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Report on the

Regional consultation on reducing health inequities in the Eastern Mediterranean Region through actions on the social determinants of health

Teheran, Islamic Republic of Iran
21–23 April 2015



World Health
Organization

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1. INTRODUCTION

In 2008 the World Health Organization (WHO) Commission on Social Determinants of Health produced an extensive prescription for what is required to “close the gap” across all sectors of society, and at the 2009 World Health Assembly, Member States resolved to put those recommendations into practice by adopting Resolution 62.14 “Reducing health inequities through action on the social determinants of health.” This was followed by the 2011 World Conference on Social Determinants of Health in Brazil, which resulted in the Rio Political Declaration on Social Determinants of Health and its subsequent endorsement by the 130th session of the Executive Board (January 2012) and WHA 65.8.

Evidence and experience show that it is entirely possible to reduce health inequities: there are many examples of successful actions which can be built on and appropriately transferred to other areas. Closing health inequity gaps requires comprehensive, coordinated actions to address the social determinants of health across sectors, including governments, civil society, United Nations (UN) agencies and other developmental organizations, academic institutions, donors and the private sector. Global initiatives on social determinants of health, universal health coverage, prevention and management of noncommunicable diseases, prevention of road traffic accidents, quality of life improvement, ageing, emergency management and response are all based on multisectoral actions. The Urban Health Equity Assessment and Response (HEART) approach is also recognized as a platform to unify all these interventions under one umbrella at the city level and under the leadership of a governor/mayor. The WHO Urban HEART tool has been successfully implemented in the Islamic Republic of Iran and Morocco to operationalize social determinants of health and address inequities in urban settings.

Although more disaggregated data need to be collected, there is enough evidence to show persistent health inequities related to socioeconomic status, gender and urban/rural differences in the countries of the WHO Eastern Mediterranean Region. There are also persistent inequities in the social determinants which drive these unequal health outcomes. Table 1 shows disparities between the three groups of countries in the Region for selected health indicators; these can be used by ministries of health to prioritize the policies which could have the greatest impact on the health of their citizens.

Given the experience in implementing health equity strategies, more evidence is needed for advocacy especially in making the cost case. Showing that action can be effective and can bring widespread benefits to a range of desirable societal goals and can illustrate how an approach based on the social determinants of health can help ministers and WHO meet the five major priority areas.

In response to the discussions at the 61st session of the Regional Committee, a regional consultation on the social determinants of health was organized on 21–23 April 2015 in Tehran under the auspices of the Iranian Ministry of Health and Medical Education. Tehran Municipality hosted the consultation and also arranged a field visit where local communities in Tehran had organized and mobilized to reduce socioeconomic health inequities.

Table 1 Disparities in selected health indicators in three groups of countries of the WHO Eastern Mediterranean Region

Health status indicator	Group 1 countries	Group 2 countries	Group 3 countries
	Range	Range	Range
Life expectancy at birth (years)			
Males	74–79	62–78	51–64
Females	78–80	73–82	55–66
Maternal mortality rate (per 100 000 live births)	8–33	15–120	170–850
Under-5 mortality rate (per 1000 live births)	7–12	9–34	60–147
Cardiovascular disease and diabetes (deaths per 100 000 population)			
Males	180–546	268–550	455–765
Females	204–382	245–384	388–578
Prevalence of tuberculosis (per 100 000 population)	2.4–33.0	8.5–140.0	70.0–897.0
Prevalence of HIV among adults aged 15–49 years (%)	No data	<0.1–0.2	<0.1–1.3
Incidence of confirmed malaria cases (per 100 000 population)	82 ^a	0–787 ^b	25–290 781
Suicide rate (per 100 000 population)			
Total	1.0–11.5	0.4–5.3	3.7–17.2
Males	1.2–18.2	0.7–9.9	4.3–23
Females	0.6–5.4	0.2–3.6	3.0–11.5
Road traffic death rate (per 100 000 population)	10.5–30.4	9.1–34.1	17.4–25.1

Source: World Health Statistics 2014 and interagency estimates.

Group 1 countries: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates;

Group 2 countries: Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Libya, Morocco, occupied Palestinian territory, Syrian Arab Republic, Tunisia;

Group 3 countries: Afghanistan, Djibouti, Pakistan, Somalia, South Sudan, Sudan, Yemen.

^aSaudi Arabia only.

^bIraq & Islamic Republic of Iran only.

The consultation was opened by HE Dr Hassan Hashemi, Minister of Health and Medical Education, Islamic Republic of Iran. Other speakers included Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean; Sir Michael Marmot, a leader in social determinants of health and the chair of the Global Commission on Macroeconomics and Health; and Mr Meitham Amroudi, Deputy Mayor of Tehran. The programme of the meeting and a full list of participants are given in annexes 1 and 2.

In his opening address, Dr Alwan noted that the social determinants of health perspective is a global approach to reducing health inequities. Despite significant advances in health indices, uneven distribution and availability of health services and outcomes have become alarming between and within the countries Region (socioeconomic status, gender, urban/rural, conflict areas). However, many causative factors lie outside the immediate control of ministries of health. The five WHO priority areas, health systems development, maternal and child care, noncommunicable diseases, communicable diseases and emergency

preparedness and response, are all impacted by the social determinants of health has on all these priorities. He urged participants to find ways to: motivate key local policy-makers to support work on the social determinants of health; enhance community empowerment in local health and social development; design, based on existing experience and lessons learned, sustainable mechanisms for intersectoral collaboration and partnership for urban health development; and develop strategies to reduce health inequities.

