

JUST SOCIETIES: HEALTH EQUITY AND DIGNIFIED LIVES

Executive Summary
of the Report of the
Commission of the
Pan American Health
Organization on Equity
and Health Inequalities
in the Americas

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Pan American
Health
Organization



World Health
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Americas



INSTITUTE of
HEALTH EQUITY

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HEALTH EQUITY**

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EXECUTIVE SUMMARY OF THE REPORT OF THE COMMISSION OF THE PAN AMERICAN HEALTH ORGANIZATION ON EQUITY AND HEALTH INEQUALITIES IN THE AMERICAS

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September 2018

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1. INTRODUCTION AND CONCEPTUAL FRAMEWORK

COMMISSION ON EQUITY AND HEALTH INEQUALITIES IN THE AMERICAS

The Americas—North, Central, South America and the Caribbean—are remarkable in their diversity. These lands, which the World Health Organization (WHO) designates as one of six global ‘regions’, contain some of the richest individuals and countries in the world, some of the poorest, and much in between. Within the Americas are tiny island states with small populations, and populous countries of vast land mass, with the different challenges that brings.

The region includes people who enjoy substantial privileges, and others who face severe human rights violations by reason of their socioeconomic position, ethnicity, gender, sexual orientation, disability status or being migrants. Each of these factors, alone or in combination, can contribute to marked inequalities in health within and between countries in the Americas. Insofar as systematic inequalities in health are avoidable by reasonable means, they are unfair—and hence inequitable. Putting them right is a matter of social justice.

It is to address these health inequities that the Commission on Equity and Health Inequalities in the Americas was set up by the Director of the Pan American Health Organization (PAHO), Dr Carissa Etienne. The PAHO Equity Commission’s starting point is that health is an end in itself. It is a worthwhile goal for individuals and for communities. Certainly, there are good instrumental reasons for improving health: good health may be a route to individuals enjoying flourishing and productive lives; a healthier population may make economic sense for a country. But that is not our central concern. Health is more than a means to some other end. Health is a state that is much valued and cherished and is part of a world view, common in the Americas as elsewhere, that human wellbeing is an end in itself. Better health and greater health equity will

come when life chances and human potential are freed: to create the conditions for all people to achieve their highest possible level of health and to lead dignified lives.

The evidence we bring together here demonstrates that much of ill health is socially determined. The reason that life expectancy for a woman in Haiti is a little less than 66 years while for a woman in Canada it is 84 (2) is not because Haitian women are biologically different to Canadian women, but because of the conditions in which each is born, grows, lives, works and ages. Similarly, in Chile, the fact that a man with a low educational level can expect to live 11 years fewer than a man with university education is mostly the result of the social determinants of health (2). As we shall show, initiatives on education and social inclusion, for example, will have health and other societal benefits.

The effect of social determinants of health is seen at the beginning of life (3). In most countries in the Americas, the chance of a child dying before the age of 5 is strongly linked with parents’ income—the lower the income, the higher the mortality (4). In Guatemala, for example, in 2014, the under-five mortality rate was 55 in 1,000 births in the poorest fifth of families, 20 in the richest fifth. In nearby Colombia, by contrast, the under-five mortality in the richest fifth was less than 5 in 1,000, in

Overcoming poverty is not a gesture of charity. It is an act of justice. It is the protection of fundamental human rights, the right to dignity and a decent life.

Nelson Mandela, London, 2005 (1)

2015 (5): this shows what should be achievable. Across the Americas, children's lifelong development and outcomes in education, income, health and wellbeing remain closely aligned with parents' situations.

There is increased evidence and awareness that good health requires not only access to health care, but action on the social determinants of health. Indeed, so close is the relation between features of society and health that, we argue, health and health equity represent important markers of societal progress. A society that meets the needs of its members, in an equitable way, is likely to be a society with a high level of population health and relatively narrow health inequities.

In addition to the challenge of addressing great social and economic inequalities, the PAHO Equity Commission's work has identified climate change, environmental threats, relationship with land, and the continuing impact of colonialism, racism and the history of slavery as critical factors slowing progress toward the goal for people in the region to lead a dignified life and enjoy the highest attainable standard of health.

The aim of the PAHO Equity Commission is to provide a better understanding of these challenges as well as make proposals for effective action to address them. We build on the foundations laid by the Commission on Social Determinants of Health (CSDH). In the decade that followed the CSDH report 'Closing the Gap in a Generation', countries in the Americas have been active in taking forward initiatives, and our examples for action come from these countries. The PAHO Equity Commission has partnered with 15 countries as this work has proceeded. There is also action at sub-national level. In the United States, for example, many cities have embraced a social determinants of health approach.

It is an important moment to publish this report. Inequality dominates the Americas: socioeconomic inequality,

but also inequalities between Indigenous and non-Indigenous people; between people of African descent and those of European origin; between genders; between disabled and non-disabled people; between people of different sexual orientation and between migrants and non-migrants. Too much inequality damages social cohesion, leads to unfair distribution of life chances, and to health inequalities. Yet at the same time, there is great interest in health in the Americas, and the region has been at the forefront of acknowledging the human right to the highest attainable standard of health with the majority of countries signing international protocols on economic, social and cultural rights. Implementation of the recommendations of these agreements is the challenge for leaders—political, professional and community.

We seek to engage governments, civil society, and academics not only in the health sector but across all the societal domains that influence health equity. The Sustainable Development Goals (SDGs) clearly recognize that societal success is multi-faceted: economic success is but one, somewhat limited, measure of a society's progress. While only one of the SDGs is explicitly related to health, evidence shows that most of the other 16 do have an influence on health and health equity (6).

While we recognize that achieving health equity in some areas will require tackling unfavorable politics, the undue priority of economics over human rights, conflict, climate change and corruption, we are not rendered hopeless in the face of these challenges because we have seen meaningful change despite great barriers. This report will highlight examples of governments making a difference, civil society and professional organizations implementing evidence-informed strategies and citizen engagement in social movements and community-building actions to achieve change. We have evidence to support our judgement that achieving health equity is a realistic goal.

Social injustice is killing on a grand scale

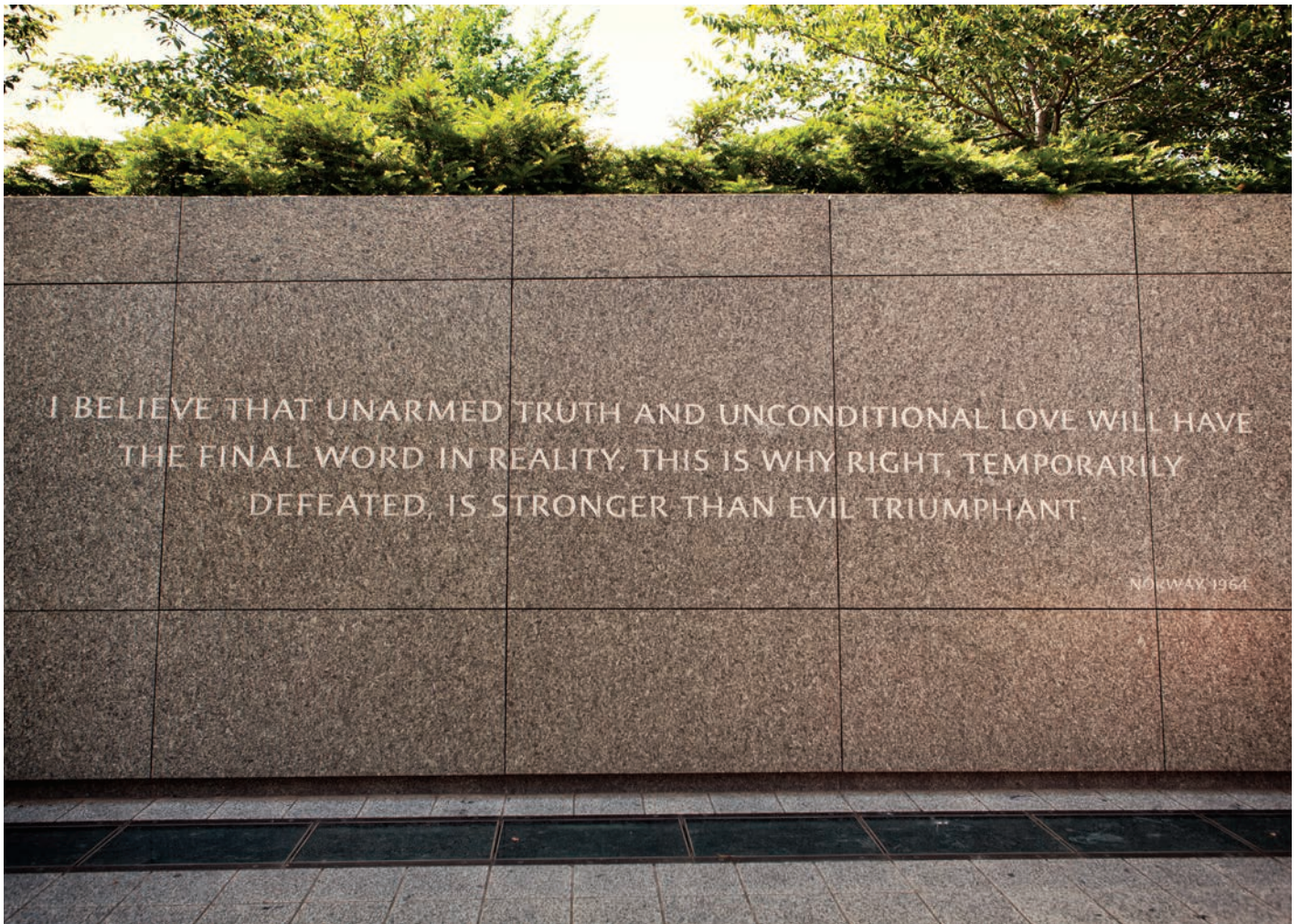
Commission on Social Determinants of Health (4)

Injustice anywhere is a threat to justice everywhere.

Martin Luther King, Jr. (7)

Peace cannot exist without justice, justice cannot exist without fairness, fairness cannot exist without development, development cannot exist without democracy, democracy cannot exist without respect for the identity and worth of cultures and peoples.

Rigoberta Menchú (8)



Taking action: Learning from the Civil Rights movement

The PAHO Equity Commission met with leaders of the Civil Rights movement in Atlanta, Georgia to learn from them about how to achieve major political and social change. Points of learning the Commission took away:

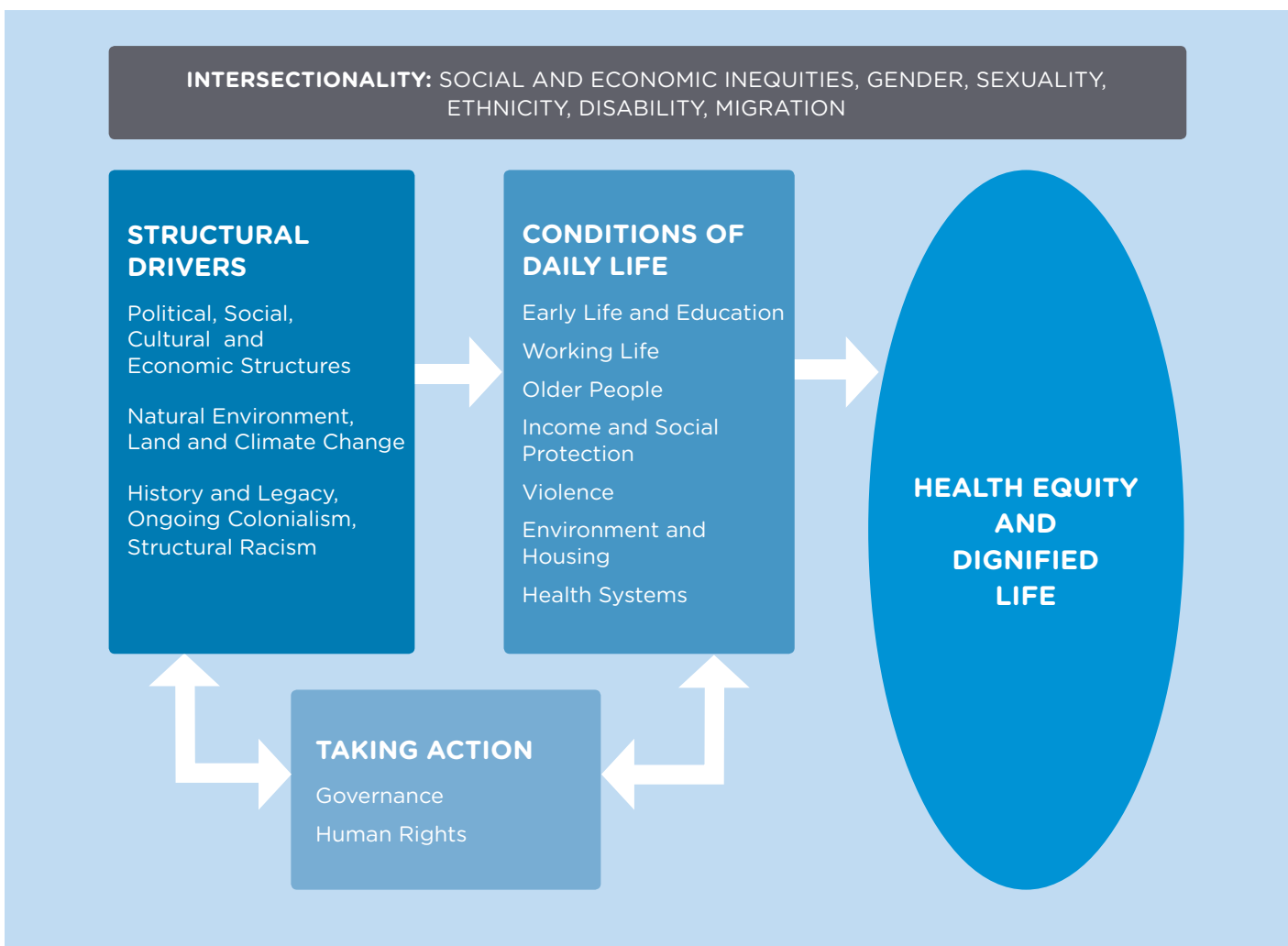
- We must target the social determinants of health equity such as jobs, education, income and safety.
- We must be willing to confront discrimination in these areas even at the risk of 'redemptive suffering', in the words of Martin Luther King, Jr (9).
- Like Rosa Parks of the Montgomery Bus Boycott, 'we must have a made-up mind'— a determination within ourselves (10).
- We must always engage the community in our efforts and keep this engagement throughout.

CONCEPTUAL FRAMEWORK

The PAHO Equity Commission’s conceptual framework, shown in Figure 1.1, summarizes our approach to both analyzing the evidence and formulating recommendations. It is the organizing framework for our report. The structural drivers are dealt with in Section 3, recommendations to improve equity in the conditions of daily life are laid out in Section 4, and recommendations for governance arrangements in Section 5.

The framework is based on the CSDH conceptual framework (11) but goes beyond it in important ways: there is emphasis on structural racism, colonialism and importance of relationships to land; it is consistent with the SDGs, with greater emphasis on the environment and climate change; there is a more explicit focus on human rights; and greater emphasis on inequities according to gender, ethnicity, sexual orientation, life stage, and disability. The PAHO Equity Commission also recognizes the interrelations between these, with emphasis on leading a dignified life as a desired outcome—aligned with greater health equity.

FIGURE 1.1. CONCEPTUAL FRAMEWORK



STRUCTURAL DRIVERS OF HEALTH INEQUITIES

Political, social, cultural and economic structures

The way markets operate, the role of the public sector and economic inequalities are structural drivers of inequities in the conditions of daily life, mostly produced or modified by political choices.

The global financial crisis of 2007/8 and its aftermath exposed the limits of unfettered markets. A move toward market fundamentalism downplayed the importance of the public sector and fostered growing economic inequality (12). Evidence assembled for the PAHO Equity Commission points to the importance of a vibrant and invigorated public sphere. A successful private sector is the complement to investment in the public good.

Economist Anthony Atkinson reported that when respondents in the United States and Europe were questioned on what they considered to be the 'greatest danger in the world', concerns about inequality outweighed all other dangers (13). Few would deny the importance of equality of opportunity, but great inequalities of income and wealth tilt the playing field. The evidence clearly shows that these big inequalities limit opportunities for the next generation. This is referred to as the intergenerational transmission of inequities.

A second and related reason for the public's concern about inequality is that it questions the legitimacy of society. If society is seen to work in the interest of the few, extremes of inequality are inconsistent with a functioning democracy. Those who are rich may question why they should pay taxes to support the poor. Those who are disadvantaged perceive the palpable unfairness of life chances for the few but not the rest. Unaddressed inequality can create the conditions for societal dysfunction and instability.

Third, highly unequal societies are associated with social evils such as ill health and crime. Central to the ill-health effect of inequality are both poverty and relative disadvantage.

We highlight that Indigenous peoples and people of African descent in the Americas are subject to multiple disadvantages that damage their health. But within all these groups of people of the region there are social gradients in health. When people are classified by their level of education, income, wealth or by the social level of their neighborhood, the higher the socioeconomic position, the better their health. This social gradient runs all the way from the top to bottom of society. Dealing with it implies not only reducing poverty but reducing relative disadvantage by improving society as a whole. Such improvement will entail action on structural drivers. It will also require social policies and programs devoted to reducing the damaging effects of inequities in power, money, and resources.

To deal with the whole social gradient in health, the English review of health inequalities, Fair Society, Healthy Lives, introduced the concept of 'proportionate universalism'. The aim was to have universal services applied to all and to distribute effort and resources proportionate to need (43). We have highlighted the importance of meeting the needs of Indigenous peoples and people of African descent in the Americas. That will be done partly through proportionate universalism, redressing the underfunding and neglect of services for Indigenous peoples and people of African descent. But also, by recognizing the physical, emotional, spiritual, and cognitive health domains of all people in the region.

History and legacy, ongoing colonialism, and structural racism

A key conclusion of the CSDH was that inequities in power, money, and resources are fundamental drivers of inequities in the conditions of daily life which, in turn, drive health inequities (4). One major source of such inequity is colonialism: it is intrinsic to the history of the Americas.

Blatant colonialism mutilates you without pretense: it forbids you to talk, it forbids you to act, it forbids you to exist. Invisible colonialism, however, convinces you that serfdom is your destiny and impotence is your nature: it convinces you that it's not possible to speak, not possible to act, not possible to exist.

Eduardo Galeano (16)

There are between 45 and 50 million Indigenous peoples living in Central America, South America and the Caribbean, who represent approximately 13 percent of the population. In the United States, approximately 5.2 million persons identify as American Indian or Alaskan Native and in Canada 1.4 million people identify as Indigenous (14). Indigenous peoples presenting to the PAHO Equity Commission made clear that the continuing effects of colonialism contribute to the depth and scope of health inequities affecting Indigenous peoples and across generations.

There are approximately 200 million people of African descent in the Americas, including the United States and Canada (15). Their history is characterized by slavery, colonialism, racism, and discrimination, the effects of which are active in the present day (5). Such structural racism drives inequities in the conditions of daily life for people of African descent.

To address the health disadvantage of Indigenous peoples and people of African descent in the Americas we need to bring together the social determinants framework, the disadvantages of daily life, with an approach that includes ending discrimination and racism, promotes self-determination, and improves support for relationships with the land, recognizing obligations to ancestors and future generations. We see self-determination as central to this and as mediating the effect of social determinants on health equity. There will be other pathways such as the effects of environment and material deprivation but self-determination and living a dignified life are of vital importance in creating the kind of society that will lead to health equity.

Natural environment, land and climate change

Climate change demands urgent change in the way societies function and the ways in which states cooperate. Such changes must respect equity and health equity. Damage to the natural environment is also a major threat to the land and its people, with significant adverse impacts on health equity. Redressing both of these threats must be done in a spirit of justice.

Effective health equity analysis of these threats to the lives of Indigenous people, and any interventions, must take account of their distinct symbiotic relationship with the land and the environment. The issue of land tenure rights also needs to be addressed - it affects all marginalised people throughout the Americas.

CONDITIONS OF DAILY LIFE

The conditions in which people are born, grow, live, work, and age are fundamental to the lives they are able to lead. We lay out the evidence to show in detail how each of the domains that affect daily life—early years and education, decent work, dignified aging, income and social protection, environmental and housing conditions, violence,

and the health system—influence health equity and the ability to lead a dignified life. These domains are affected by the structural drivers described above.

Intersectionality

PAHO's four cross-cutting themes of gender, ethnicity, equity, and human rights are central to this report. As well as socioeconomic position, gender, disability, and ethnicity are bases of discrimination that profoundly impact health outcomes in the Americas. Central to the work of the PAHO Equity Commission is the recognition that multiple disadvantages can adversely increase experience of the social determinants of health. The Commission has considered disadvantages related to gender and ethnicity, and the intersection of detriment caused by poverty, disability, sexual orientation, and gender identity. Attending to life stage is important as children and older people can experience health inequity differently and often at deeper levels than other age groups. Human rights instruments and mechanisms have identified all these characteristics as giving rise to, or exacerbating, human rights violations.

