STRATEGIC OBJECTIVE 1

To reduce the health, social and economic burden of communicable diseases

Scope

This Strategic Objective (SO) focuses on prevention, early detection, diagnosis, treatment, control, elimination, and eradication measures to combat communicable diseases that disproportionately affect poor and marginalized populations in the Region of the Americas. The diseases to be addressed include, but are not limited to: vaccine-preventable, tropical (including vector-borne), zoonotic and epidemic-prone diseases, excluding HIV/AIDS, tuberculosis and malaria.

INDICATORS AND TARGETS

- The mortality rate due to vaccine-preventable diseases. Target: one third reduction by 2015.
- Coverage of interventions targeted at the control, elimination or eradication of tropical diseases. Target: 80% of the susceptible population in 25 countries (21 in Latin America and 4 in the Caribbean) with emphasis on the five key countries by 2013.
- Coverage of interventions targeted at the control of epidemic prone diseases. Target: 80% of the susceptible population in the 40 countries/territories by 2013.
- Fulfillment of core capacities requirements in surveillance, response and points of entry, as established in the 2005 International Health Regulations. Target: 100% of the 40 countries/territories by 2013.
- The proportion of countries achieving and maintaining certification of poliomyelitis eradication and destruction or appropriate containment of all polioviruses, as well as for measles, rubella, congenital rubella syndrome and neonatal tetanus elimination. Target: 100% by 2010.

ISSUES AND CHALLENGES

The work undertaken under this SO aims at a sustainable reduction in the health, social and economic burden of communicable diseases, guided by the principles of access and equity, disease control, and development of public health infrastructure. This is in line with the global health agenda articulated in WHO's Eleventh General Programme of Work, 2006-2015 and includes investing in health to reduce poverty, building individual and global health security; harnessing knowledge, science and technology; strengthening health systems; and improving universal access. The Health Agenda for the Americas (CE 139/5) provides a strong foundation for the proposed public health interventions under this SO.

In Latin America and the Caribbean more than 210 million people live below the poverty line, and they bear the burden of communicable diseases. Communicable diseases account for 13.5% of deaths in all age groups, and 74% of deaths in children in the Region. The burden of communicable diseases is significant; WHO estimates that this group of diseases accounted for 25,000 Disability Adjusted Life Years (DALYs) in 2005. Indigenous populations are especially vulnerable to this group of diseases; they deserve culturally appropriate interventions.

National **immunization** programs have reached approximately 90% vaccination coverage for all of the childhood vaccines, and they strive to achieve greater than or equal to 95% coverage in all municipalities. This is one of the best ways to ensure equitable access to existing vaccines and ultimately provide new life-saving vaccines that address important public health priorities to the people who need them most. Despite the success of polio eradication and measles elimination, pockets of unvaccinated susceptible persons still persist, leading to outbreaks of diseases like diphtheria and pertussis (whooping cough), which carry high case-fatality rates. The rubella elimination initiative, endorsed by two Resolutions of PAHO's Directing Council (CD44.R1 and CD47/11.Rev.1), strengthens measles elimination efforts in the Region by reducing susceptible populations, decreases disability due to vaccine-preventable diseases, and increases access to health services.

PAHO promotes the strengthening of national capacity to introduce new vaccines based on the best available information. PAHO will continue to advocate that its framework and technical guides for vaccine introduction be strictly adhered to Resolution CD47.R10, as endorsed by PAHO's 47th Directing Council in September 2006. Fundamental to this process is that the vaccines be pre-qualified by WHO, so that quality and safety is assured, and supported by competent national regulatory authorities.

High quality surveillance will allow adequate preparedness for pandemics and vaccine-preventable actions related to threats of national and international concern to be in place. Surveillance systems for vaccine-preventable diseases need urgent upgrading, with emphasis on capacity development.

Emerging and Re-emerging Infectious Diseases: The international spread of infectious diseases continues to pose a problem for global health security due to factors associated with today's interconnected and interdependent world, namely, population movements, through tourism, migration or as a result of disasters; growth in international trade in food and biological products; social and environmental changes linked with urbanization, deforestation and alterations in climate; and changes in methods of food processing, distribution and consumer habits. These factors have reaffirmed that infectious disease events in one country or region are potentially a concern for the entire world. Countries need to develop core capacities to respond to these challenges. Detection and response to epidemic prone diseases, including pandemic influenza, SARS and neuro-invasive syndromes caused by arboviruses such as West Nile, need to be addressed within the framework of the International Health Regulations (IHR).

Neglected diseases (NDs), directly or indirectly, affect the capacity of many countries in the Region to meet the MDGs. NDs have adverse effects not only on health and well-being but also contribute to low levels of school attendance, to poverty, and stem from environmental problems. Lack of routine epidemiological surveillance and data-recording for the NDs in the Region make it difficult to accurately estimate disease burden. However, national surveys and special studies shed light on the burden in some populations. PAHO/WHO estimates that 20-30% of Latin Americans are infected with one of several intestinal helminths and/or schistosomiasis, two very important NDs. Lymphatic filariasis affects approximately 750,000 people while onchocerciasis puts 500,000 people at risk in the Region; both diseases are targeted for elimination. A study of cystic echinococcosis noted an estimated total of 52,693 Disability Adjusted Life Years (DALYs) lost in the Region, while economic losses total more than $120 million per year. Today, there is better knowledge of the extrinsic determinants of neglected diseases; furthermore new safe and inexpensive methods to monitor these diseases in populations and treat infected persons make their prevention, control, and even elimination more feasible than ever before.

The number of prevalent cases registered of **leprosy** in the Region of the Americas at the beginning of 2006 was 32,904 cases, with a prevalence rate of 0.39 per 10,000 people. The number of new cases reported in 2005 was 41,789, around 20% less than 2004. The global strategic target for leprosy elimination is less than one case detected per 10,000 people. All of the countries of the Region are under this rate, with the exception of Brazil, which is close to it. Brazil, which traditionally accounted for the highest burden of leprosy in the region, has improved toward the goal of elimination. Countries that have achieved this goal are making efforts to further reduce the leprosy burden with the *WHO Global Leprosy Strategy*, with emphasis on early detection and an integrated approach in primary health services.

The number of **chagas** infected persons in the Americas is estimated at 16 to 18 million. The estimated yearly incidence of vector-borne chagas is 41,800 cases, and congenital chagas is 13,550 cases. General seroprevalence in regional blood banks averages 1.28%. It is estimated that different chagasic cardiopathies occur in 4,600,000 patients, and 45,000 people die per year as a consequence of this disease.

Major progress achieved in the Region:

- Transmission by T. infestans interrupted in over 80% of endemic Southern Cone countries.
- Reduction of domiciliary T. infestans infestation and in paediatric seroprevalence of T. cruzi infection in Bolivia, the major endemic country in the Region.
- Mexico has declared Chagas disease as a public health priority and is now implementing prevention and control activities.
- Serological screening coverage of Chagas control and blood banks programs in over 98% of endemic countries.

Between 2001 and 2005, more than 30 countries of the Americas reported a total of 2,879,926 cases of **dengue,** of which 65,235 cases were dengue hemorrhagic fever. The Regional Dengue Program seeks to promote public health policies through a multi-sectoral, integrated management and interdisciplinary approach (Integrated Strategy for Dengue Prevention and Control), making it possible to prepare, implement, and consolidate a strategy at the subregional and national levels. This strategy comprises six key components: mass communication, entomology, epidemiology, laboratory, patient care and environment.

There has been a reduction of 90% in the number of cases of **rabies** transmitted by dogs as a result of 20 years of effective control efforts. During 2005, only 11 cases were reported. However some countries, mostly low income ones, still have not achieved these results. Many other zoonotic diseases need to be addressed in the Region as well.

PAHO/WHO has a primary role in preparedness, detection, risk assessment, communications and response to public health emergencies such as epidemics and pandemics. These can place sudden and intense demands on health systems. They expose existing weaknesses and, in addition to their impact on morbidity and mortality, can disrupt economic activity and development. Seventy-five percent of new diseases affecting human beings during the last ten years have been caused by pathogens originating in animals or animal products. There is an important link between human and animal health that needs to be addressed to prevent and control zoonotic diseases. The need for rapid response is a drain on available resources, staff, and supplies away from well defined public health priorities and routine disease control activities. PAHO has verified over 200 epidemics of international concern over the last five years.

Under the revised International Health Regulations (2005), which will come into effect in June 2007, PAHO/WHO will have a binding legal obligation to strengthen its internal epidemic alert and response capacity. In addition, PAHO is to support its Member States in the development and maintenance of minimum core capacities for the detection, and response to, public health risks and emergencies of which the majority are attributable to communicable diseases, thereby strengthening its early warning system. This entails technical cooperation in conducting national assessments and corrective plans of action so as to strengthen national capacities.

STRATEGIC APPROACHES

To achieve this objective, Member States will have to invest in human, political and financial resources to ensure and expand equitable access to high quality and safe interventions for the prevention, early detection, diagnosis, treatment and control of communicable diseases. Key components for this are:

- The establishment and maintenance among Member States of effective coordination with other partners and across all relevant sectors at the country level.
- Research promotion through adequate investment, capacity strengthening and effective partnership between the academic and public sector (programs). Mechanisms should be explored to encourage transfer of technology and new modalities of technical cooperation (e.g. south-to-south).
- Compliance of Member States with World Health Assembly (WHA) 2005 established target dates for the implementation of the International Health Regulations.
- The establishment of collaborative relationships with other agencies in the United Nations and Inter-American Systems, as well as the establishment of multilateral and national agreements to develop these interventions.
- The network of WHO Collaborating Centers located in the Americas, which provides support to PASB technical cooperation activities.

In supporting Member States' efforts, the PASB will focus on:

- Strengthening collaboration with regional health stakeholders, partnerships and the civil society.
- Securing community access to existing and new tools and strategies, including vaccines and medicines; that meet acceptable standards of quality, safety, efficacy and cost-effectiveness, while reducing disparities.
- Strengthening its capacity to provide technical cooperation, and build capacity of Member States to better respond to commitments as per World Health Assembly resolutions related to communicable diseases and the International Health Regulations. This includes facilitating national and international resource mobilization and advocacy efforts.
- Moving from vertical to horizontal approaches and; on the basis of a thorough assessment of past successes and failures in the creation of strategies for integrated health systems development; build on past strengths and address weaknesses, capitalizing, among others, on subregional spheres, including economic fora (e.g. Caribbean Community – CARICOM; Meeting of the Health Sector of Central America and the Dominican Republic - RESSCAD, etc.).
- Expanding institutional networks to improve public health.
- Maintaining and strengthening an effective international system for alert and response to epidemics and other public health emergencies, and facilitating public health preparedness in collaboration with other stakeholders, including private and civil society organizations as appropriate.

- Providing Member States with tools, strategies and technical cooperation to evaluate and strengthen monitoring and surveillance systems.
- Coordinating integrated surveillance systems at global and regional levels to inform policy decisions and public health responses.
- Shaping the research agenda for use in the formulation of ethical and evidence-based policy options and for direct application to public health interventions.

ASSUMPTIONS AND RISKS

This SO would be achieved under the following assumptions:

- The entry into force of the International Health Regulations in 2007 will translate into a renewed commitment by all Member States to strengthen their national surveillance and response systems, and a sustained interest in and support for PAHO/WHO's activities on the part of donors and technical partners, including networks and partnerships.
- In developing and strengthening national health systems, the aim will continue to be universal and equitable access to essential health interventions.
- There will be a receptive and positive attitude towards coordination and harmonization of actions among the increasing number of actors in global public health.
- Effective communications mechanisms will be in place to maintain a strong and interactive coordination of efforts at the global, regional and subregional level.
- Political commitment and resources will be in place to secure effective surveillance and adequate preparedness for pandemics and vaccine-preventable actions related to threats of national and international concern.

The following risks may adversely affect the achievement of this SO:

- Diversion of resources either away from the Region of the Americas (e.g. pandemic influenza), or away from communicable diseases and towards other aspects of health and development; and the fact that prevention and control of communicable diseases are not recognized and visibly maintained as a health priority, particularly in the least developed countries.
- Emergence of parallel health agendas due to lack of communication and coordination among partners.
- Low investment and/or political commitment concerning the International Health Regulations and the fragmented approach of governments towards their implementation.
- Low or insufficient investment in research activities that might impact adversely on health interventions.
- Influenza or other pandemic-prone disease that could cause unprecedented morbidity and mortality, as well as grave economic harm. Advanced planning for appropriate detection and rapid response strategies will be required.

