

Protecting the Right to Health through action on the Social Determinants of Health
A Declaration by Public Interest Civil Society Organisations and Social Movements
Rio de Janeiro, Brazil (18th October 2011)

URGENTLY REQUIRED ACTIONS BY MEMBER STATES AND WHO ON THE KEY AREAS

1. Implement **equity-based social protection** systems and maintain and develop effective **publicly provided and publicly financed health systems** that address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities.
2. Use **progressive taxation**, wealth taxes and the elimination of tax evasion to finance action on the social determinants of health.
3. Recognise explicitly **the clout of finance capital**, its dominance of the global economy, and the origins and consequences of its periodic collapses.
4. Implement appropriate international **tax mechanisms** to control **global speculation** and eliminate tax havens.
5. Use health impact assessments to document the ways in which **unregulated and unaccountable transnational corporations** and financial institutions constitute barriers to Health for All.
6. Recognise explicitly the ways in which the current structures of **global trade regulation shape health inequalities** and deny the right to health.
7. Reconceptualise **aid for health** from high income countries as an **international obligation** and reparation legitimately owed to developing countries under basic human rights principles.
8. Enhance **democratic and transparent decision-making** and accountability at all levels of governance.
9. Develop and adopt a **code of conduct** in relation to the management of **institutional conflicts of interest** in global health decision making.
10. Establish, promote and resource participatory and action oriented monitoring systems that provide **disaggregated data on a range of social stratifiers** as they relate to health outcomes.

1. We, members of public interest civil society organisations and social movements, participants in the World Conference on the Social Determinants of Health (WCSDH) note that this Conference is taking place at a time when:

- sustainable development is in crisis with neoliberalism, consumerism individualism over-riding the values of community and international solidarity;
- conflict and violence which erupt and burn in households, communities, cities and regions and blight millions of lives have complex roots in culture and governance, including the prevailing global economic regime which sanctions unbridled competition, gross inequality and obscene greed;
- the crises of development, finance, food and global warming deny for hundreds of millions of people the right to decent employment, social protection, food security, housing; in fact all the social determinants of health;
- violence, poverty and climate change contribute to large scale migrations, to cities and across national borders; in many cases migrants are discriminate against and denied their human rights;
- inequalities in income and wealth, within and between countries, are growing rapidly; and
- as a consequence there is a rising popular demand for governments to fulfill their obligations to act to guarantee social rights and state protection.

2. The participants in this Conference, the WHO Secretariat, member state delegations and participants have an historic obligation to address the causes of the multiple crises and to ensure that the conclusions and recommendations of this Conference do engage with the basic dynamics through which population health globally is determined. Behind the immediate determinants of health (education, housing, decent jobs, food security, social protection and universal health care) lie the deeper structural determinants including unequal power relations and unequal access to resources and decision making. Widening inequalities and institutionalized discrimination across axes of class, race, gender, ethnicity, caste, indigeneity, age and ability contribute to the impossibility of good health. Action on these structural determinants of health is essential to overcome the economic, environmental, development and food crises.

3.1. We highlight the evidence assembled by the Commission on Social Determinants of Health (CSDH) in its report *'Closing the gap in a generation: Health equity through action on the social determinants of health'* and its conclusion that "unequal distribution of health-damaging experiences is [...] the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics".

3.2. We recall that the WHO Constitution affirms the highest attainable standard of health as a fundamental and universal human right.

3.3. We note that General Comment 14 of the International Covenant on Social, Cultural and Economic Rights explicitly affirms key health determinants within the right to health, including "food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and health working conditions, and a healthy environment".

3.4. We reiterate the call for comprehensive primary health care, as laid out in the Alma Ata Declaration, in order to create accessible and equitable health care which can advocate in other sectors of social practice (housing, environment, industry, etc) for action on the social determinants of health.

4. There are alternative models of health and development; for millenium Indigenous people have lived in harmony with the land and developed sustainable models of living and healing. In the past few hundred years there have been numerous examples of alternative social and economic models which have resulted in good health and health equity.