TAKING ACTION: GOVERNANCE FOR HEALTH EQUITY

Governance arrangements

Governance systems determine who decides on policies, how resources are distributed across society, and how governments are held accountable. Governance for health equity through action on social determinants requires, at a minimum, adherence to the United Nations Development Program's principles of good governance (17)—legitimacy and voice, clear direction and vision, measurable performance, accountability and fairness. But it also requires whole-of-government and whole-of-society approaches to reducing inequities (18). Such approaches require new forms of leadership that shift the allocation of power and weaken centralized, top-down decision-making structures.

Many of the factors that shape the patterns and magnitude of health inequities within a country lie beyond the direct control of ministries of health and require increased involvement of local people and communities in defining problems and generating and implementing solutions.

RELEVANT PAHO RESOLUTION

CD53.R2: Plan of Action on Health in all Policies

Governance for health equity requires accountability. To achieve this, it is necessary to monitor health and its social determinants in a transparent way. While reliable data on demographic trends and morbidity and mortality are available in some countries, in most countries there is a lack of health information broken down by ethnicity, disability or socioeconomic position, such as income, employment status and education. This is a significant weakness for addressing health inequities and it limits monitoring of interventions and policies.

Human rights

The law is a counterbalance to political power and legal redress provides a vital pathway to correct policies and practices that result in or deepen health inequities. Human rights standards and commitments 'strengthen the diagnosis of injustice of differences in health outcomes due to social and political factors' (19). The strong focus on accountability in human rights requires effective and timely redress of violations and effective measures to prevent recurrence and bolster a human-rights enabling environment (20).

Observance of human rights, including taking positive measures for the most disadvantaged, is fundamental to creating conditions to ensure that all persons can live a dignified life as individuals and as members of their communities and societies.

HEALTH EQUITY AND A DIGNIFIED LIFE

The actions captured by our conceptual framework are aimed at achieving greater health equity and opportunity for a dignified life. Creating the conditions for a dignified life builds on the concept of empowerment which was emphasized by the CSDH. Empowerment potentially has three dimensions: material, psychosocial, and political. In a number of its decisions the Inter-American Court of Human Rights has developed the concept of *vida digna*—a dignified life. The Court has emphasized that the right to life must include the right to ‘not be prevented from having access to the conditions that guarantee a dignified existence’ (21).

Dignified life incorporates the principle of self-determination and the ability to envisage and seek to realize one’s life project which includes the right to make the options people feel are best, of their own free will, in order to achieve their ideals (22). This approach to autonomy and a life lived with dignity draws on Amartya Sen’s concept of capabilities (23). Freedom to live a life one has reason to value is at the heart of Sen’s capabilities.

CONSISTENCY WITH OTHER APPROACHES TO GLOBAL HEALTH

The PAHO Equity Commission builds on, and is complementary to, three other dominant strands in global health.

First, the PAHO Equity Commission endorses the strong push by WHO and others towards Universal Health Coverage (UHC). Universal access to health care should be a feature of all societies. But inequities in access to health care are not the prime cause of inequities in health. Countries such as Canada and the UK, with their universal access to health care, still have health inequities. These can be attributed to the structural drivers and conditions of daily life. Lack of

access to care when people get sick compounds the problem. That said, there is clear intersection of social determinants of health and universal health coverage, or its lack. In many countries, lack of money, marginal status, remote location and cultural barriers can all be reasons for lack of access to care; they are also social determinants of health. We endorse the approach taken by PAHO that an important component of Universal Health Coverage is to incorporate the Essential Public Health Functions. (24). Also, countries across the region have signed up and agreed to PAHO-led resolutions, many of which are important in fostering greater health equity. We draw attention to these in boxes throughout the report, along with relevant SDGs and other resolutions (24).

Second, prevention of communicable diseases is still a major priority for the region of the Americas. At its most basic, lack of access to clean water and sanitation are significant causes of ill health. Our perspective is to address the ‘causes of the causes’: the reasons why known policies and interventions that would improve health are denied to some groups in society.

Third, there is a most welcome worldwide initiative on non-communicable diseases (NCDs). Part of this movement is oriented to access to care, and part to prevention. Objectives of WHO’s Global Action Plan for the Prevention and Control of NCDs include improvements in known risk factors or causes: diet, smoking, obesity, lack of physical activity, abuse of alcohol (25). Our focus is on the ‘causes of the causes’—the social determinants of these unhealthy behaviors. Therefore, the recommendations of the PAHO Equity Commission will support the Global Action Plan on NCDs. Social determinants also act through psychosocial pathways. For example, stress has direct effects on both mental and physical health (4).

2. HEALTH INEQUALITIES IN THE AMERICAS

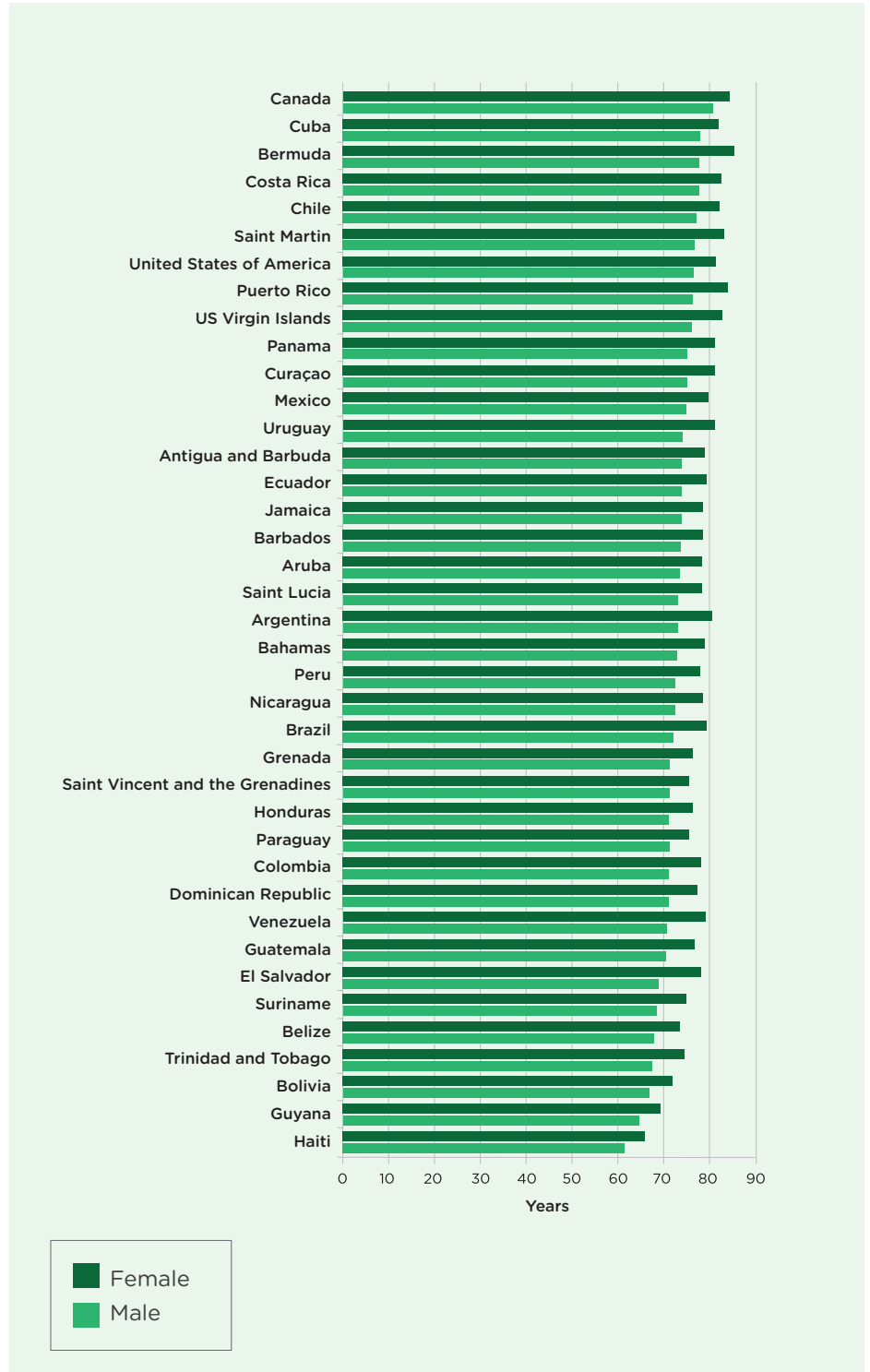


There have been many improvements in health across the Americas in recent years. Since 2003, life expectancy has improved by two years in the United States and Canada and by four years in Latin America and the Caribbean (LAC) (26, 27). Infant mortality has dropped by 42 percent in LAC since 2003 and maternal mortality by 32 percent since 2000 (while essentially staying constant in Canada and the United States) (2).

However, as with other regions in the world, profound inequalities in health remain. Within all countries in the region, those with higher levels of income or educational attainment experience better conditions of daily life and live longer, healthier lives than others.

The range of life expectancy among countries in the region was 18 years in 2016 shown in Figure 2.1. In every country, women live longer than men.

FIGURE 2.1. LIFE EXPECTANCY FOR FEMALES AND MALES IN THE AMERICAS, 2016

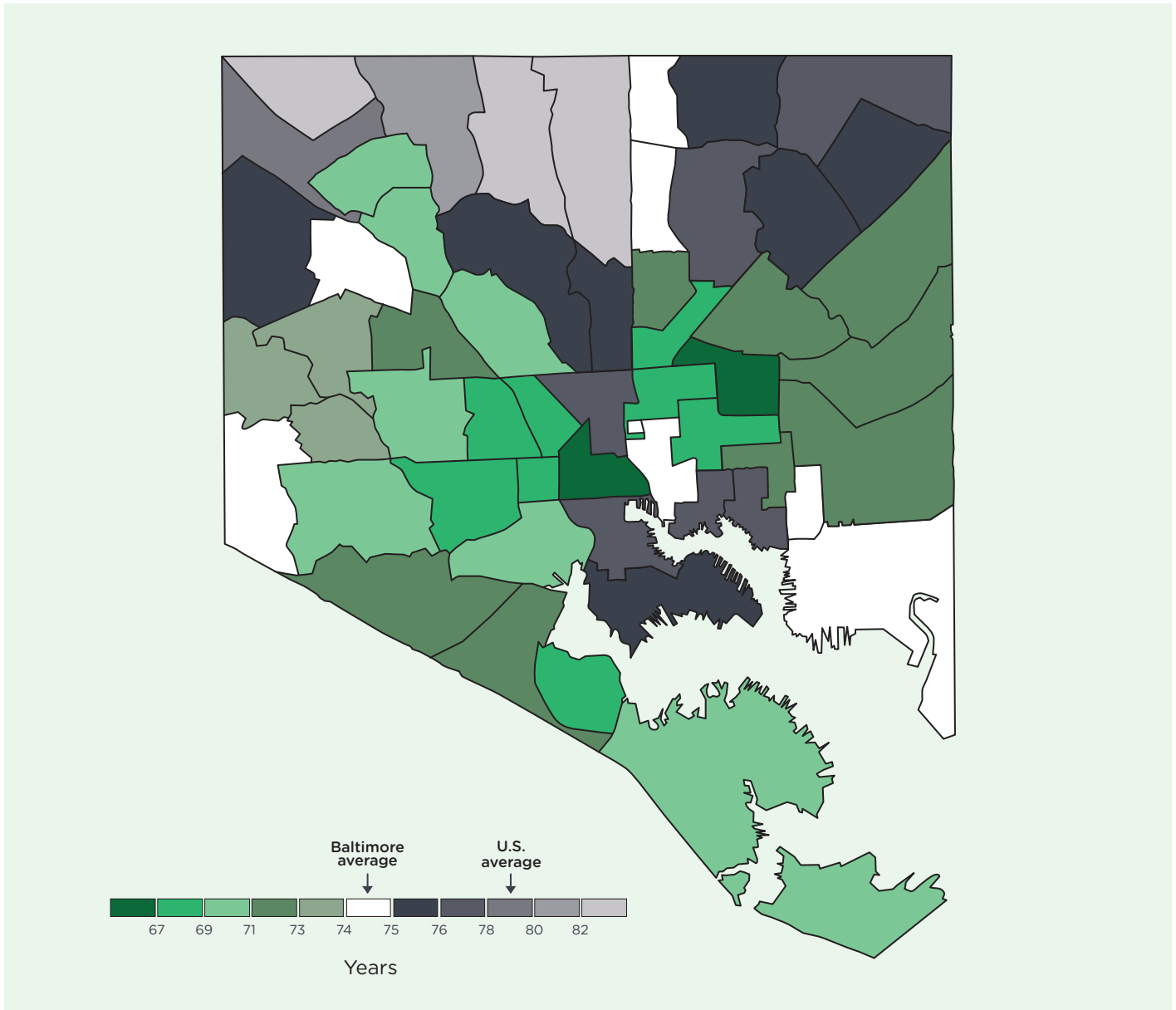


Source: World Bank Data, 2018 (2)

Within countries, health inequalities are even greater, and they are closely related to gender, Indigenous and African descent identity, educational attainment, income and wealth, disabilities, sexuality, and the intersections between these (28, 29).

In the United States there is a 19-year gap in life expectancy in Baltimore between those who live in the most disadvantaged neighborhoods and those who live in the wealthiest ones (28).

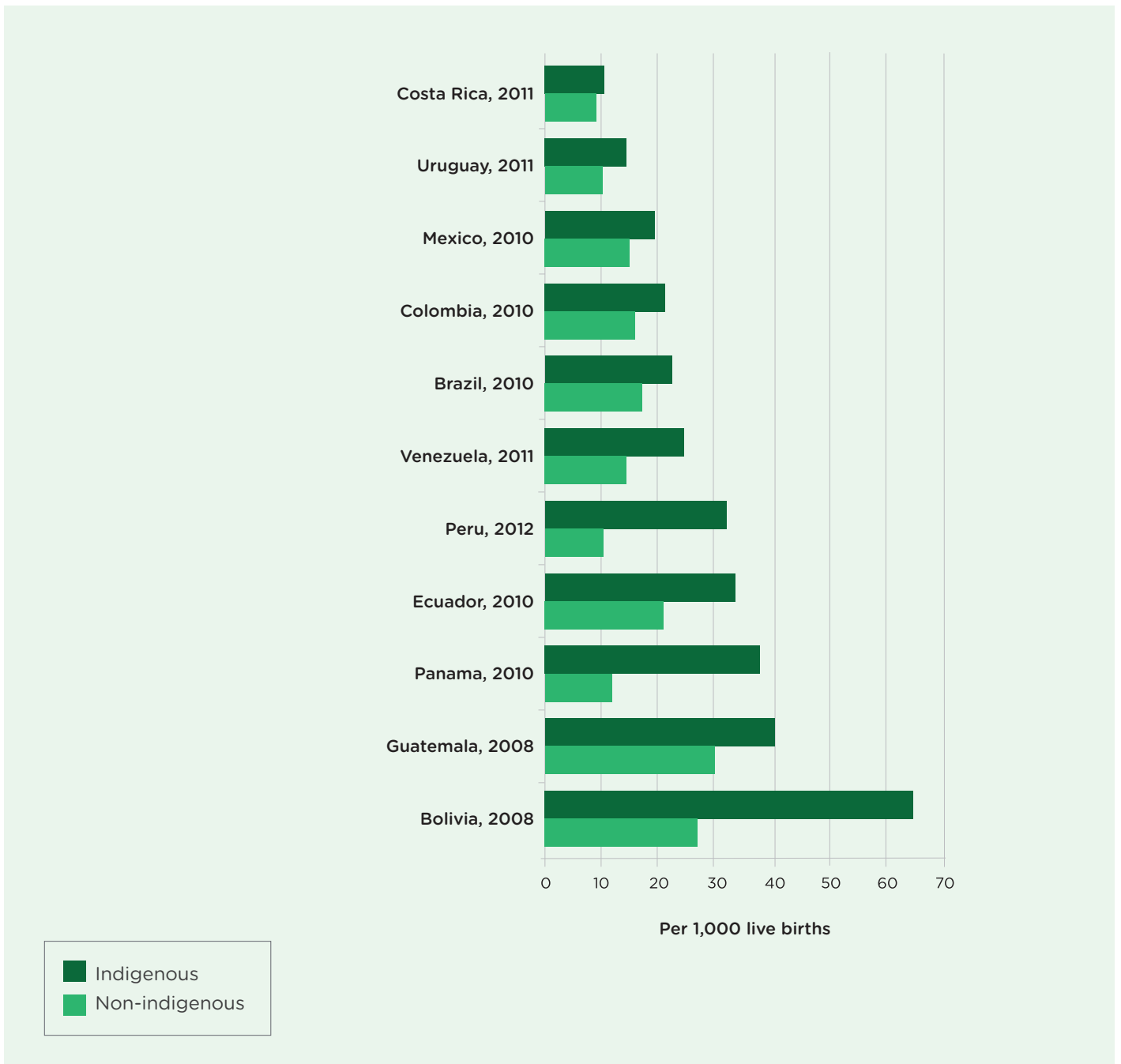
FIGURE 2.2 LIFE EXPECTANCY BY NEIGHBOURHOOD, BALTIMORE, UNITED STATES, 2014



Source: Ingraham C. Washington Post. Justice Policy Institute (28).

Despite improvements in early years and maternal health outcomes, stark inequalities remain. A key indicator is the mortality rate for children under five years of age, which shows higher levels among the poor than for the rich, and a social gradient running from the richest fifth (quintile) to the poorest (see Figure 2.3). Under-five mortality is higher among children of Indigenous people than among non-Indigenous people across all countries shown.

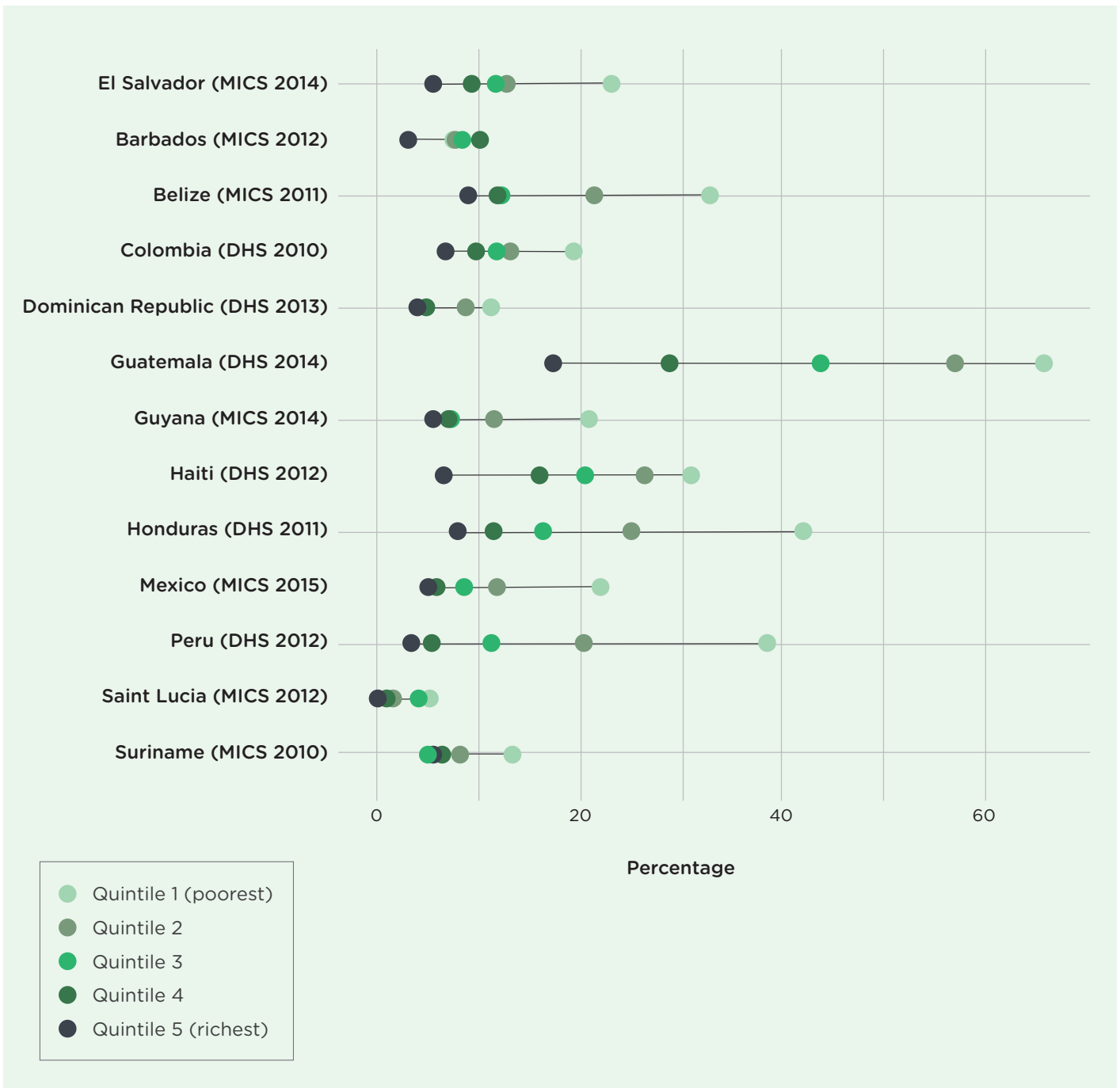
FIGURE 2.3. UNDER-FIVE MORTALITY BY INDIGENOUS IDENTITY, COUNTRIES WITH COMPARABLE DATA, 2012 OR LATEST AVAILABLE



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC (5).

