation including government officials, could produce the country's main annual progress report on the health equity program of action.

* *Joining government structures:* If the government has an interministerial body focused on Health in All Policies, it could incorporate health equity program of action implementation into its mandate. Members of civil society organizations, populations experiencing health inequities, and health workers and other service providers could be invited to join. It could be that such a body is charged with driving the process of developing the annual report on implementing the program of action.

* *Civil society and marginalized and disadvantaged population body:* The health equity program of action could establish a separate body led by and comprised primarily or exclusively of members of civil society organizations and populations experiencing health inequities. Other non-governmental stakeholders, such as academics and members of the national human rights institution, may join as well. This body could issue a formal civil society and population-led response to the official reports on implementing the health equity program of

action, with their own views on implementation and providing recommendations, to which the government and other responsible actors would respond. If members of populations experiencing health inequities have a preference whether to have such a separate body, or to be part of government structures, or both, every effort should be made to follow this preference (though members of different populations or within a particular population may have different views).

The possible structures and processes proposed above, and others that may be developed to address accountability for health equity programs of action, would be multisectoral. As such, they could also provide forums for ongoing dialogue across stakeholders and sectors on ensuring they are following a Health (Equity) in All Policies approach, on ways to improve implementation of and coordination for the program of action, and on opportunities for collaboration across sectors and stakeholders. Structures like existing interministerial bodies focused on Health in All Policies and or a continued steering committee will be most effective if they exist at a supra-ministerial level so that they have the political weight and authority to effectively coordinate policies and actions across ministries.

Political forums of accountability

The political system should build accountability for the health equity program of action into its processes. Health and other relevant committees of the legislature could hold hearings on progress in implementing aspects of the program of action that are within their remit. Sub-national legislative bodies could do the same. Health and other ministers could order reviews on how their ministries are carrying out their responsibilities under the health equity program of action. Such information could also be incorporated into other relevant ministry reports. National human rights institutions and offices of the human rights ombudsperson (for countries that have these institutions) could also review progress.

Given the intersectoral nature of health equity programs of action, it would be useful for interministerial and interagency government bodies to also review implementation of the programs of action and to work to improve coordination and interministerial and interagency collaboration in implementing it. Countries might already have governmental entities or processes fit for this purpose, such as ones developed to carry out Health in All Policies mandates. Otherwise, possibly with the health ministry or prime minister's (or president's) office taking the lead, such a body could be established.

Structured actions for health accountability

To ensuring accountability to and facilitate effective implementation of the health equity program of action, the program of action could include measures to help build an institutional framework and establish capacity for accountability to the right to health and the imperative of health equity. Such actions would include capacity-building measures and establishing or strengthening existing accountability mechanisms and processes. These would build on processes, mechanisms, and initiatives that countries already have in place, possibly strengthening, expanding, or reforming some while also adding new ones.

Capacity building

Government entities and other actors whose actions can affect health

equity may fall short in their responsibilities not out of ill intent or indifference, but rather because of inadequate capacity. For example, officials and health workers might not understand human rights and the implications of these rights on their own responsibilities, agencies might be understaffed, and information systems might not collect disaggregated data.

Capacity-building measures incorporated into the program of action could include:

- Incorporating human rights into the pre-service training curricula of all health workers and into their in-service training requirements, and developing guides for such trainings.
- Training government officials, lawyers, law enforcement officials, judges, and others on human rights, including the right to health.
- Enhancing understanding of government officials, health workers, lawyers, law enforcement officials, judges, program implementers, and others on the realities of life for people experiencing health inequities. Efforts might range from structured discussions between officials and people from marginalized and disadvantaged populations to officials visiting shantytowns, indigenous communities, neighborhoods, and other areas where these populations are concentrated, possibly holding public forums with residents.
- Training national, provincial (state), and municipal officials on identifying and monitoring health inequities in their programs, and reforming programs to redress these inequities. WHO's *Innov8* tool, discussed in the introduction, may be useful for this program review and reform. Officials could also be supported in developing information and reporting systems to facilitate this monitoring.
- Hiring additional staff to enable agencies to carry out their responsibilities, including staff members drawn from marginalized and disadvantaged populations.
- Creating new positions or changing job descriptions to clearly identify who is responsible for various actions within different agencies and other entities, and overall agency responsibility for its role in implementing the health equity program of action.
- Acquiring, disseminating, and using technology to improve transparency, including placing online more information relevant to health equity. These capacity-building activities could also include placing more information online and creating apps or texting possibilities for mobile phones to enable people to report discrimination or other actions that contribute to health inequity. Mobile phone technologies could even include training health workers on how different diseases and health conditions manifest in different populations to counter any misperceptions or stereotypes.
- Training legislators and health ministry officials on their responsibility to, and on effective measures to, regulate the private sector to protect the right to health.

Along with developing new capacities, countries might identify and unleash under-utilized capacity. If there are too few health workers who speak indigenous languages, health and education ministries can recruit indigenous people into health training institutions or use emerging technologies to provide health workers language training. Along with language skills, marginalized and disadvantaged populations may contribute many needed capacities, such as knowledge

of culture or local conditions that can be leveraged to improve health and health equity, and keen understandings of why efforts to improve health equity are or are not working. People from marginalized and disadvantaged communities can work with health workers and other actors to reduce stigma and discrimination. Community members might also want to take on direct roles in accountability, such as through community auditing (ensuring that local expenditures are proper and that funding is not misappropriated) or developing community scorecards (which rate local health facilities and services, and propose actions to improve them).

Additional capacities may be found elsewhere as well. Academics have access to vast stores of information, including lessons about efforts to improve health equity in other countries. Businesses may provide management and other skills, technology, and – recognizing the importance of the health of their employees – funding. Members of the diaspora, too, might contribute skills and resources. Parliamentary committees may have oversight functions that they have not used to the full extent that their authorities permit.

Accountability mechanisms

Countries could institute or strengthen a variety of processes and structures to improve right to health and health equity accountability.

Accountability and participation mechanisms

- Village health committees, health center committees,¹⁷⁷ or similar multi-stakeholder structures that include community members, health workers, and local officials can provide oversight of and input into health facilities and services in their communities. These must be appropriately resourced. Non-functioning or poorly functioning committees of this sort have often severely undermined their potential.
- Ensuring the existence and functioning of mechanisms to address complaints people have regarding discrimination, unavailability of medication, or other problems they encounter with health services. People should have ready access to these mechanisms.
- Training local health promoters to accompany health service users to ensure that their rights are respected and that they receive services to which they are entitled.
- Instituting annual (or other regular) national and local health assemblies. The proposed National Health Equity Dialogues are an example of what these might entail.
- Developing mobile phone apps that people can use to provide relevant authorities, human rights entities, multi-stakeholder bodies, designated NGOs, or other relevant entities information about their experiences related to health care or social determinants of health as they relate to issues of equity. Apps could also be developed to enable people to provide direct input into reviews of progress reports on health equity program of action implementation, such as through survey questions. Such apps could also help change people's expectations – with perhaps their first opportunity to engage in policymaking processes – a key step towards empowerment.

Mobile phone apps and other e-platforms may be particularly powerful when combined with transparency measures, enabling people to compare local realities to policy directives. For example, how do the health facility staffing levels they experience compare

with any mandated minimum staffing ratios? How does the local budget compare to the actual level of supplies and equipment in their local health facilities and schools?

Laws and policies for accountability and participation

- Enacting laws requiring people to have opportunities to meaningfully participate in health-related decision-making, including facilitating participation of people from marginalized and disadvantaged populations. For example, Brazil's Constitution requires that public health activities and services be organized according to the directive of community participation.¹⁷⁸ And Brazil's legislation on its Unified Health System establishes a Health Council to form health policies (which require approval by appropriate government bodies to take effect). The Health Council is a multi-stakeholder body whose members include health users.¹⁷⁹
- Enacting laws ensuring people's right to access information, such as India's Right to Information Act of 2005.¹⁸⁰ Right to information or other legislation should also protect whistleblowers, who can provide a valuable public function, both in informing the public of information that people need to understand the operations and policies of their government and to hold government agencies and the people within them accountable to the people they serve.
- Establishing a policy encouraging public officials to use public facilities, such as health facilities and schools. If public officials use public facilities – those that people with limited financial resources who cannot opt for private alternatives have no choice but to use – they would have a significant personal stake in the quality of these facilities. This could, in turn, lead them to strengthen efforts to improve governance (including addressing any issues of corruption) and ensure that these facilities meet quality and other standards.
- Enacting laws to implement the UN Guiding Principles on Business and Human Rights, which outline state and business responsibilities to prevent businesses from violating human rights and to ensure remedies when they do violate people's rights.

Health accountability tools

- Training community members on using community scorecards, to rate local health services, develop actions to improve them, and discuss ratings and actions with health workers and local authorities, and on community auditing, to ensure that health resources are spent properly. Community scorecards could also be used for other local services that affect health, such as education, water, sanitation, and public transportation.
- Promulgating laws or policies requiring health equity impact assessments on laws, regulations, policies, projects, and programs that may significantly affect health equity. Thailand's National Public Health Act, for example, affords people "the right to request...an assessment and [to] participat[e] in an assessment of [the] health impact resulting from a public policy."¹⁸¹ Slovakia's Public Health Act of 2013 empowers public health officials to require a health impact assessment for activities that may significantly impact public health.¹⁸² WHO has developed the *Urban Health Equity Assessment and Response Tool (Urban HEART)*, used to assess health inequities in urban areas and develop interventions to address them.¹⁸³ Assessments could encompass social, environmental, and human rights dimensions.

- Regularly auditing annual plans and budgets in all sectors against the strategies, actions, and targets in the health equity program of action.¹⁸⁴ Such an audit could be legally mandated.
- Requiring each sector to produce an inequalities statement, which would explain how its actions are contributing to health equity (and equity more generally), and measures it is taking to protect against perpetuating or exacerbating health (and other) inequities.¹⁸⁵
- Developing laws or policies to enable real-time monitoring of health inequities, such as through maternal and child mortality audits,¹⁸⁶ which should include disaggregated data. These audits identify causes of each maternal and child death – looking beyond the narrow medical causes to the systematic factors underlying them as well – and, based on these findings, provide recommendations to prevent similar deaths in the future. The audits' findings and recommendations should be incorporated into strategies to reduce maternal and child mortality and into updates to the health equity program of action and, most importantly, should lead to action. Similar audits might be undertaken for other health issues, particularly those diseases and health conditions most affecting marginalized and disadvantaged populations, such as TB.

Judicial and quasi-judicial accountability

- Ensuring that human rights commissions, tribunals, or other judicial or quasi-judicial mechanisms are empowered to address discrimination and other possible human rights violations.
- Providing sufficient legal aid to ensure that individuals and civil society organizations can use the courts and other judicial and quasi-judicial mechanisms to ensure accountability for legal commitments, including those related to human rights, linked to and underlying health equity programs of action.

Enabling environments for accountability

- Ensuring that legislation and policies create an enabling environment for civil society actions, including regarding ease of access to domestic and international funding.
- Vigorously safeguarding the rights to the freedoms of expression, association, and peaceful assembly, and the freedom of the press. These rights underlie effective accountability of the government and other powerful actors through social movements, civil society organizations, and an independent media. Particularly given the deeply rooted political, economic, and social factors that underlie health inequities, including inequities in power, such freedoms may prove critical to ensuring accountability for, and effectively implementing, health equity programs of action. Countries may even consider assessing the state of these rights as part of their regular reviews on progress implementing their programs of action.
- Capacity building for civil society for functions related to health accountability, including monitoring health and other public services, participating in political processes, and analyzing budgets.
- Developing public education campaigns on people's right to health, and incorporating human rights into public education standards and curricula.

- Allocating funds to cover transportation and other costs to help enable members of marginalized and disadvantaged populations to meet with policymakers.

Updating health equity programs of action

Health equity programs of action should be periodically (e.g., at least once every five years) updated to reflect progress, changing circumstances (including changes in economic circumstances and in political and social dynamics), additional information (including from improved disaggregated data, findings from health equity research, and enhanced understanding of the mechanisms generating health inequities and the pathways through which they operate¹⁸⁷), and lessons learned. Some information and lessons could come through operations research and other evidence-gathering and monitoring and evaluation that may be incorporated into different actions. The government might commission additional research and analysis to supplement the health equity research strategy (if one is developed). Civil society organizations and academics could undertake their own analyses, while information from the media or other sources may also be useful.

Updated health equity programs of action would also build on experiences with seeking to overcome impediments to implementing the programs of action – political challenges and resources constraints, for example – including lessons on possible ways to overcome these impediments. The updates could also take into account the current political and economic environment.

Building future health equity programs of action sector-by-sector

Another approach to updating health equity programs of action would be to update them through sectoral leadership, under national guidance. To guide the process, along with benefiting from input from annual National Health Equity Dialogues, countries could establish a standing multi-stakeholder, intersectoral national health equity committee, much like the steering committee discussed earlier, with its leadership including both members of government and leaders among marginalized and disadvantaged populations. Taking the health equity program of action as its starting point, including its actions, targets, and progress thus far, this committee could: 1) provide overall guidance, as well as sector-specific advice; 2) assist in determining cross-sector priorities; 3) ensure collaboration and coordination across ministries; 4) address impediments ministries may face in implementing the mandate of health equity, and; 5) engage with other key political actors, including the legislature and president's or prime minister's office. Committee membership would include representatives from ministries, particularly those whose work most impacts health equity. These representatives could also serve as liaisons between the national committee and ministries, ensuring regular flows of information, and working with ministries to incorporate the national guidance and directives into each sector's regular planning processes.

The national health equity committee could establish national and corresponding sectoral targets to guide and drive ministry efforts. These targets could be endorsed at the highest levels of the government, such as by the legislature and by the cabinet.

In line with these targets and following guidance of and advice from this national health equity committee, ministries could develop the analyses and related actions for how they will advance health equity. These actions would then be incorporated into an updated health equity program of action.

If ministries do assume responsibility for determining their health equity actions, it is vital that this be done in a way that is not business as usual, but rather includes a concerted focus on addressing their sector's role in meeting health equity needs and national targets, along with recognizing and leveraging linkages to other sectors. And these actions will need to be determined with the leadership and full participation of members of populations experiencing health inequities, as well as the participation of civil society organizations and other stakeholders. As with the initial health equity program of action, the process of developing these actions could also include interviews with and focus groups of members of marginalized, disadvantaged, and vulnerable populations, along with input from NGOs, academics, service providers, and international agencies.

The national health equity committee could also work with non-governmental entities (such as health professional associations) to develop their own processes to regularly consider health equity in their activities. The committee could also cover additional governmental actions needed for the updated health equity program of action, beyond those that emerge from ministry actions, such as legislative measures.

To further strengthen ministry action on health equity, and equity more broadly, as well as to retain the empowering processes and inclusive leadership of health equity programs of action, each ministry could establish a multi-stakeholder committee, with members of marginalized and disadvantaged populations among its leadership, and charge it with proposing actions to improving equity – including but not limited to a focus on health equity – within that ministry's mandate. Proposed actions would contribute to implementing the 2030 Agenda for Sustainable Development and its promises of leaving no one behind and of reaching first those who are the furthest behind. The national health equity committee could help ensure that such a ministry mechanism includes a strong health equity focus and provide any needed support. Ministries' equity committees could be vehicles for ministry contributions to updated health equity programs of action. Along with national ministries, departments at the provincial (state) level could also establish equity committees.

Principle 7: Sustained High-Level Political Commitment

Health equity programs of action will require effective intersectoral coordination and collaboration. The programs of action will likely entail significant policy changes and legislative action, and have budgetary implications. Such actions and necessary resource allocation will only be accomplished, and progress in health equity sustained – including to address the structural determinants of health as discussed in the principle on maximizing health equity – with high-level political commitment. Such commitment is a pre-condition for successful health equity programs of action. While we have focused on national health equity programs of action, such commitment and leadership will also be needed at other levels of government, which may be responsible for a number of actions in the health equity program of action, and which can also develop their own health equity programs of action.

Political leaders have considerable reasons to be committed to health equity. Actions on health equity will contribute significantly to achieving SDG commitments – not only in the health goal, SDG 3, but throughout the goals – and to fulfilling human rights obligations. By enabling people to be healthier, the programs of action will improve worker productivity and thus contribute to economic growth and poverty reduction. Fully engaging marginalized and disadvantaged populations in developing health equity programs of action, and addressing their priorities, stands to create a more cohesive, stable society. And given the tremendous benefits to the population that should come from implementing health equity programs of action, in health and many other aspects of life, these should be politically popular.

Given the many societal benefits of health equity, and its effects across many domains, advocates for health equity can likely find ways to tailor messages on the importance of health equity to political leaders, even as those leaders and their priorities change. Health equity may advance some of the leaders' own priorities, or connect to national principles and goals that are central to an overall national vision and narrative. Different leaders may also be motivated by different forms of information – for example, individual stories or visits to health facilities or communities experiencing health inequities that help them connect to health equity at an emotional level, data that demonstrates the extent of inequities, evidence of successful approaches, or comparisons to peer countries. They may also be most influenced by different interlocutors, different sets of people – perhaps members of marginalized and disadvantaged communities themselves, trusted members of their administration, respected national figures, or international actors or leaders from neighboring countries.

It might even be possible to create regional or other international networks and convenings where political leaders reinforce one another's efforts and motivate each other. External actors (including WHO and other UN actors, and prominent foundations) may be able to facilitate this or other approaches to sustained health equity as a political priority, such as prominent awards to or other forms of international recognition for leaders on health equity, or grants to countries that are undertaking health equity programs of action.

Beyond top political leaders, educating public servants throughout the government on health equity, the tremendous stakes, and

individuals' roles and responsibilities in contributing to health equity will be critical as well, and help to develop a broader, government-wide culture oriented towards health equity. Incorporating health equity into mandates and targets of each ministry with a role in advancing health equity, and other approaches discussed earlier to raising the profile of health equity within different sectors, will contribute towards mainstreaming health equity as a priority.