REGION-WIDE EXPECTED RESULTS

RER 1.1 **Policy and technical cooperation provided to Member States to maximize equitable access of all people to vaccines of assured quality, including new or underutilized immunization products and technologies, and to integrate other essential child health interventions with immunization.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.1.1	Number of countries achieving more than 95% DPT3 coverage at national level.	17	20	25
1.1.2	Proportion of municipalities with coverage level for DPT3 less than 95% in Latin America and the Caribbean.	38% (5,729)	35% (5,277)	30% (4,523)
1.1.3	Number of countries supported to make evidence-based decisions for the introduction of new vaccines.	9	10	20
1.1.4	Number of essential child and family health interventions integrated with immunization for which guidelines on common program management are available.	4	6	8
1.1.5	Number of counties that have established either legislation or a specified national budget line in order to ensure sustainable financing of immunization.	30	32	35
1.1.6	Number of subregions with action plans for the introduction of new vaccines according to the agreements of the subregional integration mechanisms (RESCCAD, CARICOM, ORAS y MERCO SUR).	0	2	4
1.1.7	Number of subregions with border immunization activities (vaccination and vaccine-preventable disease {VPD} surveillance).	3	3	3
1.1.8	Percentage of countries supported to develop an updated immunization plan of action.	60%	70%	90%
1.1.9	Percentage of countries supported to develop vaccine safety plans of action.	53%	70%	100%

RER 1.2 **Effective coordination and technical cooperation provided to Member States to maintain measles elimination and achieve rubella, Congenital Rubella Syndrome (CRS) and neonatal tetanus elimination; while sustaining the polio free status and the appropriate containment of polioviruses, leading to a simultaneous cessation of oral polio vaccination globally.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.2.1	Number of countries using oral polio vaccine (OPV) according to an internationally agreed time-line and process for cessation of routine use of OPV.	35	35	35
1.2.2	Percentage of final country reports or updates on polio containment certified by Regional Commission for the Americas.	100%	100%	100%
1.2.3	Number of facilities storing poliovirus in the Americas.	1	1	1
1.2.4	Number of countries with sustained surveillance of acute flaccid paralysis.	40	40	40
1.2.5	Number of countries with integrated measles / rubella and Congenital Rubella Syndrome (CRS) surveillance.	35	40	40
1.2.6	Number of countries that have implemented interventions to achieve rubella and Congenital Rubella Syndrome (CRS) elimination.	37	40	40
1.2.7	Number of countries achieving neonatal tetanus (NNT) elimination.	39	40	40
1.2.8	Number of countries that have implemented epidemiological surveillance system for the new vaccines (RV, NEUMO, INF, YF, HPV).	0	5	15

RER 1.3 **Effective coordination and technical cooperation provided to Member States to provide access for all populations to interventions for the prevention, control, and elimination of neglected communicable diseases, including zoonotic diseases.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.3.1	Number of countries achieving dracunculiasis eradication certification.	40	40	40
1.3.2	Number of countries that are implementing WHO Global Strategy for further Reducing the Leprosy Burden and Sustaining Leprosy Control Activities, especially Brazil, which is the only country in Americas with high leprosy burden.	1/24	9/24	16/24

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.3.3	Population at risk (in millions) of lymphatic filariasis in four endemic countries receiving mass drug administration (MDA) or preventive chemotherapy.	2.4	4.7	6
1.3.4	Coverage of at-risk school-age children in endemic countries with regular treatment against schistosomiasis and soil transmitted helminthiasis (STH).	38%	50%	75% coverage
1.3.5	Number of countries that have incorporated a multidisease, interprogrammatic, inter-sectoral approach for the prevention, control or elimination of neglected communicable diseases.	1/35	4/35	10/35
1.3.6	Number of countries that have incorporated an inter-sectoral, interprogrammatic approach for the prevention, control or elimination of zoonoses of public health importance.	2/21	4/21	10/21
1.3.7	Number of countries in Latin America that eliminated human rabies transmitted by dogs.	11/21	12/21	16/21
1.3.8	Number of countries supported in the maintenance of control programs in equinococosis.	4	4	4
1.3.9	Number of countries in Latin America and the Caribbean assisted to maintain surveillance and preparedness for emerging or re-emerging zoonotic diseases (e.g. avian flu and bovine spongiform encephalopathy).	10/33	13/33	22/33
1.3.10	Number of countries with total interruption of Chagas Disease vector transmission (T infestans for South Cone, and Rhodnius prolixus in Central America).	3/21	11/21	15/21
1.3.11	Number of countries with total Chagas screening of blood banks for transfusional transmission.	14/21	20/21	20/21
1.3.12	Number of endemic countries with onchocerciasis elimination certification.	0/6	1/6	3/6
1.3.13	Technical norms or recommendations provided to countries for prevention and control of zoonotic diseases.	5	7	12
1.3.14	Regional rabies surveillance system functioning on an ongoing basis (number of countries reporting).	21	21	21
1.3.15	Number of technical guidelines published for the surveillance, prevention, control of neglected communicable diseases.	0	2	4

RER 1.4 **Policy and technical cooperation provided to Member States to enhance their capacity to carry out communicable diseases surveillance and response, as part of a comprehensive surveillance and health information system.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.4.1	Number of countries with enhanced surveillance for communicable diseases of public health importance.	13/39	15/39	18/39
1.4.2	Number of countries receiving technical cooperation from PASB to adapt generic surveillance and communicable disease monitoring tools or protocols to specific country situations.	2	20	30
1.4.3	Number of countries for which joint reporting forms on immunization surveillance and monitoring are received at regional level in accordance with established timelines.	15	18	20
1.4.4	Number of new and improved anti-microbial resistance (AMR) tools, interventions and implementation strategies whose effectiveness has been determined by appropriate institutions.	5	7	10

RER 1.5 **New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed, validated, available, and accessible.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.5.1	Number of consensus reports published on subregional, regional or global research needs and priorities for a disease or type of intervention.	0	3	6
1.5.2	Number of new and improved interventions and implementation strategies whose effectiveness has been evaluated and validated.	1	2	5
1.5.3	Proportion of peer-reviewed publications based on PAHO/WHO-supported research where the main author's institution is in a developing country.	15%	30%	60%
1.5.4	Number of countries with one or more institutions which have implemented Tropical Disease Research (TDR) new ten year vision, under the coordination of PAHO/WHO.	0	6	9

RER 1.6 **Technical cooperation provided to Member States to achieve the core capacities required by the International Health Regulations for the establishment and strengthening of alert and response systems for use in epidemics and other public health emergencies of international concern.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.6.1	Number of countries that have completed the assessment of core capacities for surveillance and response, in line with their obligations under the International Health Regulations (2005).	3	32	40
1.6.2	Number of countries supported by PASB to develop national plans of action to meet minimum core capacity requirements for early warning and response in line with their obligations under the International Health Regulations.	0	32	40
1.6.3	Number of countries whose national laboratory system is engaged in at least one internal or external quality-control program for communicable diseases.	20/36	24/36	30/36
1.6.4	Number of countries participating in training programs focusing on the strengthening of early warning systems, public health laboratories or outbreak response capacities.	38/38	38/38	38/38

RER 1.7 **Member States and the international community equipped to detect, contain and effectively respond to major epidemic and pandemic-prone diseases (e.g. influenza, dengue, meningitis, yellow fever, hemorrhagic fevers, plague and smallpox).**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.7.1	Number of countries having national preparedness plans and standard operating procedures in place for major epidemic prone diseases (e.g. pandemic influenza, yellow fever, dengue, meningitis).	22	28	36
1.7.2	Number of countries that have tested their national preparedness plans and standard operating procedures for pandemic influenza through simulation exercises.	10	20	36
1.7.3	Number of international support mechanisms for surveillance, diagnosis and mass intervention (e.g. international laboratory surveillance networks and vaccine-stockpiling mechanisms for meningitis, hemorrhagic fevers, plague, yellow fever, influenza, smallpox).	5	6	7

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.7.4	Number of countries with basic capacity in place for safe laboratory handling of dangerous pathogens and safe isolation of patients who are contagious.	22	25	40
1.7.5	Number of countries implementing interventions and strategies for dengue control (Estrategias de Gestión Integrada {EGI} or Communication for Behavior Impact {COMBI}).	15	17	19
1.7.6	Number of tools (guidelines, protocols, training modules) developed to assist countries in the development and implementation of national preparedness plans for major epidemic-prone diseases (e.g. pandemic influenza).	2	5	10

RER 1.8 **Global, Regional and Subregional capacity coordinated and made rapidly available to Member States for detection, verification, risk assessment and response to epidemics and other public health emergencies of international concern**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.8.1	Number of PASB offices (regional and country) with the global event management system in place to support coordination of risk assessment, communications and field operations among headquarters, regional and country offices.	1/28	10/28	28/28
1.8.2	Number of countries with at least one participating partner institution in the global outbreak alert and response network, and other relevant regional sub-networks.	26	35	40
1.8.3	Proportion of requests for support from Member States for which 'PASB mobilizes comprehensive and coordinated international support for disease-control efforts, investigation and characterization of events, and sustained containment of outbreaks.	100%	100%	100%
1.8.4	Median time (in days) to verification of outbreaks of international importance, including laboratory confirmation of etiology.	7 days	5 days	3 days

STRATEGIC OBJECTIVE 2

To combat HIV/AIDS, tuberculosis and malaria

Scope
This Strategic Objective (SO) focuses on interventions for the prevention, early detection, treatment and control of HIV/AIDS, tuberculosis and malaria, including elimination of malaria and congenital syphilis. Emphasis is placed in those interventions that can reduce regional inequities, addressing the needs of vulnerable and most at risk populations.

INDICATORS AND TARGETS

- By 2010, there will be a 50% reduction in the estimated number of new HIV infections, followed by a further 50% reduction in new infections by the end of 2015 (baseline: 2006). (Per Regional HIV/STI Plan for the Health Sector)
- By 2010, there will be universal access to comprehensive care including prevention, care, and antiretroviral treatment. (Per Regional HIV/STI Plan for the Health Sector)
- By 2015, incidence of mother to child transmission of HIV will be less than 5% and incidence of congenital syphilis will be less than 0.5 cases per 1000 live births. (Per Regional HIV/STI Plan for the Health Sector)
- Reduction of tuberculosis incidence and prevalence in all countries. Target: by 2013, to halt and begun to reverse the incidence of tuberculosis (baseline: 39 cases per 100,000 inhabitants – 2005 data) and to reduce the prevalence from 6 per 100,000 inhabitants in 2005 to 5 in 2013 (in accordance with MDGs)
- Reduce the burden of malaria in the Americas by 2010 and further by 2013. Target: 50% reduction in morbidity and mortality by 2010; with a further 50% reduction by 2013 (baseline: 2000 morbidity and mortality figures)
- By 2013, at least 1 additional country in the region certified or enrolled in a WHO certification process for malaria elimination
- All malaria transmission-free countries retain their status

ISSUES AND CHALLENGES

HIV/AIDS/STI

At the end of 2006, it was estimated that 3,350,000 people were living with HIV in the Americas, 51% in Latin America, 42% in North America and 7% in the Caribbean. The Caribbean is the second most affected region in the world after sub-Saharan Africa. The major modes of transmission in the Americas are well known:

- Men who have unprotected sex with men account for a large proportion of cases of HIV and AIDS.
- Unprotected heterosexual sex is responsible for an increasing proportion of infections.

- Injecting drug use accounts for a significant proportion of cases in North America and in some other countries (mainly Brazil, Argentina and Uruguay).

Sex work is also implicated in the spread of HIV, with varying prevalence among countries. Some sex workers (SW) also form a bridge between IDUs and clients of sex workers, given a significant proportion of SW, in some areas, who use sex work to finance their drug habit.

In 2006, it was estimated that 30% of the total population living with HIV in the region were women. In the Caribbean women represent 50% of those affected by HIV, while in North America and Latin America they represent 26% and 31% respectively. Additionally, more and more young people are being affected by the epidemic; in Latin America and the Caribbean (LAC), the estimated number of children under 15 years old with HIV/AIDS increased from 130,000 in 2003 to 140,000 in 2005.

It is estimated that there are 50 million of new cases of sexually transmitted infections (STI) each year in the region. Additionally, in LAC, 330,000 pregnant women are diagnosed with syphilis every year but are not treated adequately, resulting in 110,000 infants being born with congenital syphilis yearly.

In agreement with the 2005 rationale for the division of labour of UN agencies in the area of HIV response, PASB effort will focus on the scaling up of HIV/AIDS services to achieve universal access that encompass prevention and treatment. Assuring the engagement of civil society as well as the reduction of stigma and discrimination related to HIV/AIDS are also essential. The promotion of a public health approach for integrated and decentralized HIV/AIDS interventions with particular emphasis on prevention and treatment for vulnerable populations continues to be a major challenge.

Malaria

Malaria is a preventable and treatable vector-borne disease that afflicts approximately a million people in the Americas each year. One out of three inhabitants of the Region are considered at risk of getting infected and 21 countries in the Region have areas where malaria is considered endemic while other nations report imported cases which can potentially cause re-introduction of local transmission if not managed appropriately.

Pregnant women and children are considered vulnerable to malaria worldwide. In addition, vulnerable population in the Americas includes people living with HIV/AIDS, travelers, miners, loggers, banana and sugarcane plantation workers, indigenous groups, populations in areas of social or armed conflict, and border areas.

Malaria-related illness and deaths cost great burden to the economy of the Americas as 55% to 64% of cases are among people in their most-economically productive years of life.

Control and prevention efforts need to be maintained as the nature of the disease, its vectors, and other factors that affect transmission is complex. A pro-active approach and better foresight is needed so that emerging and re-emerging challenges related to the disease are averted, including outbreaks and epidemics. Furthermore, advocacy on malaria must be intensified so that stakeholders are able to act, contribute concretely, and effect positive changes within their spheres of influence.

In the Americas, partners who work alongside the countries and their peoples in combating malaria include UN Agencies; multilateral and development partners (The Global Fund to Fight

AIDS, Tuberculosis, and Malaria, and the United States Agency for International Development); the research and academic community (WHO Collaborating Centers, CDC, the United States Pharmacopeia, the Special Program for Research and Training in Tropical Diseases and the International Development Research Center, among others); non-governmental organizations; foundations; and the private sector.

