Learning From the World

Global Strategies for Improving Health Equity and Social Determinants of Health

Lessons from Australia, Brazil, the Czech Republic, Indonesia, Northern Ireland, Singapore, and South Africa

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CONTENTS

ACRONYMS 1

EXECUTIVE SUMMARY 2

Background and Research Questions 2

Methods 3

Key Findings 4

Bias and Discrimination 5

Housing 5

Education 5

Health Care 5

Income Inequality 5

Notable Themes and Strategies for Improving Social Determinants of Health and Health Equity Across Countries 6

Decolonization and Trauma-Based Frameworks 6

Participatory Approaches 7

Coordinated, Multisectoral Approaches 7

Approaches to Building Spatial Equity 8

Insights Related to the RWJF COH Action Framework 8

Recommended Next Steps and Further Research 9

PROJECT PURPOSE AND AUDIENCE 10

Background 10

Research Question and Objectives 11

METHODS 12

Country Selection 12

Expert Consultations 15

Desk Review and Case Study Development 16

Qualitative Case Study Comparative Analysis 17

Gaps and Limitations 17

KEY FINDINGS AND DISCUSSION 18

Overview of Key Contextual Factors Across Selected Countries 18

Historical 18

Cultural 19

Social 19

Political 20

Economic 21

Policies, Programs, and Interventions Across Health Equity Matrix Criteria 22

Bias and Discrimination 22

Housing 23

Education 25

Health Care 26

Income Inequality 27

Notable Strategies for Improving SDOH and Health Equity Across Countries 29

Decolonization and Trauma-Based Frameworks 29

Participatory and Community-Centered Approaches 35

Coordinated, Multisectoral Approaches to Early Childhood Development and Other Social Determinants of Health 38

Approaches to Building Spatial Equity 44

CONCLUSIONS AND RECOMMENDATIONS 48

Insights Related to the RWJF COH Action Model 48

Action Area One—Making Health a Shared Value 48

Action Area Two—Fostering Cross-Sector Collaboration 49

Action Area Three—Creating Healthier, More Equitable Communities 50

Action Area Four—Strengthening Integration of Health Services and Systems 50

Recommended Next Steps and Further Research 52

REFERENCES 54

TABLES & EXHIBITS

Table 1. Overview of National Demographic Characteristics for Selected Countries and the United States; Demographic indicators from UNData 4

Table 2. Summary of Thematic Areas Across Sample of Countries 6

Exhibit 1. RWJF Culture of Health Action Framework 11

Exhibit 2. Democratic Countries by World Region (Based on WHO Classification) 13

Exhibit 3. Democratic Countries by World Region (Based on Exclusion Criteria) 13

Exhibit 4. County Health Rankings Model 14

Exhibit 5. Countries with Similar Demographic Profiles & Top 20 Performers for One/> Variables 14

Exhibit 6. Overview of National Demographic Characteristics for Selected Countries and the United States 15

Exhibit 7. Desk Review Search Results 16

Exhibit 8. Health and Education Indicators Across Sample 20

Exhibit 9. Dates of Independent Democracies Established Across Countries 20

Exhibit 10. Economic, Inequality and Well-Being Indicators Across Sample Countries 21

Exhibit 11. Brazil's Bolsa Família Primary Program Areas 27

Exhibit 12. Summary of Thematic Areas Across Sample of Countries 29

Exhibit 13. Australia: National Apology and Healing Foundation 31

Exhibit 14. Northern Ireland: Community Healing and The Flax Trust 33

Exhibit 15. Brazil: Participatory Budgeting 36

Exhibit 16. South Africa: People's-Led Process for Informal Settlement Upgrades 37

Exhibit 17. Brazil: Bolsa Família Program for Conditional Cash Transfers in Brazil 39

Exhibit 18. The Czech Republic: Supports for Working Families 41

Exhibit 19. Singapore: Affordable, Mixed-Ethnicity Housing Approach 43

Exhibit 20. Indonesia: Rural Health Care Incentive Programs 46

Exhibit 21. Action Area 1: Making Health a Shared Value 49

Exhibit 22. Action Area 2: Fostering Cross-Sector Collaboration 50

Exhibit 23. Action Area 3: Creating Healthier, More Equitable Communities 51

Exhibit 24. Action Area 4: Strengthening Integration of Health Services and Systems 51

Exhibit 25. Four Recommendations for Building on Global Lessons Learned in Health Equity for the United States 53

ACRONYMS

ABS	Australia Bureau of Statistics
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
ASEAN	Association of Southeast Asian Nations
BNG	South African Breaking New Ground policy
CFS	Child Friendly Schools
CHW	Community Health Worker
COH	Culture of Health
COPC	Community-Oriented Primary Care
CPF	Singapore Central Provident Fund
CSG	South African Child Support Grant
DAC	South African Department of Art and Culture
ECD	Early Childhood Development
EFE	Czechia Ethnic Friendly Employer project
E.U.	European Union
FHA	U.S. Federal Housing Administration
FHI	Family Health International
FHS	Brazil Family Health Strategy
FRA	European Union Agency for Fundamental Rights
GDP	Gross Domestic Product
GHS	South African General Household Survey
HDP	Singapore Housing & Development Board
HUD	U.S. Department of Housing and Urban Development
IAS	Australia Indigenous Advancement Strategy
IBA	Australia Indigenous Bureau of Affairs
JKN	Indonesia comprehensive health insurance program – *Jaminan Kesehatan Nasional*
LEAD	Victoria Localities Embracing and Accepting Diversity pilot program
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex
MCMV	Brazil Minha Casa, Minha Vida housing program
MEYS	Czechia Ministry of Education, Youth and Sports
MoLSA	Czechia Ministry of Labour and Social Assistance
NARPS	Australia National Anti-Racism Partnership and Strategy
NDP	South African National Development Plan
NGO	nongovernmental organization
NHHA	Australia National Housing and Homelessness Agreement
NHI	South Africa National Health Insurance
NHS	U.K. National Health Service
OECD	Organization for Economic Cooperation and Development
PHC	Primary Health Care
PSF	Brazil Family Health Program
RWJF	Robert Wood Johnson Foundation
SDI	Slum Dwellers International
SDOH	Social Determinants of Health
SME	Subject Matter Expert
SUS	Brazil Sistema Único de Saúde (Universal Health System)
TRC	South African Truth and Reconciliation Commission
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
U.K.	United Kingdom
UN	United Nations
U.S.	United States
WHO	World Health Organization
WIS	Singapore Workfare Income Supplement
WTS	Singapore Workfare Training Support

EXECUTIVE SUMMARY

Background and Research Questions

The Robert Wood Johnson Foundation (RWJF) understands that when it comes to health, good ideas have no borders. In fact, RWJF recognizes that in order to improve the health of our nation, we need the best possible ideas from across the world.

The FHI 360 team conducted this global health equity scan on behalf of the RWJF global team to:

1. Identify countries outside the United States that are tackling equity in areas that affect health and well-being;
2. Highlight historical, cultural, political, economic, and other contextual factors that underlie or contribute to health equity trends, interventions, or policies; and
3. Assess how drivers of health equity in these countries relate to the RWJF Culture of Health (COH) Action Framework.

The analysis sheds light on key approaches and themes across programs, policies, and projects addressing health equity and related social determinants of health (SDOH) across our sample. Lessons gleaned from this global equity scan and desk review were guided by a core set of research questions and objectives established at the outset of the project.

We followed a systematic approach; however, this present scan is not exhaustive. Rather, we sought to discover strategies and ideas that can inform potential transformations in the United States in the areas of SDOH and health equity. Another key output of the project was the methodology we adopted. Our approach also informs how to learn from the world, including a systematic approach to examining health equity globally; identifying equity domains for analysis; locating and analyzing sources of data to capture relevant contextual factors and health equity domains; and adopting a qualitative, comparative research approach that allowed our team to be flexible as insights from the data emerged. To this end, the current project very much led to insights on learning how to learn from the world.

Our qualitative, comparative research followed a phased approach. In the first phase of our investigation, we iteratively asked:

1. Which countries may be contextually comparable to the United States in terms of democratic governance and demographic trends—including having a larger total population, a modestly aging population, a marked urban-rural divide in population density, and the presence of ethnic or cultural heterogeneity?
2. Of these countries, which are making progress in key areas that align with the Robert Wood Johnson Foundation's COH Action Framework?

During the second phase of our scan, we selected a short list of seven countries from across the globe—spanning nearly every major World Health Organization (WHO) region—to explore and compare:

3. What historical, cultural, social, political, or economic factors underlie health equity trends in these countries;

4. What policies, programs, and initiatives are governments and nongovernmental organizations (NGO) employing to improve health equity and equity in other areas that affect health and well-being; and
5. Which findings are most relevant to the COH Action Framework.

Methods

Our first objective was to design a systematic approach that would allow us to identify countries from around the world that may be making progress toward improving health equity and equity in other areas that affect health and well-being. Our qualitative, comparative methodological approach allowed us to target areas with the greatest promise of garnering important insights without having to be exhaustive in our efforts. To do this, we first narrowed down the possible set of countries by selecting only those that had a heterogenous population and a democratic government[1] because we wanted to select countries that would have contexts somewhat comparable to the United States in order to facilitate translating lessons learned that might inspire recommendations applicable to the United States.

To develop our second layer of inclusion criteria, we established a theoretical framework for identifying important health equity indicators available from globally comparable sources such as the United Nations, the World Bank, and others that mirror indicators from the County Health Rankings and the RWJF COH Action Framework, such as gross domestic product (GDP) per capita, Gini coefficient, adult and infant mortality rates, and noncommunicable diseases. We used current and longitudinal outcome data for these variables to score the democratic and somewhat demographically comparable countries. We were able to narrow our list to 15 comparable countries that were among the top 20 performers for one or more of our selected variables. Ultimately, we selected Australia, Brazil, the Czech Republic, Indonesia, Northern Ireland, Singapore, and South Africa from among the 15 nations to conduct case study desk review of policies and programs that target equity in terms of health outcomes and other social determinants of health.

Table 1 outlines key demographic characteristics of the seven countries in comparison to the United States. Comparable demographic measures of ethnic, racial, or cultural heterogeneity are difficult to attain due to the wide range in measurements employed during censuses. Australia has a large proportion of foreign-born or first-generation immigrants and a small but growing population segment who identifies as Aboriginal or Torres Strait Islander. Brazil is racially diverse, with more than 40% of the population identifying as Mulatto and significant populations of Afro-Brazilians and Indigenous Brazilians. While Czechs are the largest population segment in the Czech Republic, there are communities with populations identifying as Slovak, Polish, and Roma. In Indonesia, Javans are most numerous and traditionally hold sway in the heavily populated island of Java, but many ethnic groups are present in Indonesia, which comprises thousands of islands, and there is a significant presence of Indonesians of Chinese descent. Singapore also has a large population identifying as of Chinese descent, but it also has many Malay and Indian-descent citizens. South Africa uses racial designations of White, Black African, Indian, and Mixed, with Black Africans being the largest population segment. Northern Ireland experiences significant heterogeneity in terms of identifying as Irish Catholic Unionists or Protestant Loyalists.

During our second phase, the team performed a desk review of peer-reviewed and gray literature, as well as government and key nongovernmental

1 We had originally planned to include countries with a health care payment model that is not dependent on universal health insurance. However, upon further examination, this criterion was too exclusionary, and we felt that it would omit important countries from our pool of possible candidates for our case studies.

TABLE 1
Overview of National Demographic Characteristics for Selected Countries and the United States; Demographic indicators from UNData

Country	Total Population	Urban Population	Median Age (2012)	Region (WHO)
Australia	23,717,421	92%	37.08	Western Pacific
Brazil	207,660,929	86%	29.89	Americas
Czech Republic	10,578,820	73%	40.07	European
Indonesia	258,704,986	54%	27.47	South-East Asia
Singapore	5,607,283	~100%	37.88	Western Pacific
South Africa	51,770,560	63%	42.1	African
United Kingdom*	63,379,787	81%	40.07	European
United States	308,745,538	81%	37.3	Americas

* Northern Ireland was ultimately selected for the scan, but U.K. demographic trends were assessed during the first phase of the scan.

organization and multilateral agency websites and reports, to construct case studies for each of the seven countries that outline their historical, cultural, social, political, and economic background and initiatives that have been taken to address social determinants of health. We prioritized five domains that we believed aligned with social determinants of health that also affect health equity in the United States: bias and discrimination; housing; education; health care; and income inequality. Qualitative case study comparisons then informed findings related to key thematic approaches that were utilized across the seven countries.

Our study represents an exploratory qualitative analysis, using an inductive approach to identify key findings; thus, our findings are not meant to be generalizable. Our global scan can also be thought of as cross-sectional in some regards, meaning it represents a snapshot in time, and the longer-term progress, potential, and outcomes of the highlighted policies may change over time, especially in response to internal and external factors such as political environment, economic developments, movement of people, and shocks such as climate changes or conflict. This factor is apparent in Northern Ireland, for example, where peace-building processes have been hindered by the absence of a functioning devolved government since 2017 and where the implications of Brexit are unclear (Gray et al., 2018).

Key Findings

Our analysis includes an in-depth review and description of policies, programs, and interventions to improve health equity across selected countries, organized by key social determinants of health derived from the RWJF's COH Action Framework. We highlight examples from the seven countries that we found to be notable or strong—for example, because of their demonstrated effect, their transformative potential, their high level of cooperation and buy-in from stakeholders, or their potential applicability to the United States. The country case studies provide a more exhaustive description of approaches being used in each individual country (case studies can be made available on request).

Bias and Discrimination

Virtually all of the countries in our scan have a history of conflict or violent, institutionalized discrimination toward specific segments of the population. Formalized reconciliation and social cohesion measures are being implemented in South Africa, Northern Ireland, and Australia, while more incremental, targeted initiatives have been put into place in Brazil and the Czech Republic. Singapore, where most citizens live in government housing, has a strong government housing policy meant to integrate different ethnic groups into a cohesive society.

Housing

Many of our selected countries have housing programs aimed at addressing a myriad of issues around rural/urban development, substandard housing, and segregation issues; in South Africa, Indonesia, Northern Ireland, and Singapore we observed a gradual shift from a focus on simply increasing supply via construction of new homes to more equity-focused policies and programs that seek to eliminate segregation and spatial inequality while building community cohesion. In Australia, programs and reforms have sought to make accommodations affordable for the neediest, increase homeownership, and sustain vibrant housing markets.

Education

All countries have made progress in improvements to education. Improvements in access to and enrollment in early childhood development programs were apparent across Australia and South Africa. Australia, for example, has seen significant increases in early childhood education and care programs, driven in part by funding made available through the Universal Access to Early Childhood Education Partnership arrangements.

Both countries also have targeted initiatives to improve primary and secondary school access and outcomes in rural areas. Brazil's Bolsa Família program, which provides a cash transfer to poor families with children enrolled in school, has had a positive impact on education and poverty.

Health Care

Increasing access to health care via universal health insurance and/or free health care services was observed across all countries we reviewed. Beyond these broad initiatives, an explicit focus on simultaneously addressing social determinants of health, such as education, in order to improve health equity was observed in policies implemented by Australia, Northern Ireland, and Brazil. Improving preventive health services, including community-oriented primary care, was also apparent in Brazil, Northern Ireland, Australia, Indonesia, and South Africa. Singapore has a mandatory program whereby citizens contribute to a fund that helps pay for both housing and health care.

Income Inequality

All countries have different types of programs to reduce income inequality. For example, in 2015, Australia undertook broad reforms to the previous welfare system, which led to an investment approach to help ensure funds are invested in groups of people with the largest future lifetime costs and the capacity to move to self-reliance. The approach was established as part of the 2015–2016 budget, and funding totaled over $100 million. In Brazil, the Bolsa Família program has reduced inequality by 12% to 21% in recent years, and it is estimated that it has reduced poverty by 28%. The Czech Republic has relatively low income inequality as a result of redistributive policies, and it has increased the minimum wage by almost 40% over the last five years.

Notable Themes and Strategies for Improving Social Determinants of Health and Health Equity Across Countries

Based on our review, four themes emerged that characterized and cut across many of the strategies for improving the SDOH and health equity across selected countries. These themes include the application of decolonization and trauma-informed frameworks; the prioritization of participatory and community-centered approaches; the implementation of coordinated, multisectoral approaches; and the use of approaches that target increasing spatial equity. In Table 2, we outline where we identified strong examples of the use of these approaches across the seven countries.

Decolonization and Trauma-Based Frameworks

Many of the interventions we learned about in our search were based on decolonization and trauma-informed frameworks. Reconciliation and restitution approaches were notable in South Africa, Australia, and Northern Ireland. In South Africa, a Truth and Reconciliation Commission was launched to aid healing related to decades of settler colonization and apartheid. This commission was born through a participatory process engaging civil society and human rights organizations. In Australia, a formal national apology was pivotal in launching national commitments, policies, and funding to address the legacy of discrimination against Aboriginal and Torres Strait Islander people. The National Apology laid the groundwork for further collaborative efforts toward achieving better outcomes for Aboriginal and Torres Strait Islander Australians. After decades of sectarian conflict, Northern Ireland has undertaken significant efforts to heal communities severely impacted by violence and religious tensions. In Belfast, the Flax Trust has adopted a trauma-based approach to community healing, specifically targeting areas where violent deaths and bombings have occurred. In addition to reconciliation measures, South Africa and Australia have instituted land restitution initiatives. Both countries recognized that settler colonization disposed Indigenous Peoples of their rightful claims to land.

TABLE 2
Summary of Thematic Areas Across Sample of Countries

Country	Decolonization & Trauma-Based Frameworks	Participatory Approaches	Coordinated, Multisectoral Approaches	Approaches to Increasing Spatial Equity
Australia	✓	✓	✓	✓
Brazil		✓	✓	✓
Czech Republic		✓	✓	
Indonesia				
Northern Ireland	✓	✓	✓	✓
Singapore			✓	✓
South Africa	✓	✓	✓	✓

Participatory Approaches

We observed a policy and programming shift toward the use of collaborative, participatory design and implementation approaches across several of the review countries and several of the equity domains, as opposed to relying on top-down, government-led implementation and design. For example, participatory budgeting in Brazil gives voice to priorities of disadvantaged communities, and people's-led settlement upgrading in South Africa maintains community cohesion while better integrating informal communities into municipal services and planning. The use of participatory approaches also underlies the majority of the work designed to address bias and discrimination in South Africa, Northern Ireland, and Australia. The Czech Republic and South Africa have implemented policies to allow for more inclusive school curricula that recognize the history and culture of ethnic minorities, which can also be linked to decolonization and community-centered approaches.

