

# | MEETING REPORT |



All for Equity

## World Conference on Social Determinants of Health

RIO DE JANEIRO | BRAZIL | 19–21 OCTOBER 2011



World Health  
Organization



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# FOREWORD

**G**lobalization was purported to be the rising tide that would lift all boats. However, the reality has been that it lifted the big boats but tended to sink or swamp many smaller ones. Globalization and the international systems that govern the way our highly interdependent and interconnected world works have no rules that ensure the fair distribution of growth and benefits. Consequently, the differences, within and between countries, in income levels, in opportunities, in health status and in access to care, are greater today than at any time in recent history.

A world that is greatly out of balance in matters of health is neither stable nor secure. The Constitution of the World Health Organization states that "Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures." However, far too many governments are challenged in fulfilling this basic duty. The credibility of governments in the eyes of their citizens is at stake.

In 2008, the Commission on Social Determinants of Health released its final report. At the 2009 World Health Assembly, Member States adopted resolution WHA62.14 "Reducing health inequities through action on the social determinants of health". Since then many countries have been increasing efforts to implement action on social determinants to address inequity. Nevertheless, there is an urgent need to build upon and accelerate these efforts.

The World Conference on Social Determinants of Health, convened by WHO, was a landmark event held in accordance with resolution WHA62.14. The World Conference aimed to share experiences on how to address the challenges posed by health inequities and to mobilize commitment to the urgent implementation of feasible actions on social determinants in all countries, with the goals of improving health, reducing health inequities and promoting development.

The extent and level of support that the World Conference received demonstrated the increasing understanding among governments, international organizations, civil society and other sectors of the importance and urgency in taking forward this agenda. More than 1000 participants attended the World Conference, including delegates from 125 Member States, representatives from other organizations in the United Nations system and civil society, and technical experts. In addition, the event was followed through webcast by more than 19 000 people.

On 21 October 2011, Member States adopted the Rio Political Declaration on Social Determinants of Health at the World Conference, pledging to work towards reducing health inequities and promoting development by taking action across the five priority areas discussed at the conference.

I would like to extend my deepest thanks to the Government of Brazil for hosting and funding the World Conference, in particular the Brazilian Ministry of Health, the Brazilian Ministry of Foreign Affairs and the Oswaldo Cruz Foundation (Fiocruz). I would like to sincerely thank the Advisory Group, who provided technical and strategic support on various aspects of the conference. I would also like to thank the World Conference organizing committee for their commitment and hard work in making the World Conference a success. Finally, I would like to thank all our Member States, many of them represented by ministers, the numerous civil society organizations, academia and everyone who attended the World Conference and contributed their ideas, energy and passion.

This meeting report summarizes and synthesizes the proceedings and outcomes of the World Conference on Social Determinants of Health and has been prepared in consultation with key partners and stakeholders. I sincerely hope that it will support and foster the continuing discussions and activity following on from the World Conference.

We know that, in all countries and in all contexts, it is possible to take action on social determinants of health to improve health, reduce health inequities and promote development. We now have the political commitment to do so in the Rio Political Declaration on Social Determinants of Health. We know what we need to do and how to go about it: now is the time for increased action.



*Margaret Chan*  
Director General



# SUMMARY

**T**he World Conference on Social Determinants of Health (World Conference), 19–21 October 2011, Rio de Janeiro, Brazil, was convened by the World Health Organization and hosted by the Government of Brazil.

The World Conference was held in accordance with World Health Assembly resolution WHA62.14 “Reducing health inequities through action on the social determinants of health” (2009) and followed the work and publication of the final report of the Commission on Social Determinants of Health (2008).

The World Conference aimed:

- to identify the basic principles, methods and strategies for developing national action plans to address social determinants of health to reduce health inequities;
- to strengthen political commitment by Member States to develop and implement such national action plans, as well as the provisions of resolution WHA62.14;
- to share experiences, challenges and technical knowledge on how to address social determinants of health and construct national plans to reduce health inequities, considering the need for strengthening of governance arrangements, and learning from different contexts.

Over 1000 participants attended, including delegates from 125 Member States, representatives from other organizations in the United Nations system and civil society, and technical experts. In addition, more than 19 000 people followed the event through webcast.

On 21 October 2011, Member States adopted the Rio Political Declaration on Social Determinants of Health at the World Conference, pledging to work towards reducing health inequities and promoting development by taking action across the five priority areas discussed at the conference. The Rio Political Declaration expresses global political commitment for the implementation of a “social determinants of health approach” and is expected to build momentum within countries for the development of dedicated national action plans and strategies.

The five priority areas were based on the five World Conference themes:

1. Governance to tackle the root causes of health inequities: implementing action on social determinants of health;
2. Promoting participation: community leadership for action on social determinants;
3. The role of the health sector, including public health programmes, in reducing health inequities;
4. Global action on social determinants: aligning priorities and stakeholders;
5. Monitoring progress: measurement and analysis to inform policies and build accountability on social determinants.

This meeting report summarizes and synthesizes the proceedings and outcomes of the World Conference on Social Determinants of Health.





# INTRODUCTION AND BACKGROUND

## Introduction

The World Conference on Social Determinants of Health took place from 19 to 21 October 2011 in Rio de Janeiro, Brazil, and was convened by the World Health Organization (WHO) and hosted by the Government of the Federative Republic of Brazil.

The World Conference aimed:

- to identify the basic principles, methods and strategies for developing national action plans to address social determinants of health to reduce health inequities;
- to strengthen political commitment by Member States to develop and implement such national action plans, as well as the provisions of resolution WHA62.14;
- to share experiences, challenges and technical knowledge on how to address social determinants of health and construct national plans to reduce health inequities, considering the need for strengthening of governance arrangements, and learning from different contexts.

The World Conference was a high-level ministerial event that brought together over 1000 participants, including delegates from over 125 Member States, representatives from other organizations in the United Nations system and civil society, and technical experts. In addition, more than 19 000 people followed the event through webcast.

The five themes of the World Conference were:

1. Governance to tackle the root causes of health inequities: implementing action on social determinants of health;
2. Promoting participation: community leadership for action on social determinants;
3. The role of the health sector, including public health programmes, in reducing health inequities;
4. Global action on social determinants: aligning priorities and stakeholders;
5. Monitoring progress: measurement and analysis to inform policies and build accountability on social determinants.

During the World Conference, on 21 October 2011, Member States adopted the Rio Political Declaration on Social Determinants of Health. The Rio Political Declaration expresses global political commitment for the implementation of a “social determinants of health approach” to reduce health inequities and promote development. It endorses five priority action areas based on the five conference themes outlined in the discussion paper of the World

Conference,<sup>1</sup> calling for global and national actions within each of these areas. The Rio Political Declaration is expected to build momentum within countries for the development of dedicated national action plans and strategies. In the Declaration, Member States also call upon WHO, United Nations agencies and other international organizations to coordinate and collaborate with them in the implementation of these actions.

## Background

The World Conference was a landmark event that followed and built upon the principles and tradition of the Alma-Ata Declaration on Primary Health Care adopted in 1978 by the International Conference on Primary Health Care<sup>2</sup> and of the 1986 Ottawa Charter for Health Promotion.<sup>3</sup> There has been increasing acknowledgement over the last 30 years that the bulk of the global burden of disease and the major causes of health inequities, which are found in all countries, arise from the conditions in which people are born, grow, live, work and age.<sup>4</sup> These conditions are referred to as *social determinants of health*, a term used as shorthand to encompass the social, economic, political, cultural and environmental determinants of health.

In 2008, the WHO Commission on Social Determinants of Health released its final report following three years of work coordinating a global network of policy-makers, researchers and civil society organizations brought together by WHO to gather and review evidence on what was needed to reduce health inequities within and between countries. The final report<sup>5</sup> compiled recommendations to create an extensive prescription of what is required to “close the gap” through action on social determinants across all sectors of society, structured under the following three overarching recommendations:

- improve daily living conditions;
- tackle the inequitable distribution of power, money and resources;
- measure and understand the problem and assess the impact of action.

Following consideration by Member States, in May 2009 the World Health Assembly adopted resolution WHA62.14 on “Reducing health inequities through action on the social determinants of health”. The

1 *Closing the gap: policy into practice on social determinants of health*. Discussion paper for the World Conference on Social Determinants of Health. Geneva, World Health Organization, 2011.

2 WHO, UNICEF. *Alma-Ata Declaration on Primary Health Care*. Alma-Ata, USSR, 1978.

3 WHO. *Ottawa Charter for Health Promotion*. Ottawa, 1986.

4 Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health*. Commission on Social Determinants of Health final report. Geneva, WHO, 2008.

5 Ibid.

resolution called on Member States, the WHO Secretariat and the international community to implement the recommendations of the Commission, highlighting areas such as measurement of health inequities, implementing a social determinants approach in public health programmes, adopting a Health in All Policies approach to government, and aligning work on social determinants with the renewal of primary health care. The resolution also requested the Director-General of WHO “to convene a global event, with the assistance of Member States, before the Sixty-fifth World Health Assembly in order to discuss renewed plans for addressing the alarming trends of health inequities through addressing social determinants of health”. At the Executive Board meeting in January 2010, the Government of Brazil announced its offer to host such a global event in 2011.

The World Conference, held in accordance with resolution WHA62.14 and building on the work of the Commission, aimed to share experiences on how to address the challenges posed by health inequities and to mobilize commitment to the urgent implementation of feasible actions on social determinants in all countries, with the goals of improving health, reducing health inequities and promoting development.

## Preparations

Preparations for the World Conference took place from 2010 onwards and were coordinated by WHO in close collaboration with the Ministries of Health and Foreign Affairs of Brazil and Brazil’s leading health institute, the Oswaldo Cruz Foundation (Fiocruz), and

with the involvement of other international partners. An Advisory Group, with representatives from Member States and experts, was appointed to support WHO in the planning of the conference.

Extensive consultations were carried out with Member States, United Nations bodies, civil society and academia. Evidence was collected at the country level for analysis at the regional level, with the aim of reaching agreement on actions needed at the global level. The consultations identified five priority areas for action in a social determinants approach to improve health, reduce inequities and promote development, which formed the five themes of the World Conference listed above.

Evidence from experiences in Member States was collected through a call for case studies, facilitated by the WHO regional offices. The findings of 28 case studies were analysed and formed valuable background documents to the World Conference. Regional consultations of Member States and other key stakeholders were also organized through regional and intercountry meetings and discussions, providing essential scientific and technical evidence and perspectives as well as invaluable political engagement and support for the event.

The key technical contribution developed by WHO for the World Conference was a discussion paper entitled *Closing the gap: policy into practice on social determinants of health*.<sup>6</sup>

<sup>6</sup> *Closing the gap: policy into practice on social determinants of health*. Discussion paper for the World Conference on Social Determinants of Health. Geneva, World Health Organization, 2011.





The discussion paper focused on how countries could implement action on social determinants and was structured around the five conference themes. The discussion paper was written and developed through several rounds of consultation with Member States, the Advisory Group, United Nations bodies, civil society, academia and the World Conference Secretariat. Included in the process was a public web consultation that ran from 10 May to 10 June 2011, during which time 185 submissions were received. In coordination with the production of the discussion paper was the development of a comprehensive DVD resource guide that assembles key publications and reports for social determinants generally, and the five conference themes specifically.

At the Sixty-fourth World Health Assembly in May 2011, the Government of Brazil, in collaboration with the WHO World Conference Secretariat, organized a side meeting to update Member States and stakeholders about preparations for the conference. The event was attended by over 250 participants and was addressed by a distinguished panel of speakers, including Dr Alexandre Padilha, Brazilian Minister of Health; Dr Margaret Chan, WHO Director-General; Dr Mirta Roses Periago, Director of the Pan American Health Organization (PAHO) and WHO Regional Director for the Americas; and Dr Luis Gomes Sambo, WHO Regional Director for Africa. Several ministers of health, and representatives of delegations and civil society organizations, also made interventions.

Preparations were also made for the Rio Political Declaration on Social Determinants of Health, which was developed through a series of Member State consultations held at WHO headquarters in Geneva and chaired by the Government of Brazil. On 15 August 2011, a draft text developed by the Government of Brazil with the support of the WHO Secretariat was circulated to Geneva-based Permanent Missions of Member States. The first meeting of Member States, convened by the Government of Brazil, was held at WHO headquarters on 7 September 2011. This was followed by a series of informal consultations attended by representatives of Permanent Missions in Geneva. The text of the Rio Political Declaration was

finalized during the World Conference in Rio de Janeiro, 19–21 October 2011.

## Organization

The World Conference took place over three days, with Day One and Day Three taking the form of plenary sessions and Day Two consisting mainly of parallel sessions. The plenary sessions included the official opening and closing of the conference and interviews and roundtables focusing on the intersection of the social determinants agenda with other key global priorities and agendas, such as development and the life course approach.

The parallel sessions were structured around the five World Conference themes, allowing for the sharing and analysis of experiences and more concentrated and practical discussions. A Ministerial Track was held on Day Two, where delegations were invited to make statements on social determinants. The Ministerial Track also included a session reflecting on the historical development of the social determinants of health agenda and the strategic way forward from the World Conference. Final negotiations between Member States on the Rio Political Declaration also took place on Day Two.

Day Two and Day Three began with a morning plenary session led by Ms Zeinab Badawi from BBC World, who provided highlights from the previous day and moderated interviews with selected speakers from the conference proceedings. On Day Two, Ms Badawi interviewed Kathleen Sebelius, United States Secretary for Health and Human Services, and Sir Michael Marmot, Professor at University College London and former Chair of the WHO Commission on Social Determinants of Health. On Day Three, Ms Badawi interviewed Socorro Gross-Galiano, Assistant Director of PAHO, Dr David Butler-Jones, Chief Public Health Officer, Public Health Agency of Canada, Mr Abdul Bari Abdulla, State Minister of Health and Family, Maldives and Dr Aaron Motsoaledi, Minister of Health, South Africa

The President for the World Conference was Dr Alexandre Padilha, Minister of Health, Brazil, and the Vice-President was Ms Maria Guzenina-Richardson, Minister of Health and Social Services, Finland. The Master of Ceremonies for the plenary sessions was Mr Richard Laver of Brazil.

The World Conference was held across three locations in Copacabana, Rio de Janeiro. The official programme events took place in a purpose-built building on Forte Copacabana and in the Hotel Sofitel, while the majority of side events were held at the Hotel Othon.

This meeting report summarizes and synthesizes the proceedings and outcomes of the World Conference on Social Determinants of Health and has been prepared by the WHO World Conference Secretariat in consultation with key partners and stakeholders.





SESSIONS

# DAY ONE – WEDNESDAY, 19 OCTOBER 2011



## OPENING SPEECHES

The official opening of the World Conference was held in the plenary room at Forte Copacabana and included speeches by Mr Eduardo Paes, Mayor of the city of Rio de Janeiro; Dr Alexandre Padilha, Minister of Health, Brazil, and President of the World Conference; Dr Margaret Chan, Director-General, WHO; Dr Sérgio Cabral, Governor of the state of Rio de Janeiro; and Mr Michel Temer, Acting President of the Federative Republic of Brazil.

**Mr Eduardo Paes** welcomed participants to the city of Rio de Janeiro, stating that it was an honour for the city to host such an important event. He referred to the considerable health challenges facing the city and the impressive achievements made in primary health care and poverty reduction. **Dr Alexandre Padilha** welcomed participants to the World Conference – the “Alma-Ata of the century” – and acknowledged the work of WHO, led by Dr Chan. Dr Padilha described the development in Brazil of the national universal health system over the previous 23 years and the Brazil without Poverty programme. He stated that health was a right of all citizens and a State duty. Achieving health and tackling inequities was central to the economic and social development of a country and also contributed to peace between nations and global security. Committing to act on social determinants was to instil in all government policies a concern for promoting the welfare of the entire population. Dr Padilha emphasized the need for intersectoral action, including at the global level. He invited participants to be creative, bold and purposeful in defence of the welfare of all peoples and in creating a landmark for improving the health of all countries, coming together for equity in one of the most fundamental rights of human beings: universal access to health.

**Dr Margaret Chan** thanked Brazil for hosting the World Conference, stating that it was an ideal place to host the event given the country’s long history of strong civil society movements and striking achievements in improving health through embedding social equity

in mindsets and politics. She drew attention to the responsibility of governments, as stated in the WHO Constitution, for the health of their people by the provision of adequate health and social measures. Dr Chan emphasized the need to move beyond measuring societal progress only by economic growth, which had resulted in increasing inequity within and between countries. Greater social equality, she said, must be the new political and economic imperative for a safer and more secure world. Public health was extremely well positioned to improve equity, especially when health services were delivered according to the values, principles and approaches of primary health care. While prevention of key health challenges, such as noncommunicable diseases, was entirely feasible and affordable in any resource setting, almost all of the main risk factors that contributed to those diseases fell outside the purview of the health sector. Dr Chan spoke of the critical importance but enormous challenges of establishing and enforcing health-promoting policies in all sectors of government and in international systems.

**Dr Sérgio Cabral** spoke of Brazilians’ true belief in the value of addressing social determinants and equity to improve the quality of life of its citizens. He referred to the legacy of former President Lula, which had resulted in more than 40 million Brazilians being raised out of poverty into the middle class through effective income distribution. Acting President **Mr Michel Temer** warmly welcomed participants on behalf of President Dilma Rousseff. He discussed the success of Brazil in improving health and reducing poverty, which had been achieved through a combination of health and social factors in the overarching pursuit of equity. Brazil had an amalgam of a liberal system, which constitutionally ensured individual and public freedoms and rights, including the right to health, with a social system of service provisions. Acting President Temer stated that hosting the World Conference was a source of great pride for the country of Brazil and the state and city of Rio de Janeiro.



# HIGH-LEVEL ROUNDTABLE ON SOCIAL DETERMINANTS OF HEALTH AND DEVELOPMENT

The first high-level roundtable of the World Conference focused on the relationship between the social determinants of health and broader development. It featured two health ministers and senior leaders from the United Nations system, and was moderated by Ms Zeinab Badawi from BBC World.

## SESSION PARTICIPANTS

*Moderator: Ms Zeinab Badawi, BBC World*

*Panellists:*

- *Dr Margaret Chan, Director-General, WHO*
- *Ms Tereza Campello, Minister of Social Development, Brazil*
- *Ms Rebeca Grynspan, Associate Administrator, UNDP*
- *Mr Andreas Loverdos, Minister of Health and Social Solidarity, Greece*
- *Ms Kathleen Sebelius, Secretary of Health and Human Services, United States of America*
- *Dr Michel Sidibé, Executive Director, UNAIDS*

## KEY THEMES OF THE SESSION

- *Health cannot be achieved without addressing social determinants of health.*
- *Health is also central to achieving inclusive and sustainable development and again addressing social determinants is key.*
- *There is a need for awareness, action and accountability.*
- *The answer to addressing social determinants of health does not lie only in the health sector.*
- *Better partnership is necessary, including in the culture of United Nations organizations.*
- *In hard economic times, there is the need to push even harder for good health outcomes in order to free up financing for other areas.*

**Dr Margaret Chan** made the initial statement, emphasizing the importance of understanding how to find new ways of working and having integrated, multisectoral approaches to meet the challenges of health and development. WHO had a key role in that agenda and the World Conference was extremely timely and relevant. Dr Chan stated that every country had a dream for sustainable development, but that was unachievable without addressing the social determinants of health – the conditions where people are born, grow, live, work and age. The Commission on Social Determinants of Health had paved the way by drawing attention to the social determinants, and the stage was now set for countries to understand how to act on its advice.

Dr Chan argued that action on social determinants was urgent to address policy failures that stalled progress on health. For example, why was improvement in maternal mortality still lagging

behind? Efforts had ignored the importance for women of factors such as social status, land ownership, political participation and employment. Similarly, strategies to combat noncommunicable diseases had underappreciated the importance of nutrition. Dr Chan referred to the earlier work of the Commission on Macroeconomics and Health and quoted Dr Halfdan Mahler – “Health is not everything, but without health you have nothing.” Dr Chan noted that to act on social determinants, governance had to be improved and work was required across sectors (such as transport, education) to address risks for health, with health serving as a “tracer sector”.

Dr Chan also highlighted that what gets measured, gets done. WHO was good at measuring and reporting on country progress and trends in health – that information also served to inform an assessment of a country’s governance. Decision-makers who were held accountable for their population’s health needed to act on



social determinants, as that was key to health for all, sustainable development and wealth.

Ms Badawi asked Dr Chan if she was worried about being too strong or taking political positions. Dr Chan replied that she was not afraid to be outspoken. As head of WHO, she needed to champion positions based on evidence – if she did not she would not deserve her position, regardless of the pressures and stresses that could create. There was a need to bring countries together for balanced solutions, including influencing industry to do good, balancing profits with social responsibility. To move forward on social determinants, the keys were awareness, action and accountability.

**Ms Tereza Campello** spoke about the Brazilian context. She argued that at the current time of great economic instability, in tackling crises it was imperative to stop any backsliding on social rights and policies that would result in increased inequities. Political decisions made a major impact. In Brazil, the strategy was to balance economic stability with social inclusion, growing by distributing income. Key principles had been increasing the minimum wage, supporting family farming to ensure healthy food, universal access to health, education and social welfare services, and a large-scale increase in cash transfers programmes, which now assisted a quarter of the Brazilian population.

Ms Campello discussed how conditional cash transfers had led to reduction in child malnutrition and stunting, children staying in schools for longer and better classroom performance. But following that success, there was still a need to upgrade programmes to achieve a Brazil without poverty. Those programmes coordinated and encompassed all sectors of government. It was vital to search for poverty. Rather than the poor needing to chase the State for needed services, the State needed to actively engage poor populations, reaching the least privileged members of society. The gains for Brazil had been economic as well as moral, adding dynamism to the Brazilian economy and increasing the workforce.

**Dr Andreas Loverdos** explained how Greece was facing the challenge of how to maintain social equity and better health outcomes at a time of immense fiscal pressures due to the economic crisis. The main targets were to maintain free access to health care, make structural reforms to deliver services with better quality and at lower cost, and protect the public from malpractice. Compared to 2009, the Greek public health care system was seeing 30% more patients, but needing to do so with 20% less resources. As Minister of Health, Dr Loverdos faced no choice but to reduce costs by decreasing salaries, increasing efficiencies and securing lower prices for all supplies, including pharmaceuticals. Low user fees had also been introduced in hospitals. The role of primary care services had been upgraded and the use of guidelines for treatment had been expanded. As a result of those policies, Dr Loverdos reported that Greece continued to be able to offer universal coverage of health care, including to undocumented migrants. However, the changes had provoked strong reactions from the political opposition and other stakeholders, including unions and in the private sector.



