STRATEGIC OBJECTIVE 5

To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact

SCOPE

This Strategic Objective is designed to contribute to human well-being, minimizing the negative effects of disasters and other crisis by responding to the health needs of vulnerable populations affected by such events. It focuses on strengthening the institutional capacity of the health sector in preparedness and risk reduction, while promoting an integrated, comprehensive, multisectoral and multidisciplinary approach to reduce the impact of natural, technological or manmade hazards on public health in the Region.

INDICATORS AND TARGETS

- Crude daily mortality. Target: Daily mortality of populations affected by major emergencies maintained below 1 per 10,000 during initial emergency response phase.

- Access to functioning health services. Target: Affected health networks become operational within one month following a natural disaster.

ISSUES AND CHALLENGES

Countries of the Region are not sufficiently prepared to manage the consequences of disasters. Ensuring that international assistance complements the national response remains a challenge. National disaster plans continue to focus on single hazards instead of being multi-hazard and multi-institutional.

Natural hazards remain the most common threat to Latin American and Caribbean countries. Regardless of their frequency and severity, it is generally admitted that the countries' vulnerability is on the rise as a result of unsafe development practices and the deterioration of existing infrastructure. Following Hyogo Framework of Action for 2005-2015, safe hospitals will be an indicator on the level of vulnerability in the health sector.

Technological disasters are perhaps the most overlooked risk factors for countries that have reached a certain level of industrial development. Little has been done in terms of regulation and prevention, and the health sector is poorly prepared to face a large-scale chemical, radiological and other technological disasters. This risk will likely increase with economic development in the countries and the globalization of trade.

Internal conflicts have a direct impact on the health of the population. Despite the relatively stable situation of the Region there have been a number of individual internal conflicts. A certain number of crises are to be anticipated over the next five-year period.

The emerging threat of pandemic influenza in 2005 revealed that epidemics that result in humanitarian crisis do not constitute a sufficiently important part of national disaster plans. Despite recent planning, health institutions are still inadequately prepared to face these kinds of threats.

Due to the proliferation of actors in disaster preparedness and response, coordination is becoming a challenge and competition for funding is progressively increasing. The main actors in the field of disaster reduction and response are: United Nations (UN) agencies such as the Office for the Coordination of Humanitarian Affairs (OCHA), United Nations Children's Fund (UNICEF), World Food Programme (WFP), United Nations High Commissioner for Refugees (UNHCR), International Organization for Migration (IOM); regional and sub-regional organizations: Organization of American States (OAS), Coordination Center for the Prevention of Natural Disasters in Central America (CEPREDENAC), The Andean Committee for Disaster Prevention and Assistance (CAPRADE), The Caribbean Disaster Emergency Response Agency (CDERA), International and National NGOs, National Red Cross Societies and The International Federation of Red Cross and Red Crescent Societies (IFRC), among others.

National emergency response needs to be improved in a wide range of areas, including mass-casualty management; water, sanitation and hygiene; nutrition; response to chemical and radiological accidents; communicable and non-communicable diseases; maternal and newborn health; mental health; pharmaceuticals; health technologies; logistics; health information services; and restoration of the health infrastructure.

The procedures of UN organizations are not particularly suited for field operational response activities.

STRATEGIC APPROACHES

- Ensuring the coordination, effectiveness and efficiency of activities concerning preparedness, response and recovery in relation to health action in crises, PAHO/WHO will be the Health Cluster Leader for the Western Hemisphere when called upon; this will be done in PAHO/WHO's capacity in the United Nations Humanitarian Reform Process.

- Building national preparedness and capacity to manage risk and reduce vulnerability through: advocacy, updated policies and legislation, training, appropriate structures, scientific information, plans and procedures, resources and partnerships.

- Strengthening technical guidance and leadership and better coordination will be needed to ensure that there are no shortcomings in future emergencies.

- Compiling a roster of appropriately trained experts who can be called on in case of an emergency. Criteria and procedures should be agreed for collaboration involving all sectors.

- Collaborating with partners within and outside the health sector, including governments and civil society, other UN Agencies, as well as with mechanisms and networks, in order to ensure timely and effective interventions.

- Mainstreaming disaster management within the PASB by developing technical and operational capacities across PAHO/WHO in support of countries in crises, particularly for conducting health assessments, mobilizing resources, coordinating health action, tackling shortcomings, providing guidance and monitoring the performance of humanitarian action in relation to the health and nutrition of affected populations.

ASSUMPTIONS AND RISKS

Assumption:

- Disaster preparedness and risk reduction receive strong political support and resources at all levels.

Risks:

- The risk of distracting PAHO staff from development priorities due to their involvement in disaster response activities is real, since humanitarian response is very demanding in terms of expert time and administrative support.
- Large multi-country disasters, such as those that occurred during the strong hurricane seasons of 2004 and 2005, may affect the implementation of the activities of this Strategic Objective.
- Work in the area of emergency preparedness and response may be incorrectly perceived as an additional responsibility that is secondary to the Organization's regular work.