Furthermore, establishing health equity as a priority throughout the government, including at provincial (state), district, and municipal levels, can also help sustain national commitment to health equity if political leadership at the top waivers. And today's legislators, mayors, governors, and mid-level ministry officials could become tomorrow's national leaders – and already have the capacity to influence political systems today.¹⁸⁸

Political will through health equity programs of action

Various features of the health equity program of action should help enhance political will, such as the participation of government officials in developing them, joining with populations experiencing health inequities in leadership in developing the programs of action. Capacity-building measures should empower officials to act, and could increase their own understanding of and commitment to health equity. Incorporating the program of action into the strategies and plans of other sectors will help maintain health equity as an area of focus across government.

The programs of action will be platforms for all those who support greater action towards health equity – from civil society organizations and members of marginalized communities to government officials – to advocate for action, from the halls of public opinion to the halls of parliament, or even courts, reinforcing political and public attention and pressure to act. A National Health Equity Dialogue at the beginning of the process could secure early public participation, awareness, and support. Meanwhile, the types of accountability mechanisms discussed in the chapter on accountability, such as regular National Health Equity Dialogues and a standing national steering committee on health equity, should help keep health equity high on the national agenda and in the public spotlight.

The media could also contribute to sustained attention and public support for health equity programs of action, as media outlets spotlight both health inequities and solutions. Public support should, in turn, create political incentives for elected leaders to act, including to prioritize implementing the health equity programs of action. Improved quality disaggregated data and additional health equity research can provide policymakers a convincing evidence-based case for action, demonstrate the effectiveness of certain policies or programs and thus their worthiness for continued support, and contribute to public insistence on action to redress health inequities.

Indeed, perhaps nothing is more critical to creating and sustaining political leadership for health equity than building strong public demand for it, so that political leaders recognize that taking robust actions for health equity is to their political advantage. The importance of a mobilized civil society, sustained attention from the media, and leadership from members of marginalized, disadvantaged, and vulnerable populations to generating this public demand cannot be overstated.

Further measures for maintaining health equity as a national priority

Additional measures could also help maintain health equity as a top national priority. The government could establish a high-level position to coordinate health equity efforts across all ministries, possibly even reporting directly to the prime minister or president. Or a national SDG advisor, with equity, including health equity, a central part of their mandate, might report directly to the president or prime minister. Media organizations could designate a reporter to focus on health equity, run special series on health equity, report on National Health Equity Dialogues, and analyze progress reports on implementing health equity programs of action. Media, civil society organizations, and marginalized and disadvantaged communities could establish partnerships for empowering community-based media, including by training people experiencing health inequities to become citizen journalists and providing tools (e.g., smartphones) to help them assume this role. The National Health Equity Dialogues may also devote part of their time to determining other approaches for ensuring that health equity is a top political priority.

Civil society can take initiatives to raise and sustain the political priority of health equity. For example, civil society organizations could form multisector coalitions focused on health equity, and ensure that people from marginalized and disadvantaged communities are part of coalition and individual organization leadership structures. Coalitions could include different stakeholders, including health workers and, as appropriate, government officials. Civil society organizations could also endeavor to hire more people from marginalized and disadvantaged communities. They could undertake power-mapping exercises to identify individuals and organizations (including for-profit) that may either obstruct or facilitate health equity efforts, along with strategies to effectively engage these individuals and organizations.

Another approach: enabling the public and policymakers to frequently hear from people on the front line of health inequities speaking to health equities that persist – but also to successes, changes towards greater health equity that they experience or witness. Along with individuals experiencing health inequities, the public and policymakers might hear from health workers and teachers – especially ones primarily serving and working with marginalized and disadvantaged populations – social workers, housing advocates, community organizers, and others. Civil society organizations could help bring these perspectives to policymakers, much as the Ugandan NGO REMI East Africa enables rural health workers in Uganda to tell their stories of the challenges they and their patients face and to offer recommendations, which REMI East Africa collects and shares with the public and with policymakers.¹⁸⁹ The media, meanwhile could circulate these perspectives to the broader public, as could civil society organizations and members of marginalized and disadvantaged populations through social media.

The health equity action plan itself could incorporate some of these additional measures offered above.

Annex 1: Social, Environmental, Economic, and Political Determinants of Health

This Annex offers a brief overview of a wide range of determinants of health, 34 in all. The descriptions of each determinant's connection to health policies that could contribute to health equity are far from all-inclusive. Rather, they are meant to give a sense of the importance of each of these determinants to health equity and a flavor of the types of approaches that might be incorporated into health equity programs of action.

34 social, environmental, economic, and political determinants of health

1. Health systems
2. Food and nutrition
3. Water and sanitation
4. Housing
5. Early life
6. Education
7. Working conditions
8. Employment and job security
9. Income and income distribution
10. Social safety net
11. Social support systems and community networks/social capital
12. Natural environment
13. Built environment
14. Agricultural land use and ownership
15. Transportation
16. Recreation and physical activity
17. Commercial determinants of health
18. Electricity and technology
19. Safety/violence
20. Criminal justice system
21. Gender
22. Migration
23. Indigenous status
24. Disability
25. Social, economic, political, and legal exclusion and discrimination
26. Control over resources, institutions, and decision-making
27. Political engagement and empowerment
28. Governance and corruption

29. Participatory and accountability government structures
30. Structured intersectoral collaboration mechanisms
31. Disaggregated data and health equity monitoring, evaluation, and research
32. Civil society and media enabling environment
33. Vital (civil) registration system
34. Adequacy and equitable mobilization and distribution of financial resources

Health systems: Health systems are themselves major determinants of health. People may have different levels of access to health care, whether because of financial, geographic, or other barriers. Poor quality public health systems in some areas may impede access to good quality care for people who cannot afford to pay, even if they can access the public health services. Medicines may be unaffordable. Certain populations, such as undocumented immigrants, might not be legally entitled to health coverage. Discrimination and mistreatment may discourage members of indigenous communities, women, or others from seeking care. Other barriers include physical access for people with disabilities, transportation costs, lack of cultural acceptability, and lack of health workers who speak local languages. Health financing might vary significantly across regions, with the least resources for impoverished or politically marginalized regions.

Policies to address these challenges include, among many others: ensuring universal health coverage through prepaid pooled funds, with free care at the point of service; investments in health workforce and systems development in underserved areas and among underserved communities; human rights education and other anti-discrimination training for health workers; patients' bills of rights accompanied by community- and government-led accountability practices; developing community-based health systems; prioritizing public health in patent laws; rebalancing health financing so that it is equitable; hiring health workers from linguistic and other minorities; providing interpretation services, and; creating physically accessible health facilities.

Food and nutrition: Eating a sufficient amount of nutritious food (and limiting quantities of unhealthy foods) is one of the most important steps people can take to protect their health. Nutritious food helps prevent health conditions caused by a lack of particular nutrients, such as vitamin A, and other forms of malnutrition, and protects against cardiovascular diseases, diabetes, and other non-communicable diseases, as well as such communicable diseases as tuberculosis. Yet enough food, particularly nutrient-rich food, may be unaffordable or inaccessible, leading to people having too little food or eating too much unhealthy food.

Ensuring access to safe, nutritious, and affordable food is closely linked to reducing poverty and to ensuring sufficient income. Along with policies to raise the income of poorer people, other actions to ensure sufficient nutritious food include: social protection programs; subsidies to individuals to purchase food (or healthier food in particular); agricultural subsidies that make healthier food (such as vegetables) less expensive; working with industry or developing regulations that reduce costs of nutritious foods and improve a food's nutritional profile through product reformation (such as banning artificial trans fats, or requiring lower sodium and sugar content); micronutrient supplementation; taxing sugary drinks or other unhealthy foods; using ready-to-use foods in acute cases of malnourishment; promoting breastfeeding; zoning regulations or incentives to encourage providers of healthy foods (from farmers markets to large grocery stores) to locate in poor neighborhoods and to reduce concentrations

of fast food restaurants in these neighborhoods; empowering health workers to provide and even prescribe nutritional foods free of charge, and; supporting small-scale and family farms that produce affordable, nutritious, and culturally acceptable food (which will also boost the income of often impoverished rural populations).¹⁹⁰

Water and sanitation: It is overwhelmingly people who are poor and other marginalized and disadvantaged populations, such as indigenous communities, who lack access to clean water and adequate sanitation facilities. Unsafe water and poor sanitation contribute to such diseases and health conditions as diarrhea, pneumonia, cholera, and parasitic infections, like schistosomiasis. Diarrhea, intestinal worms, and fecal contamination reduce nutrient absorption, contributing to malnourishment.¹⁹¹ Lack of private sanitation facilities often disproportionately affects women, exposing them to infection and the risk of violence.¹⁹² Among others, policies and actions are needed to develop effective waste management systems, including sewer connections to homes and other buildings; provide everyone access to clean water in their homes, particularly through free or affordable piped water;¹⁹³ construct and subsidize latrines; conduct educational campaigns to promote and provide information on proper handwashing, and; ensure working and accessible (including for people with disabilities) latrines in health facilities, schools, and other public facilities.

Housing: Without secure, safe, and stable housing, people's health is likely to suffer. The nature of one's housing is closely related to other key determinants of health. It affects whether a person has access to safe water and sanitation, safe and nutritious food (through access to electricity and refrigeration), and clean air (including by addressing indoor pollution, especially from solid fuel-burning stoves¹⁹⁴). Poor physical housing conditions (such as dampness and mold) may contribute to asthma and other respiratory illnesses as well as cognitive delays and other health problems, especially for children (who are particularly at risk from the presence of lead and other neurotoxins).¹⁹⁵ Moreover, housing where temperatures are not properly regulated may (if too cold) increase the risk of cardiovascular, respiratory, and rheumatoid diseases,¹⁹⁶ or (if too hot or too cold) can even be fatal, particularly for the elderly. Overcrowding, poor ventilation, and vermin may increase the spread of TB, pneumonia, and other infectious disease, while unsanitary living conditions can increase the risk of infection.¹⁹⁷ Poor housing conditions can also add to stress, negatively affecting mental health and contributing to substance abuse.¹⁹⁸ Poorly built housing is more likely to collapse during a natural disaster, while some housing may be built in areas simply unsuitable for living (such as in areas vulnerable to mudslides). Unsafe housing may lead to more fires – which pose added risks in housing not equipped with working fire detectors – and accidents, especially among children.

Housing may be located in areas where the air is clean or polluted (affected by nearby industrial factories, coal-burning power plants, transportation depots, or heavy traffic), where the water is safe or unhealthy (polluted or affected by toxins), where it is safe to go outside or in more violence-prone neighborhoods, where there is easy or limited access to health facilities and schools, where people can easily walk places (and benefit from the physical activity) or need to drive, and where parks or other opportunities for recreation and exercise are nearby or distant. The neighborhood may feature a strong social fabric, or instead be one where neighbors rarely communicate with each other or do not work together for their mutual well-being.

Meanwhile, the lack of any housing – homelessness – is extremely harmful to health. People who are experiencing homelessness often have increased exposure to infectious diseases (such as in crowded homeless shelters) and poor weather conditions. Environmental

conditions they experience may exacerbate health conditions such as asthma, and their unsanitary living conditions may contribute to infections and infectious diseases. People who are homeless are unlikely to have access to a stable supply of adequate, nutritious food. They are unlikely to be able to reliably access medications, such as those that help control blood pressure or diabetes. The stress of living without stable housing is likely to harm mental health, and contribute to unhealthy coping behaviors such as smoking or drug or alcohol use. People who are experiencing homelessness are at increased risk of violence, and injuries from violence or accidents may be less likely to heal properly due to the difficulty of keeping injured areas clean or getting proper rest.¹⁹⁹ Meanwhile, lack of proper sleep itself has been found to contribute to numerous health problems, such as diabetes, obesity, cardiovascular diseases, and cognitive impairment, along with reduced immune system functioning.²⁰⁰ People who are experiencing homelessness are also likely to have reduced access to such determinants of health as work and health care. Children's schooling may be interrupted, their school records lost and their ability to study harmed, while they may face teasing and not have clean clothes to wear.

Accordingly, policies to enable safe, secure, and habitable housing for all are vital. Enough affordable housing needs to be built, whether funded by government or private developers, including in developments that set aside sufficient supplies of affordable housing. Zoning and government decisions on where affordable housing is developed can help ensure that this housing is not in polluted areas and is instead located near employment, transportation, and other community resources. The government can offer subsidies to low-income households to rent market-rate housing. Housing First programs for people who are homeless, prioritizing getting people who are homeless into permanent housing, while providing supportive services, have proven to be highly successful. Along with housing for all, inspection programs and accountability for landlords can help ensure the quality of that housing. Housing must be safe and promote good health, avoiding and removing such contaminants as lead piping and asbestos. And through electrification, solar generation, and other means, households must be supported to move away from solid fuel-burning stoves.

Early life: Conditions of early life, from before birth through childhood, can have lasting and significant health effects. These effects begin with a woman's experiences during pregnancy, including substance use and poor nutrition, which can have lifelong effects on the child. Poor nutrition in the first years of life can lead to stunting, which contributes to lifelong physical and cognitive impairments.²⁰¹ Lack of home stimulation, including being read to and otherwise being exposed to a robust vocabulary, may have lasting impacts on educational attainment, itself a key determinant of health, and one linked to others, including employment and income. Likewise, early exposure to stress, toxins including lead, inadequate stimulation and social exposure, and iron deficiency can all reduce cognitive functioning and cause lasting emotional harm.²⁰²

Exposure to adverse childhood events can have lifelong and massive negative effects on health by generating what are called toxic stress responses. Triggers may include emotional, physical, and sexual abuse; emotional and physical neglect; household violence and traumas including substance use disorders or mental illness, parental separation or divorce, and an incarcerated family member, and; other traumatic events such as the death of a parent or instances of community violence.^{203,204,205,206} Exposure to a higher number of these stresses is linked to a much higher risk of depression, suicide, heart disease, and lung cancer, among other health consequences. Yet appropriate mental health care, parental education, and other

interventions can protect children.²⁰⁷ So can programs that ensure that young children have sufficient nutrition, including through social insurance programs and tax credits.

Education: Lower education levels reduce an individual's ability to access health care and health information, increases the risk of unemployment and reduces access to higher-wage employment, and restricts the ability of women to become economically independent, among other effects.

Individuals with less education also may be inclined to adopt unhealthy behaviors. For instance, smoking is often concentrated among people with low educational attainment. In addition, since knowledge of healthier food options may be limited, an individual's diet may be less healthy.

Limited education poses barriers to meaningfully accessing health information, which in turn can obstruct access to health care services. People with poor education may not have access to information that would allow them to seek redress for sub-optimal physical environments. For example, they may be less able to initiate a successful complaint against a city or workplace for unhealthy conditions. Moreover, health information is essential to empower an individual's ability to safeguard their own and their family's health.

An inadequate education markedly increases the risk of unemployment, which is linked to adverse health outcomes, since in many national contexts, people with low income are more likely to be uninsured and vulnerable to the rising costs of health care. Individuals with low education levels also have limited access to higher-wage employment, which influences where someone can live (affecting the conditions of their housing and safety of their neighborhood) and their access to health care. Education gives workers an advantage in obtaining rewarding jobs that offer not only higher salaries, but also other health-related benefits such as health insurance coverage.

In the case of girls and women, more education may enable economic independence, and thus help women escape situations of domestic violence. Higher education levels correlate to higher earning power. Women who have been able to attain higher education are empowered economically because they are able to compete for higher-paying jobs.

Policies to expand access to quality education for all include enabling universal attendance in primary and secondary schools, such as by removing any fees, including for books and uniforms (or covering costs for children from low-income households), providing free meals, and providing community and parental education about the importance of school attendance, including for girls. Countries could move towards universal pre-primary school programs and free or subsidized college, particularly for lower-income families. Well-paid and well-trained teachers, with accountability for their attendance, can help ensure that students learn when they are in school. Measures such as bilingual education programs, accommodations for children with disabilities, outreach programs to homeless children, bullying prevention and tolerance programs, along with building schools in more remote communities, can help enable marginalized and disadvantaged populations to attend and fully benefit from schooling.

Working conditions: In formal workplace settings alone, about two million people die each year from work-related illnesses or injuries. In addition, every year workers suffer 268 million non-fatal workplace accidents and 160 million cases of work-related illnesses. Occupational risks also contribute significantly to depression.²⁰⁸

Efforts by employers to cut costs, lack of employer and employee knowledge, and stressful and high-pressure work environments all can contribute to dangerous and unhealthy working conditions. Specific hazards vary by workplace, but may include chemical hazards (e.g., pesticides, asbestos, and silica), mechanical hazards (e.g., machine-related dangers such as forklifts, cranes, and assembly lines), physical hazards (e.g., excessive heat, radiation, and noise), biological hazards (e.g., workplace spread of hepatitis B, TB, mold, and lack of clean water and sanitation), ergonomic hazards (e.g., heavy lifting and repetitive movements), energy hazards (e.g., electric hazards), and mobile hazards (e.g., driving dangerous vehicles or under unsafe conditions).²⁰⁹

Strong workplace health and safety regulations, backed by sufficient authority and resources for enforcement, are vital to ensure that employers take measures to reduce, and where possible eliminate, workplace hazards, including through eliminating risks (such by substituting dangerous chemicals with safer ones), engineering controls (such as modifying machines to make them safer), or administrative controls (such as training and preventative maintenance), and by supplying personal protective equipment.²¹⁰ Workplaces can adopt injury and illness prevention programs to proactively identify and respond to risks, including through training, modifying the workplace, and establishing safety protocols.²¹¹

Further, poor working conditions can also create psychosocial risks, including poor work organization (e.g., time pressures, lack of supportive supervision, unclear job descriptions, and unpredictable scheduling), organizational culture impediments (e.g., harassment, discrimination, and intolerance), poor management style (e.g., lack of constructive feedback), lack of support for work/life balance, and fear of job loss.²¹² Working in environments where people lack control can lead to stress that contributes to cardiovascular disease and other causes of early mortality.²¹³ These risks can be modified by eliminating or mitigating their sources (e.g., zero tolerance for harassment and discrimination and through reallocated workloads), increasing flexibility (e.g., to improve work/life balance), advanced scheduling, open communications, and protecting workers through training.²¹⁴

Other modifiable workplace concerns include lack of physical activity (more flexible schedules could allow for people to walk more), poor diet due to lack of time for lunch or proper refrigeration (longer breaks could be allowed and refrigeration provided), permitting smoking at the workplace (smoking could be banned and smoking cessation programs initiated), and lack of support to prevent community hazards (instead, companies could implement workplace HIV prevention programs).²¹⁵

In addition, unionization and laws and regulations to protect workers' right to organize can enable workers to secure and enforce their right to safe and healthy working conditions.