On behalf of Dr Mohammad Bagher Ghalibaf, Mayor of Tehran, Mr Meitham Amroudi, Deputy Mayor, noted that health was a keystone of justice and development in society. There are associations between physical/mental health and socioeconomic status. Health deprivation is greater in vulnerable populations such as poor people, children, women and the elderly. The comprehensive concept of health (physical, mental, social and moral well-being) is reminiscent of the key role of municipality as a social organization. The municipality of Tehran addresses the problem through community partnership in health with a citizen- and neighbourhood-oriented approach. In this regard, Tehran has established 174 health houses since 2005.

Dr Hassan Hashemi, Minister of Health and Medical Education, stated that reducing inequities, especially in deprived and rural areas and in vulnerable groups of the community, has been one of the biggest achievements in the Islamic Republic of Iran. The expansion of the primary health care system and improvements in social infrastructures have rapidly improved health indices and narrowed the gaps between deprived and affluent areas. Access to health care services, especially among vulnerable populations, had also been a concern; it was therefore a priority to increase the partnership of government in paying for health care expenses. Now all Iranian citizens are under the coverage of the insurance system: out-of-pocket expenditure has been reduced by at least 10% over the past year and the intention is to reduce it up to 30% in the next few years.

Although the social determinants of health are responsible for more than 70% of health issues and inequities, they are outside the immediate control of the health system. Thus, the principles of intersectoral collaboration and community partnership, along with the Health in All policies approach, need to be followed. The most important way of controlling common diseases and social inequities is by tackling the adverse impact of social determinants of health. Recent intersectoral cooperation at national, provincial and district levels in the Islamic Republic of Iran is evidence of the feasibility of addressing this issue.

Sir Michael Marmot, UCL Institute of Health Equity in the United Kingdom, highlighted the three principles of action concluded by the Commission on Social Determinants of Health to improve health equity: improving daily living conditions, tackling inequitable distribution and capacity-building. There is a need to take action based on the requirements of each socioeconomic class of society and actively involve nongovernmental organizations in improving social determinants of health. Health is a human right so countries need to “Do something, Do more, Do better” according to their level of development. The drivers of health inequities lie in macro-level factors – society-wide factors and systems – and apply at different stages of life.

The aim of the meeting was to agree on an outline Eastern Mediterranean Region strategy and framework of action to address health inequity and social determinants of health. The outline strategy should motivate local policy-makers to support work on social determinants of health; empower local communities on health and social development, design sustainable mechanisms for intersectoral action and interactive action plans to reduce health inequities. Other specific objectives were to: share experiences at the global and regional level related to reducing health inequities through social determinants of health approach; review and present actions taken since the 61st session of the Regional Committee including challenges and priorities; share experiences from within and outside the Region on social determinants of health in conflict and crisis situations; and introduce options and tools to monitor and reduce health inequities, including Urban HEART.

Expected outcomes included: producing an outline of the regional strategy for social determinants of health and a framework of action addressing health inequities and social determinants of health; collecting regional evidence on social determinants of health and information gaps related to inequities; defining options that can be used for health inequity assessment and response including corrective measures in rolling out Urban HEART; and determining areas of support that can assist countries, including those in conflict and crisis situations, to implement the Rio Political Declaration on Social Determinants of Health.

2. TECHNICAL SESSIONS

2.1 Practical perspectives on the social determinants of health approach

Dr Haifa Madi, WHO Regional Office for the Eastern Mediterranean

Dr Eugenio Villar Montesinos, WHO Headquarters

Dr Madi presented the existing health inequities between and within countries of the Region in terms of outcome indicators such as life expectancy and mortality, coverage of interventions, health system response in terms of shortage of workforce and out-of-pocket expenditure, and exposure to risk factors. Based on the in-depth assessment of existing data the main social determinants of health were identified as: employment status, income, level of education, gender, residence (urban-rural); ethnicity, marginalization, environment and political context (including conflict and post conflict situations).

The main challenges for the Region in relation to social determinants of health were: lack of clear policies to address social determinants of health in countries; equity data not disaggregated by gender; socioeconomic and residency status not regularly collected; lack of sustained mechanisms for intersectoral action, including nongovernmental organizations and the private sector; non-integration of social determinants of health in the programmes of social sectors; no agreed framework for monitoring and evaluation or tracing accountability; and insufficient social protection of the poor and marginalized populations.

Dealing with social determinants of health can reduce inequities and help the countries of the Region make progress in all five WHO priority areas (health systems, maternal and child health, communicable diseases, noncommunicable diseases, emergency preparedness

and response). Action by the both governmental and non-health sectors is necessary to reduce health inequities.

Dr Villar elaborated on the link between social determinants of health and health equity with primary health coverage and universal health coverage, Millennium Development Goals and post-2015 agenda, and sustainable development goals. The key points for dealing with social determinants of health are highlighted in the Rio Declaration: better governance, participation, reorienting the health sector, global governance and progress monitoring. He also addressed the WHO secretariat recommendations to countries for implementation of social determinants of health including: Health in all policies; equity, gender and human right should be incorporated into public health programmes; linkages between social and environmental determinants of health should be enhanced; monitoring and evaluation of social determinants of health; and barriers against the access to health services must be removed.

The participants agreed that social and economic equities were critical in health equities. Social determinants of health also had to be integrated into the medical and nursing curricula in the countries of the Region and implementation of policies on social determinants of health had to be tailored according to each country's situation and capacity. Improving such factors as access to health services, water and sanitation, agriculture and job security in remote areas were instances where effective partnership and resource mobilization could be used to strengthen infrastructures.

