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Report on the

**Intercountry
workshop on
promoting urban
health equity
assessment and
response**

Cairo, Egypt
2–4 September 2012



**World Health
Organization**

Regional Office for the Eastern Mediterranean

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1. INTRODUCTION

The countries of the World Health Organization (WHO) Eastern Mediterranean Region have been going through rapid urbanization for the past three decades, due to an increase in migration from rural to urban areas as well as high urban indigenous growth. Urbanization is associated with serious health challenges related to the social determinants of health, environment, violence, road safety and unhealthy lifestyles globally. The most frequent fundamental challenges interlinked with urban health encompass air pollution, poor living conditions such as no or poor sanitary and waste facilities, inaccessibility of health and recreation facilities, poor infrastructure, lack of medical professionals and medicine, high rates of noncommunicable diseases, child malnutrition, poor transport and communication facilities, poverty, child labour, crime and illiteracy.

Regardless of the evidence, only a few countries have examined their inter- and intra-city health inequities, and not many do so regularly. Information that shows the gaps between cities or within the same city is a crucial requirement to implement appropriate local actions to promote health equity. Evidence should be comprehensive enough to provide hints on key health determinants and concise enough to facilitate policy-making and prioritization of interventions.

In order to facilitate the process of proactively addressing health inequities, the WHO Regional Office for the Eastern Mediterranean, in collaboration with the WHO Centre for Health Development, Kobe, Japan has provided technical assistance to Tehran of Islamic Republic of Iran, Sale of Morocco, Ariana of Tunisia, Giza of Egypt, Khartoum of Sudan and Rawalpindi of Pakistan to use WHO Urban Health Equity Assessment and Response Tool in reducing health inequities based on local capacities, needs and existing infrastructures. Major principles of these initiatives are intersectoral collaboration and community ownership.

The introduction of Urban HEART guides local policy-makers and communities through a standardized procedure of gathering relevant evidence and planning efficiently for appropriate actions to tackle health inequities. This collective effort towards a common goal has galvanized both city governments and communities to recognize and take action on health inequities. It is envisaged that cities with varied contexts can locally adapt and institutionalize Urban HEART, while maintaining its core concepts and principles.

The experiences of Tehran, Sale, Ariana and Giza in the implementation of the WHO Urban Health Equity Assessment and Response Tool (Urban HEART) were shared with representatives of other countries of the Region in an intercountry workshop on promoting urban health equity and response, held in Cairo, Egypt, from 2 to 4 September 2012. The overall objectives of the workshop were to build capacity of the representatives from the Ministries of Health on promoting health equity, operationalizing the Rio Political Declaration on Social Determinants of Health and strengthening multisectoral action for improving urban health settings. Specific objectives were to:

- monitor and share progress of the urban health equity assessment and response carried out in Ariana, Giza, Sale and Tehran;

- orient other countries of the region on concept, methodology and steps to introduce Urban HEART;
- discuss and share overview of urban health emergency management focusing on city resilience, response and recovery and incorporate it as part of the Urban HEART interventions;
- conduct technical consultation using the experiences of the participants to amend the first draft of the regional manual entitled Approaches and Steps to Implement Healthy Settings: Healthy Hospitals, Healthy Schools, Healthy Workplaces and Healthy Markets, based on the countries' needs and priorities;
- share current status of community-based initiatives and agree on modalities for institutionalization and adaptation of the community health and development approach in the Region;
- review and finalize the regional strategic plan to operationalize the Rio Political Declaration on Social Determinants of Health;
- assist Member States to develop an outline of national key activities to operationalize the Rio Political Declaration on Social Determinants of Health using the global plan of action and the draft regional strategic plan.

The meeting was inaugurated by Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean. In his opening remarks, Dr Alwan noted that 49% of the population of the Region were urban dwellers, and it was estimated that by 2030 two thirds of the world's population would live in urban areas. Urban health challenges were becoming more acute and complex due to unplanned urban growth which put populations at increasing risk. He drew attention to the importance of health equity, which had been emphasized by Member States in the Rio Political Declaration on Social Determinants of Health and subsequently at the World Health Assembly in May 2012 (resolution WHA65.8). He concluded by emphasizing the need to find ways to motivate key local policy-makers to support work on the social determinants of health, to enhance community empowerment in local health and social development, to design a sustainable mechanism for intersectoral collaboration and partnership for urban health development, and finally to develop strategies to reduce urban health inequity.

Dr Haifa Madi, Director, Health Protection and Promotion, presented the objectives, method of work and expected outcomes of the meeting. She highlighted importance of expanding use of equity assessment and response tool in all countries of the Region as a decision support tool. During the workshop, participants would review a draft manual on healthy settings that offered a framework for analysis of the settings and application of minimum standards based on community-based approach and intersectoral action. They would also be asked to participate actively in a panel discussion on scaling up community-based initiatives. Countries of the Region were in different stages of implementation of the programme and in the future universal health coverage, health equity and social determinants of health should be the main focus of community health and development approaches. She concluded by highlighting key areas of action proposed in the Rio Political Declaration on Social Determinants of Health and requested participants to develop draft outlines of national plans of action to operationalize the Rio Declaration in line with global and regional strategic directions.

The agenda, programme, list of participants and outputs of the working groups are included as Annexes 1, 2, 3 and 4 respectively.

2. TECHNICAL PRESENTATIONS

2.1 Introduction to Urban HEART; concept and methodology

Dr Mohammad Assai, WHO Regional Office for the Eastern Mediterranean

Currently, one third of the total urban population in the world lives in slums, with low access to social services. The rising trend of urban population should bring the attention of city planners to the urgent need for collaboration and partnership in assessing needs of the people and disparities in access to social services in order to come up with solutions that can overcome the challenges. The five case studies on urban health inequity carried out in Cairo, Sale, Rawalpindi, Khartoum and Ariana show that the Urban HEART approach is an effective tool to reduce health inequities and enhance intersectoral collaboration and community participation in improving universal health coverage.

The urban health equity assessment and response tool (Urban HEART) piloted in Tehran, Islamic Republic of Iran, enables the assessment of existing health and social situations. This can be achieved through collecting data on key indicators and creating plans to fill the priority gaps through community ownership and intersectoral action for health development. It is expected that through Urban HEART, cities can promote community ownership in overall development, structure intersectoral action for health at the city level, build partnerships and generate resources for improving health and social conditions in slum areas, and learn how to address health equity and social determinants of health. In addition, the use of information for urban health planning and action needs to be enhanced. Political commitment, plans for expanding Urban HEART and strengthening networking and the exchange of experiences are critical points that have to be considered in the Urban HEART action plan.

WHO will continue to support Member States to:

- introduce Urban HEART using the experience of Tehran, Sale, Ariana and Giza
- identify major gaps and apply appropriate local solutions led by the community and supported by the development sectors
- document Urban HEART implementation and use it for policy-making, advocacy and expansion
- participate in presenting the findings to policy-makers.

Steps in implementing Urban HEART are shown below.

