

JUST SOCIETIES

Health Equity and Dignified Lives



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

PAHO



Pan American
Health
Organization



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Americas



INSTITUTE of
HEALTH EQUITY

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This Report was prepared by the Institute of Health Equity, University College London (UCL), on behalf of the Commission
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NOTE FROM THE CHAIR

Health in the Region of the Americas, of individuals and populations, improved dramatically through the latter decades of the 20th century and the early years of the 21st century. And it has become commonly accepted that health will continue to improve, associated with better living conditions and access to ever-better standards of health care.

There are, however, threats to this bright picture, and they take at least three forms. First, there are substantial inequalities in health within countries, whatever the country's level of economic and social development, because the health benefits of the aforementioned societal improvements are unequally distributed. Second, there continue to be major inequalities in health among countries of the Americas. Third, the rate of health improvement has slowed in some countries or has even reversed on some measures; in the United States of America, life expectancy has now declined three years in a row.

The vision of PAHO Director Carissa Etienne led to the establishment of this PAHO Commission on Equity and Health Inequalities in the Americas, alongside a companion Commission on Universal Health Coverage. Dr. Etienne sees social determinants of health and universal health coverage as complementary: both are necessary to achieve health equity. Dr. Etienne's support has been accompanied by invaluable commitment to our mission by our 12

commissioners, all experts from across the Region of the Americas. They have brought their wisdom and experience to bear on our numerous deliberations and shaped both the direction of this report and its detail. They, along with a committed secretariat at PAHO and at the Institute of Health Equity, University College London, made the work possible. I am particularly grateful to Jessica Allen, Peter Goldblatt, and Joana Morrison for their support to the Commission and assistance in drafting this report.

Because we judge that knowledge and resources exist to improve health for everybody in the Americas, we label these health inequalities as unjust. Putting them right is a matter of social justice. Concern for social justice and health is the impetus for this PAHO Equity Commission. But the evidence of what can be done really matters.

I have been asked repeatedly: In this world of postfact politics, do we really need evidence to make policy? The PAHO Equity Commission is clear.

Knowledge and evidence are critically important to shine a light on unjustifiable inequalities in health and what can be done to improve health equity. We argue for the recommendations in this report precisely because they are based on evidence. Our mission, then, is at once both moral and technical. Improving the quality of lives people are able to lead—lives of dignity that would improve health—is a moral endeavor. This report brings together the technical evidence of what is needed to achieve that aim.

The evidence we have assembled builds on that synthesized by the WHO Commission on Social Determinants of Health and the European Review of Social Determinants and the Health Divide. The evidence that formed the background to our work is global. Our task as the PAHO Equity Commission was to gather new evidence from the Americas, and apply it to the special and hugely varied conditions of the Region of the Americas: Canada and the United States of America and Latin America and the Caribbean.

Action and knowledge generation have to go together. We are confident in our analysis of the social determinants of health. But the evidence of “what works” to act on these social determinants to improve health equity is never sufficient. It is vital, then, to have in place robust monitoring systems to assess the effects of the policy changes that we are recommending.

We are optimistic but not complacent: optimistic because we see great and developing interest in social determinants of health and health equity; not in the least complacent because threats abound. Empowerment of individuals, communities, and, indeed, of countries has to go hand in hand with social and economic development. Economic inequalities, climate change, and the continuing impact of colonialism and racism are major challenges to empowerment. Our report calls for action on inequities in the conditions of daily life through the life course; on violence and racism; on climate and the environment; and on the structural drivers of health inequities.

We see this report as a step on a journey. The aim now must be to encourage action by all countries in the Region, and to give governments and civil society the evidence that should inform action. Could there be a more worthwhile aim than to create the conditions for all people in the Region to lead lives of dignity and thereby advance the cause of health equity?

Professor Sir Michael Marmot

Chair, PAHO Commission on Equity and Health Inequalities in the Americas

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1. INTRODUCTION AND CONCEPTUAL FRAMEWORK



1.1 COMMISSION ON EQUITY AND HEALTH INEQUALITIES IN THE AMERICAS

The Americas—North, Central, and 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 Region of 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 among 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 well-being 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 (1) is not because Haitian women are biologically different from 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 (1). 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 (2). 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 (3). In Guatemala, for example, in 2014, the under-5 mortality rate was 55 in 1,000 births in the poorest fifth of families, and 20 per 1,000 in the richest fifth. In nearby Colombia, by contrast, in 2015, the under-5 mortality in the richest fifth was less than 5 in 1,000 (4). This shows what should be achievable. Across the Americas, children’s lifelong

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,
“Make Poverty History” speech, London, 2005

development and outcomes in education, income, health, and well-being remain closely aligned with parents' situations.

There is increased evidence and awareness that good health requires not only access to health care, but also action on the social determinants of health. Indeed, so close is the relationship 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) (5). 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 the subnational level. In the United States of America, 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. This is true for socioeconomic inequality, but also inequalities between Indigenous and non-Indigenous peoples; between people of African descent and those of European origin; between genders; between disabled and nondisabled people; between people of different sexual orientations; and between migrants and nonmigrants. Too much inequality damages social cohesion and 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 multifaceted: 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).

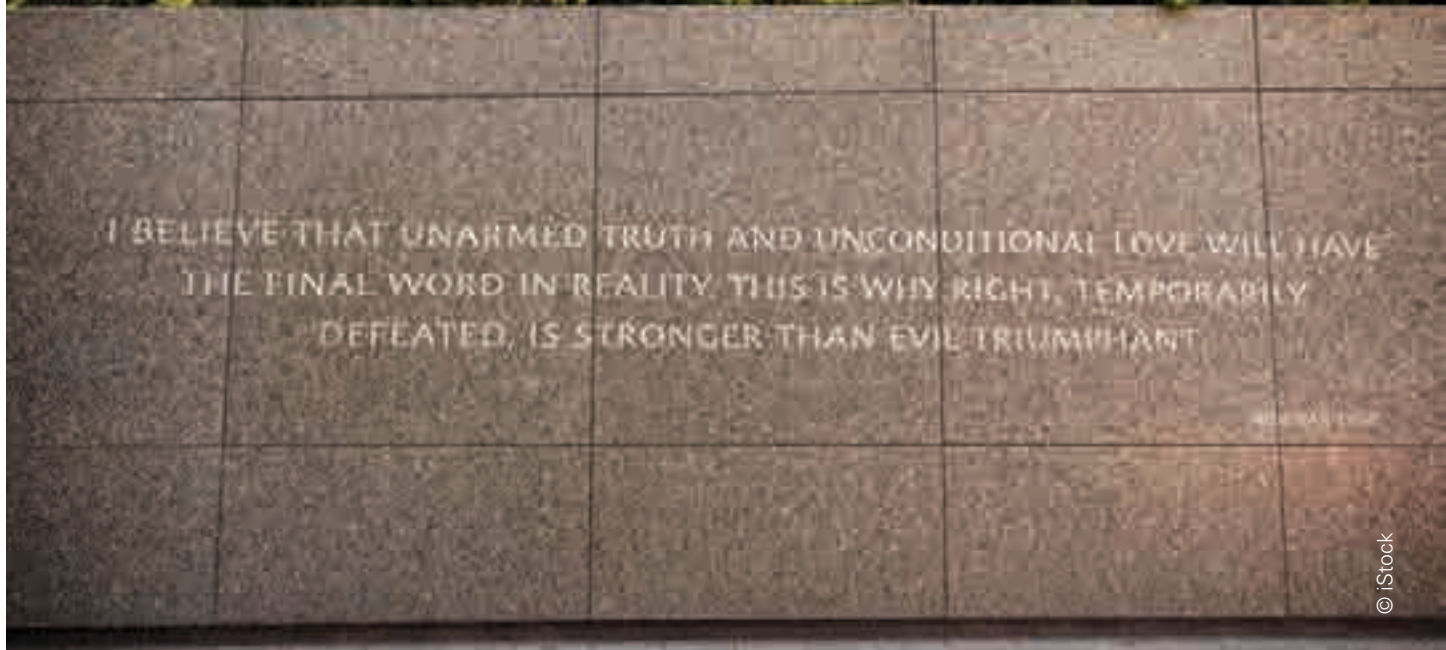
We recognize that achieving health equity in some areas will require tackling unfavorable politics, the undue priority of economics over human rights, conflict, climate change, and corruption. However, we are not rendered hopeless in the face of these challenges, because we have seen meaningful change despite great barriers. This report will highlight examples of governments making a difference, civil society

Social injustice is killing on a grand scale.

WHO Commission on Social Determinants of Health. *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Final Report, 2008*

Injustice anywhere is a threat to justice everywhere.

Martin Luther King, Jr. Letter from a Birmingham jail, 16 April 1963



© iStock

Martin Luther King Jr. Memorial, Washington, D.C., USA

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,
recipient of the 1992 Nobel Peace Prize

and professional organizations implementing evidence-informed strategies, and citizens engaging in social movements and community-building actions to achieve change. We have evidence to support our judgment that achieving health equity is a realistic goal.

Taking action: Learning from the Civil Rights Movement in the United States of America

The PAHO Equity Commission met with leaders of the Civil Rights Movement in the city of 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.¹
- Like Rosa Parks of the Montgomery, Alabama, bus boycott, “we must have a made-up mind”—a determination within ourselves.²

We must always engage the community in our efforts and keep this engagement throughout.

Sources: ¹ King ML, Jr. “The rising tide of racial consciousness,” Address at the Golden Anniversary Conference of the National Urban League [speech]. 6 September 1960, New York.

² Burks M. Trailblazers: women in the Montgomery bus boycott. In: Crawford VL, Rouse JA, Woods B, Butler BN, editors. Women in the Civil Rights Movement. New York: Carlson Publishing; 1990: 71-84.

1.2 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 provided in Section 4, and recommendations for governance arrangements are given in Section 5. All the evidence presented is supported by a series of evidence reviews undertaken by the Commission.

The framework is based on the Commission on Social Determinants of Health (CSDH) conceptual framework (5), 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, but 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 among these factors, with an emphasis on leading a dignified life as a desired outcome—aligned with greater health equity.

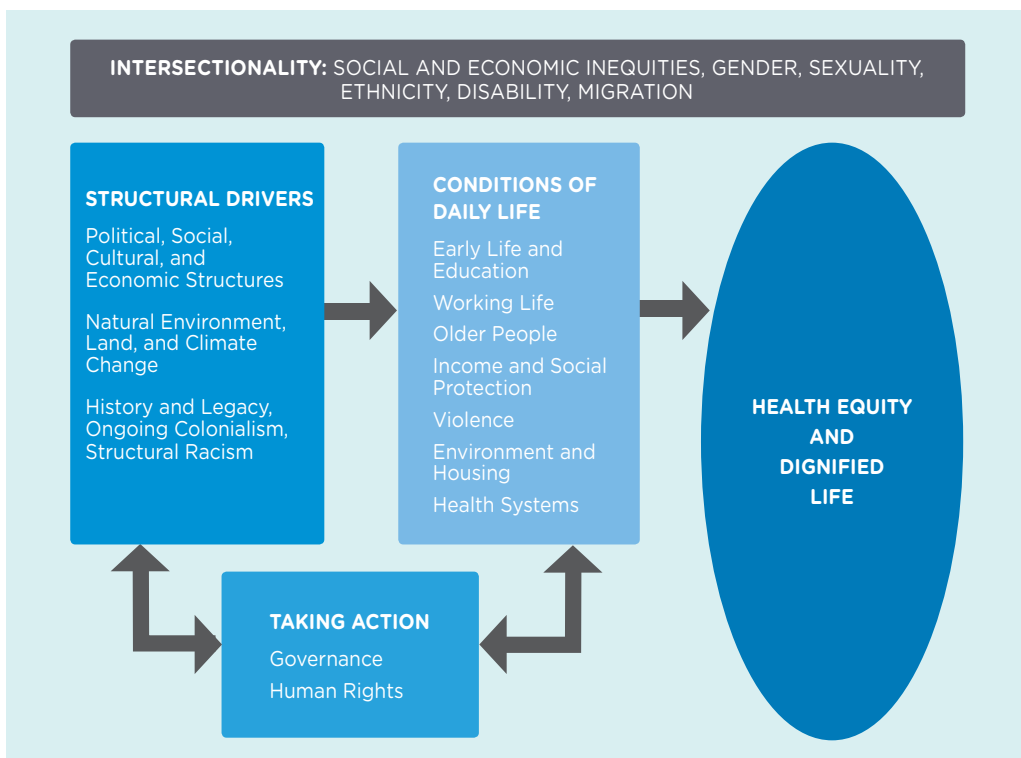
STRUCTURAL DRIVERS OF HEALTH INEQUITIES

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 2007–2008 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 (7). Evidence

Figure 1.1.
Conceptual framework



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 of America and Europe were questioned on what they considered to be the “greatest danger in the world,” concerns about inequality outweighed all other dangers (8). 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 groups of people of the Region there are social gradients in health. When people are classified by their level of education, income, or 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 also 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 review of health inequalities in England titled *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 (9). 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, by 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 (3). One major source of such inequity is colonialism: it is intrinsic to the history of the Americas.

There are between 45 and 50 million Indigenous peoples living in Central America, South America, and the Caribbean, representing approximately 13 percent of the total population. In the United States of America, approximately 5.2 million persons identify as American Indian or Alaskan Native, and in Canada 1.4 million identify as Indigenous (10). 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.

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, *The Book of Embraces*

There are approximately 200 million people of African descent in the Americas (including the United States of America and Canada) (1). Their history is characterized by slavery, colonialism, racism, and discrimination, the effects of which are active in the present day (4). 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, and an approach that includes ending discrimination and racism, promotes self-determination, and improves support for relationships with the land, while 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 to 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 marginalized 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—also affect 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. Socioeconomic position, gender, disability, and ethnicity are all 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 affect 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 since 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 Programme's principles of good governance: legitimacy and voice, clear direction and vision, measurable performance, accountability, and fairness (11). But it also requires whole-of-government and whole-of-society approaches to reducing inequities (12). 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.

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” (13). The strong focus on accountability in human rights requires effective and timely redress of violations, as well as effective measures to prevent recurrence and to bolster a human-rights-enabling environment (14).

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” (15).

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 pursue the options people feel are best, of their own free will, in order to achieve their ideals (16). This approach to autonomy and a life lived with dignity draws on Amartya Sen’s concept of capabilities (17). 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 toward 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 United Kingdom, 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 a clear intersection between 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. Also, countries across the Region have signed up to and agreed on 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 international agreements.¹

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.

¹ The documents cited in the Relevant International Agreements boxes are listed at the end of the References section.

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 noncommunicable 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, and abuse of alcohol (18). 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 (3).

RELEVANT INTERNATIONAL AGREEMENTS

Plan of Action on Health in All Policies
(PAHO Resolution CD53.R2 [2014])

2. HEALTH INEQUALITIES BETWEEN COUNTRIES IN THE AMERICAS



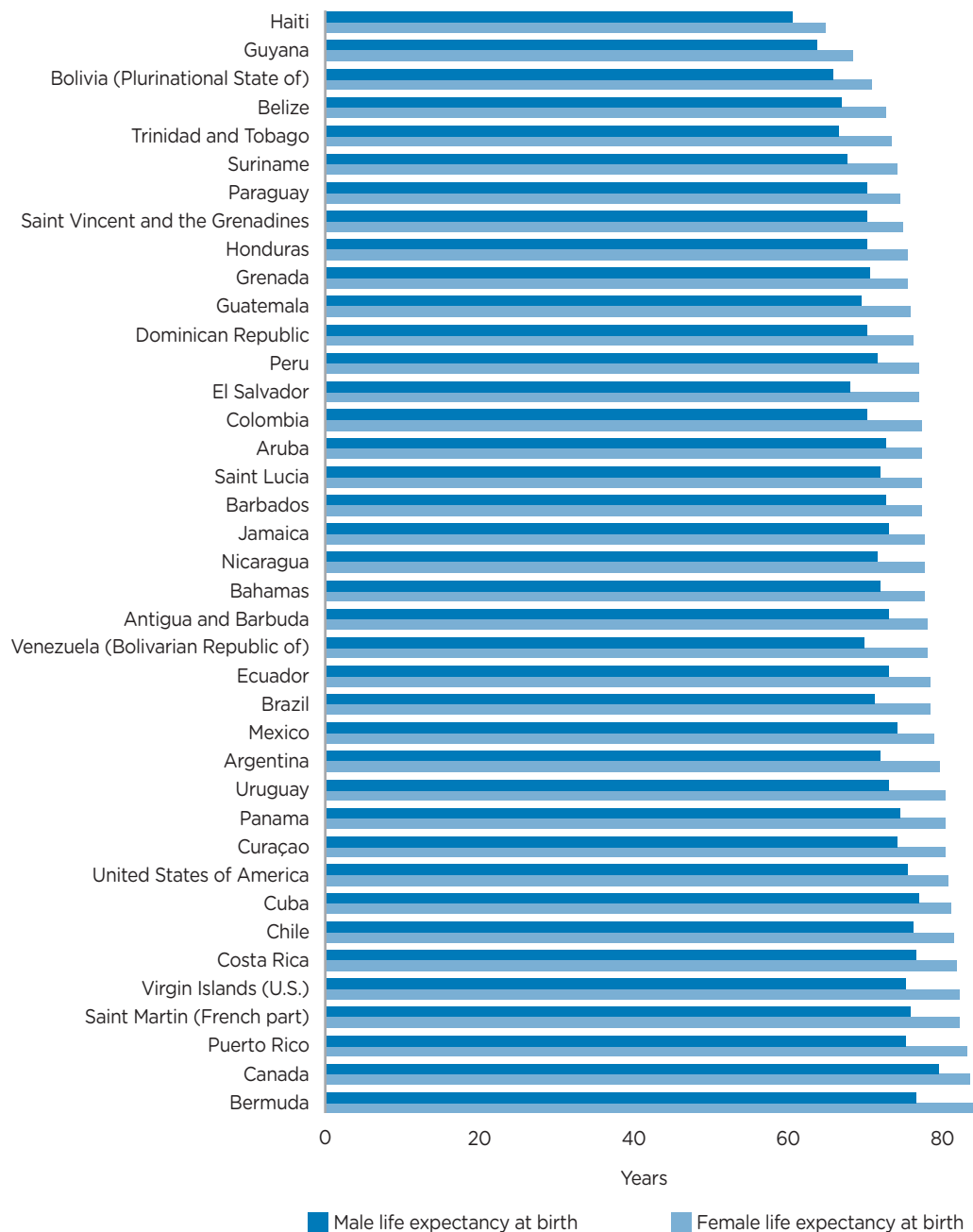
Father with his baby sitting in a house destroyed by the Haiti earthquake of 2010, Croix-des-Bouquets, Haiti

2.1 INTRODUCTION

Although overall population health has steadily improved in the Americas, levels of health vary significantly among the countries. The difference in overall life expectancy among the countries of the Region was over 19 years for both males and females in 2016 (Figure 2.1). There are also substantial within-country inequalities in life expectancy and health, based on gender, ethnicity, and socioeconomic position.

Figure 2.1.

Life expectancy at birth, by sex, Region of the Americas, 2016



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

2.2 THE HEALTH DIVIDE BETWEEN COUNTRIES

The first major type of health inequality is that among countries—the topic of this section. The challenge is to bring the health of all countries up toward that of the best. As will be illustrated in subsequent sections, there are also major inequalities within countries. Reducing health inequities within countries will be a major step in improving average health of countries, as illustrated by the figures in this section.

INEQUALITIES IN LIFE EXPECTANCY

The variation in life expectancy shown in Figure 2.1, from 66 to 85 years for females and from 61 to 80 years for males across the Region in 2016, indicates the considerable scope for improvement across countries.

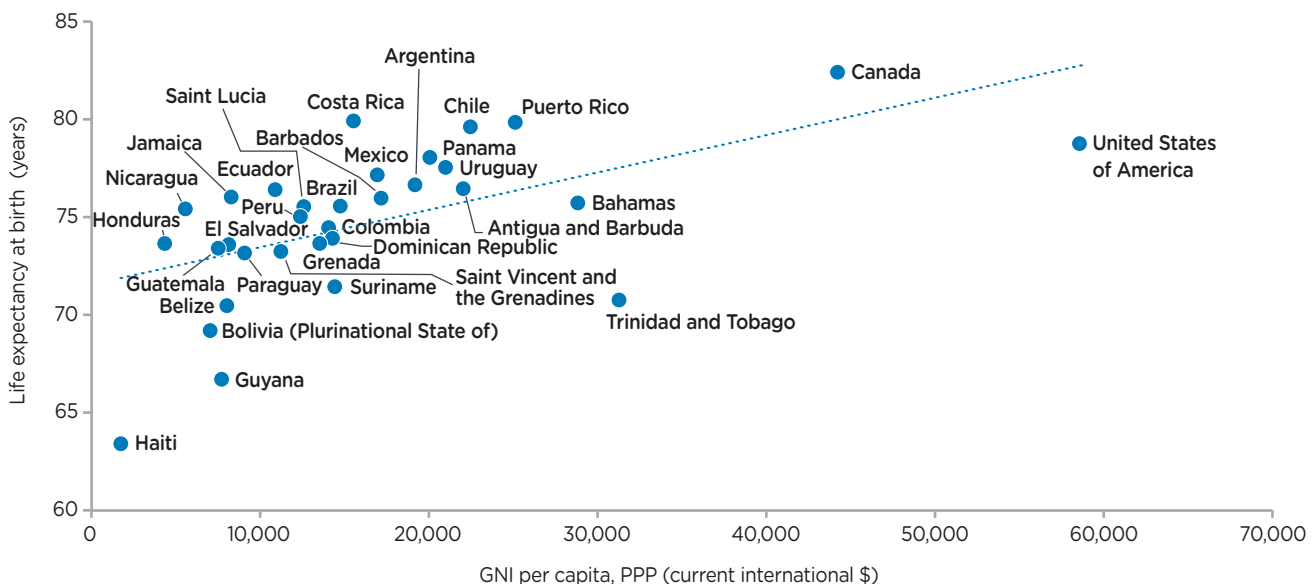
The relationship between health, as measured by life expectancy, and country income level is illustrated in Figure 2.2 by the so-called “Preston curve.” This shows that health improves in a roughly linear way with increased gross national income (GNI) per capita in countries where annual income is less than US\$ 10,000 per capita based on purchasing power parity (PPP). The relationship is less dramatic in countries where GNI is between US\$ 10,000 and US\$ 40,000 per capita, and there is no increase in life expectancy where GNI exceeds this amount. As an

illustration, in Chile, Costa Rica, and Puerto Rico, life expectancy is around 80 years and income per capita is between US\$ 15,000 and US\$ 25,000, while in the United States of America life expectancy is slightly lower—79 years—even though income per capita in 2017 was considerably higher, at over US\$ 58,000.

HEALTH AND SURVIVAL AT THE START OF LIFE

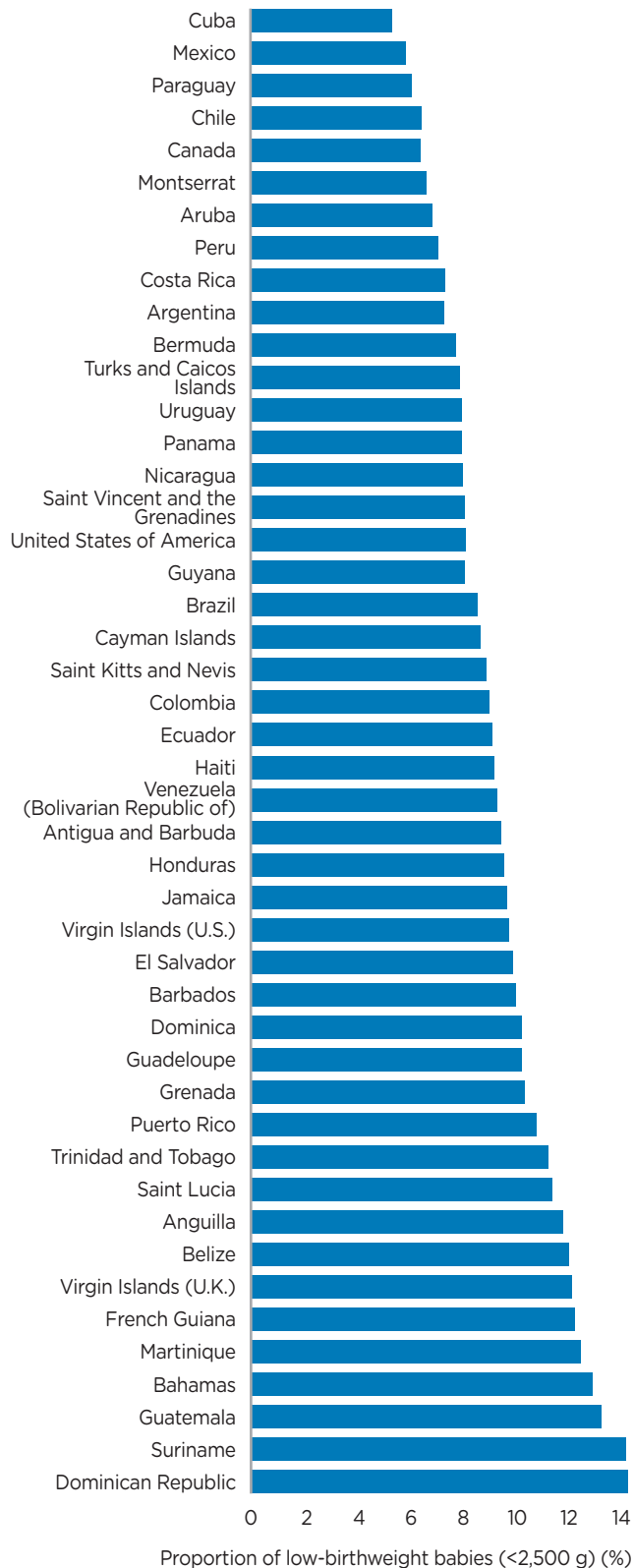
There are substantial inequalities in health at the start of life. An indicator of the quality of a pregnancy is the proportion of low-birthweight babies born. This includes both babies with lower levels of growth than normal, and those who, for this or other reasons, are born prematurely. In both cases, low birthweight can cast a shadow over the child’s subsequent health and this development throughout life.

Figure 2.2. Life expectancy by gross national income (GNI) per capita (current international \$ PPP), Region of the Americas, 2017, or latest earlier available year



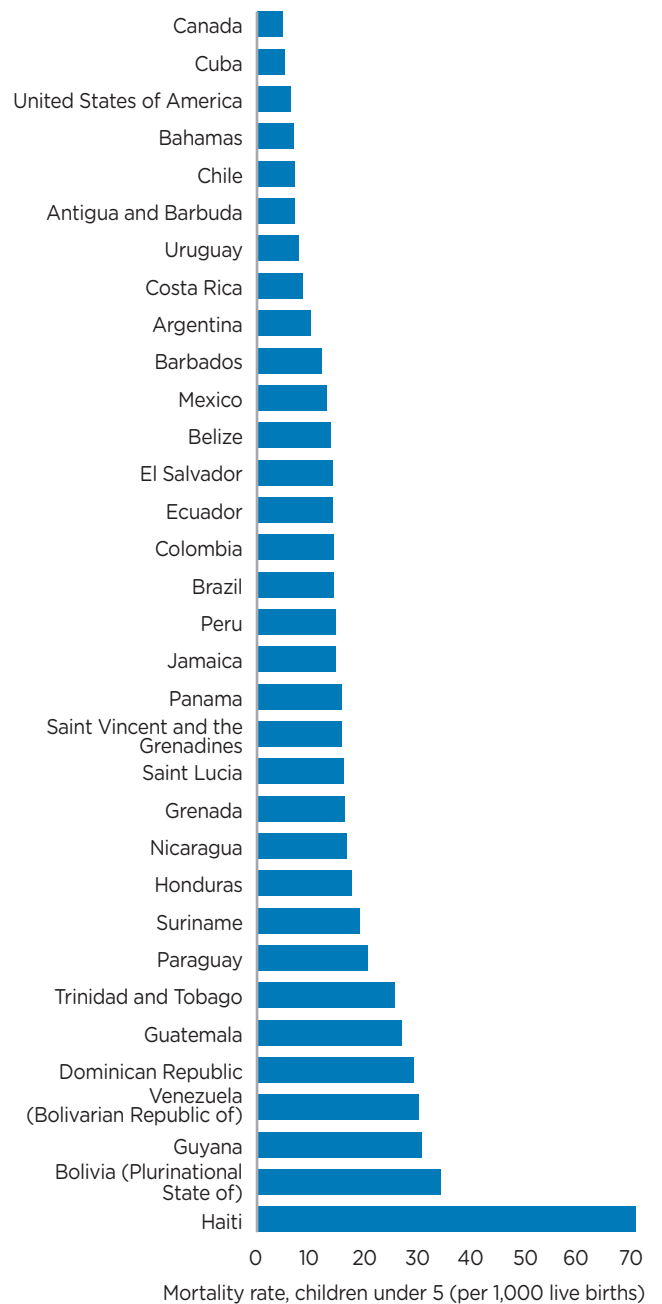
Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

Figure 2.3.
Proportion of low-birthweight babies,
Region of the Americas, 2016



Source: Pan American Health Organization. PLISA Health Information Platform for the Americas. Core indicators [Internet]; 2018 [cited 7 Nov 2018]. Available from: <http://www.paho.org/data/index.php/en/indicators/visualization.html>.

Figure 2.4.
Under-5 mortality rates, Region of the
Americas, 2017



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

Figure 2.3 shows marked variation in the proportion of live births that are of low birthweight across the Americas—from just over 5 percent in Cuba to over 15 percent in several other countries (19).

Under-5 mortality rates are shown in Figure 2.4. A large proportion of these deaths occur in the



Young mother in traditional Mayan dress nursing her baby while selling crafts, Chichicastenango, Guatemala

days and weeks after birth, and they mainly reflect pregnancy outcomes and the conditions under which babies enter the world. This is discussed further in Recommendation 4.

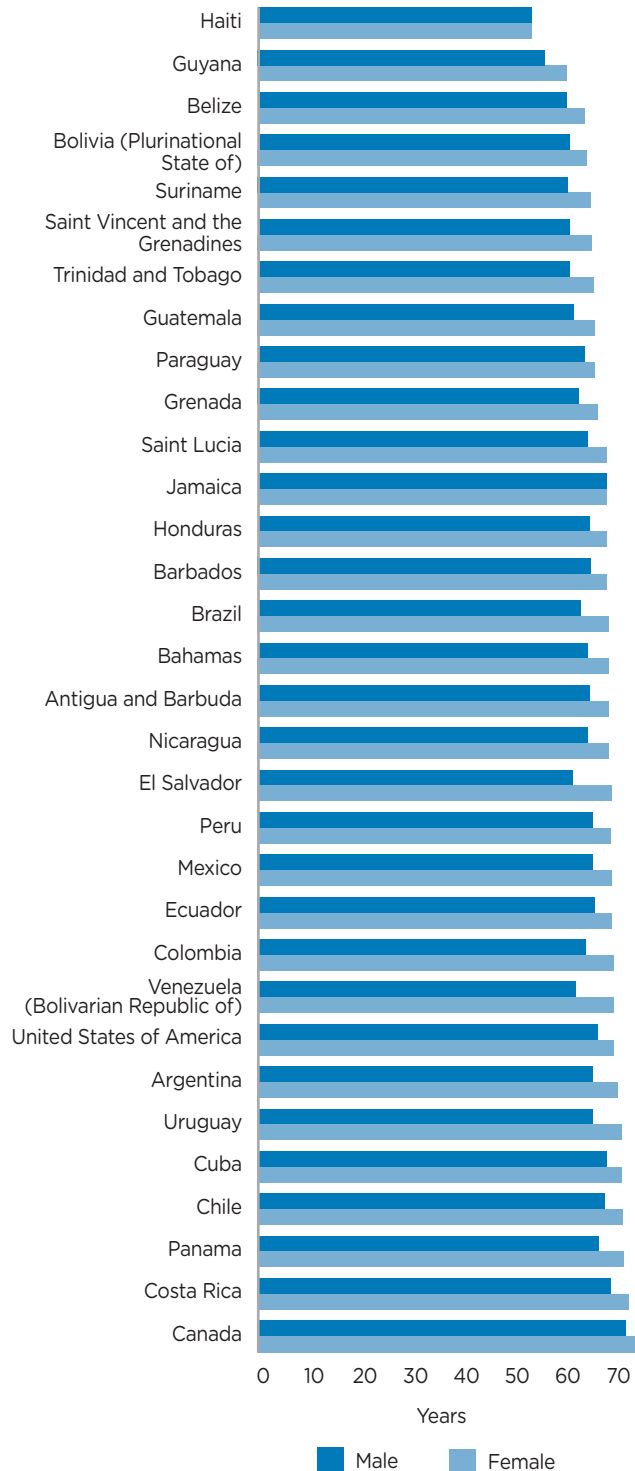
HEALTH STATES OVER THE LIFE COURSE

While mortality, as reflected in life expectancy and death rates in early years, is a powerful measure of unequal experiences in life, it does not fully reflect the health consequences of unequal lives. There are also inequalities in how long people can expect to live a healthy life. In 2016, it was estimated that the average health-adjusted life expectancy (HALE) in the Americas was 65 years, and it ranged from 57 and 54 for females and males, respectively, in Haiti to 74 and 72 years in Canada (Figure 2.5) (20).

INFECTIOUS DISEASES

While substantial progress has been made in the Region in reducing both the incidence and the impact of the most serious infectious diseases, significant challenges remain, including recently from the Zika virus. Many of these threats to health and causes of mortality are more prevalent in areas containing populations in the most vulnerable situations—in poverty, poor housing, and adverse work conditions, each of which increases exposure. Chapter 3 of PAHO's *Health in the Americas 2017* publication points to the main sources of data on disease prevalence, fatality, and prevention programs (21). Information on the distribution of childhood immunization is also available from the WHO Health Equity Assessment Toolkit (HEAT) database (22).

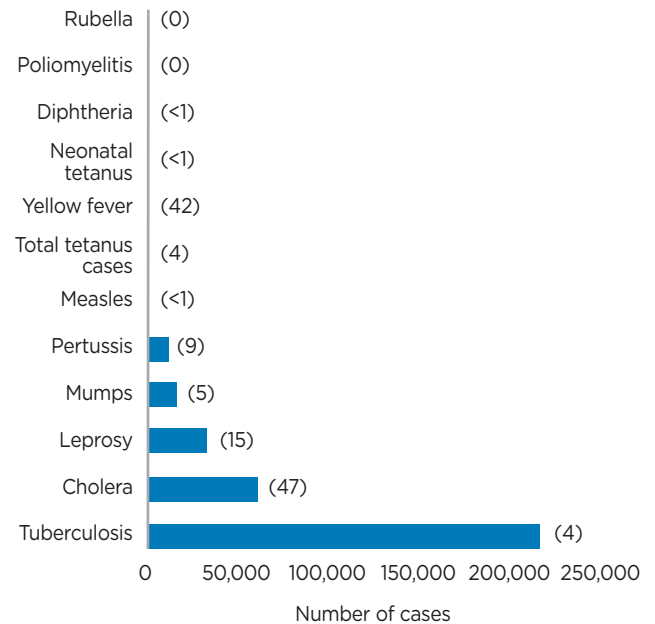
Figure 2.5.
Health-adjusted life expectancy (HALE) at birth, by sex, Region of the Americas, 2016



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

Note: HALE is a measure of population health that takes into account mortality and morbidity. It adjusts overall life expectancy by the amount of time lived in less than perfect health. This is calculated by subtracting from the life expectancy a figure that is the number of years lived with disability multiplied by a weighting to represent the effect of the disability.

Figure 2.6.
Number of infectious disease cases in the Americas (with percent of world total cases in parentheses), 2014



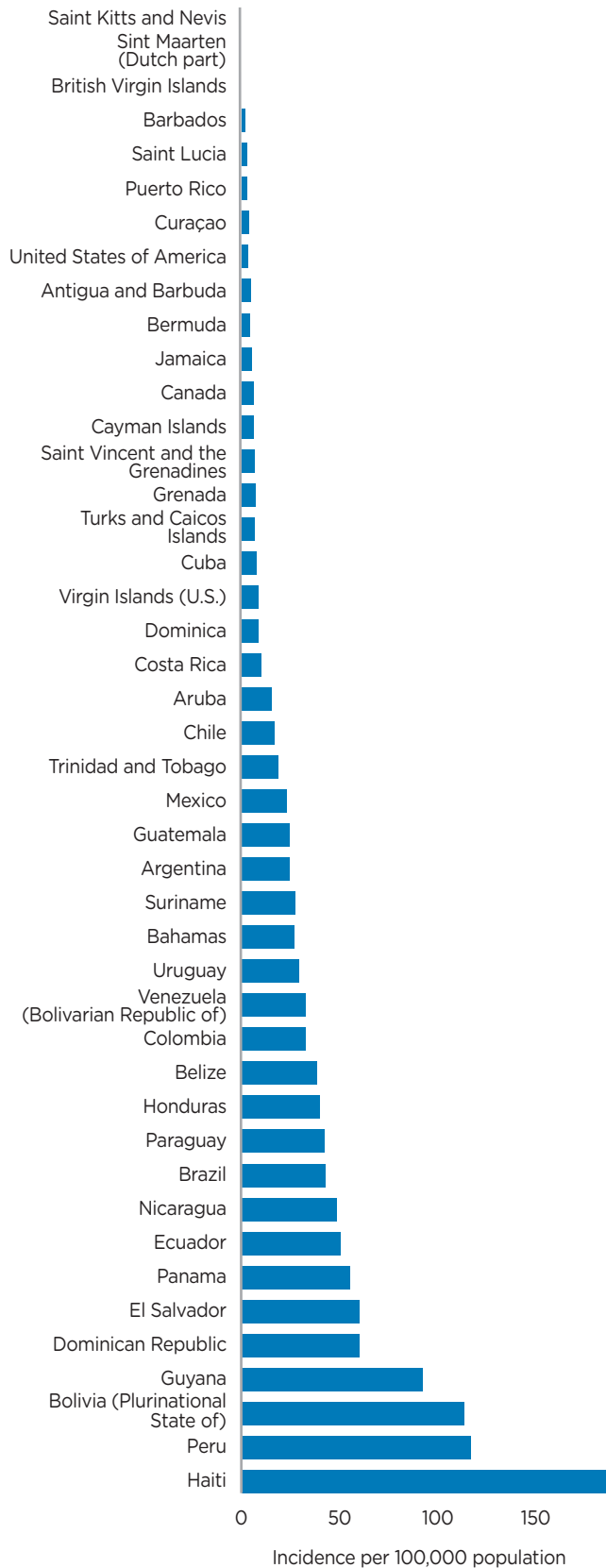
Source: World Health Organization. Global Health Observatory data repository [Internet]; 2018. Available from: <http://apps.who.int/gho/data/node.home>.

Figure 2.6 shows the share of infectious diseases routinely monitored by WHO that occur in the Americas. Nearly half of all cholera cases recorded worldwide, one of the more common diseases, and 15 percent of leprosy cases, were recorded in the Americas in 2014. It is important to consider absolute numbers too: for example, while the Americas accounted for less than 4 percent of tuberculosis (TB) cases recorded globally in 2014, this represented more than 200,000 cases (20).

Figure 2.7 shows the unequal distribution of TB cases across the Americas, with fewer than 10 cases per 100,000 people recorded in most countries in 2016, but over 50 per 100,000 in seven countries.

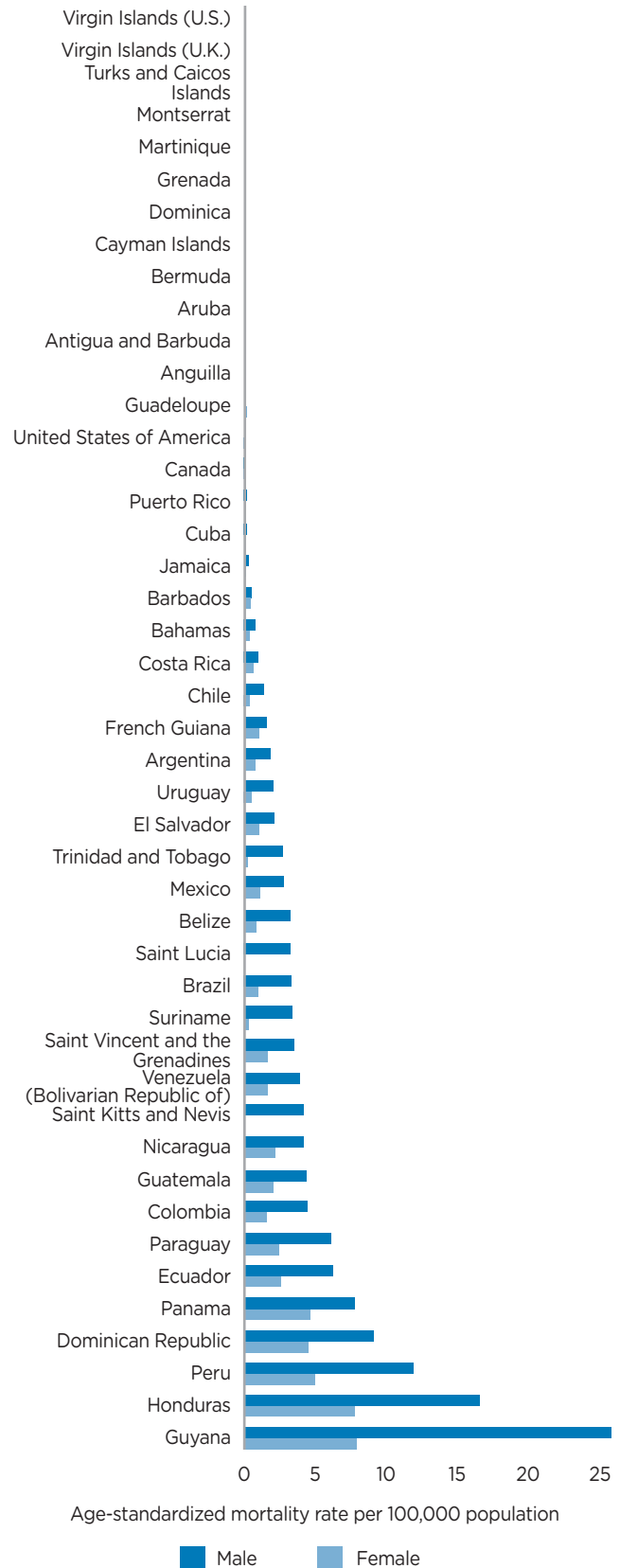
Figure 2.8 shows that death rates from TB differ markedly between men and women (data from 2016), although countries where rates are high among men also tend to have the highest rates among women. Among women, death rates were less than five per 100,000 in all but three countries, while for men rates exceeded this figure in seven countries.

Figure 2.7.
Incidence of tuberculosis, Region of the Americas, 2016



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

Figure 2.8.
Death rate from tuberculosis, by sex, Region of the Americas, 2016



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

There is considerable variability in the reported prevalence of HIV among those aged 15 to 49 in Latin America and the Caribbean, as shown in Figure 2.9. Ten countries reported levels below 0.5 percent of the population in this age group in 2017, and six reported levels above 1.5 percent.

NONCOMMUNICABLE DISEASES

The global burden of noncommunicable diseases such as cancer, circulatory disease, and diabetes is increasing. Social gradients are evident in many of the most serious of these diseases, with marked differences by socioeconomic position, ethnicity, and sex. International databases provide information on sex differences but not on within-country inequalities by ethnicity and geography. In most countries where data on socioeconomic inequalities are available, it comes from special research studies or surveys.

Figure 2.10 shows the distribution of age-standardized death rates from cancer across the Americas in 2014. Rates varied from around 50 or fewer per 100,000 for both men and women in some countries to between two and three times that number in 12 countries for women, and more than three times that figure in six countries for men.

The age-standardized rates of circulatory diseases in 2014 were fewer than 100 per 100,000 for women in 10 countries but over 400 per 100,000 in two countries (Figure 2.11). Among men, only three countries had rates below 100 per 100,000, while a further three had rates in excess of 400 per 100,000.

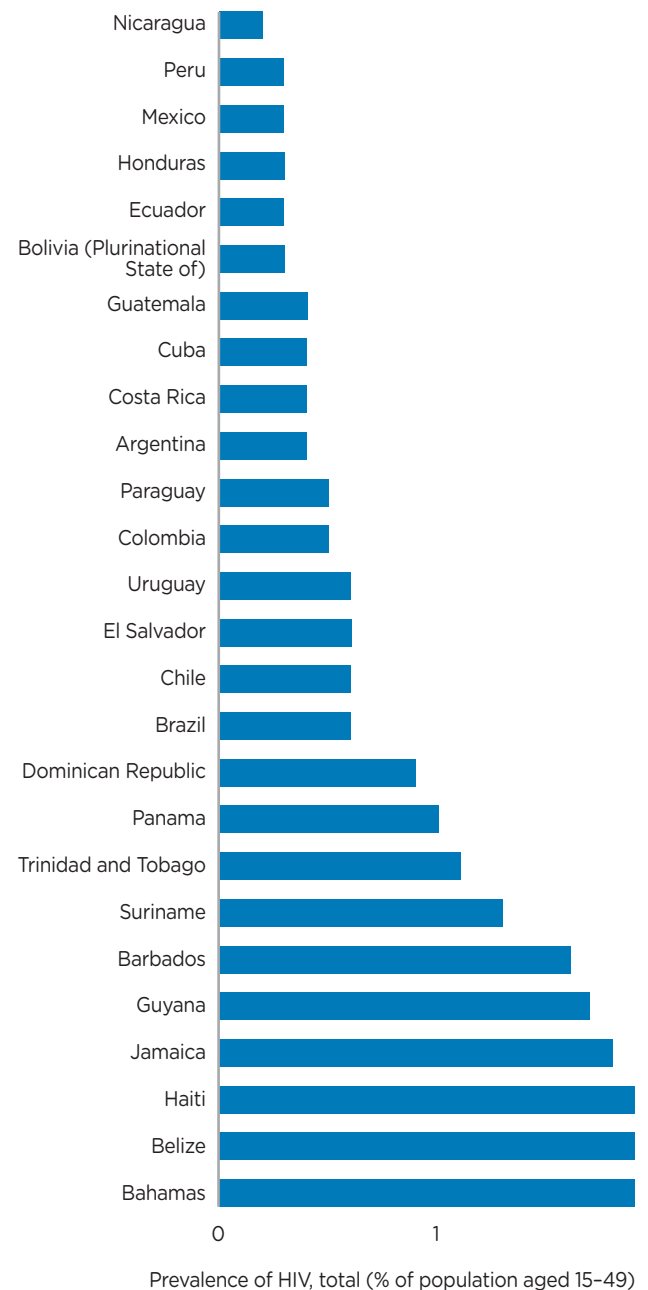
BEHAVIORAL AND ENVIRONMENTAL RISKS

This subsection summarizes current differences in some key health-related behaviors, and variations in air pollution risk and risk of accidents and violence, that contribute to many of the differences discussed above.

Smoking

The progress of smoking epidemics varies considerably across countries, among social groups, ethnic groups, by sex, and by level of vulnerability. Once an epidemic is established in a country, smoking levels tend to be highest and most persistent among the least advantaged and those in the most stressful situations. The current position of the Americas on smoking in terms of

Figure 2.9.
Prevalence of HIV, countries with available data in Latin America and the Caribbean, 2017



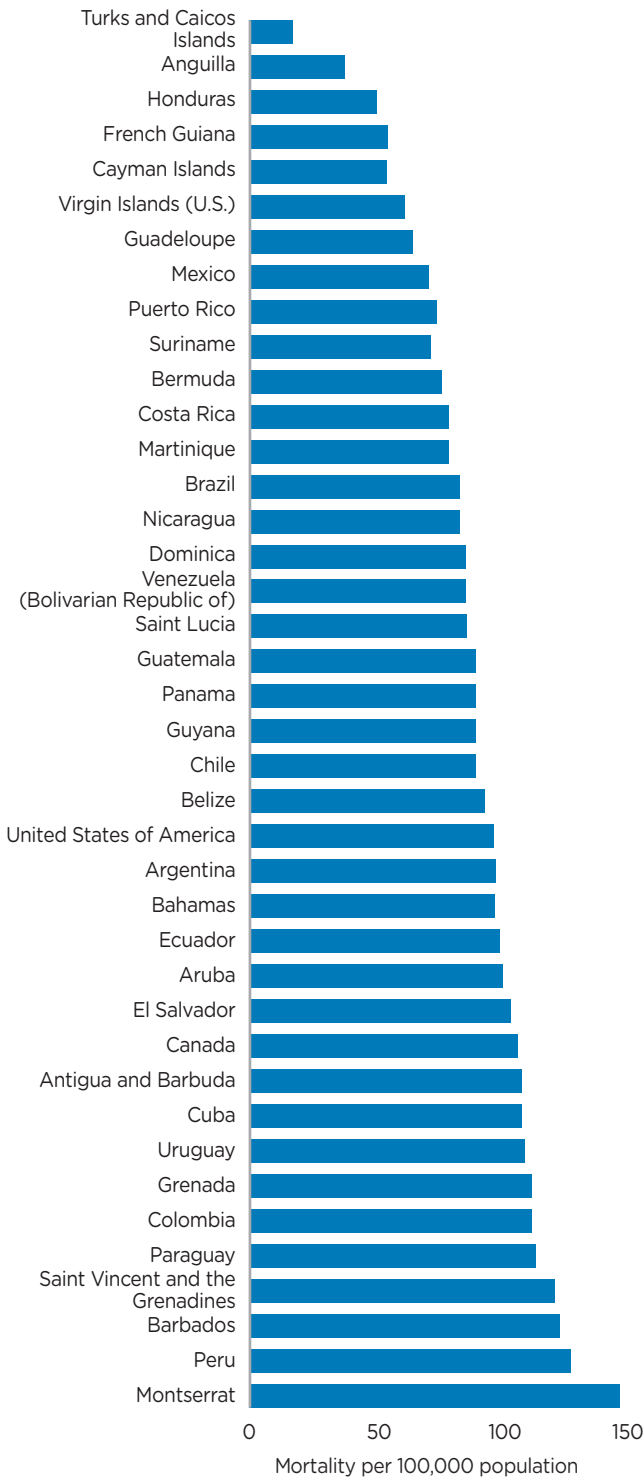
Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

prevalence and control measures is summarized in the PAHO report titled *Tobacco Control in the Region of the Americas* (23), and globally in other WHO sources (20). Current social distributions need to be obtained from survey, cohort, or research data.

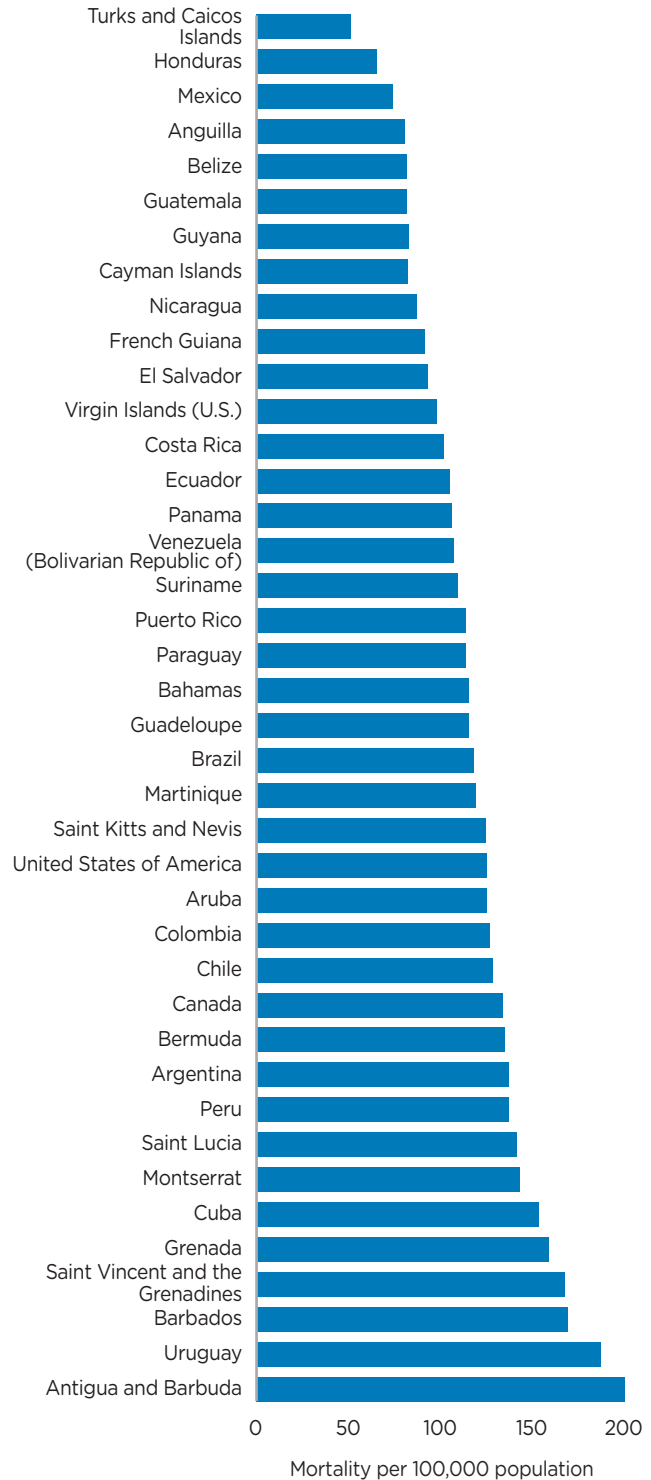
Figure 2.10.

Age-standardized mortality rates from cancer, by sex, Region of the Americas, 2014 or latest available

A) Females



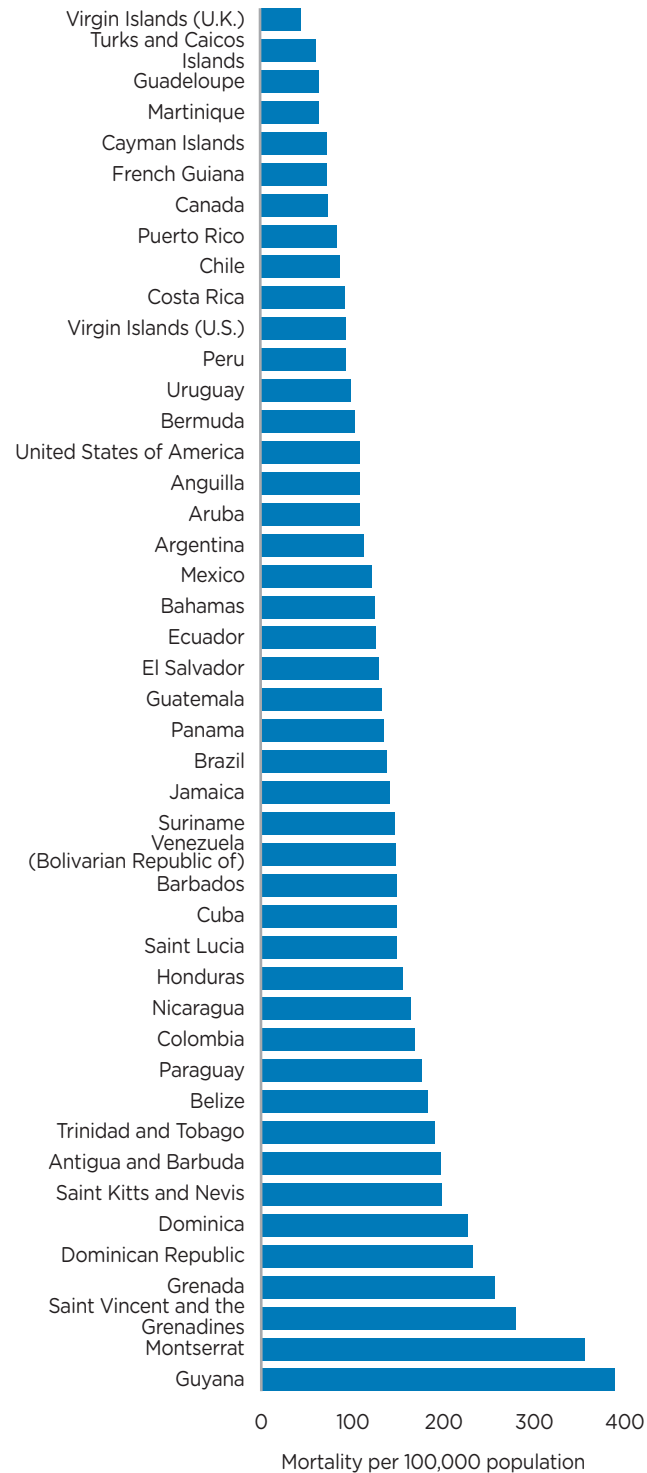
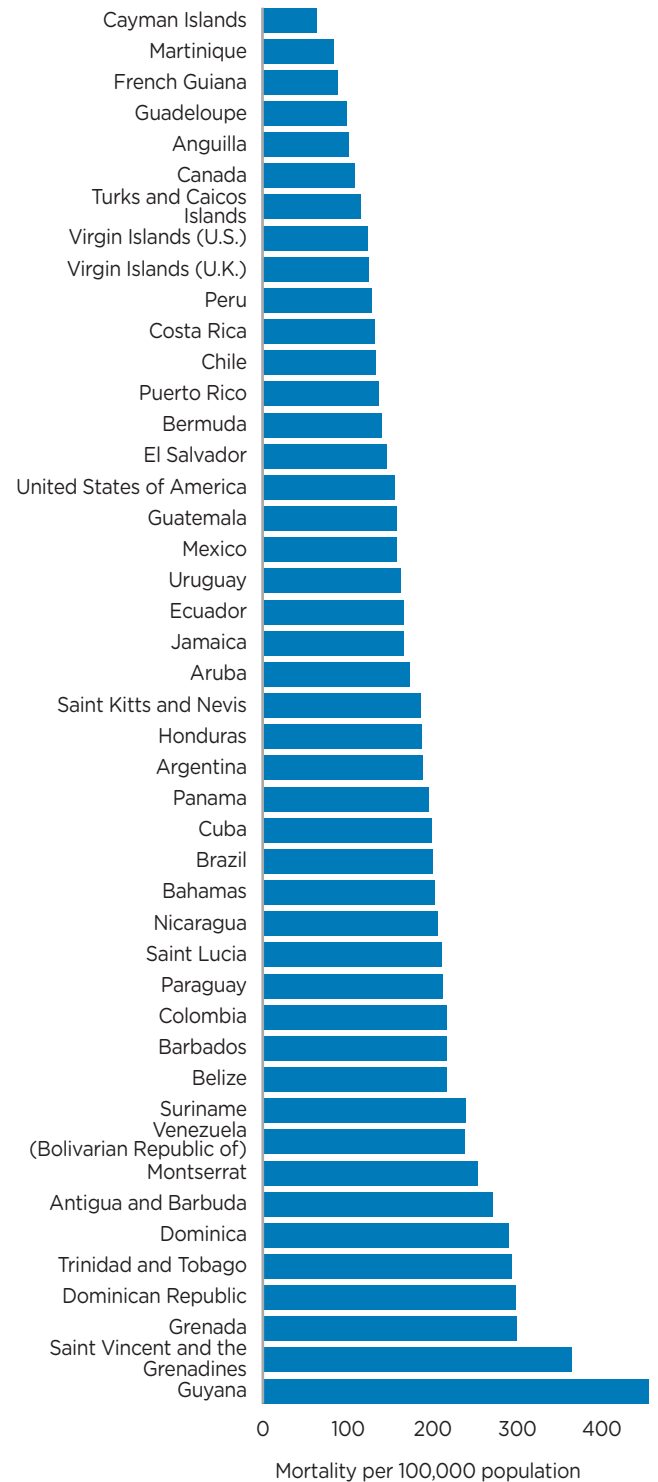
B) Males



Source: Pan American Health Organization. PLISA Health Information Platform for the Americas. Core indicators [Internet]; 2018 [cited 7 Nov 2018]. Available from: <http://www.paho.org/data/index.php/en/indicators/visualization.html>.

Figure 2.11.

Age-standardized death rates from circulatory diseases, by sex, Region of the Americas, 2014 or latest available year

A) Females**B) Males**

Source: Pan American Health Organization. PLISA Health Information Platform for the Americas. Core indicators [Internet]; 2018 [cited 7 Nov 2018]. Available from: <http://www.paho.org/data/index.php/en/indicators/visualization.html>.

Figure 2.12 shows the range in smoking rates among selected countries in the Americas. Rates for women in 2016 were uniformly lower than for men—below 5 percent in several countries, and below 40 percent in all countries shown. Nonetheless, the span—from under 5 percent to over 15 percent in several countries—is considerable. For men, rates varied from 10 percent to over 40 percent in three of the countries shown. The gap between male and female smoking rates also varies considerably. In all the countries shown, men have higher rates. The smallest differences are found in Canada, Chile, the United States of America, and Uruguay.

Data are available for the proportion of smokers in Canada by household income. Among households within the lowest income quintile, more than one in five Canadians were smokers in 2017 (22 percent), whereas the figure for households in the highest income quintile was just over one in ten (12 percent).

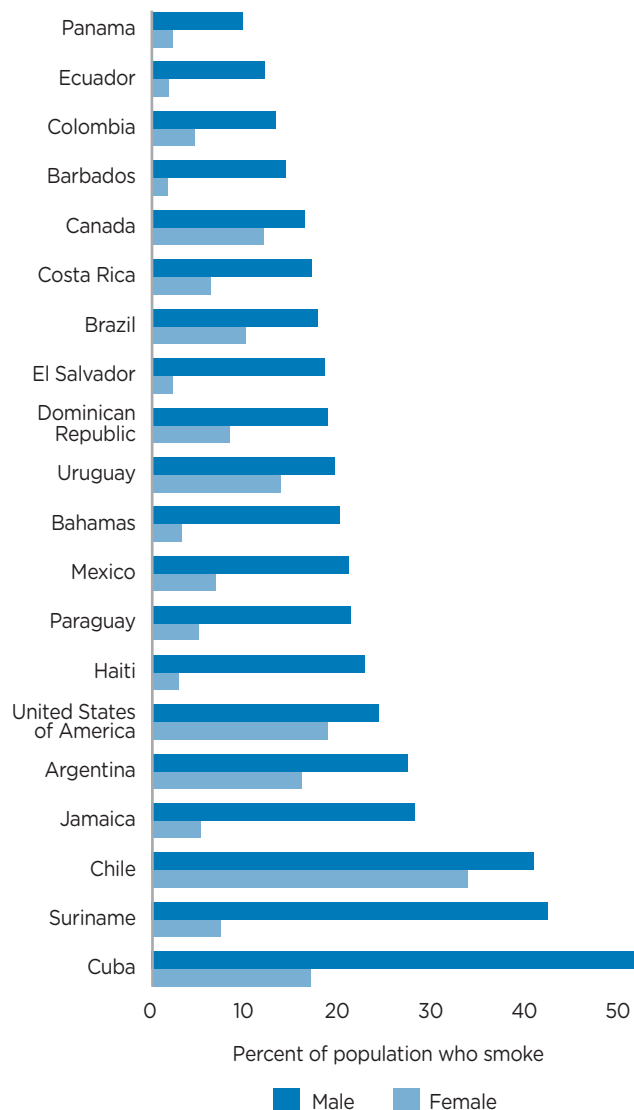
Alcohol

There is a close relationship between a country’s total per capita alcohol consumption and its prevalence of alcohol-related harm and dependence. Excessive consumption, which tends to be more common in countries with high overall levels of consumption, damages physical and mental health, and contributes to physical injury to self and others. The health effects of alcohol depend on both patterns of alcohol consumption and other associated causes that render people at social disadvantage at higher risk of alcohol-associated harm (18). Patterns of consumption are influenced by psychosocial factors, local cultural attitudes toward alcohol, price, and availability.

According to PAHO’s *Health in the Americas 2017* report (21), alcohol consumption in the Region is approximately 40 percent greater than the global average, and the typical drinking pattern of adults in the majority of countries in the Americas is hazardous to health. In 2000, alcohol was the most important risk to health in low- and middle-income countries in the Americas.

Data on usage and harm by socioeconomic group, sex, Indigenous populations, and other ethnic groups come mainly from survey data and research. The United States of America has data on the proportion of the population who binge drink alcohol by ethnicity; White people in the United States of America are more likely than others to binge drink.

Figure 2.12. Smoking rates, by sex, selected countries in the Americas, 2016



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

Note: Current smoking of any tobacco product (age-standardized rate).

Drug use

Although illegal drugs are used more frequently in the high-income countries of the Americas, the health consequences of drug dependency—disease, disability, and death—are felt disproportionately in low- and middle-income countries, among people who have less access to treatment and health care. A summary of available survey data is provided in the PAHO report *Drug Use Epidemiology in Latin America and the Caribbean: A Public Health Approach* (24). There is a need for surveys to provide more disaggregated data.



Community health session, Moskitia region, Honduras

Obesity

Prevalence of obesity in the Americas has increased in recent years and in some countries it has doubled (27). Obesity affects all age groups, ethnicities, cultures, and genders. Being overweight or obese during childhood has both immediate and long-term health effects. Increasingly, obese children in the Americas are being diagnosed with a range of health conditions previously seen almost exclusively among adults, including high cholesterol, high blood pressure, type 2 diabetes, sleep apnea, and joint problems. Moreover, being overweight or obese in childhood significantly increases the risk of overweight or obesity in adolescence and adulthood (25).

Obesity has multiple causes, including unhealthy diet and physical inactivity, which are closely linked to an increasing “obesogenic environment” and are associated with social determinants such as poverty, low education, food insecurity, more sedentary working practices, cultural norms that encourage certain diets, and lifestyle influences.

Figure 2.13 shows the proportion of the population overweight at ages 20 to 74 among men and women. For both sexes, there were only a small number of countries where less than 40 percent of the age group were overweight in 2016. For both sexes, the level of overweight reaches over 70 percent in the countries with the highest levels.

Air pollution

Air pollution has become a growing concern in the past few years. Ambient (outdoor) and household (indoor) air pollution are jointly regarded as the biggest current environmental risk to health, estimated to be responsible for about one in every nine deaths globally. People who cook using solid fuels (such as wood, crop wastes, charcoal, coal, and dung) and kerosene in open fires and inefficient stoves are at the highest risk from indoor air pollution, particularly if the cooking is done in poorly ventilated rooms. Most of these people are poor, and live in the Region’s low- and middle-income countries. Towns and cities in many low- and middle-income countries in the Region also have elevated levels of ambient air pollution. The threats from household and ambient air pollution are discussed in more detail in Recommendation 9.

ACCIDENTS, VIOLENCE, AND CONFLICT

The impact of serious injuries and death is greatest among the poorest and those in the most vulnerable situations in the Americas, as is the case in other world regions.

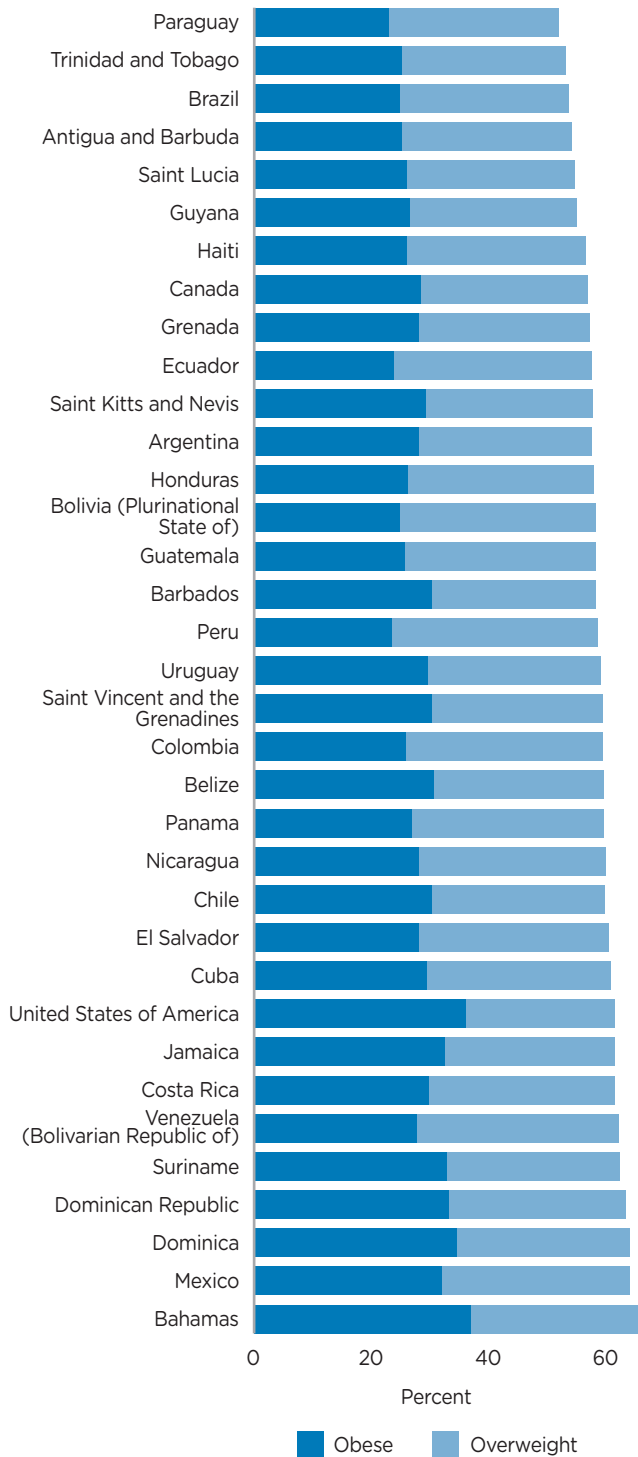
Road traffic and work-related accidents

Road traffic accidents predominantly affect men in the Americas, and rates per registered car vary considerably across the Region: car occupants

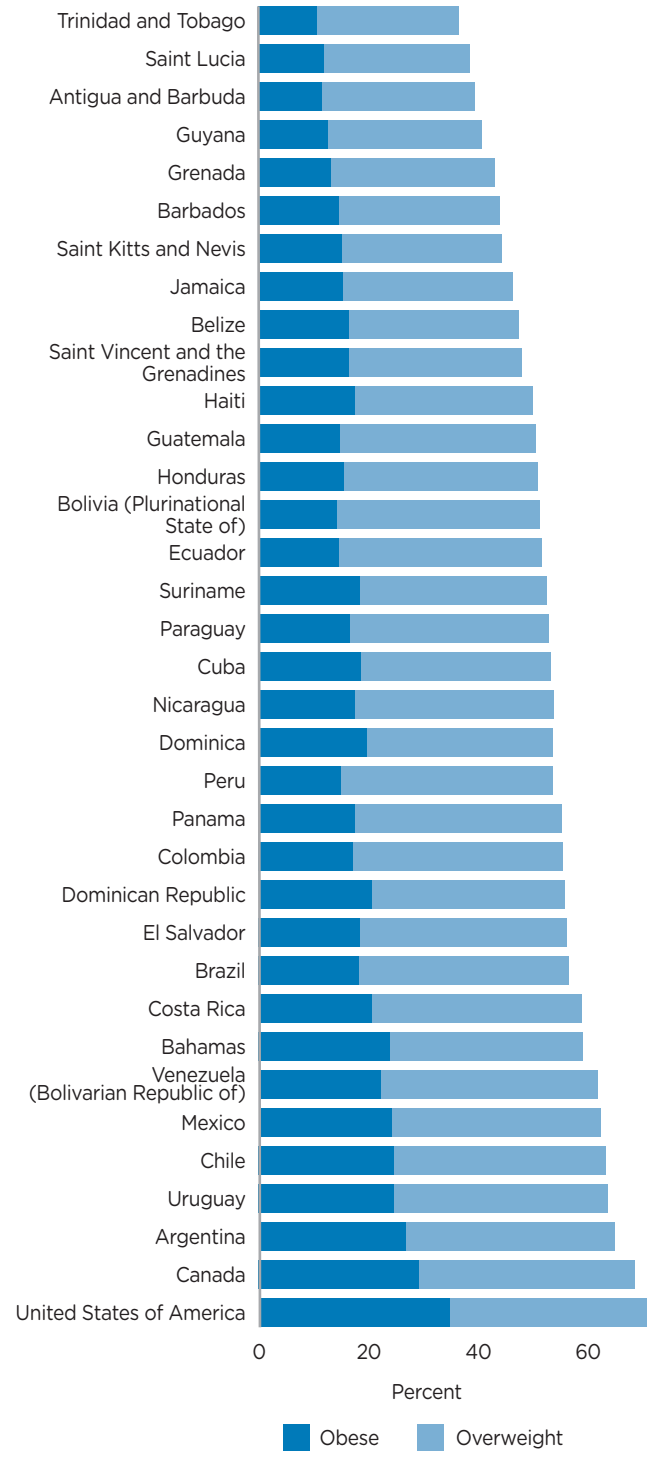
Figure 2.13.

Prevalence of overweight and obesity among adults ages 18 and over, by sex, Region of the Americas, 2016 (percent)

A) Females



B) Males



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

Note: Among those aged 18 and over, overweight is having a body mass index (BMI) that is equivalent to at least 25 but less than 30. Obesity is having a BMI of 30 or more.

are predominantly the victims in North America (Canada and the United States of America) while pedestrians and motorcyclists are the main victims elsewhere in the Region.

Among the countries shown in Figure 2.14, around three-quarters of countries in the Americas had death rates from road traffic accidents below 10 per 100,000 population for women in 2016. For men, only two countries had rates below 10 per 100,000 and four had rates in excess of 50 per 100,000 (19).

Serious occupational injuries and deaths due to accidents at work are most common in unregulated work environments, in which the most vulnerable are often employed, and are discussed in Recommendation 5.

Violence, suicide, and mental illness

Criminal violence occurs in all parts of the Americas. It particularly affects certain countries and communities, men, and some ethnic groups, and it is discussed further in Recommendation 8.

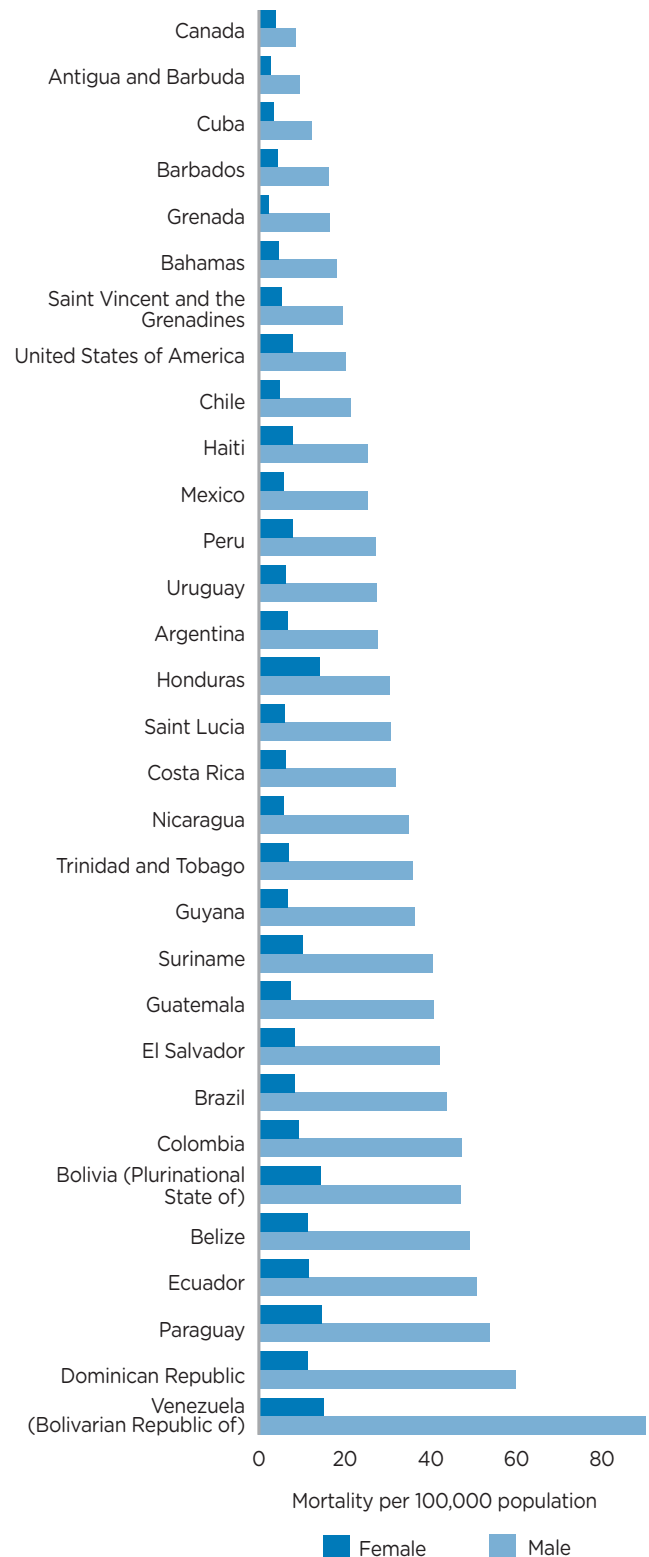
In some countries in recent years, the number of deaths associated with conflict has also been high, according to reports by the United Nations Development Programme (UNDP) and others (26). Even in places where a conflict has ended, there can be long-term impacts on development and crime-related violence, with associated impacts for health. This is particularly true in poorer areas and for groups in the most vulnerable situations, such as minority ethnic groups.

Mental illness and suicide

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 treatments. Such inequalities are seen among different ethnic groups in the Americas, as well as different socioeconomic groups, and between men and women (27). While not all mental illness leads to suicide, and not all suicide relates to mental illness, suicide is one possible outcome of mental illness (27).

Figure 2.15 shows rates of suicide in the Region, with the highest rates for both males and females in 2016 being found in Guyana and Suriname. In every country, rates are higher for men.

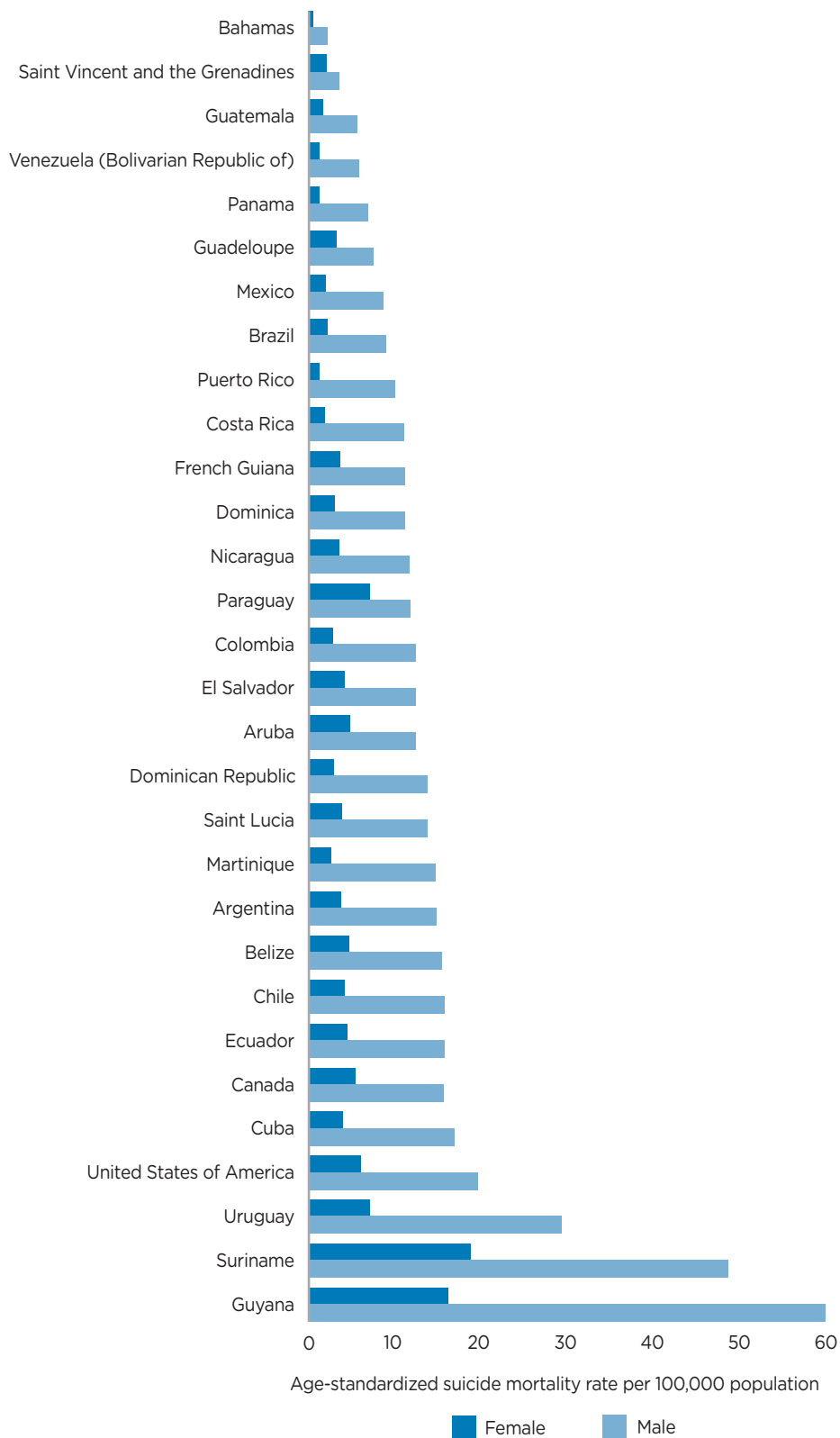
Figure 2.14.
Age-standardized mortality rate from road traffic accidents at ages 15 and over, by sex, Region of the Americas, 2016



Source: Pan American Health Organization. PLISA Health Information Platform for the Americas. Core indicators [Internet]; 2018 [cited 7 Nov 2018]. Available from: <http://www.paho.org/data/index.php/en/indicators/visualization.html>.

Figure 2.15.

Death rates from suicide, by sex, Region of the Americas, 2016



Source: Pan American Health Organization. PLISA Health Information Platform for the Americas. Core indicators [Internet]; 2018 [cited 7 Nov 2018]. Available from: <http://www.paho.org/data/index.php/en/indicators/visualization.html>.

2.3 DEMOGRAPHIC PATTERNS AND TRENDS

Rates of ill health vary by age, sex, ethnicity, and socioeconomic status. For this reason, populations' age and sex structures, and changing ethnic composition, contribute to differences in the burden of ill health across the Region, both in terms of how those differences affect the capacity of health systems to deliver care, and in relation to the absolute scale of health inequity.

Changes in fertility rates and dependency ratios are correlated with specific health outcomes and with some of the key life-course factors associated with health status, such as women's employment rates and poverty in old age.

FERTILITY RATES

The two subfigures of Figure 2.16 show the convergence of fertility rates that is beginning to occur in the Americas. Countries currently with the highest fertility rates (Figure 2.16A) have all seen dramatic reductions in these rates since 2002, while some of those with the lowest rates (Figure

2.16B) have seen stagnating rates, or very moderate increases.

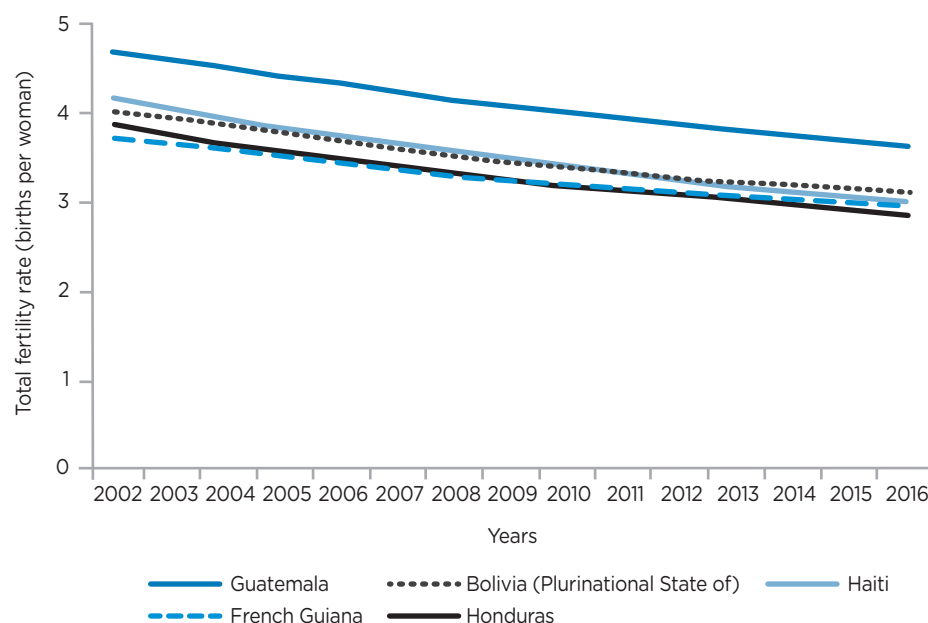
OLDER PEOPLE

Inequities in older people's health and well-being to a considerable extent relate to differences in conditions experienced earlier in their lives—the accumulation of advantage and disadvantage that takes place across the life course—for instance in income and education. However, the living conditions experienced during older age itself—such as housing, social isolation, and poverty—also contribute to health inequities, and

Figure 2.16.

Highest and lowest total fertility rates, Region of the Americas, 2016, and changes over time, 2002–2016

(A) Countries with the five highest fertility rates in the Region of the Americas in 2016

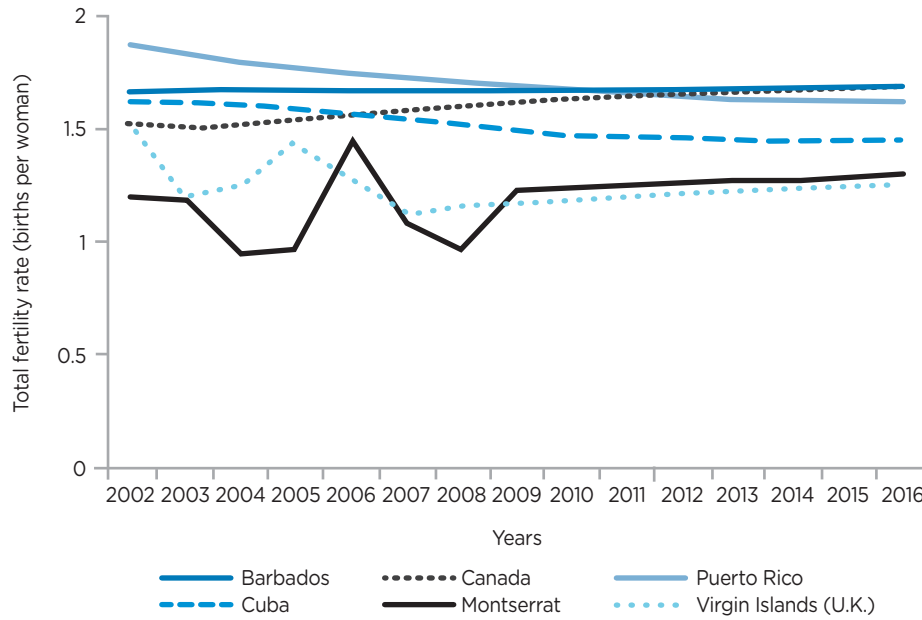


Source: Pan American Health Organization. PLISA Health Information Platform for the Americas. Core indicators [Internet]; 2018 [cited 7 Nov 2018]. Available from: <http://www.paho.org/data/index.php/en/indicators/visualization.html>.

Figure 2.16. (continued)

Highest and lowest total fertility rates, Region of the Americas, 2016, and changes over time, 2002-2016

(B) Countries with the six lowest fertility rates in the Region of the Americas in 2016

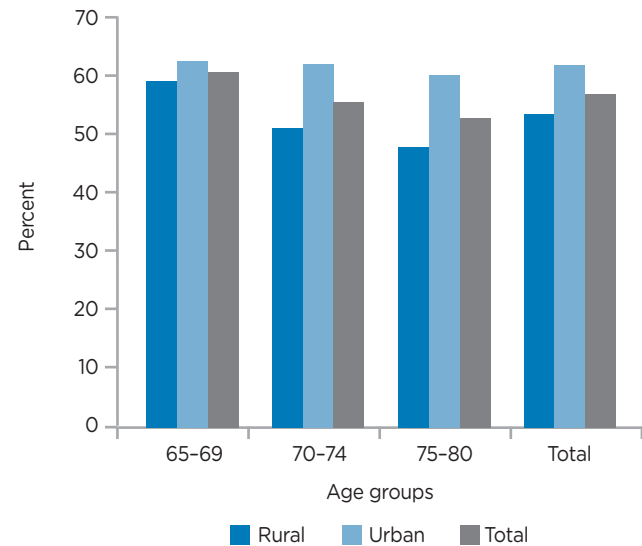


Source: Pan American Health Organization. PLISA Health Information Platform for the Americas. Core indicators [Internet]; 2018 [cited 7 Nov 2018]. Available from: <http://www.paho.org/data/index.php/en/indicators/visualization.html>.

are discussed in Section 6. The greater frequency of health problems (and indeed mortality) at older ages tends to result in lower relative differences in health according to social factors than at younger ages, but greater absolute differences. Where data are available in countries around the world, there are also clear differences in older people’s health related to their sex and ethnicity.

Inequalities in the percentage of older people reporting good or very good health also vary by geographic region. Figure 2.17 shows that older people in urban areas report better health than in rural areas, and these differences are amplified as people age.

Figure 2.17. Percentage of older persons reporting good or very good health by age, and rural/urban residence, 2012



Source: Pan American Health Organization. PLISA Health Information Platform for the Americas. Core indicators [Internet]; 2018 [cited 7 Nov 2018]. Available from: <http://www.paho.org/data/index.php/en/indicators/visualization.html>.

2.4 TRENDS IN LIFE EXPECTANCY

The main focus of the preceding discussion has been on the current or most recently available information and evidence on inequities in health among countries of the Americas. In this subsection, some trends are presented. This is important not only for providing a historical context to the patterns but also, and more importantly, as a pointer to future trends.

Life expectancy has been increasing in the Americas, as it has in much of the rest of the world. Figure 2.18 highlights how this trend has affected individual countries. For simplicity of presentation, the four subfigures focus on the 10 countries that currently have the highest life expectancies and those with the lowest, for each sex.

For women in countries with high life expectancy (Figure 2.18A), the values differ by only around four years, and most countries have seen increases although at slightly different rates. Canada, for example, has been overtaken by the Bahamas, where life expectancy has increased on a steeper trajectory. It has been a different story in the United States of America, where female life expectancy has stagnated at around 81 years since 2009 (7). Differences among countries with the lowest life expectancies (Figure 2.18B) are considerable, but the gaps are being reduced as increases take place in most countries, and the largest increases are being seen in those with the lowest levels previously (Haiti and the Plurinational State of Bolivia). However, there has

been little improvement in female life expectancy in Guyana (7).

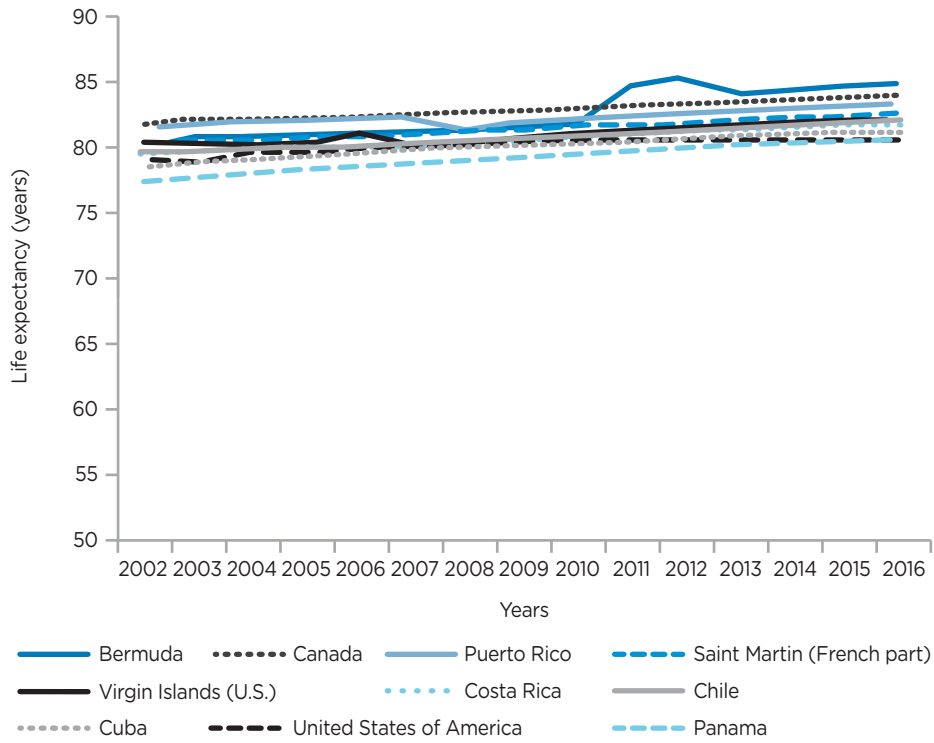
Among men, differences in levels and rates of increase in life expectancy are similar to those for women among the countries with the highest overall life expectancies (Figure 2.18C). Canada has remained the country with markedly higher life expectancy than the others. Male life expectancy has decreased slightly in the United States of America since 2014 (7). There were considerable differences in the average male life expectancy among countries with low life expectancy (Figure 2.18D), as is the case for women, although Haiti has slightly narrowed the gap that existed between it and the rest of the Region in 2002. Improvements in male life expectancy in Belize, Guyana, and Trinidad and Tobago have, however, been very modest in recent years.

Policies that impact on the ethnic and sex structure of a population also change health outcomes over time. All of this has an impact on the factors that cause health inequities, and on our measurement and interpretation of health differences.

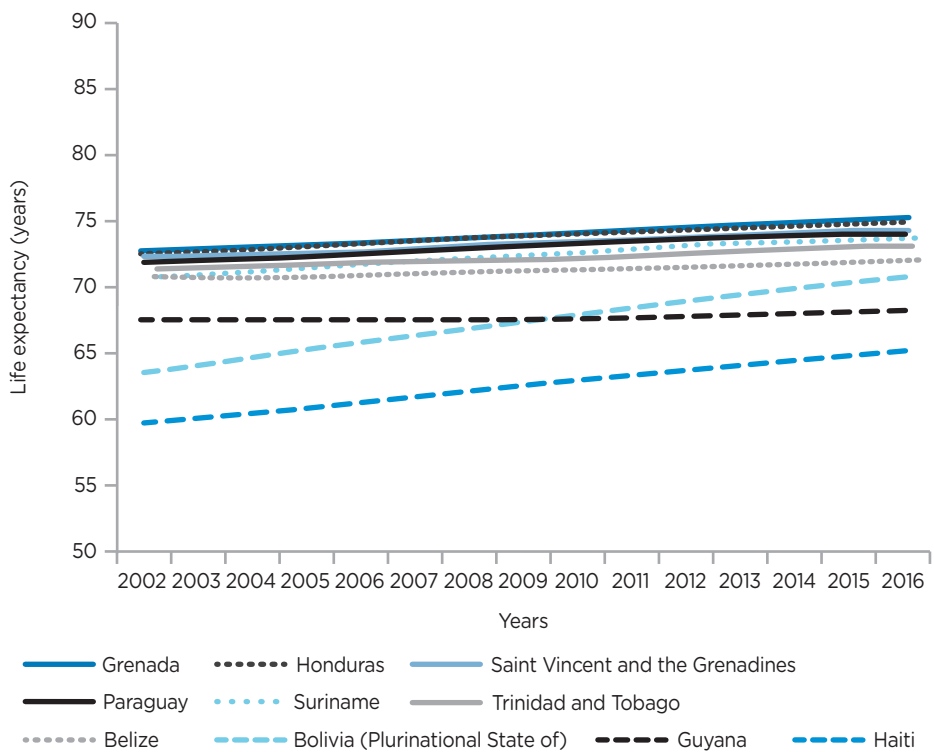
Figure 2.18.

