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 of life, ensuring universal access to coverage with effective interventions for newborn, child, young people (adolescents 10-19 and youth 15-24), reproductive age, and older adults, using a life-course approach and addressing equity gaps. Strengthening policies, health systems and primary health care is fundamental to achieving this SO, which contributes to the achievement of Millennium Development Goals 4 (reducing infant mortality), and 5 (improving maternal health).

INDICATORS AND TARGETS

- Proportion of births attended by skilled birth attendants in Latin America and the Caribbean (LAC). Baseline: 85% in 2006. Target: 90% by 2013.

- Reduction in the number of countries in the Region reporting a maternal mortality ratio above 100 per 100,000 live births. Baseline: 10 countries in 2006. Target: 6 countries by 2013.

- Number of countries in LAC with an under-5 mortality rate of 32.1 per 1,000 live births or less. Baseline: 21 countries in 2006. Target: 26 countries by 2013.

- Number of countries in LAC with a contraceptive prevalence rate above 60% (as a proxy measure for access to sexual and reproductive health services). Baseline: 13 countries in 2006. Target: 21 countries by 2013.

- Number of countries in LAC with an adolescent fertility rate (defined as the annual number of live births per 1,000 females aged 15-19) of 75.6/1,000 or less. Baseline: 8 countries in 2006. Target: 13 countries by 2013.

- Number of countries in the Region where 50% or more of the older adult population (60 years or older in LAC, 65 or older in the US and Canada) receive services adapted to their health needs. Baseline: 9 countries in 2006. Target: 15 countries by 2013.

ISSUES AND CHALLENGES

While there have been improvements in infant and child mortality rates in the Region, the situation is worsening for some conditions (e.g. the incidence of sexually transmitted infections and high fertility among adolescents in some countries), and stagnating for others (e.g., maternal and neonatal mortality). Most countries are not on track to meet the internationally agreed goals and targets for family and child health.

Child and Infant Mortality - The region of the Americas has made great strides in reducing child (under five years old) and infant mortality. During 1990-2005 the child mortality rate in children under five years old decreased by 44%. Despite this, large disparities continue among and within countries; e.g. in many Latin American and Caribbean countries the high newborn death rate has not improved to the degree expected. Several countries have experienced a marked reduction in infant mortality, but without an equivalent reduction in neonatal mortality. For example, Bolivia's infant mortality rate fell by 29% between 1989 and 1998, while the decrease in neonatal mortality was only 7% in the same period.

Each year nearly 12,000,000 babies are born in LAC. Of these, 400,000 die annually before the age of 5 years; within this group 270,000 die before 1 year, and of these 180,000 die during the first month of life. Neonatal mortality, defined as death in the first 28 days of life, is estimated at 15 per 1,000 live births. Newborn mortality accounts for 60% of infant deaths and 36% of under-5 mortality; the majority of these deaths are avoidable. Contributing factors to high neonatal mortality include: low visibility of newborn deaths and of newborn health in national priority-setting; inequalities in access to skilled birth attendants and primary health care; and poor maternal health, which adds significantly to the risk of neonatal death. In addition, interventions that directly target babies to further improve outcomes are either deficient or absent.

The leading causes of neonatal death in LAC include infections (32%), asphyxia (29%), prematurity (24%), congenital malformations (10%), and others (7%). While some are direct causes, others, as in most cases of prematurity/low birth weight, may constitute predisposing factors. PAHO estimates that approximately 8.7% of newborns suffer from low birth weight (less than 2,500 grams at birth). Low birth weight is closely associated with increased neonatal morbidity, and it is estimated that between 40% and 80% of infants who die during the neonatal period suffer from this condition. Other indirect causes include socioeconomic factors such as poverty, poor education (especially maternal education) and lack of empowerment, poor access and some traditional practices that are harmful. The rural and urban poor, other marginalized communities, indigenous and afro-descendent populations experience disproportionately high neonatal mortality.

