Social Exclusion Knowledge Network (SEKN)

Scoping of SEKN and proposed approach

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1. INTRODUCTION

As part of it work the WHO Commission on the Social Determinants of Health has establish a number of topic focused networks with the aim of collating global knowledge on the relationship between social determinants and health disadvantage and inequalities and on effective action to address these determinants. The Social Exclusion Knowledge Network (SEKN) is the latest of these global networks to be established and the purpose of this paper is to provide WHO Commissioners, other Knowledge Networks and other interested parties with an over-view of the approach the Social Exclusion Knowledge Network is planning to take to, including the way the network intends to organise itself, the scope of our work, the agreed deliverables and the timelines involved. It is intended that the paper will provide an opportunity for Commissioners and other Knowledge Networks to have an early input to the work of the SEKN and to ensure that the work of the SEKN is complementary to that of other KNs.

This scoping document is divided into the following sections: the scope and focus of the work particularly the conceptual approach proposed; the investigative framework proposed; the organisation of the SEKN; the work plan and key deliverables agreed with the SDOH Commission secretariat and finally issues relating to the integration of the work of the SEKN with other Knowledge Networks.

2. THE SCOPE OF THE SEKN

2.1 The focus of the work

The social exclusion KN will focus on and examine the relational processes that work to exclude particular groups of people in particular contexts from engaging fully in community/social life. These processes may operate at the macro level (access to affordable education, equal employment opportunity legislation, cultural and gender norms) and/or micro-levels (income, occupational status, social networks –around race, gender and religion). The SEKN will also examine the linkages between social exclusion and the proximal concepts social capital, social networks and social integration. Together these concepts highlight and help to articulate the centrality of social relational processes in the genesis of social/economic/material and health advantage/disadvantage. These relational and exclusionary processes are

interconnected and dynamic and in most cases have a bidirectional relationship with health. Therefore, the nature and operation of such processes and their association with population health status and health inequalities will be analysed in a diversity of country contexts chosen to reflect the impact of differing structural (political, economic and social) constraints. Similarly, the primary focus of the work on policies and actions appraisal will be on the extent and way in which policies/actions address the complex and dynamic relational processes that generate social exclusion and ultimately impact on individual and population health and wellbeing. This comprehensive, multisectoral approach will illuminate new entry points and mechanisms for translating existing knowledge on the processes generating social exclusion and its impact on health experiences into effective policy and action.

2.2 The purpose of definitions

As many commentators in this field acknowledge whilst the notion of 'social exclusion' has generated a significant research based literature in the last decade or so, the concept remains problematic and contested. In this context, the first and perhaps the most important challenge for the SEKN is to develop an ***appropriate*** definition of social exclusion. This definition should serve two key purposes: ***a pragmatic purpose*** of avoiding duplication and maximising synergy between the Commissions Knowledge Networks; and ***a epistemic purpose*** of ensuring that the syntheses of available knowledge on the impact of social exclusion on health inequalities and action to address social exclusion provide the Commissioners with maximum leverage as they seek to foster the leadership, policy, action and advocacy needed to turn existing SDH knowledge into actionable global and national agendas. A bibliography is being compiled (See Appendix 1) and initial steps in refining a working definition have been taken and are described below. This will be tested out with members of the knowledge network and other stakeholders including the commissioners and refined as appropriate as the work of the SEKN develops.

2.3 A definition for the SEKN: social exclusion as a relational concept

The French politician René Lenoir[i] is generally recognised to be the first person to use the specific term 'social exclusion' in his comments on poverty and disadvantage in France in the 1970's. Lenoir was concerned with relationships between people and the 'state' and argued that exclusion from formal labour markets and welfare systems

(social protection) loosened the social bond underpinning the rights and responsibilities of citizenship. Since then and in the last 15 years in particular there has been a burgeoning of the literature on social exclusion, including but not restricted to empirical research. So widespread is the use of the term now that Kleinman has argued that it has become a 'cliché to cover almost any kind of social ill'[ii]. Most commonly, definitions of social exclusion include 'indiscriminate' lists of problems and processes describing: the groups of people at risk of being excluded; the things/resources/opportunities/sources of capital people are excluded from; a wide range of social, economic, political and health related problems that may result; different levels at which processes of exclusion operate; and perhaps less frequently the types of processes that operate to exclude groups of people at different times in different contexts. Silver[iii] suggests that by 1995 the list of things people may be excluded from included:

> *'a livelihood; secure, permanent employment; earnings; property, credit, or land; housing; minimal or prevailing consumption levels; education, skills, and cultural capital; the welfare state; citizenship and legal equality; democratic participation; public goods; the nation or the dominant race; family and sociability; humanity, respect, fulfilment and understanding'.*

In the context of this disparate and discordant literature Amartya Sen [iv] has argued that there is a need to identify the particular contribution the 'new' concept of social exclusion can make to our understanding of poverty and deprivation. He suggests that this is best achieved by placing the concept within the context of the extensive and long standing literature on 'capability deprivation' i.e. poverty seen as the lack of the capability to live a minimally decent life. Many scholars from Peter Townsend in the 1980's back to Adam Smith in the 18th century and beyond to Aristotle have highlighted the importance of viewing poverty in this relative and relational way if the primary interest of research and policy is the quality of lives that people are able to lead. Sen concludes that the concept of social exclusion is not 'new' but is strongly linked to these long established approaches that conceptualise poverty and deprivation as the lack of freedom to do certain valued things that ultimately define us as 'social' beings. However, he goes on to argue that 'forcefully emphasizing and focusing

attention on' the role of *relational features* in deprivation has the potential to significantly enrich traditional approaches to understanding and ameliorating poverty.

Other commentators have similarly highlighted the additional analytical leverage that may be provided by a relational approach to understanding processes of social exclusion. Beall, for example, argues that three distinct definitional perspectives on social exclusion can be identified. The first she refers to as a discredited neo-liberal approach that views the exclusion of certain groups from formal labour markets, and from the benefits of social security and employment protection as the necessary consequence of the realignment and opening up of trade at a global level. The second approach she suggests sees the term as an unhelpful re-labelling of poverty serving to focus attention on the social realm and distract from the economic forces/processes that generate and sustain poverty. The third approach Beall labels as transformational arguing that in focusing attention on the exclusionary processes arising from social relationships embedded in formal and informal institutions this approach 'signals the use of the social exclusion framework to analyze international processes and institutional relationships associated with rapid social and economic change and local impacts and responses'[v].

Analytical leverage is provided by the linkages that can be mode between social exclusion as a relational phenomena and other concepts, in particular social capital, social networks and social integration[vi]. Whilst importantly different from social exclusion these concepts all highlight and help to articulate the centrality of social relationships in the genesis of social and health advantage/disadvantage and warrant consideration in the work of the SEKN.

A key aspect of social exclusion given particular salience by a relational perspective is agency. This is a highly contested issue in the literature on social exclusion with attention having been directed at the causal role of a wide range of 'agents' ranging from globalisation, multi-nationals and international agencies such as the World Bank and IMF, through nation states and their institutions to excluded individuals/groups themselves. Much less attention has been given in the literature to the agency of groups affected by exclusionary processes: rather than passive victims such groups may actively mould and/or resist these processes and the social, economic and health

consequences.[vii] There appears to have been relatively little research exploring the perspectives and views of people experiencing exclusion but work that has been done is revealing. One such study focusing on the perspectives of people living in low income urban areas in the UK, for example, concluded that overall the idea that social exclusion is about participation in socially valued activities was supported by respondents. However, compared with the definitions used by researchers in the UK the respondents gave greater emphasis to the dynamic nature of exclusion; they added the consumption of public goods and services to the range of normal activities included in researchers definition and challenged the view implicit in many 'academic' definitions that voluntary social exclusion was not a problem suggesting, for example, that difficulties were created for a society in which the better-off 'excluded' themselves. Respondents also felt that some forms of deliberate social exclusions were legitimate – such as a society protecting itself by excluding anti-social members. Additionally and importantly, they gave more emphasis to issues of social justice and social solidarity than is apparent in many academic definitions and resisted the limited focus on social exclusion at the individual level suggesting that a focus on area and/or neighbourhood exclusion was equally legitimate.