Highest and lowest life expectancy, by sex, Region of the Americas, 2016, and changes over time, 2002-2016

(A) The 10 countries with the highest female life expectancy in 2016



(B) The 10 countries with the lowest female life expectancy in 2016

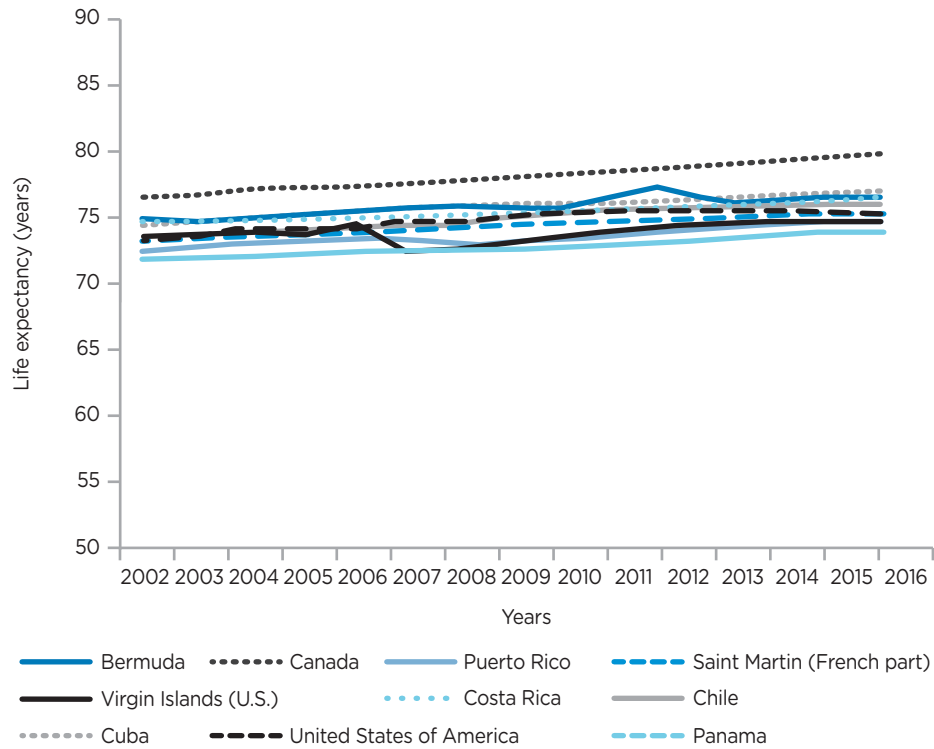


Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

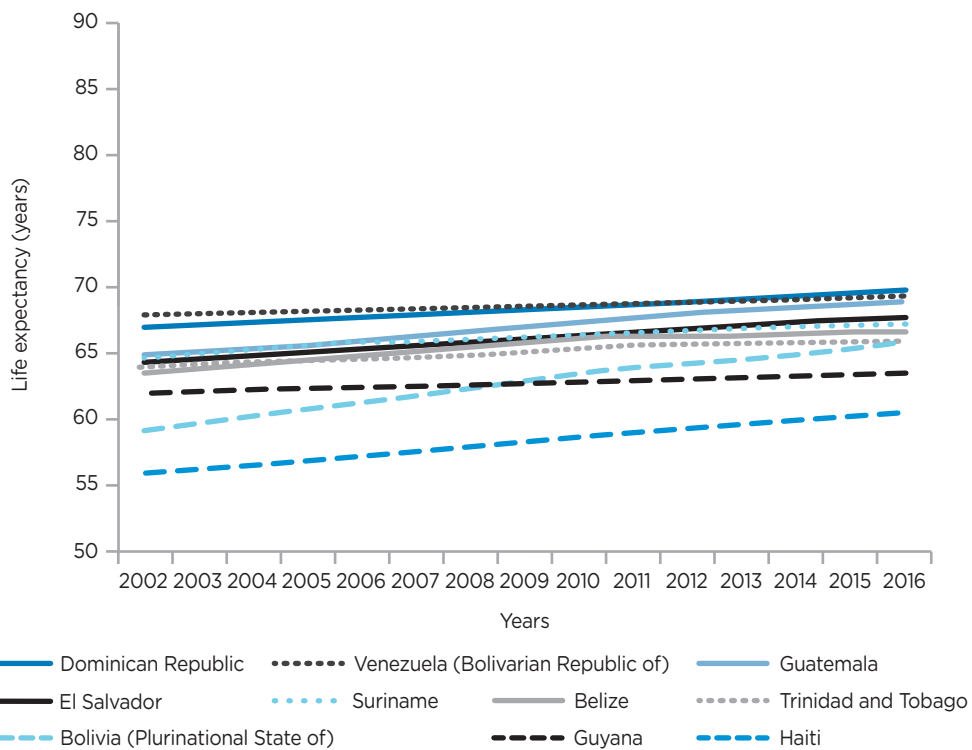
Figure 2.18. (continued)

Highest and lowest life expectancy, by sex, Region of the Americas, 2016, and changes over time, 2002-2016

(C) The 10 countries with the highest male life expectancy in 2016



(D) The 10 countries with the lowest male life expectancy in 2016



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

RELEVANT INTERNATIONAL AGREEMENTS

The Rio Political Declaration on Social Determinants of Health (WHO, 2011)

PAHO Resolutions

Sustainable Health Agenda for the Americas 2018–2030 (CSP29.R2 [2017])

Health of Migrants (CD55.R13 [2016])

Plan of Action on Mental Health (CD53.R7 [2014])

Health, Human Security, and Well-being (CD50.R16 [2010])

Policy on Ethnicity and Health (CSP29.R3 [2017])

Plan of Action on Disabilities and Rehabilitation (CD53.R12 [2014])

Strategy and Plan of Action on Dementias in Older Persons (CD54.R11 [2015])

Sustainable Development Goals

Goal 3. Ensure healthy lives and promote well-being for all at all ages

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

Inequalities of income and social conditions, threats to the environment, and the persistence of privileged elites linked to colonialism are intertwined. Together they form the structural drivers of health inequalities, and they must be addressed in order to meet the Sustainable Development Goals (SDGs) (28).

Political, social, cultural, and economic forms of power have become more concentrated across the Americas (29). That concentration, and the deterioration of the Region's position in the global economy, are further drivers of 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—due to both reduced employment opportunities and lower wages, and to government cutbacks in social protection spending.

Challenging these inequities and achieving the SDGs will, according to the Economic Commission for Latin America and the Caribbean (ECLAC), require creating global public goods, regional cooperation, national strategies, and macroeconomic, social, industrial, and environmental policies (30).

RECOMMENDATION 1.

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

Inequality dominates the Region of the Americas: inequalities of income and, importantly, inequalities in the exercise of rights and in the development of capabilities—the abilities, skills, and knowledge that enable people to lead lives they value. The result is inequality in health and well-being.

This section draws on three ECLAC reports: *Social Panorama of Latin America 2016*; *The Inefficiency of Inequality [2018]*; and *Social Panorama of Latin America 2018 (4, 28, 31)*.

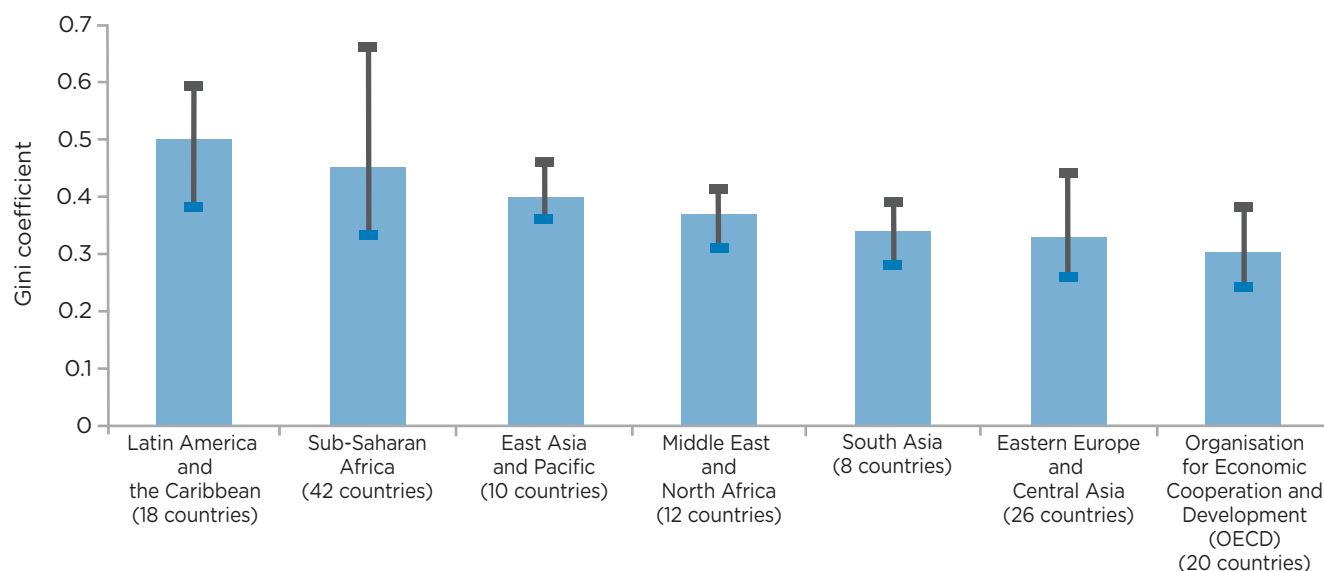
The inequality of opportunities that follows from social and economic inequalities leads to intergenerational transmission of inequity. The fact that the next generation should be damaged by inequalities affecting their parents is social injustice in extreme form.

Social and economic inequalities undermine social cohesion. Extremes of inequality lead to questioning of the legitimacy of society. A society that is seen to work primarily in the interest of the

few is 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 privileged few but not for the rest. In addition to negative effects on health and illness, there may be heightened risk of crime, violence, and civil unrest.

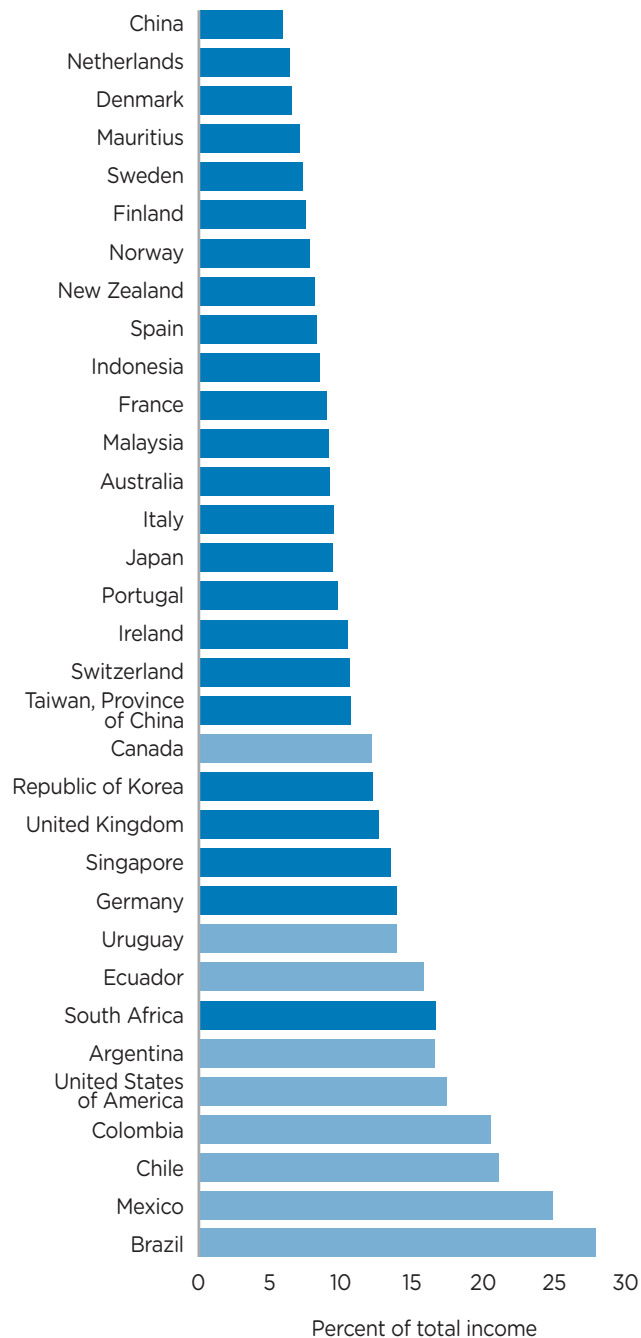
One way of seeing the magnitude of inequality in the Americas is to compare Gini coefficients, a commonly used measure of income inequality, among different regions. The Gini coefficient ranges from 0 to 1 (sometimes, as in Figure 3.6, presented as 0 to 100). A high score implies high inequality. Figure 3.1 shows that in around 2012,

Figure 3.1.
Inequalities of income, as measured by the Gini coefficient, in global regions and in OECD countries, around 2012



Source: Economic Commission for Latin America and the Caribbean. *The inefficiency of inequality*. Santiago: ECLAC; 2018. Available from: <https://repositorio.cepal.org/handle/11362/43443>.

Figure 3.2.
Share in income of the richest 1 percent of the population, selected countries, around 2014



Source: Economic Commission for Latin America and the Caribbean. The inefficiency of inequality. Santiago: ECLAC; 2018. Available from: <https://repositorio.cepal.org/handle/11362/43443>.

Latin America and the Caribbean had greater inequalities of income than the other five global regions shown, and more than double that of the average for countries of the Organisation for Economic Cooperation and Development (OECD) (32). Canada and the United States of America are compared to other countries in Figure 3.2.

A different way of looking at income inequality is to examine the share of total income that the richest 1 percent enjoy. Figure 3.2 confines attention to upper-middle-income and higher-income countries around the world. Of the nine most unequal countries, one is the United States of America, and seven are in Latin America. The only country from outside the Americas is South Africa.

Central to the ill-health effect of inequality are both poverty and relative disadvantage. We highlight in this report that Indigenous peoples and people of African descent in the Americas are subject to multiple disadvantages that damage their health. But within all groups of people 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 also 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 social gradient in health, the review of health inequalities in England, Fair Society, Healthy Lives (2010), 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 (9). In this report, we highlight the importance of meeting the needs of Indigenous peoples in the Americas. That will be done partly through proportionate universalism, redressing the underfunding and neglect of services for Indigenous peoples. But it is also necessary to recognize the physical, emotional, spiritual, and cognitive health domains of all people in the Region.

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 ECLAC's Horizons 2030 agenda for equity and the recommendations of the Oslo Commission (33) • 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 (34) • 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 whistleblowers that genuinely protect them from all forms of retaliation

1A. IMPLEMENT PROGRESSIVE FISCAL POLICY TO IMPROVE HEALTH EQUITY

Progressive fiscal policy is critically important to improving health equity. Monetary policy, social protection spending, and tax systems should aim to be redistributive, designed progressively to improve the standard of living of communities and populations most at risk of poor outcomes, and to provide them with essential services.

In many areas of fiscal policy, currently this is not the case. For example, 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 income than the poorest do.

EQUITY IMPACTS OF FISCAL POLICIES

To reduce inequalities in health, efforts should be made both to reduce inequality, for the reasons

set out in the introduction to this section, and to reduce poverty. There has been significant debate globally on the relative merits of targeted as opposed to universalist policies for reducing inequality and poverty. Targeted policies have the obvious merit that income support and services are directed to those most in need. In the Americas, conditional cash transfer (CCT) programs have been shown to be effective in improving health and encouraging young people to stay in school. They are described in Section 4.

There are significant drawbacks to this approach, however. First, the evidence we cite shows that

health follows a social gradient: people near the bottom have better health than those worse off financially or socially, but are less healthy than those above them in the social hierarchy. Targeting, by its nature, misses all those but the most deprived.

Second, targeting can imply special services for the poor. A health system for the poor will be a poor health system; an education system for the poor will be a poor education system. If there is one set of services for society at large and a separate one for those who are socially deprived, taxpayers may be intolerant of such services and reluctant to endorse investment in them—a profound expression of a lack of social cohesion consequent on inequality. This argument for universalism extends to the other end of the scale, too. If the rich make their own arrangements for health care and education, that may weaken their commitment to their taxes being used for public provision for the majority of the population.

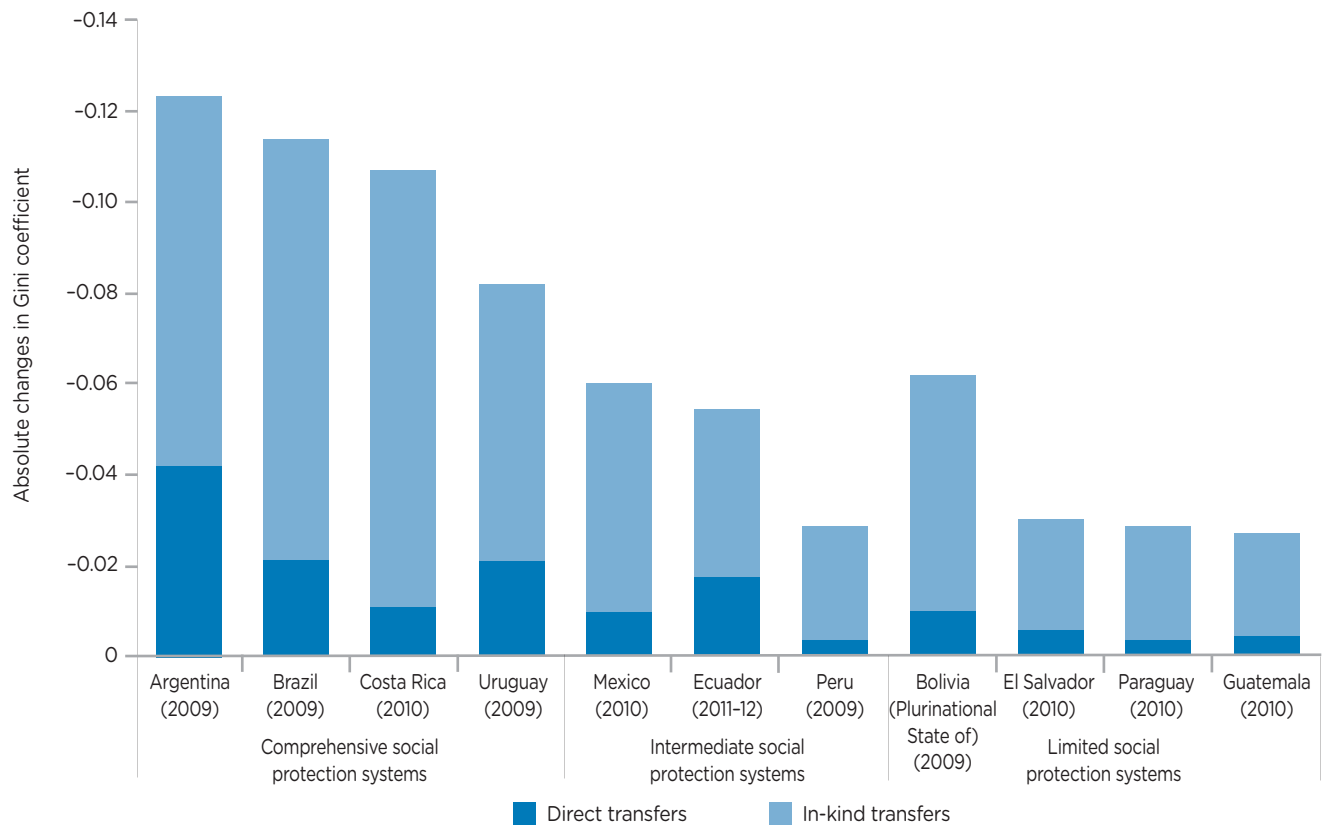
Third, and relatedly, there are administrative and social costs involved with identifying and labeling people deemed as poor. For these people, there is a real danger of demonization and social exclusion.

Research has concluded that universalist social protection does more to reduce poverty than does GDP growth, and more than targeted policies (4).

We have already seen from Figures 3.1 and 3.2 above that countries in the Region are marked by large inequalities of income. Progress was made in reducing income inequality in Latin America between 2008 and 2015, although at a faster rate during the earlier part of that period than later on. Relevant to the twin aim of reducing poverty, this reduction in income inequality was primarily associated with a rise in income for the poorest 20 percent (35).

Figure 3.3 looks at the success of reducing income inequality in Latin America through using direct

Figure 3.3. Redistributive effects of direct social spending and in-kind transfers, selected countries in Latin America, various years 2009–2012



Source: Ocampo JA, Gómez-Arteaga N. Social protection systems, redistribution and growth in Latin America. CEPAL Rev. 2017;122:7–30.

transfers such as CCTs, and in-kind transfers, particularly public spending on education and health care. Latin American countries can be divided into three groups—comprehensive, intermediate, and limited social protection systems—based on three dimensions of social protection systems: universality, solidarity, and social spending (35).

Reduction in income inequality, as measured by a reduction in the Gini coefficient, has been greatest in countries characterized by comprehensive social protection systems. But in all three groups, in-kind transfers have a bigger effect on income inequality than do direct transfers.

Behind the findings displayed in Figure 3.3 is the fact that direct cash transfers are effective in reducing poverty, but they are aimed at relatively small proportions of the population. In countries with comprehensive social protection systems, far more social spending goes for in-kind transfers, and more people are benefited, with greater reductions in inequality. These conclusions may provide one reason for the Americas having persistently high inequality. As shown in Figure 3.4, public sector social spending

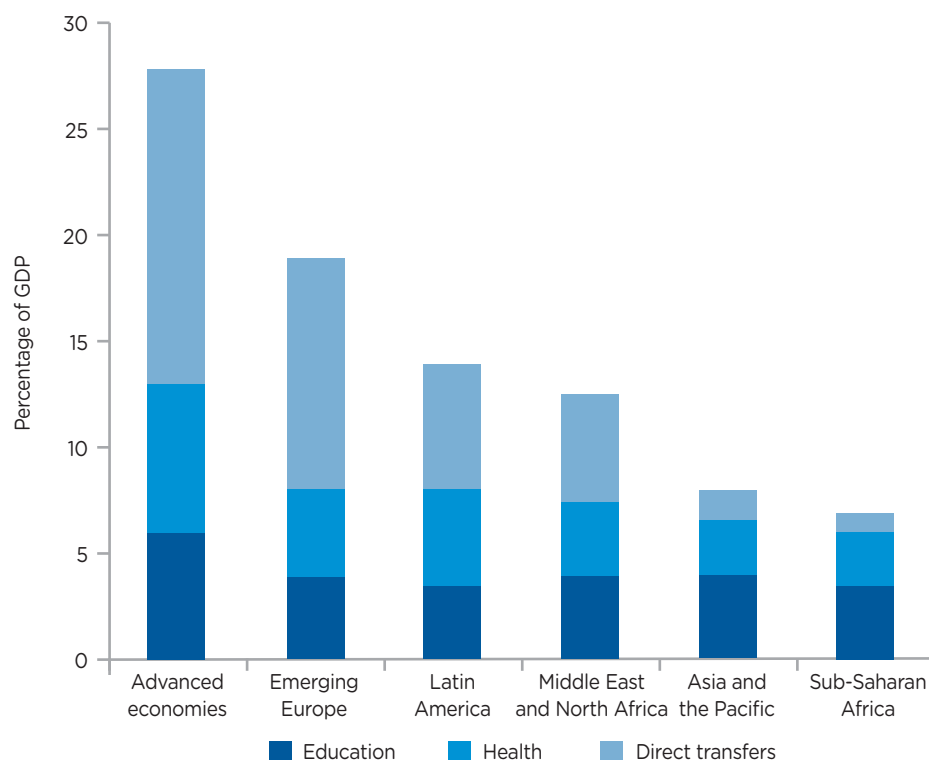
is higher as a percentage of GDP in advanced economies, and emerging European economies, than it is in Latin America. Public sector social spending in Canada and the United States of America is higher than in Latin America and the Caribbean but lower than in the European Region, and the United States of America has higher levels than Canada does, as discussed in Recommendation 7 (29, 32).

A clear implication is that Latin America could make advances in reducing inequality by increasing public spending on in-kind benefits, health care, education, and social protection. Such expenditure may be important in advancing the cause of health equity, in addition to having more indirect effects on reducing inequality.

Figure 3.5 shows GDP per capita and tax revenue as a percentage of GDP. Almost all Latin American countries fall below the line.

As seen in Figure 3.6, in selected Latin American countries there is limited or no redistributive effect of taxes in comparison to the European countries included in the graph.

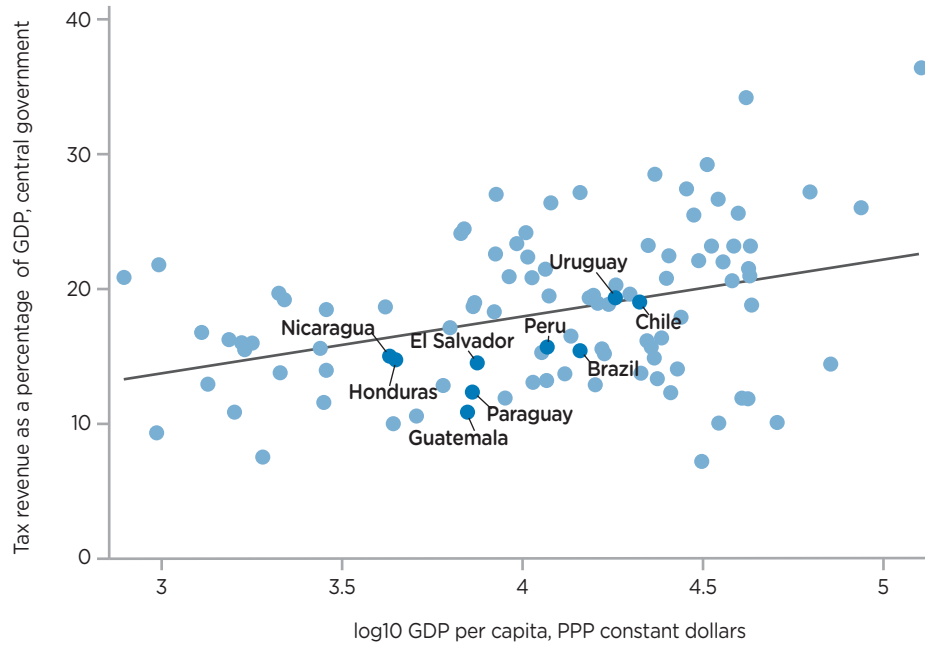
Figure 3.4.
Public social spending as a percentage of GDP, selected world regions, 2013



Source: Ocampo JA, Gómez-Arteaga N. Social protection systems, redistribution and growth in Latin America. CEPAL Rev. 2017;122:7–30.

Figure 3.5.

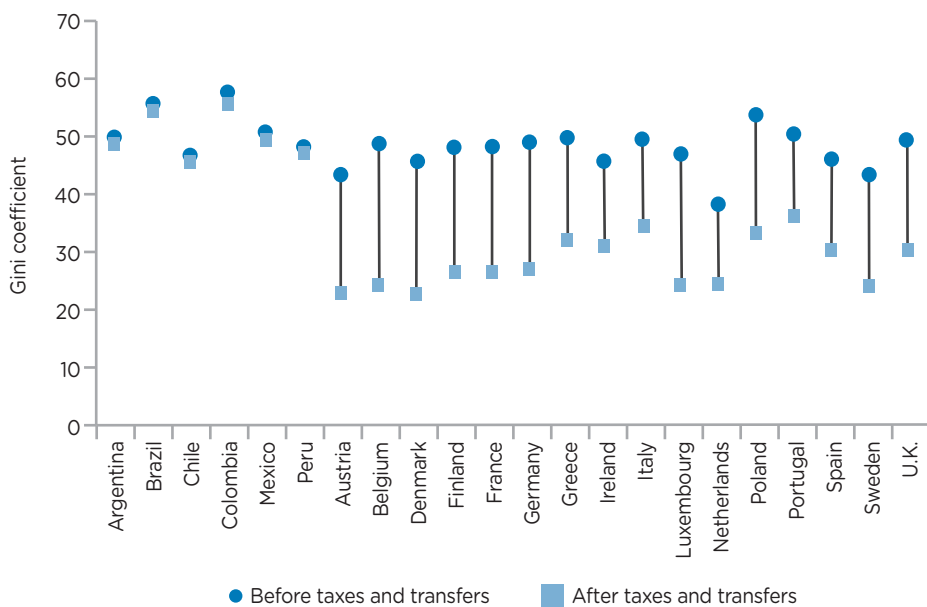
GDP per capita and tax revenue as a percentage of GDP, 2012, with Latin American countries highlighted and labeled against the trend for all countries (light blue dots)



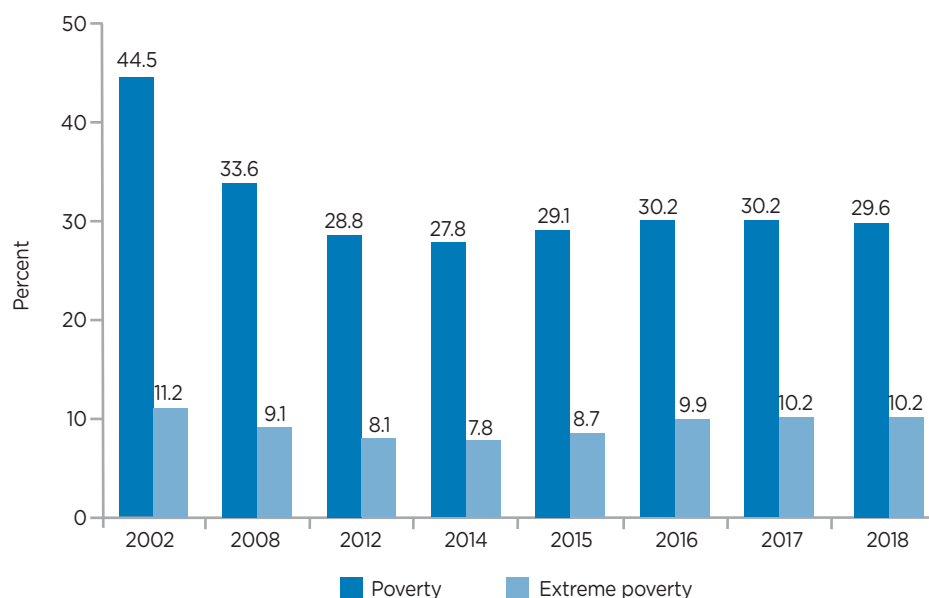
Source: Mahon JE, Bergman M, Arnson C, editors. Progressive tax reform and equality in Latin America. Washington, D.C.: Woodrow Wilson International Center for Scholars; 2015. Available from: <https://www.wilsoncenter.org/publication/progressive-tax-reform-and-equality-latin-america-no-35>.

Figure 3.6.

Gini coefficient before and after taxes and transfers, selected countries, 2012



Source: Mahon JE, Bergman M, Arnson C, editors. Progressive tax reform and equality in Latin America. Washington, D.C.: Woodrow Wilson International Center for Scholars; 2015. Available from: <https://www.wilsoncenter.org/publication/progressive-tax-reform-and-equality-latin-america-no-35>.

Figure 3.7.**Poverty and extreme poverty rates (percent), Latin America, 2002–2018**

Source: Economic Commission for Latin America and the Caribbean. *The inefficiency of inequality*. Santiago: ECLAC; 2018. Available from: <https://repositorio.cepal.org/handle/11362/43443>.

Note: Poverty is calculated by ECLAC using national surveys of expenditure, adjusted for inflation and national conditions.

Related to the goal of reducing inequality is that of reducing poverty. Figure 3.7 shows that success in reducing poverty—particularly extreme poverty—in the initial part of the 2000s has stalled or even been reversed since then (30).

One way to reduce absolute poverty is to move the whole income curve upwards, through economic growth. A different and more effective way is through social programs and social spending, as shown in Figure 3.8. The Social Protection Index is a measure of social spending. More generous spending on social protection shows a stronger relationship to poverty reduction than does growth of the economy as measured by GDP.

An argument against social spending on universalist approaches is that countries cannot afford it. Ocampo and Gómez-Arteaga (35) address this concern:

Although national social protection systems around the world have achieved major reductions in poverty and inequality . . . doubts are often raised as to whether these results are obtained by incurring high opportunity costs in terms of economic growth.

There is commonly assumed to be a trade-off between growth and redistribution. However, this trade-off is largely a myth. More broadly, there may be said to be three major myths about the relationship between social protection and economic performance, namely:

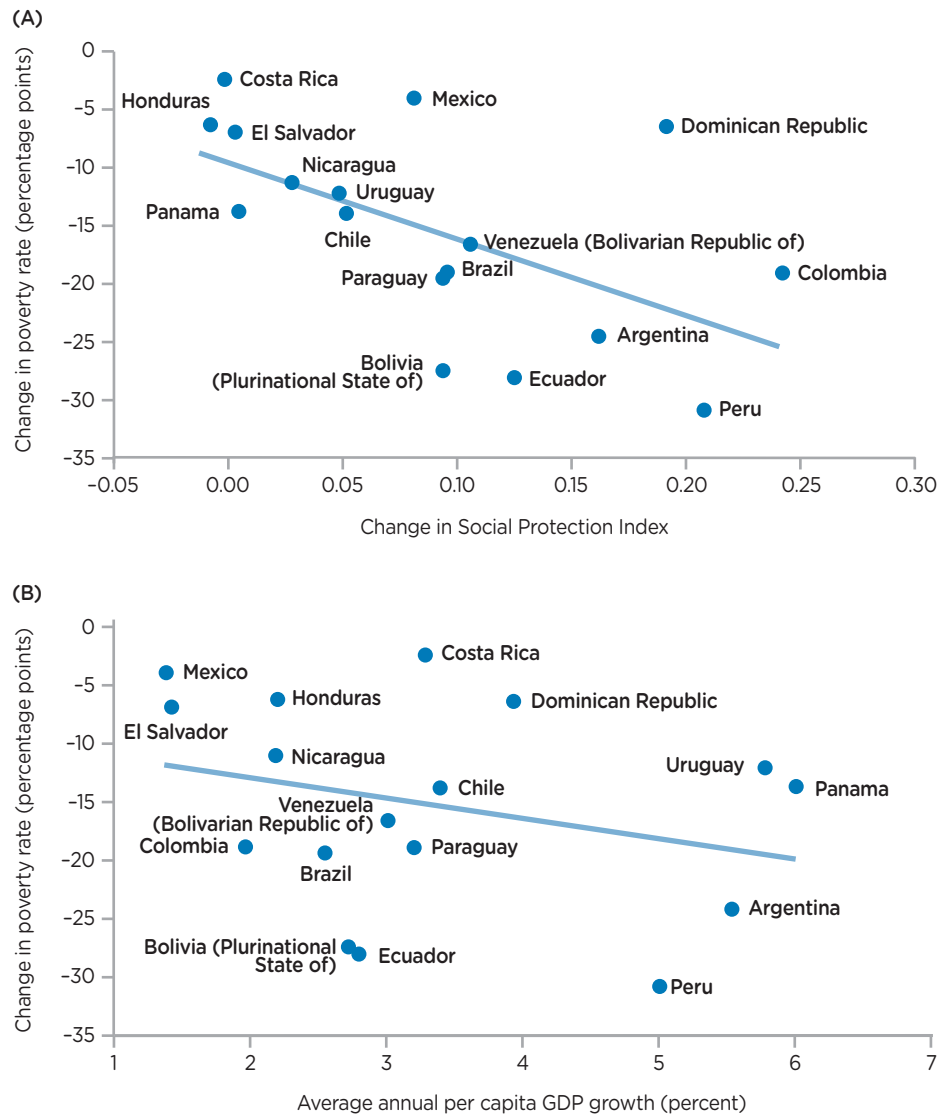
- (i) At each stage of development, societies can only afford a certain level of social expenditure (the affordability myth);
- (ii) There is a trade-off between social expenditure (redistribution) and economic growth;
- (iii) Economic growth will automatically reduce poverty (trickle-down myth).

Going by the recent experience of Latin America, it is possible to refute these myths.

First, social protection systems in the region are highly heterogeneous even when per capita GDP differences are taken into account. Second, there is no clear evidence that countries which have expanded their social protection systems have grown by less.

Figure 3.8.

Changes in poverty rates by (A) Social Protection Index scores and (B) annual GDP growth per capita, Latin America (selected countries), 2002–2012



Source: Ocampo JA, Gómez-Arteaga N. Social protection systems, redistribution and growth in Latin America. CEPAL Rev. 2017;122:7–30.

Third, there is a stronger correlation between improvements in the Social Protection Index and poverty reduction than between growth and poverty reduction.

Countries in the Americas could afford more generous social expenditure to reduce inequalities, without damaging prospects for economic growth. But ECLAC’s 2018 report titled *The Inefficiency of Inequality* goes further (28). ECLAC refutes the conventional wisdom that inequality is a driver of innovation and economic growth, and additionally argues that too much inequality threatens the 2030 Agenda for Sustainable Development and the SDGs.

We endorse ECLAC’s three proposed pillars for action:

- A macroeconomy for development;
- A welfare State based on rights and productivity gains; and
- Decarbonization of the production structure, cities and energy sources.

In Latin America and the Caribbean, inequality has been associated with a culture of privilege—a culture that is incompatible with equality of rights. It is a culture that is recognizable in Canada and the

United States of America, too. It partly results from the consequences of colonialism (which we take up in Section 3), and is a factor in tax evasion, as described below.

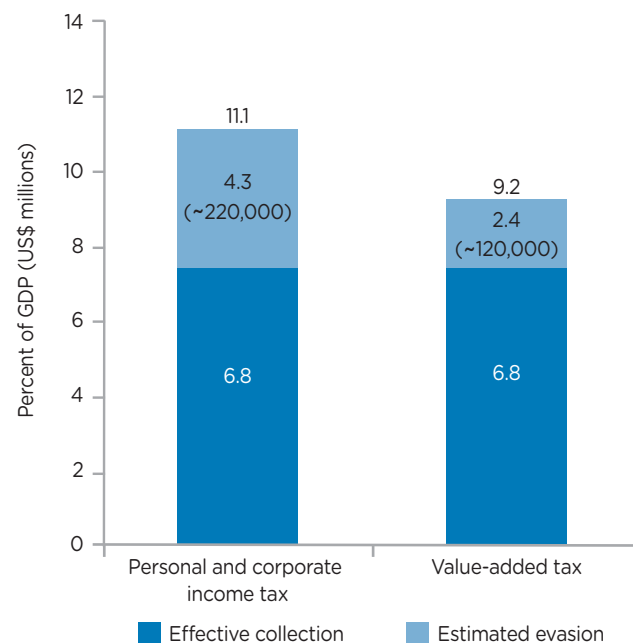
The argument is two-way: inequality hinders economic growth, and economic growth, on its own, is an inefficient way to combat inequality. Part of the reason for greater equality being good for growth is that investments in development of human capacities—education, well-being, health, guaranteed human rights—will be good for productivity, which in turn will be good for a thriving economy. Transmitting poverty and inequality to the next generation will harm future productivity.

Societies with wealth concentrated disproportionately among the few tend to be those that experience conflict. One consequence of imbalanced wealth and conflict is an increase in out-migration. In a globalized world, this in turn raises significant issues for both migrants' countries of origin and the countries of potential destination, as well as, of course, for the health and well-being of the migrants themselves.

DEALING WITH TAX EVASION

Tax evasion is widespread in the Americas. ECLAC links tax evasion in the Region to a culture of privilege—whereby people with social advantage judge that taxes are not for them (28). High rates of tax evasion are one reason for the Region's relative paucity of tax revenue and high levels of inequality. According to ECLAC, the average rate of value-added tax (VAT) evasion stands at 28 percent. Uruguay has the Region's lowest rate of evasion. Then comes a group of countries with rates close to or higher than 20 percent but below 30 percent (several South American countries and Mexico). This is followed by a group with evasion rates in excess of 30 percent (the Central American countries, plus Ecuador and Paraguay). Estimates of income tax evasion are much higher: the average for the Region is calculated at almost 50 percent.

Figure 3.9.
Tax collection and estimated tax evasion, 15 countries in Latin America, 2015



Source: Economic Commission for Latin America and the Caribbean. The inefficiency of inequality. Santiago: ECLAC; 2018. Available from: <https://repositorio.cepal.org/handle/11362/43443>.

At the high end are Costa Rica, the Dominican Republic, Ecuador, and Guatemala, with rates of about 65 percent. At the other end are Brazil, Chile, and Mexico, with much lower but still significant values, ranging from 28 percent to 31 percent. Figure 3.9 shows that millions of dollars are forgone in lost tax revenues.

The U.S. Senate estimates that revenue losses from tax evasion by individuals and by firms based in the United States of America are around US\$ 100 billion a year (36). Dealing with this problem requires many of the specific actions listed in Recommendation 1C, on tackling corruption. More generally, a commitment to developing societies characterized by a commitment to equity and social justice and to addressing the culture of privilege will be important steps to tax justice.

Examples of progressive tax reforms from Latin America

The following examples of progressive tax reforms have been selected because they have aimed to shift the tax burden toward wealthier households and away from poorer ones, mainly by increasing revenue by raising taxes among those with personal high income and property taxation. However, due to the difficulties with data and monitoring in Latin America, there are challenges in calculating tax incidence with a great deal of confidence.

Progressive tax reform in Chile, 2015

In 2009, before President Michelle Bachelet's tax reform in Chile, the top 1 percent in terms of earnings received 22 percent of the national income and paid less than 16 percent income tax.¹ In response, Chile carried out extensive tax reforms, to increase its tax collections by 3 percent of GDP. The government also aimed to eliminate mechanisms that permitted tax evasion, which would in turn lead to increased spending on education by 3 percent.

In 2009, before the tax reform, the Gini coefficient for Chile (World Bank estimate) was 49. It then declined to 47.3 in 2013 and 47.7 in 2015.² The income share held by the wealthiest 10 percent in Chile was 39.7 in 2009 before the tax reform, 38.4 in 2013, and 38 in 2015.

Tax reform in Uruguay, 2006

In 2006, Uruguay rebalanced the contribution of direct and indirect taxes, without decreasing total revenue. The reform taxed labor and capital in a more consistent way than the previous taxation system had.¹ The reform was successful despite resistance from high-income individuals. Commitment to perceived tax fairness was important for gaining support and decreasing resistance. Providing information to all taxpayers about the benefits and duties of the reform was considered one of the reasons it was successful in overcoming resistance. The reform addressed issues of horizontal equity, which were accepted because taxpayers knew about the expected equity outcomes.

The government claimed that the reform enabled a transparent discussion of general principles of taxation, forcing those expecting special treatment to justify why, publicly. This was not enough to fully eliminate pressure from some quarters, but these groups were somewhat weakened by the transparency principle established by the government and the creation of a parallel track for the negotiation of fiscal incentives. In 2014, an evaluation of the reforms showed that they had increased tax revenue and improved equity.¹

Fiscal reform in Colombia, 2012

The main objective of Colombia's fiscal reform was to rebalance the fiscal burden horizontally (across different types of activities) and vertically (related to different levels of income), to promote progressivity and formal employment, which in turn was expected to lead to accelerated economic growth. Among the main factors behind the 2012 reform were the government's legislative majority and its ability to frame the reform in terms of revenue neutrality and employment generation. The first and perhaps most important objective was to reduce the inequalities generated by the tax system. The second objective was to generate employment and discourage informal labor, which gave the business community a stake in the proposed changes. The third objective was to reduce tax evasion.

In 2014, there was debate over the need for further fiscal reform, but due to declining oil revenue, the government found itself with a fiscal gap of approximately 2.4 percent of GDP.¹

The government was able to reduce opposition and even gain supporters among workers and their representatives in the Congress by emphasizing the revenue neutrality of the reform and the generation of employment.¹ The government adjusted the reform to incorporate dissenting views while maintaining the general coherence of the proposal with an emphasis on revenue neutrality, thus securing a majority in Congress behind the president's initiative.¹

Sources: ¹ Mahon JE, Bergman M, Arnson C, editors. Progressive tax reform and equality in Latin America. Washington, D.C.: Woodrow Wilson International Center for Scholars; 2015. Available from: <https://www.wilsoncenter.org/publication/progressive-tax-reform-and-equality-latin-america-no-35>.

² World Bank. Databank. World development indicators [Internet]; 2019. Available from: <https://data.worldbank.org/>.

1B. ENSURE A FLOURISHING PUBLIC REALM AND REINFORCE THE ROLE OF THE STATE IN PROVISION OF SERVICES

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 2007–2008 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 (7).

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.

The predominance of market thinking in development has consigned the welfare state to “picking up the pieces.” In the latter part of the 20th century, the “Washington Consensus” dominated, with its call for a minimal State, a predominance of market mechanisms in delivering services, removal of subsidies, and a residual State that had social policies in those few areas where markets were thought inappropriate. The thrust of the approach we emphasize recognizes that this market-driven approach tended to be associated

There is a strong interdependence between taxation, provision of public goods, social solidarity, and environmental sustainability. A robust fiscal framework combined with the provision of quality public goods and services promotes and facilitates increased ridership of public transportation, utilization of suitable education and public health services, and the coming together of society as a whole in shared public spaces. This enhances social cohesion, solidarity, and mutual recognition through a broader sense of belonging to a society; it also prevents (or reverses) residential segregation, the recourse to private and exclusive services by the privileged, and the fragmentation and stratification of society, characterized by huge gaps in the quality and timeliness of services. In addition, the mass use of public infrastructure and transportation has positive environmental impacts and makes it easier to transform the energy matrix. Evidence from Scandinavian countries, for example, points to virtuous circles between taxation, the welfare state, the provision of quality public goods and services, and social cohesion around the universal use of those goods and services. In addition, those societies boast high-quality democracy, with greater environmental sustainability, a better energy matrix, and very low levels of violence and insecurity, compared with Latin America and the Caribbean.

Economic Commission for Latin America and the Caribbean. The inefficiency of inequality. Santiago: ECLAC; 2018. Available from: <https://repositorio.cepal.org/handle/11362/43443>.



Homeless man rests in front of a bank offering home loans, Great Barrington, United States of America

with greater inequality and downgrading of the public realm, to the detriment of the health and well-being of the population.

There is a close link between the problems of inequality and underinvestment in public goods: education, protection of the environment, security, and health care, as well as the social determinants of health. A wide body of evidence suggests that markets are not the optimal way to deliver public goods.

Failure to invest in public goods will make reducing inequality more difficult. And inequality makes it more difficult, politically, to invest in public goods. Public goods benefit everyone, but the benefits of education and social protection will be greater lower down in the hierarchy, while the costs will be borne to a greater extent by those with more taxable income—hence the political challenge. The CSDH has referred to inequities in power, money, and resources (37). Such inequities, which go along with entrenched privilege, put great difficulties in the way of achieving the kind of society that has equity in rights, in development of human

capacities, and in health. However, such a society is a goal to strive for, and democracy and equity are vital steps in its achievement.

Economist Paul Krugman, reflecting on the United States of America, calls for a mixed economy. In the context of an economy based on markets, private ownership, and capitalism, he notes that education and health care are better delivered in the public sector than in the private sector. Utilities are private, but are heavily regulated and could quite readily be in the public sector. Retail trade and manufacturing are probably better in the private sector. That said, Krugman estimates that perhaps a third of the U.S. economy could be in public ownership (38).

The public realm has an important role to play in meeting the three-fold approach to the 2030 Agenda for Sustainable Development and its Sustainable Development Goals, namely through a macroeconomy for development; a welfare State based on rights and productivity gains; and decarbonization of the production structure, cities and energy sources (Box 3.1).

Box 3.1. Policy proposals for implementing the 2030 Agenda for Sustainable Development

Sphere	Policies
Creating global public goods	<ul style="list-style-type: none"> i. Achieve greater correlation between the weight of developing countries in the world economy and their representation and decision-making power in international financial institutions. ii. Coordinate fiscal policies focused on environmental investments to give an expansionist thrust to the global economy and sustain employment. iii. Coordinate foreign-exchange and financial policies to reduce trade imbalances and volatility through redesign of the financial architecture. iv. Strengthen international coordination to reduce tax evasion and avoidance. v. Create funds to finance the adoption and transfer of environmental technologies. vi. Disseminate environmental standards and eco-labeling to promote trade in goods of lower carbon intensity. vii. Adjust global trade and investment rules to make them more compatible with the Sustainable Development Goals. viii. Participate proactively in the discussion on Internet and information governance.
Strengthening the regional contribution	<ul style="list-style-type: none"> i. Create or expand financial safety nets (e.g., the Latin American Reserve Fund (FLAR), which is a regional development banking and payments clearing system). ii. Apply common fiscal, social, and environmental standards to avoid predatory competition in international trade and foreign investment. iii. Create a digital common market. iv. Develop regional value chains in environmental goods and services. v. Establish a regional fund for the purchase and licensing of patents. vi. Create a debt relief and resilience fund for countries in the Caribbean.
National strategies and policies	<ul style="list-style-type: none"> i. Establish fiscal space and multiyear planning to protect and promote public investment. ii. Afford equal priority to nominal and financial stability in monetary policy. iii. Implement suitable macroprudential policy in the external sphere, especially at times of abundant liquidity. iv. Smart cities: expand the public transportation and social integration system. v. Increase the share of clean energies in the energy mix. vi. Develop clean technology capacities. vii. Create science centers to evaluate, implement, and monitor intended nationally determined contributions (NDCs) determined by the Paris Agreement. viii. Gradually withdraw fossil fuel subsidies. ix. Tax carbon-intensive sectors and activities. x. Include environmental costs in the cost of bank loans. xi. Achieve universal social protection. xii. Achieve universal health and education coverage.

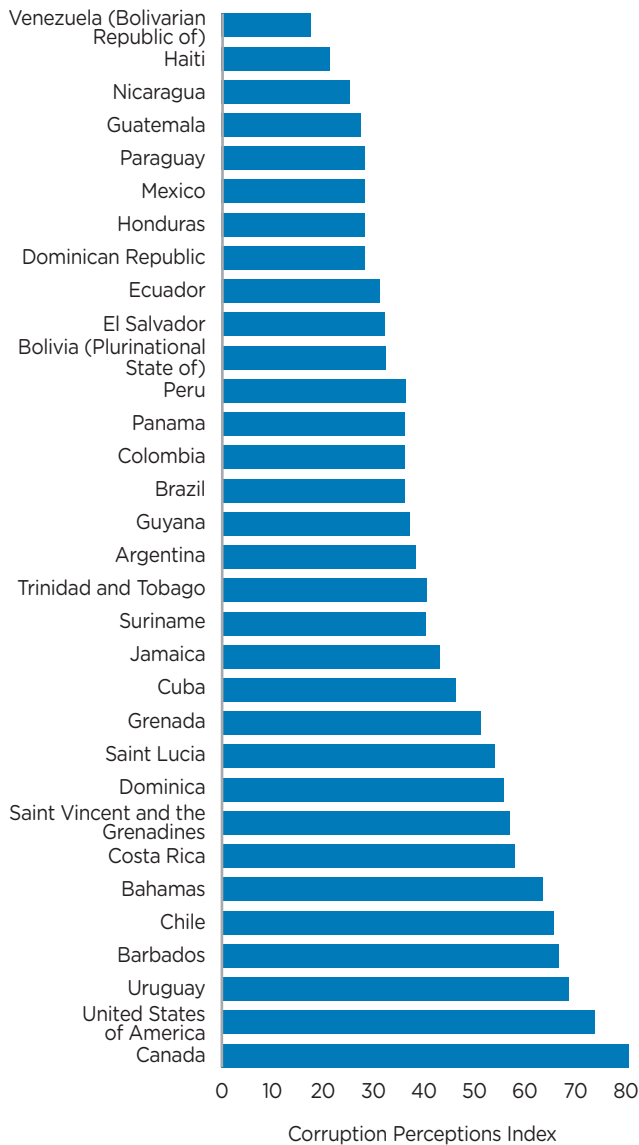
Source: Economic Commission for Latin America and the Caribbean. Horizons 2030: equality at the centre of sustainable development. Summary. Santiago: ECLAC; 2016. Available from: <https://www.cepal.org/en/publications/40117-horizons-2030-equality-centre-sustainable-development-summary>.

1C. URGENTLY ADDRESS CORRUPTION TO REDUCE ITS THREAT TO HEALTH EQUITY

Corruption is persistently high in many parts of Latin America and the Caribbean.

Figure 3.10 shows the Corruption Perceptions Index by country, created by an international nongovernmental organization (NGO), Transparency International, based on interviews

Figure 3.10.
Corruption Perceptions Index for countries in the Americas, 2017



with citizens of the countries in the survey (39). A score of 100 means very “clean”; 0 is highly corrupt. Within the Region there is wide variation. The Bolivarian Republic of Venezuela is perceived by respondents to have widespread corruption, and Haiti and Nicaragua likewise. Canada is considered the least corrupt, with the United States of America, Uruguay, Barbados, and Chile not far behind.

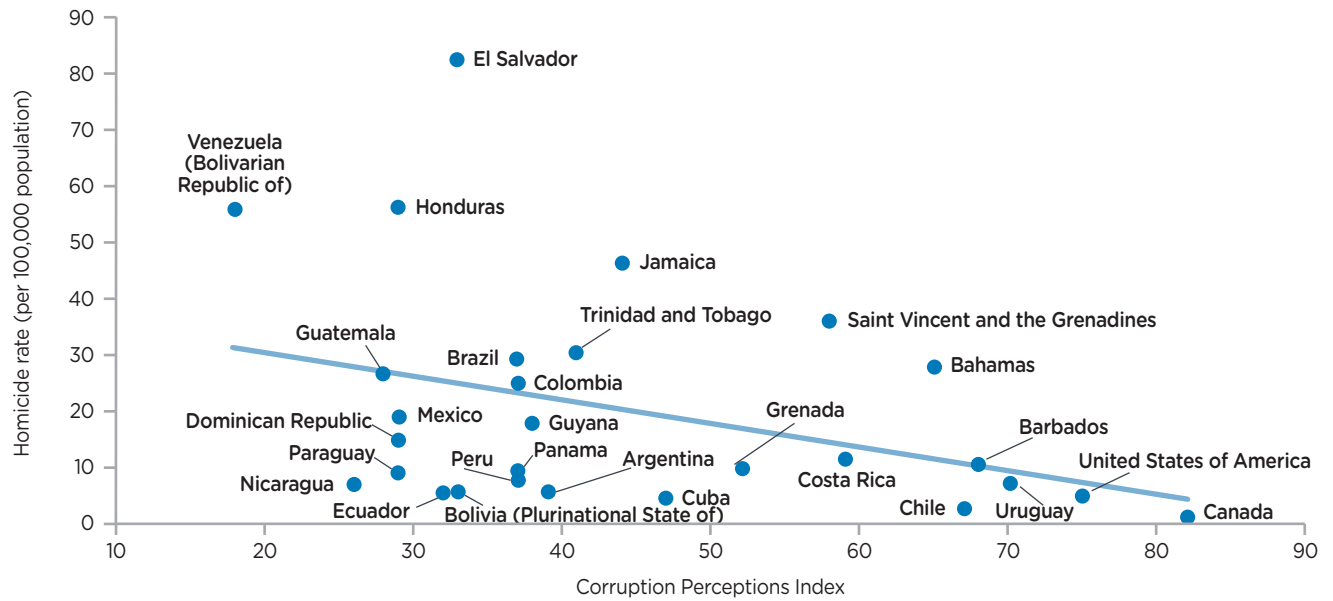
Corruption is not just a fact of life that people have to learn to live with. At the least, it is an indicator of a malfunctioning society, and itself may be a cause of malfunction. As an illustration, Figure 3.11 shows that the higher the corruption, the higher the homicide rate. This does not necessarily mean that corrupt individuals are committing homicide, although that may be the case in a society featuring gangs, organized crime, and distrust of the police and military. A high homicide rate is likely to be an indicator of a low level of social cohesion, which itself will be damaged by corruption.

Transparency International has reported on surveys of people’s perceptions of corruption



Source: Transparency International. Corruption Perceptions Index [Internet]; 2018. Available from: <https://www.transparency.org/research/cpi/overview>.

Figure 3.11.
Homicide rates and Corruption Perceptions Index scores in the Americas, 2016



Sources: 1. Transparency International. Corruption Perceptions Index [Internet]; 2018. Available from: <https://www.transparency.org/research/cpi/overview>.

2. World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

Note: A high score represents high trust, i.e., low corruption.

across the Region (Box 3.2) and has made recommendations for what can be done about corruption (Box 3.3).

We endorse Transparency International's recommendations and would add that measures

to reduce inequality and improve the public realm are likely to contribute to greater social cohesion. That, in turn, may be an important step in reducing corruption. This is consistent with the approach taken by the OECD of developing a strategy for promoting public integrity (40).

Box 3.2. What do people across the Region say about corruption? Survey results from 2016

1. Corruption is on the rise

The majority of people saw the level of corruption as increasing over the previous 12 months. In Brazil, Peru, Chile, and Venezuela (Bolivarian Republic of), three-quarters or more of respondents (78 percent to 87 percent) said that corruption was on the rise. This compares with only two in five people in Argentina and Guatemala (41 percent and 42 percent) who said the same.

2. Police and politicians are the most corrupt

Nearly a half of respondents said that most or all police and politicians were corrupt (both 47 percent), which was higher than any other institution asked about. People living in the Bolivarian Republic of Venezuela were the most likely to call the police highly corrupt (73 percent), and in Paraguay citizens were the most likely to say that their elected representatives were highly corrupt (69 percent).

3. Governments are doing badly

More than a half of people said that their government was doing badly at fighting corruption (53 percent). Only 35 percent said that their government was doing well. People in the Bolivarian Republic of Venezuela and Peru were the most likely to rate their government badly—around three-quarters of respondents gave

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Box 3.2. What do people across the Region say about corruption? Survey results from 2016 *(continued)*

a negative rating of their government's performance (76 percent and 73 percent). This contrasts with only around a quarter of people in Guatemala who said that their government was doing a bad job.

4. Nearly a third of public service users have paid a bribe (equivalent to over 90 million people in the 20 countries surveyed)

People in Mexico and the Dominican Republic were the most likely to say that they had paid a bribe when they had accessed basic public services in the previous 12 months (51 percent and 46 percent). Bribery rates were much lower in Trinidad and Tobago, where only 6 percent of people had paid a bribe when accessing basic services in the previous 12 months.

5. Bribery risks are highest for health care and schools

Around one in five people who came into contact with public hospitals and public schools in the previous 12 months had had to pay a bribe (20 percent and 18 percent, respectively). These were the highest of the six services asked about.

6. Few report corruption, and those who do suffer from retaliation

Only 9 percent of bribe payers in the survey actually came forward and reported it to the authorities. Of those who did report it, 28 percent suffered negative consequences as a result.

7. Seven in ten stand ready to support anticorruption efforts

The majority of respondents (70 percent) said that ordinary people could make a difference in the fight against corruption. People in Brazil were the most likely to feel empowered to fight corruption (83 percent), followed closely by Costa Rica and Paraguay (both 82 percent).

8. Both critical and positive responses come from across the Region

In Colombia, the Dominican Republic, Mexico, Peru, and Venezuela (Bolivarian Republic of) people were the most negative across five key questions in the survey, while in Ecuador, Guatemala, and Uruguay people had the most positive responses.

Source: Transparency International. People and corruption: Latin America and the Caribbean. Global corruption barometer. Berlin: Transparency International; 2017. Available from: https://www.transparency.org/whatwedo/publication/global_corruption_barometer_people_and_corruption_latin_america_and_the_car.

Box 3.3. Transparency International's recommendations for tackling corruption

Take measures to reduce bribery in public services

Governments should ensure that official fees for public services are clearly and publicly displayed.

Governments should streamline bureaucratic procedures to avoid lengthy and discretionary decision-making processes. Governments should invest in e-government platforms to enable applications for services without face-to-face interactions with public officials.

Governments should ensure that confidential channels are available for citizens to report on the quality of public services and their level of satisfaction with them.

Enable civil society to engage in the fight against corruption

Governments should involve civil society as a part of their efforts to fight corruption. This would increase the credibility of these efforts. Governments should create a safe and enabling environment for the involvement of civil society and the media in anticorruption efforts, including their de jure and de facto operational and physical

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Box 3.3. Transparency International's recommendations for tackling corruption (continued)

freedom. Governments should enable civic engagement in monitoring and reporting corruption in government by effectively implementing access-to-information laws.

Strengthen law enforcement and justice institutions

Governments should invest in measures to strengthen access to justice and the rule of law, by ensuring an objective and transparent process for appointing judges, protections for judicial salaries and working conditions, and transparent criteria for case assignment. Governments should strengthen the institutions involved in the detection, investigation, and prosecution of corruption-related crimes.

Governments should consider making court decisions available online to allow civil society, the media, and citizens to scrutinize and compare verdicts.

Governments should lift political immunity for corruption-related cases.

Clean up the police

Governments should strengthen police investigative capacity with specialized intelligence techniques, reinforced internal disciplinary measures, and permanent accountability mechanisms and integrity management systems across the institution.

Protect whistleblowers

Governments should create accessible, anonymous reporting channels for whistleblowers, which would meaningfully protect them from all forms of retaliation.

Authorities and employers should ensure that any act of reprisal for, or interference with, a whistleblower's disclosure should be considered misconduct, and the perpetrators must be subject to employment/professional sanctions and civil penalties.

Government legislation should ensure that whistleblowers whose lives or safety are in jeopardy, and their family members, are entitled to receive personal protection measures.

Source: Transparency International. People and corruption: Latin America and the Caribbean. Global corruption barometer. Berlin: Transparency International; 2017. Available from: https://www.transparency.org/whatwedo/publication/global_corruption_barometer_people_and_corruption_latin_america_and_the_car.

RELEVANT INTERNATIONAL AGREEMENTS

International Covenant on Economic, Social and Cultural Rights (United Nations, 1966)

The Rio Political Declaration on Social Determinants of Health (WHO, 2011)

Sustainable Development Goals

Goal 10. Reduce inequality within and between countries

Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all, and build effective, accountable, inclusive institutions at all levels

Goal 17. Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development

RECOMMENDATION 2. PROTECTING THE NATURAL ENVIRONMENT, MITIGATING CLIMATE CHANGE, AND RESPECTING RELATIONSHIPS TO LAND

Urgent changes are needed in the way societies function and countries cooperate in order to address catastrophic climate change and reduce its associated risks (41). Such changes must respect equity and health equity.

Environmental threats commonly have a stark equity dimension: socially disadvantaged people are disproportionately affected by environmental degradation and climate change, and experience shows that environmental shocks and extreme natural events become disastrous for disadvantaged people (42). Redressing these threats must be done in a spirit of justice. It is important to ensure that actions aimed at mitigation and adaptation to climate change do not have adverse impacts on health equity. Some universally applied taxes on harmful products are regressive. The transition to a low/zero carbon economy could have significant consequences for jobs in fossil-fuel-intensive industries, affecting workers in many gas and oil producing countries

in the Region as well as reducing available revenue from taxation.

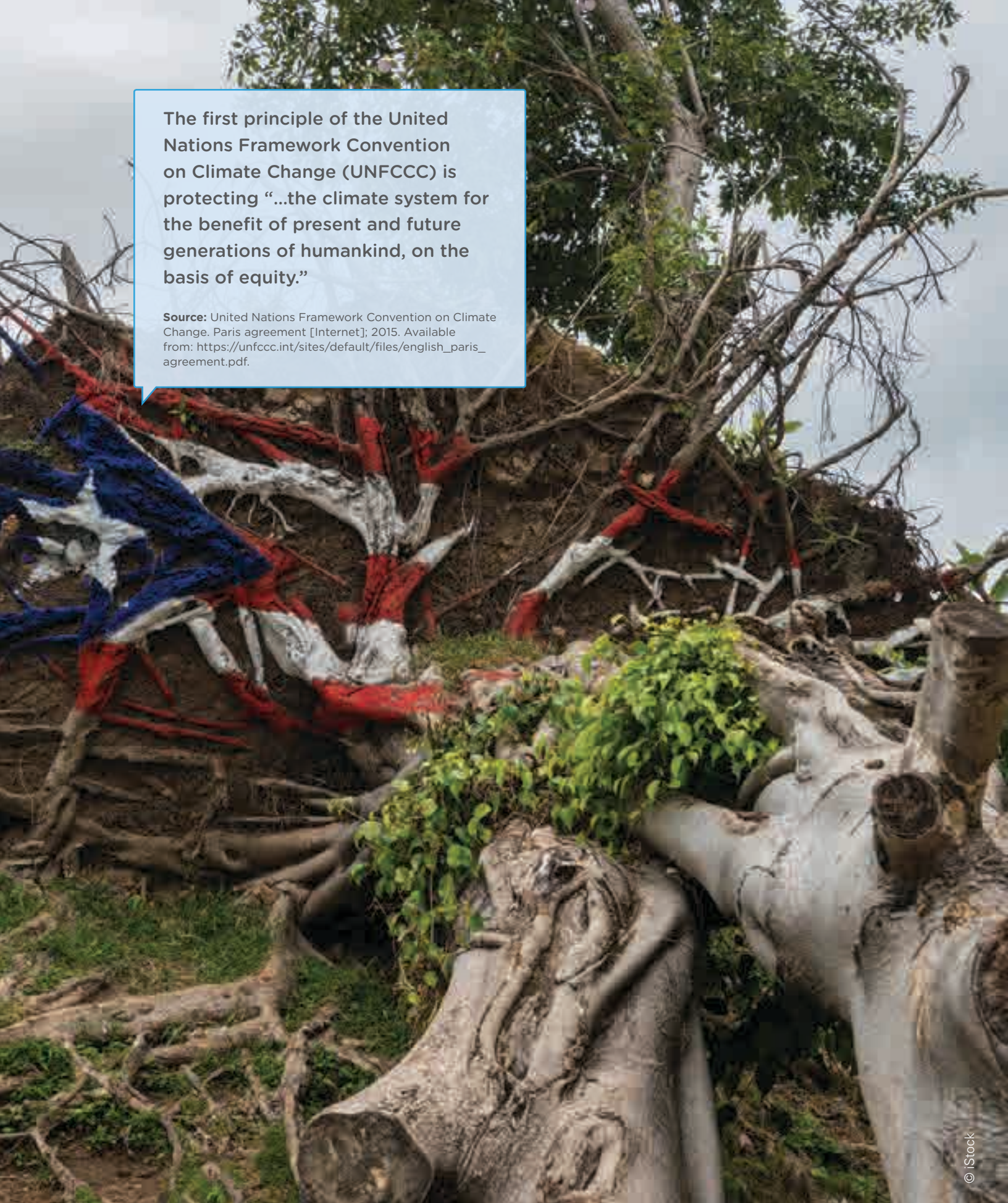
Taxation and phasing out fossil fuel production requires mitigation of potentially negative impacts on equity.

The issue of land tenure rights needs to be addressed—it affects marginalized people throughout the Americas and especially Indigenous peoples, who are being expelled from their land by agrobusinesses, extraction industries, and drug producers. Indigenous peoples and low-income farmers are increasingly affected by climate change and other environmental harms, with significant health impacts (43, 44).

PRIORITY OBJECTIVES	ACTIONS
<p>2A. Mitigate and adapt to climate change to support health equity</p>	<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 (45) • Ensure the role of the private sector in innovation as part of promoting environmental protection and mitigation of climate change
<p>2B. Minimize environmental harm from resource extraction industries and agriculture</p>	<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
<p>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</p>	<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 United Nations Framework Convention on Climate Change (UNFCCC) is protecting “...the climate system for the benefit of present and future generations of humankind, on the basis of equity.”

Source: United Nations Framework Convention on Climate Change. Paris agreement [Internet]; 2015. Available from: https://unfccc.int/sites/default/files/english_paris_agreement.pdf.



Painted flag on tree uprooted by Hurricane Maria, San Juan, Puerto Rico

2A. MITIGATE AND ADAPT TO CLIMATE CHANGE TO SUPPORT HEALTH EQUITY

The scientific consensus is that extreme weather events including droughts, heavy rainfall, flooding, heat waves, and hurricanes will be more frequent and intense as the Earth warms. Parts of the Americas are particularly prone to extreme weather events and the impacts of climate change.

In the Caribbean, the impacts of the disasters caused by the 2017 hurricane season exceeded 50 percent of GDP in some island states. In the United States of America in 2017, there were 16 major weather and climate disaster events, from which losses exceeded in total US\$ 300 billion, the highest annual total ever recorded there (46).

Climate change adversely affects health, both directly and indirectly (47). Directly, increased frequency and intensity of extreme weather events harm health—for example, hurricanes causing injury and death, prolonged high temperature and drought can increase mortality and morbidity rates; indirectly, climate change threatens the livelihoods of individuals and the land on which people live and survive. Climate change will be harmful to local, national, and international economic development (45). However, the high human cost the Region experiences is mainly the result of extreme vulnerability of sections of the population, particularly those on a low income, and Indigenous peoples (48–50).

Mitigating greenhouse gas emissions will contribute to global efforts to cap temperature increases to 1.5°C above preindustrial levels—this in turn will help minimize impacts, including on health, in the Americas (51). However, climate impacts are already being felt and further impacts are inevitable, so adaptation strategies will be increasingly necessary alongside mitigation measures.

POVERTY, INEQUITY, AND VULNERABILITY

Climate change is not just an environmental problem, but a problem that heightens poverty and inequities (52). As with other environmental events, it is usually the poorest people and countries that suffer the greatest negative cultural, social, economic, and health impacts (53). According to a report by UNDP, the level of vulnerability of households to natural disasters is determined by factors including economic structure of the household, the stage of local development, social and economic conditions, the coping mechanisms available, exposure to risk, and frequency and intensity of disasters (49). These

The 2015 Paris Agreement states:

“Acknowledging that climate change is a common concern of humankind, Parties should, when taking action to address climate change, respect, promote and consider their respective obligations on human rights, the right to health, the rights of Indigenous peoples, local communities, migrants, children, persons with disabilities and people in vulnerable situations and the right to development, as well as gender equality, empowerment of women and intergenerational equity.”

Source: United Nations Framework Convention on Climate Change. Paris agreement [Internet]; 2015. Available from: https://unfccc.int/sites/default/files/english_paris_agreement.pdf.



© iStock

Home powered by renewable solar energy, Cuba

unequal risks and impacts are further heightened by variations in pre- and postdisaster investment and planning, and poorer communities are less likely to have insurance than wealthier communities. This was the case in Puerto Rico following Hurricane Maria in 2017, for example, where there had also been a lack of safety monitoring and environmental regulation enforcement, which accentuated the effects of the hurricane with poorer communities worst affected (54, 55). In Haiti, Hurricane Matthew in 2016 caused damages equivalent to 32 percent of GDP (56). While the official death toll from the original disaster ranged from 271 to more than 1,000 people, more than 9,200 people subsequently died from cholera (57).

Climate change is expected to impact more adversely on Indigenous populations who depend on natural resources and environments and are more likely than non-Indigenous peoples to live in isolated, low-income communities (53). Indigenous peoples' livelihoods are increasingly endangered by water scarcity, the destruction of ecosystems and natural resources, changes in biodiversity, plant and livestock diseases, and crop losses. This has led to economic losses, loss of life, and food insecurity, for both the Indigenous peoples themselves and for the populations that depend on the food produced in Indigenous villages (58). Indigenous and northern communities in

Canada are particularly vulnerable to extreme weather events due to factors such as remoteness and inaccessibility, cold climate, and aging and inefficient infrastructure (59). In the United States of America, Indigenous communities and tribes face diverse climate adversities (60).

CURRENT AND PROJECTED EMISSIONS, AND MITIGATION ACTIVITY THROUGH RENEWABLES

According to the UN, implementing measures to reduce greenhouse gas emissions in Latin America and the Caribbean could reduce rates of warming (61). There would be other benefits. Measures could also annually reduce premature mortality from fine particulate matter by at least 26 percent, reduce ozone by 40 percent, and avoid the loss of 3–4 million tons of four staple crops—soybeans, maize, wheat, and rice (62).

To date there has been little progress across the Region in reducing the greenhouse gas (GHG) emissions responsible for global warming. In Latin America and the Caribbean, combined emissions represented approximately 12 percent of global emissions in 2017, while the United States of America alone contributed 13 percent and Canada 1.6 percent (63). Between 2006 and 2011, total

emissions increased by 14.2 percent in Latin America and the Caribbean.

Latin America and the Caribbean is the second largest producer of agricultural emissions globally, accounting for 17 percent of total emissions. Emissions in the United States of America and Canada combined from 2001–2010 represented 8 percent of the world’s emissions from agriculture (64). According to the Food and Agriculture Organization of the United Nations’ statistics (65), regional agricultural emissions from crops and livestock grew from 388 to over 900 million tons of carbon dioxide from 1961 to 2010. Livestock-related emissions contributed 88 percent of this total (65). We note that part of the effort to reduce the global burden of noncommunicable disease calls for a shift in diet away from meat with greater emphasis on plant-based foods. Such a shift would have the added benefit of reducing livestock-related emissions of GHG.

Meanwhile, extensive deforestation across the Region, particularly in the Amazon, has removed a significant carbon sink and increased emissions (65). The net conversion of forests to other uses was the main source of GHGs in the Amazon region between 2001 and 2010, generating an average 1.9 billion tons of carbon dioxide (CO₂) (65). Emissions from the burning of fossil fuels and from cement production in Latin America and the Caribbean grew from 2.2 to approximately 3 tons per capita between 1990 and 2015, taking them already above the level forecast for 2050 for this subregion.

Motor vehicles are currently responsible for more than one-third of the CO₂ emissions in the Americas and have been predicted to increase substantially by the International Energy Agency if no mitigation efforts are put in place.

Figure 3.12 illustrates GHG emissions for selected countries in the Americas and shows very high levels for the United States of America (66, 67).

The United States of America also produced more petroleum and natural gas hydrocarbons than any other country in the world in 2017, producing nearly 16 million barrels of petroleum a day (68).

The United States of America is the second highest GHG emitter in the world, after China, and is one of the world’s highest GHG emitters per person. It has the highest rate of emissions for a

Figure 3.12.
Greenhouse gas emissions, countries in Latin America and the Caribbean and the United States of America, 2014



Sources: ¹ Economic Commission for Latin America and the Caribbean. Statistics and indicators [Internet]; 2019. Available from: http://estadisticas.cepal.org/cepalstat/WEB_CEPALSTAT/estadisticasIndicadores.asp?idioma=i, for data for Latin American and Caribbean countries.
² For U.S. data, U.S. Environmental Protection Agency. Inventory of U.S. greenhouse gas emissions and sinks: 1990–2017. Washington, D.C.: EPA; 2019. Available from: <https://www.epa.gov/sites/production/files/2019-04/documents/us-ghg-inventory-2019-main-text.pdf>.

number of GHGs compared to the other countries in the Americas (7). In 2017, the United States of America was responsible for emitting nearly 6.5 million metric tons of carbon dioxide equivalent (69). Total U.S. emissions increased by 1.6 percent from 1990 to 2017, decreasing slightly between 2016 and 2017 by 0.3 percent (70). In Canada, greenhouse gas emissions decreased by 1 percent

between 2005 and 2015, but are projected to rise between 2015 and 2030, quite substantially missing the reduction target of 30 percent below 2005 levels (71).

One significant way to reduce GHG emissions is to replace fossil fuel-generated power with renewables. Hydrocarbons still provide 74 percent of the total energy supply in Latin America and the Caribbean (72). Across the Region there is considerable further potential for renewable sources to meet a far greater share of demand for energy. Renewable sources include wind and solar power, hydropower, and biofuels (73–75).

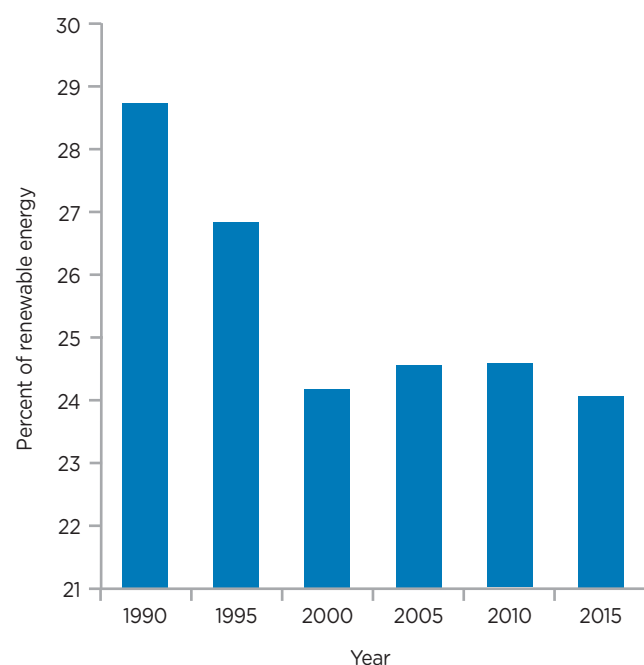
Renewable energy generation has increased in absolute terms in Latin America and the

Caribbean yet the share of renewables in total primary energy production dropped from 29 percent in 1990 to about 25 percent in 2015; see Figure 3.13 (72).

More positively, in several Central American countries, renewables constituted at least half of the energy mix in 2016 (Figure 3.14), and in Costa Rica energy is produced almost entirely from renewable sources.

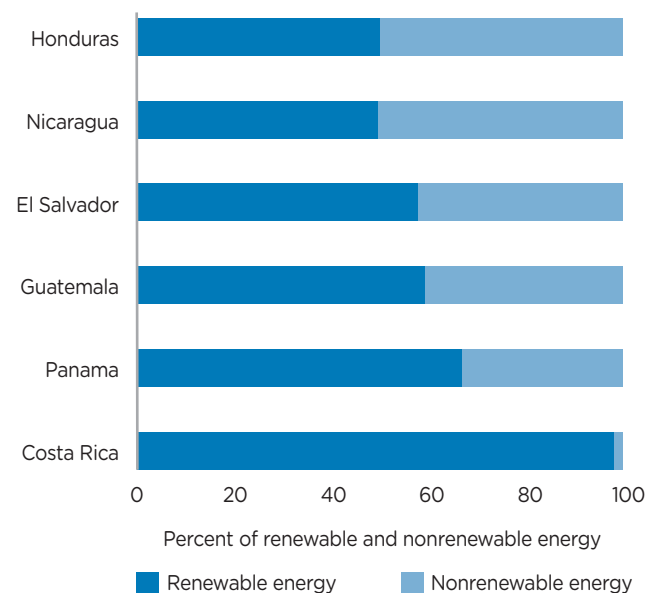
Only about 19 percent of Canada's total primary energy supply relied on renewable resources in 2015, mainly flowing water and wind (76). In the United States of America, renewable energy accounted for only 12.7 percent of all energy produced in 2015 (77, 78).

Figure 3.13.
Share of renewables in total energy production, United States of America, Latin America and the Caribbean, 1990–2015



Source: Flavin C, Gonzalez M, Majano AM, Ochs A, da Rocha M, Tagwerker P. Study on the development of the renewable energy market in Latin America and the Caribbean under the IDB climate change evaluation. Washington, D.C.: Inter-American Development Bank; 2014. Available from: <https://publications.iadb.org/publications/english/document/Study-on-the-Development-of-the-Renewable-Energy-Market-in-Latin-America-and-the-Caribbean.pdf>.

Figure 3.14.
Energy generation mix, Central America, 2016



Source: Economic Commission for Latin America and the Caribbean. Statistics and indicators: environmental [Internet]; 2019. Available from: <http://estadisticas.cepal.org/cepalstat/portada.html?idioma=english>.

Examples of policies and programs to mitigate and adapt to climate change to support health equity

Action to mitigate climate change comes from global international treaties and agreements, national policies and commitments, regional and citywide actions, and small community and individual actions. Some countries are leading the way, Costa Rica for example, while others need to strengthen commitments and considerably reduce GHG production.

Paris Agreement on Climate Change. The adoption of the Paris Agreement in December 2015 committed all Parties to accelerate and intensify the actions and investments needed for a sustainable low-carbon future, to limit global average temperature rise to below 2°C above preindustrial levels, and to pursue efforts to limit the increase to 1.5°C. All countries in the Americas signed up to the agreement except Nicaragua, but the latter went on to ratify in October 2017. To achieve these goals requires taking action on long-lived greenhouse gas emissions such as carbon dioxide, and short-lived climate pollutants such as methane, hydrofluorocarbons, and black carbon. The United States of America announced in 2017 that it would cease participation in the Paris Agreement from 2020. However, 16 states in the United States of America and Puerto Rico, and many cities, have announced that they will continue to advance the Paris Agreement objectives, through the mechanism of the United States Climate Alliance, despite federal withdrawal.^{1,2}

First Binding Regional Agreement to Protect Rights of Access in Environmental Matters, Latin America and the Caribbean. This agreement, from 2018, guarantees rights of access to environmental information, public participation in the environmental decision-making process, and access to justice in environmental matters, to protect the right to live in a healthy environment and the right to sustainable development. The agreement, together with the United Nations 2030 Agenda for Sustainable Development and the Paris Agreement, aims to ensure human rights are protected along with the planet and its natural resources.³

Regional Gateway for Technology Transfer and Climate Change Action for Latin America and the Caribbean. Launched in 2012, the objective of this ongoing program is to strengthen capacity and knowledge exchange for climate change mitigation through technologies in Latin America and the Caribbean.⁴

Economic Inclusion Program for Families and Rural Communities in the Plurinational State of Bolivia. This program (ACCESOS), which ran from 2013 to 2018, had the objective of building the resilience of communities to the impacts of climate change. Most of the communities involved had a high level of vulnerability to climate change. Community members were concerned with climate variability and were interested in opportunities generated by the increasing temperatures in the highlands such as growing fruit trees. The program relied on Indigenous peoples' approaches to land management and introduced new techniques compatible with local practices.⁵ A key feature of ACCESOS was recovering Indigenous peoples' traditional knowledge and technologies about agriculture. A register compiled by Indigenous peoples' communities catalogued bio-indicators, the behaviors of plants and animals that support management processes of agroclimatic information. The program is cost-effective and reliable, coincides with scientific data, and has helped to reduce agricultural losses. It thus constitutes good practice for producers and decision-makers developing adaptation processes to climate change.⁵

Desert Renewable Energy Conservation Plan, California, United States of America. A major component of California's renewable energy planning efforts, this plan aims to provide effective protection and conservation of desert ecosystems while allowing for the appropriate development of renewable energy projects. It covers 22.5 million acres of the state's desert regions.⁶

Sources: ¹ United Nations Framework Convention on Climate Change. Paris agreement [Internet]; 2015 [cited 6 Feb 2018].

² Bloomberg Philanthropies. Citylab [Internet]; 2018 [cited 13 Nov 2018]. Available from: <https://www.bloomberg.org/program/government-innovation/citylab/#overview>.

³ Economic Commission for Latin America and the Caribbean. Latin America and the Caribbean adopts its first binding regional agreement to protect rights of access in environmental matters [Internet]; 4 March 2018 [cited 15 Dec 2018]. Available from: <https://www.cepal.org/en/pressreleases/latin-america-and-caribbean-adopts-its-first-binding-regional-agreement-protect-rights>.

⁴ U.S. Energy Information Administration. Frequently asked questions: what is U.S. electricity generation by energy source? [Internet]; 29 October 2018 [cited 14 Dec 2018]. Available from: <https://www.eia.gov/tools/faqs/faq.php?id=427&t=3>.

⁵ International Fund for Agricultural Development. Indigenous peoples' collective rights to lands, territories and natural resources. Lessons from IFAD-supported projects. Rome: IFAD; 2018. Available from: https://www.ifad.org/documents/38714170/40272519/IPs_Land.pdf/ea85011b-7f67-4b02-9399-aea99c414ba.

⁶ Desert Renewable Energy Conservation Plan. Welcome to DRECP [Internet]; [cited 30 Jan 2019]. Available from: <https://www.drecp.org/>.

(continued on next page)

Examples of policies and programs to mitigate and adapt to climate change to support health equity *(continued)*

Clean Energy Standard (CES), New York State, United States of America. The CES is designed to fight climate change, reduce harmful air pollution, and ensure a diverse and reliable low-carbon energy supply. The CES requires that 70 percent of New York's electricity come from renewable energy sources such as solar and wind by 2030. The CES aims to ensure that the state will meet its goals of reducing greenhouse gas emissions from 2016 levels by 40 percent by 2030 and 80 percent by 2050.⁷

National Climate Change Plan, Brazil. Brazil is the fifth highest GHG-emitting country in the world. The National Climate Change plan is credited with reducing the rate of deforestation between 2008 and 2012 and starting the shift to low-emission agriculture. Agroecological zoning laws for sugar cane and palm oil are intended to balance competing land uses and prohibit cultivation of sugar cane in protected areas. The Brazil Development Bank has also restructured its guidelines to make lending conditional on environmental protection measures that avoid deforestation, and land and water pollution.^{8,9} However, according to a report by Climate Action Tracker, since 2012 progress has stalled and deforestation increased almost 30 percent between 2015 and 2016 with 50 percent of deforestation taking place in the Amazon region. This increase in deforestation and emissions sent Brazil in the opposite direction of its commitments under the Paris Agreement, which included a target of zero illegal deforestation in the Brazilian Amazonia by 2030. The results of the 2018 presidential elections have further hindered Brazil's possibilities of achieving its commitments under the Paris Agreement and potentially undermined Brazil's progress in reducing forestry emissions since 2005.¹⁰ Jair Bolsonaro's election campaign included the threat to withdraw Brazil from the Paris Agreement and to remove protections for the Amazon rainforest, including scaling back Indigenous reserves in the forest.

National Action Plan on Climate Change, Chile. This plan for the period 2017–2022 focuses on four themes of action: adaptation, mitigation, means of implementation, and climate change management at regional and communal levels. It includes commitments to reduce national greenhouse gas emissions by 30 percent below 2007 levels by 2030, the funding of nonconventional renewable energies, and the reforestation of around 100,000 hectares of woodland, with a focus on native species.¹¹ Chile's Nationally Determined Contribution includes adaptation as one of its main pillars, and commits to carrying out plans by identifying sources of financing, strengthening institutional frameworks and generating good monitoring indicators. It also establishes a second cycle of sectoral plans to be implemented from 2021.¹²

Carbon-neutral target, Costa Rica. In 2018, Costa Rica set the ambitious target of being carbon-neutral by 2021. Recently the country 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. There has been considerable growth in solar and wind power sources. In 2016, Costa Rica achieved over 300 consecutive days of energy produced entirely from renewable sources, which meant that renewables accounted for over 98 percent of its total electricity production for the year.¹³

Government of Alberta Climate Leadership Plan, 2015. Under the Plan, Alberta will phase out coal emissions by 2030, offer incentives for renewable generation, implement an economywide carbon price, legislate a cap on oil sands emissions, implement a new methane emissions reduction plan, and implement an Energy Efficiency Program.¹⁴

Sources: ⁷ New York State. Clean energy standard. 2018 RFP awards [Internet]; [cited 1 Feb 2019]. Available from: <https://www.nyserda.ny.gov/All-Programs/Programs/Clean-Energy-Standard>.

⁸ Beddington J, Asaduzzaman M, Clark M, Fernández A, Guillou M, Jahn M, et al. Achieving food security in the face of climate change: final report from the Commission on Sustainable Agriculture and Climate Change. Copenhagen: CGIAR Research Program on Climate Change, Agriculture and Food Security (CCAFS); 2012. Available from: https://cgspace.cgiar.org/bitstream/handle/10568/35589/climate_food_commission-final-mar2012.pdf.

⁹ Viscidi L, Graham N. Brazil was a global leader on climate change. Now it's a threat. Foreign Policy [Internet]; 4 January 2019 [cited 30 Jan 2019]. Available from: <https://foreignpolicy.com/2019/01/04/brazil-was-a-global-leader-on-climate-change-now-its-a-threat/>.

¹⁰ Climate Action Tracker. Brazil country summary [Internet]; 4 December 2018 [cited 30 Jan 2019]. Available from: <https://climateactiontracker.org/countries/brazil/>.

¹¹ Climate Policy Observer, Monitoring Climate Policies. Chile launches new National Action Plan on Climate Change [Internet]; 3 August 2017 [cited 17 Jan 2019]. Available from: <https://www.ndcs.undp.org/content/ndc-support-programme/en/home/impact-and-learning/ideas-and-insights/2017/chile-launches-new-national-action-plan-for-climate-change.html>.

¹² Government of Chile. Plan de acción nacional de cambio climático 2017–2022. Santiago: Government of Chile; 2017. Available from: https://mma.gob.cl/wp-content/uploads/2017/07/Plan_Nacional_Cambio-climatico_2017_2022.pdf.

¹³ Climate Action Tracker. Costa Rica country summary [Internet]; 29 November 2018 [cited 30 Jan 2019]. Available from: <https://climateactiontracker.org/countries/costa-rica/>.

¹⁴ Government of Canada, Natural Resources Canada. 7 facts on the oil sands and the environment [Internet]; [cited 6 Feb 2019]. Available from: <https://www.nrcan.gc.ca/energy/oil-sands/18091>.



Rainforest in Grenada

2B. MINIMIZE ENVIRONMENTAL HARM FROM RESOURCE EXTRACTION INDUSTRIES AND AGRICULTURE

Climate change is one threat to the environment and health; others include ignoring resource limitations, threatening biodiversity and soil health, and polluting and damaging life-sustaining ecosystems. Reducing these environmental risks will benefit health and health equity, as each of these threats affects poorer people and communities the most.

Vast tracts of forested area have been lost in Latin America and the Caribbean in recent decades, particularly in the Amazon basin: approximately 100 million hectares between 1990 and 2014 (79). In the Amazon region, around 17 percent of the forest has been lost in the last 50 years, mostly due to forest conversion for cattle ranching, described in Figure 3.15.

In the United States of America, forests are also under threat, from expansion of urban development into forested areas, and increasingly frequent wildfires, partly as a result of severe droughts associated with climate change (80). Since 2000, the United States of America has seen record fires in many states. By 2060, the United States of America faces a net forest loss of up to 15 million hectares as a result of deforestation and redevelopment of the land (81).

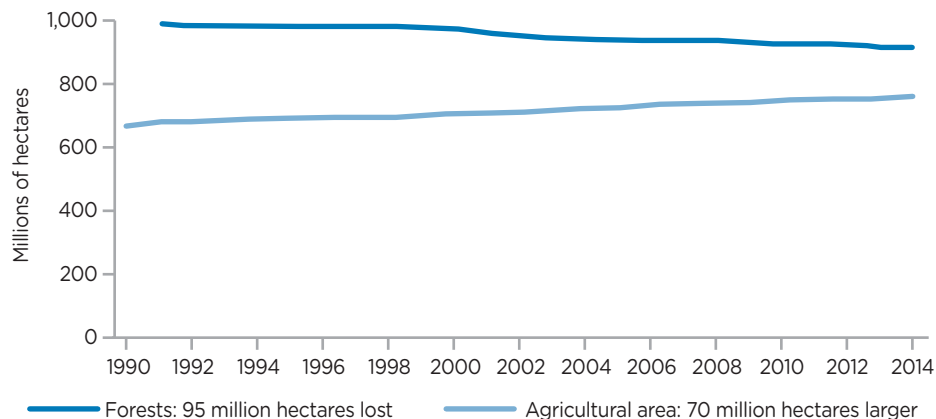
In Canada, the annual deforestation rate in 2010 was less than 0.02 percent, and the rate has been declining for over 25 years. In 1990, 63,100 hectares were lost to deforestation and in 2014 this figure dropped to 34,200 hectares (82).

In 2016, more than 30 percent of North America (Canada and the United States of America) and 40 percent of the continental United States of America was at risk of desertification (79). The most severely affected areas in the United States of America are in New Mexico, Texas, and Arizona. Over-intensive farming and agribusinesses have caused wind, soil, and water to lead to desertification (83, 84).

Parts of Latin America and the Caribbean have high rates of desertification, as a result of climate

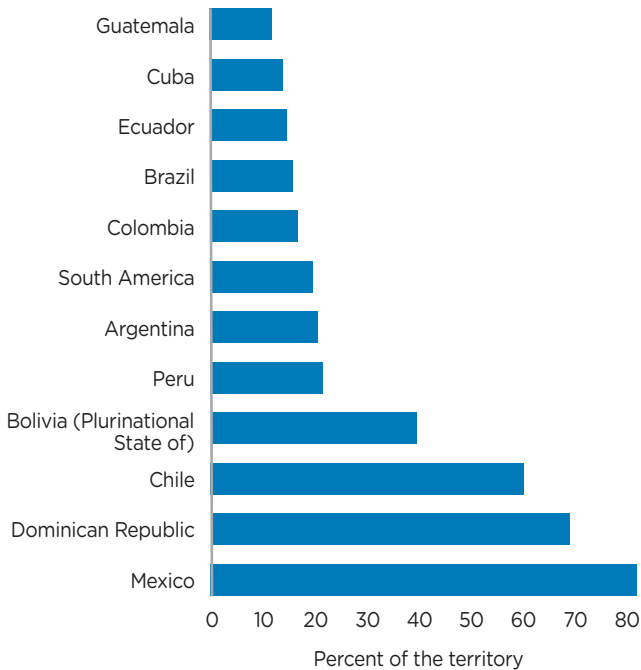
Figure 3.15.

Loss of forested area and expansion of agricultural area in Latin America and the Caribbean, 1990–2014



Source: Food and Agriculture Organization of the United Nations. FAOSTAT [Internet]; [cited 1 Feb 2019]. Available from: <http://www.fao.org/faostat/en/>.

Figure 3.16.
Percentage area of territories desertified or in process of desertification, selected countries in Latin America and the Caribbean, 2014



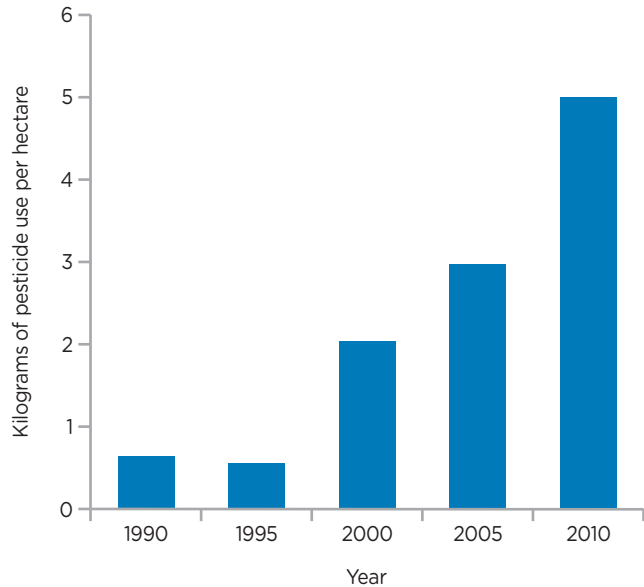
Source: Economic Commission for Latin America and the Caribbean. Statistics and indicators: environmental [Internet]; 2019. Available from: <http://estadisticas.cepal.org/cepalstat/portada.html?idioma=english>.

Note: Includes arid, semiarid, and subhumid areas due to various factors, including climatic variations and human activities in persistent degradation of dry land and fragile ecosystems.

change and soil depletion and erosion (84) (see Figure 3.16). The UN International Fund for Agricultural Development estimates that 50 percent of agricultural land in Latin America and the Caribbean will be subject to desertification by 2050 (79).