Coordinated, Multisectoral Approaches

Many of the countries we scanned have implemented multisectoral policies and programming that aim to address inequities. At a national policy level, South Africa's National Development Plan presents a cohesive national vision of a transformed post-apartheid South Africa, with clear delineation of how each sector can individually and collaboratively contribute to achieving this vision by 2030. Northern Ireland also has a strong, multisectoral plan in place to build health equity in Northern Ireland. In Australia, the Closing the Gap Refresh tackles the need for improvements across multiple sectors to achieve equity in health and wellness outcomes for Indigenous Australians. Overall, most of these plans utilize a model whereby the national government makes policy and sets quality standards, but implementation is planned and implemented at a subnational level. In some cases, implementation is tailored even more locally to a community level—creating overlaps with the other three key themes we identified.

Many countries are enacting policies, strategies, or programs that address child health and child education and development from a cross-sectoral lens, with some countries taking further steps to address parent and caregiver needs as part of a longer-term approach. Brazil and South Africa have implemented strong, national cash-transfer mechanisms to support low-income families with children for several decades, and Indonesia has also initiated a cash transfer program. In Australia, the 1000 Days initiative focuses specifically on the needs of Aboriginal and Torres Strait Islander children and families, and explicitly builds programming around indigenous cultural norms, traditions, and competencies, rather than relying solely on national or international program models considered best practices. The Czech Republic's National Family Policy outlines tax policies and robust social services aimed at both supporting families that have encountered adverse circumstances (such as poverty) and providing services in support of functioning families to facilitate and reinforce cohabitation and parenthood of partners and married couples, provide childcare support to families, and assist with reconciling work and family life.

While not necessarily multisectoral in nature, the housing policies in Australia and Singapore are examples of approaches that consider the overarching needs of individuals and families as fluid or changing over time. Australia's national housing policies envision a housing spectrum, with efforts needed to produce affordability at every stage and upward mobility for those at the bottom. Singapore's approach to housing facilitates the ability of people to transition into different living arrangements at different points, including downsizing and aging in place. South Africa has introduced financing mechanisms to meet the needs of different types of communities and families, such as those at "gap" level (too much income for social housing, not enough for commercial products). Singapore, Indonesia, and Brazil have combined government-subsidized home-building initiatives with homebuyership programs.

Approaches to Building Spatial Equity

Our desk review revealed many programs, policies, and projects that use approaches aimed at addressing spatial inequalities, many of which also incorporate trauma-informed, participatory, and/or multisectoral approaches aimed at underlying social determinants of health. Initiatives in Northern Ireland and South Africa offer strong examples of programs or policies that use place-based approaches in post-conflict settings. Strategies to address rural-urban disparities were often linked to devolution of certain government functions from centralized national government to regional or local authorities. While national governments generally still maintain oversight and the ability to set quality standards, devolution was apparent to some degree in Indonesia, South Africa, and Australia. Indonesia, South Africa, Australia, and Brazil also have strong systems for community-oriented primary care that is intended to improve the ability of even poorer, more isolated communities to access preventive health services and to stabilize the health workforce in rural areas. In Australia, states and territories are allowed latitude in policymaking and budgeting similar to U.S. states; this has allowed states such as Victoria to implement robust equity-focused initiatives such as the Health Equity Strategy and the Localities Embracing and Accepting Diversity (LEAD) program.

Insights Related to the RWJF COH Action Framework

Many of the findings from our comparative analysis are aligned with the RWJF COH Action Framework action areas. Overall, we found the themes around use of decolonization and trauma-based frameworks, participatory and community-centered approaches, and place-based approaches are most relevant to action area one—which emphasizes health and well-being, civic engagement, and strong social connections and community. In particular, building social cohesion across diverse groups, intentional engagement of marginalized population segments, and approaches that invest in or strengthen existing community networks can be linked to the longer-term goal of making health a shared value. Action area two of the COH Action Framework, Fostering Cross-Sector Collaboration, seeks to increase partnerships across organizations, invest in sustaining collaborations among organizations, and create policies that support and foster ongoing collaborations. The theme of coordinated, multisectoral programs links closely with this action area, but place-based approaches also apply, particularly when thinking about operationalizing multisectoral strategies. For example, in Australia, the national Closing the Gap strategy lays ambitious goals for addressing health and development gaps between Indigenous and non-Indigenous Australians, but the framework also outlines how community-based approaches should be used to ensure local needs are addressed, cultural knowledge and competencies are incorporated, and that those most affected have a stake in developing solutions.

Action area three considers how factors such as the built environment, the social and economic environment, and policy and governance can be leveraged to create healthier, more equitable communities. We believe the themes of participatory and community-centered approaches, coordinated, multisectoral approaches, and place-based approaches can be applied to this action area and may be strongest when multiple approaches are utilized. For example, South Africa's National Development Plan is a strong example of an overarching national framework that builds a vision of a transformed country and provides a clear, multisectoral framework for how each sector can contribute individually and collaboratively to this vision. However, to operationalize this plan, provinces and municipalities have some degree of leeway in planning and budgeting, and place-based approaches, such as settlement upgrading designed to integrate informal settlements with the larger municipal services while maintaining community cohesion, have emerged as promising practices to create equity.

Action area four is more specific in its focus on health services and systems, including access to

care, balance and integration between health care, public health, and social services, and consumer experience and health care quality. To this end, we found that all the countries we reviewed have or are moving toward universal health care coverage, either through universal insurance or free national health care. Other approaches included addressing rural-urban disparities by increasing investment in health infrastructure, workforce initiatives, or alternative models such as tele-medicine. Community-oriented primary care models meant to increase the reach of preventive services were also a tool that large countries utilized, including use of community health workers or community health teams that are embedded in local communities. Finally, integration of health and social assistance was apparent, particularly with grants focusing on impoverished children.

Recommended Next Steps and Further Research

Our findings shed light on the various drivers of health equity and notable approaches currently adopted to improve the social determinants of health and health equity. However, the current scan was exploratory and captured initial findings and emergent themes that would translate to the U.S. context and that appear to be linked to histories of settler colonialism. Based on our initial findings, we suggest more robust case studies of countries with settler colonialism. Another area of research that would complement the work presented in this report is a United States-based scan of health equity programs that may map to the analytic themes we identified. Lessons learned from the current global health equity scan, and the potential to translate findings to U.S. programs and services, would benefit from a collaborative discussion among leading experts.

PROJECT PURPOSE AND AUDIENCE

The Robert Wood Johnson Foundation (RWJF) understands that when it comes to health, good ideas have no borders. In fact, RWJF recognizes that in order to improve the health of our nation, we need the best possible ideas from across the world. A key part of improving health in the United States begins with improving equity and the underlying social determinants of health (SDOH). To this end, RWJF understands that well-being must be "relevant to all people and must address fundamental issues of equity and exclusion" (RWJF, 2019). Thus, RWJF commissioned this global health equity scan to:

1. Identify countries outside the United States that are tackling equity in areas that affect health and well-being;

2. Highlight historical, cultural, political, economic, and other contextual factors that underlie or contribute to health equity trends, interventions, or policies; and

3. Assess how drivers of health equity in these countries relate to the RWJF Culture of Health (COH) Action Framework.

Our analysis sheds light on key approaches and themes across programs, policies, and projects addressing health equity and related social determinants of health across our sample. Lessons gleaned from our global scan and desk review were guided by a core set of research questions and objectives established at the outset of the project.

The purpose of this global health equity scan is to stimulate discussion and further learning around strategies or approaches that have been used in other countries to advance health equity. We hope the results are also useful to other RWJF staff, partners, and grantees whom may be interested in developing and implementing health equity action plans and approaches that can be informed by global learning. RWJF defines health equity as follows:

Health equity means that everybody has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

(*Robert Wood Johnson Foundation*)

Background

Race-based health disparities are one of the most persistent and salient health equity issues in the United States. (Baciu et al., 2017). While the United States has made some strides in addressing disparities, significant gaps remain across diseases and health outcomes. Other countries also face health equity challenges and disparities, and, like the United States, they are working to address these issues. To help us bridge the gaps in health disparities across racial and ethnic groups, and other groups as well, such as low-income and LGBTQI populations, how might we learn from the world about what other people, communities, and countries are doing and where they are making progress in achieving health equity?

For racial and ethnic minorities in the United States, health disparities take on many forms, including higher rates of chronic disease and premature death compared to the rates among whites.

(*Baciu et al., 2017*)

We initiated this global scan in an effort to first identify where in the world progress is being made on improving equity that influences health and well-being, and second, to explore what strategies, policies, and programs are being employed by these countries that might be promising or inspiring for consideration in the United States. This report presents our findings, involving the establishment of selection criteria and targeted social determinants of health, analysis of multiple streams of data, and desk reviews of health equity gains in selected countries. We augmented our data analysis and desk review with global health equity expert interviews as a means to further refine our scan. This exploratory scan identifies policies, programs, and institutions within countries that are forging the way forward using innovative approaches. Our analysis looks at countries across the globe. The scan addresses the following:

- Identify countries outside the United States that are tackling equity in health care and social determinants of health (such as education, housing, income, access to health care, etc.).
- Outline historical, cultural, political, economic, and other contextual factors that underlie or contribute to health equity trends.
- Highlight interventions or policies that are meant to improve equity in areas that affect health and well-being.
- Assess how drivers of health equity in these countries relate to the RWJF COH Action Framework (Exhibit 1).

Research Question and Objectives

Lessons gleaned from our global scan and desk review were guided by a core set of research questions and objectives established at the outset of the project.

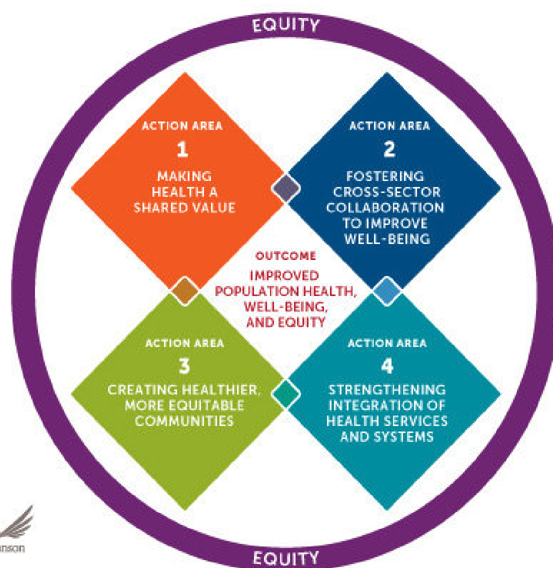
In the first phase of our investigation, we iteratively asked:

1. Which countries may be contextually comparable to the United States in terms of democratic governance and demographic trends—including having a larger total population, a modestly aging population, a marked urban-rural divide in population density, and the presence of ethnic or cultural heterogeneity?
2. Among these countries, which are making progress in key areas that align with the RWJF COH Action Framework?

During the second phase of our scan, we selected a short list of seven countries from across the globe—spanning nearly every major World Health Organization (WHO) region—to explore and compare:

3. What historical, cultural, social, political, or economic factors underlie health equity trends in these countries;
4. What policies, programs, and initiatives are governments and nongovernmental organizations employing to improve health equity and equity in other areas that affect health and well-being; and
5. Which findings are most relevant to the RWJF COH Action Framework.

EXHIBIT 1
RWJF Culture of Health Action Framework



METHODS

We used a systematic approach to structure our global scan based on comparative social science methods (Ragin, 2014). Our analysis began with selecting a core set of countries from which to choose for a deeper case-study-type desk review of policies and programs that target equity that affects health and well-being. Our goal was to select up to seven countries from around the world, including most WHO world regions. Additionally, we wanted to select countries that would have demographic and governance contexts somewhat comparable to the United States to facilitate translating lessons learned and inspiring ideation of innovative solutions to health.

Country Selection

To begin our analysis, we needed to first narrow down the possible set of countries from which our team would conduct the deeper case studies and desk reviews. Our overall process for country selection followed a three-pronged approach, including:

1. Identifying democratic countries with heterogeneous demographic profiles;

2. Reviewing current and recent trends in health and economic outcome indicators across democratic countries that aligned with relevant health equity theoretical frameworks; and

3. Conducting consultations with members of our technical steering team and with global equity experts to finalize selection.

Our first layer of inclusion criteria primarily consisted of a heterogenous population and a democratic government.[2] We utilized the 2018 Freedom House Rankings and the 2017 Economist Democracy Index to identify democracies that were categorized as at least as free or as democratic as the United States. Seventy-six countries appeared on both lists; the United States ranked 37th in the Freedom House Rankings and was rated as a "flawed" democracy according to the Economist Democracy Index. The 76 countries are shown in Exhibit 2 based on their distribution across the six WHO regions.

We then used the United Nations (UN) Statistics Division's open data website, UNdata, to assess most recent population-level estimates of ethnic or racial heterogeneity based on country-reported data. Comparable demographic measures of ethnic, racial, or cultural heterogeneity are difficult to obtain due to the wide range in measurements employed during censuses, but we used a threshold of at least two population groups comprising 10% or more of the population as an initial benchmark, with the understanding that we would delve more deeply into types of heterogeneity among countries that were selected. Given the challenges of obtaining comparable measures of population heterogeneity, we also looked at demographic structures of countries in terms of overall population size, age structure, and rural-urban distribution to characterize countries. We used U.S. characteristics (see Exhibit 6) as median benchmarks to define exclusion criteria. We excluded countries that were less than 51% and more than 95% urban, those that had a median age of less than 28 and more than 42, as well as those that had a total population of less than 10 million, resulting in a total of 29 countries (see Exhibit 3).

2 We had originally planned to include countries with a health care payment model that is not dependent on universal health insurance. However, upon further examination, this criterion was too exclusionary, and we felt that it would omit important countries from our pool of possible candidates for our case studies.

EXHIBIT 2
Democratic Countries by World Region (Based on WHO Classification)

Region	Total	Countries
Africa	8	South Africa, Mauritius, Cape Verde, Botswana, Namibia, Lesotho, Ghana, Senegal
Americas	19	Canada, United States, Uruguay, Trinidad and Tobago, Chile, Argentina, Brazil, Costa Rica, Suriname, Panama, Jamaica, Colombia, Mexico, Peru, Ecuador, Dominican Republic, Paraguay, Guyana, El Salvador
Eastern Mediterranean	2	Israel, Tunisia
European	32	Germany, Italy, Bulgaria, Greece, Austria, Croatia, Finland, Switzerland, Portugal, Netherlands, Latvia, Belgium, Spain, Denmark, Sweden, Estonia, Malta, France, Hungary, United Kingdom, Czech Republic, Lithuania, Romania, Luxembourg, Norway, Slovakia, Poland, Serbia, Slovenia, Iceland, Ireland, Cyprus
South-East Asia	4	Sri Lanka, Indonesia, India, Timor-Leste
Western Pacific	11	Taiwan, Japan, Singapore, Australia, New Zealand, Malaysia, Mongolia, South Korea, Philippines, Papua New Guinea, Hong Kong

EXHIBIT 3
Democratic Countries by World Region (Based on Exclusion Criteria)

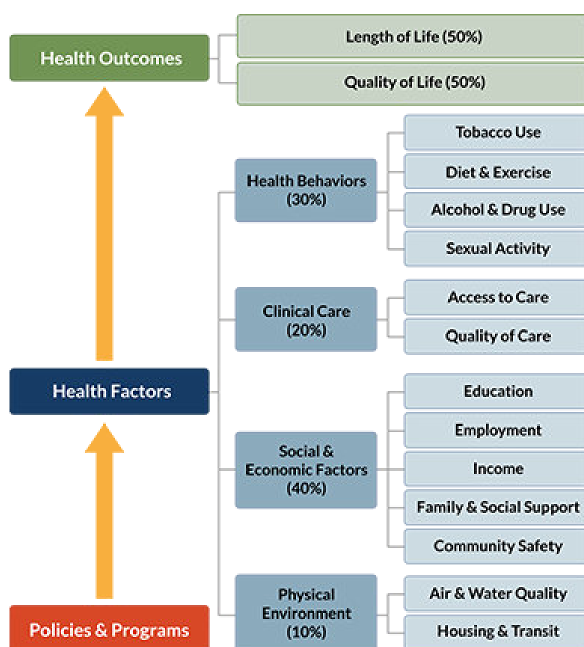
Region	Total	Countries
Africa	1	South Africa
Americas	5	Argentina, Brazil, Canada, Chile, Colombia
Eastern Mediterranean	1	Tunisia
European	10	Czech Republic, France, Greece, Hungary, Netherlands, Poland, Portugal, Romania, Spain, United Kingdom
South-East Asia	1	Indonesia
Western Pacific	2	Australia, Malaysia

As our second layer of screening, we established a theoretical framework for identifying relevant health equity indicators. We began with a review of major health equity frameworks including the WHO Framework for Measuring Health Inequality, Robert Wood Johnson Foundation (RWJF) Commission to Build a Healthier America Model, RWJF Culture of Health (COH) Action Framework (Exhibit 1), County Health Rankings Model (Exhibit 4), and the FHI 360 Equity Conceptual Framework. Based on our research objectives and consultation with our technical steering team, we chose global health equity indicators that mirror key indicators from the County Health Rankings, as well as the RWJF COH Action Framework indicators, focusing on the reduction of disparities within each indicator in these countries.

We analyzed outcome data across all democratic countries, including change over time using current and historical data from the World Development Indicators, as well as gross domestic product (GDP) per capita, Gini coefficient of inequality,[3] adult and infant mortality rates, and burden of

3 This is the most commonly used measure of inequality. The coefficient varies between 0, which reflects complete equality, and 1, which indicates complete inequality (one person has all the income or consumption, all others have none).

