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THE COMMISSION ON SOCIAL DETERMINANTS OF HEALTH

1. The conceptual framework and content of public health discussions have been changing under the influence of diverse new factors. We know that to promote health, prevent disease, avoid risks, and reduce disabilities, public policies are needed that consider broad social and economic approaches. At the same time, we must improve our ability to implement such policies at all levels with a range of agents and disciplines. Reducing or eliminating health inequities should be the common goal of all government sectors and an urgent task for public health and systems devoted to the care and well-being of individuals and their physical and social environment.

2. The conceptual framework for the social determinants of health addresses the "causes of the causes." It refers to the nature of the social conditions that affect health and to the particular channels through which these conditions exert their effects and which can be altered with sound measures.[1] After the announcement by the Director-General during the 2004 World Health Assembly, the World Health Organization (WHO) launched the Commission on Social Determinants of Health (CSDH) in March 2005 in Santiago, Chile. The CSDH requests the renewal of a process that focuses on the importance of the social causes of ill health and the health inequities that prevail between and within countries and regions. In the space of three years, the Commission will lay the foundations for sustained processes to profile and integrate the social determinants of health in public policies and practices.

3. The Commission is made up of 18 distinguished personalities, five of them from the Region of the Americas (the President of Chile, Ricardo Lagos; Monique Bégin and Stephen Lewis of Canada; and David Satcher and Gail Wilensky of the United States of America), thus representing all the regions. The Commission has reaffirmed the WHO

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[1] Krieger N. A glossary for social epidemiology. J Epidemiol. Community Health 2001; 55:693-700.

commitment to the basic principles of the Organization and expressed its decision to respond to the moral imperative of global public health to reduce and eliminate health inequities.

4.   The Commission is examining the historical lessons and taking advantage of earlier achievements to underscore the importance of acting on the social determinants of health to change situations such as those described in the Millennium Development Goals (MDG).

5.   The interest of the Pan American Health Organization (PAHO) in pursuing, contributing, and putting integrated approaches to health determinants into practice is profound and historical. In the text of the documents of the Alliance for Progress and the Charter of Punta del Este (1961), the will to promote peace, create more just societies, and develop opportunities for all citizens to enjoy the benefits of social, economic, and today, technological development, was already evident.

6.   PAHO was an active participant in the definition of the 10-Year Health Plans of that era. Later on, the Health for All (HFA) of WHO vision and initiative, defined in the 1977 World Health Assembly and articulated in the Declaration of Alma-Ata, made health pivotal to achieving these aspirations of equity and social justice, urging us to consider unacceptable the avoidable differences that hinder their full achievement.

7.   The Organization has lines of work related to this issue, among them the upgrading of analytical and measurement systems to include the disaggregation of data by sex, ethnicity, and geographical and administrative unit. This helps to improve decision-making and the initiatives to strengthen health promotion, healthy municipios, health-promoting schools, monitoring, environmental risk reduction, workers' health, the promotion of the food security, the role of health in poverty reduction strategies, the mainstreaming of the gender approach, and the intercultural approach to health.

8.   The regional consultation of 2005 brought together a regional sample of 13 countries, development agencies, civil society organizations, social scientists, and decisionmakers, as well as personnel from WHO and PAHO. The consultation offered an opportunity to study the factors that hinder health development and propose strategies for intensified action that targets the health determinants responsible for inequities. The commitment and participation of national and international leaders will strengthen the viability of many of the Commission's proposals, such as intervening at several levels of the social and health system and employing truly multidisciplinary approaches to reduce the gradients of inequity between groups and nations.

9.   The world of today and of the future faces enormous challenges (conflicts; civil wars; economic, social, technological, and biological threats); the vulnerability of

economies, the environment, and societies themselves has come to dominate the picture, and it is growing. The limited capacity of many governments to meet these challenges can also be observed. Ironically, however, these problems also represent extraordinary opportunities for require more creative thinking and joint solutions for creating a safer, healthier, and more peaceful world. The governments, key sectors, and regional integration systems recognize these challenges and the need to bridge the gaps between groups.

10.   The regional consultation currently under way is part of PAHO's responsibility to support the work of the Commission through a dialogue with the public health authorities. We hope that it will serve to inform the governments and the Secretariat about relevant issues that the Commission addresses and that could be considered when formulating the Health Agenda for the Americas and the strategic plans of the Secretariat.

11.   The Commission will work in three broad spheres: political, scientific, and social.

- In the political sphere, the Commission will attempt to interact with entities that create, inform, and strengthen public policies and practices, such as the Directing Council of PAHO and others bodies at different levels, from the global down to the local. This, it is hoped, will promote the cause and create opportunities for action in legislative/ regulatory bodies, implementing agencies, and society as a whole to address the principal social determinants that influence health.

- In the scientific sphere, networks of experts have been created for selected issues, such as: i) early child development; ii) globalization, iii) the urban environment, iv) health systems, v) priority public health conditions, vi) labor conditions, vii) social exclusion, viii) woman and gender, and ix) measurement. The Region's contribution to networks and to the dissemination of the results obtained will be made through the Public Health Forum of the Americas initiative and those of subforums such as the Urban Health Forum.

- The third sphere will be the Commission's work in the countries. A regional consultation on social determinants will be undertaken with civil society in the Region, with support from the Organization of American States (OAS). This consultation should determine how civil society in the Region will contribute to the work of the Commission and, moreover, how it can support national and local implementation of the conclusions of the Commission.

12.   As can be seen, PAHO welcomed the global initiative. This is consistent with its tireless efforts to provide technical cooperation in health and the application of integrated and intersectoral approaches. It is now essential that the members of the Directing

Council express their views on this important initiative and indicate the level of effort they wish the Secretariat to devote to it.

Annex

Commission on Social
Determinants of Health

World Health Organization

Pan American Health Organization

Regional Office of the
World Health Organization

Final Report:

Regional Consultation on the Work of the Commission on Social Determinants of Health

Washington, D. C., 5-6 July 2005

INTRODUCTION

The social determinants of health refer to both specific features and pathways by which societal conditions affect health, and that potentially can be altered by informed action.[1] Following the announcement by the Director General at the 2004 World Health Assembly, the World Health Organization launched the global Commission on Social Determinants of Health (CSDH) in March 2005 at Santiago, Chile. The CSDH calls for the renewal of a process that would draw attention to the importance of the social causes of ill health and inequities in health that prevail between and within countries and regions. Over three years, the Commission will set the foundation for sustained processes to profile and integrate the social determinants of health within public policy and practice.

The Commission's work shall be in the following three broad streams:

- Learning by consolidating, disseminating and promoting the use of knowledge that demonstrates the imperative for action on the social determinants of health and that informs both policy and effective, equitable interventions on these determinants;

- Advocacy by identifying and promoting opportunities for action on the most relevant social determinants affecting health among policy makers, implementing agencies, and the wider society; and

- Action by catalyzing and supporting processes that initiate, inform and strengthen actions to integrate knowledge on social determinants within public health policies and practice.

The creation of knowledge networks in important thematic areas will achieve work in the first stream. The areas identified are (i) early child development; (ii) globalization, (iii) urban settings, (iv) health systems, (v) priority public health conditions, (vi) employment conditions, (vii) social exclusion, (viii) women and gender, and (ix) measurement. Additional themes shall be examined as evidence gathers. Endeavors in the second area will require the Commissioner's actions at the global level to develop and leverage leadership for social determinants of health across governments, civil society, academia and other national and international institutions, while the third area will focus on the Commission's work at the country level.

The Pan American Health Organization embraces the global initiative, which is in line with its unwavering efforts in technical cooperation in health and the application of comprehensive and intersectoral approaches. The Organization's long history is one of commitment to the vision and principles of health for all and primary health care which are contained in the Alma Ata Declaration and in the tenets of the Ottawa Charter for Health Promotion.

The Regional Consultation for the Region of the Americas, of which Final Report is presented in this document, is the second event jointly organized by the World Health Organization Headquarters and the Pan American Health Organization (PAHO/WHO). It takes into consideration regional diversities and national priorities in the area of social determinants with a view to advance the Commission's work regionally and nationally. It will eventually incorporate knowledge and practice about social determinants into country work and national policies and programs. This consultation offers a unique opportunity to share the work of the Pan American Health Organization to combat disease and improve the health of the population through the application of social determinants' approaches that enhance equity for all. The first regional consultation took place in Cairo, Egypt, home of the World Health Organization Eastern Mediterranean Office.

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[1] Krieger N. A glossary for social epidemiology. J Epidemiol Community Health 2001; 55:693-700.

Expected Outputs

- A shared understanding of the work, vision and strategies of the CSDH and the corresponding organizational roles and functions.

- Opportunities identified for regional participation in knowledge networks and region-specific topics within the knowledge networks themes.

- Member States identified as interested in participating in the work of the Commission.

- A broad outline of activities, roles and responsibilities to translate the Commission's work into successful actions at the regional and country level.

Participants

The participants include representatives of the governments of Member States of the Region of the Americas, leaders of national experiences related to social determinants and reduction of health disparities, social scientists, researchers, academicians, representatives of multilateral and international agencies, civil society, appointed Commissioners to the Commission of Social Determinants of Health, and staff from the World Health Organization at Headquarters and Regional offices.

OPENING SPEECH ON BEHALF OF THE REGIONAL OFFICE

Mirta Roses Periago, Director of the Pan American Health Organization

Good morning to all. Welcome to the Pan American Health Organization, which is the Regional Office of the World Health Organization, or, as we call it, the home of health in the Americas. Congratulations to our colleagues in the World Health Organization, organizers of this regional consultation on the social determinants of health. Their true teamwork with our staff has made this event possible.

The meeting of political leaders from the developed countries of the G8 in Edinburgh also begins today in the midst of clamorous worldwide demands for rapid and effective attention to the problems of poverty and the disparities among human beings.

We are pleased to extend a welcome to the 18 members of the Commission, five of whom represent the Region of the Americas (President Lagos of Chile, Monique Bégin and Stephen Lewis from Canada, David Satcher and Gail Wilensky from the United States). The creation of this Commission, whose members include representatives of all of the world's regions, reaffirms the commitment of the Director- General of WHO, Dr. Lee, to the Organization's fundamental principles. It also reflects a decision to address the moral global public health imperative of reducing and eliminating health inequities.

A variety of new factors is changing both the concepts that frame the public health debate and the substance of that debate. We know that a wide range of social and economic approaches is required to prevent disease, avert threats, and reduce a range of disabilities, and that we need to improve our ability to implement such approaches at all levels with a gamut of actors and disciplines. Reducing or eliminating health inequities is an urgent task for public health, and for health care and environmental protection systems.

PAHO's interest in monitoring, contributing to, and implementing integrated approaches to health determinants has deep roots and a long history. The will of the governments of the Americas to promote peace, create more just societies, and give all people opportunities for social and economic development—and, today, technological development as well—has been manifest since the creation of the documents associated with the Alliance for Progress and the Charter of Punta del Este (1961). PAHO was active in the definition of the 10-Year

Health Plans at that time. Subsequently, the vision of health for all (HFA) articulated at the 1977 World Health Assembly and in the Declaration of Alma-Ata enshrined these health, equity, and social justice aspirations as permanent international health concerns. We have always regarded the preventable differences that impede full realization of this vision as unacceptable. At these important junctures, society as a whole was reacting to the obscenity, as Director Carlyle Guerra de Macedo put it, of disparities and social exclusion.

As far as health equity and the social determinants of health are concerned, my predecessors paved the way long ago. The leadership of Dr. Abraham Horwitz exemplifies this. His thinking explored the relationship between health and economic development,[2] and to demonstrate the importance of the relationship, he obtained a position at the Inter-American Development Bank for PAHO staff member Dr. Abraham Drobny. Sir George Alleyne fought, and continues to fight, for equity in health. His administration intensified the development of systems to analyze and measure inequities, carried out a number of research projects, and published important works (some of whose authors are with us today).[3]

Here, you will have a chance to hear about some of the regional, subregional, and national efforts to reduce inequity through approaches based on health determinants. You will also hear descriptions of some of the Organization's work in this vein in recent years, which includes efforts to improve decision-making by providing better methods of analysis and measurement that employ data disaggregated by sex, ethnicity, and geographical or administrative unit. It also includes action to foster health promotion initiatives and healthy municipalities, to support health-promoting schools, to monitor and reduce environmental risks, to promote food security, to strengthen the role of health in poverty reduction strategies, to mainstream the gender approach, and to foster an intercultural approach to health.

The regional consultation that we are beginning brings together representatives of 13 of the Region's countries—people from development agencies, civil society, social scientists and decision-makers, as well as WHO and PAHO personnel. It is an opportunity to examine the factors that hinder health development, and to propose strategies for intensified, targeted approaches to health determinants that create inequities. The commitment and participation of international and national leaders will facilitate the realization of many proposals for action at various levels of societies and health systems, as well as truly multidisciplinary approaches to reducing inequity gradients between groups and nations.

Despite many advances in health, both worldwide and in the Americas, much remains to be done if we are to diminish the enormous health gradients between populations, age groups, and sexes, both within and between countries. The work of this Commission promises to effectively support such action, and as the Pan American Health Organization, the countries of the Region embrace this initiative. This is consistent with sustained technical cooperation in health grounded in integrated intersectoral approaches. It is also consistent with a long-standing commitment to the vision and principles expressed in the Declaration of Alma-Ata and the Ottawa Charter for Health Promotion, with their emphasis on health for all and primary health care. Indeed, recognition of the importance of intersectoral action is an essential principle of HFA. Today, the challenge of regional and national health development is even greater than before, as a result of globalization and the advent of information and communication technologies that, while making the world interdependent, also increase the vulnerability of many nations and groups. Consequently, recognition of the social determinants of health and

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[2] Horwitz A. Relaciones entre salud y desarrollo económico, Boletín OPS Año 38, Vol. XLVII, August 1959; nº 2. Horwitz A. Reflexiones sobre economía y salud. Boletín OPS Año 40, Vol LI, August 1961, nº 2.

[3] PAHO. 2001. Equity and Health: Views from the Pan American Sanitary Bureau. Washington, D.C: PAHO. Occasional Publication No. 8.

health disparities must be accompanied by the creation of fruitful and effective partnerships with actors who share the objectives of equity, solidarity, and sustainability.

The Compact of the Millennium and the Millennium Development Goals (MDGs) are real commitments on the part of governments and many other actors. Their emphasis on poverty reduction, health, and the creation of effective partnerships represents real opportunities to advance the purposes of the health agenda, permitting us to refocus on two HFA strategies, intersectoral articulation and community participation. Moreover, the MDGs are in harmony with PAHO's new strategic priorities and directions, which are designed precisely to address the issues posed by health determinants (social, environmental and other), to protect health as a public good and a human right, to create synergy between actors, and to ensure that resources are fairly distributed.

We know that today's geographical and population disparities are not due simply to individual behavior, but that environmental, social, material, and institutional factors in the macroenvironment play a substantial role. Investing in policies and programs designed to affect the variables that influence health will help to reduce health inequities, since environmental effects are reproduced and transmitted intergenerationally.

There is controversy regarding social gradients, since elements besides wealth, such as social class, seem to influence health. However, we do know that social inequality, not only social class, has a detrimental effect on a population's health and life expectancy. Equity itself, then, is a powerful factor in social cohesion, and consequently fosters the health of the community.

Today's world—as well as tomorrow's—are characterized by enormous challenges (conflicts; civil wars; economic, social, technological, and biological threats). One of its dominant features is the growing vulnerability of economies and the environment—and indeed, of societies themselves—in a context where the ability of many governments to deal with these factors is tenuous. Paradoxically, however, these problems also create extraordinary opportunities that call for more creative thinking and invite collective approaches to creating a safer, healthier, and more peaceful world. Governments, key sectors, and regional integration systems are aware of these challenges and of the need to close the gaps between groups.

Finally, it is important to remember that health systems play an important role in progress toward more just and equitable societies. As a result, we must continue to stress

- a political commitment to universal access to health services;
- the recognition of health care as a human right;
- the ethical principles on which international commitments are based;
- the role and responsibility of the State in protecting populations' health;
- primary health care as the strategy for improving health systems;
- recognition of, and confidence in, the new sectoral reform agenda's ability to facilitate the reduction of health inequities; the need to achieve solidarity in financing systems; appropriate orientation when taking action that affects populations, and the use of health care models based on health promotion and disease prevention; proper performance of essential public health functions; sustained integral development of human resources, with emphasis on the steering role and on extending social protection in health.

I hope that the participants in this consultation will share their ideas on factors that create or exacerbate health disparities; on how to decide which particular factors merit intervention; on the questions of when, where, and how; on how to bring new working partners into the process as time goes by; and on how the international

public health community can influence social policy to reduce disparities and the inequities that they cause. Furthermore, since this task will be the object of future activities, we need to identify and share examples of policies, programs, and actions by individuals, communities, countries, and organizations that have succeeded in substantially affecting the social determinants in such a way as to reduce or eliminate health disparities/inequities.

As to the appropriate role for PAHO in the Commission's work, I believe that we must:

- recognize our responsibility to participate in the global effort;

- bear in mind the Region's particularities as we seek to properly disseminate this approach and integrate it in our technical cooperation work, following the principles set forth in the Strategic Plan, the Managerial Strategy, and the biennial programs;

- facilitate and participate in sharing experiences between countries and institutions; strengthen partnerships with a broad range of actors who have an interest in the process and share the values of equity and solidarity; and collaborate with Member States in applying these approaches in national, subregional, and regional contexts, since we believe that working together increases the benefits and efficiency of work in this area and reduces risks.

Let me take this opportunity to reiterate our interest in and commitment to the work of the Commission on Social Determinants of Health. There is no doubt in my mind that this regional consultation is an invaluable opportunity to share the work of the Pan American Health Organization to combat disease and improve the health of populations through approaches that take social determinants into account and thus advance the cause of equity for all. This event is one more example of our conviction that achieving global health requires close collaboration, cooperation, and mutual respect--processes and attitudes that allow us to learn from one another each and to reach our shared objectives.

