



**Third G20 Joint Finance and Health Task Force (JFHTF) Meeting**

**POLICY NOTE**

**G20/World Health Organization Policy Note  
on Social Determinants of Health**

October 2024

## I. THE WORK OF THE G20 JOINT FINANCE AND HEALTH TASK FORCE

The G20 is advocating for a safer, healthier, and more prosperous world through global health cooperation. During the Italian Presidency at the height of the COVID-19 pandemic in 2021, G20 leaders established the Joint Finance and Health Task Force (JFHTF) to enhance dialogue and global cooperation between the finance and health sectors at national, regional, and global levels. The JFHTF also aimed to address potential financing gaps for Pandemic Preparedness, Prevention and Response (PPPR), which led to the launch of the Pandemic Fund during the Indonesian Presidency in 2022. In 2023, under the Indian Presidency of the G20, the JFHTF took the initiative to develop, among other deliverables, the Framework on Economic Vulnerabilities and Risks (FEVR) for evaluating health, social, and economic vulnerabilities and their associated risks relating to pandemics. Building on this work, the 2024 Brazilian Presidency of the G20 has elevated a focus on addressing inequity, including through discussing the social determinants of health (SDH): the conditions in which people are born, grow, work, live, and age, that impact health and well-being across the life course and the inequities in access to power, decision-making, money and resources that give rise to these conditions. Building on these initiatives, members discussed and welcomed the potential inclusion of additional indicators in the FEVR linking the outcomes of the SDH analysis with Priority 3 of the JFHTF Work Plan, during the 2nd JFHTF meeting in June. Additional indicators that assess key SDH that can be disaggregated across population groups and that will strengthen PPPR can be considered in the FEVR.

## II. THE IMPORTANCE OF THE SOCIAL DETERMINANTS OF HEALTH IN PPPR

People living in conditions of vulnerability and marginalization, including children, women, older people, and workers in informal and precarious employment situations, are disproportionately affected by health emergencies. They are often at increased risk for infection and severe consequences from disease for a range of existing and emerging pathogens. Examples include increased vulnerability due to gender and occupational status as a driver of the spatiotemporal characteristics of the current Mpox emergency.<sup>1</sup> Those marginalised by virtue of socio-economic status and rural location are also closer to the human-animal interface and often the first impacted by new spillover events be it agricultural workers in high income countries at greater risk of influenza or exposure to novel viruses through proximity to bats and bush meat in low-income countries.<sup>2 3</sup> A World Health Organization (WHO) evidence review found that COVID-19-attributed mortality rates in diverse country settings were between two and four times higher in the lowest as compared to the highest socioeconomic groups in the period of 2020-2021.<sup>4</sup> COVID-19 infection, hospitalization and mortality have been grossly unequal between population groups – driven by inequalities in SDH.<sup>5</sup> There are multiple mechanisms to explain the inequities faced by the most vulnerable groups. In summary, unfavourable SDH for these groups have resulted in higher rates of chronic disease, increasing their risk of poor outcomes from COVID-19, greater exposure to the COVID-19 virus, reduced capacity to adhere to public health and social measures, and poorer access to health services for treatment and vaccination.<sup>6</sup>

When outbreaks occur, vulnerable population groups often face inequitable access to health information, health services, and medical countermeasures.<sup>7</sup> People's social and economic conditions, such as their income security, housing status and education level, also shape their possibility to engage in public health and social measures (PHSM), which are non-pharmaceutical interventions aimed at reducing the risk and scale of infectious disease transmission.<sup>8</sup> Examples of PHSM include hand washing, school and business measures, modifications of mass gatherings and international travel and trade measures. Such measures are critical for PPPR as they are often the first and sometimes the only intervention available at the onset of an outbreak when effective vaccines and therapeutics are not available or equitably distributed. Besides their benefits for pandemic response, the more disruptive PHSM, like movement restrictions or business closures, can have negative impacts on people's lives and livelihoods, with the most vulnerable groups bearing the largest burden. SDH influence the feasibility of these PHSM, and the extent to which people are affected by unintended negative consequences of them – such as unemployment, domestic violence, and the deterioration of mental health.

At the national level, during the COVID-19 pandemic and the West Africa Ebola epidemic, countries were exposed to macroeconomic vulnerabilities and constrained fiscal space, irrespective of their income status. Such macroeconomic instability led to inequitable distribution of individual-level social risk, such as food insecurity, housing instability, and insufficient access to safe transportation. This complex interplay of factors exacerbates existing health, social and economic inequities. Monitoring and addressing key SDH can contribute to the anticipation and mitigation of such vulnerabilities in PPPR and facilitate timely action to improve pandemic outcomes and avoid a further widening of inequity.