REGION-WIDE EXPECTED RESULTS

RER 5.1 **Member States and partners supported through technical cooperation for the development and strengthening of emergency preparedness plans and programs at all levels.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
5.1.1	Number of countries that have developed and evaluated disaster preparedness plans for the health sector	23	30	35
5.1.2	Number of countries where comprehensive mass-casualty management plans are in place	14	16	22
5.1.3	Number of countries developing and implementing programs for reducing the vulnerability of health, water and sanitation infrastructures	9	20	30
5.1.4	Number of countries that report having a health disaster program with full time staff and specific budget	10	11	15

RER 5.2 **Timely and appropriate support provided to Member States for immediate assistance to populations affected by crises.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
5.2.1	Proportion of emergencies for which health and nutrition assessments are being implemented	40%	65%	85%
5.2.2	Number of Regional training programs on emergency response operations	4	6	7
5.2.3	Proportion of emergencies for which interventions for maternal, newborn and child health are in place	50%	75%	85%

5.2.4	Proportion of emergencies where a response to emergencies is initiated within 24 hours of the request	100%	100%	100%

RER 5.3 **Member States supported through technical cooperation for reducing health sector risk in disasters and ensuring the quickest recovery of affected populations.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
5.3.1	Proportion of post-conflict and post-disaster needs assessments conducted that contain a gender-responsive health component	100%	100%	100%
5.3.2	Proportion of humanitarian action plans for complex emergencies and consolidated appeals with strategic and operational components for health included	100%	100%	100%
5.3.3	Proportion of countries in post-disaster transition or recovery situations benefiting from needs assessments and technical support in the areas of maternal and newborn health, mental health and nutrition	100%	100%	100%

RER 5.4 **Member States supported through coordinated technical cooperation for strengthening preparedness, recovery and risk reduction in areas such as communicable disease, mental health, health services, food safety, and nuclear radiation.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
5.4.1	Proportion of emergency-affected countries where a comprehensive communicable disease-risk assessment has been conducted and an epidemiological profile and toolkit developed and disseminated to partner agencies	90%	100%	100%
5.4.2	Proportion of situations involving acute natural disasters or conflicts for which a disease-surveillance and early-warning system has been activated and where communicable disease-control interventions have been implemented	90%	100%	100%
5.4.3	Proportion of emergencies where coordinated technical cooperation (PASB task force) is provided, when needed	100%	100%	100%

RER 5.5 **Member States supported through technical cooperation to strengthen national preparedness and establish alert and response mechanisms for food safety and environmental health emergencies.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
5.5.1	Proportion of food-safety and environmental public health emergencies where a response is mounted	50%	60%	70%
5.5.2	Number of countries with national plans for preparedness, and alert and response activities in respect to chemical, radiological and environmental health emergencies	20	24	28
5.5.3	Number of countries with focal points for the International Food Safety Authorities Network and for environmental health emergencies	28	29	32
5.5.4	Number of countries achieving a state of preparedness and completing stockpiling of necessary items in order to ensure a prompt response to chemical and radiological emergencies	8	10	15

RER 5.6 **Effective communications issued, partnerships formed and coordination developed with organizations in the United Nations system, governments, local and international nongovernmental organizations, academic institutions and professional associations at the country, regional and global levels.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
5.6.1	Proportion of emergencies where the United Nations Health Cluster system is operational, if called upon	100%	100%	100%
5.6.2	Number of emergency-related Regional interagency mechanisms and working groups where PAHO/WHO is actively involved	4	8	10
5.6.3	Proportion of disasters in which UN and country-originated reports include health information	100%	100%	100%

STRATEGIC OBJECTIVE 6

To promote health and development, and prevent or reduce risk factors such as use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex, which affect health conditions

SCOPE

The work under this Strategic Objective (SO) focuses on integrated, comprehensive, multisectoral and multidisciplinary health promotion and disease prevention strategies to improve public health and well-being; and the development of social and public health policies for the reduction or prevention of the six major risk factors.

INDICATORS AND TARGETS

- Number of countries reporting a 10% reduction in the prevalence rate of tobacco use. Baseline: 3 countries in 2007. Target: 10 countries by 2013. (Applies to 20 countries that have information in the WHO Database.)

- Number of countries that have stabilized or reduced the prevalence of adult obesity among males and females. Baseline: 0 countries in 2007. Target: 5 countries by 2013. (This indicator applies to 15 countries with current national representative data in the WHO Global Database on Obesity.)

- Number of countries that have decreased the non-desirable outcomes of unprotected sex, as measured by a reduction in the estimated prevalence rate of HIV cases in young people aged 15–24 years to 0.46/100 or less for females and 0.79/100 or less for males in Latin America, and 3.30/100 or less for females and 2.51/100 or less for males in the Caribbean. **Latin America** - Baseline: 11 countries in 2006. Target: 20 countries by 2013. **Caribbean** - Baseline: 4 countries in 2006. Target: 7 countries by 2013.