EXHIBIT 4
County Health Rankings Model



noncommunicable diseases. We assigned a score to each country for each variable based on reverse ranking, created two additive scores, summed across all indicators, including noneconomic indicators, and analyzed countries on a variable-by-variable basis. This resulted in 15 countries with similar demographic profiles that were also among the top 20 performers for one or more variables (see Exhibit 5). The countries in bold are those that we ultimately selected for this scan. Final selection was purposive based on the timeline for completing the scan, feedback from health equity experts (see "Expert Consultations," below), and discussion with the RWJF global team. Based on these consultations, we also included Singapore in the analysis based on the strength of a previous RWJF Global Learning Project on Singapore's approaches to equity (Ellis, Price, & Strunk, 2018), although Singapore differs from the United States both in its urban concentration and very small population size. We ultimately were not able to include a country from the eastern Mediterranean region, in large part to keep the scope of the work manageable, but also in consideration of Tunisia's short period of democratization (since 2011) and the limited amount of time equity-focused policies or programming would have had to be effective.

Exhibit 6 outlines the demographic characteristics of the selected countries at a national level, as well as those of the United States for comparison. Information on outcome indicators, including summary of changes over time, are highlighted in the sections below. Due to noncomparable measurement approaches, we have not included heterogeneity in this exhibit, although each country is considered heterogeneous and exhibits patterns of inequitable outcomes based on ethnic, racial, or cultural characteristics. Australia's population is primarily of white, European descent, but has a large proportion of foreign-born or first-generation immigrants and a small but growing population segment who identify as Aboriginal or Torres Strait Islander. Brazil is racially diverse, with approximately half of the population identifying as white, but more than 40% of the population as Mulatto and distinct populations of Afro-Brazilians and Indigenous Brazilians. While ethnic Czechs are the largest population segment in the Czech Republic, there are communities with populations identifying as Slovak, Polish, and Roma. In Indonesia, Javans are the most populous ethnic

EXHIBIT 5
Countries with Similar Demographic Profiles & Top 20 Performers for One/> Variables

Region	Total	Countries
Africa	1	South Africa
Americas	4	Argentina, Brazil, Chile, Colombia
Eastern Mediterranean	1	Tunisia
European	7	Czech Republic, Hungary, Netherlands, Portugal, Romania, Spain, United Kingdom
South-East Asia	1	Indonesia
Western Pacific	1	Australia, Singapore

EXHIBIT 6
Overview of National Demographic Characteristics for Selected Countries and the United States

Country	Total Population	Urban Population	Median Age (2012)	Region (WHO)
Australia	23,717,421	92%	37.08	Western Pacific
Brazil	207,660,929	86%	29.89	Americas
Czech Republic	10,578,820	73%	40.07	European
Indonesia	258,704,986	54%	27.47	South-East Asia
Singapore	5,607,283	~100%	37.88	Western Pacific
South Africa	51,770,560	63%	42.1	African
United Kingdom	63,379,787	81%	40.07	European
United States	308,745,538	81%	37.3	Americas

group and traditionally hold sway in the heavily populated and politically dominant island of Java, but many ethnic groups are present in Indonesia, dispersed across thousands of islands, and there is a significant presence of Chinese-descendent Indonesians. Singapore also has a large population identifying as of Chinese descent, but also many Malay and Indian-descent citizens. South Africa uses racial designations of white, black African, Indian, and Mixed, with black Africans being the largest population segment. Northern Ireland experiences significant heterogeneity in terms of identifying as Irish Catholic Unionists or Protestant Loyalists. More information on the cultural background of each country is presented in the country summaries (case studies can be made available on request).

Expert Consultations

Using a snowball sampling method as we narrowed our country selection and throughout our scan, we contacted a total of 18 global health equity experts. The FHI 360 team conducted a total of seven phone interviews with Dr. Margaret E. Kruk, associate professor of global health at the Harvard T.H. Chan School of Public Health; Dr. Stephen B. Thomas, professor, health services administration, University of Maryland, director, Maryland Center for Health Equity; Amanda Glassman, senior fellow at the Center for Global Development; Dr. Wilson Majee, assistant professor, department of health sciences, University of Missouri; and Carleigh Krubiner and Kalipso Chalkidou, both from the Center for Global Development. These expert consultations were designed to gain general knowledge from our selected countries about (1) the progress they are making on equity in areas that affect health and well-being (e.g., education, health care access, housing, income), (2) the approaches and factors that led to this progress, and (3) lessons learned from these countries.

Desk Review and Case Study Development

After finalizing our selection of countries, we compiled miniature case studies (case studies can be made available on request) that detail programs, policies, and services we identified within each country that address health equity across our key matrix criteria (bias and discrimination, education, health care, and income inequality). In consultation with our technical steering team, we prioritized five specific domains or intervention areas based on their alignment with the RWJF COH Action Framework and with the health equity domains prioritized in a previous case study of Singapore (Ellis, Price, & Strunk, 2018). These domains included housing, education, health care, income inequality, and systematic bias/discrimination.

As part of the desk review, we conducted a comprehensive literature search, which covered various global health databases, including PubMed, Web of Science, and Global Health, using search terms based on the domains, the target countries, equity, and positive improvement. We focused on articles published from 2010 or later. After an initial title screening, it was apparent that the most common results were for the United Kingdom and Australia, with very few results for Singapore and the Czech Republic (see Exhibit 7). In addition to the literature searches, we conducted web searches and website reviews of national government sites and relevant NGOs; we also conducted qualitative analysis of further readings for key programs noted by our expert consultants.

Using these sources, three analysts constructed detailed profiles of each country, including (1) key contextual factors that may condition the relative success or scalability of approaches to improve health equity, including historical, cultural, social, political, and economic background, and (2) an overview of policies, programs, or initiatives that target equity or have been shown to improve equity across the five domains of interest. These contextual factors spanned historical, cultural, social, political, and economic domains.

EXHIBIT 7
Desk Review Search Results

	Total Results	Australia	Brazil	Czech Republic	Indonesia	Singapore	South Africa	United Kingdom & Northern Ireland
Racial Bias/ Prejudice	178	68	18	4	11	0	17	60
Education	537	172	55	7	44	1	68	190
Housing	642	283	106	30	56	2	105	60
Health Care	68	21	15	1	3	0	7	21
Poverty/ Income Inequality	241	56	55	1	29	1	46	53
Total	**1666**	**600**	**249**	**43**	**143**	**4**	**243**	**384**

Qualitative Case Study Comparative Analysis

In the final step of our analysis, we conducted an iterative, qualitative comparative analysis of the descriptive cases for each country to summarize overall patterns in contextual factors and approaches across each intervention domain and to identify potential themes that may have application for the COH Action Framework. Through our qualitative inquiry we aimed to understand what each selected country may be doing to address health equity and to learn how these strategies relate across the countries in our sample. Based on these objectives, a qualitative comparative analysis approach fit our exploratory research design well. Qualitative comparative methods are often employed by social scientists studying global trends and have been the foundation of seminal works such as Theda Skocpol's *States and Social Revolutions* (Skocpol, 1979), which describes the transition to democracy across France, Russia, and China. Comparative historical methods have traditionally been used to analyze society-wide transformations such as social revolutions, the rise of capitalism and the nation-state, democratization, and the birth and transformation of welfare states (Prasad, 2014). Comparative historical methods are a subset of qualitative social research methods, and follow an inductive, exploratory approach.

Gaps and Limitations

There are several gaps and limitations of the current analysis. Our global scan was intentionally exploratory and therefore not exhaustive. It reasons that a logical next step would be to drill deeper into the programs, policies, and services that we discovered, potentially down-selecting among the countries we included in our analysis to those most relevant to any questions that may arise or persist after reading this report. Our study represents a small qualitative analysis, using an inductive approach to identify key findings, thus our findings are not meant to be generalizable.

Additionally, it is important to note that there are a relatively small number of evaluated programs with rigorous, demonstrated impact. However, some programs have had promising results and evaluations that support their positive impacts; many of these are best highlighted in *Millions Saved* (Glassman & Temin, 2016).

Our global scan can be thought of as cross-sectional in some regards, meaning it represents a snapshot in time, and the longer-term progress, potential, and outcomes of the highlighted policies may change over time, especially in response to internal and external factors such as political environment, economic developments, movement of people, and shocks such as climate changes or conflict. This factor is apparent in Northern Ireland, for example, where peace-building processes have been hindered by the absence of a functioning devolved government since 2017 and where the implications of Brexit are unclear (Gray et al., 2018).

KEY FINDINGS AND DISCUSSION

Overview of Key Contextual Factors Across Selected Countries

For each country, we explored key contextual factors that may influence a country's progress toward health equity, with a focus on historical events, cultural trends, social services, governance structure and political trends, and the economic sector. We explored these areas in order to situate our analysis properly within time and space and understand the many factors that may underlie inequitable health outcomes, as well as those that may drive improvements in health equity. We offer a brief discussion of these factors here, including, in some places, aspects that may align or differ significantly from the U.S. context (case studies can be made available on request).

Historical

Nearly all countries included in our analysis have a colonial history, some with earlier periods of colonialism such as Northern Ireland, and some with much later periods of colonialism such as South Africa. Northern Ireland, Australia, Brazil, and South Africa share a history of settler colonialism with the United States, which has created legacy systems of bias and discrimination, of which the structural, institutional, social, and cultural barriers persist today. Early governance institutions excluded Indigenous Peoples, often treating them as less than human subjects, laying the foundation for protracted bias and discrimination through the institutionalization of white/European/English supremacy. Although patterns of occupation and colonization were different in the Czech Republic, Indonesia, and Singapore, colonialism has also impacted equity across ethnic groups in these countries and reinforced or created wealth disparities for different population groups. Global economic integration and sea trade fueled colonization, and these activities were often predicated on the search for natural resources, cheap or enslaved labor, and expansion of agricultural land. Colonialism also introduced norms of land ownership and governance that did not exist previously. While each country has its own unique history and context, the Czech Republic stands out as the only country to have a formal communist regime lasting until 1989, although Brazil and Indonesia had military dictatorships for decades prior to democratization.

The extractive history of external colonialism and oppressive system of internal colonialism create enduring structures and institutions predicated on systems of inequity, which are apparent across the social determinants of health in these countries. Importantly, in Brazil, South Africa, and Australia this type of colonialism has created legacies of white supremacy and indigenous or black/brown inferiority similar to those observed in the United States. These legacies further create harm and undermine the resilience and ultimately the health of indigenous communities and communities of color. In Northern Ireland, settler colonialism has created similar divides between indigenous Irish communities (typically Roman Catholic) and English settlers (typically Protestant). External colonialism can also leave similar legacies when colonizers exploit existing ethnic tensions or create class hierarchies in areas where settling is not occurring, which can be observed in Indonesia and Singapore, as well as interior regions of Australia, Brazil, and South Africa. The Czech Republic is somewhat of an outlier in terms of colonial history, but the mass killings of Roma during World War II by German occupiers and forced resettling and other forms of marginalization of Roma under the communist regime are largely examples of internal colonialism, and also have a lasting effect today.

Cultural

All countries included in our analysis have diverse cultural landscapes encompassing multiple languages, religions, and customs. For instance, South Africa has 11 official languages, and people there often speak at least two languages, such as Afrikaans and isiZulu. Also, all of our selected countries have large portions of the population identifying with multiple religions. Northern Ireland, Brazil, and Australia are predominantly Christian, while Indonesia has a large proportion of the population who are Muslim; and the Czech Republic is mainly comprised of people who identify with no religion. Religious affiliation is changing, however. For example, Brazil has a strong history of Roman Catholicism, but in recent decades has seen a large rise in Protestant evangelism. A growing proportion of Australians identify as nonreligious. While the United States is very diverse, overall it shares similar trends with many of the countries from our scan in terms of having downward trends in civic engagement, including the increase in the proportion of the population identifying as nonreligious. This has important implications for the potential effectiveness of community engagement approaches.

Language and religion are also influenced by immigration, as nearly all of the countries are destination sites for immigrants seeking economic opportunities, or even asylum. In South Africa, international migrants from Mozambique, Zimbabwe, and Malawi come seeking jobs in the commercial and service sectors—much like migrants from Central America in the United States. Immigrants bring with them new customs, values, and traditions, which eventually integrate with the local culture and context, sometimes through forced or mandated assimilation. Xenophobia is on the rise in many of these locations, as evidenced by multiple attacks on ethnic minorities across the globe. In Australia, national surveys to measure social cohesion show that while most Australians believe that they should learn from new arrivals and their culture, at the same time they think that new arrivals should embrace “Australian values.”

Many countries have traditional or conservative values that perpetuate bias, particularly toward minority or LGBTQI groups. Singapore notably has a very strict law-enforcement system and conservative culture. This environment certainly affects the ability to implement new programs in Singapore, where adherence to policies could potentially be greater because compliance may be driven by a punitive environment.

Social

Every country in our analysis has a multitude of social support programs and services, including programs aimed to improve health care coverage and access. There are also many social policies and programs aimed at alleviating poverty, bolstering educational outcomes, and providing housing. All of our selected countries are grappling with important demographic changes, including an aging population and increased immigration amidst global economic instability and challenges also encountered by the United States. Similar to the United States, policymaking is generally handled at a national level, with some functions devolved to subnational governments. Exhibit 8 provides some national-level indicators of health and education outcomes across the countries, including change over time for several indicators. Countries such as South Africa, Brazil, Indonesia, and the Czech Republic have seen larger improvements in adult and infant mortality than wealthier countries such as Australia, Singapore, the United Kingdom, and the United States, although they still have room to improve. Every country has experienced an increase in obesity, but the rate of increase is smallest in Singapore, Indonesia, and the Czech Republic.

Housing is an area where social programming and interventions were similar across multiple countries in our group—with notable programs in South Africa, Indonesia, Singapore, and Brazil. Substandard housing in rapidly urbanizing areas has proven to be a major challenge as immigrants from other countries and people from rural areas move to major metropolitan centers seeking employment.

EXHIBIT 8
Health and Education Indicators Across Sample

Country	Adult Mortality Rate, 2016	Change Since 2000	Infant Mortality Rate, 2017	Change Since 2005	Adult Obesity Rate, 2016	Change Since 2000	Out-of-School Youth of Upper Secondary School Age (%)	Change Since 2000	Pre-Primary Enrollment Rate (2014–2016)
Australia	61	-16	3	-1.8	30.4	9.4	0.8	-7.9	88.6
Brazil	143	-41	13.2	-8.9	22.3	8.8	15.8	5.3	82.0
Czech Republic	81	-43	2.6	-0.9	28.5	6.4	—	—	—
Indonesia	176	-11	21.4	-12.1	6.9	4.5	19.0	-41.0	40.1
Singapore	51	-28	2.2	-0.1	6.6	2.0	0.07	—	—
South Africa	301	-61	28.8	-23.2	27	8.9	31.9	3.7	21.9
United Kingdom	67	-21	3.7	-1.4	29.5	9.7	0.8	-8.5	96.2
United States	114	0	5.7	-1.1	37.3	11.2	7.2	-8.2	62.4

EXHIBIT 9
Dates of Independent Democracies Established Across Countries

Australia
Independence in 1901

Singapore
Independence in 1965

Brazil
Democracy in 1985

Czechia
Democracy (“Velvet Revolution”) in 1989

South Africa
Democracy in 1994

Indonesia
Democracy in 1999

Northern Ireland
Devolution restored in 2007

The U.S. Department of Housing and Urban Development’s (HUD) housing policies and focal activities echo many of the countries from our scan, in that they have over time focused on housing supply (i.e., building new homes or apartments), stabilizing the housing market [including the introduction of insured mortgage products for first-time buyers—i.e., Federal Housing Administration (FHA) loans and other financing mechanisms]. These patterns reflect findings from the recent County Health Rankings report.

Educational outcomes across our countries have consistently higher levels of performance in urban, more affluent zones. Indonesia has also seen a large improvement in upper secondary-school attendance rates. Comparable longitudinal data were not available for pre-primary school enrollment, but it is clear that the United States lags behind many of the countries. Quality and coverage of health services are typically better in urban and/or more affluent areas, or more wealthy families choose to access privately provided health services. Australia, Singapore, Brazil, the Czech Republic, and Northern Ireland offer universal health coverage and free health services from the public sector, and Indonesia and South Africa are also moving toward universal coverage models.

Political

All seven countries generally have governance structures influenced by colonial systems, with three main branches of federal government (legislative, judicial, and executive) and some level of devolution of responsibilities to local governments. Incidentally, all countries are relatively new democracies with independence during the 1900s and early 2000s (see Exhibit 9). While Australia and Singapore have been democracies since gaining independence in 1901 and 1965, respectively, Brazil, Czechia, South Africa, and Indonesia established democracy in the 1900s in bloodless revolutions that overthrew nondemocratic governance. While a part of the United Kingdom, Northern Ireland regained local autonomy with devolution restored in 2007 following a protracted period of civil war. Each country’s political past involves conflict, either formal or informal, and many countries experienced violent political conflict perpetrated by international interveners—for instance the German occupation of Czechoslovakia at the end of WWI, the Boer Wars in South Africa, and the subjugation of native populations in Australia and Brazil.

Economic

Australia, Northern Ireland (as part of the United Kingdom), and Singapore are classified as high-income countries, while all remaining nations in our analysis are middle-income countries. All countries are seeing nationwide economic growth and increases in urbanization. Among the middle-income countries, these periods of growth are much more recent, and economic policies and programs to accommodate this growth were common. Notable increases in substandard housing and the growth of peri-urban slums were associated with booming rates of urbanization in South Africa, Brazil, and Indonesia. Patterns of rural-urban migration and spatial inequality are apparent in U.S. history across several time periods, including during the Great Migration following World War II, with movements of poor people from rural Appalachia and the Southeast to urban centers where they lived in low-quality housing in socially excluded neighborhoods—patterns that are still apparent today. Additionally, we noted that health gains in countries where economic growth and urbanization are more recent tend to be associated with improvements in infectious disease rates and water quality, hygiene and sanitation infrastructure, along with income growth and early demographic transitions. However, all countries in our analysis are seeing increases in chronic diseases often associated with the transition to early urban economies, higher incomes, and a growth in manufacturing or service-based economic sectors.

Overall, Australia, Brazil, South Africa, and Indonesia have significant natural resource- and agriculture-based economies that are applicable to more rural regions of the United States. However, Brazil, South Africa, and Indonesia have transitional economies with much lower GDPs. As countries with transitional economies, they face a dual development challenge where a high burden of infectious disease persists alongside an increasing burden of chronic, noncommunicable diseases; this poses unique health care and health equity challenges. Many of the countries in our sample, similar to the United States, also have parallel service delivery systems for housing, health care, and education, with wealthier, often more urban, individuals opting into higher-priced and higher-quality private services, while lower-income and/or rural populations must rely on lower-quality public services.

