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>> SANDRO GALEA: Okay. I'm going to convene us.

I will get us convened to start on time. I want to keep us started on schedule since people are at their computers all over the world. Thank you for joining us here in person in Geneva and wherever you are around the world.

Hello. My name is Sandro Galea and I have the privilege of serving as Dean of the Boston University School of Public Health. On behalf of our school, welcome to today's event. This is part of a series of events that we organize at our school that are intended to put a spotlight on what matters most for health. We do the events to encourage debate and discussion in multiple different formats, some in person, some hybrid to sharpen how we think about health, trying to see a way of moving forward in health through conversation.

This event is co-hosted with Alliance for Health Policy and Systems Research. With gratitude to them and delighted to have you here those that are part of World Health Assembly and those on Zoom. We will do is talk about something that I feel like has been discussed quite a bit in the academic literature in the past 25 years and seeped into the public conversation. Social determinants of health. I think that conversation has not been centered around what it means to think about and measure social determinants of health and more importantly, what does it mean to think about social determinants of health to act on them and make better decisions toward health.

You will hear from Dr. Salma Adballa and a panel of

speakers that bring different perspectives on the question of how do we think of social determinants to set up the stage to act on them and make better decisions to promote health.

Today's panel emerges from the Rockefeller-Boston University 3-D commission that originally articulated the need for global social determinants of health. And we'll talk about how that work evolved into an approach to measure social determinants to pave the way for greater global energy and synergy of measuring social determinants to improve health. I will ask our first speaker to come on. Dr. Naveen Rao is with the Rockefeller Foundation and one of the original architects in the 3D Commission in partnership with Rockefeller Foundation and Boston School of Public Health.

>> Naveen Rao: It is late in the day, so I will keep it lively and as brief as possible. Sandro forgot to mention that he and I built this at a fancy coffee shop called Starbucks, here at WHA 2019 just before COVID hit. So to come back here to talk about it five years later is very satisfying.

I remember the concept when we were starting out, it hasn't changed. But when we say health, most go to healthcare. When we talk about health, people just start seeing doctors, medicines, hospitals, and that is healthcare. What is amazing is 80% of your health depends on the food you eat, air you breathe, where you live. That is health. And 20% is doctors. By then, it is too late if you are seeing doctors. But 90% of investments and all of the talk is on the healthcare side. Only 10% goes to health.

So there is really that 80/20 rule, where 80% of the health depends on social determinants and 20% on healthcare. But we spend more time here than on that. The question is as we get better, technology is getting better, we have better at fishing bodies out of the river. But who is throwing them in? It is the social determinants of health. If you look at today, take a pregnant woman in Bangladesh, she's pregnant and drinking salinated water because of rising sea levels. That salinated water is giving her hypertension, preeclampsia and with the heat, having kidney disease. To no fault of hers, she's suffering the most. This 3D commission, when can we do to formalize it Sandro Galea said, how do we get it into advocacy and we should demand more. This is a great start. I personally am very proud to be part of this story and the 3D commission. I think the work has just begun, back to you. Thank you for the opportunity.

>> Naveen Rao: Now Dr. Salma Adballa will come and do a path of the data. Salma Adballa.

>> Salma Adballa: Usually it is too long or too short. I had it set up. Thank you for joining us on Zoom or in person. We appreciate it. We know that there are a lot of events that compete with this event. Thank you for choosing to be here with us. For my presentation, I will provide an overview of the work

we did on data on the social determinants of health to inform decision-making and I will present examples from the recent survey we conducted on the global social determinants of health.

For most of us, the role of social determinants of health in the help of shaping outcomes on the global or population level is not a new concept. We're aware of it. The concept has gained prominence and eminence in the public health field along with governments over the past few decades. Here I highlight a few good publications I think at least to my mind and the students watching if you are interested in social determinants of health, I recommend reading those, starting with the WHO report in 2008.

But despite this growing recognition, I might say from attending a lot of meetings recently. Despite the truism that everyone says we know social determinants of health matter, but then focus on healthcare, that we're not really focusing on how we translate our knowledge of the social determinants of health into action on the social determinants of health.

At the same time that there is growing understanding of social determinants of health, we were understanding technologies that led to development of data with more granularity than ever expected before. Based on the understanding of combining progress in social determinants of health and social science, we combined the 3D commission combined from Rockefeller and Boston University to combine the two fields. The commission wanted to achieve the globe from finding experts that focus on determinants of health and decision-makers from the local to global level. The 3D commission focused on barriers to action in social determinants of health and published in 2021 the recommendations and principles of how to move the field forward.

We have challenges in finding data that are not scattered or highly identifiable on the individual level and allows researchers to access the data on the social determinants of health. Now, knowing this we developed a website to work with all that provided a repos dory of international data set to action with this link. The repository is not a complete list, if there is a helpful data set that is not there, email us and we will add it.

There are other challenges with social determinants of health. The other thing to distinguish is the difference between the data in the different regions. In the first iteration of the data repository there was data set compared to 12 across 54 countries in Africa. In the existing data, they usually lack standardization. This is the Word Cloud that highlighted all of the data sources found. If you look at it, you will see we have some comparable figures, but not really that comparable to the point to be standardized and help us look into the available data across countries. Motivated by the findings and the work of the 3D commission. We launched the

global social determinants of health survey. It was to gain insight across countries.

At the same time, we also hope we will serve as proof of concept to collect the standardized data to inform decision-making when it comes to social determinants of health. We worked with teams on the ground in eight countries, including Brazil, Franz, India, Nigeria, Turkiye, Philippines and U.S.

It collected data from 8300 people. We use a model that is now standardized adopted from the WHO report on the social determinants of health. We used this because we wanted to create a standardized list others can use later if they would like to range from institutional trust experience of discrimination, level of income and assets. Debts, adequacy of healthcare and stressors, food, health outcomes. And there are a few examples of the results from the survey. Know this is not the most comprehensive but to find without regular data collection we won't be limited in our ability to actually have decision-making that is informed by data first I present a few examples on what we usually call as core asset when it comes to social determinants of health. And those are the assets that we think about when we think about social determinants of health. Those are usually income, financial situation and food insecurity. I will then present how those core assets influence other assets such as optimism and trusting government and mechanisms through which social determinants of health can act on health outcomes.