Tuberculosis

Tuberculosis (TB) is a preventable and curable disease that is far from being eliminated as a public health problem in the Region. Despite progress in the Americas in the last decade, estimates indicate more than 447,000 cases and approximately 50,000 deaths every year. It predominantly affects the adult population in reproductive age: 61% of the 2005 reported infectious cases were between 15 to 44 years old. Even though TB can affect everyone, there are specific vulnerable groups with the highest burden of the disease: the poor, migrants, marginalized populations, prisoners, people living with HIV/AIDS and the indigenous population. There are marked differences in the burden of disease among countries in the Region. Twelve countries accounted for 80% of the total burden of TB in the Americas.

The implementation of the DOTS strategy has contributed to advances in the control of this disease. A total of 33 countries had applied this strategy in 2005 with 88% coverage.

The main identified challenges for TB control in the Region are the HIV/AIDS epidemic, the TB multi-drug resistance (MDR) and the TB extremely multi-drug resistant along with the weaknesses of the health systems and the human resource crisis. In new cases of TB, HIV prevalence ranges from 8 to 10%; and the primary TB-MDR is 1.2%, with important variations among countries. These challenges are negatively impacting national programs for TB control since the burden of the disease may increase, including its mortality.

Several partners and donors come together under the new Stop TB strategy to support the countries in the Region and the rising challenges. Among them USAID, The Union (former International Union against Tuberculosis and Lung Disease), Centers for Disease Control (CDC), KNCV Tuberculosis Foundation, the Tuberculosis Coalition for Technical Assistance (TBCAP), Academy for Educational Development (AED), American Thoracic Society, the Spanish Agency for International Cooperation (AECI) and the Global Fund.

CHALLENGES FOR THE THREE DISEASES

- Limited resources with the need to optimize efforts.
- The engagement of communities, affected persons, civil-society organizations, the private sector and other relevant stakeholders in the response to ensure local ownership and sustainability.
- Greater alignment and harmonization of programs at the various levels.

STRATEGIC APPROACHES

The strategic approaches for the implementation of this SO are comprehensively discussed in the Regional HIV/STI Plan for the Health Sector, 2006-2015; the Regional Plan for Tuberculosis Control, 2006-2015; and the Regional Plan for Malaria in the Americas, 2006-2010. Strategic approaches are based on the hypothesis that interventions can be expanded even in the most resource-challenged settings, with sound planning, sustainable financing and well-supported infrastructures.

In this context, the PASB will provide policy, technical and programmatic support to countries in the following areas:

- Strengthening health systems to effectively combat HIV/AIDS/STI, TB and malaria through the development of relevant supportive gender sensitive national and local policies, leadership and management, including sustainable financing.
- Strengthening health services by:
    - Expanding, integrating and reorienting services for the delivery of gender sensitive, cost-effective interventions for prevention, diagnosis, treatment, care and support for HIV, TB and malaria.
    - Ensuring services for hard to reach populations and vulnerable groups, including indigenous populations.
    - Capacity building and strategic management of human resources.
    - Ensuring the availability and proper use of high quality medicines, quality laboratory networks, diagnostics, and health commodities with continued support to the Strategic Fund for public health supplies.
- Strengthening Surveillance and Monitoring and Evaluation Systems and promoting the use of strategic information.

The following general strategic approaches will be utilized by the PASB:

- Regional advocacy for equitable universal access to prevention, care and treatment for HIV/STI, TB, and malaria and for the elimination of stigma and discrimination against people with HIV and TB, and vulnerable groups.
- Strengthening alliances and partnerships at regional, sub-regional and country levels, particularly with networks of affected individuals.
- Country driven technical cooperation, prioritization of countries according to magnitude of the problem and the nature of the health sector response and intensifying direct support to countries. Country offices will strengthen their responses to address comprehensively these diseases, identifying mechanisms to create synergies and harmonization of resources, including technical support in development and implementations of projects submitted and approved by the Global Fund. Technical cooperation between countries and knowledge hubs will also be promoted.
- Sub-regional action to respond to the diversity of the Region. Collaborative work with subregional entities and coordinating mechanisms.
- Mainstreaming HIV/AIDS, TB and malaria in PASB by developing mechanisms for inter-programmatic and interdisciplinary action to tackle these diseases, identifying synergy and pooling of resources and expertise as required.
- Collaborative actions for Tuberculosis control through partners will include financial support through projects in some cases (e.g. Tuberculosis Control Assistance Program and United States Agency for International Development) as well as joint technical cooperation and monitoring visits, (e.g. The Union and KNCV Tuberculosis Foundation).
- Collaboration with other organizations, UN agencies and programs (United Nations Children's Fund -UNICEF, Joint United Nations Program on HIV/AIDS - UNAIDS, World Bank, United Nations Population Fund -UNFPA, International Organization for Migration - IOM), multilateral and development partners, academic partners and non-governmental organizations (NGOs) in order to advocate, increase resources available for HIV and provide technical guidance and cooperation to countries for universal access to comprehensive care, prevention and treatment for HIV.

ASSUMPTIONS AND RISKS

The following assumptions and prerequisite conditions are essential in achieving this SO:

- HIV/AIDS, TB and malaria will continue to be recognized as a priority in the national, subregional, regional and global health agendas and receive adequate resource allocations.
- National health systems will correspondingly be strengthened towards realizing universal access to essential health services and care.
- Stakeholders will work in synergy towards the attainment of common goals and targets.

The following risks have been identified that may hinder achievement of the SO:

- Raising and sustaining of the necessary resources may be difficult, both for the Bureau and Member States, as more competing priorities emerge and the cost of services increase due to the life-time chronic condition of HIV and the treatment of emerging resistance (AVR-DR, TB-MDR and TB-XDR); particularly, attracting resources to the Region will become increasingly difficult.
- Health gains in combating HIV/AIDS, tuberculosis and malaria may not be sustained in the least developed countries, without increased political and financial commitment.
- PAHO/WHO's leadership among the growing number of partners, and the interaction among them, may be difficult to sustain, especially in the face of increasing competition for resources and special problems raised by coordination and harmonization

REGION-WIDE EXPECTED RESULTS

RER 2.1 **Guidelines, policy, and strategy developed for prevention of, and treatment, support and care for patients with, HIV/AIDS, tuberculosis and malaria, including innovative approaches for increasing coverage of the interventions among poor people, and hard-to-reach and vulnerable populations.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.1.1	Number of countries that have achieved the national intervention targets for HIV/AIDS, consistent with the goal of universal access to HIV/AIDS prevention, treatment and care.	10	12	15
2.1.2	Number of malaria endemic countries implementing all components of the Global MALARIA control strategy within the context of the Roll Back MALARIA initiative and PAHO's Regional Plan for MALARIA in the Americas, 2006-2010 and national intervention targets. Within the same context, for non endemic countries, the number involved in activities to prevent re-emergence.	20	31	33

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.1.3	Number of countries detecting 70% of estimated cases of pulmonary TUBERCULOSIS with a positive TB smear test.	13/27	21/27	27/27
2.1.4	Number of countries with a treatment success rate of 85% for TUBERCULOSIS cohort patients.	10/27	21/27	25/27
2.1.5	Number of countries that have achieved targets for prevention and control of sexually transmitted infections (70% of persons with sexually transmitted infections at primary point-of-care sites diagnosed, treated and counseled).	5	25	40
2.1.6	Number of countries that have achieved regional targets for elimination of congenital syphilis.	1	15	42
2.1.7	Number of subregions that have implemented advocacy strategies to overcome barriers to universal access for HIV for the poor, hard to reach and vulnerable populations.	0	3	4
2.1.8	Number of frameworks, policy briefs and case studies made available to countries in order to achieve targets on prevention, treatment and comprehensive care for HIV in vulnerable groups.	1	6	10

RER 2.2 **Policy and technical cooperation provided to Member States towards expanded gender -sensitive delivery of prevention, support, treatment and care interventions for HIV/AIDS, malaria and TB; including integrated training and service delivery; wider service provider networks; strengthened laboratory capacities and better linkages with other health services, such as reproductive health, maternal, newborn and child health, sexually transmitted infections, nutrition, drug dependence treatment services, respiratory care, neglected diseases and environmental health.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.2.1	Number of targeted countries with integrated / coordinated gender-sensitive policies on HIV/AIDS.	40	40	40
2.2.2	Number of targeted countries that have developed integrated/ coordinated gender sensitive policies on TUBERCULOSIS.	0/27	8/27	15/27

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.2.3	Number of targeted countries with integrated or coordinated gender-sensitive policies on MALARIA, particularly in pregnant women.	0/21	8/21	12/21
2.2.4	Number of countries with sound national strategic plans for the health workforce, including policies and management practices on incentives, regulation and retention, with attention to the specific issues raised by HIV/AIDS.	3	20	40
2.2.5	Number of countries with sound national strategic plans for the health workforce, including policies and management practices on incentives, regulation and retention, with attention to the specific issues raised by TUBERCULOSIS.	0/27	10/27	25/27
2.2.6	Number of countries with sound national strategic plans for the health workforce, including policies and management practices on incentives, regulation and retention, with attention to the specific issues raised by MALARIA.	0/21	10/21	21/21
2.2.7	Number of countries monitoring access to gender-sensitive health services for HIV/AIDS.	3	20	40
2.2.8	Number of countries monitoring access to gender-sensitive health services for TUBERCULOSIS.	0/27	8/27	15/27
2.2.9	Number of countries monitoring access to gender-sensitive health services for MALARIA.	8/21	18/21	21/21
2.2.10	Number of countries with plans for monitoring provider-initiated HIV testing and counseling in sexual and reproductive health (sexually transmitted infection and family planning services).	18	20	24
2.2.11	Number of health professionals and decision makers trained through courses (including virtual self-conducted) in comprehensive gender sensitive services for prevention, treatment and care for HIV/AIDS.	0	60	200

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.2.12	Number of subregions implementing and monitoring plans with defined subregional targets for Universal access in the context of the Regional HIV/STI Plan for the Health Sector 2006-2015.	3	3	4

RER 2.3 **Regional guidance and technical cooperation provided on policies and programs to promote equitable access to essential medicines of assured quality for the prevention and treatment of HIV, tuberculosis and malaria, and their rational use, including appropriate vector control strategies, by prescribers and consumers; and uninterrupted supply of diagnostics, safe blood and other essential commodities.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.3.1	Number of global standards related to HIV/AIDS and congenital syphilis reviewed, adapted to regional needs and/or adopted.	3	8	10
2.3.2	Number of countries implementing revised / updated diagnostic and treatment guidelines on TUBERCULOSIS.	0/25	15/25	25/25
2.3.3	Number of countries implementing revised / updated diagnostic and treatment guidelines on MALARIA.	16/21	21/21	21/21
2.3.4	Number of countries with endemic MALARIA conducting regular surveys of anti-MALARIAL drug quality.	8/21	20/21	20/21
2.3.5	Number of countries with high incidence of P. falciparum MALARIA using artemisinin-based combination therapy from a pre-qualified manufacturer.	6/13	10/13	13/13
2.3.6	Number of countries receiving support to increase access to affordable essential medicines for TUBERCULOSIS whose supply is integrated into national pharmaceutical systems.	27	33	37

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.3.7	Number of malaria-endemic countries receiving support to increase access to affordable medicines for MALARIA whose supply is integrated into National pharmaceutical systems.	21/21	21/21	21/21
2.3.8	Number of countries receiving support to increase access to affordable essential medicines for HIV/AIDS whose supply is integrated into national pharmaceutical systems, with prices negotiated through the strategic fund.	18	19	21
2.3.9	Cumulative number of patients with TUBERCULOSIS treated with support from the Global Drug Facility.	40,000	60,000	100,000
2.3.10	Number of countries implementing quality-assured HIV screening of all donated blood.	32	35	40
2.3.11	Number of countries with plans to monitor the administration of all medical injections with safe equipment (e.g. disposable needles) as part of strategy to prevent transmission of HIV associated with health care.	0	4	10

RER 2.4 **Global, regional and national surveillance, evaluation and monitoring systems strengthened and expanded to keep track of progress towards targets and resource allocations for HIV, malaria and tuberculosis control; and to determine the impact of control efforts and the evolution of drug resistance.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.4.1	Number of countries that regularly collect, analyze and report surveillance coverage, outcome and impact data on HIV using PAHO/WHO's standardized methodologies, including appropriate age and sex dis-aggregation.	27	30	40
2.4.2	Number of countries that regularly collect, analyze and report surveillance coverage, outcome and impact data on TUBERCULOSIS using WHO/PAHO's standardized methodologies, including appropriate age and sex dis-aggregation.	28	30	40

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.4.3	Number of countries that regularly collect, analyze and report surveillance coverage, outcome and impact data on malaria using WHO/PAHO's standardized methodologies, including appropriate age and sex dis-aggregation.	21	21	21
2.4.4	Number of countries providing PAHO/WHO with annual data on surveillance, monitoring and financial allocation data for inclusion in the annual global reports on control of HIV/AIDS.	35	40	40
2.4.5	Number of countries providing PAHO/WHO with annual data on surveillance, monitoring and financial allocation data for inclusion in the annual global reports on control of Tuberculosis, and the achievement of targets.	27/40	30/40	40/40
2.4.6	Number of countries providing PAHO/WHO with annual data on surveillance, monitoring and financial allocation data for inclusion in the annual global reports on control of, and the achievement of targets for TB/HIV co-infection.	18/40	30/40	40/40
2.4.7	Number of countries providing PAHO/WHO with annual data on surveillance, monitoring and financial allocation data for inclusion in the annual global reports on control of MALARIA and the achievement of targets.	21/21	21/21	21/21
2.4.8	Number of countries reporting on sex and age disaggregated surveillance and monitoring of HIV drug resistance.	0	20	35
2.4.9	Number of countries reporting on sex and age disaggregated surveillance and monitoring of TUBERCULOSIS drug resistance.	0/27	12/27	25/27
2.4.10	Number of countries reporting on sex and age disaggregated surveillance and monitoring of MALARIA drug resistance.	9/21	20/21	20/21
2.4.11	Regional and subregional networks developed for HIV drug resistance including lab networks.	1	2	4
2.4.12	Regional and subregional reports published on HIV epidemic profile.	1	3	6