Exhibit 10 summarizes economic trends across the selected countries and the United States. While the United States has the highest GDP per capita, it has grown the least since 2000, while the countries with

EXHIBIT 10

Economic, Inequality and Well-Being Indicators Across Sample Countries

Country	GDP Per Capita 2011	% Change Since 2000	Current Gini Coefficient	Change Since 2009/10	Individual Well-Being (OECD Better Life Index), 2017	Unemployment Rate, 2017	Change Since 2000
Australia	25,307	14%	34.7	0	7.0	5.6	-0.7
Brazil	4,803	23%	51.3	-2.4	6.6	13.3	3.5
Czech Republic	7,927	28%	25.9	-0.7	6.6	2.9	-5.9
Indonesia	1,207	36%	39.5	—	—	4.2	-1.9
Singapore	33,530	29%	—	—	—	2.0	-1.7
South Africa	3,825	21%	63	-0.4	4.8	27.3	4.1
United Kingdom	28,272	11%	33.2	-1.2	6.7	4.3	-1.2
United States	37,691	7%	41.5	1.1	6.9	4.4	0.4

Source: World Development Indicators; Organization for Economic Cooperation and Development (OECD) Better Life Index

the lowest GDP per capita have seen some of the highest increases. Brazil, although the most unequal in terms of wealth inequality, has seen the largest improvement since 2009–2010, while the United States has seen an increase in inequality. Most of the other countries who report Gini coefficient have remained relatively static, although the United Kingdom overall has seen some improvement. While unemployment rates are largely linked to global economic trends, the Czech Republic has seen a relatively large decrease in unemployment since 2000, while South Africa and Brazil have seen relatively large increases.

Policies, Programs, and Interventions Across Health Equity Matrix Criteria

Our analysis includes a review and description of notable policies, programs, and interventions to improve health equity across selected countries, organized by key social determinants of health: bias and discrimination, housing, education, health care, and income inequality. We highlight examples from the seven countries that we found to be notable or strong, for example, because of their demonstrated impacts, their transformative potential, or their high level of cooperation and buy-in from stakeholders. The country case studies provide a more exhaustive description of approaches being used in each individual country (case studies can be made available on request).

Bias and Discrimination

Virtually all of the countries in our scan have a history of conflict or violent, institutionalized discrimination toward specific segments of the population. Formalized reconciliation and social cohesion measures are being implemented in South Africa, Northern Ireland, and Australia, while more incremental, targeted initiatives have been put into place in Brazil and the Czech Republic.

South Africa's constitution provides a key impetus for social cohesion programs aimed at reducing bias and discrimination. It states:

The country belongs to all who live in it, united in diversity — South African Constitution

This sets an important precedent for combatting bias and discrimination and healing the trauma caused by apartheid. The South African Department of Art and Culture (DAC) has implemented a National Strategy and Action Plan on Social Cohesion beginning in 2011 and is in the process of finalizing a National Action Plan to Combat Racism, Discrimination, Xenophobia and Related Intolerance. The DAC is developing infrastructure to preserve local heritages across all nine provinces, thus facilitating the celebration of local histories and cultures from diverse people across the country.

Similarly, Northern Ireland has implemented programs and policies to counter bias and discrimination based on religious affiliation. They have initiated official policies to address sectarianism, mistrust, and high levels of segregation—*A Shared Future: Policy and Strategic Framework for Good Relations in Northern Ireland* (2005), *Cohesion, Sharing and Integration* (2010), and *Together: Building a United Community* (2013). This latest iteration has four key priority areas: children and young people, shared community, safe community, and cultural expression. Planned actions include:

1. Establishing 10 new shared education campuses;
2. Placing 10,000 young people who are not in education, employment, or training in the new United Youth volunteering program;
3. Establishing 10 new shared housing schemes;
4. Developing four urban village schemes;
5. Developing a significant program of cross-community sporting events;
6. Removing interface barriers by 2023; and
7. Piloting 100 shared summer schools by 2015.

Meanwhile, bias and discrimination policies and actions in Australia employ an anti-racist framework. While xenophobia and other forms of racism are apparent in Australia, tackling the legacy of institutionalized racism affecting Aboriginal and Torres Strait Islander people has been a main focus since the late 1990s (see Exhibit 13 regarding the National Apology and follow-up actions). While much progress remains to be made, more recent efforts such as the 2019 Closing the Gap Refresh have made deeper, more participatory engagement a central tenet, including giving value to indigenous communities' norms, rather than asking communities to conform solely to non-indigenous or European-centric forms of engagement and governance.

In 2012, the Australian Human Rights Commission administered the National Anti-Racism Partnership and Strategy (NARPS), a partner-based strategy aimed at creating awareness of racism and its effects on individuals and the broader community. The NARPS also aims to identify good practice initiatives and empower communities and individuals to take action to prevent and reduce racism and to seek redress when it occurs. The strategy is informed by the following key principles:

- Building empathy and promoting dialogue about racism;
- Focusing on changing behaviors as much as changing attitudes;
- Addressing institutional or organizational racism and involving a range of coordinated interventions, which are supported by management;
- Adapting strategies to different settings and audiences, including local settings;
- Using complementary strategies and working at multiple levels, including at the individual, organizational, community, and societal levels;
- Engaging with people with relatively moderate racist views, rather than those who are particularly intolerant; and
- Targeting anti-racism initiatives toward priority areas, including workplaces, education, and sport.

The NARPS achieves its objectives through a series of strategic projects designed to reduce racism, support diversity, and build social cohesion in priority areas. Thematic stakeholder analysis from a mid-term evaluation found positive impressions of the process employed and the future potential. There are also state-led initiatives addressing bias and discrimination. Similar to South Africa, many of these initiatives—national- and state-level policies and programs—aim to improve social cohesion. One notable program includes Victoria's Localities Embracing and Accepting Diversity program, which aimed to combat racism and discrimination through an integrated, place-based program. Activities included developing organizational change strategies, changing policies, delivering diversity and cultural awareness trainings, running social marketing campaigns, and changing media reporting practices. Early evaluations of the program have reported favorable impacts (Ferdinand, Paradies, & Kelaher, 2013; Ferdinand, Paradies, Lelaher, 2014).

Housing

Many of our selected countries had housing programs aimed to address a myriad of issues around rural/urban development, substandard housing, and segregation issues; in many of the countries we investigated, we observed a gradual shift from a focus on simply increasing supply via construction of new homes to more equity-focused policies and programs that seek to eliminate segregation and spatial inequality while building community cohesion.

In South Africa, the National Development Plan sets out to break apartheid housing segregation by 2030. The Department of Human Settlements works to improve housing conditions, while also supporting policies and programs that bolster the housing market—including a Financial Sector Charter that helps provide access and regulation to mortgage financing. Another important initiative common to South Africa and Brazil is upgrading existing

human settlements to improve water, hygiene, and sanitation infrastructure, allowing communities to stay intact (see Exhibit 16 for more details on people-led processes implemented in South Africa).

In response to burgeoning urban populations and long-term project growth in major metropolitan centers, Indonesia implemented in 2015 the One Million Houses Program, whereby the government plans to build 1 million units of accommodation every year until 2019. While not fully on target, the ambitious program has added well over 3 million homes to date. Additionally, in Indonesia, government efforts to subsidize housing as a means of tackling income inequality are underway. Part of the impetus in Indonesia to address the housing shortage is that without adequate accommodations for young millennials in Jakarta, national leaders fear they will not be able to capture economic growth associated with the productivity of this demographic group.

Singapore similarly had an ambitious housing program aimed to address not only shortages, but also ethnic segregation. The Housing and Development Board leads housing planning and development in Singapore, and as of 2019 more than 1 million flats have been built across 23 towns on the island nation. More than 80% of Singapore's population lives in these flats, and nearly 90% of the residents own their home. Homeownership is seen as a means to nation-building and community cohesion in Singapore, and thus addressing residential segregation is an important part of the Housing and Development Board's strategy. The public housing scheme promoted mixed-generation housing across the life span (case studies can be made available on request). Public rental flats and housing grants, which are heavily subsidized by the government, help make housing affordable for low-income families.

Northern Ireland also experienced massive population shifts driven in larger part by political violence between Protestants and Catholics resulting in long-standing residential segregation, which is worst in urban areas of Belfast, Derry/Londonderry, and Craigavon. In 2015, the Northern Ireland Housing Executive published their Community Cohesion strategy, which aims to reduce segregation, improve racial and ethnic relations, and rehabilitate interface areas previously established as social and institutional barriers in communities. Under this strategy, mixed housing schemes are designed and shared across various public agencies to build a shared future of capital build projects. Additionally, an Interface Normalization program provides additional security measures to residents' homes at interface locations seeking transformation. The Executive is also developing a comprehensive database of all sectional symbols on their land and property as a means of monitoring sectarian divisions and targeting interventions.

In Australia, measures to boost the supply of housing have involved more than 1 billion dollars in funding through the National Housing Infrastructure Facility, formally outlined in the 2017–2018 national budget. Housing programs and reforms seek to make accommodations affordable for the neediest, increase homeownership, and sustain vibrant housing markets. The comprehensive housing affordability plan for all Australians seeks to reduce the shortage of affordable rental units for low-income households and reduce homelessness. The program provides tax incentives to increase private investment in affordable housing, and the government has established an affordable housing bond aggregator to support this. The National Partnership Agreement on Remote Indigenous Housing has facilitated agreement among participating jurisdictions to facilitate homeownership on remote community-titled land. There are a multitude of loan support and grants available to indigenous communities through the government. For instance, the Matched Savings Scheme provides matching grant of up to $1,000 for a home loan, while the Good Renter's Discount provides up to 20% discount off property purchase value for borrowers with a good rental history. In 2008, the government introduced the First Home Saver Accounts where all first home buyers received a tax incentive to save for a home purchase.

Education

Improvements in early childhood development access and enrollment were apparent across Australia and South Africa. Australia has seen significant increases in early childhood education and care programs, driven in part by funding made available through the Universal Access to Early Childhood Education Partnership arrangements. States and territories provide preschool education across various settings including child care, stand-alone preschools, and school-based programs. A combination of Commonwealth and state and territory funding ensures that all families have a minimum of 15 hours per week of preschool available to their children in the year before full-time school. National Quality Standards ensure high-quality and consistent education, while government programs are also aimed at reducing the gap in the number of indigenous four-year-old children enrolled. As of 2017, they were on track to meet the 2025 target to reach 95% enrollment. Evaluations have identified promising aspects of successful early learning initiatives in remote Aboriginal communities, including the engagement of Elders in the community; two-way learning between non-indigenous university mentors and Aboriginal early childhood educators; making indigenous ways of "knowing, being and doing" key pillars of literacy; bilingual approaches; and gradual transition of university mentors from active coach to supportive mentor (Maher & Bellen, 2015). Early childhood development is also prioritized in South Africa's National Development Plan. Early childhood grants, established in 2015, supports two primary objectives: to improve poor children's access to early childhood programs and ensure that childhood centers have adequate infrastructure. The Department of Social Development provides Early Learning Subsidies to centers meeting established norms and standards; subsidies are paid per qualifying child, taking into account caregivers' incomes. There have also been considerable efforts to reverse the segregation of schools, a legacy from apartheid, including programs such as the school funding equalization program. Under the banner of Safe and Caring Schools, Child Friendly Schools programming ensures that quality education includes rights-based, gender-responsive, and health-seeking principles. This programming has been incorporated into the Department of Basic Education's Social Cohesion Toolkit and the Education Sector Action beginning in 2014.

The government in the Czech Republic has made decreasing inequality in the education system one of its three key priorities in the Education Policy Strategy for the Czech Republic for 2020. The government has established Education Support Centres to assess the conditions for inclusive education and provide support to schools to better address student learning. Additional educational programs aim to increase opportunities for minority groups, including multicultural education to support integration of Roma students. As part of this program, the government funds a subsidy program to support education in the languages of national minorities and multicultural education. The government funds the Support of Roma Secondary-School Pupils program, allocating 10 million CZK in 2018 through the Ministry of Education, Youth and Sports. This program covers the cost of secondary education, public transport for students who live outside municipal boundaries, accommodations for students who must live at school or in the municipality where the school is located, and costs of school meals and books. Polish peoples are also a minority population in the Czech Republic, and the Pedagogical Centre for Polish National Minority Schools is an organization directly managed by the Ministry of Education, Youth and Sports that works to include the Polish language in school curricula.

Indonesia has made great strides in improving its education system since 1998. In 2002, Indonesia inserted into its constitution a requirement that governments at all levels must dedicate at least 20% of their budgets to education. This is a novel strategy that we did not observe in the other countries in our selection but that indicates a national-level commitment to education.

Health Care

Increasing access to health care via universal health insurance and/or free health care services was observed across all countries we reviewed. Beyond these broad initiatives, an explicit focus on simultaneously addressing social determinants of health, such as education, in order to improve health equity was observed in policies implemented by Australia, Northern Ireland, and Brazil. Improving preventive health services, including community-oriented primary care, was also apparent in Brazil, Northern Ireland, Australia, and South Africa.

Australia, Northern Ireland, and the Czech Republic all have some variant of universal health insurance or health care provision. Australia has achieved nearly universal access to health insurance via the federal government through the Medicare Benefits Scheme and the Pharmaceutical Benefits Scheme. Nearly half of the population had private hospital coverage in 2016, which is generally affordable among middle to upper socioeconomic households. Significant disparities in health outcomes and health care access persist among indigenous and rural populations. However, in 2007, the Council on Australian Governments set measurable targets to track and assess developments in the health and well-being of Aboriginal and Torres Strait Islanders, including reducing mortality rates among children and infants. In 2008, the prime minister signed the Close the Gap Statement where the government committed to an evidence-based path to achieving health equality among indigenous populations. A 10-year review of the Close the Gap Campaign found significant merits in the areas of chronic disease, child, and maternal health. However, the campaign did not effectively address the underlying causes of health inequality, such as access to primary health care and the social determinants of health such as housing and education.

Public health care systems programs have grown a great deal in Brazil with the establishment of the Unified Health System in 1990, the largest, universal, free-of-charge public health care system in the world. More than 60% of Brazilians depend entirely on the public health care system for their health needs. On the whole, Brazilians depend more on the public system than on the private sector, with about 20% having private health insurance. Overall, public health care is inclusive with free care with government reimbursement. The unified health system also has a robust community-based component, where preventive and primary health care are provided using a multidisciplinary core health team consisting of a physician, a nurse, and about six community health workers. These teams are supported by a dental team, mental health professionals, pharmacist, and physiotherapists to ensure all basic needs are met. Community health workers are the core of this model and provide a foundational touchpoint with communities and households, much like the health care system in South Africa.

Northern Ireland released the Making Life Better: A Whole System Strategic Framework for Public Health in 2014, which outlines a 10-year framework to improve public health by focusing on giving every child the best start, equipping people throughout life, empowering healthy living, creating conditions for health, empowering communities, and developing collaboration across groups and organizations. However, there are some concerns that health disparities may worsen in the aftermath of Brexit, particularly among lower socioeconomic households. The Making Life Better framework seeks to maximize access in rural areas through increasing services in remote areas, providing grants for community services, and enhancing health benefits for rural households. This program targets vulnerable households in the community, using a community development approach. These groups include the elderly, caretakers of disabled people, lone parents, ethnic minorities, lone adults, farming families, and low-income families. Community-based organizations lead the intervention, and early evidence suggests that home visits—a central component of the program—serve to improve community participation and increase the number of grants awarded.

Indonesia's health care system is highly decentralized and complex, with substantial gaps between health care performance and health outcomes in urban versus rural areas, the latter

of which lag behind. In 2014, Indonesia launched a comprehensive health insurance program intended to close the gaps in care across different geographic and demographic strata. This program aims to achieve universal coverage by the end of 2019. Primary care providers are a central tenet to the insurance program. The new health insurance program also absorbed traditional government programs aimed at providing health insurance to the poor. Health care workers are in demand in rural areas where health care facilities and services are often lacking; to address this need, the government has instituted policies to encourage doctors, midwives, and nurses to apply for positions in rural areas by offering contracts with above-average compensation.

Income Inequality

Australia has an impressive array of programs to address income inequality. In 2015 the government enacted broad reforms to the previous system and shifted to an investment approach to help ensure funds are invested in groups of people with the largest future lifetime costs and the capacity to move to self-reliance. The approach was established as part of the 2015–2016 budget, and funding totals over $100 million. The Priority Investment Approach is implemented via annual actuarial valuations that estimate the future lifetime cost of welfare payments to the Australian population and groups within it, similar to the way insurance companies estimate future expenses. There is also an array of financial literacy programs and programs specifically for Indigenous Peoples to help close the income gap.

Brazil has one of the most comprehensive programs, Bolsa Família, aimed at reducing income equality and improving health equity, as well as addressing other important social determinants of health such as education. The program has three main areas shown in Exhibit 11.

EXHIBIT 11
Brazil's Bolsa Família Primary Program Areas

1. Income transfer
Seeks to promote immediate poverty relief

2. Conditioning factors Singapore
Reinforce access to basic social rights in the areas of education, health, and social assistance

3. Supplementary programs
Aimed at family development so that beneficiaries are able to move out of their situation of vulnerability

Studies have estimated that the Bolsa Família program has reduced inequality between 12% and 21% in recent years. In addition, it is estimated that the program has been responsible for a 28% decline in poverty. Between 2002 and 2012, the number of Brazilians living on less than BRL70 a week has fallen from 8.8% to 3.6%. According to a study done by the United Nations, the number of people suffering from hunger has decreased from 22.8 million people in 1992 to 13.6 million in 2012. In addition to Bolsa Família, Brazil also uses participatory budgeting as a strategy for combatting economic inequality at the community level. Community representatives, usually from low-income districts, decide upon the allocation of resources through participatory budgeting. Each city adopts different formats to determine investment criteria; to select community representatives; and to deal with the city government, its bureaucracy, and the city councilors. Usually, the community representatives determine the investment priorities together. Priority is given to progressive distribution of the resources, regardless of individual representatives' demands, so that poorer areas receive more funding than well-off ones. The decisions of participatory budgeting participants mostly affect decisions on infrastructure investment. Currently, more than 140 (about 2.5%) of the 5,571 municipalities in Brazil have taken up participatory budgeting.