2.2 Evidence on cross-governmental collaboration

Eng. Mohammad Vakilli, Governor of Semnan province, Islamic Republic of Iran

Dr El Hassan Ouanaim, Ministry of Health, Morocco

Dr Ann-Lise Guisset, Health Systems Adviser, WHO Tunisia

Provincial committees in Semnan selected 38 indicators for a pilot project on social determinants of health. These indicators were categorized into 6 groups: birth and death registration; prevalence of diseases and injuries; psychosocial health and drug abuse; access to and utilization of health services and health insurance and socioeconomic factors; education and spiritual health; and environmental health. The committee defined the organizations and supporting sectors with responsibility for each group. The provincial government assessed key equity indicators related to each domain to define multisectoral actions to reduce health inequities. The initiative resulted in improved access to the health and social services. Health equity should not be limited to theoretical concepts but should be reflected in practical approaches and responses to reduce equity gaps between different groups of the community.

Dr Ouanaim emphasized defining health priorities and policies to take a multisectoral and decentralized approach. The social determinants of health project in Morocco is based on movement from the peripheral level to the provincial and central level, taking into consideration the "Health in all policies". He highlighted the importance of the National Initiative for Human Development, a methodology of action that combines ambition, realism and efficiency, which is translated into practical programmes. This is a well-defined and

integrated approach in Morocco. The key actions as the outcomes of the National Initiative for Human Development are: support for access to social facilities and basic services; training and capacity-building activities; income-generating projects; sociocultural and sports activities; and effective communication at all levels.

Dr Guisset reviewed the health sector reform programme in Tunisia and stressed the importance of people having trust in the health sector. This is achieved through accountability and engaging people, which are considered the main pillars of health system reform. These principles were followed through a “Social Dialogue” project that involved citizens in determining health issues then advising on strategic goals and operational models for health sector reform. Each task force organized workshops and prepared a background paper which was then given to a working group to prepare a white paper. Although it is too early to demonstrate the impact of this multisectoral action, some important steps have been taken that will create a more enabling environment for sound public health policies in Tunisia.

2.3 Linkages of social determinants of health with universal health coverage: Thailand experience

Ms Nanoot Mathurapote, National Health Commission Office, Thailand

There has been a shift in focus in Thailand from individual to community. The advancement of financial protection coverage has reduced health inequities through moving towards universal health coverage. According to a study by the National Health Commission Office, the root causes of teenage pregnancy in Thailand are low levels of education and literacy rates, poor understanding about sex among teenagers, family cultural barriers, high use of drugs and alcohol, gender inequality, environment and society circumstances; these all are related to the social determinants of health. The same study concluded that the top 10 causes of death are a result of financial and social status among the poor, poor transnational cooperation, work–life imbalance and cultural barriers. Thailand has planned to address health problems through social determinants of health through the following concepts: health is well-being, shifting from a focus on individual behaviours to a conducive social environment, and shifting from a focus on health risk factors to social determinants of health. As a result, health is becoming a sustainable development goal. Strengthening health governance and the creation of alternative policy processes by the National Health Assembly were among the government commitments towards universal health coverage and its linkages with social determinants of health. Some of the National Health Assembly resolutions from 2008–2014 related to health systems, noncommunicable diseases, teenage pregnancy, agriculture and food, nutrition, and the impact of free trade agreements on health. Social determinants of health and universal health coverage have the same approach and goals on equity but have different ways of solving health problems. Social determinants of health and universal health coverage should be synergistic: a single intervention is not effective.

2.4 Monitoring and reporting health equity

Sir Michael Marmot, UCL, United Kingdom

Dr Ahmad Hosseinpoor, WHO Headquarters

Dr Mohammad Assai, WHO Regional Office for the Eastern Mediterranean

Choosing too many indicators discourages policy-makers, therefore, using simple, practical yet informative indicators for monitoring health inequities is recommended. Developing evidence can identify problems and indicate the interventions that can improve the quality of previous policies. In cases where monitoring social determinants of health demonstrates progress in a specific area, this motivates progress towards addressing health inequities in other areas. In addition, national policy-makers in the Region should consider the detrimental impact of conflicts on health and well-being. Dealing with social determinants of health and health inequity is not just the responsibility of the health care sector, it is the responsibility of the whole of society, and the whole government.

Strengthening countries in addressing the issue of health inequality needs to be monitored. Monitoring consists of five steps: definition of indicators, obtaining data, data analysis, reporting (communicate) results, implementing changes. Monitoring brings a variety of advantages and it can bring about change. However, monitoring should not be performed only among average groups as this might obscure variations in the community. Some WHO publications have been developed that can be used by Member States to map health inequities at national and local levels, for example the Health Equity Monitor and the Handbook on health inequality monitoring. In addition, the WHO Global Health Observatory is largely used to monitor health equity.

The steps to develop framework for health information system in Eastern Mediterranean Region include 68 core indicators in three major domains: health determinants and risks, health status (morbidity and mortality), and health system response. However, there are disparities in the selected health indicators between rich and poor and urban and rural areas of the three groups of countries in Region. The framework of the health information system and the core indicators is endorsed by the Member States, but suggestions for additional indicators to complement the core health information system would be welcome.

There are a number of challenges related to the health information system; these include not reporting available disaggregated data, insufficient analytical capacity for equity data analysis, household surveys not being institutionalized, lack of data usage in policy and planning processes, and lack of awareness among policy-makers of the impact of non-health data on morbidity and mortality. To overcome the current challenges it is recommended that more attention should be put on partnership, non-health data, redesign of the health information system, national capacity-building, and conducting regular household surveys. Countries should also take action towards strengthening the routine reporting system for the health information system.

During the discussion, participants stressed that data collection through surveys may negatively affect routine surveillance by overburdening health staff. A possible solution could be the integration of social determinants of health indicators in routine data collection for the

health information system. Experiences from Member States in the Region have shown that the use of identity cards can help link the health system data and social determinants of health. It was also deliberated whether equipping health facilities with computers could facilitate better monitoring of the health information system; continuous monitoring could expedite the timely detection of issues. Community engagement in data collection and data analysis can also strengthen the role of the community in response to health inequities. It was also noted that the influence of building infrastructures such as electricity, transportation, and water sanitation are somehow neglected at the national level.

