



# REGIONAL BRIEFING ON THE SOCIAL DETERMINANTS OF HEALTH IN THE AMERICAS



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Sustainable Development and Environmental Health Area (SDE)

PAN AMERICAN HEALTH ORGANIZATION

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## ACRONYMS

<b>BFP</b>	Bolsa Familia Program
<b>CCT</b>	Conditional Cash Transfer
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CSO</b>	Civil Society Organizations
<b>GNP</b>	Gross National Product
<b>HHS</b>	US Department of Health and Human Services
<b>HiAP</b>	Health in All Policies
<b>MDGs</b>	Millenium Development Goals
<b>MoH</b>	Ministry of Health
<b>NCD</b>	Non-communicable Disease
<b>NPA</b>	National Partnership for Action to End Health Disparities
<b>OAS</b>	Organization of American States
<b>PAHO</b>	Pan American Health Organization
<b>PHM</b>	People's Health Movement
<b>SDH</b>	Social Determinants of Health
<b>UN</b>	United Nations
<b>USAID</b>	United States of America Agency for International Development
<b>WCSDH</b>	World Conference on the Social Determinants of Health
<b>WHAT</b>	World Health Assembly
<b>WHO</b>	World Health Organization

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## SECTION 1. INTRODUCTION

In 2005, the Director General of World Health Organization (WHO) established the Commission on the Social Determinants of Health (SDH)<sup>1</sup> to support countries and global health partners to address the factors leading to ill health and inequities. By clearly identifying the role of health determinants in the health outcomes of the population, this Commission developed a set of knowledge networks that worked together to assess the state of the world's economy, environment, gender rights, human rights, priority health conditions and urban health.

The work of the WHO Commission on Social Determinants of Health and its related knowledge networks helped to more fully define the underlying causes of health disparities, which were outlined in the Commission's landmark final report "Closing the Gap in a Generation"<sup>2</sup>, launched in 2008, as: (a) differential power and influence associated with income inequality, and social and economic status, (b) differential exposures to stress, environmental toxins, and other adverse conditions, and (c) differential consequences associated with discrimination and unequal access to services. Widespread awareness of these factors has helped to build consensus on the need to take action and where to intervene on broader conditions that affect these and related unequal outcomes.

The final report of the WHO Commission on the Social Determinants of Health also emphasized the importance of building a global movement to act on social determinants to reduce health gaps between and within countries. Building on the Report's recommendations, in 2009, the World Health Assembly Resolution 62.14<sup>3</sup>, called upon Member States, the WHO Secretariat and the international community to address health inequities by implementing the social determinants approach to public health programs and requested the WHO Secretariat to provide support to Member States in implementing the "Health in All Policies" (HiAP) approach.

To support countries in their response to this resolution, WHO convened the First World Health Conference on the Social Determinants of Health (WCSDH) that took place in Rio de Janeiro, Brazil, on October 19 to 21, 2011<sup>4</sup>. This event brought together Member States and key stakeholders to share experiences on policies and strategies aimed at reducing health inequities. It provided a global platform for dialogue on how the recommendations of the WHO Commission on Social Determinants of Health could be taken forward. The Conference focused on the following five strategic areas for action identified as key for the successful implementation of policies that address the social determinants and referred to as "building blocks" throughout the document:

1. Governance to tackle the root causes of health inequities: implementing action on social determinants of health;
2. The role of the health sector, including public health programs, in reducing health inequities;

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<sup>1</sup> For more information consult: [http://www.who.int/social\\_determinants/thecommission/en/](http://www.who.int/social_determinants/thecommission/en/)

<sup>2</sup> Link to full report: [http://www.who.int/social\\_determinants/thecommission/finalreport/en/index.html](http://www.who.int/social_determinants/thecommission/finalreport/en/index.html)

<sup>3</sup> Link to full text of the Resolution: [http://apps.who.int/gb/ebwha/pdf\\_files/WHA62-REC1/WHA62\\_REC1-en-P2.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA62-REC1/WHA62_REC1-en-P2.pdf)

<sup>4</sup> Link to Conference website: <http://www.who.int/sdhconference/en/index.html>

3. Promoting participation: community leadership for action on social determinants;
4. Global action on social determinants: aligning priorities and stakeholders; and
5. Monitoring progress: measurement and analysis to inform policies on social.

In preparation for the Global Conference on the Social Determinants of Health, WHO, in collaboration with organizations and institutions worldwide, prepared a technical paper<sup>5</sup> that discusses lessons learned on the five building blocks described above. The Rio Political Declaration on Social Determinants of Health, adopted during the World Conference on Social Determinants of Health, expresses global political commitment for the implementation of the social determinants of health approach to reduce health inequities and to achieve other global priorities. The Rio Declaration is expected to help build momentum within countries for the development of dedicated national action plans and strategies (see Annex A for a full copy of the Rio Declaration).

In preparation for the World Conference on the Social Determinants of Health, the Pan American Health Organization/World Health Organization (PAHO/WHO) carried out a number of regional consultations to highlight and build upon the social determinants of health expertise in the Region. The Regional Consultation consisted of three parts:

1. A face-to-face consultation held on August 8 and 9, 2011, in San José, Costa Rica with high-level political actors from the health and other sectors of the Region of the Americas. It aimed to formulate regional recommendations on the social determinants of health in line with the five themes identified by WHO and outlined in the technical paper developed the Conference;
2. A virtual consultation with Civil Society Organizations (CSOs) in the Americas that was organized in collaboration with the Organization of American States (OAS); this also included a face-to-face meeting of 15 organizations to synthesize the results of this very survey and make recommendations to inform the Rio Declaration;
3. An on-line consultation with a questionnaire sent to experts from the PAHO/WHO Equity ListServ to define what key priorities should be included in the survey.

The objective of this briefing is to provide a brief overview of these recent and relevant events related to the social determinants of health in the Region of the Americas. It includes a summary of the key points and recommendations that emerged from the Regional Consultation in San Jose, Costa Rica, and the WHO World Conference on the Social Determinants of Health. It also includes summaries of seven case studies of countries experiences in implementing the SDH approach in the Region (see Section 4), which were developed in preparation for the WCSDH.

It is expected that this briefing will support PAHO staff in their preparation for the following upcoming events:

- The United Nations Conference on Sustainable Development (UNCSD), also known as Rio+20, that is being organized in pursuance of General Assembly Resolution

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<sup>5</sup> [http://www.who.int/sdhconference/consultation/draft\\_WCSDH\\_Technical\\_Paper.pdf](http://www.who.int/sdhconference/consultation/draft_WCSDH_Technical_Paper.pdf)

64/236<sup>6</sup>. The Conference will take place in Brazil on 4-6 June 2012 to mark the 20th anniversary of the 1992 United Nations Conference on Environment and Development (UNCED), in Rio de Janeiro, and the 10th anniversary of the 2002 World Summit on Sustainable Development (WSSD) in Johannesburg. Envisaged as a conference at the highest political level, it will include Heads of State and Government or other representatives. The Conference aims to secure renewed political commitment for sustainable development, assess the progress to date and the remaining gaps in the implementation of the outcomes of the major summits on sustainable development, and address new and emerging challenges

- The 8th WHO Global Conference on Health Promotion that will take place in Finland in 2013, which will focus on identifying strategies to translate health promotion into concrete action through multi-sectoral action. It will provide an opportunity to analyze current and needed capacity to respond to the demands posed by previous trends and to highlight the evolution of the field and new developments.

While PAHO staff comprise the primary audience for this document, it may also be useful to inform other partners and stakeholders of recent Regional developments and of PAHO's position on the SDH in the Region.



<sup>6</sup> Link to full resolution: <http://www.uncsd2012.org/files/OD/ARES64236E.pdf>

## SECTION 2. REGIONAL CONSULTATION ON THE SOCIAL DETERMINANTS OF HEALTH

In preparation for the World Conference on the Social Determinants of Health, PAHO/WHO carried out a Regional Consultation to build upon the social determinants of health expertise in the Region and to establish a regional position on the topic. As part of this Regional Consultation, a meeting conducted in San Jose, Costa Rica, on August, 2011, brought together high-level political authorities from the health and other sectors of the Region of the Americas to formulate regional recommendations on the social determinants of health in line with the five strategic areas of action identified by WHO for the WCSDH (see Section 1).

The Regional Consultation included presentations, thematic panel discussions and working group sessions. During this two-day event, fifty-eight participants representing 27 countries from the Region of the Americas reviewed the Technical Paper prepared by WHO for the WCSDH with the objective of generating inputs for its revision and developing Region-specific recommendations.

While participants included government officials who represented the MoH in the Region, an effort was made by PAHO/WHO and country offices to incorporate high-level professionals from other Ministries into each country's delegation. Additionally, representatives of some United Nations agencies, and high-level experts on the social determinants were invited.

### Preparation of Regional Case Studies

In preparation for the WCSDH, a series of case studies were commissioned by WHO Regional Offices. The case studies describe successful examples of policy action implemented at various countries that aimed at reducing health inequities; they cover a wide range of issues, such as conditional cash transfers, gender-based violence, tuberculosis programs and maternal and child health.