OPENING REMARKS ON BEHALF OF THE WORLD HEALTH ORGANIZATION (WHO): INTRODUCTION OF COMMISSIONERS FROM THE REGION OF THE AMERICAS AND THE COMMISSION ON SOCIAL DETERMINANTS OF HEALTH (CSDH)

Timothy Evans, Assistant Director General, Evidence and Information for Policy (EIP), WHO

What do we mean by social determinants of health? Different models have been developed to interpret how social determinants influence health status and health inequalities. Some of these include, for example, the Dahlgren and Whitehead Model (1991), the Diderichsen and Hallqvist Model (1998) adapted by Diderichsen, the Evans and Whitehead (2001), the Mackenbach Model (1994) and the Marmot and Wilkinson Model (1999). These different approximations are not necessarily mutually exclusive, and the available evidence reveals gaps of uncertainty concerning their relative validity and the links between them. However, the analysis of interventions and policies addressing social determinants of health requires a framework that indicates the origins of health inequities, how inequities relate to social determinants and how various social determinants of health relate to one another.

The social determinants of health refer to both specific features of and pathways by which societal conditions affect health, and which potentially can be altered by informed action.[4] Traditionally, social

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[4] Rose G. Sick Individuals and Sick Populations. *International Journal of Epidemiology*. 1985. 14 (1).

determinants have been identified as characteristics of the individual, such as a person's social support network, income or employment status. Populations are not merely collections of individuals. Yet, the causes of ill health are clustered in systematic patterns, and the effects on one individual may depend on the exposure and outcome for other individuals,[5] because the determinants of individual differences regarding characteristics within a population may be different from the determinants of differences between populations.[6]

It is useful to distinguish two kinds of etiological questions. The first seeks the causes of cases, that is, the determinants of individual cases.[7] The second seeks the causes of incidence, that is, it addresses the determinants of population incidence rates. Therefore, when we talk about social determinants, we seek to answer how the causes of cases relate to the causes of incidence.[8] Why is there a graded relationship between social position and health status that affects people at all levels of the social hierarchy? Are the factors determining health changing for the better? Is it the same for everyone? Where and for whom are they changing for the worse?

Principles to Inform Policy: The figure illustrates the principles that inform policy. The horizontal arrows mark the levels of intervention on social determinants of health. These levels are placed in relation to the policy modalities that can or should be implemented. Thus, in addition to identifying potential intervention levels on social determinants of health, it is necessary to specify the policy principles within which interventions are implemented.
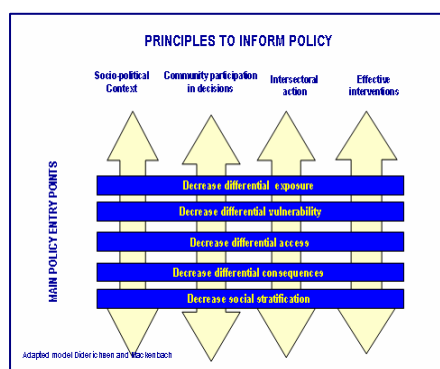
The vertical arrows identify four policy principles that are essential from the perspective of the CSDH.   The first vertical arrow underscores the need for responsiveness to national and regional socio-political context. This is a central element to develop policies that are attuned to the actual capabilities of developing countries. The second vertical arrow represents the principle of community participation in decision-making; it emphasizes the central role of civil society participation in this approach. The third arrow represents intersectoral action. This implies not only policies and actions managed from within the health sector, but also the integration of interventions and actions by other sectors whose goals include contributing to health. The fourth arrow recalls the need to focus on effective interventions; action based on evidence and evidence for action.

Why do they matter? Today's health landscape is very complex. Some of the features and trends include demands such as outcomes-based development, scaling up health systems with predominantly vertical disease intervention programs, and a general concern about the unsatisfactory performance of health systems. Moreover, safe, proven and inexpensive interventions are not reaching those in need. Those with unmet needs are, disproportionately, those with lesser means. Too many people are worse off through encounters with the health system, and the number of people that suffer financial catastrophes and impoverishment due to health

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[5] Evans T. Whitehead M., Diderischsen F., Bhuiya A., Wirth M. Challenging inequities in health from ethics to action. Oxford University Press 2001.

[6] Marmot M. Economic and social determinants of disease. *Bulletin of the World Health Organization*, 2001, 79 (10): 988 -989.

[7] Risks to ill health may include exposures, vulnerabilities/susceptibilities, while access to health services would refer to location, appropriateness, affordability, and finally, the consequences of ill health include work-related income loss, costs associated with providing care.

[8] Krieger N. A glossary for social epidemiology. *J. Epidemiology Community Health*. 2001. 55: 693-700.

spending is sizeable.

Why a Commission on Social Determinants of Health (CSDH)? The CSDH can do better because we will learn historical lessons and build on gains of previous eras. One strong and supporting example of the importance of the social determinants of health is the Millennium Development Goals (MDGs). They have become the new policy space, and they underscore the centrality of health and intersectoral connections that health, in the MDGs, requires; that is, action on social determinants.

How will the CSDH operate? The CSDH will operate through a broad consultative process to produce strategic directions in two areas. One is evidence as knowledge for action, prioritizing learning in developing countries and focusing on a limited number of determinants. The second relates to leadership and advocacy through meetings, to engage real experiences of social disadvantage and civil society as a fundamental pillar to achieve sustainability. The emphasis will be on promoting action on social determinants of health in countries interested in or already using a social determinants approach to policy and programs with a view to demonstrate, document and evaluate policy, practice, leadership and scaling-up worldwide. The composition of the CSDH includes government leaders, knowledge networks, Commissioners, WHO staff, and partnerships between "experienced" countries that are collaborating with those beginning to implement.

What are the expected outcomes? Progress can be achieved in a relatively short time. The CSDH's vision of a changed world assumes that social determinants of health will be incorporated into WHO's planning, policy, strategy and technical work. That they will be incorporated into national policy development processes and that knowledge will be consolidated, and gaps clarified for action. Moreover, we will work with selected countries towards improving health and reducing inequities.

OBJECTIVES OF THE MEETING

Cristina Puentes-Markides, Strategic Health Development, Health Policies and Systems, PAHO

The objectives of the meeting are to:

- Inform Member States on the work initiated by the recently established Commission on Social Determinants of Health (CSDH), and about its overall vision and strategy, formation of knowledge networks and planned activities at the country, regional, and global levels.

- Share experiences of work undertaken in various countries, that utilizes a social determinants approach, and that is built around the knowledge network themes. .

- Identify and agree on areas of work within the knowledge networks themes, and on opportunities for country work.

- Identify Member States that have an interest in participating in the Commission's work in specific areas.

- Identify steps, key actors and responsibilities for translating the Commission's work into country and regional action.

Question and Answer Session

The opening presentations by the Director of PAHO, Mirta Roses, and by the Assistant Director General EIP of WHO, Timothy Evans, set the tone for the Commission on Social Determinants of Health and for this event.

Are we preaching to the converted?

The question of "what good it is to treat people's illnesses and then send them back to conditions that made them sick in the first place" captures the essence of the purpose of the CSDH and of the goals set to be achieved. Some participants wondered whether when we speak about the health determinants, we are preaching to the converted, when, in fact, the challenge seems to be whether and how the ministers of health are able to convince other cabinet colleagues, actors outside the health sector, and regional and international organizations about their relevance and to convert them.

The response underscored that although associations between determinants and health are clear, it is not so obvious "who are the converted." People within the health sector —in particular those working in vertical programs— may not be as fully "converted" as we may think. The lack of skills often becomes a constraint to program achievement, and therefore they need to be revised in the short term. A good deal of good evidence needs to be synthesized and then shared. Moreover, some of our colleagues may need to develop new skills in order to address health determinants appropriately.

Where are the barriers?

The United States has been able to make some headway in educating people, yet large amounts of money are invested in a system that does not provide the desired results, simply because we are not focusing on the social dimensions of health. The barriers are often among the health professionals, since the financial motivations are on the curative side of the health care system. Educating people about lack of efficiency and effectiveness could be a strategy, but it is also necessary to introduce motivation and to address the barriers related to other social aspects, such as religion and culture.

The Political Nature of the Challenge

Several participants recognized the political and challenging nature of applying a health determinants approach. Work within Cabinets remains siloed and departments compete rather than collaborate. Therefore, success requires signals from the top of the political hierarchy.

Furthermore, the effectiveness of policies and the long-term success depends on the timely participation and the commitment of relevant stakeholders to a healthy future for all. National experiences show that success calls for evidence and effective arguments to build political and economic muscle with the government and beyond. This means establishing alliances and partnerships with the private sector, non-governmental organizations, academic institutions, and civil society, which are often interested in strengthening public health and social determinants.

Integrating players with the rest of social development efforts is essential for a healthy process and for the country's social and economic future. Critical players from the government and outside the government need to be at the table from the outset, rather than at the end. A successful example from Ontario, Canada was the interministerial work council on health and social justice, chaired by the prime minister of the province. This experience did not force coordination, but it demonstrated the importance of the presence of the ministers at regular meetings. All knowledge hubs can play a role and they should try to encourage participation. WHO could also send a strong message and help dictate the success of these programs early, rather than later, when

ministers might feel that they have not been involved. Therefore, linking the knowledge hubs and leveraging all resources will contribute to reaping mutual benefits.

Who are the critical players? What is their role and the nature of their participation?

The World Health Organization considers that as one of their main functions, the ministries of health must also have responsibility to catalyze the sense of health as a shared social goal, and to bring together those who need to work together. WHO has to provide some sense that action is doable and that it is based on evidence; this is something that the CSDH can support.

Effective change is not possible without the commitments of the governments. The CSDH needs to work with organizations like PAHO, with relations and credibility, which can help gain entry into the ministries of health. These contacts can serve as portals to other discussions about health, economics and other determinants that can be affected with strong multi and intersectoral interventions.

How can we communicate effective arguments and induce change?

The CSDH must be clear and realistic about processes of change, and must identify opportunities that may arise in different contextual settings. It is critical to understand that there is not just one right approach or process of change, but that there are rather different points of entry and strategies, which would allow the establishment of workable plans.

Long-term Thinking: Public Health as Investment

As a group of concerned professionals and practitioners, this body needs to think about how we speak about social determinants to other sectors. An appeal on social determinants appeals to altruism, but perhaps we need to use the language of commerce and talk in terms of marketing. One historical example is the US Public Health Services, which was created to protect the health of the merchant seamen of this country. It was created for reasons of commerce, and not out of pure altruism. The idea that global public health is an investment, not a cost, must be "sold" effectively. Relevant players need to be convinced to take action not out of the goodness of their heart, but because they recognize that health is good for their bottom line. We need to sell very strongly that if our children go back to the same disadvantaged conditions, their future will be affected; health is good for companies, health is good for societies.

COUNTRY PRESENTATIONS: SOCIAL DETERMINANTS AND EQUITY-ENHANCING POLICIES AND PROGRAMS

Brazil: Public Policies to Target Health Inequalities

Elisabeth Carmen Duarte, Ministry of Health

Brazil welcomes the opportunity to participate and to share with the audience their experience in inequities in health and determinants by highlighting some of Brazil's examples and pointing out health policies focused on reducing inequalities.

Brazil has a population of about 180 million people living in an area of 8.514.215, 3 km². There are 26 States and the Federal District (five regions) that include 5.900 municipalities. Around 11 million of families are poor (44 million people) and 4, 5 million are considered extremely poor. Income distribution indicates that the poorest 50% receive 14.4%, and that the richest 1% receives 13.5%.

Regions are more than geographical divisions; they represent demographic, social, cultural, educational and economic differences. Major inequalities in health exist among the population and between the different regions of the country, where according to the IBGE (Brazilian Institute of Geography and Statistics) and IPEA (Institute of Research on Applied Economy) the Gini coefficient in 2002 was 0.589. Infant mortality rates, homicides, and obesity are examples of growing inequalities in health.

Examples of public policies targeting health inequalities

1. The Family Health Program (PSF)

Seventy five percent of the population uses the SUS (Sistema Único de Saúde) (134.212.651); and there are 2,03 billion outpatient interventions, and 11, 6 millions hospital admissions per year.

The Family Health Program is a modified primary care model aimed at organizing primary care as a gateway for the SUS and to expand access for the poorest individuals. The program covers 4,707 municipalities with 21.939 facilities, 196.009 agents, 9,781 oral health equipments in 3, 346 municipalities. The Family Health Program was expanded in 2005 to cover municipalities with less than 100 thousand inhabitants (210 municipalities) with an expenditure of US$550 millions.

In all Brazilian Regions, the impact of the Family Health Program on infant mortality rates (IMR), especially those due to decreasing diarrhea mortality; and after adjusting for other IMR determinants such as water supply, sanitation, and presence of other health professionals, coincide with the evidence established by Macinko J and Marinho MF, 2005 New York University and Health Ministry-DASIS. Less developed regions exhibited higher positive impact.

2. The Bolsa Família Program (PBF)

This is a program managed by the Ministry of Social Development and Fight against Hunger *Fome Zero,* and the Bolsa Familia Program is one of the main actions of Fome Zero. Fome Zero is a public policy, which places hunger not as an individual fatality, but as a national matter. It represents a set of public and social policies that articulate government and non-government actions towards the eradication of hunger, and the promotion of social inclusion in Brazil. Moreover, it expresses the Federal Government's decision to place the fight against hunger at the core of national political agenda.

The Beneficiaries' Selection Criteria and Cash Transfer Values[9] target extremely poor[10] families; that is, households with monthly income per capita below US$ 20. These families receive a fixed benefit of US$ 20, a variable benefit of up to US$ 18, and the children 0 to15 years of age group receive US$ 6. This conditional cash transfer program works in two dimensions. First, it makes for immediate alleviation of poverty through the provision of monetary transfers; and second, it contributes to the eradication of poverty and to promotion of social inclusion through the assurance of basic social rights; such as health, education, and access to complementary policies. The requirements for participation include prenatal and postnatal health visits for pregnant and lactating women, updated vaccinations for children under seven years of age, and school attendance is required for children between 6 and15 years of age.

A poll with beneficiaries of the Bolsa Família Program showed that the program had achieved positive outcomes. It also verified that people with limited or no access to paid work need the benefits and need

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[9] Exchange Rate 05/19/05 1US$ = R$ 2,50

[10] Poor families are households with a monthly per capita income of between US$ 20 and US$ 40; they receive a variable benefit up to US$ 18.

to receive them regularly. The benefits have a positive impact on the family budget, food security and local commerce. Moreover, going to school has become a very positive incentive for children that see it as a way to improve the family's income.

The presentation concluded posing the following series of questions and plausible answers to the Commission.

What are the health inequities' main determinants? Do we know it all?	To help the fulfillment of the gaps in knowledge.
Do we need to know it all before we start action?	Advocacy based on evidences that are already available.
What works?	To help in the evaluations of program's impacts on health iniquities.
How to solve methodological difficulties in studying health inequalities? What are other governments doing?	Provide some methodological guidance on issues such as measurement, reverse causality bias, confounding, and high co-linearity.
Is the health system a protective factor against health inequity, or is it a risk factor?	Observatory of governmental experiences or forums to exchange experiences. Brings the focus to the health sector responsibilities.

Canada's Action on Social Determinants of Health

Sylvie Stachenko, Deputy Chief Public Health, Public Health Agency of Canada

Canada's action on social determinants is supported by several milestones that include the 1974 Lalonde Report, the 1986 Epp Report on Achieving Health for All (a nine-point framework that reflected Canada's response to the Ottawa Charter for Health Promotion), and the adoption by CDMH of the population health approach in 1994. This strategy aimed at addressing determinants of health and to intervene early in causal streams through multiple strategies with the public's involvement, work across sectors and supportive research infrastructure. Another milestone was the initiative Building Partnerships for Health, which expanded linkages and collaboration. The launching of the Public Health Agency in September 2004 is the most recent.

The political commitment is happening now aided by strong foundations and potentially some new contributions at the federal government level. The current activities build on Canada's experiences while looking towards present and future opportunities, such as the current strong institutional capacity in research (e.g., Canadian Population Health Initiative (CPHI) and the Health Promotion Research Consortium). Partnerships have often tended to remain in *silos* focused on specific diseases, yet some cross-cutting broader partnerships are emerging, such as more inclusive approaches to chronic diseases.

Policy Context where Action Takes Place

First, the history of the social welfare orientation of Canada is based on a progressive tax system, income support for families with children, protection for workers and support for education. There is a clear commitment to health as a social goal reflected on the September 2004 Ten-Year Plan to Strengthen Health Care. First Ministers are committed to a health agenda that includes universal health services through the Canada Health Act, intersectoral linkages through various initiatives (e.g. National Children's Agenda, Tobacco Control Strategy, Healthy Living Strategy) and community participation in decision making for health through a

process to define public health goals.

The *social union* initiative is the umbrella under which governments will concentrate their efforts to renew and modernize Canadian social policy and therefore the system of social services. The initiative focuses on the pan-Canadian dimension of health and on social policy systems, the linkages between the social and economic unions, and the recognition that reform is achieved in partnership among provinces, territories and the Government of Canada.

In working to build a strong social union, the Government of Canada, the provinces and territories have reached a broad consensus that children in poverty and persons with disabilities are the first priorities. First Ministers created the Federal-Provincial-Territorial Council on Social Policy Renewal in 1996 and directed it to guide the social union initiative. Canada is relatively far along in adhering to the principles but there is still work to do in drawing the focus of the central government to the importance of health as a social goal and strengthening intersectoral action. Three key elements have focused the discussions around the 10-year plan; namely, reducing waiting times, developing the national pharmaceuticals strategy, and advancing the definition of public health goals and targets.

HEALTH INVESTMENTS IN SOCIAL DETERMINANTS OF HEALTH
▪ Community-Based Programs focus on vulnerable populations and involve populations in identifying need and proposing solutions (e.g. Community Action Program for Children, Aboriginal Head Start, AIDS Community Action Program, Canadian Diabetes Initiative)
▪ The Population Health Fund supports projects that build community capacity to address the determinants of health.
▪ Canadian Public Health Institutes, Canadian Consortium for Health Promotion Research, Centres of Excellence for Children, PRI Strong research programmes, e.g. through Canadian Public Health Institutes, Centres of Excellence for Children (four knowledge networks, HELP has produced good syntheses, mechanisms for dialogue around specific issues of disparities, social exclusion, social capital, and knowledge translation of these issues).
▪ The Integrated Healthy Living Chronic Disease Strategy is a counterpart of the global strategy and as such, it is a collaborative integrated approach focusing on risk factors as well as on determinants.[11]
▪ The National Collaborating Centres synthesize policy relevant knowledge nationally and internationally, identify gaps, promote knowledge translation to policy and practice in public health. They address social determinants of health (e.g. public policy and risk assessment, infrastructure and tools development, environment and health, infectious diseases and Aboriginal health). The Center on social determinants of health and the center on public policy at the Institut de Santé Publique, Québec may be relevant to the work of the CSDH.