**Ms Kathleen Sebelius** began her address by saying that the United States shared a belief in working together towards building healthy societies and a stronger and more prosperous world. Health depended on where we lived, worked and played, what we ate, the air we breathed and how we got around. Social factors were at the root of many disparities and cost our societies dearly in both the developing and developed world. For example, diabetes, heart and lung disease each cost the United States US\$ 100 billion dollars a year – yet until now, less than 1% of health care dollars in the United States were dedicated to strategies effective at preventing those diseases in first place. One in three children would experience diabetes, with highest incidence in ethnic minorities such as African Americans and Hispanics. Those inequities made it harder to achieve the fullest potential of their society.

Ms Sebelius stated that to address those issues, the Obama administration was pursuing a broad agenda. The Affordable Health Care Act was a historic achievement on the path to universal health coverage in the United States. But they were not taking action only in the health sector. The government was working with schools to ensure healthier school lunches and with the transportation department to design neighbourhoods that encouraged walking and cycling. A National Prevention Strategy had been developed with joint partners across government along with the private sector, identifying the necessary measurable results to keep the population fit. The United States was taking a Health in All Policies approach – for any decision in government, they were considering the health consequences. As poverty and health were closely linked, a special commitment had been made to address social and economic factors. For example, the new health care law extended services to the most vulnerable, who had the highest rates of disease. It was important to continue to share ideas and strategies on addressing health and equity issues. And it was best to do that together – building stronger partnerships across the globe in the months and years to come.

**Ms Rebeca Grynspan** discussed the role of the United Nations Development Programme (UNDP) in promoting development as a goal, and how health was vital to achieving that aim. She agreed with Dr Chan that health was central to achieving inclusive and



sustainable development and that addressing social determinants was key. Other development actors had to contribute, because the health sector could not do that by itself. It was urgent to break down the silos to have more integrated, coherent, intersectoral interventions to address inequities, including by addressing stigma, racism and exclusion. Ms Grynspan said, “We know that being poor in this world is very expensive.” In many countries, poor people paid more for water and electricity than rich people, or could not obtain good food because they had to go farther and pay more than people in wealthier strata. Poverty of time was also an important driver of poor health worldwide, particularly of women.

To tackle those broader issues, Ms Grynspan said that there was a need for more effective partnership, bringing forward the voices of more vulnerable people. UNDP had a lot to offer in addressing those aspects of social determinants of health. But to achieve better partnership, everyone had to fight the normal culture of their organizations, which often acted like feudal owners of their own areas, into which no one else had a right to come. Without fighting that culture, and instead coming together, partnering effectively and planning together, it would not be possible to rise to the challenges. Therefore, Ms Grynspan said, “Let’s not go back and do what we do – you do health, you do development. I’d love to see how we plan together to accelerate progress towards the health Millennium Development Goals for 2015, acting together and fighting the obstacles that people face in their health and being full citizens of societies.”

Ms Badawi asked Ms Grynspan whether she thought that the Millennium Development Goals (MDGs) should have been rewritten in terms of the social determinants, and whether the MDG agenda could be integrated with the social determinants agenda. Ms Grynspan replied, “Absolutely – and not just because it’s the right political thing to say!” The Joint United Nations Programme on HIV/AIDS (UNAIDS) was a very good example of how everyone could work together to rise to the challenge of HIV/AIDS. UNDP had also piloted a tool in Morocco, Tunisia and Uganda, where the whole country teams decided to address maternal health. They brought other stakeholders to the table – such as the finance and infrastructure ministers – to discuss what the obstacles were and how to tackle them. The result was the whole system having a strategic plan with the government in the driver’s seat to accelerate progress on that MDG. The key was coming together in a coherent, integrated way.

**Dr Michel Sidibé** spoke of the importance of tackling social determinants when addressing HIV/AIDS. The World Conference was topical because social determinants were about social justice and the redistribution of opportunity. It was the first time that the real, fundamental issues were being brought to the debate of global health. Why was that person marginalized or not having the same chances? It was important to get beyond the disease-specific approach. In his experience, Dr Sidibé had realized that failure would result from not tackling HIV/AIDS as part of a global response to global health. So the World Conference was important to bring



people to the centre of global efforts by dealing with underlying and structural causes.

Dr Sidibé noted the central place of human rights. In the experience with HIV/AIDS it was very clear: when people were being denied their basic rights, HIV/AIDS increased. The world was changing fundamentally and that brought an urgent need to do business differently, changing the approach to people with health needs. Fostering governance and public accountability was crucial – making sure that people could use their human rights to ask for change. For UNAIDS and its partners, how they built new partnerships with the private sector was also critical. But moreover, dealing with equity and social justice would continue to be central to their work in the future.

Ms Badawi asked Dr Sidibé what the point was of giving expensive medicines to people who were then put back into poverty and inadequate living conditions? Dr Sidibé replied that that was the beauty of what was being discussed at the conference – talking about prevention primarily and not dealing with important issues in isolation (such as climate change, the environment, lifestyle and a more inclusive approach to development). The response could not be to let 33 million people die from HIV/AIDS because they did not have access to safe water. That would be terrible for society. The metaphor for HIV was inequity. It was very frustrating to have 400 000 babies born every year with HIV in the South when it was no longer an issue in the North. Dr Sidibé asked, How can globalization of the economy help us to deal with the globalization of social injustice? How do we address the fact that the drugs are not produced in the South because technology and knowledge sharing is not a priority in the developed world? How can we make these things happen in the context of the new partnerships? Dr Sidibé said that without addressing those issues, it was not possible to have development.

Ms Badawi asked the panel to comment on the continuing problem of lack of women’s access to reproductive health care and rights, and how far it was possible to have a global discussion about social determinants and yet not bring in societal and cultural influences on that matter. Ms Campello said that it was vital to be able to





discuss those issues. Society must face up to that as an agenda to be discussed, as it was a public sector agenda. The best way of dealing with issues of women's health was through multidisciplinary action that included multiple sectors and in particular addressed elements of employment and income. Ms Grynspan said that inequities in maternal mortality were clearly not just from health services but also from cultural norms. It had been documented worldwide that empowering women to take their own decisions was essential.

Dr Chan was asked by Ms Badawi how much headway WHO had made in pushing the social determinants agenda and showing people that health required looking beyond health sector data and services. Dr Chan answered that the central issue was that often the technical solutions were known but that the barriers lay in social, cultural and religious factors. Without talking about those issues, progress was not possible. The aversion to talk about such challenging issues was alarming. Female empowerment was effective, but there was a need to also engage men, who often dominated parliaments (for example). It was very difficult for women to champion equity alone.

Ms Sebelius was asked how she engaged with other members of the Obama administration. She replied that they had had some real success in that. The National Prevention Strategy had engaged other government departments to consider "what's your piece of this?" – what could they do in their sector in terms of incentives to reach those goals (for example, bike paths and good food access). The private sector had to be at the table – there were now very aggressive outreach activities against unhealthy food and tobacco. Therefore, there was a need to work on multiple fronts. The conversation was often centred on whether it was affordable to move on health issues. Ms Sebelius said that we had to start insisting that we could not afford NOT to, as the costs were too great. The status quo was not acceptable and we could not only move on those issues when times were good. In hard economic times, there was a need to push even harder for good health outcomes in order to free up financing for other areas.

Dr Sidibé was asked how important goals were in mobilizing support and opinion. He replied that he was increasingly convinced that what was required were sustainable development goals – not just MDGs in this or that area but to push ourselves to start thinking about how to build a society to deal with the issues we were facing in a more integrated manner. When, for example, he was in Lesotho or Swaziland, the people he saw with HIV/AIDS were the same people who lacked access to services and good nutrition and who were vulnerable to tuberculosis. There was a need to make a shift.

Ms Badawi asked for a closing message from each panellist. Dr Sidibé said, "For me it would be equity, equity, equity." Ms Grynspan agreed, arguing for putting equity in the centre of the agenda for inclusive and sustainable development for all. Ms Sebelius stressed the need for health in all sectors – "Let's work on this together." Dr Loverdos said that the huge scale of the World Conference showed a clear determination to address social determinants – it was very good that people were beginning to agree on their importance. Ms Campello returned to the theme that the key issues were not only that it was possible to grow and distribute wealth, include people socially and have sustainable development – but also that that was fundamental to anything that could be considered as "development".

Dr Chan closed the roundtable by thanking the Government of Brazil and the experts working with WHO on social determinants. Dr Chan returned to the importance of the "three As": awareness of the importance of social determinants of health and their power to change inequity; action – it was time to put the talk on social determinants into action, by returning to our countries and agencies to implement the Rio Political Declaration; and accountability – money must go to the places and people that it was meant for (instead of going just to banks, for example), so governance was important – civil society must hold everyone to account. Last but not least, "Remember the people."

## KEY AGENDA MOVING FORWARD

- *In tackling the current economic and financial crisis, ensure that there is no backsliding on social rights and policies that would result in increased inequities.*
- *Build stronger and more effective partnerships – at local, national, regional and global levels – to have more integrated, coherent, intersectoral interventions and to share ideas and strategies on addressing health and equity issues.*
- *Foster governance and public accountability to ensure that people, particularly marginalized groups, participate in policy- and decision-making processes.*
- *Lobby for equity to be at the centre of the agenda for inclusive and sustainable development.*

SESSIONS

# DAY TWO – THURSDAY, 20 OCTOBER 2011





# PARALLEL SESSION FOR THEME 1: GOVERNANCE TO TACKLE THE ROOT CAUSES OF HEALTH INEQUITIES: IMPLEMENTING ACTION ON SOCIAL DETERMINANTS OF HEALTH

## Morning session: Making policy coherent at the national level

**T**he objective of the session was to discuss the importance of governance and policy coherence for acting on social determinants of health to reduce health inequities. Through the sharing of country experiences, the session aimed to identify the key concepts, requirements, strategies and challenges for achieving good governance at the national level.

The Chair of the session, **Dr Jorge Enrique Venegas**, opened the session by reflecting on the challenges of coherent governance from his experience as a minister in Uruguay.

### SESSION PARTICIPANTS

*Chair: Dr Jorge Enrique Venegas, Minister of Public Health, Uruguay*

*Introductory note: Professor Don Matheson, Massey University, New Zealand*

#### *Panellists:*

- *Dr Dorijan Marušič, Minister of Health, Slovenia*
- *Mr Fidelis George Dakpallah, Director of Policy Planning, Monitoring and Evaluation, Ministry of Health, Ghana*
- *Ms Anne-Grete Strøm-Erichsen, Minister of Health and Care Services, Norway*
- *Dr Alberto Tejada Noriega, Minister of Health, Peru*

*Rapporteur: Dr Xenia Scheil-Adlung, Health Policy Coordinator, ILO*

### KEY THEMES OF THE SESSION

- *The reasons for inequities identified.*
- *The key concepts of good governance.*
- *The barriers to address inequities in health at the national level.*
- *The identification of key strategies to address social determinants.*
- *The structural prerequisites to be established to tackle social determinants.*
- *Institutionalizing intersectoral action.*
- *Integrating all levels of governance.*



In his introductory note, **Professor Don Matheson** provided an overview of the theme of governance. He described the key elements of governance, including who was involved, the nature of the relationships between those and other groups, and the decision-making process. At its core, governance was political and about power. Governance for health equity was not the achievement of a consensus among those that currently held power but attention to increasing the power and political leverage of disempowered groups so that an emerging consensus better served their interests. That implied a profound and sustained material and psychosocial shift in society; and a shift in the status quo, particularly in terms of the distribution of power, money and resources. The clear failure of the current global and national economic models provided a window of opportunity for shift and change.

Professor Matheson highlighted that “we are on a learning curve” regarding how to achieve good governance in different settings and contexts. He stated that the case studies in the conference strongly suggested that the struggle for health equity needed to be underpinned by strong egalitarian value sets. That was essential to drive and sustain long-term action that permeated through sectors, systems and layers of society. He explained, “Values, like muscles, grow in strength and influence the more they are exercised.” Encompassing social determinants and equity as societal goals required society to undergo a process of adaption of the dominant value system. That process was more likely to succeed if the resulting goals were compatible with the existing values, beliefs and ideas of the local culture. Nevertheless, Professor Matheson also pointed to other case studies where taking action on social determinants to address health equity was undertaken without the advantage of strong national, political and institutional leadership.

A whole-system approach was required, with governance that learnt, responded and was dynamic. Integral to any government response was the anticipation of and planning for the development of opposition and anti-equity forces through good information and communication. Conflict and debate were a necessary part of the process, as was creating a space for those debates, and having them play out in an open and transparent way. Professor Matheson described a number of governance tools that countries had used, including constitutional commitments and legal frameworks. He gave multiple examples of implementation tools, such as high-level plans; interministerial and interdepartmental committees; integrated budgets and accounts; integrated workforce development; partnership platforms; and impact assessments. Other techniques included community consultations, citizens’ juries and health equity policy lenses. Professor Matheson warned, however, that having such tools was insufficient: they must be embedded in a broader societal movement that valued and strove to address health equity.

Following the introductory note, the panellists began by identifying **key reasons for inequities in health and well-being**, which included poverty, unemployment, and disparity in education and access to water and sanitation. It was stressed that the main contributors to inequities were related to widespread poverty, which

had been significantly exacerbated by the repercussions of the recent global crises in economy and finance, climate and food. **Ms Anne-Grete Strøm-Erichsen** highlighted that women were more likely to suffer exclusion and disadvantage, for example through working in the informal labour market, receiving lower wages, or being poor and unemployed. That made women more vulnerable than other population groups to economic and other forms of turmoil or crisis.

**Dr Alberto Tejada Noriega** emphasized that when addressing inequities in health, it was critical to consider the value concepts of societies. Participants agreed that it was also important to be aware that powerful actors outside government – including economic actors, media and academia – were impacting heavily on the conditions in which inequities in health were generated.

**Key principles of good governance** identified related to legitimacy, vision and strategic direction, performance, accountability and fairness. The concept of governance should acknowledge and incorporate the relevance of addressing social determinants in order to promote not only health and well-being, but also development and economic growth. As the root causes of inequities were highly complex and multidimensional, they could not be addressed by one sector alone. Leadership by governments was therefore critical for good governance and must be supported by clearly outlined processes and means for measurement and evaluation. Ms Strøm-Erichsen and **Dr Dorijan Marušič** highlighted that the principles of good governance, as discussed by Professor Matheson, needed to be applied in a way that ensured that the resulting actions and solutions were not undermined or reoriented by competing and vested interests.

The panellists identified some of the **main barriers to addressing inequities** in health at the national level. Dr Marušič drew attention to the impacts of the economic turmoil, particularly in Europe, on the perception of diminished economic capacities to invest in emerging areas of priority, such as social determinants. More generally, other sectors in government and society often did not understand or appreciate the ways in which their activities contributed to health inequities. A key issue was deficits in trust between ministries and other institutions and organizations, which were strongly related to gaps in or lack of genuine opportunities for participation by other stakeholders in policy-making. Reflecting on the situation in Ghana, **Mr Fidelis George Dakpallah** identified funding gaps as a crucial barrier to addressing health inequities. Issues of unemployment and corruption were highlighted by Dr Noriega as primary barriers for addressing national health inequities.

Panellists discussed **key strategies for addressing social determinants of health**. An important group of strategies identified were those related to action within and beyond the health sector. Mr Dakpallah suggested that the framework for the health sector should be based on achieving universal coverage, defined as effective access to health care at all levels. For example, in Ghana, the health insurance scheme aimed at covering people in all districts through a contribution of US\$ 6 for those who were able to pay. Ms Strøm-Erichsen emphasized that in monitoring the performance



of sectors, there was a need to move beyond standard indicators of efficiency and effectiveness to include other relevant aspects. Critically, absolute figures must be separated or disaggregated by the main social factors relevant to the context, such as age, gender, income and ethnicity. Monitoring progress could not be seen as isolated from the values and political, economic or cultural context of the country. A participant from the audience added that it was important to institutionalize a feedback system reporting on health inequities, including regular monitoring of progress and critique by marginalized groups. Dr Marušič pointed to the need to develop knowledge and evidence regarding governance and policy coherence at the global, regional, national and local levels in order to inform subsequent decision-making.

Key strategies for effective collaboration between different sectors were also established. Participants agreed that the engagement of all relevant actors in continuous dialogue and in policy- and decision-making was critical and should be seen as a long-lasting, sustainable process rather than a single event or programme. Such actors included civil society, the private sector and economic groups such as trade unions and employers. The finance sector was highlighted as a particularly important area with which to engage. A discussant from the audience suggested that global learning platforms across sectors could be an appropriate measure.

The **structural prerequisites necessary to tackle social determinants** were also a central theme in the discussions. A broad

social protection floor – that provided basic access to water and sanitation, health, education, and income and employment security – was essential for achieving progress towards equity in health and development. Ms Strøm-Erichsen and Dr Marušič described how social protection had been the basis of the progress achieved in Norway and Slovenia respectively. In both countries, those efforts had led to a reduction in the coverage gaps of social security for vulnerable groups (such as the elderly, children and mothers) and had been undertaken in close coordination with other policies, including reducing precarious and informal employment and enhancing employability of people of working age. Another example from Norway was a “national breakfast” initiative in kindergartens, which was a joint activity of the Ministries of Health, Education and Agriculture to ensure that all children enrolled had access to a nutritious meal every school day to support healthy development and learning. Those panellists concluded that it was necessary to develop new forms of intersectoral cooperation to address inequity, similar to the strategies currently being implemented in Norway or Slovenia, at all levels (global, regional, national and local) and across all sectors.

The critical importance of **institutionalizing intersectoral action** was a principal message in the discussions. Participants agreed that intersectoral action was too big to be the responsibility of one institution or level. Rather, successful examples were given of tackling one specific topic or area, such as the efforts by the

## KEY AGENDA MOVING FORWARD

- *Act dynamically and proactively.*
- *Use and strengthen the evidence base for action on social determinants to address health equity.*
- *Involve all actors in policy-making and decision-making process.*
- *Connect processes, policies and actions to core societal values.*
- *Promote understanding that addressing the issues of social determinants and equity requires impacting on ongoing processes that may take a generation and require constant adjustment.*
- *Use the current window of opportunity to take action to address equity in all government and intergovernmental activities.*

United Nations Educational, Scientific and Cultural Organization (UNESCO) to address educational equity and by several United Nations agencies to extend coverage through the United Nations Social Protection Floor Initiative. Such independent efforts would then need to be coordinated and convened to have a comprehensive and systematic approach to achieving intersectoral action.

Existing instruments that had proven useful for institutionalizing intersectoral action included constitutional and legal frameworks, as in Costa Rica; expert groups or councils, as in Canada; and the use of taxation mechanisms without the leadership of governments, as in Finland. Additional implementation tools to address health inequities included high-level plans and strategies, as in Norway and Ghana; the creation of new institutions, such as the Ministry of Social Inclusion tackling health in Peru; the integration of budgets, workforces, partnerships and platforms, as undertaken in Slovenia; and the systematic use of impact assessments.

A final key theme discussed in the session was the need to **integrate all levels of governance**, including the coordination of global, national and local actors. Dr Noriega stressed the importance of building partnerships and networks to educate all actors on the impact of equitable health outcomes. The sharing and transfer of information, knowledge and good practices should be at the centre of such cooperation. Dr Marušič stated that participation should be fostered and institutionalized at all levels and contribute to transparency and accountability, highlighting that aligning various United Nations agencies was as important as coordinating at local level. Mr Dakpallah gave an example from Ghana of participation at the community level in decision-making on community-based health planning through district assemblies. Ghana had also had success with developing common government policies through a National Development Planning Commission.



## Afternoon session: Making policy coherent at the subnational and local levels

Continuing in the governance theme with the objective of the morning session, the afternoon session aimed to examine those issues at subnational and local levels. The session was chaired by **Dr David Butler-Jones**.

The first key topic of the session focused on **defining the structural prerequisites** that needed to be considered by governmental institutions at local or subnational level to effectively tackle social determinants and equity issues.

### SESSION PARTICIPANTS

*Chair: Dr David Butler-Jones, Chief Public Health Officer, Public Health Agency of Canada*

*Panellists:*

- *Dr Kevin Buckett, Director of Public Health, South Australian Department of Health*
- *Ms Monica Fein, Mayor-Elect of Rosario, Argentina*
- *Dr Mohammad Hady Ayazi, Deputy Mayor of Tehran for Social Affairs, Iran*
- *Ms Hyun Kyung Park, President of the Seoul Foundation of Women and Family, South Korea*
- *Dr Tiaõ Viana, Governor of Acre, Brazil*

*Rapporteur: Dr Orielle Solar, Greds-Emconet, Chile*

### KEY THEMES OF THE SESSION

- *Defining the structural prerequisites to effectively tackle health inequalities.*
- *Defining key strategies to implement and institutionalize intersectoral action.*
- *The lessons learnt that can be applied in other contexts.*

**Ms Monica Fein** began the discussion by noting that the community was the place where people lived, worked and mobilized to improve their conditions. It was therefore imperative that the State engaged in open dialogue with the community and was organized in a way that brought it as close as possible to people within their community contexts. She highlighted that citizens needed to have “social links” with their subnational and national governments, which included social participation mechanisms and decentralized long-term planning. **Dr Tiaõ Viana** agreed on the issue of proximity between government and citizens and added that, in the Brazilian context, education was considered a central element to effectively tackle health inequities.

**Dr Kevin Buckett** described South Australia’s experience of developing state-led action on social determinants. That strategic government plan involved state departments and civil society and encompassed more than 70 interventions across a range of areas of economy, health and development, including the tourism sector. The programme had achieved significant cooperation among different actors and sectors, and the process was monitored and supported by experts from all levels. Dr Buckett concluded by agreeing with

Ms Fein that the greater the participation from civil society, the more complex, comprehensive and legitimate programmes became. **Ms Hyun Kyung Park** highlighted the importance of interaction between local authorities and civil society in the design of policies to improve access to health care and create an environment favourable to health and well-being. She gave several examples of that, including providing healthy breakfasts in schools, having students design the chairs to be used in schools and creating accessible exercise opportunities for all family members.

**Dr Mohammad Hady Ayazi** identified ethnicity and social differences as key challenges that needed to be tackled. He explained the experience in Tehran, where a “social orientation approach” was used that not only included service delivery but also focused on concrete social action, using participation as a key component. Both the South Australian and the Tehran experiences were presented as effective examples of how to scale up the influence and strategies from the local to the national level.

The discussants agreed that territorial identities and administrative networks (including subnational, municipal, city and district) needed to be recognized at the national level in order to foster integration. They also emphasized the need to transform local municipalities and cities to be better able to incorporate social functions that affected and improved not just health but well-being and quality of life more broadly.

In terms of defining **key strategies to implement and institutionalize intersectoral action**, the right to participate was identified by Ms Fein as a fundamental prerequisite for social transformation. She suggested that the answers to problems at

governmental level were to be found in the local structures and that policy solutions should be elaborated in a public process involving all concerned groups. Ms Fein identified decentralization as a major element for local economic and social development, including mechanisms such as participatory budgeting.