Fertilizer use per hectare has intensified across the Region and there has been a large increase in the intensive use of pesticides including fungicides, herbicides, and insecticides, which pose a threat to public health and the environment, degrading the soil (85) (Figure 3.17).

Figure 3.17.
Intensity of pesticide use in Latin America, 1990–2010



Source: Economic Commission for Latin America and the Caribbean. Statistics and indicators: environmental [Internet]; 2019. Available from: <http://estadisticas.cepal.org/cepalstat/portada.html?idioma=english>.

Common factors to all forms of land degradation caused by heavy tilling, multiple harvests, and extensive use of agrochemicals are the depletion of soils' organic carbon and the reduction of biodiversity, which causes the erosion of the nonrenewable mineral composition of soil. Large-scale agribusiness models that rely heavily on large-scale, highly mechanized farms have also pushed small-scale farmers to marginal dry and poor-quality lands with insecure tenure and contributed to the eradication of rural livelihoods and traditional sustainable food production practices, and have significantly contributed to land degradation (86).

Mining of silver, copper, gold, zinc, tin, and other minerals consumes enormous quantities of water and heavily contaminates watersheds and agricultural land, in addition to the destruction of natural environments in areas being mined. Acids and heavy metals that are improperly dumped cause extreme water and environmental stress (87). There are many other reports of environmental and health harm as a result of mining (88).

Examples of policies and programs to minimize environmental harm from resource extraction industries and agriculture

National Policy for Agroecology and Organic Production (PNAPO), Brazil, 2012. PNAPO seeks to address environmental degradation. It covers aspects of sustainable food chains and systems, and involves multiple stakeholders and government bodies. In the first phase to 2015 the program advanced the agroecological agenda in the country, investing over US\$ 413 million,¹ increased access to water and seeds for small holders, established research networks and farmers associations, and created local markets for agroecological products. More than 130,000 families benefited.²

AGRUPAR Program, Quito, Ecuador, 2002. This program recognized the role of urban agriculture for wider social, ecological, and economic development. AGRUPAR supports community and family gardens, and gardens in institutions, as well as small livestock production units. Over 3,600 urban gardens have been created and more than 21,000 people, 84 percent of whom are women, have been trained in organic production. The program has also created 17 organic produce markets. It targets female-headed households, the elderly, children and youth, social and rehabilitation centers, migrants, and education institutions. Since its establishment, the program has benefited more than 70,000 people and indirectly a further 110,000. Participants surveyed in 2010 said the program improved their quality of life, nutrition, health, and well-being. The program has increased access to healthy food for vulnerable groups. Environmental impacts include land rehabilitation, better soil health, water saving, organic waste recycling, and increased biodiversity.²

Biodiversity conservation, Canada. Canada was the first industrialized country to ratify the UN Convention on Biological Diversity, and is a global leader in the conservation of biodiversity. Federal, provincial, and territorial governments across Canada have taken action to protect more than 100 million hectares of land—nearly 10 percent of Canada's land mass—and 3 million hectares of ocean.³ This was achieved by creating national, provincial, and municipal parks and other conservation areas. There has also been some progress made since 2008 for conserving terrestrial and inland water areas and through increased public funding.⁴

Organic standards certification, United States of America. From 1990 to 2010, sales of organic products in the United States of America grew from US\$ 1 billion to nearly US\$ 27 billion. Rules on labeling introduced by the U.S. Department of Agriculture require that organic products meet established standards that include assurance that organic products are produced without antibiotics, pesticides, hormones, or bioengineering, and that they adhere to criteria for soil and water conservation, and animal welfare.⁵

State policy for the agricultural sector and rural development, Costa Rica, 2010–2021. In Costa Rica the agricultural sector is responsible for the second highest level of greenhouse gas emissions, due to production of nitrous oxide and methane. This policy integrates climate change and agri-environmental management with policy promoting agrobiodiversity, clean production, and sustainable management of lands and other natural resources. It is anticipated that the policy will help reduce agriculture-related greenhouse gases and support the sector in achieving the country's carbon neutrality objective.⁶

Countries in Latin America and the Caribbean have defined national voluntary land degradation neutrality (LDN) targets at the national level, as part of the process to achieve the SDGs, in particular SDG 15.3. Currently there are 22 Latin American and Caribbean countries participating in the LDN Target Setting Programme (LDN TSP). Three of these—Chile, Costa Rica, and Grenada—have been selected as pilot countries.⁷

Sources: ¹ FuturePolicy.org. Brazil's National Policy for Agroecology and Organic Production (PNAPO) [Internet]; [cited 29 Jan 2019]. Available from: <https://www.futurepolicy.org/healthy-ecosystems/brazil-national-policy-agroecology-organic-production/>.

² World Future Council. Scaling up agroecology. Future policy award [Internet]; 2018 [cited 29 Jan 2019]. Available from: <https://www.worldfuturecouncil.org/wp-content/uploads/2018/10/FPA-2018-Brochure-for-web.pdf>.

³ Government of Canada. Environment [Internet]; 2013 [cited 29 Jan 2019]. Available from: <https://www.canadainternational.gc.ca/eu-ue/policies-politiques/environnement-environnement.aspx?lang=eng>.

⁴ Government of Canada. Canada's Sixth National Report to the United Nations Convention on Biological Diversity [Internet]; 9 November 2018. Available from: <https://www.cbd.int/doc/nr/nr-06/ca-nr-06-en.pdf>.

⁵ Beddington J, Asaduzzaman M, Clark M, Fernández A, Guillou M, Jahn M, et al. Achieving food security in the face of climate change: final report from the Commission on Sustainable Agriculture and Climate Change. Copenhagen: CGIAR Research Program on Climate Change, Agriculture and Food Security (CCAFS); 2012. Available from: https://cgspace.cgiar.org/bitstream/handle/10568/35589/climate_food_commission-final-mar2012.pdf.

⁶ NAMA Cafe de Costa Rica. Costa Rica's climate change strategy [Internet]; [cited 29 Jan 2019]. Available from: <http://www.namacafe.org/en/costa-ricas-climate-change-strategy>.

⁷ United Nations Convention to Combat Desertification. Global land outlook. 1st edition. Bonn: UNCCD; 2017.

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

Many Indigenous communities across the Region of the Americas live and adhere to sustainable environmental practices that balance people and environments, with a strong focus on protecting the environment and consideration for future generations, described further in Recommendation 3. However, expansion of agriculture and resource extraction into the lands where Indigenous peoples have lived for centuries is causing displacement of these populations and environmental degradation. In turn, these problems create and compound environmental harm and social and health inequities.

All of the countries of Latin America have seen escalating conflict related to the control and use of territory and natural resources. The majority have been related to mining, hydroelectric developments, forestry, and agro-industrial activities. In many countries in the Region, drug cartels have violently expelled whole communities from lands rich in natural resources (89).

As Oxfam reports, in Colombia, land allocated through agrarian reform processes to landless farmers ended up with the world's largest agricultural commodity trader. In Guatemala, farmers have been transformed into low-paid, seasonal workers in unsafe working conditions, and oil palm has displaced cultivation of basic grains for household consumption, exacerbating food insecurity. And in Paraguay, intensive application of pesticides and herbicides to grow soy is harming the health and livelihoods of families living near plantations (90).

A third of land granted in concessions for mining, oil, agro-industrial, or forestry exploitation, in Latin America, belongs to Indigenous peoples. In Argentina, 84 percent of concessions for soybean production are in Indigenous territories. The expansion of mining and petroleum activities in Bolivia (Plurinational State of), Chile, Colombia, Ecuador, and Peru is giving rise to increasingly frequent and intense conflicts with Indigenous peoples, because such activities either directly

impact their territories, or affect the water sources they rely on (89).

In the Americas, recognition of Indigenous territorial rights has shown some recent progress, in some countries. There has been a move from denial of rights to legal recognition and recording, and demarcation of Indigenous lands is taking place in all countries—albeit with varying degrees of success—starting with laws that recognize and protect Indigenous peoples' territorial rights. This change in recognition has mostly been driven by pressure from Indigenous peoples, together with evolving international standards. There have been constitutional reforms in Argentina, Bolivia (Plurinational State of), Brazil, Colombia, Ecuador, Guatemala, Mexico, Nicaragua, Panama, Paraguay, Peru, and Venezuela (Bolivarian Republic of), a number of which acknowledge the collective nature of Indigenous peoples, which is an essential element of land rights (91).

However, despite these constitutional reforms, gaining territorial rights recognition can still be an arduous process. For example, in Peru, Indigenous communities must overcome 27 bureaucratic hurdles and wait 10 years to obtain legal recognition of their territory, while it takes a company just seven steps and less than three months to obtain a mining or forestry concession. Between 2007 and 2015, only 50 titles were approved for Indigenous territories, while more than 35,000 mining concessions were granted (89).

Examples of policies and programs that protect and support the relationship of Indigenous peoples to the land and make progress in attainment of land tenure for marginalized communities

Legal recognition of Indigenous territories, Plurinational State of Bolivia. Since 2005, the Plurinational State of Bolivia has made significant progress in legally recognizing Indigenous territories, and has granted collective titles for 20 million hectares of original community lands. However, limited access to capital, productive resources, and information means that many of those territories still have low productivity and are under threat from farmers.¹

Agreements with First Nations peoples, Canada. In 2018, the federal and provincial governments were negotiating agreements with the First Nations peoples of British Columbia. To date, the governments have recognized only a small portion of these communities' traditional lands as Indigenous reserves, leaving the remainder to be privatized. According to the Declaration on the Rights of Indigenous Peoples adopted by the Human Rights Council, Indigenous peoples have the right to determine and establish priorities and strategies for their self-development and for the use of their lands, territories, and other resources. Indigenous peoples are demanding that free, prior, and informed consent must be the principle of approving or rejecting any project or activity affecting their lands, territories, and other resources.²

Indigenous Guardians Pilot Program, Canada. In the 2017 budget, the government of Canada announced Can\$ 25 million over four years to support an Indigenous Guardians Pilot Program. This program will provide Indigenous peoples with greater opportunity to have stewardship of their traditional lands, waters, and ice, and supports Indigenous rights and responsibilities in protecting and conserving ecosystems, developing and maintaining sustainable economies, and continuing the connections between the environment and Indigenous cultures. The Pilot Program is being implemented jointly with First Nations, Inuit, and Metis, using an individual approach that respects and recognizes the unique perspectives, rights, responsibilities, and needs of Indigenous peoples.³

Indigenous titling, Peru. Since 1974, more than 1,300 Indigenous communities in the Peruvian Amazon have obtained title to about 12 million hectares, including 17 percent of the country's forests. This is significant for forest protection, given that titling has been shown to reduce the risk of forest clearance by three-quarters in this region. However, the process that has led to these gains has seen both progress and setbacks for Indigenous communities. The titling process is long, complicated, and costly, and still plagued by logistical difficulties. Formalization of rights for Indigenous communities may take as long as 20 years. There are, however, some positive developments. By the second decade of the 2000s, nearly a dozen titling programs were underway for collective lands in the Peruvian Amazon.⁴

Sources: ¹ Oxfam International. *Unearthed: land, power and inequality in Latin America*. Oxford: Oxfam International; 2016.

² United Nations Permanent Forum on Indigenous Peoples. *Indigenous peoples - lands, territories and natural resources* [Internet]; [cited 28 Jan 2019]. Available from: https://www.un.org/en/events/indigenousday/pdf/Backgrounder_LTNR_FINAL.pdf.

³ Government of Canada. *Indigenous Guardians Pilot Program* [Internet]; 2019 [cited 19 Jan 2019]. Available from: <https://www.canada.ca/en/environment-climate-change/services/environmental-funding/indigenous-guardians-pilot-program.html>.

⁴ NYDF Assessment Partners. *Improving governance to protect forests: empowering people and communities, strengthening laws and institutions - New York Declaration on Forests Goal 10 Assessment Report*. Coordinated by Climate Focus with support from the Climate and Land Use Alliance [Internet]; 2018. Available from: https://climatefocus.com/sites/default/files/NYDF%20report%202018_0.pdf

RELEVANT INTERNATIONAL AGREEMENTS

Paris Agreement (UN Framework Convention on Climate Change [2015])

PAHO Resolutions

Plan of Action for Disaster Risk Reduction 2016–2021 (CD55.R10 [2016])

Strategy and Plan of Action on Climate Change (CD51.R15 [2011])

Coordination of International Humanitarian Assistance in Health in Case of Disasters (CSP28.R19 [2012])

Sustainable Development Goals

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 well-being for all at all ages

Goal 6. Ensure availability and sustainable management of water and sanitation for all

Goal 7. Ensure access to affordable, reliable, sustainable and modern energy for all

Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

Goal 9. Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation

Goal 12. Ensure sustainable consumption and production patterns

Goal 13. Take urgent action to combat climate change and its impacts

Goal 14. Conserve and sustainably use the oceans, seas and marine resources for sustainable development

Goal 15. Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss

RECOMMENDATION 3.

RECOGNIZE 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. The effects continue to be felt today.

The power relationships that began with the conquest and colonization of one group by another, for reasons that were essentially economic, have been reinforced by multiple exclusions from opportunities, control of power and resources, eviction from land, and large-scale forced migration. These relationships have been present for Indigenous peoples, people of African descent, and other excluded minorities since formal slavery and colonization began, and continued after it ended.

There are many dimensions to continuing racism and colonialism, including in cultural, political, and socioeconomic arenas. These lead to multiple exclusionary processes that result in peoples who are Indigenous or of African descent, as well as other minority ethnic groups, having lower life expectancy, lower healthy life expectancy, and higher mortality rates at all ages, as compared with other ethnic groups, as well as a range of poorer outcomes in key social determinants of health.

PRIORITY OBJECTIVES	ACTIONS
<p>3A. Act to address the philosophy, culture, policies, and practices that flow from historic and current colonialism</p>	<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 peoples 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 spending on services is equitable
<p>3B. Ensure people of African descent and Indigenous peoples are free to live dignified lives, including through affirmation of their distinct rights</p>	<ul style="list-style-type: none"> • Recognize spatial, cultural, social, and intergenerational inequalities as a human rights issue for all ethnic groups • Governing entities are 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 are to codify the UN Declaration on the Rights of Indigenous Peoples (UNDRIP) into domestic legislation, policies, and practices, ensuring Indigenous peoples have the resources and opportunities necessary to exercise the full enjoyment of their rights
<p>3C. Undertake positive measures to address systematic racism</p>	<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 people to be different, to consider themselves different, and to be respected as such

The black community fought yesterday for freedom and independence. Today, it fights for equal opportunities and respect for human rights.

Oscar Maturana, *Afrodescendientes en la independencia* [translated from original Spanish]



Rio de Janeiro, street decorated to celebrate the World Cup, with the message at the bottom “No to Racism”

In this subsection and throughout the report, we describe inequities experienced by Indigenous peoples and people of African descent that cumulatively contribute to the perpetuation of health inequities. Ideally, we would provide systematic comparisons across the whole of the Americas of differences in access to resources, and outcomes by ethnicity.

However, for reasons to a considerable degree associated with the colonial legacy, these data are not always collected in a consistent way by different countries. For example, some countries discourage the collection of data on ethnicity and race. Where information is available on people of mixed race or heritage, it is captured inconsistently (92, 93).

The SDGs and related indicators agreed on by the United Nations Statistical Commission in March 2016 (94) cover many of the areas identified in this review as being a particular source of inequality among ethnic and racial groups in the Americas. In view of the size of these groups in the Americas, many SDGs, such as the eradication of hunger and poverty, will only be achieved if progress on the multiple forms of disadvantage experienced by ethnic groups in every country in the Americas is made possible (95).

HISTORIC ROOTS OF ONGOING COLONIALISM AND RACISM

Colonialism and Indigenous peoples

The sustained era of colonialism in the Americas began at the end of the 15th century, led primarily by the Spanish, Portuguese, French, and British (96). The colonial States deemed themselves as “civilized” and Indigenous peoples and cultures as “savage,” in order to legitimize the unlawful taking of lands and resources and the superimposing of Western European culture, institutions, and languages (97, 98). The savage/civilized dichotomy and Spain’s interest in asserting land rights over territories “discovered” by Columbus in his 1492 journey to the Americas prompted Pope Alexander VI to issue the Papal Bull *Inter Caetera* (99), which recognized land ownership by Christian peoples (100), effectively negating Indigenous title by declaring the land *terra nullius*—owned by no one. The Papal Bull in turn gave rise to the Doctrine of Discovery (98), which codified the ineligibility of non-Christian

peoples to hold title over lands and resources. In 1823, the U.S. Supreme Court relied on the Doctrine of Discovery in the landmark *Johnson v. M’Intosh* case (101) to extinguish Native American land title, awarding it to the “discoverer” of the lands, leaving Native Americans with only a right to “occupy the land.” The Doctrine of Discovery has been relied upon by many countries in the Americas to extinguish or subjugate Indigenous peoples’ rights to lands and resources.

While the exact size of the population of Indigenous peoples in the Americas prior to colonization is not known, a recent paper suggests that approximately 56 million Indigenous peoples died in the Americas in the 1500s and 1600s alone (102). Other data show an estimated precolonial population of American Indians in the United States of America of 10 million people, which by the 1900s had decreased to fewer than 400,000 (103).

The colonial relegation of Indigenous peoples as lawless “savages” opened the door to profound human rights abuses and illegal taking of lands and resources that continue to impact on Indigenous peoples’ health today (104). The United Nations officially discredited colonialism in the 1960s. But despite this and other positive developments (see the relevant international agreements listed at the end of this section on Recommendation 3), the Permanent Forum on Indigenous Peoples notes colonialism continues in many countries (97). For example, public services are often not reflective of Indigenous peoples’ cultures and needs (105), resource extraction contributes and harms the health of Indigenous peoples (106), and some countries continue to pursue extinguishment policies regarding Indigenous rights and title (97).

There are now approximately 60 million Indigenous peoples living in the Americas, with diverse languages, cultures, and knowledge systems. An estimated 40 to 50 million Indigenous peoples live in Latin America, representing 10 percent of the total population there, with the proportion rising to 27 percent in rural areas. The Plurinational State of Bolivia and Guatemala have the largest proportion of Indigenous peoples, making up approximately 50 percent of the total population in each country. A further 6 to 10 million people with Indigenous ancestry live in the United States of America and Canada, representing 2 percent and 4 percent of the population, respectively (107, 108).

Slavery and people of African descent

The first slaves were brought from Africa in 1502, to provide labor on Hispaniola, the island today comprising Haiti and the Dominican Republic. It is estimated that the number brought to the colonies from Africa by the 19th century may have been as great as 10 million (109). They were initially brought to make up for the rapidly diminishing Indigenous population of Hispaniola to work on sugar plantations. Over the following 25 years, slaves were taken to Cuba, Jamaica, Honduras, and Guatemala, and, as the colonies expanded, they were sent to Mexico, Colombia, Venezuela (Bolivarian Republic of), and Peru to replace Indigenous populations that had been killed by Old World diseases and violence.

For most of the 16th century, the slave trade was primarily to the South American colonies of the Portuguese and Spanish empires. The subsequent phase was undertaken mostly by English, Portuguese, French, and Dutch traders, who took slaves mainly to the Caribbean and Brazil, and expanded through the 18th century (110). Transportation of slaves continued after slavery in most countries was abolished in the 19th century, accounting for over a quarter of all those ever transported (111).

All slaves were subjected to colonial laws of social stratification, although these varied slightly among the colonial powers. In Latin America, there was a caste system, driven by European ideas of racial purity and blood descent, which systematically relegated people of African descent to the bottom of the social scale. It controlled not only civil and religious rights, but also access to property, public office, travel, and finance. It ensured people of African descent experienced little social mobility and faced extreme deprivation (93).

The abolition of slavery has almost as long a history as slavery and colonialism in the Americas. Britain banned the slave trade in 1807, and the U.S. Congress outlawed the importation of slaves from 1808 (112). The 13th Amendment to the U.S. Constitution, which abolished slavery, was ratified by most states in 1865, but it was not complete until Mississippi ratified it in 1995 (113). The final abolition of slavery lasted from 1822 in the Dominican Republic to 1888 in Brazil (114).

Canada also has a history of enslavement despite the fact that it is often positioned as a country of

refuge for persons fleeing slavery in the United States of America. Both French and British colonial forces enslaved Indigenous peoples and people of African descent (115). Indigenous peoples accounted for two-thirds of the slave population in Canada over a period of 200 years, from the 1600s to the 1800s. Slavery was outlawed in 1833, with the enactment of the Slavery Abolition Act in Britain, which made slavery illegal throughout the British colonies (116).

The population of African descent in the Americas today is estimated to be in the order of 200 million, which is approximately 30 percent of the population in the Region (117) and around a quarter of the population of Latin America (93). According to the definition adopted by the American States during a 2011 meeting of the OAS in Santiago, Chile, “African descent” refers to people of African origin who live in the Americas and in all areas of the African diaspora as a result of slavery, having historically been denied the exercise of their fundamental rights (118). The U.S. Census Bureau estimates that 34 million people of African descent live in the United States of America (13 percent of the population) (119). Data from the 2016 census for Canada identify 1,198,540 people (3 percent of the population) with this background living in that country (120). The percentage of the population of African descent in Latin America is nearly 90 percent in the Dominican Republic and over 50 percent in Brazil and the Bolivarian Republic of Venezuela (121).

PERPETUATION OF INEQUALITIES

This history of exploitation of Indigenous peoples and people of African descent, and the attendant racism, has left a long shadow that affects the socioeconomic, cultural, and political positions of these populations, and their right and opportunity to have a dignified and healthy life. The diversity of the processes that began during the colonial era is key to understanding the heterogeneity of race relations in the Region, and the roles of Indigenous peoples and people of African descent in politics, economies, and societies (92, 93). The frequent denial of this situation, and inequitable provision of public services and continued forcible removal of people from land, has deepened trauma arising from colonialism, and in some cases continues to hamper efforts to redress health inequalities and their causes (92, 105, 122–124).

Continued inequalities and poverty among Indigenous peoples

Indigenous peoples presenting to the PAHO Equity Commission made clear that colonialism contributes to the depth and scope of health inequities that affect them, across physical, emotional, spiritual, and cognitive health domains, and across generations. A World Bank report confirms that Indigenous peoples worldwide are more likely to be poor and to live in deeper levels of poverty than non-Indigenous peoples, and for longer periods of time, due to the pervasive and continuing effects of colonialism (125).

While the determinants of health model has relevance to Indigenous peoples, it has typically left out determinants of health important to these populations, such as self-determination, relationship with the land and the universe, spirituality, and expansive concepts of time that recognize obligations to ancestors and future generations (104, 126, 127). Spurred by Indigenous activism, some Latin American countries have integrated these tenets into their respective constitutions (128).

In Latin America and the Caribbean, Indigenous peoples are nearly three times more likely to live in deep poverty (on less than US\$ 2.50 per day) and also three times more likely to live in extreme poverty (on less than US\$ 1.25 per day) than are their non-Indigenous peers (92). The poverty trend is also apparent 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 41 percent of all Indigenous children and 18 percent of all children (129).

Continued inequalities and poverty among people of African descent

People of African descent continue to experience greater risks of poverty than do other ethnic groups. With similar baseline conditions, being of African descent increased the chances of being poor by over 75 percent in comparison to people not of African descent in Colombia in 2016, and increased the chances of being extremely poor by 140 percent. People of African descent are also more likely to die earlier and be at risk of worse health outcomes throughout life, be victims of violence, be incarcerated, suffer human rights abuses, and be less educated, as well as less likely to be employed and in good employment, than are

people not of African descent. These inequities and exclusions are related to the history of slavery and subjugation in the Region, and ongoing racism and social and economic exclusions are still manifest in all countries in the Region (130). These situations are described throughout this report.

Populations of African descent also face low representation in political and institutional decision-making processes and low levels of participation. Furthermore, discrimination against the right to vote still takes place against populations of African descent in the United States of America, where there are limitations to exercising the right to vote by persons with judicial records, including minor offenses, imposed in some states, and which are, in practice, directed at people of African descent (122, 131).

The accumulation of disadvantage

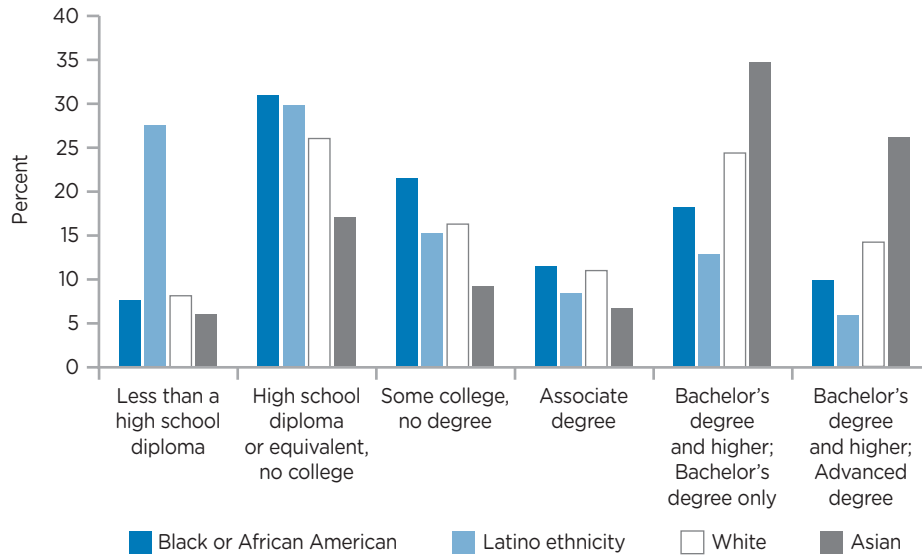
Central to this report is that the circumstances in which people are born, grow, live, work, and age affect their health. The inequalities and discrimination faced by people of African descent and Indigenous peoples have intergenerational effects on their circumstances throughout their lives.

Indigenous peoples across the Region are significantly less likely to complete secondary education than non-Indigenous peoples are. There are many barriers that impede their access to education, including deep poverty, difficulty physically accessing schools, the inappropriateness of education content, and, for girls, becoming pregnant in adolescence or having to care for family members. People in rural areas are less likely to attend secondary school than those in urban areas, and even less likely to complete a full 13 years of education. Living in rural areas is a further contribution to the educational disadvantage of Indigenous peoples. Their chances of progressing to college are even more limited (117).

The processes and consequences that underpin the accumulation of educational and subsequent disadvantage among people of African descent can be illustrated using data for the United States of America. Figure 3.18 shows that the highest level of education achieved in 2014 varied markedly by race and ethnicity. More than a quarter of those of Hispanic or Latino ethnicity were likely to have left school without a high school diploma, compared with one in 12 in most other groups. Those who identified as Black or African American

Figure 3.18.

Distribution of educational attainment in the labor force by race/ethnicity, United States of America, 2015



Source: U.S. Bureau of Labor Statistics. Labor force characteristics by race and ethnicity, 2015 [Internet]; September 2016. Available from: <https://www.bls.gov/opub/reports/race-and-ethnicity/2015/home.htm>.

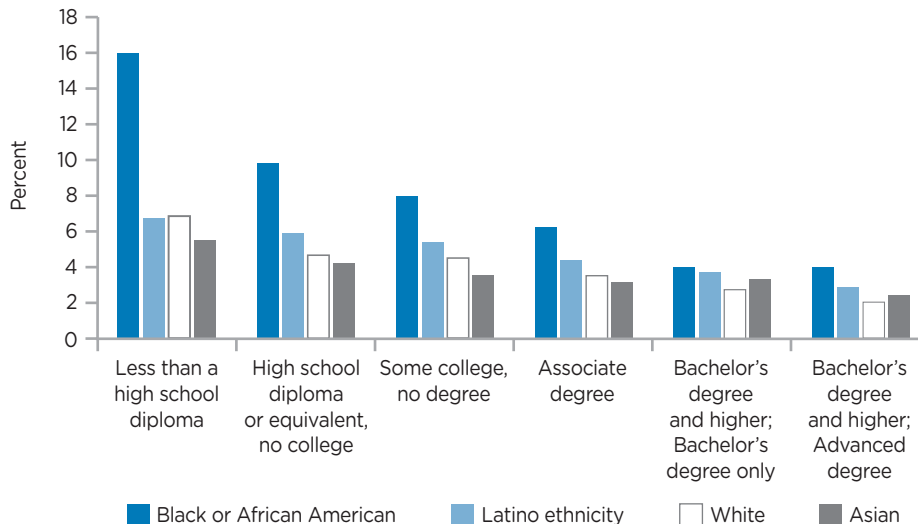
were more likely than others to have graduated from high school or college without obtaining a bachelor’s degree or higher. Asians and, to a lesser extent, Whites were more likely to have obtained a bachelor’s degree or higher than others.

This pattern of educational disadvantage experienced across racial and ethnic groups is

then amplified in the labor market. As Figure 3.19 shows, also for the United States of America, educational attainment is a strong predictor of the likelihood of being unemployed. At each level of attainment, these chances are graded by race and ethnicity. In 2014, being Black or African American was associated with the highest risk at each level, with particularly high rates of unemployment for

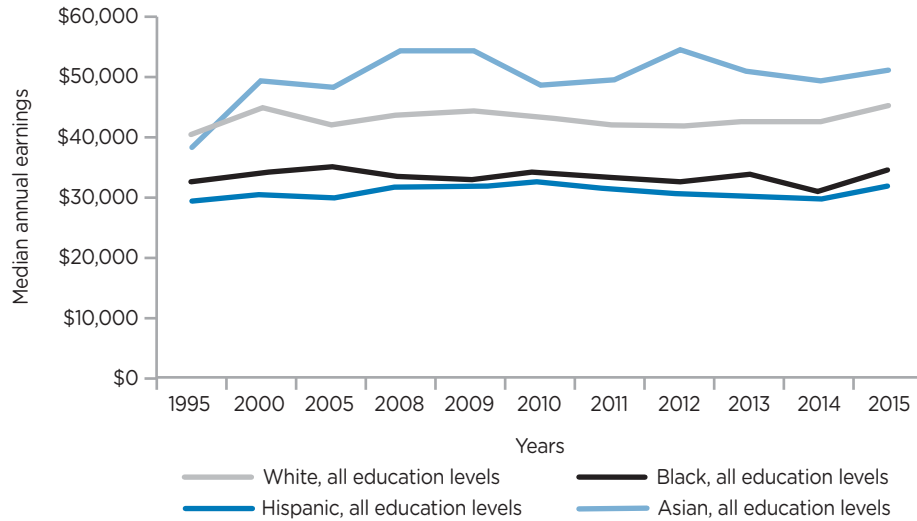
Figure 3.19.

Unemployment rates by educational attainment and race/ethnicity, United States of America, 2015



Source: U.S. Bureau of Labor Statistics. Labor force characteristics by race and ethnicity, 2015 [Internet]; September 2016. Available from: <https://www.bls.gov/opub/reports/race-and-ethnicity/2015/home.htm>.

Figure 3.20.
Median annual earnings by ethnicity, United States of America, 1995-2015



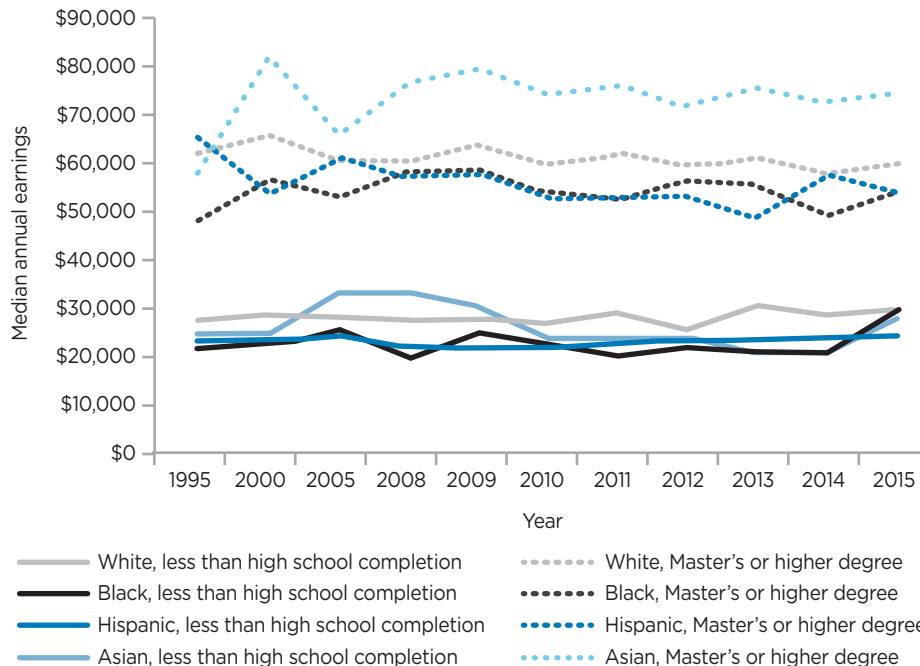
Source: Data from U.S. Census Bureau. Current Population Survey (CPS), annual social and economic supplement, 1996 through 2016 [Internet]; 2019. Available from: <https://www.census.gov/programs-surveys/cps.html>.

those who did not attain a high school diploma or progress beyond college.

For employed people of African descent and employed Hispanics, earnings have persistently

been around US\$ 10,000 less than their White counterparts in the United States of America, as Figure 3.20 shows. The differences are mainly related to inequalities in pay for those who have graduated, as depicted in Figure 3.21.

Figure 3.21.
Median annual earnings by educational attainment and ethnicity, United States of America, 1995-2015



Source: Data from U.S. Census Bureau. Current Population Survey (CPS), annual social and economic supplement, 1996 through 2016 [Internet]; 2019. Available from: <https://www.census.gov/programs-surveys/cps.html>.

THE LAND AS A DETERMINANT OF HEALTH FOR INDIGENOUS PEOPLES

Many Indigenous peoples continue to have powerful relationships and symbiosis with their land and the ecology that has traditionally culturally defined and sustained them. The land, therefore, should be considered as a determinant of health, and the disruption and/or exclusion of Indigenous peoples from the land, and irresponsible resource extraction and industrial contamination of Indigenous territories, threaten health and health equity (see also Recommendation 2).

While Indigenous peoples in the Americas comprise a great many diverse communities, each distinct, they are bound together by a belief that the land owns the people, in opposition to the Western view that the people own the land. Because many Indigenous peoples consider both the land and resource rights as determinants of health, effective programs to address health inequities should take Indigenous health knowledge and practices, sovereignty, and land interests into account (132–134). Indigenous peoples see the pathway that links colonialism to health inequities encompassing food insecurity, inadequate access to clean water or sanitation, relationship with ecology and sustainability practices, and disrupted access to traditional medicines and medicinal knowledge.

Water insecurity and inadequate sanitation

Water is sacred to many Indigenous peoples in the Americas and is foundational in their cultures. Traditionally, the water, human, animal, spiritual, and environmental domains are viewed as interrelated, and respect for water traditionally was essential to Indigenous ontologies and practices. It was viewed as a sacred life force rather than a commodity, and used for drinking, bathing, transportation, agriculture, and ceremony. In many Indigenous cultures, women are the water keepers since they embody water as a life-giving and sustaining force (135–137). When colonial settlers arrived, they presumed Indigenous peoples were savage and either unable to manage the land or water, or unable to use it to its full potential. This supposition introduced forced land grabs that included land drainage, desert irrigation, water contamination through unsustainable development and resource

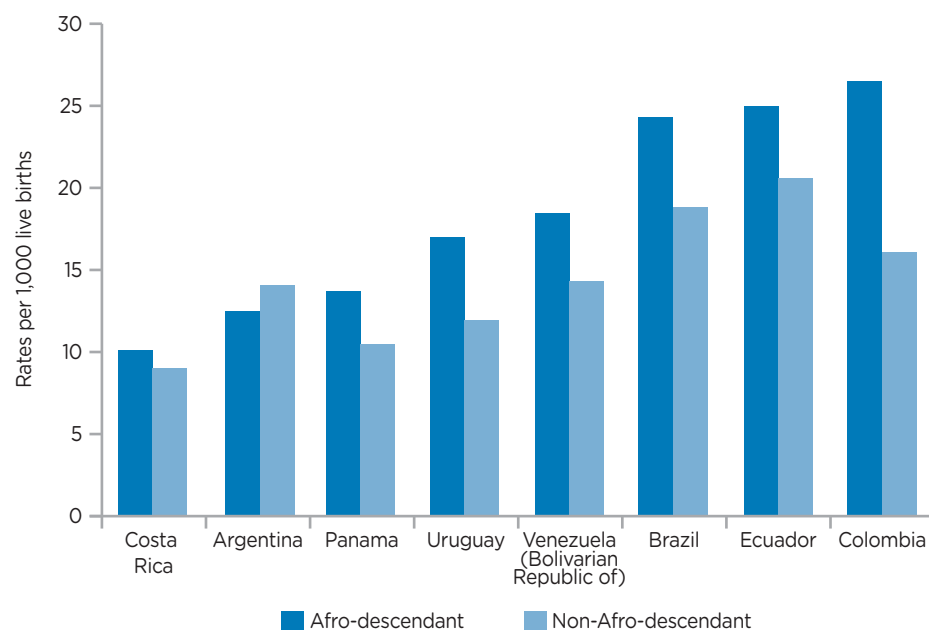
expropriation, and disruption of the natural water management ecology (138).

Inequitable access to clean water and proper sanitation is a significant problem facing Indigenous peoples in the Americas, particularly those living in rural or remote areas, the location of many Indigenous communities (see also Recommendation 9). Thus, an inadequate water supply is viewed as a contemporary manifestation of colonialism since it continues to force Indigenous peoples off their traditional lands. The scale of water insecurity among Indigenous peoples in the Americas is significant. For instance, in 2015 the World Bank Group found that 80 percent of Indigenous peoples in rural areas of the Plurinational State of Bolivia did not have access to piped water (92). In this respect, conditions for Indigenous peoples are better in urban areas, where 12 percent do not have access to piped water—although this figure is a third higher than that for their non-Indigenous peers (92).

In Canada, the Parliamentary Budget Officer estimates that an additional Can\$ 3.2 billion is needed to address the more than 151 boil-water advisories in place in Indigenous communities (of which two-thirds are long term) (139). Also, 28 percent of homes on First Nations reserves do not have piped water (139). In the United States of America, nearly half of all Native American homes on tribal lands did not have reliable access to clean drinking water or sanitation, compared with less than 1 percent of Americans overall (140). These water deficits are linked to poorer health and higher morbidity than for the non-Indigenous population. Schools sometimes have to close as a result of lack of adequate water, too (140).

Food insecurity

Indigenous peoples' close relationship with the land over time fostered sustainable food practices and ecological balance (141). Forced land dislocation and environmental contamination have disrupted these sustainable practices, introducing widespread food insecurity among Indigenous peoples (140, 141). The consequences of food insecurity are not limited to hunger or poor health among Indigenous peoples. The preamble of the Declaration of Atitlán (which was generated by Indigenous peoples and nations from over 28 countries in the world that assembled in Guatemala in April of 2002) (142) notes:

Figure 3.22.**Infant mortality rate by African-descent ethnicity, 2010**

Source: Inter-American Commission on Human Rights. Situation of Afro-descendants in the Americas. Washington, D.C.: Organization of American States; 2011. Available from: http://www.oas.org/en/iachr/afro-descendants/docs/pdf/AFROS_2011_ENG.pdf.

...the content of the Right to Food for Indigenous peoples is a collective right based on our special spiritual relationship with Mother Earth, our lands and territories, environment and natural resources that provide our traditional nutrition; underscoring that the means of subsistence of Indigenous peoples nourishes our cultures, languages, social life, worldview and especially our relationship with Mother Earth; emphasizing that the denial of the Right to Food for Indigenous peoples not only denies us our physical survival, but also our social organization, our cultures, traditions, languages, spirituality, sovereignty, and total identity; it is a denial of our collective indigenous existence.

Affirming Indigenous traditional food knowledge and practices has been shown to improve health outcomes for Indigenous peoples.

HEALTH IMPACTS OF ONGOING COLONIALISM AND RACISM

Infant and under-5 mortality

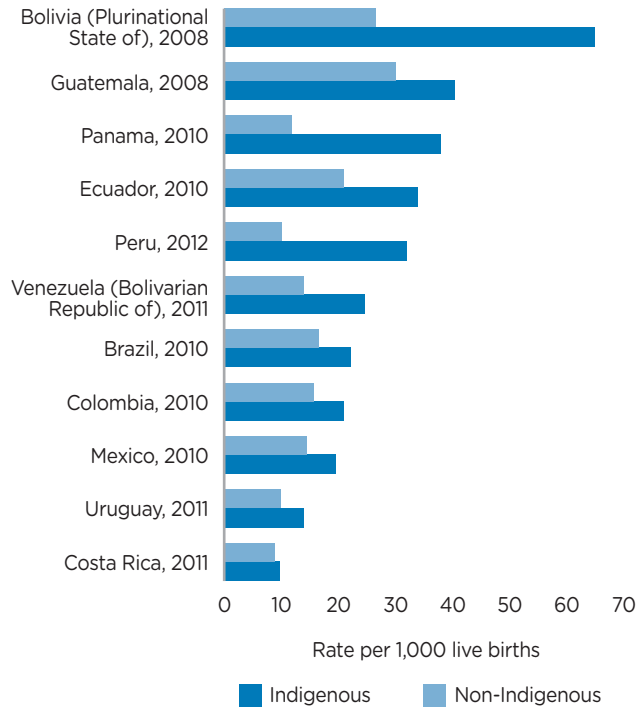
In seven of the eight countries in Latin America for which data are available, infant mortality was

higher among children of African descent than among non-African-descent children in 2010 (Figure 3.22).

Infant mortality rates in 2010 were higher among Indigenous children than among non-Indigenous children in 11 countries in Latin America for which data were available. In Panama and Peru, for example, infant mortality in Indigenous children was three times higher than in non-Indigenous children (4). The available data also show greater maternal mortality among Indigenous women (143). Figure 3.23 shows that under-5 mortality rates are far higher for babies and young children of Indigenous background than for those of other descent.

In the United States of America, too, under-5 mortality varies among ethnic groups. In 2016, the rate was highest among African American children, at 11 deaths per 1,000 live births, followed by Native Americans, Hispanics, and non-Hispanic Whites, at 8, 5.2, and 4.8 deaths per 1,000, respectively (144). A systematic review of evidence over many years of the mortality rate in Canada among First Nations children suggested it was 2.9 times that of non-Indigenous rates, and in Inuit-inhabited areas infant mortality was 4.6 times that reported in non-Indigenous-inhabited areas (145).

Figure 3.23.
Under-5 mortality rates by Indigenous identity, for Latin American countries with comparable data, 2012 or latest available

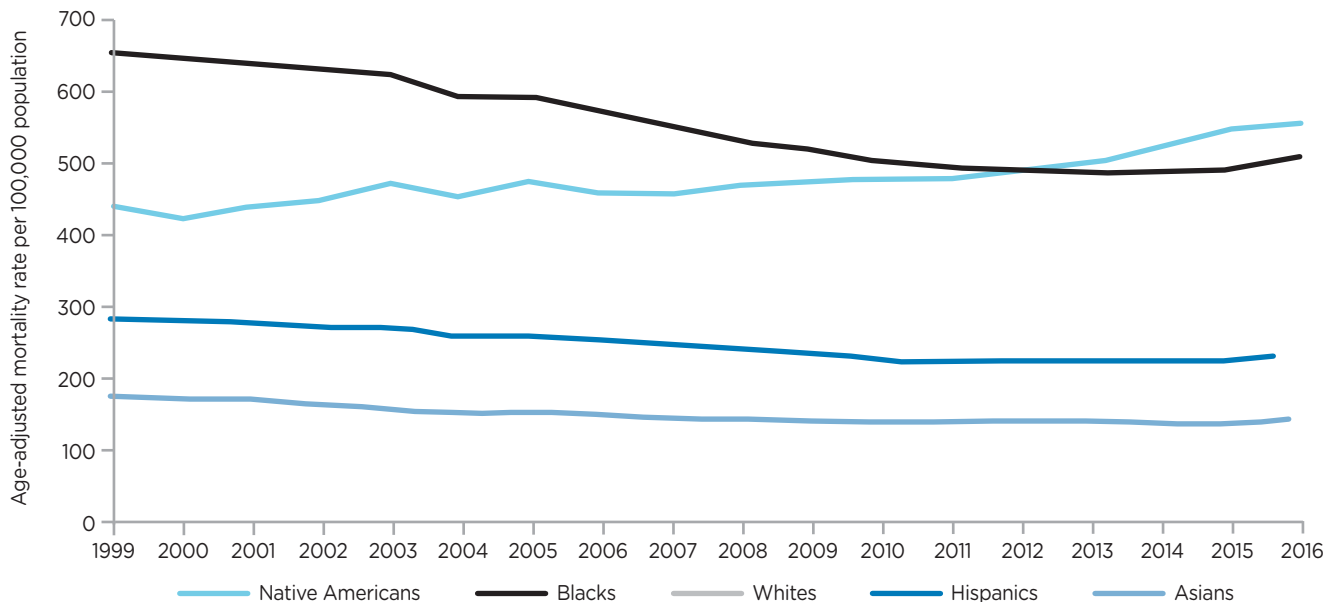


Source: Economic Commission for Latin America and the Caribbean. Social panorama of Latin America 2016. Santiago: ECLAC; 2017. Available from: <https://www.cepal.org/en/publications/41599-social-panorama-latin-america-2016>.

Life expectancy

In the United States of America, life expectancy for White people and Black people has increased over the past century (146). Life expectancy for White people is still higher than for Black people, although the gap had decreased by 2011, for males from around a 16-year difference to 5 years, and for females, from 16 to 3 years. However, there is evidence of a recent reversal in the improvement in mortality rates that underpin life expectancy. Figure 3.24 shows the trends since 1999. Mortality among White people decreased only slightly up to 2010, then increased slightly up through 2016. There were greater decreases among Blacks, Hispanics, and Asians in the years up to 2010, but thereafter improvements either slowed down or stalled, and rates increased from 2014 to 2016. In contrast to all other groups, the mortality rate of Native Americans increased from 2000 and exceeded that of Blacks in 2013. By 2016, the Native American and Black mortality rates were 56 and 43 percent higher than that of Whites, respectively (147).

Figure 3.24.
Age-adjusted mortality rates by race and ethnicity, United States of America, 1999–2016



Source: Woolf SH, Chapman DA, Buchanich JM, Bobby KJ, Zimmerman EB, Blackburn SM. Changes in midlife death rates across racial and ethnic groups in the United States: systematic analysis of vital statistics. *BMJ*. 2018;362:3096.

3A. ACT TO ADDRESS THE PHILOSOPHY, CULTURE, POLICIES, AND PRACTICES THAT FLOW FROM HISTORIC AND CURRENT COLONIALISM

As previously noted, for Indigenous peoples to live a dignified life requires addressing issues concerning self-determination, relationship with the land, spirituality, and obligations to ancestors and future generations (104, 126, 127). Spurred on by Indigenous activism, some Latin American countries have integrated these tenets into their respective constitutions (128).

For example, in 2008 Ecuador changed Article 4 of its Constitution, to read (148):

The territory of Ecuador constitutes a single geographical and historical whole, with natural, social, and cultural dimensions, which has been passed on to us by our ancestors and ancestral peoples. This territory includes the mainland and maritime space, adjacent islands, the territorial sea, the archipelago of the Galapagos Islands, the land, the undersea continental shelf, the ground under the land and the space over our mainland, island, and maritime territory. Its boundaries are those determined by treaties currently in force.

While constitutional recognition is a step forward, its scope is often limited by the interpretation by courts and legal traditions, which might contain conflicting colonial roots and Indigenous elements (98, 149).

The rights of people of African descent, as a group that has suffered discrimination and exclusion across generations, need to be recognized at every level of society too. The deficit of recognition and self-recognition that persists around this population often means that the legitimacy of the adoption of different approaches is questioned in many countries. However, most countries have some government mechanism for the promotion of racial equality.

In Latin America, in 1986, Nicaragua became the first country to recognize the collective rights of Black communities alongside the recognition of Indigenous communities' rights. Through the late 1980s and the 1990s a small number of

other countries followed, including Brazil (1988), which included land rights and cultural rights for quilombolas (escaped slave communities) in its reformed constitution, and Colombia (1991), which recognized the rights of African-descent communities on the country's Pacific Coast (150).

In the United States of America, in contrast to the positive legislation surrounding civil rights and recent efforts on affirmative action, at the beginning of July 2018 the new administration reversed executive orders issued by President Barack Obama in 2011 and 2016 that were aimed at reinforcing the application of affirmative action measures to support the access of people of African descent to higher education.

Table 3.1 describes special measures or affirmative action for the participation of people of African descent in Latin America.

We will demonstrate that we are flourishing cultures and are changing the “cultural pollution” we are submitted to and the image of backwardness and poverty that has been thrust upon us.

Rigoberta Menchú,
recipient of the 1992 Nobel Peace Prize

Table 3.1.

National legislative measures and their content and reach in selected countries of South America

Country	Law and year	Content and reach
Bolivia (Plurinational State of)	Article 32: “The Afro-Bolivian people enjoy the same rights guaranteed to indigenous peoples.”	Constitutional rights that allow for applying for a seat reserved for minority ethnic groups in the lower house, previously occupied by an Afro-descendant.
Brazil	Law No. 12,990 of June 2014. Quotas of access to public office for people of African descent.	Within federal public administration, municipalities, public foundations, public companies, and mixed economy companies, controlled by the union, 20 percent of the vacancies offered in public tenders for the provision of effective positions and public employment in the field of federal public administration. Supported unanimously by the Supreme Court of Justice 2018.
Colombia	Article 176 of the National Political Constitution provides for two seats in the House of Representatives (the lower house), of which two seats were assigned to the Black Communities of Colombia under Law 649 of 2001. Law 70 of 1993 calls for a special fund for Afro-Colombian students with limited economic resources and good academic performance.	Art. 3. Law 649 of 2001: “Those who aspire to be candidates of the Black Communities to be elected to the House of Representatives by this special circumscription, must be members of the respective community and previously approved by an organization registered with the Directorate of Matters of Black Communities of the Ministry of the Interior.” The Reliable Credits Fund was regulated by Decree 1627 in 1996. Since then, it has benefited nearly 25,000 young people.
Ecuador	Decree No. 60 of 2009. Adopts the Plurinational Plan to Eliminate Racial Discrimination and Ethnic and Cultural Exclusion.	Provides affirmative action measures for access to public positions for Afro-Ecuadorians and other discriminated-against groups, in a percentage corresponding to that of its population. The incorporation of about 30 Afro-descendants into the country’s diplomatic corps, through preferential mechanisms, is an example of its application.
Uruguay	Law No. 1922 of 2013: Afro-descendants: Norms to favor their participation in the areas of educational and labor.	Grants 8 percent of designated funds to people of African descent for capacity-building and training programs, as a measure of affirmative action and of reparation, and recognizes the historical discrimination against people of African descent.

Source: Murillo Martínez PE. The 2030 Agenda: The recognition of rights and empowerment of the Afro-descendant population in Latin America and the Caribbean. Affirmative action measures to promote political participation and reduce the citizenship deficit of people of African descent in the Americas [unpublished]. Bogotá: United Nations Development Programme; 2018.



Black Lives Matter protest, Baltimore, USA

Examples of policies, programs, and practices to address the philosophy, culture, policies, and practices that flow from colonialism

The **Civil Rights Movement** was a mass movement-based struggle for social justice that took place mainly during the 1950s and 1960s for people of African descent to gain equal rights under the law in the United States of America. A century earlier, the Civil War had brought about the official abolition of slavery, but people of African descent had continued to endure the devastating effects of racism, especially in the South. By the mid-20th century, African Americans, along with many Whites, mobilized and began an unprecedented fight for equality that spanned two decades and continues today.¹

In 1957, President Eisenhower signed the **Civil Rights Act** into law. It allowed federal prosecution of anyone who tried to prevent someone from voting. It also created a commission to investigate voter fraud.² Even though all Americans had gained the right to vote, many southern states made it nearly impossible for people of African descent to vote. They often required them to take voter literacy tests that were confusing, misleading, and extremely difficult to pass.

The landmark **Civil Rights Act of 1964** began the process of desegregation, which is still being fought for today. Title VI of the Act prohibits discrimination on the basis of race, color, or national origin by both public and private entities that receive federal financial assistance. The aim is to ensure that the vast machinery of federal social welfare funding is used to reduce segregation and discrimination in all its forms.³

Sources: ¹ National Humanities Center. The Civil Rights Movement: 1919–1960s [Internet]. Available from: <https://nationalhumanitiescenter.org/tserve/freedom/1917beyond/essays/crmcredits.htm>.

² Carson C. Martin Luther King, Jr. and the global freedom struggle. Stanford: The Martin Luther King, Jr. Research and Education Institute; 2008.

³ Purdum TS. An idea whose time has come: two residents, two parties, and the battle for the Civil Rights Act of 1964. New York: Henry Holt; 2014.

Examples of affirmative action

These actions have been mainly implemented in the field of education. Experience shows that, maintained over time, these actions have positive impacts.

- **Teacher-training quotas, Plurinational State of Bolivia.** In 2005, 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.¹
- **Policy for the entry of youths of African descent to universities, Brazil.** Established in 2003, this quota system (40 percent) showed a significant reduction in ethnic/racial inequality in income in the period 2004–2014.
- **Student loan fund, Colombia.** A fund for loans to Afro-Colombian students with limited economic resources and good academic performance was established in 1996.
- **Policy on public positions, Ecuador.** In 2009, Ecuador assured access to public positions in government for Afro-Ecuadorians, in proportion to their population.
- **Scholarship quotas, Bolivarian Republic of Venezuela.** In 2005, the Bolivarian Republic of Venezuela established scholarship quotas for African-descent youths in training and professional institutes.¹

Truth and Reconciliation Commission, Canada

The Truth and Reconciliation Commission was established in Canada in 2008 to document the history and lasting impacts of the Canadian Indian residential school system on Indigenous students and their families. Its overall goals were to focus on promoting healing, educating, listening, and the preparation of a report for all parties, including with recommendations for the government. The final report was released in 2016 and contains 94 calls to action, including calls to abandon the Doctrine of Discovery and fully implement the UN Declaration on the Rights of Indigenous Peoples.²

Sources: ¹ Schipper CJ. Teacher training in Bolivia and the implementation of the 2010 education reform [master's thesis]. Amsterdam: Graduate School of Social Sciences, University of Amsterdam; 2014.

² United Nations. Declaration on the Rights of Indigenous Peoples (A/RES/61/295), Articles 3–5. Resolution adopted by the General Assembly on 13 September 2007. New York: UN; 2007. Available from: https://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf.

3B. ENSURE PEOPLE OF AFRICAN DESCENT AND INDIGENOUS PEOPLES ARE FREE TO LIVE DIGNIFIED LIVES, INCLUDING THROUGH AFFIRMATION OF THEIR DISTINCT RIGHTS

The United Nations officially discredited colonialism in the 1960s, when it adopted the Declaration on the Granting of Independence to Colonial Countries and Peoples.

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) was adopted in 2007 (151), and the Organization of American States (OAS) adopted the American Declaration on the Rights of Indigenous Peoples (OASDRIP) in 2016 (152). UNDRIP and OASDRIP recognize Indigenous peoples' individual and collective rights to health equity and traditional medicines/practices, including spiritual traditions, within

the thematic rights of Indigenous peoples to be self-determining, self-defining, and free of discrimination and to be consulted on matters affecting them consistent with free, prior, informed consent. UNDRIP places 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.

In 2002, the Declaration of Atilán proposed several solutions to the desecration of Indigenous land, including the full adoption of UNDRIP and the elimination of persistent organic pollutants, threats from climate change, and the privatization of water. Other reforms include positive efforts to restore and support Indigenous peoples' knowledge, systems, and efforts to restore and sustainably use traditional environmental practices and food systems (142).

The 2030 Agenda for Sustainable Development (94) refers to Indigenous peoples six times: three times in the political declaration, twice in the targets under SDG 2 on zero hunger (target 2.3) and Goal 4 on education (target 4.5), and once in the section on follow-up and review, which calls for Indigenous peoples' participation. There is evidence that Indigenous knowledge can contribute to safeguarding biodiversity, and, by extension, food and water security, which is described in

Recommendation 2 (153). The value of Indigenous knowledge, including food security knowledge, is gaining currency in the international effort to address environmental degradation and climate change.

Overseen by the United Nations Educational, Scientific and Cultural Organization (UNESCO), the Convention for the Safeguarding of the Intangible Cultural Heritage (154) provides some safeguards for Indigenous social and cultural practices. For example, it recognizes the practices of the peoples of the Mexican state of Michoacán for their comprehensive food cultivation, harvesting, rituals (such as the Day of the Dead), and food preparation and sharing (155). As Santilli points out (155), foods and food-related knowledge and practices can be recognized as “intangible cultural heritage.”

The UN General Assembly proclaimed the International Decade for People of African Descent



Protest against the demarcation of Indigenous lands, São Paulo, Brazil

(2015–2024), with the theme “People of African descent: recognition, justice and development.” The Decade has as its main objective to promote the full enjoyment of the economic, social, cultural, civil, and political rights of people of African descent, along with their full and equal participation in all aspects of society. The Decade is an opportunity to underline the important contributions made by people of African descent and to propose concrete measures to promote equality and to combat discrimination of any kind (156).

Other key milestones for action against discrimination of people of African descent in the

Americas are the 2013 Inter-American Convention against Racism, Racial Discrimination and Related Forms of Intolerance (157) and the 2011 report of the Inter-American Commission on Human Rights on the situation of people of African descent in the Americas (118).

The process of recognition that Latin America has begun includes the formal expressions of historical apology to people of African descent for enslavement, decreed by the governments of Costa Rica and Peru, in response to the demands by leaders of African descent for those countries to make reparations.

Examples of self-determination practices, Canada and the United States of America

There is evidence that self-determination—having control over key decisions in life—can play a role in addressing the factors underlying health inequalities, such as poverty. Although not a panacea, Tribal sovereignty, manifested in “genuine decision-making control over the running of tribal affairs and the use of tribal resources, has contributed to the success of some interventions and the failure of others.”¹ Self-determining Tribes have translated their freedom from inflexible and often inadequate federal program delivery into social and educational progress by establishing their own services. Examples include:

- The Tohono O’odham Nation in Arizona, United States of America, operates a high-quality elder care center.
- The Potawatomi Nation in Oklahoma, United States of America, established a Tribal judicial system that includes appeals courts, and restored the Indigenous language in school systems.²
- Researchers exploring high rates of youth suicide in First Nations communities in British Columbia, Canada, found that 90 percent of the suicides were happening in less than 10 percent of the First Nations communities. They concluded that communities with no suicides or low suicide rates had more “cultural continuity,” reinforced by greater levels of self-government, expressed in active engagement in self-government processes; control over health care, education, policing, and child welfare; and having women in government.³

Honoring Nations, in the United States of America, is an awards program that identifies and shares examples of outstanding Tribal governance that demonstrate the importance of self-governance; upholds the principle that Tribes themselves hold the key to positive social, political, cultural, and economic prosperity; and affirms that self-governance plays a crucial role in building and sustaining strong, healthy Indian nations. To date, Honoring Nations has recognized 130 exemplary Tribal government programs, practices, and initiatives, and held five Tribal government symposia.⁴

In June 2018, the OAS created the Fund for the Development of the Afro-descendant Population of the Americas, which has the potential to become a special measure for historical reparations to people of African descent.⁵

Sources: ¹ Cornell S, Kalt JP. What can tribes do? Strategies and institutions in American Indian economic development. Los Angeles: American Indian Studies Center, UCLA; 1992.

² Cornell S, Kalt JP. American Indian self-determination: the political economy of a policy that works, HKS Faculty Research Working Paper Series RWPI0-043. Cambridge: John F. Kennedy School of Government, Harvard University; 2010. Available from: <https://www.hks.harvard.edu/publications/american-indian-self-determination-political-economy-policy-works>.

³ Chandler M, Lalonde C. Cultural continuity as a moderator of suicide risk among Canada’s First Nations. In: Kirmayer L, Vlaaskakis G, editors. Healing traditions: the mental health of Aboriginal peoples in Canada. Vancouver: University of British Columbia Press; 2008: 221–48.

⁴ Harvard Project on American Indian Development. About Honoring Nations [Internet]; 2019. Available from: <https://hpaied.org/honoring-nations>.

⁵ Murillo Martínez PE. The 2030 Agenda: The recognition of rights and empowerment of the Afro-descendant population in Latin America and the Caribbean. Affirmative action measures to promote political participation and reduce the citizenship deficit of people of African descent in the Americas [unpublished]. Bogotá: United Nations Development Programme; 2018.

3C. UNDERTAKE POSITIVE MEASURES TO ADDRESS SYSTEMATIC RACISM

Poverty, as Nobel Peace Prize winner Rigoberta Menchú has indicated, was thrust upon Indigenous peoples, and, as we have shown, is linked to the racism experienced by both Indigenous peoples and those of African descent.

Below, we highlight examples of policies and programs designed to address, or at the least ameliorate, the adversity of the lives of those

experiencing the combined and interlinked negative effects of racism and poverty.

Examples of programs and policies to address systematic racism

Affordable Care Act (ACA), United States of America, 2010. The change in the basis of health care delivery in the United States of America brought about by the Affordable Care Act of 2010 offered significant opportunities for African Americans and other underrepresented and minority groups to obtain health care under the Medicaid system. While all racial and ethnic groups experienced reductions in the uninsured rate between 2013 and 2016, decreases in that rate were larger among non-White than White groups. Coverage gains were particularly large for Hispanics, but Asians and Blacks also had larger percentage point reductions in their uninsured rate than did Whites. However, not all states underwent Medicaid expansion under the ACA, with negative consequences for access and the health status of minorities and the poor. Texas and Mississippi—states with higher percentages of Black populations—are among the 17 states that rejected Medicaid expansion. According to the Kaiser Foundation, 40 percent of eligible Black adults live in states that rejected Medicaid expansion, and they are twice as likely as Whites and Hispanics to remain uninsured.¹

Jordan's Principle. Jordan River Anderson, of the Norway House Cree Nation in Canada, spent over two years in the hospital unnecessarily 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 the hospital. Jordan's Principle is named in his memory and ensures that First Nations children can access all public services without discrimination.² It passed in the Canadian House of Commons in 2007 but it took another 11 years and four legal orders before the Canadian government began to implement it.³

Know Your Child program [Conozca a su Hijo (CASH)], Chile. The CASH program was developed in the 1980s to help Indigenous mothers living under the poverty line and their children. Services include early child stimulation; parent education and support; nutrition services; social protection; preschool education; early childhood intervention services for children with developmental delays or disabilities; and participatory activities with communities. It led to higher language development scores as compared with children who did not participate in the program. Participating children also had higher cognitive development scores than the control group when they entered the first grade of basic education.⁴

Sources: ¹ Noonan AS, Velasco-Mondragon HE, Wagner FA. Improving the health of African Americans in the USA: an overdue opportunity for social justice. *Public Health Rev.* 2016;37:12.

² Jordan's Principle Working Group. *Without delay, denial or disruption: ensuring First Nations Children's Access to Equitable Services through Jordan's Principle.* Ottawa: Assembly of First Nations; 2015.

³ Canadian Human Rights Tribunal. *First Nations Child and Family Caring Society of Canada and Assembly of First Nations v. Attorney General of Canada.* Ottawa: Canadian Human Rights Tribunal; 2017.

⁴ Vegas E, Santibáñez L. The promise of early childhood development in Latin America and the Caribbean. Washington, D.C.: World Bank; 2012. Available from: http://siteresources.worldbank.org/EDUCATION/Resources/278200-1099079877269/547664-1099079922573/ECD_LAC.pdf

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Examples of programs and policies to address systematic racism *(continued)*

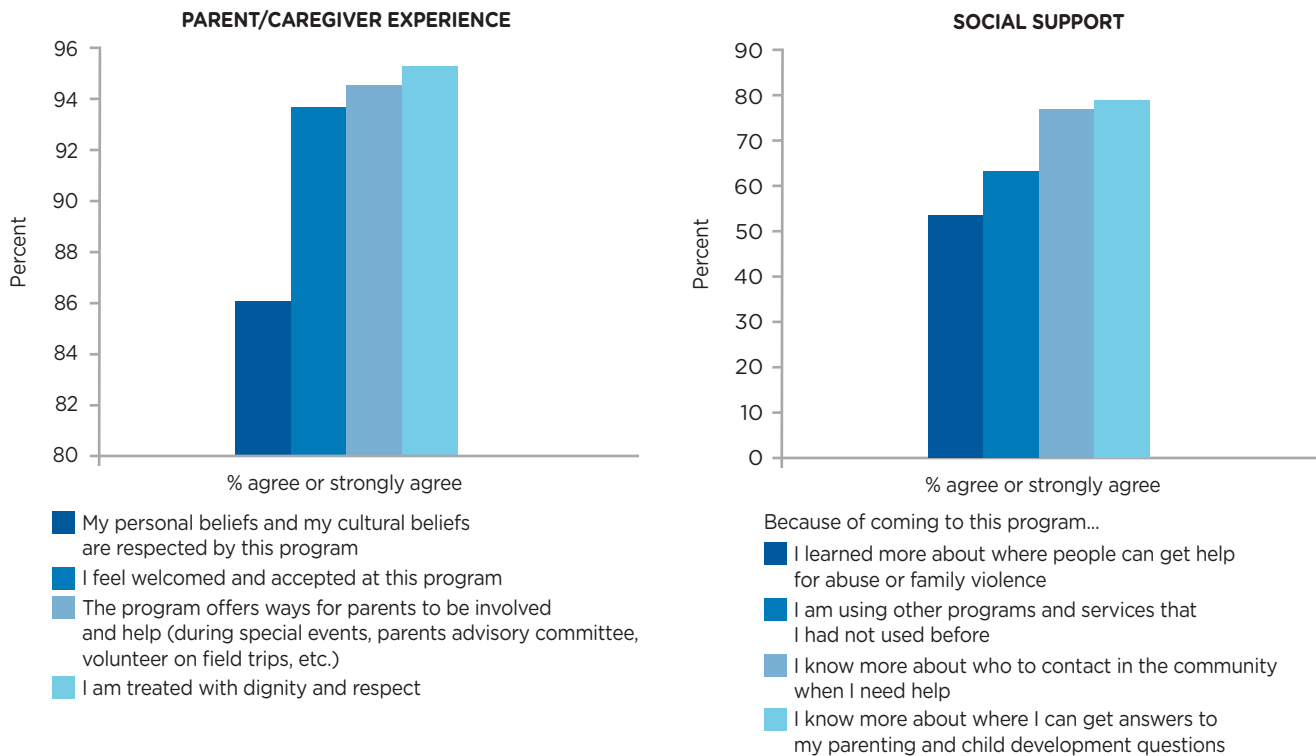
Strengthening the Child program [Kallpa Wawa], Plurinational State of Bolivia. This nonformal parenting, community-based program was established in 2004 to support Indigenous Quechua women. The program offers literacy sessions to support women’s practical ability to care for their children at home. Other program components include health, nutrition, psychosocial development, and child protection.⁴

Aboriginal Head Start in Urban and Northern Communities (AHSUNC) program, Canada. In 1995, the government of Canada established this program to help enhance child development and school readiness of First Nations, Inuit, and Métis children living in urban centers and large northern communities. Parents, families, and community members are encouraged to play a role in running the program. The program also builds relationships with other community programs and services so that children get the best care. Figure 3.25 describes its impacts.⁵

Sources: ⁴ Vegas E, Santibáñez L. The promise of early childhood development in Latin America and the Caribbean. Washington, D.C.: World Bank; 2012. Available from: http://siteresources.worldbank.org/EDUCATION/Resources/278200-1099079877269/547664-1099079922573/ECD_LAC.pdf.

⁵ Government of Canada, Public Health Agency of Canada. The impact of the Aboriginal Head Start in Urban and Northern Communities (AHSUNC) program on school readiness skills [Internet]; 2012. Available from: <https://www.canada.ca/content/dam/hc-sc/documents/services/publications/healthy-living/aboriginal-head-start/school-readiness-study-fact-sheet-en.pdf>.

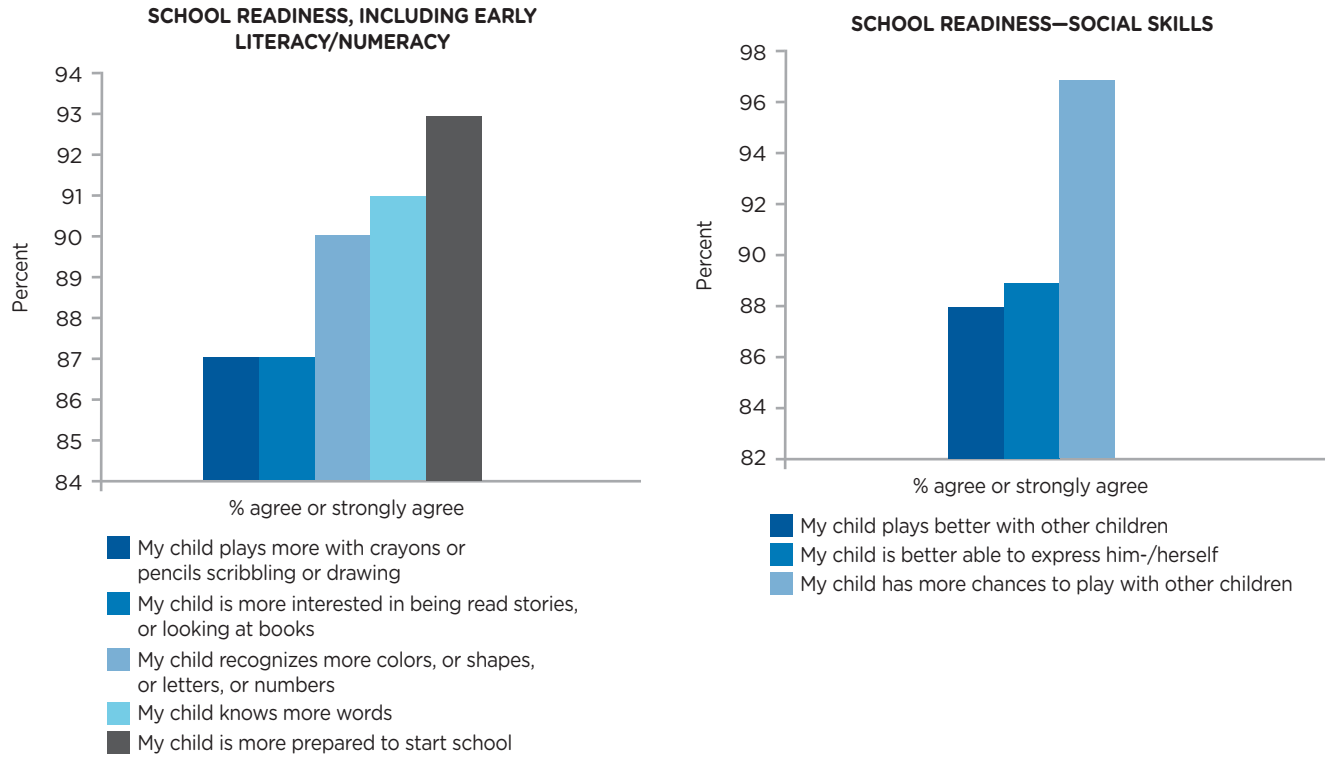
Figure 3.25.
Impact of the Aboriginal Head Start in Urban and Northern Communities (AHSUNC) program, Canada, 2012



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Figure 3.25. (continued)

Impact of the Aboriginal Head Start in Urban and Northern Communities (AHSUNC) program, Canada, 2012



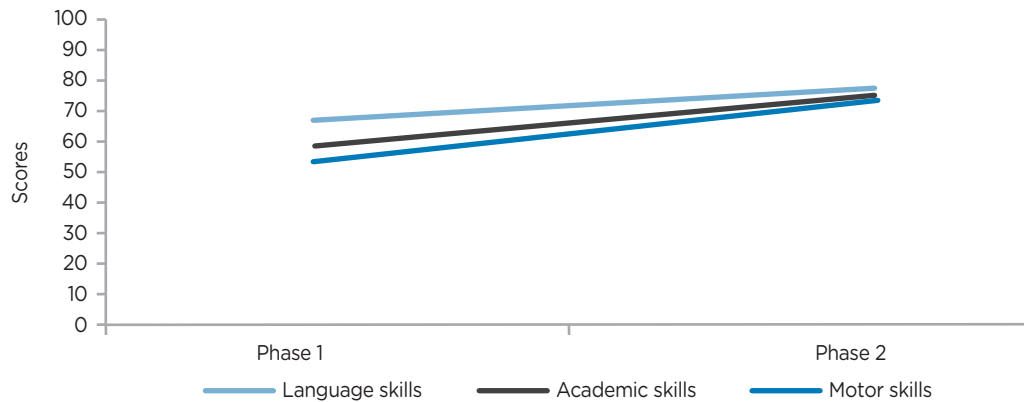
Source: Government of Canada, Public Health Agency of Canada. The impact of the Aboriginal Head Start in Urban and Northern Communities (AHSUNC) program on school readiness skills [Internet]; 2012. Available from: <https://www.canada.ca/content/dam/hc-sc/documents/services/publications/healthy-living/aboriginal-head-start/school-readiness-study-fact-sheet-en.pdf>.

Figure 3.26 shows the impact of the AHSUNC program on children’s motor, language, and academic skills. All show a positive impact,

increasing scores by more than 10 points in each case.

Figure 3.26.

Impact of the Aboriginal Head Start in Urban and Northern Communities (AHSUNC) program, Canada, on three skill areas, 2012



Source: Government of Canada, Public Health Agency of Canada. The impact of the Aboriginal Head Start in Urban and Northern Communities (AHSUNC) program on school readiness skills [Internet]; 2012. Available from: <https://www.canada.ca/content/dam/hc-sc/documents/services/publications/healthy-living/aboriginal-head-start/school-readiness-study-fact-sheet-en.pdf>.

Examples of educational programs for Indigenous peoples

Secondary/high school education

First Nations educational advisory board, Canada. The Mi'kmaw Kina'matnewey was established in 2004 as a First Nations educational advisory board independent of the federal government. With the mandate of advising rather than controlling, Mi'kmaq secondary schools prioritize cultural education and the Mi'kmaq language. In 2012 to 2013, the graduation rate was over 87 percent, compared with the national First Nations average of roughly 35 percent.¹

Tertiary education

There is growing support for Indigenous peoples to participate in tertiary education in Latin America. A number of intercultural postsecondary institutions of diverse origin have been created. They range from State initiatives, such as the Mexican government-led Network of Intercultural Universities, to institutes created by Indigenous peoples themselves, such as the Kawsay University in the Plurinational State of Bolivia, and the University of the Autonomous Regions of the Nicaraguan Caribbean Coast (URACCAN) and the Bluefields Indian and Caribbean University, both in the autonomous regions of Nicaragua. Nine Latin American countries have some sort of intercultural or Indigenous university today, which offer a framework of experiences to build on in the future.²

Traditional food knowledge

Traditional foods gardening program, North Dakota and South Dakota, United States of America. Affirming Indigenous traditional food knowledge and practices can improve health outcomes for Indigenous peoples. In 2009 the Standing Rock Sioux Tribe of North Dakota and South Dakota began a traditional foods gardening program to combat type 2 diabetes and obesity. Guided by a board of elders, the program involved planting traditional foods in 154 gardens in eight Tribal districts, with community education events, farmers markets, food harvesting and preserving activities, and publication of recipes incorporating traditional foods. A strong emphasis was placed on including children and young people in the initiative. Positive impacts included greater physical activity related to gardening, improvement in access to and use of healthy foods, and a strengthening of knowledge about food.³

Similar programs exist in Canada and in other countries in the Americas.⁴ Most are based in the traditional territories of Indigenous peoples, but efforts are underway to expand traditional food choices for Indigenous peoples living away from their lands and in urban areas, through planting traditional gardens,⁵ importing country foods to urban areas,⁶ and public education activities.

Sources: ¹ Cape Breton University. Contemporary Mi'kmaq [Internet]; [cited 23 Jan 2019]. Available from: <https://www.cbu.ca/indigenous-affairs/unamaki-college/mikmaq-resource-centre/mikmaq-resource-guide/contemporary-mikmaq-kiskukewaq-mikmaq/>.

² Economic Commission for Latin America and the Caribbean. Social panorama of Latin America 2004. Santiago: ECLAC; 2005. Available from: <https://www.cepal.org/en/publications/1222-social-panorama-latin-america-2004>.

³ Kuhnlein HV, Erasmus B, Spigelski D, Burlingame B, editors. Indigenous peoples' food systems and wellbeing. Rome: Food and Agriculture Organization of the United Nations, Centre for Indigenous Peoples' Nutrition and Environment; 2013. Available from: <http://www.fao.org/3/i3144e/i3144e00.htm>.

⁴ Earle L. Traditional Aboriginal diets and health. Prince George: National Aboriginal Collaborating Center on Aboriginal Health; 2013. Available from: <https://www.cnsa-nccah.ca/docs/emerging/FS-TraditionalDietsHealth-Earle-EN.pdf>.

⁵ Earle L. Tu'wusht Garden Project [Internet]; 2011 [cited 24 Jan 2019]. Available from: <https://www.cnsa-nccah.ca/docs/emerging/FS-TraditionalDietsHealth-Earle-EN.pdf>.

⁶ Ottawa Inuit Children's Center. AHS six components [Internet]; 2011 [cited 24 Jan 2019]. Available from: <http://www.ottawainuitchildrens.com/ahs-six-components/>.

RELEVANT INTERNATIONAL AGREEMENTS

Declaration on the Granting of Independence to Colonial Countries and Peoples (United Nations, 1960)

Declaration on the Rights of Indigenous Peoples (UNDRIP) (United Nations, 2007)

American Declaration on the Rights of Indigenous Peoples (ADRIP) (Organization of American States, 2016)

International Decade for People of African Descent (2015–2024) (United Nations, 2014)

Convention on the Rights of the Child (United Nations, 1989)

International Convention on the Elimination of All Forms of Racial Discrimination (United Nations, 1965)

PAHO Resolutions

Policy on Ethnicity and Health (CSP29.R3 [2017])

Health of the Indigenous Peoples in the Americas (CD47.R18 [2006])

4. CONDITIONS OF DAILY LIFE

People in the Americas want the basic everyday things that enable them to have reasonable, dignified lives. This includes having control over their reproductive and sexual activities; good maternity and postnatal 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 enhances their life chances; decent work that promotes, not harms, health; conditions that enable older people to live lives of dignity and independence; enough money to live on; a cohesive living environment without threat of violence; safe and affordable housing with clean water and sanitation; and access to health care that supports health as well as treats ill health.

Achieving these conditions will also contribute significantly to a flourishing, well-organized, secure, and productive society. But access to all of these necessary resources 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

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 postnatal 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 preprimary and primary education and development • Expand access to good-quality, culturally appropriate early-years programs with a 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 school	<ul style="list-style-type: none"> • Build on improvements to primary education participation, ensuring all young people in the Region complete good-quality secondary education • Expand conditional cash transfer schemes supporting children to stay in secondary education • Ensure that comprehensive sexuality education is taught in all secondary schools • Drive forward education reforms improving quality in secondary education, ensuring teachers have sufficient skills and qualifications

There are widespread inequalities throughout the Americas in experiences and outcomes during pregnancy, maternity, and the early years of life and schooling. These inequalities are found both between and within countries; in maternal, infant, and child health; and in cognitive development, education, family living conditions, experiences of parenting, and communities. They are the result of the interplay among social, economic, environmental, political, cultural, and health system influences, which all intersect with equality issues related to gender, ethnicity, and disability. Children’s experiences and outcomes relate closely to their parents’ situation—both disadvantage and advantage are passed down through generations, perpetuating inequalities.

Reducing these inequalities is central to reducing health and other inequalities later in life. Evidence from around the world indicates that intervening in

the early years is the most effective time for action to reduce subsequent inequalities.

This section presents evidence of inequalities in access to contraception and maternity services, maternal and infant health, good-quality preschool services, and primary and secondary education. The Region of the Americas has made many important improvements in these areas, but profound inequalities remain, which can and should be reduced. We place particular emphasis on increasing breastfeeding and child nutrition, the impacts of which are felt throughout life. Great strides have been made in improving access to quality primary education, but inequalities still remain. In addition, in secondary and tertiary education there are significant, persisting inequalities in access and attainment related to socioeconomic position, place of residence (rural versus urban), ethnicity, gender, and disability.

4A. ENSURE GOOD MATERNAL AND CHILD HEALTH AND OPTIMAL NUTRITION

Good maternal health is vitally important for the health and future prospects of babies and their mothers. Achieving good maternal health includes having access to modern contraception and safe abortion, and having children after adolescence. Access to skilled birth attendants and maternity services makes a significant difference, and support should cover maternal physical and mental health before, during, and after pregnancy.

Good nutrition before and after birth is vitally important for the health of mothers and babies. Children's health, education, and other outcomes relate closely to levels of nutrition. In this and all of the areas described, there are significant, persistent inequalities across the Americas.

ACCESS TO CONTRACEPTION

Promoting and protecting sexual and reproductive health includes ensuring access to information, education, and appropriate health services, including safe, effective, affordable, and culturally acceptable forms of contraception. Undesired outcomes include sexually transmitted infections, HIV, unplanned pregnancies, and unsafe abortions, all of which can have repercussions across the life course. While improvements in the Region have been made, inequalities remain between and within countries.

The growing use of modern contraceptive methods has reduced unplanned pregnancies, contributing to improvements in maternal and infant mortality. Delaying pregnancy and childbearing has also led to improvements in educational and economic outcomes for girls and women, and more education reduces adolescent pregnancies (158).

Multiple pregnancies and large family size carry higher health risks for mothers and children than having fewer children. Women can mitigate these risks by using modern contraception in order to effectively control fertility and manage family size. Education increases the likelihood of women having smaller families. For women who have children, having fewer children and delaying pregnancy until after adolescence are associated with longer participation in education systems, improved

educational outcomes, higher rates of female employment, and higher income.

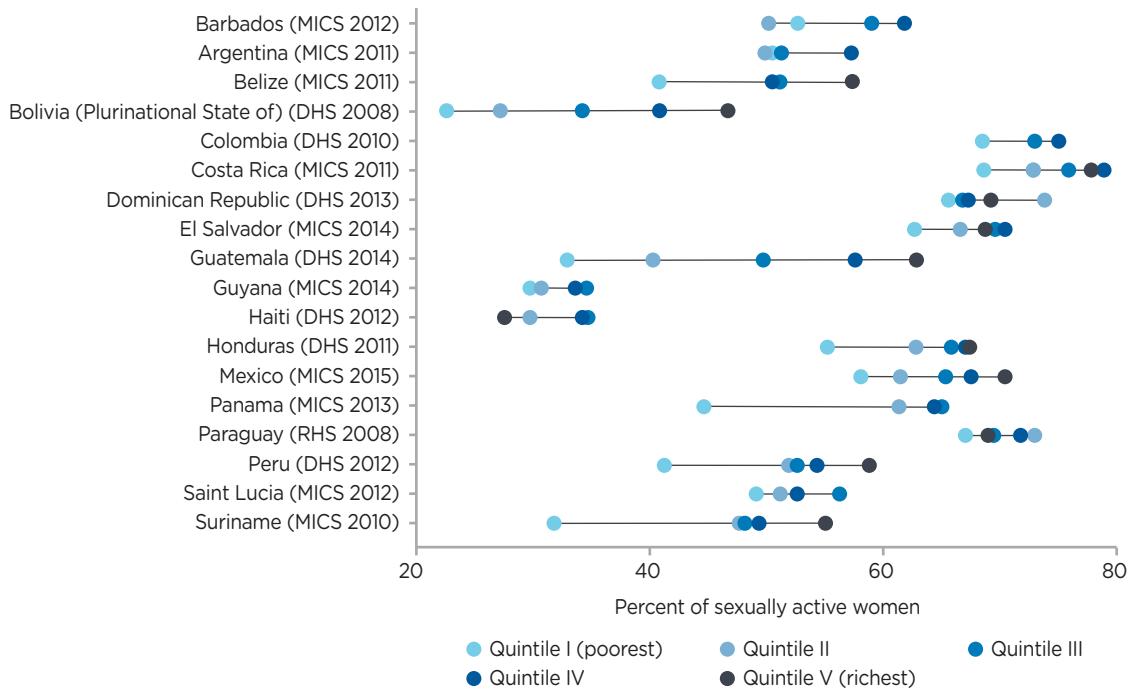
Increased use of modern contraceptive methods in the Region has not been achieved equally between and within countries, and profound inequalities in their use remain. Figure 4.1 shows inequalities in levels of modern contraception use (with a higher level of need indicated by lower level of use) in 13 countries in Latin America and the Caribbean, as related to income. In most countries in the Region, lower-income women have considerably lower use of modern contraception than do the wealthiest women. However, in some countries—Colombia, Costa Rica, and the Dominican Republic, for example—overall levels of use are high and inequalities relatively low, showing what is possible. Access to modern methods of contraception is also substantially lower for Indigenous women and women of African descent, especially those living in rural areas, than it is for other women.

ADOLESCENT MOTHERHOOD

Adolescent motherhood—usually defined as having children before the age of 19—is associated with poor health and other adverse outcomes for mothers and babies. Adolescent mothers are less likely to remain in education than their peers—and had reported 3 fewer years of schooling than adolescents who were not mothers in Latin America and the Caribbean in 2015 (29, 159). Education, per

Figure 4.1.

Percent of sexually active women using modern contraception, by income quintile, in 18 countries in the Americas

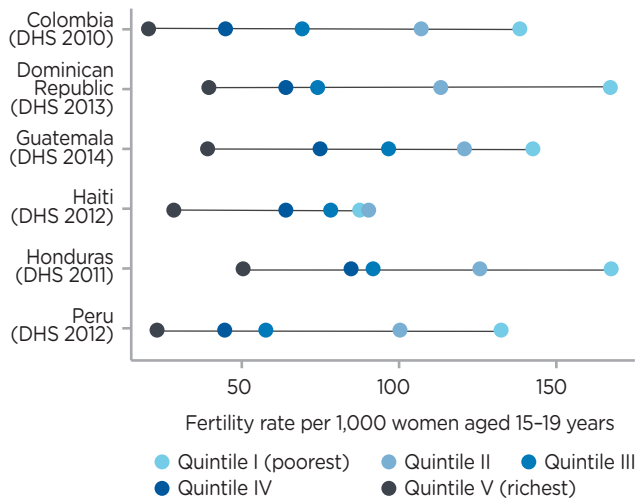


Source: World Health Organization. Health Equity Assessment Toolkit (HEAT): software for exploring and comparing health inequalities in countries. Built-in database edition. Version 2.1. Geneva: WHO; 2018. Available from: https://www.who.int/gho/health_equity/assessment_toolkit/en/index1.html.

Note: DHS = demographic and health surveys; RHS = reproductive health surveys; MICS = multiple indicator cluster surveys.

Figure 4.2.

Adolescent fertility rate, by income quintile, selected countries in the Americas, 2014 or latest available year



Source: World Health Organization. Health Equity Assessment Toolkit (HEAT): software for exploring and comparing health inequalities in countries. Built-in database edition. Version 2.1. Geneva: WHO; 2018. Available from: https://www.who.int/gho/health_equity/assessment_toolkit/en/index1.html

Note: DHS = demographic and health surveys.

se, can reduce the likelihood of adolescent fertility. Women who have children in adolescence are also less likely to be employed and more likely to have a low income. Inequalities in adolescent fertility by family wealth quintile are large in Latin America and the Caribbean, as shown in Figure 4.2.

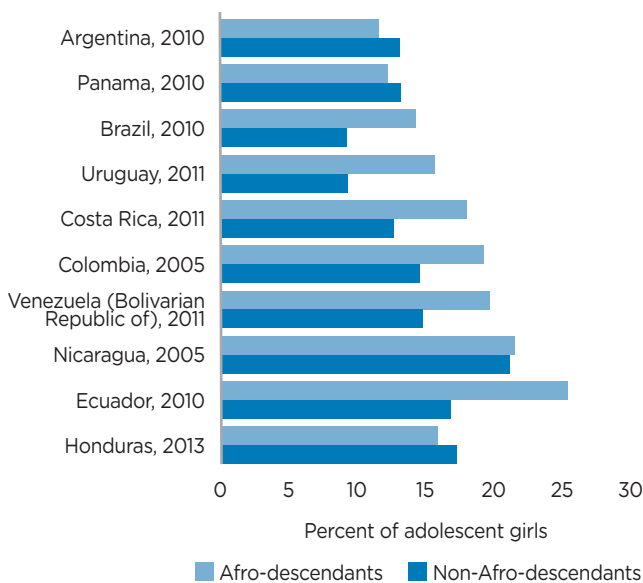
There are also higher rates of adolescent motherhood among Indigenous compared to non-Indigenous women, undermining the development potential and rights of Indigenous young women and their children. For example, in 2014 approximately 25 percent of young women aged 15–19 in Brazil who identified as Indigenous were mothers, in comparison to approximately 9 percent of non-Indigenous women (29); in Panama, 30 percent of adolescent Indigenous women were mothers, compared with 13 percent of non-Indigenous women (4).

Figure 4.3 shows that in most, but not all, countries in Latin America for which data are available, rates of adolescent motherhood are higher among adolescent girls of African descent than those not of African descent.



Young men sorting coffee beans, El Salvador

Figure 4.3.
Percent of adolescent girls who are mothers, by African-descent identity, selected Latin American countries, various years 2005–2013



Source: Economic Commission for Latin America and the Caribbean. The social inequality matrix in Latin America. Santiago: ECLAC; 2016. Available from: https://repositorio.cepal.org/bitstream/handle/11362/40710/1/S1600945_en.pdf.

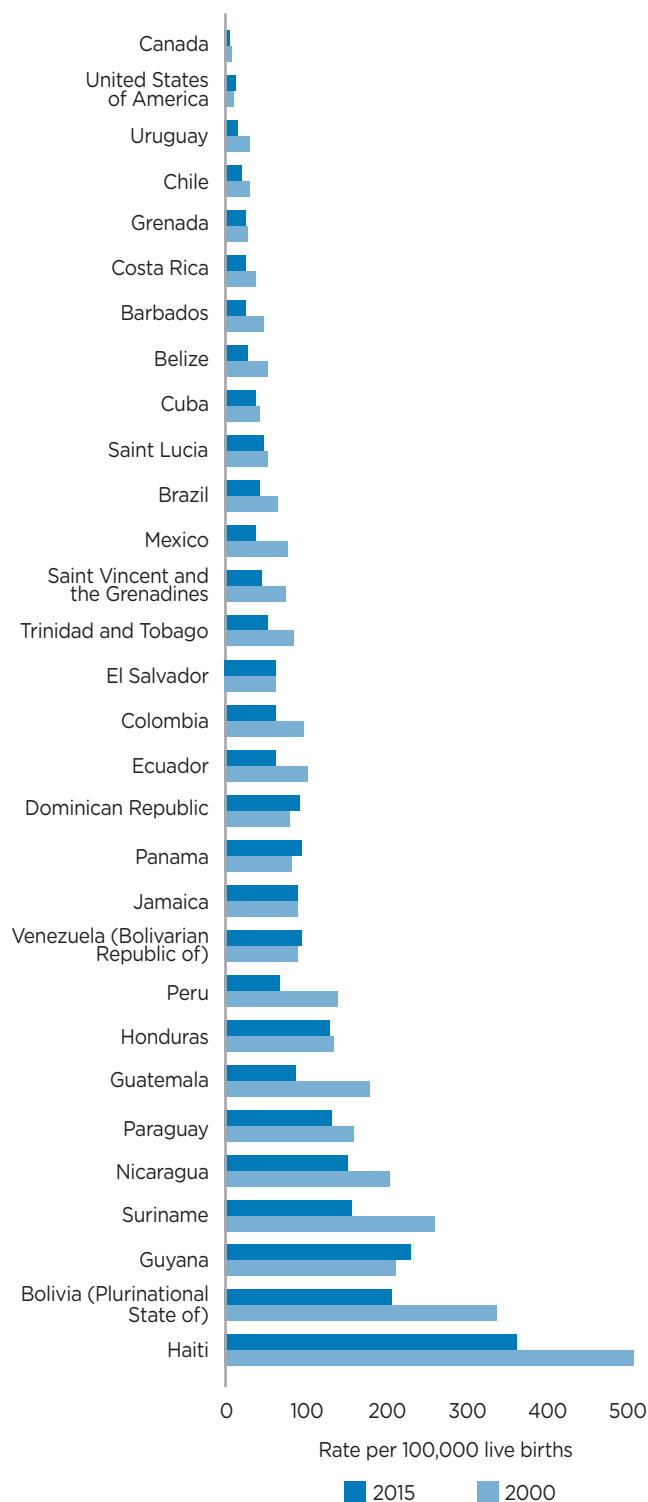
MATERNAL HEALTH AND POSTNATAL CARE

A key indicator, of both social and economic conditions and health system effectiveness, is the maternal mortality rate. It is a critical factor in the improvement of women’s conditions, and has a direct influence on efforts to extend life expectancy for women.

Over the past 20 years, the Region has made significant advances in improving maternal health. Maternal mortality rates have fallen by 32 percent since 2000, mainly due to reductions in Latin America, while staying at a relatively low level in North America (Canada and the United States of America) (7). However, substantial variations among countries persist (Figure 4.4), ranging from 4.8 women dying due to giving birth per 100,000 live births in Canada to over 220 per 100,000 in Guyana and Haiti (160).

Evidence shows that women from poor and marginalized populations have a greater risk of harm from pregnancy than do women who are better-off. Studies in Brazil, Ecuador, Mexico, and Peru, among others, have linked preeclampsia, eclampsia, and hypertensive disorders and related morbidity with lower socioeconomic position,

Figure 4.4.
Maternal mortality rates, Region of the Americas, 2000 and 2015



Source: World Health Organization. Health Equity Monitor. 2018 update [Internet]. Available from: <https://www.who.int/gho/health-equity/en/>.

mixed ethnicity (including African descent), and rural location of residence (159, 160).

Significantly, the Region did not achieve Millennium Development Goal 5, which referred to improving maternal health by reducing the maternal mortality ratio by 75 percent between 1990 and 2015 (target 5.A) and achieving universal access to reproductive health by 2015 (target 5.B).

Access to skilled health personnel during the pre- and postnatal period

Improving socioeconomic conditions, nutrition, and education levels will improve pregnancy outcomes. In addition, ensuring there is access to a skilled birth attendant before and during birth contributes to lower maternal and neonatal mortality. In the Americas, levels of coverage for this service are relatively high compared with other world regions, but there are substantial inequalities among the countries in Latin America and the Caribbean. For example, in Argentina the rate for a pregnant woman attending four or more prenatal visits was approximately 90 percent in 2016, in contrast to Suriname at approximately 60 percent (159).

There are also inequities within countries, related to household wealth, education, ethnic identity, and urban versus rural residence. For example, in terms of ethnicity, in Costa Rica in 2013, 87 percent of women of African descent versus 92 percent of women not of African descent received prenatal care. In Uruguay in 2011, 78 percent of women of African descent versus 90 percent of women not of African descent received prenatal care (4).

Postnatal care is important for supporting the health of infants and mothers, and for being a conduit for essential advice. In most countries in Latin America and the Caribbean, coverage of postnatal care within two days of birth is low (between 20 and 30 percent of newborns), and in some countries, such as Colombia and El Salvador, it was below 10 percent in 2014, while coverage was highest in Peru (above 80 percent) (22). Within countries, coverage increases as family income rises. For example, in the Plurinational State of Bolivia and Honduras, coverage was 80 percent or more for the richest quintile in 2014, while for the poorest quintile it was 50 to 60 percent in 2011 (160). Improvements in postnatal care coverage and quality, especially for those of lower socioeconomic status, would result in significant improvements in maternal and infant health.