ISSUES AND CHALLENGES

The major six risk factors: tobacco use, unhealthy diet, physical inactivity, alcohol consumption, drug and psychoactive substance use and unsafe sexual behaviors, account for more than 60% of the mortality and at least 50% of the morbidity burden worldwide and in the Americas. Environmental and social determinants play an important role. The challenge in the Region is to implement integrated intersectoral action and to promote public policies against risk factors.

Poor populations in low- and middle-income countries are predominantly affected. While emphasis has been placed on the treatment of the adverse effects of these risk factors, much less attention has been devoted to prevention and how to effectively modify the determinants.

Tobacco use is the leading cause of preventable deaths worldwide, with at least 50% of tobacco-attributable deaths occurring in developing countries. It causes one million deaths in the Region every year, with the Southern Cone having the highest mortality rate from smoking-related causes. Tobacco use and poverty are closely linked and prevalence rates are higher among the poor. Fortunately, effective and cost-effective measures are available to reduce tobacco use.

The WHO Framework Convention on Tobacco Control is an evidence-based treaty designed to help reduce the burden of disease and death caused by tobacco use, and the challenge is to ratify and implement it throughout the Region.

In 2000, alcohol consumption was responsible for 4.8% of all deaths and 9.7% of all Disability Adjusted Life Years (DALYs) lost in the Region, with most of the burden in Central and South America. It is estimated that alcohol consumption accounted for at least 279,000 deaths in that year. Intentional and unintentional injuries accounted for about 60% of all alcohol-related deaths and almost 40% of alcohol-related disease burden. Most of the alcohol related disease burden (83.3%) affects men. Also noteworthy is that 77.4% of the burden comes from the population aged 15-44, affecting mostly young people and young adults in their most productive years of life. In some countries of the Region, injection drug use is a significant force behind the rapid spread of HIV infection. The challenge is to emphasize prevention and allocate adequate resources.

A worrisome decrease in physical activity levels is widespread in the Region. While the physically active population in the United States has remained at 30% for more than a decade, in Latin America and the Caribbean (LAC) it is between 40-60%. Physical inactivity in the Region has been driven by increased urbanization, motorized transportation, urban zoning polices that promote car dependence, and lack of infrastructure for pedestrians as well as cyclists. In addition, leisure time is increasingly spent in activities, such as watching television and playing electronic games.

The Region, in terms of diet, is characterized by low consumption of fruits and vegetables, whole grains, cereals and legumes. This is coupled with high consumption of food rich in saturated fat, sugars and salt, among them milk, meat, refined cereals and processed foods. This dietary pattern is a key factor leading to a rise in prevalence of those overweight and obese. Population-based studies in the Region show that in 2002, 50% to 60% of adults and 7% to 12% of children less then 5 years of age were overweight and obese.

Unsafe sexual behavior significantly contributes to negative health consequences such as unintended pregnancy, sexually transmitted infections (including HIV/AIDS), and other social, emotional and physical consequences that have been severely underestimated. WHO estimates that unsafe sex is the second most important global risk factor to health in countries with high mortality rates. Globally, each year 80 million women have an unwanted pregnancy, 46 million opt for termination, and 340 million new cases of sexually transmitted infections and 5 million new HIV infections are reported. Risky behavior does not often occur in isolation; for example, hazardous use of alcohol and other drugs and unsafe sexual behaviors frequently go together. Many of these behaviors are not the result of individual decision-making but reflect existing policies, social and cultural norms, inequities, inequalities, and low education levels. Thus, PAHO/WHO recognizes the need for a comprehensive integrated health promotion approach and effective preventive strategies.

Significant additional investment in financial and human resources is urgently needed at all levels to build capacity as well as to strengthen national, regional and global interventions. The Member States should be very active in promoting awareness and political commitment to act decisively to promote health and healthy lifestyles, and prevent and reduce risk factor occurrence.

STRATEGIC APPROACHES

- Implementing an integrated approach on health promotion and the prevention and reduction of major risk factors to enhance synergies, improve the overall efficiency of interventions and dismantle the current vertical approaches to risk-factor prevention.

- Strengthening leadership and stewardship of Ministries of Health to ensure the effective participation of all sectors of society.

- Strengthening national capacities for surveillance, prevention and reduction of the common risk factors.

- Improving leadership and health promotion at regional, national and local levels and, scaling up activities across all relevant health programs.

- Ensuring that every country of the Region implements the Regional Strategy and Plan of Action for Integrated Prevention and Control of Chronic Noncommunicable Diseases endorsed by the Member States.

ASSUMPTIONS AND RISKS

Assumptions:

- There is additional investment in financial and human resources to build capacity for health promotion and risk factor prevention.
- Effective partnerships and multisectoral and multidisciplinary collaborations in relation to policies, mechanisms, networks and actions are established involving all stakeholders at national, regional and international levels.
- There is a commitment to comprehensive and integrated policies, plans and programs addressing common risk factors.
- Investment in research, especially to find effective population-based prevention strategies, is increased.