5. We call upon the World Health Organisation, both the Secretariat and Member States, to take decisive measures to address the deep and persistent inequities in power and opportunities which prevent a majority of the world's population from enjoying their right to health.

We call upon the WHO, including the Secretariat and the Member States, to drive the implementation of the recommendations of the CSDH through a concrete programme of action with appropriate budget allocation.

6. Five key action areas

Interventions to address the social determinants of health reflect national and local needs and contexts and take into account different social, cultural and economic realities. Five key action areas are critical:

- Promote intersectoral action and health policy coherence at all levels to create the conditions for better health;
- Ensure popular participation in policy-making;
- Reorient the health sector towards primary health care, including intersectoral action and community mobilisation around the social determinants of health;
- Democratising global health governance, including the governance of the economic and political conditions which shape population health; and
- Monitoring progress and holding governments and international agencies accountable for action on the social determinants of health.

7. Promote intersectoral action at all levels to create the conditions for better health

7.1. Existing knowledge is now available to support decisive action through inter-sectoral public policies to address the social determinants of health and promote health equity.

7.2. We call upon the WHO, the Secretariat and the member states, to:

- Ensure the full implementation of World Health Assembly resolution WHA62.14, and show clear evidence of how the work programmes of WHO are implementing the recommendations of the final report of the Commission on Social Determinants of Health;
- Promote intersectoral action in public policy making at all levels, drawing upon available knowledge and precedents, to address inequities and social determinants of health; including:
 - Implement social protection systems and universal and comprehensive access to health and social services that are explicitly designed to promote equity and affirmative action on behalf of vulnerable sections of the population;
 - Use of progressive taxation, wealth taxes and the elimination tax evasion to finance action on the social determinants of health;
 - Ensure gender equity and the promotion and protection of early childhood development in all policies;
 - Enact policies that progressively ensure full employment of the working-aged population, healthy working environments and secure conditions of employment;

- Regulate and protect populations from health hazards emanating from commercial activities, such as those created by the tobacco, alcohol, breast-milk substitutes, high fat and sugar processed food, and the petroleum and extractive industries.

8. Ensure popular participation in policy-making

8.1. Effective action on the social and structural determinants of health calls for governance structures that give full consideration to health improvement and health equity; the capture of decision making by vested interest is a barrier to such action.

8.2. Opening up decision processes to wider scrutiny and participation is necessary to protect the integrity of decision making.

8.3. We call upon the WHO, the Secretariat and the Member States to:

- Enhance democratic and transparent decision-making and accountability at all levels of governance, including through enhancing access to information, access to justice and popular participation
- Promote a more equitable distribution of resources and opportunities by enabling and supporting disadvantaged and marginalised groups such as indigenous peoples and displaced communities to participate in policy making and implementation.
- Develop and adopt a code of conduct in relation to the management of institutional conflicts of interest in global health decision making; this should set out a clear framework for interacting with companies and other organisations with commercial interests to protect policy development and program management;
- Recognize and enable the contributions and capacities of community organisations and public interest civil society organisations to advocate for action on the social and structural determinants of health.

9. Reorient the health sector towards comprehensive primary health care, including intersectoral action and community mobilisation around the social determinants of health

9.1. Universal access to quality health care is a powerful social determinant of health. Comprehensive primary health care can ensure equity, efficiency and quality health care including first contact and continuing care and access to more specialized services.

9.2. The primary health care model also provides for engagement between providers and communities regarding the social determinants of health and support for intersectoral collaboration (food, housing, jobs, etc) and community mobilization for behavioural and policy change for better health.

9.3. Private financing and private sector provision are unable to provide universal access to integrated comprehensive primary health care. Robust research studies demonstrate that they can aggravate inequalities in health care and health outcomes. They present barriers to the recognition of and action upon the social determinants of health.