Although not uniquely associated with a relational perspective on social exclusion research has highlighted other key dimensions of the concept which may increase understanding of the causal pathways between social exclusion and health disadvantage and to illuminate potential levers for policy and change. Of particular note is the relative and dynamic nature of exclusionary processes.[viii] The notion of relativity refers to the contingent nature of social exclusion – it is not an absolute state attaching to particular individuals or groups and their circumstances regardless of the wider context. It is not a dichotomous state with some groups excluded and other included in social life. Rather exclusionary processes impact in different ways to differing degrees on different groups and/or societies at particular times. The notion of relativity is closely linked to the notion of dynamism: to understand the processes that generate and sustain exclusion requires attention to the interactions between social relationships and outcomes at different levels - individual, family, community, national and global - and to how these interactions change over both historical and biographical time. As Joint-Lambert has argued exclusionary processes can evict

people from spaces they previously occupied as well as depriving people of rights of access in the first place.[ix]

Finally, a relational perspective on social exclusion allows the concept to be translated from its roots in Northern Europe into a global frame. Static definitions that view social exclusion as an outcome of poverty and disadvantage are not readily applicable to country contexts in which the majority of populations are living in severe poverty, excluded from the formal labour markets with no entitlement to welfare benefits in cash or kind. A relational perspective, in contrast, focuses attention on to the wider social, economic and political causes of poverty and inequality and allows for an analysis of the exclusionary processes generated and sustained by social relationships operating at micro, meso and macro levels from families to international agencies. This perspective more readily allows for an analysis of the dynamic and multi-level processes that may exclude whole nations and continents from the potential benefits of social and economic development or perhaps more importantly from having a voice in the nature and direction of such development. There is a growing body of work exploring the utility of the concept to LEDCs. The paper by Amartya Sen quoted earlier includes a number of insightful explorations of the way in which the concept might be used to illuminate the relational nature and causes of capability deprivation in Asia. Similarly, there is research on the experience of social exclusion amongst low income urban and rural workers in China which points to restrictions in participation in urban life alongside deprivation of political, social and economic rights[x]. There is also a long tradition of research on the experience of deprivation in low income countries and although relatively little of it has an explicit focus on the relational processes involved in the genesis of deprivation it would be feasible to apply a relational lens to some if not all of this work.

Reports from international agencies also reveal an increasingly interest in the relational nature of social exclusion as applied to LEDCs. This literature represents a valuable body of experiential evidence to be drawn on to describe the nature and scale of social exclusion and to describe and assess a range of policy responses at a local, national and international level. For example, reports from such agencies as the regional development banks, government departments focusing on international development, the United Nations and other agencies highlight the many ways in

which groups are excluded on the basis of age, sex, ethnicity, and other social characteristics by institutions and behaviours that reflect, enforce and reproduce prevailing social attitudes and values of powerful groups in societies. There is widespread recognition of the consequences of social exclusion including the direct effect on the numbers of individuals and families living on extremely low incomes, the indirect effects on the productive capacity of societies as a whole; and the links to increased conflict and insecurity.[xi] In this context, increasing attention is being paid to the need for policy initiatives that support greater engagement with excluded groups and communities, building social capital and social networks and contributing to democratic renewal.

2.4 Advantages of a relational perspective on SE: a summary

From the perspective of the WHO Commission on the Social Determinants of Health a relational approach to the identification and collation of global knowledge on action to address social exclusion has a number of significant advantages. In particular it focuses attention onto:

- **The causal processes located within social relationships embedded in formal and informal institutions that generate and sustain exclusionary processes.** From this perspective social exclusion leads to unfavourable social, economic and health outcomes rather than being the outcome of poverty and disadvantage.

- **The importance of agency**: identifying and understanding who or what is acting to exclude and acknowledging the potential for excluded groups to act in their own interest is crucial but 'agency' is also highly contested

- **Exclusionary processes operating within and beyond nation states** ensuring that the SEKN gives due attention to the way in which global processes of exclusion may be 'grafted' on to the dynamics of exclusion operating at many levels within nations from the family to the state

- **The limitations of common understandings of social exclusion for LEDCs** where the majority of people are excluded from formal labour markets, systems of social protection, etc.

