PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

51st DIRECTING COUNCIL
63rd SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 26-30 September 2011

STRATEGY AND PLAN OF ACTION ON URBAN HEALTH

Introduction

1.   The health consequences of evolving changes in urban life present enormous challenges for the Region of the Americas. The purpose of this document is to offer guidance on ways for Member States to address urban health issues, particularly those related to health determinants, health promotion, and primary health care. Based on established policies and the agreements reached during the 50th Directing Council, this document first summarizes the information included in the background document for the Council containing the situation analysis. It then outlines a strategy and plan of action to guide the development of multisectoral activities to effectively address the key urban health challenges in the Region of the Americas. Finally, it discusses the implications for action by the Directing Council.

Background

2.   Urbanization can have many benefits as well as adverse consequences, for human health and well-being. "Many of the problems of urban poverty are rooted in a complexity of resource and capacity constraints, inadequate government policies at both the central and local levels, and a lack of planning for urban growth and management. Given the high growth projections for most cities in developing countries, the challenges of urban poverty and more broadly of city management will only worsen in many places if not addressed more aggressively"(*1*). Unplanned, unsustainable urban growth puts pressure on basic services, making it difficult for governments to meet the needs of a diverse population with different behaviors and dynamics. Additionally, planning for Gross Domestic Product (GDP) growth instead of for people's well-being has resulted in favoring cars over people, greater development over the protection of natural resources, and the wasteful use of energy. Unplanned urban growth is accompanied by a number of risks, such as those related to environmental, social, and epidemiological factors and

disasters (*2*) as well as conditions that affect the safety of the population. The intersectoral action required to confront these risks and their associated determinants has been addressed in three consultative conferences held in 2010 on Health in All Policies in Adelaide, Chile, and Helsinki. Several resolutions, consultations, and documents on urban health, health promotion, and health determinants are pertinent to this Plan.

3. This Strategy and Plan of Action on Urban Health responds to a number of international and Governing Body mandates:

- The 1992 United Nations Conference on Environment and Development, popularly known as "the Earth Summit"; which issued the report *Protecting and Promoting Human Health Commitments*, whose Chapter 6: Agenda 21 discusses the challenge posed by urban health (*3*).
- Resolutions CD43.R11 (2001) of the 43rd Directing Council of PAHO, on Health Promotion in the Americas, and CD47.R20 (2006), on Health Promotion: Achievements and Aspirations Contained in the Ottawa and Bangkok Charters, both identify the need to work with all sectors of government and civil society to improve health conditions and promote equity.
- Resolution CD47.R1 (2006), Disability: Prevention and Rehabilitation in the Context of the Right to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health and Other Related Rights addresses the rights of persons with disabilities, including equal access to health care, education, housing, and employment.
- Resolution CD40.R6 (1997), Health of Indigenous Peoples, in the context of considering economic, geographic, and cultural barriers and monitoring the inequities experienced by indigenous populations, in accordance with Articles 17.2, 21.1, 23, 24.2, and 29.3 the UN Declaration on the Rights of Indigenous People (2008) (*4*).
- Resolution WHA62.14 (2009), which considers the Report of the WHO Commission on Social Determinants of Health (2008), highlights the need to address inequities deriving from social determinants, including urbanization and calls for national policies and methods to address them (*5*).
- Documents CD47.18 (2006), Regional Strategy and Plan of Action on Nutrition in Health and Development 2006-2015, and CD47/17, Rev 1, Regional Strategy and Plan of Action on an Integrated Approach to the Prevention and Control of Chronic Diseases, including Diet, Physical Activity, and Health, both consider the urban planning sector to be a key partner in addressing noncommunicable diseases and other health issues.
- Resolution CD48.R11 (2008), Preventing Violence and Injuries and Promoting Safety: A Call for Action in the Region, requested that urban health initiatives be strengthened to help prevent injuries in the Region.

- Resolution WHA57.10 (2004), Road Safety and Health, recognized Resolution WHA27.59 (1974) and considered the *World Report on Road Traffic Injury Prevention* of 2004, calling for intersectoral collaboration to integrate traffic injury prevention mechanisms into public health programs.
- Resolution WHA62.12 (2009) on primary health care (PHC), notes that the WHO *World Health Report 2008* identifies urbanization, along with globalization and the aging of the population, as the challenge for adapting PHC and calls for the adoption of appropriate local health care delivery models that include health promotion and disease prevention (*6*).
- Resolution CD50.R16 (2010), Health, Human Security, and Well-being, in the understanding that human security is affected inequity, environmental factors and the threat to groups in situation of vulnerability.

4.   Ministers of health participating in the 50th Directing Council (2010) (*7*) requested that the Pan American Sanitary Bureau (PASB) prepare a preliminary regional strategy and plan of action on urban health as an outcome of their participation in the urban health roundtable (*8*). They also requested that a resolution be drafted so that after discussion of the preliminary version, the plan can be presented to the delegations for their approval during the 51st Directing Council. This document serves to respond to both of those requests.

5.   The roundtable discussion during the 50th Directing Council was followed by the regional forums on urban health and health promotion (October 2010), which yielded a number of the recommendations (*9*) included in this Strategy and Plan of Action. The Global Forum on Urbanization and Health was subsequently held in Kobe, Japan (WHO November 2010), during which WHO-UN HABITAT launched the joint report *Hidden Cities* (2010) revealing how poverty and poor health are linked to urban living (*10*), and a Call to Action on urban health was issued (*11*). Elements from both of these documents have also been included in this Strategy and Plan of Action.

Situation Analysis[1]

6.   The world is becoming urbanized at an unprecedented rate posing an enormous challenge to health (*12*): in 1900, 13% of the world's population (220 million people) resided in cities; in 1950, the urban population represented 29.1% (732 million) of the population (*2*). In 2008, the United Nations reported that for the first time in history,

---

[1] PAHO prepared two background documents in 2010, from which most of the information in this section has been extracted: Roundtable on Urbanism and Healthy Living. Background paper for the debate. CD50/19, Add. I (Eng.) 15 September 2010 (*12*); and *Urban Health Challenges in the Americas*. Reference document prepared for the Second Regional Urban Health Forum, New York, NY, 25-26 October 2010 (*9*).

more than half the human population is living in urban areas, with that proportion expected to rise to 70% by 2050 (*13*). This trend is of particular concern in the Americas; the Region's urban population has grown by 187% since 1970. The Americas are home to six of the world's largest megacities (São Paulo, Mexico City, New York City, Los Angeles, Buenos Aires, and Rio de Janeiro). The Region of the Americas is the most urbanized in the developing world; 79.4% of the Region's roughly 556 million people live in urban areas, with that proportion expected to rise to 85%. Rapid unplanned urbanization amplifies the impact of climate change (*14*). Urban children are of special concern, and socioeconomically, less privileged children are frequently found playing or even living and working on the streets (*10*). One of the main causes of concern is the fact that 30.8% of the urban population lives in irregular settlements spawned by rapid, unplanned urban growth.

