PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

148th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 20 - 24 June 2011

Provisional Agenda Item 4.4

CE148/10 (Eng.)
9 May 2011
ORIGINAL: SPANISH

PLAN OF ACTION ON ROAD SAFETY

Introduction

1. Road safety is a priority on the agenda of the Pan American Health Organization (PAHO), given that traffic accidents are a leading cause of death and create an enormous burden of disease and disability. In this Region, road traffic injuries are the number one cause of death among children aged 5 to 14, and the second leading cause of death for the group aged 15 to 44. These figures are significant in terms of years of potential life lost. Moreover, these accidents are preventable, and ministries of health have the capacity to steer the policies of other sectors with a view to achieving health-related goals. The purpose of this document is to articulate principles to guide the actions of the countries of the Region and to define the lines of action for a strategy adapted to conditions in the Americas.

Background

2. The following are some of the relevant documents on this subject:

- Resolution WHA57.10 on road safety and health, adopted by the World Health Assembly in 2004;
- Resolution A/RES/64/255 adopted by the United Nations General Assembly in March 2010, proclaiming a "Decade of Action for Road Safety 2010-2020." This resolution called on United Nations Member States to prepare a national plan of action on road safety; and
- Resolution A/RES/58/ (2004), also of the United Nations General Assembly, on improving global road safety.

3. Following the 2004 publication of the *World Report on Road Traffic Injury Prevention*, the first report on the issue prepared jointly by the World Health Organization (WHO) and the World Bank, PAHO prepared and published a status report

on road safety in the Region of the Americas [in Spanish only] in 2009. This report drew attention to the public health burden of fatal and nonfatal injuries, specifically in the Americas, and pinpointed gaps in investment in road safety, the adoption of national policies, the reliability of information, and the enactment of relevant legislation.

4. This policy is based on the WHO strategy for road traffic injury prevention in 2001, the *World Report on Road Traffic Injury Prevention,* and the aforementioned resolutions WHA57.10, A/RES/64/255 and A/RES/58/289. These resolutions call for the strengthening of international cooperation. The United Nations Road Safety Collaboration was established in response to this call. Chaired by the World Health Organization and with the participation of United Nations Regional Commissions, since 2004 the Group has brought together nongovernmental organizations, foundations and private sector entities to coordinate effective responses to road safety issues. The regional report offers specific recommendations in support of this initiative.

5. This document is also based on the declaration of the States Parties to the Constitution of the World Health Organization (WHO), which recognizes certain principles basic to the happiness, harmonious relations, and security of all peoples, one of which states that: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

6. These road safety policies are aligned with the Areas of Action of the Health Agenda for the Americas 2008-2017. Initiatives to promote a safe and sustainable public transportation system help to effectively protect the poorest, most marginalized and vulnerable people. The activities planned for road safety are also consistent with the plan for reducing the risk and burden of disease, since they contribute to reducing obesity and increasing physical activity, in addition to reducing deaths and disabilities caused by road traffic injuries. They also adhere to the Resolution on Health, Human Security, and Well-being adopted by the 50th Directing Council of PAHO (CD50.R16 [2010]); the proposed strategy and plan of action on climate change; and the strategy and plan of action on urban health, to be presented at the 148th Session of the Executive Committee.

Analysis of the current situation

7. The adjusted mortality rate worldwide was 18.8 per 100,000 inhabitants in 2007, and 15.82 per 100,000 inhabitants in the Region of the Americas, with variations ranging from 4.3 to 21.8 per 100,000 inhabitants. According to the averages for the Region, 80% of victims are men, and traffic accidents account for 142,252 deaths annually, as well as an estimated 5 million or more people injured. In the United States, the cost of road traffic injuries in 2005 exceeded US$ 99 billion. According to a study on Brazil that same year, the cost of traffic accidents was $10 billion annually, equivalent to 1.2% of the country's Gross Domestic Product (GDP). Similarly, a study on Belize, based on 2007 data, estimated the total economic cost at $11 million, or 0.9% of the country's Gross Domestic Product.