2.5 Social determinants of health in conflict and crises situations

Sir Michael Marmot, UCL, United Kingdom

Dr Rawia Thauqan, Ministry of Health Palestine

Conflict has detrimental effects on the health of whole population and on the social determinants of health (e.g. resource distribution) as well as having effects on other countries (refugees, insecure borders, etc.); there is also an exacerbation of gender-related violence in conflict situations. Neglecting social determinants of health and inequities are drivers for conflict, and conflicts can aggravate inequities (a vicious cycle). There is no simple answer to improving social determinants of health in conflict situations, however, this does not mean that everything can be neglected. Health promotion can act as a catalyst to bring countries closer and prevent conflicts or act as a peaceful message in areas which are already involved in conflict.

Inequality in resource distribution is a triggering factor of conflicts, thus effort should be made to improve the well-being and welfare of people. Improving social determinants of health could diminish the risk of conflicts. In order to attain a long-term sustainability and a “normal” post-conflict life, social networks and health systems need to be maintained. Countries need to adhere to their principles, maintain human rights and invest in the well-being of society.

In Palestine, conflict had an impact on the planning and implementation of priority health programmes. There were difficulties in the maintenance of the health infrastructure, recruitment of the health workforce, training and retaining competent professionals, responding to waves of large numbers of casualties and the increased needs for rehabilitation and mental health services. A reduction in the area of agricultural land and in farmers’ incomes as well as increases in the population density are also consequences of conflicts in the West Bank. The challenges in the Gaza strip are: lack of security; inability to protect one’s family; vulnerability to bomb attacks; lack of access to safe drinking of water, sanitation and food; displacement; being removed from “home”; becoming a refugee; loss of livelihood; loss of daily activity; loss of access to land; and lack of employment opportunities resulting in poverty and food insecurity.

Most of the countries in the Region do not pay attention to preparedness before a crisis occurs, thus they cannot maintain sustainable public health surveillance and service in times of crisis. Sir Michael Marmot made comparisons between the earthquakes in Chile and Haiti. Although the Chile earthquake was 500 times more powerful than that in Haiti, the number of

casualties was much smaller due to highly organized city infrastructure, i.e. preparedness before a crisis can diminish vulnerability.

During the panel discussion it was agreed that preparedness and resilience should exist in all sectors. Two key components of emergency preparedness are reducing vulnerability and city resilience. Palestine is evidence of how conflict has affected the health of the people, however, due to the high level of literacy among women and knowledge on the importance of prevention and primary health care, Palestine has been able to have some successes in health outcomes despite the conflict situation. The importance of partnership in tackling the adverse impact of conflicts was also discussed: without sustainable partnership, no development is possible. In this regard, the engagement of the people in priority-setting was the first step in building partnerships.

2.6 Partnership and advocacy for actions on social determinants of health

A panel discussion was held with the participation of WHO and representatives of the United Nations Development Programme, the United Nations Children's Fund, the Joint United Nations Programme on HIV/AIDS and the United Nations Population Fund (UNDP, UNICEF, UNAIDS, UNFPA) in the Islamic Republic of Iran. Following the 2011 Conference in Rio, the International Labour Organization, UNAIDS, UNDP and UNICEF agreed to work together on social determinants of health to reduce health inequity, promote development and support countries to implement the Rio Political Declaration. The agencies agreed to work on four interlinked themes: advocacy, capacity-building, monitoring and country work.

Currently a number of areas have been highlighted by the participating UN agencies including: early child development and an equity focused approach (UNICEF), empowerment of people with HIV/AIDS (UNAIDS), population development and Global fund (UNDP), reproductive health, better access and quality of services and shifting to natural deliver (UNFPA). In addition, UNAIDS representative mentioned that in Iran, HIV is a good model for intersectoral partnership involving nongovernmental organizations, government organizations, civil society, municipality and welfare organizations including UN interagency collaboration.

Regarding working jointly to support the countries of the Region to address social determinants of health, the following proposals were made:

- considering social determinants of health as a platform and guiding principle to address disparities;
- joint planning taking advantage of the United Nations Development Action Framework to prevent duplication;
- joint programming to address advocacy, required capacity, monitoring and country support;
- south-to-south collaboration;
- supporting countries in documentation and exchange of experiences and recruiting high calibre experts to support the work on social determinants of health;
- data gathering and usage.

The UN agencies can play a key role in building partnership at national and regional levels in responding to the health inequities with the leadership of the government. In this regard, it was suggested that a formal mechanism for coordination be established.

2.7 Regional framework for action on social determinants of health: main components to be addressed

Participants were introduced to the group work and requested to draw up interventions related to five domains:

- advocacy and capacity-building: level needed (community, policy-makers, service providers, private sector, etc.); mechanisms for enhancing advocacy and capacity-building; responsibility (Ministry of Health, other sectors, specific government units); how countries can proceed to develop case studies, economic cases and social cases;
- the steps to identifying data gaps, documenting situation analysis, data validity and strengthening the monitoring and reporting system;
- partnership: key players (community, nongovernmental organizations, UN, development sectors, multisectoral teams), roles and responsibilities, effective mechanism to enhance partnership;
- governance: the strategies and steps to enhance national commitment and leadership for social determinants of health;
- integration of social determinants of health in the five WHO priority areas: responsibilities and mechanisms.

Challenges identified included inadequate political commitment by governments and poor recognition of the social determinants of health as a priority. Other problematic areas included: unsustainable leadership; political instability/security; lack of any mechanism to operationalize a national plan for the social determinants of health through defined roles and responsibilities; the absence of disaggregated data on inequities; inadequate institutional alignment and harmonization; lack of communication or any common language between different sectors; funding constraints; fragmentation of the health system infrastructure, especially in conflict areas; weak capacity of human resources to address social determinants of health; and low utilization of public health services.