Employment and job security: Unemployment is an important social determinant of poor health.²¹⁶ By contrast, higher incomes, often resulting from better employment opportunities, are linked to better health.²¹⁷ Employment itself can present its own challenges based on the nature of the work environment and its safety, stress, and compensation levels. Meanwhile, unemployment and job loss can also lead to poor health. Job security also plays an important role in people's health.

i. Employment: Employment is the main determinant of income, with the multitude of effects that has on health (discussed separately below). Employment also provides "social protections such as health

benefits and pensions...education and training, social networks, labor organizing, and solidarity.”²¹⁸ Yet a person’s ability to secure employment, the nature of that employment, their compensation, and their ability to advance in a company or organization can depend on their education and status such as sex, gender identity, race, sexual orientation, or disability. Workplace policies also affect employee health. For example, along with other health and safety concerns (discussed separately above), employers might not offer paid sick leave, leading employees to delay seeking health care.

Along with policies in the educational realm (including educational options that focus on job-relevant skills and training), policies to help people from marginalized and disadvantaged populations to secure good employment include adopting and enforcing laws prohibiting discrimination in hiring, pay, hours, and other aspects of employment (including to make reasonable accommodations for people with disabilities), tax incentives to encourage employers to hire people from disadvantaged groups, minimum or living wage laws, and transparency and other requirements to ensure equal pay for equal work.

ii. Unemployment: Loss of employment, especially long-term unemployment, reduces people’s income, with all the effects that has on health this entails. An additional stressor is the uncertainty of the duration of unemployment.²¹⁹ The stress of being out of work also can influence an individual’s physical and mental health, family dynamics, and their children’s well-being.²²⁰ Health effects of job loss include increased risk of heart attacks and stroke,²²¹ especially for older workers, as well as diabetes,²²² cancer, and suicide.²²³ The loss of income and stress may be mitigated by a strong safety net, including generous unemployment and wage insurance, employment-relevant job- and skills-training programs, continuing education and retraining opportunities, and assistance finding new employment.

iii. Job Security: At the intersection of employment and unemployment is job security, including the variability of the number of working hours and the term of employment, and the possibility of minimal notice of termination. These factors can contribute to stress and the loss of income (e.g., if an employee’s working hours are cut). Job security can also affect personal relationships, parenting effectiveness, and children’s behavior. Job security is an especially significant concern for certain types of work situations that are highly variable or not guaranteed, often disproportionately involving low-income, migrant, or other disadvantaged populations, such as construction and seasonal agricultural work. Workers in these areas might also not benefit from workplace protections, whether in law or in fact. Along with ensuring full legal protections, including their enforcement, for all workers, a strong safety net and policies such as a fair minimum notice of termination may mitigate these harms. Policies to support unions and collective bargaining are also critical.

Income and income distribution: Income is among the most important social determinants of health. Levels of income help shape our overall living conditions. People with low incomes are more likely to experience material and social deprivation, especially in societies that do not ensure essential services for all. Low-income households may be unable to afford adequate health care, good housing, nutritious food, warm clothing, a quality education, and the like. Such “[d]eprivation also contributes to social exclusion by making it harder to participate in cultural, educational, and recreational activities that promote” both physical and psychological health. Income “influences health-related behaviors such as quality of diet, extent of physical activity, tobacco use, and...alcohol use.”²²⁴ Overall, lower income levels lead to poorer health outcomes.

Another facet of income is income distribution, including the gap between the rich and the poor, and more generally how equally income is spread across populations. While controversial,²²⁵ there is strong evidence that high levels of income inequality directly contribute to reduced health, including worse health for disadvantaged populations.^{226,227} Possible reasons for this include chronic stress (which can lead to depression and cardiovascular disease, as well as other negative health consequences),²²⁸ reduced social cohesion, and reduced investment in human capital.²²⁹

Fair and sustainable economic growth, and all the policies that entails, helps lift the income of all people. Policies to promote employment and quality education for all are key. Specific policies to address low income and highly unequal income distribution include minimum and living wage laws, along with robust enforcement. Outside of employment-related income, social welfare benefits targeted to lower-income individuals can boost income, as can a more extensive approach currently being piloted in a number of countries: universal basic income. Private saving programs and public pensions can help ensure adequate income for the elderly. The tax system can create fairer income distribution and enable the government to raise sufficient resources for income-support programs. Tax credits for low-income households and child tax credits can also help.

Social safety net: The nature of the social safety net influences whether people can access a variety of critical needs tightly linked to a number of other determinants. These include health care itself, food security, and income levels and the many determinants that are linked to income. The social safety net includes health insurance; unemployment insurance; social security insurance for people who have disabilities or health conditions that prevent them from working, and for people who are elderly; child care, which can enable parents, particularly women, to work, and; social welfare for people who have very low incomes. The social safety net may extend into other areas as well, such as subsidies for people to buy food, employment guarantees, and wage insurance to cover at least part of the wage gap of people who lose one job and take another job that offers lower pay.

The solution to ensuring a strong safety net is straightforward: public financing for comprehensive health insurance (at the least for those who do not receive quality health insurance through their job), for child care, for generous unemployment insurance, for social security for people who are disabled or who are elderly, and for social welfare payments for people who earn insufficient incomes. The greatest challenge governments may face in providing this package is funding. Yet by contributing to so many determinants of health, the health (and other societal) benefits of ensuring a comprehensive social safety net are considerable.

Social support systems and community networks/social capital: Having a strong social support system and positive social relations is a significant contributor to good health. These can enable people with little income to access resources – food and housing, for instance – that they might not be able to access on their own. People may be able to continue to work because a friend or relative can care for a sick child, or care for children after school. For example, people may notice when their neighbors are unwell and should see a health provider, or if an elderly or chronically ill neighbor has not appeared outside of their home recently and therefore may need help. Beyond this, social relations can provide social and emotional support, promoting people’s mental health (people with less emotional support are more likely to suffer from depression²³⁰), can contribute to decisions that are important to people’s health, such as to leave an abusive relationship, and can sustain people’s efforts to avoid harmful substances such as

tobacco, drugs, or alcohol. People may also acquire valuable health information through social interactions, whether about good nutrition or health facilities (though false information can also spread through social networks), or gain life skills and problem-solving capabilities that can contribute positively to various social determinants of health.

Loneliness is a major risk factor for health, with studies demonstrating significantly elevated levels of early death for people who are lonely, including through increased heart attacks and stroke,²³¹ as well as diabetes, dementia, arthritis, and suicide. These effects appear to occur because loneliness can elevate stress hormones and inflammation,²³² along with the protein fibrinogen, too much of which increases blood pressure.²³³ Further, people who are socially isolated can experience accelerated cognitive decline, abnormal immune responses, and disrupted sleep, while elderly lonely people have reduced ability to perform activities of daily living.²³⁴

At the community level, social cohesion and trust can both contribute to the benefits of social support systems and add others. For example, communities with lower levels of cohesion and trust may have more violence.²³⁵ And neighbors can join together to advocate for measures that improve health, such as improved education, more green spaces, better health care, and traffic safety.²³⁶

Interventions to reduce loneliness and enhance social support systems include providing social skills training in school, including social connectedness in health screenings, and creating spaces (such as parks and recreation centers) that promote social interactions.²³⁷ Schools could become community gathering spaces. Communities could establish programs where community members visit or call elderly people who might otherwise have limited social interactions, and hold social events to encourage these interactions, reaching out to people who are lonely to join.²³⁸ Group discussions and activities conducted by phone for people who cannot leave their homes can also help.²³⁹ Successful interventions to reduce violence could enable more people to visit parks and walk in their neighborhoods, which could enhance social engagements. Measures to end discrimination and social exclusion, discussed below, can also contribute to social cohesion.

Natural environment: One-quarter of preventable illnesses result from poor environmental conditions. Particulate matter from such sources as industrial processes, coal-burning power plants, vehicles, and smoke contribute significantly to air pollution, leading to cardiovascular and respiratory diseases and lung cancer.²⁴⁰ Disadvantaged populations may have less of an ability to move away from sources of pollution, like transportation hubs and industrial plants, which may be intentionally located near these populations, who often have less political influence. Along with particulate matter, ozone, nitric dioxide, and sulfur dioxide significantly contribute to respiratory and cardiac illnesses. All told, outdoor air pollution is responsible for more than 4 million deaths per year.²⁴¹

Increased production of carbon dioxide and other greenhouse gases, such as methane, along with deforestation and other agricultural practices, are causing rapid climate change, resulting in numerous negative health consequences. Among other effects, climate change increases incidence of and exacerbates extreme weather events such as heat waves, droughts, floods, and hurricanes, causing additional deaths from injuries and heat stroke, destroying crops and leading to malnutrition, and spreading infectious diseases. Climate change also alters the reach of disease vectors, increases pollution, leads to unpredictable rainfall, and forces people to migrate. Rising sea levels cause salt water intrusion affecting arable lands, crop failures, and

worsened flooding.²⁴²

Marginalized and disadvantaged populations suffer the most from all these effects. They are least able to escape or protect themselves from extreme weather events (in part because they live in more vulnerable housing and are unable to afford air conditioning). They are most likely to be displaced from their land as the crops they depend on to survive fail and since they are most vulnerable to rising food prices from food shortages that extreme weather, unpredictable rainfall, and salt water intrusion can cause. Yet they have the least access to health services that could mitigate resulting health harms.

Along with air pollution, including greenhouse gases that cause climate change, water and soil can be contaminated. Untreated human sewage, industrial waste (including toxic metals), and agricultural discharge (including pesticides and antibiotics) pollute water. Its consumption can lead to serious illnesses such as cholera, typhoid, hepatitis, and parasitic diseases, along with diarrhea, and lead to increased risk of cancers, and of cardiovascular, neurological, and respiratory diseases. Using contaminated water to grow crops can damage the crops and harm the health of people who eat them, just as eating sea animals that live in contaminated water can lead to various ailments.²⁴³ Standing water, meanwhile, serves as the breeding ground for insects and mosquitoes that spread infectious diseases such as dengue, malaria, and chikungunya. Contaminated soil can cause cancers, neurological disorders, bone diseases, and kidney disease,²⁴⁴ while soil pollution also reduces the land available for farming. Marginalized and disadvantaged populations are again at greatest risk. They have the least access to clean water and adequate sanitation, and the least ability to mitigate harms by moving away from polluted land and waterways.

Pollution is not the only form of environmental degradation that affects human health. Deforestation (along with contributing to climate change), for example, and human encroachment upon animal habitats brings people and animals into ever greater contact, contributing to the spread of infections from animals to people. Reduced biodiversity can lead to permanent destruction of plants and animals that may have been sources of antibiotics or other medicines.

To address the many types and harms of pollution and other forms of environmental degradation, ecological sustainability and a transition to a green economy must be core features of national responses to climate change, and of energy and transportation policies, urban land use planning, and approaches to corporate social responsibility. Government regulations – backed by funding, personnel, and the technology to enforce them – can prohibit unsafe levels of pollutants, and establish regimes that put a high price on carbon creation and emissions through mechanisms like carbon taxes and carbon emissions trading schemes. Investments in developing and scaling up renewable energy are critical, as are investments in cleaning up and restoring polluted lands. Actions focused on other social determinants, such as clean water and sanitation, are a priority from an environmental health perspective as well.

Urbanization and the built environment: Cutting down forests to make way for growing human populations, agricultural activities, or livestock can increase disease transmission. For example, it may create conditions conducive for different species of mosquitoes to breed, resulting in an increase in infectious diseases. Deforestation can also increase the concentration of animals in the smaller patches of forest that remain, increasing the spread of disease among animals, and increasing their contacts with people as human settlements encroach upon the forest.²⁴⁵

The built environment in an urban context encompasses industrial, commercial, and residential facilities and other urban features such as roads, sidewalks, and parks. Urban land use patterns influence levels of physical activity, especially among lower-income groups who often get much of their physical activity through daily living rather than recreation or deliberate exercise. Access to local facilities such as shops, schools, health centers, and places of informal recreation are important for health and well-being, for the goods and services they provide, the physical activity that may be associated with them, and the valuable social interactions they offer. Deprived neighborhoods may have fewer shops with affordable, healthy foods, and a scarcity of safe parks, health centers, and other such facilities. Further, disadvantaged areas disproportionately experience the deteriorating features of an urban environment such as dilapidation, vandalism, graffiti, and litter, leading to a sense of insecurity on the streets and in parks and play areas. People in these areas may take less advantage of such facilities, and their children may be less likely to play outside, leading to reduced physical activity and exacerbating health problems such as obesity.²⁴⁶

Moreover, urban planning policies often focus on making life ecologically sustainable for people in higher-income neighborhoods while neglecting the needs of lower-income neighborhoods, thereby promoting environmental injustice. The disproportionate dumping of toxic waste products and the siting of factories and similar facilities that emit pollutants (e.g., bus terminals) and toxic wastes in or near low-income neighborhoods contribute to poor health outcomes and health inequities among low-income populations. These populations may lack the political clout, financial resources, and social connections to mitigate or remedy the adverse conditions in which they find themselves.²⁴⁷ Furthermore, corporate behaviors may be insufficiently regulated, and could lead corporations to disregard the ecological, social, and health-related costs of their actions, especially relative to marginalized and disadvantaged populations.²⁴⁸

To address the challenges posed by built environments to health and health inequity, good governance at the national, regional, and local level is crucial. Among others, the interventions that could significantly contribute to better built environments for health include: designs that encourages physical activity for all population groups, transportation safety (see below), access to healthy food options, ecological sustainability including green spaces, injury prevention efforts, cooling centers and cool roofs, the equitable distribution of environmental benefits (such as parks and other urban greenery like community gardens), and the proportionate distribution of environmental harms among all income groups, rather than primarily to the most disadvantaged groups.^{249,250}

Agricultural land use and ownership: Who owns agricultural land and how it is used can affect people's health. Whether and how much farmland a person owns, its productivity, the crops grown, and the techniques used all affect how much income a family can earn from farming. In turn, their income affects their access to adequate nutrition, education, health care, and so forth. This is a major concern for poor and other marginalized and disadvantaged groups, as nearly 80% of the world's poor live in rural areas, often relying on agriculture for their incomes.²⁵¹ Yet in many countries, corporations or wealthy families own large portions of the land. Meanwhile, a lack of clear land tenure (ownership) can prevent small farmers from using land as collateral for bank loans and other activities that could help improve productivity and increase their incomes. Lack of clear tenure also increases the risk that they could be forced off their land altogether.

While at times contentious, consensual redistributive land reform

policies can increase the land available to smallholder farmers. Governments could also implement policies to increase women's access to resources, which would increase productivity.²⁵² Other approaches to improve productivity and increase incomes can include offering and expanding agricultural extension programs, subsidizing fertilizers,²⁵³ supporting farmers in switching to higher-yield crops (including those resistant to weather shocks) and crops higher up the value chain, improving irrigation, improving rural roads to improve access to markets, and enhancing information communications technology (to inform farmers of market prices and weather conditions, for example), and increasing access to credit.²⁵⁴

Unsafe working conditions on agricultural lands can also cause health harms, with farm workers who have little say over their conditions due to their poverty and other forms of marginalization and disadvantage bearing the brunt of these harms. Along with animal-to-human disease transmission, working conditions may be hazardous. For example, farm workers may be exposed to toxic chemicals from pesticide use. They can inhale the chemicals during and after spraying, the chemicals can be absorbed through their skin, and the workers can ingest the chemicals if they eat or drink without first washing their hands. Laws and regulations, including those that ban the use of harmful pesticides and ensure that farmworkers wear protective gear, can mitigate these risks, as well as others, such as overwork, particularly in very hot conditions. Unionization can enable farmers to secure and enforce their right to safe and healthy working.

In addition to these more general effects, the land has particular meaning to indigenous populations and other groups whose health and well-being may be closely tied to a sense of belonging and long-held cultural and societal traditions linked to their land.²⁵⁵

Transportation: Transportation is vital to health, yet also poses health risks. For instance, while vehicles can cause harmful air pollution, access to transportation enables better access to medical care, education, employment, and nutritious food, all essential for health, and helps prevent social isolation. Yet people who are poor may be unable to afford their own vehicles (or taxis or ride-sharing options), and are more likely to live in areas with inadequate public transportation.

At the same time, people of a lower socioeconomic status may nonetheless disproportionately bear the harmful effects of transportation-related air pollution.²⁵⁶ Transportation arteries may be located in areas with low property values, which are often home to low-income and other disadvantaged populations. Lack of political power to oppose polluting transportation infrastructure, such as bus depots, may also contribute to marginalized and disadvantaged populations bearing the heaviest burden of pollution, with the related adverse health consequences.

In addition, road collisions are the single largest cause of fatal injuries globally,²⁵⁷ killing more than 1.2 million people each year.²⁵⁸ Studies have found the incidence of road fatalities highest among people of lower socioeconomic status.^{259,260,261} Lower-income people face added risks, such as owning older cars with fewer safety features, having farther to travel to work because they cannot afford housing closer to their workplaces, or needing walk longer distances on heavily trafficked roads that lack sidewalks. Public transportation might not be accessible to people with disabilities.