The shock absorptive capacity of countries is linked to their economic agility and health resilience, economic inequality undermines resilience. The COVID-19 pandemic has provided substantial evidence that social inequalities that caused inequalities in health pre-pandemic contributed to COVID-19 morbidity and mortality.<sup>9, 10</sup> Key pathways included intersecting discrimination (including racism and gender inequality), income security and inequality, employment status, housing quality and access to sanitation, education level, food security, and health care access. These SDH were strongly correlated with COVID 19 outcomes, in all types of countries,<sup>11</sup> and they can be acted on to support PPPR.<sup>12, 13, 14, 15</sup> The G20 has the opportunity to support SDH approaches to support PPPR. An entry point to this is the monitoring and action on interventions at the intersection of public health risks and social and economic vulnerabilities as suggested by the indicators in this note, to reduce pandemic-related risks on human health and build more resilient economies and communities.<sup>16</sup>

A key opportunity for action on SDH to support PPPR is the investment in and implementation of universal social protection, defined as a set of policies and programmes designed to reduce and prevent poverty, vulnerability and social exclusion throughout the life cycle.<sup>17</sup> It can be provided through cash payments to individuals or through in-kind approaches, such as subsidized child services. Social protection measures secure fundamental SDH – a solid evidence base has demonstrated how social protection can prevent and reduce both poverty and inequalities, increase consumption and aggregate demand, improve access to nutrition, education, and health services, and facilitate labour market participation,

especially of women – thereby ensuring a broad protective basis for population health supporting PPPR overall. Studies show that higher social protection coverage results in lower average country mortality rates.<sup>18</sup> Reaching under-resourced groups such as the poor, older people, workers in the informal sector, children and women with minimum income reduces psychosocial stress as well as secures material health needs.

A forthcoming WHO evidence review, with technical input from the International Labour Organization (ILO), illustrates the beneficial role of social protection for the reduction of unintended negative consequences of PHSM during the COVID-19 pandemic, with improvements found for food, financial, housing and employment security, social cohesion, and mental health.<sup>19</sup> During the pandemic, the negative consequences for livelihoods and income varied substantially depending on employment status, wealth, and the coverage of social protection.<sup>20, 21</sup> Social protection played a major role in shielding livelihoods during the pandemic, particularly for countries with high socio-economic inequality.<sup>22</sup> For example, India's national relief package of cash and in-kind benefits reached more than 420 million people, decreasing the prevalence of severe food insecurity,<sup>23</sup> with larger reductions seen in rural households of about 2.4 %.<sup>24</sup> Brazil's Bolsa Familia programme (family allowances) – a conditional cash transfer program implemented - has benefited families by reducing poverty and increasing cure rates for communicable diseases such as tuberculosis and leprosy. Brazil and ILO research calculated multiplier effects of this programme on GDP of 2.9 after 25 months.<sup>25</sup>

### **III. SOCIAL DETERMINANTS OF HEALTH INDICATORS FOR CONSIDERATION IN FEVR**

In 2024, the WHO published the *Operational Framework for Monitoring Social Determinants of Health Equity*, which provides critical guidance on monitoring of SDH and policies and interventions addressing determinants, such as in social protection, housing and sanitation, and education; as well as the process of using data for action to reduce health inequities.<sup>26</sup> Based on evidence from pandemic experiences and utilizing indicators with existing broad data sources, availability from the Operational Framework, comparability, periodicity, and acceptance, the SDH indicators presented below are suggested for consideration for incorporation into the FEVR. While there are a broad number of SDH domains relevant to PPPR, this analysis has focused on those that have a direct impact on vulnerabilities and policies in the context of PPPR. With the aim to improve feasibility, an initial set spanning a core set of domains with the strongest evidence and with some disaggregation potential across social groups has been included. Indicators relevant to SDH that are already in the FEVR, such as food insecurity and informal employment, were not considered, and neither were indicators measuring specific human or animal health conditions. Further inclusion and exclusion comments can be found in Annex I.

Addressing SDH is expected to lead to strengthening PPPR, positively influence countries' absorption ability against pandemic-related shocks, reduce health inequities, and fundamentally strengthen the capacity to recover.