Stunting is prevalent in Latin America and there are inequalities in rates within and between countries related to levels of education and income (30). Stunting, mainly, but not exclusively, affects low-income children, children of mothers with low levels of education and Indigenous children.

FIGURE 2.4. PERCENTAGE OF CHILDREN STUNTED BY WEALTH QUINTILE, COUNTRIES WITH COMPARABLE DATA, 2013 OR LATEST AVAILABLE

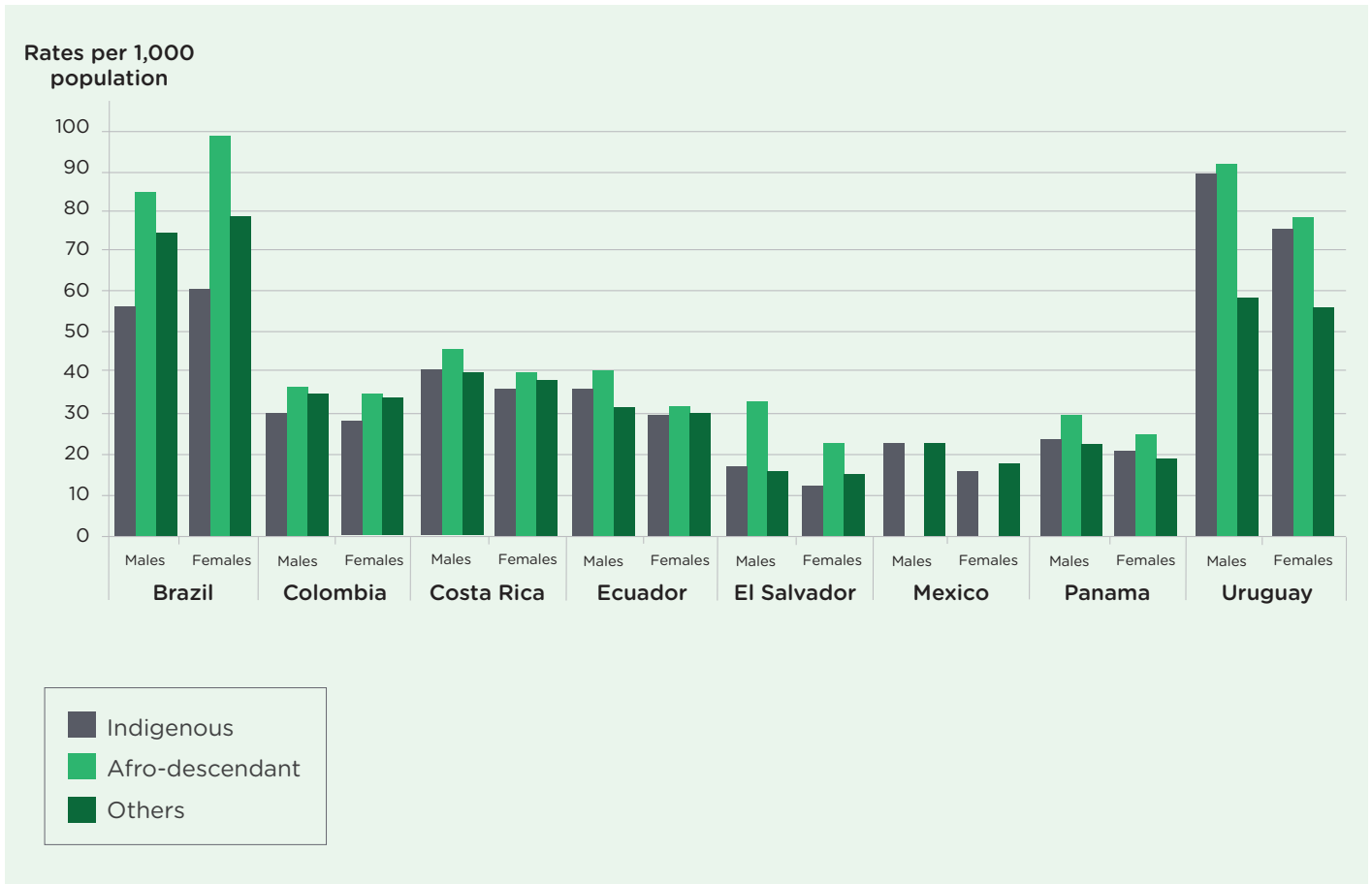


Source: Health Equity Assessment Toolkit (HEAT): Software for exploring and comparing health inequalities in countries. Built-in database edition. Version 2.1. Geneva; World Health Organisation; 2018 (31, 32).

There are marked and persistent inequalities in rates of adolescent fertility related to socioeconomic position and Indigenous and African-descent identity. Women in the richest quintile have lower rates of adolescent pregnancies and births than poorer groups. Adolescent pregnancy and birth carries risk for both mothers and children, including higher levels of maternal and under-five mortality (33).

There are large differences in rates of disability across the region, although direct comparisons are problematic, as countries use different definitions of disability and monitoring is generally weak (34). There are also significant differences in disability rates within countries (Figure 2.5). The highest rates are for people of African descent, and are associated with gender and socioeconomic position. In all countries for which data is available, those with incomplete primary education had higher rates of disability than those with higher levels of education.

FIGURE 2.5. DISABILITY RATE IN THE POPULATION AGED 0-18, BY SEX, INDIGENOUS AND AFRICAN DESCENT IDENTITY, COUNTRIES WITH COMPARABLE DATA, 2011 OR LATEST AVAILABLE

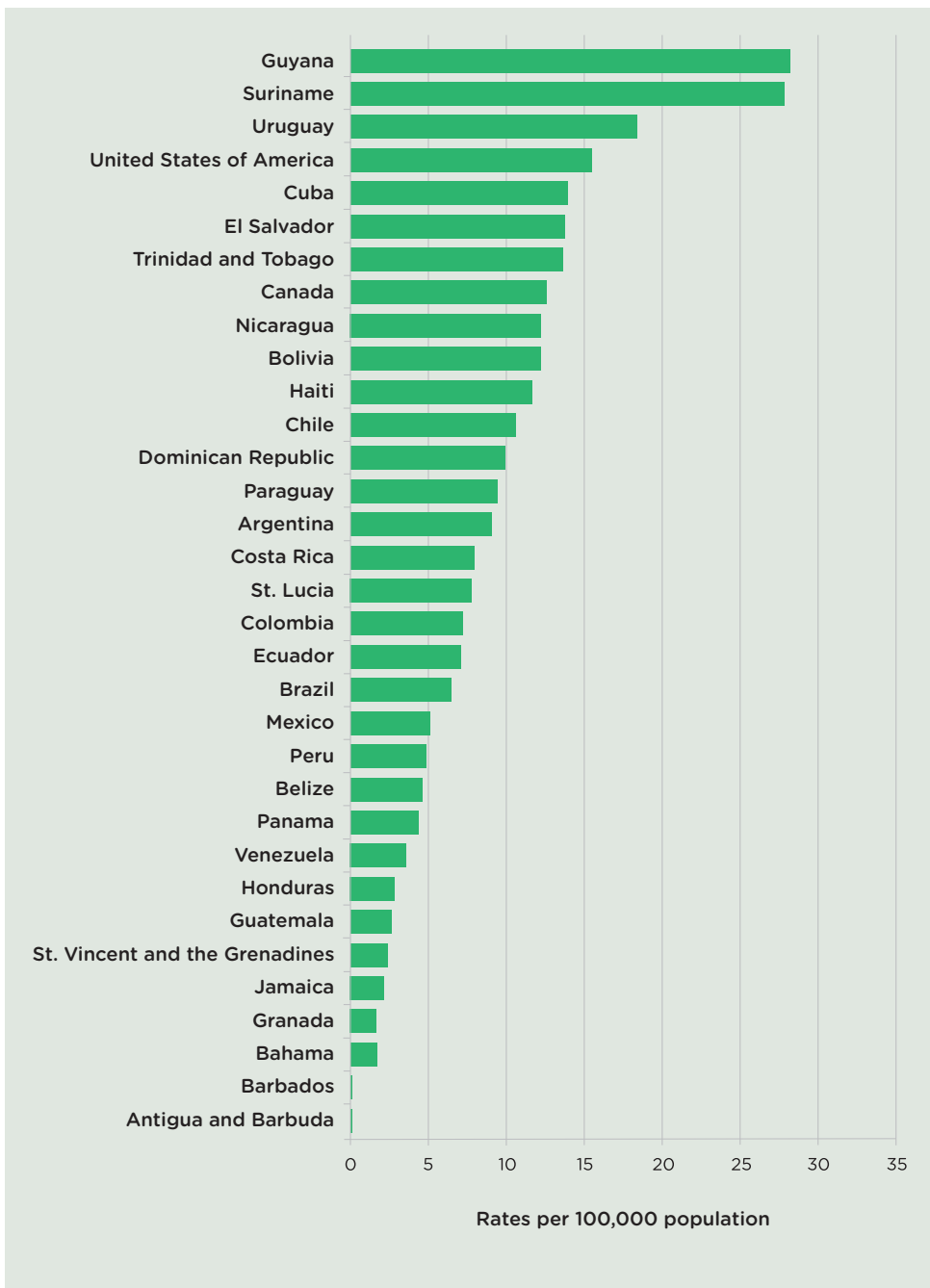


Source: Economic Commission for Latin America and the Caribbean (ECLAC), Social Panorama of Latin America, 2012 (35).

Structural inequalities in the determinants of health contribute to inequalities in the incidence and prevalence of mental illness and inequalities in access to effective mental health treatment. Such inequalities are seen among different ethnic groups in the Americas, as well as different socioeconomic groups, and between men and women (5). People with poor mental health are at increased risk of other illnesses, injury and premature death (4).

While not all mental illness leads to suicide, and not all suicide relates to mental illness, suicide is one possible outcome of mental illness (36). Figure 2.6 shows rates of suicide in the region.

FIGURE 2.6. SUICIDE MORTALITY RATE, COUNTRIES IN THE AMERICAS, 2015



Source: World Health Organization, Global Health Observatory Data Repository, obtained from World Bank World Development Indicators, 2018 (2).

INTERNATIONAL AGREEMENTS

Sustainable Development Goal 3 aims to ‘ensure healthy lives and promote wellbeing for all at all ages’ (6)

RELEVANT PAHO RESOLUTIONS (24)

- **CSP29.R2:** Sustainable Health Agenda for the Americas 2018–2030
- **CD55.R13:** Health of Migrants
- **CD53.R7:** Plan of Action on Mental Health
- **CD50.R16:** Health, Human Security and Well-being
- **CSP29.R3:** Policy on Ethnicity and Health
- **CD53.R12:** Plan of Action on Disabilities and Rehabilitation

In the United States between 1999 and 2014, suicide rates rose significantly for poorer white men and women and for American Indian and Alaskan natives (36, 37). In Canada the suicide rate for First Nations males aged 15–24 is four times higher than that of non-Indigenous young people (38).



3. STRUCTURAL DRIVERS— INEQUITIES IN POWER, MONEY, AND RESOURCES

RECOMMENDATION 1.

ACHIEVING EQUITY IN POLITICAL, SOCIAL, CULTURAL, AND ECONOMIC STRUCTURES

Political, social, cultural, and economic forms of power have become more concentrated across the Americas (39). That concentration, and the deterioration of the region's position in the global economy, are driving profound structural and health inequities. In many countries in the region, national and international economic forces have undermined economic growth, equity and stability. Parts of the region are in economic crisis, and the poorest bear the brunt - both in terms of reduced employment opportunities and lower wages, and reduced expenditure on social protection policies.

PRIORITY OBJECTIVES	ACTIONS
1A. IMPLEMENT PROGRESSIVE FISCAL POLICY TO IMPROVE HEALTH EQUITY	<ul style="list-style-type: none"> • Identify equity impacts of fiscal policies and adapt them to promote health equity • Strengthen international cooperation to stop exploitation of tax havens • Reinforce the financial safety net of the region
1B. ENSURE A FLOURISHING PUBLIC REALM AND REINFORCE THE ROLE OF THE STATE IN PROVISION OF SERVICES	<ul style="list-style-type: none"> • Develop approaches to increase political empowerment based on ECLACs Horizons 2030 agenda for equity and the recommendations of the Oslo Commission (40) • Challenge the presumption that markets are the most effective ways to deliver public services • Reinforce the role of the state in regulating public services
1C. URGENTLY ADDRESS CORRUPTION TO REDUCE ITS THREAT TO HEALTH EQUITY	<ul style="list-style-type: none"> • Implement Transparency International's recommendations to reduce corruption (41) • Strengthen the institutions involved in the detection, investigation, and prosecution of corruption-related crimes • Lift political immunity for corruption-related cases • Strengthen police investigative capacity, reinforce internal disciplinary measures, and establish permanent accountability mechanisms for the police • Create accessible, anonymous reporting channels for whistle-blowers that genuinely protect them from all forms of retaliation

Progressive fiscal policy is critically important to improving health equity. Monetary policy, social protection spending and tax systems should aim to be redistributive and designed to progressively improve the standard of living of, and provide essential services for, communities and populations most at risk of poor outcomes. In many areas of fiscal policy this currently is not the case—pension policy can be regressive when government subsidies for pensions are available only to those in formal employment, excluding unemployed people and people in informal employment. In many countries, tax and benefit systems are regressive: the wealthier pay less in taxes proportionate to their wealth than the poorest.

Across the region, many countries have retreated from involvement in provision of services, and private sector provision has replaced government provision. However, public goods are not always best delivered by markets, and private sector provision often worsens inequities in access to essential quality services. Public investment in education, research and development, health, infrastructure and many other essential services is vital for a flourishing, healthy society.

Greater political accountability could help, and people actively participating in democratic governance to enable a flourishing public realm supports good health. Without this, political and economic accountability will be undermined (40, 42).

Corruption and tax avoidance blight efforts to reduce economic and social inequalities. Multinationals use tax havens to avoid paying tax in many countries. Individuals move money around to avoid paying tax, or do not declare income and assets. National economies lose resources to invest in communities most at risk of poor health and other negative outcomes.




RECOMMENDATION 2.

PROTECTING THE NATURAL ENVIRONMENT, MITIGATING CLIMATE CHANGE, AND RESPECTING RELATIONSHIPS TO LAND

Environmental threats commonly have a stark equity dimension: socially disadvantaged people are disproportionately affected by environmental degradation and climate change (43). Experience shows that environmental shocks and extreme natural events become disastrous for disadvantaged people (44). It is important to ensure that actions aimed at mitigation and adaptation to climate change do not have adverse impacts on health equity. Land and land rights play a vital role in enabling people to lead flourishing lives and environmental justice must be central to development (45, 46).

PRIORITY OBJECTIVES	ACTIONS
2A. MITIGATE AND ADAPT TO CLIMATE CHANGE TO SUPPORT HEALTH EQUITY	<ul style="list-style-type: none"> • Transfer fossil fuel subsidies to incentivize development and use of renewable energy • Improve preparedness for, and response to, extreme weather events to reduce health inequities • Abide by the Paris Agreement on climate change and the relevant SDGs • Ensure the role of the private sector in innovation as part of the solution to environmental protection and mitigation of climate change
2B. MINIMIZE ENVIRONMENTAL HARM FROM RESOURCE EXTRACTION INDUSTRIES AND AGRICULTURE	<ul style="list-style-type: none"> • Protect biodiversity for soil health and healthy ecosystems • Develop and enforce regulations over extractive and agricultural industries to minimize environmental and health damage
2C. ENACT POLICIES THAT PROTECT AND SUPPORT THE RELATIONSHIP OF INDIGENOUS PEOPLES TO THE LAND AND MAKE PROGRESS IN ATTAINMENT OF LAND TENURE FOR MARGINALIZED COMMUNITIES	<ul style="list-style-type: none"> • Respect and affirm the distinct relationship between Indigenous peoples and the land • Include people of African descent and Indigenous communities in decisions and actions that affect their land • Establish mechanisms and legislation for formalizing occupation and tenure of inhabitants living in informal settlements

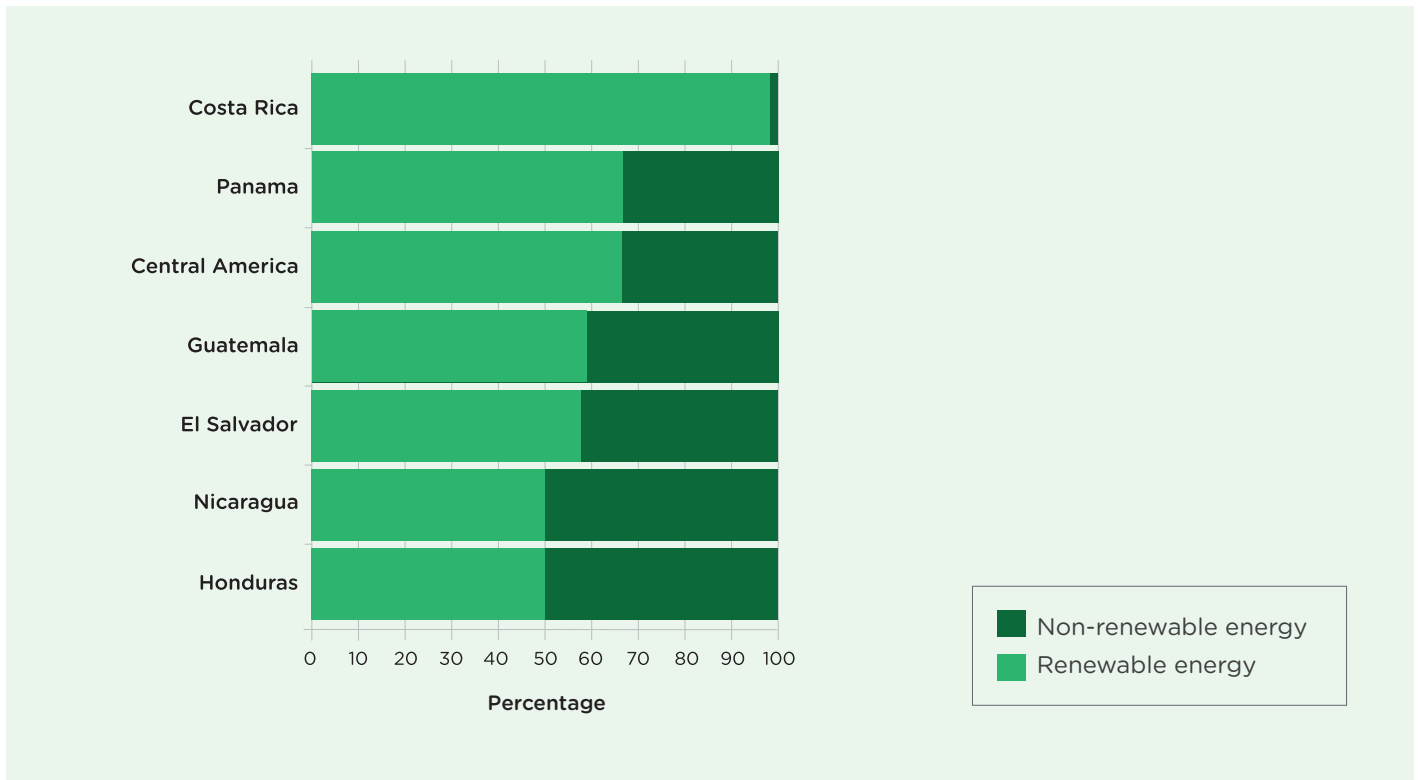


The first principle of the agency charged by the UN with addressing climate change, is protecting ‘...the climate system for the benefit of present and future generations of humankind, on the basis of equity’ (47).

Unsustainable development, and particularly climate change, increases the risk, the severity and the vulnerability of people and ecosystems to harm that will damage health and wellbeing. Climate change is one dimension of unsustainability; others include: ignoring resource limitations, threatening biodiversity and soil health, and polluting and damaging life-sustaining ecosystems. Decreasing these environmental risks will be good for both average health and wellbeing, and for flattening the socioeconomic gradient, as each affects poorer people and communities most.