Dr Viana agreed on the importance of decentralization, highlighting that a key challenge was often the disconnect between national and subnational policies. He explained how the integration of the Brazilian federal system into national government strategies meant that local governments participated in national decision-making and policy development. The most important factor was legitimacy, which could be achieved through the democratization of the public sector and of the decision-making and implementation process. Mr Ayazi added that local authorities did not just have a de facto influence on the health sector but were also able to cover social and economic aspects that national authorities were not able to.

The panellists discussed the **lessons learnt from their respective country experiences** and how those could be applied in other contexts. Dr Buckett acknowledged some of the contextual factors specific to South Australia, including its relative wealth, large size and small population. Despite those unique circumstances, however, he expressed confidence that initiatives and actions undertaken in South Australia could be applied in other developed or developing settings. The South Australian example showed that it was essential to work with other sectors and institutions to tackle social determinants. Knowing and supporting the objectives of other sectors was imperative, rather than attempting to make other sectors align their objectives with those of the health sector. Dr Buckett gave

the example of improving the capacity and skills of migrants for better development and integration through the direct cooperation with migrants in policy design – a bottom-up, as opposed to top-down, process. Ms Park explained that one of the key elements for the success in reducing health inequities in Seoul was through the improvement of gender equity and she recommended the prioritization of that strategy in other settings as well.

At the closing stage of the session, Dr Butler-Jones asked the panellists to identify **key take-home messages**. Ms Park stated that it was essential for governments to listen to the voices of the people from all levels and to coordinate with them to create a better and healthier environment. She also restated the importance of putting in place gender-sensitive policies. Dr Viana highlighted the need to strengthen democratic and ethical values in societies as democratic values were directly interlinked with health and social conditions. Ms Fein reiterated that national governments and institutions needed to recognize the importance of local governments in creating good governance and policy coherence for action on health equity. Dr Ayazi stated that the involvement of a variety of government levels and actors in policy-making often meant that changes on one level (for example due to election results) might impact policies at other levels. Therefore, the long-term involvement and responsibility of local governments was necessary to create sustainability in policy approaches over time. Dr Buckett emphasized the need to work with other actors and sectors to address the social determinants. Action and change must occur on all levels, but especially at the local level. The health sector should not expect to be the leader of those processes, but should contribute to initiatives that other sectors and actors might lead.

## KEY AGENDA MOVING FORWARD

- *Foster political will to act on a subnational and local level, with cooperation at the national level and the inclusion of civil society.*
- *Place the community, rather than health, at the centre of processes, policies and initiatives.*
- *Enable strategic and long-term planning at the local level.*
- *Use clear indicators to monitor and evaluate processes and make this information accessible to communities to strengthen ownership and accountability.*
- *Make training, support and education available, especially to vulnerable groups, to create informed communities that are able to genuinely participate.*





# PARALLEL SESSION FOR THEME 2: PROMOTING PARTICIPATION: COMMUNITY LEADERSHIP FOR ACTION ON SOCIAL DETERMINANTS

## Morning session: Institutionalizing participation in policy-making

**T**he overarching objective of the session was to foster a broad and meaningful discussion regarding social participation as a fundamental element in addressing social determinants of health to reduce health inequities. Panellists from government, United Nations agencies and civil society shared experiences on promoting participation and community leadership, with the aim of identifying key concepts, requirements, strategies and challenges for institutionalizing participation in policy-making.

**Dr Thelma Narayan** chaired the session and opened by stating that the purpose of the session was to affirm the transformative power of social participation towards achieving equity in health by addressing social determinants.

### SESSION PARTICIPANTS

*Chair: Dr Thelma Narayan, Centre for Public Health and Equity, India*

*Introductory note: Dr Bernardo Kliksberg, Honorary Professor, University of Buenos Aires, Argentina*

#### *Panellists:*

- *Dr Luiz Odorico Monteiro de Andrade, National Secretary for Strategic Planning and Participation, Ministry of Health, Brazil*
- *Ms Nonkosi Khumalo, Chairperson, Treatment Action Campaign, South Africa*
- *Dr Asa Cristina Laurell, Universidad Autónoma Metropolitana, Mexico*

*Rapporteur: Dr Barbara O. de Zalduondo, Office of the Deputy Director, UNAIDS*

### KEY THEMES OF THE SESSION

- *Social determinants of health are highly complex and “participation” is an enormous theme encompassing a range of issues.*
- *Institutionalized mechanisms within government structures are needed as a means to facilitate social participation.*
- *Civil society is also responsible for fostering spaces for participation and must maintain a critical analytical perspective to ensure that participation is genuinely representative and valued.*
- *There is a strong relationship between the economy and health and addressing social determinants of health and health equity requires challenging and changing prevailing neoliberal values and structures.*



The complexity of social determinants and the enormity of the theme of “participation” were articulated early in the session and emphasized throughout. The session covered a variety of topics initiated by both panellists and speakers, including the underlying importance of economic models and structures for social determinants; democracy and the institutionalization of participation; participation in monitoring and health care systems and by specific marginalized groups; and privatization of water and land. The range of issues made for a broad, rather than detailed, discussion in which many important issues were raised and key points emphasized, but without much opportunity to explore each topic in depth.

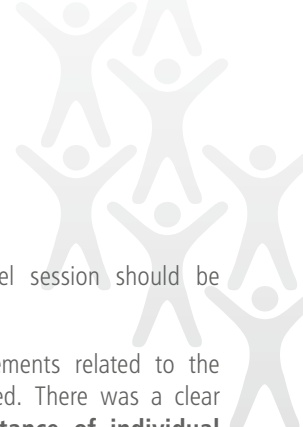
In his introductory note, **Professor Bernardo Kliksberg** highlighted international successes and personal experiences to provide a clear rationale for the value and fundamental necessity of social participation in addressing social determinants and inequity. He focused on the relationship between economy and health, presenting compelling statistics of how the economic crisis – a social determinant – had negatively impacted and exacerbated living conditions and health outcomes for many people, especially the most vulnerable. In that context, Professor Kliksberg suggested that participation was strategic: first, as one of the few instruments or tools that marginalized people possessed to improve their situation; and second, because politicians and governments needed strong social and participatory support to implement and maintain necessary structural changes, against resistance by powerful vested interests. Ultimately, participation was about the distribution of

power and was part of a political struggle against inequity that sought to shift political culture and values.

Many panellists and members of the audience expressed frustration with prevailing neoliberal policies. Professor Kliksberg described the example of how neoliberal policies had led to the privatization of water supplies, which was having significant detrimental and irreversible impacts on populations and health and well-being outcomes. One audience member commented on the contradictions inherent in the current models of social liberalism, in which the State provision of social services, such as health and education, were undermined by the continued predominance and pursuit of neoliberal values and priorities in society overall.

**Dr Luiz Odorico Monteiro de Andrade** explained the historical context of social participation in Brazil in terms of the struggles for democratic transformation. The principals of universality and social participation were embedded in the 1988 Brazilian Constitution and were therefore fundamentally a State approach, as opposed to a government policy dependent on the party in power. The Constitution guaranteed the organization and institutionalization of social participation at national, state and municipal levels of government.

**Ms Nonkosi Khumalo** emphasized the importance of society fostering and being afforded the necessary public spaces and support mechanisms to participate within the policy-making arena. She discussed the challenges in South Africa as a growing democracy, in particular with regard to the lack of institutionalized



mechanisms for participation within policy-making and the government's changing perception of civil society from a friend to an opposition of government. In such contexts, societies themselves must strive to foster space for participation as a fundamental issue of political power and administrative and social justice.

**Dr Asa Cristina Laurell** drew attention to the challenges in discussing the notions of social participation and democracy, which were highly complex and ambiguous concepts for which there was not consensus. She discussed the different modalities of social participation, including structurally transformative social and political movements, as in Brazil, Bolivia and Uruguay, for example; civil society organizing around ethical principals or specific topics; and the dialectic of social participation born under authoritative government, as seen currently in the Arab world. Dr Laurell stated that social control was an important function of participation and warned of the risk of social participation – particularly when institutionalized – being coopted by powerful voices to legitimize policies. She expressed concern that the World Conference had not provided sufficient opportunity for civil society to participate in the development of the Rio Political Declaration. Her concerns were reiterated by several member of the audience with the suggestion

that the issues discussed in each parallel session should be incorporated into the declaration.

During the discussion, several pivotal elements related to the session's objectives were broadly addressed. There was a clear and consistent articulation of **the importance of individual and community participation** for equity, socially representative policies and programmes, and political sustainability. Panellists identified and discussed a **broad range of strategies to facilitate social participation**, particularly in policy-making, from a multitude of contexts across the globe. Finally, panellists explored the way that **differences in context affected implementation** of strategies and programmes to foster and institutionalize social participation in policy-making. Democracy was seen as a central issue for participation, as was the need for institutionalized mechanisms within government structures as a means to facilitate social participation. The limitations and risks of those components – including corruption, cooption and conflict of interest – were also identified, with acknowledgement that they were not sufficient in themselves to ensure genuine participation. It was therefore crucial that civil society maintained a critical analytical perspective and pushed for accountability and transparency in decision-making and policy-making arenas.

## KEY AGENDA MOVING FORWARD

- *Promote an understanding of participation as an issue of social power and social justice that acknowledges the need to address the underlying economic values and structural systems of society.*
- *Governments and civil society should foster spaces and capacity for social participation, particularly of marginalized groups, including institutionalized mechanisms for participation within government structures.*
- *Maintain a critical analytical perspective to ensure that discussion and action on participation is genuinely representative and valued.*

## Afternoon session: Integrating new approaches to participatory action

The afternoon session shared the overarching objectives of the morning session, but focused on the integration of new approaches to participatory action and the changing roles of different actors, such as civil society and the private sector.

**Dr Luiz Loures**, Chair of the afternoon session, set the stage by emphasizing the need to move towards a social and governmental agenda that fostered and strengthened participation as a key pillar of social progress and development. Empowering and giving agency to women, young people and other vulnerable groups and ensuring that they were included in the participatory discourse was of particular importance.

### SESSION PARTICIPANTS

*Chair: Dr Luiz Loures, Director of UNAIDS Executive Office*

*Panellists:*

- *Dr Nila Heredia, Minister of Health, the Plurinational State of Bolivia and President, ALAMES*
- *Dr Roberto Morales Ojeda, Minister of Health, Cuba*
- *Ms Bridget Lloyd, Global Coordinator, People's Health Movement*
- *Dr Rene Loewenson, Coordinator, Regional Network on Equity in Health in Southern Africa (EQUINET)*

*Rapporteur: Dr Amit Sengupta, Associate Coordinator, People's Health Movement*

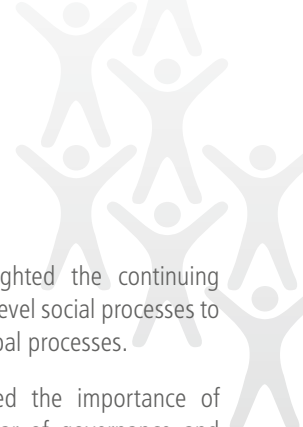
### KEY THEMES OF THE SESSION

- *Government and social agendas need to prioritize and actively foster participation, particularly of marginalized groups, as a pillar of progress and development.*
- *The private sector needs to be held accountable for their decisions and activities, which are often damaging to health and equity. This is a key role of civil society and governments.*
- *It is critical not only to increase social participation but for society to gain greater power and control of resources and decision-making authority.*
- *Genuine and ongoing participation cannot occur without both financial and educational resources.*

**Dr Nila Heredia** began by stressing that the way popular participation was understood and discussed depended to a large extent on how it fitted within the current societal structure and dominant model. Genuine participation was only possible when its role was valued and given a level of empowerment, weight and capacity comparable to other influencing voices and factors. She described the constitutional, political and structural changes that had been undertaken in Bolivia. The new Constitution, for example, recognized and acknowledged 36 different nationalities and their respective rights and duties. The country was undergoing significant decentralization, both geographically and in participational and political arenas, aimed at embedding social participation in decision-making and activities. Dr Heredia described the success Bolivia had had in its malnutrition programme, using a participatory, intersectoral and interinstitutional approach. She warned that national programmes could not be independent of global influences

and context – for example, it was critical that the Bolivian malnutrition programme took into account issues of food security and food sovereignty.

**Ms Bridget Lloyd** focused on the role and responsibilities of the private sector, whose activities and decisions were often detrimental to health and equity. She emphasized that the private sector should not be considered as part of civil society, pointing out that the private sector was accountable to its shareholders and not the community or its health. A crucial role of civil society and governments was therefore to hold the private sector accountable for its decisions and activities, particularly with regard to the impact on health, health equity and other shared societal goals. Ms Lloyd stressed that the space for participation must be accessible and facilitated and that that required significant funding and resources, including for capacity development.



Ms Lloyd described the work the People's Health Movement (PHM), an international grass-roots movement concerned with health equity and the revitalization of the principles of the Alma-Ata Declaration. That work included collaborating on producing the Global Health Watch Report, an alternative from civil society to the annual WHO World Health Report. PHM also trained grass-roots activists to use information to mobilize and be activists for change in their societies, and trained and facilitated activists at country level to engage with decision- and policy-making at the regional and global level. With regard to the World Conference, PHM coordinated with other civil society organizations and movements to contribute a response to the public consultation on the draft of the World Conference discussion paper and to develop an alternative Rio Political Declaration.

**Dr Rene Loewenson** stated that levels of participation in Africa were often underestimated despite considerable activity in the continent. The fundamental issue was that the increasing participation in Africa was occurring within the context of economic growth and development driven by the extraction of raw materials, export and the financial sector – a context in which citizens (especially those who were not consumers, producers or taxpayers) were ignored relative to multinational and other stakeholders. She therefore emphasized that discussion on social participation needed to constitute discussions about economic justice, social power and control of resources, including those for health and well-being. That point represented a pivotal moment in the session, resonating strongly with the audience, and was reiterated later on by Dr Loewenson and several audience members.

Dr Loewenson described the Regional Network on Equity in Health in Southern Africa (EQUINET), a network within the eastern and southern Africa region of professionals, civil society members, policy-makers, State officials and others. As a values-based network, members had come from very diverse disciplines and communities to work together to promote and realize their shared values and vision of equity and social justice in health. The network was active across a range of domains, including the social production of knowledge in communities through participatory processes and working to synthesize experiences and knowledge to build a regional perspective of current efforts to engage with global processes that

undermined health. Dr Loewenson highlighted the continuing challenge for civil society to link community-level social processes to build collective action with national and global processes.

**Dr Roberto Morales Ojeda** underscored the importance of governments having participation as a pillar of governance and placing human beings at the centre of attention in terms of identifying problems, contributing to development, and implementing and evaluating solutions. He described Cuba's efforts to achieve that by institutionalizing participation in decision-making, monitoring and accountability at the municipal level – referring to that as "solution with the masses". Cuba also facilitated participatory feedback within the health system specifically, assigning as the basic unit of the health system a doctor and nurse team for each family, whose responsibility was both to improve health for the individual and for the people and communities more broadly. Dr Morales also described how Cuba contributed to capacity building of human health resources at a global level, though technical leadership and knowledge sharing with other countries.

During the discussion, panellists and the audience reiterated and elaborated on several of the key issues that had been raised. There was a consensus that participation could not successfully occur or continue without financial and educational resources. Participation was fundamentally about social power and control, and accountability and monitoring were seen as essential parameters within which social participation should be centrally incorporated. Several panellists reiterated their concern that the Rio Political Declaration failed to adequately focus on the structural context that underpinned social determinants and that the declaration had been developed largely without input from the conference parallel sessions or involvement of civil society. The crucial importance of strengthening the participation of young people and other marginalized groups in civil society movements and in decision-making was also highlighted. The role of WHO and the United Nations in driving the agenda of social determinants and social participation was explored, not only in terms of global governance, but also with regard to specific related issues such as knowledge sharing and intellectual property.

## KEY AGENDA MOVING FORWARD

- *Ensure that understanding of and action to foster social participation encompasses the need to address structural issues, in particular the control of power, resources and decision-making authority.*
- *Prioritize and embed social participation in all stages of decision-making and policy-making, particularly in monitoring and accountability.*
- *Make financial and educational resources available for participation, in particular targeted towards strengthening the opportunities and capacities of communities, especially vulnerable groups, to participate.*



# PARALLEL SESSION FOR THEME 3: THE ROLE OF THE HEALTH SECTOR, INCLUDING PUBLIC HEALTH PROGRAMMES, IN REDUCING HEALTH INEQUITIES

## Morning session: Ensuring equitable universal coverage

In light of the well-acknowledged limitations of the biomedical approach in achieving global public health goals and the inadvertent contribution of the health sector and systems to exacerbating health inequities, the third theme of the World Conference concerned the specific role of the health sector, including public health programmes, in reducing health inequities.

The morning session focused on ensuring equitable universal coverage. The objective of the session was to identify key prerequisites, strategies and facilitators for, and obstacles to, promoting equitable universal coverage, and to identify the support countries required from global actors, including WHO, to implement equitable universal coverage. The session was chaired by **Dr Jeanette Vega**.

### SESSION PARTICIPANTS

*Chair: Dr Jeanette Vega, Director, Centre for Public Health Policy, Universidad del Desarrollo, Chile*

*Introductory note: Professor Ilona Kickbusch, Director of the Global Health Programme, Graduate Institute of International and Development Studies, Geneva*

#### *Panellists:*

- *Mr Simon Burns, Minister of State for Health, Department of Health, United Kingdom of Great Britain and Northern Ireland*
- *Dr Alexandre Padilha, Minister of Health, Brazil*
- *Dr Sania Nishtar, President, Heartfile, Pakistan*

*Rapporteur: Professor Cláudia Travassos, Fiocruz, Brazil*

**Professor Ilona Kickbusch** introduced the session theme. She began by providing an overview of the various agendas behind global public health, including health and well-being, social protection, and universal access to food and health as a human right. Professor Kickbusch stated that the nature of 21st-century health and its technological potential called for a radical change of mindset and a reorganization of how we governed health in the 21st century. That required significant changes in the roles of the health sector, health professionals, patients and citizens, as well as of other sectors and societal actors. Professor Kickbusch emphasized that the most important changes and challenges were political in nature. Health had risen as a priority in political agendas in many countries and in development policies and global agreements. That shift was precisely because of the relevance of health to the economy, to political ideology and legitimacy, and to the aspirations and expectations of citizens. A fundamental reorientation was required in society and in the prevailing economic mindset in particular to position health and well-being as key features of what constituted a successful society and vibrant economy in the 21st century. Population health and well-being must be valued over economic production, and key societal measures and indicators of progress should reflect that.

Professor Kickbusch said that prioritizing health and well-being as societal goals required reorientation of health governance and policy frameworks. Many of the social determinants of health and equity fell outside and were beyond the reach of the health sector and its policies. Governance for health should ground its policies and approaches in values such as human rights and equity. Synergism and cooperation for commonly agreed-upon goals and interests were necessary across health and non-health sectors,



## KEY THEMES OF THE SESSION

- *Public policy is a determinant of health. There is a need for radical change in the way health policies and programmes are conceived and implemented. The most important challenges in this process of change are political in nature. The distribution of money, power and resources must be addressed in order to increase health, equity and well-being for all.*
- *Quality universal coverage is an ethical requirement and is crucial for the sustainability of equitable health policies. Demands for universal coverage must be met through equitable financing strategies and should address, or minimally not exacerbate, health inequities. Universal access is a necessary but not sufficient condition for equity in health and health care.*
- *Across countries, there is increasing tension between the public and private sectors that threatens equity. It is imperative that the health and well-being of people and the right to health takes precedence over economic interests. Public and private relationship is a public responsibility, and private sector participation in policy-making requires effective regulation by the State to protect equity in health and health care.*
- *Human resources development is critical for achieving equity in health and health care. The quantity, quality and type of human resources available should match population needs and health systems principles. Countries must implement fair human resources policies, in particular to protect against unjust migration of trained professionals.*

public and private actors, and civil society. That must be supported by structures and mechanisms that enabled such collaboration and alignment. Such a model of governance for health gave strong legitimacy to ministers and ministries of health and public health agencies to reach out to other sectors and actors and to perform new roles in shaping policies that promoted health and well-being across all levels of governance.

Professor Kickbusch concluded by suggesting several specific ways in which reorientation was needed, including focusing on health, well-being and fairness as goals instead of health alone; making health part of a synergy with social protection, rather than the current approach of trying to put health first; considering health as an integral dimension of other sectors and policies, rather than expecting those sectors to prioritize the goals of the health sector; undertaking joint strategic assessments instead of health impact assessments; and fostering dynamic, smart and politically astute governance rather than a governance model that was hierarchical, State focused and technical and policy focused.

In their introductory discussions, the ministers from Brazil and the United Kingdom highlighted the importance of working across governments, securing leadership commitment and fostering innovations for ensuring equitable universal coverage.

**Dr Alexandre Padilha** discussed the Brazilian Sistema Único de Saúde (SUS; Unified Health System), which was established by the

Constitution of Brazil in 1988 and was one of the largest public health systems in the world, reaching out to over 190 million people. Dr Padilha explained that the democratic movement in Brazil during the 1980s and the influence of the Alma-Ata Declaration on Primary Health Care and the health reform movement contributed greatly to the development of the SUS. Urban trade union movements and redemocratization initiatives saw the emergence of new leadership from the workers and trade unions, who believed in and mobilized for a welfare state. Dr Padilha emphasized that political will was necessary in drives towards establishing equitable universal health coverage. The work of the health sector often benefited the work and objectives of other sectors, and identifying those synergies was extremely important. He discussed some of the significant challenges faced by the Brazilian Government over the last few decades in maintaining and expanding the SUS, including unequal regional development, ensuring quality of care and responding to increasing public expectations. Dr Padilha also drew attention to the increasing tension between the public and private sectors across countries, which threatened to exacerbate inequity. He concluded that the public and private relationship was a public responsibility and economic interest could not replace or take precedence over the right for health and health care. Private sector participation required effective regulation by the State for protecting equity in health and health care. Involving civil society and affected communities in making policy decisions and in efforts to improve services was extremely important.

**Mr Simon Burns** described how ensuring universal health care in the United Kingdom through the National Health System (NHS) had been evolving in the context of an ageing population, escalating drug costs and significant advances in health technology. He argued that health care goals could not be achieved through working in isolation and that intersectoral collaboration with a number of players, including housing and education, was critical. The minister stressed that ensuring universal coverage did not ensure equity unless there were also concerted efforts to reduce inequities. It was also important to ensure the quality of care of services provided. In the modernization of the NHS, critical measures taken by the government included the engagement of local authorities through health and well-being committees and ensuring the protection of Department of Health financing even in the time of financial crisis. Mr Burns stated his strong belief that budget cuts in health and social services, as seen in some countries, might widen health inequalities, which the countries would find difficult to overcome later.