The case studies were written by individual experts and were circulated as draft background papers to inform discussions at the WCSDH. Together, they formed the evidence used in the Conference to illustrate the systematic and practical aspects (the "how") of implementing the SDH approach at the country level. A total of seven case studies were prepared in the Region of the Americas (see Section 4) and these were published on the WHO's conference web-site ([http://www.who.int/sdhconference/resources/case\\_studies/en/index.html](http://www.who.int/sdhconference/resources/case_studies/en/index.html))

## SECTION 3. REGIONAL RECOMMENDATIONS

Taking into account the five strategic areas for action defined for the WCSDH, participants at the Regional Consultation in Costa Rica drafted the following recommendations for the Region of the Americas:

### **Building Block 1: Governance to tackle the root causes of health inequities: implementing action on social determinants of health in the Americas**

- Position health as beneficial to other Ministries in achieving the policy objectives; as such, the health sector should articulate the value that health adds to the work of other government departments. To accomplish this, communication related to public health should be improved.
- Enhance transparency by making the budget accessible through an official Web site.
- Communicate the term Health in All Policies in an effective manner to ensure that countries have the capacity to apply it.
- Improve coordination and communication among different Ministries. Sectors such as education, housing, finance and health should develop and coordinate national and strategic plans to ensure coherence and alignment.
- Enhance donor coordination in line with the Paris Declaration<sup>7</sup>.
- Strengthen capacity-building in public administration as lack of capacity can be a key barrier to developing good governance and ensuring accountability. Focus should be placed on building sustainable technical and administrative capacity.
- Guarantee that aid be driven by countries' needs as opposed to donor's needs (as outlined in the Paris Declaration), which in practice is emphasized through the development of national strategic plans.
- Map social services that are already in place to enhance efficiency and avoid duplication of efforts.
- Establish a social cabinet consisting of representatives from Ministers related to social services, to ensure coherence and consistency in terms of communication; one example is that of CARICOM, where a Caribbean Corporation in Health (CCH) has been established.

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<sup>7</sup> Beyond its principles on effective aid, the Paris Declaration (2005) lays out a practical, action-oriented roadmap to improve the quality of aid and its impact on development. It puts in place a series of specific implementation measures and establishes a monitoring system to assess progress and ensure that donors and recipients hold each other accountable for their commitments. The Paris Declaration outlines the following five fundamental principles for making aid more effective:

1. Ownership: Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.
2. Alignment: Donor countries align behind these objectives and use local systems.
3. Harmonization: Donor countries coordinate, simplify procedures and share information to avoid duplication.
4. Results: Developing countries and donors shift focus to development results and results get measured.
5. Mutual accountability: Donors and partners are accountable for development results.

Source: [http://www.oecd.org/document/18/0%2C2340%2Cen\\_2649\\_3236398\\_35401554\\_1\\_1\\_1\\_1%2C00.htm](http://www.oecd.org/document/18/0%2C2340%2Cen_2649_3236398_35401554_1_1_1_1%2C00.htm)

- Strengthen cash-transfer programs. These have worked very well within smaller as well as larger countries. Similar social programs that are already in place should be carefully studied and analyzed. The results should be communicated to authorities to support strengthening of such programs.
- Promote the use of the language of the SDH among collaborating agencies (USAID, CDC, World Bank and Inter-American Development Bank, etc.).
- Address human resource capacity as a social determinant.
- Recognize public policies that confront strong economic interests of transnational companies (such as the tobacco policies) as regional or global policies in order to ensure that the countries can implement them adequately.
- Promote international understanding and, if possible, the adoption of the concept of social determinants of health by other sectors in order to facilitate the intersectoral dialogue among countries.
- Establish regional policies to back government action on the social determinants of health.

### **Building Block 2: The role of the health sector, including public health programs, in reducing health inequities**

- Focus on accountability and transparency, making information available to the public.
- Encourage federal governments to serve as a convener by bringing officials from different countries together in order to address the well-being of communities in a comprehensive manner.
- Develop national work plans around a common framework where groups with different competencies can intervene.
- Promote evidence-based policy and decision-making.
- Take into account the different social determinants that are relevant to different groups.
- Conduct needs assessment so needs can be prioritized.
- Share health data with other stakeholders.
- Provide data in a timely manner, which will strengthen the role of the health sector.
- Strengthen administrative and budgetary capacities.
- Promote health programs as part of a broader effort to tackle social inequities.

### **Building Block 3: Promoting Participation: Community leadership for action on social determinants of health**

- Develop and establish formal mechanisms that provide for a sustainable relationship with civil society.
- Promote shared responsibility with communities to keep the environment clean, which will have a short-term and long-term impact on health.
- Work hand-in-hand with most marginalized and vulnerable groups to understand and address their needs.
- Promote education to ensure long-term impact on communities' well-being.
- Identify ways to integrate mechanisms of participation of different stakeholders and sectors to ensure alignment.
- Establish a reference group with representatives from different sectors to specifically address the determinants of health in an effective manner
- Make CSOs accountable through the provision of data and information.
- Include CSOs in a more comprehensive and systematic manner on issues related to the social determinants of health.
- Ensure that the participation of other sectors besides the health sector is mentioned in the discussions of social determinants of health.
- Promote community ownership of the concept of primary health care in a way that is culturally relevant.
- Promote appropriate opportunities for discussion with civil society and to establish satisfactory joint solutions.
- Provide training for the health sector on how to strengthen social participation.
- Guarantee the right of citizen participation, including in the monitoring government actions.

### **Building Block 4: Global action on social determinants of health: Aligning priorities and stakeholders**

- As part of the United Nations (UN), the World Health Organization should advocate and promote synergy to influence donors. The World Health Assembly is one place where coherence between different global agendas should be addressed using the framework of the Paris Declaration.
- Think holistically, but act strategically.

## Building Block 5: Monitoring progress: Measurement and analysis to inform policies on social determinants

- Establish or strengthen health surveillance systems to be more comprehensive and to go beyond the epidemiological surveillance systems of diseases and risk factors.
- Promote effective data collection at local level.
- Integrate data so that different services can take advantage of it.
- Use data to inform decision-making.
- Interpret the data across the system through national data repositories.
- Ensure that indicators are SMART (Specific, Measurable, Attainable, Relevant, Time-bound).
- Build capacity in entering of data into systems as well as data interpretation to ensure sustainability and coherence.
- Use health information (burden of disease, mortality for cause and groups, and morbidity) as a resource to establish national development plans and baselines, guide national health plans, audit their performance, and establish criteria for distribution of resources.
- Develop initiatives to educate and inform the general public about what government is doing to ensure transparency and accountability.
- Collect and analyze information on determinants at two levels: to guide decision-making and to monitor if the action that was taken is creating the desired effects.
- Strengthen the leadership of the health sector in order to guide the process of collection, analysis, and use of information.
- Share what countries and others sectors are doing with regards to data in order to produce examples and models that will enhance those already in place.



## SECTION 4. SUMMARY OF CASE STUDIES FROM THE REGION OF THE AMERICAS<sup>8,9</sup>

### Case Study 1. The Brazilian experience with conditional cash transfers: a successful way to reduce inequity and to improve health

*Leonor Maria Pacheco Santos<sup>10</sup>, Romulo Paes-Sousa<sup>11</sup>, Edina Miazagi<sup>12</sup>, Tiago Falcão Silva<sup>13</sup>, Ana Maria Medeiros da Fonseca<sup>14</sup>*

Concerns about poverty and inequity have been present in the Brazilian society for some decades. However, up until the year 2000, no clear reduction trend in income concentration was registered. The use of Conditional Cash Transfers (CCT) as an instrument of social policy reflects the widespread belief in Brazil that people are poor due to the “fault of an unjust society”. The 1988 Constitution established a legal foundation of social assistance as guaranteed rights for the needy – and also an obligation of the state to provide health and education services, among others, the access to which is established as a basic right of all citizens.

In January 2003, President Lula promised to eradicate hunger and fight poverty in his inaugural speech and in fact, conferred high priority to the Zero Hunger strategy. This strategy included several interventions and programs, including the Bolsa Familia Program (BFP). The BFP seeks to invest in human capital, by associating cash transfers with educational goals and uptake of health services. It evolved from a long tradition of CCT in Brazil (1995-2003), which was the first country to pioneer the CCT instrument in Latin America. From 2001 to 2003 Brazil created four cash transfer programs. There were some problems with these initial programs: they were not articulated; they employed different enrollment criteria; and they used databases that could not interface, with two of them presenting very low coverage. In early 2004 these four programs were merged into the Bolsa Familia Program and largely expanded.

The BFP is the world’s largest conditional cash transfer program. It reaches all 5,564 municipalities in the 27 states of Brazil and about 12.9 million families, or roughly 52 million people (25% of the Brazilian population). The government investment in the program has increased since 2003. Initially the BFP faced harsh criticism by some sectors of the press. However, as the seriousness of the program and its impact on the society became evident over the years, opinion polls showed wider popular support for the BFP.

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<sup>8</sup> The complete case studies can be downloaded from the following link: [http://www.who.int/sdhconference/resources/case\\_studies/en/index.html](http://www.who.int/sdhconference/resources/case_studies/en/index.html)

<sup>9</sup> This briefing includes the summaries of case studies that have already been reviewed and published by WHO. There are additional case studies that are still being reviewed and finalized.

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The BFP operations are very well regulated. There is one Law, nine Presidential Decrees, one Ordinance and about 50 Operating Instructions. This legislation guarantees direct cash transfer to families in poverty or extreme poverty contexts, which include pregnant women, nursing mothers, children between zero and twelve, and adolescents from twelve to fifteen years old. In 2008, the adolescent age group was extended to 17-year-olds. The transferred values depend on the degree of poverty and the socio-demographic composition of the family. Recently, in 2011, the number of children under 15 years of age who can receive the benefit was increased from three to five per family.

Some studies have examined the effects of the BFP on poverty, inequity, food expenditure, education, health service use, food security and nutrition outcomes. The Gini index, an indicator of income distribution that had remained stable in Brazil for many decades, started to drop consistently as of 2001; almost one quarter of the drop is attributable to the BFP. Propensity score analysis used in the baseline study for the BFP showed larger family expenditures among enrolled families than in the comparison group, especially on food (US\$ 172 more a year on food items). In another econometric study conducted in a rural area, enrolled families were found to spend US\$ 107 more on food per year than the comparison group.