7.   The consequences of population growth and unplanned, uncontrolled urbanization has widened the social gap within cities and produced major poverty belts and slums due to a lack of employment opportunities, housing, security, and environmental protection (*15*). Two-thirds of the people living below the poverty line in Latin America and the Caribbean reside in urban and peri-urban communities. While the relative incidence of urban poverty in the Region fell from 41% in 1990 to 29% in 2007, the number of urban poor rose from 122 million to 127 million during the same time period (*12*). Cities in the Americas have attracted large numbers of indigenous people seeking economic and social opportunities. Mexico's Federal District is currently considered the main indigenous metropolitan area in the Americas (*16*). Cities like Chicago, Guatemala, Lima, Los Angeles, and many others have similar challenges addressing the cultural barriers that these populations face when attempting to gain access to services. Moreover, rapid urbanization has resulted in overcrowding, leading to the creation of slums and unsafe settlements and a lack of basic health and sanitation services, due to barriers to providing adequate infrastructure and essential services (*17*). In the Americas, by the year 2003 it was estimated that 5.1% of the population in the more developed countries was still living in slums, while the figure was 31.9% in the less developed Latin America and Caribbean countries (*18*).

8.   Rapid, unplanned, and unsustainable urbanization also has a major impact on health. Conditions in urban settings can exacerbate the prevalence of a variety of vector-borne infectious diseases (*19*) and even neglected diseases (*20*). In the Americas, the infant mortality ratio of the 20% poorest to the 20% richest urban poor is 6:1 (*10*). Chronic noncommunicable diseases account for 74% of disability-adjusted life years (DALYs) lost, and obesity in urban centers is sharply on the rise, with an unprecedented increase in childhood obesity that is particularly alarming. Unhealthy diets and physical inactivity contribute to the rapid increase in childhood obesity. The recent WHO Global Status Report on NCDs 2010 (*21*) reiterates that unplanned urbanization is linked to higher risk of exposure to air pollutants, lack of basic services, more sedentary lifestyles,

unhealthy diets, and lower levels of physical activity leading to cardiovascular disease, diabetes and other noncommunicable diseases, which affect the urban poor and the elderly to a greater extent. Information systems are not equipped to clearly differentiate socioeconomic gradients, vulnerable and indigenous populations, or often, even gender differences within cities. Data systems currently lack sufficient disaggregation of data about the impact of urbanization on men and women, ethnic groups, and migrants. In the future, such disaggregation should be available in the Region. The available information, however, supports the strategies proposed below.

9.   There are three major contributors to the burden of disease in the Region: violence, alcohol abuse, and tobacco use. Violence in the Americas is concentrated in urban areas and is often clustered in the poorest, most marginalized areas of cities. The WHO *Multi-country Study on Women's Health and Domestic Violence against Women,* which included two countries in the Region, found high rates of violence in a major city in each country: 28% of women in São Paulo**,** Brazil, and 51% of women in Lima, Perú, reported having experienced physical or sexual violence by an intimate partner (*12*). Alcohol consumption is responsible for a heavy disease burden, surpassing global estimates; 5.4% of all deaths and 10% of all DALYs in 2002 were attributed to alcohol consumption, with most of the burden in Central and South America. Globally, men also have far higher rates of total disease burden (DALYs) attributable to alcohol than women—7.4% for men vs. 1.4% for women. Men outnumber women four to one in weekly episodes of heavy drinking—most probably the reason for their higher death and disability rates. Men also have much lower rates of abstinence compared to women. In the Americas, women are twice as likely to be lifetime abstainers as men. Residence in urban areas has been associated with higher consumption rates (*22*). Lower socioeconomic status and educational levels result in a higher risk of alcohol-related death, disease, and injury—a social determinant that is more significant for men than for women (*23*).

10.   In the Americas, as well as the rest of the world, tobacco use is the leading cause of preventable death, responsible for some 1 million deaths in the Region every year (*24*). Of all the chronic diseases, changes in tobacco policy could save more lives more rapidly. Urbanization is a key social determinant for smoking. Tobacco use is associated with low socioeconomic status, whether measured by national income, household or personal income, occupational status, or educational level (*25*). Data from the *World Health Survey 2003* indicate that smoking is most strongly correlated with household income or wealth. As opposed to other Regions of the world where males smoke an average of five times more than females, in the Americas smoking is two times more prevalent among males. In developing countries, smoking rates for men have peaked and have begun to decline, while they continue to rise for females (*26*). In addition, the degree of urbanization has been associated with tobacco use, being higher in more urbanized areas of developing nations, due to the greater exposure of urban populations to aggressive

marketing and weak regulatory environments. For example, the ratio between urban and rural tobacco use is 1.8:1 in Mexico (*27*), although rates are starting to decline in most large metropolitan areas (*28*).

11.   Traffic injuries are responsible for 142,000 deaths and an estimated 5 million injuries annually in the Americas. Age-adjusted mortality rates from traffic accidents vary widely from country to country, ranging from 4.3 to 21.8 per 100,000 (*12*). In the Americas, while high-income countries exhibit a 20% descending mortality rate, the trend in Latin America has been on the upswing, reaching 40% (*29*); the low-middle income countries in the Region have a 57% higher risk of mortality, with the risk being higher for individuals in the 5-14 age range (250%), as well as for children aged 0-4 (124%). In the developed countries of the Region, automobile crash fatality rates are higher in the lower-level socioeconomic groups (*30*).