For the first example we included questions that looked at social inclusion in countries. For this example, I'm showing results for the question for when we ask people, do you think your neighborhood is a close-knit neighborhood and we only had about 50% of participants across countries that said they lived in a close-knit neighborhood. And the lack of neighborhood cohesion was particularly stark in France and in the U.S.

We also asked about financial assets. The first one was asking participants about their household financial situation compared to a year ago. And we asked this metric because tell help us understand social stability and fluctuations over time when it comes to financial stability within a household. We find slightly more than a third said they were financially better this year compared to last year, and this sentiment was significantly different across countries, with only 15% of people in France and Turkiye saying they feel much better this year compared to last year. Another question was where people worried about having enough food in the house. And some had a worry about having adequate foot for them and their family over the last month, with the number up to 50% in the Philippines and Nigeria.

We asked participants looking ahead whether they experience hardship is expected in the month, focusing on adequacy of adequate food, experience food insecurity and whether they would

have available and adequate housing for them. And about 1/5 of participant of all countries said they will likely experience hardship over the next month including inadequate housing and food insecurity, and this is representative of many households experience.

This is one of the examples of the questions we ask, this is about housing asking if they experience extreme temperatures in a house for more than 24 hours, including hold or cold extreme temperatures. We had half of the participants in all countries saying they experience extreme temperature, number rose to 50% in Brazil, Indonesia, and Turkiye.

This is an example around core assets and when we think about social determinants of health, we think about those. There is another way to think about social determinants of health, that is the perceived social status. We ask questions about the perception of economic equality in a country. And their perception about optimism of the future and how those then shape the political determinants of health, in a world that is showing interest in populism and polarization. And there is questions about the perception of the economics in the opportunities in the country. Rank from 0 to 10 of the opportunity. The results varied across countries. The results ranged from more than 50% in India saying their country is very equal, so 10. But also had a significant proportion of people saying the country is very unequal, about 25%. So stark differences in India. And more than 50% of people in Nigeria and Turkiye saying their country is very unequal.

Our survey aims to assess what inequities in social determinants of health shape the perception. We show that regardless of the country, your participants reported that they experience more food insecurity or were more likely to think that their economic opportunity in the country is unequal.

Another question is if they are optimistic about the country in the next five years. Percentage increased to more than 50% in France, Turkiye and the United States.

Another area rarely discussed at first and determined it is really important in social determinants of health, is trust. Trust is gaining traction in global health. And we surveyed about government and other institutions and whether those align with recent literature that show that there is an emotion of trust in different institutions. For example, here we found that only one-third of participant indicated they trust their government. Across the sample, but more than 50% of participant indicated they have some level of distrust in the government in Brazil, France, Nigeria and United States. We see the erosion of trust currently plays out in different countries, especially what we are seeing happening now in the U.S., for example. The U.S. had the lowest proportion of people who said they completely trust their government. We cannot think about trust without thinking of the core assets. We conducted an analysis

that shows regardless of the country itself, the level of trust was higher in participants that said they live in a close-knit neighborhood. There are several mechanisms that impact the social determinants of health and those that impact our health.

Traumatic events and life stressors. We will provide examples of mental health outcomes and how those relate to social determinants of health and trauma and life stressors as ways that they manifest when it comes to health outcomes.

So we ask participant about experiencing a traumatic event in their life. The list was retrieved from a list of validated surveys on what is called a life traumatic event. Living or being in a war of conflict zone or loss of a child or loved one. In most countries, 5% of participant experienced a recent traumatic event and it was comparable across countries. However, national disasters stood out as an event that affected a sizable proportion of the population, particularly in Indonesia, Philippines and the rest of the country. Understood in the proportion in is the loss of a loved person or grief, which is rarely something we speak about when we talk about social determinants of health and impacts on health outcomes. Life experiences differed across countries. At least 30% of participant in every country except India said they feel lonely. This is an important area to monitor given that we see more and more evidence about the importance of loneliness of the social determinants of health especially in aging global population.

Now we also used as a mentioned earlier, validated surveys to look into tools that assess different health indicators including mental health outcomes, one that we assess is probable depression. 20% reach the threshold for depression.

Again, the influence of social determinants of health is pervasive. For example, when we stratify the data, using the food insecurity social determinants of health question. We found the prevalence regardless of the country, the prevalence of depression was more than twice the prevalence among those who are food insecure compared to those who are food secure or never experience food insecurity. This really highlights how social determinants of health operate to impact health outcomes.

This slide also highlights that traumatic events serve as a mechanism leading to poor outcomes in every country worldwide. For example, we found participants that experience any traumatic event had a higher prevalence of depression compared to participants that did not experience that traumatic event.

Now, I wanted to end by highlighting the growing climate change crisis warrants more focus on measuring and tackle the social determinants of health. When we talk about climate change we talk about the direct impact on health outcomes focusing on infectious diseases or vector virology and not social determinants of health. I argue the greater impact of climate change will come from its impact on water supply, food supply as well as environmental degradation that leads to job

less, forced migration and conflict among other factors that affect the social determinants of health. So the few key takeaways I have is inequity and social determinants of health are universal. These influence trust and optimism about the future and mental health outcomes. That social stressors and trauma are modifiable mechanisms of how social determinants of health impact health outcomes and climate change is likely to exacerbate the inequities. Thank you for your attention. And looking forward to the panel discussion.

(Applause)

>> Salma Adballa: We have a distinguished group of panelists from countries around the world. We asked the panelists to offer reflections, less about the slides but more about how we think about measuring social determinants of health to the end of informing the decision-making for health. And maybe I am going to start this way. And we will start from Loyce Pace the assistant secretary for global affairs for the U.S. Department of Health and Human Services.

>> Loyce Pace: I didn't hear the question. I was applauding this present. I'm a people of government which people have very little trust. I want to acknowledge that. Hopefully, I don't take that too personally. I am happy to reflect on what I saw now. That is part of my reflection, honestly.

I have to give homage to Dr. Jones who really has just a dean in this area of work. And would be the first to not just acknowledge what we saw here and probably say she's not at all surprised. But to make sure we are all trucking that this is the way that these issues play out in reality is that they both hurt individuals who face these circumstances, or barriers. And they help others who don't have to face them. So that play is important. I think to keep in mind, because it is not just this static oh, this is too bad. But wow. The longer this lasts, the wider this gap becomes across communities.