Risks:

- Working or interacting with the private sector presents risks associated with the competing interests of industries, such as tobacco, alcohol, sugar, processed food and non-alcoholic drinks, and requires that guidelines for appropriate conduct be followed in all cases.
- Integrated approaches to prevention and reduction may also compromise organizational and country capacity to provide specific disease and risk-factor expertise unless the critical mass of expertise is protected and the required level of resources obtained.

REGION-WIDE EXPECTED RESULTS

RER 6.1 **Member States supported through technical cooperation to strengthen their capacity for health promotion across all relevant programs; and to establish effective multisectoral and multidisciplinary collaborations for promoting health and preventing or reducing major risk factors.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
6.1.1	Number of countries that have health promotion policies and plans with resources	11	15	20
6.1.2	Number of countries with Healthy Schools Networks (or equivalent)	7	10	15
6.1.3	Number of countries that adopt the PAHO/WHO urban health conceptual framework	0	2	5

RER 6.2 **Member States supported through technical cooperation to strengthen national systems for surveillance of major risk factors through development and validation of frameworks, tools and operating procedures and their dissemination.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
6.2.1	Number of countries that have developed a functioning national surveillance system using Pan Am STEPs (Pan American Stepwise approach to chronic disease risk factor surveillance) methodology for regular reports on major health risk factors in adults	6	10	20
6.2.2	Number of countries that have developed a functioning national surveillance system using school-based student health survey (Global School Health Survey) and are producing regular reports on major health risk factors in youth	11	15	30
6.2.3	Number of countries generating information on risk factors (through registers and population studies); to be included in the Regional Non-communicable Disease and Risk Factor information database (NCD INFO base)	0	15	30
6.2.4	Number of countries that have implemented (use and analyze) the standardized Basic Health Indicators for chronic diseases and risk factors together with other statistical information	0	8	12

RER 6.3 **Member States supported through technical cooperation on evidence-based and ethical policies, strategies, programs and guidelines for preventing and reducing tobacco use and related problems.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
6.3.1	Number of countries that have adopted smoking bans in health care and educational facilities consistent with the Framework Convention on Tobacco Control	4	10	25
6.3.2	Number of countries that have adopted bans on advertisement, promotion and sponsorship of tobacco products consistent with the Framework Convention on Tobacco Control	0	5	10
6.3.3	Number of countries with regulations on packaging and labeling of tobacco products consistent with the Framework Convention on Tobacco Control	8	21	25
6.3.4	Number of countries that have established or reinforced a national coordinating mechanism or focal point for tobacco control	18	20	28

RER 6.4 **Member States supported through technical cooperation to develop evidence-based and ethical policies, strategies, programs and guidelines for preventing and reducing alcohol, drugs and other psycho-active substance use and related problems.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
6.4.1	Number of countries that have implemented policies, plans, or programs for preventing public health problems caused by alcohol, drugs and other psychoactive substance use	11	13	20

RER 6.5 **Member States supported through technical cooperation to develop evidence-based and ethical policies, strategies, programs and guidelines for preventing and reducing unhealthy diets and physical inactivity, and related problems.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
6.5.1	Number of countries that have developed national guidelines to promote healthy diet and physical activity including DPAS (Diet and Physical Activity Strategy)	8	10	20
6.5.2	Number of countries that have initiated or established rapid mass transportation systems in at least one of their major cities	7	10	15
6.5.3	Number of countries that have initiated or established programs on clean fuels in transport in at least one of their major cities	3	7	15
6.5.4	Number of countries that have created pedestrian and bike-friendly environments, physical activity promotion programs and crime control initiatives, in at least one of their major cities	7	10	18
6.5.5	Number of countries that have initiated policies to phase-out trans-fats and reached agreements with food industry to reduce sugar, salt and fat in processed foods	4	7	20
6.5.6	Number of countries that have initiated policies to eliminate direct marketing/publicity of food to children under 12 years old	2	7	12
6.5.7	Number of countries that have initiated policies or programs to increase consumption of low fat dairy, fish and fruits and vegetables	5	7	18

RER 6.6 **Member States supported through technical cooperation to develop evidence-based and ethical policies, strategies, programs and guidelines for promoting safer sex.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
6.6.1	Number of countries that have implemented new or improved interventions at individual, family and community levels to promote safer sexual behaviors	5	7	10

STRATEGIC OBJECTIVE 7

To address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches

SCOPE

This Strategic Objective focuses on the development and promotion of intersectoral action on the social and economic determinants of health, understood as the improvement of health equity by addressing the needs of poor, vulnerable and excluded social groups. This understanding highlights the connections between health and social and economic factors such as income, education, housing, labor, and social status.

INDICATORS AND TARGETS

- Number of countries with national health indicators disaggregated by sex and age, and including the Gini coefficient and the Lorenz curve. Baseline: 3 countries in 2007. Target: 6 countries by 2013.