RER 2.5 **Political commitment sustained and mobilization of resources ensured through advocacy and nurturing of partnership on HIV, malaria and tuberculosis at country, regional and global levels; technical cooperation provided to countries as appropriate to develop or strengthen and implement mechanisms for resource mobilization and utilization and increase the absorption capacity of available resources; and engagement of communities and affected persons increased to maximize the reach and performance of HIV/AIDS, tuberculosis and malaria control programs.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.5.1	Number of countries with functional partnerships for HIV control.	40	40	40
2.5.2	Number of countries with functional partnerships for Tuberculosis control.	5/27	8/27	15/27
2.5.3	Number of targeted countries with functional partnerships for malaria control.	21/21	21/21	21/21
2.5.4	Number of countries that receive PAHO/WHO support in accessing financial resources or increasing absorption of funds for HIV.	12	15	20
2.5.5	Number of countries that receive PAHO/WHO support in accessing financial resources or increasing absorption of funds for TUBERCULOSIS.	14/27	18/27	25/27
2.5.6	Number of countries that receive PAHO/WHO support in accessing financial resources or increasing absorption of funds for malaria.	13/21	17/21	19/21
2.5.7	Number of countries that have involved communities, academia and under represented sectors, persons affected by the diseases, civil society organizations, private sector in planning, design, implementation and evaluation of HIV programs.	40	40	40
2.5.8	Number of countries that have involved communities, academia and under represented sectors, persons affected by the disease, civil society organizations, private sector in planning, design, implementation and evaluation of Tuberculosis programs.	3/27	10/27	25/27
2.5.9	Number of countries that have involved communities, academia and under represented sectors, persons affected by the disease, civil society organizations, private sector in planning, design, implementation and evaluation of malaria programs.	13/21	21/21	21/21
2.5.10	Number of regional and subregional partnerships initiated and established by the PASB for HIV/AIDS control.	7	9	11

RER 2.6 **New knowledge, intervention tools and strategies developed, validated, available, and accessible, to meet priority needs for the prevention and control of HIV, tuberculosis and malaria, with developing countries increasingly involved in this research.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.6.1	Number of new and improved interventions and implementation strategies for HIV whose effectiveness has been determined and evidence made available to appropriate institutions for policy decisions.	1	2	3
2.6.2	Number of new and improved interventions and implementation strategies for tuberculosis whose effectiveness has been determined and evidence made available to appropriate institutions for policy decisions.	3	5	6
2.6.3	Number of new and improved interventions and implementation strategies for malaria whose effectiveness has been determined and evidence made available to appropriate institutions for policy decisions.	0	1	2
2.6.4	Number of peer-reviewed publications arising from PAHO/WHO-supported research on HIV/AIDS which the main author's institution is based in a developing country.	0	3	6
2.6.5	Number of peer-reviewed publications arising from PAHO/WHO-supported research on malaria for which the main author's institution is based in a developing country.	0	2	5
2.6.6	Number of countries with a clear and well-implemented HIV research agenda that gives adequate focus on health systems strengthening and country-level capacity building.	4	6	10
2.6.7	Number of countries with a clear and well-implemented MALARIA, research agenda that gives adequate focus on health systems strengthening and country-level capacity building.	8/21	13/21	15/21
2.6.8	Number of countries with a clear and well-implemented TUBERCULOSIS research agenda that gives adequate focus on health systems strengthening and country-level capacity building.	0/25	5/25	15/25

STRATEGIC OBJECTIVE 3

To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries

Scope

This Strategic Objective (SO) encompasses policy development, program implementation, monitoring and evaluation, strengthening of health and rehabilitation systems and services, implementation of prevention programs and capacity building, in the area of: chronic noncommunicable conditions (including cardiovascular diseases, cancer, chronic respiratory diseases, diabetes, hearing and visual impairment, oral diseases, and genetic disorders); mental, behavioral, neurological and psychoactive substance use disorders; injuries due to road traffic crashes, drowning, burns, poisoning or falls and violence in the family, the community or between organized groups; disabilities from all causes.

INDICATORS AND TARGETS

- A 2% annual reduction in chronic disease death rates from the major chronic diseases over and above current trends.
- To halt and begin to reverse current increasing trends of mental, behavioral, neurological and psychoactive substance use disorders. Target: TBD.
- To halt and begin to reverse current increasing trends in mortality from injuries (2% reduction in mortality rate from injuries per year).

Issues and Challenges

- Chronic diseases, mental disorders, violence and injuries are the major causes of death and disability in almost all countries, responsible for 75% of all deaths and most of the health costs. They are rapidly increasing, and some affect men and women differently; additionally they disproportionately affect some racial/ethnic groups.
- A major part of this increasing burden will be borne by low- and middle-income countries and poor populations in all countries.
- Management is fragmented and tertiary care still consumes most of the resources.
- A wide range of cost effective, proven solutions exist from promotion to prevention and disease management.
- Most major chronic disease determinants lie outside the health sector (diet, physical activity, alcohol, tobacco).
- Insufficient sensitization among audiences that matter about the human and economic impact and the availability of cost-effective interventions; Insufficient awareness about the link between chronic diseases and poverty; not on the MDGs explicitly.
- Resources available in the Organization are not proportional with magnitude of problem and are fragmented.

- Data and information for setting baselines and monitoring progress, especially risk factors, are not well developed; and capacities of countries to collect, analyze, report, and use non-communicable disease data in developing programs and policy vary widely.
- The challenges in this context are to increase awareness of the magnitude of the problem and the potential for health promotion and disease prevention; to increase the political will and international partnerships to address the problem; to initiate/deepen appropriate multi-sectoral collaboration; to synergize such resources as are available in the Organization, and to generate the necessary additional resources in an environment of competing interests; to develop the data and information systems for improved policy making, planning and monitoring and evaluation, especially those pertaining to modifiable risk factors, such as behaviors and the related cost data; and to re-orient the health services towards prevention and care providers' attitudes on stigmatization of mental health problems, cultural competency, etc.

STRATEGIC APPROACHES

- Advocacy, communication and policy work with governments, including an advocacy campaign to at least half the Cabinets over the life of the Plan stressing inter-sectoral action and healthy public policies, and public-private partnerships.
- Establishing a partner's forum of public, private and civil society in support of the Region strategy to change the non-health actors.
- Leveraging the subregional integration movements, e.g., Caribbean, Central America, Andean, and Southern Cone.
- Strengthening the surveillance, research and information base for policy, planning and evaluation, especially those pertaining to risk factors, using the WHO STEPwise approach to Surveillance (STEPS) methodology, and establishing this on a sustainable basis in at least half the countries.
- Shifting the balance to more Health Promotion and Disease Prevention, including a range of healthy public policies in nutrition and physical activity, oral health, tobacco control, alcohol control, and injury prevention and mental health where people live and work.
- Reorienting the health services and the integrated management of disease and risk factors to stress prevention and the use of the primary health care approach, screening, etc., and leveraging the Strategic Fund to rationalize and help countries reduce the costs of drugs needed in chronic disease management.
- Inter programmatic work within the organization, connecting national, subregional, regional and global levels, and strengthened partnerships with key actors in countries and internationally.
- Priority will be given to those options which address problems where proven, rapidly effective interventions are available ("Low hanging fruit" approach), and are based on Political Feasibility in a given country or subregion.
- Monitoring and evaluation annually against scientifically-based targets.
- Alignment and partnership with WHO's Chronic Disease Strategy and Action Plan.

ASSUMPTIONS AND RISKS

- Data and information availability for effective policy, planning, monitoring and evaluation.
- Ability to secure high-level multi-sectoral collaboration in countries, individually and collectively.

- Partners in and out of the Organization respond and embrace approach.
- The MDGs will be adapted to reflect the importance of addressing chronic diseases in combating poverty and under-development.
- Options analysis will be used in planning and prioritization processes to take into account evidence-based interventions that have been proven successful or promising.
- Options analysis also has to monitor development and use, and costs of appropriate biotechnology (e.g. vaccine for HPV), genetic involvement in the etiology of some chronic diseases, leveraging use of other developments; such as using cell phone networks for collecting risk factor data, disseminating health messages, and improving compliance with necessary medications.

REGION-WIDE EXPECTED RESULTS

RER 3.1 **Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable conditions, mental and behavioral disorders, violence, injuries and disabilities.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
3.1.1	Number of countries whose health ministries have a focal point or a unit for injuries and violence prevention with its own budget.	9	14	24
3.1.2	Number of countries whose health ministries have a unit for mental health and substance abuse with its own budget.	24	28	30
3.1.3	Number of countries whose health ministries have a unit or department for chronic noncommunicable conditions and with its own budget.	21	36	38
3.1.4	Number of countries where an integrated chronic disease and health promotion advocacy campaign has been taken to stimulate multiple sector involvement in healthy public policy implementation.	3	10	20
3.1.5	Number of countries that have a unit or focal point in the MoH (or equivalent) on disabilities prevention and rehabilitation.	10	19	27
3.1.6	Partners Forum for prevention and control of chronic diseases established including public, private sector and civil society.	0	1	1
3.1.7	Sub-regional Forums to asses and discuss the implementation of National Health Policy and Plan.	3	3	6

RER 3.2 **Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable conditions, mental and behavioral disorders, violence, injuries and disabilities, and oral diseases.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
3.2.1	Number of countries that have and are implementing national plans to prevent unintentional injuries and violence.	15	17	23
3.2.2	Number of countries that are implementing national plans for disability, including prevention, management and rehabilitation according to PAHO/WHO guidelines and Directing Council resolutions.	5	15	24
3.2.3	Number of countries that are implementing a national Mental Health plan according to PAHO/WHO guidelines and Directing Council Resolutions.	26	29	30
3.2.4	Number of countries that have and are implementing a nationally approved policy and plan for the prevention and control of chronic, noncommunicable conditions, including genetic diseases.	15	32	36
3.2.5	Number of countries in the CARMEN network (Conjunto de Acciones para la Reducción Multifactorial de Enfermedades Notransmissibles).	22	30	36
3.2.6	Number of countries that have and are implementing comprehensive national plans for the prevention of blindness and visual impairment.	7	11	20
3.2.7	Number of countries that have and are implementing comprehensive national oral health plans for the prevention of oral diseases.	27	35	35

RER 3.3 **Improved capacity in countries to collect, analyze, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable conditions, mental and behavioral disorders, violence and injuries, and disabilities, as well as their risk factors and determinants**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
3.3.1	Number of countries that have a published a document containing a national compilation of data on the magnitude, causes and consequences of injuries and violence.	12	16	22
3.3.2	Number of countries that have a published document containing a national compilation of data on the prevalence and incidence of disabilities.	8	15	19
3.3.3	Number of countries with national information systems and annual report that includes mental, neurological and substance abuse disorders.	20	24	28
3.3.4	Number of countries with a national health reporting system and annual reports that include indicators of chronic, noncommunicable conditions.	15	28	32
3.3.5	Number of countries documenting the burden of hearing and visual impairment including blindness.	8	14	21

RER 3.4 **Improved evidence compiled by the Bureau on the cost-effectiveness of interventions to address chronic noncommunicable conditions, mental and behavioral disorders, violence and injuries, disabilities, and oral health.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
3.4.1	Number of cost-effective interventions for the management of selected mental and neurological disorders (depression, psychosis, and epilepsy) prepared and made available.	1	2	4
3.4.2	Availability of summarized evidence on the cost-effectiveness of a core package of interventions for chronic noncommunicable conditions together with an estimate of the regional cost of implementation in the Americas.	Not available	Package available and disseminated to countries and subregions	Package in use by countries and subregions
3.4.3	Number of countries with cost analysis studies on violence and/or injuries conducted and disseminated.	8	12	17

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
3.4.4	Number of countries with best practice models to deliver oral health services, including cost-effective analysis.	4	10	35
3.4.5	Number of cost-effective oral health interventions with an estimate of the regional cost of implementation in the Americas.	2	2	3

RER 3.5 **Guidance and technical cooperation provided to Member States for the preparation and implementation of multi-sectoral, population-wide programs to promote mental health and prevent mental and behavioral disorders, injuries and violence, as well as hearing and visual impairment, including blindness.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
3.5.1	Number of countries implementing strategies recommended by PAHO/WHO for population wide prevention of disabilities, including hearing and visual impairment and blindness.	6	15	24
3.5.2	Number of countries for which guidance and support has been provided for the preparation and implementation of multi-sectoral population-wide programs to prevent violence and injuries.	13	15	21
3.5.3	Number of countries having program of mental health promotion, and mental, behavioral and substance abuse prevention integrated into the National Mental Health Plan.	0	9	17
3.5.4	Number of countries implementing the Regional Strategy on an Integrated approach to prevention and control of Chronic Diseases, including Diet and Physical Activity.	2	10	30
3.5.5	Regional Guidelines on mental health promotion and mental, behavioral, substance abuse and neurological disorders prevention.	0	1	1