8. There is no available data in the Region on the ethnicity of the victims. Beyond the suffering that this situation represents for the injured and their families, it also creates a heavy demand for prehospital and trauma care, overburdens healthcare services, and inflicts a high cost on society as a whole. The mortality rate from road traffic injuries in 11 countries (Brazil, Bolivia, British Virgin Islands, the Dominican Republic, Guyana, Mexico, Paraguay, Peru, Saint Lucia, Suriname, and Venezuela) exceeds the regional average. Mortality rates in the United States and Canada, at 13.9/100,000 inhabitants and 8.8/100,000 inhabitants respectively, have fallen sharply over the past 30 years. In South America, however, Colombia is the only country to report a decline in mortality in the past 10 years, while two Caribbean countries, Bahamas, and Jamaica, have reported similar trends more recently.

9. Thirty-nine percent of people who die from road traffic injuries in the Region are vulnerable users (pedestrians, cyclists, or motorcyclists), while 47% are motor vehicle occupants, particularly in North America, which has the highest rate (74%). The pedestrian death rate is over 50% in some countries, such as El Salvador (63%) and Peru (78%).

10. Information on the Region is still insufficient to identify specific factors related to urban conditions, indigenous groups, and so forth; it is worth noting that 80% of the Region is urban.

11. In response to the challenge of making motor vehicle traffic safer in the Region, PAHO is working intensively with WHO to reinforce activities in the Region and to bring in global and regional partners—including the Economic Commission for Latin America and the Caribbean (ECLAC), the Inter-American Development Bank (IDB), the Andean Development Corporation (ADC), bilateral and multilateral organizations, civil society organizations, foundations (Bloomberg Philanthropies), and the private sector—

to ensure that an intersectoral policy approach is brought to the issue of road safety with sufficient clarity and effectiveness.

Proposal

12. This document will discuss the institutional framework, intersectoral strategies, role of the health sector, and information systems on victim mortality and morbidity due to road traffic injuries; legislation addressing the main risk factors (speed, alcohol use, seat belt use, helmet use, and child and infant safety seat use); vehicle safety standards, road safety audits, promotion of public and nonmotorized transportation policies; and prehospital care of the injured. This document is aligned with the WHO General Programme of Work and PAHO's Strategic Plan, both of which set targets for reducing deaths from road traffic injuries.

Road Safety Action Plan (2012-2017)

***Objective 1*:** Member States designate a multisectoral governmental regulatory agency to guide national activities in the area of road safety, with special emphasis on the development of national plans for the Decade of Action for Road Safety.

Indicator

- Number of countries that have a multisectoral regulatory agency responsible for coordinating road safety promotion measures. (Baseline: 25. Target: 30 by 2017.)

Activities

1.1 Establish a regulatory agency for road safety with the authority and responsibility of making decisions, administering resources, and coordinating the activities of all government sectors involved in road safety, including health, transportation, education, and the police.

1.2 This agency should have sufficient resources available to it for road safety and will be held publicly accountable for its activities and their impact on health.

***Objective 2*:** Reduce the incidence of risk factors (speed and alcohol consumption) in road traffic injuries and increase the rate of protective equipment use (helmets, seat belts, and child safety seats).

Indicators

- Number of countries with maximum urban speed limits of 50 km/hour. (Baseline: 20. Target: 30 by 2017.)
- Number of countries with speed limit enforcement programs. (Baseline: 4. Target: 15 by 2017.)
- Number of countries and cities with blood alcohol concentration limits for drivers equal to or less than 0.05g/dl. (Baseline: 10. Target: 20 by 2017.)
- Number of countries with programs to discourage driving under the influence of alcohol. (Baseline: 4. Target: 15 by 2017.)
- Number of countries with laws on compulsory helmet use for all motorcycle occupants. (Baseline: 12. Target: 25 by 2017.)
- Number of countries with programs to promote and enforce helmet use. (Baseline: 13. Target: 25 by 2017.)
- Number of countries with laws on compulsory seat belt use for all vehicle occupants. (Baseline: 20. Target: 30 by 2017.)
- Number of countries with a program to promote and enforce seat belt use (Baseline: 18. Target: 30 by 2017.)
- Number of countries with laws on the mandatory use of child restraint systems in vehicles. (Baseline: 21. Target: 30 by 2017.)
- Number of countries with programs to promote and enforce the use of child restraint systems. (Baseline: 5. Target: 15 by 2017.)