- **The linkages between social exclusion and a human rights** approach to social determinants of health emphasising social & economic rights alongside political & legal rights.

- **The salience of 'identity' as an aspect of the relational processes that serve to exclude** groups of people (e.g. caste systems, gender, ethnicity, stigmatising illness, etc)

- **The dynamic & contingent nature of processes of social exclusion** which change over historical and biographical 'time' and place. Social exclusion is not a dichotomous variable: people and/or groups can be more or less excluded.

Given these benefits the SEKN believes that a relational approach to the definition of social exclusion will serve the epistemic purpose of ensuring that the syntheses of available knowledge is of maximum value to the WHO Commission on the Social Determinants of Health and the pragmatic purpose of ensuring that the work of the SEKN is complementary to that of other Knowledge Networks. As we have argued earlier it is the relational dimension to poverty and deprivation highlighted by the concept of social exclusion that provides a link to the social determinant of health distinct from the focus of other KNs. From this perspective it is important that the work of the SEKN focuses on enhancing understanding about the nature and causes of the relational components of social exclusion, the links between these components and population health and health inequalities and the implications of this analysis for policy and action to address the SDOH. Against this background we outline in the next section how the work of the SEKN should be taken forward.

3. AN ANALYTICAL FRAMEWORK FOR THE WORK OF THE SEKN

3.1 The analytical imperative –asking the relational questions

It has been argued above that there is a strong case for adopting a relational perspective for the work of the SEKN. If this is accepted then it is crucial that the SEKN analytical process should focus particularly on the key questions of whether and in what way relational processes have been responsible for social/economic and

health disadvantage and whether and if so in what way policies, programmes and/or institutional arrangements aiming to impact on social exclusion incorporate a relational perspective – whether implicit or explicit.

3.2 Strands of investigation

It is proposed that work of the SEKN be divided into three investigative strands:

- Review and synthesis of international literature on the associations between the experience of exclusionary processes and health and social disadvantage.
- Review and synthesis of available knowledge on actual and potential policies and actions aimed at addressing the relational processes generating social exclusion and health and social disadvantage.
- Country case-studies. More intensive work in a small number of countries from different regions around the world to reflect variations in social, economic and political contexts and levels of development. The aim of these country case studies would be: (1) to assess the current impact of exclusionary social processes on key social determinants of health; (2) to describe the nature and impact of policies, programmes and/or institutional arrangements aimed at addresses exclusionary processes; and (3) to provide a systems level analysis at national level of processes and factors that enable and/or constrain the implementation and scaling up of policies, programmes and/or institutional arrangements that have the potential to reduce social exclusion and ultimately reduce health inequalities.

3.3. Structuring the investigative work

The literature reviewed so far has highlighted a number of dimensions of social exclusions that could help to structure the knowledge synthesis process. These are described briefly below and additional themes/dimensions are likely to be identified as the work of the SEKN progresses.

i. Constitutive & instrumental pathways to social/economic/health disadvantage

Processes of social exclusion can lead to 'capability deprivation' and thus negative health impacts through two main pathways:

- Constitutive pathway: the exclusion of some groups of people from full participation in social and political relationships and hence from taking an active

part in community/social life can be viewed as an intrinsic element of poverty/deprivation with direct negative impacts on health and wellbeing;

- Instrumental pathway: exclusion from social relationships may cause other deprivations, for example, being excluded from the labour market may lead to low income and other deprivations such as homelessness or poor nutrition and so contribute to ill health.

ii. Active and passive exclusion.

Processes of social exclusion may be:

- Active: where exclusion is the direct and intended result of policy or discriminatory action for example the lack of political rights amongst migrant groups in some European countries or deliberate discriminatory practices on the basis of gender or age.
- Passive: When deprivation comes about through social processes in which there is no deliberate attempt to exclude for example when a downturn in the economy leads to higher than average levels of unemployment amongst young unskilled workers or older workers.

iii. Processes and interactions at different levels

- Social exclusion operates at the macro, meso and micro levels (locally, nationally and globally) and interactions within and between processes and factors at these levels are important for understand the nature of the exclusionary processes at work and complexity and diversity of the pathways from social exclusion to health disadvantage.