The Czech Republic has relatively low-income inequality compared to the other countries in our selection. An International Monetary Fund report in 2018 found the Czech Republic to have the lowest inequality and at-risk-of-poverty rates in the European Union (E.U.) and the Organization for Economic Cooperation and Development (OECD), while its social spending as a share of GDP remains below the average and heavily focused on pensions. The report found the low inequality in the Czech Republic to be explained by redistributive policies targeted at low-income groups and most at-risk-of-poverty groups and by the gradual increase in the minimum wage, which has increased almost 40% over the last five years (Chen et al., 2018). In its 2007–2008 tax and welfare reform, the Czech Republic moved away from means-testing family benefits to a single eligibility threshold and simultaneously increased tax credits for workers, spouses, and children. This practically exempted people with low earnings (the "working poor"—roughly the first income decile) from tax duty; further, only 70% of earnings are counted when the entitlements for social assistance benefits are means-tested. Additionally, those receiving social assistance payments can be rewarded with a bonus for participation in public service.

Singapore, along with other Asian countries such as Japan, South Korea, Taiwan, and Hong Kong, has successfully done away with absolute poverty. Its current focus is on relative poverty (Wong, 2015). Acknowledging the need to assist low-wage workers, Singapore established the Ministerial Committee on Low Wage Workers to recommend measures to improve employability and income security and to help families break out of the poverty cycle. After the committee's inception in 2005, low-wage workers significantly improved their incomes and availed themselves of job opportunities. On average, wages in the 20th percentile by a full-time, employed resident increased from $1,200 a month in 2006 to $1,310 in 2008. Two workfare programs have been implemented. The Workfare Income Supplement (WIS) was introduced in 2007. WIS encourages eligible workers to work and build up their Central Provident Fund (CPF) savings for their retirement, housing, and health care needs by supplementing their income and retirement savings. This program is available to Singaporean citizens who are 35 years or older and earn a gross monthly income of not more than $2,000 for the month worked. The second program is Workfare Training Support (WTS). This scheme complements WIS by encouraging Singaporean workers to attend training to improve their skills. WTS also supports employers who send their workers for training. Also, government transfers have helped to mitigate income inequality. For example, Singapore's 90/10 income inequality ratio, which measures inequality by comparing incomes of the richest 10% of a nation with the poorest 10%, declines significantly when accounting for government transfers and taxes.

Since the end of apartheid, the South African government has progressively expanded its spending on the social wage, broadly defined to encompass investments in areas deemed to help address poverty and inequality, while maintaining generally sound fiscal indicators. It broadened the tax base and built an efficient tax administration to generate the resources it needed to expand the social safety net for the poor. The country has an extensive transfers system that benefits a quarter of the population. Close to 17 million low-income South Africans have access to means-tested social grants. Social assistance has proven successful in reducing extreme poverty. In 2015, government social transfers are estimated to have reduced the poverty headcount rate by 7.9% and the poverty gap by 29.5%. This is explained by very high rates of coverage among the poorest members of society, with coverage rates among the bottom 60% far above the average coverage rates of other upper middle-income countries. Beyond social assistance to those experiencing poverty, a national minimum wage of R20 per hour is being introduced in 2019. This translates to about R3,500 for those working 40 hours per week. This represents a marked increase in income for more than 6 million workers—or 47% of South Africa's labor force–who currently earn less than R20 an hour. The Financial Sector Code is the primary mechanism through which the financial sector has voluntarily committed to Broad-Based Black Economic Empowerment Act to redress past imbalances and broaden the economic access to members of historically disadvantaged communities, thereby facilitating socioeconomic transformation. The goal of enterprise development policies is to increase the number of Black South Africans who either own or manage companies.

Notable Strategies for Improving SDOH and Health Equity Across Countries

Based on our review, four themes emerged that characterized and cut across many of the health equity programs, policies, and projects that we reviewed as part of our scan. Themes include the application of decolonization and trauma-informed frameworks; prioritization of participatory and community-centered approaches; implementation of coordinated, multisectoral approaches; and use of approaches designed to address spatial inequities. In Exhibit 12, we outline where we identified strong examples of the use of these approaches across the seven countries.

Decolonization and Trauma-Based Frameworks

Many of the interventions we learned about in our search were based on two important frameworks for improving equity, realizing justice, and healing communities. These include decolonization and trauma-informed frameworks. As described in the sections above, Australia, Brazil, Northern Ireland, and South Africa share a historical legacy of settler colonialism with the United States, defined as:

> *...the kind of colonial control that exists in "settler states" such as the United States, New Zealand, Australia, Israel/Palestine, Canada, Argentina, and other countries. It incorporates elements of both* ***external colonialism****—in which a colonizing power exports Indigenous peoples (as slaves or laborers), resources, knowledge, plants, metals, and/or animals to increase the wealth of the colonizer—****AND internal colonialism****—which is marked by the violent management of an underclass of people and lands within the "domestic" borders of the imperial nation via ghettos, reservations, borders, prisons, police, surveillance, and educational systems.* ***Settler colonialism is unique in that it combines "internal" and "external" colonialism—so the empire is in the same geographic location as the colony/ies.*** (Bloom & Carnine, 2016)

Decolonization frameworks seek to transform or dismantle modes of thinking and operating that are dominated by models such as white supremacy and transform the community's

EXHIBIT 12
Summary of Thematic Areas Across Sample of Countries

	Decolonization & Trauma-Based Frameworks	Participatory and Community-Centered Approaches	Coordinated, Multisectoral Approaches	Spatial Equity Approaches
Australia	✓	✓	✓	✓
Brazil		✓	✓	✓
Czech Republic		✓	✓	
Indonesia				
Northern Ireland	✓	✓	✓	✓
Singapore			✓	✓
South Africa	✓	✓	✓	✓

relationship to the state and economic institutions (Bloom & Carnine, 2016). In countries healing from decades of settler colonization, the process of decolonizing must deal with reconciliation and healing as fundamental components for improving social cohesion, societal development, and public health. We highlight these two themes here: (1) the need for truth and reconciliation, and (2) the need for reparations and restitution.

We can't have a conversation about reparations if we can't say we're truly sorry.
(*Giridharadas & Villanueva, 2019*)

Reconciliation and restitution approaches were notable in South Africa, Australia, and Northern Ireland. In South Africa, a Truth and Reconciliation Commission was launched to aid healing related to decades of settler colonization and apartheid. This commission operated similar to a court of law and was established to facilitate healing and bring about reconciliation by exposing the truth about human rights violations that had occurred during apartheid. This commission was born through a participatory process engaging civil society and human rights organizations. Although not without challenges, the Truth and Reconciliation Commission has been lauded by the international community as making important contributions to the healing and development in post-apartheid South Africa. These include demonstrating the importance of public participation and establishment in such processes and being the first commission to hold public hearings in which both victims and perpetrators were heard (Tutu, 2019).

In Australia, a formal national apology was pivotal in launching national commitments, policies, and funding to address the legacy of discrimination against Aboriginal and Torres Strait Islander people, which is highlighted in detail below. As with South Africa, the Australian government recognized that a better understanding among the broader Australian community of the continuing impact of past actions on the lives of Aboriginal and Torres Strait Islander people today is essential to achieving truth, justice, and healing. The apology formally acknowledged past injustices and the legacies that the injustices have on Indigenous Peoples and the nation as a whole—even preventing true reconciliation without first addressing previous harmful acts and policies upheld by the Australian government. As a result, the apology laid the groundwork for further collaborative efforts toward achieving better outcomes for Aboriginal and Torres Strait Islander Australians. Related follow-up actions have built on healing-focused approaches and participatory design.

EXHIBIT 13

Australia: National Apology and Healing Foundation

The term "Stolen Generations" refers to Aboriginal and Torres Strait Islander Australians who were forcibly removed, as children, from their families and communities and placed into institutional care or with non-indigenous foster families. Many of these removals occurred as the result of official laws and policies aimed at assimilating the Aboriginal and Torres Strait Islander population into the wider community. The authorities involved were from government, welfare, or church organizations. A 1995-1997 National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families led to the 1997 *Bringing Them Home* report. The report found that forced removal has had lifelong and profoundly destructive consequences for those taken. Stolen children lost connection to family, land, culture, and language and were taken to homes and institutions where they were often abused, neglected, and unloved. The mothers, fathers, and other family members who were left behind also suffered from the loss. These policies continued until the 1970s, and many of those affected by the trauma are still alive today. The trauma experienced by Indigenous Peoples as a result of past laws, policies, and practices continues to be passed from generation to generation, with devastating consequences. The report contained recommendations that all Australian Parliaments and State and Territory police forces acknowledge responsibility for past laws, policies, and practices of forcible removal and that on behalf of their predecessors officially apologize to indigenous individuals, families, and communities.

Addressing intergenerational trauma involves building a better understanding among the broader Australian community of the continuing impact of past actions on the lives of Aboriginal and Torres Strait Islander people today. This process is essential to achieving truth, justice, and healing. The release of the Bringing Them Home report was followed by a wave of apologies to the Stolen Generations by state parliaments, judges, churches, civic associations, trade unions, and ethnic groups. However, it remained the responsibility of the Australian government, on behalf of previous Australian governments who administered this wrongful policy, to acknowledge what was done. After winning the election in 2007, Prime Minister Kevin Rudd began consulting with Indigenous Australians about the form an apology should take. The word "sorry" in Aboriginal and Torres Strait Islander languages and cultures holds special meaning, often used to describe the rituals surrounding death. "Sorry," in this context, expresses empathy, sympathy, and an acknowledgment of loss rather than personal responsibility. The apology was not intended as an expression of personal responsibility or guilt by individual Australians. It was provided by the Australian government in recognition of policies of past governments. Similarly, the former Australian government apologized to Vietnam veterans for the policies of previous governments.

Members of the Stolen Generations were invited to hear the National Apology firsthand in the gallery of the House of Representatives chamber at Parliament House in Canberra. Crowds of people across Australia watched the apology on big screens in their own cities and towns. Following the apology, Lorraine Peeters, a member of the Stolen Generations, presented the prime minister and the Leader of the Opposition with a glass *coolamon*, made by Bai Bai Napangardi, a Balgo artist. Inside the *coolamon* was a message thanking the Parliament for saying "sorry"—that the apology showed compassion and opened a path for working together in the future. In the spirit of the new commitment to indigenous affairs, a Welcome to Country ceremony was held at the opening Parliament in 2008. This was the first time that such a ceremony was held. Matilda House, a Ngambri Elder, welcomed visitors to the country, and dancers from around Australia and the Torres Strait Islands took part in the ceremony. A message stick was presented to the prime minister by Matilda's grandchildren as a tangible symbol of the ceremony.

The apology made it clear that understanding and acknowledging past wrongs and their continuing impact is crucial to building stronger relationships, which are at the heart of reconciliation. In this way, the apology laid the groundwork for further collaborative efforts toward achieving better outcomes for Aboriginal and Torres Strait Islander Australians. Related follow-up actions have built on healing-focused approaches and participatory design:

- Three states (New South Wales, Tasmania, and South Australia) have set up compensation funds or reparation schemes to address the ongoing trauma experienced by children forcefully removed from their families.
- In 2009 the Australian government announced a healing foundation to address trauma and aid healing in Aboriginal and Torres Strait Islander communities. This followed widespread consultation with communities.
- The Closing the Gap initiative aimed at addressing disparities in life expectancy as well as education, health, and wealth between Indigenous and non-Indigenous Australians.
- Since 2008, a national survey, the Reconciliation Barometer, has been conducted every two years to measure the progress of reconciliation between Aboriginal and Torres Strait Islander people and non-Indigenous Australians.

After decades of sectarian conflict, Northern Ireland has undertaken significant efforts to heal communities severely impacted by violence and religious tensions. In Belfast, the Flax Trust has adopted a trauma-based approach to community healing, specifically targeting areas where violent deaths and bombings have occurred (highlighted in Exhibit 14). The Flax Trust states that it is "reconciliation of a divided community through economic and social development, bringing peace to both communities, one person and one job at a time" (The Flax Trust, 2019). Thus, the project integrates economic and social development approaches. As part of the social development strategy, the trust has undertaken an array of projects and tasks. These tasks include everything from job trainings, such as training women in marginalized communities to work as health paraprofessionals, to building community arts centers and establishing community investment funds for long-term planning. Importantly, however, project leaders have aimed to rebuild communities harmed by decades of violence and have structured the project's strategies around healing past harms. Sites of reinvestment are purposely chosen as those that represent prior sites of violence, and the investments made are designed to promote community and social cohesion. These efforts to promote community transcend purely economic ends, and include strategies that focus on celebrating local arts, developing gathering areas where people can socialize and play, and supporting local services for all generations. Thus, the trauma-informed approach is about not only reclaiming sites of violence but also promoting healing across multiple domains—health, economic, social, and cultural. As with other countries in our sample, Northern Ireland has embraced the approach that acknowledging and addressing trauma and social harm resulting from prolonged conflict and oppression must be central to national social, economic, and health programs.

More broadly, Northern Ireland has undertaken specific efforts to address cultural drivers of division and inequity, going so far as to routinely monitor symbolism in the form of graffiti and signage throughout communities. Understanding where more divisive symbols exist or are arising would enable the government and local community-based organizations to target their social development efforts. Similarly, South Africa has established a liberation heritage infrastructure initiative as an essential part of their community healing and social cohesion initiatives. In partnership with UNESCO, the South African DAC is developing heritage site infrastructure in all nine provinces to ensure that the Resistance and Liberation Heritage Route offers the potential of attracting economic development and tourism. This initiative also strives to create communities where local cultures and experiences are recognized and celebrated, especially among communities and peoples who dedicated their lives to the struggle for liberation in South Africa. These sites are expected to reflect key aspects of the South African resistance and liberation experience (Tibane, 2017a).

EXHIBIT 14

Northern Ireland: Community Healing and The Flax Trust

MISSION: The Flax Trust is a registered charity, formed in Belfast in 1977, which has as its mission the reduction, and, if possible, the elimination of community tensions and religious prejudices by creative engagement in economic and social development, education and training with inter-community activities including culture, the arts, sport, health, social programs, personal development and dedicated communication projects (The Flax Trust, 2019).

During the late 1960s and 1970s, there were fierce periods of community violence—burnings, bombings, rioting —in the Ardoyne areas of mainly Catholic and Irish Nationalist Northern Belfast. This area gained notoriety due to the large number of incidents during the Troubles. Looking at the youth in these areas of Belfast, Friar Kavanaugh, the founder of the Flax Trust, saw that few got jobs or went on to pursue further education after completing school. Most remained unemployed, and many went to jail or were killed in the Troubles.

The Flax Trust was started to promote economic and social development in the Catholic areas of Belfast hit by the Troubles. In the beginning, the trust took over an old complex of derelict flax mills—hence the name—that were developed into smaller units and leased to small companies. This development of the Brookfield linen mill became a 232,000 sq. ft. business center that accommodated more than 70 small businesses and acted as a business incubator for all of Belfast, creating some 400+ businesses. The trust also started training several hundred youth each year through Brookfield Business School Ltd. in skills that would give them a realistic chance of getting a job.

The Flax Trust has been committed for more than 35 years to reconciliation of the Catholic and Protestant communities through economic development—"bringing peace to both communities one person and one job at a time." Among many projects to promote economic development one person and one job at a time are these:

- In the late 1980s in a joint venture with Bombardier Aerospace, The Flax Trust redeveloped the derelict Belfast Co-operative department store in York Street into an 180,000 sq. ft. "neutral" city center block. Interpoint has housed the Northern Ireland Forum for Reconciliation; the Patton Police Commission; the Northern Ireland Justice Review; was home to the Novatech initiative, which developed new technology-based ventures through a unique process of technology transfer and licensing; housed a range of new technology-based businesses;
- Assisted Bannside Development Centre in Portadown, a socioeconomic regeneration initiative that also serves to bridge the religious divide and promote mutual understanding;
- In 1992–1993 set up Ulster Community Conference, an association of community-based economic development organizations, to support and foster community economic enterprise. The broad aims being to coordinate the community economic development sector; share resources and good practices; and help members realize their full potential through the establishment of Ulster Community Investment Trust Ltd.;
- Initiated the Foyer Project, which assists homeless and unemployed young people aged 16 to 25, providing accommodation, independent living, and developing skills to enhance employability;
- Initiated the School for Social Enterprises in Ireland, set up in 2003 in partnership with Ulster University in response to the need for high-quality education, training, and development for the growing social economy sector;
- 2016: In discussions with Argyle Business Centre re-development of a Hospitality Training facility for the Shankill area to improve local employment opportunities, the Flax Trust has acquired the site of the Shankill Mission Building to facilitate this project.

The Flax Trust also has promoted community health and social welfare through these programs:

- Initiated a Community Association and health programs;
- Initiated social programs that have served thousands of Meals on Wheels in addition to day care center meals;
- Built a Medical Centre housing Ardoyne Community Healthcare Centre, Ardoyne/Shankill Healthy Living Centre, Doctor's & Dental Surgeries, Elderly Day Care Centre;
- Flax Housing Association Ltd. was set up in the 1980s to address the acute shortage of social housing and sheltered accommodation in the North Belfast area;
- Built a shopping center, including a supermarket, post office, pharmacy, fancy goods store, florist, community-based organizations, café, offices and workshops providing services.

EXHIBIT 14

Northern Ireland: Community Healing and The Flax Trust

(*continued*)

- 2015: The new 76-bed 5-star home for the elderly in North Belfast was officially opened serving the sick elderly of both communities.
- 2016: The Flax Trust funded Houben Centre for Cross Community, personal development, community leadership and inter-community understanding has been officially opened.
- 2017: The Flax Trust set up the ABC Trust, a Community Regeneration Project and transferred the Flax Centre and St. Gemma's School to the new Trust to develop a health and leisure facility.

In the past three years the Flax Trust has expanded its focus to include reconciliation through the arts, especially the performing arts, education, business incubation, entertainment, social action, sport, and technology. Arts and entertainment developments include:

- The trust developed an international arts center with a theater, an art gallery, a dance studio, and the Pittsburgh Bar & Steelers' Restaurant.
- Flax Trust Classics, initiated in 2012, provides Bursary Awards to Queen's University for young classical musicians—singers and instrumentalists and Bursary Awards and sponsorship to Camerata Ireland's Young Musicians of the Future, City of Belfast Youth Orchestra and City of Belfast School of Music -- all with the objective of supporting their continued studies.
- In 2015, the trust created shared performance space at Holy Cross Church for the wider community as part of ongoing development and enrichment of diverse musical talent.
- Flax Trust Inter-School, Cross Community Choir Competition bursaries initiated in 2013 continues to involve more than 300 pupils from 20 schools in North Belfast Primary and Post Primary.