RER 3.6 **Support provided to countries to strengthen their health and social systems for integrated prevention and management of chronic noncommunicable conditions, mental and behavioral disorders, violence and injuries and disabilities.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
3.6.1	Number of countries that apply guidelines for violence and /or injuries in their health care services.	12	15	22
3.6.2	Number of countries that strengthened their rehabilitation services using the recommendations in The World Report on Disability and Rehabilitation and related PAHO/WHO guidelines and resolutions.	5	15	24
3.6.3	Number of countries with a systematic assessment of their mental health systems using the WHO-AIMS assessment instrument for mental health systems and utilizing the information to strengthen national mental health services.	8	15	25
3.6.4	Number of targeted countries implementing integrated primary health-care strategies recommended by WHO in the management of chronic, noncommunicable conditions.	10	20	36
3.6.5	Number of targeted countries that have established demonstration sites for integrated prevention and control of Chronic Disease.	16	24	30
3.6.6	Number of targeted countries that have elaborated and are implementing National Guidelines and Protocols for Chronic Disease.	6	24	36
3.6.7	Number of targeted countries with universal access to medication for major NCDs.	5	8	10
3.6.8	Number of countries with strengthened health-system services for the treatment of tobacco dependence as a result of using WHO's policy recommendations.	6	12	24

RER 3.7 **Strengthened inter-programmatic approach for improved synergy and impact in the prevention and control of chronic noncommunicable conditions, mental and behavioral disorders, violence and injuries and disabilities.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
3.7.1	Number of countries that have applied an Inter-programmatic approach to address violence and/or injuries.	23	28	35
3.7.2	Inter-programmatic group on chronic diseases prevention established and functioning.	0	1	1

RER 3.8 **Countries supported to develop monitoring and evaluation instruments to measure advances in the prevention and control of chronic noncommunicable conditions, mental and behavioral disorders, violence and injuries and disabilities.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
3.8.1	Number of countries that have significantly increased their capacity to deal with violence and/or injuries.	13	15	20
3.8.2	Integrated regional information system for countries and the Bureau developed for monitoring and evaluation including mortality, morbidity and risk factors, costs, programmatic coverage and input/policy indicators, for chronic diseases and risk factors (diet, physical activity, tobacco, alcohol), health promotion, mental health and injuries and violence.	System under development in collaboration with WHO Geneva	System approved by Governing Bodies	System in use
3.8.3	Number of countries that improved the measures of disabilities prevention according UN Standard Rules, PAHP/WHO Guidelines, Directive Council Resolutions, the World Report on Disabilities and Rehabilitation and others regional standard.	0	5	15

STRATEGIC OBJECTIVE 4

To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals

Scope

This Strategic Objective (SO) focuses on reduction of mortality and morbidity to improve health during key stages in life and ensuring universal access to coverage with effective interventions for maternal, newborn, child, adolescent, and sexual reproductive health, using a life-course approach and addressing equity gaps. Work will be undertaken to support actions to strengthen health systems, formulate and implement policies and programs that promote healthy and active aging for all individuals

INDICATORS AND TARGETS

- Proportion of births attended by skilled attendants at birth. Target: at least 90% in the Americas; and a 10% increase in each country with less than 60% of births attended by skilled attendants at birth.
- Maternal mortality ratio. Target: less than 8 countries with maternal mortality ratio above 100 per 100,000 live births.
- Under-5 mortality rate. Target: 28 countries having met or on track to meet Millennium Development Goal Target 4 (reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate).
- Access to reproductive health services, as measured by unmet need for family planning or contraceptive prevalence rate; the fertility of women aged 15-19 years as a proportion of total fertility among women of all ages; and syphilis screening and treatment for pregnant women. Target: 25 countries having met or on track to meet their national targets for all three indicators.
- Adolescent health, as measured by fertility proportions, HIV prevalence in young people aged 15–24 years, obesity and overweight, tobacco use and injury rate. Target: 25 countries having met or on track to meet their national targets for two of the five indicators and showing no deterioration in the three other indicators.
- Older persons receiving health and social service protection. Number of countries in which more than 50% of the population over 60 years old receives health and social service protection (in CAN and USA over 65 years). Target: 18 countries (EV)

All indicators will be disaggregated by age and, where relevant, sex.

ISSUES AND CHALLENGES

In the Region of the Americas, the situation is worsening for some conditions (e.g., the incidence of sexually transmitted infections, fertility among adolescents in some countries), and is stagnating for others (e.g., maternal and neonatal mortality). At this time, most countries are not on track to meet the internationally agreed goals and targets.

Some countries have made great strides in reducing maternal mortality; however in others have worsened and great disparities remain between and within countries. Skilled attendance at birth is particularly low in the poorest countries and in rural settings. More than 5 countries in the region have fertility rates in adolescents aged 15-19 of more than 100 per 1,000. Several actors are working in the field of adolescent health, including UNICEF, UNFPA, UNIFEM, USAID, and many major NGOs (PLAN, Pathfinder, Red Cross, Alan Guttmacher) and bilateral originations (CIDA, SIDA, GTZ, NORAD, CIDE).

Infant mortality in children has dropped 24.3% regionally, but 10 countries had a childhood mortality rate of 40 or more per 1.000 lives birth, and huge disparities continue between and within countries.

In the child health area, many national and international agencies are working in Latin America to reach full coverage with interventions that will increase a child's chance for survival and healthy development. The Region collectively needs to intervene, not only through the health system but also at the household level to promote interventions that can be effectively delivered at low cost; these include breastfeeding, oral re-hydration therapy, education on complementary feeding, among others. These interventions could jointly prevent more than one-third of all deaths.

In 2006, 9% of Latin America's population was 60 or older (over 50 million people) and 7 million were 80 years old or older. While the population in general is growing by 1.5% annually, the population over 60 is growing at an annual rate of 3.5%. This demographic shift means that by around 2025 the region will have 100 million people over 60 year old, underscoring that the healthy aging of its population will be one of the biggest challenges that Latin American and Caribbean society must face during this century

Political will to make a difference is flagging and resources are insufficient. Those most affected (e.g., poor women and children in developing countries), have limited influence on decision-makers and are often excluded from care. Some issues are politically and culturally sensitive and do not draw sufficient attention, given the burden on public health. These issues require advocacy and establishment of relevant partnerships with the United Nations and other agencies. Efforts to improve the quality of necessary health care and to increase coverage are insufficient. Competing health priorities, vertical program approaches and lack of coordination between governments and development partners result in program fragmentation, missed opportunities and an inefficient use of the limited resources that are currently available. Lack of attention to gender inequality and gaps in health equity undermine ongoing efforts to decrease mortality and morbidity. This pattern can be changed through the concerted action of all involved.

In the Region, technical knowledge and program experience indicate that effective and affordable interventions exist for most of the problems covered by this SO. Consensus exists on the need to reach universal access using key interventions. To this end, adopting a life-course approach that recognizes the influence of early life events and inter-generational factors on future health outcomes will serve to bridge gaps and build synergies between program areas while also providing effective support to ensure active and healthy aging.

Additionally, interventions must be implemented within a primary health care setting in a culturally sensitive context. Expanding social protection in health is of interest to Member States in the older adult population and it should include greater participation and expansion of coverage of primary health care.

Maternal and child health services, as well as some other reproductive health services, have long served as the backbone of primary health care and as a platform for other health programs, especially for poor and marginalized populations; but they are now overburdened. Scaling-up implies the development of a functioning health system that maintains good information systems, a suitable infrastructure, a reliable supply of essential drugs and commodities, functional referral systems, competent and well-motivated health workers, and cooperation with community leaders.

Lessons learned show that:

- The interventions that need to be scaled up are cost-effective and can be applied to scale even in resource-constrained settings, if sufficient attention is placed on developing an enabling policy environment and addressing key gaps in health systems;
- The programs concerned contribute to narrowing gaps in equity as they reach out to the most vulnerable and marginalized populations, including children, adolescents and women, indigenous populations, and serve as critical entry point and platform for other key public health programs.

STRATEGIC APPROACHES

Achieving the SO will require Member States and the Bureau to work closely together.

- This SO will require a country-led planning and implementation process for scaling up towards universal access to and coverage of maternal, newborn, child adolescent, sexual and reproductive health care, while addressing gender inequality and growing health inequities that fuel the high levels of mortality and morbidity.
- In collaborating with Member States to advance the regional health agenda, PAHO will contribute to national strategies and priorities, and incorporate country realities and perspectives into global and regional policies and priorities.
- PAHO will also provide leadership and advocacy for investing in children and adolescents. A continuum of care that runs through the life course and spans the home, the community and different levels of the health system must be ensured. This needs to occur within the broader framework of strengthening health systems to ensure adequate and equitable financing and delivery of quality health support services, with marginalized and underserved groups receiving priority attention.
- This approach will also require the promotion of community-based interventions and participation of community leaders to increase the demand for services and to support appropriate care in the home across the life course. The Region is conducting work at the family and community level within the context of primary health care and has documented best practices and lessons learned. The sexual and reproductive health of women and men outside the reproductive process should also receive consideration/attention.
- Supporting systems for improving information, decision making and emphasizing good monitoring, evaluation, and generation of evidence and best practices, and formulating strategies, including case management and integrated interventions for prevention and health promotion in an ecological model, will all ensure that the strategic objective is achieved.

- Building national capacity to reduce vulnerability and improve health calls for advocacy, update policies and legislation, training human resources, appropriate structures, knowledge management resources and partnership.
- Coordination ensures effectiveness and efficacy of activities harmonizing UN activities and leveraging impacts maximizing the participation with WHO/PAHO Collaborating Centers and PAHO Centers is needed.
- Accomplishing the strategic objective also means ensuring PAHO/WHO Country Representatives and Member States prioritize this work and allocate country funds appropriately.
- Achieving the SO also involves strengthening the promotion of active and healthy aging to prevent early deterioration (both physical and mental) and expanding human resources for education in gerontology and geriatrics for family as well as community caregivers. In addition, it will be necessary to develop, implement, and evaluate policies and programs that promote healthy and active aging and the highest attainable standard of health and well-being for their older citizens.

Partnership and harmonization with UN agencies is a key issue for the achievement of the target of this strategic objective. UNFPA support the countries in sexual and reproductive health, gender issues, information gathering, family planning, policies development and access to sexual and reproductive services UNICEF support countries in a more broad perspective of rights and health component has several entry points including nutrition, services, IMCI, PMCT and prevention of HIV among adolescents, UNIFEM is supporting policy development and women.

ASSUMPTIONS AND RISKS

The following assumptions underlie achievement of the SO:

- Overall strengthening of health systems will occur, including the development and maintenance of a suitable infrastructure, a reliable supply of essential drugs and commodities, functional referral systems and a competent and well-motivated workforce.
- National actions will be undertaken for dealing with the crisis affecting human resources for health.
- Key processes will be pursued such as the improved harmonization of the work performed by UN agencies at the country level and the integration of health issues in national planning and implementation instruments.
- Potential for raising new resources for PAHO's work in these areas will be materialized, as there is considerable political interest in making progress towards the Millennium Development Goals; which will likely increase the support of technical and financial resources within countries and the region and of global partnerships and initiatives, including the Partnership on Maternal, Newborn and Child Health.
- Latin America and the Caribbean have an aging process that will increase in the coming years. Despite the rapid aging of the Region, a significant window of opportunity exists for appropriate interventions to ensure that this does not become a factor that can contribute to the collapse of health and social security systems in Latin America and the Caribbean.

The following risks have been identified that may adversely affect the achievement of this SO:

- Threats posed by the continued possibility of a pandemic of Avian Flu in the Region, HIV and AIDS pandemic and setbacks in malaria and dengue control.

- In some countries, increasing poverty, natural crises, political instability and food insecurity may lead to the reversal of direction in some indicators.
- Lack of funds and political will.
- A debilitated healthcare force including strikes and brain-drain.