3.4. Identifying policies/actions for appraisal

It is important to stress that adopting a relational approach to an analysis of the link between social exclusion and health disadvantage and to the appraisal of policies/actions to address the negative health and social impacts of social exclusion does not predetermine which policies and actions should be the focus of critical attention. The SEKN will adopt an inclusive but pragmatic approach to the identification to policy/actions for appraisal: no policy/action will be excluded from appraisal for ideological reasons: because, for example, they assume an absolute level of resource availability, a particular political environment or adopt a particular position on the potential or feasibility of resource re-distribution. The criteria for

selecting policies/actions for appraisal will be evidence based and transparent: these criteria will be agreed within the network and discussed with the Commissioner(s) affiliated with the SEKN and the Commission secretariat before being applied.

3.5 Policy impact assessment framework

There is some evidence from both MEDCs and LEDCs that policy initiatives aimed explicitly at impacting on the relational processes that generate social exclusion can make a difference. However, as one commentator has noted 'A focus on "social exclusion" (rather than, say, poverty or deprivation) does not transform the scale or nature of the problems to be tackled. But it may change the emphasis of policy responses and can lead to a richer policy mix[xii]. It will be necessary for the SEKN to develop a framework for assessing the impact of policies and interventions focusing on social exclusion and the anticipated intermediate outcomes in relation to the affects on the SDOH and ultimately health outcomes. This framework would need to consider policy/intervention impact and potential at different levels including:

- Policies and activities of national governments (e.g. legal, regulatory and policy frameworks that promote social inclusion, policies aimed at monitoring and if necessary shifting the distribution of public expenditure, at improving economic opportunities and access to good-quality services and promoting political participation);
- The role of civic society in general and excluded groups in particular.
- The contribution of donor agencies.

A critical issue for the policy analysis work will be the nature of ***policy/program delivery mechanisms*** rather than attending only or primarily to the specific focus of a particular policy or intervention. In particular, it will be important to assess the extent to which delivery mechanisms underpinning policies and interventions aimed at addressing other structural and intermediate social determinants of health explicitly or implicitly build (or conversely undermine) social capital and/or social cohesion. The third meeting of KN hubs provides an important opportunity to discuss with other KNs how much their work includes a focus on relationally oriented delivery mechanisms.

3.6 Knowledge and its limitations

As documents from the Measurement and Evidence Network recommend the SEKN will take an inclusive approach to knowledge drawing from published and unpublished literature and include knowledge from research, practice and the experience of groups affected by exclusionary processes. This is a significant challenge for knowledge review and requires both high level skills in information science and extensive personal and professional networks.

There are also well recognised limits in the availability of research based evidence in the field of social exclusion particularly evidence illuminating the relationship between social exclusion and social/economic/health disadvantage.[xiii] These include problems with the comparability of data across nations, the lack of longitudinal data and major gaps in the coverage of data by population groups and dimensions of social exclusion. Reflecting the definitional distinctions considered earlier there would appear to be two distinct approaches to research on social exclusion: those that focus on the distributional aspects of social exclusion (e.g. on population patterns of income distribution, employment and others forms of resources) and those approaches that focus on the relational aspects of social exclusion (e.g.. on the nature, quantity and quality of aspects of social capital, relationships and networks and the dislocation of these or on the nature of and involvement in democratic processes). There appears to be a lack of research into the dynamic nature of social exclusion or that contributes to our understanding about the genesis of social exclusion at the macro level (e.g. social policies, labour market), the meso level (e.g. inner cities poverty) and the micro level (experience of the daily life) and interactions between these levels. Importantly, work explicitly linking the experience and impact of social exclusion to health status at the individual or population level appears to be very limited and the establishment of such links will depend in part on theoretical work[xiv].