Activities

Speed

2.1 Recommend the setting of speed limits that protect the most vulnerable road users from injuries and death (pedestrians, cyclists and motorcyclists), especially in urban areas, where speed limits should not exceed 50 km/h and should be reduced to 30 km/h in school zones. This recommendation is based on that of the WHO *World Report on Road Traffic Injury Prevention 2004*.

2.2 Promote, in an intersectoral manner, policies to decentralize road safety management so that local governments have the capacity to modify national speed limits.

2.3 Promote public awareness and understanding of the effects of speed and the reasons for setting speed limits.

Alcohol consumption

2.4 Advise lawmakers on the enactment of laws regulating allowable blood alcohol levels for drivers of equal to or less than 0.05 g/dl, and promote their strict enforcement.

2.5 Advise lawmakers on the importance of setting limits equal to or lower than 0.02g g/dl for young drivers.

2.6 Promote enforcement of the law to ensure that offenders do not go unpunished, setting up police checkpoints to test blood alcohol levels at pre-established locations along the roadways (also known as "sobriety points") and random alcohol testing on public thoroughfares. These types of measures are extremely cost-effective and reduce crashes by as much as 20%.

2.7 Promote the design and implementation of public policies to reduce general alcohol consumption of proven effectiveness in improving road safety, such as: tax and price increases, regulation of alcoholic beverage sales (restrictions on hours, days, locations, and sales to minors), and regulations on alcohol advertising and promotion.

Helmets

2.8 Advise lawmakers on the enactment of laws that make helmet use compulsory for all passengers of two- or three-wheeled motor vehicles and ensure that helmets meet quality standards.

2.9 Promote compliance with the law, working in hand in hand with government law enforcement entities.

2.10 Support the transit sector in setting up a data collection system on helmet use rates.

Seat belts

2.11 Promote the enactment of laws requiring automobile manufacturers and importers to equip all vehicles with seat belts for every seat.

2.12 Promote stricter laws and stepped up efforts to ensure that seat belts are used by all vehicle occupants.

2.13 Support the transit sector in setting up data collection systems on seat belt use rates.

2.14 Undertake law enforcement initiatives in conjunction with government sectors and civil society, supported by intensive information programs in the media.

2.15 Support lawmakers in the enactment and enforcement of laws on the use of child safety seats that meet quality and safety standards.

2.16 Establish mechanisms to promote and improve access to those seats, such as protocols in maternity clinics whereby each newborn is discharged from the clinic in a child safety seat, and child safety seat donation programs.

2.17 Support the transit sector in setting up data collection systems on the use of child safety seats.

***Objective 3*:** Improve mass transit policies through the adoption of the principles of safety, equity, and accessibility to ensure the exercise of human rights.

Indicator

- Number of countries with policies that support investment in public transportation. (Baseline: 14. Target: 30 by 2017.)

Activities

3.1 Promote the establishment of public mass transportation systems in Member States that help reduce the use of individual motor vehicle transportation and encourage the use of safer, cleaner modes of transportation to reduce exposure to the risk of road traffic injuries, as well of respiratory diseases caused by greenhouse gas emissions.

Objective 4: Promote the development of infrastructure conducive to the safe transit of all users of urban roads and highways, particularly that of the most vulnerable among them (pedestrians, cyclists and motorcyclists).

Indicators

- Number of countries with national policies that encourage walking and bike riding. (Baseline: 10. Target: 30 by 2017.)
- Number of countries that incorporate road safety features into road design and apply measures to reduce speed in areas frequented by pedestrians and/or cyclists. (Baseline: 4. Target: 10 by 2017.)

Activities

4.1 Recommend to the relevant sectors that they modify the current highway infrastructure, with emphasis on urban intersections, in order to better safeguard the movements of vulnerable road users such as pedestrians, cyclists, and motorcyclists.

4.2 Support and promote safety audits of existing infrastructure and the application of engineering solutions with demonstrated effectiveness in improving safety outcomes.

4.3 Support Member States to work in conjunction with the sectors responsible for road infrastructure, to require that new road projects be subject to road safety audits that include qualitative studies on traffic patterns to help justify the implementation of cost-effective measures.

***Objective 5*:** Create or strengthen a technical vehicle inspection and review system.

Indicator

- Number of countries with a technical vehicle inspection and review system in place for all vehicles. (Baseline: 23. Target: 30 by 2017.)