I would just say a couple of things, if I may, because I don't know if everyone is tracking. The White House actually released a playbook on social determinants of health at the end of last year. And that is newsworthy, I think. Because you don't have a government that is not afraid to talk about everything from structural racism to wrap around services within various sectors.

I think all of us who work in this space and just live as human beings know that you know, individuals and communities require that level of attention. Our playbook is focused, first and foremost on data and need for interoperable integrated data and second looking at flexible funding and ways to remove barriers for organizations, particularly backbone organizations to show up for communities. I think the last reflection I have

and will share is this is absolutely bringing home for me why I am not just representing the Department of Health, but the Department of Health and human services. That is why we have a refugee resettlement and refugee and family and other pieces to what we do. I will make it personal, I grew up in the inner city where we had air pollution and other elements that affected my health. I grew up in a food desert. I lived in a foster home growing up. A lot of people don't know. Right?

There are a lot of issues that required that I stayed healthy. And it wasn't just a matter of making sure that I exercised or went to the doctor or the school nurse. I very much appreciate you including the U.S. in this, frankly. And just inviting me to be here with you today.

>> MODERATOR: Thank you. We will move to the Executive Director of the Alliance for Health Policy and Systems Research. Kumanan Rasanathan.

>> Kumanan Rasanathan: Hi everyone. This is an impressive analysis and resource. Congratulations to the Foundation for funding this.

My first reaction to this is the great commissioner who was on the Commissioner of Social determinants of health, had a collection of essays called the argument of India. Clearly he would term it optimistic India. Indians are particularly happy in this survey. I think on the question of, you know, how do social determinants of health shape health and health equity as people have already said, it is very clear and we have been talking about this for a very long time, whether it is 1840ed or McKeown, whether you agree with the conclusion of the 1950s or the 1980s, there are traditional medicine, age Indigenous People have talking about this for a long time. And the great Jones who we are lucky to engage with. As Salma Adballa said, governments now, at WHO say they're supportive of WHO and those that are leading and working on this. Which is a big difference to 2008 where many governments were actively antagonistic. You remember?

And we get stuck in talking about social determinants of health in the introduction. We must introduce the social determinants of health. And you go to the budget and indicators. It is lost a bit.

All of our institutions struggle with that, I think. It was wonderful to hear the U.S. is moving on that. But the real challenges of distilling that from good will federal level through a diverse and heterogeneous country.

The question is how do we move to action? This is still a major challenge. Because there are definitely things we can do better in the practice of social determinants of health and at the Alliance for Health Policy and Systems Research we feel in collaboration we can do research better and do more and do more policy and systems research. There is ways we can engage. There are tactics we can use. There are immense political

interests that are against us moving on this. The human condition is perhaps naturally inequitable and hierarchical. Can the world act on social determinants of health? And historically, there often seems to be in times of great disruption. We talk about depression, and World War II. And post-independence movements.

My origins are in Sri Lanka. If you look when Sri Lanka made investments in social determinants in the 1960s it was an optimistic period post-independence. New Zealand where I grew up in the aftermath of the Great Depression built a wealthy estate. Sometimes crises can move us in the right direction and sometimes can entrench existing interests.

I think measurement has a lot to add. I think what you have here is a great addition. We say what measures gets done. That is only half of the story. Measurement is necessary and not sufficient. We have been measuring health inequities and they get wider. I am optimistic and I'm sure Jeannette Vega and gutta will talk about what is happening in other areas and Blessing Mberu as well. And with this reaching critical mass, promise of AI. And ability of much granular data, even when what you have done. Can we get it on a regular basis? I won't steel your thunder Jeannette Vega. They get to that. My friends have released an operational framework on monitoring the determinants of health inequity and what countries are doing and can do so it reads to results and data and action. I'm sure we'll talk about that. We need the imperative of inequity and digitalization to get the disaggregated data. And meet people in realities and not just collect data and act on it. Even as measurers it is a greater challenge.

>> MODERATOR: We will go to the founder of the initiatives, Diah Saminarsih.

>> Diah Saminarsih: Checking --

>> MODERATOR: We can hear you.

>> Diah Saminarsih: I will arrive back at the data that was ended on. I want to say how complex and diverse Indonesia is. And it has a high maternal infant mortality rate. The progress has stopped. The answer to the why is social determinants of health aspect. Surrounding death of a mother, death of newborn. And sadly, it is not just at some remote corner of Indonesia. It is high-income and low-income or least developed countries all integrated into one. And consequence can high variation of results in urban and rural settings. And I think what we found out through our work is that relies on how facilities, community health workers and health professionals to do not only health intervention, but beyond health intervention. Giving education and answering to education and aspects that bring towards improvement of the health dashboard. People are busy with the dashboard and forget that data needs to be collected, governed and be made available in order to achieve actual progress.

So I think that is the path that Indonesia is in right now.

Transforming the health system, doing a systems approach. That is the result that we see. Because when I see your results, I -- the first thing that came to mind was from which part of Indonesia is this? Because it is like Kumanan Rasanathan said, it is a decentralized country, progress depends a lot on decentralized leader not as much on the national level. I think it is very interesting to find out over the years that what can see more connection on the ground through the actions and connect that to the available data sets that we need to measure.

>> MODERATOR: Next to Jeannette Vega former Minister of Social environment. And currently a Minister of Health. In Chile.

>> Jeannette Vega: Thank you. Congratulations on the work. I will focus on the data related to social determinants of health. (Off mic)

And we have two main changes right now, related to data. The first one is how do we enhance the accessibility and use of social determinants of health data. And the second one is how do we advance in measuring solutions? Which is not usually measured. How do we advance the use and accessibility of data in almost all countries, social determinants of health data are collected in different Sectors and multiple levels. So we have data from different Sectors and multiple levels, clinical data. Electronic records, health system data, other social system data, and community and network data. But also this data are in some parts global. National, local, and individuals. We need to have -- there is a need to glean the individual and population data. In our experience, if we really want to address the issues related to social determinant, in our experience, one definition that is critical is to define population and individual data by geography. Adequate geographies. That is a nice entry point for action. We know that there is and you alluded to that in the sharing of data. We need to develop standards for social determinants of health data and also we know that there is not clear connection between the social determinants of health data and policies to address them. One of the issues is that we when developed a nice framework to explain the different determinants and basically sort of the framework.