4. ORGANISATION OF THE SOCIAL EXCLUSION KN

4.1 Organisational arrangements

The Social Exclusion Knowledge Network will consist of a central co-ordinating hub and four equal status regional co-ordinating hubs mirroring WHO regions. The central co-ordinating hub is co-located with the Western Europe Regional Hub and is based at Lancaster University in the UK and led by Professor Jennie Popay. The host organisations and lead individuals are identified for the regional hubs in Sub-Saharan

Africa (based at the Human Sciences Research Council in South Africa led by Dr Laetitia Rispel) and South East Asia (based at ICDDR,B: Centre for Health and Population Research Dhaka, Bangladesh and led by Dr Heide Johnston). The regional hub for the Americas has not yet been confirmed. Each Regional Hub has a designated research lead and a linked policy/practice lead for their region. In the two WHO regions where no hub is being established (Eastern Mediterranean & Western Pacific) there will be two members from each of these regions on the global network (one with research the other policy/practice expertise). Nominations for these members have been sought from the Civil Society Facilitators and WHO regional office focal points in these regions so that nominees with the relevant experience can be approached to join the SEKN as full members. One of the two members from the Western Pacific region will be the nominated civil society member on the global SEKN. We also intend to explore potential links with Professor Ichiro Kawachi to provide expertise on North America.

It is anticipated that the core network membership will consist of the research and practice leads from each of the four regional hubs (already identified) and a research and policy/practice representative for WPRO and EMRO to be identified through nominations provided by civil society and/or CSDH mechanisms such as the WHO regional office focal points. This core membership will attend SEKN meetings and contribute directly to the work of the KN. In addition there will be a larger 'associate' membership who will be invited to join the stakeholder network and to participate in discussion of the work of the SEKN. These will be formed in part of regional networks developed and co-ordinated by the regional hubs building on their existing extensive networks. Where funding allows some associate members may undertake specific pieces of policy analysis and/or country case studies for the SEKN. Some members of the associate network were identified in the original bid (and listed in appendix 2) others will be identified through mapping exercises to be undertaken by the network hubs which will include:

- mapping and knowledge of civil society organizations within the region
- identification by Civil Society Facilitators for regions of range of organizations and institutions to be included
- list of organizations and contacts identified through existing nominations process for work of CSD

4.2 The role of the central co-ordinating hub

The SEKN Co-ordinating Hub based at Lancaster University in the UK will have day to day responsibility for the administration and overall co-ordination of the SEKN and for ensuring that the SEKN delivers to it contractual obligations. It will operate under the direction of the SEKN core membership which will meet face to face twice during the life of the contract and interact via the CSDH shared workspace, email and telephone on a regular basis. This core network membership group will be chaired by Professor Popay and had its first meeting in Nairobi, Kenya in June 2006. At this meeting the SEKN agreed that no formal co-chair will be appointed: chairing of network meetings will rotate around the membership. Representation of SEKN at Commission meetings (in addition to Jennie Popay) and responsibility for work strands will be agreed as appropriate by core membership.

The central co-ordinating hub will act as a focal point for the work of the network for the Commission Secretariat. Together with the Regional Hubs it will develop generic templates for the knowledge databases, the policy/action appraisal work and the country case studies to be conducted by the Regional Hubs (building on the guidance provided to the KNs as a whole). Professor Popay will be responsible for ensuring the implementation of programmes of work agreed with the WHO commission Secretariat, for internal quality assurance of the work undertaken for the SEKN by external experts commissioned to produce particular pieces of work, for monitoring the allocation and management of budgets and for organising meetings of the network. The Central Co-ordinating Unit will be responsible for establishing and co-ordinating a small writers group drawn from the regional hubs to bring together reports and data from the regional hubs into final products from the network as a whole. . Professor Popay will take lead responsibility for liaising with the WHO and the Commission components at an international level with the involvement of another representative from the core membership of the network. With Regional Hub leads she will also develop proposals for additional funding for the work of the SEKN

4.3 The role of the regional hubs

Working to common templates produced by network members each regional hub will have responsibility for

1. Identifying literature from their region on the association between social exclusion and health disadvantage and inequities;
2. Identifying and appraising policies and actions with potential to address social exclusion at regional, national and local levels;
3. Conducting at least one country case studies,
4. Establishing and maintaining two regional knowledge databases (one focusing on evidence on the association between social exclusion and health inequities and the other focusing on policies/programs/institutional arrangements with potential to reduce social exclusion);
5. Establishing and maintaining relationships with relevant stakeholders
6. Stimulating country and regional debate about knowledge transfer and utilisation.