Infant and under-5 mortality

A baby’s chance of survival after birth is as much due to the social conditions into which it is born as it is to health system response. The most frequent causes of death in children under 5 continue to be infectious and deficiency diseases—influenza and pneumonia, intestinal infections, and malnutrition and nutritional anemia (69)—all of which are largely preventable. Between 2003 and 2017, infant mortality dropped by 42 percent in Latin America and the Caribbean, and stayed below 10 per 1,000 in the United States of America and 5 per 1,000 in Canada (2). However, as described in Section 2, inequalities in infant and under-5 mortality within and between countries persist. In all countries where data are available, mortality was at least 70 percent higher in the poorest than in the richest quintiles. Relative inequalities are particularly large in Bolivia (Plurinational State of), Colombia, and Nicaragua, where rates in the poorest quintile were three to four times higher than in the wealthiest quintile (22, 159).

As shown in Section 3, under-5 mortality rates related to Indigenous identity are far higher than for those of other descent. In the United States of America, too, under-5 mortality varies

among ethnic groups. In 2016, the rate was highest among African American children, at 11 deaths per 1,000 live births, followed by Native Americans, Hispanics, and non-Hispanic Whites, at 8, 5.2, and 4.8 deaths per 1,000, respectively (160). Mortality rates in Canada among First Nations children are nearly three times those of non-Indigenous ones (161).

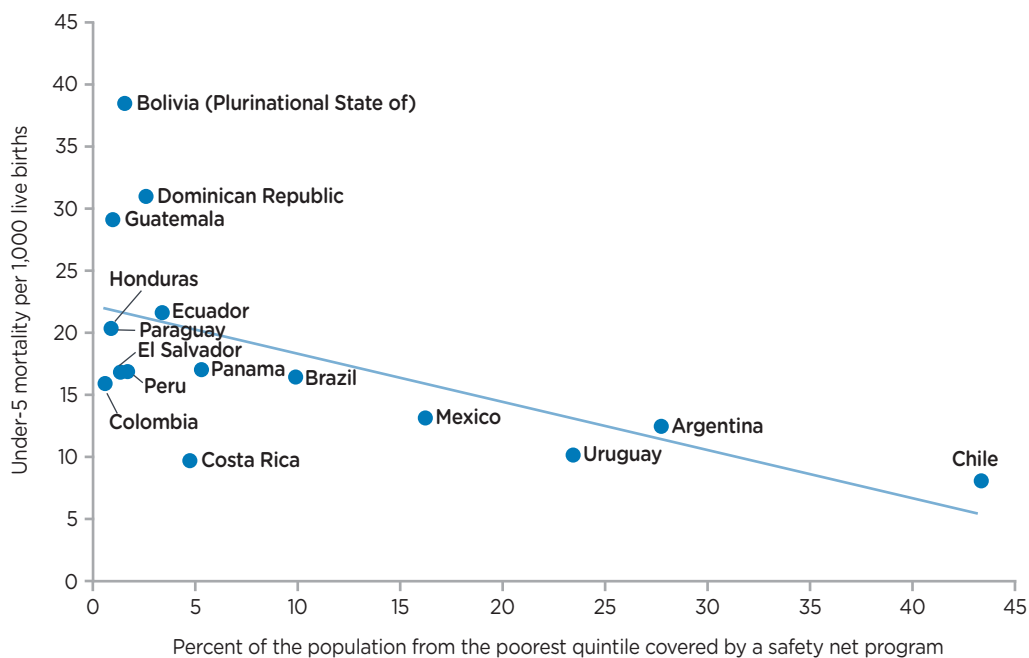
Figure 4.5 shows that coverage of social insurance programs for the poorest is associated with the under-5 mortality rate in Latin America and the Caribbean. In addition to access to pre- and postnatal care and early-years services, provision of adequate social insurance helps to reduce under-5 mortality rates (162).

NUTRITION

Breastfeeding

Breastfeeding supports good infant nutrition and has clear short-term benefits for child survival through reduction of morbidity and mortality from infectious diseases. There is strong evidence linking breastfeeding to positive long-term outcomes such as cognitive development

Figure 4.5. Under-5 mortality rate by percent of the poorest quintile covered by a safety net program, selected countries in Latin America and the Caribbean, 2017 or latest available year



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

Examples of programs and policies to improve maternal and child health

Birth Plan [*Plan Nacer*], Argentina. This ongoing program, started in 2004, has been delivered in the poorest provinces. It has increased the early engagement of pregnant women, raised the number of prenatal checks, and improved health care services. The number of children born with low birthweight decreased by 23 percent for Plan beneficiaries, and neonatal mortality improved by 74 percent. As a follow-up to Plan Nacer, Argentina launched a program called SUMAR in 2012 to extend coverage to 5.7 million children and adolescents, and 3.8 million women between 20 and 64 years, including 230,000 pregnant women.^{1,2}

If I am OK, my family is too, Mexico. This health education program for women in rural areas was provided to 39,000 women during the early 2000s over a period of three years in the state of Oaxaca. The program resulted in improvements in nutrition, sexual health, and female empowerment.³

Growing Together, Peru. During 2012, early childhood services were introduced to cover health, nutrition, infant stimulation, and protection, aiming to help mothers to develop healthy habits when bringing up their children. Preliminary results suggest strong progress in some spheres related to early learning and family interactions in areas where the program was delivered.⁴

Nurse-Family Partnership (NFP), United States of America. This program was first implemented in the United States of America in 1977 to promote a safe home environment, encourage competent caregiving, and improve material support for families by connecting them to health and social services. The program arranges home visits for registered nurses to low-income, first-time mothers during the first two years of their children's lives. Three randomized control trials of NFP, conducted over several decades, have documented many long-term positive outcomes, including fewer childhood injuries, fewer undesired pregnancies, and increased rates of maternal employment. There was also a 48-percent reduction in child abuse and neglect among families that received the home visit intervention, as compared with those that did not receive it.⁵

Early home visiting program, Chile. The objectives of this program were to support all children and their families through universal services and to provide special support to vulnerable children and their families. The program was initially rolled out in 159 small regions in 2007, then expanded to all regions in 2008. The program provides an integrated benefits system together with interventions and social services to support the child and the family. The program has had positive outcomes for mother and child attachment and physical development, and it has had a significant impact on the health and welfare of low-income Chileans. The poorest 60 percent of households have free access to nurseries and preschools, as do vulnerable families and those with special needs, as a result of the program.¹

Centers for Promotion and Community Surveillance [CPVC], Peru. The Ministry of Health supported the creation of CPVC, which started in 2012 as a child care initiative providing comprehensive care for pregnant mothers, infants under 3 years, and their parents in areas with low population density. On-site teaching sessions provided by health promoters share knowledge regarding healthy child-rearing practices (e.g., preparation of balanced meals) with parents of children under 3 years old. Health promoters record information on the growth and development of children at each visit (e.g., height and weight). In addition, health promoters, health personnel, community leaders, and families review and evaluate community surveillance information to generate feedback on the work and prepare specific actions for the intervention. The first-year results indicated that the CPVC program had a positive and significant impact on child development measures in the overall score and in areas such as fine motor skills, language and audition, and reduced child chronic and acute malnutrition.⁴

Sources: ¹ Vegas E, Santibáñez L. The promise of early childhood development in Latin America and the Caribbean. Washington, D.C.: World Bank; 2012. Available from: http://siteresources.worldbank.org/EDUCATION/Resources/278200-1099079877269/547664-1099079922573/ECD_LAC.pdf.

² World Bank. Argentina: Plan Nacer improves birth outcomes and decreases neonatal mortality among beneficiaries [Internet]; 18 September 2013 [cited 25 Jan 2019]. Available from: <http://www.worldbank.org/en/news/press-release/2013/09/18/argentina-plan-nacer-birth-outcomes-decreases-neonatal-mortality-beneficiaries>.

³ Venguer T, Pick S, Fishbein M. Health education and agency: a comprehensive program for young women in the Mixteca region of Mexico. *Psychol Health Med*. 2007;12(4):389–406.

⁴ Wilcox S, Altobelli CL, Cabrejos-Pita J. USAID final project evaluation report – “Health in the hand of women: a test of teaching methods” project in Peru: 2010–2014. Washington, D.C.: USAID; 2014.

⁵ Annie E. Casey Foundation. Kids count [Internet]; [cited 22 Jan 2019]. Available from: <https://datacenter.kidscount.org/>.

during childhood and educational attainment during childhood and adolescence (163). Breast milk at birth is recommended by WHO as the best food for the newborn, and exclusive breastfeeding is recommended to continue to 6 months of age (164).

Globally, there has been some progress in achieving the WHO recommendation of exclusive breastfeeding up to 6 months of age. However, the proportion of women undertaking exclusive breastfeeding in Latin America and the Caribbean (33 percent) is lower than the world average of 43 percent (76, 159). The proportions also vary considerably among the countries in the Region. For example, in Peru approximately 70 percent of mothers breastfed exclusively for 6 months, while in Saint Lucia and the Dominican Republic only around 10 percent did (Figure 4.6) (7).

In the majority of countries for which there are comparable data, early initiation of breastfeeding is more common in rural than in urban areas (165, 166).

Throughout the Region, there is a higher prevalence of breastfeeding among Indigenous populations than for non-Indigenous populations. However, in Canada, during 2015-16, the rate of breastfeeding initiation for the Atlantic region First Nations communities was lower than the national average rate (167, 168).

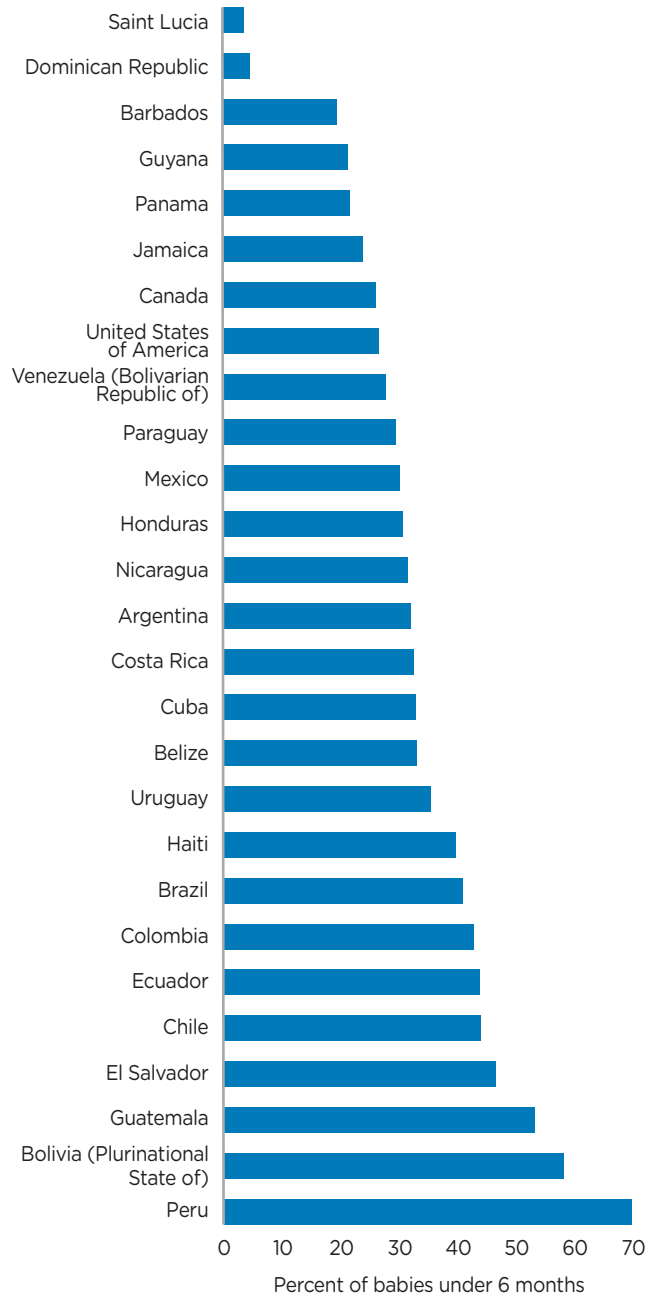
In the United States of America, breastfeeding rates differ among ethnic groups. African American infants are breastfed for substantially shorter periods than are White infants, and Hispanic infants are breastfed for significantly longer periods than are White infants (167).

Child nutrition

Poor nutrition for children and mothers increases the rate of anemia, underweight, and stunting in childhood. It is also associated with higher infant mortality and morbidity, it affects cognitive development during early childhood and during later stages of life, and it shapes educational attainment (168, 169).

Child stunting due to poor nutrition is prevalent in many parts of Latin America and the Caribbean, reflecting a failure to meet basic dietary and health needs, as a result of deficient social, economic, and environmental conditions. There are clear

Figure 4.6.
Percent of babies under 6 months exclusively breastfed, Region of the Americas, 2015 or latest available year

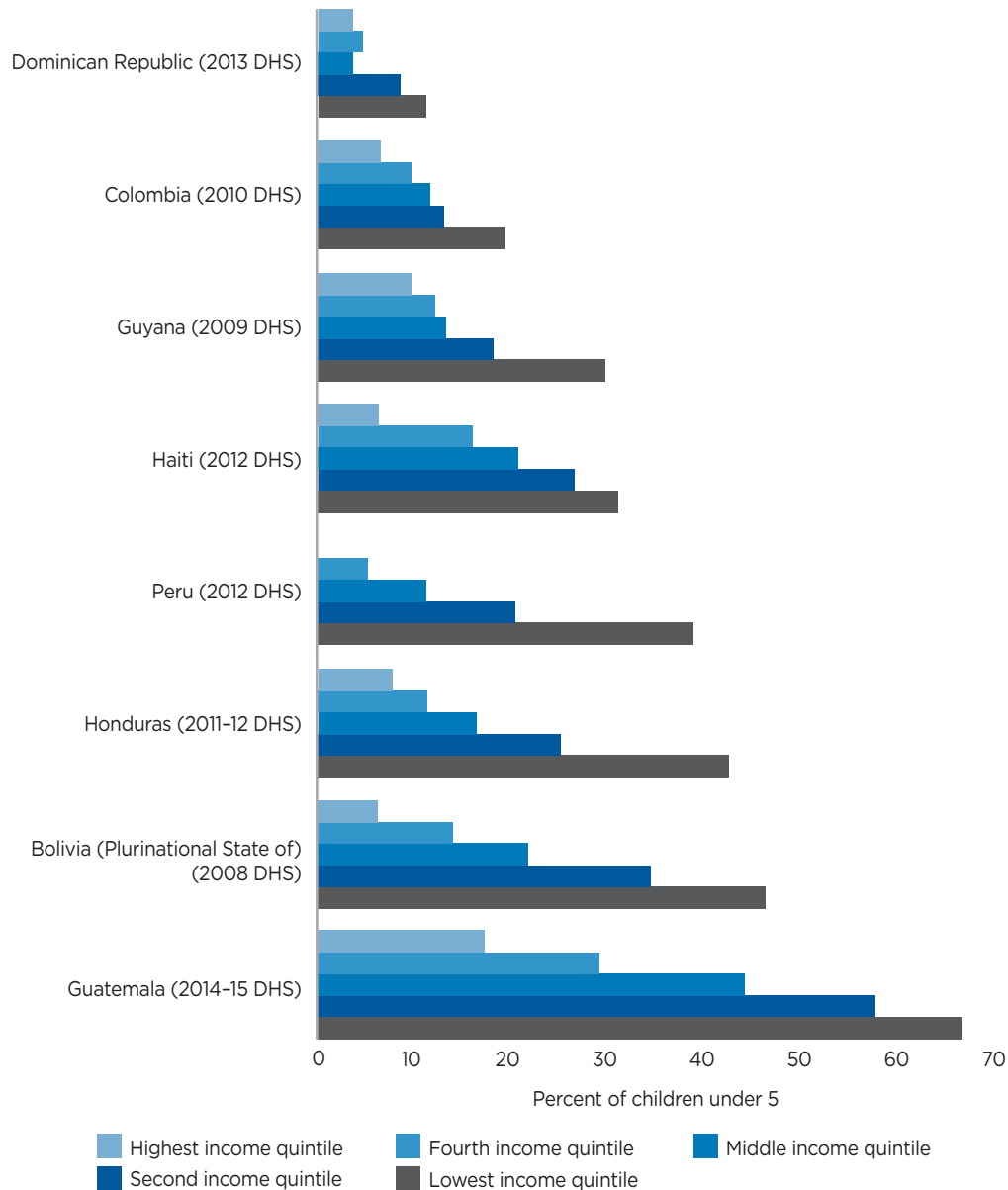


Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

inequalities within countries. Children born to mothers with no education have as much as a 50 percent greater probability of being stunted than those born to mothers with greater levels of education (170). There is a clear gradient by income quintile for stunting in children, as shown in Figure 4.7 (170).

Figure 4.7.

Rates of stunting in children under 5, by income, selected countries in Latin America and the Caribbean with comparable data available, 2015 or latest available year



Source: Data from United States Agency for International Development. DHS STATcompiler [Internet]; 2018. Available from: <https://dhsprogram.com/data/STATcompiler.cfm>.

Note: DHS = demographic and health surveys.

In Latin America and the Caribbean, prevalence rates of stunting in children are higher in Indigenous than in non-Indigenous peoples. For example, in Guatemala, where levels of stunting are high compared with other countries, 58 percent of Indigenous children are stunted, compared with 34

percent of non-Indigenous children. According to information from seven countries in Latin America and the Caribbean, in 2010 the rate of chronic malnutrition was over twice as high for under-5 Indigenous children as for under-5 non-Indigenous children (4).

Examples of policies and programs to improve maternal, infant, and child nutrition

Early-years programs across the Region offering nutritional supplements have improved physical well-being and growth, as well as certain cognitive and mental health outcomes. These results have had considerable positive effects on health equity.

Maternal and Child Health and Nutrition (PROMIN), Argentina. Maternal and Child Health and Nutrition projects were implemented between 1993 and 2003 in Argentina. They delivered a basic package of services to promote women's reproductive health and child health care. Food supplements were provided for undernourished pregnant and lactating women and for children under 6 years of age.¹

Nutritional supplementation, Colombia, Mexico, and Nicaragua. Women who had received nutritional supplements in these countries during childhood increased their educational attainment by one full grade and had an increased likelihood of completing primary and some secondary school.²

Fortified milk, Mexico. Milk fortified with iron and other micronutrients was distributed to poor families in Mexico during 2002. Provision of food supplements to young children helped reduce malnutrition and underweight, and the prevalence of anemia in the intervention group dropped by 29 percent.²

Nutritional Recovery Project, El Salvador. This project targeted children aged 6 months to 9 years suffering from malnutrition in 14 priority areas by providing fortified food. It helped to reduce anemia, congenital malformations, and child morbidity and mortality between 2008 and 2014.³

Institute of Nutrition of Central America (INCAP), Guatemala. From 1969 to 1977, the Institute of Nutrition of Central America carried out a series of community-based nutrition interventions in Guatemala. The program provided children in rural areas with a nutritional supplement and preventive health services such as immunizations and worming. A positive impact was recorded on the educational outcomes and cognitive skills of participants 25 years after their participation ended.²

Nutritional early programs, Jamaica. Nutritional supplements were provided and programs implemented to improve interactions between mother and child. The long-term benefits of this intervention on child participants' cognitive and educational outcomes were measured 18 years after their participation ended, finding sustained cognitive benefits and positive impacts on school achievement. Results also showed that stunted children who received psychosocial stimulation had sustained cognitive and educational benefits at ages 17–18 years between 1986 and 2008.²

Home visit programs, Jamaica. Another study in Jamaica found that home visit programs targeting mothers of undernourished children reduced the rate of depression in those mothers.²

Food Coupon [*Bolsa Alimentação*] Program, Brazil. This program was designed to reduce nutritional deficiencies and infant mortality among poor households in Brazil. The program has benefited approximately 2 million households throughout Brazil since 1993.⁴

Sources: ¹ World Bank. Argentina – Maternal & child health & nutrition (PROMIN). Washington, D.C.: World Bank; 2001. Available from: <http://documents.worldbank.org/curated/en/882981475072644856/Argentina-Maternal-Child-Health-Nutrition-PROMIN>.

² Vegas E, Santibáñez L. The promise of early childhood development in Latin America and the Caribbean.

Washington, D.C.: World Bank; 2012. Available from: http://siteresources.worldbank.org/EDUCATION/Resources/278200-1099079877269/547664-1099079922573/ECD_LAC.pdf.

³ World Food Programme. Country brief El Salvador [Internet]; 2017. Available from: <https://www.wfp.org/content/country-brief-el-salvador>.

⁴ World Health Organization. Bolsa Alimentação programme, Brazil [Internet]; 2014. Available from: https://www.who.int/social_determinants/knowledge_networks/phconditions/pphc_example.pdf.

4B. SUPPORT GOOD EARLY-CHILD DEVELOPMENT

Good-quality early childhood experiences have a profoundly positive effect on children, in both the immediate and the longer term. A supportive family environment, healthy living conditions, sufficient nutrition, social interaction, and cognitive stimulation set children on the right trajectory for a healthy and productive life. Unfortunately, adverse experiences in childhood can also have lifelong negative impacts for health and a range of other outcomes. Fortunately, policies and interventions during the early-years period can be particularly effective in reducing these inequalities and, in turn, improving social, economic, and health outcomes throughout the life course.

CHILD POVERTY AND ADVERSITY

Poverty in childhood is one of the most marked ways in which inequalities pass from one generation to the next, and experience of poverty in childhood means a strong, though not inevitable, likelihood that opportunities for positive early childhood experiences will be reduced.

In Latin America and the Caribbean, 43 percent of children live in households that receive less than 60 percent of the median income. The United States of America has child poverty rates 21 percent higher than the OECD 37-country average (171). In the United States of America, rates of children living in poverty are higher among African American and Native American families, followed by Hispanic children. In Canada, in 2015, approximately 1.2 million (17 percent) of Canadian children lived in a low-income household (172).

Across the Americas, persistent child poverty, along with insufficient investment in universal, good-quality early-years services, helps to explain the limited progress in equity in children's health and educational outcomes (173). However, there are a range of policies and interventions to reduce child poverty that have shown positive impacts on child development, some described below (174).

EARLY CHILDHOOD CARE AND PREPRIMARY SCHOOL

Good-quality early child care is beneficial to disadvantaged children particularly and can make a marked contribution to reducing inequalities in

educational and other outcomes, including health, throughout life. The effect that having attended preschool has on test scores at ages 8–9 is twice as large for students from poor backgrounds as compared with richer students, in Latin America and the Caribbean and for children in Canada and the United States of America (175).

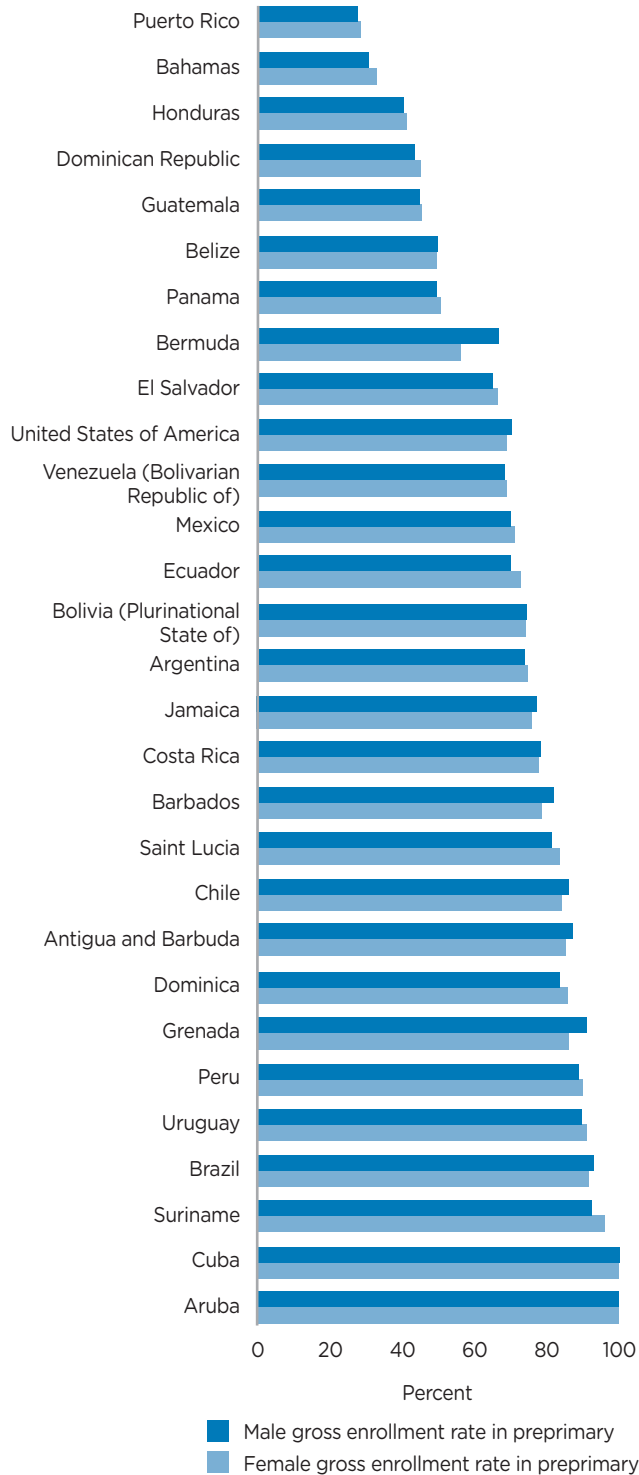
There were increases in preprimary enrollment in the Region between 1999 and 2012. However, in 2011, enrollment still remained below 50 percent in many countries, as shown in Figure 4.8 (7). There are marked differences within the Region, and many countries are far from achieving the Dakar Framework for Action goals—a collective commitment by governments to ensure that obligatory “education for all” goals and targets are reached and sustained (176).

There are clear within-country inequalities. Rates of enrollment are higher in urban areas than in rural areas in most countries in Latin America. For example, in Brazil, preschool attendance rates reached 81 percent in urban areas, compared with 69 percent in rural ones, while in Colombia the rates were 68 percent and 43 percent, respectively, in 2014 (4).

There are lower rates of enrollment among Indigenous children than for non-Indigenous children, and in most countries in Latin America and the Caribbean there are slightly lower rates of girls than boys enrolled in preprimary education (29).

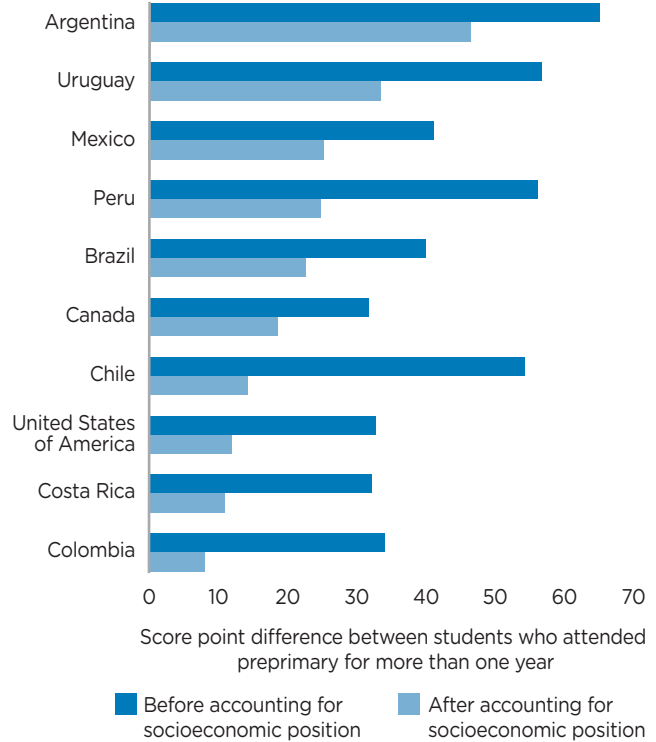
Figure 4.9 shows the score-point difference in mathematics performance on standardized tests taken at age 15 between students who reported

Figure 4.8.
Gross enrollment rate in preprimary school, by sex, Region of the Americas, 2016



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

Figure 4.9.
Difference in mathematics performance at age 15, by attendance at preprimary school for one year or more, countries in the Americas participating in the PISA survey, 2012



Source: Organisation for Economic Cooperation and Development. Programme for International Student Assessment, PISA database - Table II.4.12 [Internet]; 2012. Available from: <http://www.oecd.org/pisa/data/>.

that they had attended preprimary school for one year or more, and those who had not attended preprimary school, after accounting for socioeconomic position. The latter is important, because in most countries, children from poorer households are less likely than better-off children to attend preschool, but it is the poorer children who would benefit the most from attending (177).

Examples of policies and programs to improve early-years experiences

Evidence shows that early child development and child care programs can have positive effects and enable reductions in inequalities in a range of important lifelong and communitywide factors. If children are offered positive and enriching childhood development services through programs that are especially geared to them and their caregivers, it is probable that their developmental outcomes will be improved and lifetime health and socioeconomic inequalities likely reduced.

Parent-Child Mother Goose program, Canada. This early intervention program is designed to achieve positive impacts on children's language and their social behavior. It was developed with the aim of supporting families that may not otherwise provide their children with rich language learning experiences. Mothers in the program group reported significantly more positive changes in their parenting over time and also significantly more positive change in their children's attachment style than those who did not receive the intervention.¹

National preschool programs, Argentina. These programs, developed from 1991 onwards, are associated with an average increase in the probability of preprimary school attendance of approximately 7.5 percent. Preschool attendance at ages 3 to 5 increased performance in language and mathematics by 5 to 6 percent, with similar gains for boys and girls. The effect of having attended preschool on third grade test scores was twice as large for students from poor backgrounds as for students from nonpoor backgrounds; attendance has particularly important implications for equity later on in life. Preschool participation also positively affected students' behavioral skills, including attention, effort, class participation, and discipline. The gains realized were again bigger for students living in more disadvantaged municipalities than for better-off students.²

National preschool program, Uruguay. An expansion of public preschool education took place in Uruguay from 1995 to 2004, targeting lower-income groups in particular. The plan worked with over 40,000 children aged 0 to 3 years and their impoverished families.² It made family and children's centers available to disadvantaged communities throughout the country, helping to promote parenting skills and encouraging active family bonding. After the expansion of preschool coverage, 94 percent of children from the poorest and 99 percent from the most affluent quintiles attended preschool. Results also showed greater effects for children whose mothers had lower educational attainment, and for children from lower-income families living outside of the capital.²

Integrated Child Development project, Plurinational State of Bolivia. Implemented between 1993 and 2000, this program offered full-time child care and provided nutrition and education services to children in poor urban areas. An evaluation found that the program was successful in reaching the poorest children in the most disadvantaged neighborhoods. It had positive impacts on child participants in terms of gross and fine motor skills, psychosocial skills, and language acquisition, in comparison to nonparticipants and children who only participated for two months. Impacts were found to be cumulative, with greater impacts associated with longer program exposure, particularly for those who participated for more than seven months. An evaluation showed more positive impacts for children from wealthier families.²

Family Well-being Community Homes, Colombia. Launched between 1984 and 1986, this program sought to help pregnant women, mothers, and children living in poverty. It reached approximately 1 million boys and girls under the age of 7 and offered combined parental education and child services, and parent education and support; early stimulation; feeding services; health education and preventive health care; height and weight measurements; and day-care centers that offered child care and preschool education. An evaluation of the program in 2004 found a statistically significant effect: children receiving the program were more likely to be in school and progress a grade when they reached the ages of 13 through 17 years. The program also had positive effects on children's height gain, primarily because of enhanced nutrition.²

Sources: ¹ Scharfe E. Benefits of mother goose: influence of a community-based program on parent-child attachment relationships in typical families. *Child Welfare*. 2011;90(5):9-26.

² Vegas E, Santibáñez L. The promise of early childhood development in Latin America and the Caribbean. Washington, D.C.: World Bank; 2012. Available from: http://siteresources.worldbank.org/EDUCATION/Resources/278200-1099079877269/547664-1099079922573/ECD_LAC.pdf.

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Examples of policies and programs to improve early-years experiences *(continued)*

Head Start program, United States of America. This program was introduced in 1965 to provide disadvantaged children aged 3 to 5 years with comprehensive support services, including in the areas of early childhood education, development, health, and nutrition. The program also offered educational services for the parents of these children. Between 2001 and 2007, Head Start covered over 900,000 children a year. Several studies have found positive long-lasting effects on participating children, as documented by test scores, high school completion rates, college attendance, a higher probability of students obtaining a high school diploma, and a lower probability of being arrested. Some studies have found that the positive effects faded as participants reached ages 7 through 11.³

Early Head Start (EHS) program, United States of America. The EHS program targets children from birth to 3 years of age, together with pregnant and lactating women. An evaluation showed that 3-year-old participant children performed significantly better than children in the control group in cognitive and language development, and participants displayed lower levels of aggressive behavior, as reported by their parents. Further, EHS parents were more emotionally supportive, provided their children with more stimulation at home, read to them more often, and spanked them less than parents in the control group. The evaluation found no impact on cognitive and language development of participants in home-based programs, but center-based approaches in combination with home-based approaches yielded positive effects.⁴

Early childhood program, El Salvador. In 2014, it was reported that 25 percent of children aged 36 to 59 months attended an early childhood education program that carried out four or more activities that stimulated learning and increased school readiness.⁵

Preprimary school, Chile. Attending preprimary school improved test scores for students from poor backgrounds twice as much as for students from higher-income families.⁶

Social assistance program [Chile Solidario], Chile. Implemented from 2002 onward, this program aimed to reach the poorest households and developed an approach that combined cash assistance with psychosocial support. Chile Solidario provides a “system” of social protection: a cash transfer in combination with social programs tailored to meet the specific needs of households living in extreme poverty. It has helped to increase the rate of preschool attendance and school enrollment for children aged 6–14.²

Sources: ³ Head Start. Child trends: Head Start [Internet]; 2018 [cited 25 Nov 2018]. Available from: <https://www.childtrends.org/indicators/head-start>.

⁴ U.S. Department of Health and Human Services, Office of Planning, Research and Evaluation. Early Head Start Research and Evaluation Project (EHSRE), 1996–2010 [Internet]; [cited 25 Nov 2018]. Available from: <https://www.acf.hhs.gov/opre/research/project/early-head-start-research-and-evaluation-project-ehsre-1996-2010>.

⁵ Economic Commission for Latin America and the Caribbean. Social panorama of Latin America 2016. Santiago: ECLAC; 2017. Available from: <https://www.cepal.org/en/publications/41599-social-panorama-latin-america-2016>.

⁶ United Nations Educational, Scientific and Cultural Organization. Regional report about education for all in Latin America and the Caribbean. Santiago: UNESCO Regional Office for Latin America and the Caribbean; 2016. Available from: http://www.unesco.org/new/fileadmin/MULTIMEDIA/FIELD/Santiago/pdf/regional-report-mexico-ingles_01.pdf.

4C. REDUCE INEQUITIES IN COMPLETION OF SECONDARY SCHOOL

Across the Region of the Americas, much progress has been made toward achieving universal access to good-quality primary education. Participation and attainment levels in secondary education, however, 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.

PRIMARY EDUCATION

For the majority of countries, gender disparities in completion of primary education declined between 1999 and 2012 (178). Across the Americas, in 2016, enrollment rates in primary education for boys and girls were fairly equal, and mostly high (Figure 4.10).

Across the Region, children living with some form of disability encounter more barriers and challenges in accessing education, making it harder for them to reach the same attainment rates as those without any form of disability. In the Caribbean, where data are available, in 2010, school attendance for children with disabilities was lower than for children without disabilities. The countries with the largest differences were Grenada (25 percent), Guyana (22 percent), and Jamaica (22 percent) (179).

SECONDARY EDUCATION

Secondary education has not had the same levels of investment, focus, or improvements as primary education in Latin America and the Caribbean, and profound inequalities in participation and attainment persist. In many countries, a significant number of adolescents living in poverty drop out before completing school.

Not having a completed secondary education has lifelong implications for health and other social and economic outcomes. Inequalities in education at the secondary level can set trajectories of poor outcomes through life and into subsequent generations. It is vitally important for health equity, and social and economic equity, that rates of participation in secondary education be increased and inequalities reduced.

There are many barriers that impede access to education for the most disadvantaged, rural, and Indigenous children and adolescents, including having to participate in the work force, difficulty physically accessing schools, becoming pregnant in adolescence, and, particularly for girls, having to care for family members.

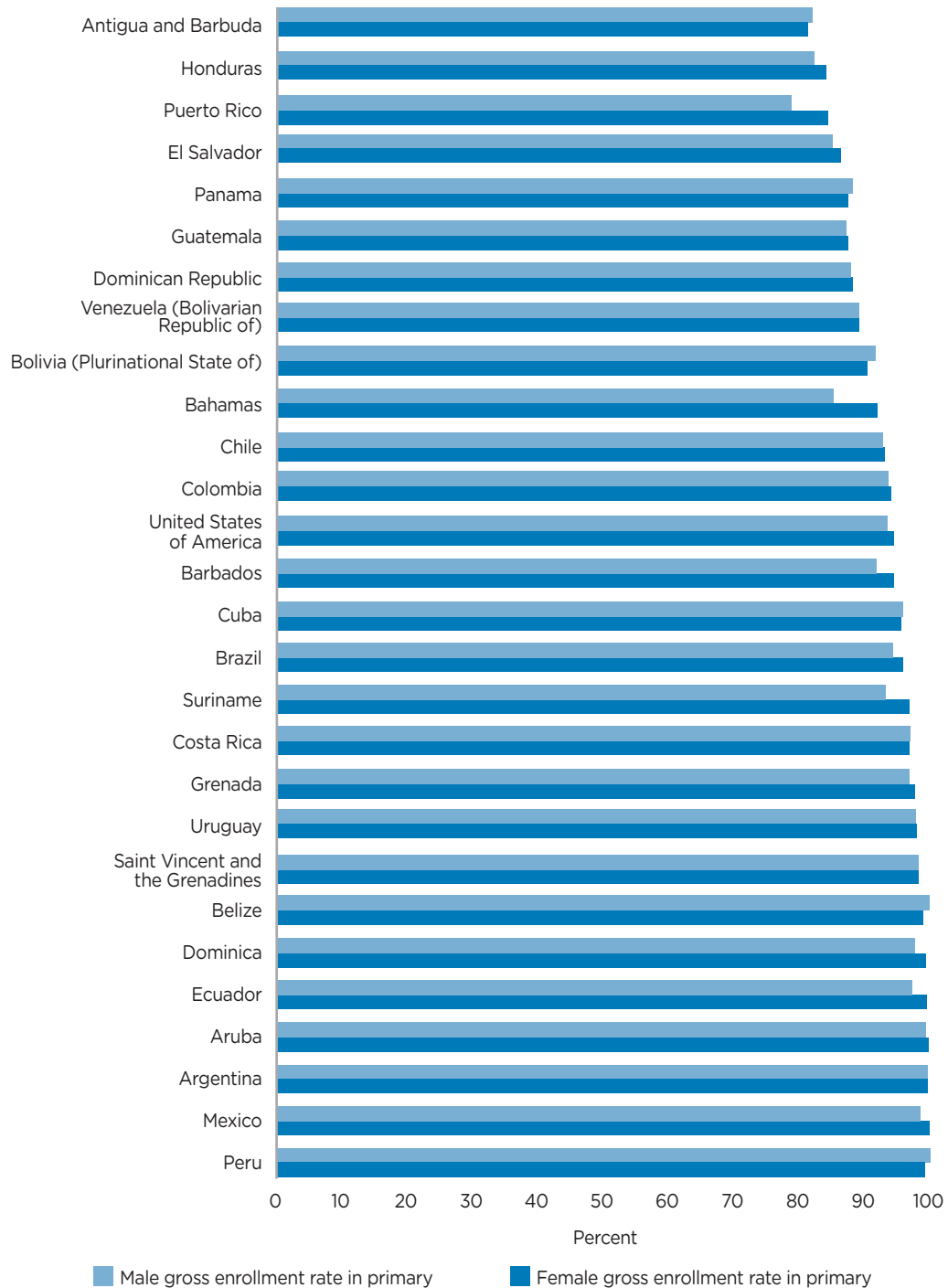
Figure 4.11 shows clear income gradients for adults finishing secondary school in selected countries for which data were available. A larger proportion from the higher income deciles (measured by household income) finished secondary education, as compared with lower deciles in each of the countries shown. In most countries, males were most likely to participate from high-income families, and some countries had very low participation rates for lower-income males and females.

According to a report published by ECLAC, only nine countries in Latin America and the Caribbean, covering less than a third of the population, guarantee the right to education on the basis of gender (179). This places that subregion behind the rest of the world, where 43 percent of countries protect the right to education on the basis of gender (179).

Figure 4.12 shows there are significant barriers experienced by Indigenous adolescents in Latin America and the Caribbean in attending secondary school, with the highest nonattendance rates being for Indigenous girls in rural areas. Rates of participation in secondary education for children with a disability are lower than for the rest of the population. Among persons with disabilities in Canada during 2012, 20 percent had less than a high school diploma, compared with 11 percent of those without disabilities (180).



Figure 4.10.
Adjusted net enrollment rate in primary education, female and male, Region of the Americas, 2016



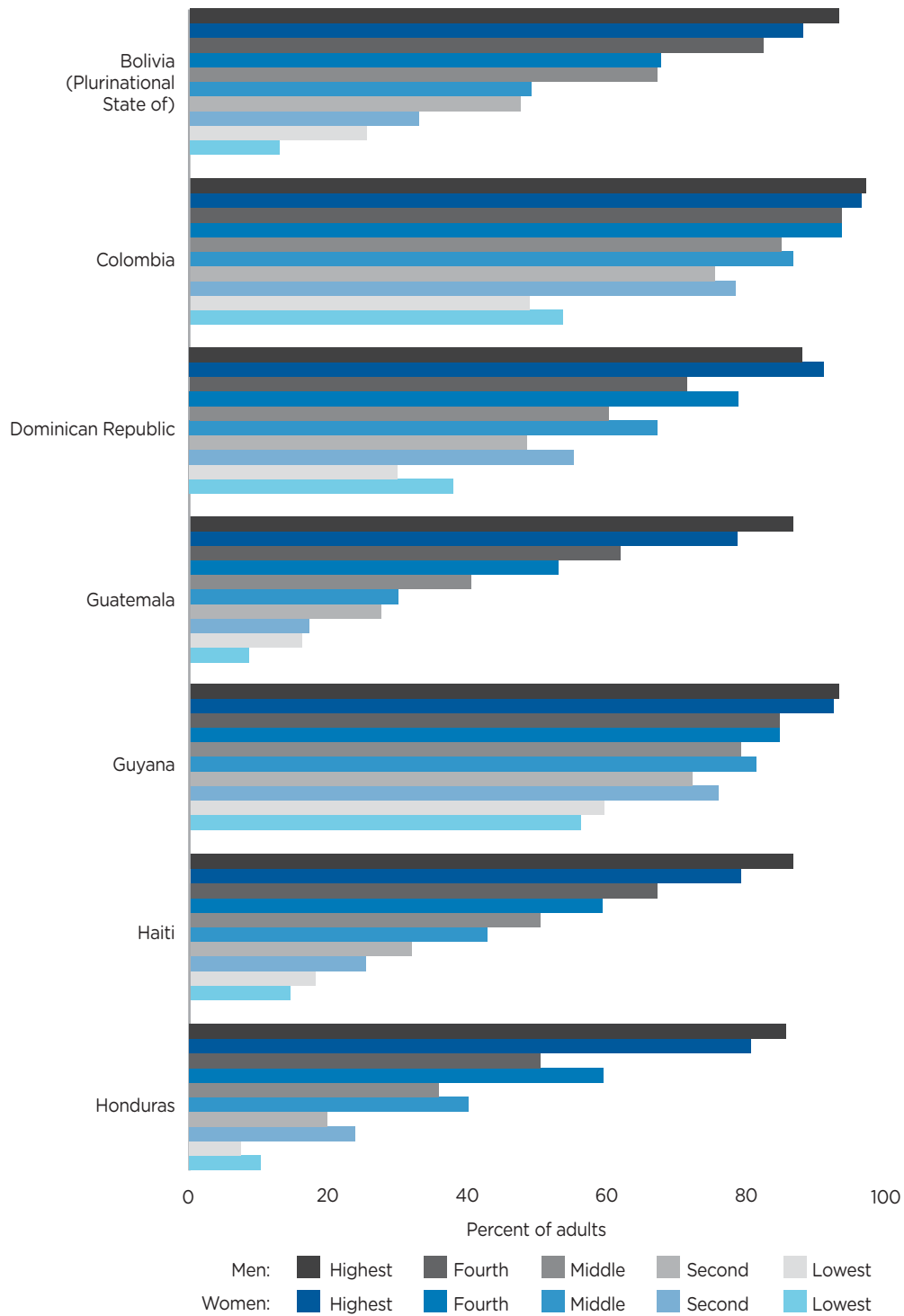
Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

Figure 4.13 shows that rates of completion of secondary education for those with disabilities in the Caribbean are lower than for those without disabilities, although rates improved between 2000 and 2010.

Figure 4.14 shows countries in which the constitution guarantees the right to education for children with disabilities. In Canada and the United States of America, there is no constitutional guarantee, while in many other countries it ranges from aspirations to

Figure 4.11.

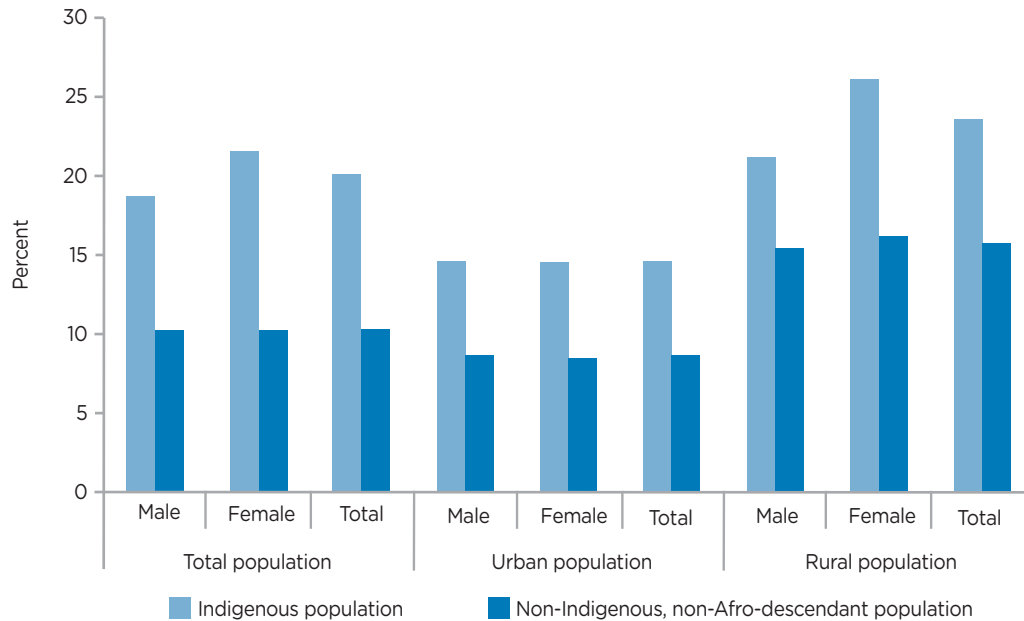
Percent of adults with secondary education or higher by income quintiles, selected countries, Latin America and the Caribbean, 2014 or latest available year



Source: Data from United States Agency for International Development. DHS STATcompiler [Internet]; 2018. Available from: <https://dhsprogram.com/data/STATcompiler.cfm>.

Figure 4.12.

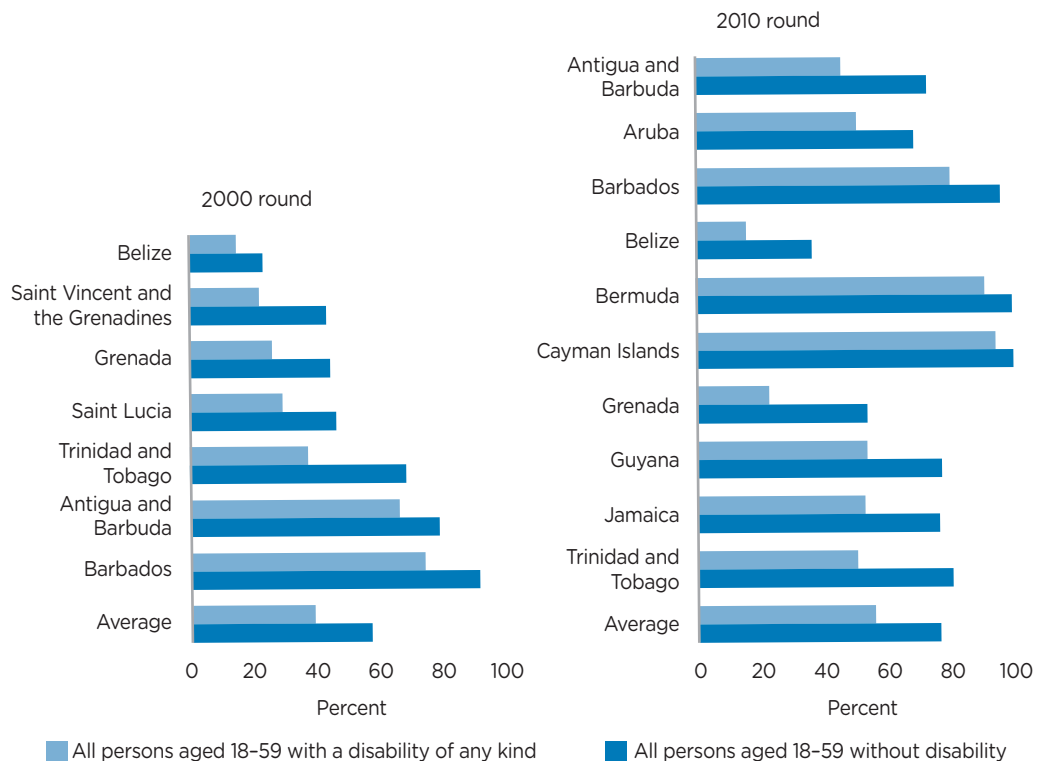
Adolescents aged 12 to 17 years not attending secondary school, by sex, ethnic origin, and place of residence, Latin America and the Caribbean, 2014



Source: Economic Commission for Latin America and the Caribbean. The social inequality matrix in Latin America. Santiago: ECLAC; 2016. Available from: https://repositorio.cepal.org/bitstream/handle/11362/40710/1/S1600945_en.pdf.

Figure 4.13.

Proportion of people aged 18-59 who have completed secondary education, by disability status, Caribbean countries, 2000 and 2010



Source: Economic Commission for Latin America and the Caribbean. The social inequality matrix in Latin America. Santiago: ECLAC; 2016. Available from: https://repositorio.cepal.org/bitstream/handle/11362/40710/1/S1600945_en.pdf.

Figure 4.14.

Constitutions that guarantee the right to education for children with disabilities, Region of the Americas, 2015



Source: WORLD Policy Analysis Center. Does the constitution guarantee the right to education for children with disabilities? [Internet]; 2018. Available from: <https://www.worldpolicycenter.org/policies/does-the-constitution-guarantee-the-right-to-education-for-children-with-disabilities>.

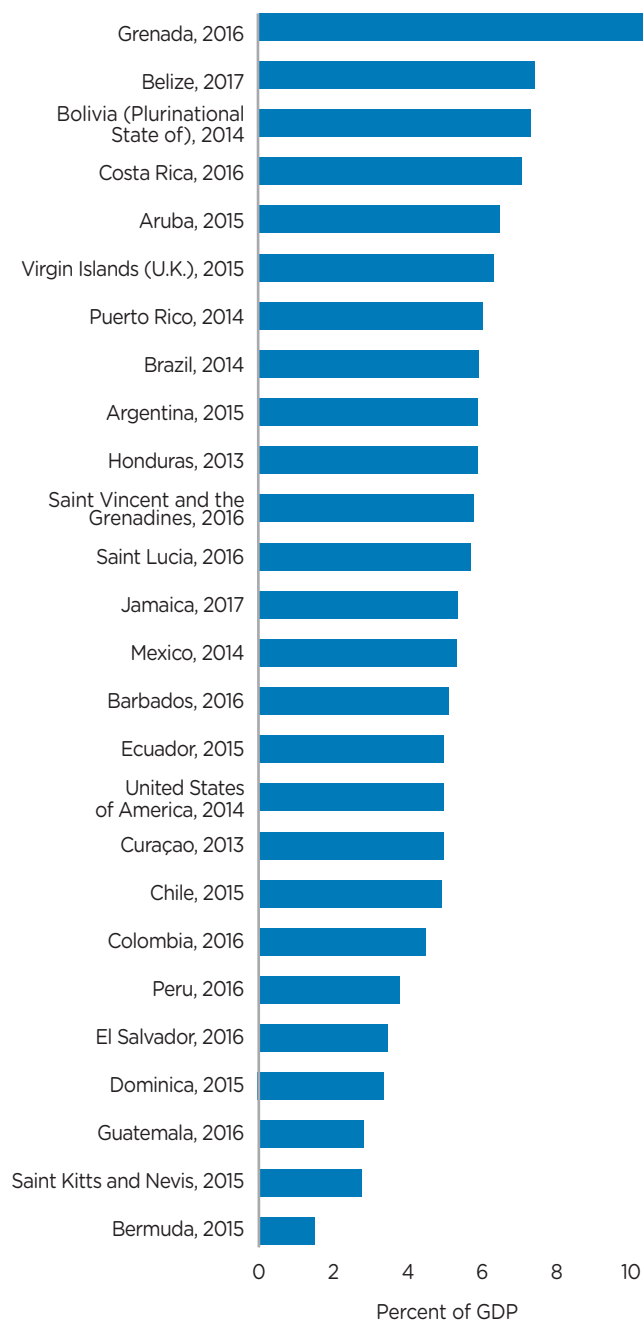
prohibition of discrimination or actual constitutional guarantees for the right to education.

Government expenditure on education

Education spending comprises the funding for all of the different levels of the education system, from preschool to tertiary, and includes all education-related support services and research and development (178).

There are wide differences in overall levels of expenditure on education among countries in the Americas, as measured by percentage of GDP. At the top end, in 2017 Grenada spent 10.3 percent of its GDP on education, while at the other end, Bermuda spent just 1.5 percent (Figure 4.15). Unsurprisingly, countries that invest less than the average in education perform worse in terms of educational results, and those spending more than the average perform better (175).

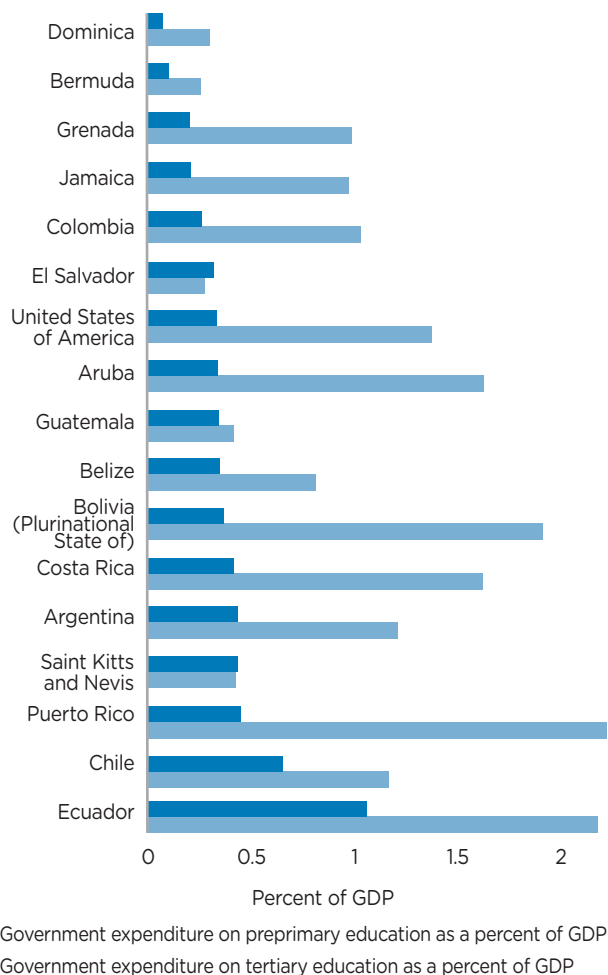
Figure 4.15.
Government expenditure on education, countries in the Americas with comparable data, 2017 or latest available year



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

In all countries, the ratio of financial expenditure per pupil between preprimary and tertiary education is weighted toward tertiary education (Figure 4.16). This is despite fewer students participating at that level; the importance of

Figure 4.16.
Government expenditure on preprimary and tertiary education, selected countries in the Region of the Americas, 2016



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

preprimary services for improving outcomes in education, income, and health throughout life; and preprimary investment being supportive of improving equity (1).

Tertiary education

Across the Americas, there are clear inequalities in participation in education beyond the secondary level. Tertiary education offers opportunities for further advancement; increases the chances of attaining highly skilled employment and higher income, status, and empowerment; and is related closely to better health outcomes. The main reasons for nonparticipation in tertiary education are material poverty, having to work at an early

age (including in subsistence activities), caring for family members, there being too great a distance between place of higher learning and place of residence, and experiencing poor-quality primary and secondary education. Accessing tertiary education is still a challenge in the Region for people living in rural areas, Indigenous peoples and those of African descent, and for people with

disabilities. The disadvantage is particularly great for rural Indigenous people, especially in Brazil, Colombia, Nicaragua, and Panama, where fewer than 5 percent have 13 or more years of education (4, 178). In Uruguay, school enrollment in the age group 18–24 years by people of African descent is just under half the rate among non-African-descent young people.

Examples of policies and programs to support participation in education

There are a wide range of policies and programs across the Americas that have supported greater participation in education. Where effective, these have helped to reduce inequalities in a wide range of outcomes, including health, throughout life. In particular, programs targeting remote rural communities and poor neighborhoods in urban areas have had positive impacts that were found to be cumulative. Greater impacts were associated with people being exposed to a program for a longer period.¹

Bolsa Escola program, Brazil. Initiated in the mid-1990s, this program has provided cash transfers to low-income families with school-age children on the condition that children were enrolled in school and attended a minimum number of days per month. The main objective of the program is to increase children's educational attainment. Several evaluations have been carried out and find that the program increases enrollment and reduces dropout rates.²

Prospera, Mexico. This targeted conditional cash transfer program, previously called *Oportunidades* and also *Progresá*, required children to participate in school and mothers to participate in pre- and postnatal clinics. Established in 1997, it provided food to families in absolute poverty. It also offered higher cash transfers to female students to improve gender equity in education among the poorest. Evaluations have found improvements in participation in secondary education.²

School vouchers, Chile. Chile offered school vouchers for access to fee-paying schools for the poorest 50 percent of children, and experienced increases in enrollment, particularly for children with mothers who had completed secondary education. This highlights the importance of female secondary education for subsequent generations as well as the current generation.³

Child Development Comprehensive Plan, Plurinational State of Bolivia. This plan ran from 1993 to 2000 to expand coverage and improve 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.²

Attention to Crisis, Nicaragua. This conditional cash transfer program provided families in drought-stricken areas with cash grants conditional upon their children's attendance at school and at health checkups. It was delivered from 2005 to 2006. The program reduced cognitive and social developmental delays in participating young children.²

Families in Action, Colombia. This program, which ran from 1997 to 2006, improved access to good-quality children's care and education, in turn increasing the probability of mothers finding employment by 31 percent.²

Sources: ¹ United Nations Educational, Scientific and Cultural Organization. Latin America and the Caribbean Education for All 2015 regional review. Santiago: UNESCO Regional Office for Latin America and the Caribbean; 2015. Available from: <https://unesdoc.unesco.org/ark:/48223/pf0000232701>.

² Vegas E, Santibáñez L. The promise of early childhood development in Latin America and the Caribbean. Washington, D.C.: World Bank; 2012. Available from: http://siteresources.worldbank.org/EDUCATION/Resources/278200-1099079877269/547664-1099079922573/ECD_LAC.pdf.

³ Organisation for Economic Cooperation and Development. School choice and school vouchers. An OECD perspective. Paris: OECD; 2017. Available from: <http://www.oecd.org/education/School-choice-and-school-vouchers-an-OECD-perspective.pdf>.

RELEVANT INTERNATIONAL AGREEMENTS

The Convention on the Rights of the Child. Article 28 states that every child has the right to an education, that primary education must be free, and that different forms of secondary education must be available to every child (United Nations, 1989).

Dakar Commitment. At the World Forum on Education for All, held in Dakar, Senegal, in 2000, the international community made a commitment to expanding and improving comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children (UNESCO, 2000).

PAHO Resolutions

Strategy and Plan of Action for Integrated Child Health (CSP28.R20 [2012])

Plan of Action on Adolescent and Youth Health (CD49.R14 [2009])

Regional Strategy for Improving Adolescent and Youth Health (CD48.R5 [2008])

Plan of Action for the Prevention of Obesity in Children and Adolescents (CD53.R13 [2014])

Sustainable Development Goals

Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture

Goal 3. Ensure healthy lives and promote well-being for all at all ages

Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

Goal 5. Achieve gender equality and empower all women and girls

Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all



Children in primary school, Higüey, Dominican Republic

RECOMMENDATION 5. DECENT WORK

Across the Region of the Americas, there are profound inequalities in income, employment rates, and conditions of work between ages 16 and 65, the stage in life during which people are working, family-building, and caring for older relatives. These work-related inequalities have profound implications for inequalities in health across the Region, given that the associations between work and health are strong.

Some of these inequalities are a result of inequalities experienced during early years, and education, as described in Section 4, and some are generated during this period of working life. Paid work is essential to relieving poverty. Work affects people’s social status, their ability to lead a dignified life, and, powerfully, their mental and physical health. Inequalities in access to good-

quality work closely relate to inequalities in health.

This section focuses on inequalities in the Americas that are related to unemployment and access to decent jobs, pay, and career progression. Income, poverty, and social protection are discussed in greater detail in Recommendation 7.

PRIORITY OBJECTIVES	ACTIONS
<p>5A. Improve access to decent jobs and conditions at work, including for people in informal and domestic labor sectors</p>	<ul style="list-style-type: none"> • Governments to regulate employers to meet International Labour Organization (ILO) conventions 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 (187) and SDG 8.7 (94) • 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
<p>5B. Support unemployed people through active labor market programs and social protection systems</p>	<ul style="list-style-type: none"> • Reduce rates of young people not in employment, education, or training, especially women of African descent and Indigenous peoples • 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
<p>5C. Reduce gender inequalities in access to work, pay, and seniority</p>	<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 employment rates, pay, and seniority

5A. IMPROVE ACCESS TO DECENT JOBS AND CONDITIONS AT WORK, INCLUDING FOR PEOPLE IN INFORMAL AND DOMESTIC LABOR SECTORS

There are several important components of “decent work.” These have been described in various reviews as being in the work force, receiving sufficient, appropriate income, not being exposed to hazards, and having a positive psychosocial working environment (182, 183).

These are summarized by the International Labour Organization (184):

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.

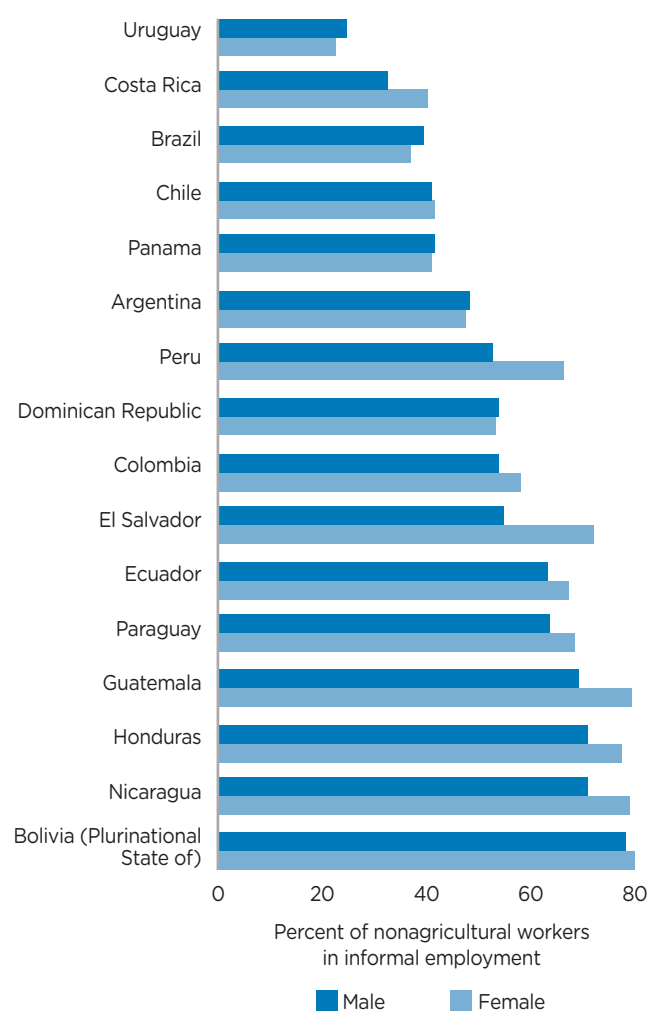
The sections that follow show how the goal of decent work can be disrupted by informal work, domestic work, lack of safety at work, and adverse psychosocial working conditions. Each of these may damage health and contribute to health inequities.

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

Informal labor includes work without a contract; with no security or guarantee of employment or income; no employer-provided social protection such as sick pay, holiday pay, or maternity leave; and no legal protections. Lack of social protection coverage, which is associated with informal employment, has been shown to be related to poor physical and mental health (185). Informal labor presents risks to mental and physical health, and to health equity.

There are high rates of informal labor in Latin America and the Caribbean, particularly among women. In several countries, more than 50 percent of working people in nonagricultural sectors lack a formal employment contract. The figures are mostly higher for women than men (Figure 4.17).

Figure 4.17.
Informal employment, by sex, selected countries in Latin America and the Caribbean, 2017 or latest available year



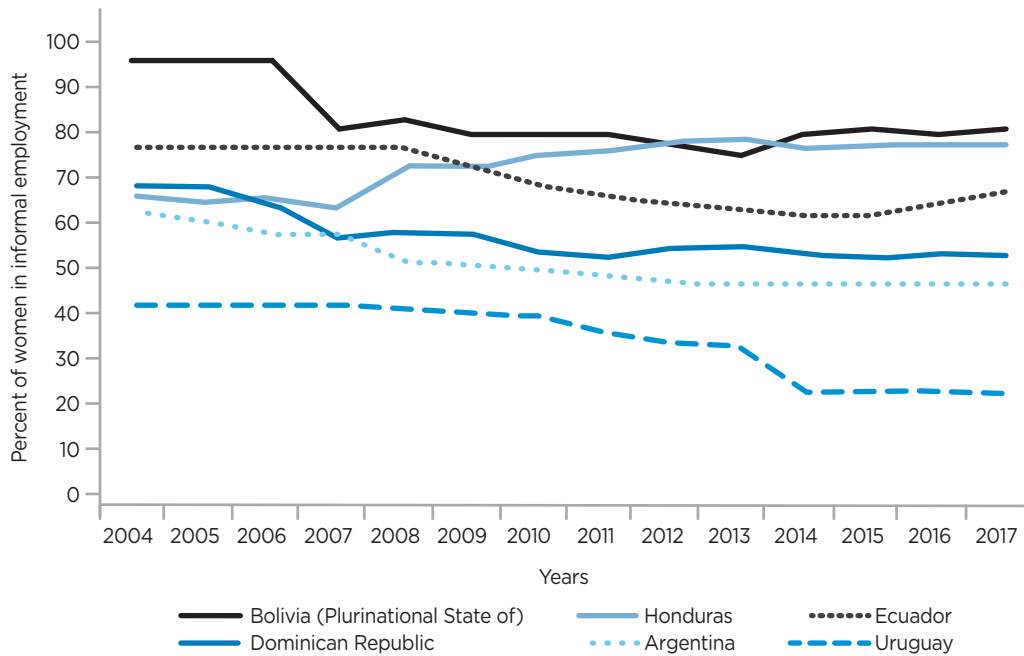
Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

While the numbers of people working in informal sectors in Latin America and the Caribbean have declined since 2004, the numbers are still high,

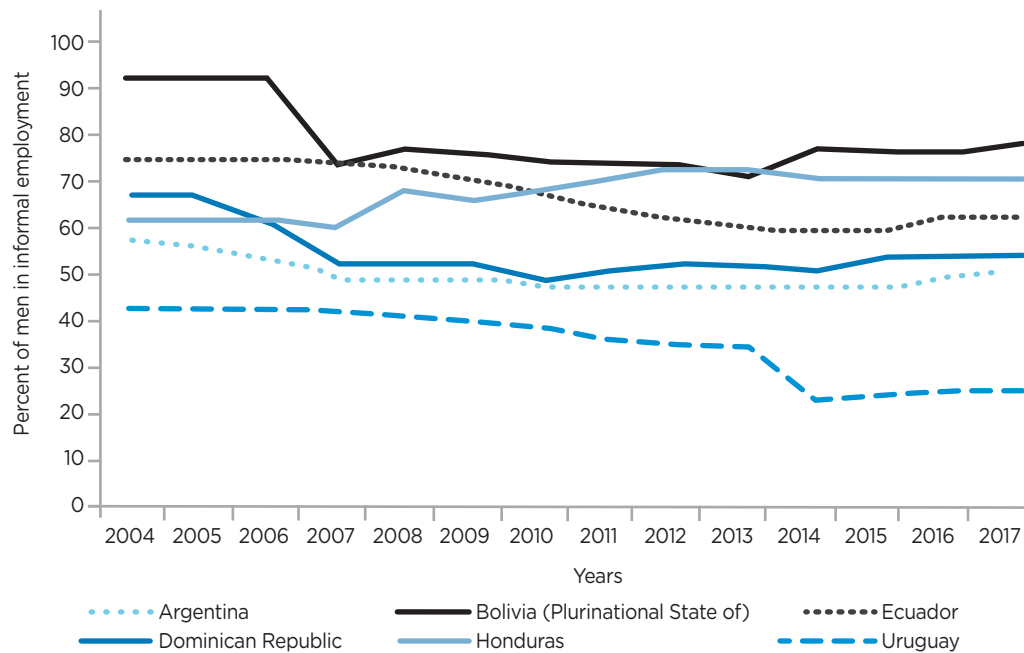
especially for women, and in some countries there have been increases again (Figures 4.18 A and B).

Figure 4.18.
Informal employment, by sex, in countries in Latin America with comparable data available, 2004-2017

A) Female



B) Male



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

Note: Employment in the informal economy includes all jobs in unregistered and/or small-scale private unincorporated enterprises. These include: self-employed street vendors, taxi drivers, and home-base workers. Agricultural activities and volunteer services are excluded.



Workers, most of whom are women and girls, manually extracting minerals from salt basins, Maras, Peru

The proportion of wage earners with formal employment contracts in the Americas is typically lower among young people than among older adults (1, 186).

Domestic work is mostly undervalued and seen as low status, poorly remunerated, and mainly carried out by women and girls. Many are migrants or people of African descent who come from disadvantaged communities (4, 187). Migrants are also often dependent on the most dangerous, insecure types of work, and have no formal forms of protection. In 2013, North America (Canada and the United States of America) as a broad subregion had the world's highest share of migrant workers; migrants tend to move to wealthier nations as destination countries if they can (187). In 2015, nearly 25 percent of Canada's total working age population were migrants, and in the United States of America the figure was nearly 20 percent. Parts of the Caribbean also have high rates (188).

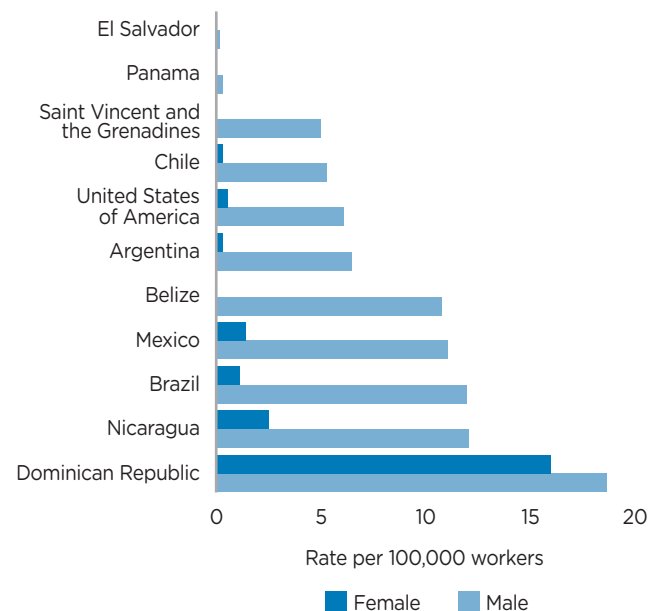
SAFETY AT WORK

A safe working environment free from hazards is an important element of decent work. Safety at work is critical to the health of workers and their ability to continue to earn a decent income and support themselves and their families. Physical, chemical, and biological hazards all pose potential threats to health in the workplace.

In some countries in the Region, there are relatively high levels of fatal occupational injuries, as shown

in Figure 4.19 (189). The actual numbers may be higher, as there is likely to be underreporting and as monitoring is ineffective in some countries.

Figure 4.19.
Rates of fatal occupational injuries, selected countries in the Americas, 2017 or latest available year



Source: International Labour Organization. ILOSTAT: key indicators of the labour market [Internet]; [data retrieved September 2018]. Available from: https://www.ilo.org/ilostat/faces/ilostat-home/home?_adf.ctrl-state=g43s30d0n_4&_afLoop=1927002885072191#.

There are some 374 million nonfatal work-related injuries and illnesses worldwide each year, many of these resulting in extended absences from work. The human cost of this daily adversity is hugely significant. The economic burden of poor occupational safety and health practices is estimated at 3.94 percent of global gross domestic product each year, according to the ILO (190).

In Canada, there were 905 work-related fatalities in 2016 (191). In the United States of America in 2017, over 5,000 workers died, and older workers had a higher fatality rate than other age groups (192).

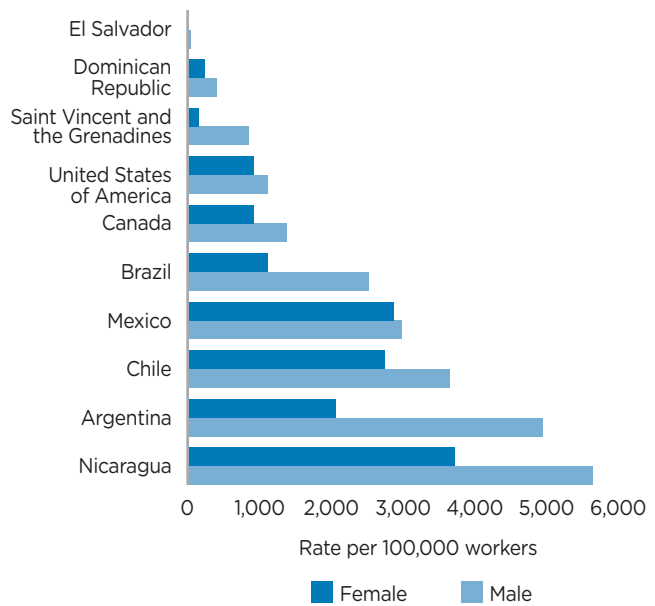
Reported rates of nonfatal injuries at work vary markedly among selected countries of the Region (Figure 4.20). Rates for men are higher than for women, as men are more likely to be working in industries with higher levels of risk, such as mining, agriculture, and fishing, and in more physically demanding, hazardous occupations.

PSYCHOSOCIAL STRESS AT WORK

Poor conditions at work may result in negative psychological, physical, and social outcomes, such as work-related stress, burnout, or depression, as well as other mental and physical health harm. Working conditions leading to psychosocial risks include excessive workloads; lack of involvement in making decisions that affect the worker; poor work organization and management, including repetitive tasks, low levels of control over tasks, and high levels of demand; job insecurity; psychological and sexual harassment; violence; and lack of support from management or colleagues (183, 193).

Many studies have reviewed the links between psychosocial stress at work and poor health outcomes, based on theories of imbalances in what tasks are demanded and how much control over these tasks workers have, or imbalances in effort put in and acknowledgment or reward for that effort (183, 194). A recent systematic review of empirical studies conducted in Latin America assessed the association of psychosocial stress at work and health using the effort-reward imbalance (ERI) model. It found that evidence from a range of countries supports the association between an imbalance in effort and reward, and psychosocial stress, which leads to poor health, including worse mental health and cardiovascular disease (195).

Figure 4.20.
Rates of nonfatal occupational injuries, selected countries in the Americas, 2017 or latest available year



Source: International Labour Organization. ILOSTAT: key indicators of the labour market [Internet]; [data retrieved September 2018]. Available from: https://www.ilo.org/ilostat/faces/ilostat-home/home?_adf.ctrl-state=g43s30d0n_4&_afrcLoop=1927002885072191#.

Studies using nationally representative samples of Chile’s working adults, using the effort-reward imbalance model, have shown that exposure to psychosocial risks at work is associated with hazardous alcohol consumption and depressive symptoms (196). Other studies found that effort-reward imbalance is associated with a higher risk of depressive disorders (197).

From available evidence, it is clear that psychosocial stress increases with low status, poor-quality employment, and is a major contributor to health inequities across the Region. Obligations on employers to ensure better-quality jobs across all employment sectors, supported by stronger legal and regulatory protections, would help to improve health outcomes and health equity. Good management practices in the workplace can ensure that employees’ tasks, as well as the quality of management and supervision, promote a good-quality work environment that enhances, rather than harms, health.

Working an excessive number of hours (over 8 hours a day) can increase psychosocial stress

and be damaging for physical and mental health and well-being. It can also hinder work-life balance, which includes time for parents to spend with children and to participate in school and community events. In many countries in the Americas, employees work more than 40 hours per week (Figure 4.21). However, these figures are averages, and it is likely that some types of work and sectors demand particularly long hours. For some, especially women, working days are extended further through the dual burden of caring for families while working a job, as discussed in Section 5C.

UNIONIZATION

The formation of unions has been associated with a range of important improvements in the quality of work and other conditions of employment, and unionization is associated with higher wages (198). Employees in unions may also be more likely to have other benefits. For example, a 2011 study in Chile showed that nearly three-quarters of unionized women had some form of health insurance, as compared to less than half of nonunionized women (199). International evidence suggests that unionization and collective bargaining contribute to empowerment and income redistribution, and both are relevant for population health and health equity (200). People who are part of a union are more likely to have paid family leave, sick days and vacation, retirement plans, and access to health care (201).

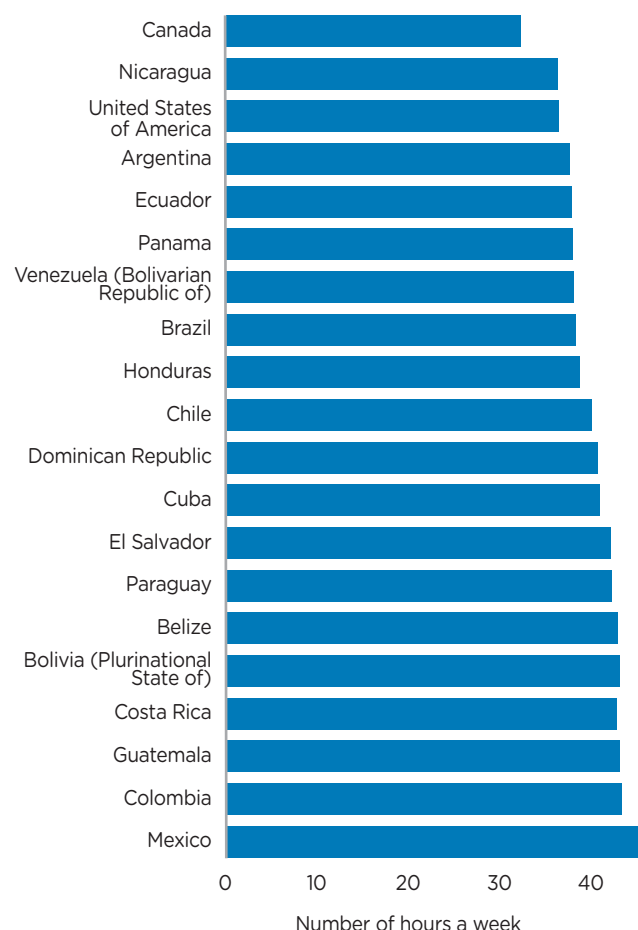
CHILD LABOR

Working in childhood is detrimental to children’s health, removes children from full-time education, and often results in children’s separation from their family and community (202). Furthermore, children who work are at high risk of experiencing the most health-damaging and dangerous forms of work.

Boys are more likely to work outside the home than are girls, and they perform a higher proportion of the most hazardous work, while girls are more likely than boys to carry out household chores.

The Americas has the third-highest burden of child labor in the world. In 2017, there were 10.7 million children and adolescents aged between 5 and 17 years in the labor market.

Figure 4.21.
Mean hours worked per week per employed person, selected countries in the Americas, 2017 or latest available year



Source: International Labour Organization. ILOSTAT: key indicators of the labour market [Internet]; [data retrieved September 2018]. Available from: https://www.ilo.org/ilostat/faces/ilostat-home/home?_adf.ctrl-state=g43s30d0n_4&_afLoop=1927002885072191#.

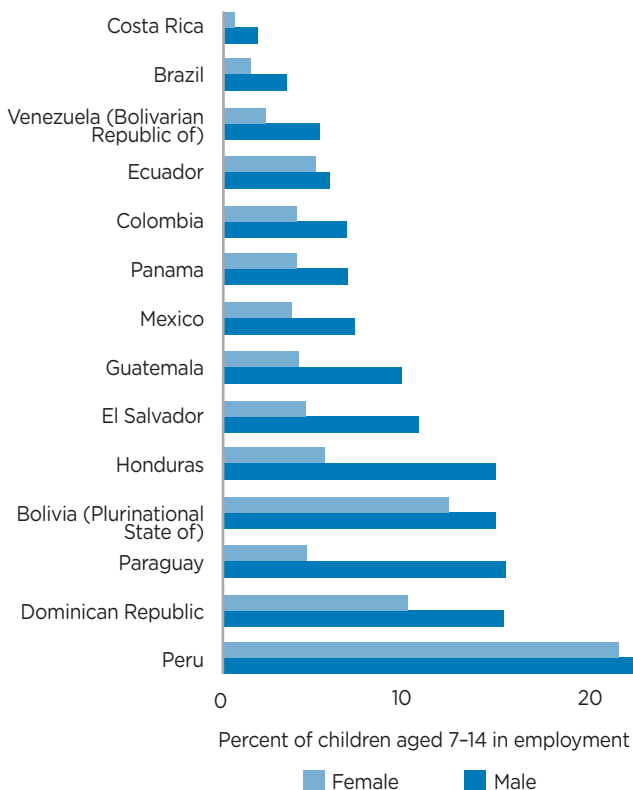
This represents a prevalence of 5.3 percent, which, while high, was considerably less than the 2008 figure; however, concerningly, rates of decline have since stagnated (203). There are higher percentages of boys than girls in employment (Figure 4.22), while girls carry out more unpaid domestic work.

Child labor disproportionately affects Indigenous children and children of African descent. For example, in the Plurinational State of Bolivia, almost half of all boys who work are Indigenous, and many of them carry out dangerous activities. In Brazil, around 2014 roughly 60 percent of child laborers between the ages of 5 and 13 were of African descent.



Young pineapple vendor in La Romana, Dominican Republic

Figure 4.22.
Percent of children aged 7–14 in employment, by sex, selected countries in Latin America and the Caribbean, 2016 or latest available year



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

Figure 4.23 shows that while many countries in the Region do ban child labor under 12, there are still many countries, including Canada and the United States of America, that legally permit some form of work for children under 12. In any case, given the relatively high levels of children working, the protections are not effectively enforced.

IN-WORK POVERTY

Many people in the Americas earn wages that are insufficient to lift themselves out of poverty, including in Canada and the United States of America.

There is wide variation across Latin America and the Caribbean in levels of poverty among employed people. At one end of the spectrum, in Costa Rica, less than 1 percent of those in work are recorded as being in poverty, while at the other end, figures for Haiti show 22 percent of employed women and 18 percent of employed men living in poverty in 2016 (Figure 4.24) (789).

In the United States of America in 2016, 7.6 million individuals were among the working poor (that is, who spent at least 27 weeks in the labor force—working or looking for work—but whose incomes still fell below the poverty level) (204). Blacks and Hispanics were about twice as likely as Whites and Asians to be among the working poor. For all ethnic groups, the rate is higher for women than for men (Figure 4.25).

Figure 4.23.**Level of protection for 12-year-olds in relation to work, Region of the Americas, 2012**

Source: WORLD Policy Analysis Center. What work protections do children have when legal loopholes are considered? [Internet]; 2018. Available from: <https://worldpolicycenter.org/policies/what-work-protections-do-children-have-when-legal-loopholes-are-considered/what-work-protections-do-12-year-olds-have-when-legal-loopholes-are-considered>.

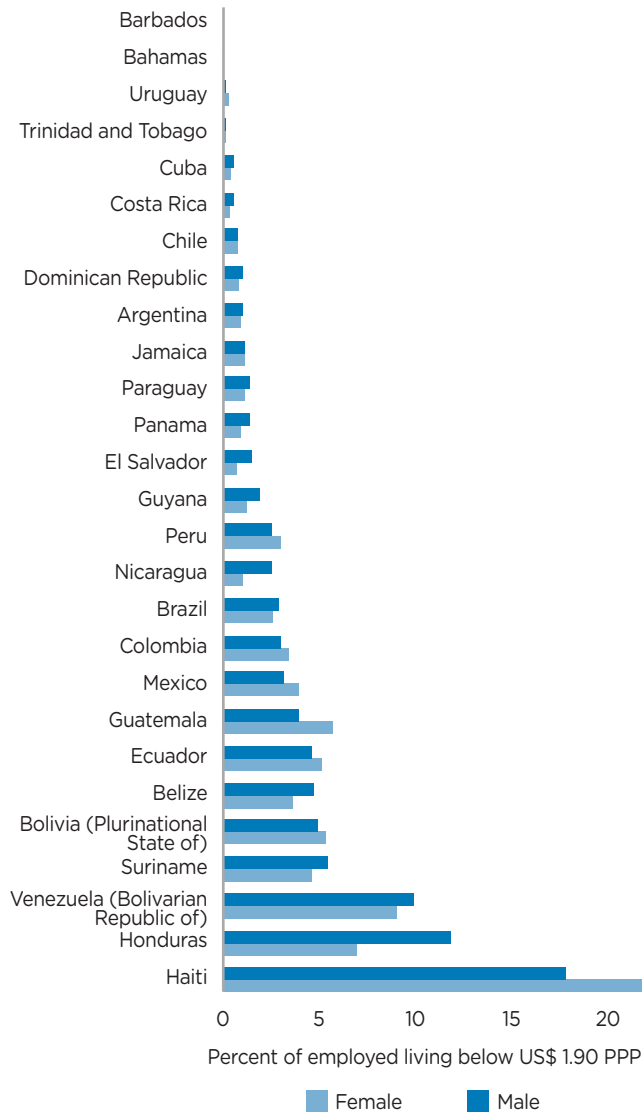
Note: The figure refers to cases where the legislation allows children to do work at a younger age under specific circumstances.

In 2014, approximately 746,000 Canadians (3 percent) lived in a family where the main income earner met the definition of working poor. While the share of Canadians living in working-poor families has declined in recent years, the rate has been stuck at between 3 percent and 4 percent since 2007 (205).

Only a few countries in the Region in 2014 guaranteed the right to equal pay for equal work for all ethnicities, as Figure 4.26 shows.

In some countries in the America, real wages declined in 2015 (Figure 4.27). In these countries, the number of people in working poverty will have

Figure 4.24.
Working poverty (below US\$ 1.90 PPP), by sex, Latin America and the Caribbean, 2016

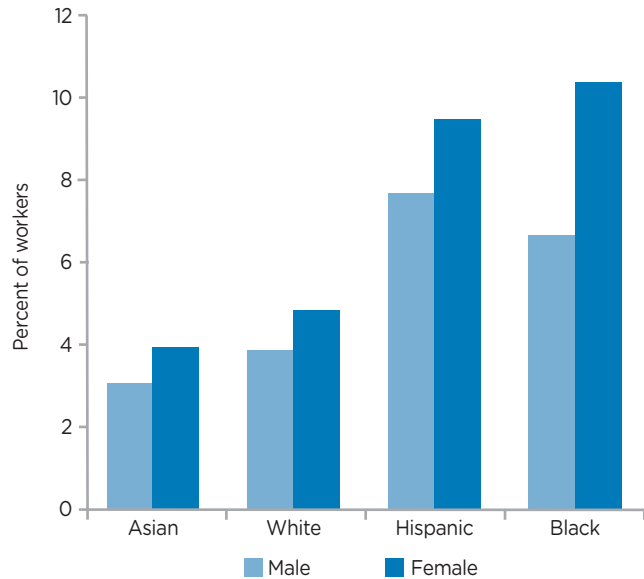


Source: International Labour Organization. ILOSTAT: key indicators of the labour market [Internet]; [data retrieved September 2018]. Available from: https://www.ilo.org/ilostat/faces/ilostat-home/home?_adf.ctrl-state=g43s30d0n_4&_afLoop=1927002885072191#.

Note: PPP: purchasing power parity.

increased. In other countries, while wages are growing, they are not keeping pace with inflation, also meaning that in-work poverty will increase.

Figure 4.25.
In-work poverty rates, by ethnicity and sex, United States of America, 2016



Source: Semega JL, Fontenot KR, Kollar MA. U.S. Census Bureau, Current Population Reports, P60-259. Income and poverty in the United States: 2016. Washington, D.C.: U.S. Government Printing Office; 2017. Available from: <https://www.census.gov/content/dam/Census/library/publications/2017/demo/P60-259.pdf>.

MINIMUM WAGE

A mandatory minimum wage has been shown to be important in securing adequate wages for low-paid workers and therefore for reducing health inequalities. In Latin America, there is evidence that the minimum wage operates as a benchmark for wages of unskilled workers, but not all countries have the minimum wage, including, importantly, for those in informal work (206). Campaigns carried out in some countries in the Region increased compliance with minimum wage legislation and benefited women, which had a positive impact on young women with little or no education.

Recently, the domestic sector has undergone significant remuneration improvements as a result of new international standards and the adoption of national legislation to recognize and regulate domestic service as employment (207).

Figure 4.26.

Does the constitution guarantee the right to equal pay for equal work based on ethnicity (as of 2012)?

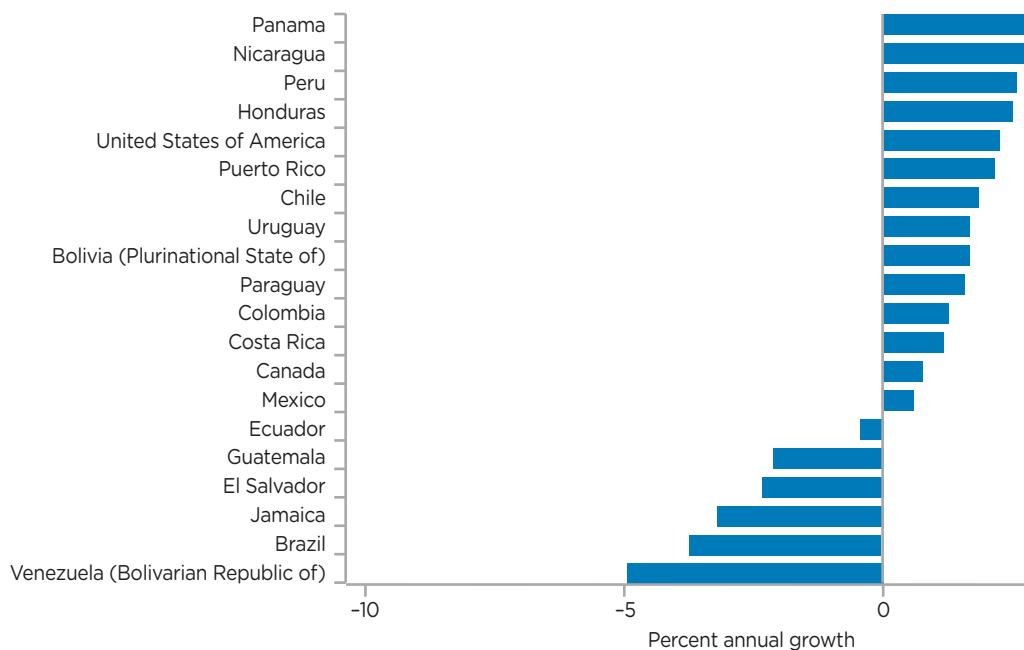


Source: WORLD Policy Analysis Center. Does the constitution guarantee the right to equal pay for equal work based on ethnicity? [Internet]; 2018 [cited 25 Nov 2018]. Available from: <https://www.worldpolicycenter.org/policies/does-the-constitution-guarantee-the-right-to-equal-pay-for-equal-work-based-on-ethnicity>.

Note: *General guarantee* means that the right to equal pay for equal work is guaranteed for all citizens, but not specifically on the basis of ethnicity; *guaranteed* means that the constitution, in authoritative language, protects the right to equal pay for equal work based on ethnicity.

Figure 4.27.

Mean real monthly earnings of employees, annual growth, Region of the Americas, 2015 or latest available year



Source: International Labour Organization. ILOSTAT: key indicators of the labour market [Internet]; [data retrieved September 2018]. Available from: https://www.ilo.org/ilostat/faces/ilostat-home/home?_adf.ctrl-state=g43s30d0n_4&_afLoop=1927002885072191#.

A recent study suggests that policy priorities in the Americas have been shifting away from a sole focus on accidents toward also addressing psychosocial and other workplace hazards (208).

This has increased the focus on stress, violence, unhealthy behaviors, and harassment in the

workplace. There are variations in focus, however, as Table 4.1 shows. While Brazil and Puerto Rico lack legislation on general psychosocial risks at work, a greater number of Latin American countries have specific laws that address harassment in the workplace (183).

Table 4.1.
Legislation on quality work in Latin America

Country	Actions	Regulation	Year
Argentina	Work violence	Law No. 13168	2003
Brazil	Work harassment	Law No. 2.120	2001
	Work harassment	Law No. 12.561	2006
Chile	Work harassment	Law No. 20607	2012
	Psychosocial risk assessment	Resolution 218	2013
Colombia	Work harassment	1010-2006	2006
	Psychosocial risks	Resolution 2646	2008
Mexico	Work harassment	Supreme Court Articles	2012
	Psychosocial risks	Occupational health mandatory rules	2013
	Psychosocial risks	Official Mexican norms (in progress)	2015

(continued on next page)

Table 4.1.
Legislation on quality work in Latin America (continued)

Country	Actions	Regulation	Year
Peru	Psychosocial risks	Law No. 29783. Decree 005-2012-TR	2012
Puerto Rico	Work harassment	Proposed legislation	2014
Uruguay	Work violence	Law No. 18561	2009
Venezuela (Bolivarian Republic of)	Psychosocial risks Work harassment	Organic Law LOPCYMAT. ¹ Article 56.5	2005

Source: Gómez V, Juárez-García A. Working conditions and effort-reward imbalance in Latin America. In: Siegrist J, Wahrendorf M, editors. Work stress and health in a globalized economy: the model of effort-reward. Cham: Springer; 2016:235–71.