The major challenges involve populations at greater risk. Aboriginal health is a major ongoing problem being addressed by significant investments for urgent needs (e.g. early learning and child care, culture and language, housing, indicators and life expectancy disparities). Other advances include the Aboriginal Health Blueprint in September 2004 (agreement between Aboriginal Leaders and First Ministers to improve access to services and set an agenda for upstream action), and the Northern Dimension Initiative, which is international and aims to promote sustainable development through improved health and social wellbeing.

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[11] Its goals are to improve overall health outcomes and reduce health disparities by addressing common risk factors. It includes an intersectoral network to direct future actions, collaborate, coordinate policy, actions, and messages, and evaluate progress. This is a combined balanced approach of population health and high risk and disease-specific approaches, including primary, secondary and tertiary prevention. Comprehensive, collaborative and in partnership with national, P/T, and NGO/NVO stakeholders, intersectoral network that provides a forum for future action, coordination and evaluation.

These long-term efforts have provided learning experiences:

- leadership and commitment across governments is essential,

- intersectoral action is essential to address social determinants of health, but difficult to achieve,

- the community is a good locus for intersectoral action and it is critical to work on improving population health and reducing disparities simultaneously,

- public involvement is an essential element of success.

Better-integrated evaluation efforts might provide more benefits and we are thus revising this approach at the federal level so that improved integration will support learning across issues and sectors alike.

Public Health Goals

Establishing public health goals is a participatory and vital process to galvanize society around health. The Public Health Goals Process involves two phases. Phase I will involve consultations with experts and the public in Provinces and Territories, twelve roundtables, thematic roundtables based on determinants of health[12] and a Web survey. We expect early results to focus on intersectoral action and vulnerable populations across goals. The Fall Summit will seek to achieve consensus on goals. Phase II will involve reporting to First Ministers, development of targets and indicators and establishing links to the work of the Public Health Network. Yet, the hardest work will be to develop targets and indicators with clear responsibilities between federal government and provinces and the complementarity of various initiatives. There will be few and broad goals, which will allow the provinces to adapt them to their own situation within an accountability framework. The Canadian Population Health Initiative is already collecting data on indicators, and strategies will be developed later. Champions at the political level have helped make this happen.

Concerning international activities, Canada is interested in the work of the Commission on Social Determinants of Health (CSDH). We will continue to support the two Commissioners and the networks on globalization and early child development. We will continue supporting the CARMEN Policy Observatory, which is a PAHO baby focused at least in part on intersectoral strategies. The observatory has been operating for a year and is initially looking at three countries (Canada, Brazil and Costa Rica) with opportunities for expansion and further collaboration and learning. Canada is committed to the MDGs and the 3X5 initiative, having increased their investment. Finally, the Bangkok charter will aid in connecting policy and practice as a continuous. Canada will be hosting the 19th IUHPE World Conference on Health Promotion and Health Education, Vancouver 2007, which focuses on inequities.

Mexico: The *Oportunidades* Program

Rodolfo Guzmán García, Technical Secretary, Oportunidades Program

An assessment of the health situation in Mexico shows that monetary income has increased, primary care has improved, and public health policy and technology have led to advances on multiple fronts. Long-standing lags persist, nonetheless, side by side with new problems associated with demographic transition and epidemiological polarization. Unequal regional distribution also remains a problem, with 34% of the uninsured

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[12] Opportunities for healthy development and learning throughout life, supportive communities and healthy working conditions, sustainable, diverse, and safe environments, vulnerable populations, supports for personal choices, skills and capacities that enhance health, an integrated supportive health system.

population served by governmental systems and the IMSS *Oportunidades* program, while 54% of the population is covered by social security or private care.

As regards health determinants, although life expectancy at birth has risen to 73 years, there are major differences between regions (65 years in some parts of the south, and 75 in the north) and between rural and urban areas (70 versus 76 years). Although mortality declined between 1930 and 1970, high fertility persisted. After 1970, when, with some difficulty, programs to prevent population growth were put in place, fertility declined, while the older adult population and chronic degenerative disease increased. Mortality from infectious diseases has declined notably over the past 70 years. Mortality from injuries and accidents has risen since 1980. Mortality from noncommunicable diseases, especially cancer, cardiovascular disease, and diabetes, has been increasing.

Results of assessment by independent organizations 2001–2002 and 2003–2004	
Registration in rural secondary schools	+24
Registration for upper levels of secondary schooling	+85%
Dropout rate in rural areas	-17%
Flunk rate in rural areas	-13%
Weight and height of children under 3	+16%
Diseases in children under 5	-12%
Maternal mortality	-11%
Household food expenditure	+13%

Five regions and 31 states have contrasting epidemiological situations.[13] Health inequalities as a function of gender, ethnicity (the south is poor), age (specifically, children and older adults), and income. Although mortality has fallen by as much as 94% in the past 110 years (the period for which there are records), it remains high (27 deaths per 1000 live births), and in some regions very high (79 per 1000 in rural areas and 29 in urban areas).

This administration has created a people's insurance plan (whose features are those typical of low-expenditure plans). Although the program has achieved almost total coverage in the relevant regions, 8% of the population remains without coverage due to population dispersion.

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[13] Transición avanzada: Capital Federal y ocho estados (Sinaloa, Sonora, Aguascalientes, Baja California Sur, Coahuila, Tamaulipas, Nuevo León y Nayarit); Transición intermedia: seis entidades: Baja California, Chihuahua, Colima, Jalisco, Morelos y Tabasco; Transición incipiente: siete estados: Zacatecas, Guanajuato, Tlaxcala, Campeche, Yucatán, Quintana Roo; Rezago diferencial: cuatro entidades: Durango, Michoacán, Querétaro, Veracruz; Rezago extremo: cinco estados: Puebla, Hidalgo, Chiapas, Oaxaca y Guerrero.

Oportunidades is the federal government's human development and social equity program. It is a part of President Fox's social policy strategy, which is called *Contigo* ("with you"). *Oportunidades* is a mechanism that plays a role in a number of programs and initiatives that employ an intersectoral approach to food, nutrition, health, and education. The program has partnerships with the Secretariat of Social Development, Ministry of Health, Mexican Social Security Institute (IMSS), state health institutes at the provincial level, municipal agencies and the Secretariat of Public Education. *Oportunidades* began in 1998, and one out of four Mexicans receives benefits under it today. In 2005, the program executed a budget of over 30 billion pesos.

It serves the poorest and covers all the country's indigenous areas, concentrating on states with the highest indices of poverty and economic/social exclusion, such as Veracruz, Chiapas, Oaxaca, Puebla, Mexico, Guerrero, and Michoacán. *Oportunidades* serves 5 million families (34% of the population), providing benefits to over 25 million individuals whose income does not meet basic needs. The program thus benefits one-quarter of the Mexican population, representing achievement of the program's six-year goal, a level that was attained in 2004. Eighty-six percent of beneficiary families live in rural areas characterized by substantial indigenous populations, and most of these areas are geographically remote and isolated from mainstream activity.

Some 96.4% of beneficiaries are mothers who receive cash payments. This support is subject to conditions. It requires students whose families receive aid to attend school regularly and families to keep medical and interview appointments.

Oportunidades supports health through free provision of the Basic Health Package,[14] with special emphasis on prevention, care for the most common diseases, and monthly educational sessions on disease prevention, hygiene, and other health-promoting habits, environmentally sound methods of dealing with human waste, and reproductive health.

The program aims to better nutrition, monitors the beneficiary population in that respect, helps to prevent and combat infant and child malnutrition from gestation on, delivers food supplements to pregnant and nursing women, and provides education on food and nutrition. The activity primarily targets the most vulnerable population, such as pregnant and nursing women and children under 5, who receive food supplements. Training sessions on self-provided health care are offered to direct beneficiaries, upper secondary-school students of covered families, and other members of the family. Monthly educational sessions on nutrition, food preparation, and healthy eating habits are designed to foster a culture of prevention and promote family and community action to promote their own health.

The monetary transfers increase and improve beneficiaries' dietary intake. The maximum amount that a family can receive monthly for education and food during the January-June semester in 2005 is $1,055.00 (one thousand fifty-five pesos) when in the family there are no upper secondary-school students, and up to $1,785.00 (one thousand seven hundred eighty-five pesos), when there are such students in the family. The benefits for girls are greater than for boys at the primary, secondary, and upper-secondary levels. There is specialized care for children and mothers.

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[14] El paquete básico incluye saneamiento básico a nivel familiar, planificación familiar, atención del parto y del puerperio, vigilancia de la nutrición y del crecimiento infantil, inmunizaciones, manejo en el hogar de casos de diarrea, tratamiento anti-parasitario en el hogar, manejo de infecciones respiratorias agudas, prevención y control de la tuberculosis pulmonar, prevención y control de la hipertensión arterial y la diabetes mellitas, prevención y control de accidentes y manejo inicial de lesiones, capacitación comunitaria para el auto-cuidado de la salud, prevención y detección del cáncer cérvico-uterino.

Josefina Vázquez Mota is Secretary of Social Development (SEDESOL), and Rogelio Gómez Hermosillo is *Oportunidades'* General Coordinator. Dr. Vázquez Mota understands the importance of intersectoral action and occupies an office beside that of the Finance Secretary. She regularly stresses that social policy is a part of economic policy. Indeed, we firmly believe that fiscal reform is social reform, and that it is urgent, because it is urgently needed by the neediest.

Guatemala: Food and Nutrition Security as a Government Priority

José Andrés Botrán, Secretary, Secretariat of Food and Nutrition Security (SAN)

Identifying the challenges that we face in Guatemala requires recognizing and understanding the country's history. From the conquest to 1900, Guatemala's economy was dominated by an agricultural export model based on coffee. This did not foster strong economic development, since coffee production does not require highly skilled labor, but thrives on low-cost human resources. Politically, the country has had less than 25 years of democracy and has generally been governed by highly militarized dictatorships in difficult circumstances that did not foster trust and human development.

The country is growing at an annual rate of 2.7%. The highest indices of population growth appear among groups that have little or no access to education. The population with the least education (under 5 years of schooling) is tremendously vulnerable, and this is reflected in the country's fiscal patterns. By 2010, almost one-third of the population will pay taxes, while the greatest demands will come from the other two-thirds.

Currently, Guatemala has the world's third worst chronic malnutrition rate, after Bangladesh and Sudan, a humiliatingly low position in comparison with most of the Region's countries and most of Central America. Acute and chronic malnutrition—especially the latter—are serious problems. This should not be the case in a country that, while small, does have the agricultural resources to feed its people.

Furthermore, people living in extreme poverty migrate from Guatemala to the United States and return. This leads to a culture of gang violence, enormous social imbalances, and problems of governance, which, in turn, create stress and disillusionment with democracy in the population whose basic needs are unmet.

Government alone cannot remedy problems of this magnitude. The political and economic muscle to make a difference can only be mustered through joint efforts by government, the private sector, and civil society, including schools, universities, churches, chambers of commerce, and others. Furthermore, malnutrition is a highly complex problem and cannot be solved in the course of one government administration. Thus, we need policy and strong legislation that provide continuity over time.

The face of hunger in Guatemala has the face of a rural indigenous woman. This is one of the most important determinants that we must change. In the eastern part of the country, more people are of European descent, and cultural capital is being diluted there. Malnutrition affects nearly 75% of children in indigenous communities and 50% of children nationwide. As adults, this percentage of people will suffer from the consequences of malnutrition, producing a collective loss of intelligence. We know that a child who fails to grow to an adequate height by three years of age suffers irreversible long-term harm and is subject to cognitive deficits.

We are convinced of the need to ensure food and nutrition security. We do not believe that discussing health is enough, for efforts in other sectors play a significant role in progress toward the objectives. We have therefore promoted legislation for systemic efforts to improve health through several government agencies. We

are developing a plan to eradicate chronic malnutrition by 2020. Its success depends on wide-ranging education and awareness, for the contribution and support of other sectors and ministries is of undeniable importance if we are to achieve the objective within the period of time set.

Again, government alone cannot solve problems of this magnitude and complexity, nor can they be solved during a single administration. Thus, we need policy and strong legislation that provide continuity over time, and for this we need. Only by the joint efforts of government, the private sector, and civil society, including schools, universities, churches, chambers of commerce, and other entities, the political and economic muscle needed to make a difference, can be mustered.

Dr. Botrán says that his position as Secretary of Food and Nutrition Security began as an honorary post with a small unfunded committee. This has changed enormously, as efforts have been made to raise awareness in the private sector and the cabinet about social development and the need to improve it.

Food and nutrition policy was absent for 25 years. In the last year and a half, however, the issue of a legal framework has been under study. Though it was difficult to bring to everyone involved into the discussion, this participation is now being achieved. A food and nutrition policy has been negotiated with the private sector, other ministries and government agencies, United Nations institutions, and civil society (organized peasants and rural groups with reform agendas), and common spheres of action have been found. The SAN is functioning and has focused on coordinating all the actors involved to guarantee food and nutrition security for the Guatemalan people. These efforts have contributed to improving health conditions for children from 3 to 59 months of age.

Rights set forth in SAN Decree 32-2005

As requisites for a healthy and active life, every person has the right to lifelong, timely physical, economic, and social access to a diet that is quantitatively and qualitatively adequate, culturally appropriate, and preferably of national origin, as well as to its proper biological utilization.

The guiding principles of the nation's food and nutrition security policy include solidarity, transparency, guidance, food sovereignty, equity, sustainability, comprehensiveness, responsible participation, and decentralization.

SAN's national strategies include raising awareness, promoting citizen participation, creating jobs, training human resources, responding to emergency situations, maintaining an information system, carrying out monitoring and evaluation, respecting ethnic diversity, and acting consistently with national development policies. The National Food and Nutrition Security Council includes ministers from several sectors, as well as representatives of the private sector and civil society. The Secretariat of Food and nutrition Security reports to this body.

Concerning SESAN's priorities and objectives, we need to integrate activities in a strategy designed to respond to risk, and we need a plan to eliminate chronic malnutrition in children under 3. In addition, knowledge of policy and legislation must be disseminated, general awareness and social mobilization must be fostered,

information and communication for and with SAN[15] must be improved, volunteer work in SAN must be promoted, and systems must be designed to monitor and evaluate the nutritional situation, provide early warning, and ensure the availability of food in Guatemala.

Discussion: Commonalities and Diversities in the Cases Presented

There are clear commonalities between Brazil's conditionalities for the *Bolsa Família* to those of Mexicos's *Oportunidades*.

How do exclusionary factors affect vulnerable groups?

Guatemala and Mexico agreed that indigenous populations are the neediest in terms of health and infrastructure; they are often the forgotten groups. It is essential to respect and to take into consideration the culture of each group. Yet, it is often difficult to communicate messages and to improve their health-promoting habits. It is a challenging but necessary effort. Frequently, lack of political weight from mayors and governors become a factor in settings when populations are not properly organized to make effective demands. Guatemala conceded the need to face this challenge and one way to approach it has been the focus of loans from the Inter-American Development Bank (IDB) and the World Bank (WB) on these groups and affected areas.

The United States mentioned that it is important to "meet the client where he/she is at." The only way to assist and help people change is to build trust as a first step in order to engage the population, since cultural and religious factors may impede health-promoting efforts. And, the US Department of Health and Human Services uses a model with people on the ground, these are the regional administrators.

What percentage of the health budget is allocated to primary health care?

Brazil stated that about 4% of the GDP is invested in health, but it does not have handy the exact amount for primary health care. The Brazilian health system is public and free. Only twenty five percent of the population pays for other systems, but when anyone in this 25% requires an important intervention, he/she is assured the right to health through the constitution. Thus the system must pay when there is such demand; and, needless to say, the patient cannot afford to pay for something such as a transplant. Ninety-five percent of all births are institutional, and women have access to prenatal exams. The national health survey recently showed that 98% of the respondents said that when they needed a service, they had it. Eighty-seven percent said that they had access to medications. Yet, the health situation is not satisfactory because access to health care is insufficient to address all health problems. There is a movement to reorient health services.

What is the role of the private sector representatives in Guatemala?

In Guatemala, the private sector participates in the CONASAN (Consejo Nacional de Seguridad Alimentaria y Nutricional), but the selection of members is currently being reassessed since some rotation would avoid the monopoly of a few. Moreover, the private sector must be kept involved in health work since they will help maintain a stable course, in spite of government changes; they provide some kind of oversight so that drastic turns do not happen in the future. Guatemala is only now developing the corresponding rules for their participation.

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[15] Apoyar a las comunidades en su lucha contra el hambre y la desnutrición y fortalecer sus capacidades para que alcancen su Seguridad Alimentaria y Nutricional a través del reconocimiento de sus potencialidades por medio de procesos de sensibilización y educación. Brindamos apoyo técnico y operativo sobre la base de los valores que nos rigen.

Are there special programs for informal sector workers who are often out or the government radar?

In Mexico, the link between *Oportunidades* and the employment categories is still insufficient.

Guatemala does not have any special programs for informal workers; the public hospital network and social security addresses only the needs of registered workers.

Brazil acknowledges serious problems in the area of occupational health. There are specific projects to address the growing problem of child labor. However, the topic of protection of informal workers has not had the full attention it deserves yet. In order to start moving this topic forward, the government has began a surveillance program in occupational health, which will allow us to focus better on these groups.

Priority Setting

Brazil has made great investments in their information system. In terms of high technology, the health system does not have all the funds to cover the wide variety of demands. Those who are most disadvantaged remain in line to access high medical technology services, and those who have more information about how to navigate the legal processes are more able to obtain the service —surgery or transplant— they need. The government is concerned about this and therefore is in the process of developing guidelines to respect health priorities.