The association evidence identified by each regional hub will be forwarded to the Lancaster co-ordinating hub which will have responsibility for producing a review of literature on the association between health experience and social exclusion with involvement from regional hubs members where appropriate and feasible (see below). Within the constraints of the financial and temporal resources available, in order to engage with relevant stakeholders and stimulate debate within their regions the Regional Hubs will seek to set up and support a regional knowledge network involving the three key stakeholder communities: knowledge experts/academics, policy makers and practitioners and civil society organisations. However, it is stressed that the primary purpose of the network is to collate and appraise relevant associational and evaluative evidence to inform policy and action to address the social determinants of health inequities.

We recognise that the proposals for the SEKN are ambitious, particularly in light of the short time available for the delivery of the outputs required by the WHO Commission on SDOH. However, we believe that this knowledge network should seek to continue after the initial work for the Commission has been completed playing a role in ensuring that the vision and work of the CSDOH endures into the future. To that end we intend to work towards the sustainability of the knowledge network, building on existing links to international movements focusing on social inclusion, participation and health including, international and national agencies as well as relevant networks operating regionally and locally.

5. WORKPLAN AND KEY DELIVERABLES

5.1 Key tasks

- The key stages in our work include: The first face to face network meeting was held in Nairobi on the 21st – 23rd June. The core network membership discussed and agreed: ways of working; draft scoping document, and the approach to be adopted to produce (1) definition briefing paper; (2) analytical templates for policy/action appraisal and country case studies and (3) other aspects of the work plan. Following this meeting the network agreed to:
- Produce a final version of the scoping document for submission to the WHO Commission and the secretariat
- Begin work on
    a. a briefing note on definitional issues in relation to social exclusion.
    b. Templates for regional knowledge databases, policy/program analysis and country case study work
    c. Identifying criteria for selection of policies and actions for appraisal
- Identify relevant literature on the associations between processes of social exclusion, SDH and health disadvantage for their regions working through regional networks and academic contacts and send these to the co-ordinating hub.
- Begin work on the review and synthesis of evidence on the associations between processes of social exclusion, SDH and health disadvantage. This will include both published and grey literature although we expect there to be limited data available linking social exclusion directly to health inequities. Relevant electronic databases and library holdings (including specialist libraries such as the Institute for Social Studies at The Hague) will be searched and data identified by Regional Hubs will be incorporated. It is envisaged that a small number of specific pieces of work will be commissioned from external experts notably the Participation Team at the Institute of Development Studies in Brighton, UK (which has a particular focus on low income countries) and CASE at the London School of Economics, UK (which has a particular focus on social exclusion in wealthier nations).
- Work through regional knowledge networks to compile lists of potential policies, programs and institutional arrangements for further study. These lists will be the

focus of discussion and short-listing at a teleconference of the SEKN core members. The short list will be discussed with the WHO KN co-ordinator and the co-ordinators of other knowledge networks to ensure the work is complementary.

- Detailed appraisals of the short listed policies/programs/institutional arrangements. These will be conducted to a common template but allowing for regional diversity where appropriate. If resources allow new policies/actions will be added as and when identified. These policy appraisals will draw on documentary evidence and interviews with stakeholders where possible. The total number of assessments to be completed will depend on the scale of the work involved and it is not possible to judge this until the first appraisals are completed. On the basis of the review of associational evidence the SEKN will also explore what new theoretically informed actions might be envisaged.
- A minimum of one country case study focusing on the countries in which the hubs are located. As described earlier the aims of these country case studies would be: (1) to assess the current impact of exclusionary social processes on key social determinants of health; (2) to describe the nature and impact of policies, programmes and/or institutional arrangements aimed at addresses exclusionary processes; and (3) to provide a systems level analysis at national level of processes and factors that enable and/or constrain the implementation and scaling up of policies, programmes and/or institutional arrangements that have the potential to reduce social exclusion and ultimately reduce health inequalities. The core membership will produce a country case study template drawing on the template developed by the Evidence team at the WHO regional office in Europe. This will allow consideration of the factors shaping the feasibility of scaling up and/or transferring policies/programs/institutional arrangements to across contexts.