- Step 1: build an inclusive team (pre assessment phase)

Assessment

- Step 2: Define set of indicators (definition and sources) and benchmarks (internal or external) fit with the status and capacity

- Step 3: Assemble relevant and valid data (available and valid datasets/desk review) identify challenges

Reponses

- Step 4: Generate evidence
- Step 5: Assess and prioritize health equity gaps and gradients
- Step 6: Identify the best response based on defined criteria

By implementing Urban HEART, we expect re-allocation of government resources and efforts to improve: health indicators; housing status; employment rates; skills development and access to quality primary health care services. Meanwhile, government will be assisted to establish sustained mechanism for collection and disposal of solid waste; smoke-free city policy and sustained intersectoral action and community involvement in decision-making

In conclusion strong political commitment is need to ensure access for all to education, quality health care services, sanitation, clean water, social protection and other services needed for the community's growth and development.

2.2 Progress of Urban HEART in six regions and way forward

Mr Amit Prasad, WHO Centre for Health Development, Kobe, Japan

WHO's Commission on Social Determinants of Health in 2005 focused on evidence from nine broad areas or determinants of health. The establishment of the Knowledge Network on Urban Settings in 2006 culminated in the idea for a normative tool to act on health inequities in cities. In 2007, a tool for field-testing in cities was developed together with WHO offices and experts from around the world. In 2008–2009, the Urban HEART preliminary tool was field-tested in 17 cities from 10 countries. In consultation with the pilot sites and an ad hoc advisory group chaired by Sir Michael Marmot, Urban HEART and the Urban HEART user manual were published in 2010.

Mr Prasad introduced the key messages of Urban HEART evaluation, including facilitators and barriers. He presented a comparison between four implementation strategies across cities in Asia: Indore in India (community-led); Jakarta in Indonesia (led by the Ministry of Health); Tehran in the Islamic Republic of Iran (led by academia in collaboration with local government); and Paranaque in the Philippines (local government led).

He concluded by presenting the barriers to implement Urban HEART as identified in the evaluation of pilot sites from 2008–2009:

- Data availability, quality and lack of sharing mechanisms
- Engaging other sectors in addition to health in taking action
- Guidance on identifying the most appropriate interventions.

2.3 Progress of Urban HEART in Gezirat Al Warak, Giza, Egypt

Dr Emad Ezaat, Ministry of Health and Population

Geziret El Warak was selected to implement Urban HEART for its situation as an unplanned residential slum area on the Nile river with no access to motorized public transportation (except the local ferry) and presence of extremely narrow streets within the city. The Ministry of Health and Population in Egypt led the planning and implementation processes of the assessment study with the participation of other relevant stakeholders. At the initial stage a local development committee was formed comprising community members and leaders. A technical team was also established for sample selection, data collection, analysis, and reporting.

Male and female hypertension, male overweight and the prevalence of diabetes mellitus in Geziret El Warak were among the core indicators assessed. They were estimated to be 20% more than the national average. Among other indicators, access to safe water and sanitation and literacy rates in Geziret El Warak were found to be 20% less than the national average.

The local development committee, community leaders, nongovernmental organizations actively participating in implementing the interventions in response to equity assessment and for improving health related behaviours, such as tobacco control, healthy diet, literacy classes, poverty alleviation etc. The local health authority is working on improving access to quality health care services and maintaining the current good coverage of the Expanded Programme on Immunization. The local authorities are working also on improving local transportation and the environmental health status, including access to water, sanitation and solid waste management.

On 18 January 2012 the Ministry of Health and Population in collaboration with the WHO country office organized a workshop to share the results of Urban HEART with the stakeholders. The workshop was inaugurated by the Governor of Giza. The participants were divided into different groups to discuss existing problems identified by the Urban HEART study and propose possible solutions. Three working groups were assigned to address main identified problems:

- High prevalence of tobacco consumption and smoking among males
- Unemployment
- High adult illiteracy rate
- Community members with no national identification card
- Early marriage
- Sewage disposal
- Lack of safe drinking water.

Response activities included improving the transportation to the island through the purchase of a new ferry by the governor, establishment (under way) of two workstations for water purification and implementation of sanitary and solid waste disposal facilities by the mayor and selected nongovernmental organizations. In addition, tobacco control activities were introduced by the nongovernmental organizations, health volunteers and the tobacco

control unit in the Ministry of Health and Population. Screening for people without national ID was conducted by local nongovernmental organizations. Necessary logistical support was provided to the health centre in the area and patients were screened for noncommunicable diseases, with a family folder developed for each patient.

Steps taken towards sustainability include ensuring community ownership at all stages of planning, implementation and monitoring, enhancing partnerships, mobilizing resources, strengthening and supporting Urban HEART response phase by assessment, monitoring and evaluation, and dissemination of this successful experience in other areas for expansion.

2.4 Progress of Urban HEART in Sale, Morocco

Ms Khadijah Zemani, Municipality of Sale

Recent decades have seen significant urbanization of the population of Morocco, with the urbanization rate rising from 28.2% to 57.8% between 1960 and 2010. If maintained, this trend would result in a rate of 68.5% in 2050.

This uncontrolled urbanization is associated with socioeconomic changes and new health demands that the health sector alone cannot satisfy and that influence in a negative way the health status of the population.

Based on the recommendation of the WHO Commission on Social Determinants of Health, the Ministry of Health adopted the Urban HEART approach to try to understand the impact of urbanization on health and revitalize multisectoral collaboration to deal with challenges of health.

The experience of Salé involved, through effective participation within the Urban HEART team, different sectors including health, environment, education, housing, nongovernmental organizations and other local authorities.

Unavailability of valid data was overcome by conducting a survey on a representative sample of 1159 household in neighbourhoods of Medina, Sidi Moussa and Said Hajji. For the first time, the relationship between socioeconomic determinants and health status was highlighted by the city authorities. This was supported by sound data and accepted by other sectors that have recognized that health must be integral part of other sectors' policies and plans.

Despite limitations in the experiment, the mobilization of different sectors with regard to health has been achieved and an action plan developed. Its implementation is under way.

2.5 Progress of Urban HEART in Ariana, Tunisia

Dr Arfa Chokri, University of Carthage, Tunis

The Urban HEART study provided a comprehensive understanding of the characteristics of the municipality of Ariana by identifying many forms of health inequities.

The Urban HEART project was conducted over seven months. The steering and technical committee, comprising the local department of health, municipality of Ariana and the WHO office in Tunis, supported all steps of project.

Results show that the municipality of Ariana, lacked rigorous evidence, efficiency and a multisectoral approach to assess health inequities and to choose appropriate interventions. Health inequities in Ariana are related to health problems resulting from noncommunicable diseases as well as the other areas such as workplace injuries, illiteracy, health direct payment and unemployment.

Using the disaggregated data, it was found that the most affected part of the city was the district of Ariana Ville, called Ariana Medina. The proposed actions for the period 2012–2013 are to:

- implement an approach to cardiovascular diseases given the higher prevalence of risk factors with respect to social and environmental factors within the municipality of Ariana
- promote tobacco-free areas
- enhance and make useful the existing green spaces.

Challenges faced during reporting Urban HEART can be addressed by integrating the Urban HEART tool (detection, response, intervention) in the daily work of the municipality and by adapting the local information system, which was shown to be very weak for small areas in Tunisia.