But we didn't develop a similar framework for successful interventions to address social determinant -- social determinants of health at each level. That is really needed. The other thing also alluded here is the data usually do not include community asset and resources. We never map community assets and resources. We assume that the population and communities are waiting for us to basically lead them what to do. In summary, I believe in order to address social determinants of health of improvement like we did. We basically need to first make sure that we improve data infrastructure and high quality data collection. Data infrastructure is important.

And it is lagging in several countries. Secondly, that we need to link individual and population data and I would argue that the level of analysis is geographic. Third, we need to develop guidelines as I said before, to basically make sure that we know and we basically share a good experience, proof of concept experiences.

And in particular, I think that one low-hanging fruit is the connection between health and social services intervention. And what somebody -- someone called is integrated care. Not integrated healthcare. And there are some countries, such as in Spain, that are advanced in these areas. Also, we need to understand how to we include the families and individuals that are affected both in data collection policymaking processes and which is basically how do we contrast our findings and recommendations with the real world? We don't have -- I don't have the time to basically show you how are we advancing in my country on that, but I am happy to talk to anyone that is interested after this session. Thank you.

>> MODERATOR: Thank you, Jeannette Vega. Now we will go to Luiz Galvao from Brazil.

>> Luiz Galvao: Glad to be here among old friends. I think a year ago we were in social determinants of health, it was the indigenous people Declaration, Resolution. Yeah, we keep in the same area and try to advance this. I think social determinants of health is very important, because we view the 80% that Naveen Rao mentioned here. I will give an example. We have a center for integration and knowledge of data from via Cruz in Salvador. They analyze and receive everyday data from social health, economic, by people when they integrate that. We analyze the consequence of the cash transfer of Brazil program in health. They find a very interesting results in adults 14 to 35 years old, cash transfer was preventing 53% of the suicides at that level. 53% prevention is much higher than vaccine prevention. So review the effect of the social determinant. That is a very central to working social determinants, because you can review that part of public health you don't see is the benefit of public health. The one that construct everything to have in terms of health and nobody see it. We only see the health services. Which of course is very important, too. Nobody is having any doubt on that.

The second part of social determinants is a passionate thing. My these in '85, the name of the these is where we work, where we live, and where we play is good for health. That is my these for the master degree. And Jeannette Vega and Kumanan Rasanathan, we were called for years on that. I'm part of the original network for health equity. It is still very active there. The Brazil and Costa Rica, we work on that. Social determinants of health bring people together. I read the goldfish column from galea every week. That is interesting and inspiring, in all of the passion for making the social justice

happening. I think that is another very important contribution of social determinant social determinants of health and public health. Bringing this to real scenario and bringing it alive. Is not only something we talk about, you know, systemic racism, whatever. This is very important to bring people together.

The third one is about data. I don't want to go -- I think Jeannette Vega covered that very well. But I want to say, it is very important to bring the data, but very important also to gauge more credit for the data we don't have it. Most of data we have is actually from the academic world. Academic world we know is a light. We need to bring people and the data from the people to the scene. So today in Brazil, we're working in popular surveillance and bringing the population to the scene and having a voice and being reflected in the whole health system.

The Minister established a special advisory for population engagement. They're mapping everything in the country. Every social movement and bring that together with the health services at very local level. At least now in the flooding, the sad flooding in the South of Brazil, historically. We had 500,000 people out. We lose four entire cities. My son worked in an insurance company. We had to recover 15,000 cars to give an idea of the dimension of that. We lose all the industry, we lose many things. Billions of dollars of things there. It is similar for New Orleans. And very sad about that. But one of the thing happening now is we have this mapping done. We are much easier to work with that and determine the social determinants of health. And I learn Jeannette Vega is doing something similar in Chile we exchange information. Thank you very much.

>> MODERATOR: Thank you. And now we will get to Blessing Mberu the head of urbanization and well-being the African Health And Research Centre.

>> Blessing Mberu: Thank you. Thank you for coming. It is a privilege to speak last. Everyone reminds you what you are thinking about.

I'm happy to see Salma Adballa there. Because Nigeria we used to be happiest, and now we're losing our spot. This is great work. I like the global dimension. You heard everyone say it is more complicated than that. If you talk about for example, Nigeria, okay. That is the first question. Where. Northern, eastern, southern, so much complications. I work in Nairobi Kenya. We cover 54 country it is. You hear about Africa, this is not a village. It is 54 countries, very complicated. Anglophone, Francophone, and it becomes more complicated. As we look at that measurement, I want to highlight those are the things that we need to begin to think about. This is a great place to start.

Let me speak a little about urban Africa where I work.

What you see is that national data sets give you averages.

So it blows the inequities and looking in a city. You have the urban averages. But if you come to an urban area, you see a lot of informal settlements across urban Africa where I work. And I'm sure the same for many parts of the Global South and probably in the north. Ha-ha. As we know about the U.S. and what is going on there.

So most of the time, you lose the major segment of the population, the marginalized, and sometimes like for example, from urban Africa, you can be a majority of the population. You talk about social determinants of health, and these are places where we are supposed to continue to look at and make investments in. Okay, often data is not disaggregated. So and yet you need disaggregated data and data at the local context. You look at where power is devolved. That came up. In Nigeria, you have States you have local Governments. If Kenya you have a devolved system. The health is devolved between the national and the local Governments. And many of the challenges reside at those levels. Okay? That is where local Governments, implementing agencies need local context and local specific data to make decisions. Okay?

To evaluate and define different priorities. Like when we talk about climate change, it is a global phenomenon but has local meaning. What does climate change mean for a local farmer? Because of the complexity of the issues. So I want to highlight that that is what we see. That investments in these local context specifically, that would be very critical. You talk about social determinants, many times the data is not quantitative and you alluded to that. Many are qualitative and you need qualitative data. You don't see a reckoning. We recognize that. The demographer, you like it. It makes my life easy. You need the disaggregated data to understand the hows and whys to address it. You hear what does the feedback loop to policy and to action. Because that is where the issue is. Okay? Maybe finally ooh, maybe not finally, there is something in Africa I keep hearing. The fact that you do this Salma Adballa and Boston University. The critical mass of researchers and skill you need for the data analysis and collection and interpretation. Converting complex models to understandable narratives is still lacking. We need a lot of investment. Sandro Galea as you move around, in this critical mass of people.