- Number of countries that have developed public policies for non-health sectors that address health conditions. Baseline: 7 countries in 2007. Target: 20 countries by 2013.

- Number of countries that have national development and poverty reduction plans integrating health, nutrition and education. Baseline: 3 countries in 2007. Target: 6 countries by 2013.

ISSUES AND CHALLENGES

Health equity is an overarching goal endorsed by PAHO/WHO Member States. In recent decades, health equity gaps among countries and among different social and ethnic groups within countries have widened, despite medical and technological progress. PAHO/WHO and other health and development actors have defined tackling health inequities as a major priority and have pledged to support countries through more effective actions to meet the health needs of vulnerable groups (WHR 2003, WHR 2004, WDR 2006). Meeting this goal will require attending to the social and economic factors that determine people's opportunities for health. An intersectoral approach, although often politically difficult, is indispensable for substantial progress in health equity. The Millennium Development Goals underscore the deeply interwoven nature of health and economic development processes, the need for coordination among multiple sectors to reach health goals, and the importance of addressing poverty, gender and ethnic/racial inequalities.

This situation raises challenges for ministries of health, which must work in innovative ways to foster intersectoral collaboration. This includes working on the social and economic determinants of health and their relationship with the MDGs, and aligning key health sector-specific programs to better respond to the needs of vulnerable populations. Effective strategies to promote health gains for vulnerable groups include the integration into health sector policies and programs of equity-enhancing, pro-poor, gender-responsive, ethnic/racial-sensitive, and ethically sound approaches. Human rights law, as enshrined in international and regional human rights

conventions and standards[11], offers a unifying conceptual and legal framework for these strategies, as well as measures by which to evaluate success and clarify the accountability and responsibilities of the different stakeholders involved.

The crucial challenges for achieving the above include: 1) developing sufficient expertise on the social and economic determinants of health and their relationship with the MDGs, as well as regarding ethics and human rights at the global, regional, and country levels; 2) ensuring that all the technical areas at PASB headquarters reflect the perspectives of social and economic determinants (including gender, ethnic origin and poverty), ethics, and human rights in their programs and normative work; and 3) adopting the correct approach for measuring effects. This final challenge is especially great, since results in terms of increased health equity and equality among the most vulnerable groups are seldom rapidly apparent or easily attributable to particular interventions. Innovative means of evaluation are required for assessing how policies, programs, plans, laws and interventions are designed, vetted and implemented. New means are also needed to assess whether interventions are effective in bringing about change, in addition to measuring health outcomes.

Indigenous peoples are culturally heterogeneous and reside in a variety of locations that often include two or more countries, complicating interventions designed to address their health needs. Other challenges are: creating or increasing awareness among decision makers; promoting effective participation of indigenous peoples in decision-making; and fostering a concerted effort to identify, develop, resource and implement an intercultural approach to address indigenous health needs, rather than imposing a single model of care. The main challenge remaining is to increase the access and utilization of health services for the indigenous peoples, at both the local and national levels.

There is a lack of vital and health statistics disaggregated by ethnicity, gender and age groups, which impedes the development of appropriate evidence-based decision-making and adequate evaluation of the health situation.

STRATEGIC APPROACHES

- Strengthening national strategies and plans to address all forms of social disadvantage and vulnerability that have a negative impact on health and produce social exclusion; involving civil society and relevant stakeholders through, for example, community-based initiatives.

- Redressing the root causes of health inequities, discrimination and inequality with regard to the most vulnerable groups will need coordinated integration by both the Bureau and Member States to support the incorporation of gender equality, ethnic/racial, poverty, ethics- and human rights-based perspectives into health guideline preparation, policy-making and program implementation.

- Focusing technical cooperation on: 1) the five priority countries (Bolivia, Guyana, Haiti, Honduras and Nicaragua), 2) urban areas in middle income countries where the highest concentration of poor people reside, and 3) indigenous peoples, in order to achieve the MDGs.

[11] Under current international law, human rights instruments include regional/international "treaties" or "conventions" negotiated and formulated by UN and/or OAS Member States and international/regional "standards" which are guidelines enshrined in declarations, recommendations and reports issued by the UN/OAS General Assembly, UN High Commissioner for Human Rights, UN Human Rights Council and UN/OAS treaty bodies, among others. See PAHO Directing Council, Technical Document CD 47/15 of 16 August, 2006, 47th session of the Directing Council, p.10-13. Available at http://www.paho.org/english/gov/cd/CD47-15-e.pdf.

- Implementing the "Faces, Voices, and Places of the Millennium Development Goals" initiative, the goal of which is to help the most vulnerable communities achieve the MDGs by reducing inequity through the empowerment of communities in Latin America and the Caribbean.

ASSUMPTIONS AND RISKS

Assumptions:

- Ministries of Health will exercise leadership to address the broader determinants of health, moving towards a multisectoral approach, prioritizing those sectors with the greatest impact on health.
- Health program designers and implementers will be willing and able to incorporate equity-enhancing, pro-poor, gender-responsive, ethnic/racial sensitive strategies into their programs despite technical and political complications.
- The governments adopt and implement the recommendations of the Global Commission on the Social Determinants of Health.
- The health and well-being of the indigenous peoples will be a high priority for national governments and national and international agencies.