Development of renewable energy across the region is necessary; it is currently underdeveloped in many countries (Figure 3.1). A notable exception is Costa Rica, where energy is produced almost entirely from renewable sources.

FIGURE 3.1. ENERGY GENERATION MIX, CENTRAL AMERICA 2016



Source: Economic Commission for Latin America and the Caribbean (ECLAC), from official figures (48).

A common factor to all forms of land degradation is the depletion of soil and the reduction of biodiversity. Fertilizer use per hectare has intensified in Latin America and there has been a dramatic increase in the intensive use of pesticides. Vast tracts of forested area have been lost in Latin America and the Caribbean; approximately 100 million hectares between 1990 and 2014 (49). Parts of Latin America and the Caribbean have high rates of desertification. The UN International Fund for Agricultural Development estimates that 50 percent of agricultural land in LAC will be subject to desertification by 2050.

Many Indigenous communities across the region live and adhere to sustainable environmental practices that balance people and environments, with a strong focus on protecting the earth and consideration of future generations. However, expansion of agriculture and resource extraction into the lands of Indigenous peoples is causing displacement of these populations from lands where they have lived for centuries as well as environmental degradation. This, in turn, creates and compounds health inequities.



EXAMPLE ACTIONS TO IMPROVE ENVIRONMENTAL CONDITIONS AND REDUCE USE OF NON-RENEWABLE ENERGY

Canada

- The federal government will deliver on its commitment of C\$2.65 billion by 2020, to help the poorest and most vulnerable countries mitigate and adapt to the adverse effects of climate change.
- The province of Alberta has committed to end emissions from coal-fired electricity and replace it with 30 percent renewable energy by 2030.
- The off-grid community of Ramea in Newfoundland and Labrador host the Ramea Wind-Hydrogen-Diesel Energy Project, one of the first projects in the world to integrate power generation from wind, hydrogen and diesel in an isolated electricity system.

Costa Rica

- The country has set itself the target of being carbon-neutral by 2021 and in 2016 achieved over 300 consecutive days of energy produced entirely from renewable sources. The government announced new measures to protect 340,000 hectares of forest in a move to become the first country to negotiate the sale of forestry carbon credits.

RELEVANT PAHO RESOLUTIONS

CD55.R10: Plan of Action for Disaster Risk Reduction 2016–2021

CD51.R15: Strategy and Plan of Action on Climate Change

CSP28.R19: Coordination of International Humanitarian Assistance in Health in Case of Disasters

RECOMMENDATION 3.

RECOGNISE AND REVERSE THE HEALTH EQUITY IMPACTS OF ONGOING COLONIALISM AND STRUCTURAL RACISM

Throughout the Americas, colonialism, slavery, and attendant racism have been catastrophic for people’s life chances and health, especially for Indigenous peoples and those of African descent. Their manifestations and effects persist today.

PRIORITY OBJECTIVES	ACTIONS
3A. ACT TO ADDRESS THE PHILOSOPHY, CULTURE, POLICIES, AND PRACTICES THAT FLOW FROM HISTORIC AND CURRENT COLONIALISM	<ul style="list-style-type: none"> • Include people of African descent and Indigenous communities in law-making, service design and provision and other decisions that affect their lives • Improve disaggregated data collection and include input of Indigenous people and people of African descent in research to define problems and solutions • Ensure people of all ethnicities have equitable access to public services that contribute to health equity, and that the spend on services is equitable
3B. ENSURE PEOPLE OF AFRICAN DESCENT AND INDIGENOUS PEOPLES ARE FREE TO LIVE DIGNIFIED LIVES, INCLUDING THROUGH AFFIRMATION OF THEIR DISTINCT RIGHTS	<ul style="list-style-type: none"> • Recognize spatial, cultural, social, and intergenerational inequalities as a human rights issue for all ethnic groups • Governing entities to recognize and be accountable for the distinct rights of people of African descent and abide by the tenets of the UN International Decade for People of African Descent • All states to codify the UN Declaration on the Rights of Indigenous Peoples (UNDRIP) into domestic legislation, policies and practices, ensuring peoples have the resources and opportunities necessary to exercise the full enjoyment of their rights
3C. UNDERTAKE POSITIVE MEASURES TO ADDRESS SYSTEMATIC RACISM	<ul style="list-style-type: none"> • Address racism through public education including in government, civil society and schools • Review existing legislation, policies and services to identify and redress activities that perpetuate racism • Develop and support effective and independent domestic and inter-American mechanisms to address cases of systemic and individual discrimination • Governments should endorse the UNDRIP position affirming that Indigenous peoples are equal to all other peoples, while recognizing the right of all peoples to be different, to consider themselves different, and to be respected as such

Indigenous peoples worldwide are more likely to be poor and to live in deeper levels of poverty than non-Indigenous peoples, due to the pervasive effects of colonialism (50). The poverty trend is apparent even in wealthy countries in the Americas. For example, in Canada, over 60 percent of children living on First Nations reserves live in poverty compared with 18 percent for all children (51).

Across the region, similar problems apply to people of African descent. In 2016 the Brookings Institute reported that in the US in 2000 the median black household had an income that was 66 percent of the median white household income. In 2015 that figure was 59 percent.

The combined effect of colonial practices has been to dismiss Indigenous self-determination over lands, resources, law and governance, and disrupt (and in some cases eradicate) Indigenous cultures, languages and oral histories, while ingraining multi-generational trauma.

Decolonization requires a change in the structures and in the philosophy, policies, and practices that flow from colonialism. An important effect or indeed intentional mechanism of colonialism that reinforces inequality is the mental construction of colonialism that supposes the superiority of one race over the others. This attitude translates into exclusionary actions for reasons of race and origin, whether by action or omission.

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) centers Indigenous peoples' rights to self-determination as a fundamental right and a necessary antecedent for the restoration of land and resource rights and the full enjoyment of human rights.

PAHO's resolution for Health of the Indigenous Peoples in the Americas (CD47.R18 [2006]) resolves to strengthen evidence-based decision-making and monitoring capacities in the region on Indigenous people's health issues (52).

Most countries have some government mechanism for the promotion of racial equality or for Afro-descendant affairs. However, experience reveals weaknesses in these mechanisms, which, added to their limited resources, slows the possibilities of implementing actions to progress the guarantee of the rights of people of African descent.

The UN General Assembly in its resolution 68/237 proclaimed the International Decade for People of African descent (2015–2024), with the theme 'People of African Descent: recognition, justice and development'. The Decade is an opportunity to underline the important contribution made by people of African descent and to propose concrete measures to promote equality and to combat discrimination of any kind (15).

Other key milestones for action against discrimination of people of African descent in the Americas are the Inter-American Convention against Racism, Racial Discrimination and Related Forms of Intolerance (53) and the Inter-American Commission on Human Rights' report on the situation of people of African descent in the Americas (54).



EXAMPLE ACTIONS TO REDUCE RACIAL AND ETHNIC INEQUALITIES AND DECONSTRUCT ONGOING COLONIALISM AND RACISM

Affirmative actions: These have been implemented mainly in the field of education and the labor market. Experience shows that, maintained over time, these actions have excellent results (54).

- In **Brazil** the policy for the entry of youths of African descent to universities showed a significant reduction in ethnic-racial inequality in income in the period 2004–2014.
- In 2009 **Ecuador** assured access to public positions in government for Afro-Ecuadorians, in proportion to their population.
- **Colombia** established the fund for loans for Afro-Colombian students with limited economic resources and good academic performance in 1996.
- In 2003 **Brazil** established quotas for Afro-descendant students (40 percent).
- In 2005 **Venezuela** established scholarship quotas for Afro-descendant youths in training and professional institutes.
- In 2005 in **Bolivia** the Ministry of Education granted 20 percent of the existing annual quotas in teacher training for secondary schools to Indigenous and Afro-Bolivian peoples without an entrance examination.

United States–Honoring Nations (55): An awards program that identifies and shares examples of outstanding tribal governance that demonstrate the importance of self-governance. Honoring Nations upholds the principle that tribes themselves hold the key to positive social, political, cultural, and economic prosperity—and that self-governance plays a crucial role in building and sustaining strong, healthy Indian nations.

Jordan’s Principle: In Canada, Jordan River Anderson from Norway House Cree Nation spent over two years unnecessarily in hospital as different levels of Canada’s government argued over payment for his at-home care because he was First Nations. Jordan died never having left hospital. Jordan’s Principle is named in his memory and ensures First Nations children can access all public services without discrimination (56). It passed in the House of Commons in 2007 but it took another 11 years and four legal orders before the Canadian government began to implement it (57, 58).

4. CONDITIONS OF DAILY LIFE

People in the Americas want the basic everyday things that enable them to live reasonable, dignified lives. This includes control over their reproductive and sexual lives; good maternity services; a good start in life for their children, including good health and quality early-child development; a good education that gives their children skills and life chances; decent work that promotes, not harms, health; conditions that allow older people to live lives of dignity and independence; to have enough money to live on; to live in a cohesive environment without threat of violence; to have safe and reasonable housing with clean water and sanitation; and to have access to health care that supports health as well as treats ill health.

Achieving these conditions will also be a major contribution to a flourishing, well-organized, secure and productive society. But access to these necessities is unequally distributed and a major contributor to health inequities. Without them the goal of living a life of dignity will be unachievable.



RECOMMENDATION 4.

EQUITY FROM THE START—EARLY LIFE AND EDUCATION

Child survival is paramount, but so too is the quality of early child development. A good start in life leads to better health and wellbeing in later life. It is during pregnancy, birth, and childhood that the foundations of greater health equity are laid.

PRIORITY OBJECTIVES	ACTIONS
4A. ENSURE GOOD MATERNAL AND CHILD HEALTH AND OPTIMAL NUTRITION	<ul style="list-style-type: none"> • Increase access to modern contraception, including for young adolescents, and to safe abortion • Extend pre- and post-natal care services for those most at risk of poor outcomes • Improve adherence to WHO guidelines on breastfeeding and child and maternal nutrition, with a focus on poor and rural communities • Introduce programs to provide nutrition, for low-income families • Provide financial and social support for low-income families, including extension of successful Conditional Cash Transfer schemes
4B. SUPPORT GOOD EARLY CHILD DEVELOPMENT	<ul style="list-style-type: none"> • Increase and rebalance public funding so that more is invested in pre-primary and primary education and development • Expand access to good quality culturally-appropriate early-years programs with focus on reducing inequalities in participation • Adopt and meet international Children’s Rights obligations, including taking effective positive measures to ensure the full enjoyment of rights by Indigenous, African-descent and disabled children
4C. REDUCE INEQUITIES IN COMPLETION OF SECONDARY EDUCATION	<ul style="list-style-type: none"> • Build on improvements to primary education participation, ensuring all young people in the region complete quality secondary education • Expand Conditional Cash Transfer (CCT) schemes supporting children to stay in secondary education • Introduce comprehensive sexuality education in all secondary schools • Drive forward education reforms improving quality in secondary education, ensuring teachers have sufficient skills and qualifications



Inequalities in maternal and babies' health, and experiences in the early years and schooling, relate directly to inequalities in a range of later life outcomes, including health. Fundamental to achieving equity in this period is reducing social and economic inequality (see Priority Objectives 1A, 1B and 1C) which leads to profound social, economic, gender, and ethnic inequalities in health and development. There are, in addition, specific actions that can be taken. These include access to contraception, ante- and post-natal care, and to safe abortion. We place particular emphasis on increasing breastfeeding and child nutrition, the impacts of which are felt throughout life. The early period of life is critical for initiating and inheriting parents' trajectories of inequality but is also the period where these inequalities can be most effectively disrupted and reduced.

The Americas region has made progress, particularly in relation to reducing maternal and infant mortality and improving access and equity in primary education. However, profound inequalities related to socioeconomic position, ethnicity and disability remain and, in some cases, have widened, particularly for secondary education.

RELEVANT PAHO RESOLUTIONS

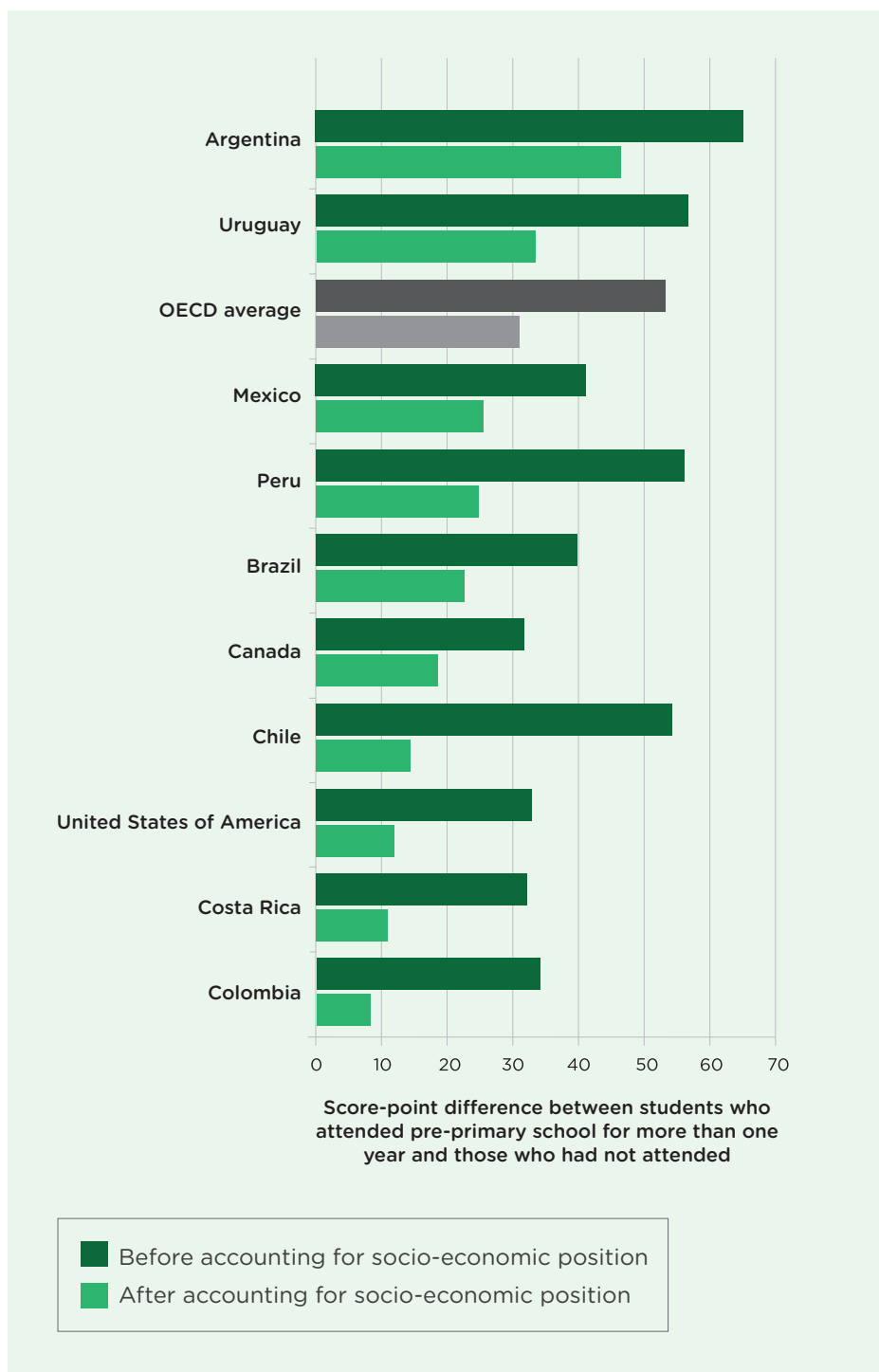
CD53.R13: Plan of Action for the Prevention of Obesity in Children and Adolescents

CSP28.R20: Strategy and Plan of Action for Integrated Child Health

In Latin America and the Caribbean, 43 percent of children live in households that have less than 60 percent of the median income, nearly double the percentage of adults generally (24 percent). The United States has similar child poverty rates to Mexico and Chile and considerably higher child poverty rates than the OECD 37-country average. Children in the bottom income decile in Canada live in families where the income is 53 percent lower than for the average child, while income inequality has increased and the rate of child poverty has persisted.

Good quality pre-primary education is an important way to improve educational attainment and participation and hence to reduce inequalities in health and improve other social and economic outcomes, such as employment and income, with effects throughout life. To illustrate this importance, Figure 4.1 shows the score-point difference in mathematics performance between students who reported that they had attended pre-primary school for one year or more, and those who had not attended pre-primary school, after accounting for socioeconomic status (59). The latter is important, because in most countries children from poorer households, who might benefit the most, are less likely to attend pre-school.

FIGURE 4.1. DIFFERENCE IN MATHEMATICS PERFORMANCE AT AGE 15 BY ATTENDANCE AT PRE-PRIMARY SCHOOL FOR ONE YEAR OR MORE, BEFORE AND AFTER ACCOUNTING FOR SOCIOECONOMIC STATUS. COUNTRIES IN THE AMERICAS PARTICIPATING IN THE PISA SURVEY, 2012



Source: OECD, PISA 2012 Database, Table II.4.12. (60)

Across the region, much progress has been made toward achieving universal access to good quality primary education. Universal participation and attainment levels in secondary education have not seen the same levels of investment, focus or improvements, and profound, inequalities persist. These are closely related to socioeconomic position, parental levels of education, ethnic identity, gender, disability status, and rural residence.

Indigenous women have the lowest rates of secondary school attendance across the region and women of African descent also have particularly low rates of school completion. In all countries children with disabilities have significantly lower completion rates than non-disabled children.

RELEVANT INTERNATIONAL AGREEMENTS

PAHO RESOLUTIONS

CD49.R14: Plan of Action on Adolescent and Youth Health

CD48.R5: Regional Strategy for Improving Adolescent and Youth Health

RELEVANT SUSTAINABLE DEVELOPMENT GOALS

Goal 4 refers to provision of free, equitable and quality primary and secondary education and equal access to affordable tertiary education and training.

THE CONVENTION ON THE RIGHTS OF THE CHILD

Article 28 states that ‘Every child has the right to an education. Primary education must be free and different forms of secondary education must be available to every child.’

EXAMPLES OF SUCCESSFUL MATERNAL HEALTH AND NUTRITION POLICIES AND PROGRAMS

- Women who received nutritional supplements in Mexico, Colombia and Nicaragua during childhood increased their educational attainment by one full grade and increased the likelihood of completing primary and some secondary school (61).
- Programs aimed at improving maternal health and supporting families were important for reducing social inequalities in women's health across the region, improving a range of other life chances, and for promoting greater gender parity (62).

EXAMPLES OF SUCCESSFUL PRE-PRIMARY AND CHILD POVERTY PROGRAMS AND APPROACHES

- Early years programs in Latin America and the Caribbean combining several strategies (parenting practices, early childhood care, nutrition) have had positive effects on language acquisition, reasoning, and schooling (61).
- Head Start in the United States had positive long-lasting effects on participating children, as documented by test scores, high school completion rates, and college attendance (63).
- Attending pre-primary school improved test scores for students from poor backgrounds twice as much as for students from higher-income families in Chile (64).
- Participation in Bolsa Familia (CCT) in Brazil was associated with reductions in child mortality (62).

EXAMPLES OF SUCCESSFUL EDUCATION PROGRAMS AND POLICIES

- Educational reforms in Latin America and the Caribbean that increased access for boys and girls and reduced the rates of early leavers, had positive effects on test scores for the poorest students, and for those with mothers with low educational attainment (61).
- Proyecto Integral de Desarrollo Infantil (The Child Development Comprehensive Plan) in Bolivia (1993 to 2000) is an example of a program that expanded coverage and improved the quality of child development provision. It had a positive effect on the test scores of the poorest students born to mothers with the lowest levels of educational attainment (61).

RECOMMENDATION 5.

DECENT WORK

The transition from school to work, the quality of working life, and the nature of employment contracts are all important determinants of health. The concept of a decent job is foundational and must be spread to those currently not in formal work. Work is essential to relieving poverty and creating opportunities for human flourishing.