12.   Because of air pollution, every year in the Americas there may be as many as 93,000 deaths from cardiopulmonary disease, 13,000 deaths from lung cancer, and 58,000 years of life lost due to acute respiratory infections in children under 4 years of age, plus 560,000 DALYs lost (*12*). Studies in the Region have shown that exposure to air pollution is systematically unequally distributed, as demonstrated with children's exposure to exhaust fumes from traffic (*31*) and human exposure to ozone (*32*). For cardiovascular mortality, there is a higher risk ratio of 6-40%, depending on the exposure to exhaust fumes from traffic) (*33*). The serious public health impact of air pollution can be seen not only in terms of disease and death, but lower productivity, missed education, and other missed opportunities for human development as well.

13.   In addition to health impacts, social inequalities are exacerbated in cities. While the Region has been making progress in equity, the evidence tends to average out the large inequalities within countries and cities. For example, in 2001, compared to national levels, the city of Buenos Aires, Argentina, was much better off, with lower rates of substandard housing (18.5% vs. 6.4%), unsafe water (21.3% vs. 1.9%) and people who had not completed primary education (8.6% vs. 4.8%). However, large disparities in health are also found within the city itself: infant mortality ranges from 6.5/1,000 inhabitants in one urban zone to 16/1,000 inhabitants in another part of Greater Buenos Aires (*12*). Disparities also exist among countries: Honduras, Nicaragua, and Paraguay have higher percentages of urban poor: 55% to 63%, a situation far removed from that of Chile, where the figure is 18.5%.

14.   The global megatrend towards urbanization is further complicated by problematic social, family, community, intercultural, and gender relations, all of which inequitably affect the health of the population, with particular impact on indigenous and Afro-descendent groups. So far, this dramatic change is not fully addressed in health policies,

structures, and services; and it is creating a major disconnect between the population's needs and the health sector's response to them.

15.   Urbanization offers significant opportunities for reducing poverty and gender inequality, promoting sustainable development, and advancing the protection of migrants and indigenous populations, while enriching the city culture by the same diversity of populations and improving the quality of life and well-being of the population. The final document from the Follow-up to the Outcome of the Millennium Summit 2010 (*34*), assessing Goal 7 "Ensuring Environmental Sustainability" to address poverty, calls for prioritizing national urban planning strategies with the participation of all stakeholders, promoting equal access for slums dwellers to public services, including health, education, energy, water and sanitation and adequate shelter. This Strategy and Plan of Action builds on examples of programs and policies that have been implemented in selected cities, addressing such topics as air and noise pollution, environmental change, healthy behaviors, healthy settings, spaces for recreation and physical activity, human security, inclusive urbanization, urban infrastructure, and violence. It proposes different options for tackling urban problems and adjusting programs currently under way to consider the social gradient and urban dimension as well as identification of the consequences of not doing anything, highlighting the benefits of urban living as a potential support for health and sustainability. It gives consideration to revising programs and improving the policies currently in place (*35*) to handle the heterogeneity of the urban population appropriately. It makes reference to the Millennium Development Goals; Healthy Municipalities, Cities, and Communities; Health Promoting Schools; PAHO's Cross-cutting Priorities; and other regional and national initiatives.

Proposal

16.   The purpose of this Strategy and Plan of Action on Urban Health is to support the ministries of health in order to: (a) strengthen their stewardship role in promoting health in light of the effects of urbanization, (b) adjust health services to meet the specific needs of urban populations, and (c) strengthen the institutional capacity to implement an urban health approach, and (d) advocate for a common goal and shared responsibility.

17.   To address the specific needs of the urban population, PAHO's strategy on Stewardship, Health Services, Development of Institutional Capacities and Advocacy for Urban Health (SHEDA) is needed to strengthen ministries of health, using four basic entry points to achieve an integrated, synchronous, regional approach, by making progress in the following areas:

(a)   *Assuming Stewardship for Promoting Health*: provide health personnel, city authorities, and key partners from other sectors with the guidance and tools they

need to buttress their health- and wellness-promoting activities across the entire social gradient:

- Revitalize the engagement of local authorities and the insights of cities in analyzing and responding to local health conditions using intersectoral and participatory approaches.
- Support the solidarity, partnership, knowledge exchange and identification of leadership and opportunities of cities through the strengthening of Healthy Municipalities / Cities Networks in the Region.
- Update and adjust the current guidelines and instruments for Mayors on Healthy Municipalities, Participatory Planning and Budgeting, and develop new ones to support their intersectoral capabilities.
- Address health and health equity in the policies of other sectors (Health and Health Equity in All Policies).
- Offer guidance on the health priorities to be addressed and guidelines for public health informed urban planning and action to be taken by other sectors.

(b) *Adjusting Health Services*: tailoring them to the needs of urban population, as appropriate, to respond to the dynamic and specific needs of diverse urban populations:

- Implement the primary health care strategy in an innovative manner to improve their accessibility to the different urban populations.
- Go where the people are, considering the specific needs of working mobile families that frequently have few transportation options.
- Address the issue of recently migrating families and indigenous populations and the barriers and difficulties they encounter in accessing adequate health services.
- Consider the size of the population working in the formal and informal sectors of the economy.
- Consider the differential hazards faced in daily living, including drugs, violence, sexual behaviors, among other.
- Include social protection for the entire population, especially the most vulnerable in terms of gender, socioeconomic status, immigration status, and race/ethnicity.

(c) *Capacity building and Policy Development*: design policies and interventions, inform evidence-based decisions, and improve human and financial capacities.

(d) *Advocating for a Common Goal and Shared Responsibility*: in equitable urban population health and well-being, with local and national governments, academia, the private sector, NGOs, and civil society.

The Plan of Action on Urban Health[2]

Principles

18.   To respond to the specific health needs of the urban population in the Region of the Americas, this Plan of Action rests on five guiding principles: equity, sustainability, sustainable development, human security, and good governance.

Expected Results

19.   Countries will have:

- An adjusted health system that addresses their urban population's health needs, taking mobility, gender, ethnicity, cultural diversity, and equity into account.
- Adapted their programs to address their social gradient.
- Adopted a coherent approach to promoting health that includes all aspects of government within their cities.
- Made significant improvements in the ability of individuals, families and communities to improve and maintain their health and well-being.