National plans need to be developed with a single path and an integrated approach. The countries in the Region should reconsider their policies and advocate for incorporating social determinants of health. Key players should be identified at country level to collaborate further in social determinants of health and health equity; integrate social determinants of health into existing projects (e.g. into all priority programmes); implement the national plans; prepare training and advocacy materials, policy briefs and mechanisms to enhance governance related to social determinants of health; identify relevant data gaps at the national level; and agree on a core set of equity indicators. Strengthening partnerships at all levels should be a priority along with enhancing community engagement, incorporating social determinants of health in the medical and nursing curriculum and developing a health system oriented towards social determinants of health.

The WHO should highlight social determinants of health and the reduction of health inequities to the UN Annual Assembly and at international conventions like the Framework Convention on Tobacco Control, thus making it legally binding for all UN Member States and all governmental sectors. It would also be expected to provide technical support in developing a standard core set of equity indicators; assist in capacity-building activities, particularly in data analysis; and develop generic tools, models and methodology for assessing and responding to inequities. In addition, WHO can facilitate the exchange of experiences (sharing success stories), design a “logic model” for how actions fit together, and advise on cross-cutting actions to address a broad set of objectives and concrete feasible interventions rather than simply adding a longer list of actions.

3. GLOBAL AND REGIONAL EXPERIENCES ON THE URBAN HEALTH EQUITY ASSESSMENT AND RESPONSE TOOL

3.1 Current implementation of the tool

The WHO Urban HEART tool guides policy-makers and decision-makers to determine the impact of socioeconomic status on the health and well-being of individuals and the community in urban settings. The major principles on which Urban HEART is based are intersectoral collaboration and community engagement. Urban HEART has been initiated by WHO in Tehran, Giza, Ariana, Sale, Aqaba and Jalalabad. The approach was to unify interventions under one umbrella at the city level under the leadership of the governor/mayor. However, selection of the cities was not based on defined or commonly agreed criteria, rather on the interests of governors/mayors. Core indicators were not calculated in all cities implementing the tool; the level of engagement and participation of academia, civil society and even development sectors, including health, varied from city to city. Setting priorities for response was not based on defined criteria or results from the Urban HEART matrix. Documentation and sharing experiences among cities and networking need to be enhanced.

3.2 Global evaluation of the tool

Dr Amit Prasad, WKC, Japan

Urban HEART is a tool to monitor a set of equity indicators that can be used in identifying equity gaps in urban settings and offers possible responses through intersectoral collaboration and community engagement. The first version of Urban HEART was used seven years ago and Tehran was one of the six model cities selected. The challenges that led to developing the second version of Urban HEART included political issues as well as some issues in conceptualization, data analysis and selecting core indicators and intersectoral action for health.

Examples of good practices and certain WHO interventions include: developing the Urban HEART description manual and a training manual elaborating on the six main steps; training 86 representatives from 86 countries; a review of successful examples of the implementation Urban HEART in Colombia, a country which has recently come out of war and which has integrated health equity in a city development programme using Urban HEART. Kenya and India were also mentioned as successful examples of the implementation

of Urban HEART at provincial and local levels. In India, the Ministry of Health was not involved so nongovernmental organizations empowered the community (particularly women living in slum areas). There are now plans for WKC to integrate emergency management for Urban HEART, as recommended by WHO.

3.3 City coordination for well-being and moving towards universal health coverage through multisectoral partnership

Dr Olga Zerrudo Virtusio, Paranaque, Philippines

There are a number of major challenges in Paranaque such as a highly dynamic population, poverty, poor sanitation, communicable and noncommunicable diseases and typhoons. Some are in part resulted from the urbanization process. Dr Virtusio overviewed success stories from the implementation of Urban HEART in the city of Paranaque: providing access to drinking water and facility-based care delivery (which reduced the under-five mortality rate and the incidence of measles, mumps and rubella), enhancing the renovation of health care facilities, introducing a registration system for pregnant women with the aim of estimating the delivery burden and enhancement of the number of hospital deliveries as opposed to home deliveries. Providing appropriate health services requires strong participation of public and private sectors and the engagement of nongovernmental organizations. Paranaque city was recognized as the most economically dynamic city of Philippine In 2014.

3.4 Multisectoral action

Ms Kelly Murphy, St. Michael's Hospital, Toronto, Canada

Ms Murphy pointed out some challenges faced in Toronto such as growing urban inequalities, poverty, homelessness and unemployment. Urban HEART was implemented by the municipality to address those challenges. This involved contributions from 130 experts from 43 different organizations who created a revised set of indicators for the tool, categorized into 5 major groups: economic opportunities, social development, participation in decision making, healthy lives and physical surroundings. Equity indicators assessed through multisectoral actions and adequate responses in filling equity gaps are being employed. Indicators were selected using benchmarks determined at local (rather than federal) level as a threshold to identify the neighbourhoods most in need of interventions.

3.5 Innovations on city health development

Dr Daniel Okello, Director Public Health and Environment, Kampala, Uganda

The main challenges in the city of Kampala are: the city/government owns just 1% of the health facilities; 60% of people reside in informal settlements; industries are concentrated around the lake, which is the main water source of Kampala, and contaminate the water. As a result of implementing Urban HEART, the main interventions were to address institutional inefficiencies, enhance revenue mobilization, modernize and automate business processes, connect the road network, establish a safe and efficient public transport service, establish safe neighbourhoods and a green environment, promote preventive health systems, develop structures for curative health, establish a waste management system and promote road safety,

as well as actions designed to empower the community economically, create employment opportunities and facilitate and sustain business growth.