9.4. We call upon WHO, the Secretariat and the Member States, to:

- Maintain and develop effective publicly provided and publicly financed health systems that address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities;
- Provide equitable universal health care coverage including high quality promotive, preventive, curative and rehabilitative health services throughout the life cycle, based on comprehensive primary health care;
- Support community engagement in monitoring and planning; democratise public health systems;
- Build, strengthen and maintain public health capacity including reform of health professional education to incorporate a strong emphasis on the social determinants of health and health care of the majority;
- Regulate the private medical sector to mitigate the negative impact of business interests on health and enhance the capacity of the public health system;
- Press for high income countries to adequately compensate poor countries for their substantial losses in the form of migrant health professionals; while 'Codes of Practice' are important, they are weak; Innovative mechanisms that may include repatriation to sending countries of taxes paid by immigrant health professionals should be explored.

10. Democratising global health governance, including the governance of the economic and political conditions which shape population health

10.1. The scope for nation states to effectively regulate for health has been progressively reduced over the last 30 years through:

- the growing power of transnational corporations which are largely unaccountable except to their shareholders and the stock markets;
- the rapid extension of trade and investment agreements which reduce the scope for democratic decision making, replacing it with obligations and sanctions which are overwhelmingly structured around the interests of powerful countries and large corporations; a key concern is the use of 'free trade' agreements to deny countries the right to use the flexibilities of TRIPS;
- the role of the IMF and the World Bank as agents for promoting the interests of transnational capital and the rich capitalist states;
- the emergence of unaccountable private donors as significant sources of global health funding and public private partnerships as tools for the disbursement of bilateral, multilateral and private donations; these initiatives have fragmented health systems and undermined countries' health policies.

10.2. The scope for small nation states to effectively regulate for health is constrained also by the bullying of great powers on behalf of 'their' transnational corporations. Some countries have been subject to trade sanctions over several decades because of their commitment to ensuring affordable access to medicines. In other circumstances bilateral aid is used to promote the interests of the donor nations and their companies. The creeping influence of Big Pharma is evidenced by the expanded definition of 'counterfeit' medicines.

10.3. Radical reform of the structures of globalisation is necessary if national governments are to act to ensure universal quality health care and action on the social determinants of health.

10.4. Incremental reforms are within reach. These include:

- continuing implementation of WHA Resolution 59.26 on Trade and Health;
- WHO Reform including moving towards full budget funding so that resources are available for implementing governing body resolutions rather than donors selectively funding their own preferred programmes;
- documentation through health impact assessments of the ways in which unregulated and unaccountable transnational corporations and financial institutions constitute barriers to Health for All;
- democratisation of the IMF and the World Bank;
- implementing appropriate international tax mechanisms to control global speculation and eliminate tax havens.

10.5. We call upon WHO, both the Secretariat and Member States, to:

- Recognise explicitly the ways in which the current structures of global trade regulation shape health inequalities and deny the right to health;
- Recognise explicitly the clout of finance capital, its dominance of the global economy, and the origins and consequences of its periodic collapses;
- Recognise explicitly the mechanisms through which the present intellectual property regime promotes the interests of knowledge-intensive TNCs and the countries which benefit from their exports; we call for action to facilitate the transfer of expertise, technologies and scientific data to low and middle income countries;
- Support global social protection, the development of strong welfare states and the work of the United Nations and ILO in this field;
- Implement fully the Framework Convention on Tobacco Control (FCTC) and develop other global treaties that promote good health and address the social determinants of health, such as in the areas of access to essential medicines and regulation of the baby food, alcohol and food industry;
- Advocate across the UN system for recognition of the social determination of health including for example in climate change mitigation, trade regulation, migration laws, industrial policy, etc;
- Reconceptualise aid for health from high income countries as an international obligation under basic human rights principles rather than an input to productivity, an investment in security or an act of charity.

11. Monitoring progress and holding governments and international agencies accountable for action on the social determinants of health

11.1. Effective action on the social determinants of health requires that needs are documented, causes are demonstrated and actions are evaluated. While there is a strong evidence base for action now on the social determinants of health continuing research will be needed to continue to trace the causes of the causes including the underlying structural determinants as well as the conditions of daily living.

