CONCEPT NOTE
PAHO’s progress in the implementation of activities for Consumers’ Health

I. Introduction

1. Numerous evidences demonstrate that health is affected by the quantity and quality of the goods available for consumers’ use. Detrimental effects range from damage to the individual’s property and integrity to severe health conditions.

2. Conscious of these risk factors, PAHO toils to safeguard and protect the health and wellbeing of consumers worldwide; bearing in mind that a coordinated and harmonious action is required with different stakeholders and economic sectors intertwined in the consumers’ market. Since 2007, PAHO initiated internal discussions and analysis to create a Program on Consumers’ Health, aimed at coordinating actions and policies addressing issues at the regional level and complementing the actions of Member States and other International entities. As a result of PAHO’s internal analysis, progress was made in with the cooperation of the Organization of American States (OAS), given the successful management of strategic alliances in the Inter-Ministerial Conferences of Health, Labour, Education, Environment and Agriculture, and acknowledging the inter-sectorial and inter-programmatic work performed inside and outside of PAHO, as well as the dual mandate for the United Nations and as a specialized health agency of the Inter-American Nations System.

3. This document presents a summary of this partnership’s accomplishments and achievements, by focusing on the needs, gaps, and the actions addressed by the Ministries of Health and their affiliated institutions. The said Ministries of Health and affiliated institutions will be present at the 1st International Workshop on Consumers’ Product Related Injuries to be held in August 5-7, 2015 in Santo Domingo, Dominican Republic.

II. The fundamentals of health-consumer relationship

4. Health- “The enjoyment of the highest attainable standard of health that can be achieved and considered as one of the fundamental rights that every human should have without distinction of race, religion, political or socioeconomic status”, “is an individual right”, which results from the relationships and interactions between biological individuality and living conditions in the economic, environmental, cultural and political realms.

5. Consumption- generally considered as “the income that goes to the purchase of goods and services for the satisfaction of needs.” Consumption is also defined as the “use of goods and services to meet current needs.” Consumption is the result of macro-economic and social policies, and resulting from growing industrial, technological and commercial production, thus making it highly dynamic and complex due to its many phases and dimensions.

6. Similarly, social order is defined by technological development, production and industrial growth, in such a way that today industrial, services, information and time are recorded, as shown in Figure 1.

7. Since the late twentieth century, the attainment, exchange of goods and products and patterns of consumption has increased and digressed into a global practice. The opening of markets and air transport

Figure 1. Desarrollo tecnológico y fases del crecimiento industrial

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1 | C://PAHO/SDE/Workers’ Health /JRG/FH-July 2015- Technical Note
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facilities, as well as digital, satellite and Internet technology communications have increased and diversified forms of products acquisition and consumption around the world. Countries with low and middle incomes have improved their income per capita; such is the case of some Latin American countries that have increased their purchasing power and their consumption. Nevertheless, risk resides in the product regulations that begin to enter their newly developing markets which may be less severe or more lenient, both in the marketing of unsafe products as well as in the protection and monitoring of product safety markets. As a result of these developing countries framework deficiencies, high levels of market informality are added for all product types (informal market, crafts, contraband, etc.) where monitoring and consumer protection becomes more precarious, hence creating greater opportunities to generate undesirable damage for consumers, and increasing health inequalities and inequities.

8. For these reasons, modern society is defined and characterized as a "consumer society", activity that is present during ALL STAGES OF THE HUMAN LIFE CYCLE: purchasing all kinds of products, objects and services to and during pregnancy, birth, infancy, childhood, adolescence, adulthood, old age, death, and even after it. It is because of this, that public health and consumer authorities must jointly ensure the security and safety of products on the market, and to protect and safeguard consumers’ health.

9. Safe and healthy consumption rises as an additional human right within the set of economic, social and cultural human rights, as well as the political rights and fundamental liberties of consumers, thus protecting their health. Within the context of sustainable development, safe and healthy consumer practices have high importance when they contribute to: 1) Development of individual healthy lifestyles that are elements of economic and social integration transferring investments to provide consumers with general wellbeing (healthy nutrition, education, clothing, transportation, exercise and leisure time, etc.); and 2) Productivity and sustainable development without damaging the environment or consumers’ health, and contributing to increase wellbeing and quality of life for all Member States of the Region.