Activities

5.1 Promote enhanced technical safety requirements for new vehicles introduced on the market.

5.2 Emphasize the importance of performing annual technical inspections on all vehicles in circulation to assess whether they meet safety requirements.

5.3 Recommend that the responsible sectors prohibit the circulation of vehicles that do not meet safety requirements.

Objective 6: Have structured and integrated prehospital care services in place for victims of road traffic injuries.

Indicator

- Number of countries with a prehospital care system integrated into the health sector. (Baseline: 22. Target: 30 by 2017.)

Activities

6.1 Strengthen prehospital care services and integrate them into the Integrated Health Services Networks that include hospital and rehabilitation services.

6.2 Develop training strategies for community health workers in first aid, basic resuscitation and other basic techniques that reduce "inadequate post trauma care."

Objective 7: Improve the quality of data on road traffic injuries so that mortality and morbidity rates reflect the characteristics of the victims.

Indicators

- Number of countries that record mortality rates from road traffic injuries. (Baseline: 30. Target: 37 by 2017.)
- Number of countries that record morbidity rates due to road traffic injuries (number of injured people who receive care from prehospital and hospital service-providers. (Baseline: 3.[1] Target: 10 by 2017.)

Activities

7.1 Improve linkages among the sectors involved in data collection and reporting on road traffic injuries to ensure that, in addition to characteristics, they document the victims' survival status, as well as any determinants and environmental factors (such as road conditions, time of day, weather) in the crashes.

7.2 Improve the use of coding from the "International Statistical Classification of Diseases and Related Health Problems" (ICD-10) in vital records so that they accurately reflect the victims of traffic accidents.

7.3 Increase use of the definition of death from road traffic injuries when death occurs up to 30 days following a traffic accident, in order to harmonize data from different sources.

7.4 Improve the information on injured people who access victim care services (prehospital, hospital, and rehabilitation) by including data on the location of the accident.

7.5 Establish mechanisms to ensure that information concerning victims left with sequelae and/or physical or mental disabilities is reported.

7.6 Train human resources to improve the quality of information at all stages: data collection, analysis, and interpretation.

[1] Taking into account countries that reported more than 50 nonfatal injuries per traffic fatality in the Status Report on Road Safety in the Region of the Americas, 2009.

Monitoring, analysis, and evaluation

13. This action plan contributes to the achievement of Strategic Objectives 3[2] and 6[3] of PAHO's Strategic Plan. The expected results at the regional level to which this Plan will contribute are outlined in Annex C. Monitoring and evaluation of this Plan will be aligned with the Organization's results-based management framework and its performance monitoring and assessment processes. Progress reports will be prepared for this purpose, based on the information available at the end of each biennium.

14. An evaluation will be conducted during the final year of the Plan to identify strengths and weaknesses in overall implementation, the causal factors of successes and failures, and future actions.

Action by the Executive Committee

15. The Executive Committee is invited to review the information contained in this plan of action and examine the possibility of approving the draft resolution presented in Annex A.

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https://www.who.int/violence_injury_prevention/road_safety_status/2009/en/index.html.

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

[3] 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.

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PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

148th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 20 - 24 June 2011

Provisional Agenda Item 4.4

CE148/10 (Eng.)
Annex A
ORIGINAL: SPANISH

PROPOSED RESOLUTION

ROAD SAFETY ACTION PLAN

The 148th SESSION OF THE EXECUTIVE COMMITTEE,

Having examined the *Plan of Action on Road Safety* (Document CE148/10)

RESOLVES:

To recommend that the 51st Directing Council adopt a resolution written as follows:

PLAN OF ACTION ON ROAD SAFETY

THE 51st DIRECTING COUNCIL,

Having examined the *Plan of Action on Road Safety* (Document CD51/__);

Recognizing the burden that road traffic injuries represent in the Region of the Americas as the leading cause of death in children aged 5 to 14 and the second leading cause of death in people aged 15 to 44, as well as the urgent need to adopt public health measures to reduce the burden of lost lives and suffering caused by traffic accidents;

