Technical Meeting for Measuring and Monitoring Action on the Social Determinants of Health

|MEETING SUMMARY REPORT|

November 14, 2016

|OTTAWA | CANADA | 20–22 June 2016|

World Health Organization

Acknowledgements

The *Technical Meeting for Measuring and Monitoring Social Determinants of Health* (SDH), held from 20-22 June 2016, in Ottawa, Canada, was jointly organized by the World Health Organization (WHO) with the Public Health Agency of Canada (PHAC) and the Canadian Institutes of Health Research - Institute of Population and Public Health (CIHR-IPPH).

The meeting largely focused on presentations, group work and discussions related to *the Background Document, Implementing Rio: Monitoring Action on the Social Determinants of Health,* which was prepared by the *Working Group for Monitoring Action on the Social Determinants of Health*. The *Working Group* was chaired by Patricia O'Campo, who was supported in her role by staff from her institution, the University of Toronto, and members of the *Working Group* from the organizing institutions (WHO, PHAC, CIHR-IPPH).

The meeting in Ottawa was attended by *Working Group* members, as well as additional experts working with or for Member States and who were nominated by WHO regional offices to attend the meeting. WHO is grateful to the Canadian hosts – PHAC and CIHR-IPPH – for providing superb support to, and facilitation of, the Technical Meeting. Finally, the Organizers owe gratitude to the *Working Group* members and to all the meeting participants, for their lively engagement with the background document and process, and for providing their keen insights and recommendations for improving the monitoring framework.

Contents

List of appendices

1. Introduction

This report summarises the main recommendations from the Technical Meeting for Measuring and Monitoring Social Determinants of Health (the "Technical Meeting"), held on 20-22 June 2016 in Ottawa, Canada. The Technical Meeting discussed a proposal for global monitoring of action on the social determinants of health (SDH) to be conducted by the World Health Organization (WHO). This proposal was presented in the meeting in the form of a Background Document, *Implementing Rio: Monitoring Action on the Social Determinants of Health*. The Background Document proposed an approach to monitoring that was based on the *Rio Political Declaration on Social Determinants of Health* (the Rio Political Declaration), which was endorsed by the WHO World Health Assembly in 2012.

The Background Document proposal for global monitoring of action on SDH, with its framework and indicators, was developed by the Working Group for Monitoring Action on the SDH (the "Working Group"), which was constituted by WHO with the Public Health Agency of Canada (PHAC) and the Canadian Institutes of Health Research - Institute of Population and Public Health (CIHR-IPPH). The Working Group consisted of 18 members who were recommended from the Organizing institutions and by WHO regional offices, based on their knowledge of effective actions to address the social determinants of health (for list of the Working Group members, see Appendix 1). Both Working Group experts and other experts attended the Technical Meeting.

This report provides an overview of the Technical Meeting's context and structure, and then highlights key group work and plenary session recommendations for monitoring action on SDH with specific reference to the proposed framework, its measurement concepts and the indicators. For the full three-day agenda and the formal meeting presentations, please refer to the WHO Technical Meeting web site (www.who.int/social_determinants/ottawa-meeting/en/).

2. Framework conceptualisation in the Background Document

The framework presented in the Working Group's Background Paper contains 5 measurement domains aligned with the 5 *areas for action* of the *Rio Political Declaration on the Social Determinants of Health.* Its five measurement domains are:

Domain 1: National governance, which captures "Adopt better governance for health and development".

Domain 2: Participation, which captures "Promote participation in policy-making and implementation".

Domain 3: Health sector reorientation, which captures "Further reorient the health sector towards reducing health inequities"

Domain 4: Global governance, which captures "Strengthen global governance and collaboration" which pledges international action and collaboration on the SDH.

Domain 5: Monitoring and accountability, which captures "Monitor progress and increase accountability" .

Across the 5 measurement domains, specific measurements concepts were derived to cover key Rio Political Declaration pledges for each action area. Measurement concepts were prioritised if they captured what experts considered to be key action elements of the Rio Political Declaration pledges.

Indicators were then selected to focus on actions rather than impacts. This implied identifying input, output or outcome indicators. An important rationale for focusing upstream, was to stay close to action steps that align with policy-maker accountability periods, rather than focusing on the consequences of actions for health, which which are often captured by information systems covering health determinants (conditions for health equity) and information systems covering health inequalities.