General Objective

20.   The general objective of the Plan of Action is to strengthen the organizational capacity and stewardship role of the ministries of health in advocating for sustainable urban growth that puts human beings and communities at the center of planning objectives. It seeks to effectively tackle health inequities and to address the needs and capitalize on the assets of the entire spectrum of urban populations through policies, programs and services for families and communities living and working in urban settings. This requires public health authorities to coordinate their work with non-health sectors, professionals, and institutions directly linked to the planning and governance of urban development matters.

Specific Objectives

21.   This is a 10-year Plan (2012-2021) that considers five specific objectives and subsequent activities that will help countries to improve the health of their urban

---

[2] At the current time, there is only partial information for fully defining the base lines and targets for some indicators. At the conclusion of the first year of the plan's execution, a review will be conducted to complete the information, and at the same time, this plan will be aligned with the Strategic Objectives and Indicators of the Organization's Strategic Plan 2013-2017.

populations and become accountable for the outcomes of related national and city policies and programs; and the Secretariat to adjust its programs and support countries in these initiatives.

***Specific Objective 1*:** Develop urban health policies.

Indicator

- Number of countries with national development plans and policies at the national and subnational levels, as appropriate, that introduce health and health equity into urban development. (Baseline: 6.[3] Target: 18.[4])

Activities

1.1   Prioritize the integration of health into city, metropolitan, and national policies, encouraging every country in the Region and, in the case of countries with federal systems of government, of states or provinces, to have an explicit urban health policy, strategy, and plan that includes the development and maintenance of healthy settings, human security, including safe places for recreation and physical activity, and the territorial management of social determinants.

1.2   Engage and partner with other non-health government sectors and industry, introducing health and health equity into all urban policies, incorporating organizational, legal, and financial mechanisms that will provide coherence across multiple urban health policies and plans, including concrete policies in the areas of sustainable urban growth, balanced land use mix, greater street connectivity and mass transit, the protection of natural resources (agriculture, land, and water), sustainable energy use (with emphasis on recycling mechanisms), the creation of healthy conditions in specific industrial and tourist areas, and the effective assessment and management of inequities, cultural barriers, and health gradients.

1.3   Promote the inclusion of health impact assessments and health equity impact assessments into national, subnational, and local public and private policies, plans, and programs that influence urban development.

---

[3] Baseline data on this and the remaining indicators is supported by the available information identified from 11 countries.

[4] 10 year targets are developed on the basis of the information available.

Specific Objective 2: Adjust urban health services to promote health and improve coverage.

Indicator

- Number of countries with a National Health Plan, and subnational health plan, as appropriate, integrating an urban health equity framework, with consideration of vulnerable groups. (Baseline: 6. Target: 25.)

Activities

2.1 Include within the National Health Plan and, in the case of countries with federal systems of government, of states or provinces, the special consideration required to address the health needs in cities.

2.2 Improve the structure of health services provided to urban populations, promoting their health, giving priority to prevention, and enhancing their effective coverage and social protection according to the social gradient, especially population in vulnerable situations such as slum-dwellers, indigenous populations, and recent migrants. Special consideration should be given to continuing protection for migrants residing outside their home area.

2.3 Adapt public health programs to urban settings, developing and using guidelines that help them explicitly consider the environmental, social, and behavioral risks, cultural diversity, and protective factors of urban populations.

2.4 Introduce health-promoting instruments to develop personal skills and foster community action that strengthens healthy assets, and build protective factors for human security among individuals, families, and communities in the urban health context.

Specific Objective 3: Construct health-promoting normative frameworks and participatory governance strategies.

Indicator

- Number of countries that apply PAHO's public health guidelines for urban health planning. (Baseline: 3. Target: 18.)

Activities

3.1 Establish a national process to disseminate and apply in cities, public health guidelines and criteria that ensure the institutional and legal foundation for urban and housing planning based on public health criteria, equity, and informed community participation.

3.2   Engage and build community organization and empowerment in the assessment and planning of urban development, especially for slum-dwellers, indigenous populations, and recent migrants.

3.3   Establish explicit organizational settings for the ongoing inclusion and accountability of intersectoral and social actors.

Specific Objective 4: Expand national and regional networks for healthy urban development.

Indicator

*   Number of countries with national healthy municipalities network applying PAHO's Healthy Municipalities Toolkit in communities with more than 100,000 inhabitants. (Baseline: 5. Target: 24.)

Activities

4.1   Buttress and stress the urban health component in national and regional networks and build upon and through existing regional networks such as the Network of the Americas for Healthy Municipalities, Cities and Communities; Health Promoting Schools; Healthy Housing; Faces, Voices, and Places; and global networks such as Safe Communities.

4.2   Integrate the urban health dimension into sustainable development and climate change initiatives.

4.3   Identify and involve regional players in urbanization, pooling the interests and capacities of other agencies and public health and urban planning professionals.

Specific Objective 5: Strengthen knowledge, capacity, and awareness to respond to emerging urban health challenges.

Indicators

*   Number of countries with surveillance systems that include indicators for urban health. (Baseline: 4. Target: 15.)
*   Number of countries that apply guidelines on assessment and action tools for health impact and/or health equity impact assessments in national or city policies, programs, or projects. (Baseline: 3. Target: 15.)

Activities

5.1   Develop guidelines and indicators for surveillance systems, including urban health determinants and determinants of the differential social distribution of health indicators, including the disaggregation of data by gender, migration conditions, and indigenous populations.

5.2   Establish a regional mechanism, such as an observatory and regional forums, that systematically mines urban health data, experiences, health service innovations, and best knowledge, policies, and practices, promoting city/metropolis-to-city/metropolis collaboration and interchange within the Region and in synergy with the efforts by the WHO Centre for Health Development, with special emphasis on improving the documentation on disparities and inequities, slums, indigenous populations, and recent migrants, and working through the modification of their health determinants.

5.3   Establish effective mechanisms for transferring information to bring rigorous, updated knowledge into the design of urban health policies and interventions.

5.4   Build closer ties with academicians and universities, fostering action by collaborating centers, promoting the funding of pertinent research, as identified from observatories and practice related to the impact of urbanization on health and the social gradient.

5.5   Build capacity for urban health action, including the development of human and financial resources for the effective development and negotiation of integrated urban health policies and interventions.

5.6   Apply evidence-based advocacy and social marketing approaches to target specific audiences for the needed changes to improve urban health.