Evidence suggests that the first week of life is the most vulnerable in terms of neonatal mortality risk, and that appropriate care in the first 24 hours of life is an important determinant for the future of the child. In countries where the infant mortality rate is not extremely high, about two-thirds of infant deaths take place in the first month of life.[9]

Collective actions are lacking, not only through the health systems and services, but also at the household level, to promote interventions that can be effectively delivered at low cost. Examples of these interventions include the promotion of breastfeeding, oral rehydration therapy, and the consumption of micronutrients, as well as education on complementary feeding. One major challenge is to reorient health services towards a model of care that encourages health promotion and disease prevention, with a family and community approach, and the development of managerial capacity at local levels.

Many national and international agencies (UNICEF, UNF, CIDA, and the Spanish bilateral agency AECI), prominent NGOs, and civil society are working in Latin America in the child health arena. This presents a challenge in terms of coordination to avoid duplication and build on synergies.

[9] Neonatal Health in the Context of Maternal, Newborn and Child Health for the Attainment of the Millennium Development Goals of the United Nations Millennium Declaration. 47th Directing Council of the Pan American Health Organization. 58th Session of the Regional Committee. *Washington, D.C., USA, 25-29 September 2006.* OPS/FCH/CA/07.08.

Young people's Health

Most of the national adolescent health plans and programs do not use an integrated approach to address the main health issues (adolescent pregnancy, STI/HIV, drug abuse, and violence) that affect a rapidly expanding youth population in the Region. Most of these programs remain as pilot interventions and there is a great need to scale them up using lessons learned from successful experiences. This situation is complicated by the fact that youth health, and in particular adolescent sexual and reproductive health, is not a priority in the political agenda of most countries in the Region. In many countries policy and legislation promoting access to adolescent and youth health services are not enforced and national programs remain fragmented. There is a deficiency of trained human resources to provide quality care to this population, adequate information systems and monitoring and evaluation.

While mortality and morbidity is generally low during adolescence, according to the Global Burden of Disease 2004 update[10], total deaths in the Region for 15-29 year olds was 287,920. The main causes of mortality for this age group are injuries (63%), non communicable diseases (22%), and communicable, maternal, perinatal and nutritional conditions (15%). These causes affect young men and women differently. For example, the distribution of deaths from injuries, including violence and homicides (43% of total deaths in the group) was 92% among males and 8% among females; deaths from road traffic accidents (26%), 79% among males and 21% among females; deaths from suicide (11%), 78% among males and 22% among females; and deaths from all other injuries (20%) AIDS makes up for 47% of all deaths by infectious and parasitic diseases for young people (15-29) in the Americas, 67% for young men and 33% for young women. In 2006, 20% of diagnosed and reported HIV cases in the Region corresponded to young people 15-24 years old.[11]

In LAC, females under 20 years of age are estimated to account for 18% of births, 30% to 40% of which are unwanted pregnancies. It is estimated that there is a 40% unmet need for contraception. Adolescent mothers (aged 10 to 19) are two times more likely than older mothers to die from pregnancy-related causes, and account for 30% to 50% of maternal mortality in the countries with higher maternal mortality ratios. The risk of dying is 4 times higher among adolescents under 15 years old. Fifty percent of unsafe abortions occur among women 20-29. More than five countries in the Region have fertility rates in adolescents aged 15-19 of more than 100 per 1,000; 12 countries have fertility rates greater than the regional average (76 per 1,000).

Violence disproportionately impacts youth with an estimated 101.7 per 100,000 men and 60.4 per 100,000 women age 15 to 29 in middle and low income countries in LAC dying from intentional injuries. The dominant conceptual framework used to respond to youth violence centers on punitive and not preventive approaches, and focuses on youth as perpetrators of violence, without addressing the underlying causes.[12]

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[10] The global burden of disease: 2004 update (2008 publication of 2004 updated dataset): Available at: http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html.

[11] Pan American Health Organization, Country Reports HIV/AIDS database, FCH/AI Project.

[12] "Políticas públicas y marcos legales para la prevención de la violencia relacionada con adolescentes y jóvenes. Estado del arte en América Latina 1995-2004." (Spanish only) Pan American Health Organization, and German Technical Cooperation (GTZ).

Alcohol and drug abuse, and tobacco use are increasing among adolescents in the Region, and are highly associated with early pregnancy, sexually transmitted infections, HIV, and violence.