A study based on a national representative sample of households enrolled in the BFP showed an increase of 79% in the amount of food purchased by those families that were suffering severe food insecurity at baseline, compared with a 60% increase among families who reported food security. Additional evidence was supported by data on food security from the 2004 National Household Sample Survey. That data showed that the average US\$ 30 transferred then by the BFP was associated with a 52% increase in food security among families. Another national study indicated that families in the BFP aspire to consume healthier foods, such as vegetables and fruits.

In one study, propensity scores showed lower rates of school evasion and less engagement in the labor market among children from families enrolled in the BFP; however, these children went through school more slowly. Because these services are less accessible than basic education, an effect on their use occurs at a later time. No significant differences were found between families in the BFP and other families in terms of vaccination coverage. This was predictable, because immunization coverage has been extremely high in Brazil for several decades.

A recent publication employed anthropometric data of a sample of 22,375 impoverished children 5 years of age and younger, to estimate nutritional outcomes among recipients of the BFP. Children from families exposed to the BFP were 26% more likely to have normal height-for-age scores than those from non-exposed families; this difference also applied to weight-for-age scores.

No statistically significant deficit in weight or height was found. Stratification by age group revealed 19% and 41% higher odds of having normal height for age at 12–35 and 36–59 months of age, respectively, in children receiving BFP benefits, and no difference at 0–11 months of age. The authors concluded that BFP can lead to better nutritional outcomes in children 12 to 59 months of age.

In Brazil, the BFP seeks to use financial incentives to change certain attitudes and behavior among impoverished families. It aims, specifically, to: (i) keep families from entering children under 14 years old in the labor market (forbidden by law); (ii) motivate families to ensure their children complete a secondary education; (iii) motivate these families to use health services, especially the pregnant women and children under 7 years of age.

In the long-term, the aim is to break the intergenerational poverty cycle. The effects of the BFP on economic inclusion are not seen immediately due to the complex variables influencing economic inclusion and the challenges in implementing specific policies. Responding to the need to decrease the economic disparities, a wide-reaching program known as “Next Step” (Próximo Passo) was launched in 2008–2009. The program, which involves three ministries and the private sector, aims to provide technical training for adults from families in the BFP and to guarantee them jobs in government construction projects. At the time of this publication, 65 thousand adults from BFP families have already concluded their training and 20 thousand are now attending training sections. A total of 229 municipalities are already running the program.



## Case Study 2. The Green Area of Morro da Policia: health practitioners working with communities to tackle the social determinants of health in Brazil

*Camila Giugliani, Denise Antunes do Nascimento, David Legge, Kátia Cesa, Neusa Vitória Marques, Vera Lúcia Machado de Oliveira*

This experience took place in the Morro da Policia community, which is located in the city of Porto Alegre, Brazil; it comprises an informal settlement established in a piece of land that has been designated as a conservation area because it contains natural springs. The community inhabitants' living conditions has negatively impacted their health. Their experience is common to other communities that are undergoing rapid urbanization without the adequate infrastructure; yet, in the context of Brazil, with its stark racial inequalities, the community faces further marginalization as its residents are mostly Afro-descendants. The challenges faced by the community included rat and mosquito infestation, high communicable disease rates and exclusion from the Brazilian universal health care system. These were compounded by rampant violence and drug trafficking, which also reflected the context of poverty, racism and exclusion to which this population was exposed.

For years, community members had sought official recognition of their community and support in terms of infrastructure and services without much progress. The precarious and unsafe situation in which the community lived placed the residents at high vulnerability for diseases and natural disasters. It also resulted in the contamination of the several water sources located in the settlement.

The municipal Health Surveillance Department developed the initiative "The divinity of water," as an approach to engaging the community around environmental health and around principles of respect to nature, valuing of natural resources and water as a sacred element. It was launched in 2008 with a community seminar open to community members and which emphasized the links between the environmental and spiritual dimensions.

Over the following three years a series of initiatives were implemented, driven largely by the local Women's Association and supported by practitioners from the Health Surveillance Department and a growing number of other official and organizations. Initiatives included cleaning up the common space and instituting regular waste collection; improved community settings with the planting of flower beds to replace strewn waste; negotiations with the water supply and sanitation departments for the provision of appropriate infrastructure; and registration of families with the local health center so that they could access health care services.

There was an immediate physical impact of these initiatives, as it resulted in a cleaner and more organized community environment. There is strong anecdotal evidence of improved health status, particularly related to child and infant health. Moreover, some profound changes have been observed in the self-esteem and confidence of community members, reflected, for example, in a low key negotiation that took place between leaders of the Women's Association and the local drug traffickers, who had been opposing the initiative due to the increased presence of public authorities in the area. While the drug dealers are not active participants in the initiative, they are no longer challenging the process.

The achievements of the Morro da Policia community have also resulted in a prosperous partnership between environmental health practitioners and the leaders of the Women's Association.

The project was sustained at two levels: by the creativity and partnership of individuals and the growing understanding and trust between the community and the public institutions which were reaching out to provide support. This project had important implications for the health sector as it improved technical staff's skills and attitudes; management capacity and leadership; and policy development and commitment to the community.

Some important elements should be highlighted in this successful experience. They include the positive and sustainable relationships that were established from the initiative's onset, some specific community characteristics and circumstances that facilitated action, and the policy environment of the city of Porto Alegre, which allowed for this type of intervention to take place. It can be "scaled up" if practitioners are provided with the necessary skills, attitude and tools to engage with communities in a respectful way and if the values and principles reflected in this experience are adopted at the practice, management and policy levels.

This story was documented and analyzed as a project of the People's Health Movement (PHM) in Brazil; the idea came out of a short course entitled "The struggle for health," which was presented by the International People's Health University, in Porto Alegre in September 2008. This link points to the role of civil society in confronting the structures of exclusion and marginalization at the global and national levels as well as in local communities.



### Case Study 3. The Canadian Reference Group on the Social Determinants of Health

*Strategic Initiatives and Innovations Directorate, Public Health Agency of Canada*

The Canadian Reference Group on Social Determinants of Health is Canada's only national, intersectoral mechanism for collective action to reduce health inequalities in Canada. The Public Health Agency of Canada established the group in 2005 in response to heightened momentum and increasing understanding worldwide of the importance of the social determinants of health. The World Health Organization's Commission on Social Determinants of Health was a critical component of this momentum and provided a foundational knowledge base for action.

The Canadian Reference Group is an autonomous group of experts and stakeholders and is co-led by government and non-government organizations. Since its creation, the group has established strong cohesive, intersectoral partnerships which have served as a critical foundation for achieving policy synergies and collaborative action on health inequalities in Canada. These partnerships engage such sectors as business, labor, social and community development, education, urban planning and the environment.

Canadians are one of the healthiest populations in the world and enjoy a broad range of social benefits and services, including the provision of universal access to health services. This national mechanism was needed, however, to further address the continuing inequalities in health in Canada. This multisectoral group serves as a catalyst for action and as a forum to review evidence, explore opportunities for action and augment attention and resources devoted to health inequalities across member organizations and other stakeholders. The group has achieved several areas of early success including: the establishment of strong partnerships and synergies across sectors; building and sharing knowledge, with a focus on the economic argument for action on social determinants of health and best practices for intersectoral collaboration; and mobilizing action in Canada to reduce health inequalities.

Within their current mandate, the group has identified poverty and Aboriginal Peoples as priority areas of focus. The Canadian Reference Group remains a unique, innovative and progressive response to the challenges associated with action on the social determinants of health in order to meaningfully address health inequalities in Canada. The group proudly serves as a catalyst for action and provides a model for countries striving to establish an intersectoral mechanism to meaningfully improve population health and reduce health inequalities.



## Case Study 4. Steps towards achieving the health equity agenda in Chile's Ministry of Health and Regional Health Authorities

*Jeanette Vega*<sup>15</sup>

The Commission on Social Determinants of Health, convened by WHO in 2005, provided advice to Member States on how to reduce health inequities. In its 2008 Final Report, the Commission proposed three overarching recommendations to close the equity gap worldwide: (1) to improve daily living conditions; (2) to tackle the inequitable distribution of power, money, and resources; and (2) to measure and understand the problem and assess the impact of action. The Commission also defined action areas and developed specific recommendations aimed at all sectors and stakeholders.

Following consideration by Member States, Resolution WHA 62.14 on “Reducing health inequities through action on the social determinants of health,” was adopted in 2009. It called on Member States, the WHO Secretariat and the international community to implement the Commission’s recommendations, particularly highlighting the need to improve measurement of health inequities, implement the social determinants approach in public health programs, adopt a health-in-all-policies approach to government, and align work on social determinants with the renewal of primary health care.

In response to the Commissions’ recommendations, and as part of the broader mandate to improve social equity, in 2008, the Chilean Ministry of Health created the Executive Secretariat on the Social Determinants of Health. This Secretariat worked until March 2010 in the promotion of the initiative “13 Steps toward equity” initiative, which aimed at improving the level and distribution of health among the Chilean population. The following six objectives were defined; each of them involved concrete actions related to policy development, program planning and specific and target interventions:

- To contribute to the reduction of social inequalities that generate health inequities;
- To reduce inequities which restrict and limit access to health and health services;
- To implement actions for the “social inclusion” of excluded groups and territories;
- To develop competencies on equity and social determinants of health among the Ministry of Health staff;
- To generate tools for planning, monitoring and evaluation of the SDH and equity in the health sector; and
- To establish bodies and mechanisms for the coordination and integration of various sectors in order to develop the necessary actions to reduce health inequities.