2.6 Overview of urban health emergency management and its linkages with Urban HEART

Dr Qudsia Huda, WHO Regional Office for the Eastern Mediterranean

The framework for urban health emergency risk management is based on health system building blocks, with cross-cutting issues given emphasis throughout the process. The health emergency risk management cycle consists of “preparedness”, “response” and “recovery”. Disaster risk reduction and resilience-building are linked with the operational cycle of emergency management. An electronic atlas of risk has been developed by WHO (WHO e-atlas). It is important to integrate some emergency related domains and indicators into the urban health equity assessment and response tool (Urban HEART). In this regard, she suggested some indicators to be included and distributed an exercise to be filled in by the participants about health emergency management indicators to be integrated into Urban HEART. The exercise requested the participants, based on their countries’ situation; to define some related indicators (disaggregation by vulnerable groups) as follows:

- Number of cities conducting risk assessment
- Number of city plans linked to the national emergency response plan
- Number of formed rapid response teams in the city
- Availability of national policy for emergency preparedness and response

- Number of training courses conducted in a year for the community on emergency risk management.

2.7 Response part of Urban HEART Tehran

Dr Mohsen Asadi Lari, Tehran University of Medical Sciences and Health Services

The response part of Tehran Urban HEART was based on formation of community-based neighbourhood organizations, setting priorities and community-based participatory interventions in reducing equity gaps. Community ownership was promoted in reducing health inequity by establishment of different civic working groups in each neighbourhood.

As a result of Tehran Urban HEART, on February 2011 the cabinet endorsed 52 indicators and relevant government organizations are obliged to collect, report and improve equity indicators in 400 districts of the country by 2013. A second round of Urban HEART has been introduced in Tehran with the following objectives:

- Measuring the trend of social determinants of health variables
- Focusing on neighbourhoods
- Revision of variables: inclusion, discard, upgrade
- Involving the social health infrastructure and all relevant organizations within the municipality
- Concentration on the 'response'

The key actions during response were as follows:

- All neighbourhoods were informed of three worst problems
- Feedbacks were sought from all neighbourhoods
- 70 indices were delivered to all neighbourhood managers, as the 'plan of action' of the fiscal year endorsed by the Mayor
- Each neighbourhood developed its own plan for a selected priority.

In the 'response part', all data were remitted to neighbourhood directors to share with the local authorities, local people and stakeholders in order to prioritize the social determinants of health variables, select main social determinants of health problem, develop appropriate proposals for interventions, finance the projects, conduct interventions, monitor the progress and document the whole process within neighbourhoods. This means that one local authority may choose, for example, reducing illiteracy, while another may choose physical inactivity, obesity, oral health, domestic violence, smoking, and so forth. Therefore, different priorities have been set, and 374 proposals are being developed with local solutions.

2.8 Panel discussion on challenges and opportunities facing in implementation of Urban HEART

Challenges	Opportunities
Lack of security in some countries	Access to health/social services
Unplanned neighbourhood development	community interest to be involved in local development activities that will have impact on their livelihood
Insufficient government/Ministry of Health ownership and commitment	Available infrastructure for intersectoral action
Weak coordination mechanism/intersectoral action	Presence of community health workers
Insufficient funds for development and multisectoral projects	Health system reform in some countries of the Region
Turnover of officers responsible for the programme at different levels	Presence of interested nongovernmental organizations, donors and partners
Rapid population movement in urban areas	Decentralized health system in some countries of the Region
Weak infrastructure	High interest of mayors and governors to lead reducing health inequity at city level
No system is support of social protection of the poor	Global commitment
Weak involvement of health system	Capacity of WHO to facilitate exchange of experiences
Lack of national capacity to implement Urban HEART	Donor commitment for joint interventions in some low-income countries
Lack of efficient system to scale up joint development projects	
Lack of sustainability of interventions	
Low quality of existing health and social services (in some countries)	
Mobilizing high level commitments	
Sectors competing priorities	
High burden of noncommunicable diseases	
Illiteracy in some remote urban areas	
Trained and qualified community	

2.9 Approaches and steps to healthy settings

Dr Mohamed Elmi and Dr Samar El Feky, WHO Regional Office for the Eastern Mediterranean; Dr Sahar Abdou, Ministry of Health, Oman; Dr Asghar Farshad, University of Tehran

A healthy setting is where people actively use and shape the environment; it is also where people create or solve health-related problems. Hospitals, schools, food markets and workplaces are among the most common public settings where people visit, get services, work and stay for quite some time.

The WHO Regional Office for the Eastern Mediterranean has developed four manuals on community-based approaches and steps to implement healthy settings for review,

modification and finalization by Member States during this workshop. The draft manuals have been shared with relevant WHO technical staff at the regional and global level and experts in respective areas in different countries. Their views, comments and amendments were applied in the draft manuals and it is expected that technical units at the Regional Office, local authorities, mayors, nongovernmental organizations and WHO country offices will take the lead in implementing the approaches and steps of the healthy settings as an integral part of the healthy cities programme.

Implementing healthy settings is based on: community participation, partnership with relevant partners and empowerment of stakeholders and promoting equity in access to health and social services. The approaches and steps to implement healthy settings can be summarized as follows:

- orient local authorities, communities and stakeholders;
- conduct a situation analysis using the manuals developed by the Regional Office containing the criteria/standards for each healthy setting;
- conduct joint planning (effective partnership) and priority-setting based on local community needs, capacities and resources;
- identify needed interventions and activities (awareness and capacity-building, screening, safety, ensuring norms and standards, quality improvement, etc.) and distribute responsibilities to implement and achieve healthy schools, hospitals, workplaces and food markets;
- conduct resource mobilization, advocacy, evidence-building and networking;
- monitor and assess the outcomes and plan for sustainability and expansion of healthy settings.

2.10 Status of community-based initiatives in the countries of Region and how to scale up the programme

Dr Mohammad Assai, WHO Regional Office for the Eastern Mediterranean

During the past few decades, the health sector has confirmed its catalytic role in health promotion, devising appropriate initiatives for improving the health and quality of life of communities. This effort has been promoted by the WHO Regional Office for Eastern Mediterranean since 1988 through community-based initiatives, which have provided opportunities to integrate health interventions in local development processes.

The community-based initiatives approach addresses the major determinants of health within a broad perspective of development, and creates access to essential social services for optimum level of equity at the grass roots level through the active involvement of the community and intersectoral collaboration.

The initiative adheres to the recommendations of the Alma-Ata Declaration, and provides an excellent, replicable model of community ownership for health development. Currently, community-based initiatives cover a population of more than 13 million in most countries of the Region. The major strength of community-based initiatives remains the empowered and organized communities who gained the knowledge and capacity to change in

order to attain better social and economic status. This has created a move among the communities to achieve self-reliance, self-sufficiency and solidarity. The success of the programme has resulted in improvements in health and other socioeconomic indicators in the implementing sites.

An assessment of community-based initiatives was carried out by ministries of health in December 2011 using a common format. In addition the presentation shared the major achievements during 2011 and 2012; challenges and opportunities in the areas of community organization and mobilization, intersectional collaboration, partnership, skills training, health coverage, financial management and documentation and advocacy. The following strategies were proposed by Dr Assai to institutionalize community health and development:

- raise political commitment;
- improve the organizational set-up at all level;
- contribute to universal coverage;
- ensure linkages of community-based initiatives with social determinants of health and health equity;
- strengthen documentation and policy development;
- enhance community involvement in local development plans and health-related interventions;
- promote community participatory research;
- build partnership and mobilize resources;
- strengthen monitoring and evaluation;
- ensure financial transparency.