Recalling World Health Assembly resolution WHA57.10 (2004) on road safety and health and the relevant resolution of the United Nations General Assembly, A/RES/58/289 (2004) on improving global road safety, the celebration of World Health Day 2004, with its emphasis on road safety, and the release of the *World Report on Road Traffic Injury Prevention*, the *Global Status Report on Road Safety*, and the status report on road safety in the Region of the Americas;

Recalling also that in March 2010, the United Nations General Assembly proclaimed the Decade of Action for Road Safety 2011-2020 (A/RES/64/255);

Recognizing the opportunities offered by the adoption of a public health approach that promotes multisectoral action in which the health sector plays a coordinating role in tackling the urgent need to effectively protect the poor, marginalized, and most vulnerable population, the people who are most affected by traffic accidents in the Region,

RESOLVES:

1. To adopt the Plan of Action on Road Safety.

2. To urge the Member States to:

a) prioritize road safety through the development of national plans for the Decade of Action for Road Safety and the designation of a governmental coordinating entity to guide national activities connected with road safety to consolidate efforts and put the World Health Assembly and United Nations General Assembly resolutions into practice;

b) improve the urban road and highway infrastructure;

c) improve mass transportation policies and laws by adopting the principles of safety, equity, and accessibility to guarantee the human rights of all persons;

d) reduce the incidence of risk factors (speed and alcohol consumption) in traffic-related injuries and increase the use of protective equipment (helmets, seat belts, and child restraint systems in automobiles);

e) set maximum urban speed limits at 50 km/h; promote decentralization so that local governments can adjust speed limits; promote public awareness about the need for setting speed limits;

f) adopt a maximum blood alcohol level for drivers that is equal to or less than 0.05 g/dl;

g) enforce the laws on compulsory helmet use, taking quality and safety standards into account;

h) enforce the laws on compulsory seat belt use taking quality and safety standards into account; promote seat belt use;

i) enforce the laws on the compulsory use of child restraint systems in automobiles taking quality and safety standards into account; promote the use of these systems;

j) establish or improve a technical vehicle inspection and examination system;

k) strengthen the technical and institutional capability for providing care to victims of road traffic injuries, particularly in the prehospitalization phase, hospitalization, and rehabilitation;

l) improve data on traffic accidents by designing surveillance services to increase understanding and awareness of the burden, causes, and consequences of road traffic injuries so that victim prevention, care, and rehabilitation programs and investments can be better targeted, monitored, and evaluated.

3. To request the Director to:

a) support the Member States in their efforts to improve road safety and prepare national plans for the Decade of Action for Road Safety;

b) facilitate the identification and sharing of good practices for the prevention of road traffic injuries;

c) encourage and support the national focal points network and foster collaboration with other networks of experts, professionals, and nongovernmental organizations;

d) assist in creating technical and policy-making capacity to facilitate data collection and dissemination, and promote research and surveillance systems connected with the prevention of road traffic injuries;

e) provide technical assistance to improve prehospital treatment and care of traffic accident victims;

f) promote the establishment of associations and collaborations with international agencies, networks of experts, civil society, foundations, and the private sector in order to guarantee an intersectoral approach.

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
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CE148/10(Eng.)
Annex B

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

1. Agenda item: 4.4 Plan of Action on Road Safety

2. Linkage to Program Budget:

a) Area of work: Sustainable Development and Environmental Health

b) Expected result:

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.

Indicator

3.1.5 Number of countries implementing institutional development mechanisms (human/financial resources, training, intersectoral partnerships) related to road safety.

RER 3.2 Member States supported through technical cooperation for the development and implementation of policies, strategies, and regulations regarding chronic noncommunicable conditions, mental and behavioral disorders, violence, road safety, disabilities, and oral diseases.

Indicator

3.2.7 Number of countries implementing a multisectoral national plan to prevent road traffic injuries, aligned with PAHO/WHO guidelines.

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 non-communicable conditions, mental and behavioral disorders, violence, road traffic injuries, and disabilities.

Indicator

3.3.5 Number of countries that have a national health information system that includes indicators of road traffic injuries.

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

Indicator

3.4.5 Number of countries with cost analysis studies on chronic non-communicable conditions conducted and disseminated.

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

Indicator

6.5.2 Number of countries that have created pedestrian and bike-friendly environments, as well as physical activity promotion programs in at least one of their major cities.