Transportation systems can also affect the opportunities people have for physical activity. Strong public transportation systems can enable people to take public transportation rather than cars, and thus

walk from home to the bus, subway, or train, and from there to their destination. Lack of sidewalks also deprives people of an important opportunity for regular physical activity, while lack of bike lanes along busy streets may deter people from biking and adds to the risks of those who do bike.

Government support for easier access to safe transportation for all through better and more targeted urban and transportation planning – including avoiding locating particularly polluted roadways in low-income or otherwise disadvantaged communities – is critical. Design and investments of clean public transportation is key, both for increasing access and reducing pollution. Regulations to increase fuel efficiency further reduce pollution. Better road design also is important, encompassing everything from well-positioned stop signs and traffic lights to structural road features that force drivers to slow down. Sidewalks and bicycle lanes can further encourage physical activity and non-polluting forms of transportation – with the added health benefit that comes with increased exercise. Seatbelt, helmet, child restraint, and other safety regulations, including reasonable speed limits and strong legislation against driving while intoxicated and against distracted driving, will also drive down transportation-related fatalities and injuries.²⁶² Laws should require that public transportation be accessible to people with disabilities.

Recreation and physical activity: With the growing trend towards a sedentary lifestyle a major contributor to many serious health issues like obesity, diabetes, and cardiovascular illnesses, the availability of recreational opportunities to promote physical activity is important to people's health. Physical activity helps to control obesity, boost the immune system, and diminish the risk of disease and increase life expectancy. Along with exercise, recreation facilities also offer numerous social benefits, and when created to be inclusive, help strengthen communities, promote social bonds by uniting families, encourage cultural sensitivity, and support youth, seniors, and individuals with disabilities.

Municipalities can organize sporting and other recreational activities in low-income neighborhoods, and build parks in disadvantaged communities and ensure their upkeep and safety, including having adequate lighting. Schools can structure physical education and recess into students' schedules. Measures linked to other social determinants of health can also facilitate access to recreational opportunities. For example, minimum wage laws, tax credits, and other approaches to boosting income of people with lower incomes may enable low-income individuals to work fewer hours and have time to take advantage of recreational opportunities. Better public transportation can facilitate access to these opportunities.

Commercial determinants of health: The commercial determinants of health involve instances where companies' profit motive conflicts with protecting or promoting health, leading to companies promoting products and activities that harm health. Commercial determinants of health have been defined as "strategies and approaches used by the private sector to promote products and choices that are detrimental to health."²⁶³ These strategies and approaches include how companies market their products, their lobbying efforts, their financing research that supports their interests, and efforts couched in corporate social responsibility initiatives that deflect attention from health harms their products and activities may cause.²⁶⁴

Chief among these harmful products are tobacco, alcohol, and unhealthy foods and beverages, such as sugary drinks. These contribute to many non-communicable diseases, including cardiovascular diseases, lung, liver, and other cancers, and diabetes. Alcohol also

contributes to neuropsychiatric disorders, domestic and other violence including suicide, collisions when people drive while intoxicated, and unintentional injuries.²⁶⁵

Smoking and alcohol use may be more prevalent in poorer or other marginalized and disadvantaged populations (including because they may provide relatively inexpensive approaches to relieving stress or despair, because of aggressive marketing to those populations, and as a response to poverty, unemployment, and despair). Also, the often relatively low prices of unhealthy foods compared to other options, and possibly lower health literacy levels, can lead to increased consumption of these products by poorer or other marginalized and disadvantaged populations.

The Framework Convention on Tobacco Control includes a host of strategies to prevent tobacco use, such as high taxes, smoking bans in public places, advertising bans, graphic warning labels and plain packaging, and prohibitions on their sale to minors. Taxes can also deter use of alcohol and unhealthy foods and drinks. As for other products or harmful ingredients, trans fats may be eliminated either by government fiat or voluntary actions by food companies and restaurants, and other voluntary or mandatory approaches may be taken to food and beverage reformulation (such as reducing sodium and sugar content). Alcohol reduction strategies include marketing restrictions, policies and countermeasures to address drunk driving, regulating the sale of alcohol and the alcohol content of certain beverages, prohibiting sale to minors, and ensuring access to alcohol dependence treatment programs.²⁶⁶

Commercial determinants of health can also encompass other product categories and commercial activities. For example, coal mining causes respiratory illnesses in workers and contributes to air pollution, the fossil fuel industry more generally contributes to climate change, and gambling, another commercial activity, can be addictive, leading to gambling disorder.^{267,268} The patent system, to the extent that it enables high prices of medicines and other medical technologies and health-promoting innovations, and stifles generic competition, could also be considered a commercial determinant of health. Patent laws can be reformed to ensure that the patent system will protect rather than undermine public health. Also, governments can use legal tools such as compulsory licenses and parallel importation where needed to protect the public's health.²⁶⁹

Electricity and technology: Electricity and the host of technologies it enables, such as the Internet, have become modern-day necessities. Electricity is required for refrigeration to keep food from spoiling and to enable clean-cooking options (as compared to solid fuel-burning stoves, a major source of lethal indoor pollution, leading to nearly 4 million deaths per year, including from pneumonia, stroke, heart and respiratory diseases, and lung cancer²⁷⁰). It is also needed for much of our daily lives, such as lighting to enable children to read and do homework when it is dark, and to recharge mobile phones and connect people to the Internet, with the manifold benefits that these may bring (even with their risks, such as increased government surveillance of human rights advocates).

The Internet can be a critical source of health information, and can link people to employment opportunities, to education, to commerce, and to each other. It can enable farmers to access market information and weather forecasts, and link farmers to traders, all leading to the potential to generate more income. Critically, the Internet can also be a source of information about government policies and initiatives, and thus is a central tool for transparency and accountability. The Internet can also enable people to learn about their rights and to organize, and

for people who are in highly marginalized groups to form connections and build alliances with others who are similarly situated.

Along with the importance of these aspects of modernity to individuals, they are critical too for health facilities, which require electricity for refrigerating vaccines and certain medicines, lighting, and more, while the Internet can facilitate access to health information and to connect remote facilities to specialists, and more, such as linking people to social services. Remote facilities serving poorer communities may be the least likely to have electricity and the Internet.

Linking people to the electrical grid can provide access to electricity, as can other clean-energy approaches, such as off-grid solar power units and mini-grids.

Safety/violence: Violence kills some 1.4 million people per year, more than half the result of self-directed violence – that is, suicide²⁷¹ – along with nearly half a million deaths from homicides,²⁷² and an increasing number linked to armed conflicts, reaching 180,000 in 2014,²⁷³ the most since the mid-1980s.²⁷⁴ The health effects of violence extend far beyond these dire statistics and include often debilitating physical injuries. Young people experience about 20-40 non-fatal injuries from violence that require treatment for every death, and attempt suicide 100 times for every attempt that succeeds. Mental health effects of violence include depression, post-traumatic stress disorder, and increased suicide attempts, while violence can also lead to chronic pain syndrome. Violence contributes to tobacco, alcohol, and other substance use, and may contribute to high-risk sexual behavior, with the manifold health harms that accompany these behaviors. Violence is often higher in marginalized and disadvantaged communities with poor access to food, decent housing, and employment, as residents experience pervasive injustices.²⁷⁵

Violence also encompasses sexual, gender-based, and domestic and intimate partner violence; more than a third of women experience intimate partner violence or non-partner sexual violence in their lifetimes. Along with other consequences of violence, this may lead to sexually transmitted infections and unwanted or abnormal pregnancies.²⁷⁶

Beyond the direct effects of violence, fear of violence can lead to stress, which contributes to cardiovascular and the other diseases. And people living in unsafe neighborhoods – largely poor and otherwise marginalized communities – may limit outdoor activities, reducing opportunities for physical activity, social engagement, and potentially even interfering with access to education. Violence may also affect schoolwork, harming a child's education, with education itself a major determinant of good health.

Investments and policies to counter the conditions that create environments ripe for violence – education, employment and economic opportunities, and social support systems, for example – are central to reducing violence. So are investments in mental health care and treatment for substance use disorders and suicide prevention measures, such as reducing access to firearms, pesticides, and other means of suicide; policies to reduce the use of alcohol, and suicide prevention hotlines and other means of community support.²⁷⁷ Early childhood enrichment programs, anti-bullying interventions, life-skills training, and mentoring youth at high risk of violence and assisting them to complete their education and enter employment have all been found to mitigate violence. Also, parents can be trained in using non-violent discipline methods and other aspects of positive child development.²⁷⁸ Streetlights, early closing of bars and nightclubs, and neighborhood watch programs can create safer communities.

Strict gun laws can significantly reduce violence,²⁷⁹ and various gang violence prevention interventions have been highly successful.^{280,281}

Legislation is critical, including to help change gender norms by affirming the full equality of women in every sphere of life – supported by initiatives to enhance women's employment and other economic opportunities – and by treating domestic and sexual violence, including marital rape, as serious crimes. So is training health workers to address violence against women, and developing educational activities, community engagement, and other efforts (e.g., partnerships with the media) to help create egalitarian gender norms.²⁸²

Criminal justice system: The criminal justice system can dramatically affect people's health, both by defining behaviors that are criminalized and therefore determining who is subject to the criminal justice system, and through what happens to a person once arrested, including the conditions and nature of prisons.

People who use drugs are in need of treatment, yet in most countries, drug use is criminalized, often leading to inadequate treatment, if any, and exposing people to the negative health effects of incarceration. Similarly, lack of mental health care often leads people with mental illnesses who commit crimes to be warehoused in prisons, often receiving inadequate or no care.

Criminalizing certain behaviors – engaging in homosexual behavior, sex work, or drug use, for example – having an abortion, or simply living in a country without proper documentation drives people in need of health care and other services underground, foregoing health care and other programs needed for their health. Criminalization may also lead to avoidable, harmful stress and social isolation, and increase stigma.^{283,284} Also in the realm of criminalization, criminalizing peaceful dissent, including through expression and peaceful assembly, restricts the activities of civil society, undermining their ability to hold the government accountable and influence policy, including in health-related areas.

Prison conditions, meanwhile, represent their own health threats. In many countries, overcrowding, poor nutrition, poor sanitation, and inadequate health care in prisons contribute to the spread of diseases, such as TB, which often has a vastly higher incidence among people who are incarcerated than the non-imprisoned population. Inadequate health care also means that chronic conditions may worsen unnecessarily while people are incarcerated, and once released, poor continuity of care between prisons and the community further adds to the health risks for all. Prisoners are often not safe, at risk of violence from both other prisoners and prison staff. And their suicide rates can far exceed those in the rest of the population.²⁸⁵

Countries could avoid or mitigate these health harms through decriminalization (e.g., of sex work, drug use, homosexual behavior, abortion, undocumented immigration status) and reducing prison sentences. In Portugal, decriminalizing use and possession of small amounts of illicit drugs came with notable health benefits, including reduced overdoses and lowered HIV infections, along with many more people who were using drugs seeking treatment.²⁸⁶ And despite a short-lived increase in drug use, overall since decriminalization, "drug use stabilized or declined."²⁸⁷

Prisons must cease to be places that contribute to ill health. Countries should adhere rigorously to the UN Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules).²⁸⁸ Education, employment opportunities, life skills training, and maintaining community connections are among key measures needed to ensure that prisons

are places of rehabilitation, thus positively influencing other determinants of health. Extrajudicial restrictions on formerly incarcerated people, such as employment restrictions, should be avoided except when genuinely necessary to protect public safety.

Critically, countries need to address the underlying circumstances that contribute to criminal behavior, by improving education, employment prospects, and ensuring safety in marginalized and disadvantaged communities, while also developing sufficient levels of safe, affordable housing. Mental health care must become a far higher priority, especially through community-based treatment options.

Gender: People's sex and gender can influence all aspects of their lives. Women and girls are often discriminated against. Maternal health may be underfunded, and limitations placed on sexual and reproductive health services and rights disproportionately harm women. False stereotypes may exist regarding women's health (such as that they are less at risk of heart disease than men, when in fact overall men and women die at similar rates, though symptoms can differ^{289,290}). And because research subjects in clinical trials were more likely to be men in past years, certain health issues for women may be less well understood. Women, particularly when poor, are also more likely to be mistreated by health providers in some societies.

Beyond health care, girls and women may face discrimination in many other areas of life, affecting numerous determinants of health. For example, discrimination against girls (such as parents placing a low value on a girl's education) may keep them out of school or lead them to receive less food and nutrition than their brothers, while workplace discrimination may keep women from well-paying jobs and high-level positions. They are also particularly at risk of sexual, domestic, and gender-based violence. Inheritance laws and property rights, including through application of customary law, may reduce a woman's economic opportunities, while discrimination in family law may leave women subject to abusive husbands or other relatives.

WHO's *Innov8* handbook includes discussions of how gender norms, roles, and relations generate health inequities and policies to address them (see pages 19-21 and 129-132):²⁹¹ <http://apps.who.int/iris/bitstream/handle/10665/250442/9789241511391-eng.pdf>

Gender identity and sexual orientation, meanwhile, are also major sources of discrimination, against transgender people, gays, lesbians, and other members of the LGBTI community. This may lead to discrimination by health providers, a high risk of being subject to violence including suicide, lack of safe employment, and more. Criminal sanctions may also drive members of the LGBTI community underground, avoiding needed health services, and subject them to unsafe and dangerous conditions if this criminalization leads to incarceration.

Along with strong legal protections against discrimination in all areas for women and sexual and gender minorities, other measures can reduce harms as well. These include ensuring robust funding for maternal health and other health services specific to or used more frequently by women; effective use of the criminal law and law enforcement against sexual, domestic, and gender-based violence; ensuring adequate child care to facilitate women's employment; health worker education; engaging community leaders; quotas regarding the minimum number of women in legislative bodies, and; gender-budgeting, where budgets are analyzed on the basis of how they affect gender, traditionally women in particular, and adjusted based on this analysis.²⁹²

Migration: The legal status and other circumstances of the world's tens

of millions of forced migrants (that is, refugees, asylum seekers, and internally displaced persons) and hundreds of millions of other migrants – crossing international borders searching for better economic opportunities or education for their children, seeking to escape environmental degradation or crushing poverty, or to be reunited with their families – greatly affects their health. Discriminatory legal restrictions on health care frequently preclude migrants, particularly those without legal documentation, from participating in national health insurance programs, as well as preventing undocumented immigrants, and often recently arrived immigrants, from participating in other social insurance programs. Even where eligible for health or other social insurance benefits, and with respect to unsubsidized health services open to all who can pay, undocumented migrants may avoid needed care and support because of fear of detention and deportation. While on the move, from their country of origin to another country or leaving the country to which they have migrated, voluntarily or after deportation, migrants are often not ensured of continuity of care for existing medical conditions. Migrants often also face other barriers to health care and other determinants of health, including cultural and linguistic obstacles. They sometimes lack identity documents, which may also prevent them from receiving health or other services.

As a result of factors such as these, migrants may have higher rates of various illnesses. For example, their TB incidence is often considerably higher than that of the overall population.²⁹³ Forced migrants, meanwhile, have often experienced trauma, and suffer from post-traumatic stress disorder or other mental health issues as a result of the circumstances that forced them from their homes.²⁹⁴ Fear of being detected by the authorities and deported can also have mental health consequences and cause toxic stress for undocumented immigrants.²⁹⁵

In some countries, internal migration can also affect health. While such population movements can open up educational and employment opportunities that people may not have nearer home, these migrants – often moving from rural areas to cities – may also feel isolated, be exploited by their employers, and live in slums or shantytowns. In certain countries, like international migrants, they face legal restrictions that limit their access to health care, education, and other social services.

One vital step to alleviate some of these threats to migrants' health is removing legal barriers that exclude or limit the ability of undocumented immigrants and other non-citizens, as well as in some countries internal migrants, to fully access health and other services and benefits on an equal basis as citizens. Consistent with a country's human rights obligations, the state must not discriminate against them with respect to health and other rights. Similarly, undocumented immigrants should be ensured that they will not face any negative consequences (such as detention or deportation, or reduced opportunities for citizenship) for seeking health care or other benefits and programs (e.g., food assistance, education, employment). Proactive measures countries can take to overcome cultural, language, and other barriers migrants may face include ensuring interpretation services, providing health and other information in multiple languages, providing health workers cultural sensitization training and information on particular health issues migrants may face, and hiring health workers and other public service workers from migrant communities. Language education can facilitate the ability of migrants to gain employment. Countries should provide health needs assessments to refugees and asylum seekers, including to ensure that they receive proper mental health care, and should also ensure continuity of care throughout a migrant's journey. This may be facilitated by providing migrants with health passports, physical copies of current treatment and other critical health information.²⁹⁶

Indigenous status: Indigenous peoples constitute nearly 5% of the world's population, living in all regions of the world, across more than 90 countries.²⁹⁷ In some countries, historic wrongs afflicted on these populations reached virtually unimaginable levels, with disease and violence decimating their populations. They have been forced from their historic lands, and their children have been removed from their parents in a cruel effort to assimilate them.