Indicators that were scoped first for inclusion were those listed for the 2030 Sustainable Development Agenda. Following this, other data sources were reviewed for potential indicators related to the measurement concepts. The final list of indicators were mapped as referring to 36 out of the 56 sets of recommendation provided in the WHO Commission on Social Determinants of Health final report (*Closing the gap in a generation: health equity through action on the social determinants of health*[1]).

3. Overview of the Technical Meeting

The Technical Meeting was held over three days (for meeting agenda, see the WHO web site link www.who.int/social_determinants/ottawa-meeting/en/). Participants were from among the Working Group members, as well as additional experts and representatives from countries across different WHO regions and from the host country, Canada (for the list of participants, see Appendix 2). There were a total of 38 participants in the meeting.

The principal objective of the meeting was:

To review and make recommendations on the proposed measurement domains and core indicators for the WHO monitoring framework for action on the social determinants of health (SDH) to improve health equity, in response to pledges of the Rio Political Declaration on Social Determinants of Health (RPD).

A short summary of each day follows below.

The first part of Day 1 focused on exchanging presentations on and SDH-related monitoring and the Working Group's proposed framework paper. The WHO context for monitoring, in particular WHO aims to strengthen capacity for monitoring progress on SDH nationally and globally was described. The Chair of the Working Group presented the framework and its conceptualisation. Following these introductions, the next agenda items focused on a general discussion on the state of evidence, and

[1] Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization, 2008.

theories and methods for assessing the impact of SDH-focused interventions on health and health equity. A presentation discussing social policies in-depth was also presented. Commentaries on the evidence presentations were made by invited experts. A summary of these discussions are presented at the end of the meeting (see day 3 presentations on the WHO Technical Meeting web site).
The second part of Day 1 provided an opportunity for Canadian and country experiences and perspectives on measuring and monitoring action on the SDH to be exchanged. These presentations are also available on the WHO Technical Meeting web site.

Day 2 focused on group work to review the proposed SDH action monitoring framework. Group work sessions were organized along the 5 measurement domains of the framework. Group discussion conclusions and recommendations were presented back in the plenary sessions. After concentrated group work discussions on Day 2, the conclusions of the group work were thoroughly reviewed and discussed on both Day 2 and Day 3. A new listing of emerging indicators, extracted from the group work presentations, was added to the existing list extracted from the background paper.

Day 3 focused on synthesizing the participant's views and recommendations on the framework's measurement concepts and its indicators, identifying strengths and weaknesses. A rapporteur was appointed to synthesize the group work and plenary discussions of Day 2 and to report them back in plenary on Day 3. Also on Day 3, the list of new emerging indicators, was added to the existing list and a survey questionnaire was constructed. The survey questionnaire asked respondents to rank the top 7 indicator/indicator concepts in order from most important to least important. The internet survey was held on Day 3 immediately after the morning break. Twenty-six individuals out of the 38 meeting attendees completed the survey. This included almost all of the international participants, but excluded some Canadian attendees in order not to bias the vote towards Canadians. The results from the survey were immediately made available on a screen at the meeting, and further discussed in plenary.

In closing, key next steps and milestones were discussed for the process of developing a global monitoring system on action on the SDH. The first milestone highlighted was the need to hold a web consultation on a revised framework for monitoring of action on SDH. This revised framework paper would build on the Working Group's proposal, and take took into account the discussions and recommendations of the Technical Meeting. The second milestone discussed was the development of in-depth country profiles applying the basic framework and to produce a global monitoring report by the end of 2017.

4. Main discussion points and recommendations for the framework

This section highlights the main recommendations for revising the framework, its measurement concepts and its indicators. Each domain of the framework is considered. The points contained in this section were synthesized from group work presentations, and report-back notes. Comments by domain are organized in terms of general comments, which focus more on the measurement concepts or generic issues, followed by indicator-specific comments.