PRIORITY OBJECTIVES	ACTIONS
5A. IMPROVE ACCESS TO DECENT JOBS AND CONDITIONS AT WORK, INCLUDING FOR PEOPLE IN INFORMAL AND DOMESTIC LABOR SECTORS	<ul style="list-style-type: none"> • Governments to regulate employers to meet International Labour Organization (ILO) conventions (65) and provide decent jobs • Governments to formalize informal work and ensure those jobs meet ILO standards for decent jobs, especially in relation to ILO convention 189 on domestic workers (66) and SDG 8.7 (6) • Develop and implement legislation that requires minimum standards for safety and ensure these are upheld • Develop and implement standards for work stress, working hours, holidays, and management practices • Allow and support the development of unionization - including in the informal sector • Reduce child labor through protecting and ensuring rights of the child • Develop and implement minimum wage policies to reduce in-work poverty
5B. SUPPORT UNEMPLOYED PEOPLE THROUGH ACTIVE LABOR MARKET PROGRAMS AND SOCIAL PROTECTION SYSTEMS	<ul style="list-style-type: none"> • Reduce rates of young people not in employment, education or training, especially women of African descent and Indigenous people • Institute active labor market programs • For countries with limited social protection coverage of unemployment, increase length of time support is available and ensure that the self-employed are covered
5C. REDUCE GENDER INEQUALITIES IN ACCESS TO WORK, PAY, AND SENIORITY	<ul style="list-style-type: none"> • Strengthen legislation and regulation to ensure gender equity in employment • Achieve SDG 5 on gender equality and empowering all women and girls • Develop effective systems for monitoring gender equity in employment • Support cultural shifts in gender equity, including holding employers accountable for gender differentials in employments rates, pay and seniority

Across the region there are profound inequalities between ages 16 and 65, a life-course stage during which people are working, family-building and caring for older relatives. Some of these inequalities relate to earlier life inequalities, in education and training, and some are generated during this phase of life. All of them have profound implications for health inequities.

The term *decent work* sums up the aspirations of people in their working lives. It involves opportunities for work that is productive and delivers a fair income, security in the workplace and social protection for families, better prospects for personal development and social integration, freedom for people to express their concerns and organize and participate in the decisions that affect their lives, and equality of opportunity and treatment for all women and men (67).

RELEVANT INTERNATIONAL AGREEMENTS

ILO Convention 189 sets a minimum age for domestic workers, guarantees the right to freedom of association and freedom from all forms of abuse, harassment and violence, and makes special provisions related to migrant workers (71).

SDG Target 8.7 highlights the need to take immediate and effective measures to eradicate forced labor, end modern slavery and human trafficking, secure the prohibition and elimination of the worst forms of child labor, including recruitment and use of child soldiers, and by 2025 end child labor in all its forms (6).

DECENT QUALITY WORK

Working an excessive number of hours can be damaging for physical and mental health and wellbeing, and for work-life balance, interaction with children and levels of community participation. In most countries in the Americas employees work more than eight hours per day.

In some countries in the region there are relatively high levels of fatal occupational injuries, with rates reaching approximately 8 fatal injuries per 100,000 a year. The actual numbers may be higher, as there is likely to be under-reporting or inadequate monitoring systems. Rates among migrant workers are higher than the average for countries (68).

There are many studies linking psychosocial stress at work with poor health outcomes (69). A recent systematic review looked at the empirical studies conducted in Latin America assessing the association of psychosocial stress at work and health using the Effort-Reward Imbalance model. It found that there is evidence from a range of countries, settings, and methods supporting the association between work stress and poor health (69).

INFORMAL LABOR, DOMESTIC WORKERS AND OTHER GROUPS OF WORKERS AT-RISK

Informal labor includes work without contract, with no security or guarantee of employment or income, no employer-provided social protection such as sick pay, and no legal protections. It is a risk to health and health equity.

There are high rates of informal labor in Latin America and the Caribbean, particularly among women. In Guatemala, Bolivia, Peru, and Paraguay employment outside the formal sector constitutes 70 percent or more of the total employed (5, 70).

Domestic work is undervalued, poorly remunerated and mainly carried out by women and girls, many of whom are migrants, people of African Descent or members of disadvantaged communities (33, 5).

CHILD LABOR

The Americas is the region with the third highest burden of child labour in the world. Boys are more likely to undertake child labor than girls and perform a higher proportion of the most hazardous work. Child labor is detrimental to health, removes children from full-time education and often results in the child's separation from their family and community (72).

MIGRANT WORKERS

In 2013, North America as a broad sub-region had the world's highest share of migrant workers at 25 percent. Migrants often depend on the most dangerous, insecure types of work and have no formal protections.



UNEMPLOYMENT

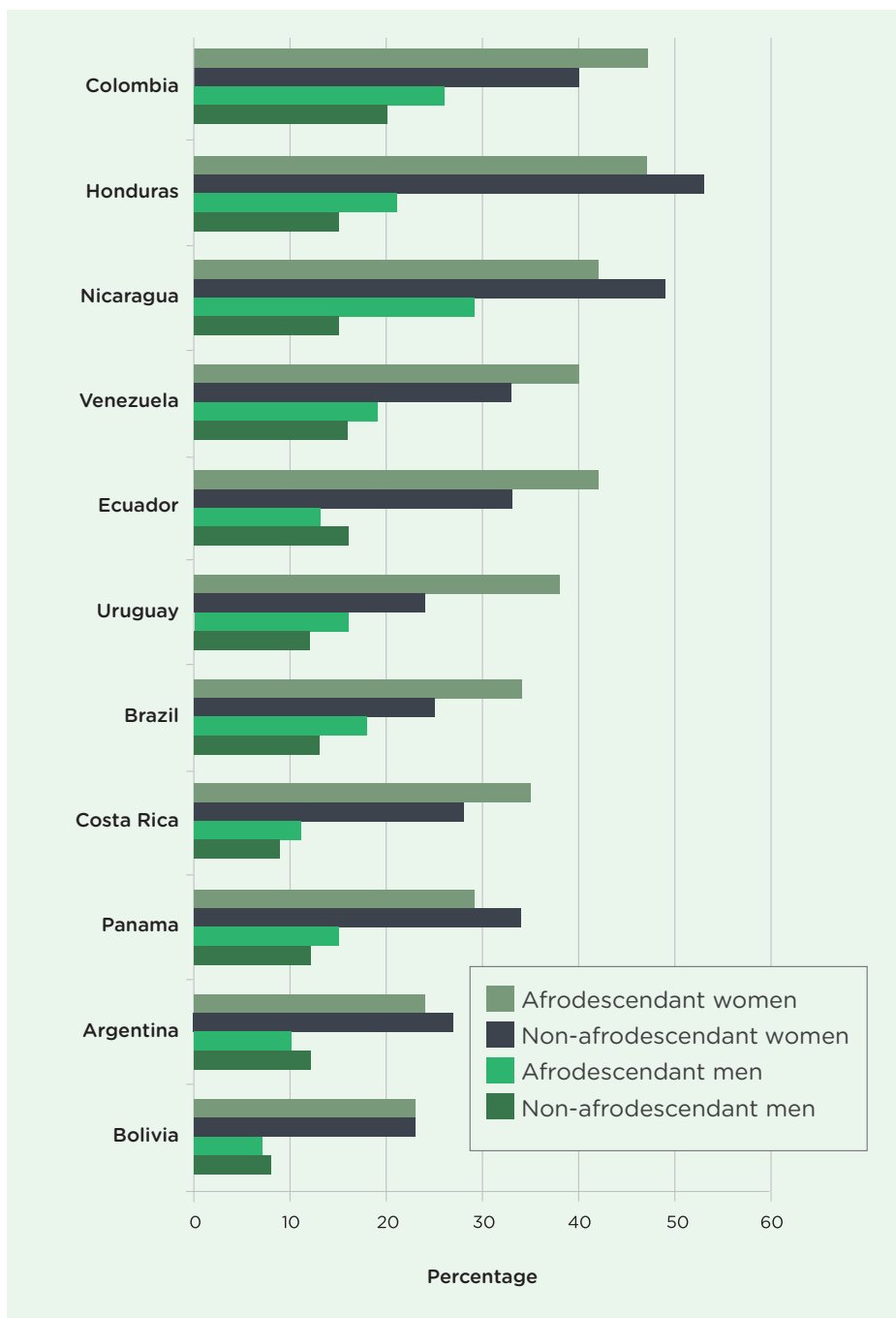
Long-term unemployment and job insecurity are damaging to health. There are clear inequalities in rates of unemployment and poor-quality employment related to socioeconomic position, gender, ethnicity, and disability status. Men and women from less educated and more deprived areas are more likely to be unemployed, working in unsafe, unregulated occupations, and outside formal employment.

In the United States, Native Americans have the highest rates of unemployment, followed by African Americans and Hispanics. In most countries in the region any government unemployment assistance is time-limited, and in many countries there is no government assistance during unemployment. The ILO has estimated that if there were a 25 percent reduction in the gender employment gap by 2025, it would increase GDP in Latin America and the Caribbean by four percent and in Canada and the United States, by two percent (5).

THOSE NOT IN EMPLOYMENT, EDUCATION OR TRAINING

Across the region, women are more likely than men not to be in education, employment or training. In most countries in the region, but not all, women of African descent are the group most likely not to be in employment or education. Native Americans also have the highest percentages of young people not in formal training or in work (73).

FIGURE 4.2. YOUNG PEOPLE AGED 15 TO 29 YEARS WHO ARE NOT IN EDUCATION OR EMPLOYED IN THE LABOR MARKET, BY AFRICAN DESCENT IDENTITY AND SEX. LATIN AMERICAN COUNTRIES WITH COMPARABLE DATA, 2012 OR LATEST AVAILABLE



Source: Adapted from the Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special processing of census micro databases using REDATAM 7. **Note:** The non-African descent population does not include people who self-identify as Indigenous or whose ethnic-racial status is unknown (35).

IN-WORK POVERTY AND PAY GAPS

For many people in the region, being employed is no guarantee of being lifted out of poverty as wages are too low. There is wide variation across the region in levels of poverty for employed people. In Costa Rica less than one percent of those in work are recorded as being in poverty, while figures for Haiti are 31 percent among women and 25 percent among men. Since it was first instituted in 1938 to protect workers from in-work poverty, the federal minimum wage in the United States has established a floor for wages. While not every worker is eligible, it provides a minimum of earnings for the lowest-paid workers. However, despite some recent increases in state minimum wages, minimum wages at the federal and most state levels are still below the peak of its real value in 1968 and are in decline (74).

RELEVANT PAHO RESOLUTION

CD54.R6: Plan of Action on Workers' Health 2015-2025 (79)

EXAMPLES OF SUCCESSFUL PROGRAMS AND POLICIES TO IMPROVE CONDITIONS DURING WORKING LIFE

Active labor market programs (ALMPs)

ALMPs have been implemented in the US since the 1960s and 1970s and in Latin America and the Caribbean since the 1990s. ALMPs are found to be more effective among those in long-term unemployment (75).

Jovenes program, Chile

This program has been effective in increasing employment chances for women and in causing some increases in earnings and job quality (76).

Unionization

There is evidence that unionization is associated with higher wages. There are other benefits. A 2011 study in Chile showed that nearly three-quarters of unionized women have some form of health insurance, compared to less than half of non-unionized women (77).

Prospera Mexico (previously Oportunidades)

A Conditional Cash Transfer program, which has contributed to a reduction in child labor outside the household, particularly for boys. Studies have shown a 14 percent reduction in children's work time outside the household coupled with more time allocated to school-related chores (78).

RECOMMENDATION 6.

DIGNIFIED LIFE AT OLDER AGES

Older age is no longer an afterthought. It characterizes the present and future of the populations of the Americas, which have the fastest growing population of older people globally. It is estimated that by 2050, approximately 25 percent of the population of Latin America and the Caribbean will be aged 60 years or more. Fulfilling the right to live a dignified life in older age is central to reducing health inequities in the region.

PRIORITY OBJECTIVES	ACTIONS
6A. CREATE CONDITIONS FOR ACTIVE AND ENGAGED AGING, WITH SOCIETY VALUING CONTRIBUTIONS OF OLDER PEOPLE	<ul style="list-style-type: none"> Local government and civil society to create conditions in communities that encourage physical and mental activity and reduce social isolation Develop multi-sector partnerships that facilitate housing, environment and transportation systems, such as ‘age-friendly cities’, which meet older people’s social, economic, health, and mobility needs
6B. INCREASE PROVISION OF PENSIONS THROUGH GOVERNMENT SUBSIDIES, PARTICULARLY FOR THOSE MOST AT RISK OF HAVING NO INCOME IN LATER LIFE	<ul style="list-style-type: none"> Develop and extend non-contributory pensions to ensure coverage of those outside contributory schemes Develop minimum income standards for older people and, for those below the threshold, provide support through pensions and other social protection mechanisms Ensure that pensions and social protection schemes have a particular focus on women, people of African descent and Indigenous people
6C. INCREASE THE FOCUS OF HEALTH CARE SYSTEMS ON PREVENTION AND PROMOTION OF HEALTHY, ACTIVE AGING	<ul style="list-style-type: none"> Develop multi-sector partnerships, including the health care system and civil society, to support prevention and health improvement Ensure appropriate continuity of care between hospitals and communities Support families to care for elderly relatives, including through provision of leave for families

RELEVANT INTERNATIONAL AGREEMENTS

Relevant PAHO Resolutions

CD54.R11: Strategy and Plan of Action on Dementias in Older Persons

CD49.R15: Plan of Action on the Health of Older Persons, Including Active and Healthy Aging

Organization of American States General Assembly resolution, 2016, on the promotion and protection of the rights of older persons (80).

Inequities in older people’s health and wellbeing relate to differences in conditions experienced earlier in the life course, as set out in Recommendations 4 and 5, as well as to conditions in older age covered here.

Societies where older people’s contributions are valued and where older people continue to live active and engaged lives, are healthier with higher levels of wellbeing. Social isolation causes ill health, and social isolation of older people is increasing, related to changing family structures and urban design. There are inequalities in risk of social isolation related to income, education level, physical and mental health, and gender: in later life, men tend to be more socially isolated than women. Evidence shows that keeping socially, physically and mentally active can extend the age at which cognitive decline develops and the age of developing dementia (81). Although the direction of causation is disputed, there is sufficient evidence to support active aging to reduce cognitive decline.

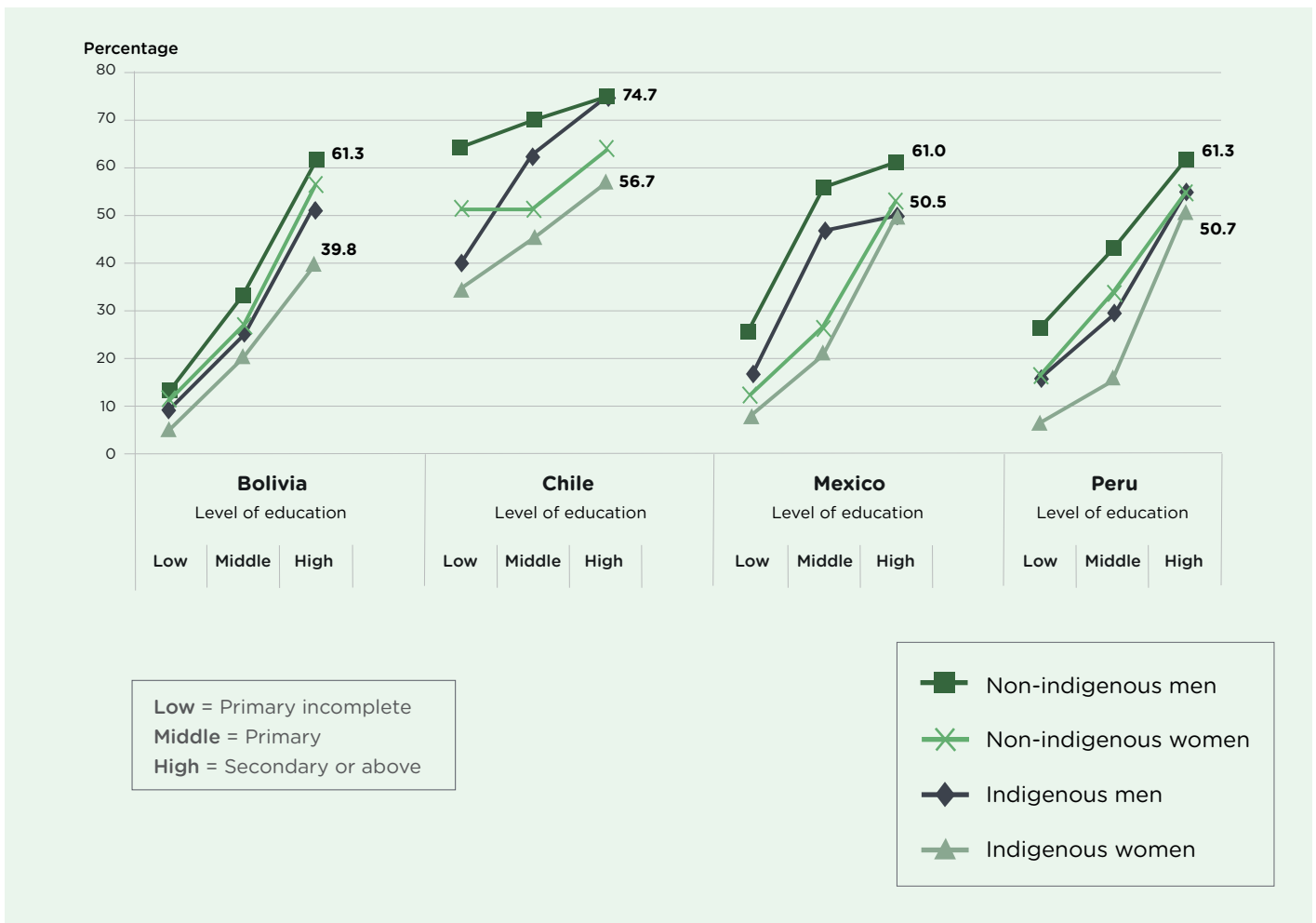
Older people with lower socioeconomic position are more likely to live in poor quality housing and environments that are not conducive to social integration, exercise, mobility or preventing ill health (82).

There are wide inequalities in income and poverty levels in later life, related to earlier life socioeconomic position, gender and ethnicity. For instance, in the US up to 19 percent of older African Americans and 18 percent of older Hispanics live in poverty, compared with an estimated 9 percent of older White Americans (83).

Across the region there are relatively low levels of government support for care and income support for older people. Most pensions are contributory, thus only available to those in secure employment. In Latin America and the Caribbean, only 40 percent of older people receive a pension (5).

Figure 4.3 shows that in four Latin American countries non-Indigenous men have the highest rates of pension coverage, and Indigenous women the lowest. For all groups pension coverage is closely related to education level.

FIGURE 4.3. ADULTS AGED 65 AND OVER IN RECEIPT OF A PENSION, BY SEX, INDIGENOUS IDENTITY AND EDUCATION LEVEL, FOUR LATIN AMERICAN COUNTRIES WITH COMPARABLE DATA, 2014



Source: ECLAC, The social inequalities matrix, 2017 (5)



Across most of the Americas there is no paid leave available to care for elderly parents, with the exceptions of Peru, Nicaragua, El Salvador and Canada. Unpaid leave is available in the United States. Women account for 90 percent of all unpaid care providers and often cut back on paid work to provide care. About 43 percent of caregivers show symptoms of depression and anxiety and a two-fold increased risk of heart disease and injuries compared with non-carers.

Prevention services should be a core part of a health system approach that is aligned with the needs of older people and that focusses on protecting health as well as treating ill health. However, data from the United States shows that even when these preventive services are available, there are significant inequalities related to ethnicity, levels of education and gender in relation to uptake.

EXAMPLES OF SUCCESSFUL PROGRAMS AT OLDER AGES

Education in earlier years

If the United States were to increase expenditure on education and incapacity to the levels of the OECD country with the maximum expenditures, life expectancy there would increase to 80.12 years which would translate to a 0.168 of a year gain (84).

Pension provision

Pension systems have an important role in alleviating old-age poverty—and countries with high levels of coverage are able to eradicate poverty to varying degrees among the elderly. The strongest impact in the region occurs in Brazil: while just under four percent of Brazilians older than 60 are poor, 48 percent of them would be poor if they did not have pensions (keeping other factors constant).

Age-friendly cities

These are city-wide programs, mostly run at municipal level, that prioritize and support active healthy aging, combined with enhanced support for those who need additional support and care. Older people are involved in the development of strategies and implementation of programs.

Programs to support physical and mental activity for older people

In the United States a study showed that following a regular, balanced, moderate exercise program for an average of 2.6 years reduced the risk of major mobility disability by 18 percent in an elderly vulnerable population (85).

RECOMMENDATION 7.

INCOME AND SOCIAL PROTECTION

Not having the minimum income for healthy living is a key driver of health inequity. Many of our recommendations relate exactly to the aim of everyone having enough money to lead a dignified life. Here we list further specific recommendations.