11.2. We call upon WHO, both the Secretariat and the member states, to:

- Establish, promote and resource monitoring systems that are participatory and action oriented; provide disaggregated data on a range of social stratifiers as they relate to health outcomes; and which are publicly accessible;
- Collaborate with other UN agencies to strengthen the monitoring of progress in the field of social determinants of health;
- Develop and implement reliable measures of societal wellbeing that go beyond economic measures;
- Promote research on the relationships between social determinants and health outcomes in order to identify pathways through which basic causes produce health inequalities that violate the right to health, as well as to identify where and how to intervene and then fund research on evaluation of the interventions;
- Systematically share relevant evidence and trends among different sectors to inform policy and action;
- Measure the impacts of policies on health and institutionalize such measurement processes into policy-making and accountability mechanisms;
- Set up accountability mechanisms that incorporate the use of indicators of inequalities in health outcomes and their social determinants and which ensure the participation of civil society and social movements.

12. Call for global action

12.1. We reaffirm the importance of action on the social determinants of ill health and health inequity to nurture inclusive, equitable and healthy societies, and to overcome national and global challenges to development. We are committed to playing our part in the achievement of the objectives and action points listed above.

12.2. We call upon WHO, member states, international organisations, social organisations and movements to work comprehensively on the social determination of health and the right to health.






12.3 We reiterate the call of the Declaration of Alma-Ata for a new international economic order.

Endorse the declaration or share your comments on globalsecretariat@phmovement.org









Organisational sign-ons should include a copy of your logo.

Signatures

Organisations and Networks

	Organisation / network		Contact person	E-mail
1		People's Health Movement (PHM) - International	Ms. Bridget Lloyd; Global Coordinator	globalsecretariat@phmovement.org
2		Association Latino Americana de Medicina Social (ALAMES)	Nila Heredia, Coordinadora General	nherediam@gmail.com
3		Medicus Mundi International Network (MMI) - International	Thomas Schwarz; Executive Secretary	schwarz@medicusmundi.org
4		Stichting Wemos - Netherlands	Remco van de Pas; Senior Health Policy Advocate, Programme Resources for Health	remco.van.de.pas@wemos.nl
5		The International Baby Food Action Network (IBFAN) - International	Ms. Ina Verzivolli; Coordinator	ina.verzivolli@gifa.org

	Organisation / network	Contact person	E-mail	
6	 Health Poverty Action - International	Corinna Heineke; Head of Policy & Campaigns	c.heineke@healthpovertyaction.org	
7	 Medico International	Thomas Gebaaur; Executive Director	gebauer@medico.de	
8	 Egyptian Foundation for Health for All - Egypt	Dr. Yasser Ebeid; Chairperson	yasser.ebeid@healthforall-eg.org	
9		Foro Salud Peru	Mario Rios Barrientos	marioriosbarrientos@gmail.com
10	 Medicos del Mundo - Espana	Herve Bertevas	herve.bertevas@medicosdelmundo.org	
11	 Medicos del Mundo - Argentina	Gonzalo BASILE ; Presidente	presidencia@mdm.org.ar	
12	 Fos – Solidaridad Socialista	Susana Terrazas / Oficial del Programa Salud en Bolivia	susana_terrazas@hotmail.com fosbolsalud@gmail.com	
13	 Centre for International Health, University of Bologna, Italy	Angelo Stefanini, Director	angelo.stefanini@unibo.it	
14	 African Network on Evidence-to-Action on Disability (AFRINEAD)			
15		Center for Global Health (Trinity Vollege Dublin)		
16	 All India People's Science Network – India	Amit Sengupta; Secretary General	asengupta@phmovement.org	
17		Development Organization of the Rural Poor (DORP)		
18	 Health Action Information Network (HAIN) – Philippines	Edelina Dela Paz	ddelapaz@phmovement.org	
19	 People's Health Movement in Philippines (PHM-Philippines)	Delina Dela Paz	ddelapaz@phmovement.org	
20	 Doctors for Global Health	Linda Sharp	inquiries@dghonline.org	
21	 Jamkhed International / North America	Connie Gate	jina@jamkhed.org	
22		Community Working Group on Health	Itai Rusilke, Executive Director	cwgh@mweb.co.zw