Concentration of Ill health and stratification of risks in poorest populations

A nutrition transition is occurring. This means that undernutrition trends persist, yet simultaneously there is a trend towards obesity with stratification of risks that affect the poorest populations. Therefore, it is fair to ask how are countries like the United States and Brazil understanding and addressing the social stratification in cases of obesity and smoking, where the trends concentrate among the poorest and most vulnerable populations? What is in the objectives of Healthy People that pertains to poor populations? Are there specific programs and targets for populations at greater risk?

Brazil

Healthy Brazil focuses on three big protective measures: physical activity, nutrition, and prevention of tobacco use. Some health promotion programs have been successful; for example, anti-tobacco, which has began to focus on the most vulnerable groups (39% to 19%), and the poor. These have been the most difficult groups to reach with the messages. We already see changes in mortality for lung cancer due to decreases in smoking among younger groups in the population compared to historical series of the same groups. In relation to other areas, the Ministry of Health has recently invested in non-communicable diseases. A major national campaign is underway to address non-communicable diseases and their risk factors. The 2004 survey shows some success, but sharper focus on the most vulnerable groups is needed. In 2005 the survey will be implementing schoolchildren, nutrition, sexual and traffic safety.

United States of America

The Healthy People goals are stated more broadly, yet data sources show us data for specific population groups, for example, racial and ethnic minorities, and we can break down the special population rates of obesity. The data sources from NCHS (National Center for Health Statistics) are housed at CDC. Special marketing materials and messages targeted at specific groups are now being used.

Ninety-five percent of the health care dollars are spent on sick people and only five percent on healthy people, and of the 1.6 trillion dollars spent on health, only about 5% of United States' health care budget is being

spent on health promotion. Therefore, there is a huge amount of work ahead. We are trying now to move towards a paradigm shift in favor of health promotion. USDHHS and the Department of Agriculture issued dietary guidelines in 2005 (every 5 years as the science requires), this time we included materials for special population groups and special pieces of advice for vulnerable groups with special problems.

The Medicare Modernization Act includes the elderly but across all population groups there are some preventive pieces never covered before, welcome to Medicare physical examination, so when an elderly American begin to take part in the program, he/she gets a physical exam, good point to move towards a more preventive care. The Medicare Modernization also includes stronger emphasis on prevention and promotion. The issue of obesity illustrates the importance of the work of the Commission, as well as lack of equity and opportunity as an intermediate determinant. Poor people have less access to healthy foods or healthy lifestyles, in many communities, there is no access to healthy food and it is not safe to go outside and exercise.

Mexico

Mexico sees marketing and commerce as sort of weapons that cut both ways since a 1999 survey on nutrition showed that obesity and malnutrition affect all levels of society in very high and very low-income deciles, and signaled some alert. They affect everyone. Therefore, Mexico not only wants to fortify foods but also address the distribution issues to reach those populations most isolated.

Gender

It appears that all programs presented incorporate the issue of gender. However, some researchers are focusing on what they call second-generation discrimination, that is, those gains of previous eras may be now a disadvantage. Therefore, it is important and necessary to continue thinking of women.

Sustainability and governance

The instability and lack of governance within nations and systems create concerns for the long-term sustainability of programs, which in turn may affect their consistency and evolution.

In the case of Mexico, Oportunidades was established in 1997 and when the current administration took over it gave the program continuity because it was in fact a good program. They have maintained the people from the start of the program, who helped design and create it. Oportunidades has obtained support from an external bank, which guarantees at least another eight years of the program even if the government changes. The government has tried to ensure that the clients begin to own the program and that they are empowered, which will contribute to increase its sustainability. Mexico is pleased to report that at least twenty-seven countries have visited the country to learn from the program and they have all said that it is the people who are its more valuable resource. In this sense, it is important to note that only 7% of the budget is allocated for administrative and overhead costs, six cents from each peso is used for administration. Few people work for Oportunidades, but we love the program as an opportunity to serve; there is some sort of mystic just by appreciating how people live and by listening to their wishes.

Human resources for program implementation

Costa Rica states that the experiences shared indicate the vital importance of political decisions and investments. However, questions remain about the type of human resources and skills needed to implement these programs.

Guatemala faced a shortage of qualified personnel to implement the SAN. This prompted the government to team up with private and public universities to begin filling the gaps. These universities now have programs on food security, having also trained two hundred technicians. The national program can be described as "top down," yet it is committed to working in a decentralized way, where leaders and communities achieve a complementary "bottom up" approach, strengthen the management capacity and increase sustainability.

Measuring outcomes among isolated and impoverished populations

Measuring, monitoring and evaluating outcomes are challenges for any government when it comes to populations who may be isolated and poor. For Brazil, these activities are crucial for the sustainability of the programs. By definition, control over the health system to achieve goals and objectives is exerted through social participation and the social pact, where civil society can debate and find solutions. Another important element for sustainability is the investment in human resources capacities, and the country has invested enormously to develop the right professionals in partnership with universities. The Ministry of Health finances several masters' degrees for professionals soon to be integrated in the system and all government agencies/units have the responsibility to reach certain targets.

Brazil emphasizes the importance of good information systems that disaggregate data at local level, which help identify inequalities. The Brazilian representatives were congratulated by the participants on the new disaggregated information systems that are being developed and that are working at the local level.

The health system: enabling or encumbering in achieving the right to health?

The participants agreed that in order to address the social determinants of health it is necessary to go far beyond health sector. Are health systems obstacles or positive factors in the realization of the right to health? On the other hand, it is important to thematize processes of health sector reform that have been pushed by multisectoral organizations. For example, some cross-cutting comments through the presentations pointed to the great importance of the Poverty Reduction Strategy (PRSP) as a preferred development instrument which is also important for the CSDH.

What represents a satisfactory health content for these strategies? Then, what represents a satisfactory health content if we place social determinants of health under the lens on the examination? If the Commission can go strongly into this issue and develop clear recommendations, it may be possible to make PRSPs more useful and supportive of health.

Strong trends that reach across a broad range of contexts will certainly continue to produce major challenges. We face today a new set of deeply entangled problems in this Region (violence andhomicide, high youth unemployment rates for example). These problems are replacing or superimposing on the "classic" more monolithic problems that we were used to addressing with our standard approaches. The increasingly unequal distribution of incomes in the Region is the root of much of the current difficulties. For example, in Brazil, violence and homicide have a powerful incidence on life expectancy. The people we saved from child death with immunization in the 1980s have no social options and are vulnerable to or forced into the drug trade because that is the only option they have. These health issues cannot be addressed without paying attention to the social factors and particularly those related to social cohesion.

What sorts of recommendations might the Commission be able to produce on the issues that would enable technical specialists in all the relevant areas to act more effectively?

Recommendations for the CSDH

- Give explicit attention to themes of ethnicity and gender in the CSDH.

- Generate some concrete strategies and recommendations for widening and focusing investment in health up stream intervention rather than mostly on vertical disease programs and commodities.

- Center attention on the social factors that strongly influence health--such as creating better conditions for youth that would avoid them falling into violence, drugs, etc.

- The economic and environmental elements of sustainable development have been taken seriously, but the social "leg" is the weak leg among these three elements. The CSDH could make a major contribution by defining clear directions to take. The concept of human security developed around Kofi Annan could be very helpful in this process.

PANEL: TECHNICAL COOPERATION IN THE REGION OF THE AMERICAS, APPROACHES BASED ON SOCIAL AND POLITICAL DETERMINANTS, AND PROGRAMS TO INCREASE EQUITY

In his initial comments on the panel, Dr. Daniel López Acuña referred to *Public Health in the Americas* and to the Report on MDGs in the Region. The writing of the latter was coordinated by ECLAC (Economic Commission for Latin America and the Caribbean). These documents reflect PAHO's integrated intersectoral approach to health and development. Moreover, he reiterated that the Organization has been working intensely on inequity of social determinants and access to health services in the Americas, problems that are an issue not only in poor countries.
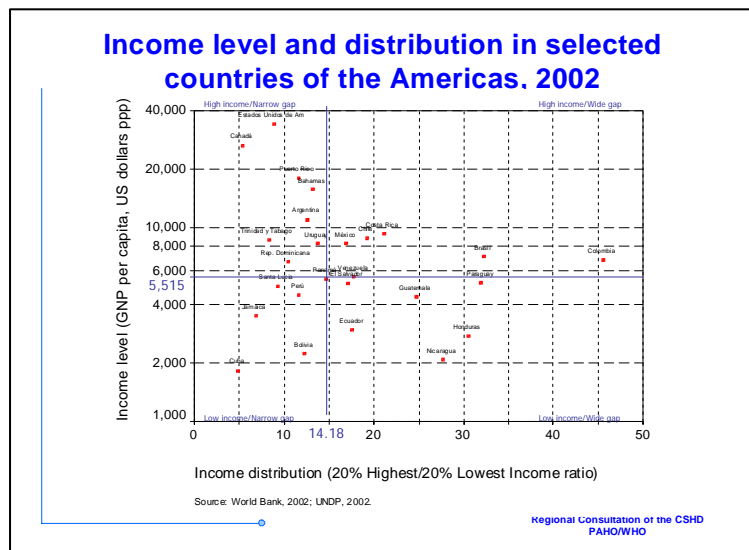
Health Inequities

Enrique Loyola, Unit Chief, a.i. DD/AIS, PAHO

The field of health analysis and health information aims to document health conditions and provide systematic analysis of health inequalities, among other things. We have seen improvements in the health situation in recent decades. Infant mortality has improved very significantly, though 2003 figures still show large disparities among countries. Haiti has an infant mortality rate of 60 per 1,000 live births, while Cuba has less than 7 per 1,000.

We know that there is a very strong and close connection between infant mortality and economic conditions—in particular, income as a reflection of the resources that a country has to meet its needs. There is a threshold where the relationship is not so linear. In the last 20 years there have been advances in the economic situation and in the nations' average income. Between 1990 and 2002, however, income distribution saw no major change. The Gini coefficient has remained virtually unchanged at .38, with 90% of income going to 55% of the population.

In terms of per capita income and income distribution, we can identify four groups of countries, some with high income and more equitable distribution; others, poorer and with very poor resource allocation. Infant mortality has tended to remain with a similar distribution to the per capita income, staying almost unchanged despite improvements in the general economic picture.

Income level and distribution in selected countries of the Americas. 2002

Source: World Bank, 2002; UNDP, 2002.

Regional Consultation of the CSHD
PAHO/WHO

The overall health situation is closely correlated to inequality in resource allocation. Differences between urban and rural areas are also important, as health surveys make quite clear.

In light of the MDGs, we can identify these different relationships and their determinants, which include basic sanitation, trained health care personnel, poverty, and access to safe water. These indicators demonstrate strong relationships with infant mortality.

PAHO is also attempting to identify differences within countries, since this more specific analysis makes it possible to identify groups requiring special intervention. Where there are geographically organized systems, we have been able to pinpoint situations and achieve more specific analysis. The Core Data Initiative, along with geographic information systems, has provided systematic information. Twenty-three countries disaggregate basic indicators subnationally, allowing us to identify health inequalities, while geographic information systems will make it possible for us to identify the interaction of different risk factors and their consequences for health.

PAHO's work on health inequities in the Region has advanced during the last 50 years, but inequities persist between and within countries. They have been substantial increases in average income, but its distribution remains unequal. There has been practically no progress in reducing health inequities, as the infant mortality rates of the last 15 years illustrate. In this connection, health information systems with data disaggregated at local and subnational levels are essential if we are to identify and monitor equity in the Region.

The Work of PAHO/WHO in Health and Poverty Reduction

César Vieira, Unit Chief DPM/GPP/GH, PAHO

The title of this presentation perhaps ought to have been health and the eradication —rather than reduction—of poverty. Latin America and the Caribbean is the world's most inequitable region in terms of health by quintile, though the statistics do not appear as bad as those of other continents. In infant mortality, for instance, the gap between the first and last quintiles is great indeed. On the other hand, health care coverage shows exactly the opposite relationship, as those most in need of care receive the least.

Our unit did a study in Bolivia, Guyana, Honduras, and Nicaragua, all four of which are considered highly indebted poor countries (HIPCs). Poverty-reduction policies have addressed various health-related issues, but much remains to be done if we want to achieve some balance and reduce poverty. Education has shown relatively strong results in terms of health benefits. However the poverty-reduction strategy papers (PRSPs) of these and other countries remain quite insensitive to health and related issues.

What is PAHO doing, or what should it be doing, in this field? I believe that we need to do much more in terms of health monitoring and analysis. Our information systems are still blind to poverty, and unless we make poverty an explicit factor, it will be very difficult to produce the evidence needed to support good policy. We need to monitor and evaluate policy, as well as provide more training for health professionals and workers in other sectors whose activity is relevant to reducing and eradicating poverty.

Unfortunately, despite the fact that poverty's impact on health has been clear for two centuries, we have not been able to improve training. There is, nonetheless, a wealth of training events and research projects on important social and political determinants. However, there is very little evaluation of these activities, very little in the way of advocacy efforts, and very little mobilization of resources. Thus, the evidence is not sufficient.

Finally, we need to make all of PAHO's units aware of the issue of health and poverty reduction, so that they become more sensitive to poverty and move us in the right direction. However, we have not yet achieved this. Other tasks facing PAHO include monitoring to ensure that systems do not remain blind to poverty, developing and assessing national policies, training human resources for both the health and other sectors, conducting research on health determinants and corresponding interventions, engaging in advocacy, and fostering mobilization of resources, and putting the issue of health and poverty front and center in all areas and units.

The Intercultural Approach To Health

Rocio Rojas AD/THS/OS, PAHO

The intercultural approach to health involves a balance among different cultural practices, beliefs, and knowledge in relation to health, disease, life, and death, as well as biological, social, and relational factors. Furthermore, not only environmentally visible factors, but factors relating to the spiritual dimensions of health, must be taken into account. The intercultural approach addresses the health issues of indigenous populations and is based on an understanding of health care as a human right in a context where the beliefs and knowledge of indigenous communities, including the spiritual dimensions of health, are taken seriously. It also recognizes the need for an intersectoral policy approach to the enormous health inequities affecting indigenous groups and others. The growing commitment of the Region's governments in this area is reflected in the policies they have formulated and implemented. However, only half of the countries disaggregate data by ethnic group.

The indigenous population of the Americas is estimated at 45 million people in 24 countries. This includes 400 different peoples, whose members represent 6% of the total population of the Americas, 10% of the Latin American and Caribbean population, and 40% of Latin America's rural population. The population of African descent is estimated at 200 million in 20 countries (75 million in Brazil and 75 million in the United States), representing 25% of the Region's population.

Inequity			
Category	Country	Indigenous Population	Non-indigenous population
Poverty	Canada	34%	16%
	Chile	32,2%	20,1%
Illiteracy	Bolivia	19,61%	4,51%
	Guatemala	Between 50% and 90% of indigenous women are illiterate. Only 43% complete primary school, 5.8% secondary school, and 1% college.	
Infant mortality	Panama	84/1000 live births	17/1000 live births
Maternal mortality	Honduras	255/100.000 live births (Intibucá)	147/100,000 live births
Malaria	Nicaragua	90% of cases of falciparum malaria are concentrated in 24 municipalities populated by indigenous communities.	
Environment	El Salvador	95% of surface water sources are contaminated. Malnutrition in children and adults is associated with parasites, and 40% of indigenous children suffer from malnutrition, compared to 20% of children nationwide.	
Health Services		40% of the 120 million people lacking access to healthcare services are indigenous (PAHO, 2002).	

Source: PAHO, 2004–Evaluation of Achievements in Health in the Americas. International Decade of the Indigenous Peoples of the World. 1995-2004.

Data for 2004[16] show that 100% of the countries that responded (20 out of 24) have policies that promote the well-being of indigenous peoples, and 94% have dedicated units in their ministries of health, as well as national projects on the health of indigenous peoples. However, the assessment showed that coordination among initiatives remains weak, and that the state of intercultural education in these societies and among their health teams is aggravated by lack of intercultural social policy. These results have been taken into account in planning related to the health of indigenous peoples over the coming years. The planning also considers the MDGs and the issue of bringing the primary health care strategy up to date.

The challenges are great. Not all sectors are ready to listen to leaders and peoples who have been neglected, and we may not be able to find easy solutions to structural problems. In our work, we must be committed to taking account of the conceptions and practices of peoples with thousands of years of history who understand health as a function of balance in all aspects of life: social, economic, political, cultural, spiritual, and environmental. If, in the terms of the present meeting, these factors intersect with social determinants of health, then we already have a basis for advancing not only in discussion, and not only in assessment of the problems, but towards solving them—and not only for indigenous peoples, but also for other groups afflicted by poverty, discrimination, and disease. The social determinants of health need to be considered seriously, as do the multi-ethnic and cultural dimensions of social policy.

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[16] OPS. 2004. Evaluación de los Logros en Salud en las Américas. Decenio Internacional de los Pueblos Indígenas del Mundo.

Gender, Equity, and Health: Making Rights a Reality

Elsa Gómez AD/GE, PAHO

The presentation focused on three major issues:

1. Basic concepts and values that guide our technical cooperation efforts to eliminate gender inequity in health. As our fundamental framework, we take the human rights associated with the principles of equality of opportunity and nondiscrimination.
2. Which dimensions of inequity are trying to eliminate, and
3. What strategies are needed to make these rights a reality?

Our unit works with two dimensions of equality: on the one hand, substantive health equity and empowerment; on the other, equity as free agency in health. This latter dimension is clearly reflected in the third of the MDGs that address gender equality.

Concerning nondiscrimination, three fundamental issues are gender, class, and ethnicity; and gender is a structural determinant of health inequities. In this connection, it is important to emphasize that the concept of gender is relational. It refers not simply to women, but to inequality between women and men in the division of labor (both productive labor and the unpaid reproductive labor that supports productive labor) and in decision-making power at various levels of the public and private spheres. This produces stratification of risks and resources, and also of the benefits of development, which themselves are determinants of health and development opportunities.

Our program attempts to look comprehensively and connectedly at discrimination based on ethnicity, economic status, class, and gender, although we concentrate on groups especially subject to exclusion. We consider both the broad effects of discrimination and its effects on each of these groups. Statistics show that the probability of survival is greater for men who are poor than for women who are not poor. Poor women, in contrast, are less likely to survive than men who are not poor. Women are more likely to die prematurely, an indication of poverty's impact on survival.