Domain 1: National governance

1.1.1 Percentage of the population covered by social protection floors/systems below the poverty line [SDG Indicator 1.3.1]
1.1I.1 Parity index (female/male) for the percentage of the population covered by social protection floors/systems below the poverty line[SDG Indicator 1.3.1, disaggregated data]
1.2.1 Participation rate in organized learning (one year before the official primary entry age) [SDG Indicator 4.2.2]
1.2I.1 Parity index (female/male) for participation rate in organized learning (one year before the official primary entry age)[SDG Indicator 4.2.2, disaggregated data]
1.2II.1 Parity index (bottom/top wealth quintile) for participation rate in organized learning (one year before the official primary entry age)[SDG Indicator 4.2.2, disaggregated data]
1.a.1 1.a Provision of the rights and public laws guaranteeing self-determination of Indigenous Peoples [no indicator yet identified]
1.b.1 Presence/lack of laws that criminalize trans identity and expression, protect against discrimination on the basis of gender identity/gender expression as a category, and determine the legal right for individuals to determine their legal gender and name [UNDP]
1.c.1 Presence/lack of laws that criminalize sex work and protect the public health of sex workers* [Review of national legislation]
1.d.1 Increase in national compliance of labour rights (freedom of association and collective bargaining) based on International Labour Organization (ILO) textual sources and national legislation [SDG Indicator 8.8.2]
1.e.1 Whether a national policy exists that addresses at least two priority determinants of health in target populations [Health in All Policies governance - PAHO]

General

Disaggregation (related also to Indicators 1.1.1-1.2II.1)

Participants noted that several indicators in Domain 1 were described in terms of the average in the population, followed by an inequality indicator. The use of inequality indicators, where feasible, was supported. Participants recommended standardizing relevant inequality stratifiers (categories of disaggregation e.g. sex, wealth/income, education, urban/rural/slum). They also recommended including age.

Tracer populations and vulnerable groups (related also to Indicators 1.e.1-1.d.1)

The concept of using particular tracer populations to track the provision of human rights for health and development was discussed and supported. Participants recommended to make a list of tracer populations. There need to be indicators for vulnerable populations (more general indicator), and a list of possible populations. If countries are not reporting on certain groups, there needs to be a justification – is it a lack of data or a lack of recognition? It was further noted that in in-depth country profiles, in contrast to the global reporting, countries should be encouraged to focus on more tracer groups as per countries national reporting requirements.

Participants recommended including larger generic populations that are discriminated against and hence more emphasis on women and children as tracer populations for discrimination. The indicator on discrimination, although more outcome-oriented, was noted as being of interest with regard to discrimination: [SDG indicator 10.3.1] "Proportion of the population reporting having personally felt discriminated against or harassed within the previous 12 months on the basis of a ground of discrimination prohibited under international human rights law".

1.1.1 Percentage of the population covered by social protection floors/systems

- Overall, there was a high degree of consensus on the importance of social protection. But having explicit reference to a clear definition of what constitutes "social protection" is needed.

1.2.1 Participation rate in organized learning (one year before the official primary entry age

- The emphasis in the framework on early years was noted, including on skills development at school age, but recommendations were to go beyond preschool experiences.

1.d.1 Increase in national compliance of labour rights (freedom of association and collective bargaining)

- It was noted that this area should include the informal sector. Also it was noted that health and safety was explicitly mentioned in Rio but was missing as an indicator/measurement concept.

1.e.1 Governance mechanisms

- Participants indicated the need for an indicator that will capture intersectoral action.
- There was recognition that national governance mechanisms cover multiple aspects, therefore justifying the use of composite indices. Participants cautioned against using only composite indices in reporting and highlighted the need to complement composite indices with information on each component of the index.
- Some participants saw health impact assessments as a crucial issue for countries - assessing the impact of their policies on health. However other participants indicated that health impact assessments require an equity lens. Other negative attributes of health impact assessments was that they are often not universal and without follow up.

Domain 2: Participation

2.a.1 Whether country has adopted and implemented constitutional, statutory and/or policy guarantees for public access to information [SDG Indicator 16.10.2]
2.b.1 Whether the country has accountability mechanisms that support civil society engagement in health impact decisions [PAHO]
2.b.2 Whether mechanisms exist to engage communities and civil society in the policy development process across all sectors[PAHO]
2.c.1 Number of policies that recognize the duty to consult and cooperate in good faith with indigenous peoples in order to obtain their free, prior and informed consent (FPIC) before adopting and implementing legislative or administrative measures that may affect them. World Conference on Indigenous Peoples commitment, paragraph 3 [source not yet identified]
2.c.2 1) Existence of special measures to strengthen capacity of indigenous peoples' representative institutions; 2) Existence and capacity of national human rights institutions (NHRI) to reach out to vulnerable groups such as indigenous peoples; 3) Institutional mechanisms and procedures for consultation with indigenous peoples, in accordance with international standards [source not yet identified]
2.c.3 1) Provisions for direct participation of indigenous peoples' elected representatives in legislative and elected bodies; 2) Recognition in the national legal framework of the duty to consult with indigenous peoples before adopting or implementing legislative or administrative measures that may affect them [source not yet identified]
2.d.1 Presence/lack of laws that prohibit LGBTI people from forming organizations and participate in political parties and social movements [UNDP]