10. The CONSUMER-HEALTH relationship is defined when it acknowledges that health can be affected because of the quality, safety, quantity and use of consumed, purchased services and products on the market, or goods that are within the reach of consumers’ use. From this point of view, a direct relationship between health and consumption is established, in which interdependence ties are established as illustrated in Figure 2. This may be a positive relationship when is health hazard free, allowing wellbeing and comfort for the consumption of goods or services by the citizens. Nonetheless, it can have negative effects when it damages consumers’ health and wellbeing, leaving sequels or even becoming lethal.

11. Food, eatable products and medication, as well as non-food Consumer products such as electrical appliances, toys, cleaning products, personal, cosmetic and care products, information technology devices, etc... are capable of causing such risks. As well, good practices of product marketing and labeling can also contribute to prevent deleterious effects to consumers’ health by means of timely alerting about dangerous effects and adequately instructing product users in the national, international and transnational trade.

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III. Consumption conceptual framework development from the perspective of the social determinants of health (SDH)

12. Given the conceptual framework and the foundations established by the SDH Commission, we found that consumption fits in the following model, illustrated in Figure 3. From this perspective, the health-disease process is understood as a dynamic interface consisting of: “a complex network of historical, social, biological and psychological conditions, organized at different levels, with particular structures and dynamic process and acting at the individual and the collective level, so that the health condition or disease is the result of the interaction of particular conditions present in the so-called living and social conditions of human populations.” In other words, social conditions are those that define the style and quality of life of individuals and communities that make up modern societies, thus able to affect health and cause diseases.

13. It is important to acknowledge that progress in knowledge and understanding the dynamics of consumption are a very complex area, given the multitude of social actors, processes and life cycle product stages, goods and services distributed and available on the market. In addition, there are multiple control mechanisms and institutions responsible for monitoring; all of which must be present to verify products safety, quality and the cycle control of hazardous processes, as illustrated in Figure 4.

14. Additionally, we take a look at the theoretical framework of consumer relationships and health inequities, which is based on the interactions of macro-policies that are defined from political powers and determine power relationships in the consumer world. They influence and affect trade and market policies, including production, distribution, and marketing chains, and products sales, as well as the state’s assistance to consumer welfare (see Figure 5). Labor policies also set the model that employment determines wages and the acquired power for workers’ and consumers’ individuals to determine the consumption conditions in different stages, modes and marketing chains;...
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hence affecting different levels by people’s characteristics who use them (social class, sex, age, ethnicity, migration, etc.), as well as for the access to product information and consumer habits. In the end, consumption conditions are able to identify inequities in consumers’ health. The set forces is affected and modulated by the effect of consumers’ family and social networks, and access, quality, quantity and availability of services provided by health systems services.

15. The SDH focus indicates that “we get sick and die according to how we live, we eat, we reproduce, we work, we fellowship, we educate, we develop our capacities and face our limitations.” For this reason, consumption is a social determinant of health in the market economy and contemporary consumer society, thus having a great impact on individual health and public health.

IV. Consumers Health and Safety Network (CSHN)

16. Since 2008 PAHO has been working in partnership with the OAS, initially with a sensitization workshop, which subsequently gave birth to the CSHN. The CSHN was created on 2010 and officially launched the same year on its OAS web page. The CSHN works as a regional knowledge network protected under the mandates of the OAS and in coordination with PAHO. Here, the consumer and health authorities meet in order to assess and control consumption risks; and to protect and safeguard consumers’ health. This aspect is sought by the ministries of health and their sanitary surveillance agencies. Figure 6 shows the CSHN milestones achieved in recent years through the contributions and support of several member states (Brazil, Canada, Peru, and Colombia, among others).

17. The Network provides easy access to relevant information on products deemed unsafe by markets from different parts of the world through the Inter-American Rapid Alert System (SIAR), whose launch and implementation began in December 2014. It also stimulates education on product safety and their impact on consumer’s health to authorities and consumers. Thus, the CSHN network has become the first Inter-American effort to strengthen national and regional systems in order to protect consumers’ health and life, enhance product safety and promote safe and healthy consumption. More information available at the CSHN website: http://www.oas.org/en/sla/cshn/about_cshn.asp

18. The CHSN institutionalization was held in 2013 led by the OAS member states with a defined organizational and functional structure as shown in Figure 7. The Plenary makes the fundamental decisions where all member states meet and define its annual work plan (projects, meetings, alert systems, etc.) The Management Committee is chaired by a Member State who leads the plan’s implementation for a period of one year. The first chair was Peru (2014), now Brazil (2015) and Colombia was...
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chosen to start on 2016. Additionally, the CSHN has two working groups, one in charge of the Inter-American Rapid Alert System (SIAR), which collects and shares information on complaints about products, consumer goods and services that have the potential to harm your health; and another group that deals with technical issues (courses, training, surveillance study metrology, regulation, etc.). It is important to note that since food products, medicines, medical supplies, tobacco, alcohol and drugs have their own policies and sanitary regulations and assigned to other relevant entities in the countries, these are not part of the CSHN routine surveillance.