Systematic marginalization and social exclusion persists today. Indigenous people may still be forced from their traditional lands, both depriving them of their livelihoods and sources of good nutrition, as well as depriving them of a central part of their culture. The harms to their health – physical, mental, emotional, and spiritual – can be significant. Their connection to the land can also make indigenous people particularly vulnerable to the effects of environmental degradation and climate change. Governments may fail to recognize indigenous peoples' very existence. Some lack citizenship, or their children are not registered. Living in remote and isolated locations may compound social, political, and economic marginalization.²⁹⁸ They may be subject to overt discrimination, such as mistreatment in health facilities. Health providers might fail to respect their cultural practices.²⁹⁹

As a result of historical and continuing discrimination, many indigenous populations experience higher – sometimes far higher – levels of disease than non-indigenous populations and, in turn, lower life expectancies. They also often suffer from far higher rates of poverty than the overall population, less access to electricity and sanitation, lower levels of education and employment, and in some societies, increased violence and alcohol and drug use.^{300,301}

Ending policies that perpetuate marginalization is one necessary element in enabling indigenous peoples to achieve good health, on par with the rest of the population, including ensuring their mental and spiritual health. Along with recognizing indigenous peoples and ensuring them their citizenship and all rights and benefits of citizenship, their treaty, constitutional, land, cultural, and other nationally and internationally recognized rights must be respected. So must their right to free, prior, and informed consent with respect to government measures that may affect them.³⁰²

Another key aspect to the health of indigenous peoples is enabling community ownership of health and education systems. Health information should be provided in local languages, with tailored messaging, such as by emphasizing the integral role of the community. Indigenous people should have the opportunity to become health workers and partake in other professional opportunities. Supportive policies might include targeted recruitment of and tuition support for indigenous health professional students and locating health worker training institutions near indigenous communities. Non-indigenous health workers should be educated on health-relevant cultural practices, and be held accountable for respecting these practices and treating indigenous people respectfully and without discrimination. Indigenous communities should be provided access to such necessities as health facilities, clean water and adequate sanitation, and electricity.³⁰³ Targeted investment and government programs may also help increase employment. Protecting the environment, including in and near indigenous communities, is necessary as well, as are protections against any unwelcome commercial development. Indigenous peoples should be at the center of all these responses, deciding how best to benefit from the progress of modern society while still protecting their long-held and valued social, cultural, economic, and political institutions.³⁰⁴

Disability: People with disabilities often experience shorter and less healthy lives.³⁰⁵ Often, this is due at least in part, and sometimes

entirely, from pervasive discrimination and exclusion, spanning mistreatment in health facilities to very low levels of employment and access to educational opportunities. People with disabilities are often subjected to violence and abuse, even in facilities that are meant to provide them care. Stereotypes may lead health workers to have mistaken notions about their vulnerability to HIV or other diseases, while they might not understand their medical needs. Children who grow up in orphanages have frequently been subjected to horrific abuse and debilitating neglect, turning lives of potential into ones of isolation, pain, and early death.³⁰⁶ Excluded from public life, and where accommodations are not present and facilities, including sidewalks and public transportation, are not accessible, people with disabilities may be socially isolated. While varying by disability, people with disability overall may be more likely to be obese or overweight and to smoke, and experience higher rates of chronic diseases and a greater risk of exposure to violence as well as of unintentional injuries. Yet despite these risks, they are also less likely to receive preventative health services.³⁰⁷

The Convention on the Rights of Persons with Disabilities³⁰⁸ provides a powerful roadmap for the health and full inclusion of people with disabilities. Central to implementing this Convention is equal protection of the law, removing all discriminatory measures, ensuring the full participation of people with disabilities in all aspects of community life – including the ability to live in the community, with supportive services as needed – and protecting their autonomy, including the freedom to make their own choices.

Towards these ends, governments should require reasonable accommodations for their employment and education, and removal of accessibility barriers for buildings, roads, transportation (including through reduced fares for public transportation), and other facilities, including schools, housing, health facilities, and workplaces, as well as for information and communication services, including the Internet. Mobility aids, devices, and assistive technologies must be affordable (government should remove any taxes placed on them) and otherwise available, and governments should promote universal design principles to facilitate accessibility for all. Governments should also provide or ensure access to early intervention, habilitation, and rehabilitation services, and ensure that health workers and others who work with people with disabilities are properly trained, including to remove stereotypes and to enhance their understanding of the complex medical needs that people with disabilities may face. Education and information campaigns can help eliminate stereotypes about people with disabilities throughout society. Sufficient resources for enforcing all legal protections for people with disabilities will also be necessary.

Special measures may be needed as well to protect people with disabilities from violence, exploitation, and other abuses, including training health providers to recognize signs of abuse, and independent monitoring and investigation and prosecution as required, while providing services to all victims of abuse. Police can be trained in de-escalation techniques for encounters that may involve people with serious mental disabilities, as well as in linking them to social services.

To prevent and reduce poverty of people with disabilities, social insurance programs should include people with disabilities, including disability-related expenses. Along with mandated reasonable accommodations, governments could set appropriate hiring targets.

Social, economic, political, and legal exclusion and discrimination: Societal exclusion entails people being unable to participate fully in a society's economic, social, political, and cultural life, as well as the processes leading to and sustaining such a state.³⁰⁹ People from

populations experiencing such exclusion include people who are poor, indigenous peoples, and people with disabilities, among many others, though to highly varying degrees across populations and countries. They are, in general, more likely to be unemployed or under-employed and to earn lower wages, to have less access to health care and social services, to have lower levels of education, and so forth. Exclusion thus accentuates the impact of negative social determinants of health while lessening people's ability to benefit from positive determinants. Exclusion is thus a fundamental structural determinant of health, underlying, perpetuating, and reinforcing health inequities. Among other dynamics, excluded groups may be concentrated in specific neighborhoods, furthering their exclusion and, because of that exclusion, have less political power and fewer economic opportunities. Often that makes such areas or communities ones subjected to high levels of pollution, poor housing, and higher levels of crime, along with reduced opportunities for employment, health care, quality education, recreation, and other contributors to good health.

Responses central to reducing such exclusion include addressing such structural determinants as political participation and empowerment and control over resources (both discussed below). Interventions in other areas that increase inclusion in particular spheres (e.g., health systems, education, and employment) will help as well. Discriminatory laws need to be repealed or reformed, and proactive inclusionary measures like affirmative action considered. With respect to concentrated areas of exclusion, actions may include efforts to promote integration (e.g., housing vouchers that may be used anywhere) and drawing investments into these areas (including coordinated efforts across government, the private sector, and educational institutions).

Control over resources, institutions, and decision-making: Closely related to social exclusion, and one of the structural determinants of health, is who controls resources, institutions, and decision-making, both within and outside of the government. Who are the leaders of the schools and school systems, health facilities and health systems, housing authorities, corporations, prisons, and other institutions that shape health systems and other determinants of health? Who leads these institutions determines who establishes their priorities and makes their rules, and the degree to which institutions implement measures to become more inclusive – and affects whether these institutional leaders understand the contexts of marginalized and disadvantaged communities. This can affect whether these institutions are structured and work to benefit those who are wealthy and already powerful, including private economic interests, or whether they can be transformed to benefit everyone equitably, serving the public interest and those who currently are and have historically been disadvantaged.

Some of the measures to address social exclusion can also enable marginalized and disadvantaged populations to have a more equitable level of control of how society's resources are allocated and of authority in its institutions, and thus in the decisions taken in all sectors that may influence health. Particularly important with respect to the ability to have greater control over institutions is to develop policies that enable people in marginalized and disadvantaged populations to rise into positions of leadership within those institutions. Different criteria for leadership roles may need to be considered; seniority, for example, maybe disfavor populations whose members hold few senior positions due to a history of exclusion. Institutions should expressly consider how to become more inclusive, including in their leadership, control, and decision-making, with members of marginalized and disadvantaged communities being among those who decide on what changes may be needed. In a world where power and wealth remain closely linked, financial reforms (such as through the tax

system) can contribute to fairer institutional control. Political leadership will be crucial, as leaders of government agencies and institutions like education systems are often in the hands of elected officials. Developing a political leadership that embraces a fair distribution of power and control will require political empowerment of marginalized and disadvantaged communities, a determinant of health to which we now turn.

Political empowerment: No institution shapes society more than the government through its laws, regulations, and programs. These structure the health system itself and other institutions critical to the social determinants of health, including structural determinants like the distribution of income and other resources. Given this, ensuring that people from populations experiencing health inequities are full participants in the political system is one of the basic structural requirements of achieving health equity. Yet very often, these populations lack fair political voice and full representation, reducing their ability to influence government decisions that could affect their health. These populations, therefore, need to have the political power to influence laws and policies, have a say in who represents them, and themselves be able to hold influential political offices.

Policies and processes are needed to enable all groups in society to have fair political representation and participation. Civil and political rights must be guaranteed to enable all voices, including those that are disfavored, to be heard, and to enable members of all populations to participate in the political process – and to believe that their participation can make a difference. People need to know their rights so that they can effectively engage the political process to secure them, bolstered through established effective systems for accountability – or developing such systems. Election systems should encourage participation, such as easy or automatic voter registration procedures. Investments in updating voter rolls and sufficiently staffing polling stations may be needed. Voting districts should be fairly drawn, and fairly designed systems of representation equitably designed so as not to favor more politically powerful constituencies.

Specific measures to politically empower marginalized and disadvantaged populations may also be needed. These could include targeted voter registration and get-out-the-vote drives, outreach, and ensuring that voting materials are accessible to people who have little education or do not speak the country's main languages or who are disabled. Legislative bodies could have quotas or targets to promote more diverse representation. Political parties have an important role in nurturing and selecting candidates from disadvantaged populations.

Governance and corruption: The quality of governance, including the nature and extent of corruption, is a determinant of health that can affect a wide range of other determinants. At one level, grand corruption – corruption that typically involves significant sums of money and higher level political issues, such as when the state provides projects to favored contractors at inflated prices, with some of the funds illegally diverted to government officials' private (or perhaps campaign) bank accounts – robs the state of critical resources. This drains government coffers, reducing funding available for state actions on other determinants – health care, education, affordable housing, water and sanitation, and so forth – including programs that could particularly benefit marginalized and disadvantaged populations. This form of corruption may also lead contractors to cut corners, which could result in unsafe housing or other unsafe facilities and infrastructure, such as roads and bridges. And it can lead politicians to become beholden to private interests rather than the public good. Similarly, apart from corruption, activities that may be legal – like large campaign contributions and easy access to politicians by corporate lobbyists – can

also lead politicians to choose to support private rather than public interests. Those private interests may be at odds with public health (e.g., producers of unhealthy foods and beverages or other products and services).

Meanwhile, petty (smaller scale) corruption occurs in people's everyday interactions and manifests itself in their daily experiences. People may have to pay for health services that are supposed to be free. Health workers and teachers may be absent without any valid reason, but be paid nevertheless. Housing inspectors might turn a blind eye to infractions of codes on safe and habitable housing. Teachers might be chosen because they pay bribes to get their jobs or promotions, rather than because of their ability to teach children. Bribes to police and judges can distort the criminal justice system and lead people to distrust law enforcement personnel and lose confidence in the courts. These harms of corruption are particularly likely to affect poor and other marginalized and disadvantaged populations who cannot afford to pay officials and cannot afford private alternatives that might be free from corruption.

One pillar of corruption reduction is effective law enforcement, including comprehensive laws with criminal penalties, independent courts, and empowered and independent prosecutors. Another is a free and independent media, which can bring corrupt officials and behavior to light. Transparency, including through right to information laws, can reveal corruption. It can also empower the public, such as to know which health services are supposed to be available without any charge, and what resources – staffing and funding, for example – their local health facilities and other public institutions, such as schools, are supposed to have. Adequate pay for health workers and other public servants may reduce the necessity they may feel to illegally demand payments. Leadership from the top is also critical, though without changing systems and incentives, is unlikely to be sufficient.

Participatory and accountability government structures: As described earlier in this guide in the chapter on empowering participation and inclusive leadership, developing structures and processes that enable people to participate in health-related decisions is a matter of people's human rights. And such structures are critical to enabling government institutions to meet the needs of marginalized and disadvantaged communities, as members of these communities have the best understanding of their realities and priorities, and can offer unique insights on how proposed policies and programs might affect them. Their perspectives are also foundational to any comprehensive approach to accountability, as they can share – and insist upon – answers from public officials when promised services are not being delivered, or new policies have not led to better practices. Such processes are all the more important for marginalized and disadvantaged populations who, absent established processes for participation, possibly along with active outreach to facilitate their participation, may lead to their views being least likely to be heard and listened to during the ordinary course of public policymaking.

The end of the chapter on the principle of comprehensive accountability described a number of examples of what these structures might be. They include multi-stakeholder health bodies (that include community members) with decision-making authority, funded and fully functioning village health or health center committees, health equity dialogues, structured forums for input into the legislative process, health equity impact assessments, community auditing of local budgets, and public notice and comment periods on proposed policies and regulations.

Structured intersectoral collaboration mechanisms: As highlighted throughout this Annex and in the chapter on health systems and the

social determinants of health, many sectors affect health. To improve their contributions to health equity, each sector needs to orient towards both health and equity. Engaging health ministry officials and other leaders in the health sector – as well as community members – will be important to enable all sectors to fully understand how their policies and activities may contribute to or undermine health equity, and what changes would most contribute to health equity.

In addition, policy, programmatic, and on-the-ground collaboration among sectors will be needed. To take several examples: Health programs should link to such sectors as housing, nutrition, and the environment, since inadequate or poor housing, poor nutrition, and pollution may be the immediate cause of ill health. Law enforcement and the judicial system should establish close ties to the health system and social service providers to ensure that people who come into contact with law enforcement or who enter the criminal justice system can, as appropriate, be diverted to mental health services, drug or alcohol treatment programs, or other social services. The social welfare and agriculture sectors can collaborate to help ensure that people with lower incomes can access healthy foods. Collaboration between the agricultural, health, and environmental sectors can help ensure good practices to reduce animal-to-human disease transmission and safety for agricultural workers. The health and financing sectors can collaborate to develop health-promoting taxes, such as introducing a sugary drink tax and increasing taxes on tobacco and alcohol products. And law enforcement should work with the health sector to enable a common understanding about the importance of policies that enable immigrants to understand that they can access health services without fear that they might be turned over to law enforcement if they lack proper documentation. Similarly, people who use drugs should be able to access harm reduction programs without fear of arrest.

To make certain that these linkages are established, there should be standing intersectoral bodies focused on health equity that meet on a regular basis. These should exist at the national level, with regular interministerial discussions, and could also be replicated at other levels of government. Specific linkages between health and other sectors, and indeed among and between other sectors – interagency groups, structured dialogues, and liaisons, for example – may well also prove beneficial.

Disaggregated data and health equity monitoring, evaluation, and research: Understanding health inequities is key to successfully eliminating them. Data that is disaggregated across the many dimensions of health inequity – from such commonly measured categories as wealth, sex, and rural/urban residence to more neglected dimensions of data disaggregation such as disability, migratory status, and gender identity – is foundational to this understanding. This data needs to be monitored and analyzed to better understand whether policy interventions are making a difference, so that policies can be continued, discontinued, or modified as appropriate, and new interventions tried. More extensive research and policy and program evaluations can reveal whether policies and programs are having their intended effects on health equity, what the underlying causes of inequities are for different populations, and what interventions might be most effective.

Given the insights that populations experiencing health inequities will have on these questions, full partnerships with them in these efforts are vital. As data is collected and used, protections are needed to ensure that people's privacy and confidentiality are protected and data is not misused. Partnerships with marginalized and disadvantaged populations, who might distrust government, is important to

assuage concerns they may have about their privacy and to help ensure that these data protections are robust.

Civil society and media enabling environment: Both civil society and the media have vital roles in ensuring governmental accountability. Among other contributions to accountability, media outlets can uncover corruption and mismanagement and inform the public on how realities, even in far-flung communities, compare to official pronouncements and policies. Civil society actions can also promote government accountability to their obligations and their commitments, and to the public, including members of marginalized and disadvantaged populations. Civil society organizations can also help governments develop innovative policies to improve health and health equity by serving as mediators between marginalized and disadvantaged populations and the government, can help empower these populations to directly engage policymakers, and can offer their own innovative policy proposals. NGOs, including community-based organizations, can also directly serve these populations, helping ensure that health and other programs reach even the most marginalized and the most remote populations.

For civil society organizations and media organizations to carry out these functions requires that governments adhere to their obligations to protect the freedom of expression, press freedoms, and the rights of peaceful assembly and of free association. Governments must avoid (or repeal) restrictive laws, such as those that limit foreign funding for NGOs, that curtail their autonomy or restrict the issues they may address, or that erect bureaucratic barriers that impede their activities. In countries where civil society advocates and journalists face threats to their safety, governments must make every effort to protect those at risk and investigate and prosecute crimes against activists and members of the media. Affirmative measures, too, are important for creating enabling environments for civil society, such as providing funding (though to maintain their independence, many civil society organizations will not accept government funding) and offering capacity-building opportunities.

Vital (civil) registration systems: Vital registration systems collect data related to key events in people's life – including births, deaths, and causes of death – as they occur, as well as basic demographic information related to these events, such as age and sex. Other vital events that such systems may capture include fetal deaths, marriages, divorces, and adoptions.³¹⁰ This information is critical for health planning, as well as for public planning and policy formulation in many areas with significant health implications.³¹¹ Understanding who is dying and why enables longer-term program and health planning as well as real-time monitoring that can be critical for interventions in ongoing health crises, such as to support contact tracing during fast-moving epidemics.³¹²

Registration systems are also “fundamental to a person's right to an identity and the entitlements that go with it.”³¹³ Having one's right to health and related rights fulfilled may depend on one's birth – that is, one's very existence – being registered. These related rights include the rights to food security, education, and social security.³¹⁴

Yet despite the importance of these registration systems, about two-thirds of deaths globally, and almost half of all births, are not registered.³¹⁵ Registration systems are weakest in poorer countries. Perversely, the very fact of a group's marginalization may mean that members of that already disadvantaged population are less likely to have their life experiences, including their births, registered, which can then exacerbate their marginalization.

Funding, proper training to ensure that relevant staff understand registration system protocols, recruiting skilled professionals (e.g., demographers, epidemiologists), and making certain that these systems cover all geographic areas (including rural and other remote regions) are all required to strengthen vital registration systems. Registration systems should be computerized and be integrated with one another and with existing record-keeping (including hospital and medical records).³¹⁶ Strengthening registration systems may mean updating existing laws or enacting new ones.³¹⁷ Emerging technologies, such as geo-mapping, can facilitate collecting birth registration.³¹⁸

Adequacy and equitable mobilization and distribution of financial resources: Many measures to advance health equity will require government investments, in health care, education, child care, worker training, social insurance, and more – even as improvements in health and health equity will lead to improved productivity and thus economic growth. The level of resources that governments can mobilize – domestic resources (e.g., through taxes, royalties, and fees) and, for some countries, international financing – will determine the level of investments that governments can make.