**Dr Sania Nishtar** described the work of Heartfile, a nongovernmental organization and think tank in Pakistan that aimed to catalyse change in health systems in order to improve health and social outcomes. One area of particular focus for Heartfile was developing solutions to address catastrophic health expenditure. Dr Nishtar explained the challenges of working in a resource-poor setting and how innovative financing in health could significantly reduce health inequities. In Pakistan, access to health care was limited and over 70% of people had to pay user fees. Severe illness could exacerbate financial insecurity for poor people and force them deeper into poverty. To address that gap, Heartfile developed a health equity fund, which enabled registered doctors and hospitals to secure financial help in an expedient and transparent manner for patients who ran the risk of catastrophic spending on health care. Resources for the fund were mobilized through donations and grants from public and private donors. The objective at inception was twofold. The first objective, at the humanitarian level, was to develop a system that could protect people against medical impoverishment and meet an urgent need among the poor. At the development level, the second objective was to develop a health-relevant social protection system suited to the specific needs of Pakistan that could help broaden the base of financial pooling for health.

Dr Nishtar stated that the financing of health systems towards achieving equitable universal coverage was a necessary but not sufficient step. The availability, quality and effectiveness of service delivery were also important. When considering financing measures, out-of-pocket expenditure at point of service needed to be minimized and prepayment pooling mechanisms, such as social insurance or taxation, should be utilized. Governments must

take into account total societal expenditure on health and how to steward that towards equity, rather than considering only the proportion of funding that they themselves supplied. In a resource-poor setting, innovation to make use of all available resources was crucial. Examples of innovations and new technologies included health credits through microcredit systems and mobile banking. Dr Nishtar concluded by emphasizing that public health experts needed to have competencies outside the health sector, including how to manage funds, regard for child protection and an applied understanding of health law.

**Dr Margaret Chan** made a guest appearance for the first hour of the panel and gave her account of what needed to be done for ensuring equitable universal coverage. She suggested that health was highly political and was the barometer by which to understand what was functioning well and poorly in a society. Dr Chan stressed that the values of equity, fairness, social justice and social participation should be part of an efficient and effective health system. In many countries, it was difficult for people to see a doctor, let alone be able to afford costs for health care and treatment. Social protection played an important role in addressing issues of inequities and health could act as a good entry point for collaboration between different sectors. Dr Chan highlighted that strengthening the measurement of inequities was also extremely important, as "What gets measured, gets done."

A rich discussion followed the panel, during which participants raised several points relating to equitable universal coverage. Participants urged WHO to continue working on the recommendations of the Commission on Social Determinants of Health to improve daily living conditions; tackle inequitable distribution of power, money and resources; and measure and understand the problem and assess the impact of action. The role of civil society in filling gaps was highlighted and seen as particularly crucial in resource-poor settings. Also raised was the need for transparent systems and mechanisms for selecting beneficiaries of financial support and targeted action. The role of health law in ensuring universal coverage was important, but just having such laws in place was insufficient. Advancing the human rights framework and enshrining it in the legal and constitutional structures of countries was critical. Other important aspects of ensuring equitable universal coverage discussed included a greater commitment to social justice by governments, a strong judiciary, and strengthening the role and accountability of the media. Universal access to health and health care was part of an integrated agenda that required moving forward with greater synergy between the health and social protection agendas and called for increased intersectoral action through Health in All Policies.



## KEY AGENDA MOVING FORWARD

- *Position human health and well-being as an important ethical base for new health policies. This implies consideration of human rights, equity in health, democratization and solidarity, and includes making universal access part of an integrated agenda. It requires moving forward with greater synergy between the health and social protection agendas, and calls for an increase in intersectoral action through Health in All Policies.*
- *Financing health systems towards equitable universal coverage is a necessary but not sufficient condition for addressing social determinants of health and inequity. The availability, quality and effectiveness of service delivery are equally important. When considering financing measures, minimize out-of-pocket expenditure at point of service and utilize prepayment pooling mechanisms such as social insurance or taxation. Governments should consider total societal expenditure of health and how to steward this towards equity, not only the proportion of funding that they themselves supply.*
- *Countries with public health systems should avoid policies and actions counter to the principle of quality universal coverage as a result of the economic crisis. Pressure from the economic crisis must not also mean a retreat in the international agreements influencing health, such as the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) and the Doha Declaration on the TRIPS Agreement and Public Health.*



## Afternoon session: Changing the role of public health

The afternoon session related to the changing role of public health and was chaired by **Dr César Victora**. The objective of the session was to discuss the rationale for reorienting public health systems and programmes and to reflect on current experiences of doing so in order to identify key strategies, barriers and facilitators.

**Dr Beth Mugo** described the changing role of the health sector in Kenya for addressing tuberculosis. Some of the major social determinants of tuberculosis in Kenya included poverty, problems with poor-quality and insufficient housing and the effects of urbanization, increased tobacco use, and increases in refugees and in the number of people living with HIV/AIDS. Dr Mugo outlined the key initiatives that had been taken to control and treat tuberculosis and to mitigate the impacts of the disease, including making treatment for tuberculosis free of charge; providing direct support to tuberculosis patients; increasing access to treatment and support through outreach activities; housing and slum upgrades; social protection initiatives to reduce vulnerabilities, for example related to diet and food; control of smoking in public spaces; and working in collaboration with faith-based initiatives. Those efforts had resulted in a stabilization of tuberculosis cases in the last few years.

### SESSION PARTICIPANTS

*Chair: Dr César Victora, President, International Epidemiological Association*

#### *Panellists:*

- *Dr Pakishe Aaron Motsoaledi, Minister of Health, South Africa*
- *Dr Beth Mugo, Minister of Public Health and Sanitation, Kenya*
- *Mr James Chauvin, President-Elect, World Federation of Public Health Associations*
- *Professor José Gomes do Amaral, President-Elect, World Medical Association*

*Rapporteur: Dr Jane Billings, Senior Assistant Deputy Minister, Public Health Agency of Canada*

### KEY THEMES OF THE SESSION

- *Health care delivery and public health systems should be seen as a continuum. Strengthening of health systems to address social determinants of health for improved health equity should include both individual and population services and the continuum of promotion, prevention and treatment.*
- *Reorienting health care services and public health programmes to address social determinants of health is essential to improve equity in health and health care access and to achieve global and national prevention, treatment and care goals set by public health programmes and strategies.*
- *Reorienting health care services and public health programmes to reduce inequities requires a primary health care approach that systematically considers who benefits from current delivery of health services. This requires considering who is not reached at each of the steps required to access effective care, and then implementing measures in collaboration with communities to remedy these issues. New universal services should be rolled out with priority given to those who are most disadvantaged, with incentives and regulation to ensure this occurs.*
- *While health care services to a large extent are dealing with the symptoms of health problems determined in other sectors, public health programmes have the responsibility to analyse and address not only how health services are provided but also how and why illhealth and inequitable distribution of health occur in populations. This goes far beyond providing medical interventions and is a more comprehensive and integrated approach than targeting vulnerable groups in isolation.*
- *The role of public health is changing and concerted efforts should be made to monitor inequities and the impact of policies on social determinants; bring other sectors together and lobby for a social determinants approach and explain how this approach is beneficial for different sectors and across society; and develop capacities for addressing social determinants and working to achieve equitable universal coverage.*



Another crucial component of the tuberculosis control programmes in Kenya was working with vulnerable groups such as those living in slums or prisons. A strong intersectoral coordinating department involving people from various ministries had been established. An important challenge highlighted by Dr Mugo was maintaining government vigilance in overcoming the resistance of the tobacco industry to public health initiatives. Dr Mugo concluded by stating that addressing social determinants did not require a new set of workers. Rather, it was important to have well-founded strategies for addressing social determinants and to work with the existing workforce within the health sector and to collaborate with actors outside health and government.

**Dr Pakishe Aaron Motsoaledi** discussed the challenges of working on HIV/AIDS in South Africa and described how the health sector in the country was responding to HIV/AIDS through intersectoral action. Dr Motsoaledi emphasized that HIV/AIDS was a socioeconomic disease that had geopolitical and economic implications, and that HIV/AIDS and tuberculosis were two sides of the same coin. The national HIV/AIDS strategy focused on prevention, treatment, care and support across several related diseases, including tuberculosis and noncommunicable diseases. The strategy prioritizes intersectoral action, which was undertaken through an interministerial committee led by the Deputy President. All sectors – including education, labour, mining, agriculture and farming and the banking sector – and civil society and affected communities were included in the process. Gender played an important role in increasing vulnerability and the impact of HIV/AIDS, and education of girl children had been found to have a positive influence on reducing their vulnerability. Community-based action was needed to fight violence against women and children. As alcohol influenced risk-taking behaviour and violence, Dr Motsoaledi stressed the need to have a framework convention on alcohol control, similar to that for tobacco.

**Professor José Gomes do Amaral** elaborated on the role of doctors in addressing social determinants, stating that physicians should be part of the solution, not the problem. He suggested that the nine million physicians in the world could contribute in a number of ways, including influencing quality of care – a direct social determinant of health; monitoring situations, including health conditions of patients and the social determinants of communities with which they worked; and assessing the effectiveness of interventions. He gave the examples of how physicians in Brazil had understood the significant health risks related to motorcycle accidents and had influenced the development of stricter regulations. Professor Amaral

also pointed out that the World Medical Association had recently adopted a resolution on how it could address social determinants issues and contribute to the broader global agenda.

**Mr James Chauvin** discussed the central role of human resources in health for reducing health inequities and how the World Federation of Public Health Associations was currently working to ensure those roles were fulfilled at the local and global levels. Mr Chauvin stated that the public health community had been actively taking a lead role in discussions on the need to address social determinants of health. He also pointed out that 25 years ago the Ottawa Charter for Health Promotion envisaged intersectoral work to improve health outcomes. Long-term commitment and political will were extremely important to efforts to address social determinants and equity. Mr Chauvin referred to the call in the report of the Commission on Social Determinants of Health for proportional universalism rather than disproportionate individualism. He suggested that that required a reorientation in the conceptualization of health from a focus on health care to a focus on health equity, as well as concerted and continuous efforts from various sectors. National policies and strategies needed to be developed using a health lens, and strong foundations in public health law should be built with long-term horizons in mind.

The panel was followed by discussions with the audience, who raised important questions on the reorientation of public health. The importance of human resources for health and for equity in access to health care was further explored. Examples of several alternative mechanisms for increasing access to health care were described. The Bangladesh Government, following WHO guidelines, was endeavouring to increase access to doctors in rural areas through a number of activities, including creating senior positions in rural areas; making community service compulsory for physicians who completed medical training; and instituting rural allowances, housing assistance and other support initiatives. Importance was also given to the rotation and retention of doctors. Another example described was from South Africa, which was trying to improve the quality of education of doctors. The potential for technology to reduce the equity gap was also raised in the discussion, in particular the use of mobile phones and other telecommunication methods. However, it was also pointed out that technology could not replace human-to-human interaction. A final theme discussed was the increasing commercialization and privatization of health care, which was increasing costs and having a negative impact on primary health care.

## KEY AGENDA MOVING FORWARD

- *Reorient health care services and public health programmes to reduce inequities using a primary health care approach that systematically considers who benefits from the current structure and delivery of health services. This requires analysis of which population groups are not reached at each of the steps to access effective care and then implementing measures in collaboration with communities to remedy the issues and barriers identified.*
- *Traditionally, the health sector tends to focus on supply-side interventions. There is an urgent need to look at the demand side as well as the needs and expectations of communities in order to improve health equity and achieve the goals set by public health programmes.*
- *The health sector has a key role in monitoring inequities in health outcomes and social determinants as well as the health and equity impacts of policies across sectors. This information can be used for evidence-based advocacy for action across society to promote health and health equity. The health sector also has an important role in building capacity for work on social determinants. Health care service providers in all sectors need to contribute to reducing inequities by measuring how existing services perform through the continuum of care for different population groups; addressing factors that cause differential performance; and working with other sectors to address those barriers.*







# PARALLEL SESSION FOR THEME 4: GLOBAL ACTION ON SOCIAL DETERMINANTS: ALIGNING PRIORITIES AND STAKEHOLDERS

## Morning session: Negotiating for health at the international level

The fourth theme of the World Conference related to aligning global priorities and stakeholders for action on social determinants of health. The morning session within that theme focused on negotiating for health at the international level. The session was chaired by **Dr Kumanan Rasanathan**.

**Professor Ronald Labonté** provided the introductory note. He began by drawing attention to three interlinked global phenomena affecting health: the crisis in global finance and capitalism; the environmental crisis of scarce natural resources and climate change; and the dramatic rise in wealth inequalities in most of the world's nations.

Given still tepid or ineffectual governmental responses to those crises, Professor Labonté questioned to what extent it was possible to promote policy coherence around health equity. Despite positive developments seen in the focus of foreign policy on health, there had not been a substantial change in closing the gap of inequity. Although there was wide recognition among many economists and most United Nations agencies of the need to enhance social protection spending, the diffusing austerity agenda in response to the financial crisis was weakening the solidaristic supports in many countries essential to reducing inequities and improving social determinants of health. Failure to act on the social determinants was not a result of lack of knowledge or technical capacity, but rather a political choice.

Professor Labonté noted that, as we moved forward, it was essential to recognize that many of the appropriate policy measures were win–lose (in the sense that they were inherently regulatory and redistributive), and not win–win (in the sense that they must disturb the status quo). In view of the current recession and policy focus on jobs, full and fair employment should be promoted, including labour standards for both formal and informal workers. Similarly, trade and investment treaties could speed up the diffusion of communicable vectors of noncommunicable diseases (for example tobacco-related illnesses) – an issue inadequately addressed in the declaration of the recent Global Ministerial Conference on Healthy Lifestyles and

### SESSION PARTICIPANTS

*Chair: Dr Kumanan Rasanathan, Technical Officer, Department of Ethics, Equity, Trade and Human Rights, WHO*

*Introductory note: Professor Ronald Labonté, University of Ottawa*

#### *Panellists:*

- *Dr Pakishe Aaron Motsoaledi, Minister of Health, South Africa*
- *Ms Sissel Hodne Steen, Minister Counsellor, Deputy Head of Mission, Embassy of Norway, Brazil*
- *Ambassador Maria Nazareth Farani Azevêdo, Permanent Representative of Brazil to the United Nations in Geneva*
- *Ambassador Jacques Pellet, Permanent Representative of France to the United Nations in Geneva*
- *Ambassador Sihasak Phuangketkeow, Permanent Representative of Thailand to the United Nations in Geneva*
- *Ambassador Dian Triansyah Djani, Permanent Secretary of Indonesia to the United Nations in Geneva*
- *Dr Haik Nikogosian, Head of Convention Secretariat, WHO Framework Convention on Tobacco Control*

*Rapporteur: Associate Professor Ted Schrecker, University of Ottawa*

## KEY THEMES OF THE SESSION

- *The world crisis is often presented as a problem that is unfortunate or tragic, but rarely as an outcome of policies that work in favour of the rich and powerful.*
- *Redistribution, regulation and rights are key issues that need to be addressed by governments and United Nations agencies.*
- *Policy coherence is both possible and necessary. A number of policy instruments are in place that work. The Doha Declaration compromise on access to medicines is an illustration of a “less greedy” approach to foreign policy, yet 30% of the world still lacks access to essential medicines.*
- *The WHO Framework Convention on Tobacco Control has shown new ways of working in global health. An essential condition for a global health treaty is that the health challenge has reached global epidemic proportions and is driven by strong transnational factors.*
- *The human rights issue has been referred to and drawn upon considerably as part of the process of learning more about the relations between different social determinants of health and their relation to foreign policy.*
- *At the moment, scales are tilted in favour of the economic sector rather than the health sector. Two key ingredients needed to address this challenge are a strong civil society and political champions within government.*
- *The issue of equity is not about the divide between developed and developing countries, but one in which all countries can come together as they did in the case of the pandemic influenza preparedness (PIP) framework. The PIP framework reflected recognition that 30-year-old policy instruments were out of date, and access to medicines was a problem not only because of intellectual property but because of limited supplies.*
- *When addressing equity it is essential to address issues related to the underlying resources and power and not just instruments and policy documents.*

Noncommunicable Disease Control in Moscow. Finally, Professor Labonté proposed that governments, WHO and United Nations agencies commit to moving forward on issues of redistribution, regulation and rights in order to change the current status quo.

**Dr Pakishe Aaron Motsoaledi** suggested that policy coherence was possible, but very specific efforts were needed to make it to happen. In South Africa, HIV/AIDS changed the entire status quo, including access to medicine. The example of HIV/AIDS in South Africa demonstrated that strong social movements, such as Global Health Watch, were needed in order to move the agenda of equity forward. South Africa was currently experiencing resistance to regulation of alcohol and tobacco – that resistance was based on economic concerns, illustrating competing agendas and interests. A similar resistance was seen when the pharmaceutical industry mobilized against government attempts to reduce the prices of antiretroviral and anti-tuberculosis drugs.

The minister suggested that new instruments were needed and that existing ones needed to be strengthened, including The Framework Convention on Tobacco Control. Scales were currently tilted in favour of the economic sector and economic values rather than the health sector. Two ingredients were needed, namely a strong civil society and political champions within government. A key example of the impact of inequity was that in South Africa, the government was spending 8.5% of gross domestic product (GDP) on health, but only 5% was going to 16% of the total population. “We are introducing national health insurance but people are fighting, saying it will collapse the economy.”

**Ms Sissel Hodne Steen** discussed how the Oslo Ministerial Declaration on Global Health (2007) had brought a total of seven countries together using WHO as an arena where negotiations could take place. The Oslo Declaration had proven to be a success and was the most-cited publication in the field of foreign policy and health,



as it encouraged different groups to work together. She emphasized that understanding the relationship between health and foreign policy was in itself a landmark. Furthermore, Ms Steen said that rights issues had been referred to and drawn upon considerably as part of the process, providing significant lessons about the relations between different social determinants of health and their relation to foreign policy.

**Ambassador Maria Nazareth Farani Azevêdo** described how people taking to the streets in the post-crisis context was sending a clear message that equity matters. Something was wrong, and we all had a responsibility to change the current status quo and shift the paradigm towards more equitable policies. Brazil served as a key example of the importance and feasibility of policy coherence, with more than 40 million people taken out of poverty through nationwide, structured, coherent social and economic policies. Ambassador Azevêdo suggested that perhaps more solidarity was needed, as opposed to more policy instruments. The compromises in the Doha Declaration on access to medicines was an illustration of a “less greedy” approach to foreign policy, yet 30% of the world still lacked access to essential medicines. “Soft law” and initiatives such as the World Conference were also important as an illustration of how far dialogue could take us. Ambassador Azevêdo stated that Brazil favoured innovative financing but not as a substitute for official development assistance. Instruments such as the TRIPS Agreement were instruments in place that worked when there was a need. She concluded that trade was a sensitive issue but was high on the agenda in the negotiations of the Rio Political Declaration

and Brazil was in favour of a strong, robust paragraph relating to the need to strike a balance between trade and health.

**Ambassador Jacques Pellet** stressed that when addressing equity it was essential to address the underlying resources and power dynamics, in addition to the relevant policy instruments and documents. He expressed hope for advancement on social protection at the Group of Twenty (G-20), citing a new task force on employment for young people as an example of potential for progress. Traditional forms of development financing were not adequate. For France, the equivalent of severe acute respiratory syndrome (SARS) was that of the HIV/AIDS crisis in the 1990s, to which the Global Fund to Fight AIDS, Tuberculosis and Malaria was responding. The permanent representative emphasized that France believed that the financial transaction tax was feasible and fair and would not give up efforts to advocate the establishment of that mechanism. In response to whether a health equity impact assessment of international agreements could be conducted, Ambassador Pellet said that the initial responsibility lay with individual countries. He also emphasized the importance of civil society in ensuring sound policy tools and having clear objectives and messages in the Rio Political Declaration.

**Ambassador Sihasak Phuangketkeow** described how the SARS crisis in Thailand had revealed the implications of health for other sectors and areas of policy. It also clearly demonstrated the need for concerted regional action, which in turn became an issue of human security. Regarding equity, the permanent representative suggested

that the issue was not a divide between developed and developing countries, but one in which they could come together, as was seen in the case of the pandemic influenza preparedness (PIP) framework.

**Ambassador Dian Triansyah Djani** stated that compromise required mutual recognition of the importance of an issue as well as elements of shared interest. He suggested that conditions must be right and that unfortunately situations of public panic could help to focus attention. The emphasis should not be on foreign policy, but on the relation between all ministries and health and on the need for coherence among instruments and organizations. The PIP framework reflected recognition that 30-year-old policy instruments were out of date and that access to medicines was a problem not only because of the influenza pandemic, but also due to limited supplies. Intellectual property rights should not affect access to essential medicines and through the PIP framework the private sector was ultimately amenable to resolution.

**Dr Haik Nikogosian** described how the WHO Framework Convention on Tobacco Control had shown new ways of working in global health. He explained that an essential precondition for a global health treaty was that the health challenge had reached global epidemic proportions and was further escalating. It would also be important to demonstrate that the global health challenge was driven by transnational factors that were largely beyond the control of individual governments and that existing instruments were no

longer adequate in responding to the challenge. Also critical was to provide evidence to national governments and other stakeholders that what was going to be negotiated would actually address the problems at which it was aimed.

The open discussion was a reflection on the various strengths and challenges of current policy instruments. A key point was made regarding the importance of mobilizing local action in support of frameworks such as the WHO Framework Convention on Tobacco Control. Such mobilization helped to ensure that public health was not only limited to good intentions within a complex and layered environment where powerful economic actors were generating pressures. The discussion also stressed that there were inequalities of power between international organizations, States and regions as well as amongst social groups within the same country. Interests in countries receiving foreign aid were often linked to transnational industries such as tobacco, alcohol and food. One participant suggested that new policy tools might still be ineffective as the current tools were weak as a result of financial constraints rather than a limitation of the tools themselves. The question was raised as to how best to move beyond a discourse of good intentions – in other words, “How do you develop policies that ensure health comes before profits?” Reflecting on that, the importance of an organized civil society and the need to ensure corporate accountability were proposed as concrete ways to address that challenge.

## KEY AGENDA MOVING FORWARD

- *Establish a clear governmental, WHO and United Nations agency commitment to addressing issues of redistribution, regulation and rights, which are fundamental to addressing social determinants and reducing equity.*
- *Foster and strengthen the capacity of civil society to engage in policy-making on health.*
- *Identify political champions within government to lead and drive the social determinants and equity agenda.*
- *Establish a global network addressing safe consumption, in particular learning from the experience of the regional network that already exists in the Americas.*





## Afternoon session: Aligning priorities and stakeholders: acting on social determinants of health for global development

The afternoon theme explored how priorities and stakeholders could be aligned to act on social determinants of health for global development. The session was chaired by **Professor Pekka Puska**.