The dimensions of gender inequity include: first, health status (the opportunity to live in health, free of preventable illness or death); second, access to appropriate resources and services (not identical resources and services, but resources and services in keeping with needs); and third, distribution of financial burden according to economic capacity. It is true in all of the Region's countries, for example, that since women need more services than men, they tend to pay more. This is particularly the case in terms of out-of-pocket expenditures, which are the most regressive form of inequity.

In terms of free agency, we are concerned about inequity in decision-making, both individually and collectively, and about the distribution of responsibility in health management. We stress unpaid work, considering its value in the context of national health accounts.

Examples of our efforts in this area are our attempts to reduce gender violence and our work on health system reform. In addition, a gender equality policy for the Organization itself is currently in the approval process. Issues and activities of concern to us in the legislative area include specific laws on violence (Central America), research on violence, and the issue of inequities in health sector reform (Chile). Something quite specific to Chile, and unique in the Region, is the management improvement program created by the Ministry of Finance and the Ministry of Women. We also seek to institutionalize participatory mechanisms for policy design and monitoring (as related, for example, to PAHO's gender equality policy); legislation; gender-based violence GBV policies and protocols (Central America); intersectoral gender statistics committees (Central America);

support for the management improvement program, coordination with the Ministry of Health and Ministry of Women, FONASA, and the gender equity observatory on health in Chile; and, the Household Satellite Accounts (Regional).

I   In conclusion, it is important to articulate strategies for making rights a reality. First, we must produce evidence to support policy action on gender inequity; second, strengthen the capacity of government and civil society by both traditional means and using computer technology; third, promote advocacy based on creation of networks and the formation of intersectoral partnerships with civil society; and fourth, institutionalize participatory mechanisms for the design and monitoring of these policies. The intersectoral approach is fundamental in these strategies.

Social Exclusion and the Extension of Social Protection in Health

Pedro Brito, Area Manager DPM/SHD, PAHO

The most dramatic dimension of social exclusion is health, where it takes the form of a lack of access by certain social groups and individuals to the services, goods, and opportunities needed to maintain, improve, protect, and restore health. People in this situation are thus unable to meet their needs, do not have access to timely, quality services, and lack financial protection as a result of economic, geographical, or other barriers.

Latin America and the Caribbean is the most inequitable region of the world in terms of income distribution and health disparities. Notwithstanding the economic changes wrought by the Washington Consensus, poverty has not declined but has worsened, placing greater pressure on populations. The Region has seen rising unemployment (13 and 14%) and limited growth. The informal sector has expanded by 50%, and eight of ten jobs created tend to be in the informal sector. This population suffers exclusion in the area of health.

Incidence and Major Causes of Social Exclusion in Health[17], [18]				
Country	Incidence	Due to		Major Causes
		Access barriers	Failures of the System	
Bolivia	77%	60%	40%	Poverty, indigenous origin, low educational status of mothers
Ecuador	51%	41%	59%	Weak health services infrastructure, lack of physicians
El Salvador	53%	54%	46%	Transportation to health facilities, informal work
Honduras	56%	45%	55%	Limited health infrastructure and service providing
Paraguay	62%	53%	47%	Being monolingual (Guarani), lack of public utilities (electricity, sewerage).
Peru	40%	54%	46%	Poverty, rural place of residence

[17] As measured by the index of exclusion in health (OPS/OMS 2003)

[18] As measured by the index of exclusion in health (OPS/OMS 2003)

Another factor to consider is the structure and performance of our health systems, which are socially segmented and structurally fragmented. Four principal fragments are evident: the public sector, social security, private for-profit, and nonprofit. Access to each of these is also an issue.

Having a position in the workforce, the ability to pay, citizenship, extreme poverty, and mechanisms for access to services are clear factors. Under traditional Bismarckian social security schemes, the mass of informal workers is not served.

As part of PAHO's technical cooperation efforts, we have conducted several studies that show troubling proportions of indigenous populations without access to health basics, particularly in those countries with large indigenous populations. This is reflected in births outside of institutional settings, high percentages of populations lacking safe drinking water, and high percentages lacking access to health services. As far as health systems are concerned, six countries show high exclusion rates, as the table above shows.

Exclusion in health is tantamount to a denial of the right to health services. Social protections, meanwhile, are the public policies whereby society guarantees that the health care needs of the entire population and all social groups can be met in timely fashion with quality health care, without the ability to pay, ethnic affiliation, social status, or place of residence constituting impediments.

The extension of social protection in health is based on the view that health services are a right. Such protection is also a mandate of the Governing Bodies of PAHO/WHO since the 2003 Directing Council, and is in line with the recent resolution of the World Health Assembly on sustainable financing for universal health coverage. The object behind both of these documents is to ensure citizens' right to health services.

Finally, in the context of providing social protections for health care, PAHO promotes a mixed approach that combines strategies and mechanisms. The latter may include improving coverage and modifying social security systems in order to cover informal workers, as well as implementing community-based protection initiatives. The countries are increasingly exploring and experimenting with protection schemes. The strategy is to collect evidence for decision-making, pursue substantive political dialogue, strengthen the capacity of the state and civil society to design policy to guide interventions, and finally, place higher priority on the health of the population.

Sustainable Development

L. A. Galvão, Area Manager, AD/SDE, PAHO

Work in this area focuses on environmental elements and its configuration is different from that of the one that bears the same name at WHO. The work here is perhaps as complex as that of the Commission on Social Determinants of Health (CSDH) in terms of social, economic, and environmental factors and we have devoted ourselves, primarily, to making some central concepts operative.

Our ultimate objective is sustainable development. Sustainable development and environmental health constitute a conceptual framework based on human security. The concept of human security can serve as an important model of how to handle social and environmental issues so that health is seen as an essential element of sustainable development. The contribution of the health sector to human security can translate into longer life expectancy. Hence, we can improve human security by working to increase the life expectancy of the hemisphere's peoples. This can be done by reducing specific environmental risks or by supporting the growth of existing healthy elements in the environment. Both of these purposes can be achieved through public policy, including advocacy and social mobilization.

Technical cooperation is aimed at improving the performance of national health sectors to address three key complex issues as effectively as possible. One of these is nutrition; the other, assessment and management of specific risks; and, the other, promoting healthy environments. The tools employed include technology, research, monitoring, development of human resources, and other.

The key issues in this area include measurement of environmental risks and support for healthy environments. The Health-promoting Schools and Healthy Municipalities Initiatives are illustrative. Other important issues are water, sanitation, and solid-waste disposal.

The Sustainable Development Area has three units and one subregional center, as described:

1. One unit deals with healthy environments (healthy municipalities, urban health, health-promoting schools, local development, and community participation);
2. A second unit covers environmental health and workers' health (violence prevention and road safety, tobacco, and consumer health (not including food and drugs);
3. A decentralized unit in Peru, the Pan American Center for Sanitary Engineering and Environmental Sciences (CEPIS) is devoted to the issues of basic sanitation, drinking water quality, hygiene, and domestic solid waste, and
4. A subregional center in Guatemala, the Institute of Nutrition of Central America and Panama (INCAP) that addresses food and nutrition security, and has an adviser in each member country, and collaborating centers that help us to make these concepts operative.

Considering the breadth of the issues, cooperation is more effective if we concentrate on issues such as local development and urban environments. Strategies include capacity building, networks, social participation in decision-making, intersectoral collaboration, social pacts, evidence of the effectiveness of health promotion strategies, and instruments and strategies to create healthy environments, such as healthy communities and cities. We work with the health sector so that its concerns are heard, and to influence other sectors whose activities affect health. The most familiar example is the *Mayors' Guide for Promoting Quality of Life.* Finally, we attempt to create opportunities for people to learn and develop useful life skills. This is the ultimate objective in terms of changing health trends in the Region.

Millennium Development Goals (MDGs)

Sofíaleticia Morales, Senior Advisor on MDGs, DPM

The close relationship between the MDGs and the social determinants of health has been demonstrated. The experiences described by the countries underscore the importance of interaction among different sectors. Consequently, a model of partnerships to meet the MDGs needs to ensure that there are connections among the labor, education, environment, and health sectors. Thus, it is essential that we work with ministers in these areas.

Here, we present a model strategic political and technical partnership, pending concrete experience that will enable us to learn from different actors. At the center are the MDGs and healthy environments, and the great challenge of social protections in the health area. In our experience, it is important to address the labor sector, the education sector, and the health sector in a connected way. Thus, improving the conditions associated with informal work, focusing on occupational health, increasing social services, and eradicating child labor are labor issues that also address health problems. Poverty can be eradicated only if problems in the education and labor sectors are addressed. Solving the problem of ignorance also involves work in the health area, and we know that mothers' level of schooling is correlated with the health of their children.

A great deal remains to be done to improve environmental conditions. This requires joint efforts by ministers of the environment and ministers of health to improve water quality and access, reduce pollution, and improve the quality of the environment in general. We also need to professionalize workers in the health sector, which again means working with other sectors.

In September, a report and proposal will be submitted to the 13th Inter-American Meeting of Ministers of Labor in Mexico. At the 4th Meeting of Ministers of Education of the Americas in Trinidad and Tobago, work will be done on an initiative to address education and health challenges in a coordinated way. The Mar del Plata meeting of health and environment ministers produced a joint proposal to reduce chemical pollutants and improve environmental health for children, an essential strategic element in bringing these different areas together. This report will be submitted to the 46th Meeting of the Directing Council of PAHO, and will explain the connections among four sectors.

Policy alliances should be grounded in technical partnerships. For example, the Hemispheric Network Program puts special emphasis on violence and on the HIV/AIDS red alert in the Caribbean, where education and health must be addressed along with labor, social protection, and workers' health issues. We also need to strengthen links between education, environment, and health. Examples of programs that do this are the Health-promoting Schools Program, created in 1995, and programs to address violence in schools and to prevent HIV/AIDS.

PAHO's attention to workplace and workers' health is assured by its stress on linking labor and health. Examples in the environmental sector are access to safe water and basic sanitation, the reduction of chemical pollutants (lead and gasoline), and the network initiative to promote healthy environments for children. All of these are examples of partnership and political will. Thus, we see that progress can be made with intersectoral schemes, political will, and technical work.

The partnerships among the four sectors will be in evidence at the Summit of the Americas in Mar del Plata, which is to address the issues of jobs, labor conditions, and democratic governance. In consultation with Member States, PAHO has been promoting attention to these issues in order to effectively link them with health, and the subjects to be addressed at the summit clearly bear close relationships to the social determinants of health.

Plenary Discussion

Sectoral Reforms: Positive or Negative Factors?

An appropriate approach to the social determinants of health requires a multisectoral approach, though it is important to recognize the specific responsibilities of the health sector as well. It is often asked whether the Region's health systems in their current form are positive or negative factors in the countries' well-being and development, since there are some indications that they play a negative role. From in-depth debate on sectoral reform in Latin America there emerges substantive evidence of the systems' harmful effects on health. Such a conclusion would necessitate rethinking the orientation of those reforms to progress toward making the right to health services a reality. In this regard, it has been commented that both WHO and PAHO should establish a different relationship with the agencies responsible for these health system reforms.

The Region's diverse health situations include common problems as well as country-specific ones requiring different interventions. For example, there are countries with good access to health services but persistent problems with quality. In Brazil, the average life expectancy is 67 years and the gender differential is eight years, a factor due primarily to external causes. Male mortality is very high, mainly as a result of homicides

with guns, and violence among young men is growing rapidly. The empoverished children whom we saved from the scourge of infant mortality with vaccines, oral rehydration, and health programs in the 1980s now face deteriorating social and economic conditions and get involved in the few labor markets within their reach, drug trafficking being one of the few available to black people and the poor in Brazil. Health-sector action alone cannot solve this problem. The existence of health policies that take the social determinants of health into account is limited, and emphasis is most commonly put on the health problems of adolescents without dealing with determinants. Ironically, the informalization of labor markets has led to the formalization of illegal markets.

Considering that PRSPs are a preferred development strategy in the Region's low-income countries, and World Bank documents are being adopted as instruments in a number of countries, we might very well ask what a satisfactory health content consists of, in the context of this poverty reduction strategy, from a social determinants perspective?

The presentations provide an idea of trends in the Region. Urbanization trends result in social harm and unhealthy integration. These trends are not surprising, but probabilistic in terms of their magnitude and direction. Knowing this, how can young people be integrated in productive labor rather than illegal and violent activity? What recommendation might help the Commission contribute to changing this trend?

It has been suggested that options must be found that make it possible for urban policy decision-makers (who deal with areas such as policing, transportation, and road safety) to more comprehensively address health problems, since some elements are, or may be, common to various cities. These trends fundamentally transcend national and local contexts and represent legitimate areas of emphasis.

It was concluded that the presentations illustrated PAHO's contribution to reducing inequities and supporting the development of public policy in the Region. This means that the Commission's value added may lie in its ability to influence investment in health and determinants. Thus, it will be necessary to create a framework to convince investors to allocate funds for projects to address the determinants of problems with high social and economic costs (e.g. tuberculosis, malaria, AIDS).

We may conceive of overlapping layers of different types of social determinants; for example, structural and traditional economic determinants, lack of social protections, and multicultural or multi-ethnic factors. At the same time, as society faces long-standing health problems, it faces new social epidemics in the form of violence, teenage pregnancy, drugs, and mental illness, which are shortening life expectancy of the young and or taking lives. These are new problems to which health systems are not necessarily responding. This constitutes a dual challenge which fortunately has more political weight today than it once did.

The "monogamous" view of health must give way to an approach that is linked with the challenges facing and involving young people. The *Oportunidades* program does that concretely. Hope for health is alive, and the role of the young in health promotion is central, but their health has deteriorated. The Commission should reconsider how to approach issues involving young people and work with other sectors as a force for health promotion to reduce their health problems.

Finally, though many social programs have been developed, their benefits do not always reach the intended beneficiaries—a situation that is one of the causes of today's social problems.

Recommendations to the CSDH:

The issues on the agenda of the Commission on Social Determinants of Health (CSDH) include no explicit reference to religion, culture, or ethnicity. Current treatment of reproductive health should also be

re-examined in the context of the poverty-reduction strategies. Hence, we recommend considering these dimensions and developing strategies that take them into account.

The economic side of sustainable development has been quite extensively developed, and the environmental issue has been taken seriously by many companies. The social development dimension is still weak, however. The CSDH can bridge this gap, leading the way by stressing the importance of the social dimension, so that it can effectively contribute to development. One concept that may facilitate this process as we attempt to organize intersectoral work is the concept of human security as defined by A. Sen. This definition goes beyond absence of war and violence to include the environment.

The great challenge is how to create synergy between the Commission and teams working on the reduction of inequalities. The Commission's work and these other areas must nurture each other and create a virtuous circle.

The Commission could create a clear framework for greater health investment in which these critical issues were linked. For example, programs for the well-being of young people might be the focus of investment, rather than the construction of sometimes unnecessary hospitals. Such framework could help international financial cooperation institutions channel resources more effectively and improve national investment patterns. This would also mean influencing development models, which would be a great advance.

It is difficult to identify (upstream) policy investments that can check the negative effects of some social determinants, and this is a matter of concern. Resources come from a variety of sources or mechanisms, such as the Global Fund, and it is difficult to find the investment funds to combat the social determinants that generate and aggravate these problems. Most of the investment is in goods that increase health systems' bulk, and this is necessary to some extent. However, more investment in public health policy is also needed.

July 6

PANEL: KNOWLEDGE NETWORKS

Introduction

Hilary Brown, Evidence and Information for Policy, EIP, WHO

The knowledge networks (KN) are the first building block in a three-year process that will come to fruition in December 2006 to set the foundation for continued policy and institutional change toward action on social determinants of health. During this first phase, they are tasked to building knowledge, profiling good practice, and supporting leadership. This involves synthesizing existing knowledge from around the world and documenting existing national processes/agendas, which could be enriched by a social determinants approach as a means to meeting its goals. The second task is to develop recommendations at country, regional, and global levels.

The knowledge networks are establishing evidence on associations between social determinants and health equity, successful policies and programs that integrate social determinants approaches to health, identifying key actors in government and non-governmental actors/institutions with interest, capacity and political will, and civil society engagement in their country context to support their work.

What do we mean about knowledge? The knowledge networks will look at evidence and associations, but the real focus is programs that have been successful in adopting a social determinants approach necessary to catalyze change, that is, existing processes that can be identified as with value added. The knowledge

networks will identify recommendations on policy and institutional change according to the specificity of countries.

The areas identified for the knowledge net works are (i) early child development; (ii) globalization, (iii) urban settings, (iv) health systems, (v) priority public health conditions, (vi) employment conditions, (vii) social exclusion, (viii) women and gender; and two new ones, (ix) financing, and (x) measurement. Currently, there are ten knowledge themes identified, however, there may be outlying issues in the Region and we will need to assess their fit into existing knowledge network themes, therefore tailored collection of evidence on regional specificity-process and priorities need to be defined.

Part of this first phase will involve developing recommendations to inform policy, action, and leadership at national and global levels to support public policy and institutional change, across different country contexts, scaling-up and transfer across countries, and produce political arguments to catalyze action for improving equity in health. Countries will feed into the knowledge generation with evidence and analysis of 'what works' and benefiting from being engaged —technical support and networking.

The knowledge networks are decentralized, and they involve expert members who are diverse in terms of geography, gender, institutional affiliation, countries and regions, governmental and non-governmental institutions, WHO staff as members of these networks, the WHO high level reference group as a way to translate the recommendations into action, and the CSDH Secretariat in Geneva and London.

Considering the crosscutting nature of gender, it will be examined as a stand-alone area. Another area, diseases of public health importance will be managed by WHO, since it is in the best position to do this and it is already working with the constituents. The focus on the area of urban settings and health systems is actually on how they are organized, which is a determinant of health.

Early Child Development

Stefania Maggi, Human Early Learning Partnership (HELP), Vancouver, Canada[19]

This provincially funded program promotes interdisciplinary research across institutions in British Columbia and conducts policy relevant research to early child development issues.

As academics, it is a challenging task to research social determinants, to define underpinnings and interactions between all the determinants and then translating them into sensible policy recommendations. Yet, some concepts need to be promoted, such as the idea of early child development, which is a very broad area, comprising domains in physical, language and cognitive determinants as well as social health and well-being.

