Priority Public Health Conditions (PPHC)

Interim Report with Snippets of Results

Prepared for the Commissioners' Meeting
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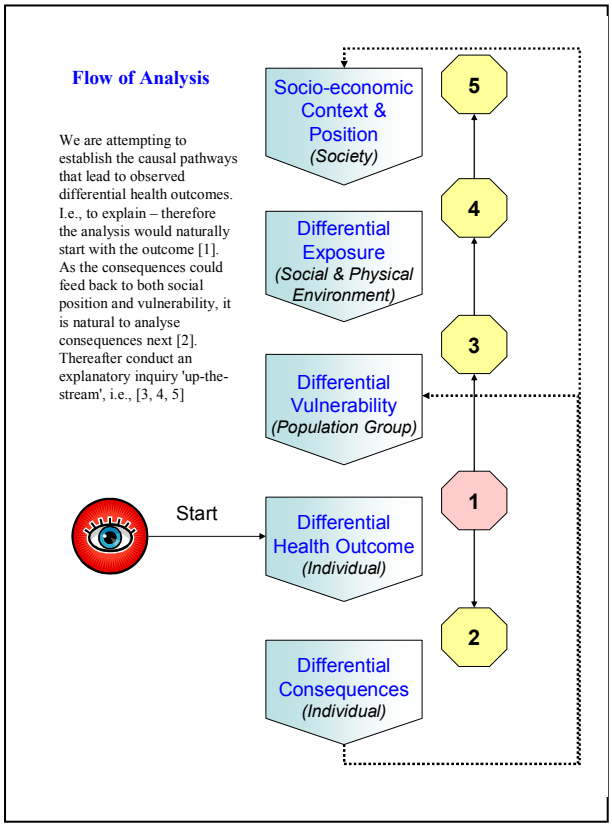
1. INTRODUCTION

The PPHC-KN is taking forward the work of the Commission on Social Determinants of Health with its other knowledge networks, adding a WHO programme and health conditions perspective. The overall goal of the PPHC-KN is to improve the level and the distribution of health in populations through a strengthened focus on the social determinants of health. This is likely to mean expanding the definitions and practices of what constitute public health actions and interventions as well as of how public health programmes are organized. The PPHC analyses the inequities in health outcomes and identifies the social determinants, including factors within as well as outside of the health sector causing these inequities with the aim to develop feasible interventions and programmatic responses.

The PPHC-KN takes an innovative, dedicated and pragmatic approach to the politics of public health as well as to the involvement of sectors other than health. Further, it, through 14 case studies documents how programmes in countries have dealt with the challenges of intervening on social determinants, scaling up, working across sectors, addressing resistance to change, etc..



The PPHC bases its work on the Commissions conceptual frame work, a simplified version of which is shown in the figure to the right. The work takes as starting point particular public health conditions and the observed differential outcome of these. Thereafter, the analysis moves up-the-stream to identify where the observed inequities are originating and what could be possible entry points for intervention. There are 15 nodes of the network each covering one or more public health conditions (See Annex 1A). The nodes go through an iterative process with three phases: (1) Analysis, (2) Interventions and implementation considerations, and (3) Measurement. This interim report is organized according to these three phases and provides an overview of the processes and approaches as well as some preliminary findings.

The PPHC takes advantage of having started after the other eight KNs of the Commission. The reports of these are now coming available in near final forms and have been analysed. Cross-reference matrices have been prepared between the issues addressed in these reports and the concerns of the Nodes of PPHC.

The PPHC-KN is a collaborative effort, a network covering WHO HQ-departments and regional programmes that are core to the health outcomes sections of WHO's Medium-Term Strategic Plan 2008-13 plus several other departments and units, as well as partners from outside the Organization. The network involves units dealing with WHO corporate learning processes as well as three research programmes, i.e., TDR, HRP, and Alliance-HPSR. A large number of individuals from across WHO and their national and international counterparts participates in the work (*see an incomplete list in Annex 1*).

The broad involvement will facilitate uptake and internalization of social determinants, equity thinking and intervention approaches within WHO as well as within the public health programme community. Two main mechanisms are being used to enhance the involvement. Each month the PPHC-Steering Group, comprising the Node Leaders meets, the turn-out for the meetings has been consistent - between 15 and 20. Further, every phase is concluded by submission from each node of a working document, which undergoes peer review by one other node, at least one WHO regional office and the Secretariat according to common guidelines. It is envisaged that the PPHC will produce a book with individual chapters for each of the Nodes, as well as a number of synthesis chapters pulling out what is common to the public health conditions addressed by PPHC. The present interim report is a first attempt to doing so.