1. Organic Law of Prevention, Conditions and Environment at Work.

Examples of policies and programs to improve access to decent jobs

Reducing child labor [*Prospera*, previously *Oportunidades*], Mexico. *Prospera* is a major conditional cash transfer program that began in 1997. It has benefited 6 million families (25 percent of the population), and contributed to a reduction in child labor outside the household, particularly for boys. Studies of rural areas have shown a 14-percent reduction in children’s work time outside the household, coupled with more time allocated to school-related tasks. A similar result has been found in urban areas, with reductions of around 13 percent in children’s work time outside the household in the second year of receiving the benefits.¹

Minimum wage policy, United States of America. Since it was first instituted in 1938 to protect workers from in-work poverty, the federal minimum wage in the United States of America 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, they are in decline overall nationwide.²

Minimum wage policies, Latin America. There is minimum wage legislation in most Latin American countries, but little evidence of impact. One study indicates that having a minimum wage policy does not necessarily lift the wages of all status employees, but does have a widespread impact on low wages, even in the informal sector.³

The minimum wage in Mexico has stagnated and is not set at a sufficient level to cover the costs of basic food requirements. It is now too low to meet the material, social, and cultural requirements of a household and to provide for the education of children, all of which was mandated by the Constitution in 2014. The minimum wage in Mexico has increased much more slowly than other minimum wages in the Region, despite evidence of significant negative impacts for equity.⁴

Sources: ¹ World Bank. A model from Mexico for the world [Internet]; 19 November 2014 [cited 7 Dec 2018]. Available from: <http://www.worldbank.org/en/news/feature/2014/11/19/un-modelo-de-mexico-para-el-mundo>.

² Amadeo K. Minimum wage with its purpose, pros, cons, and history. The Balance [Internet]; 11 March 2019. Available from: <https://www.thebalance.com/us-minimum-wage-what-it-is-history-and-who-must-comply-3306209>.

³ Kristensen N, Cunningham W. Do minimum wages in Latin America and the Caribbean matter? Evidence from 19 countries. Policy Research Working Paper No. 3870. Washington, D.C.: World Bank; 2006. Available from: <https://openknowledge.worldbank.org/handle/10986/8337>.

⁴ Moreno-Brid JC, Garry S, Krozer A. Minimum wages and inequality in Mexico: a Latin American perspective. *Revista de Economía Mundial*. 2016;43:113–30.

5B. SUPPORT UNEMPLOYED PEOPLE THROUGH ACTIVE LABOR MARKET PROGRAMS AND SOCIAL PROTECTION SYSTEMS

Unemployment and job insecurity are damaging to health (209). The effects worsen the more time is spent unemployed. The health impacts can be as a direct consequence of unemployment, including increased risks of anxiety and depression, risky health behaviors, and cardiovascular disease. There are also multiple negative health impacts from lower income and loss of status (210).

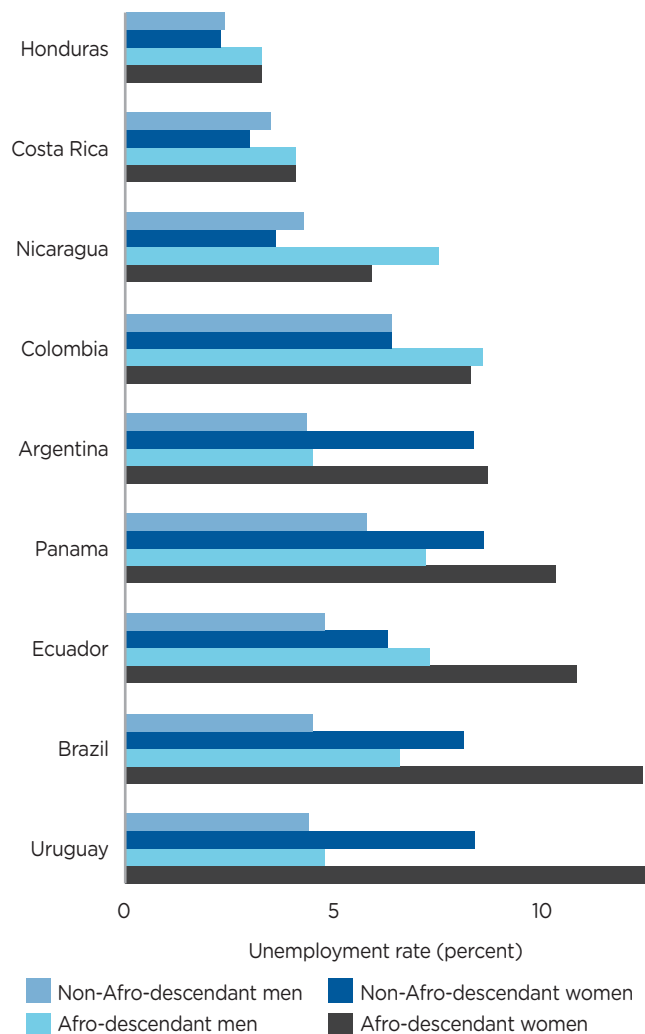
The unemployment rate is one of the key indicators of the extent of labor market exclusion within a population, and rates are high in many countries in the Americas, although data reliability is a problem. There are persistent inequalities in rates of unemployment and poor-quality employment, related to socioeconomic position, gender, ethnicity, and disability status.

In nine Latin American countries for which data are available, unemployment rates at ages 15 and over were higher for people of African descent, particularly women, than for those of other ethnic backgrounds of the same gender, as shown in Figure 4.28 (29).

In the United States of America, unemployment rates in 2015 were over twice as high for African Americans and Hispanics as for Whites and Asians (146), as discussed in Recommendation 3. The message from these figures is that an educational qualification is a route to employment, even for those with severe disability (see Figure 4.29).

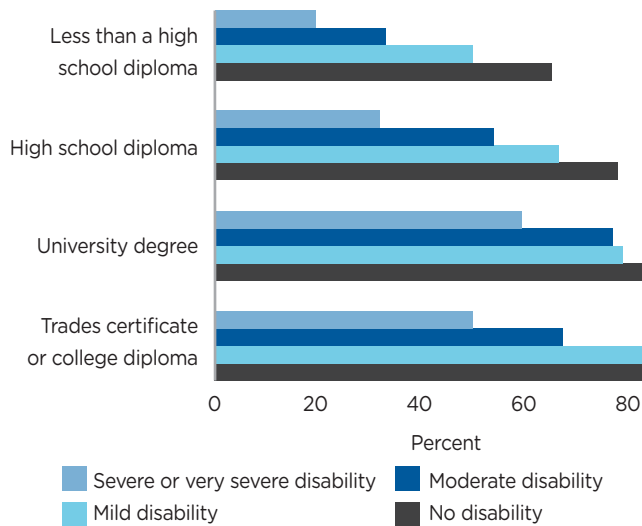
Disability also affects risk of unemployment. In Canada, employment rates for people with a disability are lower than for those without a disability (Figure 4.29). In the Caribbean, disability also has a clear impact on economic activity, as shown in Figure 4.30. Similarly, in Costa Rica and the United States of America, where data are available, people with disability experience higher rates of unemployment than do people without a disability (211).

Figure 4.28.
Unemployment rate (percent) of people aged 15 and above, by gender and ethnic identification, selected countries in Latin America, latest available years, 2005–2013



Source: Adapted from Economic Commission for Latin America and the Caribbean. The social inequality matrix in Latin America. Santiago: ECLAC; 2016. Available from: https://repositorio.cepal.org/bitstream/handle/11362/40710/1/S1600945_en.pdf.

Figure 4.29.
Age-standardized employment rate by education level and by severity of disability, Canada, 2011



Source: Adapted from Statistics Canada. A profile of persons with disabilities among Canadians aged 15 years or older. Ottawa: Statistics Canada; 2012. Available from: <https://www150.statcan.gc.ca/n1/pub/89-654-x/89-654-x2015001-eng.htm>.

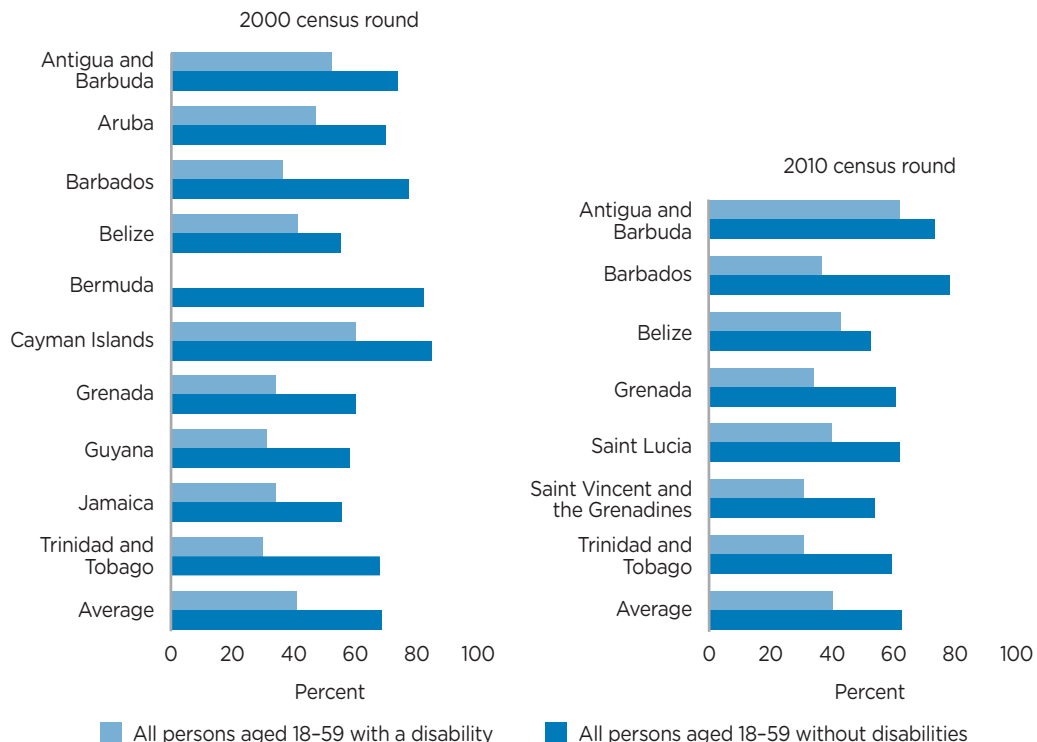
YOUNG PEOPLE NOT IN EMPLOYMENT, EDUCATION, OR TRAINING

One group of particular concern are young people who are neither employed in the labor market nor studying or training. Nonparticipation in work or education for young people has lifelong equity impacts—on employment prospects, income, status, and health. There are clear inequalities based on gender and ethnicity.

The differences between young women and young men are striking. In almost all countries in the Americas, the percentages of young women in this situation are double the rates found among their male peers. Among young women, the absence of care services for children is a significant factor that keeps those with children from participating in education or work; in turn, this limits their chances of earning their own income at this and at later stages in life (6).

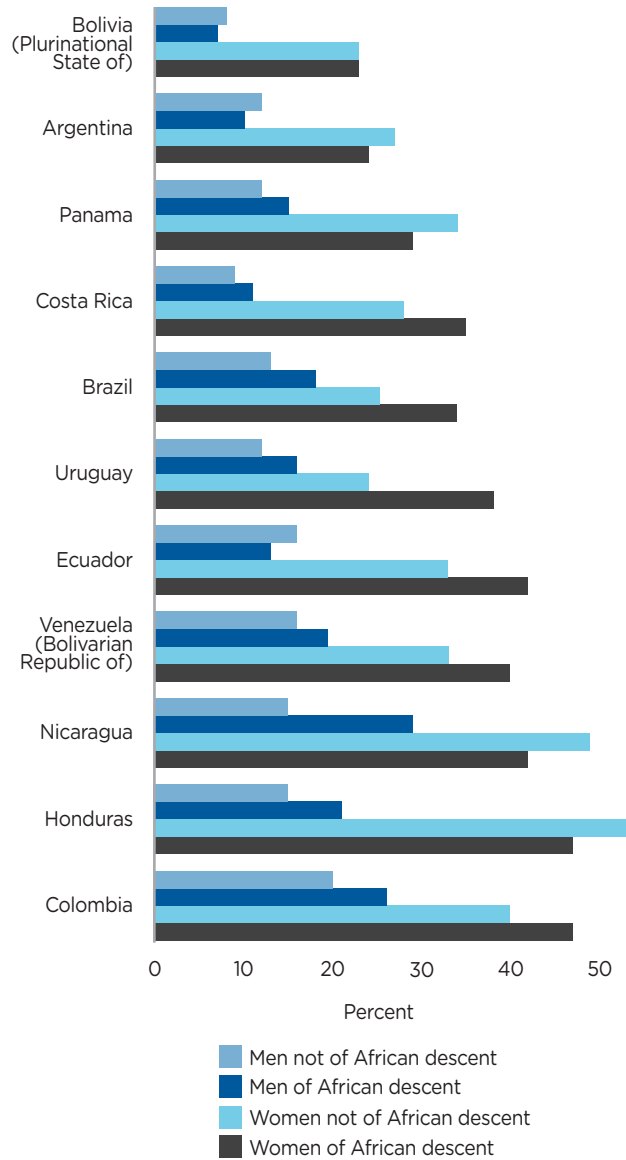
In most countries in the Region, young women of African descent are the group most likely not to be

Figure 4.30.
Economic activity of persons aged 18 to 59, by disability status, selected countries in the Caribbean, 2000 and 2010



Source: Economic Commission for Latin America and the Caribbean. Social panorama of Latin America 2016. Santiago: ECLAC; 2017. Available from: <https://www.cepal.org/en/publications/41599-social-panorama-latin-america-2016>, on the basis of national population and housing censuses in 2000 and 2010.

Figure 4.31.
Young people aged 15 to 29 years who are not in employment or education, by African-descent identity, and gender, Latin American countries with comparable data, 2012 or latest available year



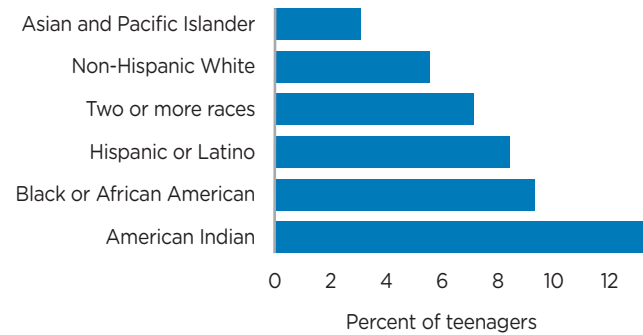
Source: Adapted from Economic Commission for Latin America and the Caribbean. Social panorama of Latin America 2016. Santiago: ECLAC; 2017. Available from: <https://www.cepal.org/en/publications/41599-social-panorama-latin-america-2016>, on the basis of special processing of census microdatabases using REDATAM 7.

Note: The non-African-descent population does not include people who self-identify as Indigenous or whose ethnic/racial status is unknown.

in employment or education, as shown in Figure 4.31. In many countries, the rates for women of African descent are double that of men.

Figure 4.32 shows similar inequalities along ethnic lines in education and labor force participation among young people in the United States of America, with the highest rates of nonparticipation being experienced by Native Americans and African Americans.

Figure 4.32.
Persons between age 16 and 19 who are not enrolled in school (full- or part-time) and not employed (full- or part-time), by race and ethnicity, in the United States of America, 2016



Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, 2008–2016 American Community Survey. Available from: <https://www.prb.org/u-s-census-and-the-ac/s/>.

Examples of policies and programs to support the unemployed and reduce inequalities in risk

For countries with limited social protection (discussed further in Recommendation 7), it is vitally important to increase the length of time for which support is available and ensure that the self-employed are covered. Increasing protection in this way will have significant health equity impacts and ensure fewer people are destitute.

Providing training and education and work experience during periods of unemployment can reduce length of unemployment, support people's social status, and reduce health harm from unemployment.

Active labor market programs (ALMPs). Government-funded programs to help people find work have been implemented in the United States of America 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.¹

There are a number of significant programs across the Region to help unemployed people find work and to provide some income support.²

The Red CIL - PROEmpleo, Peru. Established in 1996, this program is targeted at employers and unemployed individuals, with priority given to those with low educational attainment. It supports better job matching and information related to the skills required in a particular labor market. The program provides job-search assistance to jobseekers through counseling activities. In 2006, 23,642 jobseekers found a job, corresponding to 28 percent of the jobseekers registered in the program and 68 percent of the vacancies posted.³

Empleo en Acción, Colombia. This is a public works program implemented between 2002 and 2004 to mitigate the effects of the 1990s economic crisis. The program aimed to create temporary jobs for low-skilled individuals in public infrastructure sectors in low-income areas of the country. The program financed wage costs and the costs of the materials needed. Individuals recruited were unemployed, low-income adults. The maximum length of participation was five months for part-time workers. A total of 3,724 projects were funded through this program.³

Chile Joven. Since 1991, this program in Chile has been targeted at the young, low-income, poorly educated population. The programs provided training in lower-skilled trades, social-emotional skills, and on-the-job training. The program also provided job-matching services. Evaluations show the programs had positive impacts on employment prospects and job quality (measured by wages, social security, and/or formality), and have had significant positive impacts in employment for women and young people. The results of these programs in Latin America are slightly better than the impacts of similar job training projects in the United States of America and Europe.⁴

The Human Employment and Resource Training Agency, Jamaica (HEART). Formed in 1982, it has focused primarily on stimulating economic growth and job creation through the development of a skilled, productive, competitive work force. It operates 27 technical and vocational education and training locations, providing training to all Jamaicans but focusing on persons who recently left secondary school and on employed people who require training.⁵

Sources: ¹ Economic Commission for Latin America and the Caribbean. Statistical yearbook of Latin America and the Caribbean 2011. Santiago: ECLAC; 2011. Available from: <https://www.cepal.org/en/publications/926-anuario-estadistico-america-latina-caribe-2011-statistical-yearbook-latin-america>.

² Organisation for Economic Cooperation and Development; Economic Commission for Latin America and the Caribbean; Central Development Bank of Latin America. Latin American economic outlook 2017: youth, skills and entrepreneurship. Santiago: ECLAC; 2016. Available from: <https://www.cepal.org/en/publications/40722-latin-american-economic-outlook-2017-youth-skills-and-entrepreneurship>.

³ International Labour Organization. What works: active labour market policies in Latin America and the Caribbean. Geneva: ILO; 2016. Available from: https://www.ilo.org/global/research/publications/WCMS_492373/lang--en/index.htm.

⁴ United Nations Educational, Scientific and Cultural Organization. Chile Joven, job training programs in Latin America [Internet]; 2016. Available from: <https://unevoc.unesco.org/go.php?q=Promising+practices+Archives&id=6>.

⁵ HEART Trust/NTA. Training & Human Resource Development. About [Internet]; [cited 27 Nov 2018]. Available from: <https://www.heart-nta.org/about/>.

(continued on next page)

Examples of policies and programs to support the unemployed and reduce inequalities in risk *(continued)*

Canada's Employment Insurance (EI) program is central to the country's social protection system. Its primary objective is to support those who want to work but cannot find a job.⁶ Since the program's last major reform in 1996, EI has provided financial support and active labor market policy measures.⁷ There is a specific program for Indigenous peoples.

The Workforce Innovation and Opportunity Act (WIOA), United States of America. WIOA was introduced in 2014. Drawing on the evidence on what works in job training programs, WIOA aligns training with needed skills, matches employers with qualified workers, and promotes the use of career pathways and sector partnerships to increase employment in in-demand industries and occupations. WIOA serves 20 million Americans per year. The Act also supports local training and transitional jobs and promotes work-based training.⁸

Technical and Vocational Education and Training (TVET), Barbados is an education program to prepare students, jobseekers, the employed, and the self-employed for employment.⁹

Sources: ⁶ Brisson M. Employment insurance and active labour market policies in Canada. Ottawa: University of Ottawa, Graduate School of Public and International Affairs; 2015. Available from: <https://ruor.uottawa.ca/bitstream/10393/32604/1/BRISSEON,%20Michael%2020155.pdf>.

⁷ Council of Economic Advisers Issue Brief. Active labor market policies: theory and evidence for what works [Internet]; December 2016 [cited 26 Nov 2018]. Available from: https://obamawhitehouse.archives.gov/sites/default/files/page/files/20161220_active_labor_market_policies_issue_brief_cea.pdf.

⁸ U.S. Department of Labor, Employment and Training Administration. The Workforce Innovation and Opportunity Act. Highlights of WIOA reforms to the public workforce system [Internet]; 22 July 2014 [cited 26 Nov 2018]. Available from: https://wdr.doleta.gov/directives/attach/TEN/WIOA_Factsheet_Acc.pdf.

⁹ TVET Council Barbados. About TVET Council [Internet]; [cited 27 Nov 2018]. Available from: <https://www.tvetcouncil.com.bb/About/WhatisTVET.aspx>.

5C. REDUCE GENDER INEQUALITIES IN ACCESS TO WORK, PAY, AND SENIORITY

There are persistent gender inequalities related to access and quality of employment and in pay levels across the Region of the Americas, as discussed previously. These inequalities have multiple and cumulative inequity impacts, including health, income, and social position throughout life; moreover, these inequities are likely to be passed through to subsequent generations.

In general, women experience higher rates of unemployment, informal employment, and wage discrimination than men. Figure 4.33 shows unemployment rates by sex. In most countries, the female unemployment rate is higher than the male rate.

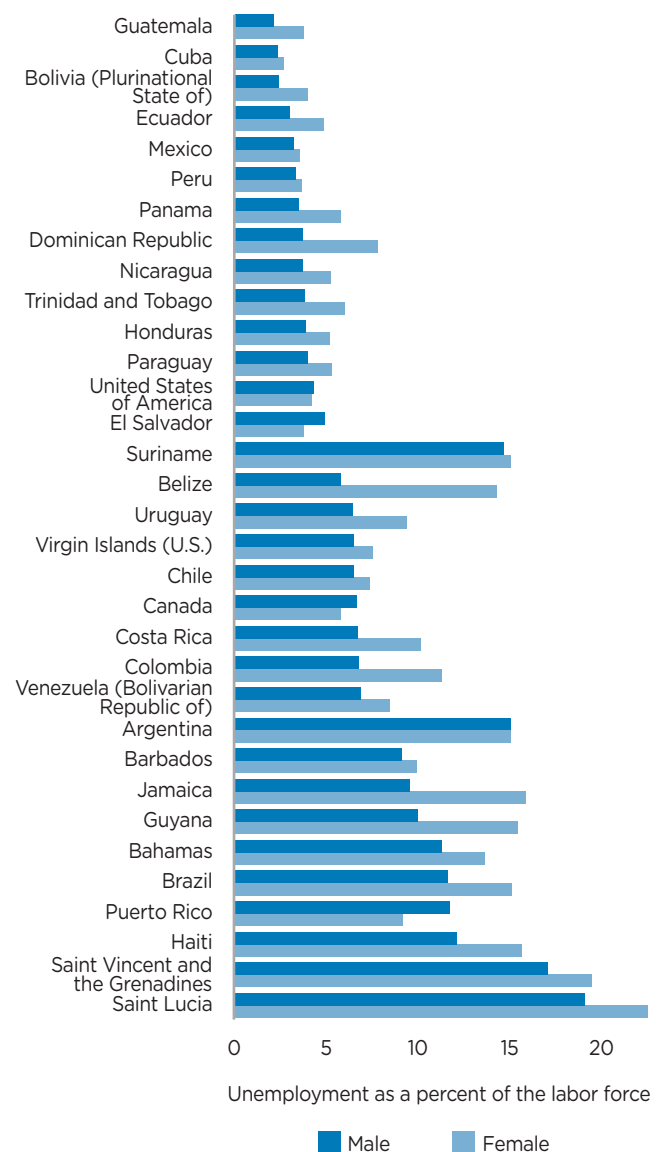
The ILO has estimated that if there were a 25-percent reduction in the gender employment gap by 2025, it would increase GDP in Latin American countries by 4 percent, and in Canada and the United States of America by 2 percent (212).

Some employment gender inequalities are linked to the fact that women undertake a higher proportion of unpaid caring responsibilities as compared to men. The consequences of this, including higher rates of unemployment and informal work, pay discrimination, and lack of access to social protections including pensions, all impact on women’s physical and mental health throughout life.

There is evidence that low control among women in unpaid domestic work is associated with a higher risk of burnout, decreased self-rated health, affective or mood disorders, and coronary heart disease (213–216).

Where women are in employment, there are significant inequalities in levels of pay compared with those for men, even for women with the same level of qualifications and at the same job level. Figure 4.34 shows the gender wage gap in a selection of countries in North, Central, and South America. Among the countries shown, Costa Rica has the smallest gap, indicating what is possible in reducing the pay gap between men and women. Figure 4.35 shows that in the United

Figure 4.33.
Unemployment rate (percent) by sex, Region of the Americas, 2017

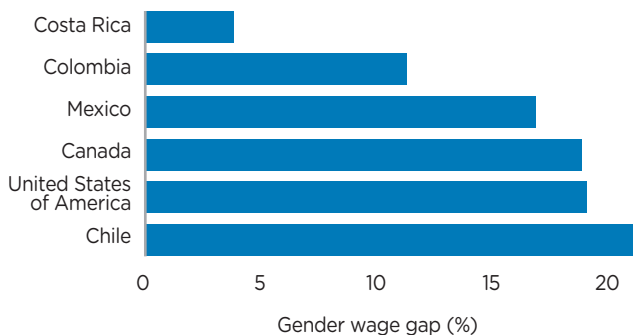


Source: International Labour Organization. ILOSTAT: key indicators of the labour market [Internet]; [data retrieved September 2018]. Available from: https://www.ilo.org/ilostat/faces/ilostat-home/home?_adf.ctrl-state=g43s30d0n_4&_afLoop=1927002885072191#.



Female worker inspecting manufacturing equipment

Figure 4.34.
Gender wage gap, selected countries in the Americas, 2015



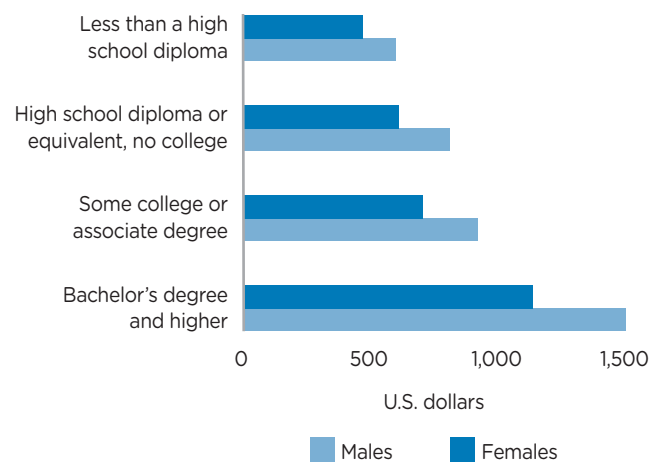
Source: Organisation for Economic Cooperation and Development. Labour statistics [Internet]; 2018. Available from: <http://www.oecd.org/sdd/labour-stats/>.

Note: The gender wage gap is defined as the difference between the median earnings of men and of women as a proportion of the median earnings of men.

States of America, women earn less than men at every education level.

Despite high levels of inequality in pay and seniority related to gender, a number of countries across the Americas have constitutional guarantees for the right to equal pay for equal work based on gender (Figure 4.36). Clearly, more regulatory mechanisms

Figure 4.35.
Median weekly earnings of full-time wage and salary workers by educational attainment and sex, United States of America, 2018



Source: U.S. Bureau of Labor Statistics. BLS. Weekly and hourly earnings data from the Current Population Survey. Table 5. Quartiles and selected deciles of usual weekly earnings of full-time wage and salary workers by selected characteristics, fourth quarter 2018 averages, not seasonally adjusted [Internet]; [cited 22 Nov 2018]. Available from: <https://www.bls.gov/news.release/wkyeng.t05.htm>.

and enforcement are required in those countries, while those that lack such guarantees need to strengthen rights to equal pay.

Figure 4.36.

Does the constitution guarantee the right to equal pay for equal work based on gender (as of 2014)?



Source: World Policy Analysis Center. Does the constitution guarantee the right to equal pay for equal work? [Internet]; 2018. Available from: <https://www.worldpolicycenter.org/policies/does-the-constitution-guarantee-the-right-to-equal-pay-for-equal-work/does-the-constitution-guarantee-the-right-to-equal-pay-for-equal-work-based-on-gender>.

Examples of programs and policies to reduce gender inequalities in access to work, pay, and seniority

Women’s Bureau, United States of America. Established in 1920, the Women’s Bureau develops policies and standards and conducts inquiries to safeguard the interests of working women; to advocate for their equality and economic security for themselves and their families; and to promote quality work environments. It is the only federal agency mandated to represent the needs of wage-earning women in the public policy process.¹ Recently, the Women’s Bureau has been working to empower all working women to achieve economic security by preparing them for higher-paying jobs, promoting equal pay, promoting workplace flexibility, helping women veterans reintegrate into the work force, and helping vulnerable women.²

The Federal Plan for Gender Equality, Canada. It recognizes the many different intersecting experiences for women in Canada related to gender, and also to age, race, class, national and ethnic origin, sexual orientation, mental and physical disability, region, language, and religion. The Federal Plan recognizes that equality can be achieved only by valuing this diversity.³ Objectives of the Federal Plan include⁴:

1. Implement gender-based analysis throughout federal departments and agencies.
2. Improve women’s economic autonomy and well-being.
3. Improve women’s physical and psychological well-being.
4. Reduce violence in society, particularly violence against women and children.
5. Promote gender equality in all aspects of Canada’s cultural life.
6. Incorporate women’s perspective in governance.
7. Promote and support global gender equality.
8. Advance gender equality for employees of federal departments and agencies.

Sources: ¹ U.S. Department of Labor. Women’s Bureau. Washington, D.C.: U.S. Department of Labor; 1990.

² U.S. Department of Labor. Women’s Bureau: our history [Internet]; [cited 26 Nov 2018]. Available from: https://www.dol.gov/wb/info_about_wb/interwb.htm.

³ Statistics Canada; Status of Women Canada. Setting the stage for the next century: the federal plan for gender equality. Ottawa: Statistics Canada; 1995. Available from: <http://www.cwhn.ca/en/node/21852>.

⁴ Government of Canada. Action plan on gender-based analysis (2016–2020) [Internet]; [cited 28 Nov 2018]. Available from: <https://cfc-swc.gc.ca/gba-ac/plan-action-2016-en.html>.

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 (International Labour Organization, 2011).

PAHO Resolutions

Plan of Action on Workers’ Health (CD54.R6 [2015])

Sustainable Development Goals

Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

Goal 5. Achieve gender equality and empower all women and girls

Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

Goal 9. Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation

Goal 10. Reduce inequality within and among countries

RECOMMENDATION 6.

DIGNIFIED LIFE AT OLDER AGES

The Region of the Americas has the fastest-growing population of older people out of all the world's regions. It is estimated that by 2050, approximately 25 percent of the population of Latin America and the Caribbean will be aged 60 years or over, while in Canada and the United States of America, that figure will be 29 percent and 32 percent, respectively (217). This section shows that there are profound inequalities across the Americas in people's health and experiences, living conditions, and economic situations during older age. This section also outlines how policies and interventions can help narrow this gap.

Among older people, there are inequalities among groups defined by socioeconomic circumstances, gender, ethnic identity, and disability, in terms of income and wealth, living conditions, levels of social interaction, and physical activity. The result is inequity in length of life, physical and mental health, and well-being. These remediable inequalities—inequities—are driven by inequalities in experiences earlier in life (as described in Recommendations 4 and 5), as well as by conditions experienced during later life.

Fulfilling people's right to live a dignified life in older age is central to reducing health inequalities in the Region, and there is much that can be done to achieve this. Reducing inequalities in later life, including health inequalities, requires that proportionately more resources are directed at those populations experiencing the worst outcomes in this life stage. The *World Report on Ageing and Health* (218) proposes that expenditure on older persons should be considered not as a cost but as an investment; the societal and economic costs of not taking action are high.

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 multisector 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 noncontributory 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 peoples
6C. Increase the focus of health care systems on prevention, and promotion of healthy, active aging	<ul style="list-style-type: none"> Develop multisector 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



Residents sitting on a bench in the Plaza de Armas, Arequipa, Peru

DEMOGRAPHIC CHANGES

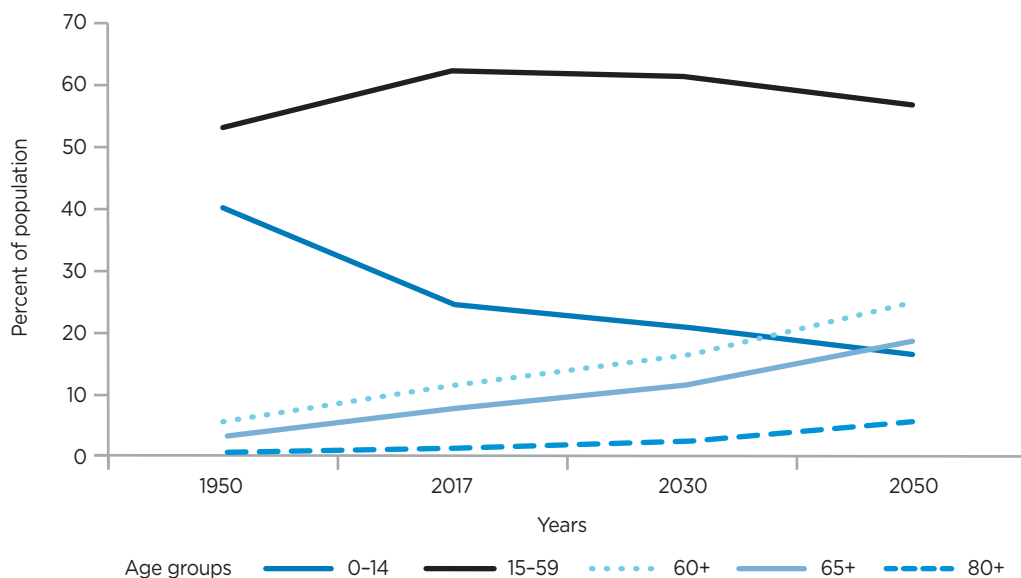
In the Americas, increasing life expectancy is contributing significantly toward current and projected increases in the size of populations aged 65 and over (21). Figure 4.37 shows trends in relative proportions of the population by age

in Latin America and the Caribbean, revealing significant increases in the proportion of people at age groups 60 and over and decreases in the proportion under 60 (217).

In both Canada and the United States of America, the proportions of the population aged 65 and

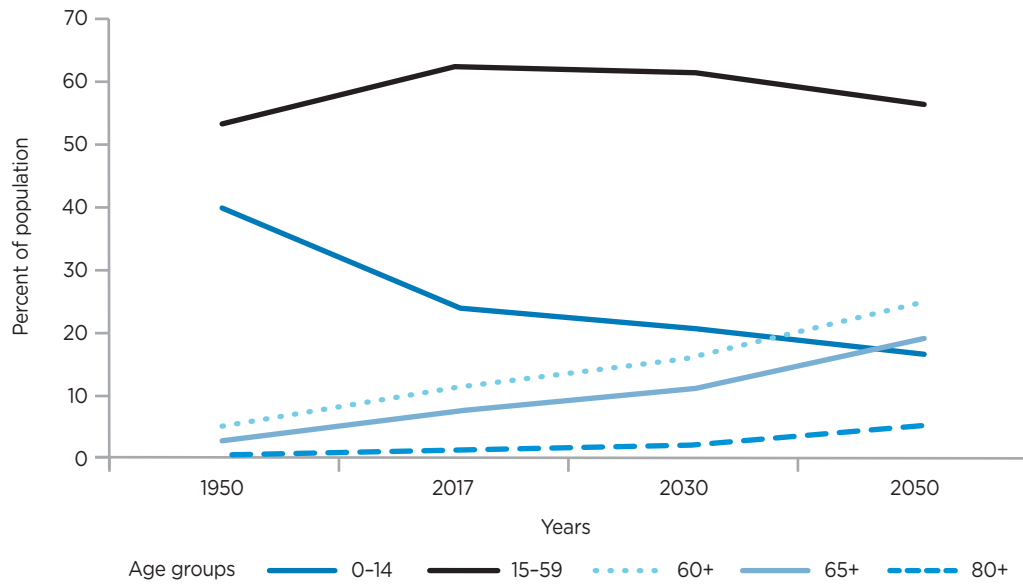
Figure 4.37.

Age distribution of population, Latin America and the Caribbean, 1950-2050



Source: United Nations. Profiles of ageing 2017 [Internet]; [cited 28 Nov 2018]. Available from: <https://population.un.org/ProfilesOfAgeing2017/index.html>.

Figure 4.38.
Age distribution of population, Canada, 1950-2050



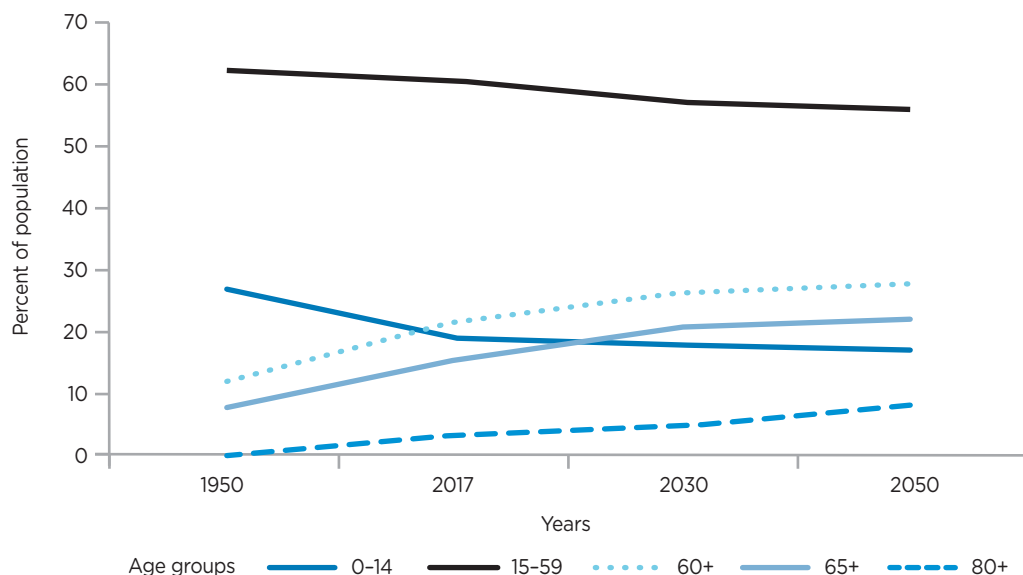
Source: United Nations. Profiles of ageing 2017 [Internet]; [cited 28 Nov 2018]. Available from: <https://population.un.org/ProfilesOfAgeing2017/index.html>.

over and 85 and over are also projected to increase significantly through 2050 (Figures 4.38 and 4.39).

The changing demographic profile in the Americas will have profound impacts on economic, social, political, and cultural factors, as well as on patterns

and experiences of aging across the Region. As shown in Section 2, experiences in later years are markedly different across the Americas. This includes how long people can expect to live, how long they can expect to live in good health, and the conditions in which they live. Within countries, there

Figure 4.39.
Age distribution of population, United States of America, 1950-2050

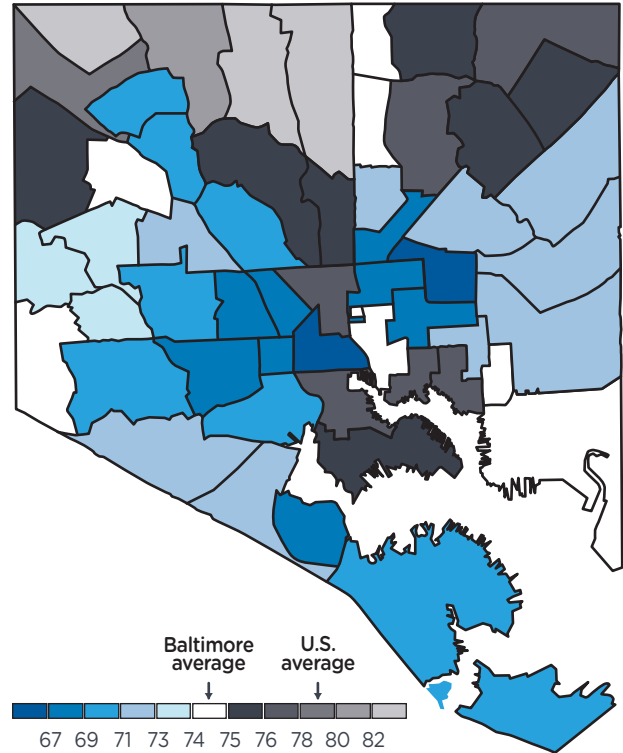


Source: United Nations. Profiles of ageing 2017 [Internet]; [cited 28 Nov 2018]. Available from: <https://population.un.org/ProfilesOfAgeing2017/index.html>.

are marked inequalities in life expectancy. In Brazil in 2013, for example, life expectancy at birth for women and men in the richest areas was five years more than in the least wealthy areas, and the loss of healthy life years was much higher among residents of the poorest regions (279). Stark inequalities can exist even within small geographic areas. In the U.S. city of Baltimore in 2014, there was a 19-year gap in life expectancy between the most disadvantaged neighborhoods and the wealthiest, as shown in Figure 4.40 (220).

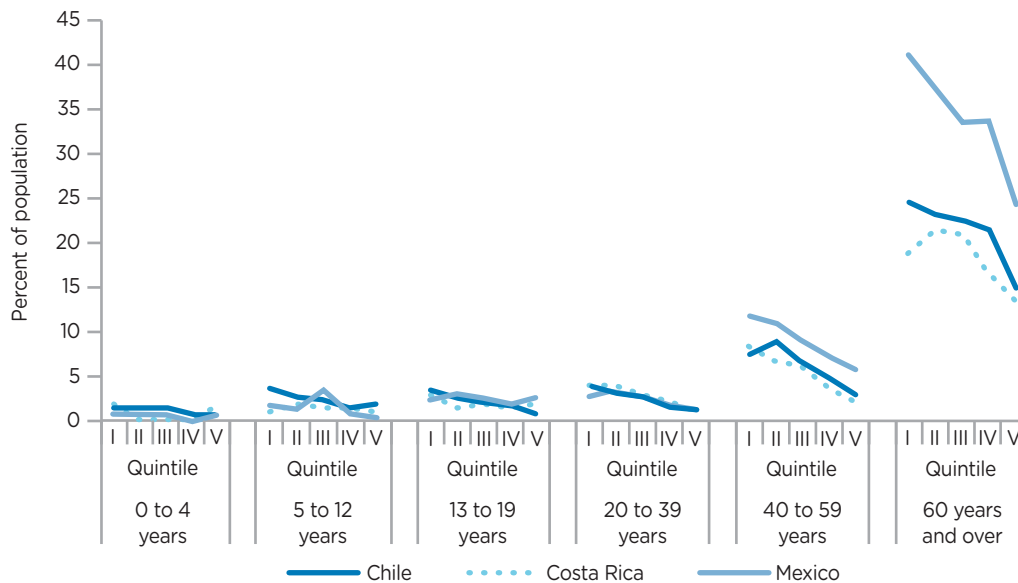
A recent study in Brazil found differences in health related to socioeconomic position, and a higher prevalence of disability in the group with lower educational attainment (279). Figure 4.41 shows the significance of income for level of disability in three Latin American countries. In this graph, quintile I is the lowest income quintile and quintile V the highest. Income inequalities in disability deepen as people age.

Figure 4.40.
Life expectancy by neighborhood, Baltimore, Maryland, United States of America, 2014



Source: Ingraham C, Washington Post. 14 Baltimore neighborhoods have lower life expectancies than North Korea [Internet]; 30 April 2015. Available from: <https://www.washingtonpost.com/news/wonk/wp/2015/04/30/baltimores-poorest-residents-die-20-years-earlier-than-its-richest/>.

Figure 4.41.
Percent of population with disabilities by age and income quintile, Chile, Costa Rica, and Mexico, 2011



Source: Economic Commission for Latin America and the Caribbean. The social inequality matrix in Latin America. Santiago: ECLAC; 2016. Available from: https://repositorio.cepal.org/bitstream/handle/11362/40710/1/S1600945_en.pdf.

Note: Quintile V is the highest income.



Men playing dominoes in Little Havana, Miami, USA

6A. CREATE CONDITIONS FOR ACTIVE AND ENGAGED AGING, WITH SOCIETY VALUING CONTRIBUTIONS OF OLDER PEOPLE

Societies in which older people’s contributions are valued, and in which older people continue to live active and engaged lives, are healthier, with higher levels of well-being (221). However, the opportunities for older people to live active and engaged lives are not equally distributed. They depend on the functioning of communities, people’s living conditions, the formal and informal financial and other forms of support available, physical and mental health, family relationships, social interactions, levels of education, and personal resources—including wealth and income—both during later life and also earlier in life.

Cumulative exposure over the life course to social and material disadvantage, as well as illiteracy or lack of education, are associated with depression in later life for men and women in Latin America and the Caribbean, and psychosocial adversity contributes to physiological changes that increase susceptibility to depression (222). While women can expect to live longer than men in every country in the Americas (see Section 2, Figure 2.1), they spend more of their longer lives in ill health—and

women tend to have higher rates of depression than men in later life. Material disadvantage and social and health conditions explain the higher frequency of depression in women (222).

Being socially isolated causes psychological and physical harm, and poor mental and physical health are both a cause and consequence of social isolation. Among older people in the Region, there are relatively high levels of social isolation.

Approximately 12 percent of people 65 and over in the United States of America reported in 2010 that they rarely or never received the social or emotional support they needed, and individuals age 60 years or older with low socioeconomic position were more likely to feel lonely than were people with higher socioeconomic position (223). Those who reported feeling lonely were found to be at greater risk of functional decline and death than those who were not lonely (223). Inequalities in the risk and rates of social isolation are related to income, education level, physical and mental health, and gender: in later life, men tend to be more socially isolated than women.

In countries with larger, younger populations, the majority of older persons still tend to live in multigenerational households, which lowers their risk of social isolation and resultant harm to health and well-being. However, as populations age, the percentage of older persons living alone increases. In Central American countries, for example, only 10 percent to 23 percent of older adults currently live alone, while in Argentina and Uruguay, which have greater proportions of their populations in the older age groups, over 50 percent live alone (224).

Many older people with lower socioeconomic position in the Americas live in poor-quality housing, without safe drinking water, modern sanitation, or bathrooms. These conditions impact directly on older people’s health. Moreover, these environments may not be conducive to social integration, and may reduce opportunities for exercise, mobility, or preventing ill health, rather than supporting older people to remain active and participate in social life or the community.

A systematic global review in 2005, assessing evidence of impacts, concluded that educational and social activity group interventions that target specific groups can alleviate social isolation and loneliness among older people (225). Indeed, reviews of health promotion interventions aimed at reducing social isolation in the elderly suggest that interventions with group-based formats and where individuals are required to actively participate are more effective than one-to-one interventions. In addition, involving the study participants in the planning, implementation, and evaluation of policies, with high-quality training of facilitators and interventions based on existing community resources, seems to increase the success of outcomes (226).

Examples of policies and programs to create conditions for active and engaged aging

Communities that are supportive of health are those that enable and encourage older people to interact socially and to participate in and contribute to community life. Such communities have good levels of physical activity, decent-quality housing, and access to leisure activities and other essential services, including health care. Policies and interventions to reduce inequities in later life need to be integrated across economic, social, cultural, and health domains, and need to seek to improve a broad range of conditions for older people.

Age-friendly communities. The goal of age-friendly communities is to support the independence and engagement of older people. They aim to offer access to transport, good-quality housing, outdoor spaces, communication and information sources, employment opportunities, community support, and health services, as well as encourage social and civic participation, respect, and social inclusion. The WHO global age-friendly cities network and program, established in 2006, supports and helps facilitate age-friendly communities.¹

Age-friendly communities, Canada. Since 2007, these communities have been set up across Canada, including in many remote, rural localities. There is an age-friendly community in Ottawa that provides age-friendly social and physical infrastructure in the city. There has been a focus on promoting the positive activities and assets of older people, where 60 percent of seniors provide care for another person, 36 percent volunteer, and 11 percent work. Infrastructure and services provided in Ottawa include additional benches, age-friendly parks, improved accessibility and safety in municipal housing, improved sidewalk maintenance and pedestrian safety audits, falls prevention schemes, physical education, health literacy workshops, peer-led socialization in seniors housing, and education sessions.²

Sources: ¹ World Health Organization. Age-friendly world [Internet]; 2018. Available from: <https://extranet.who.int/agefriendlyworld/>.

² Public Health Agency of Canada. Age-friendly communities [Internet]; 2015. Available from: <https://www.canada.ca/en/public-health/services/health-promotion/aging-seniors/friendly-communities.html>.

(continued on next page)

Examples of policies and programs to create conditions for active and engaged aging (continued)

Age-friendly policies, Guaymallén, Argentina. This urban area has been working on the development and implementation of different age-friendly policies to promote healthy and active aging for older adults.¹ Its programs provide care for older adults living on the streets; legal advisory services for older adults suffering from abandonment and/or abuse; promotion and protection of human rights for older adults; health care workshops; cultural and sports workshops; training workshops for older adults; legal advice for organizations of older adults; and development of a space where older adults can debate all public policies and proposals that will be implemented in the city.³

Examples of programs to support physical and mental activity for older people from the Region include:

Lifestyle Interventions and Independence for Elders (LIFE) study, United States of America. This randomized trial ran from 2010 to 2011. Participants were recruited from urban, suburban, and rural communities at eight centers throughout the United States of America, consisting of men and women with sedentary lifestyles aged 70–89 years who had physical limitations.⁴ It was found that a structured moderate-intensity physical activity program was more effective than a health education program, reducing major mobility disability by over 2.6 years among older adults at risk of disability. These findings suggest mobility benefits from such programs for vulnerable older adults.⁴

More Self-sufficient Senior Citizens [*Más Adultos Mayores Autovalentes*], Chile. This program aims to preserve functioning through a preventive, community-based approach to functional stimulation. The program targets older adults who have been classified at risk of dependence. The program is present in nearly half of the districts in Chile, with ongoing expansion. A 2016 study indicated that the program had a positive effect on cognitive skills of attention, memory, language, executive functions, and visuospatial abilities, but the effect was not statistically significant.⁵

Sources: ³ World Health Organization; Public Health Agency of Canada; Ministry of Health of British Columbia. Global age-friendly cities project [Internet]; 2010. Available from: https://www.who.int/ageing/projects/age_friendly_cities/en/.

⁴ Pahor M, Guralnik JM, Ambrosius WT, Blair S, Bonds DE, Church TS, et al. Effect of structured physical activity on prevention of major mobility disability in older adults: the LIFE study randomized clinical trial. *JAMA*. 2014 Jun;311(23):2387–96.

⁵ Thumala D, Kennedy BK, Calvo E, Gonzalez-Billaut C, Zitko P, Lillo P, et al. Aging and health policies in Chile: new agendas for research. *Health Sys Reform*. 2017;3(4):253–60.

6B. INCREASE PROVISION OF PENSIONS THROUGH GOVERNMENT SUBSIDIES, PARTICULARLY FOR THOSE MOST AT RISK OF HAVING NO INCOME IN LATER LIFE

As set out in previous sections, socioeconomic position is of central importance in shaping life expectancy, healthy life expectancy, and quality of life for people across the Region of the Americas. As people age and become unable to work, either through physical limitations or lack of employment opportunities, income from employment decreases or ends. Moreover, in areas where people produce their own food, their ability to subsist can be undermined through physical limitations.

Poverty in older age is widespread across Latin America and the Caribbean, Canada, and the United States of America. Risk of poverty in later

life is related to socioeconomic position in earlier life, gender, ethnicity, and health status. Reducing inequalities in risk, and overall levels of poverty for



Senior posing in front of her home, Philadelphia, USA

older people, requires effective and sufficient social protection systems, mainly in the form of pensions, support for people with a disability, and assistance for caring roles. Indeed, provision of pensions is usually the only protection against poverty and destitution among older people without property, family able to support them, or other sources of income and wealth.

In the United States of America in 2014, nearly 15 percent of older people lived below the official poverty threshold (227). The distribution of poverty in the country—and across the Region—is unequal. In terms of inequalities related to ethnicity, in the United States of America, 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 (228). There are significant differences in rates of poverty related to gender, too. In the United States of America on average, older women received about US\$ 4,500 less annually in Social Security benefits in 2014 than did older men, due to lower lifetime earnings and time taken off for caregiving (227).

Health, Well-being, and Aging (Salud, Bienestar y Envejecimiento (SABE)) is a cross-national survey on health and aging carried out in Argentina, Barbados, Brazil, Chile, Cuba, Mexico, and Uruguay (229). Almost 50 percent of the older people interviewed for the SABE study said that they did not have the financial means to meet their daily needs, and one-third did not have a pension or a paying job.

There is unequal pension coverage in Latin America and the Caribbean. Countries with

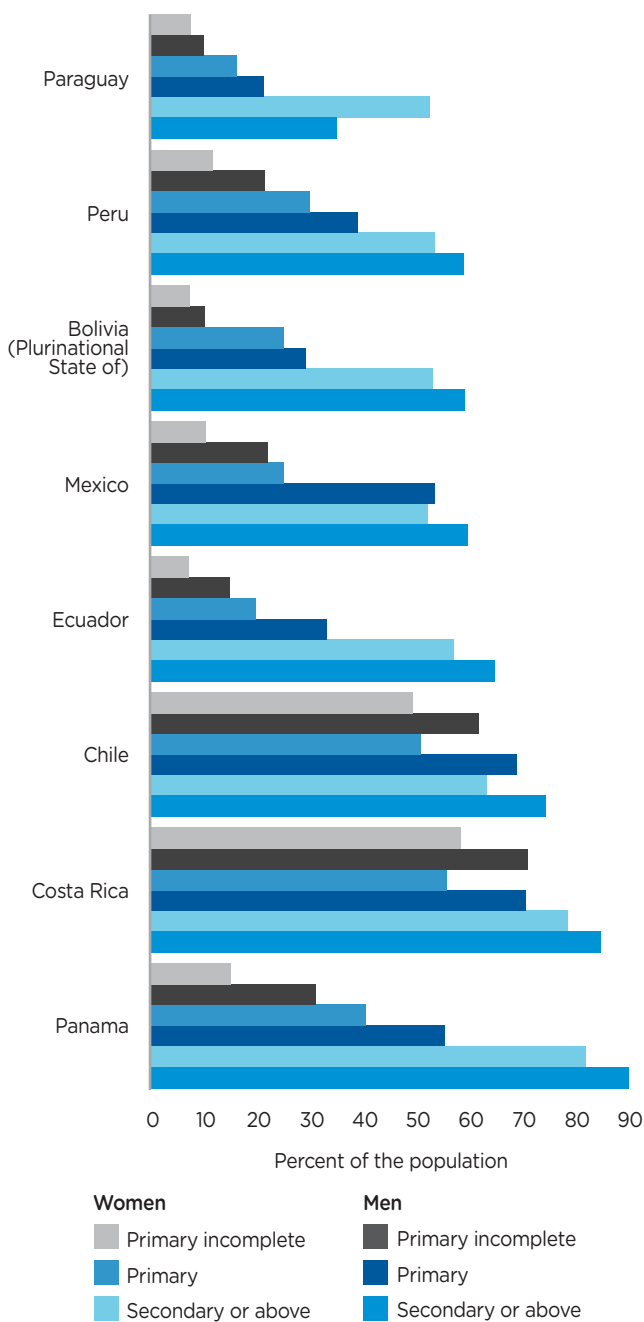
relatively high levels of coverage in 2014 included Argentina and Chile (both 55 percent) and Brazil and Uruguay (both 78 percent) (230). An analysis of the impact of pension systems on poverty shows that the pension systems in Argentina, Brazil, Chile, and Uruguay play an important role in alleviating old-age poverty, eradicating it almost completely. The strongest impact occurs in Brazil: while only 3.7 percent of Brazilians older than 60 are poor, 47.9 percent of them would be poor without pensions (if all other factors were kept constant) (230).

Pension systems in Latin American and Caribbean countries are often contributory systems. In these kinds of employment-based schemes, only people with a stable formal job have access to a pension upon retirement (4). In most countries in the Region, large proportions of people are employed in the informal sector.

Figure 4.42 depicts inequalities in access to pensions by education and sex in selected countries in Latin America. Highly educated men have the greatest access, and for each country except Costa Rica, women with low education have the least access.

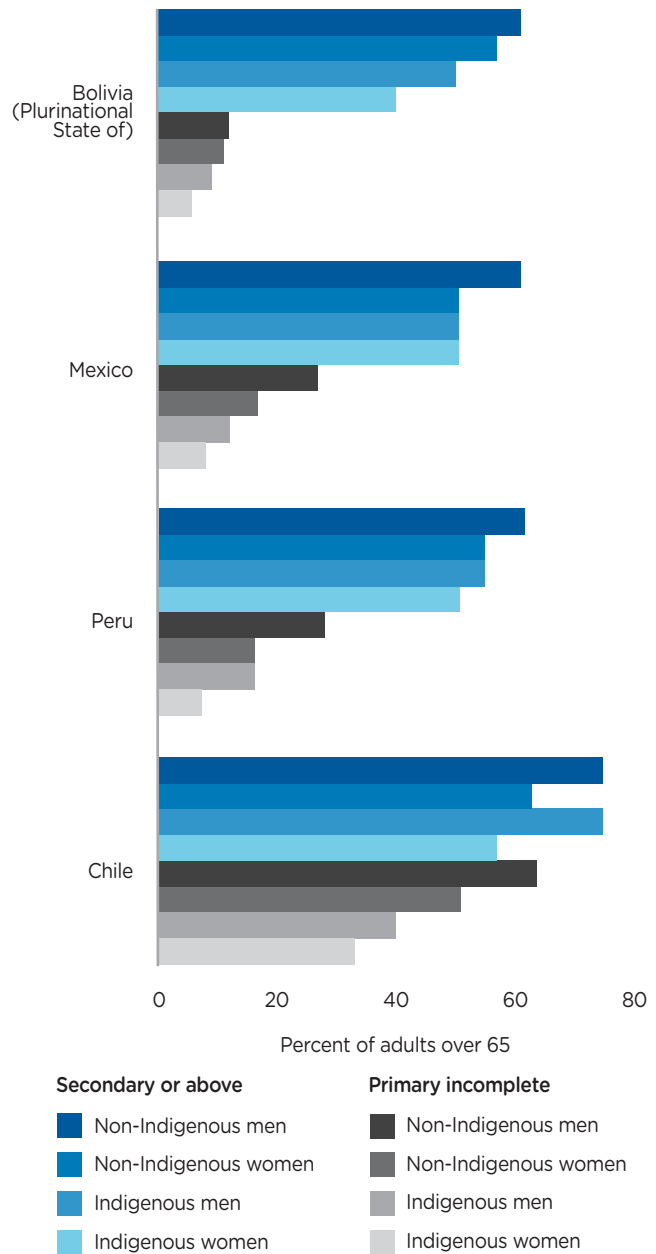
Older Indigenous people have low levels of access to pensions in Latin America and the Caribbean (29). Figure 4.43 shows that in four Latin American countries, non-Indigenous men had the highest rates of pension coverage in 2014, and Indigenous women the lowest. For all ethnic groups, pension coverage is closely related to education level.

Figure 4.42.
Percent of population receiving a pension, by education level and sex, selected countries in Latin America, 2014 or latest



Source: Economic Commission for Latin America and the Caribbean. Social panorama of Latin America 2016. Santiago: ECLAC; 2017. Available from: <https://www.cepal.org/en/publications/41599-social-panorama-latin-america-2016>.

Figure 4.43.
Percent of adults aged 65 and over receiving a pension, by sex, Indigenous identity, and education level, four Latin American countries with comparable data, 2014



Source: Based on data from Economic Commission for Latin America and the Caribbean. The social inequality matrix in Latin America. Santiago: ECLAC; 2016. Available from: https://repositorio.cepal.org/bitstream/handle/11362/40710/1/S1600945_en.pdf.

Examples of policies and programs that reduce poverty in older age groups through pensions

Rural pension program, Brazil. Established in 1963, this program has been important in reducing poverty in the poorest rural areas in Brazil. The share of elderly people in these areas receiving income from pensions is 85 percent, the result of a geographically targeted noncontributory program. These positive results highlight the potential effectiveness of noncontributory mechanisms in reducing poverty, especially in countries with a large proportion of their population excluded from formal labor markets and unable to access contributory pension systems.¹

Pension 65, Peru. Pension 65 was established in 2011 to provide economic security for adults aged over 65 years living in extreme poverty, to ensure a better quality of life and well-being. The intervention saw increases in household consumption and improvements in elderly people's emotional health, with lower depression rates. There was no evidence of increases in the use of health services by the elderly or improvements in their physical health, however.²

Pension rights in Chile. Salaried rural workers have the right to a pension in Chile, unlike most other countries in the Region. There is a basic entitlement for individuals without other pensions, payable from the age of 65 to the poorest 60 percent of the population. There is also a supplementary welfare pension targeted to individuals with low pensions, which is tax funded and not dependent on individual contributions.²

Programa 70 y Más, Mexico. Established in 2007, the pension program aimed to raise the income of the elderly and improve living conditions among adults. Beneficiaries had to be 70 years old and over and reside in localities with 2,500 or fewer inhabitants. In 2014, the number of beneficiaries was 3.9 million. A study showed a significant impact on mental health after a year.³

General Health and Social Security System (SGSSS), Colombia. SGSSS is a comprehensive pension plan, including coverage for work-related risks, supplementary social services, and the health and social security system. It includes both contributory (social security system) and subsidized (public system) programs. This ensures universal benefits through protection of the insured, the spouse, and minor children, as well as parents and other relatives. In 2007, 82 percent of Colombians aged 60 and older had subscribed to the contributory (48 percent) or subsidized (34 percent) program.⁴

Sources: ¹ Lloyd-Sherlock P, Barrientos A. Brazil's rural pension system: its development and impacts. Lessons for China. Sheffield: New Dynamics of Ageing, a UK Cross-Council Research Programme; 2010. Available from: <http://www.newdynamics.group.shef.ac.uk/assets/files/168.pdf>.

² Cavero-Arguedas D, de la Vega VC, Cuadra-Carrasco G. Los efectos de los programas sociales en la salud de la población en condición de pobreza: evidencias a partir de las evaluaciones de impacto del presupuesto por resultados a programas sociales en Perú. *Rev Peru Med Exp Salud Publica*. 2017;34(3):528-37.

³ Salinas-Rodríguez A, Torres-Pereda MP, Manrique-Espinoza B, Moreno-Tamayo K, Solís MMTR. Impact of the non-contributory social pension program '70 y más' on older adults' mental well-being. *PLoS One*. 2014;9(11):e113085.

⁴ Gómez F, Curcio CL, Duque G. Health care for older persons in Colombia: a country profile. *J Am Geriatr Soc*. 2009;57(9):1692-6.

6C. INCREASE THE FOCUS OF HEALTH CARE SYSTEMS ON PREVENTION, AND PROMOTION OF HEALTHY, ACTIVE AGING

The rapidly aging population and changing dependency ratios in the Region of the Americas, described in Section 2, pose significant challenges for many countries. They must adapt quickly, with lower revenues and a lower tax base than wealthier countries such as Canada and the United States of America, which experienced this demographic transition earlier. On the whole, the Region's health care systems were developed around a different set of demographics—for younger populations—and are unprepared to address the needs and priorities of a fast-growing older population.

In the United States of America, 66 percent of the total health care spending is directed toward care for the approximately 27 percent of the population with multiple chronic conditions, most of them older people (231). Even though there is a lack of information for Latin America and the Caribbean about the prevalence and impact of multiple chronic conditions, it is clear that increasing life expectancy and the aging population will push up demands on those countries' health care systems (21, 217).

A health system that is aligned to the health needs of older people has policies, plans, and programs to prevent mental ill health, improve or maintain physical capacity, prevent and manage multiple chronic conditions, and provide services and support for long-term care. Health systems should recognize that living in poverty, in poor-quality housing and environments, being socially isolated, and experiencing major life transitions such as bereavement are all significant risks for both mental and physical ill health. This is in addition to the natural processes of aging. Health care organizations need to establish ways to support action on these social and economic risks for ill health, as well as to treat ill health once it has presented (discussed further in Recommendation 10) (232).

SUPPORT FOR FAMILIES TO CARE FOR ELDERLY RELATIVES, INCLUDING THROUGH PROVISION OF LEAVE

In Latin America and the Caribbean, families are the main providers of unpaid care, and women provide 90 percent of all unpaid care. Family caregivers cut back on their paid work by up to 20 percent to provide care to older persons (221). A 2014 article on caring for Alzheimer patients in the Dominican Republic reported that about 43 percent of caregivers, mainly informal or family caregivers, showed symptoms of depression and anxiety (233).

In addition, when care is provided in conditions of poverty and when caregivers have no training, resources, or social or institutional support, elderly people are at increased risk of morbidity. In situations where caregivers are overwhelmed, the elderly who are being cared for are more likely to be neglected or abused (21). Factors that contribute to abuse of persons with dementia include poverty, low levels of education of both the victim and caregiver, social isolation, and alcohol abuse by the caregiver (234).

Across most of the Americas, there is no paid leave available to care for elderly parents, with the exceptions of Canada, El Salvador, Nicaragua, and Peru (235) (Figure 4.44). Unpaid leave is available in the United States of America.

Figure 4.44.

Availability of guaranteed leave for working women and men to care for their elderly parents' health needs, countries of the Americas, 2014



Source: WORLD Policy Analysis Center. Are working women and men guaranteed any leave for their adult family members' health needs? [Internet]; 2018 [cited 25 Nov 2018]. Available from: <https://www.worldpolicycenter.org/policies/are-working-women-and-men-guaranteed-leave-for-their-adult-family-members-health-needs/are-working-women-and-men-guaranteed-any-leave-for-their-adult-family-members-health-needs>.

Note: Map reflects laws in place as of February 2014. Leave for elderly parents' health needs includes leave specifically designated to care for adult family members' health needs. Leave for adult family members' health needs also includes cases where leave is available only for serious illnesses, hospitalization, or urgent health needs. In some cases, this leave may be limited to family members living in the same household as the worker. Leave that is only available to care for a spouse's health needs is not included in this variable. There are no countries that only guarantee leave for elderly parents' health needs to women.

Examples of policies and programs for prevention, and promotion of healthy, active aging

Supporting health system action for older people on the social determinants of health requires development of effective multisector partnerships, including between civil society and transportation, housing, basic infrastructure, and social protection systems, to work toward making improvements in the conditions in which people live.

Multisector approach to healthy aging, Canada. Responsibility for enhancing the well-being and quality of life of older people is shared across different federal departments and levels of government in Canada, and other entities. These include Canada Mortgage and Housing Corporation, Public Health Agency of Canada, and other organizations working on issues of employment and social development, health services, age-friendly communities, falls, and elder abuse. Key policy priorities at the national level for older people include addressing access to affordable housing; income security; fostering social inclusion and engagement; promoting healthy aging and improving access to health care; age-friendly communities (Recommendation 6A); injury prevention; seniors' mental health; and dementia.¹

Ten-Year Public Health Plan, Colombia, 2012–2021. The plan has a focus on aging and old age and has several strategies aimed at improving quality of life through a rights-based approach that incorporates the social determinants of health. It includes promotion of active aging and a positive old age culture for the Colombian population. It also aims to increase participation and social integration of older people.²

Ecuador has constitutional provisions for supporting older people, including that “they will receive priority and specialized care in the public and private sectors, particularly in the areas of social and economic inclusion and protection against violence.” There is a strong focus on rights for older people, including with housing, pensions, work, and free health care. The provisions specifically consider inequalities in experiences related to gender, ethnicity, location, and culture.²

Plan on the Elderly, Argentina, 2012–2016. This plan covers three areas: 1) participation in the labor market, education, politics, and recreation; 2) action on physical, social, and cultural environments that allow the exercise of rights and support well-being; and 3) promotion of health, including health care services.²

National Plan for Aging and Old Age, Uruguay, 2013. Actions included are based on the safeguarding of rights, universality, citizen participation, and the culture of aging as a desirable process. It includes programs to address violence and guarantee care.²

Sources: ¹ Canadian Medical Association. Health and health care for an aging population. Policy summary of the Canadian Medical Association. Ottawa: Canadian Medical Association; 2013.

² South American Institute of Government in Health. Population aging: challenges for health systems in South America towards a healthy aging. Rio de Janeiro: South American Institute of Government in Health; 2017. Available from: <http://isags-unasur.org/en/publicacao/population-aging-challenges-for-health-systems-in-south-america/>.

RELEVANT INTERNATIONAL AGREEMENTS

Organization of American States

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

Relevant PAHO Resolutions

Health and Aging (CSP26.R20 [2002])

Plan of Action on Disabilities and Rehabilitation (CD53.R12 [2014])

Plan of Action on the Health of Older Persons, Including Active and Healthy Aging (CD49.R15 [2009])

Strategy and Plan of Action on Dementias in Older Persons (CD54.R11 [2015])

RECOMMENDATION 7. INCOME AND SOCIAL PROTECTION

Poverty is one of the most important drivers of health inequities at every stage of life in the Americas, and its consequences, including poor nutrition, use of unsafe water and sanitary arrangements, and no, or insufficient, health care, have direct impacts on health. In the absence of absolute deprivation, relative poverty drives inequities in other social determinants of health, such as poor early child development, hazardous and poor-quality work, dilapidated housing, low levels of education, and unhealthy environmental conditions. The effects of poverty are transferred from one generation to the next. The impacts are seen in physical and mental health and inequities in health.

Many of the recommendations for action to improve health equity made in this report are oriented toward ensuring that everyone has sufficient income to lead a healthy and dignified life. In this section we provide further specific recommendations related to social protection policies that can support those who are in poverty, destitute, or at risk of poverty, by raising their income levels above the poverty threshold. Policies that provide income support to alleviate and reduce the risks of poverty can have multiple and cumulative beneficial societal outcomes: improved health, higher levels of education, greater gender parity, and, in some cases, protection for people experiencing exclusions, racism, and stigma. As such, these policies are absolutely central to reducing health

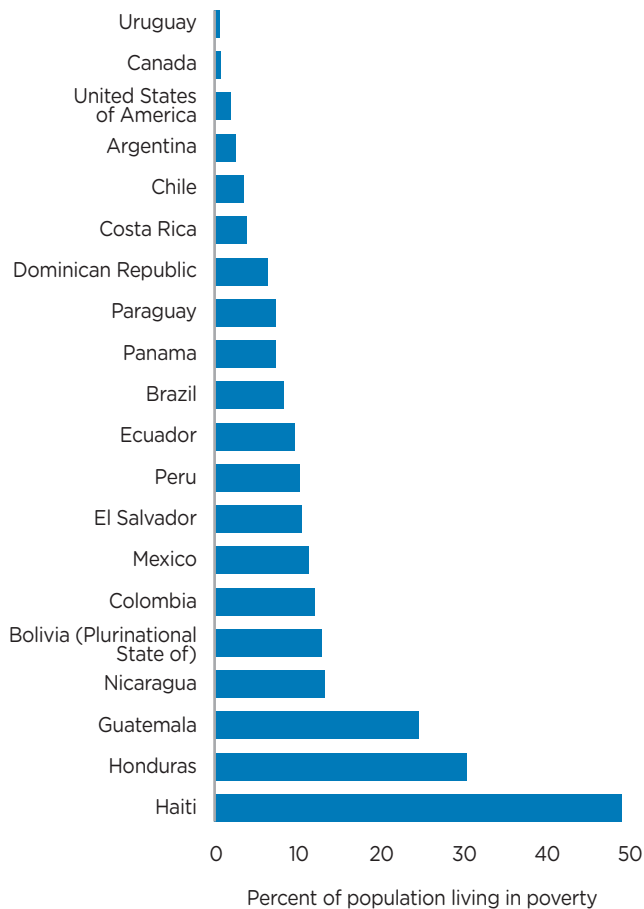
inequities in the Americas. The most effective policies are ones that are large scale, well governed, and national, and with effective targeting.

Despite recent efforts in the Region to build comprehensive social protection systems, examples of which are provided in this section, many challenges remain in the provision of universal coverage. In many countries, the social protection systems that have been established are under threat from recent social, economic, and political changes (29).

Although rates of extreme poverty fell across the Americas from 1990 to 2014 (236), the proportion of people living in poverty remains high in many

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

Figure 4.45.
Percent of population living in poverty,
selected countries in the Americas, 2016



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

Note: Living in poverty defined as US\$ 3.20 PPP a day or less.

countries (Figure 4.45). Furthermore, in many countries, the poverty rate is increasing.

Figure 4.46 shows trends in the poverty gap from 2000 to 2016, using the figure of US\$ 3.20 income a day, for selected countries with comparable data. The poverty gap is the ratio by which the mean income of the poor falls below the poverty line of US\$ 3.20 a day (counting the nonpoor as having zero shortfall).

After 2000, Argentina, Bolivia (Plurinational State of), and Colombia saw significant decreases in the size of the poverty gap. There was an increase in Honduras during and after the 2008 economic recession, and the United States of America experienced a slight increase after 2004.

Across the Region, being female means you are more likely to be in poverty. Being of Indigenous origin, of African descent, or a member of another minority ethnic group, being a child, being disabled, or living in a rural area increases the risk of poverty. These risks intersect, so that being an Indigenous woman with a disability, for instance, means the risk of poverty is amplified even more (29).

Children are usually the poorest age group in any society. Data from the Social Panorama of Latin America (4) show that in 2016, poverty affected 47 percent of children and adolescents between 0 and 14 years of age, in contrast to 31 percent among the general population. Extreme poverty affected 17 percent of children and adolescents.

GENDER AND EDUCATION

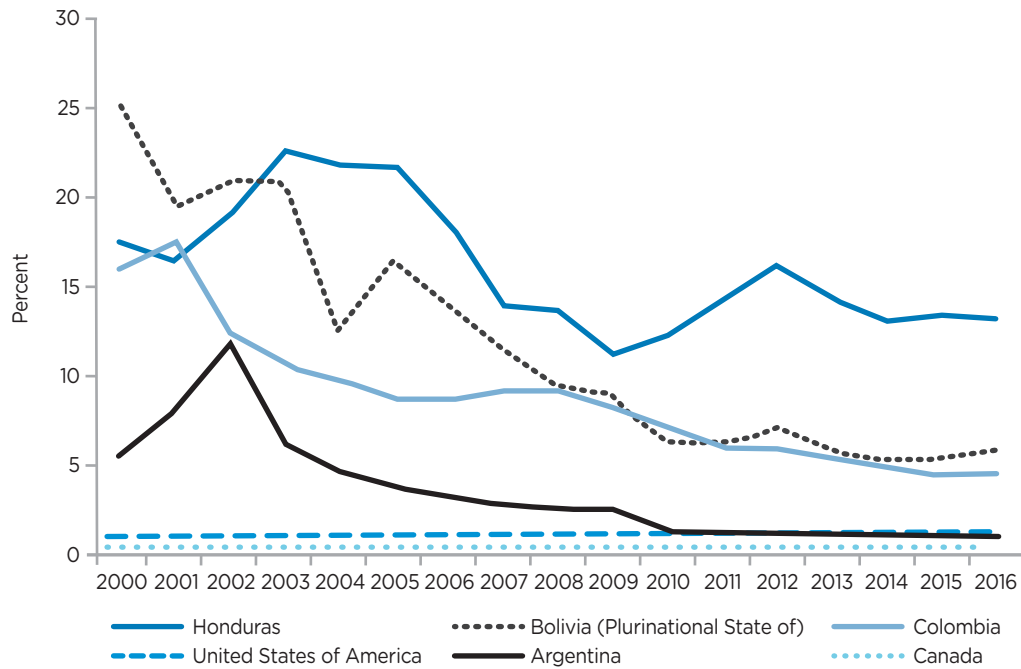
Recommendation 6 described how across the Region older women were less likely than men to have their own pension. These gender inequities in income start early and extend throughout life. Recommendation 5 described significant pay gaps between men and women across the Americas.

Women are overrepresented in the lowest two income quintiles in Latin American countries by up to 40 percent, as compared with men (4). In countries in Latin America and the Caribbean in 2015, for both quintile I (the lowest) and quintile V (the highest), women were far more likely not to have their own income, as compared with men (Figure 4.47). On average, 44 percent of women in quintile I (the lowest) lack their own income, as compared with just 23 percent of men (4). Brazil is an exception, as the situation there is similar for men and women.

There are large income inequalities across the Americas by ethnicity, as also mentioned in Recommendation 3. In Latin America and the Caribbean, average incomes are lowest for Indigenous populations, and poverty rates are also higher for those groups (Figure 4.48). In Chile, where poverty rates are low overall, there is less inequality.

Across Latin America and the Caribbean, poverty rates are also higher for people of African descent

Figure 4.46.
Poverty gap, countries in the Americas with comparable data available, 2000–2016



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

Note: Living in poverty defined as US\$ 3.20 PPP a day or less.

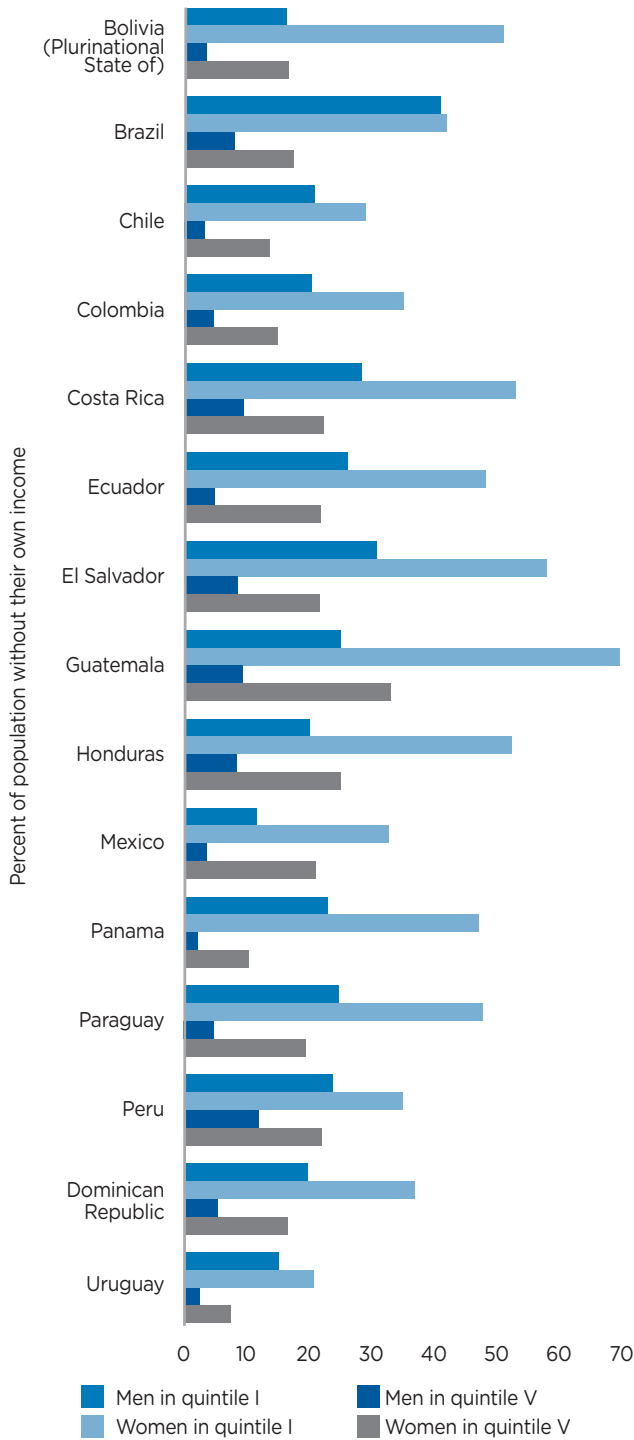
than for people who are not of African descent, as shown for selected countries in Figure 4.49.

Risks of poverty are cumulative: being female and of African or Indigenous descent significantly increases the likelihood of poverty. On average, women of African descent had incomes of just 51 percent of those of men of African descent in 2014. Similarly, average

incomes for Indigenous women were half those of Indigenous men in 2014 (4).

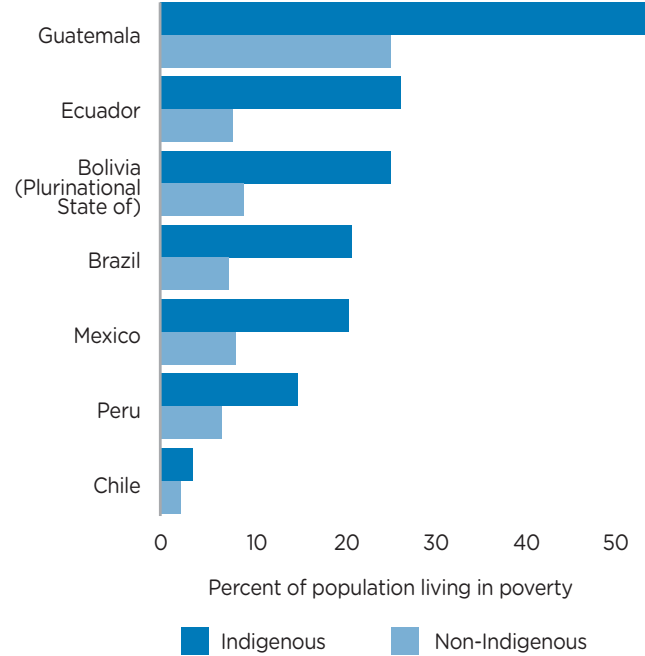
Across the Region, people with disabilities earn less than people without disabilities, and are much more likely to be living in poverty. For example, in Canada in 2012 persons aged 25 to 44 years who had a disability had 57 percent of the income reported by those without a disability (237).

Figure 4.47.
Percent of women and men without their own income, quintiles I (lowest) and V (highest), selected countries in Latin America and the Caribbean, 2015



Source: Economic Commission for Latin America and the Caribbean. The social inequality matrix in Latin America. Santiago: ECLAC; 2016. Available from: https://repositorio.cepal.org/bitstream/handle/11362/40710/1/S1600945_en.pdf.

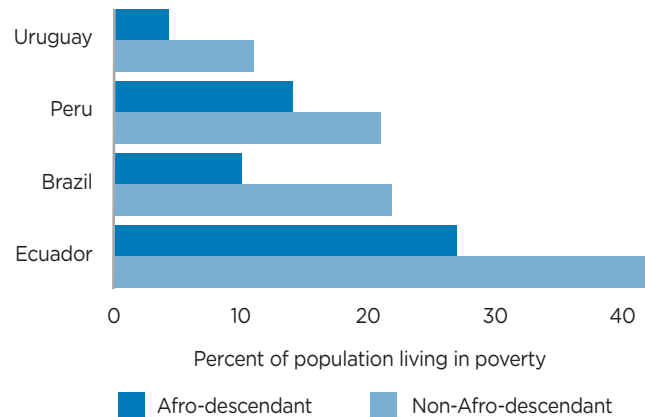
Figure 4.48.
Percent of Indigenous and non-Indigenous population living in poverty, countries in Latin America with comparable data available, 2014 or latest



Source: Freire G, Schwartz Orellana SD, Zumaeta Aurazo M, Costa D, Lundvall JM, Viveros Mendoza MC, et al. Indigenous Latin America in the twenty-first century: the first decade. Working paper 98544. Washington, D.C.: World Bank; 2015.

Note: Living in poverty defined as less than US\$ 2.50 PPP a day or less.

Figure 4.49.
Percent of African-descent and non-African-descent population living in poverty, four Latin American countries, 2014



Source: Based on data from Economic Commission for Latin America and the Caribbean. The social inequality matrix in Latin America. Santiago: ECLAC; 2016. Available from: https://repositorio.cepal.org/bitstream/handle/11362/40710/1/S1600945_en.pdf.

7A. IMPLEMENT A MINIMUM SOCIAL PROTECTION FLOOR

Social protection floors are sets of basic social security guarantees that secure government protections for people and that are aimed at preventing or alleviating poverty, vulnerability, and social exclusion (238). The International Labour Organization (ILO) defines social protection floors as “nationally defined sets of basic social security guarantees that should ensure that, as a minimum, 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” (239).

Effective social protection coverage in the Americas currently stands at only around 67 percent of the population, falling below Europe and Central Asia, where coverage is 84 percent overall, although there is wide variation among countries. Coverage of social protection refers to the proportion of population participating in social insurance, social safety net, and unemployment benefits (7). In all countries across the Region, social protection policies are insufficient to eliminate poverty and the associated risks to health. In addition, as discussed above, large proportions of the population of the Americas live in poverty, with women, children, and people of African descent, Indigenous people, and those with disability most at risk of poverty. This is, of course, not unique to the Americas. In every region of the world, a substantial proportion of the population lives in poverty (measured using a range of definitions and calculations), and in many countries the proportion is growing.

There is considerable scope for social protection policies to do more to reduce poverty levels and the risk of destitution, and, in so doing, to improve health equity and achieve other desirable goals. In a possible step toward this, 33 countries in the Americas have ratified the International Covenant on Economic, Social and Cultural Rights, which stipulates that States recognize the right of everyone to social security, including social insurance. This right “plays an important role in poverty reduction and alleviation, preventing social exclusion and promoting social inclusion” (240).

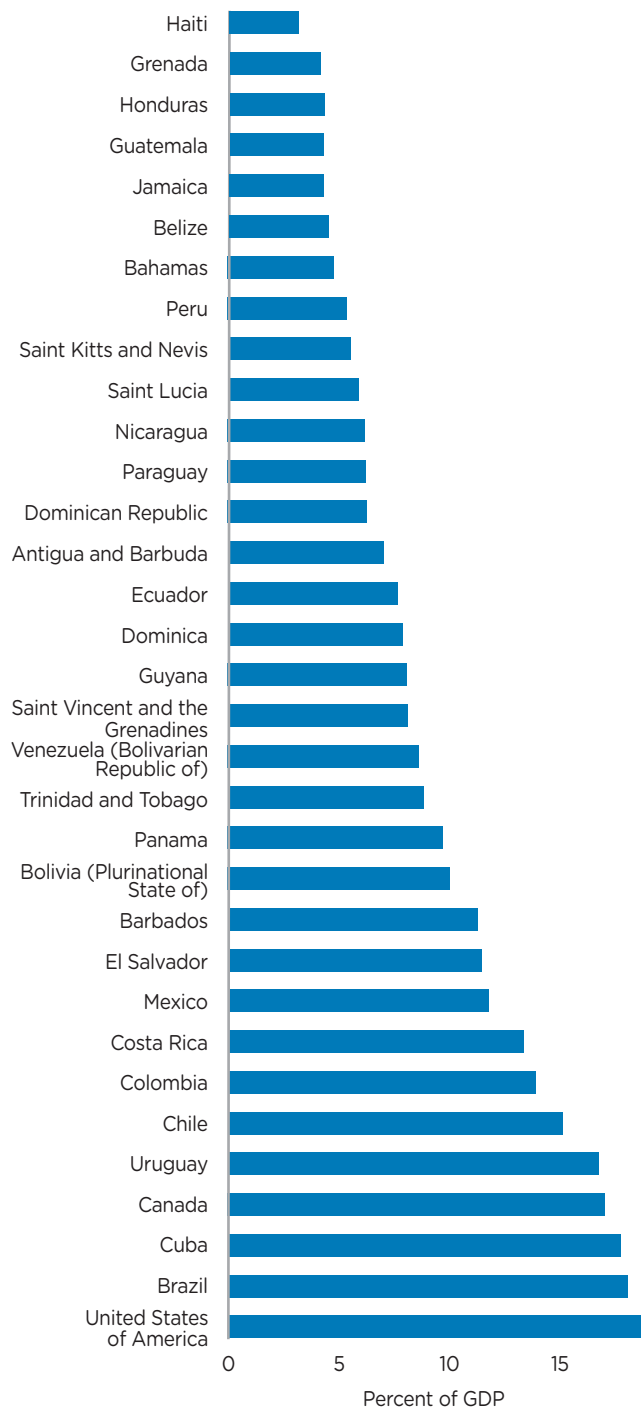
Increasing resources and improving the effectiveness of social protection policies would have significant positive impacts on health and health equity, which are also described in Recommendation 1. As an illustration, if the United States of America were to increase expenditures on education and incapacity to the levels of the OECD country with the maximum expenditures, life expectancy in the United States of America would increase to 80.12 years (a gain of 0.168 of a year), and there would be multiple other social, political, and economic equity benefits (241).

In Latin America and the Caribbean in 2017 (or latest available year for data), countries with higher coverage of social safety net programs among the lowest income quintile had lower under-5 mortality rates than those countries that spent less on this group, as described in Recommendation 4 (242).

There is a divergence in social protection coverage levels between Canada and the United States of America and Latin America and the Caribbean. Canada and the United States of America tend to have higher coverage rates, due to their higher level of economic development and social investment. In the United States of America, however, one person in four still does not have access to any kind of social protection. In the Plurinational State of Bolivia and Colombia, 60 percent of the population is still unprotected (4).

While the resources available for social protection do, of course, relate to a country’s

Figure 4.50.
Public social protection expenditure as a percent of GDP, selected countries in the Americas, 2015 or latest available year



Source: International Labour Organization. World Social Protection Database, based on the Social Security Inquiry (SSI) [Internet]; [cited 5 Dec 2018]. Available from: <http://www.social-protection.org/gimi/gess/RessourceDownload.action?ressource.ressourceId=54782>.

level of economic development, the availability and sufficiency of social protection systems are also political decisions. Countries spend different proportions of their available resources on social protection support, and they spend resources differently or do not raise sufficient income through taxation policies, as discussed in Recommendation 1. GDP expenditure on social protection is lower in the Americas than in Europe. In 2016, Belgium spent 29 percent, Finland 31 percent, and the Netherlands 22 percent, while the United States of America spent 19 percent of GDP on social protection. In 2015, the United States of America was the highest-spending country in the Americas, but it spent less than the average (21 percent) for OECD countries in 2016. Figure 4.50 shows the relative proportions of GDP spent on social protection in the Americas in 2015, ranging from 3.3 percent in Haiti to 19 percent in the United States of America (243).

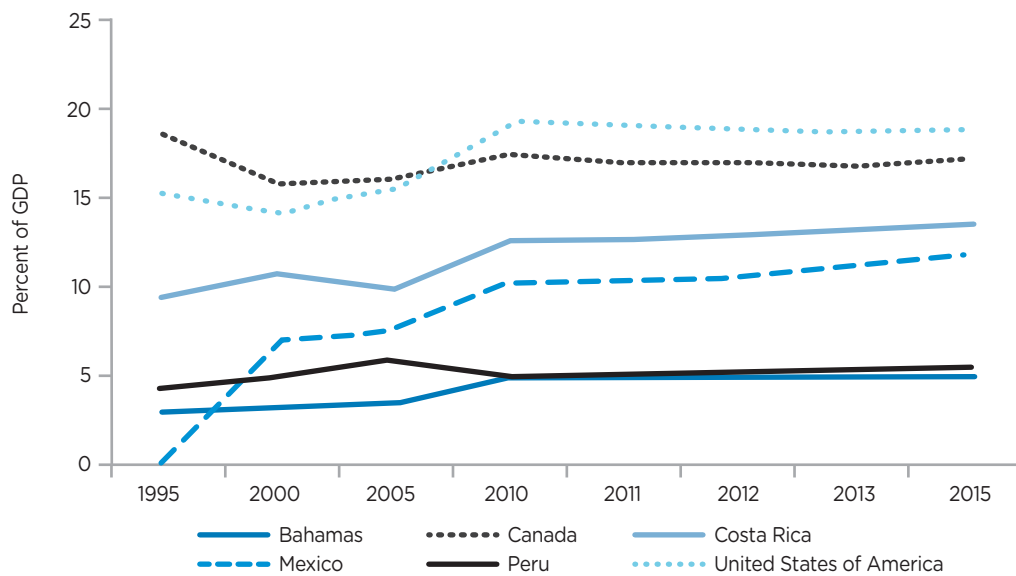
Figure 4.51 shows trends in the percentage of GDP spent on social protection between 1995 and 2015 for six countries in the Americas. Overall since 1995, the percentage of GDP expenditure on social protection has decreased in Canada, increased markedly in Mexico (albeit from a low position), and increased somewhat in Costa Rica and the United States of America. From 2010, Mexico continued to increase its coverage, while other countries' spending remained fairly stable from then until 2015 (243).

In Latin America, there were many improvements and innovations in social protection systems during the 2000s, including the introduction of universal pensions in Bolivia (Plurinational State of), Brazil, and Chile (discussed in Recommendation 6); universal health systems in Brazil and Colombia; conditional cash transfer and universal transfer programs (see 7B below); and contributory social protection schemes. Despite their impacts on poverty and health, many of these social protection systems are now under threat, with consequent likely risks to health equity and equity in other social determinants of health (35).



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Figure 4.51. Public social protection expenditure as a percent of GDP, countries in the Americas with comparable data available, 1995 to 2015



Source: International Labour Organization. World Social Protection Database, based on the Social Security Inquiry (SSI) [Internet]; [cited 5 Dec 2018]. Available from: <http://www.social-protection.org/gimi/gess/RessourceDownload.action?ressource.ressourceId=54782>.

7B. REDUCE POVERTY THROUGH SOCIAL PROTECTION POLICIES AND OTHER INITIATIVES

According to the ILO’s *World Social Protection Report 2017–19* (242), “social protection policies are also an important component of policies to contain and reduce inequality, including income inequality... together with tax policies, social protection systems are among the channels for the redistribution of income, and they play a significant role in addressing inequalities in access to services, such as access to health and education.” Recent studies have demonstrated the important contribution of social protection to the reduction of inequalities in Latin America and to promoting inclusive growth. In addition, social protection contributes to several other SDGs, including eliminating hunger by promoting food security and access to improved nutrition (SDG 2), facilitating access to quality education (SDG 4), clean water and sanitation (SDG 6), and affordable and clean energy (SDG 7) (242).

In order to effectively reduce poverty and improve health, social protection policies must be progressive, that is, redistributive. Redistributive

policies are pro-equity; however, not all social spending is progressive. Pensions, as discussed in Recommendation 6, can be regressive since



Girl in wheelchair with her family, Oaxaca, Mexico

government spending on pensions for those employed in the formal labor market excludes those in informal employment—and it is those people who are at greatest risk of experiencing poverty and poor health. On the other hand, universal provision of pensions to those who are unemployed, outside the formal labor market, or caring for family members is progressive. Recommendation 1 considers how tax regimes can be regressive and how tax and public spending could be actively redistributive.

As discussed in Recommendation 1, in Latin America, when taking into account direct social spending (direct transfers of money through conditional cash transfers, subsidies, and noncontributory pensions) and in-kind transfers (mostly in education and health services), the amount a country spends influences how redistributive the spending is. Argentina and Costa Rica devote the largest proportion of GDP on social spending, and this has the greatest redistributive effect (Figure 4.52).