Lack of social development and social skills, and learning difficulties are responsible for major social and economic problems leading many youngsters to end up in the criminal justice system. We then go back to the debate on the Mahler Grant issue.

What we know from research is that the combination of different approaches leads to success in early childhood development. We want to shift the distribution to the right to improve children's social skills and their ability. In addition, we need to address the special needs of children that already have problems, with targeted as well as more clinical approaches. Nevertheless, we need to intervene at different levels —family, work, neighborhood, governments. The environments that influence childhood development are very complex.

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[19] The Human Early Learning Partnership (HELP) from Vancouver, British Columbia, Canada leads this Knowledge Network. Members include Prof. Clyde Hertzman, Dr. Stefania Maggi, Dr. Arjumand Siddiqi and Lori Irwin.

Investing in childhood learning environments makes economic sense. Childhood development is a prime predictor of adult health; we need to be aware that targeted interventions addressing at-risk groups and more universal approaches ought to be balanced.

One of the tasks of this knowledge network will be to highlight the universal principles across cultures and contexts that can be applied and that can benefit early childhood development. An additional task is to translate our knowledge from academic research and clinical research into sensible policy recommendations and programs, and we want to do this from a global perspective.

Employment Conditions: Reviewing Evidence and Promoting Action

Rafael Moure-Eraso, University of Massachusetts, Lowell

Occupational health and Employment conditions are very often invisible to many in our profession; we constantly deal with it, as invisible, as a public health issue.

The knowledge network will consolidate and synthesize evidence on the health effects of internal factors including: psychological stress; physical and ergonomic risks; toxic chemical exposure; and employment conditions such as income, job security, flexibility in working hours, job and task control, and employment-related migration. Evidence from a variety of different country contexts and vulnerable population subgroups such as migrants and child workers will be examined. Low self-esteem due to job insecurity and lifestyle choices associated with type of employment will also be considered. The effectiveness of engineering and administrative control measures, employment and industrial relations policy and worker safety legal frameworks—, which are external factors that seek to mitigate the effects of the internal factors—will be mapped and analyzed. A concerted effort will be made to examine programs that include workers' and labor associations in the development of intervention and policy recommendations.

The parameters of the work of this knowledge network include both, the internal workplace domain—intermediary determinants—and then the larger structural factors—external, contextual domain with a predominance of structural aspects that affect health, including robustness of regulations in a given country, vulnerable populations, informal sector, and others.

The internal domain is the exposure disease spectrum in the work place, environmental health, occupational health and system of work organization of the production of wealth. This is often a silo, since most scientists study the relationship between worker and workplace, yet very little comes out of this internal domain, except perhaps in the case of catastrophes such as lead or asbestos.

Our knowledge network wants to move out of this internal domain to the external, contextual domain where more structural aspects of employment conditions affect health. Examples, such as the robustness of health regulations, determine whether the workplace affects or not the informal sector, women and children. Some of our areas of work include:

- Develop employment conditions interventions outside the internal domain —Intermediate Level— into the external domain —Structural Level.
- Examine employment conditions in the broader context of social justice and economic impact.
- Focus on the worker outside the workplace —social space— and avoid viewing the workplace as an isolated entity.

- The impact of employment conditions on health should be "mainstreamed" as an integral component of the broader social and cultural context, and this is achieved by alliances with researchers and stockholders such as economists, lawyers, unionists, politics, NGOs, and others. We will establish these partnerships.
- Increase the pool of potential "interventions" and the visibility of the issue underscoring the multidisciplinary character of the link between employment conditions and health.

Examples of External —Structural— Employment Conditions Variables associated with Health Impacts

Emphasis I. Vulnerable Groups: Women, Children, *Zona Franca* Workers.

Emphasis II. Variables are more susceptible to modification.

Emphasis III. Variables that may be subject to possible generalization in different country contexts.

Emphasis IV. Strength of association —robustness— between employment conditions (EC) Variable and Health/Health Equity.

Associations between External Employment Conditions and their Impact on Health and Health Equity				
Variable	Employment Characteristics	Impact on Health/Health Inequity	Modification Potential	Potential Scaling Up Policy
Unemployment/Underemployment	Formal Sector	Mental Diseases, Malnutrition	Low	Low
Composition Work Force: Children, Women, Aged	Informal & Formal Sectors	Injury, Access Health Care	Low	Medium
Migration of Hazards	Formal and Informal Sectors	Specific Occupational Disease	Medium	High
Robustness of Regulations	Formal Sector	Occupational Morbidity and Mortality	High	High
Workforce Level of Education	Informal &Formal Sectors	Access Health Care, Use Protective Gear	High	High

Examples of internal—intermediate—employment conditions include variables associated with health impacts, emphasis on work organization variables, sustainable production techniques as ecological interventions and net-cost method as a health improvement variable. We can measure these variablesand make recommendations.

Our collaborations with Institutions include: Brazil (Federal/State Governments committed to public health, establishment of General System of Health (SUS) through neighborhood health centers nationwide—General Health Providers—the Ministry of Health to pilot occupational and environmental health services. Other Collaborations include universities in Latin America, such as UNICAMP and UF de PEL in Brazil, UNISON in Mexico; NGOs—Fundacentro–Brazil—and companies in Brazil and Mexico.

There are program options based on priority of knowledge network members and the University of Massachusetts (Lowell) Interventions for health improvement that include vulnerable populations and work organization and health, and finally the design of pilots for testing, in knowledge networks, country members.

In conclusion, attempts to "box" employment conditions in a rigid framework within an internal domain of person-hazard interaction have tended to marginalize the employment conditions as a determinant of health. Our experience has shown that a contextual social justice orientation related to employment conditions is necessary, and we would like to work with other—external domain—researchers and practitioners, in tandem with other society stakeholders in a call for health fairness across classes. Networking in the external-contextual–structural---domain of employment conditions at the national level permits the "mainstreaming" of this important social determinant of health.

Knowledge Network on Social Exclusion

Reynold Verret and Mei-Ling Wang, University of the Sciences, Philadelphia[20]

Social Exclusion is a very broad concept that refers to structures and processes due to which individuals or communities become unable to access social, economic, political and cultural resources; or to participate in social, and community life. There are clear feedback loops between social inequities, social exclusion and health inequities, since social exclusion affects health and is aggravated by health status. The causal direction from social exclusion to health inequity is multi-directional and mutually reinforcing while poverty is the best studied.

Major Associations between Social Exclusion and Health

There are some major pathways to health. For example, access to education is a huge factor for any group; it is a gateway to participation and to resources, as well as a multiplier for other social gains. It is through education that people understand and control their environment as well as factors that affect their health. Gender inequalities go beyond biological differences and needs, and it includes unequal social, cultural practices. Gender also has an education component, particularly for girls, women and mothers. Poverty is a major cause and outcome of social exclusion. Moreover, health status can affect inclusion or exclusion and so does religion. Ethnic, racial and linguistic marginalization, as well as discrimination based on sexual orientation, physical and mental capacities, or migration status constitute very important elements that determine inclusion or exclusion. Social capital represents the collective characteristics of society that affect health status and it is a relevant correlate.

We would like to investigate these associations and pathways, but we know that they all play out different in different national contexts and that not all these associations weigh the same. Therefore, it is important to establish priorities among them.

Therefore, we are prioritizing the following associations in the short term: access to affordable/universal education, and strengthening school-based health services; economic opportunity, employment and access to resources; promoting communication, representation, bridging language barriers throughschool, media and health care system to address health issues and increase community collaborations; and, to integrate health agendas into social networks to address the health of the excluded.

Examples of current work include: the WHO's Global School Health Initiative, MDGs on universal primary education, gender equality, child, maternal health, and HIV, UNESCO's Education for All, ICTs for Intercultural Dialogue, G8's Africa Initiatives and NEPAD, International Labor Organization, Institute for Labor Studies, Government Action Plan to Combat Poverty and Social Exclusion, Quebec, Canada, Social Exclusion

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[20] Reynold Verret, Mei-ling Wang, Melody Corry lead the knowledge hub on social exclusion at the University of the Sciences, Philadelphia and Marie Yolene Surena, Université Quisqueya, Port-au-Prince Haiti.

Unit, Office of Deputy PM, UK and local/NGOs; for example, Mobile Clinics Program in Maracaibo, Venezuela; Acting through Ukubuyiselwa, Johannesburg, South Africa; and, Women's Agenda for Change, Cambodia.

Finally, examples of policy and program options include: integrating education/programs on health, anti-stigma, anti-discrimination and gender-related health issues into school curricula, increasing social network capacities for and communication with excluded populations, integrating health services into social services for excluded populations, egalitarian and anti-discrimination policies in social space, health care, work place, community and generation of a global policy platform to address forms of social exclusion, taking into account individual country differences and contexts.

Globalization Knowledge Network

Ted Schrecker, University of Ottawa, Institute of Population Health, Canada

Our research agenda defines globalization as primarily an economic process that includes economic integration and has effects reaching far beyond the economic domain. These are evident in various realms (e.g. popular culture, dietary practices) and they influence other determinants, including the structure and function of health systems, which are far removed from economics.

1. *Globalization is defined as* "A process of greater integration within the world economy through movements of goods and services, capital, technology and (to a lesser extent) labor, which lead increasingly to economic decisions being influenced by global conditions" (Jenkins, 2004).

2. *Globalization is understood as* an 'upstream' influence on social determinants of health, which is different from the subject matter of many other knowledge networks.

There is a crucial distinction between labor mobility and labor markets. Although labor mobility across borders is selective and limited, labor markets are increasingly global. Moreover, driving forces interacting at the national and supranational levels include technological change and political choice.

Studying this phenomenon requires complex methods and the participation of various disciplines, which will inevitably face areas of disagreement. This means that an evidence-based approach to assessing globalization's influence on social determinants of health requires multiple methods and disciplines, intensive interactions among researchers to describe causal pathways involving multiple intervening variables and feedback loops. This is a different subject matter from those of other knowledge networks. The degree of certainty and the standards of proof associated with clinical trials and many epidemiological study designs are neither achievable nor appropriate, since evidence is not as neat as one would expect from randomized control trials.

3. *Some key causal pathways have been identified (a non-exhaustive list):*

- Trade liberalization (e.g. tariff reduction, export processing zones) influences growth (+/-), income, income distribution

- Changes in labour markets (resulting from trade liberalization, FDI, outsourcing) affect income, income distribution, economic (in)security, exposure to hazards

- Financial market liberalization (financial crises, volatile portfolio investment flows) affects growth, income, income distribution, economic (in)security

- Changes in income distribution, labor markets, competition for land affect food (in)security, nutritional patterns, e.g. as urbanization combines with FDI in food processing, marketing.

- Numerous pathways affect pattern, speed of urbanization and resources available to provide housing, water, sanitation

- Access to health care increased access to research findings; reduced public health expenditure in response to explicit conditionalities or a 'competitiveness agenda,' which have multiple influences on the "policy space" and on policy capacity

Key points about understanding causal pathways

- Causal pathways linking globalization with social determinants of health cannot be ranked a priori, since both the relative importance of specific causal pathways and the strength of evidence about their operation vary across countries and regions and over time.

- Rather, these pathways can only be described and evaluated on the basis of cross-national comparative review and synthesis of research findings (around which our program of commissioned research will be organized)

4. *The Globalization knowledge network Hub builds on an existing research program on G8 and global health, and it will need to work closely with the other knowledge hubs.*

To date there are about twelve knowledge network hubs[21] and a good number of individuals involved.[22]

5. *Potential list of commissioned research papers subject to further consultation:*

The topics will vary depending on the national realities, and cross-country comparison reviews will be necessary. The hub will rely on commission papers. Although the following list is northern-centric, it reflects a special strength in areas of gender and health. Managing these complex topics is difficult and relevant existing policy process and initiatives are being identified.

- Globalization, health equity and environmental hazards: a conceptual overview and assessment of the main linkages

- Impacts of globalization on national and sub national human rights-based approaches to social determinants of health (country comparisons)

- Pathways from trade rules and trade liberalization to social determinants of health

- Influences of globalization on urban forms, urban health and urban policy capacity: effect of global trade union agreements on improved wage/working conditions in global production chains

- Globalization, nutritional transitions and food (in) security.

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[21] Centre for Research in Women's Health, University of Toronto, IHPR/ Liu Institute for Global Issues, University of British Columbia, Canada, International Institute for Sustainable Development, Winnipeg, Canada, North-South Institute, Ottawa, Women's Health Research Unit, University of Ottawa, Australian Health Inequities Program, Flinders University, Australia, Centre for Civil Society, University of KwaZulu-Natal, South Africa, Council on Health Research for Development, Geneva, Switzerland, Global Health Watch, London, International Food Policy Research Institute, Washington, DC., People's Health Movement (operates in 90 countries), Southern and Eastern African Trade Information and Negotiations Institute (SEATINI)

[22] Individuals involved include Ilona Kickbusch, Meri Koivusalo and Eeva Ollila (Globalism and Social Policy Program, STAKES, Helsinki, Finland), Kelley Lee (Centre on Global Change and Health, London School of Hygiene and Tropical Medicine), David Sanders School of Public Health, University of the Western Cape, South Africa, Sarah Wamala (Social Epidemiology Unit, Swedish National Institute of Public Health, Sweden), Roberto De Vogliln (International Centre for Society and Health, University College of London).

- International or global taxation and elimination of capital flight/tax avoidance: potential impacts on social determinants of health.

- Globalization, national policy/fiscal capacity and health sector reform.

- Aid, trade and debt relief: Methodology for integrated assessment of country-level social determinants of health affects the role/impact of civil society organizations in supporting policies that promote health equity.

- Globalization, flexible labor markets and social determinants of health

- Trafficking in human beings and human organs: trends and policy issues.

- Mining and tourism: analysis of social determinants of health impact of two global industries.

Plenary Discussion

Balance between policy process and policy action

Some participants noted that it was not clear how much work would be done to document policy processes, and practical models. The following two questions arose: What is the level of balance? Where is the policy action component? Calculations about economic impacts need to be carried out; although, those who do not believe in the particular program or its effects may be more difficult to be persuaded. The role of health services to improve or worsen inequities seems to be de-emphasized in the presentations of the knowledge networks. However, there is yet much to do in this area and some of these inequities can be addressed by the health service and the health system, which in turn could be a central point of discussion as a mediator in health disparities.

The social network on social exclusion considers that it is important to discuss social inclusion and define which are the enabling factors rather than center the discussion only on those that promote exclusion. Some countries are able to promote social inclusion even when they exhibit different degrees of social exclusion.

Mental health and mental illness are considered very relevant areas for discussion. Often social skills make the difference to avoid the discrimination to which people with mental disorders are subjected. Mental health is a source of social exclusion. It is a known fact that had children been diagnosed early with a mental illness, perhaps two out of three children in the justice system would not be there today. In terms of employment conditions, if communities support the conditions of hazardous employment it is because hazardous work is better then no work. As tobacco companies face more opposition here, they move elsewhere to developing countries.

Social exclusion was considered more a consequence rather than a determinant of health. Yet the following question was posed to the audience, what are the conditions that affect people without insurance and which lead to exclusion. In this regard, it is important to note that social determinants act in a chain reaction and that, therefore, insurance and financing need to be given some importance in these chains of social determinants.

Finally, the participants highlighted the importance of defining the functions related to the interaction between the knowledge networks and the countries, as well as the ways in which these networks could promote action within the CSDH. Additionally, some participants stated that it was not yet clear how all this knowledge will be transferred from the largely academic realm of these knowledge networks towards civil society and other actors in such a way that it could contribute to the overall development of society. Yet, other participants viewed

the agendas of the networks as quite convincing and relevant. However, for the knowledge network to achieve their own objectives, they need to be more inclusive since they still appear very biased towards developed countries. A question remained, what strategies are envisaged to promote greater openness or become more inclusive towards other partners in developing countries?

Another important issue referred to, which gave depth to the discussion about economic impact, included short-term vs. long-term effects of child development. Short-term impacts are more relevant when making political decisions, but long-term actions produce better developmental out comes and allow the person to develop the necessary skills. Various assessments of some educational programs in the United States, Head Start, for example, has speared a great deal of debate about their long-term effects. Therefore, if we are to offer a good argument, and make the case about the actual economic pay off—long or short term— of these programs, producing and giving credible numbers on the economic benefits, it is essential to convince policymakers. Politicians are skeptical and credibility of facts is essential. Therefore, the knowledge networks will need to face these issues when making claims of economic trade-offs.

Responses from knowledge networks

The Globalization Knowledge Network would like to receive questions and responses from countries. This hub will be working closely with civil society groups, to promote knowledge transfer and empowerment. They are northern centered, but they will try to overcome this problem and work closely with the people's health movement. About the balance of causal pathways, and what works, the network will respond to this later.

The Social Exclusion Knowledge Network stated that it is necessary to consider social inclusion as well as social exclusion. Only rich world academics or only one group will not define research questions; this network hub is engaged in seeking partners because they believe that diversification is important. They will be working with partners through UNESCO to diversify the process and to bring in voices from developed countries and developing countries. They recognize the need to understand better the relationship between forms of social exclusion and mental health in a bidirectional process, and recognize that it is difficult to define all possible parameters of social stressors and limits to access.

The Early Child Development Knowledge Network fits into the historical gap between academia and researchers and this issue has been addressed by maintaining a very close relationship between the two. Their staff is not trained in the language of politicians, but recognizes the steps required in order to bridge this gap. If the message is clear and sound, and the politicians are interested, then it will work. Establishing causal pathways is a highly challenging and very difficult aspect of research on social determinants to control, which makes the emphasis on interactions all the more crucial. In many ways, longitudinal studies are not realistic; therefore, we need to think about bidirectional processes and complex forms of causality, as in mental health for example. The knowledge network collaborates with other countries and takes opportunities to call for nominations of people from developing countries who could participate in their network. The globalization network echoes this call, which they encourage participants in this meeting to contact them and to suggest possible participants.