22.   This document is intended to cement PAHO's role in anticipating emerging urban health issues and ways of addressing them through multisectoral and multilevel action at the regional, national, and local levels.

Monitoring, Assessment, and Evaluation

23.   Derived from the proposed specific objectives, monitoring the Plan and reporting on its progress will refer to changes over time, with the baseline information used to benchmark their progress. It is expected that these elements will serve as a stimulus for countries to begin collecting data where there currently is none and that countries will report with whatever data they have available at the time. Indicators are included with each specific objective that will serve as the basis for this monitoring, assessment and evaluation process.

24.   This Plan of Action contributes to the achievements of Strategic Objectives (SO) 3,[5] 6,[6] 7,[7] and 8[8] of the PAHO Strategic Plan.[9] The specific Region-wide Expected Results to which this Plan of Action contributes are detailed in Annex C. The monitoring and assessment of this Plan will be aligned with the Organization's results-based management framework as well as its performance, monitoring and assessment processes. In this regard progress reports will be developed based on information available at the end of a biennium.

25.   With a view to determine strengths and weaknesses of the overall implementation, causal factors of successes and failures, and future actions, both a midterm and final evaluation will be conducted.

Action by the Directing Council

26.   The Directing Council is requested to examine the Strategy and Plan of Action on Urban Health and consider the possibility of approving the proposed resolution included in Annex A.

References

1. Baker JL. Urban poverty: a global view [Internet]. New York. New York: The World Bank Group; 2008 [cited 2010 Dec 3]. Available from: http://siteresources.worldbank.org/INTURBANDEVELOPMENT/Resources/336387-1169585750379/UP-5.pdf.

2. WHO Commission on Social Determinants of Health, Knowledge Network on Urban Settings. Our cities, our health, our future: acting on social determinants for health equity in urban settings [Internet]. Kobe, Japan: WHO; 2008 (Report to the WHO Commission on Social Determinants of Health from the Knowledge Network on Urban Settings) [cited 2010 Dec. 3]. Available from: http://www.who.int/social_determinants/resources/knus_final_report_052008.pdf.

---

[5] SO 3: To prevent and reduce disease, disability and premature death from chronic non-communicable conditions, mental disorders, violence and injuries.

[6] SO 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.

[7] SO 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.

[8] SO 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.

[9] For more information please consult the PAHO Strategic Plan.

3. United Nations. Protecting and promoting human health commitments [Internet]. (Chapter 6: Agenda 21 and UN Commission on Sustainable Development). Geneva, Switzerland: UN; 1992 [cited 2010 Dec 3]. Available from: http://www.earthsummit2002.org/es/national-resources/health.pdf.

4. United Nations. United Nations Declaration on the Rights of Indigenous Peoples Sixty-first Session of the United Nations General Assembly; 2007 Sep-Oct; New York, NY: UN; 2007; (Resolution A/61/295). [cited 2010 Dec. 3]. Available from: http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf

5. World Health Organization. Reducing health inequities through action on the social determinants of health [Internet]. 62nd World Health Assembly of WHO; 2009 May 18-27; Geneva, Switzerland. Geneva: WHO; 2009 (Document WHA 62.14) [cited 2010 December 3]. Available from: http://apps.who.int/gb/ebwha/pdf_files/A62/A62_R14-en.pdf.

6. World Health Organization. Primary health care, including health system strengthening [Internet]. 62nd World Health Assembly of OMS; 2009 May 18-27; Geneva, Switzerland. Geneva, CH: WHO; 2009 (Documento WHA 62.12) [cited 2010 December 3]. Available from: http://www.wpro.who.int/NR/rdonlyres/9F0B63F4-DF5C-4A57-9B34-C6C9DD25A127/0/A62_R12en.pdf.

7. Pan American Health Organization. Roundtable on urbanism and healthy living. [Internet]. 50th Directing Council of PAHO, 62nd Session of the WHO Regional Committee for the Americas; 2010 Sep 27-Oct. 1; Washington (DC), US. Washington (DC): PAHO; 2010 (Document CD50/19) [cited 2010 December 3]. Available from: http://new.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=8346&Itemid=.

8. Pan American Health Organization. Roundtable on urbanism and healthy living: final report [Internet]. 50th Directing Council of PAHO, 62nd Session of the WHO Regional Committee for the Americas; 2010 Sep 27-Oct. 1; Washington (DC), US. Washington (DC): PAHO; 2010 (Document CD50/19, Add. II) [cited 2010 Dec. 3]. Available from: http://new.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=9030&Itemid=.

9. Pan American Health Organization. Urban health challenges in the Americas: Reference Document prepared for the Second Regional Urban Health Forum. 2010 Oct 25-26; New York. Washington (DC): PAHO; 2010.

10. World Health Organiztion, the WHO Kobe Center for Health Development, and United Nations Human Settlelments Programme (UN-Habitat). Hidden cities: unmasking and overcoming health inequalities in urban settings [Internet]. Kobe, Japan. Geneva, Switzerland: WHO; 2010 [cited 2010 Dec 3]. Available from: http://www.hiddencities.org/report.html.

11. World Health Organiztion, the WHO Kobe Center for Health Development, and United Nations Human Settlelments Programme (UN-Habitat). Kobe call to action [Internet]. Kobe, Japan. Geneva, Switzerland: WHO; 2010. [cited 2010 Dec 3]. Available from: http://www.who.or.jp/index_files/Kobe%20Call%20to%20Action%20FINAL_4p.pdf.

12. Pan American Health Organization. Roundtable on urbanism and healthy living: Background paper for the debate [Internet]. 50th Directing Council of PAHO, 62nd Session of the WHO Regional Committee for the Americas; 2010 Sep 27-Oct. 1; Washington (DC), US. Washington (DC): PAHO; 2010 (Document CD50/19, Add. I) [cited 2010 December 3]. Available from: http://new.paho.org/hq/index.php?gid=8674&option=com_docman&task=doc_download.

13. United Nations Human Settlements Program (UN-Habitat), Regional Office for Latin America and the Caribbean (UN-Habitat, ROLAC). Estado de las ciudades de América Latina y el Caribe [Internet]. Rio de Janeiro, Brazil: UN-Habitat, ROLAC; 2010 [cited 2010 Dec 3]. Available from: http://www.regionalcentrelac-undp.org/images/stories/DESCENTRALIZACION/herramientas/estadociudades.pdf.