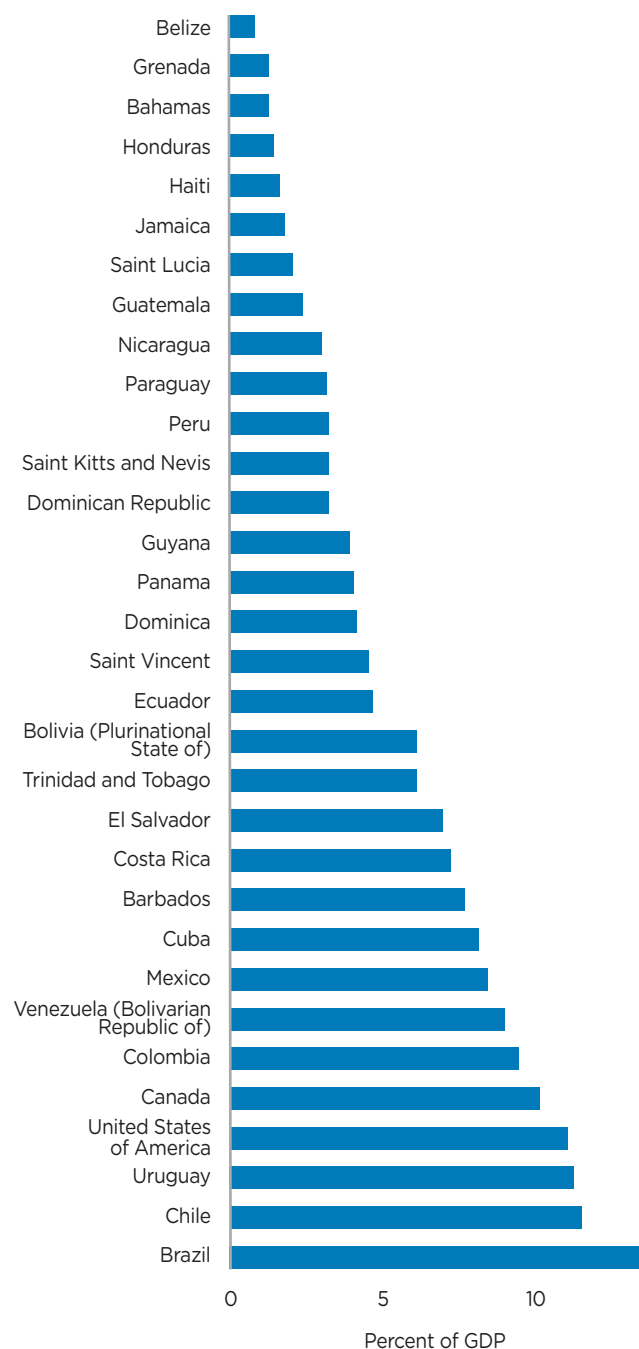
In Brazil, conditional cash transfer programs have been so widespread and large that they are more redistributive than the country’s indirect spending on education and health. However, Brazil is the only country in Latin America where this is the case.

The level of total social protection expenditure in the Americas overall, excluding health care, stands at roughly 5.3 percent of GDP (242). As Figure 4.53 shows, there is inconsistent coverage of income protection during unemployment in the Americas, as well as noticeable differences among countries in terms of the percentages of unemployed persons who receive income supplements.

To be more effective at reducing poverty, providing security, and reducing income inequalities, policies need to cover all unemployed people, provide sufficient income to prevent destitution at a minimum, and cover a longer period of unemployment.

Figure 4.54 shows that in all countries in the Americas, government unemployment assistance is time limited, which means that medium- to long-term unemployment will cause poverty and destitution unless other assets or family support are available.

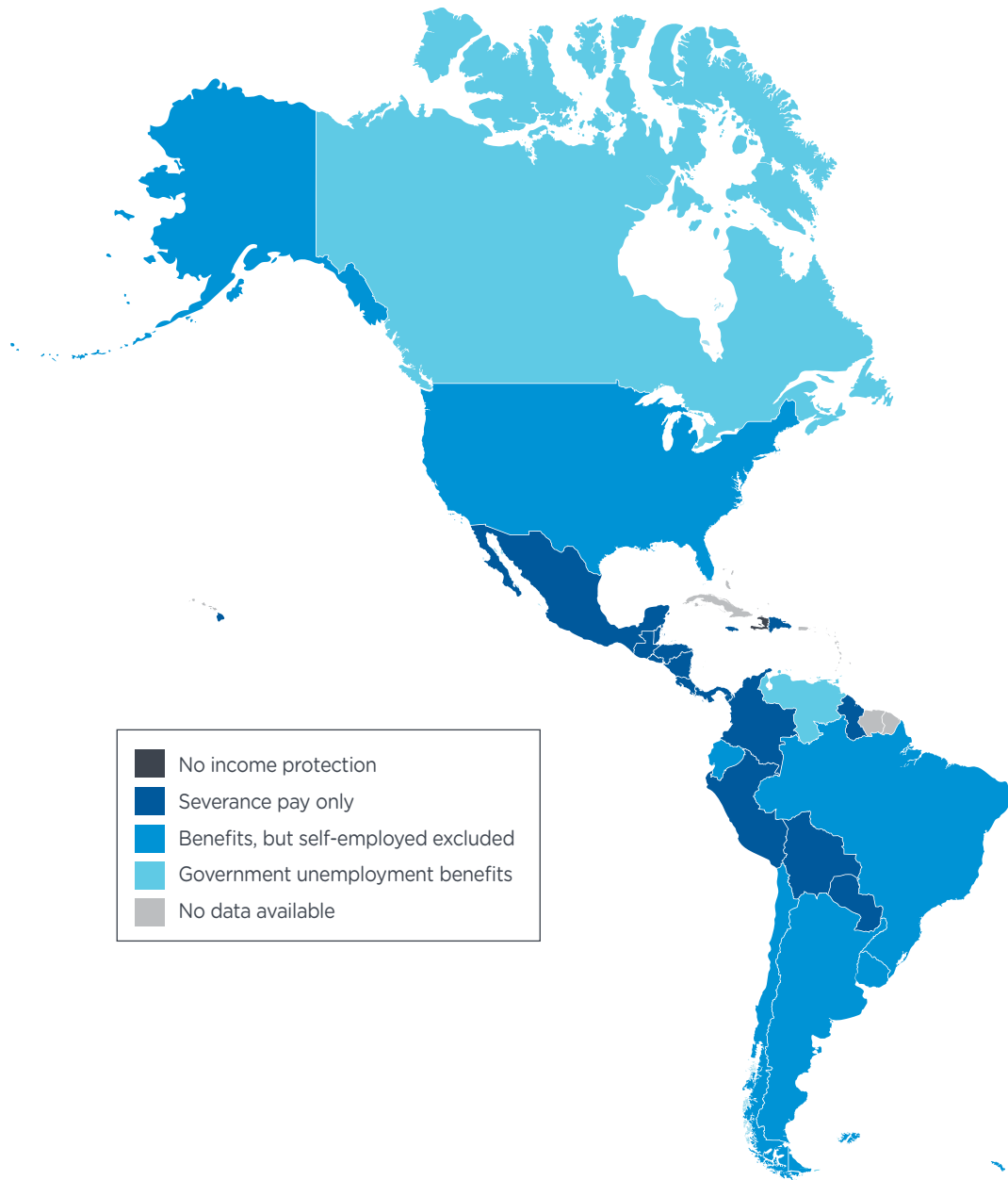
Figure 4.52. Public social protection expenditure in the Americas as a percent of GDP, excluding health care, 2015 or latest available year



Source: International Labour Organization. World Social Protection Database, based on the Social Security Inquiry (SSI) [Internet]; [cited 5 Dec 2018]. Available from: <http://www.social-protection.org/gimi/gess/RessourceDownload.action?ressource.ressourceId=54782>.

Figure 4.53.

Availability of income protection during unemployment, Region of the Americas, 2012



Source: WORLD Policy Analysis Center. Is income protection during unemployment available? [Internet]; 2018. Available from: <https://www.worldpolicycenter.org/policies/is-income-protection-during-unemployment-available>.

Note: *Severance pay* is compensation that must be provided by an employer to an employee when his or her job is terminated. Severance pay may also be required when government unemployment benefits are available.

Benefits, but self-employed excluded means that the government provides unemployment benefits, but self-employed workers are not entitled to those benefits. This category also includes cases where it is unknown whether coverage is available to individuals who are self-employed.

Government unemployment benefits means the government provides unemployment benefits, and coverage for individuals who are self-employed is available. This coverage includes both mandatory and voluntary coverage for the self-employed.

For all types of income protection, eligibility to receive these benefits may depend on a minimum period of employment, the specific type of employment (e.g., full-time, casual), age, and other factors.

Figure 4.54.

Length of time for which financial assistance is available during unemployment, Region of the Americas, 2012



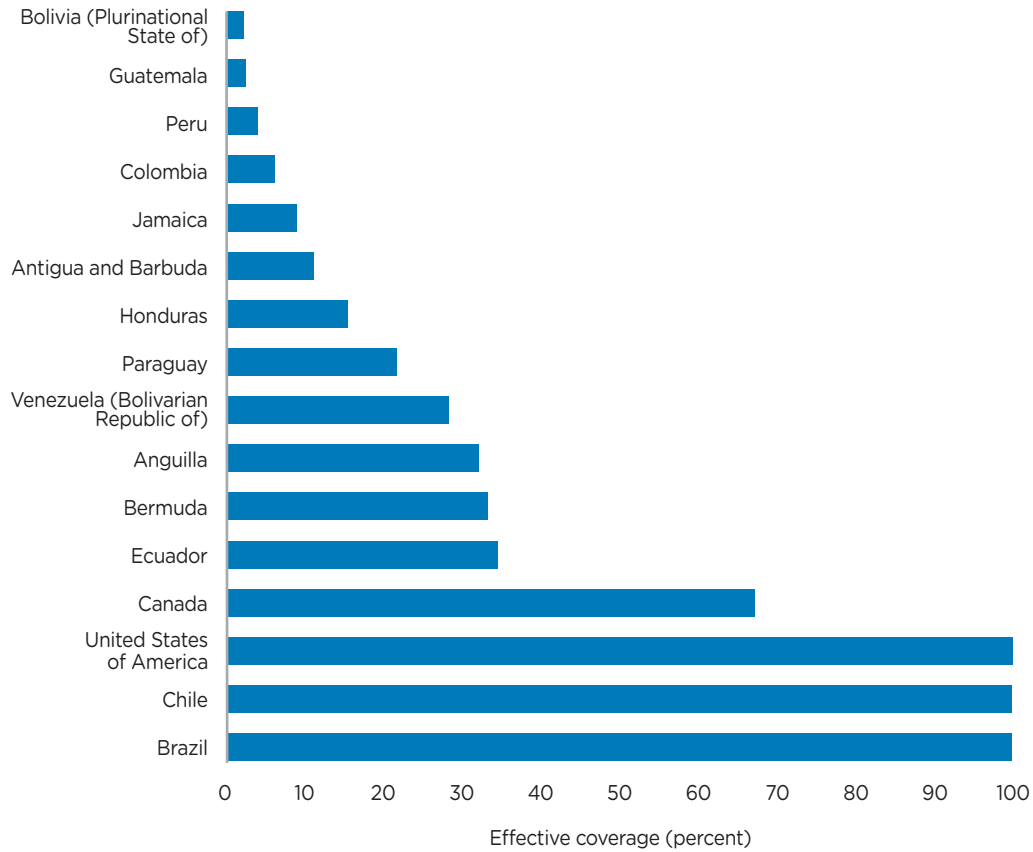
Source: WORLD Policy Analysis Center. For how long is financial assistance available during unemployment? [Internet]; 2018. Available from: <https://www.worldpolicycenter.org/policies/for-how-long-is-financial-assistance-available-during-unemployment>.

In the Americas, most countries have statutory disability schemes, but coverage varies significantly among the countries (Figure 4.55). In Brazil, the United States of America, and Uruguay, over 90 percent (in some cases 100 percent) of persons

with severe disabilities had access to disability benefits in 2015. However, in other countries, such as Bolivia (Plurinational State of), Guatemala, and Peru, fewer than 5 percent of persons with disabilities received a disability benefit (242).

Figure 4.55.

Social protection coverage for people with disabilities, selected countries in the Americas, 2015 or latest available year



Source: International Labour Organization. World Social Protection Database, based on the Social Security Inquiry (SSI) [Internet]; [cited 5 Dec 2018]. Available from: <http://www.social-protection.org/gimi/gess/RessourceDownload.action?ressource.ressourceld=54782>.

Examples of policies and programs to reduce poverty through social protection policies and other initiatives

Argentina budgeted for an increase in the social protection function in 2017 to take it up to 12 percent of GDP, a higher rate than in Canada or the United States of America, 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.

Conditional cash transfer programs. At present, 20 countries in Latin America and the Caribbean have at least one conditional cash transfer (CCT) program, with coverage of around a fifth of the general population.¹ Examples of CCTs covering maternal health, nutrition, early years, education, and working life have been set out in other relevant sections in this report, and in many cases have shown improvements in outcomes for recipients and their families.

CCT payments are often made directly to women in households, with the aim of improving gender equity and enabling them to control spending and improve their social position and status in the community.² However, some evidence from the Region suggests that by demanding compliance with conditionalities, cash transfer programs exacerbate existing gender disparities by reinforcing the notion that care is solely or mostly a woman's responsibility. In some countries, women beneficiaries of conditional cash transfers spent less time on paid employment and more time in caregiving than did women who were not beneficiaries.³

Conditional cash transfer programs and public services investment, Brazil. Brazil has the most-widespread CCT program, which together with universal programs—such as health care and provision of pensions—has had a transformative effect in reducing poverty, improving education and health, supporting families, and reducing a wide range of inequalities. 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 coefficient declined from 59 to 51.3 over the same period.⁴ Over this time, 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 expanding other disability payments. In 2015, conditional cash transfer programs covered 12.8 million families, or more than 51 million individuals.^{5,6}

Targeted Conditional Cash Transfer Program (TCCTP), Trinidad and Tobago. The TCCTP was created in 2005 and consists of two years of food assistance that allows vulnerable families to buy the basic food basket, thus reducing poverty.⁷ They are also given psychological assistance to deal with the pressures of living in poverty. Between October 2014 and July 2015, 1,403 families graduated from the program, and approximately 1,200 families benefited from training and assistance carried out in 15 regions.⁸

Zero Usury Microcredit Program [*Programa de Microcrédito Usura Cero*], Nicaragua. Created in 2007, this program was targeted at families living in extreme poverty in urban areas. It provided access to credit and training programs for women. Participants form groups of 10 persons who are not family related and do not live within the same household. The goal of the program is to create 95,000 small enterprises. In 2008, the budget of the Zero Usury program was

Sources: ¹ Stampini M, Tornarolli. L. The growth of conditional cash transfers in Latin America and the Caribbean: did they go too far? IZA Policy Paper No 49. Washington, D.C.: Inter-American Development Bank; 2012. Available from: <https://publications.iadb.org/en/publication/growth-conditional-cash-transfers-latin-america-and-caribbean-did-they-go-too-far>.

² Asian Development Bank; Food and Agriculture Organization of the United Nations. Gender equality and food security: women's empowerment as a tool against hunger. Manila: ADB; 2013. Available from: <https://www.adb.org/publications/gender-equality-and-food-security-womens-empowerment-tool-against-hunger>.

³ Holmes R, Jones N, Vargas R, Veras F. Cash transfers and gendered risks and vulnerabilities: lessons from Latin America. London: Overseas Development Institute; 2010. Available from: <https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/6042.pdf>.

⁴ World Bank. Poverty and Equity Data Portal – Brazil [Internet]; [cited 25 Jan 2019]. Available from: <http://povertydata.worldbank.org/poverty/country/BRA>.

⁵ Ibararán P, Medellín N, Regalia F, Stampini M. How conditional cash transfers work. Good practices after 20 years of implementation. Washington, D.C.: Inter-American Development Bank; 2017. Available from: <https://publications.iadb.org/en/publication/how-conditional-cash-transfers-work>.

⁶ Holmes R, Hagen-Zanker J, Vandemoortele M. Social protection in Brazil: impacts on poverty, inequality and growth. Development progress. London: Overseas Development Institute; 2011. Available from: <https://www.odi.org/publications/5477-brazil-social-protection-development-progress>.

⁷ Robles C, Varga LH. Social protection systems in Latin America and the Caribbean: Trinidad and Tobago. Santiago: ECLAC; 2012. Available from: <https://www.cepal.org/en/publications/4039-social-protection-systems-latin-america-and-caribbean-trinidad-and-tobago>.

⁸ Food and Nutrition Security Platform. Targeted conditional cash transfer programme [Internet]; [cited 27 Nov 2018]. Available from: <https://plataformacelac.org/en/programa/272>.

(continued on next page)

Examples of policies and programs to reduce poverty through social protection policies and other initiatives (*continued*)

US\$ 5.4 million. By December 2008, the program had 71,526 direct female beneficiaries in the country, which, when including family members, equated to about 426,000 beneficiaries in total.⁹

Universal Child Allowance (UCA), Argentina. This noncontributory cash transfer program was introduced in 2009 in response to the adverse effects of the global economic crisis. It provided coverage to children under age 18 (and disabled children without any age limit), as well as to unemployed workers, informal workers, domestic workers, and temporary workers. Studies show that the UCA has reduced poverty rates, especially extreme poverty. There is also evidence to suggest that the UCA contributes to improved income distribution, as measured by the Gini coefficient, and reduced income gaps. Some studies also found that the UCA had a positive impact on school attendance for adolescents between the ages of 16 and 17 (the group with the highest dropout rates), as well as on reducing child labor rates.¹⁰

Dignity Pension [*Renta Dignidad*], Plurinational State of Bolivia. Introduced in 2007 to replace the previous social pension scheme, *Renta Dignidad* is a noncontributory pension. The program has closed pension coverage gaps to achieve universal coverage. It costs around 1 percent of the country's GDP and is financed from two sources: public revenues generated from taxes on oil and gas production and dividends from a group of state-owned companies. The program led to a reduction in the poverty rate by 14 percent at the household level. In households receiving the benefit, child labor fell by 8.4 percent, as compared to children in households without *Renta Dignidad*, and school enrollment increased by 8 percent, reaching close to 100 percent in children in *Renta Dignidad* households.¹⁰

Disability and illness payments

Some countries have specific payments for families of people who are disabled, so as to support those with caregiving roles (discussed in Section 7C below). There are also some benefits and protections available for people with disabilities themselves, and additional provisions made for school-age children with physical and learning disabilities.¹¹

National Centre for Persons with Disabilities (NCPD), Trinidad and Tobago. This is a government-assisted nongovernmental organization that promotes the full participation of persons with disabilities in society. The NGO creates opportunities for trainees to gain on-the-job experience to enhance their competitiveness in the job market.⁷

Disability pensions, Argentina. Argentina increased the effective coverage of disability pensions between 1999 and 2016, quintupling the number of recipients to 1.5 million. The expansion of social spending is estimated to have been between 0.03 and 0.35 percent of GDP between 1997 and 2010.¹²

Continuous Cash Benefit Program, Brazil. Available beginning in 1993, the benefit is an unconditional cash transfer to the elderly or to extremely poor individuals with disabilities. The value of the transfer is equivalent to a monthly minimum wage. In 2015, it benefited 4 million people.¹³

Disability payments, Caribbean. Average monthly invalidity pensions in the Caribbean are highest in the Bahamas and Barbados, around US\$ 500 per month. In Antigua and Barbuda, Saint Kitts and Nevis, Saint Lucia, and Trinidad and Tobago they are about US\$ 200–300 per month; they are lower in Guyana.⁷

Ontario Disability Support Program (ODSP), Canada. This program provides income and employment support to people with disability living in the province of Ontario. The income support branch provides financial assistance for living expenses, such as food and housing, and provides support for finding work.¹⁴ The number of persons receiving ODSP assistance increased from about 280,000 in 2003 to over 475,000 in late 2016.¹⁵

Sources: ⁹ Franzoni JM. Social protection systems in Latin America and the Caribbean: Nicaragua. Santiago: ECLAC; 2013. Available from: https://repositorio.cepal.org/bitstream/handle/11362/4059/1/S2013119_en.pdf.

¹⁰ World Bank; International Labour Organization. Universal social protection: country cases. Global partnership for universal social protection USP2030. Washington, D.C.: World Bank; ILO; 2016. Available from: <http://www.social-protection.org/gimi/gess/RessourcePDF.action?id=55072>.

¹¹ International Labour Organization. World Social Protection Database, based on the Social Security Inquiry (SSI) [Internet]; [cited 5 Dec 2018]. Available from: <http://www.social-protection.org/gimi/gess/RessourceDownload.action?ressource.ressourceid=54782>.

¹² International Labour Organization. World social protection report 2017–19: universal social protection to achieve the Sustainable Development Goals. Geneva: ILO; 2017. Available from: https://www.ilo.org/global/publications/books/WCMS_604882/lang--en/index.htm.

¹³ Vaitsman J, Lobato LVC. Continuous cash benefit (BCP) for disabled individuals: access barriers and intersectoral gaps. *Cien Saude Colet.* 2017;22(11):3527–36.

¹⁴ Gewurtz RE, Cott C, Rush B, Kirsh B. How is unemployment among people with mental illness conceptualized within social policy? A case study of the Ontario Disability Support Program. *Work.* 2015;51(1):121–33.

¹⁵ Kerr D, Smith-Carrier T, Wang J, Tam D, Kwok SM. Population aging and the Ontario Disability Support Program (ODSP). *Can J Disabil Stud.* 2017;6(4):33–55.

7C. ESTABLISH SUPPORT FOR UNPAID CARING ROLES

Across the entire Region of the Americas, levels of support for people in caring roles are low and mostly insufficient to meet the needs of the carer or the person being cared for. In previous sections, we have set out that being a carer can harm employment prospects, income, and well-being, and increases a person’s risk of being in mental or physical ill health.

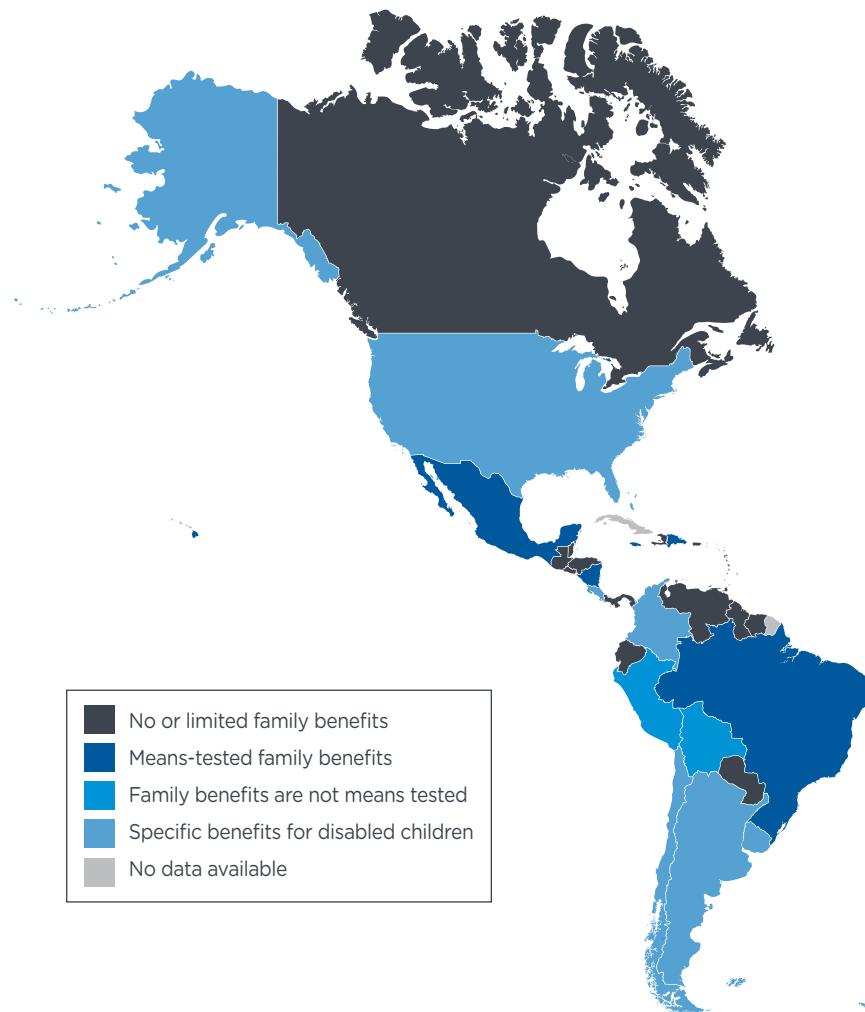
Women undertake most of the caregiving across the Americas.

In some parts of the Region, there are specific benefits for children with disabilities, in others there are family benefits for all families, and in some

countries the benefits are means tested. Several countries in the Americas have no family support available at all, as shown in Figure 4.56.

Figure 4.56.

Countries in the Americas where benefits are available to families with children with disabilities, 2015



Source: WORLD Policy Analysis Center. Are benefits available to families with disabled children? [Internet]; 2018. Available from: <https://www.worldpolicycenter.org/policies/are-benefits-available-to-families-with-disabled-children>.

Examples of policies and programs to support unpaid caregivers

Joaquin Gallegos program, Ecuador. This program provides health care and a monthly cash transfer of US\$ 240 to caregivers of persons with severe disability. Caregivers may also receive training in health, hygiene, nutrition, and rehabilitation. During 2013, almost 15,000 caregivers received this transfer. The total budgeted amount since it began is US\$ 41.8 million (0.78 percent of GDP).¹

Financial support policies, Canada. In Canada, about 20 percent of caregivers were receiving some form of financial support in 2012. Seven percent received help from a government program and 5 percent received a caregiver tax credit. Caregivers spending the greatest number of hours on caregiving tasks were more likely to receive financial support.²

Sources: ¹ Economic Commission for Latin America and the Caribbean; UNICEF. Rights of children and adolescents with disabilities. Santiago: ECLAC; 2013. Available from: <https://www.cepal.org/en/publications/35980-rights-children-and-adolescents-disabilities>.

² Sinha MM. Portrait of caregivers, 2012. Spotlight on Canadians: results from the general social survey. Ottawa: Statistics Canada; 2013. Available from: <https://www150.statcan.gc.ca/n1/pub/89-652-x/89-652-x2013001-eng.htm>.

RELEVANT INTERNATIONAL AGREEMENTS

Article 22 of the Universal Declaration of Human Rights. Social security is a basic human right. This right constitutes the first source of legitimacy for the extension of social security coverage to all (United Nations, 1948).

Social Security (Minimum Standards) Convention 102 (ILO C102) is the only international instrument, based on basic social security principles, that establishes worldwide-agreed-upon minimum standards for all nine branches of social security (medical care, sickness benefit, unemployment benefit, unemployment injury benefit, old-age benefit, family benefit, maternity benefit, invalidity benefit, and survivors' benefit) (International Labour Organization, 1952).

Maintenance of Social Security Rights Convention (ILO C157). Recommendation 157 addresses the issue of the maintenance of social security rights of migrant workers. Recommendation 167 proposes a model agreement for the coordination of bilateral or multilateral social security instruments (International Labour Organization, 1982).

Social Protection Floors Recommendation (ILO R202). It is designed to secure the progressive achievement of higher levels of protection within comprehensive social security systems, according to the Social Security (Minimum Standards) Convention, 1952 (No. 102). The ILO's policy on the extension of social protection aims for the rapid implementation of national social protection floors that contain basic social security guarantees that ensure universal access to essential health care and income security at least at a nationally defined minimum level (International Labour Organization, 2012).

PAHO Resolutions

Social Protection in Health (CD52.R11 [2013])

Sustainable Development Goals

Goal 1. End poverty in all its forms everywhere

Goal 5. Achieve gender equality and empower all women and girls



Man pushing wheelchair with elderly woman, Los Angeles, USA

RECOMMENDATION 8. REDUCING VIOLENCE FOR HEALTH EQUITY

Across the Region of the Americas, rates of violence are high. Latin America and the Caribbean have the highest rate of homicide in the world. In 2015, the rate for homicides in Latin America and the Caribbean was 22 per 100,000 of the population, while the second-highest rate was in sub-Saharan Africa, at 9 per 100,000 (1, 244). Young men are disproportionately the perpetrators and the victims of violent crime in the Americas, but there are high levels of violence against women, too.

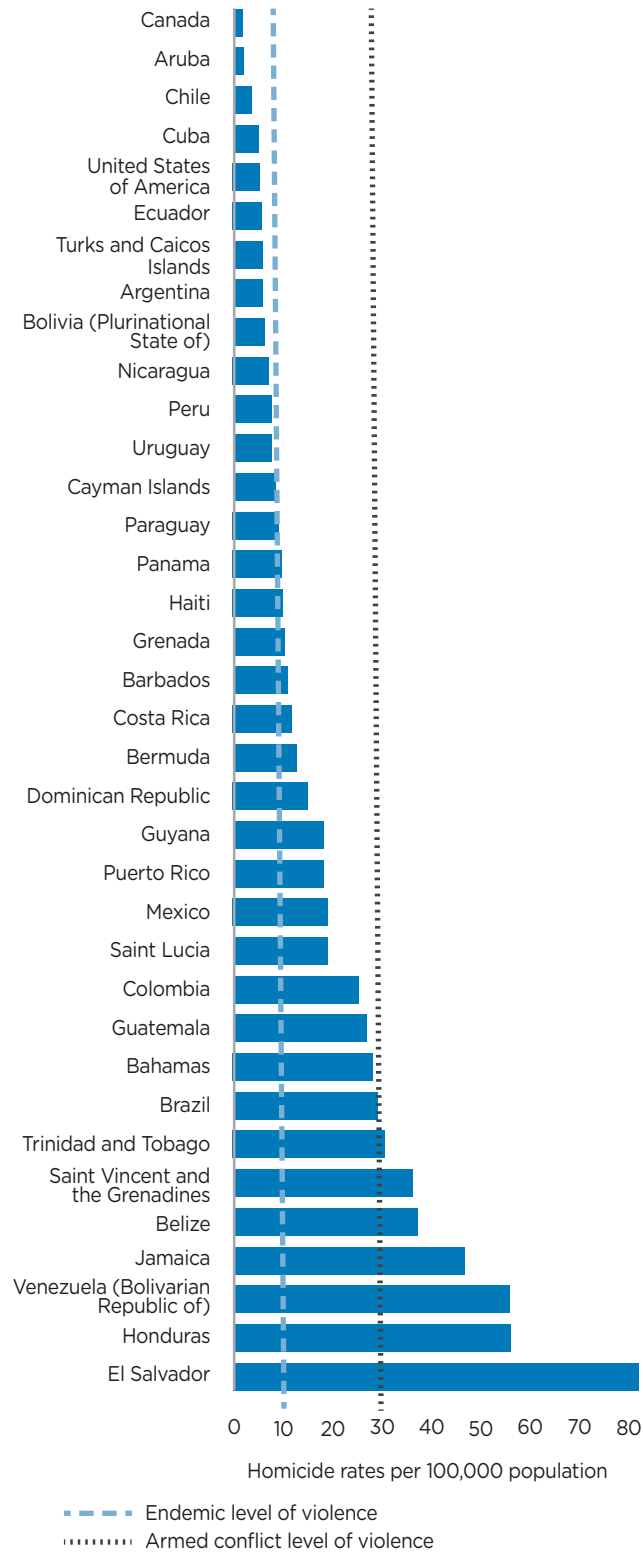
Physical violence directly affects health through death, injury, and harm to mental health. High levels of crime also indirectly affect health. Fear of crime and living in areas with high rates of crime lead people to limit their social interactions, physical activity levels, and community involvement in order to avoid crime, all of which undermine physical and mental health. High levels of crime weaken confidence and trust in public institutions,

particularly the criminal justice and political system. Confidence in politics and the public realm are important for social cohesion, community functioning, and health (245).

Figure 4.57 shows the homicide rates in 2016 for countries in Latin America and the Caribbean, Canada, and the United States of America. WHO follows the United Nations Office on Drugs

PRIORITY OBJECTIVES	ACTIONS
<p>8A. Eliminate gender-based violence, especially that affecting women and girls</p>	<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
<p>8B. Reduce structural violence, focusing on those most at risk</p>	<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
<p>8C. Eradicate institutional and political violence</p>	<ul style="list-style-type: none"> • Eliminate all forms of political violence, including violence to migrants through separation of families, violation of women, and 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 work forces

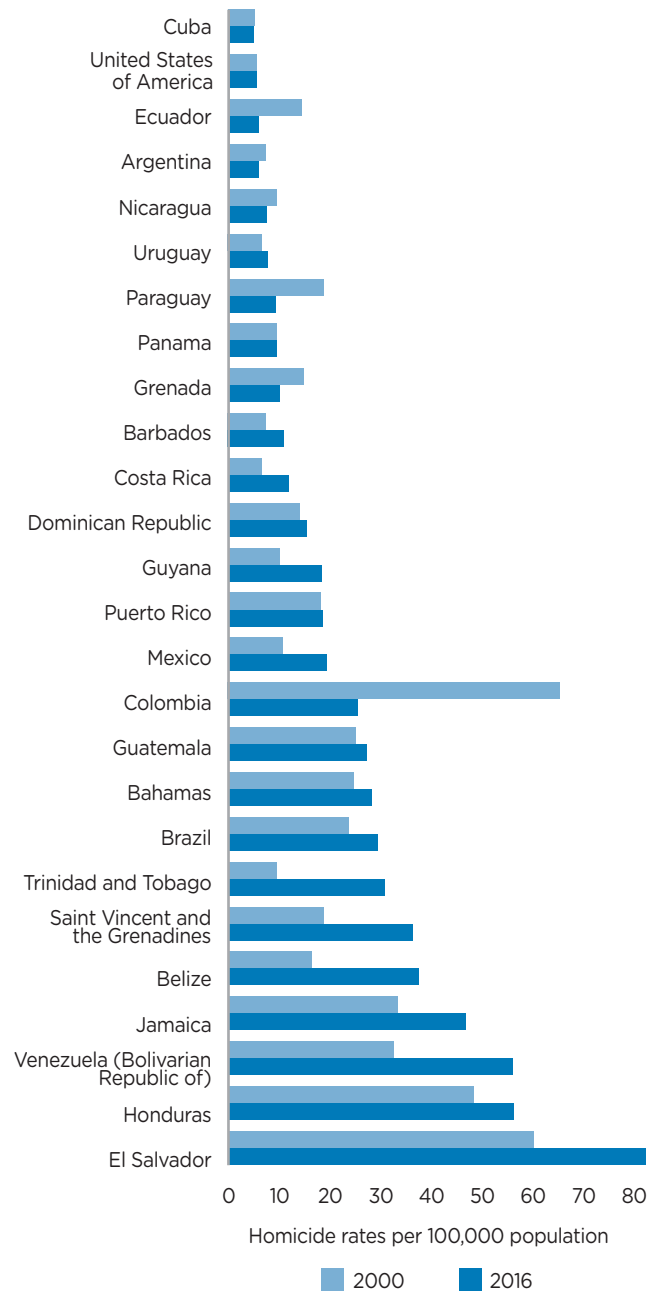
Figure 4.57.
Homicide rates for countries in the Americas, 2016



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

Note: Armed conflict level of violence defined according to the United Nations Office on Drugs and Crime (UNODC).

Figure 4.58.
Homicide rates, countries in the Americas with comparable data available, 2000 and 2016



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

and Crime (UNODC) in considering 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 an armed conflict level of violence (246). Several countries in the Region have surpassed this conflict level threshold. By way of contrast, the average homicide rate of Scandinavian countries, with some of the lowest homicide rates in the world, is under one per 100,000 of the population (247). In some countries in the Region, there were significant increases in

homicide rates between 2000 and 2016, as shown in Figure 4.58.

These rises were particularly marked in some Central American and Caribbean countries, and are mainly a result of increased drug trafficking and associated violence. Conversely, some countries in the Americas—Ecuador, Paraguay, Grenada, and Colombia in particular—saw significant decreases in homicides over the same period.



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8A. ELIMINATE GENDER-BASED VIOLENCE, ESPECIALLY THAT AFFECTING WOMEN AND GIRLS

Gender-based violence includes femicide—a hate crime where women are killed because they are women, usually perpetrated by men, and mostly committed by partners or ex-partners, and involving ongoing abuse in the home, threats, or intimidation (248); intimate partner violence (IPV); sexual harassment, assault, and exploitation; violence against lesbian, gay, bisexual, transgender, and intersex (LGBTI) people; and obstetric violence, when health professionals remove women’s autonomy and capacity to make decisions over their own bodies and sexuality (249).

There are high levels of gender-based violence against women, including that which leads to femicide, in Latin America, the Caribbean, and the United States of America, as well as some, lower levels of gender-based violence against men (250, 251). There are also clear cumulative risks for experiencing gender-based violence that are associated with being a woman, disabled, or of Indigenous identity, each of which raises the risk in many countries in the Region.

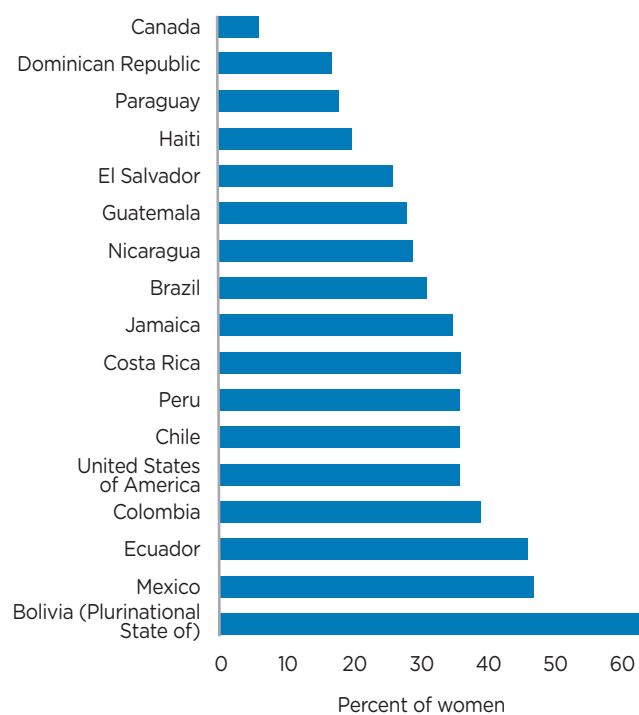
Intimate partner violence has multiple psychological trauma and mental health impacts, as well as causing direct physical harm. Figure 4.59 shows rates of intimate partner violence, including physical and/or sexual violence, experienced by women in countries in the Americas where data were available.

Between 2003 and 2012, about one-third of femicide victims in the United States of America died at the hands of an intimate partner (252). Disabled women in the Americas are subject to higher levels of violence than are women without disabilities, and many of the disabilities in the former group have been caused by violence (253). Such data are scant, particularly in Latin America. However, the first Specialized National Disability Survey in Peru in 2012 indicated that of 16,662 women with disabilities, more than 10,800 had become disabled due to domestic violence (253). A survey carried out in Colombia and the Dominican Republic in 2010 found higher levels of violence against women with disabilities, as shown in Figure 4.60 (4).

Data from Canada for 2014 (Figure 4.61) show that the rate of violent victimization is slightly higher for

women than for the general population, higher for people with a disability, and the highest for lesbian, gay, and bisexual people (254).

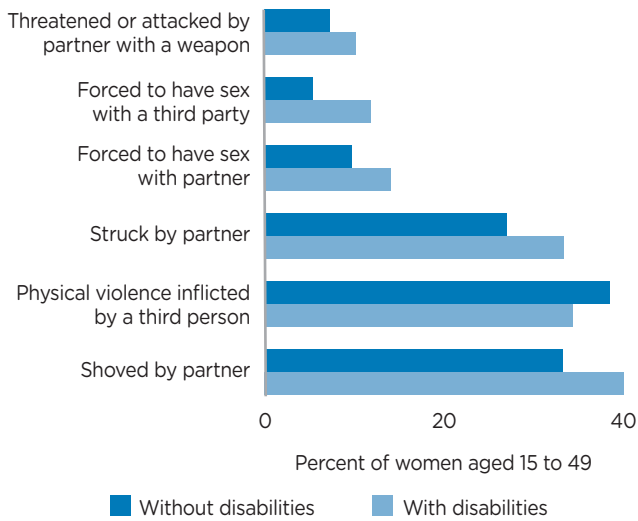
Figure 4.59.
Rate of intimate partner violence against women, across the whole lifetime, selected countries in the Americas, 2014



Source: Organisation for Economic Cooperation and Development. OECD data: violence against women [Internet]; 2018. Available from: <https://data.oecd.org/inequality/violence-against-women.htm>.

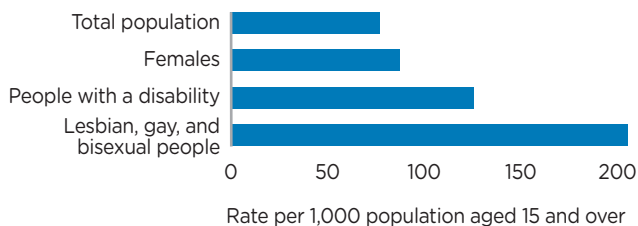
Note: Prevalence of violence in the lifetime: the percentage of women who have experienced physical and/or sexual violence from an intimate partner at some time in their life.

Figure 4.60.
Women aged 15 to 49, with and without disabilities, who reported violence, Colombia, 2010



Source: Economic Commission for Latin America and the Caribbean. The social inequality matrix in Latin America. Santiago: ECLAC; 2016. Available from: https://repositorio.cepal.org/bitstream/handle/11362/40710/1/S1600945_en.pdf.

Figure 4.61.
Violent incidents reported in Canada, by selected population groups, 2014



Source: Perreault S. Criminal victimization in Canada, 2014. Ottawa: Statistics Canada; 2015. Available from: <https://www150.statcan.gc.ca/n1/pub/85-002-x/2015001/article/14241-eng.htm>.

Note: Violent incidents include sexual assault, robbery, and physical assault.

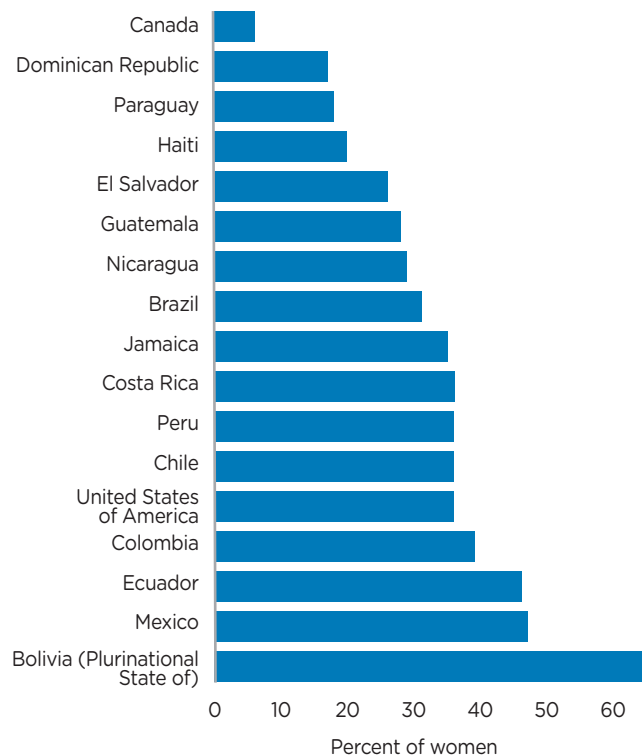
“Obstetric violence” refers to the removal of women’s autonomy and ability to make decisions over their own bodies and sexuality by medical staff (249). It also includes dehumanized care, disrespect and abuse, or mistreatment during childbirth (255). Unsafe abortion can also be considered a form of gender-based violence. There are six countries in Latin America and the Caribbean where abortion is prohibited altogether: the Dominican Republic, El Salvador, Haiti, Honduras, Nicaragua, and Suriname. In many

others, abortions are permitted only to save the life of the pregnant woman. In the period 2010–2014, only approximately one in four abortions in Latin America and the Caribbean were safe, and in 2014 at least 10 percent of maternal deaths were a result of unsafe abortion (256).

The Inter-American Court of Human Rights’ first report on the rights of LGBTI persons, in 2015, highlighted the pervasive violence against LGBTI persons in the Americas (257). In the United States of America, gender identity and sexuality-based hate crimes made up about 21 percent of hate crimes reported by law enforcement in 2013 (258). A 2010 survey reported that bisexual women are most at risk, as described in Table 4.2 (259).

In many countries in the Region, violence against women is widely accepted and tolerated, including by women themselves, as illustrated in Figure 4.62 (260).

Figure 4.62.
Percent of women who think violence against women is acceptable, selected countries in the Americas, 2014



Source: Organisation for Economic Cooperation and Development. OECD data: violence against women [Internet]; 2018. Available from: <https://data.oecd.org/inequality/violence-against-women.htm>.

Table 4.2.**Lifetime prevalence (percent) of having been a victim of violence, by sexual orientation and type of violence, United States of America, 2010**

Sexual orientation	Rape	Sexual violence other than rape	Stalking victimization	Intimate partner violence
Bisexual women	46.1	74.9	36.6	61.1
Lesbian women	13.1	46.4	No data available	43.8
Heterosexual women	17.4	43.3	15.5	35
Bisexual men	No data available	47.4	No data available	37.3
Gay men	No data available	40.2	No data available	26
Heterosexual men	0.7	20.8	No data available	29

Source: Walters ML, Chen J, Breiding MJ. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 findings on victimization by sexual orientation. Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2013. Available from: https://www.cdc.gov/violenceprevention/pdf/nisvs_sofindings.pdf.

Note: The National Intimate Partner and Sexual Violence Survey focused on interpersonal violence based on sexual orientation. Complete interviews were obtained from 16,507 adults (9,086 women and 7,421 men).

Examples of policies and programs to eliminate gender-based violence

High levels of violence against women, particularly intimate partner violence and tolerance of it among wide sectors of society, indicate that cultural attitudes are important in driving gender-based violence. Poverty and lack of control over finances make women more at risk. Education programs have had some success in addressing this, and programs that empower women economically and socially are also effective.

World Food Program (WFP), Ecuador. Since April 2011, the WFP has provided cash-based assistance to refugees, displaced persons, migrants, returnees, and other vulnerable women in Ecuador to purchase fresh and nutritious products in local markets. The WFP also provides nutrition education and training.¹ The program has aimed at reducing poverty and food insecurity, but it has also reduced intimate partner violence. In a 2011 experiment, participating households received monthly benefits from April to September of that year, for a total of US\$ 240 over the six-month period. The transfer program helped to reduce intimate partner violence by increasing women's decision-making and empowerment. The results indicated that the transfers reduced partners' controlling behaviors, as well as physical and sexual violence, by approximately 38 to 43 percent.²

Brazil's Federal Law 11340, also known as the *Maria da Penha Law*. This law, of 2006, was intended to prevent domestic and family violence against women, and included integrated measures of prevention, assistance to women victims of violence, and temporary restraining orders issued to the aggressor by empowering judges. It was named after Brazilian activist Maria da Penha Maia, a victim of domestic violence. A before and after study in 2013 showed female mortality rates fell very slightly from 5.28 to 5.22 per 100,000 women between the periods 2001–2006 and 2007–2011. The deaths were predominantly of women aged 20–39 and women of African descent with lower levels of education. The law is credited with increasing attention and resources for programs aiming to reduce violence against women.³

Sources: ¹ United Nations. What the World Food Programme is doing in Ecuador [Internet]; [cited 28 Nov 2018]. Available from: <http://www1.wfp.org/countries/ecuador>.

² Hidrobo M, Peterman A, Heise L. The effect of cash, vouchers and food transfers on intimate partner violence: evidence from a randomized experiment in Northern Ecuador. *Amer Econ J: Appl Econ.* 2016;8(3):284–303.

³ Gattegno MV, Wilkins JD, Evans DP. The relationship between the Maria da Penha Law and intimate partner violence in two Brazilian states. *Int J Equity Health.* 2016;15:138.

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Examples of policies and programs to eliminate gender-based violence *(continued)*

The Youth Relationship Project in Ontario, Canada, was a community-based intervention to help at-risk youth 14 to 16 years old to develop healthy, nonabusive relationships with dating partners by providing education about healthy and abusive relationships, conflict resolution and communication skills, and social action activities. A randomized controlled trial showed that the intervention was effective in reducing incidents of physical and emotional abuse and symptoms of emotional distress over a 16-month period after the intervention.^{4,5,6} The Youth Relationship Project was discontinued and succeeded by “The Fourth R,” an ongoing program that focuses on fostering healthy relationships through teaching.⁷ Results indicated that physical dating violence was about 2.5 times greater among control versus intervention students.⁸ The Fourth R also lowered the likelihood of participants engaging in violent delinquency.⁹

The Men’s Program, United States of America. The Men’s Program challenges young men about rape and helps them develop empathy for survivors. The men are taught how to support rape victims and confront peers who have joked or boasted about raping women. It was first developed in 1993 as a peer education program and is now used in over 100 colleges across the United States of America. A randomized controlled trial found that in treatment groups, it led to a 40 percent decline in sexual violence committed by high-risk men, and participants were significantly less likely to accept myths about rape or to commit sexual assault or rape than members of the control group.⁴

Program H, Brazil. The program fosters healthy relationships and combines educational sessions with role-playing and discussions to promote changes in norms of masculinity and behaviors. An evaluation among males 14 to 25 years old found that at six months, participants in the two communities that received one or both of the interventions were less likely to support traditional gender norms than before the intervention.⁴

Sources: ⁴ JMU Liverpool; World Health Organization. Promoting gender equality to prevent violence against women. Geneva: WHO; 2009. Available from: <https://apps.who.int/iris/handle/10665/44098>.

⁵ National Institute of Justice. Program profile: Youth Relationships Project [Internet]; 16 May 2016. Available from: <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=467>.

⁶ Wolfe DA, Wekerle C, Scott K, Straatman AL, Grasley C, Reitzel-Jaffe D. Dating violence prevention with at-risk youth: a controlled outcome evaluation. *J Consult Clin Psychol.* 2003;71(2):279-91.

⁷ Ontario Center of Excellence for Child and Youth Mental Health. Evidence in-sight: teen dating violence prevention programs [Internet]; October 2016. Available from: http://www.excellenceforchildandyouth.ca/sites/default/files/resource/EIS_Teen_Dating_Violence_Prevention.pdf.

⁸ Wolfe DA, Crooks CV, Jaffe PG, Chiodo D, Hughes R, Ellis W, et al. A school-based program to prevent adolescent dating violence: a cluster randomized trial. *Arch Pediatr Adolesc Med.* 2009;163(8):692-9.

⁹ Crooks CV, Scott K, Ellis W, Wolfe DA. Impact of a universal school-based violence prevention program on violent delinquency: distinctive benefits for youth with maltreatment histories. *Child Abuse Neglect.* 2011;35(6):393-400.

8B. REDUCE STRUCTURAL VIOLENCE, FOCUSING ON THOSE MOST AT RISK

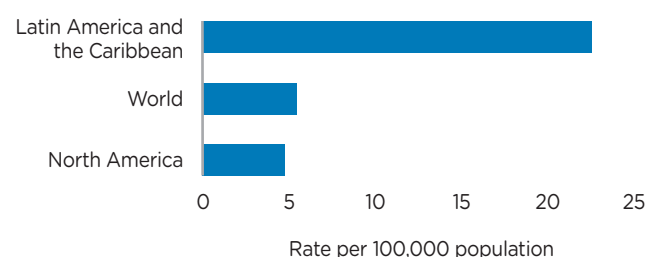
Structural violence is violence that is closely related to inequities in social, economic, and political structures and social institutions (261). Structural violence affects people differently according to their position in these structures and institutions, and leads to greater levels of violence being experienced by those at the lower end of socioeconomic structures and those whose needs are not met by social institutions. Across the Region of the Americas, there are profound inequalities in rates of violence that are related to ethnicity, socioeconomic position, and gender.

Globally, there is some association between a country's GDP and its homicide rate, with rates fairly static until GDP per capita reaches approximately US\$ 8,000, when rates of violence begin to decrease. These decreases accelerate with a GDP per capita of US\$ 10,000 and higher. However, countries in the Americas don't follow this pattern. Most countries in the Region, including the United States of America, have far higher rates of homicide than might be expected from their GDP. Figure 4.63 shows that homicide rates per 100,000 of the population in Latin America and the Caribbean were more than four times higher than the world average in 2015. However, a few countries, including Argentina, Bolivia (Plurinational State of), Canada, Ecuador, and Nicaragua, have homicide rates below what might be expected from their GDP per capita based on global data.

There is a close association between homicide rates, levels of drug production, and, particularly, drug trafficking in the Americas. 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-related violence (26, 262). According to the United Nations Office on Drugs and Crime, drug seizures are mostly concentrated in northwest Latin America and in Central America, where most drugs are produced and trafficked. There are also high levels of drug trafficking in the Caribbean, and these levels have grown in recent years as drug trafficking patterns shift (263). The United States of America is a major consumer of drugs produced and trafficked in the Region.

In Latin America and the Caribbean, almost half of all homicide victims are aged between 15 and 29,

Figure 4.63.
Average homicide rates for Latin America and the Caribbean, the world, and North America, 2015

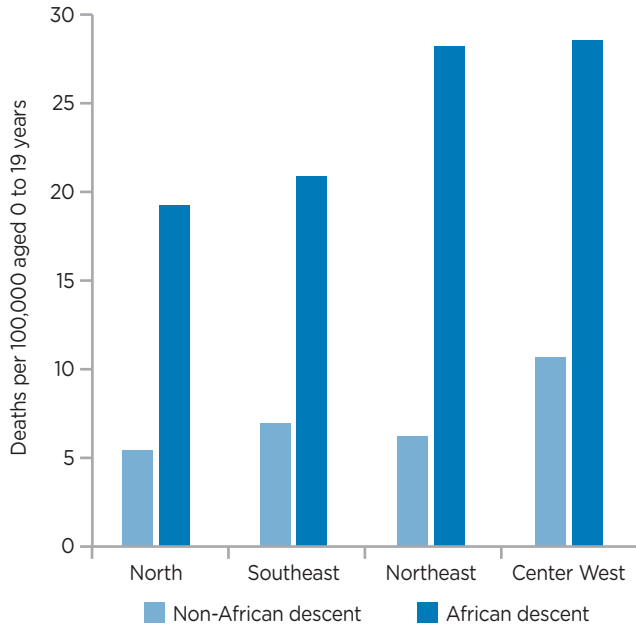


Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

and violence is committed by and affects young males at a disproportionate rate compared with other age groups and with females. In the United States of America, similarly, nonfatal and fatal violence rates are substantially higher among young people than any other age group (264, 265).

There is generally a lack of data on the ethnicity of homicide victims for Latin America and the Caribbean, but where data are available, they show that rates of homicide and violence in the Region are higher for people of African descent than for other ethnic backgrounds. Data from Brazil for 2013 show that most young murder victims were of African descent, on average affecting 23.6 per 100,000, in comparison with 8 per 100,000 for those not of African descent—a ratio of three victims for young people of African descent to each one of non-African descent. This ratio differs among Brazilian states. In some states, the proportion is

Figure 4.64.
Homicide rate at ages under 20, by African-descent identity and region, Brazil, 2013



Source: Waiselfisz JJ. Homicides of children and adolescents in Brazil. Rio de Janeiro: Igarapé Institute; December 2017. Available from: https://igarape.org.br/wp-content/uploads/2017/12/2017-12-04-Homicide-Dispatch_4_EN.pdf.

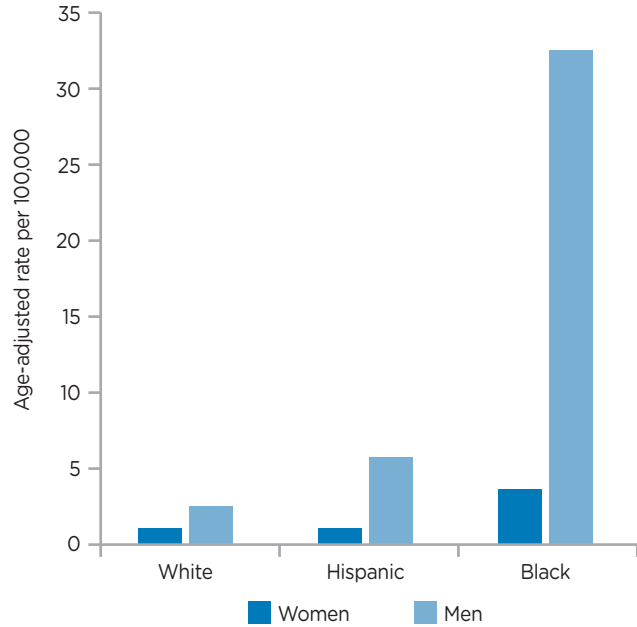
as high as 20 youths of African descent becoming homicide victims for each victim of non-African descent (266) (Figure 4.64).

In the United States of America, the age-adjusted homicide rate in 2015 was 32 per 100,000 among men of African descent—approximately 16 times the rate for White men (2 per 100,000), and five times the rate for those of Hispanic descent (6 per 100,000) (267, 268). Figure 4.65 shows the age-adjusted rate of male and female homicide victims by ethnicity in the United States of America in 2015: the highest rates were among Black men.

In Canada in 2013, people of Indigenous identity were more likely than non-Indigenous people to report having been violently victimized in the previous 12 months (269).

Perpetrators of violence tend to have lower levels of education than the general population. For example, in Mexico in 2011, perpetrators of homicides tended to have fewer years of schooling (265). In Brazil in 2012, in comparable municipalities that were the most violent, a 1 percent increase

Figure 4.65.
Homicide victimization rate by ethnicity and sex, United States of America, 2015



Source: U.S. Census Bureau. Survey on sexual violence [Internet]; 2017. Available from: <https://www.census.gov/econ/overview/go2700.html>.

in the school dropout rate was associated with 0.35 additional homicides per 100,000 population (265). Good-quality schooling has been shown to help prevent crime and reduce homicide rates. For example, a one-year increase in the average education level reduced state arrest rates by 15 percent in the United States of America (270).

Despite high overall levels of violence and homicide across Latin America and the Caribbean, there have been remarkable changes in levels of violence in many areas. This underlines how rapidly improvements can be made, and conversely, how rapidly the situation can deteriorate. Notably, Colombia has experienced very significant reductions in homicide rates. For instance, the city of Medellín had a homicide rate of 23 per 100,000 in 2017, down from 266 per 100,000 in 1991 (251, 265). Once one of Brazil's most dangerous cities, Rio de Janeiro had its homicide rate fall from 70 per 100,000 in 1995 to 19 per 100,000 in 2015 (251). Overall, however, the homicide rate in Brazil has risen from 26 per 100,000 in 2000 to 30 in 2016, with significant local variations (26, 251).

Examples of policies and programs to reduce structural violence, focusing on those most at risk

Reducing socioeconomic and other structural inequalities should be at the heart of policies to reduce violence, since the association between a range of socioeconomic and gender and ethnic inequalities and violence is strong. Programs to reduce violence should also be central to the work of public health and associated organizations. Many of the recommendations made in this report would help to reduce violence, through their attention to reducing socioeconomic inequalities and inequities related to gender and ethnicity. Reducing violence would, of course, in turn directly and indirectly reduce inequities in health.

Violence Zero, Brazil. Conducted around 2014, this program aimed to decrease the levels of school violence, maximize student engagement, and improve teachers' well-being. It consisted of twelve 90-minute sessions with educators on school violence prevention. The sessions included presentations, discussions, and classroom exercises. Significant reductions in self-reported perpetration of violence by students were reported.¹

Lengthening the school day, Chile. Increasing the school day from a half to a full day reduced youth crime over the study period of 2005 to 2008. The results showed that an increase in full-day school for 20 percent of the population reduced property crimes by 24 percent and violent crimes by 11 percent.²

Conditional cash transfer programs in Mexico and Brazil. By increasing household income and by mitigating the impact of income shocks, these programs have contributed to crime and violence prevention. In Mexico, for example, conditional cash transfer and redistribution programs are strongly associated with reductions in both homicides and sexual violence at the state and city levels.^{3,4,5}

Families in Action [*Familias en Acción*], Colombia. A 2013 study examined the indirect effects that the income transfers made under Colombia's most important conditional cash transfer program had on crime in the urban area of the capital, Bogotá. Results indicate that, through the so-called income effect, the program was responsible for reducing thefts and vehicle theft by 7.2 percent and 1.3 percent, respectively, in the days following the transfers.⁶

Public transit, Medellín, Colombia. In 2004, municipal authorities in Medellín built a public transit system to connect isolated low-income neighborhoods to the city's urban center. A comparison of neighborhood conditions and violence before (2003) and after (2008) the transit project was completed found that the physical and social integration of informal urban neighborhoods partly as a result of the transit system may have contributed to the steep decline in homicide rates (by 66 percent) in the neighborhoods; the principal reason for the decline in homicides was the dismantling of the organized drug production and trafficking and the decrease in military and civil conflict.⁷

Becoming a Man, Chicago, United States of America. Launched in Chicago in 2001, Becoming a Man (BAM) is a cognitive behavioral therapy mentoring program for disadvantaged male youth from high-crime neighborhoods. The intervention included regular interactions with a social worker, after-school activities, and in-school programs providing cognitive behavioral therapy. Program participation reduced violent-crime arrests during the program year by 8.1 per 100 youths (a 44 percent reduction). It also generated sustained gains in schooling outcomes and graduation rates of 3 to 10 additional percentage points.⁸

Sources: ¹ Stelko-Pereira AC, Williams LCA. Evaluation of a Brazilian school violence prevention program (*Violência Nota Zero*). *Pensam Psicol.* 2016;14:63-76.

² Berthelon ME, Kruger DI. Risky behavior among youth: incapacitation effects of school on adolescent motherhood and crime in Chile. *J Public Econ.* 2011;95(1-2):41-53.

³ Murray J, Cerqueira DR, Kahn T. Crime and violence in Brazil: systematic review of time trends, prevalence rates and risk factors. *Aggress Violent Behav.* 2013;18(5):471-83.

⁴ Muggah R. The rise of citizen security in Latin America and the Caribbean. *Int Devel Policy.* 2017;9:291-322.

⁵ Vilalta C, Muggah R. What explains criminal violence in Mexico City? A test of two theories of crime. *Stability.* 2016;5(1):1.

⁶ Camacho A, Mejia D. The externalities of conditional cash transfer programs on crime: the case of *Familias en Acción* in Bogotá. Working paper. Bogotá: Universidad de los Andes; 2013. Available from: http://siteresources.worldbank.org/EXTLACOFFICEOFCE/Resources/870892-1265238560114/ACamacho_Oct_2013.pdf.

⁷ Cerdá M, Morenoff JD, Hansen BB, Tessari Hicks KJ, Duque LF, Restrepo A, Diez-Roux AV. Reducing violence by transforming neighborhoods: a natural experiment in Medellín, Colombia. *Am J Epidemiol.* 2012 May 15;175(10):1045-53.

⁸ Heller S, Pollack HA, Ander R, Ludwig J. Preventing youth violence and dropout: a randomized field experiment. Working paper series No. 19014. Cambridge: National Bureau of Economic Research; 2013.

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Examples of policies and programs to reduce structural violence, focusing on those most at risk *(continued)*

Citizen Security approaches are increasingly being implemented across Latin America and the Caribbean. They are an array of ideas and activities intended to prevent and reduce violence, promote public security and access to justice, strengthen social cohesion, and reinforce the mutual rights and obligations of States and citizens.⁴ The approaches vary but focus on prevention of violence through a range of upstream interventions, rather than resorting to tougher law-and-order policies. There is evidence that investments in the prevention of violence are more cost-effective than expenditures on public or private security.^{9,10}

Truce, El Salvador. A truce was agreed to in 2012 between the two most powerful organized crime organizations and the government of El Salvador. In 2011, before the truce, the homicide rate had been over 71 per 100,000. The rate subsequently decreased to 40.8 per 100,000 in 2012 and 2013. However, after the truce began to collapse in 2013, the rate rose again, climbing to 105 per 100,000 in 2015.¹¹

Sources: ⁹ Abt T, Winship C. What works in reducing community violence: a meta-review and field study for the Northern Triangle. Washington, D.C.: United States Agency for International Development; 2016. Available from: <https://www.usaid.gov/sites/default/files/USAID-2016-What-Works-in-Reducing-Community-Violence-Final-Report.pdf>.

¹⁰ Development Bank of Latin America. Towards a safer Latin America: a new perspective to prevent and control crime. Caracas: Corporación Andina de Fomento; 2014. Available from: <http://scioteca.caf.com/handle/123456789/708>.

¹¹ World Bank. World Bank Open Data [Internet]; 2019. Available from: <https://data.worldbank.org>.



U.S. Border Patrol agent taking into custody suspected illegal immigrant, Rio Grande Valley, Texas, USA

8C. ERADICATE INSTITUTIONAL AND POLITICAL VIOLENCE

Institutional violence refers to violence from social and State institutions, including the criminal justice system. Across the Region of the Americas, particularly in Latin America and the Caribbean, there are high levels of institutional violence, including political violence and violence against journalists, and against people and organizations that challenge power systems and vested economic interests. In some areas, violence relates to police and military corruption and the criminal justice system, including selective and prejudiced incarceration.

Institutional violence poses direct threats to physical and mental health through physical attacks on individuals, and indirectly harms health through erosion of social trust in institutions and organizations. This erosion of trust threatens social cohesion and people's sense of individual and community control. All of these factors undermine the conditions conducive to good health.

INCARCERATION

The likelihood of being incarcerated is related to ethnic identity, migrant status, and socioeconomic position, and it contributes to health inequities across the Region. Throughout the Americas, there are high rates of incarceration for people of low income and of African descent. Incarceration affects individuals'



Rally for national plan to end violence against women, Parliament Hill, Ottawa, Canada

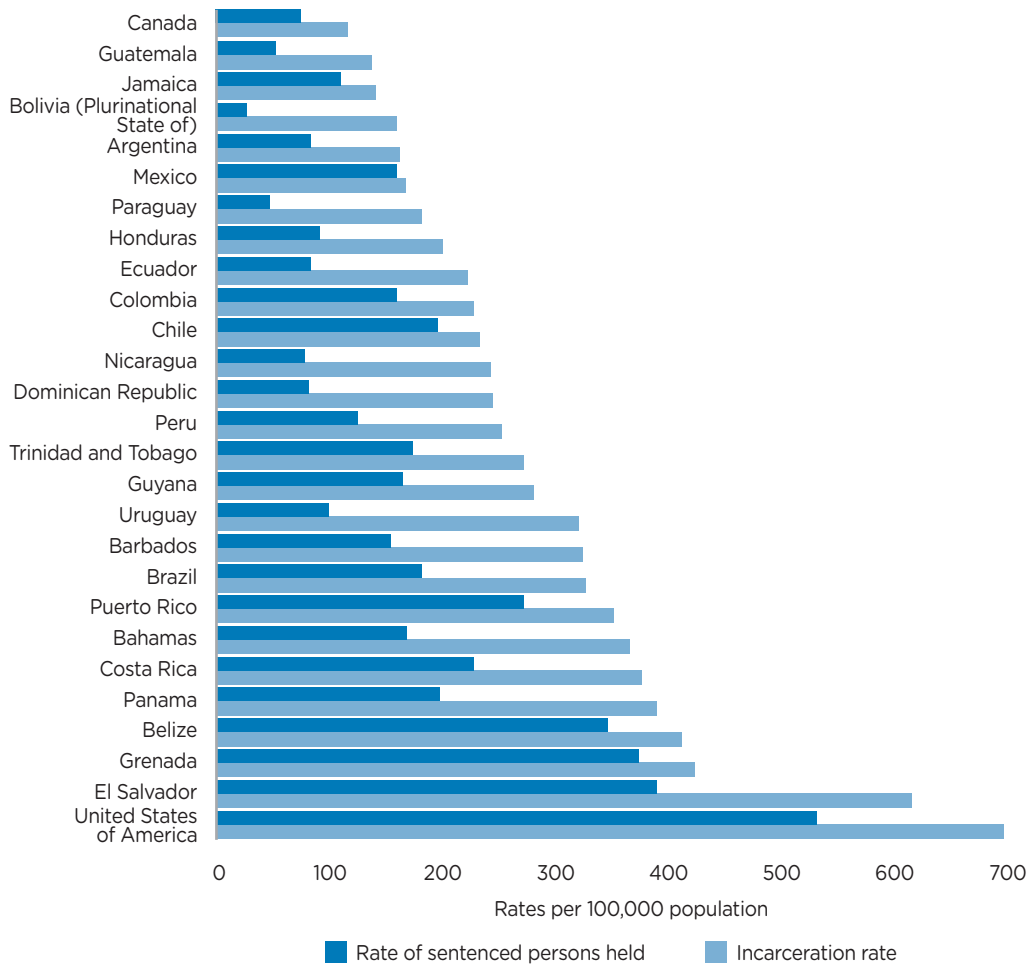
health directly, as well as indirectly through harm to social determinants that include income, prospects for employment, family functioning, trust in institutions, and community functioning.

Incarceration damages the physical and mental health of incarcerated individuals, their families, and communities (271). It raises the risk of HIV, hepatitis C, and TB infections, as well as mortality from heart disease, liver disease, and respiratory diseases (272). There are much higher rates of mental ill health in prisons than in the general population, including depression, posttraumatic stress disorder,

personality disorder, and anxiety disorders (273). Suicide is the leading cause of death in jails. For example, in the United States of America in 2013 a third of inmate deaths were due to suicide (274). Children of incarcerated parents are more likely than those without incarcerated parents to exhibit behavioral problems and low self-esteem, and to experience traumatic separation and increased rates of premature mortality (275).

The United States of America has the highest proportion of incarcerated and sentenced people in the Americas and in the world (Figure 4.66).

Figure 4.66. Incarceration rates and rates of holding sentenced persons, countries in the Americas, 2018 or latest available year



Sources: 1. United Nations Office on Drugs and Crime. Data. Total persons held in prisons [Internet]; 2018. Available from: <https://dataunodc.un.org/crime/total-prison-population>.
 2. Wagner P, Sawyer W. Mass incarceration, the whole pie. Prison Policy Initiative [Internet]; 2018. Available from: <https://www.prisonpolicy.org/reports/pie2019.html>.
Note: The number of sentenced persons held represents prisoners who have been convicted of a crime, while the incarceration rate represents the total number of prisoners (including those not convicted of a crime) held in prisons, penal institutions, or correctional institutions on a specified day, excluding noncriminal prisoners held for administrative purposes, such as persons held pending investigation into their immigration status, or foreign citizens without a legal right to stay.

Table 4.3.
Incarceration rates in the United States of America, by race/ethnicity, 2016

Race/ethnicity	Percent of U.S. population	Percent of U.S. incarcerated population	National incarceration rate (per 100,000)
White	64 percent	39 percent	450
Hispanic	16 percent	19 percent	831
Black	13 percent	40 percent	2,306

Source: Wagner P, Sawyer W. Mass incarceration, the whole pie 2016. Prison Policy Initiative [Internet]; 14 March 2016. Available from: <https://www.prisonpolicy.org/reports/pie2016.html>.

In Canada and the United States of America, the rates of incarceration are considerably higher than the rates of sentencing. In other words, the two countries arrest and detain a high proportion of people, many of whom are subsequently found not guilty and are released. They are still at risk of considerable harm to physical and mental health and social determinants as a result of incarceration and being exposed to organized crime gangs. In 2018, incarceration rates in the United States of America were 698 per 100,000 people, the highest incarceration rate in the Americas (276). The three states with the highest incarceration rates in 2018 were Louisiana, Mississippi, and Oklahoma, with rates of around 1,079 per 100,000 people (276).

According to the U.S. Census, people of African descent are five times more likely to be incarcerated than are White people in the United States of America, and Hispanics are nearly twice as likely to be incarcerated as Whites (276).

On any given day, approximately 53,000 young people are held in correction facilities in the United States of America. Nearly one in ten is held in an adult jail or prison, and thousands of young people are held before they have been found guilty, many for nonviolent, low-level offenses and even for behaviors that are not criminal violations (276).

POLICE CORRUPTION AND VIOLENCE

Police corruption has impacts on health equity, because it can lead to higher levels of crime, including violent crime and drug trafficking, with their adverse impacts on health. 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. Residents of Latin America and the Caribbean who report that paying bribes is justified are between 2 and 8 percentage points more likely to have been victims of violence, depending on the country. Police corruption undermines faith in government organizations and the ability of police to contribute to security and community cohesion (277). To put the magnitude of this effect into perspective, the negative effect of police corruption more than offsets the protective effect of living in a safer neighborhood (265).

In 2016 in the United States of America, 1,093 people (including 62 women) were killed by the police. In terms of rates, 10 per million were Native American, 7 per million were of African descent, 3 were Hispanic, and 3 were White (278). According to the Center for Policing Equity's analysis of nearly 20,000 instances of police force used against civilians across the United States of America, the use of force disproportionately affects racial minorities, despite controlling for ethnic disparities in crime (279).

VIOLENCE AGAINST JOURNALISTS

Levels of violence and harassment against journalists have been increasing across Latin America and the Caribbean, particularly since 2012. One hundred and twenty-five journalists were killed between 2012 and 2016, the second-highest regional number in the world. In the Americas, there were 37 journalists killed in Mexico, 29 in Brazil, 19 in Honduras, 14 in Guatemala, 12 in Colombia, and six in Paraguay (280).

Both Freedom House and Reporters Without Borders (RWB) produce annual indexes rating and ranking countries worldwide in terms of press freedom. Freedom House rates countries by providing a press freedom score. Based on that score, it classifies the countries as “free,” “partly free,” and “not free.” In

2018, Freedom House placed Mexico in the lowest, “not free” category of countries, along with Cuba, Ecuador, Honduras, and Venezuela (Bolivarian Republic of) (287). In RWB’s 2018 index, Mexico was the second-most violent country in the world for journalists in 2017, after Syria (287).

Examples of policies and programs to reduce institutional violence

Restorative Justice Project, Costa Rica. This project, which began in 2012, includes several measures aiming to reduce the size of the prison population. It created a drug treatment court, in which drug use is decriminalized. Targeted populations include low-level and first-time offenders who have committed an offense related to their drug dependence. An interdisciplinary group tailors their justice response to the needs of the beneficiary, focusing on residential or outpatient treatment.¹ The nationwide program was a joint collaboration of the Costa Rica government as well as private and public groups. Its work to rehabilitate adult and juvenile criminals since 2012 showed a 96 percent effectiveness rate among the 3,542 people who participated in the program up until 2017.²

Pacifying Police Units/Upps [Unidades de Polícia Pacificadora], Brazil. This ongoing program is based in favelas (informal settlements) in Rio de Janeiro with high levels of violent crime and organized criminal groups. UPPs provide community policing and link people to social services. In 2015, there were 38 UPPs in 264 *favelas* in Rio de Janeiro.³ Official data show decreases in homicide rates, as well as robbery rates, since the UPP program began in 2008.⁴ The trend in homicide was already decreasing in the areas now controlled by UPPs prior to their establishment, but the decline has continued, so that they all now show a greater decrease than the overall decrease recorded for Rio de Janeiro over the same period.⁴ However, the number of reported sexual assaults in the same period significantly increased (by almost 200 percent) in communities where UPPs operate.⁴ This may be due to higher rates of reporting resulting from growing trust in the police, or better recording practices. In 2010, 93 percent of people resident in UPP areas said they felt safer than before the UPP, while 70 percent of residents of communities without UPPs would have liked to have had the program implemented in their neighborhood. The installation of UPPs demonstrates that social inclusion and community development are key components in preventing crime.⁴

Prison Entrepreneurship Program (PEP), Texas, United States of America. Founded in 2004, this program trains incarcerated men on how to become business entrepreneurs upon their release, and then works with them and their families indefinitely after their sentence is over. PEP also owns transition housing and assists with job placement, parole compliance, and reconnecting men to their families.⁵ Men who had been involved in the PEP program reoffended at a rate of 7 percent, about one-third the overall recidivism rate for Texas, at 21 percent. Other positive results include: 100 percent were employed within 90 days of release; 74 percent had been employed by their employer for more than one year; 41 percent of those released more than three years previously earned more than US\$ 52,000 per year; 41 percent of those released more than three years previously owned their own home; 51 percent of all PEP men with children saw them daily; and another 17 percent saw their children weekly.⁵

Sources: ¹ International Drug Policy Consortium. Chapter 3.4. Alternatives to incarceration. In: IDPC Drug Policy Guide. 3rd ed. London: IDPC; 2016: 83–9. Available from: http://fileserver.idpc.net/library/IDPC-drug-policy-guide_3-edition_FINAL.pdf.

² Anders W. Costa Rica’s restorative justice successfully rehabilitates over 3,500 people. Costa Rica Star [Internet]; 2 June 2017. Available from: <https://news.co.cr/costa-ricas-restorative-justice-successfully-rehabilitates-over-3500-people/61684/>.

³ von der Wehl CB. The impact the Pacifying Police Units (UPPs) have on Rio de Janeiro’s favelas. Leiden: Leiden University [bachelor’s thesis]; 2016.

⁴ United Nations Office on Drugs and Crime. Global study on homicide. Washington, D.C.: UNODC; 2013. Available from: <https://www.unodc.org/gsh/>.

⁵ English E. The Prison Entrepreneurship Program: an innovative approach to reentry. Washington, D.C.: American Enterprise Institute; 2016. Available from: <http://www.aei.org/wp-content/uploads/2016/12/Prison-Entrepreneurship-Program.pdf>.



Flowers on a memorial for young man killed, Portland, USA

RELEVANT INTERNATIONAL AGREEMENTS

Declaration on the Elimination of Violence against Women (United Nations, 1994)

The Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Belém do Pará convention) 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. (Organization of American States, 1994)

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. This is in spite of the Inter-American Convention named above, and in spite of the Arms Trade Treaty (ATT), adopted by the United Nations General Assembly in April 2013, which was designed to regulate and improve the management of the international trade in conventional arms, with the intention of preventing, disrupting, and eradicating the illicit trade in such arms, and thwarting their diversion. (United Nations, 2013)

PAHO Resolutions

Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women (CD54.R12 [2015])

Preventing Violence and Injuries and Promoting Safety: A Call for Action in the Region (CD48.R11 [2008])

WHO Resolutions

Prevention of Violence: A Public Health Priority (WHA49.25 [1996])

Strengthening the Role of the Health System in Addressing Violence, in Particular against Women and Girls, and against Children (WHA67.15 [2014])

At the World Health Assembly in May 2016, Member States endorsed a global plan of action on strengthening the role of health systems in addressing interpersonal violence, in particular against women, girls, and other children (WHO, 2016).

Sustainable Development Goals

Goal 5. Achieve gender equality and empower all women and girls

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

RECOMMENDATION 9. IMPROVING ENVIRONMENT AND HOUSING CONDITIONS

The dwellings, communities, and environments in which people live and work are highly significant for health, and substantial inequalities in these features of the environment drive health inequalities across the Region of the Americas. This section analyzes data related to urbanization, housing, informal settlements, access to water and sanitation, air pollution, electricity, and the internet, and, where data are available, describes inequalities in these related to income, place of residence, and ethnicity.

PRIORITY OBJECTIVES	ACTIONS
<p>9A. Develop and implement national planning strategies for sustainable rural and urban development</p>	<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 multistakeholder governance arrangements • Develop standards to ensure good-quality, environmentally sustainable development • Balance development of rural and urban areas to reduce unplanned settlements
<p>9B. Set and achieve environmental standards and upgrade poor-quality environments and housing</p>	<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
<p>9C. Ensure security of land tenure in informal settlements and other environments</p>	<ul style="list-style-type: none"> • Establish legislation and mechanisms for formalizing land tenure of inhabitants living in informal settlements

9A. DEVELOP AND IMPLEMENT NATIONAL PLANNING STRATEGIES FOR SUSTAINABLE RURAL AND URBAN DEVELOPMENT

Rapid population growth and urbanization during the 20th century and early part of the 21st have limited the ability of countries in the Region of the Americas to pursue sustainable development, and to make improvements to housing and environmental conditions. This includes the capacity to make investments in essential services, such as safe drinking water and sanitation services, reducing air pollution, and provision of electricity and waste disposal services.

In Canada and the United States of America, over 80 percent of the population live in urban areas. The majority of cities in those countries have a population under 3 million inhabitants. Growth rates in cities in Canada and the United States of America were between 1.1 and 1.4 percent in 2016. In the two countries, urban population growth is mostly now occurring in medium- and small-sized urban areas.

Between around 1900 and the year 2018, the population of Latin America and the Caribbean increased from some 60 million to nearly 652 million. The rate of increase is now slowing considerably, and forecasts indicate a deceleration in population growth to less than 1 percent a year by 2030 (282). Cities have grown particularly quickly. The percentage of the population living in cities in Latin America and the Caribbean increased from 40 percent in 1900 to 80 percent in 2016 (283). Forecasts indicate that the proportion of the population in Latin America and the Caribbean that is urban will approach 90 percent by 2050 (284).

Rural to urban migration is a significant factor in urban growth, and it usually involves people migrating to seek better opportunities. They are driven by poverty; lack of access to services, education, and employment; environmental harm; and forcible or threatened exclusion from land (as described also in Recommendations 2 and 3). For many, migration to urban areas results in migrants living in extreme poverty and large slum areas in temporary, poor-quality housing with minimal services, including lack of sewerage and access to safe drinking water, and no access to

social protection. In these informal settlements, inhabitants often do not have security of land tenure, discussed below in Section 9.C, and can be removed from their dwellings, often forcibly.

Planning requires managed migration and should include:

- Policies and activities that can support improvements to those factors that drive migration, particularly lack of security of tenure, forced displacement, high levels of poverty, and lack of access to education and employment. As a first step, improving security of tenure and ending forced displacement in rural areas is a priority.
- Support for communities and areas experiencing high levels of both outward and inward migration, including but not limited to cost-effective, flexible investments and improvements in infrastructure, particularly transport, water and sanitation, housing, and other services, in a cost-effective and flexible way.

Reducing health inequalities requires making improvements to environments and housing, reducing the numbers living in slums, and upgrading existing slums. All of these improvements require long-term investment, as well as coordinated, strategic planning at the national level to reduce unplanned development. However, most countries do not have national planning strategies to facilitate these processes.

Given the rates of urbanization in the Americas, planning and management of both migration and of cities is absolutely crucial to the future

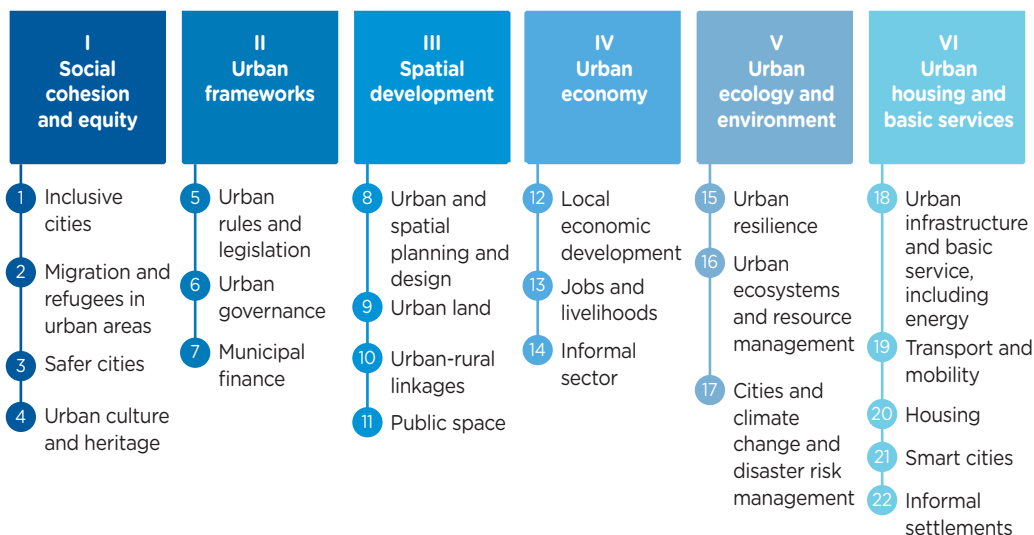


Tents house the growing number of homeless people, Seattle, USA

development, health, and health equity of the entire Region. 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. Important arenas for the planning of cities have been identified by ECLAC and are described in Figure 4.67.

Figure 4.67.
Themes proposed for the Latin American and Caribbean Urban and Cities Platform



Source: Economic Commission for Latin America and the Caribbean. Proposal for the Latin American and Caribbean Urban and Cities Platform. Santiago: ECLAC; 2018. Available from: <https://www.cepal.org/en/publications/44159-proposal-latin-american-and-caribbean-urban-and-cities-platform>.

Examples of programs and policies to develop national planning strategies for sustainable rural and urban development

Ministry of Cities, Brazil, is a cabinet-level federal ministry that deals with urban policies, including land regularization, housing, sanitation, and transport.¹ Within this Ministry, the National Department of Transport and Urban Mobility was established to formulate and implement the National Policy for Sustainable Urban Mobility. Key to this policy was the integration of transport and urban development policy in order to provide broad, democratic access to urban space, by prioritizing public and nonmotorized transport and ensuring secure, socially inclusive, and sustainable mobility.²

WHO Healthy Cities is a global movement whose aim is to put health high on the social, economic, and political agenda of city governments. For 30 years in Europe, the WHO European Healthy Cities Network has connected approximately 100 cities and 30 national networks. WHO provides political, strategic, and technical support, as well as capacity-building. Their goal is to engage local governments in political commitment, institutional change, capacity-building, partnership-based planning, and innovation. There are now Healthy Cities networks in every WHO region.³

Action on social determinants of health using the Urban Health Equity and Response Tool (HEART) in the Americas. The Urban HEART experience was evaluated in four cities from 2010 to 2013: Guarulhos (Brazil), Toronto (Canada), and Bogotá and Medellín (Colombia). Reports were submitted by Urban HEART teams in cities and by first-hand accounts of key informants. Urban HEART provided local governments with a method for assessing and responding to health inequity. Through the social determinants of health approach, the tool provided a platform for intersectoral action and community involvement. While some areas of guidance could be strengthened, Urban HEART was a useful tool for directing local action on health inequities.⁴

Healthy Cities movement, Salamá, Honduras. The Healthy Cities movement was launched in Salamá in 1994 and established intermunicipal alliances for furthering sustainable community development in the face of seemingly overwhelming obstacles. The initiative showed a positive impact on material and physical conditions throughout the municipality and its surrounding communities, and it helped address the underlying determinants of poverty at the community level.⁵

Healthy Cities movement, Canada. Since the Healthy Cities movement began in Canada in 1984, strong provincial networks of Healthy Cities have developed in Ontario and Quebec, representing a total of 200 communities. In addition, provincial networks were formed in New Brunswick and Saskatchewan, and they include youth programs, community safety, local economic development, recreation, and urban planning.⁵

Curitiba, Brazil provides an example of a city region plan for sustainable and managed growth. In 1965, prompted by fears among city officials that Curitiba's rapid growth would lead to unchecked development and congested streets, the city adopted a new master plan. Curitiba would be prevented from growing in all directions from the center, but would grow along designated corridors, with zoning along each.⁶ The city also promoted public transport systems by developing and building a high-capacity bus system known as Bus Rapid Transit, which costs much less than rail-based systems.⁷ While the city has one of Brazil's highest rates of car ownership, in 2011 approximately 70 percent of the city's population commuted by bus, including 28 percent of users who previously commuted by personal car. As a result, Curitiba has reduced air pollution levels and has one of the country's lowest rates of ambient pollution.⁷

Sources: ¹ Valença MM, Bonates MF. The trajectory of social housing policy in Brazil: from the National Housing Bank to the Ministry of the Cities. *Habitat Int.* 2010;34(2):165-73.

² United Nations Environment Programme. Brazil [Internet]; [cited 25 Jan 2019]. Available from: <https://www.unenvironment.org/es/node/567>.

³ World Health Organization. Types of healthy settings: healthy cities [Internet]; [cited 13 Jul 2018]. https://www.who.int/healthy_settings/types/cities/en/.

⁴ Prasad A, Groot AM, Monteiro T, Murphy K, O'Campo P, Broide EE, Kano M. Linking evidence to action on social determinants of health using Urban HEART in the Americas. *Rev Panam Salud Publica.* 2013 Dec;34(6):407-15.

⁵ WHO Europe. Healthy Cities around the world. An overview of the Healthy Cities movement in the six WHO regions [Internet]; 2003. Available from: http://www.euro.who.int/__data/assets/pdf_file/0015/101526/healthycityworld.pdf.

⁶ Goodman J, Laube M, Schwenk J. Curitiba's bus system. Case studies and solutions. *Race, Poverty & the Environment* [Internet]; 2006. Available from: <https://www.reimaginerpe.org/curitiba-bus-system>.

⁷ Kelly E, Gustafsson HR. Urban innovations in Curitiba: a case study. New Haven: Eugene & Carol Ludwig Center for Community and Health; 2012.

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Examples of programs and policies to develop national planning strategies for sustainable rural and urban development *(continued)*

Habitar Brasil BID (HBB-BID), Brazil, 1999. This pilot program aimed to help the government to develop national policy and a framework for slum upgrading and financing interventions in capital cities and municipalities. The program has benefited some 119 municipalities in two main ways: 1) institutional development in areas related to housing and capacity development to strengthen national housing policy and 2) informal settlement upgrading.⁸ Knowledge accumulated from previous local programs, such as Favela-Bairro, was incorporated, and the program helped to establish the foundations of the new national housing policies and slum upgrading programs that followed. Slum upgrading was based on a broad process of social support aimed at encouraging the participation of local inhabitants, improving income indicators, building capacity, and supporting health and environmental education. The interventions were recognized for their impact on social inclusion, innovation in the local context, and strengthening of local leadership.⁸

Sources: ⁸ Lonardon F. From mass public housing to a twin-track approach. In: Magalhães F, editor. Slum upgrading and housing in Latin America. Washington, D.C.: Inter-American Development Bank; 2016: 31-59. Available from: <https://publications.iadb.org/en/publication/12558/slum-upgrading-and-housing-latin-america>.

9B. SET AND ACHIEVE ENVIRONMENTAL STANDARDS AND UPGRADE POOR-QUALITY ENVIRONMENTS AND HOUSING

Across the Region of the Americas, there are widespread and high levels of inequalities in access to decent, affordable housing, and in access to the basic services that support healthy environmental standards and good health, including electricity, clean water, sanitation, and clean air.

Environmental conditions that have direct impacts on health include but are not limited to (285):

- 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 the internet;
- Effective, affordable public transportation systems to access employment, educational opportunities, community facilities, healthy food, and other services;
- Clean air, water, and soil; and
- Access to green spaces and areas for physical activity.

Improvements are entirely possible, and have been achieved in many parts of the Americas, even

for those living in the most health-damaging and insecure, precarious, poor-quality environments and housing.

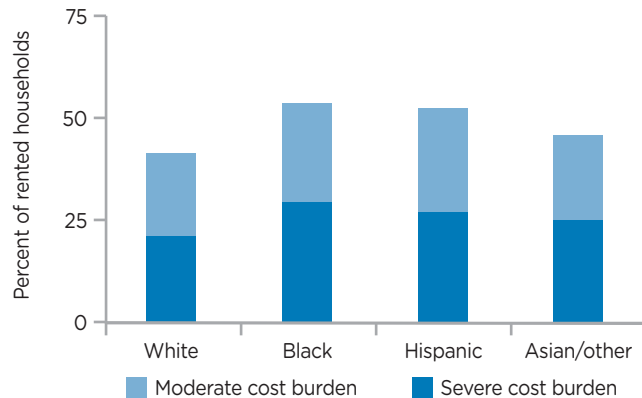
HOUSING

Supply and affordability

More than 50 percent of families in Latin America's biggest cities cannot afford to buy a formal dwelling using their own means. In addition, in many large cities across Latin America and the Caribbean, two-thirds of families cannot afford to buy decent housing (285). In most cases, poverty is the biggest obstacle to home ownership, along with the inability to document income due to high levels of informal labor across Latin America and the Caribbean. Furthermore, adequate low-cost housing is scarce.

In the United States of America in 2017, only 7.5 million rental homes were affordable to low-income

Figure 4.68.
Renter cost burdens, by ethnicity,
United States of America, 2016



Source: Joint Center for Housing Studies of Harvard University. State of the nation's housing 2018. Cambridge: President and Fellows of Harvard College; 2018. Available from: https://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_State_of_the_Nations_Housing_2018.pdf.

Note: Moderate cost burden refers to households that spend 30–50 percent of their income on rent; severe cost burden refers to households that spend over 50 percent of household income on rent.

renters (persons whose income was at or below the poverty guideline) (286). This left an absolute shortage of nearly 4 million affordable rental homes (286). Rent burdens disproportionately affect ethnic minorities. Figure 4.68 shows that in the United States of America, White renters are less burdened than renters of other ethnic identities (287).

The high levels of housing unaffordability across the Americas have significant negative health impacts. These include direct impacts related to having to live in poor-quality housing, which raises the risk of a wide range of communicable and noncommunicable diseases, including cardiovascular disease, respiratory illnesses, and mental health problems. Indirectly, trying to secure and retain appropriate and affordable housing raises the risk of a range of physical and mental health harm in several ways. Spending a large proportion of income on housing means there is insufficient income available for other essentials for healthy living, including nutritious food, socializing, paying travel costs for work and education, and purchasing other critical household items. Unaffordable housing also causes high levels of stress, anxiety, and other mental health problems (288).

Housing standards

According to UN Habitat, adequate housing should provide legal security of tenure, services, materials, facilities, and infrastructure, including safe drinking water, adequate sanitation, energy for cooking, heating, lighting, food storage, and refuse disposal. It should be habitable; guarantee physical safety; provide adequate space; and protect against the cold, damp, heat, rain, wind, other threats to health, and structural hazards. It should also be affordable. Housing is inadequate if the specific needs of disadvantaged and marginalized groups, including disabled people, are not taken into account. Adequate housing should be in a location that is connected to health care services, schools, child care centers, and other social facilities (289).

In 2014, approximately 40 percent of families in Latin America and the Caribbean lived in a house that was either unsuitable for habitation or built with poor materials and lacking basic infrastructure services (290).

There is also evidence of inequalities in housing conditions related to ethnicity. For example, in Canada in 2016, 19 percent of the total Indigenous population lived in a dwelling that was in need of major repairs, in comparison to 6 percent of the non-Indigenous population (291). In the United States of America, residential segregation and ongoing poverty have left African Americans in some of the least desirable housing in some of the lowest-resourced communities in the country, and persons of African descent are over one and a half times more likely than the rest of the population to occupy homes with severe physical problems (292).

Overcrowding

Household overcrowding, a result of poor-quality and unaffordable housing, also poses significant risks to health, including increased rates of infectious disease transmission and higher risks of poor mental health. In 2016 in Canada, close to one-fifth (18.3 percent) of the Indigenous population lived in housing that was considered unsuitable for the number of people who lived there, according to the National Occupancy Standard (297). Figure 4.69 shows levels of overcrowding for countries in Latin America. Costa Rica and Uruguay have very low levels of overcrowding (29).

Examples of policies and programs to improve housing

Property Today [Patrimonio Hoy], Mexico, 1998. This program aims to help 20 million residents living in inadequate shelter. It is a government and private sector partnership, which helps low-income families form self-financing groups and expedites the homebuilding and home improvement process in slums.¹ The program provides financing, materials, technical assistance, and customer services to low-income families in order to support self-construction of low-income housing. There have been positive impacts on children from the additional space and increased financial resources. Furthermore, children's aspirations have increased by witnessing their parents' ability to save and improve or build their house.² The program started in Mexico but has since expanded to Colombia, Costa Rica, the Dominican Republic, and Nicaragua.