The disproportionate impact of these issues on low income, poorly educated, indigenous, migrant, and ethnic minority young people needs to be specifically addressed.[13]

Several actors are working in the field of adolescent health, such as UNICEF, UNFPA, UNIFEM, USAID, many major NGOs (PLAN, Pathfinder, Red Cross, Alan Guttmacher) and bilateral organizations (CIDA, SIDA, GTZ, NORAD, CIDE), posing a challenge in the coordination of efforts and the harmonization of programs.

Maternal Mortality - Some countries have made strides in reducing maternal mortality (MM), while in others the situation has worsened. Great disparities remain among countries (MM of 630 per 100,000 live births in Haiti vs. 17.3 in Chile) and within countries (in Argentina, MM of 7 per 100,000 live births in the Autonomous City of Buenos Aires versus 150 in La Rioja province). The population that has access to skilled birth attendants is particularly low in the poorest countries and in rural settings. In some countries a large proportion of women (69% of women in Bolivia and 89% of women in Haiti) do not have access to skilled birth care. In Central America, skilled attendance at birth is available to no more than 55% of pregnant women, and in Haiti such skilled care is only available to 26% of urban women. The majority of MM results from preventable causes such as hemorrhage (21%), pregnancy-induced hypertension (26%), sepsis (8%), obstructed and prolonged labor (12%), and abortion-related complications (13%). In some countries, essential obstetric and neonatal services are either not in place or of poor quality, or under-utilized because of cultural or physical barriers and lack of skilled personnel, especially in remote areas.

The coverage of prenatal control attention (normally referred to as one contact) is 89.1%; delivery coverage by trained staff is 88.2%. Five countries with figures above 90% of prenatal control or delivery attention by qualified staff have a MM ratio above 91.1 per 100,000 live births, which shows quality problems in maternal and perinatal health services.

Health and well-being among older persons - 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 years old. This fact underscores that active and healthy aging will be one of the biggest challenges that Latin American and Caribbean societies face during the 21st century. Expansion of primary health care coverage to the older adult population and greater participation of this group in their health care are important issues to be addressed by health systems.

Overall Challenges - Political will to make a difference in this Strategic Objective is declining in some countries of the Region, 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. Communities need to be empowered to improve local decision-making and action. In addition, some issues are politically and culturally sensitive and complicate the consensus needed to improve public health. Furthermore, efforts to improve the quality of health care and to increase coverage rates are insufficient. Competing health priorities among organizations, vertical program approaches, and lack of coordination among governments and

[13] For the extensive situation analysis, please refer to the Regional Strategy for Improving Adolescent and Youth Health. http://www.paho.org/english/gov/cd/CD48-08-e.pdf.

development partners result in program fragmentation, missed opportunities, and an inefficient use of limited financial resources. Better coordination among various partners and harmonization with UN agencies is an important factor for the achievement of this strategic objective. Additionally, interventions must be implemented within a primary health care setting, in a culturally sensitive context.

In the Region, technical knowledge and program experience indicate that effective and affordable interventions exist for most of the problems covered by this Strategic Objective. Consensus exists on the need to reach universal access using key interventions. The PAHO Directing Council set out agreed actions in Resolution CE124.R4 (IMCI) and Resolution CD47/12 (Neonatal health in the context of maternal, newborn and child health) to achieve universal access. 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 among program areas, while providing effective support to ensure active and healthy aging.

In summary, the crucial challenge of this strategic objective is to ensure the conditions that allow all pregnant women, infants, children, adolescents and adults to develop their human potential, and to achieve their maximum physical and cognitive development and the highest quality of life.

STRATEGIC APPROACHES

- Implementing the *Integrated Management of Childhood Illness* (IMCI) strategy, formulated to focus on the care of children under five, not only in terms of their overall health status but also on the diseases that may occasionally affect them; scaling-up efforts to expand the coverage of clinical, household, and community interventions to the most vulnerable populations, including the indigenous groups, and linking community actions with health services and systems.

- Promoting integral child development, emphasizing psychosocial development of the child, affective development, early stimulation, physical activity and healthy feeding practices, prevention of child abuse, mental health disorders, among others, through the Community IMCI Strategy.