The impact of these investments on health equity also depends on how equitably funds are distributed across populations. Are poorer and other populations experiencing health inequities receiving a higher proportion of public expenditures? Or are public resources focused on better off populations, such as more generous health insurance benefits for civil servants, or more funding for wealthier school districts, or agricultural subsidies that benefit agribusiness rather than smallholder farmers? Such approaches stand to exacerbate health inequities. Stewardship of these resources is vital, as similar levels of government expenditures could have vastly differing effects on health equity based on the effectiveness and efficiency of those expenditures.

How resources are raised will also affect health equity. How progressive are tax systems, for example? This depends on factors such as tax rates across different income levels, whether wealthier or poorer taxpayers benefit from income tax deductions and credits, the proportion of individual tax payments coming from income taxes and from generally regressive value added or sales taxes (which, unlike income taxes, do not vary by a taxpayer's income), and the level of corporate tax rates and extent of corporate tax breaks. Also, what royalties does the government gain from corporations that extract natural resources? How the government raises its revenue will affect people's incomes, one of the most important social determinants of health, and the government's overall revenue, and thus its capacity to devote its financial resources to advancing the social determinants of health.

Annex 2: Incorporating Health Equity Programs of Action Into National Health Plans

As emphasized in this guide, national health plans and strategies have the potential to be a central vehicle for developing health equity programs of action. As we have seen, seven principles underlie health equity programs of action: 1) empowering participation and inclusive leadership; 2) maximizing health equity; 3) encompassing the health system and social determinants of health; 4) every population counts; 5) specificity and measurability, with actions, targets, and timelines; 6) comprehensive accountability, and; 7) sustained high-level political commitment. These are often loosely incorporated into national health plans and their processes. For example, plans may focus on equity in some areas, such as bridging the rural/urban divide, increasing services in underserved regions and communities, and increasing access for people with limited financial means, and may include some measures to address health needs of certain populations, like women and people with disabilities. Health plans may also extend beyond the health sector to cover such determinants of health as clean water and sanitation, nutrition, and a healthy environment. They will often include specific targets and timelines, with a monitoring and evaluation process to assess progress towards these targets. Community members may be consulted as the plans are developed, and other ministries may also provide input.

Plans that take these approaches are already on the path to incorporating health equity programs of action – but are not fully there. Every country will have its own plans, processes, and contexts, some far further along the path than others towards robust, comprehensive, and prioritized approaches to health equity. In this Annex, we offer key points to consider when developing national health plans based on the health equity program of action framework. Incorporating these points should ensure that countries have established a strong foundation for action towards health equity, national health plans that will offer great promise towards eliminating one of the most destructive of social injustices, inequities around the opportunity to live a long and healthy life, while accelerating action towards equitable universal health coverage and achieving the SDG promise of leaving no one behind.

1. A People's Plan: Empowering Participation & Inclusive Leadership

Public participation

- Are there processes to enable widespread public participation in developing the plan?
 - Do these include mechanisms that have a particular focus on health equity, such as national dialogues on health equity?

Marginalized and disadvantaged populations and decision-making

- Do members of marginalized and disadvantaged populations have central decision-making roles in the scope, priorities, content, and other aspects of the national health plan?
 - Do these decision-making roles extend to decisions around the specific actions to be included in the plan?
- Does the process of developing the plan include outreach to and participation of members of all populations experiencing health inequities for their perspectives, including their priorities and their views on the greatest obstacles they face to achieving good health and on measures for improving their health?
 - Is there adequate funding to support the participation of diverse members of populations experiencing health inequities in developing the national health plan?
 - Is their input systematically considered and prioritized for incorporating into the national health plans?
- Does the process of developing national health plans include measures, such as targeted capacity-building, to enable members of marginalized and disadvantaged communities to know their rights and to have the confidence to engage policymakers in order to enable their meaningful participation?
- Do members of populations experiencing health inequities have the opportunity to review and validate the final draft of the plan, ensuring that their priorities and perspectives are incorporated, and have the opportunity to recommend changes in cases where these are not adequately addressed?

Leadership roles for marginalized and disadvantaged populations and inclusive governance

- Are members of marginalized and disadvantaged populations part of the leadership process of developing national health plans, from determining their priorities and scope through their completion?
- If a task team, steering committee, or other defined group is leading the development of the national health plan, does it include members of diverse populations experiencing health inequities? If the group has a chair (perhaps from the ministry of health), is a member of a marginalized or disadvantaged community a co-chair?
- Does the process of developing national health plans include forums where members of marginalized and disadvantaged communities and policymakers can meaningfully engage each other, gaining a better understanding of their respective perspectives?

2. Maximizing Health Equity

- Is reducing and ultimately eliminating health inequities an explicit goal of the plan?
- Does the plan address deep, systemic causes of health inequities?

- Does it address the inequitable distribution of power, money, and other resources?
- Does it address the ability of marginalized and disadvantaged populations to have a meaningful say in the political system?
- Does it address systematic exclusion of certain populations from positions of authority within societal institutions?
- Does the plan address corruption and governance (which often disproportionately affects poor and other marginalized and disadvantaged populations)?
- Have transnational factors (e.g., climate change, migration) been considered and addressed in formulating the plan's actions?
- Did these considerations include ways in which transnational factors contribute to health inequities domestically, and how to mitigate any harms?
- Do these actions respond to ways in which the country's own policies and actions may contribute to or mitigate health inequities in others countries in order to ensure a more positive impact on health equity globally?

3. Health Systems and Beyond: Addressing All Social Determinants of Health

Health systems

- Does the health plan comprehensively address equity within the health sector? Among others factors:
 - Does it address any inequitable distribution of health workers, facilities, services, and funding?
 - Does it address discrimination within the health sector?
 - Does it address affordability, including indirect costs, such as transportation?
 - Does it address any legal barriers that may limit the ability of certain populations (e.g., immigrants) to receive health coverage?
 - Does it address the diversity and the linguistic and cultural competencies of the health workforce?

Social and other determinants of health

- Does the plan address all social, environmental, economic, and political determinants of health (including structural determinants), or has there been a process to determine the most important determinants, with these being addressed?
 - Does the plan address equity with respect to these determinants, or is it linked to strategies for other determinants that do thoroughly address equity?
- Do the plan's actions encompass any reforms needed in laws and policies with respect to different determinants and how they affect health equity?
 - Do these actions encompass improving any shortcomings with respect to implementing and enforcing laws and policies that promote health equity?
- Is each determinant of health considered in the plan reviewed systematically for each population experiencing health inequities?
 - If the plan is only addressing certain prioritized determinants of health, is there scope to address additional determinants for certain populations where these are particularly important?

Intersectoral and multi-stakeholder engagement and processes

- Are all sectors that impact health and health equity (which will be most sectors) involved in developing the health plan?
 - Are a wide range of stakeholders – governmental and members of marginalized and disadvantaged populations, along with others including civil society organizations, academics, human rights bodies, health professional associations and other service provider representatives, international partners, and private sector representatives – involved in developing the health plan?
- Is there an intersectoral body focused on health to enable effective coordination across ministries as part of a Health in All Policies approach?
 - Do different sectors and their ministries incorporate equity, including contributing to health equity, as an explicit part of their mandates?
 - Is each sector that has a role in health equity required to produce annual statements on measures it is taking to address health inequities?
 - Do each of these sector's own targets and indicators address equity and encompass targets and indicators that may be relevant to health and health inequity?
- Does the plan set standards, including through plans for legislation if not already in place, for widespread use of health equity impact assessments?

4. Every Population Counts

Systematic approach

- Does the plan systematically identify each population that is experiencing health inequities?
 - For each population identified, does the plan take a systematic approach to understanding the extent of health inequities, their causes, and the strategies and actions needed to address them?
- Do members of populations experiencing health inequities have a central role in contributing to strategies and actions that relate to those populations, as well as the understanding of the health inequities on which these strategies and actions are based?

Sub-populations and multiple identities

- Does the plan account for sub-populations (e.g., different categories of migrants, different types of disability, different indigenous populations), and different situations they may be experiencing in regard to health equity and measures required to address these inequities?
- Does the plan account for layered discrimination that many individuals face, where people's multiple identities may lead to a unique set of obstacles to achieving health equity?

Research

- Does the plan include a strategy for further research on health inequities to fill knowledge gaps as to their present extent and nature, their causes, and approaches to addressing them?

5. Actions, Targets, and Timelines

Diverse and systematic actions

- Does the plan, or accompanying documents, identify specific actions to systematically address health equity across populations and determinants of health?
 - Do these actions address the full range of factors underlying health inequity that have been identified, or at least those that have been identified as priorities, particularly by populations experiencing health inequities?
- Do the actions include "quick wins" along with actions needed to address systemic causes of health inequities over the longer term?
- Do actions include measures to address any discrimination and mistreatment that members of marginalized and disadvantaged populations may face when accessing health services?

Taking responsibility

- Do the actions identify, as specifically as possible, the entities responsible for carrying them out?
- Do the actions encompass those that non-governmental entities (such as health professional associations) will need to take?

Targets

- Does the plan include targets on health equity?
- Are the targets accompanied by timelines for achieving them?

Costs

- Does the plan include, wherever possible, the budgetary implications of its actions?

6. Accountability

Accessibility

- Is the national health plan genuinely accessible to the public?
 - Is the plan accessible to people who do not speak the country's primary language(s)?
 - Is the plan accessible to people who are living with disabilities?
 - Is the plan accessible to people who are illiterate or have limited education?

Integrating and monitoring health inequity in all sectors

- Are the actions of non-health sectors fully integrated into their own plans and strategies, as well as their budgets?

Monitoring and evaluation

- Will there be regular reporting on how the plan is being implemented, including with respect to progress towards achieving its targets?
 - Does this monitoring and evaluation process include an analysis of plan implementation, including reasons that benchmarks and targets are not being or are not on track to be met, as well as measures needed to address any shortcomings in implementation? Are there mechanisms to ensure that these measures will be taken?
- Does the plan include measures to strengthen data disaggregation?
 - Do data disaggregation actions include disaggregation regarding health status, health services, and health outcomes?
 - Do data disaggregation actions encompass not only the health sector, but also sectors related to other determinants of health?
- Does the plan include forums to ensure a continued high-level national commitment to health equity?
 - Do these forums enable civil society and community members to provide policymakers with their own perspectives on how the plan is being implemented and what measures could improve implementation?

Local action

- Does the plan include measures that will stimulate local actions for health inequity? For instance:
 - Does the plan include establishing legal mandates for sub-national jurisdictions to act on health equity?
 - Does the plan provide for technical support for sub-national jurisdictions?
 - Does the plan include funding for pilot programs?

Capacity building

- Does the plan include measures to increase capacity at community, district, provincial (state), and national levels for improving health equity? For instance:
 - Does the plan include right to health education, including for health workers?
 - Does the plan include training local officials on health inequity monitoring?
 - Does the plan include measures to promote government agencies hiring staff from marginalized and disadvantaged populations?
 - Does the plan cover any needs that government agencies may have to develop and fill positions for staff who are focused on health equity, or on equity more broadly?
 - Does the plan include ensuring that within different agencies and ministries whose mandates affect health equity, individuals or offices that hold these responsibilities are clearly identified?

Health accountability measures

- Does the plan include measures to strengthen health accountability at all levels?
 - Possibilities include:
 - public education on the right to health
 - functioning village health committees
 - complaint mechanisms
 - community scorecards
 - community audits
 - mobile phone technology for health user feedback and monitoring
 - improved access to justice
 - enabling environments for civil society
 - civil society capacity-building
 - laws guaranteeing people's right to participate in health-related decision-making
 - parliamentary hearings
 - annual audits of sectoral strategies and actions against the national health plans and its equity actions

7. Sustained High-Level Political Commitment

- Does the plan include specific measures to ensure a continued high-level commitment to health equity? For instance:
 - Does the plan provide for annual or other regular national dialogues on health equity?
 - Does the plan establish a high-level government position or entity to oversee health equity efforts throughout the government?
 - Does the plan include media training on health equity to enhance media coverage?

Annex 3: Additional Resources

Note that while we categorize resources below into the category that seems most relevant, a number of resources pertain to several areas.

General resources

Health equity assessments

World Health Organization, “HEAT: Health Equity Assessment Tool,” http://www.who.int/gho/health_equity/assessment_toolkit/en/

This tool is a software application that both includes data from WHO’s Health Equity Monitor and enables users to upload their own data at the national and sub-national levels across a range of health indicators and dimensions of inequality. Users can explore health inequality across these dimensions and indicators, as well as how these inequalities change over time, and can compare inequalities across different settings.

World Health Organization, *Urban HEART: Urban Health Equity Assessment and Response Tool* (Kobe, Japan: WHO, The WHO Centre for Health Development, Kobe, 2010). http://apps.who.int/iris/bitstream/handle/10665/79060/9789241500142_eng.pdf

This guide can be used to identify inequities in urban settings and plan actions to respond to these inequities, taking a holistic approach. Along with this guide, a user manual for *Urban HEART* is available through: <http://apps.who.int/iris/handle/10665/79060>

World Health Organization, *Towards Universal Coverage for Preventive Chemotherapy for Neglected Tropical Diseases: Guidance for Assessing “Who Is Being Left Behind and Why”* (Working draft for further piloting during 2018-2019) (Geneva: WHO, 2017). <http://apps.who.int/iris/bitstream/10665/259487/1/WHO-FWC-17.3-eng.pdf>

This guidance provides a module that can be used to identify specific barriers affecting the effectiveness and equity of preventive chemotherapy coverage for neglected tropical diseases, and to use the data collected and analysis to develop plans of action to respond to the findings. The processes, concepts, and questions covered in the guidance may also inform analysis and action in other health areas.

World Health Organization, Regional Office for Europe, *Barriers and Facilitating Factors in Access to Health Services in the Republic of Moldova* (Copenhagen: WHO Regional Office for Europe, 2012). http://www.euro.who.int/__data/assets/pdf_file/0018/183510/e96775-final.pdf

This policy paper provides an example from Moldova of how the five domains of coverage measurement in the Tanahashi framework – availability, accessibility, acceptability, contact, and effective coverage – can be used to identify barriers to and factors that can facilitate equitable access of health services. It also shows how factors outside of the health care sector affect the framework’s dimensions of health coverage.

World Health Organization, Regional Office for Europe, *Barriers and Facilitating Factors in Access to Health Services in Greece*

(Copenhagen: WHO Regional Office for Europe, 2015). http://www.euro.who.int/__data/assets/pdf_file/0006/287997/Barriers-and-facilitating-factors-in-access-to-health-services-in-Greece-rev1.pdf

This report is a comprehensive study of barriers to accessing health services in Greece, and factors that can facilitate equitable access to health care, using the Tanahashi framework dimensions of health coverage as the assessment framework, and drawing on both a desk review and interviews.

WHO Regional Office for Europe, *Review and Reorientation of the “Programme for Active Health Protection of Mothers and Children” for Greater Health Equity in the Former Yugoslav Republic of Macedonia: Roma Health – Case Study Series No. 2* (Copenhagen: WHO Regional Office for Europe, 2015). <http://www.who.int/life-course/partners/innov8/case-study-2-macedonia/en/>

This case study describes one approach to reviewing the equity of health programs, here using an equity review analysis known as EQUITY, drawing on this approach to analyze barriers that vulnerable women and children (especially Roma) face to benefitting from maternal and child health programs and to develop recommendations to respond to these barriers. It focuses specifically on the distribution and use of the Maternity Card.

Health in All Policies and intersectoral action

World Health Organization, *Intersectoral Action on Health: A Path for Policy-makers to Implement Effective and Sustainable Action on Health* (Discussion paper) (First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, Moscow, Russia, April 28-29, 2011). http://www.who.int/nmh/publications/ncds_policy_makers_to_implement_intersectoral_action.pdf

This document summarizes a set of approaches to intersectoral action on health and offers a 10-step approach to intersectoral actions on health. It also offers several examples, including from Vietnam, South Africa, and Ghana, covering intersectoral collaboration on public health issues including extractive industries, mental health, and physical activity’s role in improving health. The document also summarizes key lessons learned on intersectoral action on health.

Carmen de Paz, Nicole B. Valentine, Ahmed R. Hoseinpoor, Theadora Swift Koller and Megan Gerecke, *Intersectoral Factors Influencing Equity-Oriented Progress Towards Universal Health Coverage: Results From a Scoping Review of Literature* (Geneva: World Health Organization, 2017). <http://apps.who.int/iris/bitstream/10665/255607/1/9789241512329-eng.pdf>

This review of literature provides users with a framework that helps identify intersectoral barriers (such as socioeconomic constraints, social norms, and physical barriers), which are largely outside the health sector’s immediate control, to universal health coverage. The review covers both general health services as well as specific areas such as maternal health, HIV prevention, diabetes treatment, and treatment for depression.

Erik Blas, Nathalie Roebbel, Dheepa Rajan and Nicole Valentine, “Chapter 12. Intersectoral Planning for Health and Health Equity,” in Gerard Schmets, Deepha Rajan, Sowmya Kadandale (eds.), *Strategizing National Health in the 21st Century: A Handbook* (Geneva: World Health Organization, 2016). <http://www.who.int/healthsystems/publications/nhpsp-handbook-ch12/en/>

This chapter on intersectoral planning, part of a WHO handbook on health planning in the 21st century, explains the importance of intersectoral action as a component of national health planning processes, the role of the health sector and other sectors, as well as how to go about planning for and implementing intersectoral actions, including situational analyses, intersectoral policy dialogues, and monitoring and evaluation. It also points to the lack of comprehensive intersectoral integration into health planning processes at present.

World Health Organization, “Contributing to Social and Economic Development: Sustainable Action Across Sectors to Improve Health and Health Equity (Follow-Up of the 8th Global Conference on Health Promotion): Report of the Secretariat,” WHA 68/17, May 18, 2015. http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_17-en.pdf

WHO’s draft framework aims to guide member states on taking country-level action across sectors in their efforts to improve health and health equity, whether for particular health programs or for a comprehensive approach. Along with explaining the importance of actions across sectors and underlying values and principles, the framework explains six components of implementing health actions across sectors, such as establishing priorities, identifying support structures, building capacity, and evaluating and monitoring and evaluation mechanisms.