The Employment Conditions Network acknowledges the major importance of health services as a determinant of health. They are very proud to work closely with the Minister of Health of Brazil on their experience with occupational health services, which are now experimental and offered at neighborhood centers. They will continue work in this area. The partnership of the knowledge centers are in what they call "dynamic countries," a term preferred to developing countries when referring to Brazil and Mexico, for example. The question of unions is explored as a factor of impact on health. Although there are studies in this area, they

would like to examine this phenomenon in Latin America in the formal production sector, since there are no unions in the informal sector and there are many ways to evaluate. In terms of economics, it is not only important to know the variables and their associations, but also the published studies. This hub can offer this type of analysis, including the most interesting net cost studies, which can be used to compare with results from investment studies. These studies demonstrate that not intervening may have an important economic effect as well as health costs.

Comments from the World Health Organization

There is a specific knowledge network on health systems that will be run by a hub in South Africa, and there will be links between the country work and the knowledge hubs. There will be country support representatives on each of the knowledge networks and they will participate in developing and implementing recommendations. The knowledge networks will not work in isolation, they will connect to other CSDH components and processes. We will seek to maintain balance between evidence and documenting policy processes and political arguments.

The emphasis is in the expertise of each knowledge hub, which has to stand up to scrutiny. The Commission will have a public visibility. We will have to have evidentiary basis, and needs that will be managed by each of the knowledge networks. There are considerable intersections between the knowledge networks, and the hubs dissemination and awareness are there to be accessed.

How are we managing the knowledge access dimension? Dr. Richard Van West Charles, Area manager, IKM, PAHO, states that knowledge dissemination is a crucial factor. There will be a number of collaborative spaces set up and we need to think about linking knowledge networks together down the road. PAHO will support this with the SharePoint portal that already exists in PAHO, and we will provide technical support.

In terms of investment, society may already be investing heavily in many of these social areas, but there may be ways to do this more intelligently and effectively to benefit from efficiency gains. Therefore, we will review what works and what does not work, but this does not mean that new resources will be allocated but that they will be better allocated. There will be recommendations on the intrinsic value and sufficient rationale, as well as other recommendations with supplementary arguments raising issues of cost benefit. The knowledge networks will develop plans and syntheses.

PANEL: OPPORTUNITIES FOR THE MEMBER STATES AND THE PAHO/WHO SECRETARIAT TO ADVANCE THE COMMISSION'S WORK

Introduction: Country Action

Christine Brown, WHO Venice Office

The overall goals of country action are to position health as a cross government priority integral to a country's overall development agenda, and to build understanding of how social determinants can be tackled in practice, drawing on experiences across countries.

Currently, there is a disproportionate investment in downstream factors. Common drivers of current investment decisions may be financial; for example, balance of payments and cost containment; efficiency related; for example, demand management; or, political; such as quick wins, health as a private/individual

concern. Within this context, 'health' is commonly viewed as a cost, and 'public health' as peripheral to delivering the mainstream development agenda. Thus, it is necessary to identify the critical success factors for moving investments upstream and reorient investments, which create conditions for good health. A key part of the CSDH learning will examine political processes, understanding how political processes that have enabled action on social determinants of health have unfolded in those countries where this has been achieved. The different stages of development of the countries or their different capacities should not preclude their involvement with the CSDH.

Key focus of work in countries will produce tactics, examples and argumentation

1. Draw out the critical success factors for moving investments upstream: synthesis of learning about what works, to shape and influence political and policy processes to reflect a social determinants perspective. Examples of these are Guatemala, Brazil, Mexico, and Chile.

Principles of Country Action
Country-led
Driven by political will at a high level
National coverage
Institutionalization and sustainability
Inclusive of different types of countries
Foster community participation and ownership
Promote intersectoral cooperation
Promote inter-country exchange

2. Spotlight on know–how which strengthens the policy bargaining process and generates political support across key ministries. Articulating health as a central resource for achieving a country's overall development goals, and in a way that supports targets of other sectors.

Health accumulates over the life course. Lifestyle choices and behavior are mediated by social determinants, social status, and social structure. However, given current drivers, and the way in which health is viewed, there seems a common assumption that we cannot or should not intervene in market and economic development conditions. Our response is to 'Buy back health" through public health programs targeted at individuals. This goes against the evidence, which shows how many behavior change interventions are hard to get off the ground and to sustain because the structural factors are left untouched. It also seems to suggest that evidence alone is insufficient to produce change. Thus, the argument we heard about treating people and then sending them back to the conditions that make them sick is true here. We do not intervene upstream but buy back health downstream.

A comprehensive social determinants model should be able to clarify the mechanisms by which social determinants generate health inequities; show how major determinants relate to each other; provide a framework for evaluating which social determinants of health are the most important to address; and map specific levels of intervention and policy entry points, for action on social determinants.

Spectrum of options for action[23]

1. Create awareness with different stakeholders and understanding of context and opportunities. This involves creating dialogue and in-country mechanisms for debate, highlighting the relevance of social determinants to the broad development agenda, and perhaps developing "demonstration" projects; and documenting and sharing decision-making processes, incentives and opportunities.

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[23] There is a spectrum of options for action on social determinants. These include creating understanding the problem in a specific context, generating political will and opportunity, implementing, adapting, or scaling up circumscribed programmes and developing policies for health.

2. Strengthen ownership and prioritize options for action. This involves (a) facilitate and support technical consultations, engagement with the knowledge networks; such as planning, option appraisal and scenario testing; (b) social determinants' footprints across government and society to articulate the best entry points and priorities for sustainable action; (c) existing and potential capacities, such as institutional, regulatory, human resources, and knowledge are needed to implement the approach, and (d) develop an inclusive communication strategy; that is, inform and sustain interest and understanding.

3. Implement —including financing, managing systems— and monitor and review learning and impacts, both of which involve (a) strengthen systems and capacities to mainstream action on social determinants —financial sustainability, technical and institutional, for example, legal frameworks and budgeting protocols; (b) develop, test and innovate interventions; and, (c) monitor and fine-tune to ensure compliance, and document process of learning and change.

Evidence-based policymaking is not a value-free process, nor is it linear; it is about bargaining, winning support and building alliances for creating policy and securing investments or political will to reinvest existing resources. Other sectors ought to consider health, and it is up to the health ministries to make the connections if they want to secure that the actions of other sectors are health-proofed from a social determinants' perspective. Although finding such synergy is not always possible, it is still necessary to build alliances. Therefore, despite political and paradigm shifts, we need to know how this is happening across different contextual settings and how the agenda can be advanced over time. It is important to build this agenda into the country action programs.

Products at country level

- Information and knowledge on pathways and actions
- Mechanisms for policy integration and partnership within government, across levels and with the private sector
- Development of specific health policies and strategies that address the most important determinants —multisectorial
- Mechanisms to assure civil society, public, and community participation and ownership

Support from the Commission and other actors

- *Technical support* will include sharing experiences, expertise, innovations and idea-twinning, intercountry exchanges, regional fora for dialogue, and support for problem solving, development of tools and technologies for action. It will pool together policy and practice experts and it will be supported by network members and products as a resource base for action at country level and between countries.

- *Capacity Development* will include high-level policy laboratories on health investment processes. The WHO Venice Office training involving regional officers and community of experts in delivery and support to application.

- *Political and Moral Support.* WHO legitimacy and support is part of a wider work of the CSDH's components, creating a critical mass to make the system more receptive to a social determinant's perspective. It will relate national and international action through cooperation, partnership and sharing experiences among countries. This cooperation adds up to an alliance for strengthening the evidence-base and the capacities on heath equity and social determinants.

Subregional Perspective: English Caribbean

Sir George Alleyne, President, Caribbean Commission for Health and Development

The objective of this presentation is to examine some of the results of the work of the Caribbean Commission on Health and Development through the lens of the social determinants, those that have been modified, and those that can potentially be modified.

Thinking futuristically, we can imagine that a new pill can change easily the detrimental effects of some determinants. However, in more realistic ways, how will we look at these proximal causes until the day that we can change them biologically at the population level?

What do the determinants determine? There are two fundamental truths. First, social determinants are not immutable over time. Second, what is immutable over time is our responsibility to present to decision makers the proper information for decision-making.

Looking through the years and using standard indicators such as life expectancy, infant mortality rate has improved, and many programs put in place by the governments have been successful. For example, there is no measles in the Caribbean. This is a fact that shows that the successes in immunization programs in the past were due to interventions that were technically and financially feasible, politically supportable, and socially acceptable.

Data on health expenditure as percentage of GDP are well below the average of Latin America and the Caribbean, but as total percentage of, in spite of poor level of health expenditure, they have done reasonably well. One determinant was political, and the other was social; that is, education. They have maintained their government expenditures for education. The relevance of the political climate is often forgotten. Much of the change in public health has been due to a political climate favorable to self-determination. Sen says that people's freedom is also a social determinant. of health.

The Caribbean has made impressive gains in health in the past four to five decades, but these are threatened by the "new" problems; such as obesity, co morbidities of chronic diseases, diabetes, HIV/AIDS, and the sequelae of injuries and violence, which are coterminous with self-determination and the ability to be free. Heart disease and cancer are rising. Non-communicable diseases are very much the number one killers in the Caribbean. Obesity is behind the increase in diabetes and cardiovascular mortality, and there is no comfort that this is a problem worldwide. For example, In St Kitt's, almost 70 percent of adult population is overweight or obese. The second major concern is HIV/AIDS, which continues to ravage countries and shorten life expectancies.

	Infant Mortality Rate Infant deaths/1000 live births 1980-2004		Life Expectancy at birth (years) 1980-2004	
The Americas	37.8	20.1	68.8	73.5
North America	11.2	6.7	74.6	74.8
Caribbean	36.9	17.3	68.1	73.5

Many past improvements have been the result of social engineering, and unwittingly modifying social determinants. The "secrets" of success are mostly due to the introduction of interventions that were technically feasible, politically supportable, financially affordable, socially desirable, and acceptable. The current concern is whether the levers of that social change that were applicable in the past are of relevance in dealing with the new epidemiological profile. For example, education—yes, but different; economic growth—yes, but with more emphasis on distribution; food security—yes, but very different; social inclusion—yes, expanding pilot experiments and reducing discrimination.

Other mega issues include HIV/AIDS. The Caribbean has the second prevalence rate, lower only to Africa. We know that had AIDS not occurred, the life expectancy would have been higher than what it is today.

Injuries and homicides are the second leading cause of death in some countries, followed by traffic accidents and homicides. We ask, what are the determinants of these new epidemics? What are the policy levers to address and modify these trends? In the Dominican Republic, For example, more females than males are affected by AIDS; and, in the younger group, women have a higher seroprevalence. Our current concern is that the problems of the past cannot be solved with levers of the past. General education is important, but we need to address it in a different way, ways that include exercise and life skills. It is not enough to say education, but what kind of education. As an example, we can ask, what does it mean to eat right? Alternatively, in terms of poverty, what are the levers to improve income distribution? We recognize that this is difficult, but it can be done.

Government Expenditure in Education as % Total Government Expenditures				
	1970	1980	1990	2000
Barbados	21.2	20.5	22.2	18.5
Jamaica	---	13.1	12.8	11.1
Guyana	13.2	---	---	18.2
St. Lucia	---	---	---	16.9

We believe that food security is one. In the sixties malnutrition was highly prevalent. Today, there is an over availability of calories. Yet, there is a decrease in the activity levels that jobs demand, and a phenomenal increase in the number of cars. Correcting this situation is not easy; however, various ministries such as transport, parks, and others have levers that they can pull in order to improve health outcomes. Social inclusion is another example. How do you reduce gender discrimination? It is not gender per se; it is the social construct around the biological sex that is responsible.

We are conscious of our responsibility. That is to say how do we show the policy makers the actual policy levers, in addition to pointing to the social determinants of health?

Member States' Perspective

Patricia Frenz, Minister of Health of Chile

"...equity in health is a moral imperative at the root of the will to reform. The health reform seeks to reduce avoidable and unjust disparities... for the sphere of health is where social inequalities are expressed with singular harshness." President Ricardo Lagos, May 2002

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Our plan to work on social determinants is linked to the reform processes. Equity is at the heart of the reforms in Chile, and we speak of equity not only in terms of the distribution of resources but in terms of results as well.

Health sector reform begins with national objectives, and, in Chile, these processes have led to changes in a number of areas. For example, in public health, the national and regional authorities have assumed new political and regulatory roles and ensure that policies are enforced. Health councils use public health plans to review and address social determinants.

We have been working on a new definition of public health, heavily inspired by the definition in the Wanless report of Great Britain, which emphasizes health and prevention with the object of improving health and achieving equity. This goes beyond sectoral and government work and should bring together all the organizations working in the community and the efforts of individuals. We define public health as the art and science of promoting health, preventing disease, and prolonging life for better health and greater equity in the population's health status through the organized efforts and informed choices of society, organizations, the private and public sectors, communities, and individuals.

With regard to policy entry points, Chile views the Commission on Social Determinants of Health as a commitment by WHO at the highest level and as an opportunity to bolster activities to address the social determinants of health. It also represents a similar opportunity for the Region of the Americas.

In terms of the work plan to integrate the focus on social determinants, the Ministry of Health of Chile has defined the objectives and products for the period June 2005 to February 2006. The emphasis on equity in health is at the center of national reform processes, and achieving it requires action on the social determinants of health.

At present, social gradients can be seen in the distribution of major diseases by income quintiles. Responses to a recent survey show that people in the lowest income quintiles consider their health to be worse. With regard to noncommunicable diseases such as hypertension and cardiovascular risks, a social gradient in education levels can be seen. This situation is repeated for other risk factors, such as smoking and obesity. Coverage of primary school education is essential for interventions to achieve greater equity and social justice; the present coverage is unequal based on income. While there may have been greater growth in the lowest quintiles, a major gap still exists.

Our work with social determinants is closely related to the AUGE (*Acceso Universal con Garantías Explícitas,* or Universal Access with Explicit Guarantees) program and reform, on the one hand, and in the other, with *Chile Solidario,* which exemplifies an integrated vision of human and social development that targets the most vulnerable. We have created a social protection system in which social programs are understood as civil rights. If these guarantees are not honored, people have recourse in the courts.

The AUGE program exemplifies a program that guarantees rights with respect to priority diseases through evidence-based clinical guides. Networks of care are managed by the health services and are coordinated and regulated by a special Under Secretary; there is heavy emphasis on primary care,

Statement of the IV Meeting of Ministers of Health and Social Protection of South America, Santiago, April 1, 2005

"We are convinced that economic and social factors are determinants of health conditions in our countries and should be addressed by society as shared challenges... "We celebrate the recent efforts and decisions of PAHO/WHO to actively promote the social determinants of health approach by launching a Commission..."

Argentina, Brazil, Bolivia, Colombia, Chile, Ecuador, Paraguay, Peru, and Venezuela

monitoring, and evaluation, with new information systems, digital agendas, and a new regulatory framework for the private system. The AUGE program works with 225,000 low-income families to meet 53 basic conditions related to human development to which people must have full rights; 10 of these conditions are specific to health. These conditions are integral to human development, to which people must have the right.

During the first phase, a social protection system for children will be implemented in the coming months, which will mean defining the basic conditions for the comprehensive development of all children between 0 and 14 years of age. It will begin this year with first-time mothers, and we can say that no child in Chile will grow up without a set of options and support for its full and integral development.

We see the possibility of making great strides, and we have a commitment to this Commission. President Lagos is a member of the Commission, and at the Ministry of Health we have been doing the work and have set up a unit to coordinate it. Implementation of the country strategy involves cooperation with the World Health Organization in order to complete the plan, approval by the Minister of Health and the office of the President, participation in regional consultations, the holding of national and regional intersectoral workshops in November and January, and submission of a second progress report and then a report to the Commission in January 2006.

We are finishing up with our priorities after a six-year term in office, but we can also view it as a great opportunity to perform interventions that the next administration can assume. Thus, it is essential to demonstrate the concept, expand its understanding, generate a shared vision among people working in health at the national level, government, and civil society, and build capacities.

Talk is not enough; we must show that this approach is relevant, practical, and capable of achieving results. With this year's work we are building capacity and identifying what still needs to be done to reach an intersectoral consensus in 2006 on priority interventions and move on to a trans-sectoral planning and budgeting effort.

Our goal is to promote reform in such a way that it begins to impact structural as well as intermediate determinants. It is essential for us to advance toward a situation in which health is viewed and acted on as a broad shared social goal and in which it is possible to have goals for health and other sectors.

This position translates into certain projects for which we have had the support of CSDH. This year, the history of social policies will be documented, including an evaluation of Chile's national objectives in order to include their trajectory. Other issues of special interest in terms of support for knowledge networks are early child development, equity in occupational health, gender equity, and social protection systems for children, a policy affirmation shared by relevant intersectoral actors through formal and informal consultations, and mapping and developing abilities to use the framework.

The coordination and support structure for achieving objectives and products includes the Ministry of Health unit under the Under Secretary of Public Health, with political bodies and technical advisers to set up the work plan, and the collaboration of sectoral and intersectoral focal points. We have also increased the opportunities for dialogue with other sectors and the commitment to this process at the regional level. CSHD will support Chile's work with a shared definition of technical cooperation and links to the knowledge networks and country experiences.

The type of cooperation needed has been defined with PAHO. We should share experiences, and we have much to learn from each other, which is why certain benchmarks have been set. Chile is much better because of the reform but it will be better still if we heighten efforts to address the dimension of social determinants.

Secretariat's Perspective

Daniel López-Acuña DPM, PAHO

This presentation centered on the "nuts and bolts" between the linkages of the work of the Secretariat and the work of the CSDH. We can address what are the opportunities for the PAHO regional office to advance the work, in close connection with the country work, and in line with technical cooperation lines.

From the perspective of the regional office we want to ensure PAHO's full support to the work of the CSDH at the global level. In order to do that, we need to identify the synergies at regional, subregional and at country levels. We have 3000 people working in the Region of the Americas and their work must be factored into the Commission's work. Therefore, it is important not to undertake processes that are parallel to the work already underway. PAHO's clearinghouse functions can also support the work of the CSDH

Let us do whatever is necessary to avoid parallel processes, let us be interdependent, including in areas of the knowledge networks and the work of the CSDH, which means the work of the Commissioners and the work of the knowledge networks, and of the secretariat of the Commission. It is essential that we define, exactly, where the ongoing work in PAHO feeds the Commission; and, where can the Commission support these ongoing processes within PAHO.