- Implementing the Regional Strategy for Improving Adolescent and Youth Health (CD48/8) to ensure that young people receive timely and effective health promotion, prevention and care through integrated health systems. The Strategy will support Member States to establish national adolescent and youth health objectives that integrate interventions of the main health issues[14] affecting young people using promotion and prevention strategies.

- Implementing the *Integrated Management of Adolescent and Adult Illness* (IMAI) strategy, this addresses the overall health of the patient, focusing on the management of chronic disease and prevention, rather than just the treatment of acute illness.

- Implementing the *Regional Strategy for Maternal Mortality and Morbidity Reduction* to reduce the burden of disease, unnecessary disability, and death that are associated with pregnancy, puerperium and childbirth; and expanding the coverage of clinical, household, and community interventions to the most vulnerable populations, including indigenous groups, and linking community actions with health services and systems.

[14] See Issues and Challenges section of this document

- Implementing the *Regional Initiative for Maternal Mortality Reduction* to strengthen the regional technical and national capability and political environment in favor of the reduction of maternal mortality.

- Implementing the *WHO Global Strategy for Reproductive Health* directed to governments, normative agencies of international organizations, professional associations, nongovernmental organizations, and other institutions.

- Provide technical cooperation to Member States to develop integrated and comprehensive health systems and services to address the needs of mothers, newborns, children, and young people, and older adults with an emphasis on primary health care, gender inequality, and growing health inequities that fuel the high levels of mortality and morbidity.

- Integrating and harmonizing programs and interventions throughout a continuum of care that runs through the life course and spans the home, the community, and different levels of the health system and services.

- Promoting community-based interventions with the active participation of the community to increase the demand for services and to support appropriate care in the home across the life course.

- Improving surveillance, and monitoring and evaluation systems; these will include audits of all the deaths of children under the age of 1, medical certification of deaths, appropriate registries by services and geographical units and the availability of statistics and epidemiology services to facilitate better decision making.

- Promoting partnerships with bilateral and UN agencies to harmonize actions that scale–up interventions and maximize the use of resources.

- Developing policies and programs that expand human resources in gerontology and geriatrics education for family as well as community caregivers in order to promote active and healthy aging and to prevent early deterioration (both physical and mental).

ASSUMPTIONS AND RISKS

Assumptions:

- Overall strengthening of health systems and services 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.
- 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.
- Political will for these activities will be reflected in additional technical and financial resources for making progress towards the Millennium Development Goals.

Risks:

- Threats posed by the possibility of a flu pandemic in the Region, diverting financial and human resources.

- Political instability, economic crisis, and natural disasters may lead to the reversal of direction in some indicators.
- Lack of political commitment by donor agencies and governments to properly address family and community health needs.
- A healthcare workforce weakened by strikes, migration, frequent changes in political appointments, and high turnover of trained personnel.

REGION-WIDE EXPECTED RESULTS

RER 4.1 Member States supported through technical cooperation to develop comprehensive policies, plans, and strategies that promote universal access to a continuum of care throughout the life course; to integrate service delivery; and to strengthen coordination with civil society, the private sector and partnerships with UN and Inter-American system agencies and others (e.g. NGOs).

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
4.1.1	Number of countries that have an integrated policy on universal access to effective interventions for improving maternal, newborn and child health	0	2	3	4
4.1.2	Number of countries that have a policy of universal access to sexual and reproductive health	7	11	13	16
4.1.3	Number of countries that have a policy on the promotion of active and healthy aging	11	15	17	18

RER 4.2 Member States supported through technical cooperation to strengthen national/local capacity to produce new evidence and interventions; and to improve the surveillance and information systems in sexual and reproductive heath, and in maternal, neonatal, child, adolescent and older adult health.

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
4.2.1	Number of countries that implement information systems and surveillance systems to track sexual and reproductive health, maternal, neonatal and adolescent health, with information disaggregated by age, sex and ethnicity	10	15	17	20
4.2.2	Number of PASB systematic reviews on best practices, operational research, and standards of care	0	5	7	10

RER 4.3 Member States supported through technical cooperation to reinforce actions that ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods.