**Dr Paison Dakulala** noted that key challenges in Papua New Guinea were the lack of awareness of the social determinants and the lack of alignment in relevant bilateral and multilateral policies. Understanding and contextualizing inequities and developing new programmes within and between countries must be connected to the global community. Papua New Guinea was part of a very diverse region where different countries and stakeholders understood the social determinants differently. The key point, however, was the actions taken to address those determinants.

### SESSION PARTICIPANTS

*Chair: Professor Pekka Puska, Director-General, National Institute for Health and Welfare, Finland*

#### *Panellists:*

- *Dr Paison Dakulala, Deputy Secretary, National Department of Health, Papua New Guinea*
- *Ms Sofiya Malyavina, Assistant Minister of Health and Social Development, Russian Federation*
- *Dr José Gomes Temporão, Director, South American Institute of Health Governance*
- *Dr Rebeca Grynszpan, Associate Administrator, UNDP*

*Rapporteur: Mr Jeffrey O'Malley, Director, HIV/AIDS Group, UNDP*

Dr Dakulala spoke of the power of a shared vision – in the case of Papua New Guinea, the goal was to have an educated, equitable and healthy society by 2050. Civil society must be involved in defining the agenda and collaborative action with multiple stakeholders was crucial, including not only different sectors of government but also churches, civil society groups, donors and multilateral agencies. Looking forward, Dr Dakulala made a call for all stakeholders to initiate and mainstream action on the social determinants, just as many stakeholders now mainstreamed action on gender equality. Lastly, he highlighted that climate change should be included within the social determinants agenda.

### KEY THEMES OF THE SESSION

- *Action on social determinants to address health inequities must understand and take account of the specific local and global factors and context.*
- *Action on social determinants and equity should be undertaken collaboratively with multiple stakeholders and sectors, including new and less traditional players in the dialogue on public health. This requires negotiating with other social sectors to create a unified position in order to enhance health outcomes at the global, regional and national levels.*
- *Action on social determinants to address health inequities requires the creation of new and innovative public policies. While parallel action on health and development can be mutually beneficial, the strongest gains could be made by bringing health and development actors together for joint analysis, planning and action.*
- *Civil society should be involved at all stages of developing, implementing and evaluating programmes, including in defining the agenda.*

**Ms Sofiya Malyavina** stated that the role of lifestyle and environmental factors in causing noncommunicable diseases was increasingly well understood by policy-makers in the Russian Federation. Ms Malyavina outlined concrete steps taken by Russia to respond to its noncommunicable disease burden, including a new programme to promote healthy lifestyle launched in Russia in 2009. The programme used an intersectoral approach to act on social determinants through work in areas including education, labour standards, environmental standards and tobacco control. The programme had had positive impacts and the country had experienced an increase in population life expectancy by almost four years and a reduction in overall mortality by more than 11%. Ms Malyavina noted that the approach had also been presented at the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control in Moscow.

**Dr José Gomes Temporão** outlined the five-pronged Brazilian health strategy, which included a specific focus on the social determinants. He also discussed issues of access to drugs and diagnostics, as well as universal access to health care, which also required integration of action to address social determinants. There was a need to include new and less traditional players in the dialogue on public health and to create new and innovative public policies in the quest to decrease inequities. Dr Temporão spoke of the role of the democracy movement in Brazil and of “active citizenship” to demand action on social determinants. That theme of democracy was further built upon by other panellists and audience members. The experience in Brazil and a number of other countries suggested that with growth inequities had decreased, but that part of the change came from the emergence of democracy; when communities were given a voice, inequities decreased. Overall, the importance of deepening democracy and participation, especially of marginalized communities, was a strong message throughout the session.

**Dr Rebeca Grynspan** commended on behalf of her organization Brazil and a number of other countries in the region for successfully pursuing a combination of inclusive economic growth, improved health outcomes and improved education outcomes over the

previous decade. That multipronged combination represented the human development paradigm promoted for many years by UNDP, and those country experiences demonstrated that it was indeed possible to act positively on development in a way that improved health outcomes. UNDP had emphasized that, while parallel action on health and development would be mutually beneficial, the strongest gains could be made by bringing health and development actors together for joint analysis, planning and action – an approach being utilized by the United Nations Development Group in its MDG Acceleration Framework. At country level, joint United Nations action could best be promoted through the United Nations Development Assistance Framework, agreed upon by governments and all active United Nations organizations in a country.

Dr Grynspan also stressed the opportunity and importance of continued work on MDG achievement. She acknowledged that the MDGs lacked explicit attention to social determinants and were perhaps too separated into individual, vertical silos. However, given the intersectoral nature of development, MDG progress was recognized as important both in and of itself and as a foundation for the next development paradigm, which would hopefully embrace equity, intersectorality and social determinants of health in a much more explicit way. She stressed that nothing was separate; if there was anything that could be learnt from the MDGs, it was that working in silos was not effective and that the global community should move away from averages and work in an aligned manner, including incorporating social determinants and equity into analysis.

During the discussion, one key challenge noted by the audience was that there was still not a common understanding, even among the people strongly committed to that work, on the definition and parameters of social determinants. The importance of deepening democracy and participation, particularly for marginalized communities, was a strong message from the session and several panellists and participants expressed their hopes that those themes would be followed up and included in the Rio Political Declaration, in addition to the need to explicitly address power imbalances and the prevailing economic order.

## KEY AGENDA MOVING FORWARD

- *Align the agenda of the United Nations Conference on Sustainable Development (Rio+20) in a cohesive manner with the Rio Political Declaration on the Social Determinants of Health.*
- *Include new and less traditional players in the dialogue on public health.*
- *Create new and innovative public policies in our quest to decrease inequities.*
- *Negotiate with other social sectors, creating a unified position in order to enhance health outcomes at the global, regional and national levels.*



# PARALLEL SESSION FOR THEME 5: MONITORING PROGRESS: MEASUREMENT AND ANALYSIS TO INFORM POLICIES AND BUILD ACCOUNTABILITY ON SOCIAL DETERMINANTS

## Morning session: Measuring, monitoring and integrating data into policy

**T**he fifth theme of the World Conference related to the importance of monitoring and measuring progress. The morning session in the theme focused on discussing and identifying key concepts, strategies and challenges for measuring, monitoring and integrating data into policy.

The session was chaired by **Sir Michael Marmot**, Professor at University College London and former Chair of the WHO Commission on Social Determinants of Health.

### SESSION PARTICIPANTS

*Chair: Sir Michael Marmot, Professor,  
University College London*

*Introductory note: Professor Hoda Rashad,  
American University in Cairo*

#### *Panellists:*

- *Ms Taru Koivisto, Director for Promotion of Welfare and Health, Ministry of Social Affairs and Health, Finland*
- *Dr Carmen Amela Heras, Director-General of Public Health, Ministry of Health, Social Policy and Equality, Spain*
- *Mr Rahhal El Makkaoui, Secretary-General, Ministry of Health, Morocco*
- *Associate Professor Papaarangi Reid, University of Auckland, New Zealand*

*Rapporteur: Professor Mauricio Barreto,  
Universidade Federal da Bahia*

### KEY THEMES OF THE SESSION

- *Policy and political context are important for promoting monitoring and measurement of health equity (through the whole process).*
- *Civil society organizations are essential in keeping governments accountable.*
- *Goals for equity need to be set but there are tensions in what to measure: measures should be meaningful to society and comparable.*

**Professor Hoda Rashad** provided an introduction to the theme of the session using cross-country examples. The presentation underscored that equity in health should be a priority of societies and that indicators needed to be sensitive and disaggregated by appropriate stratifiers. It also emphasized the need to follow trends across the life-cycle and over time, to use outcome measures beyond survival, and to seek higher degrees of disaggregation and more clustered stratification. For example, while the trend in average life expectancy was improving in the Russian Federation over time, disaggregation of that trend revealed that life expectancy for some subgroups was actually decreasing.

Considerable achievements in measurement and monitoring had been made, though challenges remained. Too few countries placed health equity as a national priority and still only considered issues of health within the narrow boundaries of the health system. The big challenges, therefore, were to increase public awareness of health inequities, define the stewardship role of the ministry of health, and work together with civil society and academia to create the necessary paradigm shift towards social determinants of health and equity.

Following the presentation by Professor Rashad, panellists provided an overview of the progress of monitoring in their respective countries. **Ms Taru Koivisto** emphasized the importance of having data and collecting information. In Finland, data were available by population group, allowing for the development of reports on population health and well-being that were used as valuable tools for evidence-based decision- and policy-making. Municipalities in Finland were autonomous and the role of the Ministry of Health was to support municipal governments to use data and information to design appropriate objectives and policies. Indicators were available and further developed in a web portal that provided data on risk factors, social determinants and health outcomes. The indicators were monitored by the national data institute and also influenced public policies. A target under the National Health Programme since 2001 had been to reduce inequities, which had led to the drafting of an action plan to decrease inequities in health and to policies directing all sectors to consider health and well-being in their activities. Ms Koivisto stated that that was a priority of the current government and there was expectation of much improvement over the coming four years.

**Mr Rahhal El Makkaoui** said that political commitment and policies were crucial for the establishment of priorities such as good governance, participation of the population and training. An important contribution of the Moroccan Family Code to reducing inequities was to define the participation of women and abolish polygamy, which paved the way for the sharing of responsibility between men and women. National initiatives for human development had also been undertaken in the areas of poverty, exclusion and sewage. Improved communication and sharing was an important strategy in Morocco for improving health and equity outcomes. A monitoring system had been implemented and integrated with the health care system, whereby reports were sent to an independent commission composed of experts from the private sector, civil society and other key actors. As a result of those efforts, maternal mortality had been halved in less than three years.

**Dr Carmen Amela Heras** discussed the Spanish experience with the national Scientific Commission on Inequalities in Health, which was supported by the European Commission to develop tools to reduce inequities. The Commission began by establishing a plan of disclosure of political progress. The first step to incorporate health as a priority across all sectors and policies was to conduct impact assessments for all policies. Informed by the results of those assessments, key strategies included implementing a monitoring

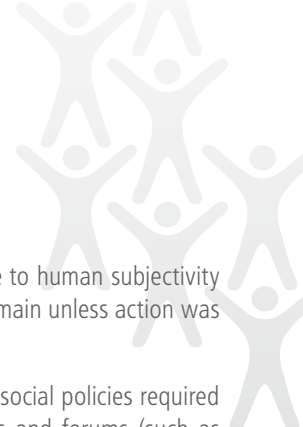
system, developing intersectoral tools and elaborating a plan for visibility of the demographic surveillance system. Those strategies were geared towards ensuring that health was inserted into the programmes that the government considered the most vulnerable in terms of addressing access barriers to health services. For example, a State Council for the Roma People was established to assist the Roma people, who were not included in the national census and experienced significant barriers in access to health services. The Council was part of the Surveillance Network for Equity in Health and used the same variables as monitored for the general population, which enabled the government to compare differences and social gradients in indicators and to identify possible strategies and solutions for addressing them.

**Dr Papaarangi Reid** drew attention to the “right to be counted”. Agencies first needed to ensure that the data they collected were complete and consistent and were comprehensive across sectors and data collections – otherwise future improvements might be masked by or indistinguishable from changes in data quality. From that base, decisions about what to measure should focus on the most marginalized populations. Indigenous populations were often in that category and in some countries facing up to their colonial histories was difficult.

Associate Professor Reid described the experience in New Zealand of integrating values and indicators of equity into monitoring systems and policy. That was largely undertaken through partnership between research institutions and civil society. Indigenous groups in particular gained significant visibility with the equity agenda and legislation provided momentum for prioritizing and addressing equity issues. One challenge, however, was to overcome public perception that those efforts demonstrated a preference for indigenous groups rather than for equity in general. Associate Professor Reid stressed that, as reducing inequity was highly political, measures must be taken to bring the public on board with the aims and objectives of the policy, otherwise the public might pressure the government to restrict or discontinue the policy platform. Beyond collection of data, there was a need to ensure that reporting on data was empowering and not “victim blame” with regard to marginalized groups. Data reporting must be informed by and include in its analytical gaze a structural and systems analysis.

Several main points and themes emerged during the open discussion. The measurement challenges in health equity and the difficulties in identifying what was important to monitor were raised. That included, for example, what was meant by equity, key categories and comparisons to make, how political imperatives could be managed and how success should be measured.

Setting targets to reduce inequities in health and mobilizing society for that agenda were seen as essential. Decision-making was more sensitive when good measures were also socially and politically useful indicators. However, finding parameters that united stakeholders towards global equity was a significant challenge. Having data on cash transfer and social and health indicators was important. While large databases on such data currently existed,



they did not have a unique identifier, pointing to the need for databases and databanks that matched and “talked to each other”. Nevertheless, while common indicators enabled comparability, it needed to be kept in mind that countries and contexts were starting from very different baseline situations. Professor Rashad suggested three indicators for Egypt that would be sensitive to social policies: burden of ill health (particularly in a family context), measures on mental health, and measures of well-being (which would need to be developed).

Another key point raised in the open discussion was that “data don’t tell stories; we tell stories”. Data should be used to demonstrate and bring attention to social injustice and inequity and to give voice to marginalized groups. It was therefore critically important to consider the framing of data, including how a social justice frame could be integrated into reports and policies. In defining equity in health, individuals should be valued equally, historical inequities should be recognized in light of social justice, and services and resources should be provided for all equitably. Looking at death, disability and injury was insufficient; it was also crucial to consider those who

were alive and suffering, including reference to human subjectivity and mental suffering, as inequities would remain unless action was also taken to address those issues.

In summary, the evaluation of the impact of social policies required good information and permanent structures and forums (such as intersectoral committees) that allowed for comparison of data. Researchers had a key role in influencing policies and assessing whether leaders of government and other actors were on track and making progress towards agreed-upon goals. Strategic relationships needed to be created with other social sectors and stakeholders, in particular opinion leaders, key researchers and institutes, and other influential actors who could give momentum to efforts to reduce inequities.

Sir Michael Marmot concluded the discussion by stating that measurement was an important moral and political issue: “We are watching the government and they are watching us.” It was imperative that civil society and academia monitored governments and stakeholders and held them accountable for their decisions and actions and the impact those had on health and equity.

## KEY AGENDA MOVING FORWARD

- *Establish high-level political commitment to address social determinants of health.*
- *Set goals for equity.*
- *Disaggregate indicators by appropriate stratifiers (sex, ethnicity, education, urban/rural).*
- *Direct additional effort towards improving the link between data on social context and health inequities.*
- *Strengthen information systems to make better use of data and to monitor trends.*
- *Disclose data to reduce invisibility and inequalities in health.*
- *Develop cross-sectoral tools to assess the impact of social determinants.*
- *Create mechanisms to establish partnerships with other sectors and actors (for example opinion leaders, researchers) to produce information.*
- *Involve civil society.*



## Afternoon session: Raising accountability for equity impacts of policy

The afternoon session in the monitoring theme focused on raising accountability for the equity impacts of policy. **Dr Ala Alwan** chaired the session.

The first panellist, **Dr Henry Madzorera**, described how equity had been a central theme in Zimbabwe since 1980. Significant progress had been made in that area in recent years, particularly due to the involvement of other sectors that affected health in conducting research. Zimbabwe was one of first countries to implement Equity Watch, with the aim of making inequities more visible through household surveys, data collection and use, and parliamentary enquiries. The first Equity Watch report was published in 2008 with the collaboration of many stakeholders in an inclusive process. The periodic reports of Equity Watch were reviewed by both parliament and the population. Another initiative in Zimbabwe was a new policy document that addressed equity in health. Local demands were being reviewed, which had helped to pressure the Ministry of Finance to increase resources for health, in particular to remove user fees for pregnant women to access health services.

### SESSION PARTICIPANTS

*Chair: Dr Ala Alwan, Assistant Director-General, Noncommunicable Diseases and Mental Health, WHO*

*Panellists:*

- *Dr Abdul Bari Abdulla, State Minister of Health and Family, Ministry of Health, Maldives*
- *Dr Henry Madzorera, Minister of Health and Child Welfare, Zimbabwe*
- *Dr Jaime Breilh, Director of the Health Area, Universidad Andina Simon Bolivar, Ecuador, and founding Director of the Health Research and Advisory Center (CEAS)*
- *Dr Myrna Cunningham, President, United Nations Permanent Forum on Indigenous Issues*
- *Professor Nancy Krieger, Professor of Society, Human Development and Health, and Co-Director of the Interdisciplinary Concentration on Women, Gender and Health, Harvard School of Public Health, United States of America*
- *Dr Abhay Shukla, Coordinator, Support for Advocacy and Training to Health Initiatives (SATHI), India*

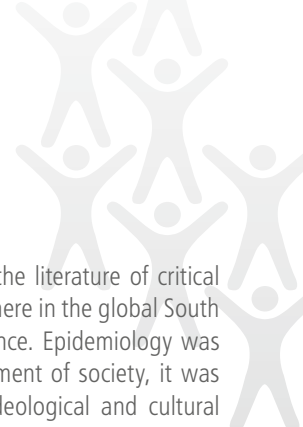
*Rapporteur: Dr Sharon Friel, Australian National University and HealthGAEN*

### KEY THEMES OF THE SESSION

- *The role of community is essential in increasing accountability of governments.*
- *There is a need for new frameworks to better understand the questions that are being addressed, which often frame the data that are collected and the way they are reported.*
- *The involvement of other sectors in planning to promote equity is important.*
- *The development of indigenous movements to participate in the formulation of public policies is central to empowerment and promotion of independence.*

**Dr Abdul Bari Abdulla** described the structural shift from a centralized to decentralized government in the Maldives, involving administrative, political and health system decentralization. The work on addressing health inequities had focused on noncommunicable diseases; the health system had increased service for people with chronic diseases to cover 50% of the population, and the country was aiming to reach full population coverage. Significant progress had also been made in controlling polio and tuberculosis, though dengue fever remained a challenge. Dr Abdulla explained that the government believed primary care was key to the organization of the health system, and public health was being expanded in both the public and private sectors. The aim was to make the local councils responsible and accountable for primary care and public health.

**Dr Abhay Shukla** described the work of Support for Advocacy and Training to Health Initiatives (SATHI) in India, an organization working towards the realization of the fundamental human rights



to health and health care. That included establishing community monitoring in rural India through the formation of committees with representatives of civil society. Those committees were responsible for collecting information on the health and social services available, including enabling users to evaluate and rank health services. The indicators were developed based on the specific services offered, and that mechanism had been successful in promoting accountability of the health system and fair practice in the buying and selling of drugs.

**Professor Nancy Krieger** highlighted the necessity of bringing the perspective of social epidemiology to the discussion. When developing and using indicators for monitoring, she stressed the need to reflect on what the evidence was about health inequities that fed government policies, and the critical theoretical frameworks that were vital to informing the conceptualization of those indicators in relation to issues of power, property, deprivation and discrimination. It was also important to consider the possibility of producing and utilizing reports about social inequalities in health, such as the well-known “Black Report” issued in 1980 in the United Kingdom, the attempted suppression of which by a Conservative government led to its greater visibility and impact.

Professor Krieger noted that 150 years ago, Friedrich Engels had described the deplorable living conditions of the impoverished urban working classes and the structural conditions, especially political and economic priorities, that produced them. She warned that while much about the social inequality in health was known and knowable, those with power and privilege not surprisingly did not act to change the status quo – which was why public pressure, especially from those harmed by health inequities, was essential. She concluded by suggesting two strategies to ensure that information from monitoring health inequities was generated, integrated and used. First, it was necessary to put in place legally required, publicly available, annual standardized reporting on social inequities in health status and health services, as such reports could lead – via the organizing of those affected – to greater accountability of government and health systems for acting to reduce health inequities. Second, epidemiologists must collect data on diverse dimensions of economic and social inequality and discrimination in population health monitoring systems.

**Dr Jaime Breilh** stated that the World Conference was taking place in the eye of the storm, amidst the greatest crisis of international global capitalism. He suggested that society was operating under the false idea that technicalities were going to help overcome world conflict and crises. He expressed discomfort with some subtleties and words used around the concept of “governance”, in particular in countries with experience of profound struggles for social rights, where those words sometimes lacked meaning or denoted the functionalization of social participation and science. Dr Breilh emphasized that it was therefore imperative to have critical thinking and debate around the concepts of social determinants. There were different schools of thought and important clashes of paradigms in the interpretation of social determinants and such debates were crucial for the future design of scientific, teaching and social accountability strategies.

He expressed surprise that the richness of the literature of critical epidemiology from Latin America and elsewhere in the global South was largely absent from the World Conference. Epidemiology was a social science and, as a diagnostic instrument of society, it was very vulnerable to political, institutional, ideological and cultural pressures. For such pressures to be managed, epidemiology must be defined as having a critical view.

Dr Breilh concluded that the field of international cooperation was being penetrated by “big corporate capital”, the same culprits of the current global crises. That those corporately funded foundations had more resources and capacity for advocacy than WHO to direct the research agendas and technical manuals of training in countries was highly concerning. In order to protect the current and future research and training agendas and programmes, and protect health equity, sustainability and diversity, Dr Breilh suggested that two key challenges were (a) to overcome the restrictions of the social determinants of health theory as it had been predominantly conceived before endeavouring to design research and monitoring tools; and (b) to embed in all deliberations, research actions and programmes the political economy of social determination and the emancipatory ideas of critical intercultural knowledge.

**Dr Myrna Cunningham** reflected on how data on the situation of indigenous peoples could be produced with their cooperation. Indigenous peoples currently had no voice in decisions; their wishes and vision of health needed to be incorporated into their claims and the policy- and decision-making processes. That included integrating traditional health care into national health systems. Indigenous peoples had adopted international standards of human rights and the United Nations Permanent Forum on Indigenous Issues worked on defining cultural indicators in a participatory way. Urgent objectives were to advance the legislation of countries to recognize the rights of indigenous peoples and to support them, in particular through recognizing local knowledge, obtaining the consent of indigenous communities to conduct research, learning to use disaggregated data and defining indicators, including cultural ones.

A discussion by speakers and the audience following initial statements by panellists took place, during which several key themes emerged. Dr Alwan asked what could be done in the situation in which equity in health was not a priority. One main strategy identified was developing means of accountability of various actors, for example through legislation and by establishing mechanisms of report issuance and monitoring. Accountability was needed at all levels and should also be directed towards other social issues that linked to issues of health equity, such as sustainability and biosecurity. For example, conflict occurred between local biodiversity and monocultural farming practices due to the monopoly of multinational agribusiness companies and their increasing control of seeds, water and other production components. Binding international agreements such as the Framework Convention on Tobacco Control were powerful and important as they brought the perspective of accountability to federal and international levels.