14. Friel S, Bowen K, Campbell-Lendrum D, Frumkin H, McMichael A.J, Rasanathan K. Climate change, noncommunicable diseases, and development: the relationships and common policy opportunities. Annu Rev Public Health 2011 Apr 21;32:133–47. [cited 2010 Dec 3]. Available from: http://www.ncbi.nlm.nih.gov/pubmed/21091194

15. Economic Commission for Latin America and the Caribbean/International Labour Organization Regional Office for Latin America and the Caribbean (ECLAC/ILO). Crisis in the labour markets and countercyclical responses [Internet]. Santiago, Chile: *ECLAC/ILO Bulletin The employment situation in Latin America and the Caribbean*; 2009 Sep; No. 2. [cited 2010 Dec 3]. Available from: http://www.eclac.org/publicaciones/xml/1/37301/2009-639-Bulletin_2_ECLAC-ILO-WEB.pdf.

16. Albertani C. Los pueblos indígenas en la ciudad de México. Una Aproximación [Internet]. Ciudad de México, MX: Universidad Autónoma Metropolitana

Xochimilco (UAMX); 1999 (Política y Cultura No. 012) [cited 2010 Dec 3]. Available from: http://redalyc.uaemex.mx/pdf/267/26701211.pdf.

17. Global Research Network on Urban Health Equity. Improving urban health equity through action on the social and environmental determinants of health: final report of the GRNUHE [Internet]. London, UK: GRNUHE; 2010 [cited 2010 Dec 3]. Available from: http://www.ucl.ac.uk/gheg/GRNUHE/GRNUHEPublication/grnuhefinal.

18. United Nations Human Settlements Program (UN-Habitat). The challenge of slums: global report on human settlements 2003 [Internet]. Nairobi, Kenya: UN-Habitat. London: Earthscan Publications Ltd.; 2003 [cited 2010 Dec 3].Available from: http://www.unhabitat.org/pmss/listItemDetails.aspx?publicationID=1156.

19. U.S. Centers for Disease Control and Prevention (CDC). Dengue [Internet]. Atlanta (GA), US: CDC; 2010 [cited 2010 Dec 7]. Available from: http://www.cdc.gov/Dengue/.

20. Holveck JC, Ehrenberg JP, Ault SK, Rojas R, Vasquez J, Cerqueira MT, et al. Prevention, control, and elimination of neglected diseases in the Americas: pathways to integrated, inter-programmatic, inter-sectoral action for health and development [Internet]. *BMC Public Health*; 2007 Jan;7:6. [cited 2010 Dec 3]. Available from: http://www.biomedcentral.com/content/pdf/1471-2458-7-6.pdf.

21. World Health Organization. Global status report on noncommunicable diseases 2010. Advance Copy. WHO, 2011 Geneva Switzerland

22. Nayga R, Capps O. Analysis of alcohol consumption in the United States: probability and level of intake. Journal of Food Distribution Research [Internet]. Sep 1994, Vol. 25, issue 2:17-23 [cited 2010 Dec 3]. Available from: http://econpapers.repec.org/article/agsjlofdr/27601.htm.

23. World Health Organization. Global status report on alcohol and health, 2011 [Internet]. Geneva, Switzerland: WHO; 2011 [cited 2011 Mar 3]. Available from: http://www.who.int/substance_abuse/publications/global_alcohol_report/msbgsruprofiles.pdf.

24. World Health Orgnaization. The world health report 2002: reducing risks, promoting healthy life [Internet]. Geneva, Switzerland: WHO; 2002 [cited 2010 Dec 3]. Available from: http://www.who.int/whr/2002/en/.

25. World Health Organization. Blas E, Sivasankara Kurup A, eds. Equity, social determinants and public health programmes [Internet]. Geneva, Switzerland: WHO; 2010 [cited 2010 Dec 3]. Available from: http://whqlibdoc.who.int/publications/2010/9789241563970_eng.pdf.

26. Jonathan M. Samet and Soon-Young Yoon (eds.). Gender, women, and the tobacco epidemic [Internet]. Geneva, Switzerland: World Health Organization; 2010 [cited 2010 Dec 3]. Available from: http://www.who.int/tobacco/publications/gender/women_tob_epidemic/en/index.html.

27. Instituto Nacional de Salud Pública (INSP). Encuesta nacional de adicciones 2008 [Internet]. Secretaría de Salud, Secretariado Técnico del Consejo Nacional contra las Adicciones. Mexico: 2008 [cited 2010 Nov 5]. Available from: http://www.insp.mx/encuesta-nacional-de-adicciones-2008.html.

28. Kopstein A. Tobacco Use in America: Findings from the 1999 National Household Survey on Drug Abuse (Analytic Series: A-15, DHHS Publication No. SMA (02-3622). Rockville (MD), US: Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies; 2001 [cited 2010 Dec 3]. Available from: http://www.oas.samhsa.gov/nhsda/tobacco/tobacco.pdf.

29. Nantulya VM and Reich MR. Equity dimensions of read traffic injuries in low- and middle-income countries. *Inj Control & Safety Promotion* 2003 Mar-Jun; 10(1-2):13-20.

30. Factor R, Yair G, Mahalel D. Who by accident? The social morphology of car accidents. *Risk Analysis* Sep. 2010;30(9):1411-1423.

31. Gunier RB, Hertz A, Von Behren J, Reynolds P. Traffic density in California: socioeconomic and ethnic differences among potentially exposed children. *J Expo Anal Environ Epidemiology* 2003 May;13(3):240-246.

32. Korc ME. A Socioeconomic Assessment of Human Exposure to ozone in the South Coast Air Basin of California. *J Air Waste Manag Assoc.* 1996 Jun;46(6):547-557.

33. Finkelstein MM, Jerrett M, Sears MR. Environmental inequality and circulatory disease mortality gradients. *J Epidemiol Community Health* 2005 Jun;59(6):481-487.

34. United Nations General Assembly Keeping the promise: united to achieve the Millennium Development Goals. Follow-up to the outcome of the Millennium Summit. A/65/L.1.