Another phenomena is the growing linkage of data to national security. In Kenya, it is becoming difficult to do the research. There is all of the controls.
I don't know about other countries. You know, so that have a lot of data protection legislation. So when you talk about sharing data access to data is not as easy as that. There are a lot of local challenges. I want to at least speak about the example of Kenya where I work. It typifies Africa and bank crisis and the challenge around data. What you see is 5% growth

rate for informal settlements in the city. You come to Nairobi, you see the first ward and second ward as you move from one neighborhood to the other. 5% in their the slums. This is areas characterized by critical social determinant indicates. Which is limited access to sanitation overcrowded housing conditions, limited employment opportunities. And the near absence of the Public Sector. It is like you are on your own. You are your own Government. Yet you are in the city. These are challenges I wanted to highlight.

Just to conclude. I have two more points, Sandro Galea. That is the absolute number of slum dwellers, marginalized and continue to grow. It will continue to grow. We need sustained investment. This is a move in the right direction. Particularly how do we address the marginalized, the vulnerable? You know? Because that is critical if we are going to actually make advocacy that speaks to people. So providing municipalities, local Governments, city managers. Data that helps them, granular data. It is here, that helps them prioritize the interventions. That helps monitor and evaluation. Okay? If you look at DHS for instance. First of all, it comes four years and so. A lot of changes happen. I want to highlight the fact that there is a lot of complexities. Our work is cut out for us. I think I am happy that I was wondering where I met the Treaty Commission -- the 3D Commission and the group are determined to push the agenda. We need data and need it timely and to incorporate in places that exist in many cities and around the world. Thank you.

>> MODERATOR: So I will ask a couple of questions of the panel and then I will open it up to the audience for questions. Priming the audience for questions. I will pick up on something that Kumanan Rasanathan said. In times of great disruption there are moments of opportunity and peril as well. Accepting as perhaps of the commune understanding we are in a time of great destruction and globally. There are opportunities. Given the it challenges and this evolution of social determinant and agenda and challenge of moving from abstraction to concrete action, I am curious what the panelists see as one opportunity in the moment around advancing this agenda. If I can force each panelists to say one opportunity to advance this agenda, in this moment in time in history. I'm going to get comments from everybody. Anyone can jump in.

Jeannette Vega go ahead.

>> Jeannette Vega: Well, I think I said it. For me, a low-hanging fruit right now is to basically advance, connecting (feedback) services and care. That is a huge opportunity in most countries.

>> Kumanan Rasanathan: I don't think it is an authority of science, but it is seen as if crises are seen as having a clear reason, the question is where is blame directed? If blame is directed in a way that leads to the greater possibilities for

alternative ways of organizing societies, you can move in that direction. Imagine in a depression, really people, you know, the economy failed. People were homeless, people were desperate. So that sort of challenged some of the existing order. And the blame was very much put on certain Sectors of society, open the space for welfare States, greater Union rights.

Not in all of the world, right? But if you look at the global financial crisis in late 2000s, which was a major disruption, it didn't really lead to a major reordering. The real resilience in the existing system. So I suppose the question is firstly, what is the extent of the disruption in our society? And again, what is the narrative around what has happened that might lead to new opportunities? And I think at the moment, I mean, it is with the challenges we're having, the challenges of polarization, and disaggregation. It is how to disrupt. My wife says I'm pathologically optimistic. Must be origins in our Region seem to be optimistic people.

So there are two grand transformative forces of digitalization and decarbonization. Right?

And I always say, you know, utilization in health Sector hasn't done much. The two most sort of institutions in our society most resistant to change are the health Sector and the Academy. We are all complicit. The way people get care is similar to it has happened in decades. And the way we teach is similar. The technology is at such a critical mass it can disrupt that and what we know about people and how we harness data. I was talking to this 26-year-old guy working at Open AI. They have a team thinking about what to do and how. People have justifiable concerns about hallucination and concentration of IP in a few corporations. The question is can we steer this force that is really transforming our society? It will transform healthcare and transform the way we track people through society the way we deliver health and social sciences.

Can we steer that? There is a possibly there. Second is decarbonization. One hand, countries saying we will lose whole industries and worried we're not competitive and we need to maintain. On the other hand, it does promise an energy boom to open up services in communities and way that whole communities never had a fixed line telephone.

Not sure it will work, but there is an opportunity to take the forces to improve the social determinants and improves health equity.

>> Loyce Pace: Forgive me, I'm afraid. You never want to follow Kumanan Rasanathan. I give a basic example. We need to talk about the COVID pandemic as much as people want to move on. I can hear people saying yeah, but did that work, to wake us up? Not entirely. Clearly, otherwise it would have gone better. And yet ... hear me out. I am able to have very different conversations within Government because it is undeniable the

ways that social determinants from the individual and truly through the systemic level played a role in the inequities that were just so glaring. It has in a week and at a time when we are all -- maybe not all of us, but many are wondering whether countries will come through with real action to make it right. I know that many of us around that table have been at the table and stayed at the table because of that disruptive event. Not because it was really bad and we lost a lot of lives and all of the terrible things that happened but because it was so obvious and shameful and tragic how preventable it was because of these external factors, the factors external to health. Can we and will we solve all of the problems?

No, it is not how it works. For those of us working in this space a long time, that is not how it has been. And ... there are Ernest efforts, I will say, and I am also an optimist to acknowledge these not even underlying factors. These overlying factors and the fundamental considerations to say hey, we have to take a much closer look at the issues beyond health that will drive health and protect if not improve it.

>> MODERATOR: Diah Saminarsih.