	Organisation / network		Contact person	E-mail
23		UBINIG (Policy Research for Development Alternative), Bangladesh	Farida Akhter, Executive Director	kachuripana@gmail.com
24	 Malaysia	PHF Malaysia (PHM-Malaysia)	Shila Kaur, Coordinator	kaur_shila@yahoo.com
25		The African Centre for Volunteers, Kenya	Omondi E. Otieno, Executive Director	eomondi@acvkenya.org
26		Training and Research Support Centre, Tanzania	Mwajuma Masaiganah	mwinoki@yahoo.com
27		Canadian Alliance of Community Health Centre Associations (CACHCA)	Scott A. Wolfe, Federal Coordinator	communications@cachca.ca
28		GROUPE-TADAMOUN, Mauritania	Cheikh Hassan Saleh, Journaliste	hassan6091@yahoo.fr
29		Ecumenical Committee of English Speaking Religious Personal	Nan McCurdy	nanmig1@yahoo.com
30		Social Work and Health Inequalities Network, UK	Julie Fish, Co-convener	jfish@dmu.ac.uk
31		Acampada BCN, Bloomberg Faculty of Nursing, University of Toronto, Canada	Carles Muntaner, Professor	carles.muntaner@utoronto.ca
32		Health Providers Against Poverty, Canada	Gary Bloch	gary.bloch@utoronto.ca
33		Third World Network	Evelyne Hong	ehong28@yahoo.com
34		Registered Nurses' Association of Ontario, Canada	Lynn Anne Mulrooney, Senior Policy Analyst	lmulrooney@rnao.org

Individuals

	Name	Title	City	Country	E-mail
1	Halfdan Mahler	Former Director General of the World Health Organization	Geneva	Switzerland	halfdan.mahler@bluewin.ch
2	Amit Sengupta	PHM Associate Coordinator, PHM	Delhi	India	asengupta@phmovement.org
3	Bridget Llyod	Global Coordinator, People's Health Movement (PHM)	Cape Town	South Africa	bllyod@phmovement.org

	Name	Title	City	Country	E-mail
4	Claudio Schuftan	Member of the Steering Council, People's Health Movement (PHM)	Saigon	Vietnam	Cschuftan@phmovement.org
5	Hani Serag	Associate Coordinator, People's Health Movement (PHM)	Cairo	Egypt	hserag@phmovement.org
6	David Legge	Associate Professor. Member of the Steering Council, People's Health Movement (PHM)	Melbourne	Australia	d.Legge@Latrobe.edu.au
7	David Sanders	Emeritus Professor, School of Public Health, University of Western Cape, South Africa Member of Global Steering Council, PHM Chairperson, PHM South Africa.	Cape Town	South Africa	dsanders@phmovement.org
8	Camila Giugliani	Medical Doctor	Porto Alegre	Brazil	giugli@hotmail.com
9	Laura Turiano	MS, PA-C	Oakland, CA	United States	phm@turiano.org
10	Francoise Barten	Professor of Public Health	Nijmegen	Netherlands	francoiseb@gmail.com
11	Erika Arteaga Cruz	Oficial de proyectos de Salud – fos (solidaridad socialista Belga)	Quito	Ecuador	Erika.artega@fos-andes.org
12	Fran Baum	Professor and Director, Southgate Institute SACHRU, Faculty of Health Sciences; School of Medicine, Flinders University. Co-Chair, PHM Steering Council.	Adelaide	Australia	fbaum@phmovement.org
13	Chiara Bodini	Centre for International Health, University of Bologna	Bologna	Italy	chiara.bodini@unibo.it
14	Angelo Stefanini	Centre for International Health, University of Bologna	Bologna	Italy	angelo.stefanini@unibo.it
15	Ilaria Camplone	Centre for International Health, University of Bologna	Bologna	Italy	ilariacamplone@gmail.com
16	Marta Brigida	Centre for International Health, University of Bologna	Bologna	Italy	brigida.marta@gmail.com
17	Fernando Borgia	Association Latino Americana de Medicina Social (ALAMES)	Montevideo	Uruguay	fernando.borgia@gmail.com
18	Abhay Shukla	SATHI & PHM-India	Pune	India	Abhayshukla1@gmail.com
19	Narendra Kumar	Prayas & PHM India	Chittorgarh	India	narendra@prayaschittor.org
20	Smita Pakhale	Univ. of Ottawa & Ottawa Hospital Research Institute	Ottawa	Canada	spakhale@ohri.ca
21	Carles muntaner	University of Toronto	Toronto	Canada	Carles.muntaner@utoronto.ca
22	Hasheem Mannan	Senior Research Fellow, Project EquitAble Centre for Global Health, Trinity College	Dublin	Ireland	MANNANH@tcd.ie
23	Gonzalo Basile	President, Medicus del Mundo - Argentina	Buenos Aires	Argentina	
24	David Mosca	IOM			
25	Armando de Nigri	PHM-Brazil	Porto Alegre	Brazil	armandodeneigri@yahoo.com