General

There was a general concern with the extent to which domain 2 lent itself to measurement. Participants noted that indicators which work at the national level might not work at other jurisdictional levels. It was noted that the work of PAHO on the Regional Health in All Policies monitoring framework has made progress with measuring social participation concepts using binary assessments. Other key points were as follows:

1. In spite of measurement challenges, this area needs to be addressed.
2. Participants recommended emphasizing participation mechanisms and transparency in this domain, referring to Rio Pledge 2.3 ("Promote inclusive and transparent governance approaches, which engage early with affected sectors at all levels of governments, as well as support social participation and involve civil society and the private sector, safeguarding against conflict of interests").
3. Accountability was also mentioned as being important.
4. The SDGs were considered weak here as they do not fully reflect the mechanisms for engaging populations.
5. There is a need to have positive engagement with vulnerable groups, particularly Indigenous groups, during the consultation process.

2.a.1 Guarantees for public access to information

- Participants supported the use of "access to information" as a necessary condition for transparency.
- Participants supported further efforts to consider measurement of other aspects related to ensuring transparency in policy making.

2.b.1-2.b.2 Social participation and civil society engagement mechanisms

- Participants recommended using the exact PAHO wordings for the indicator.
- Participants noted that the depth of social participation cannot be measured with one indicator. There was support for using more than one indicator with a clear measurement approaches for defining effective participation and for considering how to deal with the problem that smaller vulnerable populations may not meet the definition of "civil society" .

2.c.1- 2.d.1 Tracer populations and vulnerable groups

- As discussed for domain 1, see: tracer populations and vulnerable groups.
- Participants recommended that participation of indigenous populations should be kept as a separate indicator, but that any use of the indicator should be approved by indigenous populations and should at a minimum come from data sources approved by indigenous populations.

Domain 3: Health sector reorientation

3.1.1 Percentage of population using safely managed drinking-water services [SDG Indicator 6.1.1]
3.1I.1 Parity index (by wealth quintile) in coverage with safely managed drinking-water [SDG Indicator 6.1.1, disaggregated data]
3.1.2 Percentage of general government expenditure on primary health care and health promotion as a proportion of total government health expenditure (if data unavailable proxy: General government expenditure on health as a proportion of total government expenditure) [WHO]

3.2.1 Percentage of population with catastrophic health expenditure (universal health coverage) [WHO]
3.2I.1 Out-of-pocket (OOP) payments as % of income among lowest wealth quintile/OOP as % of income amongst highest wealth quintile [WHO]
3.3.1 Percentage of total government health expenditure on prevention and public health services as a proportion of total government health expenditure [OECD health accounts] [WHO – see 3.1.2]
3.3.2. Equity-adjusted universal health service coverage index [WHO]
3.a.1 National and/or subnational policy addressing the reduction of health inequities established and documented [WHO EURO]
3.a.2 Existence of a national policy which supports routine consideration of health equity in health promotion and disease prevention programs [source unclear]

General

Participants wanted measurement concepts in this domain to place more emphasis on equity in access, who is covered with health services, and by what type of health services (e.g. chronic medication, hospitalization, dental). The latter is necessary to address how "comprehensive" access and coverage are. There was also a stress on the importance of human resources – health workers – and their equitable distribution. Participants also thought that the life-course orientation of health services needed emphasis. The tension between indicators measuring intersectoral work by the health sector in domain 3, versus these indicators as part of domain 1 was noted, as the pledges in the Rio Political Declaration on intersectoral action overlap.

3.1.1 Percentage of population using safely managed drinking-water services

- Participants discussed how access to basic services formed part of the intersectoral vision of action for health in Alma Ata's rendition of primary health care.
- Participants suggested augmenting the focus on water to a broader assessment on access to *proximal* determinants.