He opened the panel discussion by raising the following questions:

- Should the programme be renamed?
- How to achieve universal coverage through community health and development?
- Challenges and solutions for intersectoral and intrasectoral collaboration to reduce health inequity?
- Key actions to scale up the programme?
- What should WHO's role be?

After the presentation, the participants shared their own country experiences on implementation of community-based initiatives. The following are some of the highlights raised and agreed during panel discussions:

- Countries are in different stages of implementation of community-based initiatives with different levels of government commitment.
- The participants supported the expansion and scaling-up of community-based initiatives. Accordingly they were mostly in support to name it the community development approach, community-based approach, community health development approach or community-based development.
- Community-based initiatives should be evaluated in the countries of the Region. The result of evaluation can be used to scaling up the programme at national level.

- The community-based initiatives approach is a feasible tool to reduce health inequity among disadvantaged areas targeting poor and in line with Rio Declaration on social determinants of health;
- Community-based initiatives approach should be linked with social determinants of health and health equity agenda.
- In urban areas, the healthy city programme should be introduced by assessing health inequity using WHO Urban HEART and introducing healthy settings.
- In rural areas, the healthy village is a tool to empower community in local needs assessment, priority-setting, planning and management of local interventions.
- Both initiatives (healthy city and health village programmes) are based on community ownership and intersectoral collaboration aimed at reducing adverse effects of social determinants of health, promoting better quality of life and reducing health inequities.

2.11 Highlights of the global plan of action on implementation of the Rio Political Declaration on Social Determinants of Health

Dr Eugenio Montesinos, WHO headquarters

Key features of Rio Declaration are:

- Interconnectedness of policies
- Action on social determinants of health
- Health contributes to other goals of society and thus to broader development.

All representatives of governments will strive individually and collectively to develop and support policies, strategies, programmes and action plans which address the social determinants of health. Following the express mandates of the Rio Political Declaration and Health Assembly resolutions WHA62.14 (2009) and WHA65.8 (2012), the WHO secretariat will put all efforts to respond to country demands for support in the implementation of social determinants of health policies at country level.

The critical functions for social determinants of health global plan implementation are advocacy; technical assistance and capacity strengthening; evidence generation; norms and standards; and monitoring and accountability.

Action areas of the global plan of action to implement the Rio Political Declaration are as follows.

- Action area 1: Adopt better governance for health and development.
- Action area 2: Promote participation in policy-making and implementation for action on social determinants of health.
- Action area 3: Further reorient the health sector towards reducing health inequities.
- Action area 4: Strengthen global governance and collaboration.
- Action area 5: Monitor progress and increase accountability to inform policies on social determinants of health.

2.12 Draft regional strategic plan on implementation of Rio Political Declaration and expected deliverables

Dr Mohammad Assai, WHO Regional Office for the Eastern Mediterranean

Social determinants of health are the economic and social conditions in which people are born, grow, live, work and age including the health system. These circumstances are shaped by the distribution of income, wealth, influence, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. Hence, combating health inequities requires comprehensive, coordinated action to address the social determinants of health (social determinants of health) by key actors including governments, civil society, United Nations agencies and other developmental organizations, academic institutions, donors and the private sector.

The World Conference on Social Determinants of Health that was held in Rio de Janeiro in October 2011 generated tremendous enthusiasm and demand for assistance from Member States with work on social determinants of health. In addition the Rio Political Declaration on Social Determinants of Health was adopted by the World Health Assembly at its sixty-fifth session in May 2012. Resolution WHA 65.8 requested WHO to support Member States in implementing the Rio Declaration.

To reduce inequities, governments should be committed to improve living and working conditions of the people and redistributing resources with giving priority to poor and disadvantaged areas. Strengthening intersectoral collaboration and involving civil society in local decision-making processes should be the core of interventions.

Countries are recommended at the initial stage to select a model district located in a remote area for operationalizing the Rio Declaration. WHO should convene, technically support and facilitate following key actions:

- Mapping remote areas, at-risk and disadvantaged groups within selected districts;
- Building awareness among high-level authorities on the importance of social determinants of health and reducing health inequity;
- Identifying valid and sensitive equity indicators and mapping health inequities in different geographical parts of the district and build evidence on disparities between poor and rich , men and women, different ethnic groups etc (equity assessment);
- Identifying challenges and gaps and setting priorities;
- Building capacities at the managerial level and at the service delivery point responding to inequities;
- Ensuring access of remote areas to quality social services including literacy, primary health care services and social protection of poor etc;
- Promoting community ownership of interventions related to social determinants of health;
- Strengthening/establishing sustained intersectoral collaboration for reducing health inequity at district level under leadership of governor/ mayor and local authorities;

- Promoting partnership and developing joint responses.

The draft regional strategic directions to operationalize the Rio Declaration were developed based on the global plan of action on social determinants of health. The important point is that global plan of action, regional strategic plan and hopefully the national plan of action all are in line with the following five key action areas identified by the Rio Declaration that are crucial to address health inequities:

- Strengthening of global governance and collaboration
- Improving governance for health and development
- Increasing participation in policy making and implementation
- Reorienting health sector towards reducing health inequities
- Monitoring progress and increase accountability.

The strategic plan proposed a few strategic directions for each of the action areas, relevant expected deliverables, responsible units or organizations, monitoring indicators and time frame to perform the tasks. The participants were requested to review the regional strategic plan, provide their feedback and come up with outline national plans of action to operationalize the Rio Declaration on social determinants of health based on country capacities and needs.

2.13 Mobilizing resources from the Region to support implementation of the Rio Declaration on Social Determinants of Health

Mr Amine Kébé, WHO headquarters

From the hypotheses that governed the work of the Commission on Social Determinants and Health, and picking up from the report's recommendations and policy actions and those of last year's International Conference on Social Determinants of Health in Rio, the strategic areas at stake have been identified and the sectors to be focused on recognized as a set of cross-cutting actions within a comprehensive development context.

Reading all this into the WHO Programme Budget and related Strategic Objectives, in particular SO4, SO7, and SO10, brings questions on how the financing from various sources is distributed. The idea is to analyse whether the actions based on the Political Declaration (as stated in the report, the Health Assembly resolution and the Rio conference conclusions) are matched by resource allocations, and how the current financing and the funding gap are matching those statements.

Recognizing that current financing is hardly meeting requirements and expectations, opportunities need to be identified as how to take advantage of the current geopolitical move at global level (G-20) and the availability of potential donors in the Region (e.g. Gulf Cooperation Council) to engage into a more strategic approach – multisectoral proposals, pilot programmes, intercountry projects, support to national planning, mainstreaming of social determinants of health approach into country policies, to ensure sustainable change towards expected targets.