>> Diah Saminarsih: I want to build on what you point out Loyce Pace and feel it further. Yes, pandemic, but what did the pandemic leave us with, besides the destruction? I think it is also the pandemic left us with scattered availability of community-based data. That can be made into an opportunity to address the social and health intersection, the social health and climate intersections. With, if we have -- if we layer it with lens of gender, diversity and inclusion. I think that is an opportunity left wide open by the pandemic that is for us to fill it in with more robust data. And to not stop at leaving it scattered, but how to make it into a systematic community-based data. Then tell enrich the decision-making process and enrich policy direction and long-term planning further. At national level, but I'm sure it will somehow be brought up to the global level.

>> MODERATOR: Really interesting answers. Salma Adballa?

>> Salma Adballa: That is interesting. I was thinking about this. I fully agree with almost everyone here. I am a big proponent of AI. I think it would help generally speaking. I think some would disagree with Kumanan Rasanathan. But what Luiz Galvao said, the pandemic highlights the social determinants of health that no one can dispute. People start the meeting with oh, the social determinants of health are so important, we need to talk about solutions. And what talks about solution is the healthcare system. I don't think it is because people don't recognize social determinants of health are important, it is feeling overwhelming and beyond what we think we can do. Maybe I'm getting older, but I think what all of it taught me the past few years, is this was an opportunity in health to think about tradeoffs. How do we speak with people

who can do work on social determinants of health that are not in the healthcare Sector? We were having conversations earlier. Thinking more about how to convince people beyond the health argument or beyond the moral argument, where it is important to care about the social determinants of health. I think the pandemic provided a good opportunity for that, sadly. But yeah.

>> Luiz Galvao: In terms of crisis and recovering of the crisis. One thing you always say is how you can be less reactive and more proactive. So I think the crisis always bring us the opportunity to be more proactive for the next. And particularly the most vulnerable population. I want to mention, homeless and Indigenous People. If you are looking for the two populations, they suffer the most in the pandemic.

And they are suffering the most in the heat wave, flooding, everything else. So how we can be more proactively and more focused on the most vulnerable population, and this is always come back. Always we talk about that. But that is a good opportunity to actually, you know, at least save lives of the people that is out there. I think this transition from being reactive to proactive, particularly for the vulnerable population is essential when you talk about the unnecessary and unjust inequities that bring the social determinants of health. That is kind of the thinking. Climate is one. But I agree, pandemics is closing in the window. Without the solution. So we are actually, you know, leaving this open for the next pandemic and the result actually be more proactive in that. So I agree with Loyce Pace. We need to reopen the window and look for opportunities for that.

>> Blessing Mberu: I will give you an example of what we have done. A good example to speak to the spectrum of the discussion. One is how we collect the data. Okay. And collecting granular data. We work -- Nairobi is the capital of East Africa. Like I said, majority of that city is slums. So we decided to collect qualitative data on who are the most vulnerable from Nairobi? And we didn't refine them. We ask the communities. They give us older persons. Persons with disability and children, head of household. Can the margin being 60 years in the slums of Nairobi. With that kind of housing, very hot at night. They bring you free water, the free water to the settlement, but during the pandemic you can't access it. There are thousands of kids.

So the old person would not get that water. You have disability, how do you survive in this flooding? Go to the most vulnerable community identified. These are children head and households. If you live in Africa, you drive to the traffic light. You see kids come to the window. You think they are miscreants. No, they're heads of households. Thinking of their parents and siblings. They're begging. They think about rent and food and so on, so forth. The pandemic hit them hard, but in the pandemic, the school closed. That made us look beyond

Nairobi and saw it is in issue in other areas including Mombasa. You have prevalence of that. You have this data, but because it is focused on the cities, where we approach the Nairobi city. You say what do we do about this? We have a policy. This policy process, I'm sure you know how long it takes. This program cannot wait.

So you are going to get into the youth caucus of the Nairobi country assembly. They passed a bill on child headed household. In the social determinant, food, housing, training, so on and so forth. Now, that bill has been passed and we have engagement with the executive to say how do you put it in the budget? What program? So we are going to continue the discussion on how do you, you know, move that policy? That bill to actually foldable projects that will address some of the issues. It will address a start. Our thinking is data is great. How you collect it is also important. But more importantly, what is the feedback to it? How does that inform the policy in action? And this is a very good example of how you collect the data that is context specific, relevant to the local authorities and we are moving forward in that direction. I think for us, that is where to go. Not that you solved global problem, but to solve that problem at the local level. Thank you.

>> MODERATOR: Thank you. One or two questions from the audience.

Here in the middle, there is a mic coming.

>> ATTENDEE: Thank you, everyone. I am the Director of the Office of Global health at peace corps. In preventive medicine, public health for over 25 years and proud alumni of Boston University School of Public Health. It is great to see the work that you're doing. I have many questions, but I will keep it to one.

>> MODERATOR: Just one.

>> ATTENDEE: The panel, you know, different -- all of you have touched a little bit of what I want to say, Professor I was shaking my head and almost jumping up when you are speaking most of the time.

But I think for you will of us that have been in this for a long time, we know what social determinants of health are. We need to Google Search or one of the searches. And you will see it is flooded with papers that have been published, you know, and the data there. So it is good to add this, but there is so much out there. I think what is missing is how that is used to inform decision-making. I think someone alluded to it. That we a lot of times keep it and keep that to either the session institutions or the health Sector. The decision-makers are not in the health Sector.

How do we use and socialize this data so the people making the decisions, the Congress, the ministries of finance are the ones that use this data have been invited at the beginning. Not

at the end. I think it is something that we really need to look at. That is what we need to move. The data is out there already.

>> MODERATOR: I will ask you to comment on this. You refer to this in your comment.

>> Diah Saminarsih: I can give an example of what the Government of Indonesia has done since 2017, 2018, it is an approach called health in all policy. We term it in a different language of course, but it is basically health in all policy, where health is expected to be budgeted in different ministries. That took off 2017, now, I remember, it is 2017. However, the flaw in that set up, in that planning, is that it includes all the ministries but not other development actors. So it is as it is owned by government only and has to be owned by everyone. And being taken from planning into action, by multiple development actors. But the foundations are there. And right now, Indonesia is embedding health in all policy in our long-term planning. So it will extend into 2045. At least in the medium term planning, it is there as well. Hope as the second time around, this attempt will work better, have more Civil Society and other Private Sector Academia chipping in to ensure the success of health in all policy.