	Name	Title	City	Country	E-mail
26	Delen P Dela Paz	Professor of Community Medicine, University of Manila A member of the Steering Council, People's Health Movement (PHM)	Manila	Philippines	ddelapaz@phmovement.org
27	Yasser Ebeid	Chair, the Egyptian Foundation for Health for All	Cairo	Egypt	Y_ebeid@yahoo.com
28	Jack McCarthy	Past President of the Canadian Alliance of Community Health Centre Associations; Executive Director of Somerset West Community Health Centre.	Ottawa	Canada	Jmccarth@swchc.on.ca
29	CHAN Chee Khoon	Center for Population Health Dept Social & Preventive Medicine Faculty of Medicine, University of Malaya	Kuala Lumpur	Malaysia	chan.cheekhoon@yahoo.com
30	Anwar Fazal	Director, Right Livelihood College	Penang	Malaysia	anwarfazal2004@yahoo.com
31	Miguel San Sebastián	Umeå International School of Public Health	Umeå	Sweden	miguel.sansebastian@epiph.umu.se
32	Mwajuma Saiddy Masaiganah	Training and Research Support Centre	Dar es Salaam	Tanzania	mwinoki@yahoo.com
33	Olga Lidia García Cárdenas	Instituto Cubano de Oftalmología	Havana	Cuba	olguitacalidad@horpf.sld.cu
34	Lynn Anne Mulrooney	Senior Policy Analyst, Registered Nurses' Association of Ontario	Toronto	Canada	lmulrooney@rnao.org
35	José Utrera	Medical Doctor	The Hague	Netherlands	j.utrera@wxs.nl
36	Mohammad Ali Barzegar	Medical Doctor	Tehran	Iran	barzgar89@yahoo.com
37	Nancy Krieger	Professor, Department of Society, Human Development and Health, Harvard School of Public Health	Boston	USA	nkrieger@hsph.harvard.edu
38	Linda Mashingaidze	People's Health Movement, Africa Outreach Coordinator	Polokwane	South Africa	linda@phmovement.org
39	karen giffin	Public Health Professor	Rio de Janeiro	Brazil	karengi@ensp.fiocruz.br
40	Camlus Otieno	Environmental Health Specialist and Member of PHM Kenya	Nairobi	Kenya	codhus20@gmail.com
41	Anneleen De Keukelaere	Global Networking Coordinator, People's Health Movement	Cape Town	South Africa	anneleen@phmovement.org
42	Anne-Emanuelle Birn	Professor and Canada Research Chair in International Health, University of Toronto	Toronto	Canada	ae.birn@utoronto.ca
43	Alex Scott-Samuel	Director, IMPACT - International Health Impact Assessment Consortium, Department of Public Health and Policy, University of Liverpool	Liverpool	UK	alexss@liverpool.ac.uk
44	Agustín Salazar Azócar	Medico Cirujano Centro de Rehabilitación La Florida	Santiago	Chile	absalaza@uc.cl
45	Hugo Villa Becerra	Medical Doctor	Lima	Peru	hugo.villa@essalud.gob.pe