Belfast had become in the late 1960s and 70s a place where ghettoization had occurred. North Belfast, in particular, had become a place apart, a place where those who could, left, and where the rest of the city chose to avoid as much as possible. The Flax Trust sought to reclaim those spaces that were derelict and where youth had little hope of finding employment or of furthering their education. The trust took over abandoned buildings and created opportunities for training, education, support, and eventually, art to rejuvenate this community. The Flax Trust project set about to not only revitalize Belfast, but to also rebuild a community and, in doing so, heal the divisions of the past so that a more promising future could be realized.

In addition to reconciliation measures, South Africa and Australia have instituted land restitution initiatives. Both countries recognized that settler colonization disposed indigenous and enslaved peoples of their rightful claims to land. In an effort to redress this and as part of decolonization within both countries, land restitution initiatives are underway. South Africa has the strongest land restitution initiatives, with the issue written into the constitution; the Constitution of the Republic of South Africa of 1996 allows for restitution to any person or community dispossessed of land rights before April 27, 1994. The Constitution also guarantees the right to property, albeit with the power of expropriation, subject to compensation that is just and equitable. As a result, South Africa established the Department of Rural Development and Land Reform, which is constitutionally empowered to change the skewed land-ownership patterns while maintaining economic growth, food security, and increased agricultural productions. South Africa also has a formal body that oversees land restitution—the Commission on Restitution of Land Rights—which seeks to provide equitable redress to victims of racially motivated land dispossession, in line with the provisions of the Restitution of Land Rights Act of 1994.

Land restitution efforts are also underway in Australia, but the strategies encompass bureaucratic and government programmatic solutions, as opposed to being codified in a constitution as a rights-based issue. There is a substantial gap in homeownership rates between Indigenous and non-Indigenous Australians, with indigenous households twice as likely to be renting (Australian Bureau of Statistics [ABS], 2016). In remote areas, homeownership rates were even lower, with 18% indigenous homeownership compared to 57% for non-indigenous households (ABS). As an output under the National Partnership Agreement on Remote Indigenous Housing, jurisdictions have agreed to the progressive resolution of land tenure on remote community-titled land in order to facilitate homeownership opportunities in economically sustainable communities. These policy actions are being progressed by the Select Council on Housing and Homelessness. Primary vehicles to address the disparity in indigenous homeownership rates are implemented through the Indigenous Bureau of Affairs' Indigenous Home Ownership program, which provides concessional housing loans to eligible Indigenous Australians who wish to purchase an established residential property, purchase land and construct a new home, or make essential improvements to an existing home.

Participatory and Community-Centered Approaches

We observed a policy and programming shift toward the use of collaborative, participatory design and implementation approaches across several of the review countries and several of the equity domains. Exhibits 15 and 16 spotlight two examples: participatory budgeting in Brazil to give voice to priorities of disadvantaged communities and people's-led settlement upgrading in South Africa to maintain community cohesion while better integrating informal communities into municipal services and planning. The use of participatory approaches also underlies the majority of the work designed to address bias and discrimination, including community conversations in South Africa to build post-apartheid social cohesion and address xenophobia toward labor migrants; peace-building approaches in post-conflict Northern Ireland; and as the foundation for Australia's 2019 Closing the Gap Refresh, which is meant to close the gap in life expectancy and social determinants of health between Aboriginal and Torres Strait Islander people and non-Indigenous Australians. The 2019 refreshed approach is based on key lessons from the previous 10 years of implementation, with a commitment to focus on recognizing and building the strength and resilience of Aboriginal and Torres Strait Islander communities and supporting initiatives led by Aboriginal and Torres Strait Islander communities to address the priorities identified by those communities. The Closing the Gap Refresh also calls for developing partnerships at all levels to draw on the enduring wisdom and local knowledge of Aboriginal and Torres Strait Islander people; the need to work address the drivers of intergenerational trauma through a focus on early childhood; using economic participation to drive social change; and using a whole of government approach to harness effort across agencies to ensure a cohesive approach to providing services for First Australians. Part of the approach under the Closing the Gap Refresh process will involve providing leadership that ensures Commonwealth, state, and territory governments have direct ownership of targets, specific action plans, and the oversight of an Indigenous Productivity Commissioner. Australia's recognition of the inherent value of the enduring wisdom and local knowledge of Aboriginal and Torres Strait Islander people is an important step in dismantling models of white supremacy, as described in the sections above. The Czech Republic and South Africa have implemented policies to allow for more inclusive curricula that recognize the history and culture of ethnic minorities, which can also be linked to decolonization and community-centered approaches.

EXHIBIT 15
Brazil: Participatory Budgeting

The extreme disparities in income and quality of life between the rich and the poor pose a challenge to the Brazilian government. Near-homelessness and hunger are everyday realities for a sizable number of people in the urban areas of Brazil. Porto Alegre, the capital of Brazil's southernmost state, Rio Grande do Sul, was a city where, despite high life expectancy and literacy, a third of the city's population lived in isolated slums at the city outskirts and lacked access to such public amenities as clean water, sanitation, medical facilities, and schools. To overcome this situation, certain innovative reform programs were started in 1989. Participatory budgeting emerged as the centerpiece of these programs. Participatory budgeting was initiated and supported by three mayors, elected from a coalition led by the Workers Party and their staff.

Processes such as participatory budgeting can have a significant impact in regions with high disparities in income. Through a platform such as participatory budgeting, the poor can put forth their needs and obtain access to facilities or services that other groups already have. The participation and involvement of the poor can help to focus public welfare works on less developed areas.

Community representatives, usually from low-income districts, decide upon the allocation of resources through participatory budgeting. Each city adopts different formats to determine investment criteria; to select community representatives; and to deal with the city government, its bureaucracy, and the city councilors. Usually, the community representatives determine the investment priorities together. Priority is given to progressive distribution of the resources, regardless of individual representatives' demands, so that poorer areas receive more funding than the well-off ones. The decisions of participatory budgeting participants mostly affect decisions on infrastructure investment. Currently, more than 140 (about 2.5%) of the 5,571 municipalities in Brazil have taken up participatory budgeting. Over the years, resources allocated through participatory budgeting have increased. However, participatory budgeting grants vary from one city to another.

The Porto Alegre example suggests that (1) initially, local citizens can be involved in the allocation of a small part of the city's total budget, and (2) over time, more of the city's budget can be allocated through public participation. The increase in the amount of funds allocated through participatory budgeting in Porto Alegre reflects the growing power of citizens to decide civic matters that affect them directly.

The process of participatory budgeting has brought substantial changes in some municipalities in Brazil as it relates to housing. Although difficulties arising out of a troubled economy intensified poverty and unemployment problems in all Brazilian cities, some gains have been made.

Key challenges for this approach identified by the evaluation include:

- While low-income groups reportedly influence the allocation of a portion of public funds, apparently the "very poor" are left out of the process.
- Some municipalities continue to serve and be influenced by affluent groups of people due to a lack of transparency and accountability.
- Financial resources for participatory budgeting are limited, which restricts the scope of budget programs.
- Lack of participation from underrepresented groups such as the very poor and young people.
- Lack of participation from communities who feel their demands are met.
- The slow progress of public works can be frustrating for the participating public and can inhibit participatory budgeting's promotion in other places.
- Difficulty in defining standard roles of government and participatory budgeting, as these processes differ across municipalities.

Meanwhile, the evaluation also identified several key factors for success worth noting:

- There are claims that participatory budgeting is not reaching the very poor in Porto Alegre, but it is accomplishing an important goal by moving resources to segments earlier deprived of government attention. This experience points to a step-by-step approach in implementing participatory budgeting projects, which can start with low-income groups and move to the very poor in the next phase.
- The case of participatory budgeting in Porto Alegre suggests that lack of support by the local media for local initiatives, such as participatory budgeting, can hinder the dissemination of such initiatives to other parts of the country.
- Participatory budgeting can influence long-term planning.
- Participatory budgeting can strengthen accountability in the government's budgeting mechanism.
- For successful implementation of participatory budgeting, and to avoid the possibility of unreasonable demands made by the citizens, it is important to maintain transparency and make the citizens aware of the fund's position and constraints of the municipal administration.

EXHIBIT 16

South Africa: People's-Led Process for Informal Settlement Upgrades

Initial housing policies formulated in the post-apartheid era prioritized new housing as the primary tool with which government sought to make towns and cities in South Africa more inclusive—see Hendler & Fieuw, 2018. Since 1994, the government has built 2.8 million new houses, but the construction of mass-scale housing resulted in urban sprawl, the spatial marginalization of the poor, the absence of a low-income housing market, and a social phenomenon of dependency where residents wait on government to provide housing. Concurrently, informal settlements and so-called backyard shacks proliferated in urban areas and remain a consistent feature of towns and cities across South Africa. The number of informal settlements grew from about 300 in 1994 to 2,700 in 2015. Backyard shacks increased from 460,000 households in 2001 to 710,000 in 2011. The formation of informal settlements is driven by urbanization, demographic shifts toward smaller households, poor urban planning, and exclusionary housing markets. The National Development Plan (NDP) recognizes informal settlements as important entry points to cities for migrants to urban areas but observes that the residence period in informal settlements increased from two to four years in the 1990s to 10 years in 2018.

Introduced in 2004, the Breaking New Ground (BNG) policy called for informal settlements to be "urgently integrated into the broader urban fabric to overcome spatial, social and economic exclusion." BNG also promised to introduce a new funding instrument to support the in-situ upgrading of informal settlements, in line with international best practice. Along with BNG, the concept of social compacts was introduced, a form of a "people's contract," for changing the housing delivery paradigm. Since 2010, local governments have been compelled to action on settlement upgrading through the introduction of municipal performance targets. The NDP also observes that the process of securing incremental tenure, infrastructure, and shelter upgrades should occur in "a participatory and empowering way." To this effect, funding is available to support community involvement and 3% of the total project cost is reserved for social facilitation, which includes activities such as socioeconomic surveying and profiling, conflict resolution, facilitated community participation, and housing support services.

There are still many challenges to settlement upgrading. Some upgrading schemes provide only rudimentary improvements (e.g., communal water gaps and better drainage), and there are challenges for governments and community organizations to increase scale from one or two small successful upgrading initiatives to supporting initiatives in a much larger and more diverse range of settlements. The South African Slum Dwellers International (SDI) Alliance consists of four partner organizations who work together to build organized communities and collaborative partnerships with urban poor communities to make cities more inclusive and pro-poor. The SDI has rich and varied experiences in implementing community-led practices for upgrading, especially mobilizing communities through savings and data collection and through partnering with local governments.

As an approach, in-situ upgrading recognizes existing power relations between actors, social networks, and livelihoods in a settlement. It is critical to engage with these actors, existing patterns, and logics to facilitate a meaningful, community-centered interaction. Successful informal settlement upgrading should therefore be marked by the central endorsement and participation of residents. This is critical as upgrading projects often involves the internal relocation of some residents to open space for infrastructure development, such as roads, water and sanitation reticulation and service points, parks, and facilities. SDI relies on deep social facilitation and engagement for each upgrading initiative. After facilitating initial contact, community mobilizing and organizing takes place through savings, data collection (settlement profiling, enumerating, and mapping), and peer-to-peer learning exchanges with other community-led initiatives. For SDI-linked communities, informal settlement upgrading is not an end in itself, but a means to challenge patterns of exclusion and realize cities and structures that prioritize and engage urban poor residents as equals.

Over the past decade, the Alliance has made progress in influencing how government relates to urban poor communities in terms of informal settlement upgrading. This is particularly evident in the era of Alliance upgrading initiatives that were implemented in the context of strong partnership agreements and financial support from municipalities. Key SDI achievements include:

- Supported 1,420 informal settlements to profile themselves (52% of all settlements nationally);
- Supported 100 communities to enumerate themselves;
- Prepared 23 communities for upgrading projects in seven municipalities;
- Five memoranda of understanding agreements with metropolitan and local governments of Cape Town, Stellenbosch, Midvaal, Nelson Mandela Bay Metro, and Msunduzi;
- Established two "local urban poor funds" in Stellenbosch (2012–2014) and Cape Town (2014–2018);
- Leveraged more than R20m from local governments for incremental upgrading of informal settlements; and
- R10m pledged by the Western Cape Provincial Minister of Human Settlements for the purpose of informal settlement upgrading.

Coordinated, Multisectoral Approaches to Early Childhood Development and Other Social Determinants of Health

Many of the countries we scanned have implemented sequenced, multisectoral policies and programming that aim to address inequities. At a national policy level, South Africa's National Development Plan presents a cohesive national vision of a transformed post-apartheid South Africa, with clear delineation of how each sector can individually and collaboratively contribute to achieving this vision by 2030. Northern Ireland also has a strong, multisectoral plan in place to build health equity in Northern Ireland. In Australia, the Closing the Gap Refresh tackles the need for improvements across multiple sectors to achieve equity in health and wellness outcomes for Indigenous Australians. Overall, most of these plans utilize a model whereby the national government exercises policymaking and sets quality standards, but implementation is planned and implemented at a subnational level. In some cases, implementation is tailored even more locally to a community level—creating overlaps with the other three key themes we identified.

Many countries are enacting policies, strategies, or programs that address child health and child education and development as a single issue, with some countries taking further steps to address parent and caregiver needs as part of a longer-term approach. Brazil and South Africa have implemented strong, national cash-transfer mechanisms to support low-income families with children, which have shown promise in terms of closing historical gaps in health and education. Indonesia has also initiated a cash-transfer system for young children, although it is much newer than Brazil's and South Africa's programs. Brazil's Bolsa Família transfers (see Exhibit 17 for a detailed description) are designed to reduce poverty and inequality by providing a minimum level of income for extremely poor families. The transfers are conditional on families' commitment to adhere to core responsibilities such as taking their children to the doctor whenever the need arises and ensuring that they attend school. It aims to break the poverty cycle by obliging the recipients to invest in human capital (in their children's education, for example) and by linking recipients to complementary services, such as education and health care. Implementation of Bolsa Família followed scale-up of Brazil's Family Health Programs, which expanded access to primary care services. Approximately 28% of the total poverty reduction in Brazil has been attributed to Bolsa Família, and from 2002 to 2012 the number of Brazilians living with less than BRL70 a week had fallen from 8.8% to 3.6%. In addition, Bolsa Família has had spillover effects into health and economic areas unrelated to its main objectives, such as women's decision-making in urban households (de Brauw et al., 2013).

EXHIBIT 17

Brazil: Bolsa Família Program for Conditional Cash Transfers in Brazil

In the late 1990s, Brazil was notorious for its high levels of hunger, poverty, and inequality, particularly in its densely populated major cities. Bolsa Família is a government program introduced in 2003 by President Lula that makes cash transfers to low-income families on condition that they, for example, send their children to school and ensure that they are properly vaccinated (Centre for Public Impact, 2016).

In the period up to 2003, the federal government under the then President Cardoso introduced a number of conditional cash-transfer programs that all addressed different aspects of poverty and inequality. In October of that year, President Lula da Silva introduced the Programa Bolsa Família. It was created from the merger of four existing programs: Bolsa Escola, Bolsa Alimentação, Cartão Alimentação, and Auxílio-Gás. Its aim was to "improve the efficiency and coherence of the social safety net and to scale up assistance to provide universal coverage of Brazil's poor" (Lindert, Linder, Hobbs, & de la Briere, 2007).

The main objectives of the Bolsa Família are to:

- Reduce poverty and inequality by providing a minimum level of income for extremely poor families.
- Break the cycle of poverty by making the cash transfers conditional. The conditional element is that families receive the cash only if they adhere to core responsibilities such as taking their children to the doctor whenever the need arises and ensuring that they attend school. It aims to break the poverty cycle by obliging the recipients to invest in human capital (in their children's education, for example).
- Empower Bolsa Família beneficiaries by linking them to complementary services.

It is estimated that "the level of extreme poverty would be between 33 per cent and 50 per cent higher without the Bolsa Família. Bolsa Família has also contributed to reducing income inequality, accounting for 12-21 per cent of the recent sharp decline." Bolsa Família was responsible for approximately 28% of the total poverty reduction in Brazil, and from 2002 to 2012 the number of Brazilians living with less than BRL70 a week had fallen from 8.8% to 3.6%. "According to a recent UN study, [the number of people suffering from hunger] had decreased from 22.8 million people in 1992 to 13.6 million in 2012" (Nobrega, 2013). Bolsa Família has now succeeded in reaching 11.1 million families (more than 46 million people), which makes it the largest such program in the world.

In addition, Bolsa Família has had spillover effects into health and economic areas unrelated to its main objectives. One study showed that Brazil's Bolsa Família program has significant impacts on women's decision-making, but with considerable heterogeneity in effects. In aggregate, Bolsa Família significantly increases women's decision-making power regarding contraception. This effect is driven by urban households, in which Bolsa Família also significantly increases women's decision-making power in spheres related to children's school attendance and health expenses, purchases of household durable goods, and contraception use. However, in rural households, researchers found no increases and possible reductions in women's decision-making power (de Brauw et al., 2013).

Researchers from Action Aid Brazil highlight the impact of Bolsa Família in reducing internal migration. "The northeast is going through one of the worst droughts ever. But people are not migrating. Bolsa-Família is helping them tackle this. On the other hand, there are some negative aspects. It is necessary to combine transfer income with access to productive inclusion and public services that ensure basic quality of life" (Nobrega, 2013).

While BFP is the largest conditional cash-transfer program in the world, research to date suffers from estimation problems, data that cover only part of the country, and (in most cases) analysis of the program is limited to its very early stages. In addition, the studies conducted on Bolsa Família could not determine whether the effects seen in the studies were specifically a result of Bolsa Família, or other conditional cash-transfer programs. This difficulty in assessing Bolsa Família's impact on main program objectives is reflected in other studies related to schooling (de Brauw et al., 2015) and education of economically disadvantaged children (Simones & Sabates, 2014), pointing to the difficulty in evaluating the effects of a program that touches so many social points.

Despite these limitations, Bolsa Família demonstrates how conditional cash transfers can be implemented on the national level as a unifying force in social policy, integrating social policy both horizontally across sectors and vertically across levels of government. Brazil is now being consulted for advice on income transfer programs by countries across Africa (Ghana, Angola, Mozambique), the Middle East (Egypt, Turkey) and Asia (including India). Even New York City has implemented a version of the program (Nobrega, 2013).