35. United Nations. World urbanization prospects: the 2009 revision. UN Department of Economic and Social Affairs, Population Division, (Population Estimates and Projections Section, document. ESA/WP/215). New York: United Nations; 2010 [cited 2010 Dec 3]. Available from:
http://esa.un.org/unpd/wup/Documents/WUP2009_Highlights_Final.pdf.

CD51/5 (Eng.)
Annex A
ORIGINAL: ENGLISH

PROPOSED RESOLUTION

STRATEGY AND PLAN OF ACTION ON URBAN HEALTH

THE 51st DIRECTING COUNCIL,

Having reviewed the *Strategy and Plan of Action on Urban Health* (Document CD51/5);

Recognizing that there are numerous Governing Body mandates dating back to 1992 that highlight the need to address urban health issues and the inequities in health caused by urbanization in the Region, in addition to the opportunity offered by the Health Agenda for the Americas 2008-2017 and the PAHO Strategic Plan 2008-2012;

Recognizing that the urbanization megatrend has rapidly accelerated in the Region and countries have not been able to react and adjust their programs to the wide diversity of cultural, community, family, migration, and socioeconomic challenges posed by this urbanization process;

Having studied the opportunity presented to address many of the most challenging public health problems now confronting our countries in the areas of noncommunicable diseases, injuries, vector-borne and other communicable diseases, and the challenge of tackling the diverse population needs in urban settings;

Considering that the lack of adequate, systematic consideration of public health criteria in the largely unplanned growth of cities in the Region has resulted in an increase in morbidity and mortality and a widening of the equity gap within cities;

Understanding that to succeed in advancing public health in the Region, the ministries of health will have to include information in their health surveillance systems

that differentiates the gradient of health inequities and their causes and implications for national and city health policies, programs, and services;

Recognizing that achieving urban health is a multisectoral endeavor that involves concerted action to promote physical activity; design safe, effective and accessible public transport options; prevent and reduce injuries; and address the particular access and wellness needs of the most vulnerable groups, including children, older persons, and people with special needs; and further recognizing that countries that adopt this holistic approach are not only improving the health of their citizens but achieving important environmental and sustainability gains;

Bearing in mind that the implementation of this Strategy and Plan of Action means marshalling a unique combination of stewardship over the health system and with the other social actors in urban settings to advocate for and adjust all manner of urban health services that can address the special needs of the social gradient and the heterogeneity of urban populations;

Having requested during the 50th Directing Council that the Pan American Sanitary Bureau prepare a preliminary strategy and plan of action to be presented to the 51st Directing Council,

RESOLVES:

1.   To endorse the Strategy and approve the Plan of Action on Urban Health and support its implementation within the context of the specific conditions of each country in order to respond appropriately to the current and future needs and trends in urban health in the Region.

2.   To urge the Member States to:

(a)   adopt the guidelines, tools, and methods developed by PASB and Centers of Excellence to support their intersectoral stewardship role and health services reorientation;

(b)   support national, subnational, and local health promotion policies and programs, including the strengthening of social participation, with appropriate legal frameworks and financing mechanisms;

(c)   adjust surveillance systems to include determinants and indicators related to urban health, indigenous populations, gender, and migration conditions, and documentation of urban health processes and experiences;

(d)   further the commitment of city and metropolitan authorities to healthy urban planning and development, with consideration of urban health and health equity in national and subnational health policies and plans;

(e)   collaborate with city and metropolitan authorities in the development of transport policies and systems that prioritize safe walking, cycling, and public transport; and in urban design regulations and infrastructure that provide for equitable and safe access to recreational physical activity throughout the life course;

(f)   assist city and metropolitan authorities with the use of assessment and action tools to address healthy and equitable urban planning and programs more effectively;

(g)   raise awareness among key stakeholders and develop social marketing plans and programs;

(h)   report back every two years on the progress made, with data for a mid-term evaluation at five years and a final evaluation at 10 years.

3.   To request the Director to:

(a)   produce and disseminate public health criteria, guidelines, model policies, and legal frameworks for urban health planning, urban health services, and methods for achieving multisectoral action, including health impact assessment, health equity impact assessment, and cross-sector data collection and analysis;

(b)   collect and disseminate new information about experiences, lessons learned, and best practices obtained through regional forums, research, observatories, documentation, and the sharing of promising experiences and processes;

(c)   further develop health promotion and health determinants approaches into technical cooperation in urban health and Country Cooperation Strategy implementation in the Member States;

(d)   promote capacity building for urban health planning and implementation, surveillance, and information systems across the Region;

(e)   support ministry of health engagement with city and metropolitan authorities and other relevant sectors, along the lines of the issues itemized in the final report of the roundtable discussions in the 50th Directing Council, the final report of the Urban Health and Health Promotion Forums, and the Global Call to Action on Urbanization and Health.

Report on the Financial and Administrative Implications for the Secretariat of the Proposed Resolution

1. Agenda item: 4.2 Strategy and Plan of Action on Urban Health	

2. Linkage to Program Budget 2012-2013:

(a) Area of work: Number of countries that adopt the PAHO/WHO urban health conceptual framework (6.1.3).

(b) Expected result:

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.

3. Financial implications

(a) Total estimated cost for implementation over the biennium 2012-2013 of the resolution (estimated to the nearest US$ 10,000, including staff and activities):

The strategy has financial implications for the Organization that will be determined during the preparation of the plan of action.

At the current time, it is estimated that implementation of the plan of action in this time period will require a total of $911,940 including:

Partial Salaries	*US$*
Senior Advisor at WDC	70,400
Advisor on Urban Health	40,500
Focal points at Representative Offices	300,000
Support for follow-up	15,000
Subcontract for guideline development	
Urban planning	40,000
Surveillance	40,000
Health Equity Impact Assessment	40,000

Health services	40,000
Model policy and legal frameworks	40,000
Subcontract for follow-up system	20,000
Temporary advisors	
On Health Impact Assessment and Health Equity Impact Assessment implementation	68,000
On urban health determinants monitoring	68,000
3rd Regional Urban Health Forum	75,000
Virtual Course development	50,000
Publications	45,000

(b) Estimated cost for the biennium 2012-2013 (estimated to the nearest US$ 10,000, including staff and activities): $911,940

(c) Of the estimated cost noted in (*b*), what can be subsumed under existing programmed activities? The cost of the advisors and country advisers, $425,900 could be assumed.