Thus, it is important to articulate knowledge networks with WHO/PAHO collaborating centers connected with the themes and topics of concern for the networks, link into research promoted in these centers and use the clearinghouse functions of the PAHO/WHO Secretariat. This is of the essence since, otherwise, we would be wasting some of the existing relationships. And, we need to make a concerted effort to dialogue with the collaborating centers as well as with other institutions.

The Region of the Americas is rich in the number and quality of research undertakings; we have observatories, clearinghouses, and repositories, among others. Therefore, we should seek alignment, rather than duplication; and, the more stakeholders that we can engage, the better.

Another point relates to the need to establish linkages and mechanisms between the work of the Commission at large and the technical work of the Organization. For example, the work of the CSDH ought to be mainstreamed into the regular daily work of PAHO and WHO at global, regional, subregional and country levels. Social determinants and Commission activities need to be included in the Secretariat's activities related to the CSDH and incorporated into the Program Management Cycle of the Organization and the "One Program Budget" that guides the Organization's work. In addition, these can also be developed into the Country Cooperation Strategy (CCS) framework, connecting teams at the regional and global levels so that social determinants can be integrated in their approach. The promotion of country analyses of social determinants and social policies should be part of the CCS framework, and they will contribute to enrich the repository of relevant experiences.

We can take advantage of current events to build policy and political support, avoid duplication and mainstream activities. We also need to articulate common messages, similar to what is happening for the attainment of the MDGs, or the work of PAHO with ECLAC (Economic Commission for Latin America and the Caribbean). These are just two examples of work related to social determinants. The CSDH needs to be heard

in different spaces. In such spaces as high-level forum for health-related MDGs, or the forum for harmonization and alignment which, in some way, are guiding the articulation of bilateral and multilateral efforts in support to key health development issues.

From our perspective, it will be important to have an articulated framework of operational definitions and guidelines to guide WHO's technical work —that of the CSDH and the Secretariat— at country, subregional and global levels in support of the work of the CSDH in the next few months. They can add value to the CSDH, to the policy development, and to the knowledge networks. Our teams engage on a daily basis with many ministers about issues pertaining to some of these matters. On the other hand, it will also be important to define opportunities to take part on the World Health Organization's activities that may be out of the remit, but related.

It is necessary to define opportunities for the Commissioners and the knowledge networks to take part in WHO's work on social determinants. We ask, how is the Commission connecting with lines of work in health promotion, investment in health or violence, and others in order to improve their influence? Linking the CSDH with technical cooperation and advocacy activities can draw together a wide variety of stakeholders such as governments, civil society, academic, and private sectors.

Nevertheless, we should be cautious. The generation and systematization of evidence does not begin with these knowledge networks, and we need to build on many important processes already underway. Furthermore, although we recognize that English is the lingua franca, gathering information should not be limited to English language sources; there is a wealth of information in Spanish and Portuguese that never reaches the English-speaking world. We need to draw on sources in other languages, particularly in this Region with a long tradition of work in social medicine.

These are only a few ideas of what needs to be done to make explicit the need to build the bridges in the work of the Commissioners, the secretariat of WHO and the knowledge networks. Doing so will allow us to take stock of national situations and policies with a view to advance actions that can revert the negative effect of some social determinants.

The spirit to contribute with synergies is clear. The Pan American Health Organization reiterates its full commitment to support the work of the CSDH and to see the success of the recommendation.

Plenary Discussion

Several participants requested that differences between the social determinants of health and the social determinants of other outcomes such as education, housing, or human development in general, be better defined since both types of determinants —those affecting health and/or education and housing— seem to be part of the broader agenda. Thus, it seems artificial to isolate those that refer to health. Moreover, it is important to consider local government experiences where some of the initiatives focus on social determinants, such as those sponsored by ALAMES (*Asociación Latinoamericana de Medicina Social*).

Sir George Alleyne cautioned about being reductionist and looking only at health. The world is not divided into sectors; however, it is possible to separate those determinants that are more likely to affect the health of a modest fisherman, and distinguish them from those that are most likely to impact on education. Yet, at same time, human development is based on interconnectivity, and evidence has shown that we can influence the determinants of health over time.

One of the WHO representatives commented, "Maybe the response is that while human development is on the agenda, it is not necessarily sensitive to health." Dr. Timothy Evans stated that we are beginning to recognize that much of what is being done in human development might be done differently if we think about the

social determinants of health and the health equity dimension. How can education be different if we think about the social determinants of health; for example, include physical education in the curriculum? What might be the role of the ministries of health in influencing negotiations about job creation and economic growth? Different countries may approach the issue differently. For example, Chile is addressing social determinants of health "by strengthening the social protection network, which is centered on citizens' rights." Chile is better off because of the reforms in its health care system, but the situation will be even better off if we strengthen the social determinants of health.

The World Health Organization believes that there are opportunities for synergy between the CSDH and the Commission on Health and Development in the Caribbean headed by Sir George Alleyne. This is not merely about intersectoral work, but it involves an intrasectoral aspect, whereby the latter involves thinking about how the health sector might do its work differently with a view to increase sensitivity to social dimensions that influence how people interact with the health system and benefit from it.

GROUP WORK (SIMULTANEOUS SESSIONS)

Group Work I: Regional input and follow-up for the knowledge networks

This was a working meeting, preparing for next steps, particularly the upcoming meeting in India. As a key part of the work, documenting the processes and mechanisms of change were discussed.

- The political argument should be constructed, and the ministries of health should be empowered to involve other sectors in the process.

- The recommendations included the use of the existing overall framework as the reference for the different components of the CSDH.

- Avoid working in isolation, particularly to ensure gender and regional diversity as well as supporting the knowledge network on measurement so that it can support the work of the other hubs.

Group Work II: Regional input and follow-up for the country work

Imperatives/processes for next steps

- Existing mechanisms should be used to involve countries that were not present at this meeting, and WHO needs to follow up with interested parties.

- Knowledge networks and country work needs to be coordinated.

- Tools and technologies are needed in countries already taking action under the Commission's framework.

PLENARY: STRATEGIES AND NEXT STEPS FOR PARTICIPATION OF MEMBER STATES IN THE COMMISSION'S WORK AND INCORPORATION INTO REGIONAL WORK

Engaging countries that are not present

The CSDH is part of the WHO, and a formal consultation with the Member States must occur. Most of the knowledge hubs are in a few developed countries, yet considering that struggling countries, particularly in the developing world need to be engaged, the knowledge networks members have to be selected accordingly.

In addition, a regional strategy —technical cooperation mechanism— developed jointly between WHO and the Regional Office is very important, since it can address the specificities and different levels of development of each country; and, thus, contribute to sustain the initiative.

The participants expressed that it was important to go outside of the formal WHO framework to make a positive impact, and that this is why the CSDH was created. Yet, it seems that the CSDH has not considered some important experiences already underway in some of the countries, such as, local development and local leadership.

Selection of countries

To the question of how countries were invited to participate in the work of the CSDH, one of WHO's representatives stated that in the EMRO Region, the Regional Director invited a group of countries to the consultation whereby the selection criteria was political will, ongoing efforts, and sincere interest in participating.

Several strong warning comments underscored the importance of not being restrictive to the participation of any country or to the numbers of countries. One of the Commissioners stated that there is a possible danger to have countries scrutinized by WHO. All countries and not only those countries present need to have a fair chance to be involved in the process, and there must be clarity about the mechanisms to ensure this participation.

The CSDH has to be able to take stock of development in the countries, and local policies; the more that we can learn from these experiences the better, and the process ought to be as inclusive as possible.

Regional representation in the Commission

Several participants expressed concern about the unbalanced, yet critical representation of the Region of the Americas in the CSDH. The only Commissioner from Latin America is the President of Chile, Ricardo Lagos, who will not be active until March, when the new government assumes functions in Chile. Yet, there is no Commissioner from the Caribbean.

Evidence is important, but politicians are important too, therefore political parties, civil society and parliaments need to be involved in the process and internal consultations. The concern and commitment to the knowledge networks needs to be balanced with the appropriate support to civil society networks. It is important to note that civil society groups have been already invited to design a regional strategy and to define how to shape the process in a manner that serves their agendas. In some cases, case studies will be beneficial and the regional offices and country representatives involvement is necessary.

The relation between the ongoing work of WHO/PAHO and the CSDH, particularly in the areas of country work, and of the modes of interaction in the process of defining which countries, is critical. "The ball is now with the countries," that now have the responsibility to make the process work bottom up and be the voice of those that are absent in this meeting.

The Commissioner's point of view

During the Cairo meeting, the Commissioners' pointed out their concern regarding the proliferation of unsustainable pilot projects, which should be avoided.

The Commissioners want to take a systemic approach whereby countries should have high-level political commitment to health and health equity, recognizing health as key component of development. This approach would entail assigning the work on social determinants of health to a key minister—which could be

Minister of Health—becoming actively engaged in intersectoral action; willing to share and exchange information, and facilitate community involvement in health.

The CSDH ought to document retrospectively and prospectively those experiences that work and open up the dialogue. Moreover, it is also necessary to ensure that all the documents and products be made available in languages other than English to ensure proper dissemination.

The WHO Secretariat needs to respond to inquiries and take on board the comments from this meeting since it will serve as a hub for questions and for brokering relationships.

The presentations of the knowledge networks appeared very academic in orientation, and it was believed that the knowledge networks ought to be infrastructures at the service of the countries. It is necessary to be clear about how policymakers can access and use the knowledge networks most effectively and appropriately, and what will happen after this meeting, and how countries will be engaged. Furthermore, the issue of equity in heath is very different from the issue of social determinants of health, and in this regard, most ministers of health may say that equity is not within the realm of their responsibilities.

The knowledge networks on health services should make explicit the linkage with the primary health care agenda, and the CSDH could try to advance in developing an area of economics of public health.

The meaning of success

Chile

The experience of Chile Solidario shows that there was more than political leadership—although a key ingredient for success—in achieving positive outcomes. What enabled this uniting of the forces of different sectors to achieve results? The developments in Chile relate to the sense of a backlog of demand for social progress that had built up during the dictatorship and that have surged strongly since the recovery of democracy. Reasserting social justice and health equity is very important now, and this feeling has helped propel progress in Chile. Chile Solidario, funded through a social solidarity fund, was developed to address the needs of segments of population that were excluded from key sources of social support and opportunity. Following the recommendations of different agencies, the work was carried out by local governments, as well as by technical people within various ministries; work went on at local government level. The same type of lessons are being drawn for the new system of Social Protection of Children, which is bringing together the health and education sectors to work closely. The success shows the importance of a balanced mixture of political will at all levels, strong technical capacity and building up of social demand.

Costa Rica

First, at the political level, one government strategy is to gather ministers in what they call the social council—Consejo Social. Currently, the Ministry of Health is the head of this social council. The CSDH should notice this experience, which could be extrapolated to other contexts.

Second, the creation of the national agenda for health research within the Ministry of Health, which was shaped by the Ministry of Health in cooperation with universities,and other entities. This national research agenda has been oriented towards the themes of social determinants of health and health equity. At same time, Costa Rica could call on the CSDH to support and help, and to strengthen this orientation within the Costa Rican government.

Third, there is a network of five Latin American universities —the Social Determinants of Health network, which includes Universities in Montreal, Cayetano Heredia Peru, Salud Colectiva Bahía, Escuela de Salud Pública de Nicaragua and the Escuela de Salud Pública de Costa Rica. They have created a training course on social determinants of health that include 100 hours in modules and that can orient formation of human resources in the direction of social determinants of health.

What is needed to build on existing entry points and open up new opportunities?

Evidence alone is insufficient. We need an explicit focus to developing politically marketable arguments, and this could be done within each knowledge network. The WHO Venice office will try to develop strategies in this direction.

Policymakers in any country are seriously overworked. It is hard to keep up with the day to day activities, let alone take on new initiatives. Therefore, it would be very useful to have some visual graphs and other learning materials that would show how these problems are being addressed in other countries around the world.

The differences between countries, particularly those related to federal or unitary structure, decentralization and other relevant ones must be considered.

The role of the WHO is essential to the sustainability of the projects. Moreover, the country work needs to be about applying existing instruments of technical cooperation for policy advice and for carrying on the projects, rather than inventing parallel processes. The experience of some country representatives in drawing other United Nations colleagues to this initiative can serve as an example.

Brazil

Brazil stated their commitment to support the CSDH and will have a national meeting on social determinants of health in September. This meeting will involve universities, public health associations, and other relevant stakeholders. Brazil is also very interested in being part of the health systems knowledge networks based with Equinet and want to be invited to other CSDH meetings in Africa or India.

Summary and Closing

Dr. Jeannette Vega, speaking on behalf of the World Health Organization and Dr. Timothy Evans thanked the staff of the Pan American Health Organization who organized the meeting, particularly Cristina Puentes and Daniel López Acuña, the country representatives, the knowledge network participants and the Commissioners present.

Dr. Vega remarked that the process is complex, not lineal, but that we are revitalizing an agenda that was absent lately: health for all in the world. In this reincarnation, she said, we are putting our grain of sand and others will help us grow; we are the foot soldiers, and with our passion, we can make the changes to make this world more equitable and better. We will find the mechanisms, we are united in this.

Dr. Daniel López Acuña also thanked all the participants and underlined the high relevance of the Commission as well as the need to take into consideration the specificity of the Region in their work.

He also remarked that as a WHO Regional Office, the Pan American Health Organization will be working actively with the WHO's Secretariat to define the regional strategies. This means, seeking the best way to ensure the largest possible participation in the work of the Commission on Social Determinants of Health, and use the outcomes and processes to advance social policies in the Region. The Regional Office is committed to work with the Commission, and to facilitate the work through a continuous interaction that will involve the PAHO

Country Representatives, as well as the different structures of the World Health Organization and the Commission.

He ensured that PAHO will provide specific information and guidance to the country offices to maximize the work, but that yet interaction is necessary. He finalized his remarks by stating: "We want to hear from the Commission, we want to learn about its progress, and how we can strengthen it. The Commissioners have a daunting task, and we will support and liaise as much as possible."

ANNEX I AGENDA

JULY 5		
08:30	Registration	
09:00	Opening speech on behalf of the Regional Office	Mirta Roses Periago, Regional Director PAHO/WHO
09:15	Opening remarks on behalf of the World Health Organization and introduction of Commissioners from the Region of the Americas	Timothy Evans, Assistant Director General EIP, WHO
09:25	Objectives of the meeting	Cristina Puentes-Markides DPM/SHD/HP, PAHO
09:35	Introduction of the Commission on Social Determinants of Health (CSDH)	Timothy Evans, Assistant Director General EIP, WHO
10:30	Break	
11:00	Question-and-answer session	Session Chair/Moderator: Monique Begin, Commissioner Rapporteur: Orielle Solar EIP, WHO
11:30	Country Presentations: Social Determinants and Equity-Enhancing Policies and Programs	Session Chair/Moderator: Honorable Damian Greaves, Minister of Health Saint Lucia Rapporteur:
	▪ Brazil	Elisabeth Carmen Duarte, Ministry of Health
	▪ Canada	Sylvie Stachenko, Deputy Chief Public Health, Public Health Agency of Canada
12:30	Break	
14:00	Country Presentations (continued)	
	▪ Mexico	Rodolfo Guzmán García, Secretario Técnico, Programa Oportunidades
	▪ Guatemala	José Andrés Botrán, Secretaría de Seguridad Alimentaria y Nutricional
	▪ United States of America	Capt Penelope Royall, Deputy Assistant Secretary for Health, Office of the Secretary, USDHHS
15:15	Discussion: Commonalities and diversities in the cases presented.	
15:45	Break	
16:00	Panel: Technical Cooperation of the Region of the Americas: Social Determinants Approaches and Equity Enhancing Policies and Programs	Session Chair/Moderator: Daniel Lopez-Acuña, Director of Program Management PAHO Rapporteur: Roberto Escoto D/CSU, PAHO
	▪ Inequities in Health	Enrique Loyola, Unit Chief, a.i. DD/AIS
	▪ Poverty Reduction Strategies in Health	Cesar Vieira Unit Chief DPM/GPP/GH
	▪ Intercultural Approach to Health	Rocío Rojas AD/THS/OS
	▪ Gender, Equity and Health	Elsa Gómez AD/GE, PAHO
	Social Exclusion and Extension of the Social Protection in Health	Pedro Brito Area Manager DPM/SHD, PAHO

	Sustainable development	L. A. Galvao Area Manager, AD/SDE, PAHO
	Millennium Development Goals	Sofíaleticia Morales Senior Advisor MDGs, DPM
17:00	Plenary Discussion	
JULY 6		
09:00	**Panel: Knowledge Networks**	Session Chair/Moderator: Timothy Evans, WHO, Assistant Director General EIP, WHO Rapporteur: Ana Lucia Ruggiero DD/IKM/WE, PAHO
	Introduction	Hilary Brown EIP, WHO
	▪ Early Child Development	Stefania Maggi, (HELP), Canada
	▪ Employment Conditions	Rafael Moure-Eraso, University of Massachusetts Lowell
	▪ Social Exclusion	Reynold Verret and Mei-Ling Wang, University of the Sciences, Philadelphia
	▪ Globalization	Ted Schrecker, University of Ottawa, Ontario
	Comment from the Area of Information and Knowledge Management	Richard Van West Charles, Area Manager, IKM PAHO
	Plenary Discussion	
10:00	**Panel:** Opportunities for the Member States and the PAHO/WHO Secretariat to Advance the Commission's Work	Session Chair/Moderator: Rodolfo Guzman Garcia Rapporteur: Maritza Tennassee, AD/SDE/RA, PAHO
	Introduction	Christine Brown, WHO/EURO
	Member States' Perspective	Patricia Frenz, Ministry of Health of Chile
	Subregional Perspective: English Caribbean	Sir George Alleyne, President Caribbean Commission for Health and Development
	Secretariat's Perspective	Daniel López-Acuña DPM, PAHO
	Plenary Discussion	
10:45	Break	
11:00	Group Work (Simultaneous sessions)	
	Regional input and follow-up for the knowledge networks	Session Chair/Moderator: David Satcher, Commissioner Facilitator: Jeannette Vega EIP/WHO Rapporteur: Hillary Brown EIP, WHO
	Regional input and follow-up for the country work	Session Chair/Moderator: Monique Bégin, Commissioner Facilitator: Christine Brown WHO/EURO Rapporteur:

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