Several aspects of the experience should be emphasized as levers to keep continuous engagement and sustainability:

- the participative methodology of work used by all the activities promoted staff empowerment and engagement with the program;

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- the investment made in competency building of the public health staff yielded benefits as trained professionals turned into trainers to other professionals throughout the country;
- with regard to intersectorality the “13 Steps” initiative demonstrated that earmarking budget is a good strategy to promote sustainability of work with other sectors, mainly because money requested goes with the understanding that these initiatives are a priority for the health sector;
- the experience with the “13 Steps” initiative reaffirms the importance of generating a broad base of consensus on the problems and the solutions, before embarking on new initiatives. Its design was the result of the convergence on objectives and key pillars of action, within the Ministry of Health, despite ideological perspectives that could have resulted in greater discord; it was enriched by public discussion that involved thousands of participants. It is also an example of a different style of leadership exercised by mid-level managers that remain in the institutions through political changes.

Yet, it is also important to notice that despite significant advances that resulted from implementation phase the “13 Steps” initiative, tension occurred when the need to respond meant modifying technical criteria, changing administrative procedures or adapting services or goods to the population demands.

The “13 Steps” initiative is one of few experiences in Chile in which the Ministry of Health has been able to play a true leading role. The process of developing and implementing the “13 Steps” agenda influenced the philosophy of people within the Ministry of Health but also from other sectors. Some of the lessons learned during the process include:

1. In order to strengthen health equity, there must exist explicit political commitment at the highest level;
2. It is important to have an explicit agenda with clear incentives defined for action;
3. Building trust is a must;
4. Intersectoral relationships are crucial and any initiative should include a clear strategy to mobilize intersectoral relationships in order to take action on improving equity in health;
5. Engaging the community is essential; initiatives must include clear opportunities and mechanisms to engage the community in decision-making and action; and,
6. Training is an effective strategy for institutionalization of change in the processes of developing and implementing policies to address the social determinants of health.

Most of the initiatives that were part of the “13 Steps” agenda remain in place more than one year after the change of government. Maintaining the work on the social determinants and health is an ongoing effort. The main challenge for the future is sustainability. One priority task involves constant advocacy of the agenda and its opportunities to the new authorities in order to obtain their explicit commitment to continue the work over the next 4 years. While important, this is not necessarily crucial for sustainability because of the institutionalization of the approach within mid-level stable technical staff that have control

over their budget and because of the ongoing active participation of the community in the process and the institutionalized through formal channels (like Boards and others).

The willingness to participate from people coming from different institutional cultures and backgrounds do not necessarily depend on institutional support. Building institutional commitment shaped by shared objectives, goals and results and supported by concrete mechanisms to safeguard them are key elements not only for success but also for sustainability. Ministers can be changed, support can vanish, programs shelved but if shared objectives remain, new policy windows of opportunities continue to open.

The systematic documentation of the experience and sharing it with other countries and with the scientific community is also an important mechanism for sustainability and visibility. Such efforts introduce evidence as a driver for change and provide the opportunity for broader consensus at regional and global level. In this regard, leadership of global agencies is key.

Working together changed the way people related to one another within the professional teams involved in the process. Rights-based approaches and democratic values demand a culture of respect and of institutional social capital. In this experiences where action was proactive but not an order, actors were invited and not forced, and duties and obligations were negotiated; this sustained commitment and development of institutional social capital are enduring objectives achieved that will be put to test on the years to come.



## Case Study 5. Public policies and a health model based on social determinants: the case of Costa Rica

*Ana Morice and Arodes Robles*

In the 1950s, at the same time that it abolished its army, Costa Rica adopted a development model that gave priority to public investment in the social sector. To that end, the State promoted access to health, education, housing, sanitation, and social welfare. In the early 1970s, the country reached its political maturity and began a profound transformation of the health sector by expanding health and maternity insurance to workers' dependents, transferring hospitals to the Social Security Fund, developing infrastructure for health services delivery throughout the country, and supporting community and rural health programs.

In the 1980s, faced with an international economic crisis and the need to modify its organizational structure, the country launched a health sector reform process that led to the transfer of all public health facilities to the Costa Rican Social Security Fund and modified the model of patient care, significantly reinforcing the management role of the Ministry of Health. This case study documents the case of Costa Rica through a historical analysis of the evolution of a conceptual and strategic health model guided by a strong Ministry of Health.

The strategy to improve the health of a society is closely allied with the conceptualization of the health-disease process. For decades, Costa Rica recognized that the population's health status does not depend exclusively on action taken by institutions traditionally linked with health and health service providers; rather, it is a product of the coordinated development of society as a whole, a concept known as the social production of health. This historical realization has been key to improving Costa Rica's health indicators.

The National Health System of Costa Rica consists of a series of entities that act synergistically, resulting in a positive impact on health, with priority given to the most vulnerable population. The Ministry of Health is responsible for governance in the social production of health, guaranteeing protection and improvement of the health status of the population, through its management and direction of the different social actors.

Governance is exercised through eight substantive, nonexclusive functions, performed in a continuous, systematic, multidisciplinary, intersectoral, and participatory manner: policy direction; marketing of the health promotion strategy; culture of inclusiveness; health surveillance; strategic health planning; modularization of health financing; harmonization of the health service delivery; and regulation and assessment of the impact of health-related action.

The current governance model in Costa Rica's Ministry of Health is centered on the need to influence the social determinants of health in order to protect and improve it. To this end, the model is based on the master strategy of "moving from the treatment of disease to the promotion of health," which is a fundamental shift in paradigm towards a culture of inclusiveness and equity in access to well-being.



## Case Study 6. A national partnership for action to end health disparities in the United States

*Mirtha R. Beadle<sup>16</sup>, Garth N. Graham<sup>17</sup>, Paul E. Jarris<sup>18</sup>, Carlessia A. Hussein<sup>19</sup>, Alan Morgan<sup>20</sup>, Ron Finch<sup>21</sup>*

In its effort to achieve health equity, the United States joins other countries that are also confronting the problem of ending health disparities. Health equity is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.

Health disparities are persistent and pervasive in America, affecting its racial and ethnic minorities, other at-risk populations, and those of low socioeconomic and educational status. The vision for a healthier America was the force that brought together thousands of community and government leaders to develop the National Partnership for Action to End Health Disparities (NPA). Although efforts to address health equity began prior to the NPA, those efforts were carried by specific organizations and sectors (e.g., local health departments, universities, health systems, philanthropy, etc.).

Efforts to end health disparities are inherently a comprehensive community and systems change effort. The NPA is about change: why there should be change, who should effect the change, and the strategies that can be applied to implement change. The changes needed to achieve health equity in the United States can take place only with the cooperative effort of individuals at all levels of public and private enterprise. The NPA is the first national, multi-sector, community- and partnership-driven effort on behalf of health equity—with government leading the way.

The development of the NPA was sponsored by the U.S. Department of Health and Human Services and its Office of Minority Health through a sequence of activities that included regional meetings for community and stakeholder leaders throughout the country, a national public commentary period, and numerous levels of review, analysis, and content refinement by a range of experts. More than 2000 individuals participated on behalf of community- and faith-based organizations; businesses; healthcare and insurance industries; academia; city/county, state, tribal, and federal governments; and other sectors.

The NPA's prime product, the National Stakeholder Strategy for Achieving Health Equity, offers a set of 20 community-driven strategies to end health disparities in the United States and to achieve health equity through collaboration and synergy. It was released nationally on 8 April 2011 simultaneously with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (it represents the federal commitment for health equity and a response to the strategies recommended in the National Stakeholder Strategy for Achieving Health

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<sup>18</sup> Association of State and Territorial Health Officials, USA

<sup>19</sup> National Association of State Offices of Minority Health, USA

<sup>20</sup> National Rural Health Association, USA

<sup>21</sup> National Business Group on Health, USA

Equity). Together the two documents offer new strategies and a mechanism for new partnerships aimed at closing the health gap for the nation's racial, ethnic, and underserved communities.

Comprehensive change takes time, significant resources, and the efforts of many partners. Beyond financial and human capital, these efforts also require wide-ranging coordination, transparency, and commitment. The NPA is forging a new path for which there is no prior roadmap. Although early in its implementation, the NPA has already made a difference in the way partners frame their work, individually and collectively. Partners are beginning to use NPA goals and, ultimately, these actions translate into positive opportunities for communities. A key lesson learned is that the NPA achieves a momentum for change as it creates a national forum and strategy for cooperation.



## Case Study 7. How can we get the social determinants of health message on the public policy and public health agenda? Translating data into an SDH Information Tool to inform policy and public health programs: Using existing databases to create community profiles of social factors that shape Utah's health

*Len B. Novilla, Michael D. Barnes, Carl Hanson, Josh West, Eric Edwards<sup>22</sup>*

From 1990 to 2010, the State of Utah had consistently been ranked among the top 10 healthiest states in the United States. However, a closer look at Utah's life expectancies belies problems that run deep into the local levels. Disaggregating state-level data into 29 counties and then further down into 61 small areas as to groups or single zip codes, revealed disparities in life expectancies at birth (2009 estimates). Within the same county, there was a graded difference in life expectancies. Some areas have life expectancies over 80 years, far better than the nation's and comparable to the five best in the world. Yet residents living just three to ten miles away within the same county, could die three to 10 years sooner with an average life span about as long as those in developing countries.