19. Although the network is based on the interaction of health and consumer sectors, it also involves and affects other sectors and stakeholders who have interest and relevance in the health-consumer relationship. Some of these international organizations specialized in the subject are: (ICPHASO, OECD, etc.) and consumer organizations at global and regional level (Consumers' International). In order to address national and local need, we have been promoting for each country to have its own National Consumer Safety and Health Network. Several countries such as Brazil and Chile already have their own national network; and others like Peru, Colombia and the Dominican Republic, are in the process of forming them.

V. Challenges/priorities from a PAHO and Health authorities perspective

20. While there have been robust regional partnerships with the OAS and with the CSHN, this has yet to be implemented at a national level in most Member States. Since 2012 PAHO has strongly promoted the involvement of health authorities (Ministries and affiliated institutions), seeking to facilitate engagement with consumers’ authorities. For this reason, the task has been of reaching out to health authorities; promote actions to protect consumers’ health and life through capacity building and training officials from the Ministries of Health. This also sought to strengthen and support the CSHN growth, and even seek for an equitable representation among health and consumers authorities; in order to jointly coordinate efforts to prevent damages to consumers’ health and lives.

21. Since 2012, four very important work lines were programmed to advance in the development of policies and programs to protect consumers’ health: a) the construction of the theoretical framework that defines and sustains consumption as a SDH (summarized in this document); b) the review of Member States’ health codes in order to determine consumers’ health authorities level of competence; c) construction of a glossary that would find a common language between the consumers’ world and health; and, d) seek paths that would allow to reveal the damage extent over consumers’ health, and determine the burden of disease and death from dangerous or unsafe consumption.

22. Based on the revised document reviews, we have identified a number of gaps based on queries made with some ministries of health, as well as limitations to access these analysis and CSHN operation. Hence, we have identified a series of gaps that are part of PAHO’s unfinished agenda.

a. The absence of statistics, indicators and/or information systems that systematically identify and collect consumers’ product-related injuries. Some countries do this by buying or finding information in hospitals, or make projected estimations based on data from population surveys, population censuses or other registries.

b. The need to systematically gather information in building indicators on consumers’ product-related injuries determine the burden of these events and raise evidence for decision makers and policymakers.
c. Consult ministries of health to identify and understand the obstacles or difficulties in collecting and analyzing information; and define their needs for technical cooperation in consumers’ health.

d. The need to increase awareness and joint training of health officials and consumers in order to strengthen skills and communication between them by having a comprehensive view of consumers’ health.

e. The need to spread information about safe and healthy consumption and thus, encouraging the creation of healthy consumption habits.

f. The need to identify, collect and document good practices of consumption, which can be highlighted as safe, healthy and satisfying for consumers.

23. For these reasons, it was considered necessary to: move forward towards the definition of consumers’ product related injuries, make a regional consensus on it, and propose some alternatives that would close information gaps existing today. This includes:

a. Define consumers’ product related injuries, in line with the parameters and categories of the International Classification of Diseases ICD-10 and along with the World Health Organization/WHO ICD-11, which will take effect in 2017.

b. Detect primary information sources that provide robust and reliable data, either through hospital discharge records, external or outpatient and emergency services; and secondary sources such as vital statistics (death certificates), household surveys, health, employment or equity. This will allow for the building of damage profiles in each country.

c. Draw a roadmap for the building of national information systems corresponding to the two items mentioned above, and at the same time define the information flow from the main sources to the Ministries of Health. Consequently, units of epidemiology and surveillance programs will know the amount and proportion of the damage caused to people; consumers’ health burden of diseases and injuries; and the inequalities that these can cause.

24. From this first preliminary exercise, a report will be created that elaborates on the decisions, steps, and agreements from the road map. This will be followed by a second stage where best alternatives would be defined for the consumers’ product related injuries information system; and subsequently resulting on a second International Workshop to be held in the first semester of 2016.