The following activities were recommended: moving away from an exclusively hospital-oriented health services toward a primary health coverage-oriented system, provision of medical services in urban settings should be viewed in terms of scope rather than fixed packages, exploring the possibility of cross subsidy in the provision of services. It is not only the integration of services that is important, the integration of the organizational structures around processes is vital.

In the discussion session that followed, the participants noted that sharing the good experiences of other countries via the WHO website would be highly recommended, the Healthy Cities initiative should be expanded using the Urban HEART approach, leadership and partnership are key in addressing social determinants of health and health inequity and the selection of sensitive indicators and establishing a multisectoral monitoring system is essential to the success of Urban HEART.

3.6 Case study: Urban HEART implementation in Tehran

Dr Mohsen Asadi-Lari, Ministry of Health and Medical Education, Islamic Republic of Iran

Dr Asadi-Lari introduced some actions taken in the Tehran Urban HEART project such as rapid assessment, removal of barriers in the second round of the project based on the outcomes of the first round, and development of the tool and framework of action addressing equity indicators in six domains. Each local community council selected one priority area for action; the selection criteria were severity of identified problems and feasibility of action. There was community involvement in identifying causes of inequities and determining local solutions. In all, 52 health equity indicators have been identified in the Urban HEART project. The third round of the project in Tehran will be start in October 2015, and the National Social Determinants of Health Commission will also be established in 2015.

4. GROUP WORK ON THE FIELD VISITS TO TEHRAN NEIGHBOURHOODS

The participants were divided into three groups to visit Tehran local communities. They provided positive feedback and commended the activities. The main points of the feedback were: people serving the people; the Tehran experience is a practical response to Urban HEART; in Tehran the project addresses social determinants of health and health risks through community ownership rather than through the health ministry; other countries can learn from the project in Tehran.

The health system alone should not implement Urban HEART: it is based in multisectoral action and community ownership. The Iranian Ministry of Health and Medical Education established a primary health coverage steering committee from 1984 to 1994. This committee set strategies and a technical committee of university professors outlined the structure of a primary health coverage-oriented health system. At first it was mainly an

academic exercise but later on it became a community exercise, with women playing a strong role in the project.

Urban HEART evaluation should not wait until the final results; it should mainly focus on sustainability of intersectoral partnership and it should be process-oriented, not outcome-oriented. A tool for monitoring and evaluation of Urban HEART should be developed by WKC. Documentation and dissemination of results can facilitate sharing experiences and learning from others in the expansion phase.

5. CONCLUSIONS

Considering the large number of countries facing conflicts and emergencies in the Eastern Mediterranean Region, a session was entirely devoted to social determinants of health in conflicts and crisis situations. Preparing for crisis – strengthening response interventions through vulnerability reduction, intersectoral actions, city resilience, restructuring of the health system and protecting public health facilities from damage as a result of crisis – should be seriously considered as an integral part of a country's social determinants of health plan of action.

In discussing the importance of partnership and the need for multisectoral action to monitor health inequities, it was considered that UN agencies can play a key role in building partnerships at national and regional levels in response to the health inequities. Capacity-building in the local community and their active engagement are crucial elements for implementation of social determinants of health. In addition the participants critically reviewed the implementation of Urban HEART in the Region and concluded that countries should be assisted in using a refined Urban HEART as an option to address inequities in urban settings. Closing health inequity gaps requires comprehensive, coordinated actions to address social determinants of health across sectors, including government, civil society, UN agencies and other development organizations, academic institutions, donors and the private sector. In this regard the experiences of the Islamic Republic of Iran, Morocco, Thailand and Tunisia presented during the consultation are evidence of successful multisectoral collaboration that can largely be used by other countries of the Region. Global initiatives such as social determinants of health, universal health coverage, prevention and management of noncommunicable diseases, prevention of road traffic accidents, quality of life improvement, ageing, emergency management and response are all based on multisectoral action.

Countries of the Region need help in implementing the recommendations for social determinants of health, mainly promoting Health in All Policies; incorporating equity, gender and human rights into public health programmes; enhancing linkages between social and environmental determinants of health; monitoring and evaluating social determinants of health; and removing all barriers that hinder access of all to health and other social services. Choosing simple, practical yet informative indicators for monitoring health inequities is essential to proceed with the implementation of the social determinants of health national plan of action. The importance of monitoring equity indicators was highlighted; this comprises five steps: definition of indicators, obtaining data, data analysis, reporting (communicating) the results and implementing changes. Countries also need assistance in

using the WHO Global Health Observatory and other tools like Urban HEART to monitor health equity and assist in developing responses in filling equity gaps.

An integrated approach and framework of action based on social determinants of health need to be developed in order to achieve a coherent and systematic linkage between social determinants of health and the development and reform of health systems. This would include mainstreaming the social determinants of health approach within public health programmes and health systems in order to reduce health inequities more systematically. Equitable health services will be unable to reduce health inequities unless the social determinants of health are addressed. Priority actions required include: developing a guide for integration of social determinants of health in the five priority programmes; strengthening coordination between different priority areas and agree on responsibilities of each priority programme in reducing health inequities; and incorporating the social determinants of health framework in the national plan for all priority programmes.

The participants agreed that an in-depth assessment of health inequity and social determinants of health in accordance with the framework in some countries would help in moving the agenda forward. The Islamic Republic of Iran, Jordan, Morocco and Sudan announced their commitment, and expressed their readiness, with the support of WHO, to be the first group of countries to conduct this exercise.

6. ACTION POINTS

The participants put forward a number of proposals for the Member States and WHO based on the framework identified by the 61st session of the Regional Committee addressing five major domains. Member States and WHO agreed to implement the following components of the proposed framework and their related actions, with technical support from WHO.