Indicator	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
4.3.1	Number of countries adapting and utilizing PAHO/WHO-endorsed technical and managerial norms and guidelines for increasing coverage with skilled care at birth, including prenatal, post-natal, and newborn care	10	12	19	23

RER 4.4 Member States supported through technical cooperation to improve neonatal health.

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
4.4.1	Number of countries with at least 50% of selected districts implementing interventions for neonatal survival and health	4	6	12	18
4.4.2	Number of guidelines and tools developed and disseminated to improve neonatal care and survival	4	6	6	9

RER 4.5 Member States supported through technical cooperation to improve child health and development, taking into consideration international agreements.

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
4.5.1	Number of countries that have expanded coverage of the integrated management of childhood illness to more than 75% of target districts	8	10	11	13
4.5.2	Number of countries implementing the WHO/PAHO Key Family Practices approach at the community level to strengthen primary health care	9	10	11	13

RER 4.6 Member States supported through technical cooperation for the implementation of policies and strategies on adolescent health and development.

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
4.6.1	Number of countries with a functioning adolescent and youth health and development program[15]	10	12	16	17
4.6.2	Number of countries implementing a comprehensive package of norms and standards to provide adequate health services for young people's health and development (e.g. Integrated Management of Adolescent Needs [IMAN])	3	10	14	15

RER 4.7 Member States supported through technical cooperation to implement Reproductive Health Strategies to improve prenatal, perinatal, postpartum, and neonatal care, and provide high quality reproductive health services.

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
4.7.1	Number of countries that have adopted strategies to provide comprehensive reproductive health care	5	8	11	15
4.7.2	Number of countries that have reviewed public health policies related to sexual and reproductive health	7	10	11	12

RER 4.8 Member States supported through technical cooperation to increase advocacy for aging as a public health issue, and to maintain maximum functional capacity throughout the life course.

Indicator	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
4.8.1	Number of countries that have implemented multisectorial community-based programs with a focus on strengthening primary health-care capacity to address healthy aging	5	7	10	12

[15] Functioning National Adolescent and Youth Health Programs, defined as one that is at least 2 years old, has a medium or long-term plan of action that has been implemented in the last year has a person in charge, has an assigned budget.

STRATEGIC OBJECTIVE 5

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

SCOPE

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

INDICATORS AND TARGETS

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

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

ISSUES AND CHALLENGES

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

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

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

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

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

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

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

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

STRATEGIC APPROACHES

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

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

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

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

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

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

ASSUMPTIONS AND RISKS

Assumption:

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

Risks:

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

REGION-WIDE EXPECTED RESULTS

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
5.1.1	Number of countries that have developed and evaluated disaster preparedness plans for the health sector	23	30	34	35
5.1.2	Number of countries implementing programs for reducing the vulnerability of health infrastructures	9	20	24	30
5.1.3	Number of countries that report having a health disaster program with full time staff and specific budget	10	12	14	15

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
5.2.1	Number of Regional training programs on emergency response operations	4	6	7	7
5.2.2	Percentage of emergencies where a response to emergencies is initiated within 24 hours of the request	100%	100%	100%	100%

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
5.3.1	Percentage of post-conflict and post-disaster needs assessments conducted that contain a gender-responsive health component	100%	100%	100%	100%
5.3.2	Percentage of humanitarian action plans for complex emergencies and consolidated appeals with strategic and operational components for health included	100%	100%	100%	100%

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
5.4.1	Percentage 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%	100%
5.4.2	Percentage of emergencies where coordinated technical cooperation (PASB task force) is provided, when needed	100%	100%	100%	100%

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
5.5.1	Number of countries with capacity to respond to food safety emergencies	15	19	24	30
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	26	28
5.5.3	Number of countries with focal points for the International Food Safety Authorities Network and for environmental health emergencies	28	29	30	32

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
5.6.1	Percentage of emergencies where the United Nations Health Cluster, as defined by the UN Humanitarian Reform, is operational, if called upon	100%	100%	100%	100%
5.6.2	Number of emergency-related Regional interagency mechanisms and working groups where PAHO/WHO is actively involved	4	8	9	10
5.6.3	Percentage of disasters in which UN and country-originated reports include health information	100%	100%	100%	100%

RE 5.7 Acute, rehabilitation, and recovery operations implemented in a timely and effective manner, when needed.