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TABLE 1: Suggested SDH indicators for incorporation in FEVR

Indicator proposed	Disaggregation	Data source and metadata source	Data availability
<b>DOMAIN: SOCIAL PROTECTION</b>			
As outlined in the Policy Note and in the forthcoming WHO evidence review, social protection is critical to mitigate health and socio-economic shocks from a pandemic emergency and unintended negative consequences of PHSM.			
<b>Coverage of social safety net programmes (% of population)</b>	Per capita income/ consumption quintiles, including transfers	ASPIRE: The Atlas of Social Protection - Indicators of Resilience and Equity, The World Bank. Data are based on national representative household surveys. ( <a href="https://datatopics.worldbank.org/aspire">datatopics.worldbank.org/aspire</a> )  <a href="https://databank.worldbank.org/metadataglossary/world-development-indicators/series/per_sa_allsa.cov_q1_tot">https://databank.worldbank.org/metadataglossary/world-development-indicators/series/per_sa_allsa.cov_q1_tot</a>	ASPIRE (Atlas of Social Protection – Indicators of Resilience and Equity) includes 500+ nationally representative household surveys from 130+ countries. Country data represent all regions of the world: East Asia & Pacific, Europe & Central Asia, Latin America & the Caribbean, Middle East & North Africa, Sub-Saharan Africa and South Asia.  ASPIRE makes a constant effort to update indicators as soon as new country surveys become available.
<b>Proportion of population covered by at least one social protection benefit (%)</b>	Sex, age	SDG 1.3.1: UN SDG Indicators Database. Available at <a href="https://unstats.un.org/sdgs/dataportal">https://unstats.un.org/sdgs/dataportal</a>  <a href="https://unstats.un.org/sdgs/dataportal/SDMXMetadataPage?1.3.1-SI_COV_BENFTS">https://unstats.un.org/sdgs/dataportal/SDMXMetadataPage?1.3.1-SI_COV_BENFTS</a>	The Social Security Inquiry/World Social Protection Database includes data on 214 countries and territories. As of March 2017, ILO is processing the Social Security Inquiry data for approximately 70 countries per year.  An updated pre-filled version of the questionnaire is sent to the countries in April-May.
<b>DOMAIN: PHYSICAL ENVIRONMENT</b>			
The COVID-19 pandemic worsened the plight of slum dwellers. With many direct and indirect impacts of COVID-19 in cities, the numbers of slum dwellers and people who downgraded to live in slum-like conditions increased, while the quality of life and vulnerabilities for those already living in the slums also worsened. The close to one billion people estimated to live in urban slums or informal settlements were highly susceptible to COVID-19 infection since basic facilities such as safe water and sanitation, sewers, drainage, waste collection, and secure and adequate housing.			
Safely managed drinking water, sanitation, and hygiene services are vital to human health. Frequent and proper hand hygiene is essential to prevent the spread of infectious diseases.			
People living in overcrowded housing conditions are at increased risk for morbidity and mortality from communicable diseases.			



Indicator proposed	Disaggregation	Data source and metadata source	Data availability
<b>Proportion of urban population living in slums, informal settlements or inadequate housing (%)</b>	<p>Location (intra-urban)</p> <p>Income group</p> <p>Sex, race, ethnicity, religion, migration status (head of household)</p> <p>Age (household members)</p> <p>Disability status (household members)</p>	<p>SDG 11.1.1: UN SDG Indicators Database. Available at <a href="https://unstats.un.org/sdgs/dataportal">https://unstats.un.org/sdgs/dataportal</a></p> <p><a href="https://unstats.un.org/sdgs/dataportal/SDMXMetadataPage?11.1.1-EN_LND_SLUM">https://unstats.un.org/sdgs/dataportal/SDMXMetadataPage?11.1.1-EN_LND_SLUM</a></p>	<p>Data on slums is available for all developing countries, as it has been reported yearly by UN-Habitat in the MDGs' reports. Recently, UN-Habitat has disaggregated information on this indicator at city level, increasing its suitability for SDG 11. The people living in slums' indicator is currently measured in more than 320 cities across the world as part of UN-Habitat City Prosperity Initiative. UN-Habitat and World Bank computed this indicator for many years (1996-2006) as part of the Urban Indicators Programme. Data on inadequate housing, measured through housing affordability, is available for all OECD countries as well as in UN Global Sample of Cities covering 200 cities.</p> <p>Data on inadequate housing, measured through housing affordability, is available in many countries. UN-Habitat and World Bank computed this indicator for many years (1996-2006) as part of the Urban Indicators Programme. Recently, the Global Housing Indicators Working Group, a collaborative effort of Cities Alliance, Habitat for Humanity International, the Inter-American Development Bank, UN-Habitat proposed the collection of data on this indicator worldwide.</p>
<b>Population using safely managed sanitation services (%)</b>	<p>Geographic location (urban/rural, sub-national regions, etc.) and by socioeconomic characteristics (wealth, education, ethnicity, etc.) is possible in a growing number of countries. Sanitation services are disaggregated by service level (i.e. no services/open defecation, unimproved, limited, basic, and safely managed services).</p> <p>Disaggregation by individual characteristics (age, sex, disability, etc.) may also be made where data permit. Some of the datasets used for producing estimates are household surveys and censuses which collect information on sanitation at the household level and cannot be further disaggregated.</p>	<p>SDG 6.2.1a: UN SDG Indicators Database. Available at <a href="https://unstats.un.org/sdgs/dataportal">https://unstats.un.org/sdgs/dataportal</a></p> <p>WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply, Sanitation and Hygiene (<a href="http://washdata.org">washdata.org</a>)</p> <p><a href="https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4820">https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4820</a></p> <p><a href="https://unstats.un.org/sdgs/metadata/files/Metadata-06-02-01a.pdf">https://unstats.un.org/sdgs/metadata/files/Metadata-06-02-01a.pdf</a></p>	<p>As of 1 July 2020, national estimates could be produced for 120 countries, areas, and territories, including 115 UN member states, and covering 81% of the global population. Estimates were available for rural areas in countries representing 73% of the global rural population, and for urban areas in countries representing 75% of the global urban population.</p>