Evidence-building, advocacy and capacity-building

1. Support the four countries (Jordan, Islamic Republic of Iran, Morocco, Sudan) who expressed their readiness in conducting in-depth assessments of health inequity and the main social determinants of health according to the available data and identify the data gap. [Ministry of Health and WHO]
2. Conduct a national workshop with participation of all stakeholders to present equity gaps and identify key interventions to be implemented by the concerned sectors. [Ministry of Health and WHO]
3. Review available economic and social cases from other regions and their impact on social determinants of health and produce an outline and template to promote such undertakings in the Eastern Mediterranean Region. [WHO and UCL Institute of Health Equity]
4. Develop economic and social case studies through research, academia and nongovernmental organizations at the national level in line with the template provided

by WHO. [ministries of health of the Islamic Republic of Iran, Jordan, Morocco and Sudan]

5. Develop policy briefs and use these along with advocacy materials to orient high-level policy-makers and parliamentarians and encourage informed policy-making. [local experts supported by WHO]
6. Orient media groups on the importance of social determinants of health and their impact on overall development, including health. [high-level task force]

Identifying data gaps and the integration of core indicators for social determinants of health in the framework of the health information system

7. Organize a regional meeting participated by health information system experts from the four volunteer countries and develop a list of core equity indicators. [WHO and UCL Institute of Health Equity]
8. Integrate the list of core equity indicators in the framework of the health information system. [WHO, Ministry of Health]
9. Engage multiple departments/ministries to identify the data gaps and the sector responsible for collection, analysis and reporting. [relevant sectors supported by ministries of health and WHO]
10. Analyse core equity data and trend analysis, and use a geographic information system (GIS) mapping to identify target populations. [ministries of health supported technically by WHO]
11. Establish national mechanisms for reporting and monitoring equity trends, social determinants of health and actions taken by the relevant sectors. [ministries of health]

Governance

12. Establish a high-level multisectoral task force, with defined terms of reference, chaired at the highest possible level with the ministry of health as secretariat and with membership from all relevant sectors, selected parliamentarians and civil society. [high-level government authorities]
13. Select the targeted province/state/governorate according to equity gaps. [high-level task force]
14. Allocate or redirect available resources to the sector concerned to implement the agreed interventions. [high-level task force]
15. Engage civil society and other development sectors at the local level in needs assessment, planning and implementation of social determinants of health interventions.
16. Distribute tasks, monitor progress and report to all levels, including the local community.
17. Assess outcomes, expand and institutionalize the social determinants of health approach as part of government development policies and plans. [high-level national task force]

Partnership and harmonization

18. Map UN interventions in line with the social determinants of health concept and methodology. [UN Resident Coordinator]
19. Direct the UN Country Team to strengthen synergy between UN agencies and partners on social determinants of health interventions. [ministry of health and UN Resident Coordinator]
20. Facilitate the exchange of experiences and document good practices in addressing health inequities and social determinants of health. [WHO with other UN organizations]
21. Introduce and expand health insurance schemes and social protection for the poor to reduce out-of-pocket health expenditure. [high-level task force]
22. Engage civil society in policy dialogue and the implementation of local interventions. [high-level task force]

Integration of social determinants of health in the WHO 5 priority areas

23. Conduct an assessment of health system performance, including gaps and needs, and apply measures to improve access to quality health services.
24. Incorporate social determinants of health in national development policies and plans. [ministry of health]
25. Develop training materials on social determinants of health and their impact on health inequities for mid-level managers and health care providers. [ministry of health in collaboration with WHO]
26. Implement the WHO guide for the integration of social determinants of health in the five priority programmes: communicable diseases, noncommunicable diseases, maternal and child health, health system development and emergencies.
27. Integrate social determinants of health in health, medical and nursing pre-service education. [local academia]

Annex 1**PROGRAMME****Tuesday, 21 April 2015***Inaugural session*

08:30–08:45	Address by WHO Regional Director	<i>Dr Ala Alwan, WHO</i>
08:45–09:00	Address by Mayor of Tehran	<i>Mr Meitham Amroudi, Deputy Mayor</i>
09:00–09:15	Opening remarks by Minister of Health and Medical Education, Islamic Republic of Iran	<i>Dr Hassan Hashemi, Ministry of Health and Medical Education</i>
09:15–09:30	Keynote speech: Social determinants of health: global perspectives	<i>Sir Michael Marmot, UCL Institute of Health Equity</i>

*Practical perspectives on the social determinants of health approach**Chairs: Dr Ala Alwan and Dr Syed Alireza Marandi, MP*

10:00–10:15	Objectives and introduction of participants	<i>Dr Mohammad Assai, WHO</i>
10:15–10:30	Social determinants of health: regional situation and outcomes of the 61st session of the Regional Committee	<i>Dr Haifa Madi, WHO</i>
10:30–10:45	Responding to the Rio Political Declaration on Social Determinants Of Health: global progress	<i>Dr Eugenio Villar Montesinos, WHO</i>
10:45–11:30	Discussion: how are we moving towards concrete actions at the national, regional and global level?	