>> Jeannette Vega: I want to provide an example. In my country we are doing it the other way. So we are basically creating a unique window for people to go at the municipal level and basically we use integrated data, we have integrated all the data sources in the country. But not integrated the data on social determinant but integrated on social and health services. So basically, what we have now is that for every sort of geography in our case, the geography are the neighborhoods and the countries if you go to your municipality to request anything the person that is the first person that takes you have in their screen all the data from you and your family, including services, including subsidies, including health alarms that we have put in we're going to your preventive services, so on. Including all data related to community assets and resources that you can use in your neighborhood.

So when you go, there at the same time that you get the service that you are basically asking for, you get additional services that are proactively and basically get some of the monitor subsidies. It is good, but you haven't had your preventive screening. So let me refer you to the people and then the referral is in turn and the health teams -- the people if the person doesn't show up, go to get them and capture them back to the services. In addition to that, what is interesting is we have done mapping of community resources, we, the communities and in charge of that are mixed teams of social and health teams that basically work through the communities and meet with the communities and map these resources. And that mapping of course, we basically geo localize them. So when you

go, you also get your map of resources available in infrastructure and others such as classes, all of that. Of course, we map everything else geographically. You have the maps in each community. Regaled in social determinant and benefit it is and main issues related to health impact.

>> MODERATOR: We will take one more question and then move to closing remarks. Right there.

>> ATTENDEE: Thank you very much. My name is Kennedy, from Kenya based in Nairobi. Thank you for enlightening the Nairobi situation. I was reflecting on the discussions going on, we may not achieve our SDG targets and the only reason to not make us achieve those is social determinant. There are multiple resources in health in countries that we support. But we have seen little progress. And that is why in the new strategy, we have intentionally focused on social determinants of health as a key strategic focus area for health interventions.

I'm asking just a follow on what the presenter of the research shared. This social determinants are basically not within the confines of health. We have very little control on those social determinants because education is a full-flung area, climate change is full flung and not in the health Sector. What should define our role as health? As a health Sector? Towards addressing those social determinants of health. When they occur, two or three weeks okay. Nairobi and Kenya was flooded. You had it all over the media. The worst flooding, and the health system was collapsing. Can we build a resilient or adaptable health system as parts of the contribution towards addressing social determinants of health? Can we ensure our communities can make informed decisions as a way of handling education as a social determinants of health to make informed decisions regarding their health.

Are we able to see our communities having sort of sustainable livelihoods towards ensuring they can enable the health determined. How can the health Sector help with the social determinants of health given that we have little forces or sources to enable, with the Intersectoral communities and Boards that are formed. The last one is a challenge. Given this timely discussion, is it maybe time from Boston University to form a collaborative that Regions can learn? When you talk about inequities it is demonstrated and made me reflect. I thought wealth is health. When you have countries that are wealthy have issues with social determinants of health at that level, it makes me reflect other ways. Is it time to form a collaborative as part of this session to easily track and support countries on how to address social determinants of health.

>> MODERATOR: I will answer quickly. On the collaborative, no better time to do that. I will ask for closing remarks from Dr. Krug. Ask the panel, what is one thing to do today to infuse in all Sectors to make it clear social determinants of

health matter.

>> Salma Adballa: It may be basic and simple. I teach social determinants of health in the master's program. If you want to improve health outcomes don't work in the Health Department after you graduate. Work in transportation department, work in education department that you bring then a health lens to the conversation instead of working in the healthcare Sector. I say this because I think multiple people said this. We keep having the conversation about how social determinants of health are important in healthcare. We need to move beyond that. If you are interested in shaping the social determinants of health, it is time to work in different Sectors. Yeah.

>> Loyce Pace: Same. Also. I don't know, work in Government! Ha-ha-ha. Build the trust and make a difference. Apologies, I have to run off, people are waiting on me.

>> MODERATOR: Thank you.

>> Kumanan Rasanathan: I think the short answer is we in the health Sector need to do our job better it is clear what our contribution is on social determinants of health, we have talked about it a long time. When we develop the health SDGs, we framed and said health is a prerequisite, indicator and outcome of development. That is the framing of the SDGs but we haven't managed to integrate that thinking into the way we do our work and the job better. In a health Sector that is three things. The health Sector is a social determinant and we need to make sure we don't exacerbate inequities and doing our job in delivering healthcare and policies. Secondly, we have a role and are custodian as you have contributed to on the measurement and monitoring. Who else will measure health and health inequities and link social factors better than the health Sector. The third we fall down on.

And the other two are better. The limited role in stewarding the catalyst in the society, social determinants, being humble and realized limitations. The big challenge is continuing discussions on social determinant among health people about what the other Sectors should do. We really find that a challenge. There are collaboratives. Nicole is in the audience. She coordinated on the social determinants and number of countries. There is progress. The initiatives are moving. The social determinant, language, interests, not engaging with the Sector, why they might engage with us, there are good examples. Overall, we need to do our job better.

>> Jeannette Vega: I think embracing diversity. We work in the health Sector, we think that if you want to be heart or you would like to -- heard or have a voice, you either work as Government or you work as someone in the international or multilateral organization in health. I think there are groups or population groups, that need to embed variety in the health Sector thinking. Like you said. Not too far from the health

Sector.

But take a role as Civil Society for example. And then present a different perspective and different point of view which is somewhat missing. Take a role as an academic in Indonesia, we still need public health academics and researchers. So take a position and be aware that your position is enriching the conversation. It is good if you have diversity in your background, so not only health. I think in general, health Sector cannot be governed only by Government. Health Sector needs to be governed by different actors in the health Sector itself.

>> Jeannette Vega: I will say two things. One is basically instead of talking about health in our policies, let's talk about health without policies.

I think in my experience, at least the most difficult change is the change of the mind of the health people. Most of the times, the other Sectors were much more together than we were. And when we say health in our policies, we are saying everybody should take health into their own policies, why is that? Why is health more important? So I could say instead of that, we need to basically have a different target, which is basically well-being. And well-being is not only a health issue. So I do think that it has to be achieved in the way that we in the health Sector think about action in social determinants of health. We need to incorporate to the other Sectors.