3. CONCLUSIONS

Urban HEART is a decision-making tool that facilitates urban health equity assessment and response. The tool was applied in many parts of the world including four countries in the Eastern Mediterranean Region: Egypt, Islamic Republic of Iran, Morocco and Tunisia. High-level political commitment, formation of a multisectoral team, active participation of the community, involvement of representatives from different development sectors and the selection of valid data using available resources are among the success factors of the programme. The WHO Regional Office for the Eastern Mediterranean and WHO Centre for Health Development, Kobe (Japan) will continue providing technical support to the cities interested to implement Urban HEART. This will facilitate better understanding of the unequal health determinants, unequal health risks and unequal health outcomes faced by people belonging to different socioeconomic groups within the city. Urban HEART documentation, evidence-building and expansion at the regional and national level will facilitate empowering communities, municipal and national authorities to apply a health equity lens in policy-making and resource allocation decisions for reducing health inequity and improving the access of disadvantaged groups to social and health services. It is expected that by the end of 2014, at least one city in each country will implement Urban HEART, which is a good mechanism for strengthening intersectoral collaborative action to reducing health inequity at the city level.

The main principles for implementation of the healthy settings are community participation, empowerment, and building partnership with key stakeholders for achieving universal access to health and social services. It was concluded that implementation of healthy settings should be an integral part of the healthy city programme. It was concluded by the participants that the needed steps and actions to implement healthy settings can be as follows:

- raising awareness and orienting the community, policy makers and key stakeholders about the rationale of healthy settings;
- adapting the WHO healthy settings manual according to the local needs, circumstances and resources. The adaptation process should be done jointly with the relevant technical units; for example school health, food and chemical safety, occupational health and health system units or departments;
- performing situation analysis using the manuals criteria/standards in each domain for different settings;
- joint priority-setting and planning (effective partnership) for needed interventions and activities with clear role assignments and responsibilities based on local needs, capacities and resources;
- resource mobilization, evidence-building for advocacy purposes and networking;
- monitoring and assessing the outcomes and planning for expansion of healthy settings.

Community-based initiatives have been implemented in the Region since 1988 and have provided Member States with different opportunities to integrate health interventions in local development processes. The community-based initiatives approach addresses the major determinants of health within a broad perspective of development, and creates access to

essential social services for optimum equity at the grass-roots level through community involvement and intersectoral collaboration.

Considering major achievements, challenges and opportunities in implementation of community-based initiatives, the following strategies were proposed to institutionalize community health and development in the countries of the Region:

- conducting independent evaluation;
- raising political commitment;
- improving organizational set-up at all level;
- contributing to achieve universal coverage;
- integrating social determinants of health in community health and development for better health equity;
- strengthening documentation for sharing experiences and policy development;
- enhancing community involvement in local development planning and health related interventions;
- promoting community participatory research;
- networking, building partnerships and mobilizing resources;
- strengthening supervisory, monitoring and evaluation processes.

It has been also concluded that future vision, mission and goal of the community health and development approach should focus on provision of a defined package of services to the poor and underprivileged groups of the community who have less access to the social services including primary health care services. Strengthening intersectoral action and partnership is the major strategy that results in tackling adverse effects of social determinants of health.

Social determinants of health are the economic and social conditions in which people are born, grow, live, work and age including the health system. The social determinants of health are mostly responsible for health inequities and the unfair and avoidable differences in health status seen within and between countries. Therefore, combating health inequities requires comprehensive, coordinated action to address the social determinants of health by key actors including governments, civil society, United Nations agencies and other developmental organizations, academic institutions, donors and the private sector.

The Rio Declaration on Social Determinants of Health was endorsed by Member States during the World Conference on Social Determinants of Health held in Rio de Janeiro, Brazil, in October 2011 and was adopted by the World Health Assembly at its sixty-fifth session in May 2012.

To reduce inequities, governments should be committed to improve living and working conditions of the people and redistributing resources with giving priority to the poor and disadvantaged areas. Strengthening intersectoral collaboration and involving civil society in local decision making processes should be the main target of social determinants of health interventions.

Draft regional strategic directions to operationalize the Rio Declaration have been developed based on the global plan of action on social determinants of health and focus on the five key areas of action identified by Rio Declaration:

- Strengthening of global governance and collaboration
- Improving governance for health and development
- Increasing participation in policy making and implementation
- Reorienting health sector towards reducing health inequities
- Monitoring progress and increase accountability.

Member States will be assisted to develop their own national plan of action to operationalize the Rio Declaration.

4. RECOMMENDATIONS

To Member States implementing Urban HEART (Egypt, Islamic Republic of Iran, Tunisia and Morocco)

1. By the end of 2013, improve and sustain the quality of intersectoral action and community participation with continuous needs assessment, using the existing sites as demonstration sites for expansion of Urban HEART.
2. By the end of 2014, measure the effectiveness of Urban HEART in tackling adverse effects of social determinants of health.

To all Member States

3. By end of 2014, implement Urban HEART in at least one city.
4. By end of 2014, encourage 200 local authorities registered in “1000 lives, 1000 cities” to register on the regional healthy city network website.
5. After the healthy settings manuals are finalized by WHO, form multisectoral committees to review and adapt them based on the local needs and capacities and then implement them in at least one healthy city per country by end of 2014.
6. Contribute to the comprehensive and independent evaluation of community-based initiatives that will be initiated by the Regional Office.
7. Develop national plans of action to operationalize the Rio Political Declaration on social determinants of health with special emphasis on incorporating social determinants of health as an integral part of all priority health programmes.
8. Mobilize the required funds, through partnerships with donors at the national level, to strengthen implementation of social determinants of health policies and plans of action.

To WHO

9. Develop a sixth domain of Urban HEART indicators titled “Urban Emergency Management” with a defined set of core indicators. This domain will be implemented as part of the existing Urban HEART approach in countries of the Region.
10. Provide technical support, facilitate exchange of experience, document best practices and generate evidence for advocacy and policy-making related to health equity and social determinants of health.
11. Finalize the healthy settings manuals, after applying the amendments proposed by the participants, and field test the manuals in one country by the end of 2012.
12. Develop a regional plan of action in consultation with Member States on expansion and implementation of Urban HEART and Healthy Cities.
13. Mobilize additional voluntary funds and build partnerships with donors including Member States to strengthen expansion of community-based initiatives and implementation of social determinants of health national plans of action.
14. Develop policy briefs, evidence-based advocacy kits and training materials for Member States for developing national plans of action to operationalize the Rio Declaration on Social Determinants of Health by the end of 2014.