REGION-WIDE EXPECTED RESULTS

RER 4.1 **Support provided to Member States to develop comprehensive policies, plans and strategies promoting universal access to effective interventions in collaboration with other programs and sectors, paying attention to gender inequality and gaps in health equity, providing a continuum of care throughout the life course, integrating service delivery across different levels of the health system and strengthening coordination with civil society and the private sector and partnerships with UN agencies and others (NGOs).**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.1.1	Number of countries that have policies, plans and programs that promote universal access to effective interventions in maternal, neonatal, child health.	9	12	24
4.1.2	Number of countries that have a policy of universal access to sexual and reproductive health.	7	11	16
4.1.3	Number of countries that have a policy on the promotion of active and healthy aging.	11	15	18
4.1.4	Number of functional partnerships and alliances (with NGO's, civil society, collaborating centers, national institutions of excellence and private partnerships) to advance maternal, newborn, child and adolescent health.	12	15	20

RER 4.2 **National/local capacity strengthened to produce evidence, technologies, and interventions and to improve national/local surveillance and information systems to improve sexual and reproductive heath, maternal, neonatal, child and adolescent health, and promote active and healthy aging.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.2.1	Number of institutions that have functioning information systems (such as the perinatal information system), surveillance systems and others, to track sexual and reproductive health, maternal, neonatal, child and adolescent health - with information disaggregated by age, sex and ethnicity.	50	75	100

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.2.2	Number of new or updated systematic reviews on best practices, operational research, policies and standards of care.	0	5	10
4.2.3	Number of guidelines and tools developed for monitoring and evaluation systems for child care and survival.	3	4	5
4.2.4	Regional database system(s) in Adolescent Health functioning on an ongoing basis.	0	10	15
4.2.5	Number of centers of excellence (in research, service delivery and training courses) that build national capacity (pre-service and in service), and are supported by regional programs in maternal, neonatal, child and adolescent health.	12	15	20

RER 4.3 **Guidelines, approaches and tools for improving maternal care in use at the country level, with technical support provided to Member States to reinforce actions that ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods, particularly for poor and disadvantaged populations, with progress monitored.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.3.1	Numbers of countries that have implemented national strategies to ensure skilled care at birth, including ante- and post-natal care.	10	12	22
4.3.2	Number of countries adapting and utilizing IMPAC (integrated management of pregnancy and childbirth) policy, technical and managerial norms and guidelines and perinatal technologies to improve the quality of care for mother and newborns.	5	9	16
4.3.3	Number of countries that have a functioning network of basic emergency obstetric and neonatal care at all levels of referral.	6	10	15
4.3.4	Number of countries that have implemented evidences base normative guides and perinatal technology to improve the quality of care for mother and newborn.	8	12	27

RER 4.4 **Guidelines, approaches and tools for improving neonatal survival and health applied at country level, with technical support provided to Member States for intensified action towards universal coverage, effective interventions and monitoring of progress.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.4.1	Number of countries with breast milk banks and at least 50% of targeted districts implementing strategies for neonatal survival and health including neonatal Integrated Management of Childhood Illnesses (IMCI).	4	8	18
4.4.2	Number of countries that have adopted and implemented evidence-based guidelines and norms (including WHO Growth Standards) for the continuum of maternal care and IMCI, including newborns.	9	15	20
4.4.3	Number of guidelines, approaches and tools on effective interventions and/or monitoring and evaluation systems developed to improve neonatal care and survival.	4	6	9

RER 4.5 **Guidelines, approaches and tools for improving child health and development applied at the country level, with technical support provided to Member States for intensified action towards universal coverage of the population with effective interventions and for monitoring progress, taking into consideration international and human-rights norms and standards, notably those stipulated in the Convention on the Rights of the Child.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.5.1	Number of countries implementing strategies for increasing coverage using a rights-based approach in child development and health interventions.	6	11	21
4.5.2	Number of countries that have adopted integrated management of childhood illness (IMCI) guidelines and where 75% or more of targeted districts are implementing them, including a micronutrient package.	5	10	20
4.5.3	Number of countries that have implemented community-based policies using an IMCI methodology based on social actors to strengthen primary health care including key family and practices (e.g. promotion of exclusive breastfeeding, complementary feeding and prevention of micronutrients deficiencies).	9	15	20

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.5.4	Number of guidelines, tools and approaches to tools develop and implement policies and plans promoting the implementation of effective interventions to improve child health and scale-up universal coverage.	8	12	15

RER 4.6 **Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, and for the scaling up of a package of prevention, treatment and care interventions in accordance with established standards.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.6.1	Number of countries with functioning national programs in adolescent health and development.	10	12	17
4.6.2	Number of countries in the region implementing integrated strategies and a comprehensive package of services in adolescent health and youth development (Integrated Management of Adolescent Needs - IMAN).	3	10	15
4.6.3	New guidelines, approaches and tools to support the implementation of evidence-based policies and strategies on adolescent health and development.	2	4	6
4.6.4	Number of Regional Training Programs supplied by PAHO to build capacity on Adolescent health and development including advocacy events and different methodologies (online-CD Rom-Modules).	2	5	10

RER 4.7 **Guidelines, approaches and tools available, with technical support provided to Member States for accelerated action towards implementing the Global Reproductive Health Strategy, with particular emphasis on ensuring equitable access to good quality sexual and reproductive health services, particularly in areas of unmet need, and with respect for human rights as they relate to sexual and reproductive health.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.7.1	Number of countries that have adopted the WHO Global Strategy of Reproductive Health.	5	8	15
4.7.2	Number of countries that have reviewed - and updated as necessary - national laws, regulations and policies related to and in support of sexual and reproductive health.	2	4	6
4.7.3	Number of countries that have implemented evidence based normative guides and programs in sexual and reproductive health.	8	11	26

RER 4.8 **Guidelines, approaches, tools, and technical cooperation provided to Member States for increased advocacy for aging and health as a public health issue; for the development and implementation of policies and programs to maintain maximum functional capacity throughout the life course; and to train health care providers in approaches that ensure healthy aging.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.8.1	Number of countries that have implemented community-based policies with a focus on strengthening primary health-care capacity to address healthy aging.	5	7	12
4.8.2	Number of countries that have multi-sectoral programs for strengthening primary heath care capacity to address healthy aging.	9	10	14
4.8.3	Number of countries in which more than 50% of the population over 60 years old receive health and social service protection (in CAN and USA over 65 years).	12	13	15

STRATEGIC OBJECTIVE 5

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

Scope

The focus of this Strategic Objective (SO) is on an integrated, comprehensive, multi-sectoral and multidisciplinary approach to reduce the impact of natural, technological or manmade hazards on public health in the Western Hemisphere. This is achieved primarily by strengthening the institutional capacity of the health sector, and in particular the Ministries of Health, in preparedness, risk reduction and in assuming its operational and regulatory responsibilities promptly and appropriately in response to any type of disaster. Main activities encompass: advocacy, technical cooperation, knowledge management and training.

INDICATORS AND TARGETS

- Access to functioning health services. Target: following a natural disaster 90% of the affected populations enjoy levels of access similar to, or better than, pre-emergency conditions, within one year.
- Formal Health Disaster Program. Target: 15 Member States have a health disaster program with full time staff and specific budget.
- Resource mobilization. Target: In all major disaster situations, human, technological, and financial resources are mobilized and coordinated at the national and regional levels within 48 hours.

ISSUES AND CHALLENGES

- This SO is designed to contribute to human wellbeing, minimizing the negative effect of disasters and other humanitarian crises by responding to the health needs of vulnerable populations affected by such events.
- Disaster response will depend on the national capacity to manage disasters. International assistance only complements the national response. All efforts of the Organization must be directed to building national capacity and ensuring that international humanitarian health assistance supports the national structure.
- Disaster plans still focus on single hazards. They must be 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 can only 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 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.
- The main actors in the field of disaster reduction and response are: United Nations (UN) agencies such as Office for the Coordination of Humanitarian Affairs (OCHA), United Nations Children's Fund (UNICEF), World Food Program (WFP), United Nations High Commissioner for Refugees (UNHCR), International Organization for Migration (IOM); 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.

STRATEGIC APPROACHES

- As part of the United Nations humanitarian reform process, WHO has been asked to ensure the coordination, effectiveness and efficiency of activities concerning preparedness, response and recovery in relation to health action in crises. WHO leads the United Nations Inter-Agency Standing Committee Health Cluster. PAHO/WHO is the Health Cluster leader for the Western Hemisphere.
- Preparedness is a prerequisite for effective emergency response. Building national capacity to manage risk and reduce vulnerability calls for the following: advocacy, updated policies and legislation, training, appropriate structures, scientific information, plans and procedures, resources and partnerships.
- 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. Strong technical guidance and leadership and better coordination will be needed to ensure that there are no shortcomings in those areas in future emergencies.
- The right people with the right skills need to be identified immediately after a disaster; the faster the response, the better the outcome. It is important to build national capacity and compile a roster of appropriately trained experts on call. Criteria and procedures should be agreed for collaboration involving all sectors.
- Collaborate with partners within and outside of 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.
- Mainstream 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.

- There is a proliferation of global actors working in the field of disasters reduction and response –each with an organized response capacity and mandate, which has translated into the "internationalization" of a number of emergencies that otherwise, might have been handled locally.

ASSUMPTIONS AND RISKS

Assumption:

- Disaster preparedness and risk reduction receive strong political support at all levels. All Member States remain relatively stable.

Risks:

- Humanitarian response is very demanding in terms of expert time and administrative support. The procedures of UN organizations are not particularly suited for field operational response activities. The risk of distracting PAHO staff from development priorities due to their involvement in disaster response activities is real.
- Large multi-country disasters, such as occurred during the strong hurricane seasons of 2004 and 2005, seriously affect the implementation of the Program's Workplan. However, they also offer great opportunities for new ideas, political support and creative initiatives.
- 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 normative and developmental work.

REGION-WIDE EXPECTED RESULTS

RER 5.1 **Standards developed, capacity built and technical support provided to all Member States and partners for the development and strengthening emergency preparedness plans and programs at all levels.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
5.1.1	Number of countries in which disaster preparedness (including risk communication) plan for the health sector are developed and evaluated.	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 with a health disaster program with full time staff and specific budget.	10	11	15

RER 5.2 **Timely and appropriate support provided to all Member States in providing immediate assistance to populations affected by crisis.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator 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	Number of countries where a response to emergencies is initiated within 24 hours.	10/10	TBD based on occurrence of emergencies	TBD based on occurrence of emergencies

RER 5.3 **Standards developed, capacity built and technical support provided to Member States for reducing health sector risk in disasters and ensuring the quickest recovery of affected populations.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator 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 formulation processes for consolidated appeals with strategic and operational components for health included.	100%	100%	100%
5.3.3	Proportion of countries in 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 **Coordinated technical support on all technical areas such as communicable disease, mental health, health services, food safety, radio nuclear, in response to most likely public health threats provided to all Member States in preparedness, recovery and risk reduction.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator 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	Number of countries where coordinated technical support is provided as needed by the PASB in emergency responses (universe of countries varies per biennium based on occurrence of emergencies).	10/10	TBD based on occurrence of emergencies	TBD based on occurrence of emergencies

RER 5.5 **Support provided to Member States for strengthening national preparedness and for establishing alert and response mechanisms for food-safety and environmental health emergencies.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
5.5.1	Number of countries where expert networks are in place for responding to food-safety and environmental public health emergencies.	8	10	15
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	Proportion of food-safety and environmental health emergencies benefiting from inter-sectoral collaboration and assistance.	25%	65%	100%
5.5.5	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 other 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	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
5.6.1	Number of affected countries in which the United Nations Health Cluster is operational.	40	40	40
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 following a disaster include health information.	100%	100%	100%

STRATEGIC OBJECTIVE 6

To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex

Scope

The work under this Strategic Objective (SO) focuses on integrated, comprehensive, multi-sectoral and multidisciplinary health promotion processes and approaches across all relevant PAHO/WHO and country programs, and the prevention and reduction of the major risk factors listed.

INDICATORS AND TARGETS

- Proportion of Member States reporting a 10% reduction in the prevalence rate of tobacco use. Target: 50% of Member States reporting a 10% reduction by 2013.
- Number of Member States that have stabilized or reduced the level of harmful use of alcohol. Target: A 10% increase in number of Member States reporting a stabilized or reduced level by 2013.
- Proportion of Member States with a high burden of adult obesity that have stabilized the prevalence. Target: 10% of Member States with a high burden that have stabilized the prevalence of adult obesity by 2013.
- Proportion of Member States that are collecting population based information on major risk factors: low fruit and vegetable intake, physical inactivity, tobacco use, and alcohol abuse; and anthropometry. Target: 75% of Member States collecting information by 2013.
- Increase in the proportion of youth who can correctly describe at least three ways of preventing non-desirable outcomes of unprotected sex. Target: 30% increase among youth aged 15-24 in the Americas by 2013.

ISSUES AND CHALLENGES

The 2002 World Health Report "Reducing Risks, Promoting Healthy Life"[8] reports that in 26 countries of the Americas the attributable mortality (number of deaths per 1,000) by risk factor and sex rank is the following:

[8] WHO 2002 World Health Report assigned countries to the following categories, according to their mortality : A-very low child, very low adult; B-low child, low adult; C-low child, high adult; D- high child, high adult; E- high child; very high adult. In the Americas only Canada, Cuba and the United states are in category A, 26 countries are in category B; Bolivia, Ecuador, Guatemala, Haiti, Nicaragua, and Peru are in category D. There are no countries in categories C or E.

(a) Males

- Alcohol (207)
- High Blood Pressure (170)
- Tobacco (163)
- Overweight (117)
- Cholesterol (88)
- Low fruit and vegetable intake (81)

(b) Females

- High Blood Pressure (162)
- Overweight (144)
- Cholesterol (79)
- Low fruit and vegetable intake (58)
- Tobacco (58)
- Physical inactivity (55)

In the poorest countries of the Region, those in group D of WHR categories, the attributable mortality by risk factors for men have a very similar ranking: alcohol (22%), high blood pressure (20%) and unsafe sex (17%); and for women high blood pressure (20%), overweight (18%) and unsafe sex (11%). In these countries, underweight contributes to 14,000 deaths among males and 11,000 deaths among females.

The major risk factors addressed in this SO are responsible for more than 60% of the mortality and at least 50% of the morbidity burden worldwide. 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 a 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.

In 2000, alcohol consumption was responsible for 4.8% of all deaths and 9.7% of all Disability Adjusted Life Years (DALYs) 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 it is noteworthy 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. Despite evidence of the substantial burden on heath and society arising from alcohol and other psychoactive substance use, there are limited resources at PAHO and in countries for preventing and treating substance use disorders, even though US$1 invested in prevention and treatment produces at least US$ 7 of savings in health and social costs

A worrisome decrease in physical activity levels is widespread in LAC. Between 30-60% of the population in LAC does not achieve the minimum recommended levels of physical activity. This has been driven by increased urbanization, motorized transportation, urban zoning polices that promote car dependence in suburbs, and lack of infrastructure for pedestrians as well as cyclists.