Risks:

- Lack of effective consensus among partners in countries – including agencies within the UN System, other international partners and non-governmental organizations – on policies and frameworks for action.
- Economic, gender, ethnic/racial and poverty analysis may not be widely available.
- Lack of appropriate response from governments to address the health needs of indigenous peoples; paucity of cooperative efforts between indigenous peoples and governments in this regard.

REGION-WIDE EXPECTED RESULTS

RER 7.1 **Significance of determinants of health and social policies recognized throughout the Organization and incorporated into normative work and technical cooperation with Member States and other partners.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
7.1.1	Number of countries that have implemented national strategies that address key policy recommendations of the Commission on the Social Determinants of Health	0	4	12
7.1.2	Number of countries whose PAHO/WHO Country Cooperation Strategy (CCS) documents include explicit strategies at the national and local level that address the social and economic determinants of health	0	5	12

RER 7.2 **Initiative taken by PAHO/WHO in providing opportunities and means for intersectoral collaboration at national and international levels in order to address social and economic determinants of health and to encourage poverty-reduction and sustainable development.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
7.2.1	Number of countries whose public policies target the determinants of health and social policy on an intersectoral and interprogrammatic basis	0	7	12
7.2.2	Number of subregional fora organized for relevant stakeholders on intersectoral actions to address determinants of health, social policies and achievement of the Millennium Development Goals	0	1	3
7.2.3	Number of countries which have implemented the Faces, Voices and Places initiative	6	12	15

RER 7.3 **Social and economic data relevant to health collected, collated and analyzed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
7.3.1	Number of countries that produce health data of sufficient disaggregation and quality to assess and track health equity among key population groups	8	12	18
7.3.2	Number of countries with at least one national policy on health equity that incorporates an analysis of disaggregated data	0	3	8
7.3.3	Number of countries with at least one national program on health equity that uses disaggregated data	0	2	6

RER 7.4 **Ethics- and human rights-based approaches to health promoted within PAHO/WHO and at national, regional and global levels.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
7.4.1	Number of countries using: 1) international and regional human rights norms and standards; and 2) human rights tools and technical guidance documents produced by PAHO/WHO to review and/or formulate national laws, policies and/or plans that advance health and reduce gaps in health equity and discrimination.	9	10	18
7.4.2	Number of countries using tools and technical guidance documents produced for Member States and other stakeholders on use of ethical analysis to improve health policies.	8	12	30

RER 7.5 **Gender analysis and responsive actions incorporated into PAHO/WHO's normative work and Member States supported through technical cooperation for the formulation of gender-sensitive policies and programs.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
7.5.1	Number of PAHO publications that contribute to building evidence on the impact of gender inequalities in health	8	12	16
7.5.2	Number of tools and guidance documents developed by PASB for Member States on using gender analysis in health	0	2	5
7.5.3	Number of AMPES entities that address and incorporate gender perspectives, including mainstreaming, in the design and implementation of their programs	3	10	40

RER 7.6 **Member States supported through technical cooperation to develop policies, plans and programs that apply an intercultural approach based on primary health care and that seek to establish strategic alliances with relevant stakeholders and partners to improve the health and well-being of indigenous peoples.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
7.6.1	Number of countries that implement policies, plans or programs to improve the health of indigenous peoples	3/21	5/21	10/21
7.6.2	Number of countries that collect data on the health of indigenous peoples within their health information systems	3/21	5/21	10/21
7.6.3	Number of countries that integrate the intercultural approach in the development of national health systems and policies within the framework of PHC	0	3	5

STRATEGIC OBJECTIVE 8

To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health

SCOPE

The work under this Strategic Objective (SO) focuses on achieving safe, sustainable, and health-enhancing human environments, protected from social, biological, chemical, and physical hazards, and promoting human security and environmental justice from the effects of global and local threats.

INDICATORS AND TARGETS

- Proportion of urban and rural populations with access to improved water sources in the Region. Baseline: 95% of urban and 69% of rural populations in 2002. Target: 96% of urban and 77% of rural populations by 2013 (per the Millennium Development Goals).
- Proportion of urban and rural populations with access to improved sanitation in the Region. Baseline: 84% of urban and 44% of rural populations in 2002. Target: 90% of urban and 48% of rural populations by 2013 (per the Millennium Development Goals).
- Number of countries implementing national plans on Workers Health. Baseline: 10 countries in 2007. Target: 20 countries by 2013.
- Number of countries with toxicological information centers. Baseline: 14 countries in 2006 (estimated). Target: 24 countries by 2013.
- Reduction in the attributable factor of the burden of diarrheal diseases among children/adolescents age 0-19 years, due to environmental causes. Baseline: 94% in 2002 (estimated). Target: 84% by 2013. (Methodology for Assessment of Environmental Burden of Disease developed by WHO, measured by the attributable factors in DALYs)
- Number of environmental health policies on chemical substances, air quality and drinking water adopted by countries of the Region. Baseline: 11, 7, 13, respectively, in 2007. Target: 20, 12, 20, respectively, by 2013.