Firm Floor [Piso Firme] Program, Mexico. This program replaced dirt floors with cement floors in low-income housing. It began around 2000. The government offered homeowners with dirt floors up to 538 square feet of concrete flooring at a subsidized rate, and homeowners laid the new flooring themselves. An evaluation was carried out comparing households with improved flooring with those left with unimproved floors, and found that adults in upgraded homes were substantially happier (as measured by their degree of satisfaction with their housing and quality of life), and experienced lower rates of depression and stress. Children in the improved housing experienced approximately 13 percent fewer episodes of diarrhea and a 20 percent reduction in anemia. Toddlers' language and communication skills improved 30 percent, and children scored 9 percent higher on vocabulary tests.³

TECHO [Roof] program, Chile and other countries. Founded in 1997, this NGO provides basic, prefabricated, transitional houses to extremely poor families living in informal settlements in Latin America and the Caribbean, whether or not they own the land on which they live. Program volunteers help build the houses. The aim of the program is to improve the health and well-being of these families.⁴ TECHO has expanded to 19 countries. By 2014, the NGO had built 100,000 houses.⁵ The cost of a TECHO house is less than US\$ 1,000, of which the beneficiary family contributes 10 percent.⁴ A study of the program carried out in 2014 in El Salvador, Mexico, and Uruguay showed it resulted in substantial improvements in the quality of floors, walls, and roofs, as well as increases in the percentage of rooms with windows.⁴ Findings show that the improvements have a positive effect on overall housing conditions and inhabitants' subjective well-being: members of participating households were more satisfied with the quality of their lives.⁴

Housing Choice Voucher (HCV) program, United States of America. Implemented since 1998, this is the federal government's major program for assisting very-low-income families, the elderly, and the disabled to afford decent, safe housing in the private market. Rental units must meet minimum standards of health and safety, as determined by the public housing agency (PHA). The family pays the difference between the actual rent charged by the landlord and the subsidized amount. Eligibility is based on total annual gross income and family size. In general, the family's income may not exceed 50 percent of the median income for the area in which the family chooses to live.⁶ In 2014, one in eight families with children participating in the HCV program used their vouchers to live in a low-poverty area, where fewer than 10 percent of residents are poor, disrupting the concentration of poverty.⁷ More than 5 million people in 2.2 million low-income families use vouchers.⁸

Sources: ¹ Peters A, Schmidt J. CEMEX Patrimonio Hoy: providing integral housing solutions for low-income families. Case study [Internet]; 2014. Available from: http://endeva.org/wp-content/uploads/2015/08/bcta_casestudies_cemex_ph_final.pdf.

² Esper H, London T. Improved housing and its impact on children: CEMEX's "Patrimonio." Impact Case study No. 1. Ann Arbor: The William Davidson Institute; 2013. Available from: <https://wdi.umich.edu/wp-content/uploads/Child-Impact-Case-Study-1-Improved-Housing-Patrimonio-Hoy.pdf>.

³ Cattaneo MD, Galiani S, Gertler PJ, Martinez S, Titiunik R. 2009. Housing, health, and happiness. *Amer Econ J*. 2009;1(1):75-105.

⁴ Galiani S, Gertler PJ, Undurraga R, Cooper R, Martínez S, Ross A. Shelter from the storm: upgrading housing infrastructure in Latin American slums. *J Urban Econ*. 2017;98:187-213.

⁵ CAF America. International and domestic – donor advised funds [Internet]; 12 January 2016 [cited 25 Feb 2019]. Available from: <https://www.cafamerica.org/>.

⁶ U.S. Department of Housing and Urban Development. Housing choice vouchers fact sheet [Internet]; [cited 13 Dec 2018]. Available from: https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/about/fact_sheet.

⁷ Sard B, Rice D. Realizing the housing voucher program's potential to enable families to move to better neighborhoods [Internet]; 12 January 2016 [cited 25 Jan 2019]. Available from: <https://www.cbpp.org/research/housing/realizing-the-housing-voucher-programs-potential-to-enable-families-to-move-to>.

⁸ Center on Budget and Policy Priorities. Policy basics: the Housing Choice Voucher Program [Internet]; 3 May 2017 [cited 25 Jan 2019]. Available from: <https://www.cbpp.org/sites/default/files/atoms/files/PolicyBasics-housing-1-25-13vouch.pdf>.

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Examples of policies and programs to improve housing *(continued)*

Moving to Opportunity, United States of America. The U.S. Department of Housing and Urban Development's Moving to Opportunity (MTO) for Fair Housing program was approved by the U.S. Congress in 1992. MTO made use of rental assistance vouchers, in combination with intensive housing search and counseling services, to assist low-income families to move from some of America's most distressed urban neighborhoods to lower-poverty communities. A total of 4,600 low-income families with children, the vast majority of them headed by African American or Hispanic single mothers, were recruited from high-poverty public housing projects in five participating cities between 1994 and 1998. A follow-up study carried out seven years later found that the program had improved neighborhood outcomes, and that participating adults felt safer and more satisfied with their housing and neighborhoods. MTO improved adults' mental health, as well as several important aspects of physical health.⁹

Rental subsidy program, Chile. Chile was the first country in South America, in 2014, to adopt a national rental subsidy program. It aims to make rental housing more affordable to low- and moderate-income young families with household heads who are 18 to 30 years old. Eligibility is not determined solely by income (which can be hard to measure due to a substantial informal economy and poor systems for income reporting) but instead by a Social Vulnerability Score measured by a government-issued survey. The program also requires participants to establish a savings account with the equivalent of at least US\$ 180. The housing where the subsidy is used must also meet certain physical requirements to ensure a decent and safe standard.¹⁰

Free Housing program, Colombia. This program was developed in 2012 to provide 100,000 free housing units. The success of the first stage of the program led to its expansion by an additional 300,000 units. The housing is usually two-bedroom units in apartment blocks or single-story row houses in neighborhoods built for 3,000 to 15,000 people. Program beneficiaries are usually drawn from waiting lists, administered locally and supplemented with names of families classified as being in extreme poverty and/or victims of natural disasters. The Free Housing projects are seen as relatively secure places which offer "quiet" and "dignified" living conditions. It is estimated that up to 900,000 households were on the waiting lists for Free Housing in 2016, while 100,000 households had benefited from the housing program up to that date.¹¹

My House, My Life [*Minha Casa, Minha Vida*], Brazil. This program, established in 2009, is ongoing and is currently the main program for social housing construction in Brazil. The program has delivered 4.5 million affordable housing units, reducing the country's housing deficit. However, it has also received criticism for the planning, design, and quality of its end products. Residents living in some of the areas where houses have been built are located up to four hours from areas of employment and other services and resources.¹²

Sources: ⁹ Kling JR. A summary overview of moving to opportunity: a random assignment housing mobility study in five U.S. cities. Washington, D.C.: National Bureau of Economic Research; 2008.

¹⁰ Ross LM, Pelletiere D. Chile's new rental housing subsidy and its relevance to U.S. Housing Choice Voucher Program reform. *Cityscape*. 2014;162(2):15.

¹¹ Sliwa M, Wiig H. Should I stay or should I go: the role of Colombian free urban housing projects in IDP return to the countryside. *Habitat Int*. 2016;56:11-9.

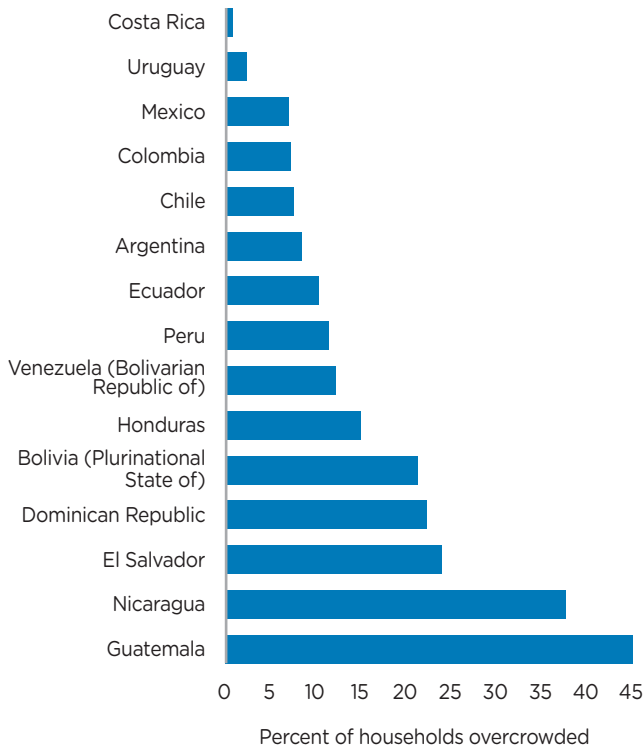
¹² Pacheco P. 6 features that make Brazil's affordable housing programme good for people and the environment [Internet]; 26 September 2018. Available from: <https://www.urbanet.info/brazil-affordable-housing-sustainability/>.

ACCESS TO DECENT ENVIRONMENTAL STANDARDS

Safe water supplies, hygienic sanitation, and good water management are fundamental to health and to reducing health inequalities in the Region of the Americas. Almost one-tenth of the global disease burden could be prevented by increasing access to safe drinking water, improving sanitation and hygiene,

and enhancing water management to reduce the risks from waterborne infectious diseases (293). The Region has made enormous strides in improving environmental standards, but there is still considerable scope for improvement. Some of the poorer countries in the Americas still have low levels of access to safe water and sanitation, and even in the wealthiest countries—Canada and the United States of America—

Figure 4.69.
Percent of overcrowded households, selected countries in Latin America and the Caribbean, 2015



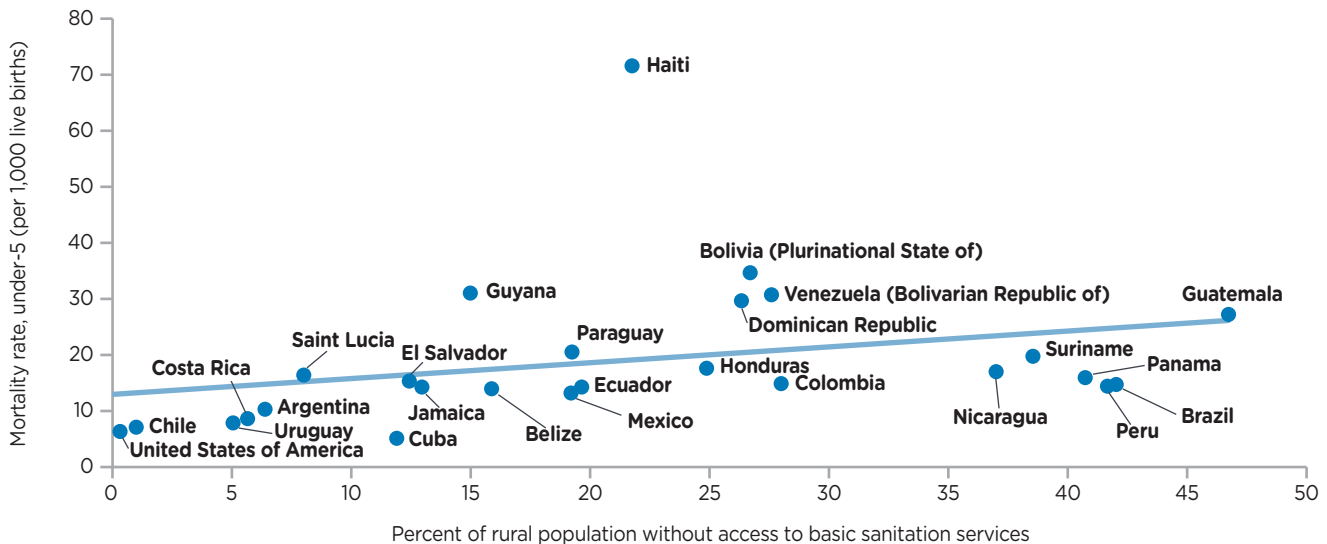
Source: Economic Commission for Latin America and the Caribbean. The social inequality matrix in Latin America. Santiago: ECLAC; 2016. Available from: https://repositorio.cepal.org/bitstream/handle/11362/40710/1/S1600945_en.pdf.

there are particular communities, mainly Indigenous ones, that do not have access to safe water.

In 2016 in Latin America and the Caribbean, the mortality rate attributed to unsafe water, unsafe sanitation, and lack of hygiene was 1.7 per 100,000 population. In Canada and the United States of America, it was 0.2 per 100,000 (7). In Latin America in 2015, 0.2 percent of neonatal deaths, 7.9 percent of postneonatal deaths, and 4.4 percent of deaths of children aged under 5 were caused by diarrhea, related to unsanitary conditions and unsafe water (294). There is a strong association between the lack of access to sanitation facilities for rural populations and under-5 mortality rates. Having a higher proportion of population in rural locales without access to improved water facilities is associated with greater maternal mortality in those areas, across the Region (Figure 4.70) (294).

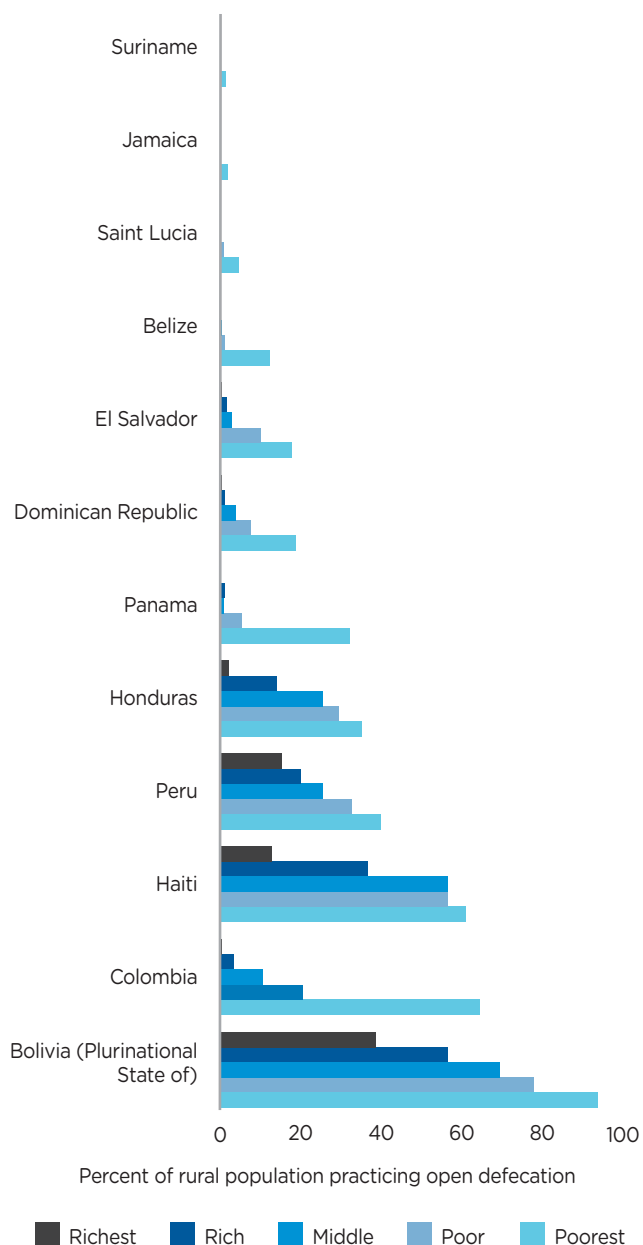
In Latin America and the Caribbean, an average of 83 percent of the population used an improved sanitation facility in 2015. Rates in rural areas increased from 36 percent to 64 percent between 1990 and 2015 (295). However, the availability of improved sanitation facilities in rural areas is still relatively low despite these improvements. There are clear income-related inequalities, and in some countries in the Region much of the population, especially poorer people, were still

Figure 4.70.
Under-5 mortality rate by percent of rural population with no access to improved sanitation facilities, countries in the Americas with comparable data available, 2017



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

Figure 4.71.
Percent of the population practicing open defecation in rural areas, by income quintile, selected countries in the Americas with available data, 2015

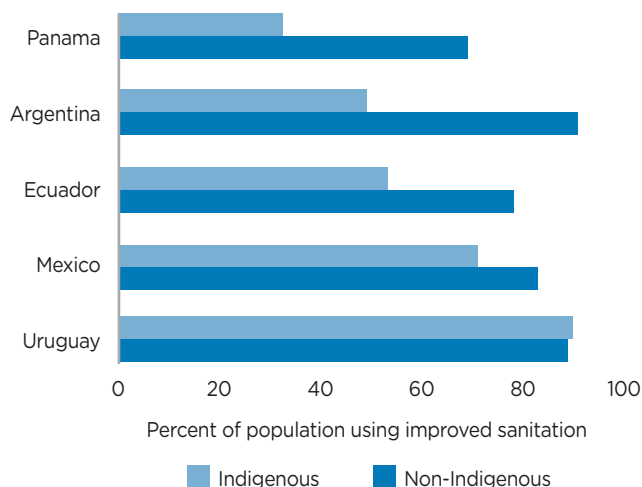


Source: United Nations Children’s Fund; World Health Organization; Joint Monitoring Programme for Water Supply and Sanitation. Country files [Internet]; 2018. Available from: <https://washdata.org/monitoring/schools/country-files-2018>.

practicing open defecation in rural areas in 2015 (Figure 4.71) (296).

There are wide inequalities in access to improved sanitation for Indigenous populations as compared

Figure 4.72.
Percent of Indigenous and non-Indigenous populations using improved sanitation, selected countries in Latin America, 2014



Source: United Nations Children’s Fund; World Health Organization; Joint Monitoring Programme for Water Supply and Sanitation. Country files [Internet]; 2018. Available from: <https://washdata.org/monitoring/schools/country-files-2018>.

with non-Indigenous populations. Of the countries shown in Figure 4.72, Panama, Argentina, and Ecuador have particularly wide inequalities between Indigenous and non-Indigenous communities in this respect.

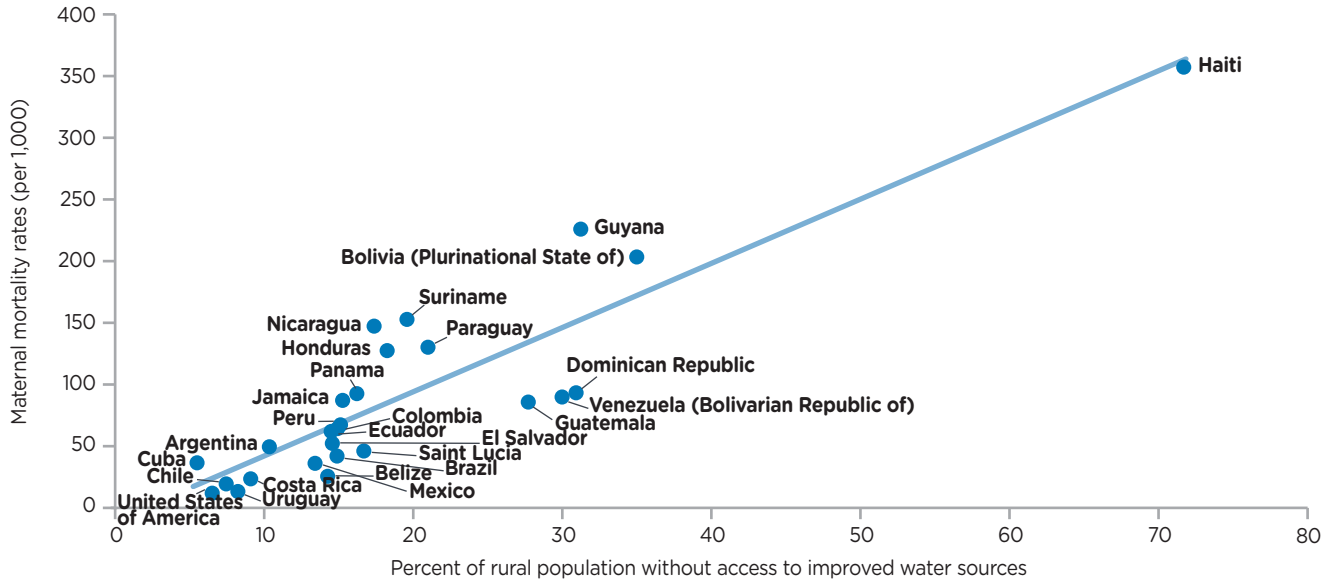
Water supplies

There are inequalities in access to safe and improved water sources in the Region, including in Canada and the United States of America, and many rural, low-income, and Indigenous people still do not have access. Not having safe water has multiple negative health impacts, and differences in access are a significant contributor to health inequalities. A higher proportion of rural inhabitants without access to improved water facilities is closely associated with higher maternal mortality and under-5 mortality across the Americas. Figure 4.73 shows the association between lack of access to safe water and maternal mortality for rural populations.

In rural Latin America and the Caribbean, significant increases in improved drinking water coverage have been made since 1990, driven by an expansion of piped water. In 2015, 95 percent of the total population used an improved

Figure 4.73.

Maternal mortality by percent of rural population without access to improved water sources, countries in the Region of the Americas with comparable data available, 2017



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

drinking water source (295). However, the rate is considerably lower in rural Central America, and approximately one in five people still relies on nonpiped water in the Caribbean, Central America, and Mexico (296).

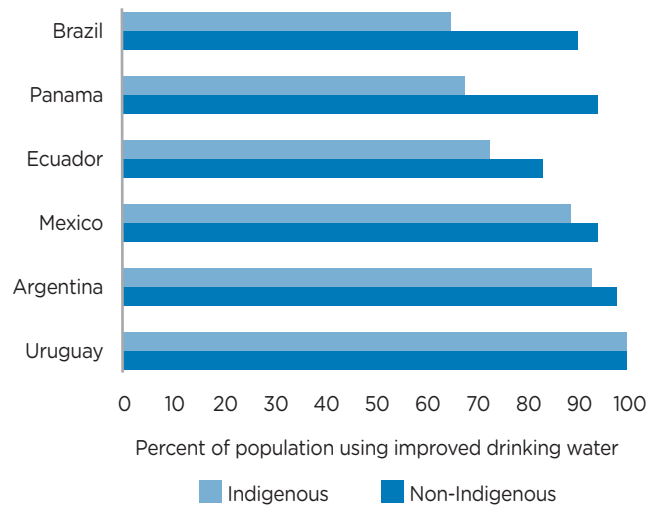
Approximately 15 percent of the population of the United States of America access their drinking water from private wells. Diseases and infections caused by waterborne agents such as *Legionella* bacteria, which are present in some of these sources, result in approximately 40,000 hospitalizations each year. Arsenic contamination, which is associated with heart disease and cancer, contributes to approximately 1,000 deaths annually (297).

In many countries, Indigenous communities have lower rates of access to safe water than non-Indigenous communities. Figure 4.74 shows that for countries with available data, Indigenous populations had less access to improved water coverage in 2014 than non-Indigenous populations, especially in Brazil, Panama, and Ecuador (298).

As described in Recommendation 3, many Indigenous peoples in Canada still do not have access to safe water.

Figure 4.74.

Percent of Indigenous and non-Indigenous peoples using improved drinking water, selected countries in Latin America, 2014



Source: United Nations Children’s Fund; World Health Organization; Joint Monitoring Programme for Water Supply and Sanitation. Country files [Internet]; 2018. Available from: <https://washdata.org/monitoring/schools/country-files-2018>.

Examples of policies and programs to improve environmental standards

Indigenous Drinking Water Projects, Ontario, Canada, 2016. The Indigenous Drinking Water Projects Office provides technical and engineering support for on-reserve drinking water systems and, at the request of First Nation communities and Tribal Councils,¹ undertakes technical assessments of existing drinking water systems, including water quality sampling; provides technical advice and support for water quality improvement and maintenance projects; supports the development of sustainable operations and maintenance business plans for drinking water systems; assesses and supports water system operator training and certification requirements; and provides advice and support for source protection and watershed planning.

CDC's Safe Water Program, United States of America. This program is intended to reduce environmental threats to water systems and people's exposure to waterborne contaminants. The program provides expertise and resources to investigate the environmental causes of waterborne illness outbreaks; respond to toxic contamination and natural disasters that affect drinking water; assess exposures in unregulated drinking water sources; and provide guidance, tools, and training.²

Joint Program on Establishing Effective and Democratic Water and Sanitation Management in Mexico, 2008–2012. The Joint Program aimed to improve the integrated management of water in peri-urban and rural areas of Mexico to help achieve the Millennium Development Goals (MDGs) with regard to water and sanitation, and to encourage environmental sustainability and gender equality. It led to increased democratic water governance, transparency, and participation of civil society, with particular emphasis on women's participation. The program focused on populations in three states in the south of the country characterized by high levels of social and economic deprivation, a significant proportion of which were Indigenous populations. Some of the water systems have become local microenterprises. In Sitalá, in the state of Chiapas, the water system is managed and operated by a group of midwives.³

Clean Water [Agua Limpia], Peru. This NGO, founded in 2007, and its partners have helped over 25,000 people in peri-urban areas over the last few years to take out loans to improve sanitation. Prior to this program, numerous households were not able to afford to invest in connections to sewer networks. Agua Limpia worked with Peruvian microfinance institutions (MFIs) to design a sanitation loan product, targeting households that were interested in improving their sanitation but were too financially constrained to do so without access to credit. Agua Limpia has helped identify a key barrier to sanitation services—household financing.⁴

Rural Electrification Project (REP), Peru. REP was designed to expand electricity service in remote areas and to promote productive uses of sustainable electricity in agricultural, commercial, and industrial activities in rural areas in order to help alleviate poverty in Peru. In 2005, electricity coverage in rural Peru was 30 percent, but by 2013 the rate was 75 percent.⁵

Holistic Sanitation Service Model, Haiti. The socially oriented business Sustainable Organic International Livelihoods (SOIL) in Haiti has initiated innovative sanitation business models that seek to respond to lower-income and traditionally underserved households living in urban and peri-urban areas. The focus is on household sanitation infrastructure (e.g., latrines, bathrooms) and waste transport and treatment. The business relies on an ecological sanitation toilet model, which is rented or leased to households. Households pay a regular service fee that covers the periodic waste collection from their toilets. The waste is then composted, rendered sanitary, and sold for agricultural purposes.⁴

Sources: ¹ Ontario. Working with First Nations to improve drinking water [Internet]; [cited 18 Dec 2018]. Available from: <https://www.ontario.ca/page/working-first-nations-improve-drinking-water>.

² U.S. Centers for Disease Control and Prevention, National Center for Environmental Health. CDC's Safe Water Program [Internet]; [cited 18 Dec 2018]. Available from: https://www.cdc.gov/nceh/information/safe_water_programs.htm.

³ UN Women. Mexico: gender mainstreaming to establish effective and democratic water and sanitation management [Internet]; [cited 13 Dec 2018]. Available from: http://www.unwomen.org/mdgf/downloads/MDG-F_Mexico_C.pdf.

⁴ Sparkman D, Sturzenegger G. Fostering water and sanitation markets in Latin America and the Caribbean: low-income populations. Washington, D.C.: Inter-American Development Bank; 2016. Available from: <https://publications.iadb.org/en/fostering-water-and-sanitation-markets-latin-america-and-caribbean-how-public-sector-can-support>.

⁵ World Bank. Peru: rural electrification project. Independent evaluation group, project performance assessment report 117145. Washington, D.C.: World Bank; 30 June 2017. Available from: <https://ieg.worldbankgroup.org/sites/default/files/Data/reports/ppar-pe-ruralelectrification-09012017.pdf>.

(continued on next page)

Examples of policies and programs to improve environmental standards *(continued)*

Liaisons [Enlaces] education program, Chile, 1992. Its main objective was to improve access to information technology in public schools to reduce the gap between the technology services offered to students in private and public schools. Through the initiative, by 2008 at least 87 percent of the schools in the country had access to information and communication technology.⁶

Connecting Equality [Conectar Igualdad], Argentina, 2010. The aim of this program was to enhance public education to reduce the digital, educational, and social gaps between public education and private education. The program delivered netbooks to all students and teachers in secondary public schools and promoted the use of netbooks at home, to have an impact on the daily lives of families and communities. By July 2015, 5 million computers had been delivered and more than 1,428 digital classrooms were established across the country.⁶

Sources: ⁶ Sharma A, Arese Lucini B. Connected society: digital inclusion in Latin America and the Caribbean [Internet]; 2016. Available from: <https://www.gsma.com/mobilefordevelopment/wp-content/uploads/2015/02/Connected-Society-Digital-inclusion-in-Latin-America-and-the-Caribbean-1.pdf>.

Access to electricity and the internet

The proportion of households with access to electricity in urban areas across the Americas is

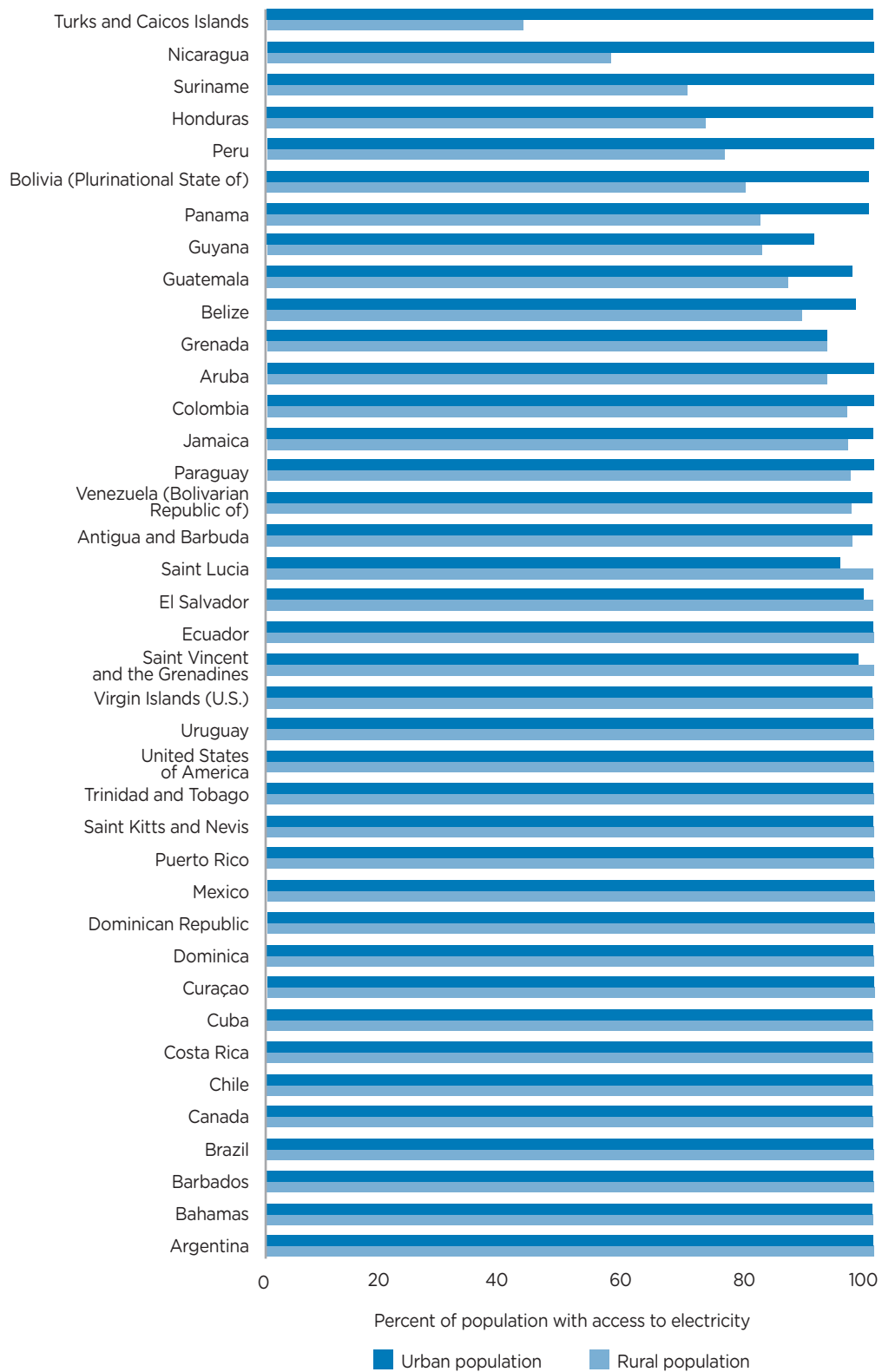
high, but for some countries access to electricity in rural areas remains relatively low, as shown in Figure 4.75.



Capturing clean drinking water, Haiti

Figure 4.75.

Percent of rural and urban households with access to electricity, countries in the Americas, 2016



Source: World Bank, Databank, World development indicators [Internet]. Available from: <https://data.worldbank.org>.



Air pollution, Mexico City

Access to the internet is increasingly considered an essential service, and lack of access results in inequities in a range of access to services, social connections, employment opportunities, and other factors that are essential to good health. Among the countries in the Region, there are large differences in this access. For example, in Aruba, Bermuda, and Canada more than 90 percent of the population used the internet in 2016, in contrast to Haiti, where only 12 percent of the population did so (299).

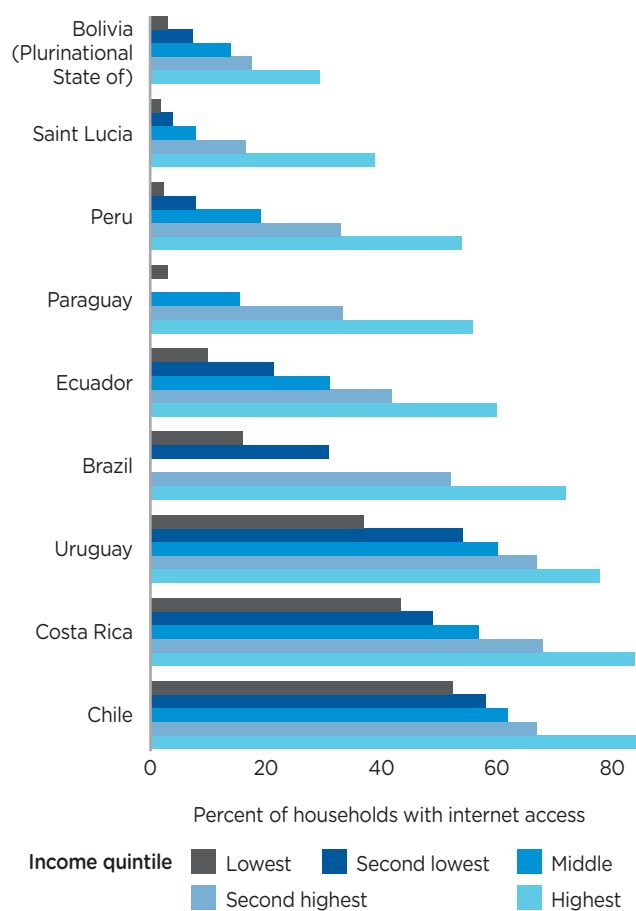
Figure 4.76 shows the proportion of households with access to the internet by household income quintile for 2011 and 2015. In every country shown, there is a clear income gradient in access to the internet.

The Pew Research Center highlighted inequities in access to information technologies and found that in 2016, approximately 50 percent of U.S. households with annual incomes below US\$ 30,000 did not have access to high-speed internet in the home, and nearly one-third did not own a smartphone (300). In Canada, 58 percent of low-income households lacked internet access in 2012 (301).

AIR POLLUTION

Ambient or outdoor air pollution is a major cause of death and disease in the Region. Age-standardized mortality attributed to household and ambient air pollution in 2016 in Latin America and the Caribbean was 39 per 100,000 of the population, and in North America (Canada and the United States of America) the rate was 13 per 100,000 (7).

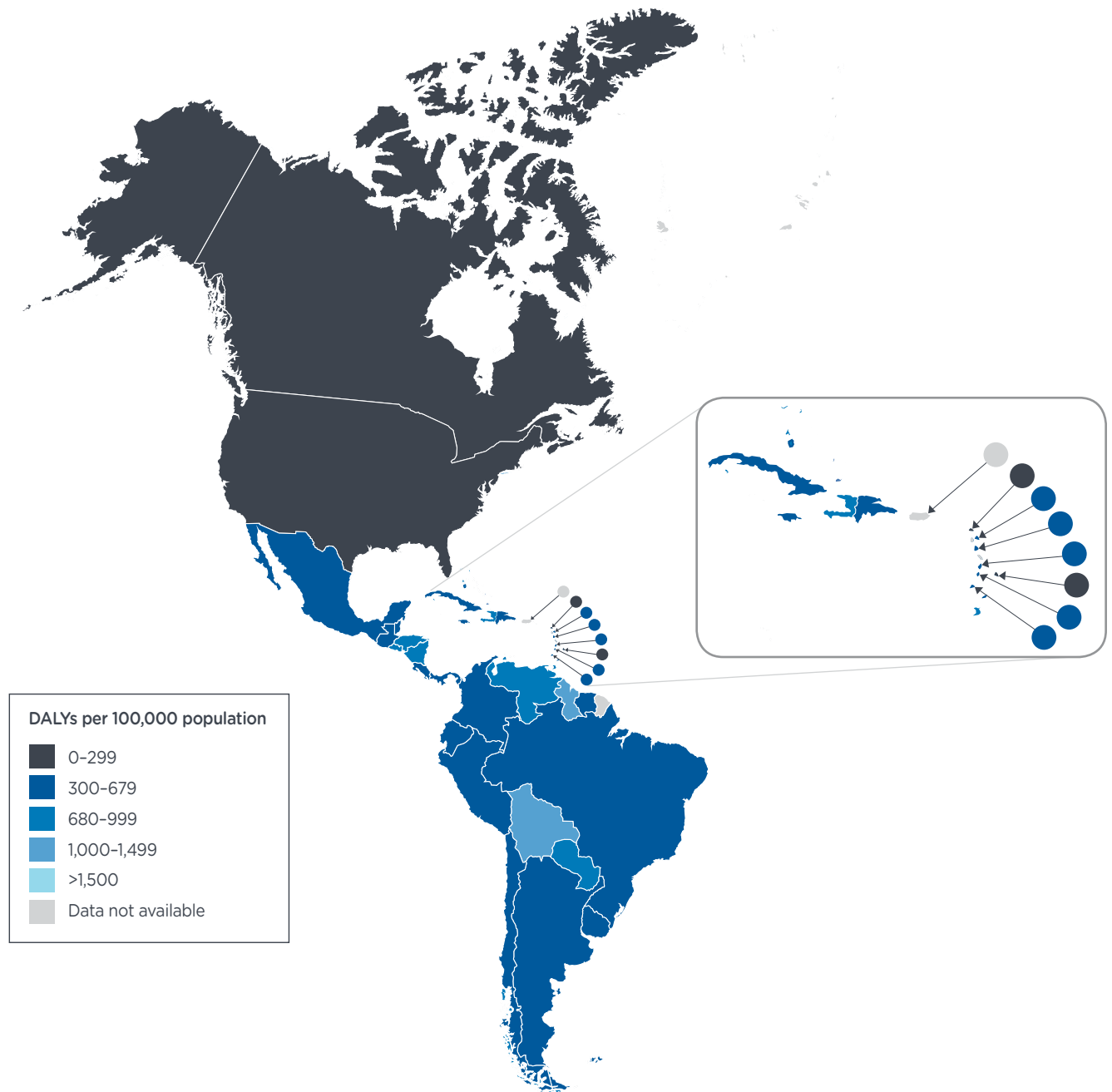
Figure 4.76.
Percent of households with internet access, by income quintile, countries in Latin America and the Caribbean with comparable data available, 2015



Source: Economic Commission for Latin America and the Caribbean. State of broadband in Latin America and the Caribbean. Santiago: ECLAC; 2017. Available from: <https://www.cepal.org/en/publications/43670-state-broadband-latin-america-and-caribbean-2017>.

Figure 4.77.

Age-standardized disability-adjusted life years (DALYs) lost per 100,000 population that are attributable to ambient air pollution, Region of the Americas, 2012



Source: World Health Organization. Ambient air pollution: a global assessment of exposure and burden of disease. Geneva: WHO; 2016. Available from: <https://apps.who.int/iris/bitstream/handle/10665/250141/9789241511353-eng.pdf?sequence=1>.

In addition to outdoor air pollution, indoor smoke within households poses a serious health risk for people who cook and heat their homes with biomass fuels and coal. For the Latin America and the Caribbean region as a whole, biomass, especially wood for cooking, continues to account for more than a third of total energy consumption (302).

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 (303). The proportion of people exposed to levels exceeding WHO guidelines for fine particulate matter in Latin America and the Caribbean was 90 percent in 2016,

Examples of policies and programs to improve air quality

Air Quality Management Program, Jamaica. This program, which ran from 2010 to 2016, intended to achieve improved ambient air quality to support human and environmental health.¹ Its goals were to protect public health and welfare; to prevent degradation of air quality in unpolluted areas in the country; to control the emission of greenhouse gases and priority pollutants; and to provide data and information to guide policy development and decision-making.²

Strengthening the Role of the United Nations Environment Program in Promoting Air Quality. In June 2014, the United Nations Environment Assembly (UNEA) adopted resolution 1/7 Strengthening the Role of the United Nations Environment Programme in Promoting Air Quality. UNEA has reported on some of the major actions being undertaken by governments in the Caribbean to improve air quality. These include establishing incentives that promote investments in renewable energy, pollution control technologies, energy efficiency, and clean production mechanisms; increasing industrial energy efficiency and tightening vehicle emission standards; and increasing investments in public and non-motorized transport infrastructure and systems. For indoor air pollution, actions include improving access to cleaner cooking and heating fuels and to cleaner, more efficient cook/space heating stoves.³

Program to improve air quality in Mexico City—ProAire. The current program, ProAire IV (2011–2020), has 81 measures and 116 actions across nine themes: reduction of energy consumption; cleaner and more efficient energy across all sectors; promotion of public transport and regulation of fuel consumption; technology shift and emissions control; environmental education and sustainability; culture and citizen participation; green areas and reforestation; institutional capacity-building and scientific research; and strengthening health protection. Specific initiatives include fuel quality standards, a no-driving-day program, bus fleet renewal, subway and bike-sharing expansion, and air monitoring system modernization. The project goals are to improve air quality and reduce ozone concentration levels, decrease health risks from air contaminants, and cut greenhouse gas emissions.⁴

Clean Air Act, United States of America. The Clean Air Act came into force in 1970. Its programs have lowered levels of six common pollutants—particles, ozone, lead, carbon monoxide, nitrogen dioxide, and sulfur dioxide—as well as other toxic pollutants. From 1970 to 2017, aggregate national emissions of these pollutants dropped an average of 73 percent, while GDP grew by 324 percent. Between 1990 and 2017, national concentrations of air pollutants improved 80 percent for lead, 77 percent for carbon monoxide, 88 percent for sulfur dioxide, 56 percent for nitrogen dioxide, and 22 percent for ozone. A key reason is higher emissions standards for new vehicles.⁵

Sources: ¹ The Jamaica Environment Trust. Commonwealth Foundation. Review of the legal and policy framework for air and water quality in the Island of Jamaica [Internet]; August 2016 [cited 20 Dec 2018]. Available from: <https://www.jamentrust.org/publications/law-advocacy-publications/?&SingleProduct=209>.

² The National Environment and Planning Agency. Jamaica Air Quality Management Programme [Internet]; 2010 [cited 20 Dec 2018]. Available from: http://nepa.gov.jm/new/services_products/subsites/air_quality/docs/jamaica_air_quality_management_programme.pdf.

³ United Nations Environment Programme. Actions taken by governments to improve air quality [Internet]; [cited 20 Dec 2018]. Available from: https://wedocs.unep.org/bitstream/handle/20.500.11822/20244/Caribbean_report.pdf?amp%3BisAllowed=&sequence=1.

⁴ Climate Interactive. Mexico. Program to improve air quality in Mexico City - PROAIRE [Internet]; [cited 19 Dec 2018]. Available from: <https://img.climateinteractive.org/wp-content/uploads/2018/01/Proaire.pdf>.

⁵ U.S. Environmental Protection Agency. Clean Air Act overview. Progress cleaning the air and improving people's health [Internet]; [cited 19 Dec 2018]. Available from: <https://www.epa.gov/clean-air-act-overview/progress-cleaning-air-and-improving-peoples-health#pollution>.

and approximately 41 percent in Canada and the United States of America (304). Progress in reducing air pollution in the United States of America appears to have slowed, and it continues to worsen in some areas in Latin America and the Caribbean (305).

Across the Region, there are large differences among countries in disability-adjusted life years

(DALYs) attributable to ambient air pollution, as shown in Figure 4.77.

Studies in the Region have shown that exposure to air pollution is unequally distributed: poorer communities suffer most, and children in particular (306, 307).

9C. ENSURE SECURITY OF TENURE IN INFORMAL SETTLEMENTS AND OTHER ENVIRONMENTS

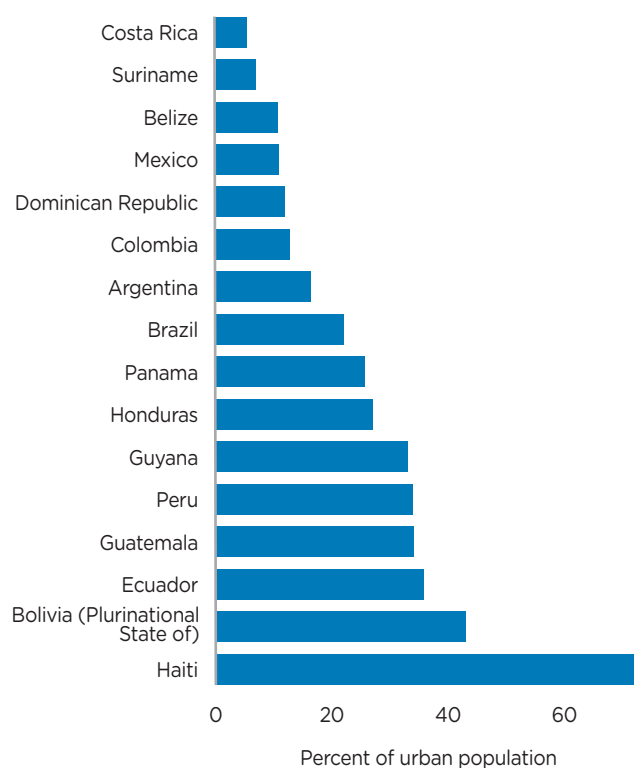
Across Latin America and the Caribbean there are still high levels of people living without any security of tenure, either in slums or in rural areas, although rates have improved in many countries.

The proportion of the urban population living in slums in Latin America and the Caribbean decreased from 35 percent in 1990 to 20 percent in 2014, but there were still large inequalities between countries. In 2014, approximately 70 percent of the urban population in Haiti lived in slums—the highest rate in the Americas (7). This sharply contrasted with the 7 percent in Suriname and the 6 percent in Costa Rica, as shown in Figure 4.78 (7).

People who live in informal settlements are exposed to infectious diseases due to confined living conditions and substandard housing, which fosters the spread of communicable and vector-borne diseases such as tuberculosis, hepatitis, dengue fever, pneumonia, cholera, and malaria. The lack of safe water and sanitation contribute to the high prevalence of diarrhea within slums (7). Informal settlement areas are often left out of major city networks of access to health care services, and unplanned urban development exacerbates noncommunicable disease risks related to outdoor and indoor air pollution. People living in informal settlements are also more exposed to road traffic injury and violence, and have lower levels of physical activity than do those in formal settlements (70). Persons of African descent are more than twice as likely to live in slums as are individuals who are not of African descent (308).

Urban informal settlements or slums have little official recognition, and limited services and infrastructure. It is difficult for residents to move, sell their house, or access social protection. They also face risk of eviction due to lack of land title certifying their right to ownership (308).

Figure 4.78.
Percent of urban population living in slums, countries in the Americas with available data, 2014



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

Formalizing tenure and granting land titles is an important step forward in improving conditions in informal settlements and enabling residents to access services, education, social protections, and employment (309).

Examples of policies and programs to improve conditions in slums

Granting of land titles, Argentina. An evaluation was carried out in Buenos Aires in 2010 concerning occupants who had been granted land titles in 1984. Families that received a title had substantially increased housing investments, and an index of housing quality rose by 37 percent. Land titling also reduced household size to an average of 5.11 members, as compared to 6.06 members for families still living on untitled parcels. Children in benefited households showed significantly better educational achievement, with an average of 0.69 more years of schooling and twice the completion rate of secondary education (53 percent versus 26 percent).¹

Granting of land titles, Peru. In Peru, approximately 1.2 million ownership status titles were awarded to families living on public land in urban areas between 1996 and 2003. Strengthening property rights in urban slums had a significant effect on residential investment, with the rate of housing renovation rising by more than two-thirds of the baseline level. Land titling also boosted employment, due to the reduced need to stay at home to informally secure one's home.²

Favela Bairro program, Brazil. Operating from 1996 to 2008, this program significantly improved slum dwellings and environments, with water and sewage works, public works on streets, public lighting, and other urban improvements. Investments concentrated on improving accessibility by opening new roads and footpaths, paving streets, and expanding household water supply, sewerage, and drainage. Investments were made in day-care centers, primary health care facilities, and sports and recreation areas. Families living in high-risk areas were relocated to safer areas within the favela. In its third phase, the program expanded to include housing improvements, income generation, crime prevention, youth and adult professional training, and energy efficiency. To contain future settlement expansion, a geographic information system and an aerial photography monitoring system were developed, formal street addressing was implemented, and slum boundaries were marked by reforestation of original vegetation.³

Favelas under the program experienced a significant increase in the availability of all services. Water connections reached 81 percent in favelas that participated in the program, compared with 55 percent in others outside the program. Favela-Bairro II increased the incidence of formal property ownership by 3 percent as compared with communities outside the program, and it also increased the number of informal means of documenting ownership, such as bills of sale, which was a critical factor in the program's success. The program had a large impact on the perception of how much inhabitants' homes were worth. The program also had a small but statistically significant impact on school attendance, there was an increase in child care attendance, and household incomes rose by around 15 percent.⁴

Some of the program's critical success factors were its multisectoral scope, the strong institutional and technical capacity of the local government, and the active involvement of slum dwellers. More recently, measures to contain crime and violence, such as community policing units (*unidades de policía pacificadora*), helped to improve security in communities, reducing violence and creating better conditions for local businesses to flourish.³

Municipal Favela Regularization Plan [PROFAVELA] and Plan for Regularization and Urbanization of Special Social Interest Zones [PREZEIS], Brazil. These initiatives from municipal governments were designed to guarantee tenure security and improve the lives of slum dwellers. Created in the early 1980s, the programs responded to the increasing demands of social movements. Both programs drew on the principle of recognizing and regularizing slum areas within the zoning laws. This enabled the declaration of special social interest zones where building standards for upgrading were more flexible and appropriate to the conditions of slums. By 2002, the program had issued close to 9,500 property titles, benefiting more than 13,000 families.³

Sources: ¹ Jaitman L. Urban infrastructure in Latin America and the Caribbean: public policy priorities. *Latin Amer Econ Rev*. 2015;24(1):13.

² Galiani S. Land property rights and resource allocation. *J Law Econ*. 2011;54(S4):S329-S345.

³ Lonardon F. From mass public housing to a twin-track approach. In: Magalhães F, editor. *Slum upgrading and housing in Latin America*. Washington, D.C.: Inter-American Development Bank; 2016: 31-59. Available from: <https://publications.iadb.org/en/publication/12558/slum-upgrading-and-housing-latin-america>.

⁴ Inter-American Development Bank. *Development effectiveness overview 2010*. Washington, D.C: IDB; 2011. Available from: <https://publications.iadb.org/en/publication/development-effectiveness-overview-deo-2010>.



Santa Marta favela, Rio de Janeiro, Brazil

RELEVANT INTERNATIONAL AGREEMENTS

PAHO Resolutions

Strategy and Plan of Action on Urban Health (CD51.R4 [2011])

Sustainable Health Agenda for the Americas 2018-2030 (CSP29/6, Rev. 3 [2017])

Sustainable Development Goals

Goal 3. Ensure healthy lives and promote well-being for all at all ages

Goal 5. Achieve gender equality and empower all women and girls

Goal 6. Ensure availability and sustainable management of water and sanitation for all

Goal 7. Ensure access to affordable, reliable, sustainable and modern energy for all

Goal 9. Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation

Goal 10. Reduce inequality within and among countries

Goal 11. Make cities and human settlements inclusive, safe, resilient and sustainable.

RECOMMENDATION 10. EQUITABLE HEALTH SYSTEMS

The PAHO Equity Commission is focused on the social determinants of health in the Americas, but health systems are crucial to greater health equity too. Universal health care supports health equity through provision of accessible and affordable health care services that provide effective treatment for ill health, and provision of services and vaccinations that can prevent ill health.

Health services, including health care organizations and the health work force, can also support health equity through action on the social determinants of health. Such action would address the causes of the causes of ill health, through work with individuals and through support for health equity in policies and interventions at community,

national, and international levels. Across the Region, there is significant scope for health care systems to broaden their approach to health and to work with partners in other sectors to support improvements in the social determinants. Currently, in most health care systems this approach is underdeveloped.

PRIORITY OBJECTIVES	ACTIONS
<p>10A. Develop universal health systems and ensure access to health care, regardless of ability to pay</p>	<ul style="list-style-type: none"> • Follow WHO universal health care recommendations and guidelines, and ensure compliance with the right to the 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 as well as access to safe, effective, quality, affordable essential medicines and vaccines for all
<p>10B. Focus health systems on protecting and improving physical and mental health through meeting essential public health functions</p>	<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 (310) • Universal health systems should monitor access and outcome inequities—drawing on the right to health—and aim to eliminate and not exacerbate health inequities
<p>10C. Focus health systems on social and economic drivers of health-related behaviors, mental health, and suicide</p>	<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, and providing treatment for patients • Include in health professional education and training how to understand and take action on the social determinants, and how to refer patients to support to improve their conditions of daily life

10A. DEVELOP UNIVERSAL HEALTH SYSTEMS AND ENSURE ACCESS TO HEALTH CARE, REGARDLESS OF ABILITY TO PAY

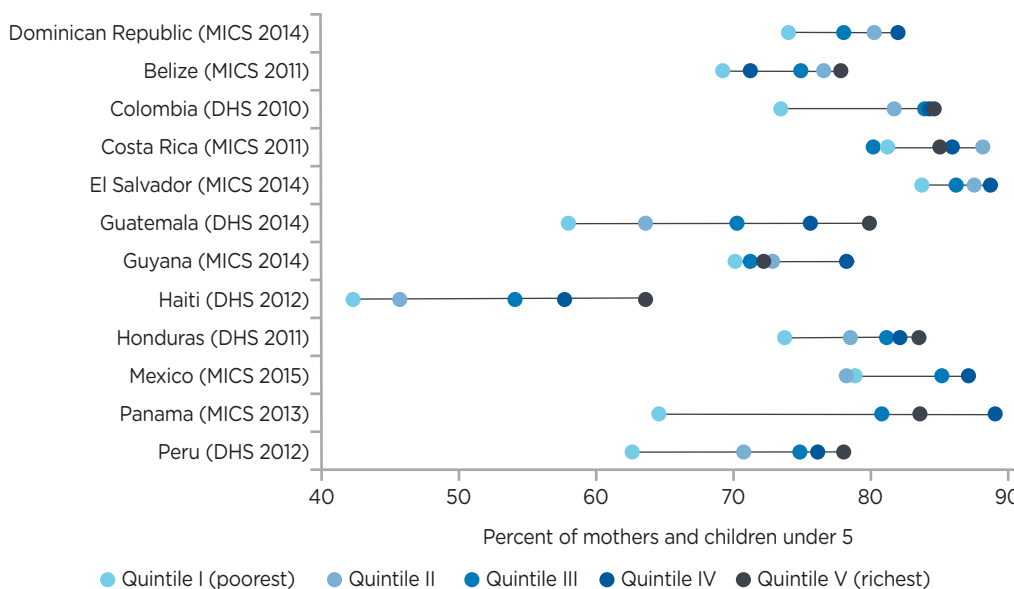
Universal health coverage is a key component of the right to health and is a prerequisite to equity in health. Across the Americas, there are high degrees of socioeconomic and ethnic inequities in access to health care, resulting from the cost of services, discrimination and exclusion of some groups of people, unsuitability of some types of services, and, in some countries, highly inadequate levels of provision, particularly in rural areas and informal settlements (29).

Some of these inequities in access have been described in previous sections, particularly Recommendation 4 in terms of access to contraception and maternal and newborn services. Additional data, presented here, show inequities that are closely related to ethnicity, place of residence, and socioeconomic status in access to

uptake of a range of basic health care services and treatments throughout life.

The composite reproductive and child health coverage index was developed by the International Center for Equity in Health, based in Pelotas, Brazil. The index describes coverage of eight reproductive,

Figure 4.79. Reproductive, maternal, newborn, and child health index (percent), by income quintiles, countries in Latin America and the Caribbean with comparable data available, 2014 or latest year available



Source: World Health Organization. Health Equity Assessment Toolkit (HEAT): software for exploring and comparing health inequalities in countries. Built-in database edition. Version 2.1. Geneva: WHO; 2018. Available from: https://www.who.int/gho/health_equity/assessment_toolkit/en/index1.html.

Note: The index covers demand for family planning satisfied (modern methods); antenatal care coverage (at least four visits); births attended by skilled health personnel; BCG immunization coverage (against TB) among 1-year-olds; measles immunization coverage among 1-year-olds; DTP3 immunization coverage (against diphtheria, tetanus, and pertussis) among 1-year-olds; children aged under 5 years with diarrhea receiving oral rehydration therapy and continued feeding; and children aged under 5 years with pneumonia symptoms taken to a health facility. DHS = demographic and health surveys; RHS = reproductive health surveys; MICS = multiple indicator cluster surveys.

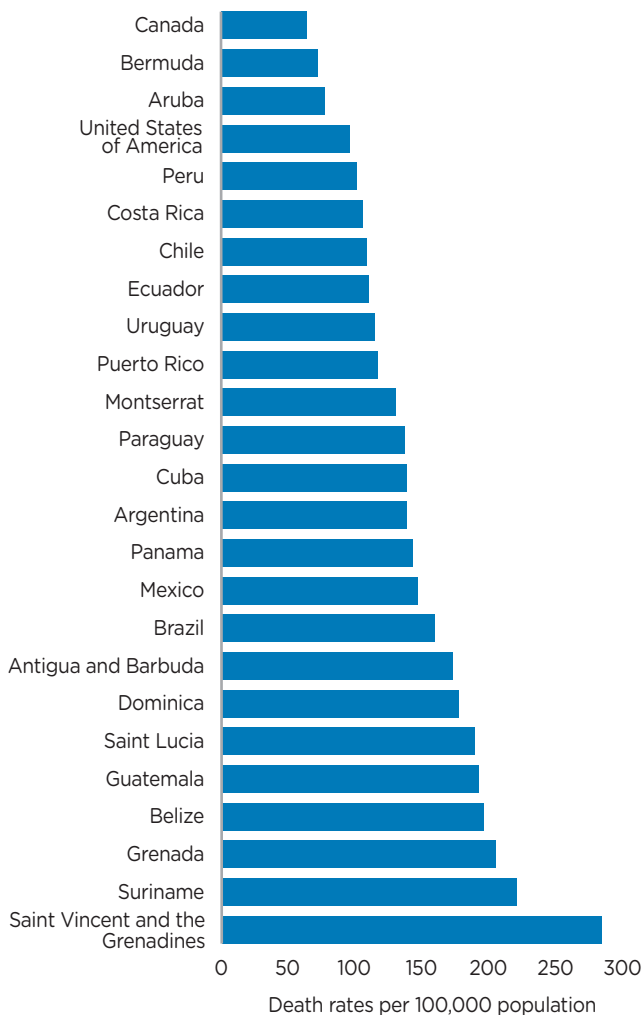
maternal, newborn, and child health interventions (described in the note below Figure 4.79). The coverage is related to socioeconomic status for the countries listed in Figure 4.79 (311–313). In some countries, there are significant inequalities, but in others, including Costa Rica, the Dominican Republic, and El Salvador, overall coverage rates are high and inequalities low.

Assessments show that while universal health coverage is a clear priority and ambition, there are still many deaths across the Region—including

in the highest income country, the United States of America—that could be avoided through improvements in access to quality health care (Figures 4.80, 4.81). Death rates are still high in some countries in the Caribbean.

Health care affordability is a key dimension determining access to health care, including treatments and prevention services. In the Region, out-of-pocket health care expenses are high in comparison with other regions of the world. According to World Bank data from 2017, 15

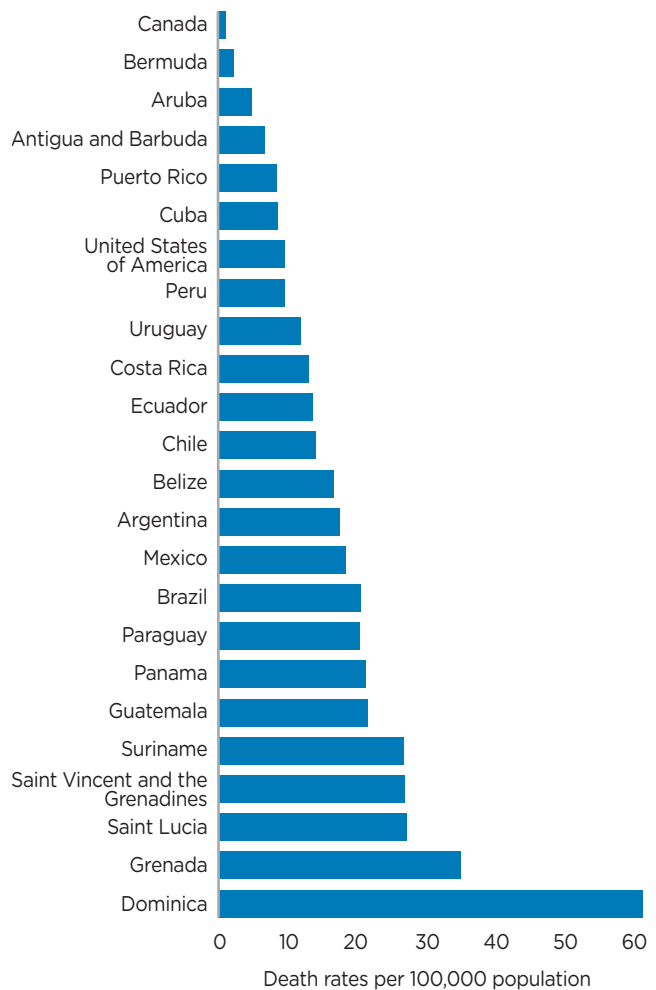
Figure 4.80.
Age-adjusted death rates (per 100,000 population) considered amenable to health care, selected countries in the Americas, 2014



Source: Pan American Health Organization. PLISA Health Information Platform for the Americas. Core indicators [Internet]; 2018 [cited 7 Nov 2018]. Available from: <http://www.paho.org/data/index.php/en/indicators/visualization.html>.

Note: Data for Canada are from 2011.

Figure 4.81.
Age-adjusted death rates for maternal and perinatal deaths (per 100,000 population) considered amenable to health care, selected countries in the Americas, 2014



Source: Pan American Health Organization. PLISA Health Information Platform for the Americas. Core indicators [Internet]; 2018 [cited 7 Nov 2018]. Available from: <http://www.paho.org/data/index.php/en/indicators/visualization.html>.

Note: Perinatal deaths are the death of a fetus immediately before or after birth.

percent of the population of Latin America and the Caribbean (88.3 million people) spent at least 10 percent of their household budget on health, while for 2.5 percent of the population (15 million people), the proportion spent was at least 25 percent (314).

The proportion of people in Latin America and the Caribbean who are at risk of expenditure on surgical care—defined as direct out-of-pocket payments for surgical and anesthesia care—leading to impoverishment has declined in recent years, from almost 20 percent in 2003, but still stands at approximately 11 percent of the total population in the Region (7).

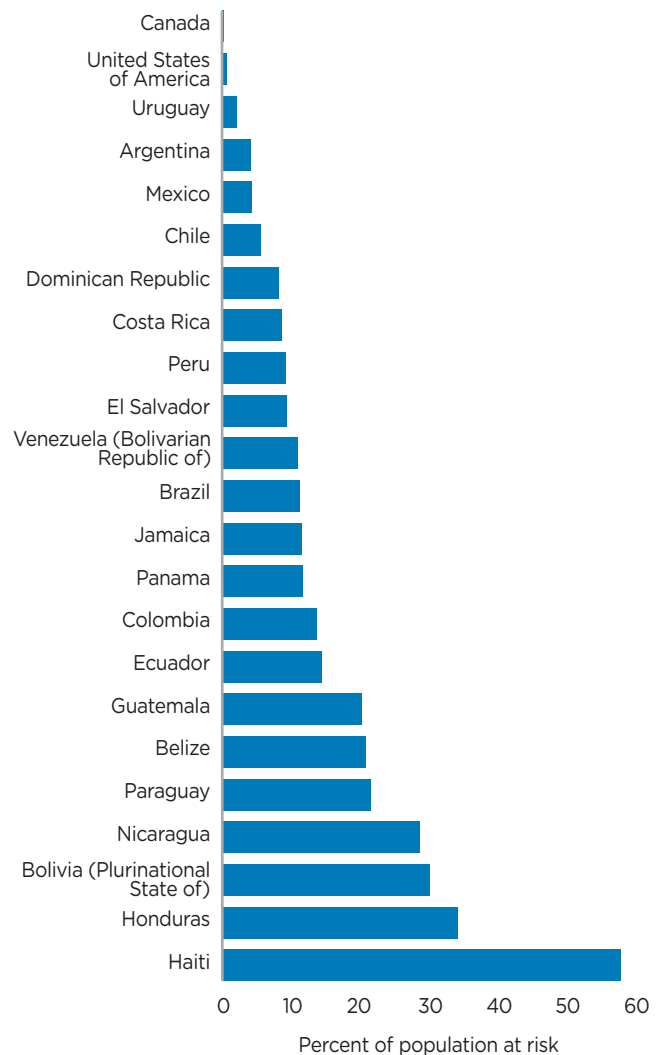
In some countries, the proportion of people at risk of impoverishment as a result of expenditure on surgical care is much higher than the 11 percent average for the Region (Figure 4.82) (7). Of course, risk of impoverishment is much higher for those who are already poor or who are at risk of poverty than it is for wealthier parts of the population.

When examining the impact of health expenditure on household well-being and the likely impact on access to, and use of, health services, out-of-pocket health expenditure (or direct payment) is an important indicator. This term refers to the payment required at the time of service and for any required health products, after discounting any subsequent reimbursement. Insurance premiums (or any other form of prepayment) are not considered out-of-pocket expenditure; nor are the indirect costs associated with the use of services (for transportation, meals, and so on) (315). The indicator most commonly used to measure the burden of out-of-pocket health expenditure in a country is the proportion of total health expenditure that it represents. The higher the proportion, the greater the number of households likely to face financial difficulties as a result of using health services (Figure 4.83).

Figure 4.84 shows government expenditure on health care at purchasing power parity. Especially noticeable are the very high levels of expenditure on health care in Canada and the United States of America.

Figure 4.85 shows that the level of health care expenditure has some association with life expectancy at birth in countries in the Americas. However, there is

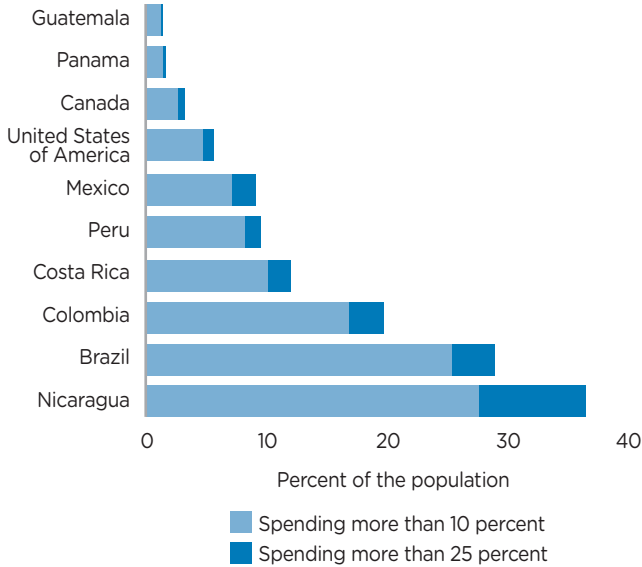
Figure 4.82.
Percent of the population at risk of impoverishment due to expenditure for surgical care, countries in the Americas with comparable data available, 2017



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

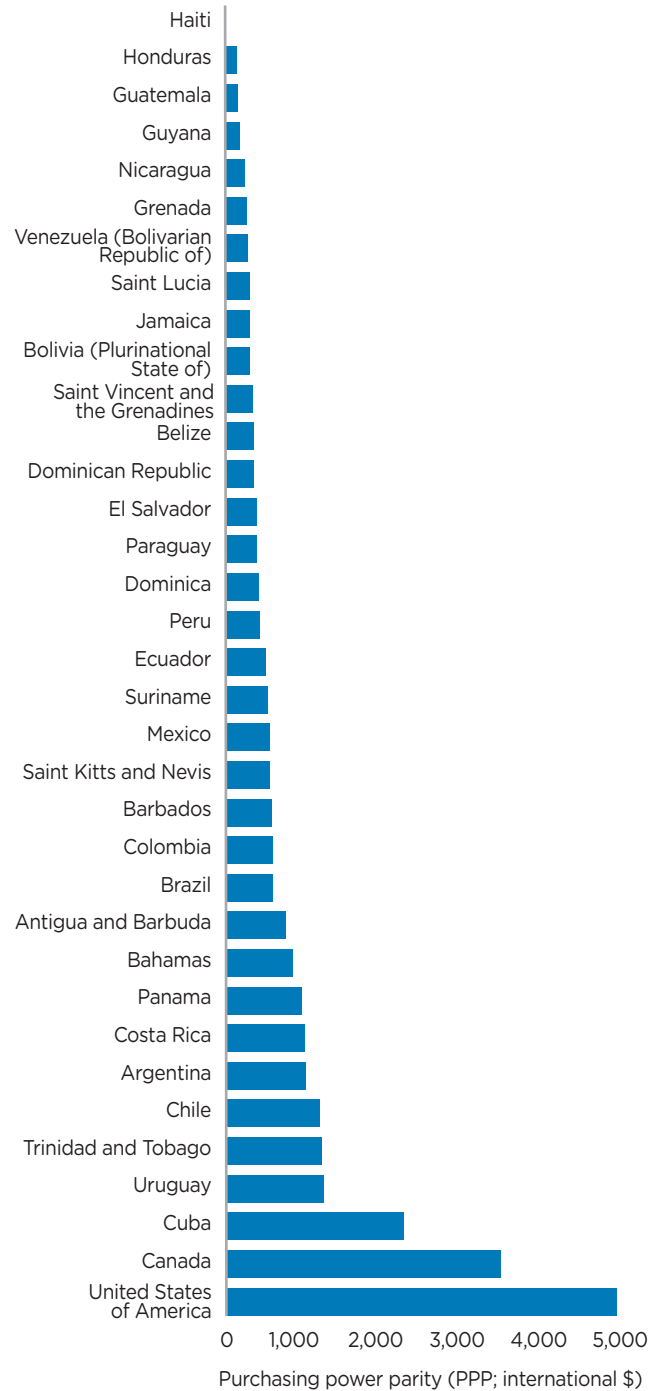
considerable variation. The United States of America, for example, spends the highest percentage of GDP on health care, but has lower average life expectancy than other countries in the Region that spend much less proportionally—including Canada, Chile, and Costa Rica. These variations are to be expected, because, as this report sets out, there are many other factors involved in shaping health and life expectancy besides health care spending.

Figure 4.83.
Percent of population spending more than 10 percent and 25 percent of household consumption or income on out-of-pocket health care expenditure, countries in the Americas with comparable data, 2014 or latest



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

Figure 4.84.
Domestic government health care expenditure per capita, countries in the Americas, 2015



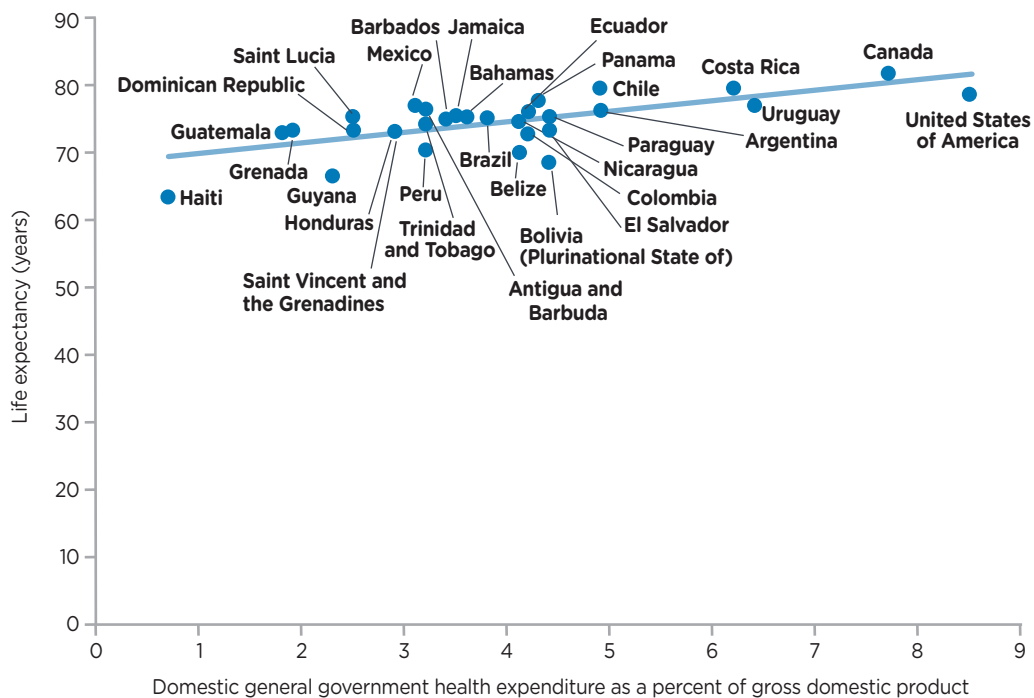
Source: World Health Organization. Global Health Observatory data repository [Internet]; 2018. Available from: <http://apps.who.int/gho/data/node.home>.



Men and women of all ages using public exercise equipment, Copacabana Beach, Rio de Janeiro, Brazil

Figure 4.85.

Life expectancy by domestic general government health care expenditure as a percent of gross domestic product, countries of the Americas, 2015



Source: World Health Organization. Global Health Observatory data repository [Internet]; 2018. Available from: <http://apps.who.int/gho/data/node.home>.

Examples of policies and programs to develop universal health systems and ensure access to health care regardless of ability to pay

EBAIS primary health care teams [*Equipos Básicos de Atención Integral en Salud*], Costa Rica. This health care reform from 1995 aimed to extend coverage, and to provide more comprehensive care without charge, including creating multidisciplinary primary health care teams to deliver comprehensive preventive, acute, and chronic disease management.¹ Before the reform, which expanded primary health care across Costa Rica, only 25 percent of the population had access to primary health care; by 2006, this proportion had reached 93 percent.² A study found that in areas in which EBAIS teams had been implemented, the proportion of underserved patients decreased by 13 percent more than in areas that did not yet have EBAIS teams.² In 2014, 72 percent of all medical consultations happened at the primary health care level.¹

National health service, Brazil. The 1988 constitution established the national Unified Health System (SUS). Health was seen as a fundamental human right and its provision a duty of the State.³ In 2000–2014, total health expenditure rose from 7.0 percent to 8.3 percent of GDP, and per capita health expenditure from US\$ 263 to US\$ 947. Expansion of the SUS has enabled increased provision of public health programs (e.g., immunization, TB, and HIV) as well as complex medical treatments. From 2000 to 2016, family health coverage increased from 7.8 percent to 58.5 percent of the population. However, large variability in the quality and productivity of family health services across the country has contributed to inequities in access to primary health care.⁴ Although it contributed to great improvements in people's health, more than half of health care spending is still private.³

Family Health Strategy, Brazil. Since 1994, community health workers (CHWs) have been at the center of Brazil's primary health care policy. The Family Health Strategy aims to provide preventive and basic health care using multidisciplinary teams, usually consisting of a physician, a nurse, and around six CHWs. 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 hospitalizations; increases in the uptake of screening, breastfeeding, antenatal care, and immunizations; and reductions in mental health problems. More than 265,000 CHWs serve nearly 67 percent of Brazil's population. Most of the population served are from lower-income groups.⁵

Children's Health Insurance Program (CHIP), United States of America. Responding to the needs of 10 million children who lacked health insurance, CHIP was established in 1997. It provided states with federal assistance to create programs specifically designed for children from families with incomes that exceeded Medicaid thresholds but that were insufficient to enable them to afford private health insurance. Evidence demonstrates that CHIP increased insurance coverage. Between 1997 and 2011, enrollment grew from under 1 million to 5.3 million children. Legislation passed in 2009 provided significant new financial support for the program and introduced initiatives to increase enrollment, improve retention, and strengthen access and quality of care in Medicaid and CHIP. A total of 8.13 million children were enrolled in CHIP at some point in 2013, and by 2017 CHIP covered nearly 9 million children.^{6,7} Medicaid and CHIP have succeeded in reaching the target population of uninsured children and have contributed to the reduction in uninsurance among low-income children from 25 percent in 1997 to 15 percent in 2012. All ethnic and

Sources: ¹ Pesec M, Ratcliffe H, Bitton A. Building a thriving primary health care system: the story of Costa Rica. Case study, Ariadne Labs [Internet]; 2017 [cited 17 Dec 2018]. Available from: <https://www.ariadnelabs.org/wp-content/uploads/sites/2/2017/12/CostaRica-Report-12-19-2017.pdf>.

² Organisation for Economic Cooperation and Development. Health at a glance. Paris: OECD; 2017. Available from: <http://www.oecd.org/health/health-systems/health-at-a-glance-19991312.htm>.

³ Gurgel GD, de Sousa IMC, de Araujo Oliveira SR, de Assis da Silva Santos F, Santos S, et al. The national health services of Brazil and Northern Europe: universality, equity, and integrality—time has come for the latter. *Int J Health Services*. 2017;47(4):690–702.

⁴ Massuda A, Hone T, Leles FAG, de Castro MC, Atun R. The Brazilian health system crossroads: progress, crisis and resilience. *BMJ Glob Health*. 2018;3(4):e000829.

⁵ Wadge H, Bhatti Y, Carter A, Harris M, Parston G, Darzi A. Brazil's family health strategy: using community health workers to provide primary care. Case study. New York: The Commonwealth Fund; 2016. Available from: https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_case_study_2016_dec_1914_wadge_brazil_family_hlt_strategy_frugal_case_study_v2.pdf.

⁶ Centers for Medicare and Medicaid Services. Unduplicated number of children ever enrolled in CHIP and Medicaid. Statistical Enrollment Data System (SEDS) Combined CHIP Enrollment Total Report and Form CMS-64.EC [Internet]; 2018. Available from: <https://www.medicaid.gov/chip/downloads/fy-2017-childrens-enrollment-report.pdf>.

⁷ Harrington M, Kenney GM, Smith K, Clemans-Cope L, Trenholm C, Hill I, Orzol S, et al. CHIPRA mandated evaluation of the Children's Health Insurance Program: final findings. Washington, D.C.: Report submitted to the Office of the Assistant Secretary for Planning and Evaluation. Ann Arbor: Mathematica Policy Research; 2014. Available from: <https://www.mathematica-mpr.com/our-publications-and-findings/publications/chipra-mandated-evaluation-of-the-childrens-health-insurance-program-final-findings>.

(continued on next page)

Examples of policies and programs to develop universal health systems and ensure access to health care regardless of ability to pay (*continued*)

income groups experienced gains in coverage, but the gains have been particularly striking among Hispanic children. Together, CHIP and Medicaid covered 39 percent of children in the United States of America in 2015.^{8,9}

SUMAR Program, Argentina. Started in 2012, this program originally facilitated access to health care for pregnant women and children up to 6 years of age. It was then extended to children and subsequently to men and women 20 to 64 years of age who did not have contributory social health protection. In 2015, the SUMAR Program covered 13 million people. According to the 2010 national census, the population without any social health protection was 14 million. Therefore, the SUMAR Program has contributed significantly to closing the social health protection gap in Argentina. The program is run by the National Health Ministry and financed from the public budget. Its link with the Universal Child Allowance and Pregnancy Allowance contributed to an increase in the enrollment of children and pregnant women in the SUMAR Program by 50 percent and 14 percent, respectively, in 2014.¹⁰

Baylor Health Care System (BHCS), Texas, United States of America. BHCS 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.¹¹ BHCS established Project Access to provide care to Dallas County's uninsured working poor. In 2008, Project Access provided over US\$ 3.5 million in free care.¹²

National Maternal-Child Health Program [*Programa Nacional de Atención Materno-Infantil (PAMI)*], Cuba. Established in 1970, in this program, governmental sectors work with community organizations to provide a network of community-oriented services of pre- and perinatal services.¹³ The aim is to reduce maternal and child mortality through prevention, promotion, treatment, and rehabilitation services. Cuba's infant mortality decreased from 11.1 per 1,000 live births in 1989 to 4.3 per 1,000 in 2015.^{14,15}

Local and community health services, Canada. Researchers sought to document the relationships among local access to primary care, measures of community control, and the rates of hospitalizations for First Nations on-reserve populations. The study demonstrated that communities with better local access to primary health care consistently showed lower rates of ambulatory care-sensitive conditions (ACSCs). Also, the longer community health services had been under community control, the lower its ACSC rate was.¹⁶

Sources: ⁸ Kaiser Family Foundation. Next steps for CHIP: what is at stake for children? [Internet]; June 2017 [cited 21 Jan 2019]. Available from: <http://files.kff.org/attachment/Fact-Sheet-Next-Steps-for-CHIP-What-is-at-Stake-for-Children>.

⁹ Committee on Child Health Financing. Children's Health Insurance Program (CHIP): accomplishments, challenges, and policy recommendations. *Pediatrics*. 2014;133(3):784-93.

¹⁰ International Labour Organization. Building social protection systems: international standards and human rights instruments. Geneva: ILO; 2016. Available from: <https://www.social-protection.org/gimi/gess/ShowResource.action?resource.ressourceId=54434>.

¹¹ Mayberry RM, Nicewander DA, Qin H, Ballard DJ. Improving quality and reducing inequities: a challenge in achieving best care. *Proc (Bayl Univ Med Cent)*. 2006;19:103-18.

¹² Baylor Health Care System. Report to the community 2008. Garland: Baylor Health Care System; 2009.

¹³ Cooper RS, Kennelly JF, Fernandez-Garcia PO. Health in Cuba. *Int J Epidemiol*. 2006;35:817-24.

¹⁴ Gorry C. Cuba's family doctor-and-nurse teams: a day in the life. *MEDICC Rev*. 2017;19(1):6-9.

¹⁵ Pattison KH. The family doctor and nurse: the dynamic duo of Cuban healthcare. *Int J Stud Nursing*. 2018;(1):3.

¹⁶ Lavoie JG, Forget EL, Prakash T, Dahl M, Martens P, O'Neil JD. Have investments in on-reserve health services and initiatives promoting community control improved First Nations' health in Manitoba? *Soc Sci Med*. 2010;71(4):717-24.

10B. FOCUS HEALTH SYSTEMS ON PROTECTING AND IMPROVING PHYSICAL AND MENTAL HEALTH THROUGH MEETING ESSENTIAL PUBLIC HEALTH FUNCTIONS

Across the Region of the Americas, there is significant scope for health care systems to broaden approaches to health and strengthen health improvement to support action on the social determinants, enabling people to maintain good health and allow more effective treatment of ill health.

Currently, in most health care systems these types of approaches are underdeveloped. Partnerships with other sectors tend to be weak, or nonexistent; even partnerships between health care and public health can be underdeveloped.

However, there is evidence that partnerships between health care services and other sectors, such as housing, environment, urban planning, and social protection, and between services and employers, can, together with local communities, foster development of a health system that is based on improving social, economic, and

environmental conditions. This approach will support good health as well as treat ill health. Health care systems that focus on improving the social determinants as well as providing health care can make improvements to health and health equity as well as other desirable social and economic outcomes, such as housing improvements and employment practices. This is backed by evidence that includes recent studies in the United States of America that have described how greater attention to social determinants of health can improve health outcomes and reduce health care expenditure (316).



Mother and son buying vegetables during market day, Zunil, Guatemala

Box 4.1. Components of a population health system, based on prevention and health equity

Focus on preventing ill health and supporting good health, in addition to treating ill health. This involves moving from reactive services that focus solely on treatment for people who are already ill toward services that work to improve the conditions in which people live, which, in turn, will improve their health.

Focus on place. This supports a focus on small areas, and seeks to influence the environmental, social, and economic conditions of the place in order to improve the health of residents, especially for the most disadvantaged areas.

Cross-sector collaborations. Reducing health inequalities requires close collaborations between multiple organizations and sectors reaching beyond health care, public health, and social care. These may include, for instance, housing, early-years services, and education, all of which profoundly influence health.

Focus on population health. In order to improve health and reduce inequalities it is important to understand local population health and health risks for groups and areas. This requires health assessments that include the broader social and economic drivers of health as well as a focus on and inclusion of particular communities that are at risk of poor health.

Action on the social determinants of health as well as medical treatment. There is much that health professionals and health care organizations can do to take action on social, economic, and environmental factors that would significantly drive improvements to health outcomes and health inequalities.

Development of proportionate universal approaches. Designing interventions and strategies that respond to local health risk and need requires additional resources and actions for more deprived communities and areas. Approaches that focus on improving health equity may look quite different from those that focus only on improving average population health, as they are responsive to those with the greatest levels of need and the highest risks of poor health.

Community involvement. Active community involvement and participation in the design and delivery of health care and other health system services.

Source: Allen J, Goldblatt P, Daly S, Jabbal J, Marmot M. Reducing health inequalities through new models of care: a resource for new care models. London: Institute of Health Equity; 2018. Available from: <http://www.instituteofhealthequity.org/resources-reports/reducing-health-inequalities-through-new-models-of-care-a-resource-for-new-care-models>.

A health care system that focuses on health and health equity through action on social determinants is known as a “population health system,” as described further in Box 4.1.

In the early 2000s, PAHO led a process to define essential public health functions (EPHFs) (310). The EPHFs were conceived as activities necessary to improve the health and well-being of the population, and aimed to assess the capacity of national health systems to implement these actions. The underlying idea was to strengthen the governance and stewardship of the health systems, with a broad vision of personal and population services (317).

PAHO pinpointed 11 essential public health functions (310):

- EPHF 1. Monitoring, evaluation, and analysis of health status
- EPHF 2. Surveillance, research, and control of the risks and threats to public health
- EPHF 3. Health promotion
- EPHF 4. Social participation in health
- EPHF 5. Development of policies and institutional capacity for public health planning and management
- EPHF 6. Strengthening of public health regulation and enforcement capacity
- EPHF 7. Evaluation and promotion of equitable access to necessary health services

- EPHF 8. Human resources development and training in public health
- EPHF 9. Quality assurance in personal and population-based health services
- EPHF 10. Research in public health
- EPHF 11. Reduction of the impact of emergencies and disasters on health

While the implementation of these 11 essential functions would considerably strengthen public health capacity and performance across the Region, there is insufficient accountability and performance management of how countries are taking them forward. It is important that public health outcomes and system performance be monitored, in order to facilitate greater understanding of the most effective approaches in differing contexts.

Examples of actions to focus health systems on protecting and improving physical and mental health through meeting essential public health functions

Implementing public health functions. Countries were actively encouraged to use the results of essential public health functions-based assessments of their public health systems as a basis for public health reforms at the national level. However, only a few countries did so. Among them, most notably Argentina began long-term work with the World Bank to strengthen the EPHFs, and Brazil adapted them into its health system. Colombia, Costa Rica, Cuba, the Dominican Republic, El Salvador, Guatemala, Honduras, Panama, Peru, and the States of the Eastern Caribbean region all continued work on the EPHFs as well.¹ A new list of functions is currently circulating among national partners for consultation.

Kaiser Permanente, United States of America. This long-established not-for-profit U.S. health care plan provider launched a US\$ 100 million national loan fund in 2019. The fund is intended to provide multiunit housing for low-income residents in eight regions of the country. This approach to provision of sustainable housing is expected to improve health for those living there. Kaiser Permanente will also help provide a range of services, including housing, financial help, and social care for those who are homeless. These programs are part of a plan to improve the economic, social, and environmental conditions in the communities Kaiser Permanente serves.^{2,3}

Bold Goal program, Humana, United States of America. This strategy from U.S. health plan provider Humana aims to improve population health. Begun in 2015, it focuses on identifying and addressing social determinants of health in order to boost outcomes for Medicare beneficiaries. The program aims to make communities 20 percent healthier by 2020, by prioritizing social determinants of health, including food insecurity, loneliness, and social isolation, and specific groups in need, such as older people and lower-income adults. Humana found that food-insecure seniors were 50 percent more likely to have diabetes, and 60 percent more likely to experience a heart attack than those with enough food. Lonely or socially isolated older people are at twice the risk of developing Alzheimer's, and over three times more likely to suffer from depression than those not experiencing loneliness.^{4,5} In 2017, the Bold Goal initiative worked to implement pilots and programs in several U.S. communities, to alleviate the health problems resulting from these key social determinants. All the communities showed some improvements in health outcomes as a result. The program consisted of collaborative work bringing together Humana, health advisory groups, food banks, the Young Men's Christian Association (YMCA), and organizations that work to improve health literacy.^{4,5}

Sources: ¹ World Health Organization. Essential public health functions, health systems and health security: developing conceptual clarity and a WHO roadmap for action. Geneva: WHO; 2018. Available from: <https://extranet.who.int/sph/sites/default/files/document-library/document/WHO%20EPHF-Health%20Security-compressed.pdf>.

² Pruitt Z, Emechebe N, Quast T, Taylor P, Bryant K. Expenditure reductions associated with a social service referral program. *Popul Health Manag.* 2018;21(6):469-76.

³ Kaiser Permanente. Fast facts about Kaiser Permanente [Internet]; [cited 24 Jan 2019]. Available from: <https://share.kaiserpermanente.org/about-us/fast-facts/>.

⁴ Health IT Analytics. Humana targets social determinants to improve population health [Internet]; [cited 24 Jan 2019]. Available from: <https://healthitanalytics.com/news/humana-targets-social-determinants-to-improve-population-health>.

⁵ Humana. We are at the center of something BOLD [Internet]; [cited 24 Jan 2019]. Available from: <http://populationhealth.humana.com/#bold-goal>.

10C. FOCUS HEALTH SYSTEMS ON SOCIAL AND ECONOMIC DRIVERS OF HEALTH-RELATED BEHAVIORS, MENTAL HEALTH, AND SUICIDE

As described throughout this report, health outcomes are often closely related to conditions of daily life, as well as broad structural drivers in society. Similarly, behaviors such as drug misuse, alcohol misuse, and smoking are related to the social and economic conditions in which people live.

Reducing behaviors that are risky for health will have significant impacts on health and health equity throughout the Region of the Americas, but substantial improvements will not come without improvements in the conditions of daily life. There is a close relationship that needs to be addressed between risky health behaviors and poverty, relative disadvantage, poor working conditions, unemployment, low-quality and insecure housing, loneliness, and stress. There are also close relationships between mental health and the conditions of daily life, many of which have been described in this report, and between mental health and risky health behaviors.

The PAHO Equity Commission has been concerned with the political, social, economic, and environmental drivers of poor health behaviors, and improvements in these arenas would lead to reductions in such behaviors and improvements in mental health. Therefore, while many of the ways to improve health behaviors lie outside the conventional realm of health care services, there are significant ways in which health care organizations and people working in health care can improve health behaviors through action on the social determinants.

Improving health and reducing inequalities requires health care organizations, the health care work force, public health systems, and other partners to influence the conditions of daily life, through action with patients and community organizations, and in their roles 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 access to quality education, 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, by arguing for Health in All Policies (HiAP) approaches and more equitable policies, as well as supporting more access to affordable health care systems (318).

In turn, health care organizations can use their local assets—financial resources, buildings, expertise, and knowledge of population health—to support and develop healthy local employment practices and a strong civil society (318). As with the health work force, health care organizations can be powerful local and national advocates. Health professional education and training should include how to understand and take action on the social determinants, and how to refer patients to support to improve their conditions of daily life. In many medical schools, there is little or no focus on the social determinants of health. However, in order to make real strides in health improvement and health equity, the medical work force needs expertise and knowledge on the factors that drive, or undermine, good health. More effective education and training in the social determinants is needed, so that health professionals have the skills and experience to begin to influence the broad factors that are shaping all their patients' health.

Examples of policies and programs to focus health systems on social and economic drivers of health-related behaviors, mental health, and suicide

Greater University Circle Initiative (GUCI), Cleveland, United States of America, 2005. This is a multistakeholder initiative, with coordination among three large anchor institutions located in Cleveland's University Circle area, including educational, cultural, and health institutions. Through the initiative, the Cleveland Clinic, University Hospitals, and Case Western Reserve University deployed their resources to challenge the persistent poverty and disinvestment in seven surrounding neighborhoods, where local residents had little connection or benefit from the prestigious institutions in their area.

The strategy seeks to improve the prospects and income of the 60,000 people who live in these neighborhoods, to strengthen community networks, to improve the quality of life in surrounding neighborhoods, and to give residents a greater voice and connection to the resources of the anchor institutions.¹ The institutions established a series of programs to support training and employment of local residents, bring investments into deprived areas, and, through these programs, improve the health of residents.¹ From around 2010 to 2015, University Hospitals steered 92 percent of a US\$ 1.2 billion construction and expansion budget into the regional economy, including purchasing from more than 100 minority-owned local businesses based in the area.²

Affordable Care Act and social determinants, United States of America. This Act became law in 2010. It has a requirement that nonprofit hospitals regularly assess the social, economic, environmental, and health challenges facing their community and commit themselves to addressing them, to help produce a healthier population. The Act's broad focus on prevention has helped to build recognition that health care interventions play only a small part in creating healthy people and communities. The Act's regulations include requirements to prioritize community health needs through a comprehensive review of local health data and local community input. Following this initial assessment, each nonprofit hospital is required to prepare an implementation strategy that shows how the hospital will use its community benefit or charitable resources and the assets of the local communities to address health needs.³

Medical school application policy, Cuba. At the international Latin American School of Medicine (ELAM), preference is given to applicants who are from lower socioeconomic groups, who otherwise could not afford medical studies, and/or people of color who show the most commitment to working in disadvantaged communities. Eighty percent of graduates end up working in poor rural areas.⁴ The ELAM curriculum is designed to graduate physicians who will provide relevant, quality care while fostering equity and improving individual and population health outcomes. ELAM has a number of noteworthy characteristics, including providing six-year scholarships to all students; encouraging students to commit to practice as primary care doctors in underserved areas upon graduation; integrating concepts of prevention, social determinants of health, and active community partnering into curriculum design; using a community-based, service-learning methodology; preparing students to resolve local health problems; and providing postgraduate clinical, research, and continuing education opportunities.⁵

Sources: ¹ Wright W, Hexter KW, Downer N. Cleveland's Greater University Circle Initiative. An anchor-based strategy for change. Washington, D.C.: The Democracy Collaborative; 2016. Available from: <https://docs.google.com/viewerng/viewer?url=https://democracycollaborative.org/sites/clone.community-wealth.org/files/downloads/ClevelandGreaterUniversityCircle-web.pdf>.

² Norris T, Howard T. Can hospitals heal America's communities? "All in for Mission" is the emerging model for impact. Washington, D.C.: The Democracy Collaborative; 2015. Available from: <https://democracycollaborative.org/sites/clone.community-wealth.org/files/downloads/CanHospitalsHealAmericasCommunities.pdf>.

³ Rosenbaum S. Law and the public's health. *Public Health Rep.* 2011 Jan-Feb;126(1):130.

⁴ Reed G. Cuba answers the call for doctors. *Bull World Health Organ.* 2010;88(5):325-6.

⁵ Gorry C. Cuba's Latin American medical school: can socially-accountable medical education make a difference? *MEDICC Rev.* 2012;14(3):5-11.