The "nutrition transition" in the Region 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 five 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 and low education levels. Thus, PAHO-WHO recognizes the need for a comprehensive integrated health promotion approach and effective preventive strategies.

Despite the substantial global burden of poor health associated with the major risk factors, the effort continues to be focused on control of transmission of infectious diseases. The countries of the Americas should emphasize action against related risk factors to non-communicable diseases, which have become the principal cause of morbidity and premature mortality in the Region.

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.

Significant additional investment in financial and human resources is urgently needed at all levels within WHO, Region of the Americas and, Member States to build capacity as well as strengthen national and global interventions.

STRATEGIC APPROACHES

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

The strengthening of institutions and national capacities for surveillance, prevention and reduction of the common risk factors and related health conditions are essential actions for each country. Furthermore, strong leadership and stewardship by Ministries of Health is necessary to ensure the effective participation of all sectors of society. Action at the multi-sectoral level is vital because the main determinants of the major risk factors lie outside the health sector.

Leadership and capacity in health promotion need to be significantly scaled up in line with increased needs and activities across all relevant health programs. There is a need to implement

resolutions at global (WHO 2005), regional (PAHO 2001 and PAHO 2006) and subregional levels (REMSAA and RESSCAD 2002) as country commitments, which incorporate both the Mexico Declaration and the Bangkok Charter, respectively (see health promotion document DC 47.16, 2006).

Comprehensive approaches that use a combination of strategies to address policy issues, surveillance, health promotion and prevention as well as the integrated management of risk factors are recognized and endorsed by Member States through the Regional Strategy and Plan of Action for Integrated Prevention and Control of Chronic noncommunicable Diseases. Comprehensive approaches require changes at individual, household and community levels, and their sustainability can be assured only if they are accompanied by environmental, institutional and policy changes. Implementation of the Global Strategy on Diet, Physical Activity and Health (DPAS) is an example.

In supporting Member States' efforts, the Bureau will significantly enhance its presence in countries and focus on:

- Providing global and regional leadership, coordination, communication, collaboration and advocacy for health promotion to improve health, reduce health inequalities, control major risk factors and contribute to national development objectives.
- Providing evidence-based ethical policies, strategies and technical guidance and support to countries for the development and maintenance of national systems for surveillance, monitoring and evaluation, giving priority to countries with the highest or increasing burdens.
- Encouraging increased investment at all levels and building internal PAHO/WHO capacity, especially in subregional and country offices, in order to respond effectively to organizational and Member States' needs in health promotion and risk-factor prevention and reduction.
- Supporting countries to build multi-sectoral national capacities in order to mainstream gender and equity perspectives and strengthen institutional knowledge and competence in relation to the major risk factors.
- Supporting the establishment of multi-sectoral partnerships and alliances throughout Member States and building international collaboration for the generation and dissemination of research findings.
- Leading effective action to address policy and structural barriers, strengthen household and community capacity and ensure access to education and information in order to promote safe sexual behaviors and manage the consequences of unsafe sexual behaviors and practices.
- Leading effective actions to control alcohol consumption and related harms and providing direct technical cooperation in the development, review and evaluation of alcohol policies which can have the most impact at the population level.
- Providing direct technical cooperation in the implementation of the WHO Framework Convention on Tobacco Control, in collaboration with the permanent secretariat of the Convention, as well as to non-Parties to enable them to strengthen their tobacco control policies and become Parties to the Convention.
- Promote and urge investment in urban planning within an urban sustainable development framework. More specifically, priority should be given to areas that: promote clean air, promote walking and biking, create incentives for Mass Public Transportation systems, defense of public spaces, develop more recreational areas and promote road safety and crime-free streets.

- Facilitate a common understanding of evidence-based practice, and the need to strengthen the evaluation of health promotion effectiveness.
- Providing direct technical cooperation in the implementation of the WHO Global Strategy on Diet, Physical Activity and Health (DPAS) on a regional, subregional and national level in collaboration with multiple actors; such as governments, sports and food industry, and media.
- Provide direct technical cooperation in the implementation of the Regional Strategy and Action plan for integrated prevention and control of chronic noncommunicable diseases (CNCDs).

ASSUMPTIONS AND RISKS

This SO would be achieved under the following assumptions:

- There is additional investment in financial and human resources to build capacity for health promotion and risk factor prevention;
- Effective partnerships and multi-sectoral 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, and recognition that integrated approaches to major risk-factor prevention result in benefits across a range of health outcomes;
- That investment in research, especially to find effective population-based prevention strategies, is increased.

The following risks may adversely affect achievement of the SO:

- Working or interacting with the private sector presents risks associated with the competing interests of industries, including the tobacco, alcohol, sugar and processed food and non-alcoholic drinks industries, and requires that the rules of engagement are followed in all cases. Improvements in public health are of paramount importance.
- Health promotion and risk-factor prevention may be adversely affected by the low priority afforded to this area and hence the scarcity of resources allocated by WHO, Region and countries. Continued advocacy for increased investment is essential in order to minimize this risk.
- 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. Adequate resources for integrated approaches, as well as critical mass of expertise in major areas, must be maintained.

REGION-WIDE EXPECTED RESULTS

RER 6.1 **Facilitate technical cooperation and support to countries to strengthen their health promotion capacities in all the pertinent programs and forge inter-sectoral, interagency, decentralized, and effective interdisciplinary alliances, with the intention to promote healthy public policies and prevent and reduce the presence of principal risk factors.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
6.1.1	Number of countries that have health promotion policies and plans with a budget.	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 enact the PAHO/WHO Urban Health Conceptual framework.	0	2	5
6.1.4	Number of countries that use evidence-based policies for health promotion.	6	10	15
6.1.5	Number of subregions that promote the partnerships among Ministers of Health and Ministers of Education to strengthen Health Promoting Schools networks.	0	1	4
6.1.6	Regional network of healthy municipalities, cities and communities that incorporate the urban health conceptual framework and stimulate healthy public policies.	0	1	1

RER 6.2 **Provide technical cooperation to strengthen the national surveillance systems with an integrated focus on the principal risk factors, preparing, validating, promoting, and strengthening frameworks, instruments and operational procedures for the countries.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
6.2.1	Number of countries supported that have developed a functioning national surveillance mechanism 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 supported that have developed a functioning national surveillance mechanism using school-based student health survey (Global School Health Survey) methodology for regular reports on, major health risk factors in youth.	11	20	34

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
6.2.3	Functional Regional Non-communicable Disease and Risk Factor information database (NCD INFO base).	Inter programmatic working group formed and active	Demo developed and tested	CARMEN network countries all included

RER 6.3 **Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease and death associated with tobacco use, enabling them to strengthen institutions in order to tackle or prevent related public health problems.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
6.3.1	Number of countries that have adopted legislation or its equivalent in relation to smoking bans in health-care and educational facilities consistent with the Framework Convention on Tobacco Control.	4	14	28
6.3.2	Number of countries that have adopted legislation or its equivalent in relation to bans on direct and indirect advertising of tobacco products in national media consistent with the Framework Convention on Tobacco Control.	0	5	10
6.3.3	Number of countries that have adopted legislation or its equivalent in relation to health warnings on tobacco products consistent with the Framework Convention on Tobacco Control.	8	21	28
6.3.4	Number of countries with comparable national data – disaggregated by age and sex – on prevalence of tobacco use.	33/36	35/36	35/36
6.3.5	Regional Surveillance System on Tobacco with comparable prevalence data disaggregated by age and sex.	0	1	1
6.3.6	Number of countries that have established or reinforced a national coordinating mechanism or focal point for tobacco control.	18	20	28

RER 6.4 **Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease or death associated with alcohol, drugs and other psychoactive substance use, enabling them to strengthen institutions in order to combat or prevent related public health problems.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
6.4.1	Number of countries that have developed policies, plans, advocacy and programs for preventing public health problems caused by alcohol, drugs and other psychoactive substance use.	11	13	20
6.4.2	Number of policies, strategies, recommendations, standards and guidelines provided to Member States for the prevention and reduction of public health problems caused by alcohol, drugs and other psychoactive substance use.	3	6	9
6.4.3	Information systems established and maintained for implementation and evaluation of global policies, strategies, recommendations, standards and guidelines to reduce or prevent public health problems caused by alcohol, illicit drugs and other psychoactive substances.	Under development	Info systems in place	Info systems in place

RER 6.5 **Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed and technical support provided to Member States with a high or increasing burden of disease or death associated with unhealthy diets and physical inactivity, enabling them to strengthen institutions in order to combat or prevent related public health problems.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator 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 (with cities above 500,000 inhabitants) that have initiated or established programs on rapid mass transportation systems.	7	12	25
6.5.3	Number of countries (with cities above 500,000 inhabitants) that have initiated or established programs on clean fuels in transport.	3	7	20
6.5.4	Number of countries (with cities above 500,000 inhabitants) that have initiated or established programs on pedestrian-friendly environments, bicycle-friendly cities, and crime control.	7	30	40

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
6.5.5	Number of countries that have initiated policies to phase-out trans-fats, reached agreements with food industry to reduce sugar, salt and fat in processed foods.	4	15	30
6.5.6	Number of countries that have initiated policies to eliminate direct marketing/publicity of food to children under 12 years.	2	7	12
6.5.7	Number of countries that have initiated policies to initiate programs to increase consumption of low fat dairy, fish and fruits and vegetables.	10	20	30

RER 6.6 **Evidence-based and ethical policies, strategies, interventions, recommendations, standards and guidelines developed and technical support provided to Member States to promote safer sex and strengthen institutions in order to tackle and manage the social and individual consequences of unsafe sex.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
6.6.1	Guidelines developed on the determinants and consequences of unsafe sex to identify effective interventions and to develop guidelines accordingly.	Not available	Research implemented on determinants and consequences of unsafe sex in order to develop three evidence based guidelines for promoting safe sexual behaviors.	3 new or adapted guidelines validated and implemented in 10 countries with WHO-PAHO technical support.
6.6.2	Number of countries supported that have initiated or implemented new or improved interventions at individual, family and community levels to promote safe sexual behaviors.	5	10	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 inter-sectoral 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; education, housing, labor trade, and social status among others. In the region, the social determinants of health need to be addressed in relation to the MDGs and require the formulation of policies and programs that are ethically sound, responsive to gender inequalities, effective in meeting the needs of poor people and other vulnerable groups, and consistent with human-rights norms international and regional human rights conventions and standards.

INDICATORS AND TARGETS

- Number of countries with national health indicators disaggregated by sex and age and at least two other determinants (ethnicity, place of residence, and/or socioeconomic status) and available for exploratory research. Target: By 2013, at least 15 countries.
- Number of countries that have developed social and economic indicators on conditions favorable to health, disaggregated by sex, race-ethnicity and place of residence (e.g. education levels, agricultural production, infrastructure, housing and employment conditions, criminal or violent events, community development, and household income). Target: By 2013, 15 countries. 15 countries in LAC have undertaken censuses between 2000 and 2005 that have being validated by CELADE, data desegregation work will take place with these countries.
- Number of countries that have developed policies and Workplans for priority non-health sectors (e.g. agriculture, energy, education, finance, transport) incorporating health targets. Target: By 2013, 10 countries.
- Number of countries that have health-related policies, plans, programs, legislations, and national mechanisms for protection (e.g. national constitutions and health sector strategies) that explicitly address and incorporate gender, ethnic and socioeconomic equity, and human rights in their design and implementation, consistent with international and regional human rights conventions and standards. Target: By 2013, 15 countries

- Number of countries that have undertaken critical interventions to address the needs of the poorest and most vulnerable communities under the Faces, Voices and Places of the MDGs initiative to advance the MDGs within the framework of the social determinants of health. Target: By 2013, 10 countries.

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 social 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 inter-sectoral 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 inequality.

This situation raises challenges for Ministries of Health, which must work in innovative ways to foster inter-sectoral 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 means to promote health gains for vulnerable groups include the integration into health sector policies and programs of equity-enhancing, pro-poor, gender-responsive, multicultural/racial ethically sound approaches. Human rights law as enshrined in international and regional human rights convention and standards offer a unifying conceptual and legal framework for these strategies and standards 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 regarding 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 to be able to support Member States in collecting and acting on relevant data and acting on an inter-sectoral basis; 2) ensuring that all the technical areas at PASB HQs reflect the perspectives of social and economic determinants (including gender and poverty), ethics, and human rights in their programs and normative work.; and 3) to adopt the correct approach for measuring effects. This final challenge is especially great because results in terms of increased health equity and equality with regard to the most vulnerable groups will seldom be rapidly apparent or easily attributed to particular interventions. Distinctive modes of evaluation are required for assessing processes—how policies and interventions are designed, vetted and implemented. One must assess whether the steps taken are known to be effective in bringing about change, rather than measuring health outcomes themselves. The relationship of the health sector as a whole with other parts of government and society is also an important indicator.

STRATEGIC APPROACHES

The structural determinants of health encompass the political, economic and technological context; patterns of social stratification by differentiating factors such as employment status, income, education, age, gender and ethnicity; the legal system; and public policies in areas other than health. Fostering collaboration across sectors is therefore essential.

Achieving this strategic objective will require policy coherence among all ministries based on a whole-government approach that positions health as a common goal across sectors and social constituencies in light of a shared responsibility to ensure the right of everyone to enjoy the highest attainable standard of health consistent with international and regional obligations of PAHO Member States under international human rights law.