These disparities across counties was key to the drop in Utah's 2010 health ranking, from second in 2009 to seventh in the nation in 2010, the lowest it had ever garnered in the last 20 years. Since life expectancies measure health status and summarize mortality across age groups in a specific area, these differences in life expectancies point to inequalities in health stemming from the "causes of the causes," or the living conditions and processes that determine the overall quality of life, broadly referred to as the social determinants of health. Though much more apparent among the vulnerable, at-risk, and underserved populations, disparities in health occur differentially across social groups, limiting life spans as well as socio-economic mobility.

Despite the impact of social factors on health, translating the social determinants of health through policy and practice is fraught with challenges. First, health data are typically reported as individual indicators rather than being presented comprehensively by geographic area within the context of non-medical indices that likewise affect health. Without accounting for the relationship between health outcomes and social determinants, there is no way of fully assessing the impact of policies and programs on the health of the people. Second, even with years of data collection, there remains a lack of evidence translation into policies and public health activities consistent with the social determinants of health principles. Public policy agenda and public health efforts remain dichotomous instead of being coherent and coordinated in the service of health. Thus, driving a sustainable change that distills into the various levels of governance becomes an almost herculean task.

The challenge in translating the social determinants of health message lies in linking health policy with public health practice. The overall purpose of this ongoing study is to translate the social determinants of health concept into practical approaches that are meaningful at the local levels of governance and constituency in Utah by utilizing data as an SDH information tool for policy and public health programs. Using health and demographic indicators common across five existing population metrics, this initiative developed a Community SDH Profile for Utah and its vulnerable populations down to the small area or zip code-level. This profile was then presented using an open-source data visualization software to provide policy makers, public health practitioners, and the public a visual image of how social factors within Utah impact health at the state down to the community level.

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Key research lessons in translating the social determinants of health at the local level included:

1. **The social gradient is deeper.** Inequalities in health resulting in disparities in life expectancies are evident even at the lowest reportable data level, down to the small area or zip code-level. The challenge has always been what to do about it.
2. **Communicating contextualized and actionable data.** In as much as comprehensive epidemiology reports are helpful and serve various purposes, to act on the evidence, policy makers and public health practitioners need simple, precise, accurate, easy-to-understand, easy-to-learn, visualize-able information at their constituents' level. Where reliable data are already available and regularly reported, use technology and existing health metrics to support the SDH message. A succinct and visually clear demographic and health landscape that focuses on vital priorities and trends at the community level can be a mechanism by which the social determinants of health message could be recognized, acted upon, directed, and evaluated down to the local levels of governance.
3. **Framing the message according to local needs.** "What's wrong? Why does it matter? What should be done about it?" The problem is not always the lack of data as much as how data are communicated. How we communicate the evidence is strategic in engaging both policy makers and the public. Presented wisely, used effectively, directed to the right audience, within the context of the social determinants of health, data can persuade, elicit interest, help inform, engage, advocate, and initiate action. Existing data framed in a manner that speak to community needs and issues that the people can connect with and in a language that people can understand are much more likely to resonate across the political spectrum.
4. **Keep repeating the message.** The message can get lost in a flurry of competing political and health issues. Marketing the message calls for repeatedly disseminating and reiterating the information to counter the fatalistic mindset towards change.
5. **Engaging the right people in doing the right thing.** Having a shared vision and focus of improved health and reduction of health disparities. The social determinants of health result from "the way we organize our affairs in society." These factors are so intricately embedded in the realities of daily living that reducing the inequities we have created means partnering with the right people from various sectors—those who share a vision and have the skills, courage, and resolve to bring about change in the system or with the system.



## SECTION 5. HIGHLIGHTS OF THE WHO WORLD CONFERENCE ON THE SOCIAL DETERMINANTS OF HEALTH

From October 19 to 21, 2011, the World Health Organization convened the World Conference on Social Determinants of Health, in Rio de Janeiro, Brazil. The event aimed to focus the attention of health leaders and policy-makers on how health inequities between and within countries could be reduced, and to forge a global vision for a coordinated international response.

It was held in accordance with the World Health Assembly Resolution WHA62.14 on 'Reducing health inequities through action on the social determinants of health' (2009) and followed the publication of the final report of the Commission on Social Determinants of Health (2008). The event was supported and hosted by the Government of Brazil and organized jointly by WHO, the Ministry of Health of Brazil and Brazil's leading health institute, FIOCRUZ.

Health leaders and decision-makers from over one hundred Member States met with a diverse group of stakeholders, including UN agencies, civil society organizations, academic institutions and research groups. Over a thousand people participated while more than 19,000 people followed the event through webcast. As many as nineteen stakeholder-led events were held prior to and after the conference.

During this three-day event, plenary sessions, parallel sessions and a dedicated ministerial track, allowed participants to share experiences on policies and strategies that could help to reduce the dramatic 36-year gap in life expectancy around the world. Participants also discussed how the Commission's recommendations and the suggestions outlined in the WHO Conference Discussion Paper, could be translated into concrete policy action.

### WHO Discussion Paper

A WHO Discussion Paper<sup>23</sup> was developed for this Conference, in consultation with an Advisory Group of prominent experts, and an extensive web-based, public consultation. The paper laid out the key components that all countries would need to integrate while implementing a "social determinants of health approach." In particular, it outlined five key policy areas which require immediate action: 1) governance to tackle the root causes of health inequities: implementing action on social determinants of health; 2) promoting participation: community leadership for action on social determinants; 3) the role of the health sector, including public health programs, in reducing health inequities; 4) global action on social determinants: aligning priorities and stakeholders; and 5) monitoring progress: measurement and analysis to inform policies to build accountability on social determinants.

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<sup>23</sup> To read the Discussion Paper, go to: [www.who.int/sdhconference/discussion\\_paper](http://www.who.int/sdhconference/discussion_paper)

WHO also developed five sector-specific policy briefs and WHO Regional Offices coordinated the production of 28 case studies, covering a range of issues such as conditional cash transfers, gender-based violence, tuberculosis programs and maternal and child health.

## Rio Political Declaration on Social Determinants of Health

On 21 October 2011, Member States adopted a political declaration, pledging to work towards reducing health inequities by taking action across the five priority areas discussed at the conference (see Annex A).

The declaration expresses global political commitment for the implementation of a “social determinants of health approach,” and it is expected to help build momentum within countries for the development of dedicated national action plans and strategies.

Member States also agreed that action should be adapted to the national and sub-national contexts of individual countries and regions to take into account different social, cultural and economic systems. Member States called upon WHO, United Nations agencies and other international organizations to coordinate and collaborate with them in the implementation of these actions.

## Action SDH: A new platform for innovative action on health equity

On the second day of the conference, WHO launched an innovative web-based platform to facilitate discussion on how health equity could be improved through action on social determinants of health<sup>24</sup>. This will allow WHO to join forces with a range of other organizations and networks around the world that are also committed to this agenda.

The platform enables its members to share experiences on the opportunities and challenges in this complex area, and provides a repository for innovative practices, examples and tools. In the Members Forum, members can initiate and respond to discussion topics. These discussions will be summarized periodically to draw out lessons on key barriers and facilitators to action. The platform also has Closed-door Forums, which can be used to hold restricted discussions

## WHO’s policy recommendations

In the Discussion Paper prepared for the conference, WHO developed a five-point, global call to action to address the SDH. The key messages can be summarized as follows:

1. **Reform of health governance is essential.** To achieve sustainable results in the reduction of health inequities, ministries of health need to engage systematically with other sectors to address the health and well-being dimensions of their activities. This should be based on action plans that set out values, strategies and targets on health inequity reduction, as well as established frameworks for collaborative action between sectors (“intersectoral action”).

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<sup>24</sup> To access the platform, go to: [www.actionsdh.org](http://www.actionsdh.org)

2. **Need for a new culture of participation.** There is a need for a new culture of participation in health; one that closely engages actors and influencers outside of the realm of government. In particular, governments should facilitate the key role of civil society organizations by formalizing their involvement in policy-making, enabling them to act as guarantors of governmental accountability and transparency, and recognizing their potential to gather health-related data and analysis to inform policy-making.
3. **The health sector should take up a new role.** Strong health systems, based on primary health care, are the cornerstone of a healthy society. The health sector should move towards universal health care coverage that is accessible, affordable and of good quality for all, funded through taxation, social insurance or other pre-payment pooling mechanisms. In addition, the health sector should be pro-active in reaching out to other sectors and steward the establishment of a whole-of-society approach to health.
4. **Coordinated, global action is needed.** National action on social determinants is not sufficient. International organizations, bilateral cooperation partners, and civil society organizations need to align their efforts on social determinants with national governments. There is also a need for the alignment of global priorities - such as the efforts to reach the MDGs, building social protection, addressing climate change and tackling the NCD epidemic. The UN system should lead by example and harmonize its work on social determinants of health.
5. **Health data should be broken down.** Governments need to break down the data to reveal the social gradient in health, which is apparent in all countries. They should establish a framework for the monitoring of inequities in health outcomes, social determinants and the impact of policies outside of health. Health and equity assessments should be done during the development of all new government policies. Integrated monitoring systems are needed both on the national and global levels, along with universally endorsed targets.

## Next steps

In January 2012, the WHO Executive Board will review the outcome of the World Conference on Social Determinants of Health, including progress on the implementation of resolution WHA 62.14. During this meeting, Member States will decide whether to take the declaration to the Sixty-fifth World Health Assembly in May 2012. The discussions that will take place during these meetings of Governing Bodies will further contribute to the priority-setting at the national and global levels for future work on the social determinants of health. These deliberations will also provide guidance on how the pledges contained in the Rio Political Declaration on Social Determinants of Health should be taken forward. Action will also be taken to ensure that a solid linkage is established with the Rio+20 Conference in Brazil and the 2013 Health Promotion Conference in Finland.