And just a quick response to one of the questions. There is an initiative in WHO, working with countries, specifically on that, on how do we advance solutions, how do we basically walk the talk? And I would recommend you that you can get more information. In fact, one of the leaders of the initiative is in the room right now. Nicole. It is a very nice initiative to participate on. Thank you.

>> Luiz Galvao: There are the health policies. Inspirational principles, but same time, you know, when you talk about that, people say oh, here is the king of the all Sectors, health, you want to give and govern all the Sectors and then that doesn't work. I think it is the right you need to have another way of doing business in terms of engaging others.

For me, one important point is education. So the other Sectors should embrace the idea of health. And understand the consequence of what they do for health. To be essential in terms of promoting. Another idea of health policies and health within the policies or within all the disciplines. I think that is an essential role. There are other opportunities today. Digital health is really very important. Means to create digital health, one Vice-Minister on digital health. One of the most important part of that is fake news. Fake news is everywhere. And fake news today is one of the determinants of health. We can work on that. That is one of the possibilities

to engage in that conversation and make it less damage for the population. That would be for me the two things. Education and digital, particularly fake news combat, which is very important for the social determinants of health.

>> MODERATOR: Blessing.

>> Blessing Mberu: Again, maybe I will give an example. We have decided, it is out of experience, working in Africa, that you need a different approach. Co-creation, co-definition of programs. So we normally would engage Government departments. Okay. As many as we think are relevant to that issue. So, you know, more am disciplines and in terms of not just scientists but actors, including communities. And I give an example. We have a program where we call idea maps. Integrated deprived area mapping. We use GIS and earth observation to map changes in Nairobi like what just happened. But for you to define what is you are looking for, we engage the people in the Government and people in urban planning, we have partners in the investment of (?) and we gather. It is a big meeting. A lot of negotiation. But if you really want this to make sense, you better do it from the beginning.

So they finally agreed on how and what would the city need? So we are setting up a platform. We are using the technology to monitor changes within the city to see what is happening, to monitor air quality, so on. So if you go to that platform, you can click an area within Nairobi, like the authority level of changes and you go to a map. It was really exciting. There is a lot of education there. For example, maybe here you will help us. What does AI mean in Swahili? Because for the community to understand what you are talking about, they need to know what it means.

If an issue is local, they have a name for it. If it is foreign, they have a description for it.

So we ask what is AI. If you go to Google AI is a fake brand in Swahili. How do you tell someone to talk about fake bread? In essence, this mode of collaboration, even those people that dot mapping are from the communities. We hire young people and give them the technologies to do the GPS, so on, so forth. Stay lot of work, if you want the relevant of what you are collecting, anybody that uses it, it is a transdisciplinary approach, collaboration. It is key. But from the Global North and Global South. At the end, all of us are learning. That synergy creates something you are sure will have some ownership.

Some legacy impact, where you finish all of the projects and you know we are all guilty of that. We do a lot of inbreeding in academics, in research, where we talk to each other, criticize what happens. But the people we talk to, we have been a lot to bring them in. I think that is a way to go. It is a lot of work. But it is better than doing work that nobody uses or nobody wants. Thank you.

>> MODERATOR: I will invite Dr. Krug, the Director of

Department of Social Determinants of Health at WHO who will summarize and tell us what we are going to remember from today.

>> ETIENNE KRUG: Thank you. Before we started this event, I was told, you will be the last speaker, everybody will remember only what you said. And he kind of astutely transformed this now into I will give a summary of the discussion, which I will not fall into his trap. I also know that what he really meant is be short, everybody is tired and wants to go to the reception. I don't have much to add. We have gurus of the social determinants work on this panel. And I agree with many of the points made.

First of all, I will congratulate the team, and those who worked on this important data, which was very stimulating and I think on every slide it raised questions on why is it that in this country, there is more or less trust in Government than in other country. Sorry Loyce Pace, the U.S. wasn't faring well in that one. Why do people worry more about the future or financial security, et cetera, et cetera. I was particularly pleased also that this study was based on a similar methodology used in different countries because I think having comparable data from a series of countries helps a lot advanced thinking on this topic.

This is why, as Kumanan Rasanathan said, we released the framework for collecting data on social determinants of health not so long ago. At the request of the World Health Assembly. If you haven't seen it, it is an important tool for all of us to use for further comparable data collection.

What I like about this event is that is happened. Thanks for setting it up. We need more events on social determinants in margins of the World Health Assembly. It is a rise of the interest on this topic. I'm very pleased to see this discussion happening. But I agree with what was said also. I want to paraphrase. But it was basically "so what." We want more data. And I agree, Kumanan Rasanathan it is hard to collect data. It is harder to use the data for action. I think that is my challenge to you Sandro Galea. Since you challenged me. Let's have an event next year about so what. How can we use data for furthering decision-making and how -- what should be the decision-making be focusing on? I think it is time for the field of social determinants of health to narrow it down to some ever the most cost effective interventions. And we need to know what they are. I think there is a whole research piece there, thinking about best buys in the field of social determinants of health. And I hope together with the alliance and partners we can engage in that in years to come. It is a needed piece.

We're doing a great job in making noise about social determinants of health. And there is more attention going to it. No doubt, including tomorrow in the WHA, if all goes well, tomorrow or Friday it will happen anyway. There will be another discussion on the topic, looking at the recommendations of our

upcoming world report.

But we're not so good at transforming all of the noise into concrete action at country level. Think about how to do that better.

For me, it is slicing up the field and looking at the best buys. Housing social determinants and urban health, these are areas where we can have easy wins -- it is complicated because it is a complex field, but certainly some wins in those areas. The more wins we have and more we advertise and so the success, the better we will fare in building up the field. Thanks to all for the support. Thanks Sandro Galea and team for setting up the discussion. Thanks to the great panelists, it is a pleasure to listen to you, your passion and your knowledge. And I am really having the last word or you will? I suspect it is you. Thank you, go ahead. Thanks.

>> MODERATOR: Thank you to the panelists. Thank you to the audience in the room. There are a thousand people on Zoom sorry we couldn't get to your questions there was a lively discussion on Zoom that was happening that people in the room didn't see. Thank you for being a part of it and giving time to the issues. Everybody, thank you. Have a good rest of the evening.

(Applause)

(Concluded)