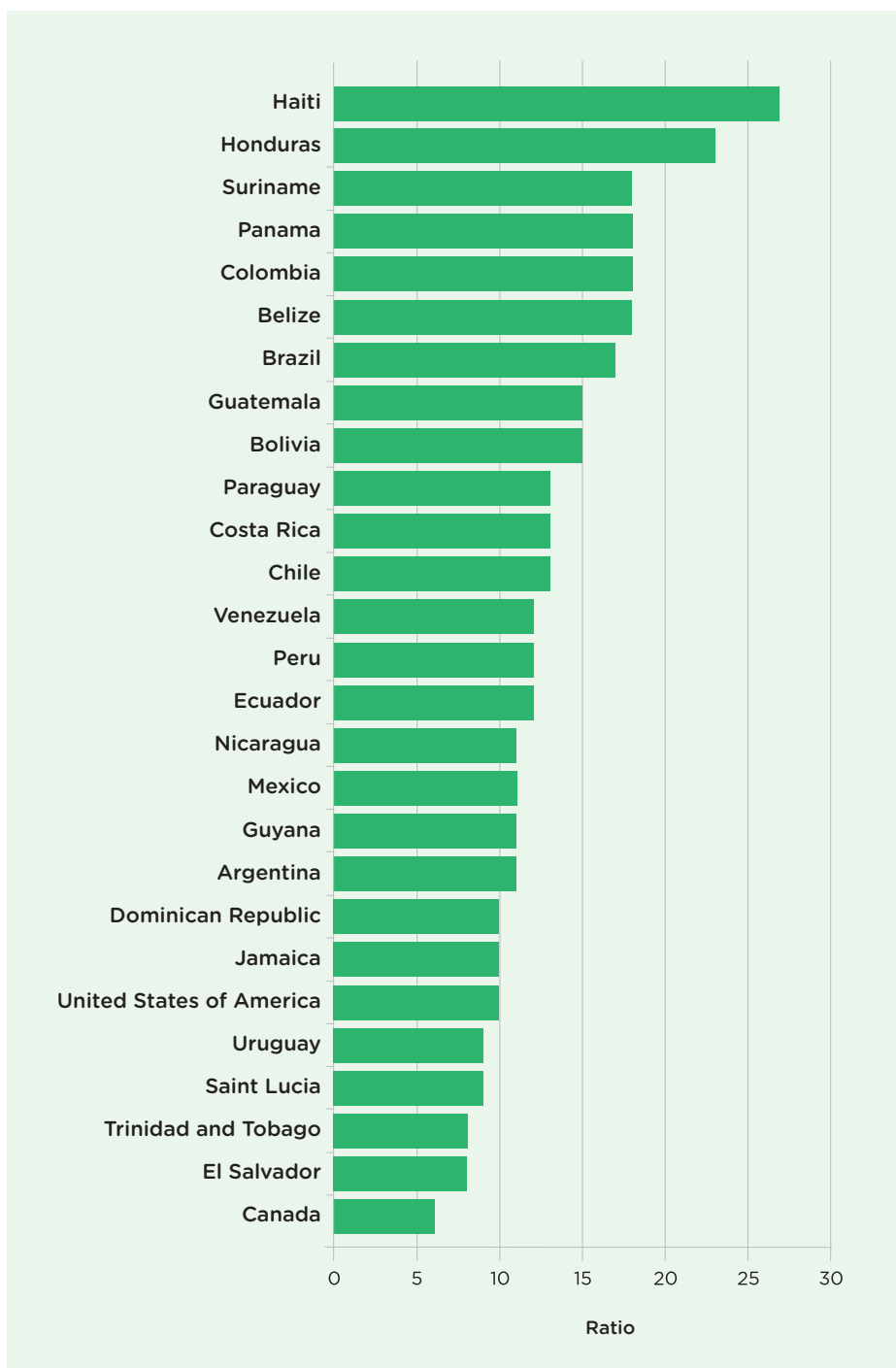
PRIORITY OBJECTIVES	ACTIONS
7A. IMPLEMENT A MINIMUM SOCIAL PROTECTION FLOOR	<ul style="list-style-type: none"> Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable, to achieve SDG 1.3
7B. REDUCE POVERTY THROUGH SOCIAL PROTECTION POLICIES AND OTHER INITIATIVES	<ul style="list-style-type: none"> Protect against unaffordable, out-of-pocket health care expenditure (SDG 3.8.2) through support for health care and through financial support for individuals Develop monitoring systems and other evidence to inform development of progressive policies, with particular regard to those groups currently excluded Build on successful elements of Conditional Cash Transfer schemes to ensure extreme poverty and hunger are eliminated
7C. ESTABLISH SUPPORT FOR UNPAID CARING ROLES	<ul style="list-style-type: none"> Support development of government and employer benefits for those with caring responsibilities

Although levels of extreme poverty have fallen across the region, high levels of poverty remain, and in many countries, poverty is increasing as economies struggle and inequalities widen. The share of national income for the bottom 20 percent varies from 2 percent of national income to 7 percent, with the majority between 3 and 5 percent. An ILO report discusses the universal social protection required to achieve the Sustainable Development Goals (86).

Income inequality is high across the region. Comparing the 80th centile point with the 20th, the ratio is 15 or higher in nine of the countries in Figure 4.4.



FIGURE 4.4. RATIO OF TOP INCOME QUINTILE TO LOWEST QUINTILE [HIGHEST 20 PERCENT/LOWEST 20 PERCENT] IN THE AMERICAS, 2012 OR LATEST PREVIOUS AVAILABLE YEAR



Source: World Bank World Development Indicators (2).

Children are usually the poorest age group in societies. The average rate of destitution in 18 countries in Latin America and the Caribbean for children was 21 percent in comparison with 11.5 percent in adults in 2014 (39). The rates of children in poverty in the United States in 2016 among non-Hispanic whites and Asians and Pacific Islanders was 12 percent while Black or African American or American Indian children had nearly three times the rate at 34 percent (87).

WAGES AND POVERTY

Wage growth in Latin America and the Caribbean has been consistently below the world average, and since 2014 it has been negative. There is considerable scope to implement mandatory minimum wages, although only in the formal sector. This would reduce in-work poverty. Other measures are necessary for those who are unemployed or economically inactive.

INCOME INEQUALITIES RELATED TO GENDER, ETHNICITY AND DISABILITY

Between the ages of 20 and 59, women are overrepresented in the lowest two income quintiles in countries from Latin America and the Caribbean by up to 40 percent compared with men.

Across the Americas average income is lowest for Indigenous populations, followed by people of African descent. In the United States between 1995 and 2015 the median incomes of Asian and white people were higher than that of Hispanic and Black people.

Across the region, people with disabilities earn less than people without disabilities. In Canada, in 2012 persons with disabilities aged 25 to 44 years had 57 percent of the income reported by those without disabilities.

The intersections between disability, gender and ethnicity are apparent in relation to income and poverty rates. In the United States, older women with a disability were more likely than their male counterparts to be in poverty (15 percent for women and 9 percent for men).

SOCIAL PROTECTION SYSTEMS

Social protection systems have a clear and substantial impact on poverty and income inequality, improve educational attainment, improve nutrition, reduce social conflict and improve economic productivity. Social protections have direct and indirect impacts on health inequities and reduce gender and ethnic inequities. These have been outlined in priority objectives and actions in Recommendations 4, 5, 6, 8 and 10.

Effective social protection coverage in the Americas stands at around 67 percent of the population, falling below coverage in Europe and Central Asia where it stands at 84 percent. Despite recent efforts in building comprehensive social protection systems, challenges remain in the provision of universal coverage (39).

There is a divergence in coverage levels between the United States and Canada, and Latin America and the Caribbean. Canada and the United States tend to have higher coverage rates, based on their higher level of economic development and social investment, but in the United States one in four people do not have access to any kind of social protection. In Bolivia and Colombia, 60 percent of the population is still unprotected (5). Between 2000 and 2014, Brazil increased investment in social protection in cash benefits and public services.

BRAZIL: SOCIAL PROTECTION AND CONDITIONAL CASH TRANSFER PROGRAMS (CCTS)

The number of people living below the national poverty line in Brazil declined from 44 million in 2000 to 17.9 million in 2014, and the Gini index declined from 59 to 51.3 over the same period (88).

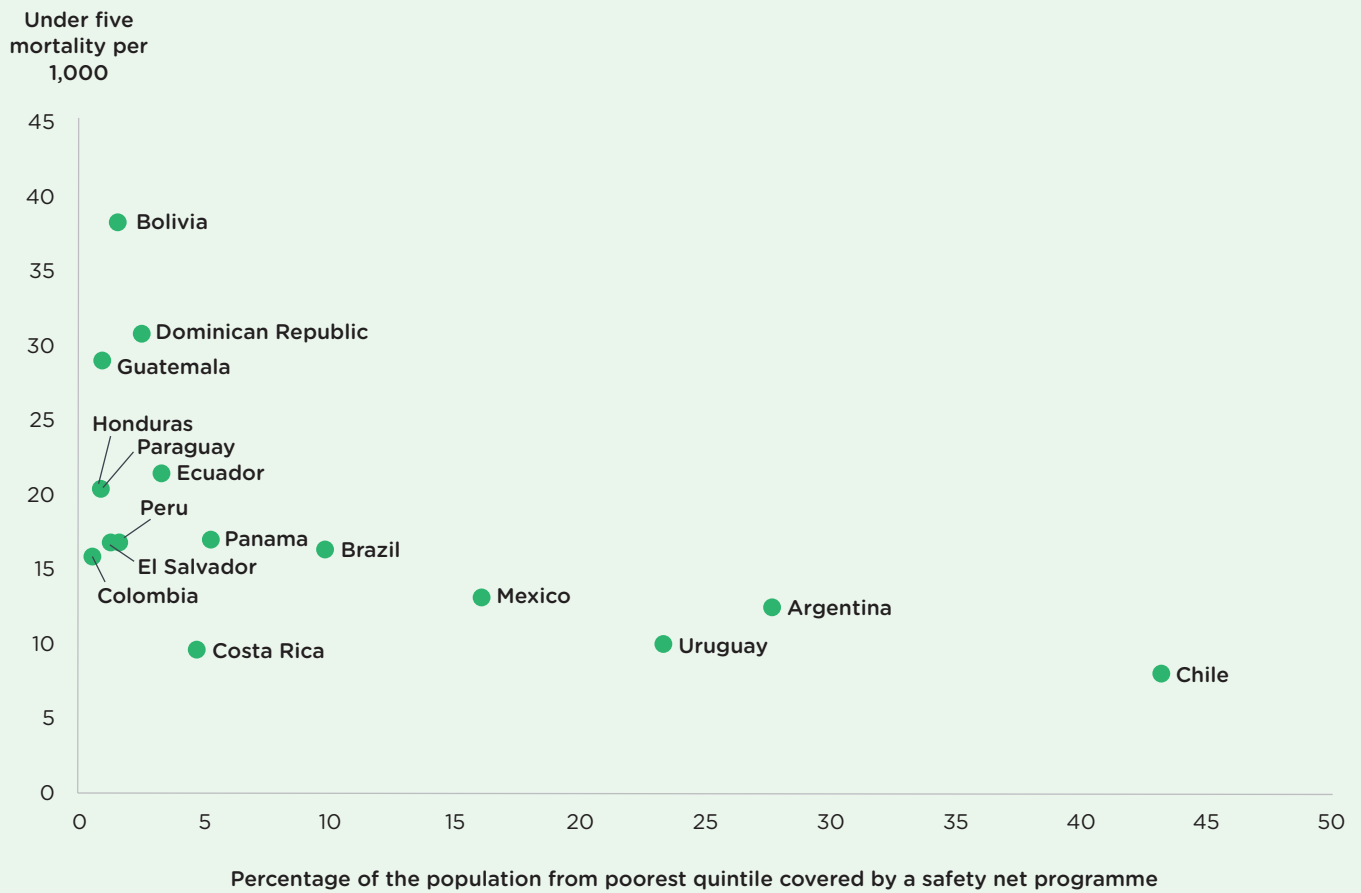
Over this period Brazil invested significantly in social protection and public services. Actions included increasing the minimum wage and public expenditure on health, education and other social services, and extending non-contributory pensions for rural informal sector workers and other disability payments. Conditional Cash Transfer programs have been consolidated and expanded in the form of the Bolsa Familia (Family Allowance Program), targeted at extremely poor households and poor parents with children living at home. In 2010, the Bolsa Familia CCT program covered 12.8 million families, more than 51 million people. The overall cost of non-contributory cash transfers in Brazil is approximately 2.5 percent of GDP.

The Zero Hunger strategy was introduced in 2003 and combined with others in 2011 to form the Strategy to Eradicate Extreme Poverty by 2014, the narrative of which stresses social justice, dignity and rights for the most deprived groups in the population.

The overall effect of these programs was to reduce poverty and inequality among their respective target groups: children, adolescents and pregnant and breastfeeding women

Countries with higher social expenditure aimed at the lowest income quintile had lower under-5 mortality rates than those that spent less on this group (89) – see Figure 4.5.

FIGURE 4.5. UNDER-FIVE MORTALITY RATES BY COVERAGE OF SOCIAL SAFETY NET PROGRAMS IN THE POOREST QUINTILE, COUNTRIES IN THE AMERICAS WITH COMPARABLE DATA, 2014 OR LATEST AVAILABLE



Source: World Bank World Development Indicators, 2018 (2).

The objective of the joint United Nations Social Protection Floor Initiative is to ensure a basic level of social protection and a decent life as a necessity and an obligation under human rights instruments (90). The ILO defines social protection floors as ‘...nationally defined sets of basic social security guarantees that should ensure, as a minimum that, over the life cycle, all in need have access to essential health care and to basic income security which together secure effective access to goods and services defined as necessary at the national level’ (91). In addition, SDG 1.3 specifically refers to meeting social protection floors. Universal social protections include maternity and child support, unemployment protections, sickness protections, disability protections, pensions and access to health care throughout life.

Thirty-three states in the Americas have ratified the International Covenant on Economic, Social and Cultural Rights, which provides that states recognize the right of everyone to social security including social insurance. It emphasizes that this right ‘plays an important role in poverty reduction and alleviation, preventing social exclusion and promoting social inclusion’ (89).

EXAMPLE OF A SOCIAL PROTECTION PROGRAM TO REDUCE POVERTY AND INCOME INEQUALITIES: ARGENTINA

Argentina budgeted for an increase in its social protection function in 2017 to take it up to 12.07 percent of GDP, with plans to maintain and expand various cash transfer programs (such as the universal child allowance and family allowances) and to create a program of historical redress for retirees and pensioners.

RECOMMENDATION 8.

REDUCING VIOLENCE FOR HEALTH EQUITY

Latin America and the Caribbean are home to less than 9 percent of the world's population yet 33 percent of the world's homicides take place here. The highest rates occur in the 15–29 age group. As in other regions, gender-based violence is of great and continuing concern.

PRIORITY OBJECTIVES	ACTIONS
8A. ELIMINATE GENDER-BASED VIOLENCE, ESPECIALLY THAT AFFECTING WOMEN AND GIRLS	<ul style="list-style-type: none"> • Develop education programs in school, community and workplace settings to prevent gender-based violence in schools and at places of employment • Empower women through education and financial independence • For women who have experienced violence, provide protection and support for them and their children to reduce exposure to violence, and reduce femicide • Provide information, education and appropriate punitive arrangements for men who commit violence against women
8B. REDUCE STRUCTURAL VIOLENCE, FOCUSING ON THOSE MOST AT RISK	<ul style="list-style-type: none"> • Institute controls on the availability of weapons, particularly firearms • Improve environmental conditions and safe public spaces, particularly in areas with high crime rates • Improve or create statistical systems to register all forms of violence, disaggregated by indicators of social and economic position, gender, and ethnicity • Implement evidence-based interventions to reduce gang violence
8C. ERADICATE INSTITUTIONAL AND POLITICAL VIOLENCE	<ul style="list-style-type: none"> • Eliminate all forms of political violence, including violence to migrants through separation of families, violation of women, attacks on journalists and on candidates in election processes • Develop information systems to document discrimination in the criminal justice system and hold institutions accountable • Recognize mass incarceration as a determinant of health • Develop and incorporate protocols to care for victims of violence, including sexual, psychological and physical violence, and develop policies on proportionate use of force by institutional workforces

GENDER-BASED VIOLENCE

Gender-based violence includes violence against women, including femicide, as well as intimate partner (IP) violence, sexual harassment, sexual assault and exploitation, violence against LGBTI people and obstetric violence.

There are high rates of femicide in the Americas. Latin America and the Caribbean is the most violent region in the world for women (92). In 2014, rates of violence experienced by women during their lifetime reached 64 percent in Bolivia, the highest in the region; Canada had the lowest rate at 6 percent (93). In 2011 in the United States, 19 percent of women had been raped at some time in their lives, and 44 percent experienced sexual violence other than rape (94). Between 2003 and 2012, approximately one-third of female homicide victims in the United States died at the hands of an intimate partner (37). Disabled women are subject to even higher levels of violence, and in many cases their disabilities are caused by violence (95).

Across the region violence against women is widely accepted and tolerated, including by women themselves (93).

RELEVANT PAHO RESOLUTIONS

CD54.R12: Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women

CD48.R11: Preventing Violence and Injuries and Promoting Safety: A Call for Action in the Region



VIOLENCE AGAINST WOMEN AND THE INTER-AMERICAN CONVENTION ON THE PREVENTION, PUNISHMENT AND ERADICATION OF VIOLENCE AGAINST WOMEN (BELÉM DO PARÁ CONVENTION)

A UN report notes that 24 of the 33 countries in Latin America and the Caribbean have laws against domestic violence, but only nine of them have passed legislation that tackles a range of forms of other violence against women, in public or in private (96). This is in spite of the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women, which established that women have the right to live a life free of violence and that violence against women constitutes a violation of human rights and fundamental freedoms (80).

Lesbian, gay, bisexual, transgender and intersex (LGBTI) people suffer high levels of violence. Gender identity and sexuality-based hate crimes made up about 21 percent of hate crimes reported by law enforcement in 2013 in the United States (97). The Inter-American Court of Human Rights' first report on the rights of LGBTI persons in 2015 highlighted the pervasive violence against LGBTI persons (98).

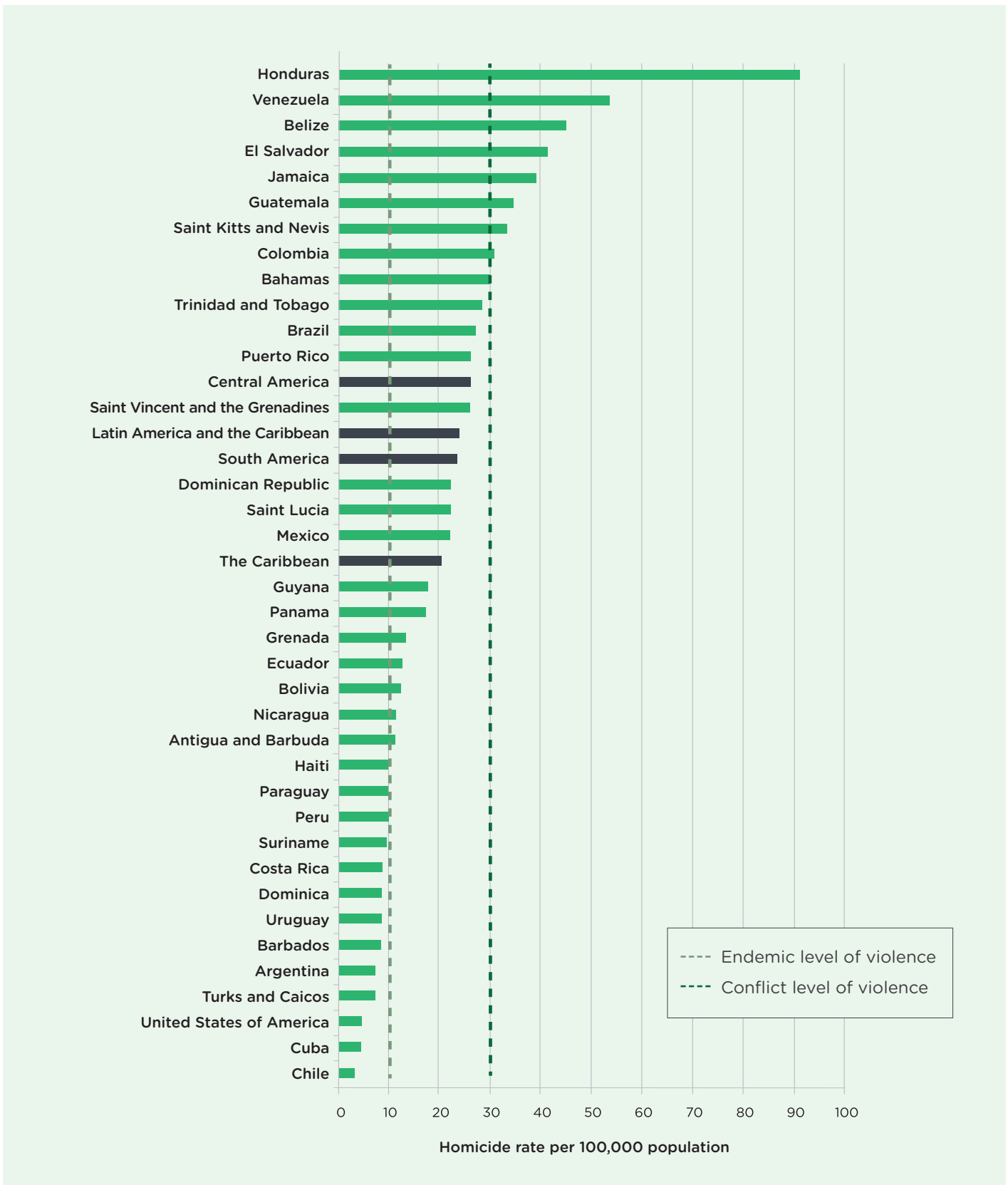
Unsafe abortion can also be considered a form of gender-based violence. There are six countries in Latin America and the Caribbean where abortion is prohibited altogether: Dominican Republic, El Salvador, Haiti, Honduras, Nicaragua, and Suriname. Abortions are permitted only to save the life of the pregnant woman in: Antigua and Barbuda, Brazil, Chile, Dominica, Guatemala, Mexico, Panama, Paraguay, and Venezuela. During 2010–2014, only approximately one in four abortions in Latin America and the Caribbean were safe. In 2014 at least 10 percent of all maternal deaths in Latin America and the Caribbean resulted from unsafe abortion (99).