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
5.7.1	Percentage of emergencies for which PAHO/WHO mobilizes national and international resources for operations, when needed	100%	100%	100%	100%
5.7.2	Percentage of recovery operations for which health interventions are implemented, when needed	100%	100%	100%	100%

STRATEGIC OBJECTIVE 6

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

SCOPE

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

INDICATORS AND TARGETS

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

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

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

ISSUES AND CHALLENGES

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

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

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

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

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

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

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

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

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

STRATEGIC APPROACHES

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

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

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

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

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

ASSUMPTIONS AND RISKS

Assumptions:

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

Risks:

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

REGION-WIDE EXPECTED RESULTS

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
6.1.1	Number of countries that have health promotion policies and plans with resources allocated	11	15	18	20
6.1.2	Number of countries with Healthy Schools Networks (or equivalent)	7	10	13	15
6.1.3	Number of countries that adopt the PAHO/WHO urban health conceptual framework	0	2	4	5

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
6.2.1	Number of countries that have developed a functioning national surveillance system using Pan Am STEPs (Pan American Stepwise approach to chronic disease risk factor surveillance) methodology for regular reports on major health risk factors in adults	6	10	15	20
6.2.2	Number of countries that have developed a functioning national surveillance system using school-based student health survey (Global School Health Survey) and are producing regular reports on major health risk factors in youth	11	15	23	30
6.2.3	Number of countries that have implemented the standardized indicators for chronic diseases and risk factors in the PAHO Regional Core Health Data and Country Profile Initiative	3	8	10	12

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
6.3.1	Number of countries that have adopted a smoke-free legislation which includes all public places and all workplaces (public and private), consistent with the WHO Framework Convention on Tobacco Control	1	3	5	7
6.3.2	Number of countries that have adopted bans on advertisement, promotion and sponsorship of tobacco products consistent with the WHO Framework Convention on Tobacco Control	0	2	3	4
6.3.3	Number of countries with regulations on packaging and labeling of tobacco products consistent with the WHO Framework Convention on Tobacco Control	8	10	17	23
6.3.4	Number of countries that have updated at least one of the components of the Global Tobacco Surveillance System (GTSS)	9	20	28	35

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
6.4.1	Number of countries that have implemented policies, plans, or programs for preventing public health problems caused by alcohol, drugs and other psychoactive substance use	11	13	16	20

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
6.5.1	Number of countries that have implemented national policies to promote healthy diet and physical activity according to PAHO/WHO guidelines	8	10	15	20
6.5.2	Number of countries that have created pedestrian and bike-friendly environments, physical activity promotion programs and crime control initiatives, in at least one of their major cities	7	10	13	18

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
6.6.1	Number of countries that have implemented new or improved interventions at individual, family and community levels to promote safer sexual behaviors	7	9	10	11

STRATEGIC OBJECTIVE 7

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

SCOPE

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

INDICATORS AND TARGETS

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

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

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

ISSUES AND CHALLENGES

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

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

conventions and standards[16], offers a unifying conceptual and legal framework for these strategies, as well as measures by which to evaluate success and clarify the accountability and responsibilities of the different stakeholders involved.

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

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

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

STRATEGIC APPROACHES

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

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

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

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

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

ASSUMPTIONS AND RISKS

Assumptions:

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

Risks:

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

REGION-WIDE EXPECTED RESULTS

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
7.1.1	Number of countries that have implemented a national strategy for addressing key policy recommendations of the Commission on the Social Determinants of Health	0	4	10	12

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
7.2.1	Number of published country experiences on tackling social determinants for health equity	6	8	10	12
7.2.2	Number of countries implementing at least one systematized intervention for the most vulnerable communities, as defined by the PASB's MDGs Cross-Organizational Team	0	0	6	12
7.2.3	Number of countries which have implemented the "Faces, Voices and Places" initiative	6	12	13	15

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
7.3.1	Number of countries that have published reports incorporating disaggregated health data at sub national level to analyze and evaluate health equity	2	4	6	9