The systematization of knowledge remains a key goal. Efforts will be put in place to promote collaboration with civil society organizations and academia, whose initiatives will be instrumental in translating the conference's outcomes into action. While the knowledge networks of the Commission on Social Determinants of Health have been instrumental in generating evidence on health inequities, it is important to now work on building up the necessary infrastructure to connect all key stakeholders and facilitate knowledge-sharing.

## PAHO-specific highlights

A number of Ministers from the Region of the Americas attended the conference; whilst attending the Ministerial track, three ministers actively contributed in the parallel session either as a Chair or as a Panelist. At the beginning of the conference, representatives from different WHO regions met to discuss the preparations for the conference and addressed the different regional consultations as well as the case studies developed; this was an open meeting and facilitated debate on a series of relevant issues.

Upon closure of the conference, representatives from the WHO regions met again to discuss how best to move the agenda forward beyond the conference and agreed upon establishing a regional network which will facilitate discussion, enhance the quality of the regional products as well as ensure coherence of the efforts that are made worldwide to address inequities by working with the social determinants of health.

In preparation for the Global Conference on Sustainable Development, Rio+20, the Pan American Health Organization's "Seminar Series towards Rio+20" contributed to an important debate between the social determinants of health, health promotion and sustainable development as well as the themes under discussion at the Rio+20 Conference. The series of 19 seminars allowed for in-person and online participation and included discussions on workers' health, non-communicable diseases, globalization, road safety, and water, to name a few. One seminar was led by key note speaker Sir/Professor Michael Marmot, former Chair on the Commission of the Social Determinants of Health.

Sir/Professor Marmot's expert contribution to the Seminar Series was part of Marmot's two-day visit to PAHO. Dr. Marmot discussed lessons learnt from the Commission's work and linked these to the issues of health equity as they relate to the determinants of health and sustainable development, emphasizing the critical need for monitoring of equity in the Region. While the discussion/debate contributed to keeping health and the social determinants of health on the agenda of Rio+20, it also provided direction on the way forward for the Region and offered ways to best collaborate and advance the agenda of health equity.

The 65th World Health Assembly (WHA) that took place in Geneva, Switzerland in May 2012 was attended by delegations from all WHO Member States and focused on a specific health agenda prepared by the Executive Board. Although the agenda covered some of the biggest challenges and opportunities facing public health today, delegates noted significant achievements in health in recent decades and the emergence of global solidarity around health. Appointed for a second five-year term as Director-General of WHO, Dr. Margaret Chan pledged her continued commitment to improve the health of the most vulnerable and to maintain the momentum for better health that marked the start of the 21st century.

Among the resolution and decisions adopted by the Member States during the Health Assembly were those related to the Social Determinants of Health. The WHA endorsed the Rio Political Declaration and its recommendations, and approved measures to support the five priority actions recommended in the Declaration to address social determinants of health. The measures will lead to, among other things, greater collaboration between UN and partner agencies and more support for Member States to adopt an inclusive 'health-for-all' approach.

## SECTION 6. NEXT STEPS

During the WCSDH, an Internal Inter-regional Meeting on the Social determinants of Health was held with representatives from the different WHO Regions. Each WHO Region presented their “Moving Beyond Rio” Plan and agreed to establish an inter-regional network with the objective of addressing the social determinants of health and follow-up on the recommendations from the Rio Conference. **This inter-regional network plans to meet on a regular basis; WHO/HQ and PAHO will organize the next meeting.**

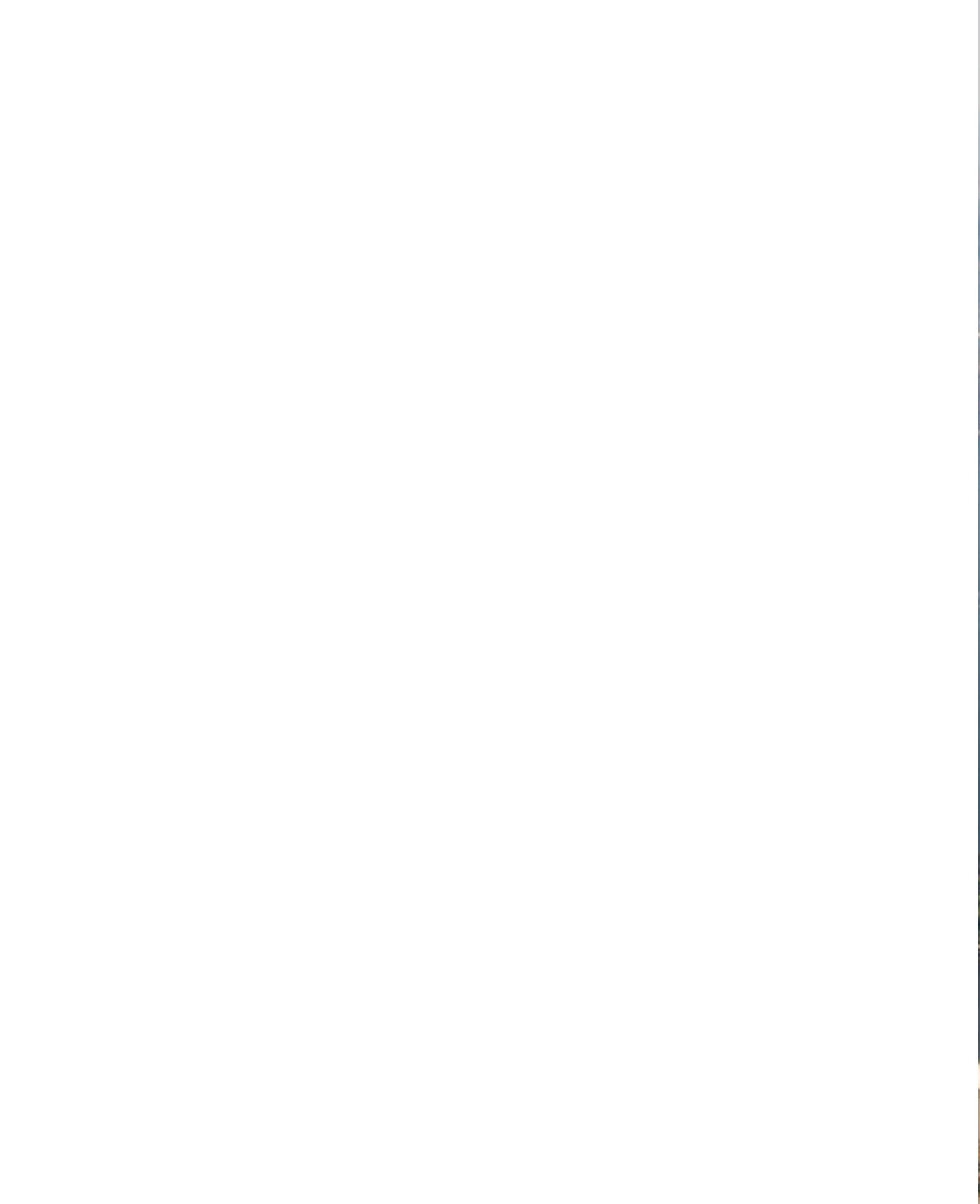
In 2012, WHO and its Regions are required to report back to the World Health Assembly on the progress related to WHA62.14; this is an opportunity to align the work in the Regions and strengthen the SDH agenda further.

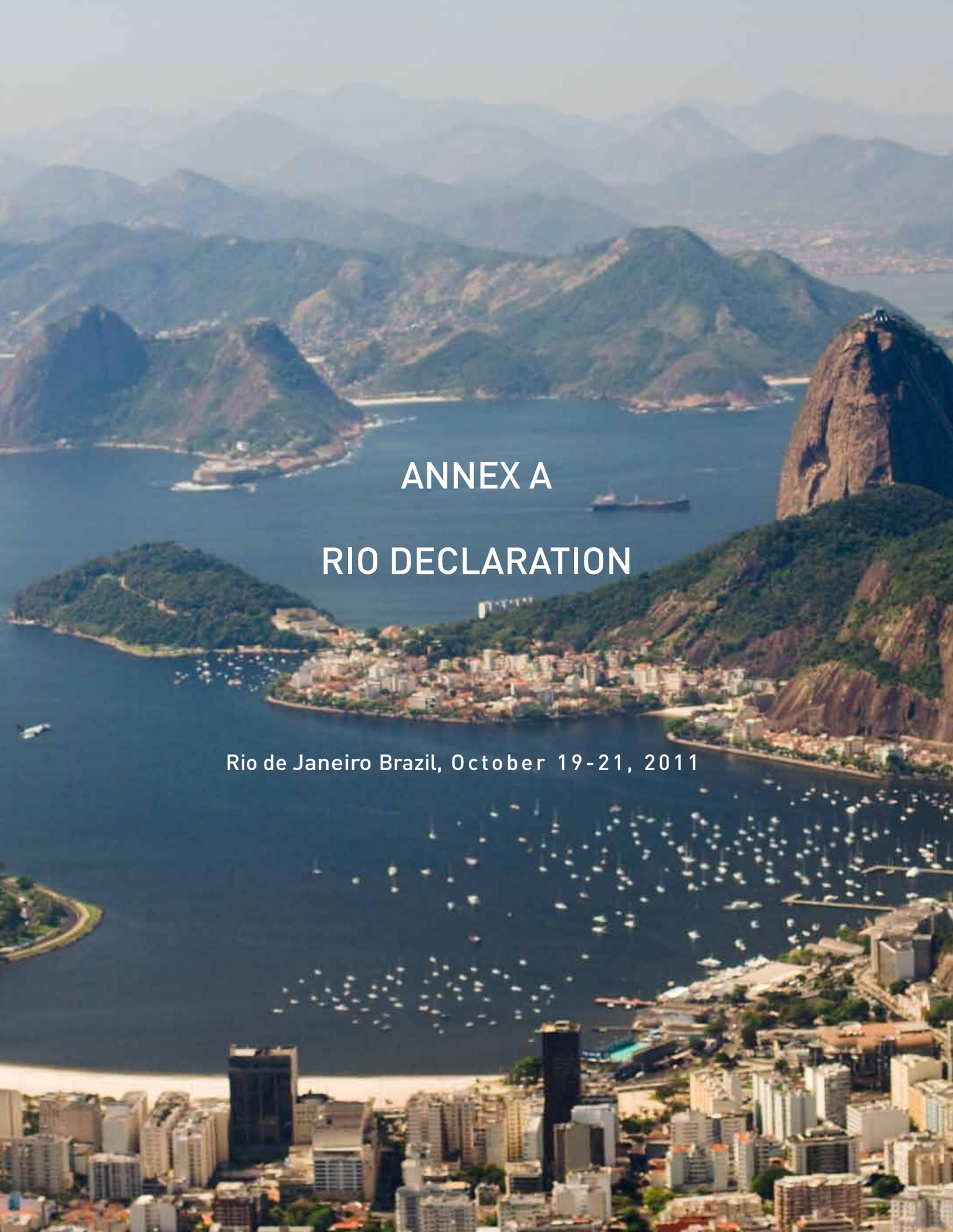
The main points highlighted by PAHO during this meeting included:

- Three major Global Conferences either took place in 2011 or are taking place in 2012, namely The UN-High Level Meeting on Non Communicable Diseases (September 2011), The World Conference on Social Determinants of Health (October 2011), and the World Summit on Sustainable Development (Rio+20, June 2012). All of these have development as a common issue, along with the transformation of population conditions through shared agendas and synergies between sectors and societal groups. **Addressing these meeting’s agendas in a coherent and consistent manner is a key priority for PAHO.**
- Following the Rio Conference, PAHO/SDE’s bi-annual meeting with the Collaboration Centers took place in order to analyze PAHO’s Biennium Work Plan and identify how each center can best contribute to the plan. This year’s key theme was the upcoming Rio+20 and how PAHO in collaboration with the WHO Collaborating Centers could build upon the Rio Declaration on SDH in preparation for Rio+20. **PAHO will continue to work with its Collaborating Centers to define and enhance the work on the social determinants of health that the centers are doing and can be doing.**
- In PAHO, a Cross-Organizational Team (COT) on Determinants of Health and Risks has been established to promote inter-programmatic and inter-sectorial work; this includes using the concept of “Health in all Policies” in order to be in line with other global and regional strategic orientation. The COT has brought together advisors with different backgrounds, expertise and competencies to address specific challenges related to risks and the social determinants of health. **PAHO is proposing a similar mechanism to be established amongst the other WHO regions.**
- In 2011 AMRO approved six documents in the Directive Council, which are highly relevant for the social determinants of health. As a result PAHO now has some sound political instruments in place to promote the agenda on the social determinants of health. **PAHO will use the Region’s 10-Year Strategy and Plan of Action on Urban Health in the Americas approved by Member States during its 51st Directing Council to address the social determinants of health.**

- PAHO's three key priorities for the future were identified as the following: 1. Capacity-building (ensuring that countries have the necessary tools to "close the equity-gap"); 2. Monitoring and evaluation (gathering and strengthening disaggregated data); and 3. Strengthening and expanding the region's networks (bringing together the skills, knowledge and evidence in order to work in a coordinated, coherent and strategic manner). **PAHO will focus on three priority areas: Capacity-Building, Monitoring and Networking.**





An aerial photograph of Rio de Janeiro, Brazil, showing the bay, mountains, and city buildings. The bay is filled with many small white sailboats. In the foreground, there are several tall buildings, including a prominent black skyscraper. The background shows a range of mountains under a clear sky.

# ANNEX A

## RIO DECLARATION

Rio de Janeiro Brazil, October 19-21, 2011





World Conference on  
Social Determinants of Health  
RIO DE JANEIRO | BRAZIL | 19-21 OCTOBER 2011



# RIO POLITICAL DECLARATION ON SOCIAL DETERMINANTS OF HEALTH

RIO DE JANEIRO, BRAZIL, OCTOBER 2011

1. **Invited by the World Health Organization**, we, Heads of Government, Ministers and government representatives came together on the 21st day of October 2011 in Rio de Janeiro to express our determination to achieve social and health equity through action on social determinants of health and well-being by a comprehensive intersectoral approach.
2. **We understand that health equity** is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an “all for equity” and “health for all” global action.
3. **We underscore the principles and provisions** set out in the World Health Organization Constitution and in the 1978 Declaration of Alma-Ata as well as in the 1986 Ottawa Charter and in the series of international health promotion conferences, which reaffirmed the essential value of equity in health and recognized that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”. We recognize that governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures and that national efforts need to be supported by an enabling international environment.
4. **We reaffirm that health inequities within and between countries** are politically, socially and economically unacceptable, as well as unfair and largely avoidable, and that the promotion of health equity is essential to sustainable development and to a better quality of life and well-being for all, which in turn can contribute to peace and security.
5. **We reiterate our determination to take action** on social determinants of health as collectively agreed by the World Health Assembly and reflected in resolution WHA62.14 (“Reducing health inequities through action on the social determinants of health”), which notes the three overarching recommendations of the Commission on Social Determinants of Health: to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action.
6. **Health inequities arise from the societal conditions** in which people are born, grow, live, work and age, referred to as social determinants of health. These include early years’ experiences, education, economic status, employment and decent work, housing and environment, and effective systems of preventing and treating ill health. We are convinced that action on these determinants, both for vulnerable groups and the entire population, is essential to create inclusive, equitable, economically productive and healthy societies. Positioning human health and well-being as one of the key features of what constitutes a successful, inclusive and fair society in the 21st century is consistent with our commitment to human rights at national and international levels.

7. **Good health requires a universal**, comprehensive, equitable, effective, responsive and accessible quality health system. But it is also dependent on the involvement of and dialogue with other sectors and actors, as their performance has significant health impacts. Collaboration in coordinated and intersectoral policy actions has proven to be effective. Health in All Policies, together with intersectoral cooperation and action, is one promising approach to enhance accountability in other sectors for health, as well as the promotion of health equity and more inclusive and productive societies. As collective goals, good health and well-being for all should be given high priority at local, national, regional and international levels.
8. **We recognize that we need to do more** to accelerate progress in addressing the unequal distribution of health resources as well as conditions damaging to health at all levels. Based on the experiences shared at this Conference, we express our political will to make health equity a national, regional and global goal and to address current challenges, such as eradicating hunger and poverty, ensuring food and nutritional security, access to safe drinking water and sanitation, employment and decent work and social protection, protecting environments and delivering equitable economic growth, through resolute action on social determinants of health across all sectors and at all levels. We also acknowledge that by addressing social determinants we can contribute to the achievement of the Millennium Development Goals.
9. **The current global economic and financial crisis urgently requires** the adoption of actions to reduce increasing health inequities and prevent worsening of living conditions and the deterioration of universal health care and social protection systems.
10. **We acknowledge that action on social determinants of health** is called for both within countries and at the global level. We underscore that increasing the ability of global actors, through better global governance, promotion of international cooperation and development, participation in policy-making and monitoring progress, is essential to contribute to national and local efforts on social determinants of health. Action on social determinants of health should be adapted to the national and sub-national contexts of individual countries and regions to take into account different social, cultural and economic systems. Evidence from research and experiences in implementing policies on social determinants of health, however, shows common features of successful action. There are five key action areas critical to addressing health inequities: (i) to adopt better governance for health and development; (ii) promote participation in policy-making and implementation; (iii) to further reorient the health sector towards reducing health inequities; (iv) to strengthen global governance and collaboration; and (v) to monitor progress and increase accountability. Action on social determinants of health therefore means that we, the representatives of Governments, will strive individually and collectively to develop and support policies, strategies, programmes and action plans, which address social determinants of health, with the support of the international community, that include:
11. **To adopt better governance for health and development**
- 11.1 Acknowledging that governance to address social determinants involves transparent and inclusive decision-making processes that give voice to all groups and sectors involved, and develop policies that perform effectively and reach clear and measurable outcomes, build accountability, and, most crucially, are fair in both policy development processes and results;
- 11.2 We pledge to:
- (i) Work across different sectors and levels of government, including through, as appropriate, national development strategies, taking into account their contribution to health and health equity and recognizing the leading role of health ministries for advocacy in this regard;
  - (ii) Develop policies that are inclusive and take account of the needs of the entire population with specific attention to vulnerable groups and high-risk areas;

- (iii) Support comprehensive programmes of research and surveys to inform policy and action;
- (iv) Promote awareness, consideration and increased accountability of policy-makers for impacts of all policies on health;
- (v) Develop approaches, including effective partnerships, to engage other sectors in order to identify individual and joint roles for improvements in health and reduction of health inequities;
- (vi) Support all sectors in the development of tools and capacities to address social determinants of health at national and international levels;
- (vii) Foster collaboration with the private sector, safeguarding against conflict of interests, to contribute to achieving health through policies and actions on social determinants of health;
- (viii) Implement resolution WHA62.14, which takes note of the recommendations of the final report of the Commission on Social Determinants of Health;
- (ix) Strengthen occupational health safety and health protection and their oversight and encourage the public and private sectors to offer healthy working conditions so as to contribute to promoting health for all;
- (x) Promote and strengthen universal access to social services and social protection floors;
- (xi) Give special attention to gender-related aspects as well as early child development in public policies and social and health services;
- (xii) Promote access to affordable, safe, efficacious and quality medicines, including through the full implementation of the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;
- (xiii) Strengthen international cooperation with a view to promoting health equity in all countries through facilitating transfer on mutually agreed terms of expertise, technologies and scientific data in the field of social determinants of health, as well as exchange of good practices for managing intersectoral policy development.