PATTERNS OF VIOLENCE

There are profound inequalities in violence by ethnicity, socioeconomic position, and gender, which are related to cultural, socioeconomic and political factors, and also result from racism, the drug trade, criminal organizations, and people trafficking.

Figure 4.6 shows the homicide rates for countries in LAC and the United States in 2012. WHO considers a rate of 10 homicides per 100,000 inhabitants or higher to be characteristic of endemic violence and a rate of 30 homicides per 100,000 or higher as conflict levels of violence (100). Several countries have surpassed this 'conflict' level of violence threshold. By contrast the average homicide rate of Scandinavian countries is just under 1 death per 100,000 of the population (101).

FIGURE 4.6. HOMICIDE RATES FOR COUNTRIES IN LATIN AMERICA AND THE CARIBBEAN AND THE UNITED STATES, 2012 OR LATEST AVAILABLE



Source: World Bank, based on United Nations Office of Drugs and Crime (UNODC) data (102).

Young men are disproportionately the perpetrators and the victims of violent crime in the region and compared with other regions, the Americas have the highest male homicide and femicide rates. Honduras, had the highest homicide rate in the region in 2012. Rates of homicide and violence in the region are higher for people of African descent. Central America experienced a declining homicide rate from 1995 to 2004, followed by a marked increase from 2007, related to drug trafficking and high levels of organized crime.

In the United States in 2015, of all homicides (5.5 per 100,000) a high proportion were committed using a firearm (4 per 100,000). The age-adjusted homicide rate for non-Hispanic blacks (22.8 per 100,000) was approximately eight times the rate for non-Hispanic whites (2.9 per 100,000), and four times the rate for Hispanics (5.3 per 100,000) (103). Native American and Alaskan Native persons surveyed were more likely to have been violently victimized in the previous 12 months compared with the rest of the population (104).

INSTITUTIONAL VIOLENCE

Institutional violence is violence by the state, including selective incarceration and selective detention based on migrant status, ethnicity, and socioeconomic position.

Across the region there are high levels of incarceration, and in many cases this incarceration is related to ethnicity. In some countries there are also punitive institutional practices and high levels of political violence. Mass incarceration is likely to damage the health of individuals, families, and communities (105). Police asking for bribes is associated with a 17-percentage point increase in the probability of experiencing some form of crime in Latin America and the Caribbean (106).

EXAMPLES OF ACTIONS TO REDUCE VIOLENCE

Violence against women

- In Peru the introduction of violence prevention and care centers for women has reduced the likelihood of domestic violence (107).
- In Brazil in 2006 the effect of community campaigns targeting young men had positive changes in reducing violence against women (107).
- In Ecuador a cash, food, and voucher program targeting women in relationships decreased sexual violence by 6 percent in 2013 (107).

Education-based interventions

- Good quality schooling and education help prevent crime and reduce homicide rates. A one-year increase in the average education level reduces state arrest rates by 15 percent in the United States (108).
- The 15-year follow-up of the Nurse Family Partnership in the United States showed strong significant positive effects on children's criminal and antisocial behavior (109).
- Lengthening the school day from a half to full day in Chile (in 2011) reduced youth crime.
- Educational workshops held for young men in public schools in Chile showed significant changes on the acceptance of violence as a conflict-resolution mechanism.

Income

- A 2012 study estimated that a Conditional Cash Transfer program in São Paulo, Brazil, led to a reduction in crime of almost 8 percent in the school neighborhood.
- Familias en Acción helped to reduce crime in Colombia, with robberies and car thefts declining by 7.2 percent and 1.3 percent, respectively.

Regeneration

- The physical and social integration of informal urban neighborhoods in Medellín, Colombia may have contributed to a steep decline in homicide rates (66 percent) in intervention neighborhoods.

Policing

- Research in Brazil has found that the integration of police forces' operations leads to increased efficacy and reductions in crime.

RECOMMENDATION 9.

IMPROVING ENVIRONMENT AND HOUSING CONDITIONS

As well as broader issues of environment and climate change, the dwellings, environments and communities in which people live and work are vital for health and health equity.

PRIORITY OBJECTIVES	ACTIONS
9A. DEVELOP AND IMPLEMENT NATIONAL PLANNING STRATEGIES FOR SUSTAINABLE RURAL AND URBAN DEVELOPMENT	<ul style="list-style-type: none"> • Develop national urban and rural strategies that plan along four dimensions: economic performance, social conditions, sustainable resource use, and finance and governance • Build capacity and resources for local implementation, including multi-stakeholder governance arrangements • Develop standards to ensure good quality, environmentally sustainable development • Balance development of rural and urban areas to reduce unplanned settlements
9B. SET AND ACHIEVE ENVIRONMENTAL STANDARDS AND UPGRADE POOR QUALITY ENVIRONMENTS AND HOUSING	<ul style="list-style-type: none"> • Develop standards for universal basic services that cover housing, food, health care, education, transport, and communications • Ensure universal provision of safe water, sanitation, and electricity • Government financial support for upgrading poor quality housing, including through civil society and private sector and community partnerships • Reduce air pollution through managed, clean transportation systems, reducing car use and regulating pollutant emissions • Improve sustainable transportation infrastructure and systems and access to employment and services for deprived and rural areas • Ensure universal access to the internet • Meet SDGs 6, 7 and 11
9C. ENSURE SECURITY OF TENURE IN INFORMAL SETTLEMENTS AND OTHER ENVIRONMENTS	<ul style="list-style-type: none"> • Establish legislation and mechanisms for formalising tenure of inhabitants living in informal settlements

The Americas is the most urbanized region in the world and unplanned urban migration is continuing. The proportion of the population living in cities in Latin America and the Caribbean increased from 40 percent in the 1950s to 80 percent in 2016 (110). Growth is mostly now occurring in medium and small-sized urban areas, boosted by people migrating to seek better opportunities, and those being forced out of rural areas as their land is turned over to large agricultural businesses and resource extraction industries.

RELEVANT PAHO RESOLUTIONS

CD51.R4: Strategy and Plan of Action on Urban Health

PAHO SUSTAINABLE HEALTH AGENDA FOR THE AMERICAS 2018-2030 (111)



For many, migration to urban areas results in extreme poverty and living in large slum areas in temporary, poor quality housing with minimal services, including lack of sewerage and access to safe drinking water. There are large inequalities between countries regarding the proportion of populations living in slums: it is approximately 70 percent in Haiti whereas Suriname has very low levels. In cities, informal settlements mean that inhabitants do not have security of tenure, can be removed from their dwellings, and do not have access to essential services or social protections. There are clear health and other impacts resulting from lack of land tenure.

Sustainable Development Goal 11 refers to slums and informal settlements. It aims to ‘make cities and human settlements inclusive, safe, resilient and sustainable’. Within that goal is the target by 2030 to ‘ensure access for all to adequate, safe and affordable housing and basic services and upgrade slums’. (112)

Inequalities in environmental and living conditions and access to services across the region drive inequalities in health. Poor performance on the

following environmental determinants compound the risk to health and affect Indigenous communities disproportionately:

- Decent-quality, affordable housing in safe places with security of tenure
- Access to safe drinking water, modern sanitation services, and sustainable waste disposal systems
- Access to electricity and effective, affordable public transportation systems
- Access to employment and educational opportunities
- Clean air, water, and soil
- Access to green spaces and areas for physical activity

All these and associated issues require long-term investment and coordinated, strategic planning at national level to reduce unplanned development and development of slums, but most countries do not have national urban planning strategies. National and local planning strategies should be developed on principles of good governance, balanced economic and environmental national strategies, and integrated system and service planning. Brazil, for example, has a Ministry of Cities.

ACCESS TO IMPROVED SANITATION AND DRINKING WATER

In Latin America and the Caribbean, improved sanitation coverage in rural areas increased from 36 percent to 64 percent between 1990 and 2015. However, there remain large inequalities between and within countries in the region. Open defecation is most common in rural areas of South America and rural Caribbean. (113).

There is a wealth gradient in many countries in access to improved drinking water. A higher percentage of population in rural areas with access to improved water facilities is closely associated with lower maternal mortality and under-five mortality across the region. In every country Indigenous communities have lower levels of access. In Canada in 2016 there were 100 long-term advisories to boil drinking water and 47 short-term advisories in First Nation communities. Current spending levels will only address 50–70 percent of need despite the Canadian government’s promise to end all boil-water advisories by 2021 (114, 115).

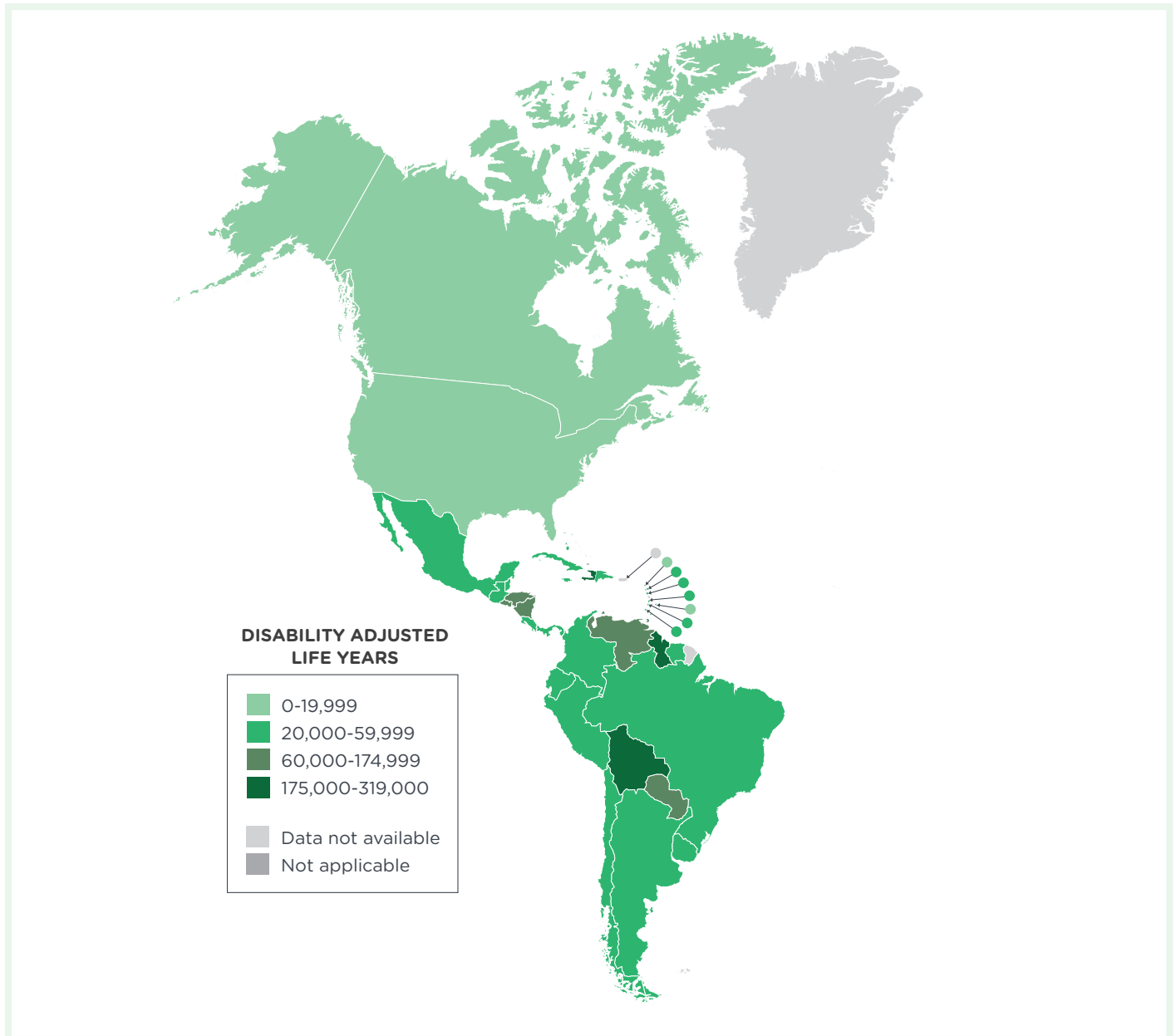
Water pollution disproportionately affects poorer, Indigenous and African-descent communities-as do land and air pollution.

AIR POLLUTION

Air pollution in the Americas causes as many as 93,000 deaths from cardiopulmonary disease, 13,000 deaths from lung cancer, and 58,000 years of life lost due to acute respiratory infections in children under 4 years of age annually (116). Studies in the region have shown that exposure to air pollution is unequally distributed: poorer communities suffer most, and children in particular (117).

There are large differences in disability adjusted life years (DALYs) attributable to ambient air pollution as shown in Figure 4.7 below. For example in Haiti, Bolivia and Guyana, DALYs per 100,000 of the population were between 1000 and 1499 in 2012, while in Canada and the United States, these remained below 299 during the same period.

FIGURE 4.7 AGE-STANDARDIZED DISABILITY ADJUSTED LIFE YEARS LOST PER 100,000 POPULATION ATTRIBUTABLE TO AMBIENT AIR POLLUTION, THE AMERICAS, 2012



Source: WHO. Ambient air pollution: a global assessment of exposure and burden of disease. Geneva: World Health Organization; 2016

Progress in reducing air pollution in the United States appears to have slowed and in Latin America and Caribbean pollution continues to worsen (118).

HOUSING CONDITIONS AND ACCESS

Currently, one in three families in Latin America and the Caribbean, 59 million people, live in dwellings that are either unsuitable for habitation or are built with poor materials and lack basic infrastructure services (119). Housing conditions relate closely to health: poor quality housing, overcrowding, and insecurity of occupancy and tenure are important drivers of physical and mental ill health across the region.

Housing is unaffordable to much of the population in the region. More than 50 percent of families in Latin America's biggest cities cannot afford to buy a formal dwelling using their own means. In the United States, the physical segregation of the poor and less poor is increasing (110).

EXAMPLES OF SUCCESSFUL INTERVENTIONS TO IMPROVE ENVIRONMENTAL CONDITIONS

Housing

The Piso Firme Program in Mexico, delivered from 2000, demonstrated the benefits that targeted upgrades, such as concrete flooring, can provide for the urban poor. Following the program, poorer communities in Mexico had relatively high rates of finished floors. There were 13 percent fewer episodes of diarrhea, a 20 percent reduction in anemia, and communication skills improved by 30 percent (120).

Patrimonio Hoy and Self-Help Housing in Mexico help low-income families form self-financing groups. They expedited the homebuilding process in many slums from 1988 onward and reduced costs by 30 percent.

Formal tenures

An evaluation in Buenos Aires, Argentina, in 2010 showed that families that received a formal tenure substantially increased housing investments and reduced overcrowding.

PRIMED upgraded settlements in Medellín, Colombia, by promoting citizen participation, helping with home improvement, and promoting the legalization of tenure.

Water and sanitation

Favela Bairro in Brazil significantly increased the availability of services such as water and sanitation from 1996 to 2007: results showed that the program had a small but statistically significant impact on school attendance among those aged 5–20 years old.

Urban planning and transportation

The Trans Milenio Bus Rapid Transit in Bogotá, Colombia (2000) connected low-income neighborhoods and by 2006 traffic fatalities had decreased by 89 percent and carbon dioxide emissions dropped by 40 percent (121).

The WHO-led Healthy Cities program supports cities to improve health through development of positive environments, provision of basic sanitation and hygiene needs, and access to health care. Programs are unique to each city, but all involve multi-stakeholder partnerships and involvement of citizens (122).

RECOMMENDATION 10.

EQUITABLE HEALTH SYSTEMS

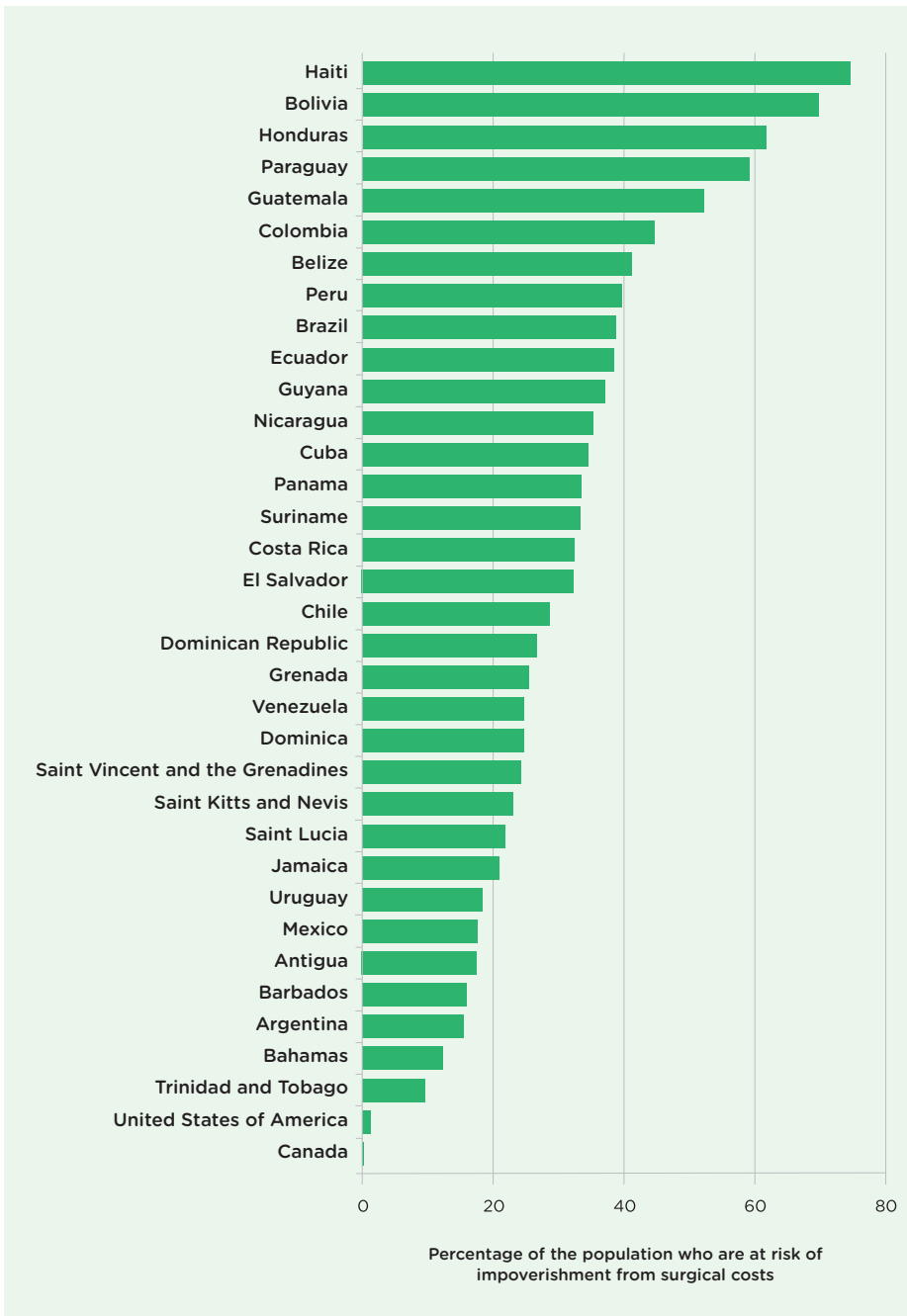
The Commission is focused on the social determinants of health, but health systems are crucial too. Social determinants can exert a powerful influence on access to and quality of care; and universal access to quality care is an absolute necessity. Health systems can also address the causes of ill health, as well as treating them when they occur.