We envisage at least monthly telephone conferences of the SEKN core members to review progress, continual interaction of Share-point and by email. There will also be a second face to face meeting of the Group early in 2007 to review the initial associational literature review and the first reports on the policy appraisals. Similarly, a writers' workshop will be organised March 2007 and a draft of the final report will

be submitted to the WHO Commission Secretariat in April. 2007. The final report will be finalised and submitted in June 2007.

5.2 Knowledge transfer, dissemination and stakeholder relationships

We envisage this being the primary responsibility of the Regional Knowledge Hubs operating through regional networks. Given the importance of the socio-political context (as highlighted in the CSDOH Conceptual Framework document) for both understanding and interpreting evidence and for the successful transfer of knowledge to support decision making we believe that this work is best located at a regional and sub-regional level. The Regional Hubs are already embedded in extensive stakeholder networks involving policy makers, service providers and civil society organisations which provide powerful platforms from which to launch this element of the SEKN work to stimulate debate within the regions and individual countries about knowledge needs and opportunities for action.

5.3 Deliverables

1. Scoping document on work of the SEKN and organisational arrangements.
2. Short briefing paper exploring differing approaches to the definition of social exclusion globally.
3. Production of two analytical protocols to shape the policy/action appraisal and country case studies including criteria for section.
4. Production of a report on the synthesis of literature on the association between social exclusion and other social determinants of health disadvantage and inequities
5. The production of a report on the analyses of policies, programmes, actions and institutional arrangements with potential to reduce social exclusion and the factors and/or processes that may enable implementation and scaling up of these including country case studies.
6. The production of reports on country case studies.
7. An inventory of actions (policies, programmes, etc.) that can be taken to reduce inequities in health resulting from social exclusion and to illustrate how the mixtures of social policies and inter-sectoral collaboration can work to promote health equality.

8. Final report of the SEKN by 30th June 2007 approved by regional hub leads and majority of SEKN members

6. INTEGRATION WITH OTHER STREAMS OF WORK

We recognise that as the work of the SEKN develops it will be important that we work closely with other Knowledge Networks to ensure that our work is complementary to theirs and that we seek to integrate our work with that of other Commission work strands in particular the country work and the civil society work strands. Connections with all these strands have already been developed through attendance at the second KN hubs meeting in Nairobi for example. As a result of contacts established through this meeting regional hub leads are in discussions with relevant regional civil society facilitators and strong links with also be made with WPRO and EMRO through the members who will join the core membership of the SEKN. Additionally, discussions are already underway with the UK country representatives to explore the possibility of case study work on the UK experience of developing policies to reduce social exclusion. We will work with other KNs through the CSDH shared workspace and one to one relationships. For example, Jennie Popay is a member of the Measurement and Evidence Network ensuring good links with that group and discussions have already begun with the globalisation and employment conditions networks to identify potential overlaps and explore areas for joint working. As agreed at the second meeting of KN hubs:

1. the document outlining the interests and expected product of the CSDH country work partners has been circulated within the SEKN and to regional co-ordinating hubs for their follow up with relevant countries. In particular, regional co-ordinating hubs will follow up with country work partners who have expressed a specific interest in social exclusion and/or where a case study undertaken or supported by the country partner will address a particular knowledge gap in the work of the SEKN (globally and regionally); and
2. the SEKN will work with the CSFs in each region (through regional co-ordinating hubs) and the CSFs in the region responsible for the SEKN globally (Eastern Mediterranean) to explore the possibility of **additional** case studies that might be undertaken by civil society and contributing to the work of the SEKN. These case studies will need to be identified and agreed with the CSFs for the each of the regions**.**

Appendix 1: SEKN Preliminary bibliography

I General Social exclusion:

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Appendix 2: Network members AT 1ST July 2006

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Role	Name	Institution/Address
Regional Hub Lead:	TBC but would be good to hold two places if possible	
South East Asia		
Role	Name	Address
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