Indicator proposed	Disaggregation	Data source and metadata source	Data availability
<b>DOMAIN: EDUCATION:</b>			
<p>Before pandemic emergencies, access to and completion of education enables better understanding and awareness of pandemic control and preparedness as well as communication during response; ii) schools are places where pandemics can spread; iii) during the COVID-19 pandemic school closures and lack of access to education was one of the main challenges of PHSM in need for mitigation; iv) access to education measures are basic social infrastructure within a country and has relevance also for gender equality if stratified by gender; v) schools can be a route for children and families to access Primary Health Care and preventive measures e.g. vaccinations.</p>			
<b>Education completion rate (primary education, lower secondary and upper secondary) (%)</b>	Sex, location (urban or rural) and household wealth (socioeconomic quintile) based on household survey data availability.	SDG 4.1.2 - UN SDG Indicators Database. Available at <a href="https://unstats.un.org/sdgs/dataportal">https://unstats.un.org/sdgs/dataportal</a> <a href="https://unstats.un.org/sdgs/metadata/files/Metadata-04-01-02.pdf">https://unstats.un.org/sdgs/metadata/files/Metadata-04-01-02.pdf</a>	This indicator is globally monitored, with data available from population censuses and household surveys with complimentary administrative data from ministries of education. The UNESCO Institute for Statistics (UIS) maintains the global database, and the data is regularly updated as survey and census data become available. Survey data through demographic and health survey (DHS) and multiple indicators clusters (MICS) surveys is typically collected on average every 3-5 years in target countries.
<b>Net school enrolment rate (preprimary, primary, secondary, tertiary) (%)</b>	Level of education, sex	UNESCO Institute for Statistics. Available at: <a href="http://uis.unesco.org">http://uis.unesco.org</a>	This indicator is widely tracked with extensive data coverage across countries. The data is collected and maintained by the UNESCO Institute for Statistics, with disaggregation by education level (preprimary, primary, secondary, tertiary) and sex. Data updates are frequent, ensuring that the statistics are reflective of current enrollment trends across different regions.

## **ANNEX I – SELECTION OF INDICATORS**

Many indicators relevant to SDH were considered but not included due to excluding general aspects such as monitoring the population's exposure to harmful commercial products, such as tobacco, alcohol, and ultra-processed foods, with a focus on vulnerable groups. For example, the inclusion of an indicator for air pollution was excluded as it would be more predominately applicable in case of a respiratory disease outbreak. The FEVR analysis conducted in 2023 explored the inclusion of the indicator "Detect, notify, respond" a global mechanism for early warning and One Health surveillance but identified a weak correlation which led to its exclusion. However, we recognise the importance of a One Health approach in the context of PPPR and see room for additional analysis going forward as it affects the frequency and risk of pandemics. Furthermore, in 2023 the original FEVR assessment explored the inclusion of the "Individualism" indicator to address social isolation. However, the data was a compound measure, and its interpretation was challenging, therefore it was decided to exclude this indicator.

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