PRIORITY OBJECTIVES	ACTIONS
10A. DEVELOP UNIVERSAL HEALTH SYSTEMS AND ENSURE ACCESS TO HEALTH CARE, REGARDLESS OF ABILITY TO PAY	<ul style="list-style-type: none"> Follow WHO Universal Health Care recommendations and guidelines, and ensure compliance with the right to highest attainable standard of health, as recognized in international human rights law Achieve SDG 3.8 by providing universal health care, including financial risk protection, and access to safe, effective, quality, and affordable essential medicines and vaccines for all
10B. HEALTH SYSTEMS SHOULD FOCUS ON PROTECTING AND IMPROVING PHYSICAL AND MENTAL HEALTH, MEETING ESSENTIAL PUBLIC HEALTH FUNCTIONS	<ul style="list-style-type: none"> Public health and health care systems to work together with other sectors, including communities, to ensure interventions are undertaken to improve conditions of daily life Establish health system performance assessments of the 11 public health functions developed by PAHO (123) Universal health systems should monitor access and outcome inequities - drawing on the right to health - and aim to eliminate and not exacerbate health inequities
10C. HEALTH SYSTEMS SHOULD FOCUS ON SOCIAL AND ECONOMIC DRIVERS OF HEALTH-RELATED BEHAVIORS, MENTAL HEALTH AND SUICIDE	<ul style="list-style-type: none"> Health systems should build public and system understanding that health behaviors and mental health are influenced by structural drivers and conditions of daily life Health professionals should work as national and local advocates for improvement of individual and community conditions as well as providing treatment for patients Include in health professional training and education how to understand and take action on the social determinants, and how to refer patients to support to improve their conditions of daily life

Universal health coverage is a key component of the right to health and is a prerequisite to equity in resources and health. Across the region there are high degrees of socioeconomic and ethnic inequities in access to health care resulting from the cost of services and, in some countries, the inadequacy of provision, particularly in rural areas and informal settlements (39).

At least 20 percent of the population in the majority of countries in the region are at risk of becoming poor due to catastrophic expenditure to cover health care. In Bolivia and Haiti approximately 70 percent of the population are at risk. The risk of having to make catastrophic payments for medical care is also correlated with under-five mortality rates in countries in the Americas.

FIGURE 4.8. RISK OF IMPOVERISHMENT DUE TO SURGICAL COSTS IN THE AMERICAS, 2012



Source: World Bank database, 2017 (2)

DEVELOPMENT OF HEALTH SYSTEMS: FOCUS ON HEALTH IMPROVEMENT

There is great scope for health care systems to broaden their approach to health and strengthen health improvement, enabling people to maintain good health as well as treating ill health. Currently in most health care systems this approach is underdeveloped. Meeting the essential public health functions would provide a firm basis for action.

Improving health requires health care organizations, the health care workforce, public health systems and partners to influence the conditions of daily life, through action with patients and community organizations, and in their role as employers and community leaders. There is much that health professionals

can do. On an individual basis health professionals can refer patients to available support for housing, financial support, access to benefits, and social protections. At a community level, health professionals can be advocates for action to protect and improve health: through effective transportation systems, reducing pollution, protecting natural environments, and fostering social integration. At a national and international level, health professionals can influence governments and international approaches—arguing for health in all policy (HiAP) approaches and more equitable policies, as well as supporting more access to affordable health care systems (124).

In turn, health care organizations can use their local assets—buildings, expertise and knowledge of population health—to develop healthy local employment practices, and support for civil society (124).

Prevention services, screening and vaccination, are frequently hard to access or unaffordable for many at-risk communities. In the United States, data shows that where prevention services are available there are clear inequities in access related to ethnicity and socioeconomic position. Risky health behaviors are related to socioeconomic position and gender. Across the region being male and poor increases the likelihood of harmful alcohol consumption, smoking, and drug misuse.

RELEVANT PAHO RESOLUTIONS

CSP29.R15: Strategy on Human Resources for Universal Access to Health and Universal Health Coverage

CD55.R8: Resilient Health Systems

CD53.R14: Strategy for Universal Access to Health and Universal Health Coverage

EXAMPLES OF SUCCESSFUL HEALTH SYSTEM PROGRAMS

In Cuba, at the Latin America School of Medicine, preference is given to applicants who are from lower socioeconomic groups and/or people of color who show the most commitment to working in disadvantaged communities; 80 percent of graduates end up working in poor rural communities.

In the United States, Baylor Health Care System, Texas established an Office of Health Equity in 2006 with the purpose of reducing variations in health care access, care delivery, and health outcomes that arise from race and ethnicity, income and education, age and gender, and other personal characteristics (for example, primary language skills). The health care organization has redeveloped programs and improved outreach in services where inequities have been identified.

In Canada, researchers sought to document the relationship between local access to primary care, measures of community control, and the rates of hospitalizations for First Nations on-reserve populations (120). The study found that the longer community health services have been under community control, the lower the hospitalization rate in the area.

In North Carolina, USA a multiagency partnership was set up in 2011 to address the relatively high long-term unemployment rate of the local, rural population by training them to join the health care workforce. Projections suggest that 25 percent or more will gain employment upon successful workforce training.

In Brazil, community health workers have been working for over 20 years, serving 54 percent of the population. Since their introduction, Brazil has seen significant health improvements and a reduction in health inequity, which researchers have attributed to the program. Improvements include a reduction in infant mortality and in hospitalizations. There have been improvements in the uptake of screening, breast-feeding, antenatal care and immunizations, and reductions in mental health problems.



5. GOVERNANCE FOR HEALTH EQUITY



RECOMMENDATION 11.

GOVERNANCE ARRANGEMENTS FOR HEALTH EQUITY

Experience shows that committed governments can make significant progress on addressing social determinants of health equity through their policies and actions. These policies and actions can be at the level of local government, national government, or transnational organizations. Action needs to be taken across the whole of government, not just by the health sector. Civil society also has an important role to play in achieving more equitable, dignified lives for people, with better health.

PRIORITY OBJECTIVES	ACTIONS
11A. MAKE HEALTH EQUITY A KEY INDICATOR OF SOCIETAL DEVELOPMENT AND ESTABLISH MECHANISMS OF ACCOUNTABILITY	<ul style="list-style-type: none"> • All government ministries, not just health ministries, to work towards improving health and reducing health inequities by taking action on the social determinants of health • Establish cross-government mechanisms and develop strategic plans for improving health equity • Undertake health equity assessments of all policies and develop policies to amplify action on health equity • Develop public, national plans of action for health inequities and incorporate local government, communities and cross-sector approaches, including private sector
11B. THE WHOLE OF GOVERNMENT—INCLUDING LEGISLATURE, JUDICIARY AND EXECUTIVE—TO TAKE RESPONSIBILITY FOR ENSURING EQUITY IN ALL POLICIES	<ul style="list-style-type: none"> • Involve all sectors and levels of governance in creating and sustaining political support for health equity as a societal good • Strengthen the coherence and resourcing of actions between sectors and public, private, and voluntary stakeholders to redress the current patterns and magnitude of health inequities
11C. DEVELOP AND ENSURE THE INVOLVEMENT OF WIDER SOCIETY—INCLUDING CIVIL SOCIETY AND COMMUNITIES—IN SETTING PRIORITIES AND POLICIES FOR ACHIEVING HEALTH EQUITY	<ul style="list-style-type: none"> • Make intelligence and data on health, equity and social determinants accessible within the public domain, locally and nationally • Promote transparent, public reporting of actions and progress through a comprehensive monitoring system for health equity and social determinants • Provide support for local people and communities to participate in local decision-making and develop solutions that inform policies and investments at local and national levels • Strengthen the capacity of non-governmental organizations and local authorities in their use of participatory planning methods that improve health and reduce social inequities • Take positive measures to support children's rights to participate in matters affecting them, including in public education, legal proceedings and advocacy to achieve health equity

Governance systems determine who decides on policies, how resources are distributed across society and how governments are held accountable. Governance for health equity through action on social determinants requires, at a minimum, adherence to the UNDP principles of good governance—legitimacy and voice, clear direction and vision, measurable performance, accountability, and fairness (125). But it also requires whole-of-government and whole-of-society approaches to reducing inequities based on ‘smart governance’ principles—of collaboration, citizen engagement, regulation and persuasion, use of independent agencies and expert bodies, adaptive policies, resilient structures, and foresight (18).

These approaches require new forms of leadership that shift the allocation of power and move from centralized, top-down decision-making structures involving local communities and strengthen coherence between sectors and stakeholders.

THE RIO POLITICAL DECLARATION ON SOCIAL DETERMINANTS OF HEALTH

A key step in implementing a social determinants approach to health inequities globally was the adoption of the priorities outlined in the Rio Political Declaration on Social Determinants of Health, in 2011 (42). The five priority areas were:

- Better governance for health and development
- Promotion of participation in policy-making and implementation
- Further reorientation of the health sector toward reducing health inequities
- Strengthening global governance and collaboration
- Monitoring progress and increasing accountability

It is necessary to make each of these appropriate for different country and locality contexts.

HEALTH IN ALL POLICIES (HIAP)

The HiAP approach to public policy can provide a basis for addressing the need for coherent concrete action across government to improve health (126). While the health sector commonly serves a central role, HiAP systematically takes into account the health implications of decisions across sectors and improves the accountability of policymakers for health impacts at all levels of policy-making. It includes an emphasis on the health consequences of public policies, including promoting health equity as a societal goal.

A cautionary note: a review of past HiAP approaches showed that intersectoral action appears to have been used most often to address downstream and midstream determinants of health, such as behaviors, with action on the ‘causes of the causes’ occurring less often (127). Suriname provides an example of taking forward a social determinants approach to health equity as part of HiAP (128).

THE SURINAME EXPERIENCE OF IMPLEMENTING HEALTH IN ALL POLICIES (HIAP) TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH

Under the leadership of the Ministry of Health, with support from PAHO, the Government of Suriname implemented a ‘Quick Assessment of the Social Determinants of Health’ to understand the underlying causes of major health problems and associated health inequities in the country. Results from the assessment of available data found that the social determinants are predominately geographical location, socioeconomic position, population group, and gender. These findings were used to establish eight areas of action. Suriname’s experience demonstrates the success of taking on an intersectoral approach to health and highlights the strong links between the social determinants of health and HiAP (129).

A whole-of-government approach goes further than HiAP (130, 131). In addition to having explicit recognition of health in all policy formulation, a whole-of-government approach is aligned more strongly with the holistic approach of the 2030 Agenda for Sustainable Development (6). Governments can make progress by ensuring health equity in all policies as part of a whole-of-government approach.

SUSTAINABLE DEVELOPMENT GOALS

In 2015, countries adopted a set of goals to end poverty, protect the planet and ensure prosperity for all as part of a global sustainable development agenda. They may not have been formulated with health as a specific goal—they did not take the HiAP approach—but achieving the following SDGs will have profound impacts on achieving greater health equity:

- **Goal 1.** End poverty in all its forms everywhere
- **Goal 2.** End hunger, achieve food security and improved nutrition and promote sustainable agriculture
- **Goal 3.** Ensure healthy lives and promote wellbeing for all at all ages
- **Goal 4.** Ensure inclusive and quality education for all and promote lifelong learning
- **Goal 5.** Achieve gender equality and empower all women and girls
- **Goal 6.** Ensure access to water and sanitation for all
- **Goal 8.** Promote inclusive and sustainable economic growth, employment and decent work for all
- **Goal 10.** Reduce inequality within and among countries
- **Goal 11.** Make cities inclusive, safe, resilient and sustainable
- **Goal 16.** Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
- **Goal 17:** Revitalize the global partnership for sustainable development

To make progress towards achieving the SDGs, it is necessary to develop governance arrangements, including legislation and regulations, to strengthen joint accountability for equity—across sectors and decision-makers, and within and outside of government (18). These include:

- Mechanisms that actively promote involvement of local people and stakeholders in problem definition and solution development
- Ensuring regular joint review of progress, which fosters common understanding and commitment to delivering shared results
- Using evidence to ensure policies address the main causal pathways and are capable of adapting over time

MONITORING

Integral to good governance is the transparent monitoring of performance — to allow access to information and inform debate nationally with communities and others on achievements and challenges, including through the use of local intelligence.

Measurement of trends is also needed to track the consequences of policy decisions on inequities in health (132). For this to be sustainable, infrastructure support is required for successful monitoring in terms of both information technology and capacity-building.

From a social determinants and health equity perspective, monitoring of performance and trends requires disaggregated data. While reliable data on demographic trends and morbidity and mortality are available in some countries (as illustrated in Section 2), in most countries there is a lack of health information broken down by ethnicity or socioeconomic position indicators. This is a significant weakness in developing effective policies to address health inequities.

DISAGGREGATION OF DATA

The ways in which different groups are affected by and react to policies and social change vary systematically. As indicated above it is important to disaggregate indicators based on actual or proxy measures both of social groups and changes over time. Crucially, the list of SDG indicators starts with a paragraph about disaggregation from the Addis Ababa Action Agenda which reads:

Sustainable Development Goal indicators should be disaggregated, where relevant, by income, sex, age, race, ethnicity, migratory status, disability and geographic location, or other characteristics, in accordance with the Fundamental Principles of Official Statistics (General Assembly resolution 68/261) (133).

CASE STUDY: KEY INDICATORS, CANADA 2016/17

In the report *Key health inequalities in Canada: a national portrait* (134), a number of key indicators are identified as providing a baseline for monitoring (see Figure 5.1). These indicators were analyzed by each of the following social stratifiers, where feasible:

- Sex/gender
- Indigenous identity
- Cultural/racial background
- Sexuality
- Functional health
- Participation and activity limitation
- Immigrant status
- Income
- Education
- Employment
- Occupation
- Material and social deprivation
- Urban/rural residence

FIGURE 5.1. BASELINE LIST OF KEY INDICATORS, CANADA 2016/17

HEALTH OUTCOMES	Life expectancy and mortality	<ul style="list-style-type: none"> • Life expectancy at birth (ecological level) & Health-adjusted life expectancy at age 18 years (individual level) • Infant mortality - weight > 500 grams • Unintentional injury mortality - all ages
	Mental illness	<ul style="list-style-type: none"> • Intentional self-harm/suicide - all ages • Mental illness hospitalization ages 15+ years
	Self-assessed health	<ul style="list-style-type: none"> • Perceived mental health - fair or poor, age 18+ years
	Cause-specific outcomes	<ul style="list-style-type: none"> • Arthritis age 18+ years • Asthma age 18+ years • Diabetes - excluding gestational, age 18+ years • Disability age 18+ years • Lung cancer incidence • Obesity - age 18+ years • Oral health - no ability to chew age 18+ years • Tuberculosis
HEALTH DETERMINANTS (DAILY LIVING CONDITIONS)	Health behaviours	<ul style="list-style-type: none"> • Alcohol use - heavy drinking • Smoking - age 18+ years
	Physical and social environment	<ul style="list-style-type: none"> • Core housing need • Exposure to second-hand smoke at home age 18+ years
HEALTH DETERMINANTS (STRUCTURAL DRIVERS)	Social inequities	<ul style="list-style-type: none"> • Food insecurity - household • Working poor
	Early childhood development	<ul style="list-style-type: none"> • Vulnerability in early childhood development ages 5-6 years

Source: Public Health Agency of Canada and the Pan-Canadian Public Health Network, 2018 (134)

The most promising way forward appears to be to align indicators, as far as possible, to the Rio Political Declaration on Social Determinants of Health (42) and to those indicators recommended for monitoring progress on key SDGs, which are relevant to health equity. Indicators should be suitably disaggregated to reveal whether or not there is a narrowing of social inequity in society.

CAPACITY-BUILDING

Delivery of the 2030 Agenda for Sustainable Development requires considerable capacity-building in skills and substantial cultural change in organizations at national, local, and community level.

The health sector has a critical role in cross-government action, as advocates for making health equity a government priority and for leveraging change. It has a key role in leading and influencing public opinion. But this will only be effective if there is the capacity in other sectors—legislatures, government ministries, local government, NGOs, civil society, communities—to address the challenges posed by intersectoral action on the ‘causes of the causes’.

RECOMMENDATION 12.

FULFILLING AND PROTECTING HUMAN RIGHTS

Human rights laws can be powerful tools, both for building awareness and consensus around shared values and for guiding analysis and strengthening measurement and accountability of human rights and health equity (135).

PRIORITY OBJECTIVES	ACTIONS
12A. STRENGTHEN RIGHTS RELATING TO SOCIAL DETERMINANTS OF HEALTH AS ASPECTS OF THE RIGHT TO HEALTH AND TO A DIGNIFIED LIFE	<ul style="list-style-type: none"> • Develop further the UN Committee on Economic, Social and Cultural Rights' principles and recommendations on rights relating to social determinants of health • Increase consideration of social determinants of health by the Inter-American Human Rights System and other human rights bodies in monitoring compliance with the right to health and a dignified life • Strengthen the human rights perspectives of international health organizations, including WHO
12B. STRENGTHEN ACCOUNTABILITY FOR SOCIAL DETERMINANTS OF HEALTH AS AN ASPECT OF THE RIGHT TO HEALTH AND TO A DIGNIFIED LIFE	<ul style="list-style-type: none"> • Expand the training of judges on the inclusion of social determinants of health as being within the scope of the right to health and on the interdependence of other rights and the concept of a dignified life • Expand the training of public officials and leaders, including officials in health systems, on the full accountability required by human rights commitments, in particular relating to disadvantaged populations • Strengthen reporting on social determinants of health to the UN Committee on Economic, Social and Cultural Rights • Strengthen access to justice and access to remedies for human rights violations related to the right to health and its social determinants
12C. STRENGTHEN PROTECTION AGAINST ALL FORMS OF DISCRIMINATION IN ALL SPHERES, INCLUDING RESPONSIVENESS TO MULTIPLE FORMS OF DISCRIMINATION	<ul style="list-style-type: none"> • Strengthen legal protections and remedies against all forms of discrimination in public and private spheres • Integrate non-discrimination principles into all public policies and services and ensure adequate data collection to monitor equality and non-discrimination



The human right to health is an ‘inclusive right’ that extends beyond access to health care or physical health. Good governance can build on key human rights actions that:

- Require equity in social conditions, as well as in other modifiable determinants of health
- Underpin the right to a standard of living adequate for health
- Improve the distribution of the determinants of opportunities to be healthy, across the whole population

The United Nations Declaration on the Rights of Indigenous Peoples places peoples’ rights to self-determination as a fundamental and inherent right and a necessary antecedent for the restoration of and and resource rights and the full enjoyment of human rights (53).

RELEVANT HUMAN RIGHTS APPROACHES AND MECHANISMS

United Nations Human Rights. International decade for People of African Descent 2015-2024 (15)

United Nations Declaration on the Rights of Indigenous Peoples (53)

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979 (136)

Convention on the Rights of the Child, 1990 (137)

International Convention on the Elimination of All Forms of Racial Discrimination, 1969 (138)

International Covenant on Economic, Social and Cultural Rights, 1976 (139)

Convention on the Rights of Persons with Disabilities, 2006 (140)

Inter-American Convention on Protecting the Human Rights of Older Persons, 2015 (141)

Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women, 1994 (4)

Inter-American Court of Human Rights (20)

6. CONCLUSIONS



The PAHO Equity Commission was set up to address health inequities—those systematic inequalities in health between social groups that are judged to be unfair. We have set out recommendations with priority objectives and, associated with these, specific actions to achieve this. We start with the premise that health is an end in itself, a worthwhile goal for individuals and for communities. Achieving this for all requires social justice. A society that meets the needs of its members, in an equitable way, is likely to be a society with a high level of population health and relatively narrow health inequities.

Our perspective is to address the ‘causes of the causes’: the reasons why known interventions that would improve health are denied to some groups in society. The roots of the current inequities lie in the very structures of society—the distribution of power, money, and resources—and colonial attitudes and attitudes to gender that are the past and present realities of the region.

Public action is necessary to create the conditions for people to lead a dignified life, characterized by self-determination, recognizing the indivisibility, interrelatedness and interdependence of civil, political, economic, social, cultural, and Indigenous rights. We have highlighted that health inequities are not a matter of ‘them and us’, the excluded and non-excluded, but to varying degrees affect everyone in society—this is the social gradient in health. But the most vulnerable suffer multiple disadvantages. For this reason, action on the social determinants of health is necessary for everyone, but so too is action to meet the distinctive needs and aspirations of people whose lives are most affected by exclusion, discrimination, and disadvantage.

Human rights laws can be powerful tools to strengthen these principles, not only by contributing toward building awareness and consensus around shared values, but also by guiding analysis and strengthening measurement and accountability of both human rights and health equity.

Through the Sustainable Development Goals, countries have agreed to mobilize efforts over the next 15 years to end all forms of poverty, fight inequalities, and tackle climate change, while ensuring that ‘no one is left behind’. As part of this process, each country should review the priority objectives, as set out by this Commission, adapt them to their specific context, and identify the resources, legislative changes, and capacity-building needed to take forward the specific actions. The achievement will be more just societies in which all people are enabled to lead dignified lives and in which health equity is a realizable goal.

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