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
7.4.1	Number of countries using: 1) international and regional human rights norms and standards; and 2) human rights tools and technical guidance documents produced by PAHO/WHO to review and/or formulate national laws, policies and/or plans that advance health and reduce gaps in health equity and discrimination	9	10	11	18

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
7.5.1	Number of countries that are implementing plans for advancing gender in the health sector	0	6	12	18
7.5.2	Number of tools and guidance documents developed or updated by PASB to include gender equality in health analysis, programming, monitoring, or research	8	15	22	28
7.5.3	Number of PASB entities that include gender perspectives in their situation analysis, plans, or monitoring mechanisms	3	10	15	20

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
7.6.1	Number of countries that implement policies, plans or programs to improve the health of indigenous peoples or other ethnic/racial groups	3/21	9/21	12/21	19/21
7.6.2	Number of countries that collect data on the health of indigenous peoples or other ethnic/racial groups within their health information systems	3/21	9/21	13/21	15/21

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, occupational, biological, chemical, and physical hazards - and promoting human security and environmental justice to mitigate the effects of global and local threats.

INDICATORS AND TARGETS

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

ISSUES AND CHALLENGES

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

Rapid changes in lifestyle, increasing urbanization, production and energy consumption, climate change and pressures on ecosystems could, in both the short and long terms, have

consequences for public health and health costs. These consequences will be even worse if the health sector fails to act on currently existing occupational and environmental hazards to health. For effective health sector action, risks have to be reduced in the settings where they occur: homes, schools, workplaces and cities; and in sectors such as energy, transport, industry, agriculture, as well as water, sanitation and solid waste.

Of particular concern in the Region are the needs of agricultural workers, workers in small-scale enterprises, workers in the informal sector, and migrant workers. These workers are at high risk and often have no access to occupational health services.

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

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

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

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

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

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

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

The use of consumer products has changed in the Region and in many cases poses new risks to health. Revision of sanitary surveillance and regulatory processes in the Region has been the main tool to respond to consumers' health hazards.
It has been estimated that every year 5 million occupational accidents occur in Latin America, of which 90,000 are fatal, equivalent to approximately 250 deaths per day.

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

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

STRATEGIC APPROACHES

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

ASSUMPTIONS AND RISKS

Assumptions:

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

Risks:

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

REGION-WIDE EXPECTED RESULTS

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
8.1.1	Number of new or updated risk assessments or environmental burden of disease (EBD) assessments conducted per year	2	3	4	7
8.1.2	Number of international environmental agreements whose implementation is supported by PASB	5	5	5	6
8.1.3	Number of countries implementing WHO norms, standards or guidelines on occupational or environmental health	13	18	21	24
8.1.4	Number of countries implementing WHO guidelines on drinking water towards MDG 7	6	8	11	14

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
8.2.1	Number of countries implementing primary prevention interventions for reducing environmental risks to health in workplaces, homes or urban settings	4	7	8	10

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
8.3.1	Number of countries receiving technical and logistical support for developing and implementing policies for strengthening the delivery of occupational and environmental health services and surveillance	10	15	17	20
8.3.2	Number of national organizations or collaborating or reference centers implementing PAHO/WHO-led initiatives at country level to reduce occupational risks	2	4	5	6

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
8.4.1	Number of regional, subregional and national initiatives implemented in other sectors that take health into account, using PASB technical and logistical support	2	3	3	4
8.4.2	Number of PAHO/WHO guidelines and tools produced inter-sectorally for global environmental health protection	0	2	3	4

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

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
8.5.1	Number of regular high-level fora on health and environment for regional policymakers and stakeholders supported by PASB	1	2	3	4
8.5.2	Number of current PASB five-year reports on environmental health available, including key health drivers and trends, and their implications	1	1	1	2

RER 8.6 Member States supported through technical cooperation to develop evidence-based policies, strategies and recommendations for identifying, preventing and tackling public health problems resulting from climate change.

Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
8.6.1	Number of studies or reports on the public health effects of climate change published or copublished by PAHO	N/A	0	1	2
8.6.2	Number of countries that have implemented plans to enable the health sector to respond to the health effects of climate change	N/A	0	3	5