ISSUES AND CHALLENGES

Environmental and occupational risks contribute to a large portion of morbidity and mortality in the Region, but few countries have comprehensive policies to perform analysis and establish public policies to manage them. Modern production processes introduce new or magnify old chemical, physical and biological health risks in the Region. Countries do not have policies on urban development that promote health, social equity, and environmental justice. These risks affect not only the present generation, but also future generations due to their long-term health effects.

Rapid changes in lifestyle, increasing urbanization, production and energy consumption, climate change and pressures on ecosystems could, in both the short and long terms, have consequences for public health and health costs. These consequences will be even worse if the health sector fails to act on currently existing environmental hazards to health. For effective

health sector action, risks have to be reduced in the settings where they occur: homes, schools, workplaces and cities; and in sectors such as energy, transport, industry, agriculture, as well as water, sanitation and solid waste.

Health systems urgently need new information about the epidemiological impacts of key environmental hazards and their prevention, and need to be equipped with tools for primary intervention. Increasingly, health policy-makers are called on to participate in economic development and policy forums whose decisions have profound long-term impacts on pollution, biodiversity, and ecosystems, and thus on environmental health. Health professionals, often trained to treat individuals, need to be better equipped to monitor and synthesize health and environmental data, proactively guiding strategies for public awareness, protection and prevention, and responding to emergencies.

Although the health sector cannot implement development policies on its own, it can provide the epidemiological evidence and the tools, methods or guidance necessary for assessing the health impacts of development and designing healthier policies or strategies. Concurrently, non-health sectors must be made aware of hazards to health and thus be informed and empowered to act. For this to happen, integrated assessment and cross-sectoral policy development should be encouraged, bringing parties from the health and other sectors together.

More than five million children die each year from environment-related diseases and conditions, such as diarrhea, respiratory illnesses, malaria, and unintentional injuries. Millions more are debilitated by these diseases or live with chronic conditions linked to their environment, ranging from allergies to mental and physical disabilities. Most of the environment-related diseases and deaths can be prevented using effective, low-cost, and sustainable tools and strategies.

Latin America is one of the areas of the world with the greatest use of pesticides. Central America, for example, imports 1.5 kg of pesticides per inhabitant, which is 2.5 times higher than the world average. Banned pesticides are still imported into many Latin American countries. More stringent national and international legislation and comprehensive interventions are needed.

The deleterious health effects from persistent organic pollutants (POPs) and heavy metals, such as lead, mercury, and others, are increasingly recognized. However, there are no information systems to track these POPs, and disseminate knowledge about the identification, control, and elimination of related risks.

Climate change and other global environmental risks add to the current health burden. Negative impacts include increased health hazards, poor nutrition profiles, water scarcity, and increased vector-borne diseases.

Accidental release or the deliberate use of biological and chemical agents, or radioactive material requires effective prevention, surveillance, and response systems to contain or mitigate harmful health outcomes.

The use of consumer products has changed in the Region and in many cases poses new risks to health. Revision of sanitary surveillance and regulatory processes in the Region has been the main tool to respond to consumers' health hazards.

It has been estimated that every year 5 million occupational accidents occur in Latin America, of which 90,000 are fatal, equivalent to approximately 250 deaths per day.

Local governments are challenged to find suitable, sanitary, sound solutions for 360,000 tons of garbage produced daily in Latin America. Although water coverage has reached 90.3%, and 84.6% of the population has access to drinking water in Latin America (2004 data), the most vulnerable populations – those living in rural areas and urban slums – still lack access.

Political, legislative, and institutional barriers to improving environmental conditions are numerous, and human resources with adequate specialization in risk assessment and management are still lacking in many countries. National and local health authorities are thus often unable to collaborate with other social and economic sectors where health-protective measures need to be taken. Agenda 21, adopted at the United Nations Conference on Environment and Development (Rio de Janeiro, 1992), the World Summit on Sustainable Development Plan of Implementation (Johannesburg 2002), together with the Millennium Development Goals (MDGs), provide the necessary international policy framework for action. The challenge is to maintain and expand the strategic alliance among the health, education, labor and environmental sectors.

STRATEGIC APPROACHES

- Improving the health and environment ministries' strategic alliance to build stronger links between the health and environmental sectors in national policy planning and implementation.
- Promoting the achievement of the MDGs through Children's Environmental Health strategies in response to the Joint Action Plan on Health and Environment agreed upon by the Ministers of Health and Environment in 2005 in Mar del Plata.
- Strengthening the networks and promoting the participation of Collaborating and Reference Centers from several sectors to promote inter-programmatic and inter-institutional integration.