National strategies and plans should take into account all forms of social disadvantage and vulnerability that have an impact on health and should involve civil society and relevant stakeholders through, for example, community-based initiatives. Principles, norms, and standards of human rights and ethics should guide the policy-making process to ensure the fairness, responsiveness, accountability and coherence of health-related policies and programs while overcoming social exclusion.

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

The PASB's strategic approaches in LAC are as follows;

- Develop national and sub national data bases disaggregated by gender and ethnicity on the social determinants of health and the human rights that have an impact the quality of life and the well being of citizens.

- Create a social observatory to study and highlight social discrepancies

- Foster social dialogue and consensus building on the determinants of health and the generation of public policies through the Health Social Forum

- Promote the creation strategic inter-sector alliances and the creation of social policies aimed at reducing social, economic and cultural inequities in order to increase social investment and mobilize resource to promote sustainable advances in health from the perspective of local development

- Establish a regional evidence base on social policies with an emphasis on the social determinants of health

ASSUMPTIONS AND RISKS

The principal assumptions underlying this strategic objective are:

- In many settings, Ministries of Health, provided with adequate information and political and technical backing, will be willing and able to take leadership on addressing the broader determinants of health, moving towards a "whole government" approach to health.
- Within PAHO/WHO and country offices-it will be possible to build sustained support for the incorporation of social determinants of health (in relation to the MDGs, gender equality, multi-ethnic concerns and human rights) into the Organization's technical cooperation and policy dialogue with Member States in a manner that is consistent with international human rights instruments and standards.

- In many countries, health program designers and implementers will be willing and able to incorporate equity-enhancing, pro-poor, gender-responsive, multi-ethnic and human rights-based strategies into their programs despite technical and political complications.

The key risks for progress on this strategic objective are identified as follows:

- Lack of effective consensus among partners in countries, including agencies within UN System, other international partners and non-governmental organizations on policies and framework for action;
- There may be insufficient investment by national governments to ensure that treaties, declarations, guidelines, and standards of human rights are effectively implemented;
- Economic, gender, multiethnic and poverty analysis may not be widely available.

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 collaboration with Member States and other partners.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator 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.	2/12	7/12	12/12
7.1.2	Number of countries whose PAHO/WHO Country Cooperation Strategy documents (CCS) include explicit strategies at the national and local level that address the social and economic determinants of health.	0/12	5/12	12/12
7.1.3	PAHO has a Regional Plan of Public Health for action on the determinants of health and social policy.	0	1	1
7.1.4	Number of subregions that are taking action to strengthen integrated approaches to determinants of health and social policies.	0	1	4
7.1.5	Number of countries supported to build capacity to take action on determinants of health and social policies.	0	11	40
7.1.6	Regional model developed to promote community empowerment, inter-sectoral alliances and social policies at the local level taking as a point of departure healthy settings (homes, schools, municipalities).	0	1	1

RER 7.2 **Initiative taken by PAHO/WHO in providing opportunities and means for inter-sectoral 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	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
7.2.1	Number of countries whose public policies target the determinants of health and social policy on an inter-sectoral, interprogrammatic basis.	0/12	7/12	12/12
7.2.2	Number of subregional fora organized for relevant stakeholders on inter-sectoral actions to address determinants of health, social policies and achievement of the Millennium Development Goals.	0	1	3
7.2.3	Number of tools developed and disseminated for assessing the impact of non-health sectors on health and health equity (such as Faces, Voices and Places).	1	1	3
7.2.4	Number of countries that have implemented Faces, Voices and Places in at least one of their poorest municipalities.	8	10	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	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
7.3.1	Number of countries having health data of sufficient disaggregation and quality to assess and track health equity among key population groups.	8	15	36
7.3.2	Number of institutional mechanisms, supported by PAHO, that are installed in countries to develop and/or support the development and monitoring of gender equity in health.	8	10	13
7.3.3	Number of countries with at least one national policy on health equity that incorporates an analysis of disaggregated data.	TBD	TBD	TBD
7.3.4	Number of countries with a national program on health equity that uses disaggregated data.	0	3	6

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

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
7.4.1	Number of countries using: 1) international and regional human rights norms and standards; and 2) 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 guidance documents produced for Member States and other stakeholders on use of ethical analysis to improve health policies.	TBD	TBD	TBD

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

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
7.5.1	Number of publications that contribute to building evidence on the impact of gender and ethnic/racial equity on health and on effective strategies to address it	8	12	16
7.5.2	Number of tools and guidance documents developed for Member States on using gender and/or ethnic/racial analysis in health.	0	1	2
7.5.3	Number of PWR that include expected results, indicators, and specific budgetary resources for the implementation of the Gender Equality Policy and ethnic groups in their biennial Workplans.	4	9	15
7.5.4	Number of entities (technical areas and PWRs) whose biennial Workplan includes gender and ethnic/racial considerations as applicable.	TBD	40/80	80/80
7.5.5	Number of subregions that apply the PAHO Gender Equality Policy in its biennial Workplan.	0	1	4
7.5.6	Number of subregions with an analysis of the health situation of ethnic groups.	0	1	3
7.5.7	Number of methodological, validated and widespread conceptual tools developed for the implementation of the Gender Equality Policy.	10	13	16

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
7.5.8	Number of countries with national plans to specifically improve the health of ethnic/racial groups.	11/21	13/21	19/21
7.5.9	Number of subregions that are working through plans and health programs to improve the health of ethnic/racial groups within the framework of the social determinants of health and the MDGs (Millennium Development Goals).	0/3	1/3	2/3
7.5.10	Number of units in the regional and subregional offices that have incorporated the ethnic/racial perspective in its biennial Workplan.	7	10	19
7.5.11	Percentage of technical documents produced for the Governing Bodies related to the MDGs that include the ethnic/racial perspective.	20%	50%	70%

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 and improved sanitation. Target: according to the Millennium Development Goals, by 2013 96.2% of urban populations and 76.9% of rural populations will have access to improved drinking water sources (2002 baseline estimates 95% and 69% respectively); by 2013 90.1% of urban populations and 48% of rural populations will have access to improved sanitation facilities (2002 baseline estimates 84% and 44% respectively).
- Burden of disease measured by years of life expectancy lost from poisoning due to environmental risks. Target: by 2013, 46% for adults and 60% for children (2002 baseline estimates 68% and 85% respectively).
- Burden of disease from selected occupational risks measured by percentage of hepatitis B infections in health workers due to inappropriate handling of syringes. Target: by 2013, estimated 20% (2002 baseline estimate 40%).
- Proportion of population with access to toxicological information services. Target; by 2013, 60% of countries (2006 baseline estimate 35%).
- Burden of disease from diarrheal diseases with environmental causes among children. Target: by 2013, reduce burden of disease to 84% for diarrheal diseases (2002 baseline estimates 94%).

ISSUES AND CHALLENGES

Environmental and occupational risks contribute to a large portion of morbidity and morality 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 term, have even greater consequences for public health and health costs than is already the case 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 sectors and 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 in treatment of the individual, thus need to be better equipped with skills and methods for monitoring and synthesizing 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 5 million children die each year from environment-related diseases and conditions, such as diarrhea, respiratory illnesses, malaria, and unintentional injuries. Millions more children are debilitated by these diseases or live with chronic conditions linked to their environment, ranging from allergies to mental and physical disabilities. This suffering is not inevitable. 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 consumption of pesticides. Central America, for example, imports 1.5kg 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 in place so that risks can be analyzed and knowledge disseminated about the identification, control, and/or elimination of these risks.

Climate change and other global risks add to the current health burden. Some impacts include an increase in current health hazards, from changed nutrition profiles, water scarcity, to patterns of vector-borne diseases.

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

The consumption of products has changed in the Region and in many cases poses new risks to health. A revision of sanitary surveillance and regulation processes in the Region has been the main tool to respond to human consumers' health.

It has been estimated that every year 5 million occupational accidents occur in Latin America, of which 90,000 are fatal, the equivalent to 300 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, lack access.

Political, legislative, and institutional barriers to improving environmental conditions are numerous and the human resources with adequate specialization on 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.

Through a strategic alliance with the areas of education and labor, a Joint Action plan on Health and Environment was agreed upon by the Ministers of Health and Environment at a June 2005 meeting in Mar del Plata. The Action Plan will develop strategic programs in response to the Millennium Development Goals with three main priorities: Integrated water resource and waste management, sound management of chemicals, and children's environmental health. All ministers expressed the urgent need for PAHO, the Organization of American States and the United Nations Environmental Program to work together on these issues. PAHO will take the lead on Children's Environmental Health as an integrated strategy to achieve the MDGs.

STRATEGIC APPROACHES

- Improving the development, training, and availability of technical human resources.
- Developing and improving methodologies to evaluate and manage risks and preventive services.
- Updating the normative and regulatory processes.
- Establishing information systems to identify, analyze, monitor, and control environmental and occupational risks.
- Promoting the adequate use of technology to improve the sensitivity and specificity of environmental surveillance.
- Developing and strengthening inter-sectoral and interagency networks for the strategic alliance between heath, environment, education and labor.
- Creating a network on children environmental health as a strategy to support countries in the achievement of the MDGs.
- Improving data recording and indicators formulation systems.
- Promoting research projects.
- Implementing technical cooperation with the participation of centers of excellence and networks from several sectors to promote inter-programmatic and inter-institutional integration.

ASSUMPTIONS AND RISKS

The following assumptions underline the achievement of this SO:

- 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 and put 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 makes a major contribution to the achievement of the relevant Millennium Development Goals.
- The climate remains favorable, in the context of United Nations system reform, for WHO/PAHO to show more global leadership in public health and the environment, setting health more explicitly in humanitarian response and goals of environmental sustainability and economic development.

Because hazards to environmental health come primarily from actions in non-health sectors, risk reduction depends on intervention beyond the direct control of the health sector. The health sector, therefore, must influence those other sectors to pay more attention to environmental health and exert enough leverage to effect the desired changes. In that context, the risks that may prevent achievement of this SO include the following:

- 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. This pitfall can be avoided by selecting realistic, achievable aims.
- Information about the best options for sectoral interventions to improve occupational and environmental health is inaccessible. This danger can be overcome through investment by health agencies in analysis and documentation of the most effective and cost-beneficial interventions.
- Global leaders and partners in the arenas of development and/or the environment show weak or transient commitment to improving environmental health. Investments in partnerships, outreach and more strategic global communications on environmental health issues (such as flagship reports on global environmental health and prospects) can overcome this problem.

Health systems continue to respond weakly in reducing the range of occupational and environmental health risks and rooting out their causes. This weakness can be overcome by establishing global and regional forums and focused initiatives in order to give health and the environment a high priority and to push for action through partnerships; by outreach and communications targeted to health-sector interests and needs; and by strengthening the capability of health systems to integrate health and environmental issues into traditional health sector agendas.

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) developed and updated; technical cooperation provided for the implementation of international environmental agreements and for monitoring the Millennium Development Goals (MDGs).**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator 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 PAHO/WHO guidelines on air quality.	7	8	12
8.1.5	Number of countries implementing PAHO/WHO guidelines on drinking water.	13	16	20
8.1.6	Number of countries implementing WHO guidelines on recreational waters.	0	5	10

RER 8.2 **Technical cooperation and guidance provided to countries 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, elderly).**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
8.2.1	Establishment of regional strategies for primary prevention of environmental health hazards under the health determinants and health promotion framework implemented in specific settings (workplaces, homes, schools, human settlements and health-care settings).	2	4	6
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

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
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 studies evaluating the costs and benefits of primary prevention interventions in specific settings that have been conducted and 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
8.2.6	Regional Initiatives on Children's Environmental Health promoted and disseminated.	2	3	4

RER 8.3 **Technical cooperation provided to countries for strengthening occupational and environmental health policy- making, planning of preventive interventions, service delivery and surveillance.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
8.3.1	Number of countries receiving technical and logistical support for developing and implementing policies for strengthening the delivery of occupational, basic sanitation, and environmental health services and surveillance.	10	15	20
8.3.2	Number of national organizations or universities implementing PAHO/WHO-led initiatives to reduce occupational risks (e.g. among workers in the informal economy, to implement the WHO global strategy for occupational health for all, or to eliminate silicosis).	2	4	6

RER 8.4 **Guidance, tools, and initiatives supporting the health sector to influence policies in priority sectors (e.g. energy, transport, agriculture); assessing health impacts; costs and benefits of policy alternatives in those sectors; and harnessing non-health sector investments to improve health, environment and safety.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
8.4.1	Number of initiatives implemented in countries to develop and implement health-sector policies at the regional and national levels.	0	2	4
8.4.2	Production and promotion in target countries of sector-specific guidance and tools for assessment of health impacts and economic costs and benefits and promotion of health and safety.	Use of tools and guidance produced	Use of tools and guidance produced in 2 sectors	Use of tools and guidance produced for 4 sectors
8.4.3	Establishment of networks and partnerships to drive change in specific sectors or settings, including an outreach and communications strategy.	Use of networks established by WHO/PAHO	Use of networks established by WHO/PAHO in 2 countries	Use of networks established for 4 sectors, with com-munications strategy implemented
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 economic sectors.	1	2	4

RER 8.5 **Enhanced health sector leadership for 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	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
8.5.1	Number of citations by mass media, of outreach and communications strategy on occupational and environmental issues implemented regionally and in partnership.	TBD	TBD (5% increase in citations)	TBD (10% increase over baseline in citations)

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
8.5.2	Number of regular high-level fora on health and environment for global and regional policy-makers and stakeholders.	0	1	2
8.5.3	Number of quinqennial reports available on trends, scenarios, and key development issues and their health impacts.	1	1	2