World Health Organization and Public Health Agency of Canada, *Health Equity Through Intersectional Action: An Analysis of 18 Country Case Studies* (2008). http://www.who.int/social_determinants/resources/health_equity_isa_2008_en.pdf

This analysis draws on 18 case studies from around the world and across a diverse set of issues (e.g., housing, mental health for indigenous youth, infrastructure development, reducing life expectancy disparities) to offer lessons on successful intersectoral actions, along with obstacles, the importance of monitoring, and innovative approaches.

Government of South Australia and World Health Organization, *Progressing the Sustainable Development Goals Through Health in All Policies: Case Studies From Around the World*. (Adelaide, Australia: Government of South Australia, 2017). http://www.who.int/social_determinants/publications/Hiap-case-studies-2017/en/

This publication shares 13 case studies of the Health in All Policies approach in action, with overviews of experiences combined with reflections on lessons learned, challenges, and ways forward.

Douglas Dover and Ana P. Belon, “The Health Equity Measurement Framework: A Comprehensive Model to Measure Social Inequities in Health,” *International Journal for Health Equity* (2019) 18:36. <https://equityhealth.biomedcentral.com/articles/10.1186/s12939-019-0935-0>

The Health Equity Measurement Framework provides a comprehensive approach to analyzing and understanding the direct and indirect effects of social determinants of health on health equity by identifying pathways through which these determinants can affect health, including how they affect health service utilization. It can be used to help identify intervention points for public policies. The framework encompasses the socioeconomic, political, cultural context; the social stratification process and social location; material and social circumstances; biology; the environment; health-related beliefs and behaviors; pre-existing health states; psychosocial factors; appraisal and coping; the stress response; health state; perceived and evaluated needs; the health policy context; the availability of health-promoting

resources and their uses; the accessibility, acceptability, appropriateness, safety, effectiveness, and continuity of care, and; health outcomes.

Health equity monitoring

World Health Organization, *Handbook on Health Inequality Monitoring: With a Special Focus on Low-and Middle-Income Countries* (Geneva: WHO, 2013). http://apps.who.int/iris/bitstream/handle/10665/85345/9789241548632_eng.pdf

This handbook introduces concepts in health equity monitoring, and provides a step-by-step approach to such monitoring. It uses examples from low- and middle-income countries. An accompanying series of PowerPoint lectures based on the handbook is available at: www.who.int/gho/health_equity/handbook/en/

WHO Regional Office for Europe, *Barriers and Facilitating Factors in Access to Health Services in the Republic of Moldova* (Copenhagen: WHO Regional Office for Europe, 2012). http://www.euro.who.int/data/assets/pdf_file/0018/183510/e96775-final.pdf

This manual explains the importance of carefully monitoring national health inequalities and how to incorporate such monitoring into the regular practices of national health information systems. The guide details a 5-step cycle for this health inequality monitoring.

World Health Organization, *Global Monitoring of Action on the Social Determinants of Health: A Proposed Framework and Basket of Core Indicators* (Geneva: WHO, 2016). http://www.who.int/social_determinants/consultation-paper-SDH-Action-Monitoring.pdf

This consultation paper introduces users to the Global Monitoring System for Action on Social Determinants of Health proposed by WHO. It explains the guiding principles and structure of the proposed monitoring framework, along with the proposed core basket of indicators. The structures draws on domains based on the objectives of the Rio Political Declaration on the Social Determinants of Health, and the indicators are chosen from the indicator framework for the Sustainable Development Goals, as well as from a variety of WHO and other indicator databases and sources.

Health equity programming

Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health* (Geneva: World Health Organization, 2008). http://www.who.int/social_determinants/thecommission/finalreport/en/

This landmark report drew global attention to the social determinants of health, pointing to the reality that “[s]ocial injustice is killing people on a grand scale,” and calls for closing the gap within a generation. The report details a number of actions needed to improve equity across the broad domains of improving “the conditions of daily life” (such as childhood development and education, healthy working conditions, and social protection) and tackling “the inequitable distribution of power, money, and resources.” It also emphasizes the importance of measuring and monitoring health inequity, and evaluating actions on the social determinants.

Government of Mongolia, Ministry of Health, *Leaving No One Behind in the Context of Sub-national Health System Strengthening in Mongolia: Resource Handbook* (2017). <http://www.wpro.who.int/mongolia/publications/20171214-mongolia-report-leaving-no-one-behind.pdf>

This resource handbook, developed by Mongolia's health ministry and drawing heavily on material from WHO and other partners, is a thorough guide to identifying equity barriers throughout the health system and action areas to address them, as well as to developing monitoring and evaluation frameworks for sub-national health plans to better respond to the commitment to leaving no one behind. The handbook, with its valuable discussions of approaches to improving equity across the building blocks of the health system, also includes a focus on intersectoral actions and social participation to enhance participatory approaches to health planning and programming. The handbook includes a useful annotated set of resources for more in-depth work.

United Nations System, Chief Executive Board for Coordination, *Leaving No One Behind: Equality and Non-Discrimination at the Heart of Sustainable Development: The United Nations Shared Framework for Action* (New York: UN, 2017). <https://www.unsceb.org/CEBPublicFiles/CEB%20equality%20framework-A4-web-rev3.pdf>

This report sets out the UN Shared Framework for Action, which describes the responsibilities of actors in the UN system for combating inequalities. The Framework sets out a common approach for the systematic integration of equality and non-discrimination into United Nations support to member states for implementing Agenda 2030. It offers a set of policies and programs that can be implemented at country, regional, and global levels to combat discrimination and inequality, and common approaches for equity analysis, monitoring progress, and accountability.

World Health Organization, *Equity, Social Determinants and Public Health Programmes* (Geneva: WHO, 2010). http://whqlibdoc.who.int/publications/2010/9789241563970_eng.pdf

Each of this volume's 12 chapters on major public health programs explains the causal relationship between leading public health problems – such as diabetes, mental disorders, neglected tropical diseases, tobacco use, and violence – and inequalities (in health outcomes and socioeconomic consequences) attributable to social determinants of health. Each chapter also offers comprehensive sets of recommendations on actions to address the social determinants of these public health problems, along with discussions in other areas such as monitoring, knowledge gaps, and possible sources of resistance.

David H. Peters, Anu Garg, Gerry Bloom, Damian G. Walker, William R. Brieger and M. Hafizur Rahman, "Poverty and Access to Health Care in Developing Countries," *Annals of the New York Academy of Sciences* (2008) 1136: 161-171. <https://www.ncbi.nlm.nih.gov/pubmed/17954679>

This article explains how poverty in low- and middle-income countries causes health inequity across the dimensions of quality, geographic accessibility, availability, financial accessibility, and acceptability of health care services, as well as the lack of attention to health inequity in health service innovations. It points to a number of approaches that have been successful in improving health services for people who are poor, as well as a World Bank study (*Reaching the Poor with Health, Nutrition, and Population Services*, 2005, <https://openknowledge.worldbank.org/handle/10986/7393>) that examined 11 examples of efforts to reach people who are poor in low- and middle-income countries, with many of the strategies proving effective.

UNICEF, "EQUIST," <http://equist.info>

This tool, which UNICEF developed, enables users to visualize

inequalities based on wealth, geography, and rural/urban residence; users may also input other dimensions. Users can identify bottlenecks, examine how different interventions might help reduce mortality (based on evidence of their effectiveness), and learn what these interventions would cost. The tool currently covers under-five mortality but is being expanded to cover other areas as well (including nutrition, HIV, and adolescent health).

World Health Organization, Gender, Equity and Human Rights Team, *Country Support Package for Equity, Gender and Human Rights in Leaving No One Behind in the Path to Universal Health Coverage* (Geneva: WHO, 2017). <http://www.who.int/gender-equity-rights/knowledge/country-support-package-lnb-to-uhc.pdf>

This brochure identifies guidance and other material and forms of support from WHO that can support countries' efforts to leave no one behind along the path to universal health coverage.

WHO's Innov8 approach to health programming

World Health Organization, *The Innov8 Approach for Reviewing National Health Programmes to Leave No One Behind: Technical Handbook* (Geneva: WHO, 2016). <http://www.who.int/life-course/publications/innov8-technical-handbook/en/>

This resource explains and gives examples of WHO's 8-step *Innov8* approach to reviewing and redesigning health programs to address barriers to people being left out of the programs, and incorporating intersectoral action and social participation as central components of these programs.

World Health Organization, *Innov8 Approach for Reviewing Health Programmes to Leave No One Behind* (Geneva: WHO, 2017). <http://www.who.int/life-course/partners/innov8/innov8-informative-brochure-171106.pdf>

This brochure offers basic information on WHO's 8-step *Innov8* approach – used to review national health programs and make recommendations so that they will leave no one behind – with a brief review of the experiences of Indonesia and Nepal in applying this approach.

Thomas Swift Koller, Victoria Saint, Rustini Floranita, Gita Maya Koemara Sakti, Imran Pambudi, Lukas Hermawan, et al., "Applying the Innov8 Approach for Reviewing National Health Programmes to Leave No One Behind: Lessons Learnt from Indonesia," *Global Health Action* (March 23, 2018) 11(suppl 1). <https://www.tandfonline.com/doi/full/10.1080/16549716.2018.1423744>

This article provides an example from Indonesia of applying the 8-steps of the *Innov8* approach to greater equity in national health programs and action plans. It offers lessons from Indonesia's experience, including challenges the country faced, and explains how the outcomes of the *Innov8* approach help in planning and programming future actions and how it "integrates focus on tackling inequities in national health action plans."

Further information on *Innov8* is available through: <http://www.who.int/life-course/partners/innov8/en/>

Health equity political commitment

WHO World Conference on Social Determinants of Health, Rio Political Declaration on Social Determinants of Health, Rio de Janeiro, Brazil, October 21, 2011. <http://www.who.int/sdhconference/declaration/>

[Rio_political_declaration.pdf](#)

This landmark declaration is an expression of states' political will to make health equity a national, regional, and global goal. It sets out their call for global action, and their determination to act across the social determinants of health towards a more equal distribution of health resources and conditions, and to strengthen global governance and intersectoral policy actions.

World Health Organization and UNDP, *#HealthinSDGs: Policy Brief 2: Action Across Sectors* (9th Global Conference on Health Promotion, Shanghai, China, 2016). <http://www.undp.org/content/dam/undp/library/hiv/aids/English/Policy%20brief%202%20-%20Action%20across%20sectors%20-%20FINAL%20-%20CORR3.pdf>

This policy brief provides examples of the connections between health and eight of the SDGs, as well as examples from the Philippines, Kenya, and Vietnam on actions across sectors on tobacco control and road safety that contributed to advances in health and health equity. The policy brief also points to the importance of synergies in financing development, where cross-sector interventions contribute to numerous SDG goals and targets.

Resources on health equity for several frequently marginalized and disadvantaged populations

Below are selected resources that addressed six frequently marginalized and disadvantaged populations: women, people with disabilities, indigenous peoples, migrants and refugees, members of the LGBTI communities, and rural populations. Most of the resources included address interventions that countries can take to improve the health of these populations.

Women

World Health Organization, Office of the UN High Commissioner for Human Rights and Swedish International Development Cooperation Agency, *Human Rights & Gender Equality in Health Sector Strategies: How to Assess Policy Coherence* (Geneva: WHO, 2011). http://www.who.int/gender-equity-rights/knowledge/human_rights_tool/en/

This tool supports users in assessing states' fulfillment of human rights commitments and gender equality, aiming to "operationalize a human rights-based approach and gender mainstreaming through their practical application in policy assessments" to help bring equitable results in the health sector. This extensive tool provides a framework for analyzing and identifying entry points for action in these areas across a country's laws, policies, and institutions, as well as throughout the different building blocks of the health system.

Flavia Bustreo, Paul Hunt, Sofia Gruskin, Asbjørn Eide, Linsey McGoey, Sujatha Rao, et al., *Women's and Children's Health: Evidence of Impact of Human Rights* (Geneva: World Health Organization, 2013). http://www.who.int/maternal_child_adolescent/documents/women_children_human_rights/en/

This report offers evidence of how a human rights-based approach improves women's and children's health. It provides case studies from Nepal, Brazil, Malawi, and Italy to demonstrate how this approach has led to increased access to women's and children's health

interventions. The range of measures discussed include, for example, a community transport and health emergency fund, "people's fora," creating women's and pressure groups, health professional training on how to work with women survivors of sexual violence, and a "right to a companion" during delivery. The report also provides evidence of how participatory and empowering approaches (with references that detail the nature of these approaches, such as women's groups and cultural brokers) are associated with better health outcomes, as well as the need to proactively include the poorest and most marginalized populations in these mechanisms.

Every Woman Every Child, *The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)* (Every Woman Every Child, 2015). http://www.everywomaneverychild.org/wp-content/uploads/2017/10/EWEC_GSUpdate_Full_EN_2017_web-1.pdf

This global strategy highlights the health challenges women, children, and adolescents face, including in humanitarian and fragile settings (e.g., conflict and post-conflict settings), emphasizing the importance of a rights-based response. Encompassing several areas (e.g., financing, health systems, community engagement, multisector action), the strategy offers key actions, such as health and human rights literacy, formalizing the contributions of community leaders and health workers, and context-specific participatory mechanisms. The strategy also highlights the economic benefits and cost effectiveness of investing in the health of women, children, and adolescents.

Committee on the Elimination of Discrimination against Women, *General Recommendation 24, Women and Health*, U.N. Doc. A/54/38 (1999). <http://hrlibrary.umn.edu/gencomm/gener124.htm>

This general recommendation elaborates on the right to health of women as enshrined in article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), including the meaning of discrimination in the context of women and health. It offers several specific measures states must take to fulfill women's right to health, including reproductive health, such as not criminalizing medical procedures that only women undergo and training all health workers on women's health and the right to health. Beyond article 12, fully implementing all rights included in CEDAW will help address many of the social determinants of health that contribute to health inequities that women often experience. The treaty's text is available at: <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm>

WHO Western Pacific Region, *Advancing Health Through Attention to Gender, Equity and Human Rights: Stories From the Western Pacific Region* (WHO, 2017). <http://iris.wpro.who.int/bitstream/handle/10665.1/13642/9789290618300-eng.pdf>

This publication compiles success stories of how countries in the WHO Western Pacific Region integrated gender, equity, and human right into health programs, with examples across the policy cycle, from analysis and policy dialogue and design to program implementation and monitoring and evaluation. Programs covered are as diverse as vaccinations, water and sanitation, psychosocial disabilities, gender-based violence, and tobacco control.

Stop TB Partnership and UNAIDS, *Gender Assessment Tool for National HIV and TB Responses* (July 2016). http://www.stoptb.org/assets/documents/resources/publications/acsm/Gender_Assessment_Tool_TB_HIV_UNAIDS_FINAL_2016%20ENG.pdf

This tool supports countries in assessing their national HIV and TB epidemics and responses from a gender perspective. It helps them

to identify gender-specific needs and barriers to services, and to make their responses gender sensitive and gender transformative in reducing the dual burden of HIV and TB infection.

WHO Western Pacific Region, *Integrating Poverty and Gender Into Health Programmes: A Sourcebook for Health Professionals: Foundational Module on Gender* (WHO, 2008). <http://www.who.int/gender-equity-rights/knowledge/poverty-and-gender-in-health-programmes-gender/en/>

This module explains how gender inequality affects the health outcomes of women in the Western Pacific Region. It analyzes how a wide range of factors (e.g., nutrition, education, division of labor, socio-cultural barriers) contribute to gender inequities, and briefly surveys how the health sector can respond (e.g., gender-sensitive budgeting, equal opportunity staffing policies) and overcome geographic, socio-cultural, and other barriers (e.g., participatory methods, training on gender stereotypes, developing gender-sensitive indicators). The sourcebook details how to incorporate this information into training for learners in the health field, with an extensive guide for training facilitators.

World Health Organization, *Global Plan of Action to Strengthen the Role of the Health System Within a National Multisectoral Response to Address Interpersonal Violence, in Particular Against Women and Girls, and Against Children* (Geneva: WHO, 2016). <http://www.who.int/reproductivehealth/publications/violence/global-plan-of-action/en/>

This global plan of action provides a range of actions that states can take to reduce violence against women and girls, as well as to reduce violence against children generally. It focuses on the role of the health system, namely leadership (e.g., incorporating violence against women and girls in universal health coverage programs), strengthening health services and health provider capacity (e.g., facilitating multisectoral protocols and eliminating violence and discrimination within the health sector), strengthening programming (e.g., addressing risk factors), and improving information and evidence (e.g., establishing baselines for SDG violence against women and girls indicators). The plan also includes a global monitoring and evaluation framework, which may also inform national accountability.

Gary Barker, Christine Ricardo and Marcos Nascimento, *Engaging Men and Boys in Changing Gender-Based Inequity in Health: Evidence From Programme Interventions* (Geneva: WHO, 2007). http://www.who.int/gender/documents/Engaging_men_boys.pdf

This report analyses 58 studies to draw out which interventions involving men and boys can enhance gender equity programs in several areas: sexual and reproductive health, fatherhood and participating in care and support of their children, gender-based violence, maternal, newborn, and child health, and gender socialization. The analysis found that such interventions can be effective, particularly those that are gender transformative, with deliberate efforts to transform gender norms. The most effective programs (group interventions and health services) were integrated with community outreach, mobilization, and mass media campaigns (e.g., public service announcements, health fairs, street theater, “training...promoters to reach out to other men or organize community activities”) that sought to change the societal context in which the programs occurred. The report includes a brief analysis of each intervention and its effectiveness, along with references.

People with disabilities

World Health Organization and World Bank, *World Report on Disability* (Geneva: WHO, 2011). http://www.who.int/disabilities/world_report/2011/en/

This report is a comprehensive review of the increased health risks and obstacles faced by people with disabilities in health and other areas critical to their health and well-being. It also provides recommendations on actions states can take to remove these obstacles. The report and its recommendations cover general health services, rehabilitation (including assistive devices and telerehabilitation), assistance and support, enabling environments (including universal design), education, and work and employment. Throughout, the report offers detailed recommendations and possible approaches to overcoming barriers, with numerous short country examples of successful approaches and innovative solutions.