3.1I.1 Parity index (by wealth quintile) in coverage with safely managed drinking-water

- Participants understood that this indicator related to the inequity measure for access to basic services, namely water, but wondered whether only addressing water was sufficient. They pointed out that depending on the country, access to water may not be an issue.
- Participants recommended considering the privatization of water and other essential services.

3.1.2 General government health expenditure on primary health care , health promotion

- Participants supported indicator 3.1.2 but were uncertain whether proxy – 3.1.2 *General government expenditure on health as a proportion of general government expenditure* – was a suitable substitute for the original indicator focused on *primary health care and health promotion expenditure*.
- Some participants indicated the indicator on *public* sector health expenditure was a priority as it showed the emphasis of public expenditure on health care, as *public* health expenditure is usually oriented towards more disadvantaged populations, compared with *private* sector health expenditure. Participants also supported considering the percent of GDP allocated to public health expenditures.

3.2.1 Percentage of population with catastrophic health expenditure; 3.2I.1 Out-of-pocket (OOP) payments as % of income among lowest wealth quintile/OOP as % of income amongst highest wealth quintile [WHO]

- Participants emphasised that access to financial protection was very important. Participants wondered whether financial protection access was sufficiently captured by either indicator. WHO indicated that these indicators were recommended by the WHO department dealing with health systems financing. However, it was noted that indicator 3.2I.1 was stronger with respect to inequalities in financial barriers to access.
- Participants recommended a stronger focus on inequities in level of financial health protection.
- Participants recommended following a measure of financial protection that aligns with the UHC monitoring framework.

3.3.1. Percentage of total government health expenditure on prevention and public health; 3.3.2. Equity-adjusted universal health service coverage index [WHO]

- Some participants were satisfied that using the composite equity-adjusted Universal Health Coverage metric would be adequate. Others were concerned it would not address the issue of access sufficiently, nor the comprehensiveness of coverage.
- Participants recommended identifying the different types of services included in the index to have more clarity.
- Participants recommended indicator 3.3.2 over 3.3.1, which were aligned with the same measurement concept (Level of integration of equity into health systems, policies and programmes).

3.a.1-2 National and/or subnational policy addressing the reduction of health inequities

- Participants supported use of indicators 3.a.1 over 3.a.2. (Indicator 3.a.1 is being collected for countries in the WHO European Region.)

Domain 4: Global governance

4.1.1 Amount of water and sanitation related official development assistance that is part of a government coordinated spending plan [SDG Indicator 6.a.1]
4.a.1 The country's performance on the International Health Regulations (IHR) capacity and health emergency preparedness index [SDG Indicator 3.d.1]
4.a.2 Number of countries with tax policies have been implemented to reduce tobacco demand [WHO FCTC]
4.b.1 Percentage of members or voting rights of developing countries in international organizations [SDG Indicator 10.6.1/16.8.1]
4.c.1 US dollar value of financial and technical assistance (including through North-South, South-South and triangular cooperation) committed to developing countries [SDG 17.9.1]

General

Overall, participants wanted indicators in this domain to focus more on the role of WHO and the United Nations in influencing global actors to address the social determinants of health inequalities.

Participants specifically drew attention to the Rio Political Declaration pledges addressing the role of the WHO and the UN with regards to promoting the health impacts of trade agreements and lending policies as mentioned in the Rio Political Declaration:

Acknowledging the importance of international cooperation and solidarity for the equitable benefit of all people and the important role the multilateral organizations have in articulating norms and guidelines and identifying good practices for supporting actions on social determinants, and in facilitating access to financial resources and technical cooperation, as well as in reviewing and, where appropriate, strategically modifying policies and practices that have a negative impact on people's health and well-being (pledge 14.1).

Participants indicated that the SDG framework was weak in this area as a whole: there was a lack of discussion about international trade agreements and links to health. In this regard the following points were made:

1. Participants recommended that there should be routine reporting on the implementation of agreements and their impacts. This would require the development of a new indicator.
2. Participants suggested to capture explicitly patents and agreements for mutually beneficial patents in indicators.
3. Participants also indicated a stronger emphases on South-South was needed.

4.1.1 Amount of water and sanitation related official development assistance

- Participants said that the indicator was not applicable to all countries; not all countries receive development assistance.
- Participants indicated that the measurement concept of comprehensive health service coverage and broader basic service coverage should also be addressed with respect to the "global coordination of international funding for comprehensive, equitable service coverage".
- Participants recommended splitting this indicator into 2 indicators to reflect the measurement concept. Indicators to reflect: 1) comprehensive basic services 2) expenditures allocated to coordinated government spending plans.