Another key strategy was the need to disaggregate data to ensure they revealed multiple aspects of social inequalities in health, for example in relation to socioeconomic position, gender, race and ethnicity, indigenous status and sexuality. For example, indicators for the MDGs needed to be disaggregated and organized in a way that ensured comparability of data across countries and over time, so as to permit meaningful cross-national comparisons of the magnitude of health inequities, at a given point in time and over time. It was also pointed out that increasing the amount of data collected might run the risk of reduced quality of data and analysis.

The need for civil society to be heard by governments and included in the formulation of public policy and decision-making was reiterated, as was the point that “civil society” was itself not one entity but was highly heterogeneous, spanning the full spectrum of political perspectives and including both defenders and challengers of the status quo. The policy-making process was likewise diverse and complex and was not a purely rational process, meaning that data alone were insufficient to formulate good policies. Civil society had a key role as an important source of information and pressure for accountability, and communities must use data to tell stories and bring attention to issues of social injustice. Furthermore, while

policies might be ready and in place, there was a need to know how to make them a reality, and civil society could help identify the type of interventions agencies needed to implement. Dr Shukla described the example of India, where civil society was playing a critical role in addressing issues of corruption and how public money was being used. Increasing the involvement of the population, including media, in accountability required empowering and giving autonomy to people and developing their capacities.

Using the human rights approach and tools to address health inequities and strengthen the implementation of actions in the social determinants framework was discussed. It could be useful to analyse whether policies included the principles of basic human rights, and efforts could be made to have human rights included within national legislation and constitutions. However, human rights were universal and interdependent and the challenge therefore was how to include and act upon human rights, both individually and collectively. Dr Cunningham gave the example that increasing access to health services for indigenous communities did not mean that the collective human rights of indigenous peoples were not being violated.

## KEY AGENDA MOVING FORWARD

- *Disaggregate data and include indicators on inequity and social injustice in monitoring systems.*
- *Conduct research to investigate the causes of health inequalities.*
- *Perform standardized reporting services to generate accountability.*
- *Define indicators in a participatory manner.*
- *Empower and build the capacity of civil society, particularly marginalized groups, to advocate inclusion of the social determinants of health and participate in the formulation of public policies.*
- *Include other sectors that affect health in planning to promote health and equity.*
- *Encourage agencies, governments and international organizations to work to enforce corporate responsibility.*
- *Adopt a critical approach to the social determinants of health.*
- *Include traditional health care (for example of indigenous peoples) in health systems.*
- *Include the dimensions of sustainability and biosafety in social determinants of health.*
- *Use tools for human rights to address health inequities.*

# MINISTERIAL TRACK

## Statements by heads of delegation of Member States

Day Two included a “Ministerial Track” session for government delegations, giving them the opportunity to officially address the World Conference and present on behalf of Member States their positions on social determinants of health. The session consisted of a morning and an afternoon meeting and was chaired by the former Minister of Health of Hungary, Dr Mihaly Kökény, supported by the WHO Secretariat. Overall, 50 official delegations enrolled for the session, of which 46 delegations made statements. Fifteen of the speakers that took the floor on behalf of their delegations were ministers of health.

Participating delegations covered a diverse range of social determinants of health topics that were related to their national contexts. Key messages repeatedly raised by speakers included (a) the need for intersectoral action to address the social determinants, particularly because most of those determinants were located outside the health sector; (b) the relevance of primary health care approaches to expand health systems and address common social determinants through action in the health sector; and (c) the need to promote and encourage social participation and empowerment. Other key topics addressed were the need to promote universal social policies – such as in education, employment and social protection – and the need to enhance international collaboration to promote work on social determinants.



Countries also acknowledged the critical challenges facing work to address social determinants, including the increasing burden of noncommunicable diseases, the increased impacts on health and equity resulting from environmental degradation, and the impact of the global financial crisis in significantly undermining national economies and governments' capacity for social expenditure.

The following Member States (listed in alphabetical order) took the floor in the Ministerial Track to make statements: Algeria, Angola, Argentina, Australia, Bangladesh, Plurinational State of Bolivia, Burkina Faso, Canada, Cape Verde, Chile, Comoros, Cuba, Ecuador, Ethiopia, Finland, France, Germany, Guinea Bissau, India, Indonesia, Iraq, Islamic Republic of Iran, Israel, Kenya, Mauritius, Mozambique, Nigeria, Norway, Peru, Philippines, Poland, Portugal, Russian Federation, Senegal, Sierra Leone, Slovenia, Sri Lanka, Sudan, Suriname, Swaziland, Sweden, Switzerland, Tunisia, Uganda, Zambia, and Zimbabwe.

## Reflections on social determinants of health

**T**he purpose of the session, which took place during the Ministerial Track, was to have a reflective discussion on the historical development of the social determinants of health agenda and the strategic way forward from the World Conference. The session was moderated by **Dr Mihaly Kökény**.

### SESSION PARTICIPANTS

*Chair: Dr Mihaly Kökény, Former Minister for Health of Hungary and former Chairman of WHO Executive Board*

*Panellists:*

- *Sir Michael Marmot, Professor, University College London*
- *Professor Paulo Buss, Oswaldo Cruz Foundation (Fiocruz), Brazil*
- *Professor Ilona Kickbusch, Director of the Global Health Programme, Graduate Institute of International and Development Studies, Geneva*

### KEY THEMES OF THE SESSION

- *The World Conference builds upon the legacy of the Alma-Ata Declaration and the Ottawa Charter and is a further stepping stone in this movement recognizing the need to address social determinants of health to reduce health inequities.*
- *The social determinants and equity agenda must be legitimately linked with other key agendas and high-level debates in the coming years, including those relating to the environment, sustainable development and economy and finance.*

The session focused on three key historical developments, which the World Conference built upon. The 1978 Alma-Ata Declaration on Primary Health Care emphasized primary health care as a tool to achieve “health for all”, by focusing health systems and other parts of government on health equity, community participation, solidarity and intersectoral action. The Ottawa Charter for Health Promotion in 1986 focused on the fundamental conditions and resources for health, which included peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. In its final report, the Commission on Social Determinants of Health had recommended three principal actions to address social determinants of health:

- Improve the conditions of daily life – the circumstances in which people are born, grow, live, work and age;
- Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally and locally;
- Measure the problem, evaluate action, expand the knowledge base, develop a workforce trained in the social determinants of health, and raise public awareness about the social determinants of health.

**Professor Ilona Kickbusch** suggested that the World Conference was the “most wonderful birthday present” the Ottawa Charter could have been given in its 25th anniversary year. She stated that

the significance of the Ottawa Charter was that it was the first time the social concept of health had been spoken about and articulated – “Health is created and lived by people within the settings of their everyday life; where they learn, work, play, and love.”<sup>7</sup> The approach and concepts of the Ottawa Charter were taken up and strengthened by the Commission on Social Determinants of Health to advance the understanding of the need for healthy public policies and supportive environments to address people’s everyday living conditions.

Professor Kickbusch described two concepts that had gained particular strength in the 25 years since the Ottawa Charter. First, the notion of empowerment and the understanding that health needed to empower people had been strengthened and highlighted over time. Second, the Ottawa Charter defined health promotion as a process of empowering people – working with the full participation of the people and other stakeholders in the context of settings, such as healthy cities, schools and workplaces. The value and necessity of empowerment plus participation had continued to be considered essential.

**Sir Michael Marmot** stated that the principles of the Ottawa Charter were implicit in the whole framework of the Commission and influenced all its thinking. He reflected on the importance of the Commission in following on from the Alma-Ata Declaration, namely that the Alma-Ata ideals and principles had been worth reiterating;

<sup>7</sup> WHO. *Ottawa Charter for Health Promotion*. Ottawa, 1986.





that the Commission's report had captured the considerable body of experience and evidence that had been collected in the subsequent 30 years; and that the report had been released at a very timely point in history, when the global community was seriously reflecting on and challenging the limitations of the prevailing economic model.

Sir Michael highlighted three key roles for national ministers of health: (a) "putting our house in order" – ensuring equitable access to health care, particularly primary health care, with greater focus on prevention and health promotion; (b) advocacy and partnership, particularly across government; and (c) contributing to improved knowledge, measurement and understanding of the social determinants. He expressed his hopes that countries would leave the World Conference with a commitment to creating equitable access to good health care systems in the context of wider access to social determinants of health. He urged that, following the World Conference, United Nations agencies, countries, academics and civil society working on the social determinants build and strengthen networks to share information and provide mutual support.

**Professor Paulo Buss** emphasized the importance of placing discussions on social determinants in a political perspective. He pointed out that the Alma-Ata Declaration and the Ottawa Charter had been developed with a Eurocentric and North view, which was vastly different than the experiences of countries in Latin America and Africa, for example, at that time. He therefore aimed to discuss social determinants from the standpoint of the South, rather than the North. In those contexts, Professor Buss suggested that issues of health, health care and social security were seen as eminently social and inextricably linked to democratic processes. Good social and health policies could only come about when governments affirmed the power of the people "in the driver's seat". He suggested that all governments must open up more to social movements and civil society, which had extremely important contributions to offer in terms of defining policies and supporting monitoring and accountability.



The panellists discussed their ideas for moving forward from the World Conference. They asserted that the agenda for social determinants and equity must be addressed at the global governance level, through the leadership of the United Nations. They urged that the United Nations General Assembly hold a session on social determinants and equity, as it had done with noncommunicable diseases. They also stressed that health and equity advocates needed to be inclusive and ensure that they were legitimately part of other key agendas and high-level debates in the coming years. One key step highlighted was linking social determinants with the environment and sustainability agendas, in particular getting social determinants on the agenda of the United Nations Conference on Sustainable Development in 2012. Professor Kickbusch asked, what was the sustainable development model of the 21st century and how did it relate to health? The panellists also emphasized the need to push the social determinants agenda in the context of discussions and responses relating to the global financial crisis and the economic and financial systems. Sir Michael Marmot suggested that economists use moral criteria for framing economic policies and analysis, specifically in terms of health and equity considerations and the impacts on the circumstances in which people lived.

## KEY AGENDA MOVING FORWARD

- *Advocate and foster support for a United Nations General Assembly session on social determinants and equity.*
- *Advocate and foster support for the inclusion of social determinants in the agenda of the United Nations Conference on Sustainable Development in 2012.*
- *Urge and support the United Nations to take leadership in addressing social determinants and equity issues at the global governance level.*

SESSIONS

# DAY THREE – FRIDAY, 21 OCTOBER 2011





# HIGH-LEVEL ROUNDTABLE ON SOCIAL DETERMINANTS OF HEALTH AND THE LIFE COURSE

**T**he second high-level roundtable of the World Conference focused on the relationship between the social determinants of health and the life course, and was moderated by **Mr Riz Khan**.

**Dr Geeta Rao Gupta** stated that the United Nations Children's Fund (UNICEF) had understood that social factors were the most powerful causes of inequities in child health and development outcomes and that inequities would worsen without meaningful targeted action. Services had traditionally been provided in an undifferentiated way without consideration of equity. A recent UNICEF analysis in 15 countries showed that a deliberate focus on the most disadvantaged populations was not only the right moral course to take but was also the most cost-effective. Every US\$ 1 million invested in an equity approach would avert 60% more child deaths than would current traditional approaches. Dr Rao Gupta pointed out that UNICEF was strongly positioned to address social determinants because the organization worked across many different sectors, including health, education, early child development, adolescent empowerment, nutrition and water and sanitation.

## SESSION PARTICIPANTS

*Moderator: Mr Riz Khan, Al Jazeera English*

*Panellists:*

- *Dr Marie-Paule Kieny, Assistant Director-General, Innovation, Information, Evidence and Research, WHO*
- *Ms Maria Guzenina-Richardson, Minister of Health and Social Services, Finland*
- *Mr William Lacy Swing, Director-General, IOM*
- *Dr Purnima Mane, Deputy Executive Director, Assistant Secretary-General, UNFPA*
- *Dr Geeta Rao Gupta, Deputy Executive Director, UNICEF*
- *Dr David Sanders, Emeritus Professor, University of the Western Cape*

## KEY THEMES OF THE SESSION

- *Action on social determinants to improve health and equity must be undertaken with a life course perspective, with a particular focus on early child development and ageing populations.*
- *United Nations agencies must work in a collaborative and coordinated manner to address social determinants and equity issues. Representatives of United Nations agencies in the panel expressed their organizations' commitment to doing this.*
- *Economic and trade policies are an important underlying source of issues related to social determinants and inequities. Governments, United Nations agencies and civil society need to work to ensure that such policies and commercial vested interests do not take precedence over or detrimentally impact health and social equity.*



**Dr Purnima Mane** stated that social factors gave rise to inequities not just in health but in all spheres of life. If the recommendations had been taken up by countries, more progress would have been seen in achieving equity, and we would be closer to achieving the MDGs. The life-cycle approach was at the centre of the core beliefs and way of working of the United Nations Population Fund (UNFPA), with a focus on young people and women. Addressing social determinants required a context-specific approach that acknowledged and fully engaged with the culture of each society and the heterogeneity of populations between and within countries. Dr Mane said that UNFPA's slogan was "everyone counts". Putting that into practice meant appreciating the reality of all individuals and groups, particularly the most marginalized, listening to their voices and allowing the agenda to be driven by the beneficiaries of services. There was also a need to work with others engaged with and working on social determinants in a coordinated manner.

**Dr Marie-Paule Kieny** began by pointing out that discussions on social determinants were important but that now was also the time for action, in order to utilize fully the burgeoning social movement striving to address social determinants. When taking a life course approach, WHO considered it crucial to pay specific attention to social determinants around early child development and ageing populations—issues currently relevant for all societies. Addressing social determinants was imperative to ensure that older people continued to be included in and contribute to society, and were not subject to poverty, disability or isolation.

Dr Kieny emphasized WHO's commitment to supporting Member States by providing technical support on how to adopt social determinants approach across all sectors. Key areas where WHO could offer assistance were providing advice and support on how to monitor health indicators that were disaggregated according to social factors throughout the life course; taking a leading role in coordinating joint United Nations work on social determinants, building on the momentum of the World Conference; and playing a convening role to bring Member States together to share key learning and best practices, including what did not work. The World Conference had contributed greatly to the task of bringing the United Nations agencies together, and meetings to consolidate that were planned immediately after the end of proceedings. WHO had also launched the "Action SDH" web platform at the World Conference to further foster such knowledge sharing. Dr Kieny congratulated civil society on doing an excellent job of pushing United Nations agencies and Member States to act on social determinants. Part of the current WHO reform was to strengthen the role of WHO representatives in countries, particularly their ability to convene different sectors, such as education, trade and finance, for health and equity goals.

Dr Kieny stated that she understood some of the criticisms being expressed about the Rio Political Declaration, but that it was not feasible to have a perfect declaration as the document was the result of negotiation between the interests of different Member States. However, the Rio Political Declaration contained decisive actions and its implementation provided a way forward and a

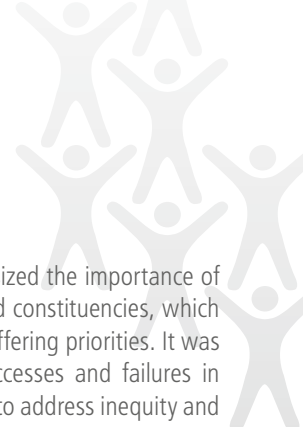


steppingstone for further action, perhaps to resolve some of the perceived critical omissions being identified.

**Professor David Sanders** drew attention to the unacceptable gaps between rich and poor within and between countries, particularly with regard to maternal and child mortality. Malnutrition was responsible for 35% of child deaths globally. Professor Sanders stated that unfair trade was a key source of those inequities; however, it was not mentioned in the Rio Political Declaration. He gave a number of examples of the negative impact of trade on health and equity. Heavily subsidized agricultural produce from rich countries undermined the ability of local producers to compete in markets, such as in Africa, and also undermined food security. Another example provided by Professor Sanders related to the export to countries such as Ethiopia by United Nations and international development and aid agencies of high-energy therapeutic food to treat severe acute malnutrition. He argued that the use of that expensive product medicalized the problem and obscured broader structural factors, such as that Ethiopia imported approximately 700 000 tonnes of food a year but had recently sold three million hectares of land to a transnational corporation for the purpose of growing and exporting food. Professor Sanders stated that that was the real context of undernutrition that was not being addressed. Similarly with the issue of noncommunicable diseases; South Africa had the third highest rates of overweight and obesity in the world, but food imports of packaged foods had doubled in the previous five years.

Professor Sanders noted that the Rio Political Declaration also failed to mention the unfair trade and movement of health professionals. For example, the intercontinental migration of health professionals trained in Africa represented a more than US\$ 400 billion "subsidy" of rich countries due to the lost expenses of training.

**Ms Marie Guzenina-Richardson** highlighted the crucial importance of fighting against the overcommercialization of health, which was a problem in Finland and in all countries of the world. Those global challenges must be fought collectively, including with regard to alcohol, tobacco and obesity. Ms Guzenina-Richardson stated that the health and equity impacts of those commercial and economic decisions and activities were often overlooked when



making political decisions. Challenging such powerful national and multinational commercial interests therefore required brave politicians and leadership. Ms Guzenina-Richardson stated that she was raised by a single immigrant mother and represented a personal example of what the welfare state made possible. Nevertheless, even in Finland and other countries with strong social systems, there were significant issues relating to the commercialization of health and the broader impact of commercial activities, in terms of threatening health, equity and access to health care.

**Mr William Lacy Swing** expressed his disappointment and concern that the Rio Political Declaration did not make reference to issues around migration or migrants. He stated that migration was a social determinant of health. The international migrant population was large – if all international migrants were assembled into one country, they would be the third largest country in the world – and their combined remittances equalled the GDP of Finland, Austria or Kuwait. Denying migrants access to health information and health services resulted in unhealthy and inequitable consequences for all of society, not just migrants themselves. Despite that, there was continuing silence about migrants in global texts and forums, including the MDGs and the final report of the Commission on Social Determinants of Health. The reality of that significant population could not continue to be ignored. Mr Lacy Swing said the increasing movement of people had been accompanied by increased antimigrant sentiment. That had been exacerbated by the economic crisis, as in similar previous historical periods. More needed to be done to educate populations on the positive contributions of migrants and to better coordinate policies to protect migrants.

In terms of next steps for action, Dr Rao Gupta called for more coordination across the United Nations system on social determinants of health and inequity. That required having a common platform and taking joint action, including providing advice and technical capacity to governments to overcome bottlenecks in providing services to marginalized populations, with robust processes of community participation and monitoring. Dr Rao Gupta stated that early childhood development was also a very powerful equalizer, as early investments in health went a long way towards sustained health

throughout the life course. Dr Mane emphasized the importance of talking and reaching out to other sectors and constituencies, which might speak different languages and have differing priorities. It was also important to better document the successes and failures in efforts to take action on social determinants to address inequity and to learn from those experiences in a systematic manner.

Professor Sanders said that he was a member of the People's Health Movement (PHM), which had a position of unconditional but critical support for United Nations agencies. Nevertheless, those agencies had been substantially weakened because Member States had reduced their commitments to supporting them. He suggested that United Nations agencies needed to be strengthened and that they needed to work together more closely and act more boldly. Professor Sanders also argued that a key problem was that public-private institutions, such as the Bill and Melinda Gates Foundation, now dominated global health funding and, consequently, heavily influenced the direction of United Nations agencies because "money speaks". The weakening of United Nations agencies was also due in part to the concurrent global financial crisis, food crisis and climate crisis, which were crises of the capitalist system. Professor Sanders emphasized the need for civil society to hold governments accountable as they represented their populations in the United Nations agencies and system. He drew attention to the alternative Rio Political Declaration, developed collaboratively by PHM, which listed 10 demands, including support for a Tobin tax to "start taxing the casino economy".

Questions were then taken from the floor by the panel on a variety of topics, including the influence of corporations on politicians, the role of civil society in ensuring that governments maintained the interest of their citizens as paramount, the needs of disabled people, and the contribution of racism and caste prejudice to health inequities.

The panellists made closing statements. Mr Lacy Swing said that he would continue to press for equal treatment for migrants around the world, considering the challenges and opportunities of large-scale migration and the various models of migration, in order to realize greatest benefit for all. Ms Guzenina-Richardson stated, "Human





dignity should never be for sale.” Professor Sanders called for the strengthening of health systems, including universal coverage, and the need to address the causes of health inequities through broad civil society movements from all sectors to push governments and the United Nations agencies. Dr Kieny suggested the key was to work together on practical approaches, implementing the lessons of the World Conference and putting a social determinants lens to the work of WHO. Dr Mane called for improvements in using

cultural and gender lenses in the field of health and development and stressed the need to be vigilant in identifying the emergence of new forms of inequity. Finally, Dr Rao Gupta urged delegates to look behind rhetoric to action – “The devil is in the detail.” She stated that UNICEF needed to operationalize its mandate to adopt equity-based approaches and monitoring to ensure its policies and programmes benefited the most disadvantaged.



## KEY AGENDA MOVING FORWARD

- *Consolidate, maintain and strengthen the momentum and commitment from the World Conference to take action on social determinants to address inequity.*
- *Urge and support United Nations agencies to work in a more collaborative and coordinated manner to address social determinants and equity issues.*
- *Urge and support governments, United Nations agencies and civil society to collectively work to ensure that economic and trade policies and commercial vested interests do not take precedence over or detrimentally impact health and social equity.*



## CLOSING SPEECHES

The official closing of the World Conference included speeches by Dr Alexandre Padilha, Minister of Health, Brazil; Dr Rüdiger Krech, Director, Department of Ethics, Equity, Trade and Human Rights, WHO; Dr Marie-Paule Kieny, Assistant Director-General, Innovation, Information, Evidence and Research, WHO; Ms Maria Guzenina-Richardson, Minister of Health and Social Services, Finland, and Vice-President of World Conference; and Mr Antonio Patriota, Minister of Foreign Relations, Brazil.

**Dr Alexandre Padilha** thanked WHO and all his Brazilian colleagues for organizing the World Conference and the participants for contributing to making history and launching a new journey in health and social justice. He discussed several features that signalled and represented the force and strength of the World Conference. The conference recalled the ideals of the Alma-Ata Declaration, to resubmit and reclaim them for the challenges of the 21st century. The Rio Political Declaration reaffirmed the role of the State, not only in providing health but in developing a set of economic and social policies that tackled inequity. The World Conference had made clear that health policies could not intensify and aggravate inequities, but must reduce them across all determinants of health. The Rio Political Declaration also stated that the economic and financial crisis should not be viewed as an obstacle to the achievement of the universal right to health; on the contrary, it should be seen as an opportunity for expanding further the right to health and social policies. The economic crisis could not be tackled by cutting social expenditures; it could only be tackled by expanding investments in social policies.

**Dr Rüdiger Krech** formally announced the Rio Political Declaration, stating that it was a clear galvanizing point for the many stakeholders, contexts and agendas that needed to be considered during negotiations of the text. He congratulated Member States on their dedication and commitment to reaching full consensus. Dr Krech urged the global health community to use the strong language in the political document in taking forward the social determinants and equity agenda.