ASSUMPTIONS AND RISKS

Assumptions:

- Health sector personnel become increasingly cognizant of the mounting burden of disease from environmental health risks in light of new evidence.
- Decision-makers (such as policymakers, banks and civil society in sectors of the economy with the greatest impact on public health) will increasingly prioritize health, putting the health costs and benefits of their actions at the center of their decision-making processes.
- Development partners (collaborating centers, cooperation agencies, foundations, recipient countries and banks) will increasingly recognize that reducing environmental hazards to health contributes significantly to the achievement of the relevant Millennium Development Goals.
- United Nations system reform will allow WHO/PAHO to show more global leadership in public health and the environment, prioritizing health in humanitarian responses and environmentally sustainable economic development.

Risks:

- Expectations from other sectors for quick results and reductions of environmental health risks may exceed the capacity of the health sector to provide support for their actions.
- Information about the best options for sectoral interventions to improve occupational and environmental health is inaccessible.
- Global leaders and partners in the arenas of development and/or the environment show weak or transient commitment to improving environmental health.
- Health systems continue to respond weakly in reducing the range of occupational and environmental health risks and rooting out their causes.

REGION-WIDE EXPECTED RESULTS

RER 8.1 **Evidence-based assessments, norms and guidance on priority environmental health risks (e.g., air quality, chemical substances, electro-magnetic fields (EMF), radon, drinking water, waste water re-use) disseminated.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
8.1.1	Number of new or updated risk assessments or environmental burden of disease (EBD) assessments conducted per year	2	4	8
8.1.2	Number of international environmental agreements whose implementation is supported by PASB	5	5	6
8.1.3	Number of countries implementing PAHO/WHO guidelines on chemical substances	11	15	20
8.1.4	Number of countries implementing WHO guidelines on air quality	7	8	12
8.1.5	Number of countries implementing WHO guidelines on drinking water	13	16	20
8.1.6	Number of countries implementing PAHO/WHO guidelines on recreational waters	1	5	10

RER 8.2 **Member States supported through technical cooperation for the implementation of primary prevention interventions that reduce environmental health risks; enhance safety; and promote public health, including in specific settings and among vulnerable population groups (e.g. children, older adults).**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
8.2.1	Number of regional strategies for primary prevention of environmental health hazards under the health determinants and health promotion framework implemented in specific settings and groups (workplaces, homes, schools, human settlements, health care settings and children's environmental health)	4	7	10
8.2.2	Number of countries where global or regional strategies for primary prevention of environmental health hazards are implemented in specific settings (workplaces, homes, schools, human settlements and health-care settings)	10	14	20
8.2.3	Number of new or maintained global or regional initiatives to prevent occupational and environmentally-related diseases (e.g. cancers from ultraviolet irradiation or exposure to asbestos, and poisoning by pesticides or fluoride) that are being implemented with PASB technical and logistics support	1	4	5
8.2.4	Number of cost-effectiveness studies assessing primary prevention interventions in specific settings whose results have been disseminated	1	2	4
8.2.5	Number of countries following WHO's guidance to prevent and mitigate emerging occupational and environmental health risks, promote equity in those areas of health and protect vulnerable populations	0	1	2

RER 8.3 **Member States supported through technical cooperation to strengthen occupational and environmental health policy-making, planning of preventive interventions, service delivery and surveillance.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
8.3.1	Number of countries receiving technical and logistical support for developing and implementing policies for strengthening the delivery of occupational and environmental health services and surveillance	10	15	20
8.3.2	Number of national organizations or collaborating or reference centers implementing PAHO/WHO-led initiatives at country level to reduce occupational risks	2	4	6

RER 8.4 **Guidance, tools, and initiatives created to support the health sector to influence policies in priority sectors (e.g. energy, transport, agriculture), assess health impacts, determine costs and benefits of policy alternatives in those sectors, and harness non-health sector investments to improve health.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
8.4.1	Number of regional, subregional and national initiatives implemented in other sectors that take health into account, using PASB technical and logistical support	2	3	4
8.4.2	Number of sector-specific guidelines and tools produced for health impact assessment	1	3	5
8.4.3	Number of non-health sectors with established networks and partnerships to drive change in support of health-related initiatives	1	3	5
8.4.4	Number of regional or national events conducted with PASB's technical cooperation with the aim of building capacity and strengthening institutions in health and other sectors for improving policies relating to occupational and environmental health in at least 3 sectors	1	2	4

RER 8.5 **Health sector leadership enhanced to promote a healthier environment and influence public policies in all sectors to address the root causes of environmental threats to health by responding to emerging and re-emerging environmental health concerns from development, evolving technologies, global environmental change, as well as consumption and production patterns.**

Indicator #	RER Indicator text	Baseline 2007	Target 2009	Target 2013
8.5.1	Number of regular high-level fora on health and environment for regional policymakers and stakeholders supported by PASB	1	1	1
8.5.2	Number of current PASB five-year reports on environmental health available, including key health drivers and trends, and their implications	1	1	1