Annex 1

AGENDA

1. Introduction and objectives of the workshop
2. Urbanization and health equity in the Region
3. Exchange of experiences on progress of the Urban Health Equity Assessment and Response Tool (HEART) in implementing countries
4. Orientation on concept, methodology and steps to introduce Urban HEART and identify gaps and opportunities to expand the tool
5. Overview of urban health emergency management as part of Urban HEART
6. Technical consultation on the draft of the healthy settings manuals (healthy hospitals, healthy schools, healthy food markets and healthy workplaces)
7. Review CBI status in the countries of the Region and discussion of how to scale it up at the national level
8. Implementation of the Rio Political Declaration on Social Determinants of Health
9. Recommendations

Annex 2**PROGRAMME****Sunday, 2 September 2012**

09:00 – 09:30	Registration	
09:30 – 10:00	Inauguration session: Opening Address Objectives and expected outcomes	Dr Ala Alwan, WHO Regional Director Dr Haifa Madi, Director, Health Protection and Promotion

*First Technical Session: Exchange of experiences on implementation of Urban HEART**Chair: Mr Iman Icar, Deputy Mayor of Mogadishu*

10:30 – 10:50	Introduction to Urban HEART; concept and methodology	Dr Mohammad Assai, WHO/EMRO
10:50 – 11:10	Progress of Urban HEART in 6 Regions and way forward	Dr Amit Prasad, WKC, Japan
11:10 – 12:00	Discussion	
12:00 – 12:30	Progress of Urban HEART in Gezirat Al Warak, Giza, Egypt	Dr Emad Ezaat, Egypt
12:30 – 13:00	Progress of Urban HEART in Sale, Morocco,	Ms Khadijah Zemani, Morocco
14:00 – 14:30	Progress of Urban HEART in Ariana, Tunisia	Dr Arfa Chokri, Tunisia
14:30 – 15:15	Discussion on Giza, Sale and Ariana Urban HEART; what are the next steps	
15:30 – 15:50	Overview of Urban Health Emergency Management and its linkages with urban health	Dr Qudisia Huda, WHO/ EMRO
15:50 – 16:30	Discussion	

Monday, 3 September 2012*Chair: Dr Ahmad Al Shatti, Kuwait*

08:30 – 09:00	Response part of Urban HEART Tehran	Dr Mohsen Asadi-Lari, Islamic Republic of Iran
09:00 – 09:30	Discussion on Tehran Urban HEART	
09:30 – 10:30	Panel discussion: Gaps and Opportunities in implementation of Urban HEART: How WHO can be more effective?	In presence of Dr Samir Ben Yahmed, WHO/EMRO

Second Technical Session: sharing draft Healthy Setting manuals

11:00 – 11:10	Why healthy setting? Objectives and expectations	Dr M. Assai, WHO/EMRO
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11:10 – 11:30	Healthy hospitals	Dr Samar ElFeky, WHO/EMRO
11:30 – 11:50	Healthy schools	Dr Sahar Abdou, Oman
11:50 – 12:10	Healthy workplaces	Dr Asghar Farshad, Islamic Republic of Iran
12:10 – 12:30	Healthy food markets	Dr Mohamed Elmi, WHO/EMRO
12:30 – 13:00	Discussion/questions and answers	
14:00 – 15:30	Group work on revising the draft manuals	
16:00 – 16:30	Group presentations	
16:30 – 16:50	CBI status in the countries of the Region	Dr M. Assai, WHO/EMRO
16:50 – 17:30	Panel discussion on how to scale up CBI in the Region	

Tuesday, 4 September 2012

Third Technical Session: implementation of Rio Political Declaration on social determinants of health
Chair: Dr Mohammed H. Al Thani, Qatar

08:30–09:00	Highlights of Global Plan of Action on implementation of Rio Political Declaration on social determinants of health	Dr Eugenio R.V. Montesinos, WHO/HQ
09:00–09:30	Draft Regional Strategic Plan on implementation of the Rio Political Declaration and expected deliverables	Dr M. Assai, WHO/EMRO
09:30–10:30	Discussion: how can we jointly operationalize Rio Declaration? Challenges/ opportunities/ responsibilities?	
11:00–13:00	Working groups: outline national key activities to implement Rio Political Declaration on social determinants of health Group 1: Afghanistan, Sudan, Somalia and Yemen Group 2: Egypt, Morocco, Palestine and Tunisia Group 3: Iraq, Islamic Republic of Iran, Jordan and Lebanon Group 4: Bahrain, Oman, Kuwait, Qatar and United Arab Emirates	
14:00–14:45	Report outcomes of the four working groups	
14:45–15:45	Mobilizing resources from the Region to support implementation of Rio Declaration on social determinants of health	Dr Amine Kébé, WHO/HQ
16:00–16:15	Draft recommendations of the workshop and next steps	Dr Lamia Mahmoud (Rapporteur), Sudan
16:15–16:45	Discussion	
16:45–17:30	Closing remarks	Dr Haifa Madi, WHO/EMRO

Annex 3

LIST OF PARTICIPANTS

AFGHANISTAN

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Director General

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Sana'a

WHO SECRETARIAT

Dr Ala Alwan, Regional Director, WHO/EMRO

Dr Samir Ben Yahmed, Director, Programme Management, WHO/EMRO

Dr Haifa H. Madi, Director, Health Protection and Promotion and A/Director,
Noncommunicable Diseases and Mental Health, WHO/EMRO

Dr Eugenio V. Montesinos, Coordinator, Social Determinants of Health, WHO/HQ

Mr Amine M. Kebe, Manager, Resource Mobilization Service, WHO/HQ

Mr Amit Prasad, Technical Officer, Urban HEART, WHO Kobe Centre

Dr Mohammad Assai, Regional Adviser, Community-based Initiatives, WHO/EMRO

Ms Joanna Vogel, Regional Adviser, Gender and Health Equity, WHO/EMRO

Dr Mohamed Elmi, Coordinator, Food and Chemical Safety, WHO/EMRO

Dr Qudsia Huda, Technical Officer, Emergency and Humanitarian Action, WHO/EMRO

Dr Faten Ben Abdel Aziz , Regional Adviser, Health Education, WHO/EMRO

Dr Sussan Watts, Technical Officer, Health Policy and Planning, WHO/EMRO

Dr. Sharifullah Haqmal, Focal Point, Community-based Initiatives, WHO Afghanistan

Dr Ruth Marby, Technical Officer, WHO Oman

Dr Lamia Mahmoud, National Professional Officer, Primary Health Care, WHO Sudan

Dr Mostafa Loutfy, Technical Officer, WHO Egypt

Mr Abdul Malik Mofadal, Technical Officer, WHO Yemen

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Dr Ali A. Farshad, WHO Temporary Adviser, WHO/EMRO

Dr Mohsen Asadi-Lari, WHO Temporary Adviser, WHO/EMRO

Dr Sahar Abdou, WHO Temporary Adviser, WHO/EMRO

Ms Evelyn Hannalla , Programme Assistant, Community-based Initiatives, WHO/EMRO

Ms Dalia Mohamed, Team Assistant, Community-based Initiatives, WHO/EMRO

Annex 4**GROUP WORK****Group work on healthy settings, Day 2**

The participants requested to register their names in healthy hospitals, healthy schools, healthy workplace or healthy food markets working groups that matches with their working experiences and qualification. The participants reviewed the draft manual and shared their comments to make the manual more comprehensive and applicable using the template that was shared with them. Following areas were the major areas that participants asked to consider in the reviewing process of the manual:

- General comments: length of the manual, usefulness of the content to improve the status of the setting, usefulness of the manual in self assessment and response;
- Introduction, concept and objectives: clear and well described implementation process, any suggestion for improvement;
- Criteria: clear, practical and applicable, any suggested criteria and how can it be improved;
- Key action needed to implement healthy settings ;
- The criteria for reviewing the manuals.