2. ANALYSIS (PHASE 1)

Submissions from programme nodes were assessed against these questions during the peer review for Phase 1

Statement of condition and equity issues: Is the public health outcome(s) in question clearly defined and the pertinent equity issues of these outcomes made evident?

Methods of analysis: Can the methods used in the analysis stand for a scientific scrutiny? How could they be further strengthened?

Results: (below are suggested questions to review the five steps of Phase 1)

1. *Social determinants at play and their contribution to inequity, e.g.: main path-ways, magnitude and social gradients* - Have all the levels of the PPHC framework been convincingly addressed?
2. *Promising entry points for intervention* - Have the path-ways / determinants been comprehensively analysed with respect to potential entry points? What can further be suggested?
3. *Potential side-effect of eventual change* - have these been analysed for each entry point? What more could there be?
4. *Possible sources of resistance to change* - have these been proposed? Are they exhaustive?
5. *What has been tried and what were the lessons learned* - What can be added?

Limitations of analysis: are these made explicit, including what are the data / information availability constraints?

2.1 Social Determinants at Play (Snippets of Results)

	Alcohol	Child H	Diabetes	Injury	Neg. Trop.	Oral H.	Sex. & Repr. H	TB	Tobacco
Context	Lack of enforced rules/control systems on production, marketing, selling and serving cheap alcohol	Poverty Education, in particular maternal	Globalization and industrialization Mechanization and urbanization	Skewed resource allocation in disfavour of low income neighbourhoods	Poverty	Unequal distribution of resources and opportunities	Politicalization inhibits sound programme and service development	Rapid and poorly planned urbanization Sustained poverty Low education Poor, uncoordin-ated health care infrastructure	Weak enforcement of laws and policies on: taxation, advertisement and smoking bans
Exposure	Availability for poor people and under-aged Poor quality and illicit market . Acceptance of "drunkenness"	Poor children have: inadequate water and sanitation, more crowding and indoor air-pollution	Food with high energy and low in fibre	Congested, multi-user road networks particularly dangerous in low income neighbourhoods	Unsafe water and sanitation Poor housing and crowding	Water and sanitation Exposure to fluorides Food supply lifestyles	Social norms inhibit couple communication and promote risky behaviours	Increased population density, crowding, and population mobility	
Vulnerability	Increased harmful use among poor low educated and marginalised groups (adding up to clustering of other neg. social determinants).	Poor children are: subject to higher disease incidence, less likely to adopt behaviours to mitigate exposures, less likely to access care	Change in diet Low physical activity Barriers in access to health care	Poorer people more likely to use lighter and more unsafe means of transport	Malnutrition and co-infection Financial barriers in access to health care	Access to oral health services and protective options	Discrimination and disempowerment of women HS exacerbate limited access by not taking into account inelastic demand	Poor access to basic quality health care Clustering of risk HIV, malnutr-ition, smoking, air-pollution, diabetes, and alcoholism	Control measures primarily reaching / accessible to upper SES
Outcome	Poor receiving less / lower quality of treatment	Difficulties in adherence to treatment Perverse incentives in health system	Difficulties in adhering, continuing care due to poverty			Extractions rather than fillings as they are cheaper when resources are tight	Provider practices restrict use of services for some vulnerable groups	Difficulties in adherence to treatment Perverse incentives in health system	
Consequence	More social harms marginalization High social , health and productivity costs.		Reduced life quality Missing, losing or being refused work		Catastrophic health care expenditures, leading to impoverishment	High personal, social and health service costs; impact on other communities & social groupings	Maintaining vicious poverty and disadvantage circles	Huge direct and indirect health care costs	

2.2. PROMISING ENTRY POINTS (SNIPPETS OF RESULTS)

The analysis of promising entry points looks for where on the pathways of determinants effective action can feasibly be deployed. This analysis forms basis for development of interventions and is done under three rubrics. The preliminary findings include:

Potential entry points for direct Programme action

- Improve individual case detection and treatment adherence, targeting vulnerable groups, e.g.: slum dwellers, homeless, migrants, drug abusers, prisoners, people living with HIV, etc..
- Improve population access - targeting and relevance of promotional and preventive measures and means to empower and enable vulnerable groups to take responsibility and act