4.a.1 The country's performance on the International Health Regulations (IHR) capacity

- Participants noted the importance of the following pledges in this measurement concept: "Level of implementation of international agreements that improve the SDH". They thought that measurement should go beyond the IHR capacity to include indicators reflecting other agreements. Participants drew attention to the Rio Political Declaration pledge:

  Support for the leading role of the World Health Organization in global health governance, and in promoting alignment in policies, plans and activities on social determinants of health with its partner United Nations agencies, including in joint advocacy (pledge 14.2.vi).
- Yet in view of data availability issues, participants still supported the use of the recommended indicator on the IHR.

4.a.2 Number of countries with tax policies have been implemented to reduce tobacco demand

- Participants indicated that this is a controversial indicator regarding its impact on health equity. Working Group members responded that there was evidence that it reduced the social gradient in smoking, as it impacts demand behaviour of households with lower income. Participants further commented that by reduces smoking, it does not the tackle root SDH.
- Participants noted that there could be useful indicators emanating from the UN Assembly Declaration of Noncommunicable Diseases. Participants proposed a replacement indicator/measurement concept: "*measuring action on preventing commercial sector from*

targeting resource-poor communities (i.e. fast food/tobacco advertisements) as a more comprehensive indicators on NCDs."

4.b.1 Percentage of members or voting rights of developing countries

- Participants suggested splitting the indicator into one indicator about voting rights per Organization, and one about number of members:
  - Percentage of member states to multilateral organizations that are developing Countries.
  - Percentage of developing countries with voting rights in these organizations.

4.c.1 Dollar value of financial and technical assistance (incl. North-South, South, South)

- Participants recommended separating this area into two measurement concepts with separate indicators for North-South, versus South-South.
  - One indicator focusing on South-South collaboration to facilitate technology transfer (e.g. with explicit reference to patents);
  - One indicator focusing on the share of funding that is spent on training, community awareness programs, mobilizing communities, etc., which were important aspects of the Rio Political Declaration pledge:

Fostering North-South and South-South cooperation in showcasing initiatives, building capacity and facilitating the transfer of technology for integrated action on health inequities (pledge 14.2.ix).

Domain 5: Monitoring and accountability

5.1.1 Percentage of indicators in the Global Health Observatory that are provided disaggregated by a social characteristic [WHO]
5.a.1 Country has dedicated SDH action monitoring system (as per WHO definition to be developed) [WHO/PAHO]
5.a.2 Country has dedicated monitoring system for health inequalities [WHO]
5.b.1 Proportion of national health research spending related to actions on SDH [source unclear]
5.c.1 Whether country has adopted and implemented constitutional, statutory and/or policy guarantees for public access to information [SDG Indicator 16.10.2]

General

Participants noted that it was important to ensure collection and disaggregation of health and (social) determinants information. They also discussed **the use of evidence and monitoring information** as important concepts, highlighting the importance of the translation of knowledge on SDH: a) to engage and inform decision-makers, to measure the impacts of social policies; b) to ensure accountability; and c) to support other sectors in making decisions that impact health. Participants also noted the need to consider steps for harmonizing systems and information sharing. In light of these perspectives, the following amendments to the measurement concepts were recommended. However, no specific data sources were proposed. The recommended concepts included:

1. Adding *development* of the the monitoring systems as an important attribute of actions to measure – thereby showing the incremental progression in national monitoring;
2. Emphasizing the measurement of the use of information by other sectors in the national settings (to work towards in the definition of the monitoring system in the future);
3. Emphasizing evaluation of interventions and public health research.

5.1.1 Percentage of indicators in the Global Health Observatory that are disaggregated (by stratifiers)

- Participants recommended adding a minimal cut-off for qualifying for this indicator, including something similar to WHO use of four/five aspects of disaggregation (stratifiers) for monitoring health inequalities (namely: wealth, education, sex, place of residents, age).

5.a.1. Monitoring of action on SDH

- The participants supported the need for dedicated systems for SDH-related monitoring and distinguishing this from systems for monitoring health inequalities.
- Participants recommended that in defining systems for monitoring action on SDH it was necessary to make clear that there would not be duplication of monitoring systems.