Outcomes of the healthy settings working groups

Healthy hospitals, schools, workplaces and food markets	
Item	Recommended modifications
Overall assessment	<p>The manual has to be:</p> <ul style="list-style-type: none"> • translated into the local languages • field tested • updated by the regional case studies after implemented in different countries of the Region <p>In addition the following should be added:</p> <ul style="list-style-type: none"> • a glossary • a note at the beginning of the manual that the components of the manual including objectives, implementation steps and criteria can be adapted according to the local needs, capacities and priorities
Objectives	The SMART objectives for each manual should be developed
Criteria	<p>The criteria should be revised wherever is needed to be:</p> <ul style="list-style-type: none"> • standardized based on the accepted international measures • more detailed • rearranged according to the priorities • re-worded to be in an active voice, e.g. physical work environment could be re-worded as “improve physical work environment” <p>The following additional criteria must be considered:</p> <ul style="list-style-type: none"> • in healthy hospital manual: teamwork and how to solve conflicts • in healthy hospital manual: radiation, chemicals and infection control • in healthy school manual: disabilities, students’ creativity and self-reliance • in healthy workplace manual: availability of a comprehensive policy on six workplace hazards

Instructions for working group on social determinants of health, Day 3

Considering the socioeconomic status of the countries of the Region the participants were divided into four working groups:

- **Group 1:** Afghanistan, Pakistan, Somalia, South Sudan, Sudan and Yemen
- **Group 2:** Egypt, Libya, Morocco, Palestine and Tunisia
- **Group 3:** Islamic Republic of Iran, Iraq, Jordan and Lebanon
- **Group 4:** Bahrain, Kuwait, Oman, Qatar and United Arab Emirates

The participants were asked to review the regional strategic plan and identify challenges, opportunities they face in operationalizing the Rio Declaration and come out with solutions to overcome the challenges and how best WHO can assist Member States to implement national plans of action.

Outline of national strategic plan to operationalize the Rio Declaration based on socioeconomic status and health-related priorities of countries

Group 1: Afghanistan, Pakistan, Somalia, South Sudan, Sudan and Yemen

Key areas	Suggested actions	Challenges	Opportunities	How to overcome challenges	WHO's role
Strengthening of global governance and collaboration through political commitment at national level	Integrate social determinants of health in priority health programme	Lack of awareness Political commitments	Rio international commitment Availability of success stories	Advocacy Mobilization and capacity building	Provide a platform for bringing together policy/ decision makers and donors nationally and internationally to align and reorient intersectoral team and support in community development in less developed countries Technical assistance to advocate for fund rising Promote accountability
	Include social determinants of health in country cooperation strategies, national health plans	Inappropriate timing	Availability of tools and evidence	Updating and revising the country cooperation strategy in 2014 by integration of social determinants of health Revision of national health plans	
	Partnership development	Different agenda of each partner Competition	International commitment UN platform	Honest cooperation and collaboration	
	Social protection of poor	Voiceless Hard to reach	“Arab spring” Youth involvement	Awareness raising and empowerment	
Improving governance for health and development	Develop national social determinants of health Plan; Monitor and report progress; Build networking and share information; Capacity building at all levels	Poor capacity and lack of consensus	Political commitment	Convincing stakeholders	
Increasing participation in policy making and implementation	Community empowerment; Introduce Urban HEART Evidence building	Lack of awareness, capacity and resources	Guidelines available Other countries' experiences	Fund raising and rising awareness	
Reorienting health sector	Improve quality of primary	Lack of commitment	Available experiences	Pilot programme	

towards reducing health inequities	health care services with focus on disadvantaged areas; Deliver social determinants of health oriented health services; Incorporate social determinants of health in health in all policies	Not clear vision Financial barriers		Advocacy	
Monitoring progress and increase accountability	Monitoring and supervision mechanism; Develop, analyse and use disaggregated equity data	Lack of capacity Lack of valid data and coordination	WHO expertise Availability of training packages and tools	Building capacity Improve coordination among stakeholders Accountability of government and UN agencies	

Group 2: Egypt, Libya, Morocco, Palestine and Tunisia

Key areas	Suggested actions	Challenges	Opportunities	How to overcome challenges	WHO's role
Strengthening of global governance and collaboration through political commitment at national level	Integrate of social determinants of health in priority health programme	Lack of knowledge about social determinants of health in the context of other health programme Limited cooperative and intrasectoral collaboration	Qualified health staff WHO expertise Global movement	Orientation of health related programme Regular meeting Involve central department	Capacities building Development of training manuals
	Include social determinants of health in country cooperation strategies, national health plans etc	Weak coordination between different sectors Setting an achievable objectives	Healthy city programme and Urban HEART as available tools for intersectoral collaboration	Expansion of Healthy city and urban HEART Establish a national intersectoral social determinants of health committee at national and local level	Orientation of government officials
	Partnership development	Leadership	Global priority and commitment to social determinants of health	The partnership should be strengthened through establishment of an intersectoral committee under	Encourage other UN agencies and build sustained partnership

			Build on existing partnership processes	the leadership of the prime minister/ president	
	Social protection of poor	The response part of urban health is not included in the social programme Lack of funds Lack of database	Sporadic activities	Intersectoral collaboration and transparency	Build national capacities
Improving governance for health and development	Develop national social determinants of health plan	Lack of evidence Lack of awareness No solid body responsible of social determinants of health	Availability of good practices	Establish a national social determinants of health committee at national level	Technical support and raising political commitment Assist national authorities in fund raising Sharing evidence at the regional level
	Monitor and report progress	Lack of tools and resources	Field experiences	Advocate for fund allocation from different sectors Training of monitor team	
	Build networking and share information	Weak documentation	Success stories may be subjected for replication	Improve documentation and dialogue Sharing experience through website, media and application	
	Capacity building at all levels	Lack of tools and resources	Availability of experts who need to be trained and implemented	Advocate for fund sharing from different sectors Training of monitoring team	
Increasing participation in policy-making and implementation	Community empowerment	Nil	Many activities have been conducted at the community level		
	Introduce Urban HEART	Leadership for the process Existing Local management system Limited cooperative culture Data collection process and mechanism	Healthy city programme household survey if already done	Recognition of Urban HEART as a tool at the local and central level	

	Evidence building	Lack of national evidence and experience Urban HEART implementation	Existing information system and studies	Strengthening the information system and data collection Linkages of Ministries of Health with Academia	
Reorienting health sector towards reducing health inequities	Improve quality of primary health care services with focus on disadvantaged areas	Lack of funding Human resources Poor management	Community empowerment through the community-based initiatives approach in some countries	Risk assessment approach Improve volunteerism at the community level	Awareness building Training at community level on essential issues
	Deliver social determinants of health oriented health services	Vertical approach of health system and diseases oriented approach	Existing infrastructure of primary health care	Intersectoral collaboration Central level commitment	Technical support and sharing experiences
	Incorporate social determinants of health in health in all policies (HiAPs)	Lack of evidence Lack of awareness No solid body responsible of social determinants of health Weak intersectoral collaboration	New context of our countries after revolution	Establish a national social determinants of health committee at national	
Monitoring progress and increase accountability	Monitoring and supervision mechanism	Lack of tools and resources	Field experiences	Advocate for funds sharing by different sectors Training of monitoring team	Technical support Assist national authorities in fund raising
	Develop, analyse and use disaggregated equity data	Lack of national evidence and experience	Existing information system and studies	Strengthening the information system and data collection mechanism Linkages of ministries of health with academia	Sharing evidence at the regional level