Potential entry points for intra-sectoral / inter-programme action

- Capitalize on inter-linkages with other conditions, e.g., co-infection, HIV, smoking, malnutrition, diabetes, alcoholism, and indoor air pollution
- Address dichotomous sexual standards in the community and in the health system
- Strengthen health systems to respond to needs rather than demands, eliminate or reduce barriers in access and perverse incentives, improve collaboration between public and private providers

Potential entry points for inter-sectoral action

- Convince politicians to address the social determinants
- Reduce poverty and redress the access to and control over wealth at the individual level specifically for women.
- Improve legislative, policy, and reproductive rights and enforcement base
- Improve living conditions, water and sanitation, and nutritional status
- Improve financial and educational opportunities, including changing gender norms and opportunities for women
- Improve infrastructure and transportation design to encourage physical activity, heighten [road] safety, and serve the needs and circumstances of vulnerable groups
- Mobilize communities to address vulnerabilities

2.3 CASE STUDIES

Each Programme node reviews lessons learned with respect to dealing with social determinants of health and inequity. However, the PPHC also supports 14 case studies of programmes in countries that have addressed social determinants of health in order to elucidate five key aspects of implementation:

- *Going to scale*, the challenges of going from small to large scale operation and how these were dealt with
- *Managing policy change*, how the enabling and supportive policy environment was established
- *Managing intersectoral processes*, the challenges in and solutions found for dealing with many actors across sectors and disciplines, often having conflicting interests and agendas
- *Adjusting design*, implementing and scaling up is reality check of ideas and approaches. Frequently, these have to be adapted and revised during the process through learning
- *Ensuring sustainability*, financing small scale limited projects is one thing - ensuring sustainability of large scale continuous activities is quite another, raising questions of integration, mainstreaming, getting into resource allocation cycles, etc..

The draft final reports from the 14 case studies are due by 15 October. A list of the case studies, including which of the aspects of implementation they address is provided in the table next page.

Case studies by country and condition	Going to scale	Managing policy change	Managing intersectoral processes	Adjusting design	Ensuring sustainability
01 Bangladesh (RH)	✓	✓	✓	✓	✓
02 Canada (MH)		✓	✓		✓
03 Chile (NCD)	✓	✓	✓	✓	✓
04 China (MCH)	✓	✓			
05 Indonesia (All)	✓	✓	✓		✓
06 Iran (Nut)	✓		✓		✓
07 Kenya (All)		✓	✓	✓	
08 Nigeria (EPI)	✓	✓		✓	✓
09 Pakistan (Nut)	✓	✓	✓	✓	✓
10 Pakistan (TB)	✓		✓		✓
11 Peru (All)	✓	✓	✓	✓	
12 South Africa (HIV)	✓		✓	✓	✓
13 Tanzania (MAL)	✓	✓	✓	✓	✓
14 Vanuatu (NCD)	✓		✓	✓	✓

3. INTERVENTIONS AND IMPLEMENTATION (PHASE 2)

Submissions from programme nodes are currently being assessed against these questions during the peer review for Phase 2

Interventions

Identification of interventions should be comprehensive, based on and responding to the analysis.

Structural interventions: Have structural interventions been defined? Do they address the three top-levels of the PPHC framework? Are they addressing the promising entry points [if] defined in the analysis? Are all three types of structural, i.e.: availability, acceptability, and accessibility interventions defined?

Health service interventions: Have service interventions been defined? Do they address the two lower levels of the PPHC framework? Are they addressing the promising entry points [if] defined in the analysis? Are all five types of structural, i.e.: availability, acceptability, accessibility; and compliance, and adherence interventions defined?

Implementation

Considerations about implementation is where reality sets in and the range of interventions gets honed down. Implications for organization and action will follow.

General test of interventions: Does the submission address for each and the combined interventions proposed questions of : replicability, sustainability, scalability, political feasibility, economic feasibility, and technical feasibility?

Managing change processes and multiple actors: The need for champions or enablers? Critical resources and paths; timing and sequencing; and stumbling blocks/challenges? Key stakeholders and their power relations? Possible side-effects that can mobilize resistance?

Institutionalization - implications: Changing the way we think about public health? Organization and action of public health programmes? Organization and action of the Ministry of Health, intra- and inter-sectorally? Organization and action of WHO?