International Convention on the Protection and Promotion of the Rights of Persons with Disabilities, UN G.A. Res. 61/106 (2006), *entered into force* May 3, 2008. <http://hrlibrary.umn.edu/instreet/disability-convention2006.html>

The treaty on the rights of people with disabilities provides a comprehensive roadmap for ending discrimination against and ensuring the rights of people with disabilities in all walks of life, ranging from such spheres as health care, education, work, and justice, to protections against exploitation, violence, and deprivations of liberty, and affirming their legal capacity and right to live independently and be included in the community. Fulfilling these rights, and adhering to the treaty’s overall principles, such as accessibility, equal opportunity, full inclusion in society, and the freedom to make one’s own choices, would be transformative in improving the health and lives of people with disabilities.

World Health Organization, UNESCO, International Labour Organisation and International Disability Development Consortium, *Community-Based Rehabilitation: CBR Guidelines* (2010). <http://www.who.int/disabilities/cbr/guidelines/en/>

This series of guidelines provides detailed recommendations on strategies to ensure community-based inclusive development for people with disabilities, to empower people with disabilities in decision-making, and to facilitate people with disabilities in accessing health and other services. Separate sets of guidelines cover health, education, livelihoods, social life, and empowerment. The guidelines contain numerous case studies from around the world of community-based rehabilitation, and actions and specific activities within the guidelines’ broad domains of how to implement community-based rehabilitation approaches.

United Kingdom Department of Health, *Transforming Care: A National Response to Winterbourne View Hospital* (December 2012). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

This report lays out the United Kingdom’s Transforming Care initiative to move people with mental or intellectual disabilities or challenging behavior to community-based care, following abuse of people with learning disabilities in a hospital. While embedded in the UK context, this approach provides valuable detail on steps countries can take to implement this transformation to community-based care, such as developing personal care plans to meet individual needs, pooled budgets to enable comprehensive support within communities, and

measures to ensure accountability and quality care, including within health facilities. The report includes a detailed, timebound action plan.

Indigenous peoples

Government of Australia, *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* (Commonwealth of Australia, 2013). [http://www.health.gov.au/internet/main/publishing.nsf/content/B92E980680486C3BCA257BF0001BAF01/\\$File/health-plan.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/B92E980680486C3BCA257BF0001BAF01/$File/health-plan.pdf)

This health plan of Australia is a valuable example of a comprehensive, targeted approach to addressing the health needs of a marginalized population, here the Aboriginal and Torres Strait Islanders, indigenous peoples of Australia. Based on principles of human rights and equity, Aboriginal and Torres Strait Islanders control and engagement, partnership, and accountability, the plan offers strategies in 11 areas related to the social determinants of health. These include health enablers, such as a culturally respectful and non-discriminatory health system and supporting mental health and well-being, and key strategies to achieve these goals. Along with discussing target-setting and an implementation framework, the health plan details the partnership and consultative processes that were used to develop the plan.

Declaration on the Rights of Indigenous Peoples, UN G.A. Res. 61/295 (2007). <http://hrlibrary.umn.edu/instree/declaration.html>

Fully respecting the rights of indigenous peoples, both to non-discrimination with respect to the rights that all people enjoy and to those particular to their histories, cultures, traditions, and aspirations, would contribute enormously to the health of indigenous peoples. The Declaration on the Rights of Indigenous Peoples lays out the international understanding of these rights.

Stop TB Partnership, *Key Populations Brief: Indigenous Peoples* (July 2017). http://www.stoptb.org/assets/documents/resources/publications/acsm/6_27-UNOPS-KPB-Indigenous-Print.pdf

This brief explains the sociocultural and structural barriers indigenous peoples face in accessing TB services (e.g., poverty, reliance on traditional medicine, remote location and inequities in access to health care services), and the resulting inequities. It shares successful intervention approaches (such as training indigenous health workers and educating family members) in several countries including Kenya, Namibia, and Indonesia, and outlines actions a range of key stakeholders can take to improve TB prevention, treatment, and care, and health programs in general, including supporting indigenous researchers, producing communications material aligned with the needs, cultures, and lifestyles of indigenous populations, supporting indigenous health workers and clinics, and developing appropriate cultural protocols.

UNFPA, UNICEF and UN Women, *Fact Sheet: Indigenous Women's Maternal Health and Maternal Mortality* (2018). https://www.unfpa.org/sites/default/files/resource-pdf/factsheet_digital_Mar27.pdf

This fact sheet highlights the immense disparities that indigenous women and adolescent girls experience in maternal health services and outcomes, as well as a wide range of causal factors, as diverse as a rejection of indigenous health concepts or practices and discriminatory social attitudes and malnutrition, poverty, and unemployment. Along with emphasizing the importance of disaggregated data, it recommends interventions such as participatory processes (including to review maternal and adolescent health policies), incorporating an intercultural approach into sexual and reproductive health policies, and

allocating funds to address sociocultural and other barriers.

Migrants and refugees

International Organization for Migration, Migration Research Health Portal, <https://migrationhealthresearch.iom.int/publications-search>

This is a searchable database with all migration and health publications for which the International Organization for Migration was a primary contributor, more than 500 in all, including many that address policy issues.

World Health Organization, *Beyond the Barriers: Framing Evidence on Health System Strengthening to Improve the Health of Migrants Experiencing Poverty and Social Exclusion* (Geneva: WHO, 2017). <http://apps.who.int/iris/bitstream/10665/259486/1/9789241513364-eng.pdf>

This paper describes how barriers in the migration process affect the health of migrants who are experiencing poverty and social exclusion. It examines the role of health systems in responding to these barriers and meeting the needs of migrants, including in responding to poverty, and offers a “non-exhaustive compilation of evidence on measures taken across the health system building blocks that aim to address these barriers.”

Ana Fernandes and José Pereira Miguel (eds.), *Health and Migration in European Union: Better Health for All in an Inclusive Society* (Lisbon, Portugal: Instituto Nacional de Saúde Doutor Ricardo Jorge, 2009). https://www.researchgate.net/publication/294580663_Health_and_migration_in_european_union_better_health_for_all_in_an_inclusive_society/

The annexes to this book, which includes a detailed review of “health challenges in the age of migration,” include 35 case studies of good practices in the European Union to responding to the health needs of migrants. Several case studies are drawn from transnational actions, such as establishing a National Observatory of Discrimination and migrant-friendly hospitals, while the rest are country case studies. The latter are as diverse as access to health care for undocumented immigrants, interpretation services, healthy eating, and public health mediators (people recruited from marginalized and disadvantaged communities, or who are close to these communities, who work with individual community members to facilitate their access to health services and social support systems).

Kaisa Kontunen, Barbara Rijks, Nenette Motus, Jenna Iodice, Caroline Schultz and Davide Mosca, “Ensuring Health Equity of Marginalized Populations: Experiences From Mainstreaming the Health of Migrants,” *Health Promotion International* (June 2014) 29(Supp. 1): i121-i129. https://academic.oup.com/heapro/article/29/suppl_1/i121/647124

This paper reviews several obstacles to migrants’ health and a four-part framework to migrants’ health (monitoring, migrant-sensitive health policies and laws, migrant-sensitive health systems, and partnerships and networks). It also provides case studies on multi-sector action for migrants’ health. These case studies, from countries including Finland, Argentina, Sri Lanka, and the Philippines, include a successful whole-in-government approach, ensuring the health of a country’s migrants abroad, and interpretation services for migrants.

World Health Assembly, “Health of Migrants,” WHA61.17, May 24, 2008. http://apps.who.int/gb/ebwha/pdf_files/WHA61-REC1/A61_REC1-en.pdf

This World Health Assembly resolution represents a global commitment to the health of migrants, and includes a set of actions that states could take to improve migrants' health (e.g., using health information systems to analyze trends in migrants' health and increasing health worker sensitivity to gender and cultural issue pertaining to migrants).

Stop TB Partnership, *Key Populations Brief: Mobile Populations* (May 2016). http://www.stoptb.org/assets/documents/resources/publications/acsm/KPBrief_MobilePopulations_ENG_WEB.pdf

This briefing paper describes barriers that migrants and other mobile populations face to accessing TB services, including discriminatory policies, health workers' stereotypes and prejudices, and lack of continuity of care. The paper also describes several actions to improve TB and other health services, including mobile clinics, health passports (written records that facilitate continuity of care), and social protection schemes, and provides recommendations to governments and other actors, such as to revise discriminatory laws and policies and to create a unified referral system for migrants.

Council of Europe, Committee of Ministers, Recommendation CM/Rec(2011)13 of the Committee of Ministers to Member States on Mobility, Migration and Access to Health Care, November 16, 2011. https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805cbd6d

Council of Europe, Committee of Ministers, *Explanatory Memorandum of the Draft Recommendation CM/Rec(2011)13 of the Committee of Ministers to Member States on Mobility, Migration and Access to Health Care* (c. 2011). https://www.coe.int/t/dg3/migration/archives/Source/Recommendations/CM%20ExM%20Rec_2011_13E%20Migration%20Exp%20Memo_en.pdf

International Organization for Migration, *Summary Report on the MIPEX Health Strand and Country Reports* (Geneva: IOM, 2016). https://publications.iom.int/system/files/mrs_52.pdf

This trio of documents builds on the first of these documents, recommendations from the Council of Europe on measures that states should take to improve the health of migrants, which cover entitlement to health provision, accessibility to health services (e.g., simplifying admission procedures), quality of health services (e.g., using all available means to reduce language barriers and develop culturally competent organizations, including a diverse workforce), and other measures such as coordination between health and other social services. The explanatory memo (developed before the recommendations were adopted) further explains these policies and their importance. The third document, the report on the MIPEX health strand, rates 38 European countries on their implementation of the Council of Europe's recommendations, in the process making clear what the best policies approaches are to supporting the health of migrants.

WHO Regional Office for Europe, *How Health Systems Can Address Health Inequities Linked to Migration and Ethnicity* (Copenhagen: WHO Regional Office for Europe, 2010). http://www.euro.who.int/data/assets/pdf_file/0005/127526/e94497.pdf

This document analyzes obstacles to health for migrants and ethnic minorities in Europe, as well as policy measures and other strategies to help overcome them. Policies and strategies encompass, for example, education policies that pay special attention to the needs of migrants and ethnic minorities, cultural mediators, and comprehensive and clear information on health entitlements.

LGBTI communities

Office of the UN Commissioner for Human Rights, *Living Free and Equal: What States are Doing to Tackle Violence and Discrimination Against Lesbian, Gay, Bisexual, Transgender and Inter-sex People* (New York and Geneva: United Nations, 2016). <https://www.ohchr.org/en/issues/discrimination/pages/livingfreeequal.aspx>

This resource provides a comprehensive set of measures that states can take to reduce violence and discrimination against lesbian, gay, bisexual, transgender, and intersex people, encompassing measures as diverse as education (such as to combat myths, stereotypes, and misinformation, training police, health workers, and other officials and professionals, and developing anti-bullying school curricula), repealing discriminatory laws (including through de-criminalization), developing laws that prohibit discrimination, and protecting the freedom of expression, association, and assembly of LGBTI populations (including registration of civil society organizations). Examples come from countries including Norway, Argentina, South Africa, Malta, the United Kingdom, and the United States.

UN High Commissioner for Human Rights, "Report of the United Nations High Commissioner for Human Rights on Discriminatory Laws and Practices and Acts of Violence Against Individuals Based on Their Sexual Orientation and Gender Identity," U.N. Doc. A/HRC/19/41, November 17, 2011. <http://www.refworld.org/cgi-bin/texis/vtx/rwmain?docid=4ef09202>

This report outlines states' human rights obligation to protect against violence and discrimination against people based on their sexual orientation and gender identity, as well as discriminatory practices in a number of areas, including in health care (e.g., impact of criminalization, homophobic, sexist, and transphobic practices and attitudes, inaccessibility of gender reassignment surgery). It also points to a range of emerging responses in a number of countries, and lists several measures member states should take to end this discrimination (e.g., repealing discriminatory laws, sensitization training, public information campaigns).

World Health Organization, *Policy Brief: Transgender People and HIV* (Geneva: WHO, July 2015). <http://www.who.int/hiv/pub/transgender/transgender-hiv-policy/en/>

This policy brief explains the heavy burden of HIV on transgender people, and describes measures states can take to create an enabling legal and policy environment that enables transgender people to fully access and benefit from HIV interventions, including brief illustrative examples from several countries, including Uruguay, Argentina, and Nepal. Measures to create enabling environments encompass, among other actions, include de-criminalizing behaviors that may particularly affect transgender people (e.g., "cross-dressing"), reducing stigmatization (e.g., training journalists on using de-stigmatizing language and presenting positive depictions of transgender people), empowering communities, and reducing violence.

MPact Global Action for Gay Men's Health and Rights, World Health Organization, UNDP and UNFPA, *Out With It: HIV and Other Sexual Health Considerations for Young Men Who Have Sex With Men* (Oakland, California, USA: MPact Global Action for Gay Men's Health and Rights, 2018). <http://www.who.int/hiv/pub/populations/out-with-it/en/>

This technical brief explains why young men who have sex with men have an increased risk of acquiring HIV and other sexually transmitted

infections, and briefly summarizes approaches to making health services accessible to these young men, as well as to creating enabling legal and policy environments for such interventions. These include removing censorship or laws that interfere with health promotion efforts, banning conversion therapy, and taking disciplinary measures and ensuring remedies in cases of violence and harassment by law enforcement officers.

Rural and remote populations

Stop TB Partnership, *Key Populations Brief: Rural Populations* (May 2016). http://www.stoptb.org/assets/documents/resources/publications/acsm/KPBrief_RuralPopulations_ENG_WEB.pdf.

This briefing paper addresses structural (e.g., health worker shortages and distance to health facilities) and sociocultural barriers (e.g., alternative health services and discrimination) that rural dwellers face in accessing TB diagnosis and treatment, and briefly describes several examples of interventions to overcome these barriers. These encompass modes of treatment that engage family members, the community, and traditional healers; the possibilities of mobile clinics and *mHealth* (mobile phones), and; “TB Clubs,” support groups for TB patients meant to battle the stigma of TB.

World Health Organization, *Increasing Access to Health Workers in Remote and Rural Areas Through Improved Retention: Global Policy Recommendations* (Geneva: WHO, 2010). http://apps.who.int/iris/bitstream/handle/10665/44369/9789241564014_eng.pdf

WHO offers 16 evidence-based recommendations on interventions for attracting health workers to and retaining them in rural and remote areas. The recommendations span education (e.g., training students closer to rural communities and providing curricula that match rural needs), regulatory interventions (e.g., training health workers faster), financial incentives, and personal and professional support (e.g., career ladders and knowledge exchange). Each recommendation includes a summary of evidence and further commentary. The document also includes a framework for selecting and evaluating policy options.

Rajan Parajuli and Philippe Doneys “Exploring the Role of Telemedicine in Improving Access to Healthcare Services by Women and Girls in Rural Nepal,” *Telematics and Informatics* (November 2017) 34(7): 1166-1176. <https://www.sciencedirect.com/science/article/pii/S0736585317300977>

Along with a brief review of the potential for telemedicine to improve health care for people in rural areas, this case study from Nepal focuses on the role of mobile phone and video-based telemedicine in reducing gender-based barriers women and girls experience in rural areas in accessing health services. The study found that telemedicine reduces obstacles to travel (e.g., family permission, distance, expenses – both travel and treatment costs), helps women overcome the responsibility for household chores and child care as an impediment to accessing health care, and reduces women’s apprehension in discussing their sexual and reproductive health concerns (due to increased privacy and anonymity). Addressing literacy and income concerns could further increase the potential of telemedicine.

Lisa Bourke, John S. Humphreys, John Wakerman and Judy Taylor, “Understanding Rural and Remote Health: A Framework for Analysis in Australia,” *Health & Place* (2012) 18: 496-503. http://www.flinders.edu.au/medicine/fms/sites/southgate/documents/events/2014/Understanding%20rural%20and%20remote%20health_a%20framework%20analysis%20for%20Australia.pdf

Focused on Australia but with broader applicability, this paper provides a conceptual framework for better understanding health in rural and remote areas. It encompasses: 1) geographical isolation; 2) the social relations within rural locations; 3) health responses in rural locations; 4) broader health systems; 5) broader social systems (e.g., economic status, education, culture), and; 6) power structures. Using this framework and recognizing the multi-layered aspects of health in rural areas may help contribute to more effective policies to improving health in rural populations.

U.S. Congress Joint Economic Committee Democratic Staff, *Keeping Rural Communities Healthy* (July 2014). https://www.jec.senate.gov/public/_cache/files/d9e7711e-5576-49f4-a00d-67b0d66074d8/keeping-rural-communities-healthy.pdf

This U.S. Senate report offers several policy measures that may be applicable in other countries as well, namely increased government reimbursement for hospitals in rural areas to protect them from financial losses, scholarship and other policies to attract health professionals to and retain them in rural communities, and telemedicine.

Walsh Center for Rural Health Analysis, NORC at the University of Chicago, *Exploring Strategies to Improve Health and Equity in Rural Communities* (Bethesda, Maryland, USA: Walsh Center for Rural Health Analysis, February 2018). <http://www.norc.org/PDFs/Walsh%20Center/Final%20Reports/Rural%20Assets%20Final%20Report%20Feb%2018.pdf>

This study of rural communities in the United States provides a valuable framework for identifying opportunities to improve health in rural communities through recognizing the assets these communities have, their strengths rather than their “needs and deficiencies,” namely individual assets, organizational and associational assets, and community assets. The study demonstrates how understanding these assets can be used to identify strategies to improve health in these communities and leverage these assets through relationship-building and partnerships, funding opportunities, collaboration and shared learning, and more.

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