5.a.2 Dedicated monitoring system for health inequalities

- Participants indicated this indicator needed a clearer definition.
- National monitoring systems that provided disaggregation by governance were considered to be important elements of monitoring systems for health inequalities. Governance refers to something that is not captured by geography but speaks to the political / structural organization of governance: level of governance (municipal, national, etc.); type of governance (e.g. self-governance in indigenous populations).

5.b.1 Proportion of national [public] health research spending related to actions on SDH

Participants recognized the importance of this indicator but that obtaining data to measure this concept was difficult. They indicated that this type of information is sometimes collected by National Research Funding Councils but even so, the focus on SDH is hard to assess.

- Participants recommended changing this indicator to measure: research capacity (e.g. are there university programmes on SDH?); research on effectiveness of interventions.
- Participants did not identify any specific cross-country data sources.

5.c.1 Whether country has adopted and implemented constitutional, statutory and/or policy guarantees for public access to information

Participants felt that this indicator was not aligned with the measurement concept (*Mechanisms for guaranteeing access to information*) and recommended an indicator on "Whether the country has an open data repository" but no data source was identified.

Overall framework recommendations

1. There was common support for having a monitoring framework linked to the pledges of the Rio Political Declaration on Action on the Social Determinants of Health, with indicators aligned to the Sustainable Development Goal indicators where feasible. In general, it was noted that there are areas where it is possible to give priority to the SDG indicators, but there are also areas where the SDG indicators are not up to the task (e.g. intersectoral mechanisms, participation mechanisms, global health governance in trade).

2. Participants recommended strengthening the action monitoring framework by explicit reference, where possible to:
   a. Life cycle approach: different countries are in very different places with regards to population demographics and age structures;
   b. Experiences in the daily lives of people – environmental, work, social and community context.

3. Participants made specific recommendations on several measurement concepts and indicators that are noted in this document. These included reference to: inequality stratifiers; the use of tracer groups to track discrimination; the importance of mechanisms for intersectoral action; the importance of mechanisms for engaging populations, in particular vulnerable groups; addressing how comprehensive and equitable health care access and coverage are; the role of WHO and the United Nations in influencing global actors to address the SDH and in protecting health and public goods from commercial interests; measuring the use of information; evaluating interventions; establishing national SDH-related and equity monitoring systems.

4. Participants recommended strengthening the action monitoring framework by having a more consistent listing of categories for disaggregation, aligned with health inequalities monitoring, and by making a list of specific tracer populations.

5. Participants recommended the inclusion of more indicators related to wider national and global influences, including trade, economics, governance of commercial interests impacting health, and patents. Within this, a wider economic context should be considered– ranging from aid arrangements to austerity.

6. The meeting saw a shift in the framework focus of measurement domain 4 –from looking at what specific nations are doing, to looking at what global actors are doing to address SDH. Yet, the meeting participants noted that there is a challenge on how to measure the international environment appropriately.

7. Participants recommended that the action monitoring framework should incorporate explicit reference to progress – noting that the rate of progress is as important as the level of progress. Countries should not be penalized for being at a low level now, and countries should not be complacent if their level is already high.

Appendix 1. Members of the Working Group for Monitoring Action on the Social Determinants of Health

CHAIR: Professor Patricia O'Campo[2] , University of Toronto

WHO region of external representative	Member
Africa	Dr James Humuza; Dr Doris Kirigia
Pan American Health Organization	Professor Aluisio Barros; Dr Hazel Dean; Dr Patricia Frenz
Eastern Mediterranean	Professor Abdesslam Boutayeb
European	Dr Rita M. Ferrelli; Ms Tone P. Torgesen
South-East Asian	Dr. Srinath Reddy
Western Pacific	Professor John Glover
	Dr Christine Brown
WHO representatives	
Headquarters	Dr Frank Pega
	Ms Nicole Valentine
	Dr Eugenio Villar Montesinos
Canada representatives	
Public Health Agency of Canada	Ms Mana Herel
	Ms Agata Stankiewicz
Canadian Institutes of Health Research	
- Population and Public Health	Dr Erica Di Ruggiero

[2] The work of the Chair and the Working Group was supported by staff of the Chair's institution, University of Toronto: Ariel Pulver; Michelle Dimitris; Kandace Ryckman; Philip Baden and the organizing institutions (WHO: Frank Pega, Nicole Valentine; PHAC: Mana Herel, Agata Stankiewicz; CIHR-IPPH: Erica Di Ruggiero).