Health care worker providing medical care to Indigenous rural community in Bolivar State, Bolivarian Republic of Venezuela

RELEVANT INTERNATIONAL AGREEMENTS

PAHO Resolutions

Strategy on Human Resources for Universal Access to Health and Universal Health Coverage (CSP29.R15 [2017])

Addressing the Causes of Disparities in Health Service Access and Utilization for Lesbian, Gay, Bisexual, and Trans (LGBT) Persons (CD52.R6 [2013])

Resilient Health Systems (CD55.R8 [2016])

Strategy for Universal Access to Health and Universal Health Coverage (CD53.R14 [2014])

Sustainable Health Agenda for the Americas 2018-2030 (CSP29/6, Rev. 3 [2017])

Health of Migrants (CD55.R13 [2016])

Plan of Action on Mental Health (CD53.R7 [2014])

Health, Human Security, and Well-being (CD50.R16 [2010])

Policy on Ethnicity and Health (CSP29.R3 [2017])

Plan of Action on Disabilities and Rehabilitation (CD53.R12 [2014])

Sustainable Development Goals

Goal 3. Ensure healthy lives and promote well-being for all at all ages

Goal 5. Achieve gender equality and empower all women and girls

5. GOVERNANCE FOR HEALTH EQUITY

This section covers the development of approaches to governance that would foster and support policies and actions to improve health equity across the Region of the Americas. Effective governance arrangements are a prerequisite for countries committed to developing action on social determinants: they are necessary for understanding the problem, and for developing appropriate and effective responses, and strong accountability systems, as discussed in Recommendation 11. Throughout the report, human rights approaches that would support health equity and greater equity in social determinants have been highlighted. Human rights approaches are well established in Latin America and the Caribbean and provide important ways forward for this subregion, and are also required for making progress in Canada and the United States of America, as discussed in Recommendation 12.

RECOMMENDATION 11.

GOVERNANCE ARRANGEMENTS FOR HEALTH EQUITY

Committed governments can make significant progress on addressing social determinants of health through their policies and actions, as described in previous sections. To understand why good intentions about improving health equity have not always translated into greater health equity, it is necessary to look at policy responses and how those policy decisions are being made, implemented, monitored, and reviewed, and what accountability mechanisms—in other words, governance arrangements—are in place. A social determinants of health approach to greater health equity requires a new approach to governance (319).

While governance is typically used to describe the institutions, rules, and norms through which policies are developed and implemented, and through

which accountability is enforced, governance needs to constitute more than a set of regulations or bureaucratic mechanisms. It is also about

PRIORITY OBJECTIVES	ACTIONS
<p>11A. Make health equity a key indicator of societal development and establish mechanisms of accountability</p>	<ul style="list-style-type: none"> • All government ministries, not just health ministries, to work toward 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
<p>11B. The whole of government—including legislature, judiciary, and executive—to take responsibility for ensuring equity in all policies</p>	<ul style="list-style-type: none"> • Involve the different 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 among sectors and public, private, and voluntary stakeholders to redress the current patterns and magnitude of health inequities
<p>11C. Develop and ensure the involvement of wider society—including civil society and communities—in setting priorities and policies for achieving health equity</p>	<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 nongovernmental 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

power relationships in society (320). 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 Programme's principles of good governance—legitimacy and voice, clear direction and vision, measurable performance, accountability, and fairness (71). But it also requires whole-of-government and whole-of-society approaches to reducing inequities, based on collaboration, citizen engagement, regulation and persuasion, use of independent agencies and expert bodies, adaptive policies, resilient structures, and foresight (321).

The overall aims of health equity approaches should be to improve the distribution of

determinants affecting health; to redress current patterns and reduce the magnitude of health inequities; and to reduce the risks and consequences of disease and premature mortality across different population groups. These aims require governance arrangements that are capable of building and ensuring joint action and accountability by all key actors that have a strong political and public commitment to improving health equity, and equity in social determinants. These include health and non-health sectors, public and private sectors, civil society, and communities and citizens (322).

In this section, we make recommendations for the types of governance and monitoring systems needed to support health equity and the ethical, rights-based approach that needs to underpin these systems (323).



Community meeting, Port-au-Prince, Haiti

11A. MAKE HEALTH EQUITY A KEY INDICATOR OF SOCIETAL DEVELOPMENT AND ESTABLISH MECHANISMS OF ACCOUNTABILITY

Because the health of every individual is influenced by the conditions of their daily lives and the structural drivers of these conditions, unequal health outcomes provide sensitive indicators of how well a society is performing. Dysfunctional and unequal societies tend to have worse health and greater health inequalities than better functioning, more equal societies do. As societies develop, the widening or narrowing of health equity signals the extent to which social justice is integral to that development (324).

Ensuring that governments take action across the whole of society to achieve greater health equity requires that health equity is recognized as a key indicator of societal development and that governments are held to account for its achievement. In turn, this requires a new approach to governance and the measurement of policies (319). Governments need to take action to ensure that all ministries, not just health ministries, are taking action on the social determinants of health.

We have illustrated that there are many examples of countries and cities in the Americas that are working both to improve health and reduce health inequalities. We have also shown that while overall health may have improved as a result of their efforts, inequalities have often persisted. One key reason for this persistence is that ministries and the sectors they cover operate in silos, without cross-government action or accountability. This method of delivering policy reflects a lack of recognition of how their combined effect impacts on both health and its social determinants (322). An effective delivery chain is required that is capable of acting on multiple determinants to reduce inequities, recognizing the pathways that connect social position, social structures, material factors, and individual behaviors (presented in Figure 1.1 in this report). Critically, cross-government mechanisms, based on national strategic plans for improving health equity, are required (see Box 5.1).

While the components of the Rio Declaration are all necessary, they do not provide sufficient detail or indicate practical solutions. For example, at both global and country levels, a wide range of social, technological, political, and cultural factors are

making effective governance a more complex task, as the locus of control for governance dissipates across multiple sectors and multinational global influences (5, 325).

As a first step, governments should ensure that they undertake health equity assessments of all policies, and develop policies to amplify action on health equity. Examples of action plans and strategies that have been developed in the Region are shown in Box 5.2.

Equity assessments of policies and interventions are important to ensure that the equity impact of every policy and program is identified and modified accordingly, for the greatest positive impact on health equity. Equity assessments are most frequently carried out within the framework of health impact assessments (HIAs), by using an equity lens to evaluate impact. However, there is general agreement across the literature that consideration of equity within standard impact assessments is difficult to achieve (326). Equity issues are not systematically addressed, and even where differential impacts on health are considered explicitly, they are rarely discussed in terms of whether or not these differences are avoidable or unfair (327). The rationale for health equity impact assessments is that they strengthen current impact assessment processes and approaches, and in their own right, allow policymakers to focus specifically on the differing needs of population groups (328). Without such assessments, there is evidence that policymakers do not make equitable decisions (329). A number of health equity impact assessment tools have been developed in the Region and elsewhere (Box 5.3).

Box 5.1. 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 in 2011 of the priorities outlined in the Rio Political Declaration on Social Determinants of Health. Below we summarize the five priority areas, all of which relate to governance.

Better governance for health and development. Governance has to do with how governments (including their different sectors) and other social organizations interact, and how these bodies relate to citizens. Intersectoral action for health that ensures a Health in All Policies approach is essential to addressing the social determinants of health.

Promotion of participation in policy-making and implementation. The participation of communities and civil society groups in the design of public policies, in the monitoring of their implementation, and in their evaluation is essential to action on social determinants.

Further reorientation of the health sector toward reducing health inequities. The health sector has a key role to play in advocating a social determinants of health approach and explaining how this approach is beneficial, both across society and for different sectors. The health sector has particular expertise in and responsibility for monitoring health inequities and the impact of policies on social determinants. The health sector can play an important role in bringing sectors together to plan and implement work on the social determinants of health. The health sector should also develop its own capacities for work on social determinants.

Strengthening global governance and collaboration. Global governance and collaboration should be strengthened and aligned with national and local priorities and policies. That will improve the national–global interconnectedness of governmental and nongovernmental actors to promote a social determinants of health approach in order to reduce health inequities.

Monitoring progress and increasing accountability. Effective governance for social determinants requires monitoring and measurement of policy inputs and outcomes to inform policy-making, evaluate implementation of interventions, and build accountability.

Source: World Health Organization. Rio Political Declaration on Social Determinants of Health. Geneva: WHO; 2011. Available from: https://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf?ua=1.

Box 5.2. Examples of national social determinants action plans

Several countries in the Americas have developed action plans. For example, in 2006, a presidential act created the Brazilian National Commission on Social Determinants of Health (CNDSS), with a two-year mandate. The CNDSS was organized around production and dissemination of knowledge, strengthening the social determinants of health focus in policies and programs, mobilization of civil society, communication, and international cooperation.¹

More recently, the Union of South American Nations (UNASUR) plan of action for 2010–2015 included social determinants among the five priorities, and the Southern Common Market (MERCOSUR) created an Intergovernmental Commission on Health Promotion and Social Determinants of Health.²

The current PAHO Strategic Plan for 2014–2019 includes, as one of its six broad categories, the determinants of health and promoting health throughout the life course.³

Sources: ¹ World Health Organization. Social determinants of health – Brazil [Internet]; [cited 9 Jan 2019]. Available from: https://www.who.int/social_determinants/thecommission/countrywork/within/brazil/en/.

² Union of South American Nations Health. South American Health Council 2010–2015 five-year plan. Rio de Janeiro: Union of South American Nations; 2010. Available from: <http://isags-unasur.org/en/documento/plan-quinquenal-del-consejo-de-salud-suramericano-2010-2015/>.

³ Pan American Health Organization. Strategic plan of the Pan American Health Organization 2014–2019. Championing health: sustainable development and equity. Washington, D.C.: PAHO; 2014. Available from: <https://www.paho.org/hq/dmdocuments/2017/paho-strategic-plan-eng-2014-2019.pdf>.

Box 5.3. Examples of health equity impact assessment tools

The Health Equity Assessment Toolkit (HEAT) is a collaboration between WHO and the International Centre for Equity in Health, Brazil.¹ It focuses on assessing unequal health outcomes within-country rather than interventions or programs. It allows for exploring unequal outcomes within and between countries. Disaggregated data and summary measures of unequal outcomes are available. Indicators reflect multiple SDG goals and targets. At present, the information available focuses on reproductive, maternal, newborn, and child health, using data from the WHO Health Equity Monitor database.^{1,2}

Health Equity Impact Assessment (HEIA) tool, Ontario, Canada. This tool was developed in 2013 by the Ontario Ministry of Health and Long-Term Care in partnership with Public Health Ontario, Public Health Units, and Local Health Integration Networks. It can be used to help decision-makers consider equity issues in planning decisions. It incorporates international evidence as well as input gathered during regional pilots and conversations with health service providers.³

This tool identifies five steps in conducting health equity impact assessments:

1. Scoping: identify affected populations and potential unintended health impacts on those groups of the planned policy, program, or initiative.
2. Potential impacts: use available data or evidence to prospectively assess the unintended impacts of the planned policy, program, or initiative on the identified groups in relation to the broader population.
3. Mitigation: develop evidence-based recommendations to minimize or eliminate negative impacts and maximize positive impacts on identified vulnerable groups.
4. Monitoring: determine how implementation of the initiative will be monitored to determine its impact on vulnerable groups related to other subpopulations or the broader target population.
5. Dissemination: share results and recommendations for addressing equity.

Haber, at the Wellesley Institute in Ontario, produced a primer on conducting HEIA. The Wellesley website contains information on a wide range of tools, frameworks, and templates.⁴ Harris-Roxas and Harris developed a conceptual framework for evaluating the effectiveness of equity-focused health impact assessment.⁵

Sources: ¹ World Health Organization. Health Equity Assessment Toolkit (HEAT): software for exploring and comparing health inequalities in countries. Built-in database edition. Version 2.1. Geneva: WHO; 2018. Available from: https://www.who.int/gho/health_equality/assessment_toolkit/en/index1.html.

² World Health Organization. Health Equity Monitor. 2018 update [Internet]. Available from: https://www.who.int/gho/health_equality/en/.

³ National Collaborating Centre for Methods and Tools. Conducting a health equity impact assessment (HEIA): MOHLTC tool. Toronto: Ministry of Health and Long-Term Care; 2012. Available from: <https://www.nccmt.ca/knowledge-repositories/search/146>.

⁴ Haber R. Health equity impact assessment: a primer. Health equity road map. Toronto: Wellesley Institute; 2010. Available from: <https://www.wellesleyinstitute.com/publications/health-equity-impact-assessment/>.

⁵ Harris-Roxas B, Harris E. The impact and effectiveness of health impact assessment: a conceptual framework. *Environ Impact Assess Rev.* 2013;42:51-9.



May Day March, Los Angeles, USA

Health equity assessments of policies and interventions can be used to ensure that individual policies do not create or widen inequities and, ideally, they are designed to narrow them. However, this in itself will not result in coherent actions across sectors to reduce inequalities.

Similarly, national plans and targets are generally designed to improve overall economic

performance and, in many instances, achieve overall improvements in health and well-being. For this reason, it is important to develop public, national plans of action for health inequities, and to incorporate local government, communities, and cross-sector approaches, including those from the private sector. One example of such a plan is described in Box 5.4.

Box 5.4. Example of a strategic national plan engaging civil society

National Plan for Good Living [*Plan nacional para el buen vivir*], Ecuador. Ecuador’s countrywide action plan incorporates a social determinants of health approach to health and policy. The plan is committed to developing and implementing social policies. It was developed through consultation with diverse actors, and it recognizes citizen participation as a basic right. Forums for dialogue were created to enable the participation of different groups, including women and men from different social/cultural backgrounds and of different ages and sexual orientations, to provide their opinion on the achievements of the previous National Development Plan. The feedback given was incorporated into the new plan.

Source: Republic of Ecuador, National Planning Council. National development plan/national plan for good living, 2013–2017. Summarized version. Quito: National Secretariat of Planning and Development; 2013. Available from: <http://www.planificacion.gob.ec/wp-content/uploads/downloads/2013/12/Buen-Vivir-ingles-web-final-completo.pdf>.

11B. THE WHOLE OF GOVERNMENT—INCLUDING LEGISLATURE, JUDICIARY, AND EXECUTIVE—TO TAKE RESPONSIBILITY FOR ENSURING EQUITY IN ALL POLICIES

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. For this reason, effective approaches to governance for health equity require a whole-of-government approach, in which the different sectors and levels of governance are involved in creating and sustaining political support for health equity as a societal good.

Such an approach includes strengthening the coherence of actions across sectors and stakeholders—public, private, and voluntary—to increase resource flows to redress current patterns and reduce the magnitude of health inequity. The approach also includes improving the distribution of the determinants of opportunities to be healthy, across the whole population.

To achieve these goals, it is important to strengthen the coherence and resourcing of actions. The health sector has a critical role in cross-government action, as an advocate 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” of health inequalities.

HEALTH IN ALL POLICIES (HiAP) APPROACH

One of the approaches taken in the Region is the Health in All Policies (HiAP) approach to public policy. Such an approach can provide a basis for addressing the need for coherent concrete action across all of government to improve health. It has been adopted by many countries in the Americas (330). However, there needs to be additional strong emphasis on ensuring equity in all policies.

Health equity in all policy approaches go further than conventional HiAP approaches (331). While the health sector commonly serves a central role, the approach systematically takes into account the health equity implications of decisions across sectors. As a cautionary note, however, a review of past 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 (332).

The Americas was the first WHO region to establish a regional plan of action on Health in All Policies, in 2014. The regional plan of action marks a significant step toward global acceptance for collective and coordinated action for health. Progress since then in the Americas includes a series of guiding documentation and activity designed to support Member States in implementation, including the Road Map for the

Without ethical commitments, organizing socially and redistributing resources is not possible; these efforts must be voluntary and rest on moral grounds... The public at large, elected representatives and other government officials must accept and embrace the moral claim of health equity for all.

Jennifer Prah Ruger, Professor of Health Equity, Economics, and Policy at the University of Pennsylvania, in *Global Health Justice and Governance*, 2018

Box 5.5. Examples of plans based on a Health in All Policies approach

The Suriname experience—implementing a Health in All Policies approach to address the social determinants of health

After hosting the Caribbean subregion's first Health in All Policies (HiAP) training in 2015, the government of Suriname began moving toward implementation of the HiAP approach to address the social determinants of health. Under the leadership of the Ministry of Health and 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. The assessment of available data found that the social determinants that are predominately related to the major diseases impacting disability-adjusted life years in the country are geographical location, socioeconomic status, population group, and gender. These findings were used to establish eight country-specific areas of action for the implementation of HiAP:

- Education and employment
- Planning and land management
- Environments (housing, road infrastructure, mobility)
- Comprehensive community planning (integrate the community in the sociopolitical and administrative processes)
- Responsible consumption (tobacco, alcohol, and food)
- Training for employment
- Governance of the health system
- Organization and management of the health system

Suriname's experience highlights the strong links between the social determinants of health and the adoption of HiAP across sectors.¹

United States of America: Evaluation of HiAP initiatives

To help inform evaluation of HiAP initiatives in the United States of America, an approach was developed in 2017 by public health practitioners in various states. It includes a logic model and a set of potential indicators that can be used to describe and assess HiAP activities, outputs, and outcomes. It focuses on policies that aim to address the social determinants of health by increasing cross-sector collaboration and integrating health considerations into decisions made by “nonhealth” sectors. It is based on:

- a review of the literature of current HiAP approaches, practices, and evaluations; and
- consultation with experts with substantive knowledge in implementing or evaluating HiAP initiatives.

Case studies from the states of California and Washington and the city of Nashville highlight emerging examples of HiAP evaluation, and the ways in which local context and goals inform evaluation efforts.²

Sources: ¹ Pan American Health Organization. Health in All Policies in the Americas. Health in All Policies approach: quick assessment of health inequities [Internet]; 2015. Available from: <http://saludentodaslaspoliticass.org/en/experiencia-amp.php?id=29>.

² Gase LN, Schooley T, Lee M, Rotakhina S, Vick J, Caplan J. A practice-grounded approach for evaluating health in all policies initiatives in the United States. *J Public Health Manag Pract.* 2017;23(4):339–47.

Plan of Action on Health in All Policies, and the creation of the Task Force and Working Group on Health in All Policies and the Sustainable Development Goals. Additionally, several countries, including Brazil, Chile, Mexico, and Suriname, have recently embarked on capacity-building and planning that will ensure that health is firmly placed at the center of national policy development and planning (21).

Examples of within-country plans based on a HiAP approach are shown in Box 5.5.

ALIGNMENT WITH THE SUSTAINABLE DEVELOPMENT GOALS

In addition to having explicit recognition of Health in All Policies formulation, a whole-of-government approach is aligned with the holistic approach of



the 2030 Agenda for Sustainable Development and its 17 SDGs (94). The SDGs may not have been formulated with health as a specific goal, since they did not take the HiAP approach. However, almost all the SDGs are directly relevant to achieving greater equity in health and its social determinants, if they are consistently disaggregated to address distributions within society. Many of the SDGs are also directly relevant to combatting discrimination that often underpins inequalities.

Each of the SDGs has specific targets to be achieved over the 15 years from their adoption in 2015, and most have either existing or aspirational indicators attached to each target. For the SDGs to be reached, the UN recognizes that everyone needs

to do their part, including governments, the private sector, and civil society (6). This aspiration aligns with the governance arrangements identified above as being necessary to tackle social determinants and improve health equity.

To make progress toward 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 (321). This requires considerable capacity-building in skills and substantial cultural change in organizations at the national, local, and community level. A country example, from Canada, is given in Box 5.6.

Box 5.6. Example programs and policies for the whole of government—including legislature, judiciary, and executive—to take responsibility for ensuring equity in all policies

Public Health Agency of Canada’s steps for intersectoral action

The Public Health Agency of Canada has identified the necessary steps for the implementation of intersectoral action on health as follows:

- Create a policy framework and an approach to health that are conducive to intersectoral action.
- Emphasize shared values, interests, and objectives among partners and potential partners.
- Ensure political support; build on positive factors in the policy environment.
- Engage key partners at the very beginning; be inclusive.
- Ensure appropriate horizontal linking across sectors as well as vertical linking of levels within sectors.
- Invest in the alliance-building process by working toward consensus at the planning stage.
- Focus on concrete objectives and visible results.
- Ensure that leadership, accountability, and rewards are shared among partners.
- Build stable teams of people who work well together, with appropriate support systems.
- Develop practical models, tools, and mechanisms to support the implementation of intersectoral action.
- Ensure public participation; educate the public and raise awareness about health determinants and intersectoral action.

Source: Public Health Agency of Canada. Crossing sectors – experiences in intersectoral action, public policy and health. Ottawa: Government of Canada; 2007. Available from: <https://www.canada.ca/en/public-health/services/reports-publications/2007/crossing-sectors-experiences-intersectoral-action-public-policy-health.html>.

11C. DEVELOP AND ENSURE THE INVOLVEMENT OF WIDER SOCIETY—INCLUDING CIVIL SOCIETY AND COMMUNITIES—IN SETTING PRIORITIES AND POLICIES FOR ACHIEVING HEALTH EQUITY

Governments need the involvement of civil society and communities as part of the whole-of-society approach. In particular, civil society involvement is needed in setting priorities and developing policies. As a step toward this, it is essential to make intelligence and data on health, equity, and social determinants accessible within the public domain, locally and nationally, so that governments can be transparent about the nature and scale of the health equity challenge.

This requires governments to undertake and make available analyses of a range of health outcome data, both in absolute terms (for example, the numbers of additional years in ill health as a result of inequities) and in relative terms (for example, the ratio of ill-health rates in the worst-off group as compared with those in the best-off group).

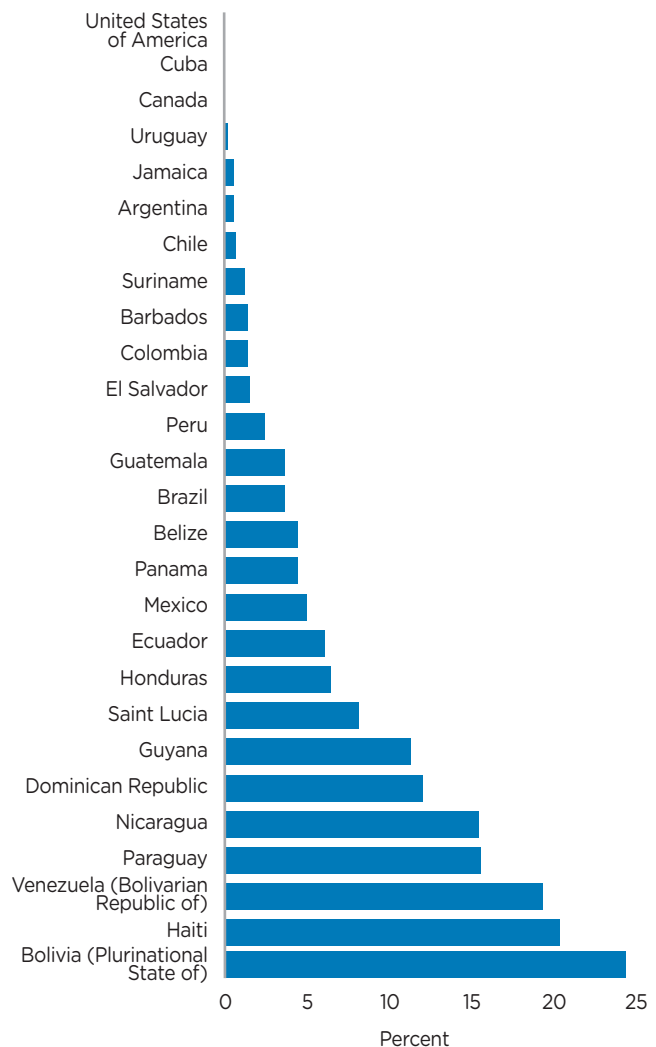
Comparisons are required of the gaps between the best- and worst-off, as well as of measures of distribution such as the slope index and indices of the concentration of inequality across the gradient. However, in the Americas there is huge variability in the data available. Some countries lack even the most basic information. Surveillance systems must be built, and investments made in the required infrastructure.

An important marker of the quality of information for countries and areas within countries is the level of “vital registration,” particularly of births, deaths, and marriages. In many low-income countries, overall registration levels are often low, or they are patchy across the country, with lower levels in less accessible areas or those affected by conflict. The United Nations estimates that around a quarter of the countries in the Americas have less than 90 percent coverage (7).

Figure 5.1 shows 27 countries in the Americas for which birth registration data are readily available. While seven had complete or near-complete registration at the time of recording, in seven countries more than 10 percent of births were unregistered (7).

Important as it is to identify and be transparent about the scale of inequities in health and its

Figure 5.1.
Percent of births unregistered, selected countries in the Americas, 2016 or latest



Source: World Bank. Databank. World development indicators [Internet]. Available from: <https://data.worldbank.org>.

social determinants, it cannot be a once-and-for-all process. Governments must actively promote transparent, public reporting of actions and progress through a comprehensive monitoring system for health equity and social determinants.

Measuring change in the average levels of indicators of health and social conditions in a country is important for monitoring the overall effectiveness of health systems, the contribution being made by social programs, and the likely contextual impact on these of wider national and global developments outside the control of governments. But these overall measures seldom provide sufficient information for converting monitoring information into action.

DISAGGREGATION OF DATA

The ways in which different groups are affected by and react to policies and social change vary systematically from one to another. It is therefore important to disaggregate indicators based on actual or proxy measures of both social groups and changes over time. Crucially, the list of SDG indicators starts with a paragraph in the Addis Ababa Action Agenda (333) about disaggregation, 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.

Measurement of trends in inequalities in these conditions is also needed to track the consequences of policy decisions on inequities in health (334), and to be able to hold governments to account for progress on health equity. Disaggregation needs to reflect—as much as is possible in routine monitoring statistics—variations over time, and across generations. On this basis, it is desirable to have disaggregation by age, gender, geographies (such as urban/rural, region, local administration, or area deprivation), education, and some indicator of material resources (such as income, material possessions/deprivation, wealth, socioeconomic status). Where vulnerability is associated with a specific additional characteristic, this will be required to understand the contextual basis of inequality—for example, gender, ethnicity/race, or migrant status.

Box 5.7 shows which SDG indicators can be used to monitor the social determinants of health equity in the Americas.

WHO held a global consultation on its proposed global monitoring system for action on the social determinants of health in 2016 (325). A revised framework and set of core indicators are being developed that aim to align the dimensions of the Rio Declaration with SDG indicators or other existing indicator sets where relevant SDG indicators are not currently available.

An existing framework for the disaggregation of indicators for baseline monitoring has been provided by Canada (Box 5.8).

INVOLVEMENT OF CIVIL SOCIETY

There is often a lack of understanding of the social, cultural, and economic lives of communities and groups for whom policies are being designed in addressing equity issues. When this occurs, the result is interventions that are mismatched to the realities of people's lives and that can fall short of delivering intended benefits for those most in need. There is therefore a need for increased involvement of local people and communities in defining problems and generating and implementing solutions. This is also required in order to place more emphasis on local solutions to tackle inequities, and to understand the social, cultural, and economic lives of the most affected populations. This type of engagement with local people and communities can be seen in the examples presented earlier of Ecuador's National Plan for Good Living (Box 5.4) and the Public Health Agency of Canada's steps for intersectoral action (Box 5.6).

Governments must 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. To achieve this through a whole-of-government and whole-of-society approach, governments must:

- Strengthen the capacity of NGOs and local authorities in their use of participatory planning methods that improve health and reduce social inequities;

Box 5.7. Using SDG indicators to monitor the social determinants of health equity

To achieve greater availability of indicators of social determinants of health, the most promising way forward appears to be to align these indicators with some of those recommended for monitoring progress on key SDGs, selected on the basis of their relevance to health equity. This also requires ensuring that indicators are suitably disaggregated to reveal whether or not there is a narrowing of social inequity in society.

The list below is illustrative of the range of SDG indicators that might be appropriate for monitoring equity in the Region, if suitably disaggregated as recommended by the UN General Assembly (333).

Sustainable Development Goal	Key target indicators for monitoring health equity and its determinants
	<p>1.2.1. Proportion of population living below the national poverty line, by sex and age</p> <p>1.a.2. Proportion of total government spending on essential services (education, health and social protection)</p> <p>1.3.1. Proportion of population covered by social protection floors/systems, by sex, distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work injury victims, and the poor and the vulnerable</p>
	<p>2.2.1. Prevalence of stunting among children under 5 years of age</p> <p>2.2.2. Prevalence of malnutrition among children under 5 years of age, by type (wasting and overweight)</p>
	<p>3.1.1. Maternal mortality ratio</p> <p>3.1.2. Proportion of births attended by skilled health personnel</p> <p>3.2.1. Under-5 mortality rate</p> <p>3.6.1. Death rate due to road traffic injuries</p> <p>3.7.1. Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods</p> <p>3.7.2. Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group</p> <p>3.8.2. Proportion of the population with large household expenditure on health as a share of total household expenditure or income</p> <p>3.9.1. Mortality rate attributed to household and ambient air pollution</p> <p>3.9.2. Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene</p>

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(continued)

Sustainable Development Goal	Key target indicators for monitoring health equity and its determinants
	<p>4.5.1. Parity indices for all education indicators on this list that can be disaggregated: female/male, rural/urban, bottom/top wealth quintile and others such as disability status, Indigenous peoples and conflict-affected, as data become available</p>
	<p>5.1.1. Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex</p> <p>5.4.1. Proportion of time spent on unpaid domestic and care work, by sex, age and location</p> <p>5.5.1. Proportion of seats held by women in national parliaments and local governments</p> <p>5.5.2. Proportion of women in managerial positions</p> <p>5.a.1. (a) Proportion of total agricultural population with ownership or secure rights over agricultural land, by sex; and (b) share of women among owners or rights-bearers of agricultural land, by type of tenure</p> <p>5.a.2. Proportion of countries where the legal framework (including customary law) guarantees women's equal rights to land ownership and/or control</p> <p>5.c.1. Proportion of countries with systems to track and make public allocations for gender equality and women's empowerment</p>
	<p>6.1.1. Proportion of population using safely managed drinking water services</p> <p>6.2.1. Proportion of population using (a) safely managed sanitation services and (b) a hand-washing facility with soap and water</p>
	<p>8.5.2. Unemployment rate, by sex, age group and persons with disabilities</p> <p>8.6.1. Percentage of youth (aged 15–24) not in education, employment or training</p> <p>8.7.1. Proportion and number of children aged 5–17 years engaged in child labor, by sex and age</p>


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Sustainable Development Goal	Key target indicators for monitoring health equity and its determinants
	<p>10.1.1. Growth rates of household expenditure or income per capita among the bottom 40 percent of the population and the total population</p> <p>10.2.1. Proportion of people living below 50 percent of median income, by age, sex and persons with disabilities</p> <p>10.4.1. Labor share of GDP, comprising wages and social protection transfers</p> <p>10.6.1. Proportion of members and voting rights of developing countries in international organizations</p> <p>10.a.1. Proportion of tariff lines applied to imports from least developed countries and developing countries with zero-tariff</p>
	<p>11.1.1. Proportion of urban population living in slums, informal settlements or inadequate housing</p>
	<p>16.1.1. Number of victims of intentional homicide per 100,000 population, by sex and age</p> <p>16.1.2. Conflict-related deaths per 100,000 population, by sex, age and cause</p> <p>16.1.3. Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months</p> <p>16.1.4. Proportion of population that feel safe walking alone around the area they live</p> <p>16.7.1. Proportions of positions (by sex, age, persons with disabilities and population groups) in public institutions (national and local legislatures, public service, and judiciary) compared to national distributions</p> <p>16.7.2. Proportion of population who believe decision-making is inclusive and responsive, by sex, age, disability and population group</p> <p>16.8.1. Proportion of members and voting rights of developing countries in international organizations</p> <p>16.10.1. Number of verified cases of killing, kidnapping, enforced disappearance, arbitrary detention and torture of journalists, associated media personnel, trade unionists and human rights advocates in the previous 12 months</p>

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Sustainable Development Goal	Key target indicators for monitoring health equity and its determinants
	17.18.1. Proportion of sustainable development indicators produced at the national level with full disaggregation when relevant to the target, in accordance with the Fundamental Principles of Official Statistics
	17.19.2. Proportion of countries that (a) have conducted at least one population and housing census in the last 10 years; and (b) have achieved 100 percent birth registration and 80 percent death registration

Source: United Nations. SDG indicators. Metadata repository [Internet]. Available from: <https://unstats.un.org/sdgs/metadata/>.

Box 5.8. Baseline monitoring in Canada

In a 2018 report titled *Key Health Inequalities in Canada: A National Portrait*, a number of indicators are identified as providing a baseline for monitoring, as shown in Table 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

Source: Public Health Agency of Canada; Pan-Canadian Public Health Network. Key health inequalities in Canada: a national portrait [Internet]; 2018. Available from: <https://www.canada.ca/en/public-health/services/publications/science-research-data/key-health-inequalities-canada-national-portrait-executive-summary.html>.

- Undertake, require, or encourage public reporting of actions and progress to allow access to and debate on results and new challenges, by and with communities/third parties; and
- Make intelligence and data on health, equity, and social determinants accessible within the public domain, locally and nationally (319, 322).

Governance for health equity also requires new forms of leadership that shift the allocation of power toward communities and support a move toward decentralized decision-making systems involving local communities. This necessitates strengthening the capacity of NGOs and local authorities in their use of participatory planning methods that improve health and reduce social inequities.

To achieve these changes, instruments and mechanisms need to be strengthened to ensure equity of voice and perspectives in decision-making. Specifically, emphasis should be placed on ensuring that the differential needs of marginalized and at-risk groups are recognized, and that they are involved in resource allocations as well as the design, monitoring, and review of policies, services, and interventions. To recognize these needs and involve these groups requires:

- Use tools and instruments to provide support to the local level in order to define local problems and solutions, informed by local data;
- Mechanisms that actively promote involvement of local people and stakeholders in problem definition and solution development;

Table 5.1.
Baseline list of key indicators, Canada, 2016–2017

Health outcomes	Life expectancy and mortality	<ul style="list-style-type: none"> • Life expectancy at birth (ecological level) and 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 age 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 behaviors	<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; Pan-Canadian Public Health Network. Key health inequalities in Canada: a national portrait [Internet]; 2018. Available from: <https://www.canada.ca/en/public-health/services/publications/science-research-data/key-health-inequalities-canada-national-portrait-executive-summary.html>.

- Ensuring regular joint review of progress, which fosters common understanding and commitment to delivering shared results; and
- Using evidence to ensure policies address the main causal pathways and are capable of adapting over time.

CHILDREN’S PARTICIPATION

The central role that childhood plays in the development of health inequalities across the life course necessitates giving children an appropriate voice in the factors that affect their health and their futures. Governments need to take positive

measures to support these rights to participate, including in public education, legal proceedings, and advocacy to achieve health equity.

Children’s human rights institutions, in their various forms across the Region, have the potential to enable children to have a voice. They can contribute to challenging and dismantling the legal, political, economic, social, and cultural barriers that impede children’s opportunity to be heard and to participate in all matters affecting them (335). Institutions have become a source of expertise and support to governments and other stakeholders in creating opportunities for child participation. These institutions were brought into being in the 1920s

Box 5.9. Examples of supporting localities to improve social and physical environments as a means of promoting good health for all

Healthy People 2020, United States of America. This strategic plan is coordinated federally by the U.S. Department of Health and Human Services (DHHS).¹ The social determinants of health topic area within Healthy People 2020 is designed to identify ways to create social and physical environments that promote good health for all.² It has a “place-based” organizing framework that reflects five key areas of social determinants of health: economic stability, education, social and community context, health and health care, and neighborhood and built environment. Specifically, the 2020 plan emphasizes the need to consider factors such as poverty, education, and aspects of the social structure that not only influence the health of populations but also limit the ability of many to achieve health equity.²

Participative Budget, Porto Alegre, Brazil. In 1989, the City Hall of Porto Alegre developed an innovative and participative municipal budget system called Participative Budget, as a response to mismanagement of municipal budgets, tax collection, and public spending. The Participative Budget aimed to enforce a democratic and transparent administration of municipal resources to avoid corruption and support investment in urban infrastructure. Citizens were able to make decisions on public issues, and actively participate in meetings, regional conventions, and assemblies. In 1996, approximately 1,000 entities and associations were registered with the Participative Budget, and the City Hall had steered 15 to 25 percent of the income to investments, the rest being spent on paying staff and other administrative expenses. As a result, in Porto Alegre, water supply coverage increased from 400,000 households in 1990 to 465,000 in 1995. Coverage of waste and sewerage facilities also increased, from 46 percent of the population in 1989 to 74 percent in 1996.³

Sources: ¹ Koh K, Piotrowski JJ, Kumanyika S, Fielding JE. Healthy people: a 2020 vision for the social determinants approach. *Health Educ Behav.* 2011 Dec;38(6):551-7.

² Office of Disease Prevention and Health Promotion. Social determinants of health [Internet]. Available from: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>.

³ United Nations Educational, Scientific and Cultural Organization. *The experience of the participative budget in Porto Alegre Brazil.* Paris: UNESCO; 1996. Available from: <http://digital-library.unesco.org/shs/most/gsd/cgi-bin/library?e=d-000-00---0most-00-0-0--0prompt-10---4-----0-1l-1-en-50---20-about---00031-001-1-OutfZz-8-00&a=d&c=most&cl=CL3.1&d=HASHdc400ee310c647023cf286>.

and 1930s as a result of awareness in the Americas of the abuse experienced by children in very vulnerable situations (such as institutionalization). However, the legislative reforms that followed were more concerned with preventing excesses in institutions, such as prisons, rather than preventing children being placed there in the first place and deprived of liberty (336).

The adoption of the Convention on the Rights of the Child in 1989 (337) accelerated the creation of independent children’s human rights institutions and enabled them to have a wider and more creative remit. The Convention recognizes that

each child is entitled to special care and assistance, and to being prepared fully to live an individual life in society, brought up in the spirit of peace, dignity, tolerance, freedom, equality, and solidarity. To these ends, the Convention’s Article 12 requires States to ensure that a child who is capable of forming his or her own views has the right to express those views freely in all matters affecting the child, with the views of the child being given due weight in accordance with the age and maturity of the child. Similarly, Article 13 gives children freedom of expression, including freedom to seek, receive, and impart information and ideas of all kinds.

Box 5.10. Examples of institutions and policies promoting measures to support children's rights to participate

Promoting equitable approaches for the most marginalized children

Independent human rights institutions for children play an important role in advocating policies that aim to correct the disadvantages experienced by some children, and to address exclusion. In 2010, for example, the Canadian Council of Child and Youth Advocates called for a national plan to improve the well-being and living conditions of Canada's Indigenous children and youth. In particular, it recommended a coordinated strategy to narrow the significant gaps in health, education, and safety outcomes apparent between Indigenous and non-Indigenous children.¹

Many of the challenges of promoting equitable approaches lie in the marginalization of the issues concerned in the wider social and political context. Bringing about change for excluded children requires significant efforts to increase the visibility of the issues that affect them, and for these issues to be deemed worthy of political attention. Other challenges concern the nature of the individual institution itself. An institution's ability to promote the rights of the most excluded children often requires specific consideration of its internal profile and workings, for example by hiring staff from minority or Indigenous groups to help meet the needs of the most marginalized children.²

In Ontario, Canada, the Office of the Provincial Advocate for Children and Youth makes monthly visits to special schools for hearing- and vision-impaired children and/or children with severe learning disabilities to learn about their experiences of accessing services. Since other means of communication present significant barriers to these students, they feel more comfortable raising concerns in person with staff from the Office of the Provincial Advocate.³

Promoting child participation in society

In 2012, UNICEF published a report titled *Championing Children's Rights: A Global Study of Independent Human Rights Institutions for Children*, which concluded with a number of recommendations.⁴ Those relevant to supporting children's right to participate can be summarized as follows:

- **Governments and parliaments** should ensure that institutions are founded on adequate legislation, which includes a number of core provisions. An institution must explicitly set forth its grounding in the Convention on the Rights of the Child.
- **Governments** should instruct relevant departments and public bodies at all levels to fully cooperate with institutions in all of their phases of operation.
- **Parliaments** should engage actively with independent institutions.
- **Independent human rights institutions for children**, especially those integrated into a broad-based human rights institution, should review their effectiveness in encouraging child participation, especially of younger and marginalized children.
- **Civil society** should support independent institutions by cooperating with them, sharing information, supporting children and other actors in making complaints, supporting the follow-up of recommendations, and, where appropriate, sharing technical expertise.
- **Donors and intergovernmental organizations** should provide technical assistance in establishing and strengthening independent institutions, raise awareness of their role, advise on their legislative mandate, and build supportive capacities within the country.⁴

Sources: ¹ Canadian Council of Provincial Child and Youth Advocates. Aboriginal children and youth in Canada: Canada must do better. Position paper, 23 June 2010. Edmonton: Canadian Council of Provincial Child and Youth Advocates; 2010.

² Hughes T. Final progress report on the implementation of the recommendations of the BC Children and Youth Review. Victoria: Representative for Children and Youth; 2006. Available from: https://rcybc.ca/sites/default/files/documents/pdf/reports_publications/final_progress_report.pdf.

³ Provincial Advocate for Children and Youth. Report to the legislature: annual report 2010–2011. Toronto: Provincial Advocate for Children and Youth; 2011: 19. Available from: <https://open.alberta.ca/dataset/2053399b-8ddd-4b0f-8060-c5d7b7c57d26/resource/5b865c09-34fe-4516-b1ef-914c620e2447/download/4439121-2010-2011-Children-Youth-Services-Annual-Report.pdf>.

⁴ United Nations Children's Fund. *Championing children's rights: a global study of independent human rights institutions for children – summary report*. Florence: UNICEF Office of Research - Innocenti; 2012. Available from: https://www.unicef-irc.org/publications/pdf/championing2_eng.pdf.

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Box 5.10. Examples of institutions and policies promoting measures to support children's rights to participate *(continued)*

NGOs can complement and support the role played by independent human rights institutions for children in numerous ways.⁵ Representatives of NGOs in many places are also members of human rights commissions and therefore have the ability to influence an institution's priorities.⁶

Many independent human rights institutions for children in Latin America have local ombudsmen (*defensorías*), who facilitate geographic accessibility. This helps rural and Indigenous communities to access these institutions in the same way as people living in urban centers. In Peru, for example, there are 840 local Defenders of Children and Adolescents (*Defensorías del Niño y del Adolescente*), who dealt with more than 130,000 cases in 2010.⁷

The website of the Ombudsman's Office (*Defensoría del Pueblo*) in Peru is made more readily accessible by being available in the Indigenous language, Quechua, including with a complaint form in that language.⁷

Another way of enhancing the geographic accessibility of institutions is to physically travel to remote areas for the purpose of having direct interaction with people. In 2009, the National Commissioner for Human Rights (*Comisionado Nacional de los Derechos Humanos*) in Honduras set up mobile units to foster public awareness of the Commission, collect complaints, and inform the public about pending cases and the outcome of investigations.⁸

Sources: ⁵ Vuckovic-Šahovic N. The role of civil society in implementing the general measures of the Convention on the Rights of the Child. Innocenti Working Paper No. 2010-18. Florence: UNICEF International Child Development Centre; 2010: 39. Available from: https://www.unicef-irc.org/publications/pdf/iwp_2010_18.pdf.

⁶ Public Health Agency of Canada. Canadian best practices portal: social determinants of health [Internet]; 2016. Available from: <http://cbpp-pcpe.phac-aspc.gc.ca/public-health-topics/social-determinants-of-health/>.

⁷ Ministerio de la Mujer y Poblaciones Vulnerables. Government of Peru [Internet]; 2018 [cited 3 Mar 2018]. Available from: <https://www.gob.pe/mimp>.

⁸ Comisionado Nacional de los Derechos Humanos de la República de Honduras. Informe anual 2009 [Internet]; 2009 [cited 3 Mar 2018]. Available from: http://190.92.18.85/descargas/InformesAnuales/CONADEH_2009.pdf.

RELEVANT INTERNATIONAL AGREEMENTS

Convention on the Rights of the Child (United Nations, 1989)

The Convention has 54 articles, which cover all aspects of a child’s life and set out the civil, political, economic, social, and cultural rights to which all children everywhere are entitled. It also explains how adults and governments must work together to make sure all children can enjoy all their rights. Every child has rights, whatever his or her ethnicity, gender, religion, language, abilities, or any other status.

The Convention assumes recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice, and peace in the world. The Convention includes four special “General Principles”:

- Non-discrimination (Article 2)
- Best interest of the child (Article 3)
- Right to life survival and development (Article 6)
- Right to be heard (Article 12)

PAHO Resolutions

Plan of Action on Health in All Policies (CD53.R2 [2014])

Plan of Action for Implementing the Gender Equality Policy (CD49.R12 [2009])

Sustainable Development Goals

Goal 5. Achieve gender equality and empower all women and girls

Goal 10. Reduce inequality within and among countries

Goal 14. Conserve and sustainably use the oceans, seas and marine resources for sustainable development

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. Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development

RECOMMENDATION 12.

FULFILLING AND PROTECTING HUMAN RIGHTS

A human rights approach to achieving health equity aligns well with a social determinants approach. There are many existing human rights mechanisms that support equity in health, all of which have high profile and agreement in most of the Region of the Americas, but particularly in Latin America. Human rights laws can be powerful tools for building awareness and consensus around shared values, and for guiding analysis and strengthening measurement and accountability to support health equity (201). They can help to ensure that governmental actions are reasonable and justified in light of commitments that countries agree to when ratifying human rights (338).

Good governance for health equity needs to build on human rights actions that, as Braveman has observed (201):

- 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; and
- Improve the distribution of the determinants of opportunities to be healthy, across the whole population.

The existence of the right to health in both national and international agreements strengthens the argument that, where differences in health outcomes are observed among groups due to social and political factors, reduction of these inequities in health should be seen to be a direct requirement of justice (339). Thus, when the United Nations Declaration on the Rights of Indigenous Peoples places Indigenous peoples' rights to self-determination as a fundamental and inherent right and a necessary antecedent for the full enjoyment of human rights, this includes the right to health (151).

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' (CESCR) 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 CESCR • 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 nondiscrimination principles into all public policies and services and ensure adequate data collection to monitor equality and nondiscrimination



WELCOME TO

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our legislators say

NO! to WOMEN

NO! to VOTING

NO! to TEACHERS

NO! to HEALTHCARE

NO! to CHILDREN

NO! to the UNEMPLOYED

12A. STRENGTHEN RIGHTS RELATING TO SOCIAL DETERMINANTS OF HEALTH AS ASPECTS OF THE RIGHT TO HEALTH AND TO A DIGNIFIED LIFE

In the Region of the Americas, the explicit use of human rights frameworks and strategies can be demonstrated to have led to the exposure of systematic discrimination against marginalized populations, the reallocation of health budgets to improve equity, enhancement of quality of care in facilities, increased oversight of health systems, and access to quality care as a political and legal entitlement by the public (338). Beyond access to health care, human rights mechanisms can drive action on social determinants of health.

The human right to health is an “inclusive right” that extends beyond access to health care or physical health, to the social determinants of health. The Committee on Economic, Social and Cultural Rights (CESCR), which monitors implementation of the UN International Covenant on Economic, Social and Cultural Rights, indicates that the right to the highest attainable standard of health includes a right to the underlying social determinants of health (340):

The right to health embraces a wide range of socioeconomic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and health working conditions and a healthy environment.... The Committee interprets the right to health... as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health.

Venkatapuram, building on concepts developed by Sen and Nussbaum, has developed the notion of a “capability to be healthy” as the basis for the right to health and human dignity (341). According to Venkatapuram, this notion emphasizes the moral entitlement to a sufficient and equitable capability to be healthy, grounded in the respect for human dignity (341):

Every human being has a moral entitlement to the capability to be healthy and at a

sufficient level that it is commensurate with human dignity.... The Capability to be Healthy includes the capability to live a normal length of life span and achieve a cluster of capabilities and functionings.... Without health capability there is no equal human dignity nor can economic and social justice be pursued.

A social determinant rights approach implies not just a need to address individual wrongs but also to produce structural changes as well—governments acting according to the principles of participation, equality, nondiscrimination, and accountability—and the right of citizens to demand that States act in this manner. Ascertaining if failures have occurred in matching human rights obligations with appropriate action and, conversely, where human rights agreements have led to improved policies and practical actions, requires bringing together evidence of inequities with the evaluation of compliance and noncompliance with these agreements (342).

The paper “Health and Human Rights,” presented to the 50th Directing Council of PAHO in 2010, analyzed the relationship between the health of groups in situations of vulnerability and the human rights recognized in international human rights instruments (343). The paper identified which articles in these instruments related to specific human rights. Table 5.2 is an extract from that paper, indicating those rights in the analysis that are most closely related to social determinants of health, and the articles in each of the instruments that are relevant to these (343).

Table 5.2. International human rights instruments and the specific articles in them that are applicable to selected social determinants of health for groups in situations of vulnerability

a) UN human rights system

Example human rights	Universal Declaration of Human Rights	International Covenant on Civil and Political Rights	International Covenant on Economic, Social and Cultural Rights	Convention on the Rights of the Child	Convention on the Elimination of All Forms of Discrimination against Women	Convention 169 concerning Indigenous and Tribal Peoples in Independent Countries	Convention on the Rights of the Persons with Disabilities
Life	Art. 3	Art. 4		Art. 6.1			Art. 10
Freedom of movement and residence	Art. 13	Art. 22		Art. 10.2	Art. 15.4		Art. 18
Work	Art. 23		Arts. 6, 7	Art. 32	Art. 11	Art. 20	Art. 27
Highest attainable standard of health	Art. 25		Art. 10	Arts. 17, 19.1, 24	Art. 12	Art. 25	Art. 25
Education	Art. 26		Art. 13	Art. 28	Art. 10	Arts. 26, 27	Art. 24
Social security	Art. 22		Art. 9	Art. 26	Art. 11	Art. 24	Art. 28
Food and nutrition	Art. 25		Art. 12	Art. 24	Art. 14		Art. 28
Protection of the family	Art. 16		Art. 17	Arts. 5, 27	Art. 16		Art. 23
Protection of older persons	Art. 25	Art. 17	Art. 15				Art. 25

b) Inter-American human rights system

Example human rights	American Declaration on the Rights and Duties of Man	American Convention on Human Rights (Pact of San José)	Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights (Protocol of San Salvador)	Inter-American Convention for the Elimination of All Forms of Discrimination against Persons with Disabilities	Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (Convention of Belém do Pará)
Life	Art. I	Art. 4			Art. 4.a
Freedom of movement and residence	Art. VIII	Art. 22			Art. 4
Work	Art. XIV		Arts. 6, 7	Art. III.1.a	Art. 4
Highest attainable standard of health	Art. XI		Art. 10	Arts. III.2.a, III.2.b	Art. 4.b
Education	Art. XII		Art. 13	Arts. III.1.a, III.2.b	Art. 4
Social security	Art. XXXV		Art. 9		Art. 4
Food and nutrition	Art. XI		Art. 12		Art. 4
Protection of the family	Art. VI	Art. 17	Art. 15		Art. 4
Protection of older persons	Art. XVI		Art. 17		Art. 9

Source: Pan American Health Organization. Health and human rights: concept paper. 50th Directing Council, 62nd Session of the Regional Committee, Washington, D.C., 27 September-1 October 2010 (CD50/12). Available from: <http://iris.paho.org/xmlui/handle/123456789/31127>.

Box 5.11. Examples of strengthening rights relating to social determinants of health as aspects of the right to health and to a dignified life

Examples of instruments

The Universal Declaration of Human Rights, Article 25 states: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family.”¹

The American Declaration on the Rights and Duties of Man, Article XI states: “Every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources.”²

The Protocol of San Salvador to the American Convention, Article 10 states: “Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being.”³

Case law examples

The right to life is not just a negative right but a right to a dignified existence

“The right to life is a fundamental human right, and the exercise of this right is essential for the exercise of all other human rights. If it is not respected, all rights lack meaning.... In essence, the fundamental right to life includes, not only the right of every human being not to be deprived of his life arbitrarily, but also the right that he will not be prevented from having access to the conditions that guarantee a dignified existence. States have the obligation to guarantee the creation of the conditions required in order that violations of this basic right do not occur.” *Street Children, case 63, 1999*⁴

Protection of a dignified existence

“This Court has asserted that the right to life is crucial in the American Convention, for which reason realization of the other rights depends on protection of this one. When the right to life is not respected, all the other rights disappear, because the person entitled to them ceases to exist. Due to the basic nature of this right, approaches that restrict the right to life are not admissible. Essentially, this right includes not only the right of every human being not to be arbitrarily deprived of his life, but also the right that conditions that impede or obstruct access to a decent existence should not be generated.

“One of the obligations that the State must inescapably undertake as guarantor, to protect and ensure the right to life, is that of generating minimum living conditions that are compatible with the dignity of the human person and of not creating conditions that hinder or impede it. In this regard, the State has the duty to take positive, concrete measures geared toward fulfilment of the right to a decent life, especially in the case of persons who are vulnerable and at risk, whose care becomes a high priority.” *Indigenous Community Yakye Axa v. Paraguay*⁵

Sources: ¹ United Nations. International Bill of Human Rights. Universal Declaration of Human Rights. General Assembly, Paris, 10 December 1948 (217A). Available from: [https://undocs.org/A/RES/217\(III\)](https://undocs.org/A/RES/217(III)).

² Organization of American States, Inter-American Commission of Human Rights. American Declaration of the Rights and Duties of Man. Adopted by the Ninth International Conference of American States, Bogotá, Colombia, 1948. Available from: <https://www.cidh.oas.org/basicos/english/basic2.american%20declaration.htm>.

³ Organization of American States. Additional protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights. “Protocol of San Salvador.” San Salvador, 17 November 1988. Available from: <http://www.oas.org/juridico/english/treaties/a-52.html>.

⁴ Inter-American Court of Human Rights. Case of the “Street Children” (Villagran-Morales et al.) v. Guatemala. Inter-Am. Ct. H.R. (ser. C) No. 63 (Nov. 19, 1999).

⁵ Inter-American Court of Human Rights. Case of Yakye Axa Indigenous Community v. Paraguay, Merits, Reparations and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 125 (June 17, 2005).

(continued on next page)

Box 5.11. Examples of strengthening rights relating to social determinants of health as aspects of the right to health and to a dignified life *(continued)***Protection across the life course**

“We all live in time, which eventually consumes us all. Precisely because of this self-perception we have of ourselves as existing in time, each one of us seeks to envisage a life project. The term ‘project’ implies in itself a temporal dimension. The concept of life project has therefore an essentially existential value, grounded in the idea of complete personal achievement. In other words, within the framework of a transient life, people have the right to make the options they feel are best, of their own free will, in order to achieve their ideals. Therefore, endeavors to achieve a life project appear to have great existential value, and the potential to give meaning to each person’s life.

“When this quest is suddenly torn apart by external factors caused by man (such as violence, injustice, discrimination), which unfairly and arbitrarily alter and destroy an individual’s life project, it is especially serious—and the Law cannot remain indifferent to this. Life—at least the one we know—is the only one we have and has a time limit, and the destruction of the life project almost always implies a truly irreparable damage or sometimes reparable only with great difficulty.” *Judge Antônio A. Cançado Trindade, in case of Gutiérrez-Soler v. Colombia*⁶

Sources: ⁶ Inter-American Court of Human Rights. Case of Gutiérrez-Soler v. Colombia. Judgment of September 12, 2005. Case No. 132.

12B. STRENGTHEN ACCOUNTABILITY FOR SOCIAL DETERMINANTS OF HEALTH AS AN ASPECT OF THE RIGHT TO HEALTH AND TO A DIGNIFIED LIFE

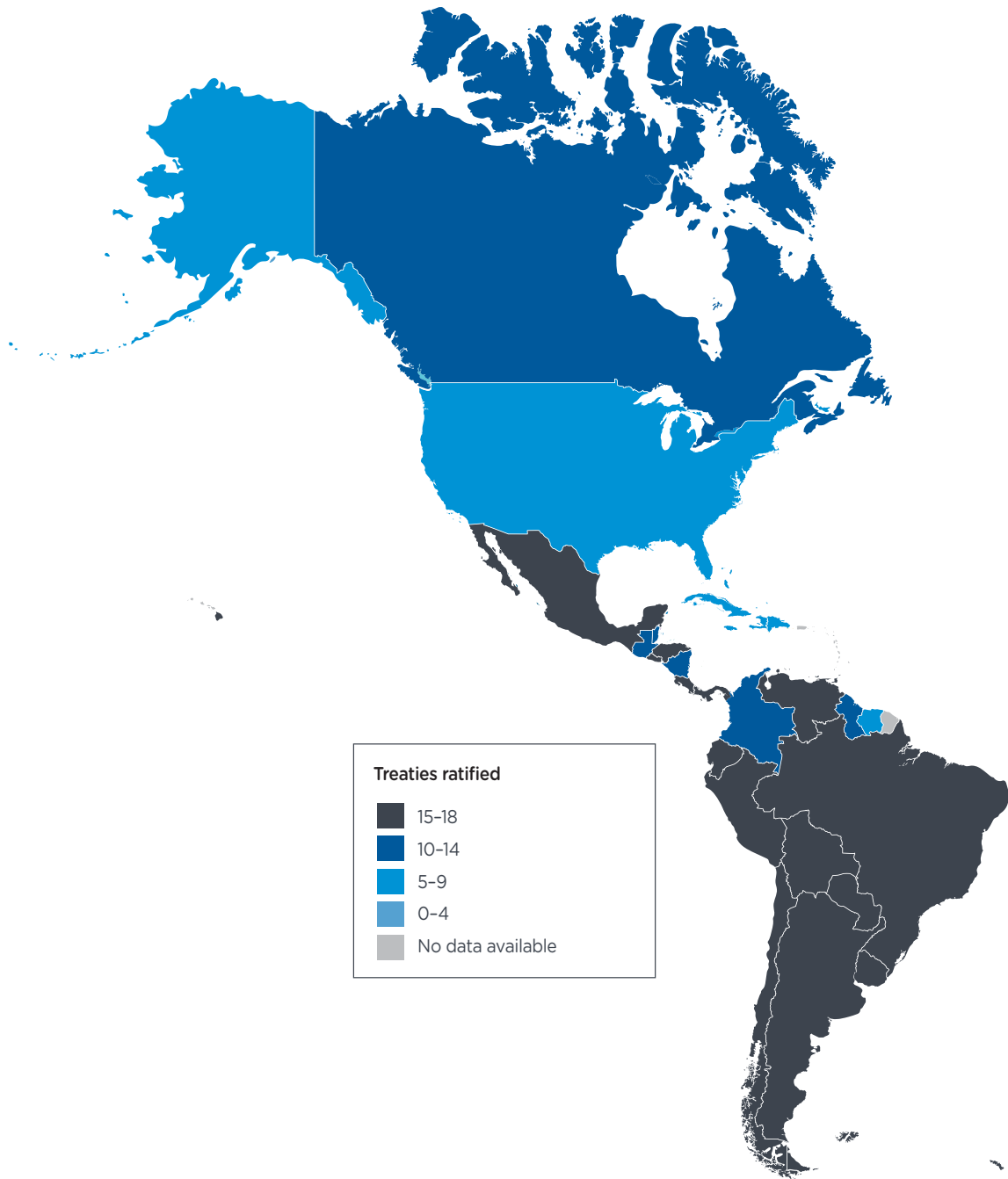
The monitoring done by the Center for Economic and Social Rights (CESR) includes identifying which UN international human rights treaties have been ratified by countries. Figure 5.2 summarizes the number of such treaties ratified by each country in the Americas. All but seven countries had ratified 15 or more of the 18 treaties monitored. Ratification does not necessarily involve compliance, however, and monitoring also includes assessments of which countries are complying with the rights, but ratification is an important first step (344).

Figure 5.3 indicates the numbers of human rights instruments each PAHO Member State had ratified by 2010. While 15 of them had ratified nine or more instruments, six had only ratified between one and four. Notably, the United States of America had only ratified one.

Using a slightly different approach, the WORLD Policy Analysis Center has developed a framework of rights and protections to analyze the constitutions of UN Member States, based on 37 international conventions. This has enabled it to identify and compare the existence and quality

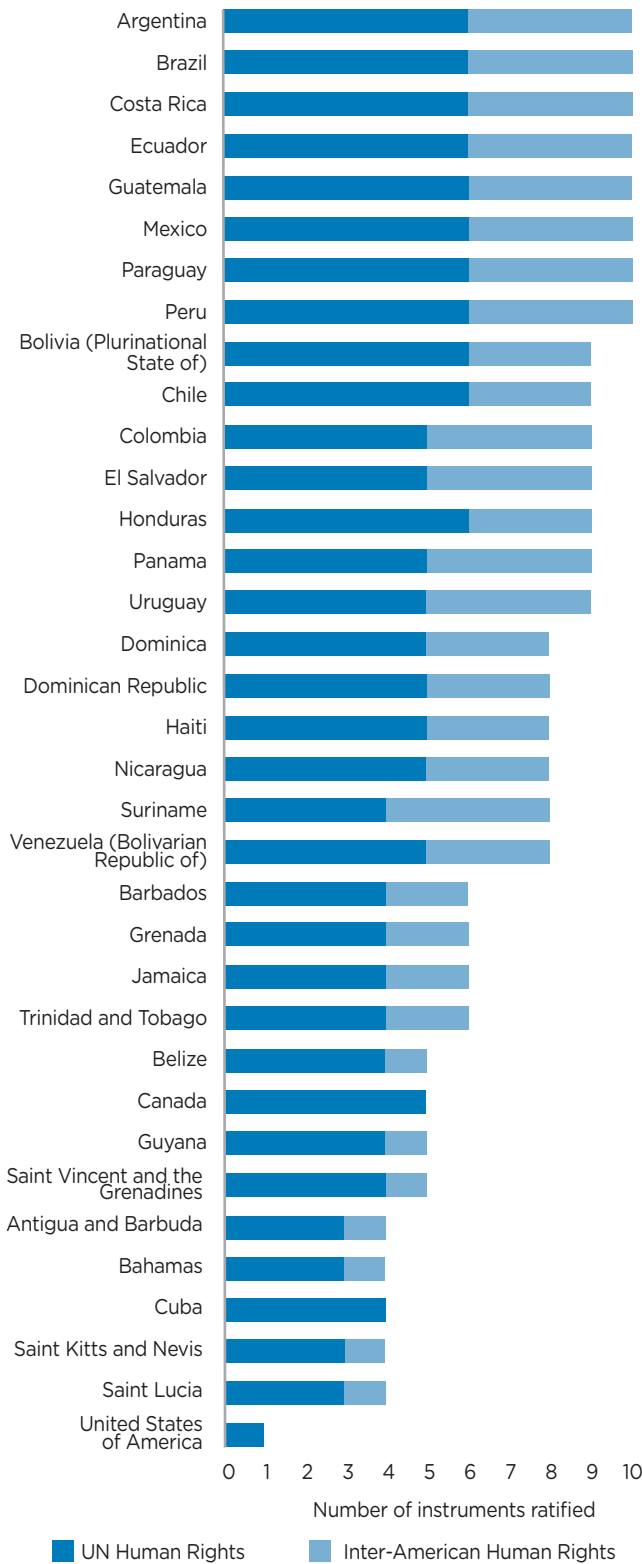


Human rights demonstration, Halifax, Canada

Figure 5.2.**Number of international human rights treaties ratified by countries in the Americas, 2018**

Source: United Nations, Office of the High Commissioner. Human rights indicators [Internet]. Available from: <https://www.ohchr.org/EN/Issues/Indicators/Pages/HRIndicatorsIndex.aspx>.

Figure 5.3.
PAHO Member States that have ratified human rights instruments, by number ratified, 2010



Source: Pan American Health Organization. Health and human rights: concept paper. 50th Directing Council, 62nd Session of the Regional Committee, Washington, D.C., 27 September–1 October 2010 (CD50/12). Available from: <http://iris.paho.org/xmlui/handle/123456789/31127>.

of protections across civil and political rights, economic and social rights, and protection against discrimination across the life course (345). The Center argues that (345):

Constitutions reflect the social and political character of nations and frame their legal and political systems. Constitutional guarantees can be used to demand greater equity in the delivery of and access to basic services, to challenge discriminatory legislation and practices, and to change social norms. Equal rights lay the foundation for equal life chances for all.

For example, Article 2 of the UN Convention on the Rights of the Child (337) requires that:

States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child’s or his or her parent’s or legal guardian’s race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

The WORLD Policy Analysis Center has also analyzed the labor legislation in each country, to create a database regarding workplace guarantees of protections from gender-based discrimination in terms of working conditions, promotions and/or demotions, equal pay, training, and sexual harassment at work.

As an example of the Center’s approach, Figure 5.4(A) illustrates what type of guarantees that countries in the Americas offer to children to undertake secondary/high school education. Figure 5.4(B) indicates whether completing secondary education is compulsory, and Figure 5.4(C) shows in what countries there is a right to primary education and if it extends through to secondary education. As indicated in Section 4, attaining a secondary educational qualification is a major source of social differentiation and discrimination in societies across the Americas. Figure 5.4(D) shows the extent to which the right to education is guaranteed for girls across the Americas.

Figure 5.4.

Selected constitutional and legal guarantees in the Americas to secondary education, 2014

A) Does the constitution guarantee citizens the right to secondary education?



Source: WORLD Policy Analysis Center. Does the constitution guarantee citizens the right to secondary education? [Internet]; 2018. Available from: <https://www.worldpolicycenter.org/policies/does-the-constitution-guarantee-citizens-the-right-to-secondary-education>.

Figure 5.4.

Selected constitutional and legal guarantees in the Americas to secondary education, 2014

B) Is completing secondary education compulsory?



Source: WORLD Policy Analysis Center. Does the constitution guarantee citizens the right to secondary education? [Internet]; 2018. Available from: <https://www.worldpolicycenter.org/policies/does-the-constitution-guarantee-citizens-the-right-to-secondary-education>.

Figure 5.4.

Selected constitutional and legal guarantees in the Americas to secondary education, 2014

D) What type of right to secondary education does the constitution guarantee for girls?



Source: WORLD Policy Analysis Center. What type of education rights does the constitution guarantee for girls? [Internet]; 2018. Available from: <https://www.worldpolicycenter.org/policies/what-type-of-education-rights-does-the-constitution-guarantee-for-girls>.

TOOLS AND RECOMMENDATIONS FOR ADDRESSING VIOLATIONS OF HUMAN RIGHTS

In undertaking monitoring of the ratification of human rights instruments, the CESR recognizes that although laws and policies in the socioeconomic sphere can contribute significantly to fulfilling economic and social rights—in providing infrastructure and services such as schools, hospitals, or investment capital—they may be designed or implemented in a way that excludes or fails to meet the needs of particular sectors of society (346). This creates or perpetuates inequity and deprivation. In order to use human rights monitoring as an advocacy tool for social justice, CESR provides civil society organizations, NGOs, and other advocates with practical, accessible

resources to utilize multidisciplinary tools to monitor the economic and social rights, and to demand accountability for denials and violations of these rights. It has developed a framework for analyzing the obligation to fulfill economic and social rights, as well as for assessing outcomes, policy efforts, and resources.

CESR has built up a community of human rights activists and practitioners who have been using a range of tools to monitor the actions of governments and other actors from a human rights perspective. This has enabled CESR and other national and international NGOs to make evidence-based recommendations on how to address systemic violations in seven countries in the Americas. Examples of these are given in Boxes 5.12 through 5.19.



United Nations, Geneva, Switzerland

Box 5.12. Brazil: human rights in times of austerity

In 2017, the Institute for Socioeconomic Studies (INESC) of Brazil, Oxfam Brazil, and the Center for Economic and Social Rights (CESR) examined the human rights impacts of austerity measures in Brazil. That analysis found that inequality posed significant costs to economic performance, sustainable development, and human rights enjoyment. Budget cuts in 2015 had targeted investments in human rights, social protection, climate change, and racial and gender equality. These reductions affected health and education spending, food programs, institutions that ensure gender equality, and women's rights programs. The analysis argued that these measures breached international human rights and Brazilian constitutional law. Brazil's Supreme Federal Court ruled that some austerity policies were not allowable, since they undermined clauses of the Brazilian Constitution, such as the duty to progressively fulfill social rights. As an alternative to austerity, the three groups' 2017 analysis proposed comprehensive progressive tax reform based on principles of fiscal justice and the elimination of corruption and tax dodging.

Source: Instituto de Estudos Socioeconômicos; Oxfam; Center for Economic and Social Rights. Brazil – human rights in times of austerity [Internet]; 2017. Available from: <http://www.cesr.org/sites/default/files/Brazil%20Austerity%20Factsheet%20English%20FINAL.pdf>.

Box 5.13. Plurinational State of Bolivia: making human rights accountability more graphic

To contribute to holding States accountable for their economic and social rights obligations, the Center for Economic and Social Rights (CESR) has produced fact sheets analyzing and interpreting selected human rights and human development indicators. The intention is to highlight possible areas of concern with regard to governments' compliance with their obligations to uphold economic and social rights, in order to assist UN and other intergovernmental human rights mechanisms, including the Treaty Bodies, Special Rapporteurs, and the Human Rights Council's Universal Periodic Review.

A CESR analysis of the Plurinational State of Bolivia raised the following questions:

- Why has income inequality increased in recent years?
- Is the government adopting any redistributive policies to satisfy its minimum obligations regarding, inter alia, the rights to health, education, food, and housing?
- Has the government recently taken any concrete steps to reduce child malnutrition and improve household food security among the poor?
- Why are there such high disparities in education opportunities between girls and boys, Indigenous and non-Indigenous populations, and children living in rural areas and those living in urban areas?
- What is the government doing to reduce the high inequality of access to education, which impairs the enjoyment by all persons, on an equal footing, of the right to education?
- What steps is the country undertaking to ensure that children in rural areas and other children from marginalized communities enjoy an equal right to primary education of good quality?

Source: Center for Economic and Social Rights. Bolivia: making human rights accountability more graphic. Fact sheet no. 2 [Internet]; 2008. Available from: http://www.cesr.org/sites/default/files/Bolivia_Fact_Sheet.pdf.

Box 5.14. Colombia: fiscal policy, peace, and human rights

Since 2015, CESR has contributed to Colombian civil society's efforts to achieve greater economic justice. By bringing the framework of human rights to the field of fiscal policy at the national, regional, and international levels, CESR helped construct an alternative narrative about fiscal justice in Colombia and more broadly throughout the Andean Subregion and the rest of Latin America. This narrative aims to favorably position the demands of the communities that are most disadvantaged (e.g., women and Indigenous and Afro-descendant populations) by the current distribution of public resources.

Source: Center for Economic and Social Rights. Colombia factsheet: Fiscal policy, peace and human rights [Internet]; 2018. Available from: <http://cesr.org/colombia-factsheet-fiscal-policy-peace-and-human-rights>.

Box 5.15. Ecuador: rights violations in the Ecuadorian Amazon

Development policies in the Amazon have had devastating impacts on the health and welfare of local communities as well as the environment, as described in Recommendation 2 and Recommendation 3. In 1993, CESR organized a team of scientists that produced the first substantive proof that communities in the Ecuadorian Amazon were being systematically exposed to toxic wastes dumped by oil companies. Their report strengthened local efforts to confront irresponsible oil development, by providing two critical elements: an international human rights framework and credible scientific evidence of violations.

After an 18-year struggle by the affected communities, mostly Indigenous ones, seeking damages from the Chevron oil company and redress from the Ecuadorian government, in 2011 a provincial court in Ecuador ordered Chevron to pay more than US\$ 9 billion in compensation for the environmental and health impacts of oil contamination in the Ecuadorian Amazon. A coalition of human rights, Indigenous, and environmental groups supported the affected communities.

Source: Center for Economic and Social Rights. Rights violations in the Ecuadorian Amazon: the human consequences of oil development [Internet]; 2018. Available from: <http://www.cesr.org/rights-violations-ecuadorian-amazon-human-consequences-oil-development>.

Box 5.16. Guatemala: rights or privileges? Fiscal commitment to the rights to health, education, and food

A report by the Central American Institute for Fiscal Studies (ICEFI) and CESR analyzed the compliance of the Guatemalan State with its obligation to use the maximum resources available to advance progressively toward the realization of economic and social rights of all citizens, without discrimination, as well as to promote the role of fiscal policy as an important tool to comply with this obligation.

It found that Guatemala's development indicators lag behind those of other countries in the Americas despite the country's income. Although it has a GDP per capita comparable to that of Ecuador, more than half the population lives below the national poverty line, and one in seven Guatemalans lives in conditions of extreme poverty. According to the United Nations Development Programme, Guatemala has the lowest Human Development Index (HDI) in Latin America and the Caribbean except for Haiti, highlighting the disparity that exists between the economic resources available to the country and its economic and social rights outcomes.

The report's recommendations included an estimate of the various fiscal measures, such as taxation and increased proportions of GDP resources, necessary to advance toward the realization of the rights to education, health, and nutrition, as well as a series of mechanisms that could strengthen State funding of these rights.

Source: Center for Economic and Social Rights; Central American Institute for Fiscal Studies. Rights or privileges? Fiscal commitment to the rights to health, education and food in Guatemala. New York: CESR; 2009. Available from: <http://www.cesr.org/guatemala-rights-or-privileges>.

Box 5.17. Haiti: integrating rights into budget processes

The UN Office of the High Commissioner for Human Rights organized training in Haiti focused on integrating the protection of human rights into public policies and government budget processes in 2009. It was attended by 50 people, from civil society groups, UN entities, and the Haitian government. Given the context of Haiti's persistent poverty and inequality, the purpose was to build awareness and capacity to promote and protect economic, social, and cultural rights, as well as civil and political rights within public policy-making processes. As one Haitian participant commented, "Our resources are limited, but our needs are enormous, making it very difficult to establish priorities."

Source: Center for Economic and Social Rights. Integrating rights into budget processes in Haiti [Internet]; 2009. Available from: <http://www.cesr.org/integrating-rights-budget-processes-haiti>.

Box 5.18. The Lima Declaration on Tax Justice and Human Rights

The Lima Declaration, endorsed by 157 organizations worldwide in 2015, calls for deep reforms to tax policies and practices, to bring them in line with human rights standards and principles. It sets the stage for concerted collaborative efforts across the human rights community at large, including persons and groups working for tax justice, women's rights, trade unions, development, and human rights.

Source: Center for Economic and Social Rights. Endorse the Lima Declaration on Tax Justice and Human Rights [Internet]; 2015. Available from: <http://www.cesr.org/endorse-lima-declaration-tax-justice-and-human-rights>.

Box 5.19. Afrodescendent Women in Latin America and the Caribbean: Debts of Equality

The ECLAC report *Afrodescendent Women in Latin America and the Caribbean: Debts of Equality* provides an overview of the types of inequalities experienced by women of African descent in the region and discusses the types of policies that can help to do away with all the various forms of discrimination to which they are subject. It focuses on three main dimensions of women's autonomy: economic autonomy, physical autonomy, and autonomy in decision-making. It examines a number of public policy initiatives that governments have designed and implemented in an effort to close the inequality gaps that persist in the region.¹ The importance of addressing the intersectionality of ethno-racial and gender-based discrimination is also highlighted in the ECLAC report for the thirteenth session of the Regional Conference on Women in Latin America and the Caribbean (Montevideo, 25–28 October 2016). It identifies the commitments and obligations regarding women's rights, necessary to pave the way for the region to attain sustainable development with full gender equality.²

Sources: ¹ Economic Commission for Latin America and the Caribbean. Afrodescendent women in Latin America and the Caribbean: debts of equality. Santiago: ECLAC; 2019. Available from: <https://www.cepal.org/en/publications/44387-afrodescendent-women-latin-america-and-caribbean-debts-equality>.

² Economic Commission for Latin America and the Caribbean. Equality and women's autonomy in the sustainable development agenda. Santiago: ECLAC; 2016. Available from: <https://www.cepal.org/en/publications/40675-equality-and-womens-autonomy-sustainable-development-agenda>.

12C. STRENGTHEN PROTECTION AGAINST ALL FORMS OF DISCRIMINATION IN ALL SPHERES, INCLUDING RESPONSIVENESS TO MULTIPLE FORMS OF DISCRIMINATION

There are various mechanisms that result in denying individuals and groups the right to health. These include barriers to accessing health and other services, as well as to securing adequate conditions for daily living. One of these is overt discrimination, based on, for example, ethnicity. There are financial constraints, such as co-payments, bribes, or excessive costs that restrict participation. Among the more subtle barriers are complex rules and regulations (requiring high levels of numeracy and literacy that correlate with education and skills) and social controls or rationing (such as requiring permission to use a service).

If barriers exist within governance structures, through a lack of rights to participate in the policy-making process for example, then it is highly likely that access and outcomes will be unequal (347). Of course, participation alone is not sufficient to achieve equality of access and outcomes. Other rights commonly listed are the freedom to make decisions about one's own health; entitlement to a system of health protection; the availability and accessibility of acceptable health facilities, goods, and services that are appropriate and of good quality; protection from discrimination; and provision of culturally appropriate services (348).

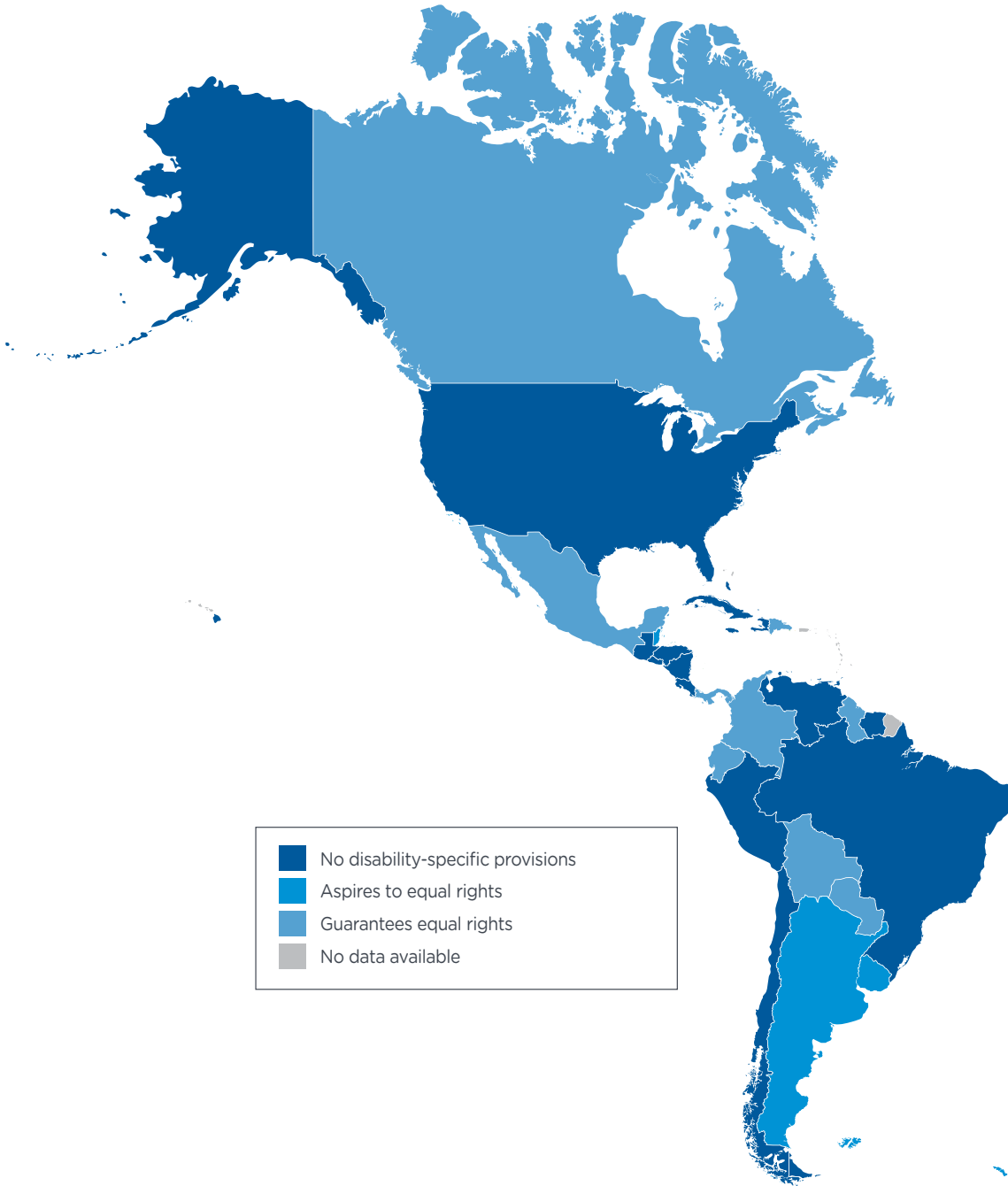
Barriers such as those mentioned above can effectively limit the use of services by women or people in vulnerable situations. They can also create the conditions leading to the "inverse care law," whereby those with the greatest need

for services, on account of their adverse social conditions, receive less care than those with lesser needs (349).

Access to all social determinants is highly unequal, as has been described throughout this report. In many cases, inequalities in social determinants are the result of overt or covert discrimination against particular groups, including in terms of access to land, education, and employment; incarceration and violence; political participation; and decent environmental conditions. Constitutional mechanisms that are based on human rights approaches can support nondiscrimination. However, there are unequal constitutional protections across the Americas (Figures 5.5 through Figure 5.8), and even where constitutions do afford protections, compliance does not always occur.

Figure 5.5.

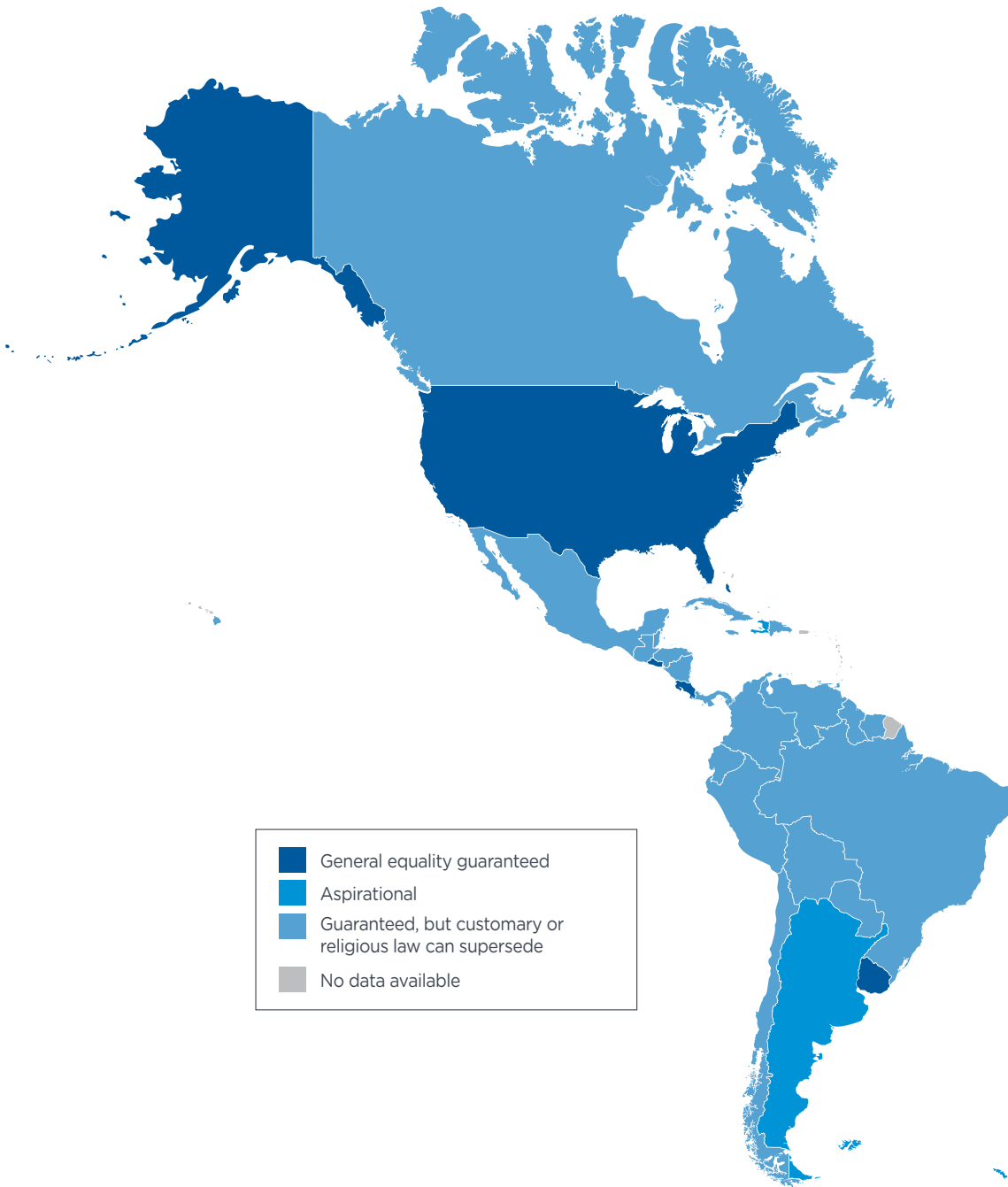
Does the constitution guarantee equality for and nondiscrimination against persons with disabilities (as of 2014)?



Source: WORLD Policy Analysis Center. Does the constitution guarantee the right to education for children with disabilities? [Internet]; 2018. Available from: <https://www.worldpolicycenter.org/policies/does-the-constitution-guarantee-the-right-to-education-for-children-with-disabilities>.

Figure 5.7.

Does the constitution take at least one approach to gender equality (as of 2014)?



Source: WORLD Policy Analysis Center. Does the constitution take at least one approach to gender equality? [Internet]; 2018. Available from: <https://www.worldpolicycenter.org/policies/does-the-constitution-take-at-least-one-approach-to-gender-equality>.

Figure 5.8.

Does the constitution take any approach to guaranteeing health for citizens (as of 2014)?



Source: WORLD Policy Analysis Center. Does the constitution take any approach to health? [Internet]; 2018. Available from: <https://www.worldpolicycenter.org/policies/does-the-constitution-take-any-approach-to-health>.

RELEVANT INTERNATIONAL AGREEMENTS

UN human rights system

Declaration on the Rights of Indigenous Peoples (2007)

Universal Declaration of Human Rights (1948, not subject to ratification)

International Covenant on Civil and Political Rights (1966)

International Covenant on Economic, Social and Cultural Rights (1966)

Convention on the Rights of the Child (1989)

International Convention on the Elimination of All Forms of Racial Discrimination (1965)

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

Convention 169 concerning Indigenous and Tribal Peoples in Independent Countries (1989)

Convention on the Rights of Persons with Disabilities (2007)

Inter-American system: the Inter-American Court of Human Rights

The Inter-American Court of Human Rights is a principal and autonomous organ of the Organization of American States (OAS), whose mission is to promote and protect human rights in the Americas.

American Declaration on the Rights and Duties of Man (1948, not subject to ratification)

American Convention on Human Rights (Pact of San José) (1969)

Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights (Protocol of San Salvador) (1988)

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

Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities (1999)

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

PAHO Resolutions

Disability: Prevention and rehabilitation in the context of the right to the enjoyment of the highest attainable standard of physical and mental health and other related rights (CD47.R1 [2006])

Health and Human Rights (CD50.R8 [2010])

6. CONCLUSION



© PAHO

We have laid out 12 evidence-based recommendations that are key steps to achieving greater health equity in the Americas. Twelve sounds like a great deal. If there were just one thing we would recommend to governments, to civil society, and to international organizations, it would be: equity in all policies. In order to make health equity a priority, you must make equity a priority.

Health equity should be a priority because it goes to the heart of the kind of societies we want. It is unacceptable that the prospect of living a dignified, fulfilled, healthy life is unequally distributed in society—determined by ethnic and Indigenous background, socioeconomic circumstances in childhood and throughout life, gender identity, sexual orientation, and the presence of disability. The actions laid out in this report will redress those inequities and achieve better health for all.

It is also likely that the cross-government actions necessary to achieve health equity will lead to more cohesive societies, with more educated citizens, a higher level of well-being, and less crime and civil unrest—in short, better functioning, fairer societies. Climate change and inequalities loom over the Americas as they do over other world regions. The agenda we have laid out confronts both these threats to health equity.

When one is asked for priorities, it is tempting to respond: give every child the best start in life—equity from the start. The injustice of having life

chances shaped by accident of birth is simply indefensible. Early childhood is vitally important. That said, we have resisted the temptation to single this out for two key reasons. First, there is much that needs to be done at other stages of the life course, from childhood, through working age, to older age. Second, action needs to address the structural drivers and conditions of daily life that influence conditions in early childhood, as they do other stages of the life course.

Recommendations 1 through 10 have laid out what needs to be done. How to do it is the substance of Recommendations 11 and 12. Here we summarize how to lay the basis for sustained action to achieve health equity.

CROSS-GOVERNMENT COMMITMENT TO ACTION

Governments need to decide that health equity through action on the social determinants of health is a priority. Such a decision needs to come from the top. Health is usually seen as the province of ministers of health. Indeed, PAHO is governed by ministers of health. But action on social determinants of health requires action by the whole of government, with cross-government action. Such action requires ministers of education, and finance, or social protection, or environment to assess the effects of their policies on equity and hence on health equity. A more equitable education system will advance the cause of health equity; reductions in poverty and inequality will be beneficial for health equity.

To repeat, experience shows that the lead for such cross-government action needs to come from the top, while much of the technical expertise will come from the ministries of health. An example of what a country can do comes from Brazil. At the time of the WHO Commission on Social Determinants of Health, Brazil set up a national commission, including members from important areas of Brazilian life beyond the health sector. Part of the reasoning behind this initiative was the need to

We are confronted with the fierce urgency of now. In this unfolding conundrum of life and history, there is such a thing as being too late.

Martin Luther King, Jr.
Stride toward Freedom: the Montgomery Story

This is no time for apathy or complacency. This is a time for vigorous and positive action.

Martin Luther King, Jr.
“Beyond Vietnam, A Time to Break Silence”
speech, 4 April 1967, New York City

adapt recommendations of a global commission to make them suitable for a national context.

It is for this reason that we recommend governments of all countries in the Americas set up cross-government mechanisms to address social determinants of health inequities, of the type that have been laid out extensively in this report.

Such action can be at the subnational as well as national level. Some policies and programs are best developed and carried out at the national level. But cities and regions can be appropriate levels of government action. It is in cities where life plays out for a majority of the population, and many of our recommendations need to be planned and implemented at the city level. While the recognition of the increased importance of cities for the majority of the population is welcome, the danger is that rural areas are left behind. Focus on sustainable development in rural areas can also happen at the regional level.

SOCIAL DETERMINANTS OF HEALTH AND THE SUSTAINABLE DEVELOPMENT GOALS

The SDGs have been endorsed by countries. As we set out under Recommendation 11, action on the SDGs means, in effect, action on some of the social determinants of health. Achieving the SDGs set for 2030—on poverty, hunger, education, gender equality, clean water and sanitation, decent work and economic growth, reduced inequalities, sustainable cities and communities, peace, and justice and strong institutions—quite apart from those on health and partnership, would mean making great progress on social determinants of health and health equity. Or, to put it differently, government commitment to health equity through action on the social determinants of health would be to take important steps toward attaining the SDGs by 2030.

HUMAN RIGHTS

Throughout this report, and brought together in Recommendation 12, are the human rights instruments that we have identified as having the potential to lead to action on social determinants of health and to improve prospects for all people of the Americas to lead lives of dignity. We see human rights mechanisms as an important way of taking forward the health equity agenda.

CIVIL SOCIETY

Civil society has a key role to play. Civil society groups can bring pressure to bear on governments to act in the interest of equity. Civil society groups have often been in the lead in bringing new knowledge to bear on the structural drivers of health inequities. Without civil society action, there might have been even less attention paid to issues of inequities between Indigenous peoples and others, to the real needs of people of African descent, to gender inequalities, to discrimination according to sexual orientation, and to neglect of or discrimination against people with disabilities.

Civil society groups can also be instrumental in delivering services. Charities should not be seen as letting government off the hook, but they do much that is irreplaceable in current circumstances. To the extent that civil society groups are true representations of communities, they are instruments of community empowerment.

MEASUREMENT AND MONITORING

This report has drawn on the data available within countries on inequities in health and their social determinants. Much of the data on health inequities relate to maternal and child health. In many countries in the Americas, there is a severe lack of data on inequalities in adult health. While Canada and the United States of America show what is possible, even they still have significant gaps. It is a matter of urgency to have the evidence: measures of health disaggregated along the dimensions of inequality that are the focus of this report.

Work by ECLAC is vital in charting economic and social inequalities within countries and across the Region.

PROPORTIONATE UNIVERSALISM

We have drawn attention to two overlapping phenomena. First is the health disadvantage of groups at special social disadvantage: Indigenous peoples, people of African descent, the poor, women, LGBT people, the disabled. Second is the social gradient in health. When people are classified by education, income, or some other measure of social disadvantage, health inequalities are

not confined to poor health for the poor, but the relationship is graded: the lower people are in the social hierarchy, the poorer their health. The first requires focusing on those at special disadvantage; the second requires universal policies that improve living conditions for all.

To bring the two together, we emphasize proportionate universalism: universalist policies with effort proportionate to need.

UN ORGANIZATIONS

This Equity Commission was set up by PAHO. PAHO representatives in Member States and in Washington, D.C., have a clear role to play in bringing knowledge of what works in partnership with country actors.

Our focus is on cross-government work, and not only in the health sector. Therefore, other UN agencies have a clear role to play on action across the life course and on the domains identified in this report.

RESEARCH

Reading our recommendations will reveal that they are based on the best evidence available, and our judgments are based on that evidence. The fact that the evidence is incomplete is not, by itself, a reason to do nothing. Inaction because of lack of evidence is as much a policy judgment as is action in the face of evidence that is incomplete. We are confident the recommendations we have made have real possibility to advance the cause of health equity. But the evidence of what

works is never to the level desirable. Each of the domains of recommendations can be seen as a research agenda, looking at the questions of what works and in what contexts, and how to make improvements.

We need to act now, but we also need to continue to evaluate the evidence on what works.

ACTION IN THE AMERICAS

We see this report as a stage in a journey. Its aim is to be an important step in synthesizing the evidence and setting out what can be done in policies and programs. The next stage is doing it.

The First World Conference on Social Determinants of Health was held in Rio de Janeiro in 2011. We call for a regional conference on social determinants of health and health equity in the Americas within five years of the launching of this report.

“SOCIAL INJUSTICE IS KILLING ON A GRAND SCALE”

This phrase is from the Commission on Social Determinants of Health. It is as true now as it was when the CSDH reported in 2008. Health has improved in the last decade in much of the Americas, but inequalities in health and in length of life abound. It is our judgment that many of these health inequalities could be avoided by reasonable means. Hence, they are inequitable.

Putting right these social inequities in health is a matter of social justice.

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In the last decades, health in the Region of the Americas has improved dramatically, yet many people are being left behind. PAHO has established the Commission on Equity and Health Inequalities in the Americas to analyze the impact of drivers influencing health, while proposing actions to improve inequalities in health.

According to the evidence presented in this report, much of ill health is socially determined. Factors such as socioeconomic position, ethnicity, gender, sexual orientation, disability status, being a migrant—alone or in combination—can contribute to marked inequalities in health on life. The analysis also reveals that other structural factors, such as climate change, environmental threats, and one’s relationship with the land, as well as the continuing impact of colonialism and racism, are also slowing progress towards a dignified life and enjoying the highest attainable standards of health. Furthermore, the impact of daily life conditions shows that the effect of inequalities is seen at the start of life.

The report provides examples of successful policies, programs, and actions implemented in countries and presents 12 recommendations to achieve health equity, calling for coordinated actions among local and national governments, transnational organizations, and civil society to jointly address the social determinants of health.



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