3.1 Implications for Programmes (Snippets of Results)

The implications for the condition specific public health programmes of taking up a social determinants approach are numerous and potentially significant, including:

Need to advocate for social and economic change and to address resistance to change, e.g. due to vested interests and/or increased cost in other sectors to deal with the social determinants of and inequities in health this may include:

- Enhance the evidence base for social determinants of health and inequity in health
- Strongly advocate the need for and benefits of social interventions to prevent increased prevalence of HIV, smoking, malnutrition, diabetes, alcoholism, risky sex and indoor air pollution
- The successful realization of these interventions will need to be done in close collaboration with other sectors of the government
- Sensitize and build capacity among planners and those involved in international financial and development assistance to better understand how linkages between development and health vary over socio-economic strata

The direct programme implications are potentially enormous in order to refine and enhance approaches to better reach the poor / vulnerable, including:

- Develop and implement tailor-made interventions targeting circumstances and needs of the endemic and/or vulnerable populations
- Change mode of action to transcend individual disease specific programmes in order to reduce prevalence of co-infections and common risk-factors

Taking a social determinants approach is likely to require additional resources and broadening the skills and knowledge mix of programme staff due to:

- Necessity of diversifying and targeting the set of interventions to cater for the specific needs and circumstances of different population groups
- Expanding the range of interventions up-stream to influence the social determinants before they manifest in differential vulnerabilities and health outcomes
- Requirements for policy and public dialogue, cross-programme and sector coordination, as well as understanding and management of complex social, economic and political change processes.

4. Measurement (Phase 3)

Questions addressed by the Programme nodes in Phase 3

PPHC takes a management perspective, i.e., focusing on the concrete practical programme needs.

- *Data shortcomings experienced in the analysis* (Phase 1) in making the case for policy and programme action. Which data are missing to explain the observed differential outcomes and to make the case more convincing? Which research and further analysis are required?
- *Which types of data are needed to manage and to monitor / evaluate the effect* of the interventions proposed by the Programme Node in Phase 2?
- *What needs to be done differently or additionally* in order to make such data available and useful for programme management? By:
  - The public health programme(s) in question? E.g.: redesign of programme specific information systems; redesign of survey instruments; change of guidelines; etc..
  - Ministries of Health (intrasectorally)? E.g.: redesign of sector-wide information systems; change of incentives; introduce, change or expand health surveys; etc.
  - Other sectors (intersectorally)? E.g.: adding health components to general or sectoral surveys or census in particular where links matters, etc..
  - WHO? E.g: changing its guidelines; changing its way of reporting - to focus on gradients; developing and testing new instruments; etc..

ANNEX 1: KN-PARTICIPANTS

ANNEX 1A: PPHC PROGRAMME NODES, NODE LEADERS AND CO-LEADERS

Programme Nodes (Conditions)	**Node Leaders and co-leaders**	**email**
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Nutrition/Malaria	Maria del Carmen Casanovas	casanovasm@who.int
	Sergio Spinaci	spinacis@who.int
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Food related conditions	**Awa Aidara-Kane**	aidarakanea@who.int
HIV/AIDS	**Carla Obermeyer**	Obermeyerc@who.int
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Injuries	**David Meddings**	meddingsd@who.int
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Learning Node		
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ANNEX 1B: CONSULTANTS AND WHO REGIONAL OFFICES

Programme Nodes	Consultants	Regional Reviewers (Phase 1)
Alcohol related conditions		
Cardiovascular diseases	A. Banerjee	
Child-Health/ Nutrition/Malaria	Fernando C. Barros Cesar G. Victora Davison Gwatkin	WPRO: Marianna Trias and Emma Manalac
Diabetes	Nigel Irwin David Whiting	SEARO: Jerzy Leowsky
Food related conditions	Jean L Jouve	WPRO: Anthony Roy (Tony) Hazzard
HIV/AIDS		
Injuries	Helen Roberts	
Maternal Health	Les Olson	AMRO: Francisco Martínez Guillén
Mental health		
Neglected tropical diseases	Jens Aagaard-Hansen	EMRO: Susan Watts
Oral Health	Stella Kwan	
Reproductive Health		WPRO: Anjana Bhushan
TB		EMRO: Ridha Djebeniani and Amal Bassili
Tobacco	Kathy Esson	EMRO: Fatimah Elawa
Vaccine preventable		

PPHC Focal Points in WHO Regional Offices:

AFRO: Ngenda Chris Mwikisa, Benjamin Nganda
AMRO: Luiz A. Galvao
SEARO: Than Sein, Davison Munodawafa
EURO: Erio Ziglio, Christine Brown, Sarah Simpson
EMRO: Sameen Siddiqi, Susan Watts
WPRO: Anjana Bhushan