**Dr Marie-Paule Kieny**, on behalf of Dr Chan and WHO, expressed deep thanks to the Government of Brazil for hosting and leading the organization of the World Conference. She described the history of the understanding and acknowledgement that public health required working across sectors and attention to equity: from the WHO founding Constitution to the Alma-Ata Declaration, the Ottawa Charter, the Commission on Social Determinants of Health and its associated 2009 World Health Assembly resolution, to the World Conference. She pointed to the challenge for the growing global constituency to continue to endeavour and learn from experiences on how actions on social determinants to address health inequities could be implemented and to expand and extend efforts in difficult global times. Dr Kieny stated that WHO was determined to continue to play its role in convening and assisting that global movement and

in assisting Member States to make progress on health inequities. The United Nations system must also set an example of how intersectoral action was possible in its own work.

**Ms Maria Guzenina-Richardson** stated that the World Conference was a landmark in the pursuit of better health and equity for people in the world. She congratulated and thanked WHO and the Government of Brazil for organizing and hosting the event. Ms Guzenina-Richardson discussed the growing awareness that health must be a cross-cutting aim in national policy-making and the development of the concept of "Health in All Policies". Future efforts should build and elaborate on the work at the World Conference, which also provided a good basis for the eighth Global Conference on Health Promotion in Helsinki, Finland, in 2013.

**Mr Antonio Patriota** thanked all the organizers and participants for making the World Conference a successful event. Mr Patriota suggested that the World Conference was another chapter written in the history of public health and the reduction of social injustices. More than the closing of an international event, it was a celebration of a new state for public health policy aimed at the constant integration of social determinants. The Rio Political Declaration acknowledged that equity in health was a common responsibility and that fair and inclusive societies had as their centre point human well-being. Mr Patriota expressed his confidence that the Rio Political Declaration would be a successful tool in ensuring the central position of health in all public policies and he called on all Member States to ensure that the declaration was endorsed at the World Health Assembly in 2012. He drew attention to the importance of protecting and defending the equitable distribution of new medications and therapies as part of the human right to health, as acknowledged in the Rio Political Declaration and at the United Nations Summit on Noncommunicable Diseases in New York. Mr Patriota underlined the important links between social determinants and sustainable development, with the World Conference acting as a crucial step towards the United Nations Conference on Sustainable Development in Brazil in 2012.











# ANNEX A. RIO POLITICAL DECLARATION ON SOCIAL DETERMINANTS OF HEALTH

## Rio Political Declaration on Social Determinants of Health

**RIO DE JANEIRO, BRAZIL, 21 OCTOBER 2011**

1. Invited by the World Health Organization, we, Heads of Government, Ministers and government representatives came together on the 21st day of October 2011 in Rio de Janeiro to express our determination to achieve social and health equity through action on social determinants of health and well-being by a comprehensive intersectoral approach.
2. We understand that health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an “all for equity” and “health for all” global action.
3. We underscore the principles and provisions set out in the World Health Organization Constitution and in the 1978 Declaration of Alma-Ata as well as in the 1986 Ottawa Charter and in the series of international health promotion conferences, which reaffirmed the essential value of equity in health and recognized that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”. We recognize that governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures and that national efforts need to be supported by an enabling international environment.
4. We reaffirm that health inequities within and between countries are politically, socially and economically unacceptable, as well as unfair and largely avoidable, and that the promotion of health equity is essential to sustainable development and to a better quality of life and well-being for all, which in turn can contribute to peace and security.
5. We reiterate our determination to take action on social determinants of health as collectively agreed by the World Health Assembly and reflected in resolution WHA62.14 (“Reducing health inequities through action on the social determinants of health”), which notes the three overarching recommendations of the Commission on Social Determinants of Health: to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action.
6. Health inequities arise from the societal conditions in which people are born, grow, live, work and age, referred to as social determinants of health. These include early years’ experiences, education, economic status, employment and decent work, housing and environment, and effective systems of preventing and treating ill health. We are convinced that action on these determinants, both for vulnerable groups and the entire population, is essential to create inclusive, equitable, economically productive and healthy societies. Positioning human health and well-being as one of the key features of what constitutes a successful, inclusive and fair society in the 21st century is consistent with our commitment to human rights at national and international levels.
7. Good health requires a universal, comprehensive, equitable, effective, responsive and accessible quality health system. But it is also dependent on the involvement of and dialogue with other sectors and actors, as their performance has significant health impacts. Collaboration in coordinated and intersectoral policy actions has proven to be effective. Health in All Policies, together with intersectoral cooperation and action, is one promising approach to enhance accountability in other sectors for health, as well as the promotion of health equity and more inclusive and productive societies. As collective goals, good health and well-being for all should be given high priority at local, national, regional and international levels.
8. We recognize that we need to do more to accelerate progress in addressing the unequal distribution of health resources as well as conditions damaging to health at all levels. Based on the experiences shared at this Conference, we express our political will to make health equity a national, regional and global goal and to address current challenges, such as eradicating hunger and poverty, ensuring food and nutritional security, access to safe drinking water and sanitation, employment and decent work and social protection, protecting environments and delivering equitable economic growth, through resolute action on social determinants of health across all sectors and at all levels. We also acknowledge that by addressing social determinants we can contribute to the achievement of the Millennium Development Goals.



9. The current global economic and financial crisis urgently requires the adoption of actions to reduce increasing health inequities and prevent worsening of living conditions and the deterioration of universal health care and social protection systems.
10. We acknowledge that action on social determinants of health is called for both within countries and at the global level. We underscore that increasing the ability of global actors, through better global governance, promotion of international cooperation and development, participation in policy-making and monitoring progress, is essential to contribute to national and local efforts on social determinants of health. Action on social determinants of health should be adapted to the national and subnational contexts of individual countries and regions to take into account different social, cultural and economic systems. Evidence from research and experiences in implementing policies on social determinants of health, however, shows common features of successful action. There are five key action areas critical to addressing health inequities: (i) to adopt better governance for health and development; (ii) to promote participation in policy-making and implementation; (iii) to further reorient the health sector towards reducing health inequities; (iv) to strengthen global governance and collaboration; and (v) to monitor progress and increase accountability. Action on social determinants of health therefore means that we, the representatives of Governments, will strive individually and collectively to develop and support policies, strategies, programmes and action plans, which address social determinants of health, with the support of the international community, that include:
11. **To adopt better governance for health and development**
  - 11.1 Acknowledging that governance to address social determinants involves transparent and inclusive decision-making processes that give voice to all groups and sectors involved, and development of policies that perform effectively and reach clear and measurable outcomes, build accountability, and, most crucially, are fair in both policy development processes and results;
  - 11.2 We pledge to:
    - (i) Work across different sectors and levels of government, including through, as appropriate, national development strategies, taking into account their contribution to health and health equity and recognizing the leading role of health ministries for advocacy in this regard;
    - (ii) Develop policies that are inclusive and take account of the needs of the entire population with specific attention to vulnerable groups and high-risk areas;
    - (iii) Support comprehensive programmes of research and surveys to inform policy and action;
    - (iv) Promote awareness, consideration and increased accountability of policy-makers for impacts of all policies on health;
    - (v) Develop approaches, including effective partnerships, to engage other sectors in order to identify individual and joint roles for improvements in health and reduction of health inequities;
    - (vi) Support all sectors in the development of tools and capacities to address social determinants of health at national and international levels;
    - (vii) Foster collaboration with the private sector, safeguarding against conflict of interests, to contribute to achieving health through policies and actions on social determinants of health;
    - (viii) Implement resolution WHA62.14, which takes note of the recommendations of the final report of the Commission on Social Determinants of Health;
    - (ix) Strengthen occupational health safety and health protection and their oversight and encourage the public and private sectors to offer healthy working conditions so as to contribute to promoting health for all;
    - (x) Promote and strengthen universal access to social services and social protection floors;
    - (xi) Give special attention to gender-related aspects as well as early child development in public policies and social and health services;
    - (xii) Promote access to affordable, safe, efficacious and quality medicines, including through the full implementation of the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;

- (xiii) Strengthen international cooperation with a view to promoting health equity in all countries through facilitating transfer on mutually agreed terms of expertise, technologies and scientific data in the field of social determinants of health, as well as exchange of good practices for managing intersectoral policy development.

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

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

12.2 We pledge to:

- (i) Promote and enhance inclusive and transparent decision-making, implementation and accountability for health and health governance at all levels, including through enhancing access to information, access to justice and public participation;
- (ii) Empower the role of communities and strengthen civil society contribution to policy-making and implementation by adopting measures to enable their effective participation for the public interest in decision-making;
- (iii) Promote inclusive and transparent governance approaches, which engage early with affected sectors at all levels of governments, as well as support social participation and involve civil society and the private sector, safeguarding against conflict of interests;
- (iv) Consider the particular social determinants resulting in persistent health inequities for indigenous people, in the spirit of the United Nations Declaration on the Rights of Indigenous Peoples, and their specific needs, and promote meaningful collaboration with them in the development and delivery of related policies and programmes;
- (v) Consider the contributions and capacities of civil society to take action in advocacy, social mobilization and implementation on social determinants of health;
- (vi) Promote health equity in all countries particularly through the exchange of good practices regarding increased participation in policy development and implementation;
- (vii) Promote the full and effective participation of developed and developing countries in the formulation and implementation of policies and measures to address social determinants of health at the international level.

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

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

13.2 We pledge to:

- (i) Maintain and develop effective public health policies which address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities;
- (ii) Strengthen health systems towards the provision of equitable universal coverage and promote access to high-quality, promotive, preventive, curative and rehabilitative health services throughout the life-cycle, with a particular focus on comprehensive and integrated primary health care;
- (iii) Build, strengthen and maintain public health capacity, including capacity for intersectoral action, on social determinants of health;
- (iv) Build, strengthen and maintain health financing and risk pooling systems that prevent people from becoming impoverished when they seek medical treatment;
- (v) Promote mechanisms for supporting and strengthening community initiatives for health financing and risk pooling systems;
- (vi) Promote changes within the health sector, as appropriate, to provide the capacities and tools to act to reduce health inequities including through collaborative action;

- (vii) Integrate equity, as a priority within health systems, as well as in the design and delivery of health services and public health programmes;
- (viii) Reach out and work across and within all levels and sectors of government by promoting mechanisms for dialogue, problem-solving and health impact assessment with an equity focus to identify and promote policies, programmes, practices and legislative measures that may be instrumental for the goal pursued by this Political Declaration and to adapt or reform those harmful to health and health equity;
- (ix) Exchange good practices and successful experiences with regard to policies, strategies and measures to further reorient the health sector towards reducing health inequities.

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

14.1 Acknowledging the importance of international cooperation and solidarity for the equitable benefit of all people and the important role the multilateral organizations have in articulating norms and guidelines and identifying good practices for supporting actions on social determinants, and in facilitating access to financial resources and technical cooperation, as well as in reviewing and, where appropriate, strategically modifying policies and practices that have a negative impact on people's health and well-being;

14.2 We pledge to:

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

## 15. **To monitor progress and increase accountability**

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

15.2 We pledge to:

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

## 16. **Call for global action**

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

16.2 We call upon the World Health Organization, United Nations agencies and other international organizations to coordinate and collaborate with us in the implementation of these actions. We recognize that global action on social determinants will need increased capacity and knowledge within the World Health Organization and other multilateral organizations for the development and sharing of norms, standards and good practices. Our common values and responsibilities towards humanity move us to fulfil our pledge to act on social determinants of health. We firmly believe that doing so is not only a moral and a human rights imperative but also indispensable to promote human well-being, peace, prosperity and sustainable development. We call upon the international community to support developing countries in the implementation of these actions through the exchange of best practices, the provision of technical assistance and in facilitating access to financial resources, while reaffirming the provisions of the United Nations Millennium Declaration as well as the Monterrey Consensus of the International Conference on Financing for Development.

- 16.3 We urge those developed countries which have pledged to achieve the target of 0.7 percent of GNP for official development assistance by 2015, and those developed countries that have not yet done so, to make additional concrete efforts to fulfil their commitments in this regard. We also urge developing countries to build on progress achieved in ensuring that official development assistance is used effectively to help achieve development goals and targets.
- 16.4 World leaders will soon gather again here in Rio de Janeiro to consider how to meet the challenge of sustainable development laid down twenty years ago. This Political Declaration recognizes the important policies needed to achieve both sustainable development and health equity through acting on social determinants.
- 16.5 We recommend that the social determinants approach is duly considered in the ongoing reform process of the World Health Organization. We also recommend that the 65th World Health Assembly adopts a resolution endorsing this Political Declaration.



## ANNEX B. SIDE EVENTS

A number of side events were organized in connection with the World Conference, including by Member States, United Nations agencies, WHO headquarters and regional offices, academic institutions and nongovernmental and civil society organizations. The side events related to a broad range of topics relevant to the World Conference theme and were well attended, contributing greatly to the discussions, sharing of experiences and networking at the World Conference.

### Tuesday, 18 October 2011

#### **The Social Determinants of Adolescent Health**

Organizers: Johns Hopkins Bloomberg School of Public Health and Plan International

#### **Asia-Pacific Hub of the Global Action for Health Equity Network – Future Action and Engagement**

Organizer: Global Action for Health Equity Network (HealthGAEN)

#### **Political Dialogue on Addressing Social Determinants of Health through National Policies, Programmes and Health System Change in South-East Asia**

Organizers: Ministry of Health of India and WHO South-East Asia Regional Office (SEARO)

#### **Protecting the Right to Health through Action on Social Determinants**

Organizers: People's Health Movement (PHM) and the Latin American Social Medicine Association (ALAMES)

#### **Urban Slums and Health Equity: Forging a Global Network for Joint Learning**

Organizers: James P. Grant School of Public Health BRAC University, Bangladesh

#### **Mobilizing and Creating Awareness for Adolescent and Young People on the Social Determinants of Health as a Way to Implement Changes**

Organizers: Vision International and WHO AMRO/PAHO

#### **Forum on the Lancet Series on Early Childhood Development in Developing Countries**

Organizers: Global Alliance for Improved Nutrition (GAIN), United Nations Children's Fund (UNICEF) and Bernard van Leer Foundation (BvL)

### Wednesday, 19 October 2011

#### **WHO Inter-Regional Meeting on the World Conference on Social Determinants of Health**

Organizers: WHO AMRO/PAHO and WHO Regional Offices

#### **The Links Between Social and Environmental Determinants of Health and the Rio+20 Summit on Sustainable Development**

Organizers: Fundação Oswaldo Cruz (Fiocruz) and WHO Headquarters

#### **Politics of Health: Lessons from the AIDS Movement**

Organizers: Ministry of Health of Brazil and UNAIDS

#### **NCD Prevention, Social Determinants and Policies for Health**

Organizers: Ministry of Social Affairs and Health of Finland and WHO Headquarters

#### **Water and Sanitation and the Social Determinants of Health**

Organizers: Fundação Oswaldo Cruz (Fiocruz) and WHO AMRO/PAHO

#### **Global Health Watch 3: An Alternative World Health Report**

Organizers: People's Health Movement (PHM) and Medico International

#### **Help Shape the Agenda! The Second Global Symposium on Health Systems Research: Inclusion and Innovation towards Universal Health Coverage**

#### **Health Professional Education and Social Determinants of Health: What Needs to Change?**

Organizers: Secretariat of the Second Global Symposium on Health Systems Research, and Global Independent Commission on Health Professionals for the 21st Century

## Thursday, 20 October 2011

### **Launch of Action: SDH – a WHO Electronic Discussion Platform**

Organizer: WHO Headquarters

### **SDH: Future Directions**

Organizer: Sir Michael Marmot, University College London

### **Oil, Health and Development – Mechanism for Enhancing Governance and for Promoting “Social Accountability”**

Organizers: Ministry of Energy of Brazil and WHO

### **Noncommunicable Diseases – Social Determinants – Sustainable Development: The Inherent Agenda**

Organizers: AMRO/PAHO

## Friday, 21 October 2011

### **Global Movement for Health Equity through Action on the Social Determinants of Health**

Organizers: Global Action for Health Equity Network (HealthGAEN)

### **WHO Second Inter-Regional Meeting (for WHO only)**

Organizers: WHO AMRO/PAHO and WHO Regional Offices



# ANNEX C. ORGANIZATION OF THE WORLD CONFERENCE

In May 2011, an Advisory Group was appointed to support WHO with technical advice on various aspects of the World Conference. The group was composed of the following members, acting in their personal capacity:

- Ms Jane Billings, Public Health Agency of Canada
- Dr Nils Daulaire, US Department of Health and Human Services, United States of America
- Dr Luiz Odorico Monteiro de Andrade, Ministry of Health, Brazil
- Dr Rômulo Paes de Sousa, Ministry of Social Development and Fight against Hunger, Brazil
- Dr Carmen Amela Heras, Ministry of Health and Social Policy, Spain
- Dr Ilona Kickbusch, Graduate Institute of International and Development Studies, Switzerland
- Dr Bernardo Kliksberg, UNDP Bureau of Development Policies, Argentina
- Ms Taru Koivisto, Ministry of Social Affairs and Health, Finland
- Prof. Sir Michael Marmot, University College London, United Kingdom
- Ms Malebona Precious Matsoso, Department of Health, South Africa
- Ms Tone P. Torgersen, Norwegian Directorate of Health, Norway

The World Conference Organizing Committee included:

- Minister-Counsellor Silvio Albuquerque, Head of Division of Social Affairs, Ministry of External Relations, Brazil
- Ambassador Eduardo Barbosa, Ministry of Health, Brazil
- Professor Paulo Buss, Oswaldo Cruz Foundation, Brazil
- Minister-Counsellor Ms Maria Luisa Escorel, Permanent Mission of Brazil to the United Nations Office and Other International Organizations in Geneva
- Dr Luiz A.C. Galvão, Pan American Health Organization
- Dr Kira Fortune, Pan American Health Organization
- Dr Rüdiger Krech, Director, Department of Ethics, Equity, Trade and Human Rights, WHO
- Dr Alvaro Matida, Oswaldo Cruz Foundation, Brazil
- Dr Eugenio Villar Montesinos, WHO Headquarters, Geneva
- Dr Alberto Pellegrini, Oswaldo Cruz Foundation, Brazil
- Dr Felix Rigoli, WHO Country Office, Brazil

The Focal Point at WHO for the organization of the Conference was Dr Rüdiger Krech, Director of the Department of Ethics, Equity, Trade and Human Rights. The WHO Conference Secretariat was in the same Department.

Regional consultations prior to the World Conference were coordinated by WHO focal points on social determinants of health in the regional offices: Dr Anjana Bhushan (Western Pacific), Dr Suvajee Good (South-East Asia), Dr Kira Fortune (the Americas), Dr Mohammad Assai and Dr Abdi Momin (Eastern Mediterranean), Dr Davison Munodawafa (Africa) and Dr Erio Ziglio (Europe).

# ANNEX D. CONFERENCE PROGRAMME

## Programme at a Glance

### DAY ONE – Wednesday, 19 October 2011

14:00 – 15:15	<b>Opening</b> Michel Temer, Acting President, Federative Republic of Brazil Margaret Chan, Director-General, WHO Alexandre Padilha, Minister of Health, Federative Republic of Brazil
15:30 – 17:00	<b>High Level Roundtable on Social Determinants of Health and Development</b> Opening Statements by panelists and moderated roundtable discussion
17:00	<b>Closing Followed By Reception and Brazilian Popular Music Hosted by Government of Brazil</b>

### DAY TWO - Thursday, 20 October 2011

09:00 - 09:30	<b>Highlights from the Previous Day and Interviews</b>
10:00 - 12:30	<b>Morning Roundtables of Experiences from Countries</b> Parallel sessions based upon the five SDH action areas
12:30 - 14:00	<b>Lunch Break</b>
14:00 - 16:30	<b>Afternoon Roundtables:</b> Parallel sessions based upon the five SDH action areas
17:00	<b>Closing Followed By Reception and Brazilian Popular Music Hosted by Government of Brazil</b>

#### Ministerial Track

**10:00 – 12:30** Statements by Heads of Delegation of Member States  
**14:00 – 14:45** Reflections on Social Determinants of Health  
**14:45 – 16:30** Statements by Heads of Delegation of Member States

### DAY THREE - Friday, 21 October 2011

09:00 - 09:30	<b>Highlights from the Previous Day and Interviews</b>
09:30 - 11:00	<b>High Level Roundtable on Social Determinants of Health and the Life Course</b> Opening Statements by panellists and moderated roundtable discussion
11:00 - 11:30	<b>Break</b>
11:30 - 12:30	<b>"Bringing it All Together"</b> Roundtable with Chairs of parallel sessions from previous day
12:30	<b>Rio Political Declaration on Social Determinants of Health and Closing Remarks</b>

#### Stakeholder Events:

Tuesday, 18 October 2011	09:00 – 17:00
Wednesday, 19 October 2011	09:00 – 12:00
Thursday, 20 October 2011	12:45 – 20:00
Friday, 21 October 2011	14:00 – 17:00

(See page 7 for complete list of Stakeholder Events)

## Conference Details

### Registration

All participants are required to register and receive their badges before the opening of the Conference. The registration desk will be located at the Conference Secretariat in **Hotel Sofitel** and will be open on the following days and times:

- Tuesday, 18 October 2011, from 09:00 to 20:00
- Wednesday, 19 October 2011, from 08:00 to 18:00
- Thursday, 20 October 2011, from 08:00 to 18:00
- Friday, 21 October 2011, from 08:00 till end of session

### Seating Arrangements

Member State delegates will be seated in English alphabetical order at seats displaying country names. Other participants will be accommodated in other reserved areas in the room.

### List of speakers

Member States wishing to have the name of their Head of Delegation inscribed on the list of speakers for the Ministerial Track on 20 October should notify the Secretariat **by Wednesday, 19 October, 17:00 at the latest**. (Speakers are requested to limit their statements to four minutes.)

### Room Allocations

Panels and forums will take place at three different locations (Forte Copacabana, Hotel Sofitel and Hotel Othon) with the room options as listed below. For a full map of conference room locations, please refer to the 'Guide for Participants'.