4. Administrative implications

(a) Indicate the levels of the Organization at which the work will be undertaken: Regional, subregional, and national levels.

(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile): One professional post (Master's in Public Health) to provide technical support and coordinate and monitor implementation of the specific projects in each country.

(c) Timeframes (indicate broad timeframes for the implementation and evaluation): 2012: For development guidelines and methods, and recruit first demonstration cities and countries for PAHO on urban health.

2013-2021: Implementation of the strategy and plan of action.
Progress report will be provided to the Goberning Bodies at 5 and 10 years.
A final evaluation will be made at the conclusion of the plan.

ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES

1. Agenda item: 4.2 Strategy and Plan of Action on Urban Health

2. Responsible unit: Urban Health and Determinants of Health Team, Area of Sustainable Development and Environmental Health.

3. Preparing officer: Marilyn Rice and Carlos Santos-Burgoa

4. List of collaborating centers and national institutions linked to this Agenda item:

- Bilateral cooperation: Centers for Disease Control and Prevention (CDC), European Union, German Agency for Technical Cooperation (GIZ), National Institutes of Health (NIH), Public Health Agency of Canada (PHAC), Swedish International Development Cooperation Agency (SIDA), United Kingdom Health Action Partnership International (HAPI), United States Agency for International Development (USAID).

- Communications and mass media (TV and Radio).

- Financial institutions: Andean Development Corporation, Caribbean Development Bank, Central American Bank for Economic Integration, Inter-American Development Bank, The World Bank.

- Global and international commissions and foundations: International Program on Climate Change, Gates Foundation, Red Cross, Rockefeller Foundation, World Economic Forum

- Health and other public sectors: economy, education, housing and urban planning, local governments-municipalities, transportation.

- Inter-American systems: Organization of American States (OEA): Economic Commission for Latin America and the Caribbean (ECLAC); Federation of Latin American Cities, Municipalities, and Associations (FLACMA); Federation of Municipalities of the Central American Isthmus (FEMICA).

- Multilateral Organizations: Food and Agriculture Organization - FAO, International Labor Organization–ILO, OCHA-Human Security Unit, Organization of Cooperation and Economic Development (OCDE), United Nations–HABITAT, United Nations Children's Fund (UNICEF), United Nations Development Program (UNDP), UNESCO, World Food Program (WFP), WHO-HQ.

- PAHO/WHO Collaborating Centers: Center for the Development and Evaluation of Politics and Technology in Public Health (CEDETES); Center for Studies, Research, and

Documentation on Healthy Cities (CEPEDOC); Center for Environmental Health (CENSE-INSP); Center for the Development of Healthy Cities and Towns; Center for Investigation of Health and Violence (CISALVA); Centre for Addiction and Mental Health (CAMH); Dalhousie University; Emory University Centre for Injury Prevention (CIP); Federal University of São Paulo; the Great Lakes Center; McGill University; the National Cancer Institute; the National Center for Environmental Health (NCEH-CDC); National Center for Injury Prevention and Control; National Institute for the Psychotherapies (NIP); the New York Academy of Medicine; the University of Kansas (UK); the University of Ottawa; the University of Puerto Rico (UPR); the University of Texas (UT); the University of Toronto; the University of Washington.

- Professional organizations: American Public Health Association (APHA), Canadian International Development Agency (CIDA), Canadian Public Health Association (CPHA), International Society of Urban Health; International Union of Health Promotion and Education (IUHPE).

- Private sector and civil society organizations: NGOs and social organizations.

- Regional Government Bodies: Caribbean Community and Common Market (CARICOM), Integration System for Central America (SICA), Union of South American Nations (UNASUR).

- Universities, educational, and research institutions.

5. Link between Agenda item and Health Agenda for the Americas 2008-2017:

- Action Area B) Address the Social Determinants of Health; item 40, unplanned urbanization and legislative framework for it.

- Action Area C) Increase the Social protection and Access to Quality Health Services; item 49, health care in marginal periurban areas inclusion of indigenous population in the health system.

- Action Area D) Diminishing Health Inequalities among Countries and Inequities within Them; item 52, 54, specially the priority to indigenous and other vulnerable populations.

- Action Area E) Reducing the Risk and Burden of Disease: items 58, 59, 60, specially those related to healthy environments.

6. Link between Agenda item and Strategic Plan 2008-2012:

SO 3: To prevent and reduce disease, disability and premature death from chronic non-communicable conditions, mental disorders, violence and injuries.

RER 3.1: Member States supported through technical cooperation to increase political, financial and technical commitment to address chronic noncommunicable conditions, mental and behavioral disorders, violence, road safety, and disabilities.

RER 3.2: Member States supported through technical cooperation for the development and implementation of policies, strategies and regulations regarding chronic non-

communicable conditions, mental and behavioral disorders, violence, road safety, disabilities, and oral diseases.

RER 3.3: Member States supported through technical cooperation to improve capacity to collect, analyze, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable conditions, mental and behavioral disorders, violence, road traffic injuries and disabilities.

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

SO 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.

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.

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.

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.

SO 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.

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.

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.

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).

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 and racial/ethnic groups.

SO 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.

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

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).

7. Best practices in this area and examples from countries within the Region of the Americas:

- Municipal System of Prevention and Care in Disasters (Sistema Municipal de Prevención y Atención de Desastres, SIMPAD), from the office of the Mayor of Medellín, Colombia. It is focused on reducing social, environmental and physical vulnerabilities of the city inhabitants through a strategy that shares responsibility between the city government and community participation oriented towards controlling risk.
- District Secretary of Health of Bogota, Colombia and its experience with Promoting Health Work Environments in the Informal Work Sector (Unidades de Trabajo Informal).
- Autonomous City Government of Buenos Aires, Argentina, through the Ministry of Urban Development's Plan for Sustainable Mobility.
- Transmillennium Sustainable Environment of Bogota, Colombia.

8. Financial implications of this Agenda item:

The strategy has financial implications for the Organization that will be further adjusted during follow-up of the Strategy and Plan of Action. At this time, it is estimated that a total of US$ 911,940 would be needed for the biennium 2011-2012 to implement the plan of action. Many of these resources relate to the allocation of time by staff already on PAHO's payroll in the Regional and Representative Offices.

- - -