Group 3: Islamic Republic of Iran, Iraq, Jordan and Lebanon

Key areas	Suggested actions	Challenges	Opportunities	How to overcome challenges	WHO's role
Strengthening of	Integrate of social	Lack of awareness of other sectors about	Global action plan	Sustained advocacy	Technical and financial

global governance and collaboration through political commitment at national level	determinants of health in priority health programmes	social determinants of health Lack of security Migration/ immigration No global and national tool on “integrating social determinants of health in different health programmes”	WHA resolution Availability of national plan (Islamic Republic of Iran)		supports to develop national plans of action
	Include social determinants of health in country cooperation strategies, national health plans, etc	Lack of awareness of different sectors and even in ministries of health Insufficient evidence about social determinants of health Roles/ components of different health programmes	Good relationship between and within different Ministries	Coordination between different Ministries Agreement/ collaboration between and within Ministries	Develop regional guidelines Regional road map
	Partnership development	Different agendas and work plans	Partnership between ministries of health with international and national organizations	Collaboration between nongovernmental organizations and state departments and academia Share the plan of action with all partners Financial support	Technical support Coordination between 3 tiers
	Social protection of poor	Insufficient health facilities at remote areas Lack of strategic plans High rate of unemployment	National poverty alleviation plans (Iraq, Jordan, Lebanon)	Data collection/gathering Implementing strategies for poverty alleviation	Technical support (Health Economic Unit)
Improving governance for health and development	Develop national social determinants of health plan	Recognizing the social determinants of health issues Changing positions in ministries of health	Availability of social determinants of health national plan (Islamic Republic of Iran)	Collecting/gathering data and analysis Priority setting Developing policy briefs	Coordination and technical support
	Monitor and report progress	Lack of timely reports	Plan of action, with defined deadlines Annual meeting	Regular reporting mechanism	Follow up procedures and compiling the countries' reports

	Build networking and share information	Weak culture for data sharing Limitations for within and between countries Keeping data current Insufficient supervision mechanisms at national/regional levels	Current best practices at the local/national level	Regular international and regional meetings	Supervision and provision of feedbacks Development of a user-friendly website
	Capacity building at all levels	Lack of knowledge on social determinants of health at all levels Lack of sustained intersectoral coordination Lack of experience/capacity	Annual workshops on health systems A number of knowledgeable people at national/regional levels		Development modules Training of trainers
Increasing participation in policy-making and implementation	Community empowerment	Lack of trust between local people and NGO/state Lack of support from nongovernmental organizations	Social and political changes in the countries of the region	Fulfilling social promises on health and social issues Supporting small businesses/microfinance projects Women's empowerment	Developing training packages Technical support Information sharing Website Networking
	Introduce Urban HEART	Different approaches between countries/cities Good relationship between ministries of health and municipalities/implementing agencies	Every country is going to have one city by 2014! Evidence of best practices (Ariana/Giza/Sale/Tehran)	Standard approach	Technical support from WHO Kobe Centre Field tour visits (study tours) Website
	Evidence building	Advocacy for Urban HEART expansion Different languages	Good evidences Success stories	Present data in different languages	Financial and technical support
Reorienting health sector towards reducing health inequities	Improve quality of primary health care services with focus on disadvantaged areas	Lack of data Priority for disadvantage area Accreditation criteria Insufficient qualified personnel Financial problems to support healthcare workers	Accreditation system in primary health care (as in Lebanon/Jordan)	Sharing information More GDP share on health	Developing technical tools Coordinating role Organize regular intercountry meetings

	Deliver social determinants of health oriented health services	Development social determinants of health policies in all health programmes Lack of knowledge about social determinants of health Lack of social protection in some countries	Social protection in some countries International commitment (Rio Declaration, Urban HEART)	Development of social determinants of health-oriented primary health care plans Reviewing the curricula making it social determinants of health oriented	
	Incorporate social determinants of health in HiAPs	National commitment and enforcement	WHA resolution Intersectoral steering committees		
Monitoring progress and increase accountability	Monitoring and supervision mechanism;	Lack of website IT personnel at national/regional level	Available experience and materials	Capacity building Development of website Networking	Coordination
	Develop, analyse and use of disaggregated equity data	Country level data (aggregated) Lack of intersectoral cooperation Lack of common language for standard definitions Different agendas for each sectors	Common and shared goals in different sections	Collection of disaggregated data	Sharing the standardized definitions

Group 4: Bahrain, Kuwait, Oman, Qatar and United Arab Emirates

Key areas	Suggested actions	Challenges	Opportunities	How to overcome challenges	WHO's role
Strengthening of global governance and collaboration through political commitment at national level	Integrate of social determinants of health in priority health programme Include social determinants of health in country cooperation strategies, etc	Political commitment Limited acceptance of social determinants of health among health worker	Existing programmes and interventions	Advocacy To review existing programmes to identify if social determinants of health included	Advocacy To review existing programmes to identify if social determinants of health included
	Partnership development	Weak intersectoral collaboration	GCC executive health Board	Advocacy Follow up with partners	Networking and sharing best practices

	Social protection of poor	No clear plan to address poverty	National support network at government/ nongovernmental organizations		
Improving governance for health and development	Develop national social determinants of health Plan	Weak and unsustainable intersectoral action	Presence of systematic planning approach	High level advocacy	High level advocacy Monitoring
	Monitor and report progress	Gaps in the available data	Good health information system (HIS)	Strengthen HIS	Development tool for monitoring
	Build networking and share information	Weak intersectoral action	Intersectoral action committees		
	Capacity building at all levels	Limited specialized staff High dependence of non nationals	Availability of financial resources	Training and partnership	Technical support
Increasing participation in policy making and implementation	Community empowerment	Weak and unsustainable intersectoral action	Presence of some nongovernmental organizations and volunteers	Advocacy Involve community in decision making	Sharing the best practices Standardization
	Introduce Urban HEART and Evidence building	Lack of awareness	Good HIS	Advocacy and training	
Reorienting health sector towards reducing health inequities	Improve quality of primary health care services with focus on disadvantaged areas	Overwhelmed Patient focused rather than community focused	Good health system and universal accessible	Promoting community participation and intersectoral action	Technical support
	Deliver social determinants of health oriented health services				
	Incorporate social determinants of health in HiAPs				
Monitoring progress and increase accountability	Monitoring and supervision mechanism;	Absence of good quality disaggregated data	Good HIS	Better utilization of the HIS Capacity building	
	Develop, analyse and use disaggregated equity data				

The participants agreed with the draft regional strategic plan and are committed to develop their own national plan in line with global and regional plans of action. Considering the plan of action developed by country representatives the following major areas of action and requirements are prepared and presented at the end of the panel discussion related to this session.

Major areas of action	Requirements					
Capacity building	Tools	Strategies	Plan of action	Defined target groups		
Orientation and commitment of high level policy-makers	Evidence building	Global commitment	Find an influential ambassador			
Partnership (Governmental and nongovernmental organizations, private sector, UN agencies, donors, community)	Local	National	International	Communication skills	Evidence	Networking
Fundraising (national and international)	Projects	Stakeholder mapping	Redirect available resources	Communication skills	Capacity building	
Building infrastructure	Where?	Who?	How?	Integrated approach	Task distribution	
Health system development	Leadership	Integration	Intrasectoral action	Intersectoral action	Information sharing	



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