Appendix 2. List of meeting participants

No.	Category	Region	Name	Institution
1	WHO Member States	AFRO	Francisco MBOFANA	Ministry of Health, Mozambique
2	WHO Member States	AFRO	Adiel CHIKOBVU	Gauteng Department Of Health, South Africa
3	WHO Member States	WPRO	Jackie FAWCETT	Health and Disability Information Services, Ministry of Health, New Zealand
4	WHO Member States	AMRO	Jacqueline ACOSTA DE LA HOZA	Instituto Nacional de Salud, Colombia
5	WHO Member States	EMRO	Dr Abdleghani DRHIMEUR	Ministry of Health of Morocco
6	WHO Member States	EURO	Mojca GABRIJELCIC	National Institute for Public Health Slovenia
7	WHO Member States	SEARO	Saroj JAYASINGHE	Department of Clinical Medicine, University of Colombo, Sri Lanka
8	WHO Member States	SEARO	Wiput PHOOLCHAROEN	Ministry of Public Health, Thailand
9	WHO Member States representative and referred expert	EMRO	Reza MAJDZADEH	Institute of Public Health Research, Tehran, Iran
10	WHO Member States representative and referred expert	AMRO	Orielle SOLAR	Facultad Latinoamericana de Ciencias Sociales / Latin American School of Social Sciences, FLACSO, Chile
11	WHO referred expert	AMRO	Peter GOLDBLATT	Institute of Health Equity, University Colleage London, United Kingdom
12	Working Group Members	EMRO	Abdesslam BOUTAYEB	Faculty of Sciences, University Mohamed Ier, Oujda, Morocco
13	Working Group Members	AMRO	Hazel DEAN	CDC Office for Health Equity, United States of America
14	Working Group Members	AMRO	Patricia O'CAMPO*	University of Toronto, Dalla Lana School of Public Health, Canada
15	Working Group Members	AFRO	Eshetu WORKU	Department of Health, South Africa
16	WHO Staff	HQ	Eugenio VILLAR	WHO/HQ
17	WHO Staff	HQ	Nicole VALENTINE	WHO/HQ
18	WHO Staff	HQ	Frank PEGA	WHO/HQ

No.	Category	Region	Name	Institution
19	WHO Staff	HQ	Maria NEIRA*	Director, PHE /WHO/HQ
20	WHO Staff	EURO	Christine BROWN	WHO/EURO
21	WHO Staff	AMRO	Oscar MUJICA	WHO /AMRO/PAHO
22	Canada Participant	Ottawa	Corey NEURDORF	Province of Saskatchewan
23	Canada Participant	Ottawa	Michael ROUTLEDGE	Province of Manitoba, Winnipeg
24	Canada Participant	Ottawa	Adrian EGBERS (in place of Kristina GUIGUET)	Employment & Social Development Canada (ESDC)
25	Canada Participant	Ottawa	Cara WILLIAMS	Statistic Canada
26	Canada Secretariat	HQ	Mana HEREL	Public Health Agency of Canada
27	Canada Secretariat	HQ	Marie DESMEULES	Public Health Agency of Canada
28	Canada Secretariat	HQ	Gerry GALLAGHER	Public Health Agency of Canada
29	Canada Secretariat	HQ	Agata STANKIEWICZ	Public Health Agency of Canada
30	Canada Secretariat	HQ	Maha HAMMOUD	Public Health Agency of Canada
31	Canada Support	Ottawa	Kandace RYCKMAN*	University of Toronto
32	Canada Support	Ottawa	Ariel PULVER*	University of Toronto
33	Canada Support	Ottawa	Kathryn ROCHE	CIHR-IPPH
34	Canada Support	Ottawa	Alexander MAISONNEUVE	CIHR-IPPH
35	Canada Support	Ottawa	Victoria SPOFFORD	Public Health Agency of Canada
36	Canada Support	Ottawa	Ariane RENAUD	Public Health Agency of Canada
37	Canada Support	Ottawa	Christine HARMSTON	Public Health Agency of Canada, PHAC, International Affairs Official (WHO file lead)
38	Canada Support	Ottawa	Nelly DESROSIERS	Public Health Agency of Canada, PHAC International Affairs Official (WHO file lead)

* Excused from part of Day 2 or Day 3 due to other commitments