*Evidence on cross-governmental collaboration**Chairs: Dr Suliman Abdelrahman Suliman, Ministry of Health, North Kordofan State, Sudan and Dr Ahmed Alshatti, Ministry of Health, Kuwait*

11:30–12:15	Successful practices and lessons learnt from countries of the Eastern Mediterranean Region on reducing health inequities through intersectoral action and mainstreaming health equity in all public policies	<i>Engineer Vakilli, Governor of Semnan; Dr El Hassan Ouannaim, Ministry of Health, Morocco; Dr Ann-Lise Guisset, WHO, Tunisia</i>
12:15–12:30	Linkages of social determinants of health with universal health coverage: Thailand experience	<i>Ms Nanoot Mathurapote, National Health Commission Office, Thailand</i>
12:30–13:30	Discussion	

*Monitoring and reporting health equity**Chair: Dr Hossein Malekafzali Ardakani, Tehran University, Islamic Republic of Iran*

14:30–14:45	Methodology for collecting and generating economic evidence/cases	<i>Sir Michael Marmot, UCL</i>
14:45–15:00	WHO work on health inequality monitoring “exploring the tools” and information gaps in health inequities	<i>Dr Ahmad Hosseinpoor, WHO</i>

- 15:00–15:15 Selecting equity indicators for each priority programme *Dr Mohamed Assai, WHO*
- 15:15–16:15 Discussion: What are the data gaps and how can they be filled? Tools, mechanisms and interventions? Member States' actions for generating economic evidence

Social determinants of health in conflict and crises situations

Chair: Dr Salih Hasnawi, Iraqi MP

- 16:30–16:45 Methodology for collecting and generating economic evidence/cases *Sir Michael Marmot, UCL*
- 16:45–17:30 WHO work on health inequality monitoring “exploring the tools” and information gaps in health inequities *Dr Ahmad Hosseinpoor, WHO*

Wednesday, 22 April 2015

Partnership and advocacy for actions on social determinants of health

Chair: Dr Haifa Madi, Director health protection and promotion, WHO/EMRO

- 08:30–09:30 Panel discussion: partnering to advocate action on social determinants of health *WHO, UNDP, UNICEF representatives*

Regional framework for action on social determinants of health (main components to be addressed)

Chair: Dr Ala Alwan

- 09:30–09:45 Introductory remarks
- 09:45–11:00 Group work: what are the priority actions in each domain for countries of the Eastern Mediterranean Region?
- 11:00–13:00 Group presentations and panel discussion: future actions to scale up social determinants of health in the Region

Global and Regional experiences on Urban HEART

Chairs: Dr Alex Rose, Director, WKC

- 14:00–14:15 Global evaluation of Urban HEART *Dr Amit Prasad, WKC, Japan*
- 14:15–14:30 Philippines: city coordination for well-being and moving towards universal health coverage through multisectoral partnership *Dr Olga Zerrudo Virtusio, City Health Office, Paranaque*
- 14:30–14:45 Canada: multisectoral action *Ms Kelly Murphy, St. Michael's Hospital, Toronto*
- 14:45–15:00 Uganda: innovations on city health development *Dr Daniel Okello, Public Health and Environment, Kampala*
- 15:00–15:30 Discussion
- 15:45–16:00 Case study: Urban HEART implementation in Tehran *Dr Mohsen Asadi-Lari, Ministry of Health and Medical Education*

16:00–16:15	Overall Urban HEART implementation in the Region: achievements, challenges, gaps and required actions	<i>Dr Mohammad Assai, WHO</i>
16:15–17:15	Discussion: critical review and corrective measures related to the tool, methodology and processes of Urban HEART implementation	
17:15–17:30	Brief on the field visit to Tehran neighbourhoods	<i>Dr Mehdi Golmakani, Tehran Municipality</i>

Thursday, 23 April 2015

Field visit to Tehran Municipality interventions: neighbourhood visit

08:30–12:30	Field visit
13:00–14:00	Reflection on the field visits by the participants

Closing session

14:00–14:30	Recommendations for future action	
14:30–15:00	Closing remarks	<i>Dr Haifa Madi, WHO</i>

Annex 2

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Annex 3

PROPOSED LIST OF QUALITY INDICATORS

Classification	Indicator
Structure	% of individual patient files with unique identifier within the health care facility
	% of catchment population registered with the facility
Process	% of appropriate (upward) referrals during past 6 months (by specific condition)
	% of staff who have attended continuing training on quality and patient safety during past year
	Average waiting time at outpatient clinics
	% of prescriptions that include antibiotics in outpatient clinics
	% of hypertension patients with initial laboratory investigations
	% of registered hypertension patients with BP < 140/90 at last 2 follow up visits
	% of registered diabetic patients with fasting blood sugar controlled at last 2 follow up visits
	Number of days of stock-outs per year for 15 identified essential medicines in the available essential drug list in the facility
	% of the 8 essential cardiovascular disease and diabetes mellitus medicines with no stock out in past 3 months
	% of safe injections in the health care facility
	% of health facility staff immunized for hepatitis B (3 doses)
	% of children screened for anaemia
	% of registered noncommunicable disease patients with 10-year cardiovascular risk recorded in past 1 year
	% of registered noncommunicable disease patients with blood pressure recorded twice at last follow-up visit
	Timely ambulatory follow-up after mental health hospitalization (% of persons hospitalized for primary mental health diagnoses with an ambulatory mental health encounter with a mental health practitioner within 7 and 30 days of discharge)
Outcome	% of patients aware about patients' rights and responsibilities
	Patient satisfaction rate
	Number of adverse events reported (immunization/medication)
	Staff satisfaction rate
	% of smokers attending smoking cessation counselling
	% of children under 12/23 months immunized according to the national protocol
	% of children under 5 who had weight and height measured in past 1 year
	% of high risk group immunized against influenza
	% of diabetes patients with HbA1c less than 7%
	% of diabetes mellitus patients who had fundus eye examination during last 12 months
	% of pregnant women with first visit at the first trimester
	% of pregnant women received at least 4 antenatal checks
	% of pregnant women who received health education (nutritional care, anaemia, sanitation, and high risk pregnancy signs)
	% of pregnant women fully vaccinated against tetanus
	Mortality for persons with severe psychiatric disorders (standardized mortality rate for % of persons in total population with specified severe psychiatric disorders)



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