<b>HOTEL SOFTEL</b>	<b>HOTEL OTHON</b>	<b>FORTE COPACABANA</b>
Rio de Janeiro	Sao Conrado	Plenary room
Rio de Janeiro II	Pontal	Auditorium of the Tent
Rio de Janeiro III	Itaipu A	SEC room
Copacabana	Itaipu B	Galeria de Arte
	Guaratiba	Forte
	Mar Azul	

### Conference Presidency

President: Alexandre Padilha, Minister of Health, Brazil

Vice-President: Maria Guzenina-Richardson, Minister of Health and Social Services, Finland

### Master of Ceremonies

Richard Laver



## Full Programme

### DAY ONE – Wednesday, 19 October 2011

<i>All participants are expected to be seated at 13:00. It may take up to one hour to get security clearance</i>		
PLENARY ROOM (FORTE)	14:00 – 15:15	<b>Opening</b> Michel Temer, Acting President, Federative Republic of Brazil Margaret Chan, Director-General, WHO Alexandre Padilha, Minister of Health, Federative Republic of Brazil  Also in attendance on stage will be Sergio Cabral, Governor of the State of Rio de Janeiro, Eduardo Paes, Mayor of the City of Rio de Janeiro, and other dignitaries
	15:30 – 17:00	<b>High Level Roundtable on Social Determinants of Health and Development</b> Opening Statements by panellists and moderated roundtable discussion by Zeinab Badawi, BBC World Margaret Chan, Director-General, WHO Tereza Campello, Minister of Social Development, Brazil Rebeca Grynspan, Associate Administrator, UNDP Andreas Loverdos, Minister of Health and Social Solidarity, Greece Kathleen Sebelius, Secretary of Health and Human Services, United States of America Michel Sidibé, Executive Director, UNAIDS
	17:00	<b>Closing Followed by Reception and Brazilian Popular Music Hosted by the Government of Brazil</b>

### Ministerial Track - Thursday, 20 October 2011

PLENARY ROOM (FORTE)	10:00 – 12:30	<b>Statements by Heads of Delegation of Member States on the Theme of the Conference</b> Chair: Mihaly Kökény, Hungary
	12:30 – 14:00	Lunch Break
	14:00 – 14:45	<b>Reflections on Social Determinants of Health</b> Discussion with Michael Marmot, University College London, Paulo Buss, FIOCRUZ, Brazil and Ilona Kickbusch, Graduate Institute, Switzerland
	14:45 – 16:30	<b>Statements by Heads of Delegation of Member States on the Theme of the Conference (continued)</b>

### Rio Political Declaration on Social Determinants of Health - Thursday, 20 October 2011

**Drafting Group on the Rio Political Declaration on Social Determinants of Health (closed session) - 10:00 – 16:00**

**DAY TWO – Thursday, 20 October 2011**

<b>09:00</b> <b>PLENARY ROOM (FORTE)</b>	<b>Highlights from the Previous Day and Interviews by Zeinab Badawi (BBC World) with Kathleen Sebelius, US Secretary for Health and Human Services, and Michael Marmot, UCL</b>	
<b>Conference Theme</b>	<b>Governance to Tackle the Root Causes of Health Inequities: Implementing Action on Social Determinants of Health</b>	<b>Promoting Participation: Community Leadership for Action on Social Determinants</b>
<b>Room:</b>	<b>RIO DE JANEIRO I (SOFITEL)</b>	<b>RIO DE JANEIRO II (SOFITEL)</b>
<b>Session Theme</b>	<b>Making Policy Coherent at the National Level</b>	<b>Institutionalizing Participation in Policy Making</b>
<b>Chair</b> 10:00 – 10:10	<b>Jorge Enrique Venegas</b> Minister of Public Health, Uruguay	<b>Thelma Narayan</b> Centre for Public Health and Equity, India
<b>Introductory Note</b> 10:10 – 10:30	<b>Don Matheson</b> Professor, Massey University, New Zealand	<b>Bernardo Kliksberg</b> Honorary Professor, University of Buenos Aires
<b>Roundtable of Experiences from Countries</b> 10:30 – 12:30	<b>Dorijan Marušič</b> Minister of Health, Slovenia  <b>Robert Joseph Mettle-Nunoo</b> Deputy Minister of Health, Ghana  <b>María Isabel Rodríguez</b> Minister of Public Health and Social Assistance, El Salvador  <b>Anne-Grete Strøm-Erichsen,</b> Minister of Health and Care Services, Norway  <b>Alberto Tejada Noriega</b> Minister of Health, Peru	<b>Luiz Odorico Monteiro de Andrade</b> National Secretary for Strategic Planning and Participation, Ministry of Health, Brazil  <b>Siriwat Tiptaradol</b> Senior Advisor, National Health Commission Office, Thailand  <b>Nonkosi Khumalo</b> Chairperson, Treatment Action Campaign, South Africa  <b>Asa Cristina Laurell</b> Universidad Autónoma Metropolitana, Mexico
<b>Rapporteurs</b>	<b>Xenia Scheil-Adlung</b> Health Policy Coordinator, ILO	<b>Barbara O. de Zalduondo</b> Office of the Deputy Director, UNAIDS
12:30 – 14:00	Lunch Break	
<b>Session Theme</b>	<b>Making Policy Coherent at the Sub-National and Local Levels</b>	<b>Integrating New Approaches to Participatory Action</b>
<b>Room:</b>	<b>RIO DE JANEIRO I (SOFITEL)</b>	<b>RIO DE JANEIRO II (SOFITEL)</b>
<b>Chair</b> 14:00 – 14:10	<b>David Butler-Jones</b> Chief Public Health Officer, Public Health Agency of Canada	<b>Luiz Loures</b> Director of UNAIDS Executive Office
<b>Roundtables</b> 14:10 – 16:30	<b>Kevin Buckett</b> Director of Public Health, South Australian Department of Health  <b>Monica Fein</b> Mayor-Elect, Rosario, Argentina  <b>Mohammad Hady Ayazi</b> Deputy Mayor of Tehran for Social Affairs, Iran  <b>Hyun Kyung Park</b> President, Seoul Foundation of Women and Family, South Korea  <b>Tiaô Viana</b> Governor, Acre, Brazil	<b>Nila Heredia</b> Minister of Health, the Plurinational State of Bolivia and President, ALAMES  <b>Roberto Tomas Morales Ojeda</b> Minister of Health, Cuba  <b>Bridget Lloyd</b> Global Coordinator, People's Health Movement  <b>Rene Loewenson</b> Coordinator, Equinet
<b>Rapporteurs</b>	<b>Orielle Solar</b> Greds-Emconet, Chile	<b>Amit Sengupta</b> People's Health Movement, India
18:00 <b>FORTE</b>	<b>Reception and Brazilian Popular Music</b>	

## DAY TWO – Thursday, 20 October 2011

Conference Theme	The Role of the Health Sector, Including Public Health Programmes, in Reducing Health Inequities	Global Action on Social Determinants: Aligning Priorities and Stakeholders
<b>Room:</b>	<b>COPACABANA (SOFITEL)</b>	<b>AUDITORIUM OF THE TENT (FORTE)</b>
<b>Session Theme</b>	<b>Ensuring Equitable Universal Coverage</b>	<b>Negotiating for Health at the International Level</b>
<b>Chair</b> 10:00 – 10:10	<b>Jeanette Vega</b> Universidad del Desarrollo de Chile	<b>Daisy María Corrales Díaz</b> Minister of Health, Costa Rica
<b>Introductory Note</b> 10:10 – 10:30	<b>Ilona Kickbusch</b> Professor, Graduate Institute, Switzerland	<b>Ron Labonté</b> Professor, University of Ottawa
<b>Roundtable of Experiences from Countries</b> 10:30 – 12:30	<b>Simon Burns</b> Minister of State for Health, Department of Health, United Kingdom of Great Britain and Northern Ireland  <b>Maurício Hernández-Ávila</b> Undersecretary of Health, Mexico  <b>Alexandre Padilha</b> Minister of Health, Brazil  <b>Sania Nishtar</b> President, Heartfile, Pakistan	<b>Aaron Motsoaledi</b> Minister of Health, South Africa  <b>Sissel Hodne Steen</b> Minister Counsellor, Deputy Head of Mission, Embassy of Norway in Brazil  <b>Maria Nazareth Farani Azevêdo</b> - Permanent Representative of Brazil to the UN in Geneva  <b>Jacques Pellet</b> - Permanent Representative of France to the UN in Geneva  <b>Sihesak Phuagketkeow</b> - Permanent Representative of Thailand to the UN in Geneva  <b>Dian Triansyah Djani</b> - Permanent Representative of Indonesia to the UN in Geneva  <b>Haik Nikogosian</b> - Head of the Convention Secretariat, WHO Framework Convention on Tobacco Control
<b>Rapporteurs</b>	<b>Claudia Travassos</b> Professor, FIOCRUZ, Brazil	<b>Ted Schrecker</b> Associate Professor, University of Ottawa
12:30 – 14:00		
<b>Session Theme</b>	<b>Changing the Role of Public Health</b>	<b>Acting on Social Determinants of Health for Global Development</b>
<b>Room:</b>	<b>COPACABANA (SOFITEL)</b>	<b>AUDITORIUM OF THE TENT (FORTE)</b>
<b>Chair</b> 14:00 – 14:10	<b>Cesar Victora</b> President, International Epidemiological Association	<b>Pekka Puska</b> Director-General, National Institute for Health and Welfare, Finland
<b>Roundtables</b> 14:10 – 16:30	<b>Aaron Motsoaledi</b> Minister of Health, South Africa  <b>Beth Mugo</b> Minister of Public Health and Sanitation, Kenya  <b>James Chauvin</b> President-Elect, World Federation of Public Health Associations  <b>José Gomes do Amaral</b> President-Elect, World Medical Association	<b>Paison Dakulala</b> Deputy Secretary, National Department of Health, Papua New Guinea  <b>Sofiya Maliavina</b> Assistant Minister of Health and Social Development, Russian Federation  <b>José Gomes Temporão</b> Director, South American Institute of Health Governance  <b>Rebeca Grynszpan</b> Associate Administrator, UNDP
<b>Rapporteurs</b>	<b>Jane Billings</b> Senior Assistant Deputy Minister, Public Health Agency of Canada	<b>Jeffrey O'Malley</b> Director HIV/AIDS Group, UNDP
18:00 <b>FORTE</b>	<b>Hosted by the Government of Brazil</b>	

## DAY TWO – Thursday, 20 October 2011

<b>Conference Theme</b>	<b>Monitoring Progress: Measurement and Analysis to Inform Policies on Social Determinants</b>
<b>Room:</b>	<b>GALERIA DE ARTE (FORTE)</b>
<b>Session Theme</b>	<b>Measuring, Monitoring and Integrating Data into Policy</b>
<b>Chair</b> 10:00 – 10:10	<b>Michael Marmot</b> Professor, University College London
<b>Introductory Note</b> 10:10 – 10:30	<b>Hoda Rashad</b> Professor, American University of Cairo
<b>Roundtable of Experiences from Countries</b> 10:30 – 12:30	<b>Jorge Díaz</b> Deputy Minister for Health, Chile  <b>Maria Guzenina-Richardson</b> Minister of Health and Social Services, Finland  <b>Carmen Amela Heras</b> Director-General of Public Health, Ministry of Health, Spain  <b>Rahhal El Makkaoui</b> Secretary-General, Ministry of Health, Morocco  <b>Papaarangi Reid</b> Associate Professor, University of Auckland
<b>Rapporteurs</b>	<b>Mauricio Barreto</b> Professor, Universidade Federal da Bahia
12:30 – 14:00	
<b>Session Theme</b>	<b>Raising Accountability for Equity Impacts of Policy</b>
<b>Room:</b>	<b>GALERIA DE ARTE (FORTE)</b>
<b>Chair</b> 14:00 – 14:10	<b>Ala Alwan</b> Assistant Director-General, Noncommunicable Diseases and Mental Health, WHO
<b>Roundtables</b> 14:10 – 16:30	<b>Abdul Bari Abdulla</b> State Minister of Health and Family, Maldives  <b>Henry Madzorera</b> Minister of Health and Child Welfare, Zimbabwe  <b>Jaime Breilh</b> Universidad Andina Simon Bolivar, Ecuador  <b>Myrna Cunningham</b> President, UN Permanent Forum on Indigenous Issues  <b>Nancy Krieger</b> Harvard School of Public Health, USA  <b>Abhay Shukla</b> Coordinator, SATHI, India
<b>Rapporteurs</b>	<b>Sharon Friel</b> Australian National University/ HealthGAEN
18:00 <b>FORTE</b>	

**DAY THREE – Friday, 21 October 2011**

PLENARY ROOM (FORTE)	09:00 – 09:30	<b>Highlights from the Previous Day and Interviews by Zeinab Badawi (BBC World) with Socorro Gross-Galiano, Assistant Director, PAHO and Selected Speakers from Proceedings of Previous Day</b>
	09:30 – 11:00	<b>High Level Roundtable on Social Determinants of Health and the Life Course</b> Opening Statements by panellists and moderated roundtable discussion by Riz Khan, Al Jazeera English Marie-Paule Kieny, Assistant Director-General, Innovation, Information, Evidence and Research, WHO Maria Guzenina-Richardson, Minister of Health and Social Services, Finland William Lacy Swing, Director-General, IOM Purnima Mane, Deputy Executive Director, Assistant Secretary-General, UNFPA Geeta Rao Gupta, Deputy Executive Director, UNICEF David Sanders, Emeritus Professor, University of the Western Cape
	11:00 – 11:30	Break
	11:30 – 12:30	<b>"Bringing It All Together"</b> Roundtable with Chairs of parallel sessions of previous day Moderated by Riz Khan, Al Jazeera English
	12:30	<b>Rio Political Declaration on Social Determinants of Health</b> <b>Closing Remarks</b> Antonio Patriota, Minister of Foreign Relations, Brazil Alexandre Padilha, Minister of Health, Brazil, President of Conference Maria Guzenina-Richardson, Minister of Health and Social Services, Finland, Vice-President of Conference Marie-Paule Kieny, Assistant Director-General, Innovation, Information, Evidence and Research, WHO Also in attendance on stage will be other dignitaries

**- End of Programme -**



## **Stakeholder Events**

– All events are open to Conference participants and the public –

**Tuesday, 18 October 2011**

<p><b>Title: The Social Determinants of Adolescent Health</b>  Organizers: Johns Hopkins Bloomberg School of Public Health and Plan International  Contact: Dr Robert Blum (<a href="mailto:rblum@jhsph.edu">rblum@jhsph.edu</a>)  Location: Rio Othon Palace Hotel  Room: Itaipu A  Time: 9:00 – 12:00</p>
<p><b>Title: Asia-Pacific Hub of the Global Action for Health Equity Network – Future Action and Engagement</b>  Organizer: Global Action for Health Equity Network (Health GAEN)  Contact: Dr Belinda Loring (<a href="mailto:belinda.loring@healthgaen.org">belinda.loring@healthgaen.org</a>)  Location: Rio Othon Palace Hotel  Room: Sao Conrado  Time: 9:00 – 12:00</p>
<p><b>Title: Political Dialogue on Addressing Social Determinants of Health through National Policies, Programmes and Health System Change in South East Asia</b>  Organizers: Ministry of Health of India and WHO South East Asia Regional Office (SEARO)  Contact: Dr Suvajee Good (<a href="mailto:goods@searo.who.int">goods@searo.who.int</a>)  Location: Rio Othon Palace Hotel  Room: Guaratiba  Time: 9:00 – 12:00</p>
<p><b>Title: Protecting the Right to Health through Action on Social Determinants</b>  Organizers: People's Health Movement (PHM) and the Latin American Social Medicine Association (ALAMES)  Contact: Hani Serag (<a href="mailto:globalsecretariat@phmovement.org">globalsecretariat@phmovement.org</a>)  Location: Rio Othon Palace Hotel  Room: Itaipu B  Time: 9:00 – 12:00 &amp; 14:00 – 18:00</p>
<p><b>Title: Urban Slums and Health Equity: Forging a Global Network for Joint Learning</b>  Organizers: James P. Grant School of Public Health BRAC University, Bangladesh  Contact: Dr Tim Evans (<a href="mailto:evanst@bracu.ac.bd">evanst@bracu.ac.bd</a>) and Sabina Rashid (<a href="mailto:sabina@bracu.ac.bd">sabina@bracu.ac.bd</a>)  Location: Rio Othon Palace Hotel  Room: Mar Azul  Time: 14:00 – 16:00</p>
<p><b>Title: Mobilizing and Creating Awareness for Adolescent and Young People on the Social Determinants of Health as a way to Implement Changes</b>  Organizers: Vision International and WHO AMRO/PAHO  Contact: Dr Kira Fortune (<a href="mailto:fortunek@paho.org">fortunek@paho.org</a>)  Location: Rio Othon Palace Hotel  Room: Guaratiba  Time: 14:00 – 16:00</p>
<p><b>Title: Forum on the Lancet Series on Early Childhood Development in Developing Countries</b>  Organizers: Global Alliance for Improved Nutrition (GAIN), United Nations Children's Fund (UNICEF) and Bernard van Leer Foundation (BvL)  Contact: Dr Patrice Engle (<a href="mailto:pengle@calpoly.edu">pengle@calpoly.edu</a>)  Location: Hotel Sofitel Copacabana  Room: Rio de Janeiro II  Time: 14:00 – 17:00</p>

### Wednesday, 19 October 2011

<p><b>Title: WHO Inter-Regional Meeting on the World Conference on Social Determinants of Health</b> Organizers: WHO AMRO/PAHO and WHO Regional Offices Contact: Dr Kira Fortune (<a href="mailto:fortuneek@paho.org">fortuneek@paho.org</a>) Location: Hotel Sofitel Copacabana Room: Rio de Janeiro I Time: 9:30 – 11:00</p>
<p><b>Title: The Links Between Social and Environmental Determinants of Health and the Rio+20 Summit on Sustainable Development</b> Organizers: Fundação Oswaldo Cruz (FIOCRUZ) and WHO Headquarters Contact: Dr Carlos Dora (<a href="mailto:dorac@who.int">dorac@who.int</a>) Location: Hotel Sofitel Copacabana Room: Flamengo &amp; Copacabana Time: 9:00 – 12:00</p>
<p><b>Title: Politics of Health: Lessons from the AIDS Movement</b> Organizers: Ministry of Health of Brazil and UNAIDS Contact: Cintia Freitas (<a href="mailto:cintia.freitas@ids.gov.br">cintia.freitas@ids.gov.br</a>) Location: Hotel Sofitel Copacabana Room: Rio de Janeiro II Time: 9:00 – 12:00</p>
<p><b>Title: NCD Prevention, Social Determinants and Policies for Health</b> Organizers: Ministry of Social Affairs and Health of Finland and WHO Headquarters Contact: Dr Tang Kwok-Cho (<a href="mailto:tangk@who.int">tangk@who.int</a>) and Eeva Ollila (<a href="mailto:eeva.ollila@stm.fi">eeva.ollila@stm.fi</a>) Location: Rio Othon Palace Hotel Room: Sao Conrado Time: 9:00 – 10:30</p>
<p><b>Title: Water and Sanitation and the Social Determinants of Health</b> Organizers: Fundação Oswaldo Cruz (FIOCRUZ) and WHO AMRO/PAHO Contact: Dr Kira Fortune (<a href="mailto:fortuneek@paho.org">fortuneek@paho.org</a>) Location: Rio Othon Palace Hotel Room: Pontal Time: 9:00 – 12:00</p>
<p><b>Title: Global Health Watch 3: An Alternative World Health Report</b> Organizers: People's Health Movement (PHM) and Medico International Contact: Ms Bridget Lloyd (<a href="mailto:globalsecretariat@phmovement.org">globalsecretariat@phmovement.org</a>) Location: Rio Othon Palace Hotel Room: Itaipu B Time: 9:00 – 12:00</p>
<p><b>Title: Help Shape the Agenda! The Second Global Symposium on Health Systems Research: Inclusion and Innovation towards Universal Health Coverage</b> Time: 9:00 – 10:15</p> <p><b>Title: Health Professional Education and Social Determinants of Health: What Needs to Change?</b> Time: 10:30 – 12:00</p> <p>Organizers: Secretariat of the Second Global Symposium on Health Systems Research, and Global Independent Commission on Health Professionals for the 21st Century Contact: Dr Tim Evans (<a href="mailto:evanst@bracu.ac.bd">evanst@bracu.ac.bd</a>), Dr Jeanette Vega (<a href="mailto:ivega@udd.cl">ivega@udd.cl</a>) and Dr Kent Ranson (<a href="mailto:ransonm@who.int">ransonm@who.int</a>) Location: Rio Othon Palace Hotel Room: Guaratiba</p>

## Thursday, 20 October 2011

### **Title: Launch of Action: SDH – a WHO Electronic Discussion Platform**

Organizer: WHO Headquarters  
Contact: Nicole Valentine ([valentinen@who.int](mailto:valentinen@who.int))  
Location: Hotel Sofitel Copacabana  
Room: Rio de Janeiro III  
Time: 12:45 – 13:15

### **Title: SDH: Future Directions**

Organizer: Sir Michael Marmot, University College London  
Contact: Felicity Porritt ([felicity.porritt@googlemail.com](mailto:felicity.porritt@googlemail.com))  
Location: Hotel Sofitel Copacabana  
Room: Rio de Janeiro III  
Time: 13:15 – 13:45

### **Title: Oil, Health and Development – Mechanism for Enhancing Governance and for Promoting “Social Accountability”**

Organizers: Ministry of Energy of Brazil and WHO  
Contact: Dr Carlos Dora ([dorac@who.int](mailto:dorac@who.int))  
Location: Rio Othon Palace Hotel  
Room: Mar Azul  
Time: 17:00 – 19:00

### **Title: Noncommunicable Diseases – Social Determinants – Sustainable Development: The Inherent Agenda**

Organizers: AMRO/PAHO  
Contact: Dr Kira Fortune ([fortunek@paho.org](mailto:fortunek@paho.org))  
Location: Rio Othon Palace Hotel  
Room: Itaipu A  
Time: 18:00 – 20:00

## Friday, 21 October 2011

### **Title: Global Movement for Health Equity through Action on the Social Determinants of Health**

Organizers: Global Action for Health Equity Network (Health GAEN)  
Contact: Dr Belinda Loring ([belinda.loring@healthgaen.org](mailto:belinda.loring@healthgaen.org))  
Location: Rio Othon Palace Hotel  
Room: Sao Conrado  
Time: 14:00 – 17:00

### **Title: WHO Second Inter-Regional Meeting (for WHO only)**

Organizers: WHO AMRO/PAHO and WHO Regional Offices  
Contact: Dr Kira Fortune ([fortunek@paho.org](mailto:fortunek@paho.org))  
Location: Hotel Sofitel Copacabana  
Room: Rio de Janeiro III  
Time: 14:00 – 16:30

### Addresses:

<b>Hotel Othon Palace Hotel</b>	<b>Hotel Sofitel Copacabana</b>
Avenida Atlantica 3264	Avenida Atlantica 4240
Copacabana, Rio de Janeiro	Copacabana, Rio de Janeiro
RJ 22070-000, Brazil	RJ 22070002, Brazil

For further information about these events, please contact the organizers directly.  
With general queries, please contact Dr Monireh Obbadi at (21) 8608 – 1178.







All for Equity

# World Conference on Social Determinants of Health

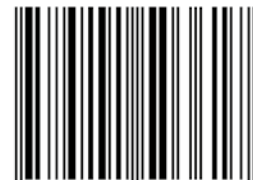
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