The South African government created the Child Support Grant (CSG) in 1998 as a primary tool to reverse long-term negative impacts of apartheid. The CSG program offers regular, predictable payments to the caregivers of eligible children. When the CSG was first launched, the government set a household income threshold of ZAR800 (US$170) in rural areas and ZAR1,100 (US$234) in urban areas. In 2008, thanks to a long-overdue policy change, the government increased the income threshold, pegging the cutoff at 10 times the value of the grant. At first, receipt of the grant was conditional on meeting health requirements, which in practice meant possession of a Road to Health card—a record of a child's immunization and growth rate. However, it soon became clear that those requirements penalized eligible children who lacked the card, leading the CSG to eliminate its conditions. In 2010, the government recommended conditioning receipt on children's schooling, but to little effect—the system was not set up to collect the information needed to link school attendance with receipt of the grant. The government has regularly adjusted the size of the transfer. The grant is relatively large compared to poverty-reducing grants in some other countries, and this served as a strong incentive for South Africans to enroll. Many millions of South Africans now rely on the transfer to top up their meager household incomes. As of 2015, the CSG provided regular monthly payments to nearly three-quarters of South African children living in poverty. A wealth of evidence shows that CSG receipt is good for children's health and other dimensions of welfare: improved nutrition, more schooling, legally documented identities, and less labor-force participation. The earlier children receive the grant, the more it helps. Receipt before age two provides the most durable benefits. The impact of CSGs may be further reinforced by more recent efforts to expand access to early childhood development programs. The 2015 National Integrated Early Childhood Development Policy covers the period from conception until the year before children enter formal school or, in the case of children with developmental difficulties and disabilities, until the year before the calendar year they turn seven, which marks the age of compulsory schooling or special education.

In Australia, the 1000 Days initiative focuses specifically on the needs of Aboriginal and Torres Strait Islander children and families, and explicitly builds programming around indigenous cultural norms, traditions, and competencies, rather than relying solely on national or international program models considered best practices. Programming covers the preconception period up until a child reaches the age of three, as these are formative years that impact future health, education, and development outcomes and can have multigenerational impact. Programming focuses on infants and children, but also on building capacity, resilience and skills of both male and female caregivers.

The Czech Republic's National Family Policy outlines tax policies and robust social services aimed at both supporting families that have encountered adverse circumstances (such as poverty) and services in support of functioning families, which are intended to facilitate and reinforce cohabitation and parenthood of partners and married couples, provide childcare support to families, and assist with reconciling work and family life (Ministry of Labour and Social Affairs, n.d.). Over the long term, these measures are meant to address future financing gaps that are forecasted based on an aging population and declining birth rate coupled with expensive, state-provided pensions and health care schemes. These policies are also intended to reverse damage caused by totalitarian policies that were meant to undermine family cohesion and support networks under the communist regime. The National Family Policy provides for financial assistance available to families at any income level (caregiver allowance; funeral grant), as well as specific programs for low-income families (child allowance; birth grant; housing allowance). In its 2007–2008 tax and welfare reform, the Czech Republic moved away from means-testing family benefits to a single eligibility threshold and simultaneously increased tax credits for workers, spouses, and children that generally exempted people with low earnings (the "working poor"—roughly first income decile) from tax duty; additionally, those receiving social assistance payments can be rewarded with a bonus for

EXHIBIT 18

The Czech Republic: Supports for Working Families

After World War II, a reunited Czechoslovakia fell within the sphere of Soviet influence. The communist dictatorship's rise to power significantly affected Czech society, with the period from 1948 to 1989 marked by state intervention in all private areas of human life. The communist regime promoted the model of a double-income family, where both parents were gainfully employed and provided suitable conditions for the realization of this model (child day care facilities, etc.). The traditional functions of the family—raising children, socialization, etc.—were gradually taken over by the totalitarian state, which largely strove to restrict the scope of the family's activities to its biological reproductive function. Its purpose was to weaken family ties and restrict the importance of the family in society; an extensive system of direct financial assistance was geared toward families with both parents economically active over the provision of childcare at home (Ministry of Labour and Social Assistance-MoLSA 2014).

Today, the Czech Republic faces future financing challenges due to reliance on state support systems and a deterioration of social networks including family and community support, which is compounded by an aging population. The National Family Policy outlines tax policies and robust social services aimed at both supporting families that have encountered adverse circumstances (such as poverty) and services in support of functioning families, which are intended to facilitate and reinforce cohabitation and parenthood of partners and married couples, provide childcare support to families, and assist with reconciling work and family life. Financial assistance for families includes the child allowance, birth grant, parental allowance, and funeral grant, as well as housing allowances. In its 2007-2008 tax and welfare reform, the Czech Republic moved away from means-testing family benefits to a single eligibility threshold and simultaneously increased tax credits for workers, spouses, and children. This practically exempted people with low earnings (the "working poor"—roughly first income decile) from tax duty; further, only 70% of earnings are counted when the entitlements for social assistance benefits are means-tested. Additionally, those receiving social assistance payments can be rewarded with a bonus for participation in public service.

The child allowance and birth grant are grants provided to families with dependent children up to the age of 26 years with an income of less than 2.7 times the calculated living minimum—which is based on family size and municipality. The child allowance is a long-term benefit provided in three levels, depending on the child´s age and in two amounts according to type of income. Eligibility for the increased amount is determined by having income from employment or from certain social benefits. The birth grant is a one-time benefit to help lower-income families cover costs related to the birth of their first child and second live-born. The birth grant amounts to 13,000 CZK for the first child and 10,000 CZK for the second child.

The parental allowance and funeral grant are available to families regardless of income level. A parent who personally cares for the youngest child in the family is entitled to parental allowance if their child under the age of two years attends a creche or other facility for preschool children for no more than 46 hours in a month; longer allowances are available to disabled parents and parents of disabled children. However, the parent may carry out an occupational activity without losing their entitlement to parental allowance, provided the parent ensures that the child is in the care of another adult. Parental allowance is provided up to a ceiling of 220,000 CZK, maximum up to four years of child's age. A parent may elect the amount of parental allowance and thus the period of its drawing. The monthly amount of parental allowance is adjusted based on a caregivers' receipt of maternity benefit or sickness benefits related to delivery or adoption (MoLSA 3, n.d.).

Property owners or tenants registered as permanently resident in that property are entitled to a housing allowance if 30% of family income is (1) insufficient to cover housing costs, and (2) lower than the relevant prescriptive costs set by law. The prescriptive housing costs are set as average housing costs based

	Monthly Amounts of Child Allowance in CZK	
Age of the Dependent Child	**Basic Amount**	**Increased Amount**
Up to 6 years of age	500	800
From 6 to 15 years	610	910
From 15 to 26 years	700	1,000

EXHIBIT 18

The Czech Republic: Supports for Working Families

(*continued*)

on the size of the municipality and the number of members of the household. They include a rent and similar costs for residents of cooperative flats and flat owners. They also include the cost of services and energy. Prescriptive housing costs are calculated on the basis of reasonable sizes of flats for the number of persons permanently residing in them. In Prague the percentage is raised to 35% (MoLSA 4, n.d.).

Czech labor laws and social services are also aligned to enable parents to reconcile their professional and family roles if they prefer to achieve parenthood and retain their career. Female employees are entitled to a minimum of 28 weeks of maternity leave and are not required to submit any special application to their employer; during this period, the employer is not responsible for paying salary, but state social support benefits are available, as described above, and parents are entitled to use of insurance benefits. Parental leave may be requested by male or female employees at any time up to the child reaching age three; wages are not paid during this time, but employment is protected and parental allowances are available. Modifications to working hours and work-from-home are available to both male and female parents, as well as childcare allowances during periods of work travel. State-provided childcare services are also universally available for children up to three years of age in the form of day care and babysitting; preschool education including kindergarten; and after-school care services for young school-age children.

While these robust family supports are aimed specifically at repairing the damaging legacy of communist policies that undermined family function in the Czech Republic, there are potential implications for U.S. policies affecting families in the United States. For example, while the Czech Republic's Family Policy explicitly outlines rationale and policies that prioritize marriage, cohabitation, and two-parent families, the income thresholds surrounding the Earned Income Tax Credit in the United States. disadvantages married couples with dual income, potentially undermining family stability via marriage. In the United States, means-testing of benefits and work requirements can serve as deterrents to parents seeking employment, while in the Czech Republic, parents and families can receive additional benefits by engaging in employment or public service. Additionally, lack of consistent policies around family leave and lack of universal access to child care services may exacerbate inequitable outcomes across families who have access to these services via higher income, family, or community support networks, or residence in municipalities where services are made available compared to those who do not have such networks of support.

participation in public service. Czech labor laws and social services are also aligned to enable parents to reconcile their professional and family roles. Female employees are entitled to a minimum of 28 weeks of maternity leave. Parental leave may be requested by male or female employees at any time up to the time his or her child reaches age three. Modifications to working hours and the option to work from home are available to both male and female parents, as well as childcare allowances during periods of work travel. State-provided childcare services are also universally available for children up to three years of age in the form of day care and babysitting; preschool education including kindergarten; and after-school care services for young school-age children.

While not necessarily multisectoral in nature, Australia's and Singapore's housing policies are examples of approaches that consider the overarching needs of individuals and families as fluid or changing over time. Nationally in Australia, their housing policies envision a housing spectrum, with efforts needed to produce affordability at every stage and upward mobility for those at the bottom. Singapore's approach to housing also facilitates the ability of people to transition into different living arrangements at different points, including intergenerational living arrangements and downsizing and aging in place (see Exhibit 19), which is of relevance to the United States' aging population. South Africa has introduced financing mechanisms aimed to meet the needs of different types of communities and families, such as unique financing mechanisms to meet the needs of those at "gap" level (too much income for social housing, not enough for commercial products). Singapore, Indonesia, and Brazil have combined government-subsidized homebuilding initiatives with homebuyership programs. While the United States generally does not have large tracts of informal dwellings, we do see areas affected by significant problems such as lead poisoning and water supply issues, as well as threats from climate change that can result in mass displacements that disrupt communities and sever social bonds.

EXHIBIT 19

Singapore: Affordable, Mixed-Ethnicity Housing Approach

Singapore's Housing & Development Board (HDB), established in 1960 during a national housing crisis, plans and develops Singapore's housing estates and provides commercial, recreational, and social amenities for towns. Its predecessor, the Singapore Improvement Trust, had built 20,907 units of public housing from 1947 to 1959. However, these were not enough to house the population of about 1.6 million at that time, the majority of which lived in overcrowded slums and squatter settlements. The new HDB was tasked with providing sanitary living conditions to replace the prevalent unhygienic slums and crowded squatter settlements. Today, more than 1 million flats have been completed in 23 towns and three estates across the island nation. More than 80% of Singapore's population live in HDB flats, with about 90% of these residents owning their home.

For low-income families who are unable to afford homeownership, HBD offers public rental flats. The monthly household income ceiling to rent an HDB flat is $1,500. HDB is increasing the public rental stock from the current 50,000 units to 60,000 units to help more lower-income households. The rental rates are highly subsidized starting from as low as $26 a month. HBD also helps rental flat tenants become homeowners. For first-time buyers, the Special Central Provident Fund (CPF), a mandatory savings account program, provides housing grants for the purchase of the flat. Up to $60,000 in grants may be obtained to lower the loan amount and subsequent mortgage repayments for the flat (Singapore Housing & Development Board, n.d.).

In pricing flats, the HDB has tried to keep homes within the reach of the majority of flat buyers. In 2006, the additional CPF Housing Grant Scheme was introduced to help lower-income families own their first homes. Since then other measures have been put in place to help home buyers afford HDB flats such that buyers would need to use less than a quarter of their monthly household income for the mortgage installment of their first flat (Singapore Housing & Development Board, n.d.).

Singapore actively employs an Ethnic Integration Policy, ensuring that each neighborhood and block is racially mixed by stipulating racial quotas that correspond to the national ethnic composition. The policy's aim is to prevent ethnic enclaves from forming. HDB has created priority schemes to make housing policies more inclusive. Under these schemes, a proportion of available flats is set aside for various groups such as first-timer families with or expecting children, extended families who want to live closer to each other, seniors who want to age in place, divorced or widowed parents with young children, and public rental tenants who are able to move on to homeownership (Singapore Housing & Development Board, n.d.).

Approaches to Building Spatial Equity

Nearly every country in our review exhibits patterns of spatial disparities in health, income, and education outcomes, many of which are rural-urban. As a large, highly urban city-state, Singapore faces unique place-based and spatial inequality challenges. Affordable housing and community development schemes were central to the government's strategy for national development and in fostering favorable conditions among social determinants of health. The housing help for different needs program encompassed tactics to counter ethnic-based discrimination and social cohesion while also fostering place-based community identity and attachment. Thus, going beyond mixed-income housing schemes, the government of Singapore strived to create communities where multiple generations, ethnic groups, and households of varying income levels could thrive together. This program is detailed in Exhibit 19. Some of these policies are echoed in Northern Ireland's approaches to mixed housing, designed to create mixed-income and mixed-religion neighborhoods to facilitate post-conflict healing.

Rural-urban disparities were apparent in nearly every country, a trend predicated on economic processes that have seen urban areas benefit from the systematic resource extraction from rural hinterlands (Foster, 1999); this is often part of a global economy where these benefits then accumulate in urban centers and are exported to foreign investors (Dicken, 2007). In Brazil, South Africa, and Australia, spatial inequalities were reinforced by colonial policies and development that created intentional separation between settlers and indigenous populations, which have resulted in disparities between both rural and urban communities and within urban centers that persist today. Brazil, South Africa, and Australia also have vast remote interiors characterized by very low population density, abundant natural resources, and harsh living conditions; Indonesia's outlying islands share similar characteristics. Communities in these areas often fare worse across the multitude of SDOH indicators and often vary from dominant urban areas in terms of demographic characteristics and/or political and educational background, which may undermine social cohesion and contribute to real or perceived inequality in policymaking and budget decisions. Spatial inequalities are also apparent in urban areas, particularly those affected by rapid rural-urban migration. In Northern Ireland, these inequalities are apparent when looking at areas affected by conflict during the Troubles, while in the Czech Republic, Roma communities were forced from traditional caravan settlements in eastern Slovakia to industrial areas of what is today the Czech Republic. Neighborhoods settled for Roma were created on the edges of cities, often in the form of what are called "barren flats" (*holobyty*). The resettlement of the Roma to barren flats unintentionally established ethnic ghettos (Sirovatka, 2011), while simultaneously severing important social bonds and deepening the isolation of Roma who remained in Roma villages.

Our desk review revealed many programs, policies, and projects that use place-based approaches to address spatial inequalities, many of which also incorporate trauma-informed, participatory, and/or multisectoral approaches aimed at underlying social determinants of health. Initiatives in Northern Ireland and South Africa offer strong examples of programs or policies that use place-based approaches in post-conflict settings. South Africa's constitution and National Development plan explicitly call for the dismantling of apartheid geographies, thus it is not surprising that many place-based approaches are apparent. Beyond the in-situ settlement upgrading highlighted above, South Africa is working with UNESCO to nominate sites across South Africa that will be part of a Liberation Heritage Route to honor their value as part of global history of struggle to overcome colonization; over time this route is envisioned to include sites from Mozambique, Namibia, Zimbabwe, Angola, and others from across Southern and Eastern Africa. South Africa's Department of Arts and Culture (DAC) supports this movement and has actively worked with nongovernmental organizations and civil society to gather input on the selection of sites from each of the nine provinces. Over time, the heritage route is

also intended to increase the potential of attracting economic development and tourism to provinces that are currently underdeveloped. As noted above as another example of a participatory approach, the DAC also implements community conversations to promote social cohesion, which provide a space for people from diverse backgrounds to find levers for social cohesion within their communities toward bridging divisions and form a common understanding of what it means to be South African.

We also saw strategies that embraced the importance of community identity and place-based programming in Northern Ireland where leaders of the Flax Trust project sought to remake violent landscapes in Belfast into vibrant and inclusive communities. Belfast had become in the late 1960s and 70s a place where ghettoization had occurred. North Belfast, in particular, had become a place where those who could, left, and where the rest of the city chose to avoid as much as possible. The Flax Trust sought to reclaim derelict spaces such as abandoned buildings and created opportunities for training, education, support, and eventually, art to rejuvenate this community. The Flax Trust project set about to not only revitalize Belfast, but to also rebuild a community and, in doing so, heal the divisions of the past so that a more promising future could be realized.

Strategies to address rural-urban disparities were often linked to devolution of certain government functions from centralized national government to regional or local authorities. While national governments generally still maintain oversight and the ability to set quality standards, devolution was apparent in Indonesia, South Africa, and Australia to some degree; more details to Indonesia's approach to improving rural health care are highlighted in Exhibit 20. South Africa, Australia, and Brazil also have strong systems for community-oriented primary care that is intended to improve the ability of even poorer, more isolated communities to access preventive health services and to stabilize the health workforce in rural areas. In Australia, states and territories are allowed latitude in policymaking and budgeting, which have allowed states such as Victoria to implement robust equity-focused initiatives such as the Health Equity Strategy and the Localities Embracing and Accepting Diversity program.

EXHIBIT 20

Indonesia: Rural Health Care Incentive Programs

Regarding the structure of the health system in Indonesia, there are 33 provinces, and each province is divided up into districts and each district is subdivided into subdistricts. Decentralization was implemented in 1999 and certain responsibilities including health care were removed from the national to the district level. The levels of care are central, province, district, subdistrict, and village—see Global Health Workforce Alliance, 2013. (See chart below.) Each subdistrict has at least one health center headed by a doctor, usually supported by two or three subcenters, the majority of which are headed by nurses. Despite recent increases in health spending, Indonesia spends less than 3% of GDP on health. The health infrastructure is less developed, with fewer beds per 10,000 people than other countries in the region. The country as a whole suffers from a lack of doctors, nurses, and to some extent midwives, particularly in rural and remote areas. Indonesia's difficult geography also presents challenges to health service delivery, and most health workers prefer to serve in urban areas, resulting in an uneven distribution of health workers and shortages in remote areas.