## 12. To promote participation in policy-making and implementation

12.1 Acknowledging the importance of participatory processes in policy-making and implementation for effective governance to act on social determinants of health;

12.2 We pledge to:

- (i) Promote and enhance inclusive and transparent decision-making, implementation and accountability for health and health governance at all levels, including through enhancing access to information, access to justice and public participation;
- (ii) Empower the role of communities and strengthen civil society contribution to policy-making and implementation by adopting measures to enable their effective participation for the public interest in decision-making;
- (iii) Promote inclusive and transparent governance approaches, which engage early with affected sectors at all levels of governments, as well as support social participation and involve civil society and the private sector, safeguarding against conflict of interests;
- (iv) Consider the particular social determinants resulting in persistent health inequities for indigenous people, in the spirit of the United Nations Declaration on the Rights of Indigenous Peoples, and their specific needs and promote meaningful collaboration with them in the development and delivery of related policies and programmes;

- (v) Consider the contributions and capacities of civil society to take action in advocacy, social mobilization and implementation on social determinants of health;
- (vi) Promote health equity in all countries particularly through the exchange of good practices regarding increased participation in policy development and implementation;
- (vii) Promote the full and effective participation of developed and developing countries in the formulation and implementation of policies and measures to address social determinants of health at the international level.

### **13. To further reorient the health sector towards reducing health inequities**

13.1 Acknowledging that accessibility, availability, acceptability, affordability and quality of health care and public health services are essential to the enjoyment of the highest attainable standard of health, one of the fundamental rights of every human being, and that the health sector should firmly act to reduce health inequities;

13.2 We pledge to:

- (i) Maintain and develop effective public health policies which address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities;
- (ii) Strengthen health systems towards the provision of equitable universal coverage and promote access to high quality, promotive, preventive, curative and rehabilitative health services throughout the life-cycle, with a particular focus on comprehensive and integrated primary health care;
- (iii) Build, strengthen and maintain public health capacity, including capacity for intersectoral action, on social determinants of health;
- (iv) Build, strengthen and maintain health financing and risk pooling systems that prevent people from becoming impoverished when they seek medical treatment;
- (v) Promote mechanisms for supporting and strengthening community initiatives for health financing and risk pooling systems;
- (vi) Promote changes within the health sector, as appropriate, to provide the capacities and tools to act to reduce health inequities including through collaborative action;
- (vii) Integrate equity, as a priority within health systems, as well as in the design and delivery of health services and public health programmes;
- (viii) Reach out and work across and within all levels and sectors of government by promoting mechanisms for dialogue, problem-solving and health impact assessment with an equity focus to identify and promote policies, programmes, practices and legislative measures that may be instrumental for the goal pursued by this Political Declaration and to adapt or reform those harmful to health and health equity;
- (ix) Exchange good practices and successful experiences with regard to policies, strategies and measures to further reorient the health sector towards reducing health inequities.

### **14. To strengthen global governance and collaboration**

14.1 Acknowledging the importance of international cooperation and solidarity for the equitable benefit of all people and the important role the multilateral organizations have in articulating norms and guidelines and identifying good practices for supporting actions on social determinants, and in facilitating access to financial resources and technical

cooperation, as well as in reviewing and, where appropriate, strategically modifying policies and practices that have a negative impact on people's health and well-being;

14.2 We pledge to:

- (i) Adopt coherent policy approaches that are based on the right to the enjoyment of the highest attainable standard of health, taking into account the right to development as referred to, inter alia, by the 1993 Vienna Declaration and Programme of Action, that will strengthen the focus on social determinants of health, towards achieving the Millennium Development Goals;
- (ii) Support social protection floors as defined by countries to address their specific needs and the ongoing work on social protection within the United Nations system, including the work of the International Labour Organization;
- (iii) Support national governments, international organizations, nongovernmental entities and others to tackle social determinants of health as well as to strive to ensure that efforts to advance international development goals and objectives to improve health equity are mutually supportive;
- (iv) Accelerate the implementation by the State Parties of the WHO Framework Convention on Tobacco Control (FCTC), recognizing the full range of measures including measures to reduce consumption and availability, and encourage countries that have not yet done so to consider acceding to the FCTC as we recognize that substantially reducing tobacco consumption is an important contribution to addressing social determinants of health and vice versa;
- (v) Take forward the actions set out in the political declaration of the United Nations General Assembly High-Level Meeting on the Prevention and Control Noncommunicable Diseases at local, national and international levels – ensuring a focus on reducing health inequities;
- (vi) Support the leading role of the World Health Organization in global health governance, and in promoting alignment in policies, plans and activities on social determinants of health with its partner United Nations agencies, development banks and other key international organizations, including in joint advocacy, and in facilitating access to the provision of financial and technical assistance to countries and regions;
- (vii) Support the efforts of governments to promote capacity and establish incentives to create a sustainable workforce in health and in other fields, especially in areas of greatest need;
- (viii) Build capacity of national governments to address social determinants of health by facilitating expertise and access to resources through appropriate United Nations agencies' support, particularly the World Health Organization;
- (ix) Foster North-South and South-South cooperation in showcasing initiatives, building capacity and facilitating the mechanisms to guide policy-making in all sectors are essential, taking into account different national contexts; transfer of technology on mutually agreed terms for integrated action on health inequities, in line with national priorities and needs, including on health services and pharmaceutical production, as appropriate.

## 15. To monitor progress and increase accountability

15.1 Acknowledging that monitoring of trends in health inequities and of impacts of actions to tackle them is critical to achieving meaningful progress, that information systems should facilitate the establishment of relationships between health outcomes and social stratification variables and that accountability mechanisms to guide policy-making in all sectors are essential, taking into account different national contexts;

15.2 We pledge to:

- (i) Establish, strengthen and maintain monitoring systems that provide disaggregated data to assess inequities in health outcomes as well as in allocations and use of resources;
- (ii) Develop and implement robust, evidence-based, reliable measures of societal well-being, building where possible on existing indicators, standards and programmes and across the social gradient, that go beyond economic growth;
- (iii) To promote research on the relationships between social determinants and health equity outcomes with a particular focus on evaluation of effectiveness of interventions;
- (iv) Systematically share relevant evidence and trends among different sectors to inform policy and action;
- (v) Improve access to the results of monitoring and research for all sectors in society;
- (vi) Assess the impacts of policies on health and other societal goals, and take these into account in policy-making;
- (vii) Use intersectoral mechanisms such as a Health in All Policies approach for addressing inequities and social determinants of health; enhance access to justice and ensure accountability, which can be followed up;
- (viii) Support the leading role of the World Health Organization in its collaboration with other United Nations agencies in strengthening the monitoring of progress in the field of social determinants of health and in providing guidance and support to Member States in implementing a Health in All Policies approach to tackling inequities in health;
- (ix) Promote appropriate monitoring systems that take into consideration the role of all relevant stakeholders including civil society, nongovernmental organizations as well as the private sector, with appropriate safeguard against conflict of interests, in the monitoring and evaluation process;
- (x) Promote health equity in and among countries, monitoring progress at the international level and increasing collective accountability in the field of social determinants of health, particularly through the exchange of good practices in this field;
- (xi) Improve universal access to and use of inclusive information technologies and innovation in key social determinants of health.

## 16. Call for global action

16.1 We, Heads of Government, Ministers and government representatives, solemnly reaffirm our resolve to take action on social determinants of health to create vibrant, inclusive, equitable, economically productive and healthy societies, and to overcome national, regional and global challenges to sustainable development. We offer our solid support for these common objectives and our determination to achieve them.

- 16.2 We call upon the World Health Organization, United Nations agencies and other international organizations to advocate for, coordinate and collaborate with us in the implementation of these actions. We recognize that global action on social determinants will need increased capacity and knowledge within the World Health Organization and other multilateral organizations for the development and sharing of norms, standards and good practices. Our common values and responsibilities towards humanity move us to fulfil our pledge to act on social determinants of health. We firmly believe that doing so is not only a moral and a human rights imperative but also indispensable to promote human well-being, peace, prosperity and sustainable development. We call upon the international community to support developing countries in the implementation of these actions through the exchange of best practices, the provision of technical assistance and in facilitating access to financial resources, while reaffirming the provisions of the United Nations Millennium Declaration as well as the Monterrey Consensus of the International Conference on Financing for Development.
- 16.3 We urge those developed countries which have pledged to achieve the target of 0.7 percent of GNP for official development assistance by 2015, and those developed countries that have not yet done so, to make additional concrete efforts to fulfil their commitments in this regard. We also urge developing countries to build on progress achieved in ensuring that official development assistance is used effectively to help achieve development goals and targets.
- 16.4 World leaders will soon gather again here in Rio de Janeiro to consider how to meet the challenge of sustainable development laid down twenty years ago. This Political Declaration recognizes the important policies needed to achieve both sustainable development and health equity through acting on social determinants.
- 16.5 We recommend that the social determinants approach is duly considered in the ongoing reform process of the World Health Organization. We also recommend that the 65th World Health Assembly adopts a resolution endorsing this Political Declaration.