Most doctors are trained in, and wish to remain in, the urban areas of Java. These areas offer good hospital facilities and lucrative opportunities for private practice. Previously, in Indonesia, doctors, dentists and midwives were required to work as civil service contract staff during a period of compulsory service ranging from six months to three years, depending on the remoteness of the location. Until the early 1990s, all medical school graduates automatically became civil servants and were obliged to serve at *puskesmas* (subdistrict health centers).

In 1992, this system was modified in order to limit civil service and control public spending. Doctors were hired under contract rather than as civil service employees. Service was and still is a prerequisite for obtaining a license to practice. Pay was tied to remoteness. In 1996, the system was further modified: doctors serving in very remote regions would be given a 90% chance of subsequent civil service appointments; those in remote regions would have a 50% chance; and those serving in ordinary areas a 10% chance.

Medical graduates, however, were dissatisfied with the program policy and mandatory service. In 2007, this period of compulsory service became voluntary, but the contract scheme has remained popular among new graduates due to increased financial incentives, and the short length of the contract period. Thus, a new policy was established offering a six-month period of service in remote areas for new graduates and an attractive salary. In addition to the base pay, the new graduates received a monthly bonus amounting to as much as two and a half times the base pay for very remote postings. This incentive package, along with the increased number of graduating doctors, has increased the interest of graduates to go to rural and remote postings. In addition, the service as a contract doctor in a remote area still contributes to a positive evaluation for recruitment into the civil service.

In 2009, the ministry of health introduced an additional Special Assignment of Strategic Health Workers Program in order to address specific shortages in strategic health workers including nurses, nutritionists, and public health workers in specific underserved locations.

Administrative Level	Facilities	Schedule of Service	Function
Village	Community based-facilities: Integrated health post (*pos pelayanan terpadu—posyandu*)	1 day per month	All facilities in villages (*posyandu, polindes, pustu, pusling*) focus on primary care (promotion and prevention). *Posyandus* are volunteer-based.
	Maternity hut (*pondok bersalin desa—polindes*)	Daily office hours	Monitoring growth charts; health education and immunization
	Subhealth centers (*puskesmas pembantu—pustu*)	Daily office hours	*Pustus* extend the services of the *puskesmas* (health centers) to remote areas. They provide services similar to those of the *puskesmas*, except for dental. There are no inpatient facilities.
	Mobile service units (*puskesmas keliling—pusling*)	1-4 times per month	*A pusling* is a mobile unit (car) that visits villages, usually on market day. It often stops in a big field (soccer pitch) where it offers routine services similar to those offered by *puskesmas*.
	Private clinics (physicians and midwives)	Daily services, usually open after working hours	Private health services where patients consult doctors or midwives for a fee

EXHIBIT 20

Indonesia: Rural Health Care Incentive Programs (*continued*)

Subdistrict (*kecamatan*)	Health centers (*puskesmas*) with or without an inpatient facility (including simple laboratory facility)	Daily office hours	There are two types of health centers: ▪ Inpatient facility – Open 24 hours – Specialist team – Simple surgery ▪ Outpatient facility – Daily clinic, open during office hours. These provide promotion and prevention for primary health care and a simple laboratory facility. Some *puskesmas* (especially with inpatient facilities) are designated for maternity services.
	Private clinics (physicians and midwives)	Daily services, usually open after working hours	Services for a fee
District	First-referral hospitals	Daily office hours for consultation with doctors	24-hour emergency unit; focus on clinical services (surgery, etc.); provide daily consultation with specialist doctors, laboratory facilities, emergency maternity services
	Private hospitals	Daily	Usually exist in a big district; some private hospitals are built only for mother and child (*rumah sakit bersalin dan anak,* women's and children's hospital)
	Private clinics (physicians and midwives)	Weekdays, after working hours	Services for a fee
Province	Second-referral hospitals	24 hours a day, seven days a week	24-hour emergency unit; focus on clinical services with more advanced medical equipment than hospitals at the district level
	Private hospitals		More specialist doctors
Central	Tertiary or top-referral hospitals Hospital as center of excellence	24 hours a day, seven days a week	24-hour emergency unit; advanced medical technology with complete team of specialists

CONCLUSIONS AND RECOMMENDATIONS

We embarked on this global health equity scan to identify countries outside the United States that are tackling equity in areas that affect health and well-being; to highlight historical, cultural, political, economic, and other contextual factors that underlie or contribute to health equity trends and interventions or policies that are meant to improve health equity; and to assess how drivers of health equity in these countries relate to the RWJF COH Action Framework. Our analysis sheds light on key approaches and themes across programs, policies, and projects addressing health equity and related social determinants of health across our sample. To conclude this report, we will look at insights relevant for the RWJF COH Action Framework, and we will close out the report with recommendations and next steps.

Insights Related to the RWJF COH Action Model

Many of the findings from our comparative analysis align with the four RWJF COH action areas. Here we present approaches from across our country profiles (case studies can be made available on request).

Action Area One—Making Health a Shared Value

This action area emphasizes health and well-being, civic engagement, and strong social connections and community. Overall, we found the themes around use of decolonization and trauma-based frameworks, participatory and community-centered approaches, and place-based approaches are most relevant to this action area. In particular, building social cohesion across diverse groups, intentional engagement of marginalized population segments, and approaches that invest in or strengthen existing community networks can be linked to the longer-term goal of making health a shared value.

Brazil's participatory budgeting process is a strong example, as it intentionally engages the most economically disadvantaged segments of the population in a community. Australia and South Africa have a multitude of programs and policies to counter xenophobia and increase social cohesion that rely on dialogue and collaboration across diverse groups, including those who may typically be subject to social exclusion, such as indigenous or ethnic/cultural minorities, immigrants, youth, or other marginalized populations. For instance, Australia uses indigenous healing circles and community conversations as part of its strategy for program implementation across multiple sectors, such as housing, education, and finance. South Africa also employs community conversations to build social cohesion and address xenophobia and employs participatory approaches to their policymaking process, including gathering public input on the design of the Truth and Reconciliation Commission, demonstrating a commitment to honoring the voices of those who were oppressed during apartheid. The Czech Republic engages the Roma community in their childhood-education curriculum development, and Northern Ireland directly engages youth in their peace-building initiatives. All of these strategies complement the primary objectives of action area one in the RWJF COH Action Framework and can inform potential approaches going forward.

EXHIBIT 21
Action Area 1: Making Health a Shared Value

Global Strategies that Support Action Area 1*	Decolonization & Trauma-Based Frameworks	Participatory and Community-Centered Approaches	Spatial Equity & Place-Based Approaches
Australia	Indigenous healing circles & community conversations	Indigenous-led initiatives	Native land title
Brazil		Participatory budgeting	Favela upgrading
Czech Republic	Policies to rebuild family cohesion	Roma-inclusive curriculum	
Indonesia			
Northern Ireland	Peace-building processes	Youth engagement	Investment and development in conflict-affected communities
Singapore			Housing policies to facilitate aging in place and integrated neighborhoods
South Africa	Community conversations around social cohesion and xenophobia	Inclusive curricula; people's-led settlement upgrades	Preserving liberation infrastructure

* Global strategies listed in Exhibit 21 are explained in detail in the country summaries.

Action Area Two—Fostering Cross-Sector Collaboration

Action area two seeks to increase partnerships across organizations, invest in sustaining collaborations among organizations, and create policies that support and foster ongoing collaborations. The theme of coordinated, multisectoral programs links closely with this action area, but place-based approaches also apply, particularly when thinking about operationalizing multisectoral strategies. For example, in Australia, the National Closing the Gap strategy lays ambitious goals for addressing health and development gaps between indigenous and non-Indigenous Australians, but the framework also outlines how community-based approaches should be used to ensure local needs are addressed, cultural knowledge and competencies are incorporated, and that those most affected have a stake in developing solutions. Child health and development emerged as an area where many countries are using multisectoral strategies to prioritize improved outcomes for children and families who have historically suffered from poorer outcomes across health, education, and other outcome areas. Brazil's and South Africa's cash transfers, for example, both prioritize family economic stability, health, and education. The Czech Republic has implemented a comprehensive Family Policy that aligns labor laws, child care and early education services, and financial support mechanisms to facilitate work-life balance for all parents, ensure adequate child care and child development services for all families, and ensure poor families have access to financial resources and housing.

EXHIBIT 22

Action Area 2: Fostering Cross-Sector Collaboration

	Coordinated, Multisectoral Approaches	Spatial Equity Approaches
Australia	Closing the Gap Refresh; First 1000 Days	First 1000 Days; Victoria Health Equity Strategy; LEAD pilot
Brazil	Bolsa Família	
Czech Republic	Child and Family Support Policies	
Indonesia		
Northern Ireland	National Equity Strategy	Flax Trust social & economic development initiatives in Belfast
Singapore		
South Africa	National Development Plan; Child Support Grant + strengthened Early Childhood Development services	Settlement upgrading

Action Area Three—Creating Healthier, More Equitable Communities

Action area three considers how factors such as the built environment, the social and economic environment, and policy and governance can be leveraged to create healthier, more equitable communities. The themes of participatory and community-centered approaches, coordinated, multisectoral approaches, and place-based approaches apply to this action area and may be strongest when multiple approaches are utilized. For example, South Africa's National Development Plan is a strong example of an overarching national framework that builds a vision of a transformed country and provides a clear, multisectoral framework for how each sector can contribute individually and collaboratively to this vision. However, to operationalize this plan, provinces and municipalities have some degree of leeway in planning and budgeting, and place-based approaches, such as settlement upgrading designed to integrate informal settlements with the larger municipal services while maintaining community cohesion, have emerged as promising practices to create equity.

Action Area Four—Strengthening Integration of Health Services and Systems

Action area four is more specific in its focus on health services and systems, including access to care, balance and integration between health care, public health, and social services, and consumer experience and health care quality. As such, we have chosen to focus on specific approaches to improving health care access and systems, rather than the overarching themes we identified. Specifically, we found that all the countries we reviewed have or are moving toward universal health care coverage, either through universal insurance or free national health care. Other approaches include addressing rural-urban disparities by increasing investment in health infrastructure, workforce initiatives, or alternative models such as tele-medicine. Community-oriented primary care models meant to increase the reach of preventive services were also a tool that large countries utilized, including use of community health workers or community health teams that are embedded in local communities. Finally, integration of health and social assistance was apparent, particularly with grants focusing on impoverished children.

EXHIBIT 23

Action Area 3: Creating Healthier, More Equitable Communities

	Participatory and Community-Centered Approaches	Coordinated, Multisectoral Approaches	Spatial Equity Approaches
Australia	Indigenous-led initiatives	Closing the Gap Refresh; First 1000 Days	First 1000 Days; Victoria Health Equity Strategy; indigenous housing policies
Brazil	Participatory budgeting	Bolsa Família	Favela upgrading; primary health care system
Czech Republic	Roma-inclusive curriculum	Child and Family Support Policies	
Indonesia			
Northern Ireland	Youth engagement; Flax Trust social & economic development initiatives in Belfast	National Equity Strategy	Flax Trust social & economic development initiatives in Belfast; mixed-housing strategy; mixed-school strategies
Singapore			Ethnic integration in housing system
South Africa	Inclusive curricula; people's-led settlement upgrades; heritage and liberation infrastructure	Child Support Grant + strengthened Early Childhood Development services	People's-led settlement upgrades; community-oriented primary care

EXHIBIT 24

Action Area 4: Strengthening Integration of Health Services and Systems

	Universal Health Coverage/ Health Insurance	Investment in Rural Healthcare Access and Quality	Community-Oriented Primary Care Model	Integration of Health and Social Services
Australia	✓	✓	✓	
Brazil	✓	✓	✓	✓
Czech Republic	✓			
Indonesia	✓ (in progress)	✓	✓	
Northern Ireland	✓	✓		
Singapore	✓			
South Africa	✓ (in progress)	✓	✓	✓

Recommended Next Steps and Further Research

Our findings shed light on the various drivers of health equity and notable approaches currently adopted to improve the social determinants of health and health equity among a select group of countries with relevance to the United States. This scan was exploratory, not exhaustive, or definitive. It captured initial findings and emergent themes that could translate to the U.S. context.

Based on our initial findings, we suggest:

- Conduct deeper dive case studies of countries with settler colonialism. Potentially expand the sample to include countries such as Canada or Mexico, where geographic and historical similarities may shed additional insights on the roles of settler colonialism, institutionalized bias and discrimination, and health equity.

Another area of research that would complement the work presented in this report is:

- A United States-based scan of health equity programs that may map to the analytic themes we identified: decolonization and trauma-based frameworks; participatory and community-centered approaches; coordinated, multisectoral approaches to early childhood development and other social determinants of health; and approaches to building spatial equity. This scan could also map important contextual factors that may impact the relative success of programs and projects across the myriad of U.S. geographies and subnational regions. For instance, programs in Australia designed to improve health equity in remote hinterlands may well inform strategies aiming to improve health in remote areas of the Alaskan wilderness or remote rural areas in the continental United States. Likewise, Singapore, while a city-state, may have some vast differences in terms of geography and governance for the United States as a whole, but the Singapore country profile can also provide important lessons for urban planning in large metropolitan areas.

Our assessment of programs and policies is derived from qualitative analysis of programmatic descriptions and country contexts and is meant to spark conversation, inspire new ideas, and provide new perspectives on how other countries tackle challenges. These types of analysis are ideal for exploratory work or work that aims to build theories of change based on inductive analysis. However, assessing program impact and success for scaling up should entail more rigorous impact evaluation learnings. Therefore, we also recommend:

- Supporting evaluation of programs to learn impacts so that theories of change[4] can be tested and modified to create standard best practices useful for the United States

Lastly, insights gleaned from the current global health equity scan should be shared and expanded. Concerted efforts should be made to disseminate findings among key stakeholders. Additionally, although the analysis of subject matter expert interviews was not a significant portion of our analysis, these interviews provided tremendous insights into promising countries and projects to include in our analysis. Lessons learned from the current global health equity scan, and the potential to translate findings to U.S. programs and services, would benefit from a collaborative discussion among leading experts. One potential next step would be to:

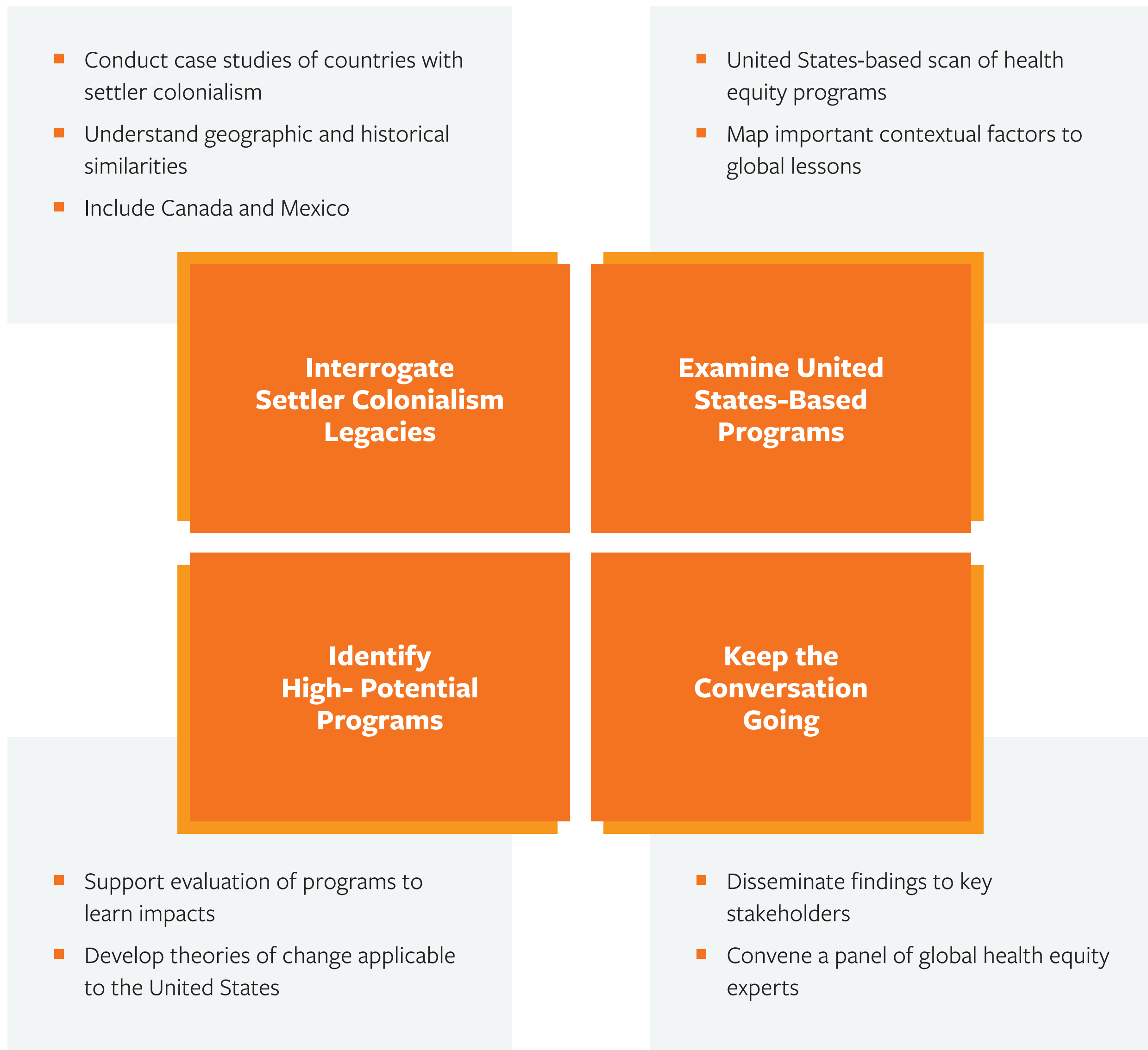
- Convene a panel of global health equity experts to foster collaboration and information sharing. This event could shed light on global health equity programs broadly and would foster important collaboration across experts and their organizations. It would also serve as an important mechanism for sustaining interest and action in bringing innovative approaches and lessons learned from around the globe to bear on efforts to improve health equity in the United States.

Exhibit 25 depicts our four recommendations.

4 By theories of change, we mean the interrelated set of hypotheses regarding social and behavioral change that inform program design and implementation. By evaluating these theories of change, implementers can learn if their programs are effective and if the theories of change are valid.

EXHIBIT 25

Four Recommendations for Building on Global Lessons Learned in Health Equity for the United States



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