3. Financial implications

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

Five years: US$ 2,850,000

Specifics: Staffing: $520,346 annually, five-year total $2,601,730.

These resources are already budgeted in the regional office (one regional adviser), and in the offices of two countries (2 posts in Mexico and 2 posts in Brazil). A technical post is added in the regional office.

Monitoring and evaluation of achievement of the targets:
$50,000 annually, five-year total $250,000.

Monitoring and evaluation will be carried out using the status report on road safety in the Region of the Americas, PAHO (2009), and the reports planned for 2012 and 2014 as the baseline, and extrabudgetary resources already have been committed under an agreement signed in November 2009 between WHO and Bloomberg Philanthropies in the amount of $250,000 for 5 years.

(b) Estimated cost for the biennium 2010-2011 (estimated to the nearest US$ 10,000, including staff and activities):

$1,040,000 (2 years)

(c) Of the estimated cost noted in *(b),* what can be subsumed under existing programmed activities?

$894,000

4. Administrative implications

a) Indicate the levels of the Organization at which the work will be undertaken:

Regional, subregional and at the country level.

b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):

A professional post (Master's Degree in Social Sciences) to provide regional technical support for coordination and monitoring of the implementation of specific projects at the country level.

c) Time frames (indicate broad time frames for implementation and evaluation):

2012-2017

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
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CE148/10 (Eng.)
Annex C

ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES

1. **Agenda item:** 4.4 Plan of Action on Road Safety

2. **Responsible unit:** Sustainable Development and Environmental Health Area/Urban Health and Health Determinants Team

3. **Preparing officer:** Eugênia Rodrigues

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

- National Institute of Public Health (INSP), Cuernavaca, Mexico
- Centers for Disease Control and Prevention (CDC), USA
- Centre de Santé Publique et Sécurité dans les Milieux de Vie, Canada
- Health and Violence Research Center, CISALVA Institute, Colombia
- Center for Injury Control, Emory University, USA
- International Injury Research Unit, Johns Hopkins University, USA
- National Highway Traffic Safety Administration (NHTSA), USA

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

<u>Tackling health determinants</u>

Paragraph 40: The determinants of health should be tackled in order to effectively protect poor, marginalized, and vulnerable populations This refers to determinants that are related to a) social exclusion, b) exposure to risks, c) unplanned urbanization, and d) the effects of climate change. This approach requires revision of legislative frameworks, which currently provide adverse incentives for the improvement of health determinants.

<u>Reducing health inequalities among countries and inequities within them</u>

Paragraph 52: In trying to achieve greater equity, interventions to improve health should prioritize the poorest and most marginalized and vulnerable people. Indigenous peoples and tribal communities, as well as other groups, should be a priority. Countries should safeguard these groups' inclusion, their access to culturally acceptable health services, the collection and use of specific data for appropriate decision-making, and the full exercise of their rights as citizens. Health interventions should respond to the specific characteristics of each group.

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 non-communicable conditions, mental and behavioral disorders, violence, road safety, and disabilities.

Indicators

3.1.5 Number of countries implementing institutional development mechanisms (human/financial resources, training, intersectoral partnerships) related to road safety.

3.2.7 Number of countries implementing multisectoral national plan to prevent road traffic injuries, aligned with PAHO/WHO Guidelines.

3.3.5 Number of countries that have a national health information system that includes indicators of road traffic injuries.

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.

Indicator

3.4.5 Number of countries with cost analysis studies on road safety conducted and disseminated.

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

Indicator

6.5.2 Number of countries that have created pedestrian and bike-friendly environments, as well as physical activity promotion programs in at least one of their major cities.

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

The United States and Canada have been working for many years on a multisectoral approach to road traffic injury prevention and have succeeded in reducing deaths and injuries. Canada has one of the lowest death rates from road traffic injuries in the Region (8.8/100.000 inhabitants). Laws on drinking and driving are enforced rigorously in the United States and the death rate associated with this risk factor is approximately 12%; this figure is actually low relative to that of other Latin American and Caribbean countries. In recent years, Brazil and Mexico have undertaken multisectoral initiatives to improve road

safety by amending and enforcing laws related to risk factors in road traffic injuries, and initial outcomes point to a decrease in injuries and deaths. Colombia has invested in healthy spaces in major cities in order to improve the safety of motorcyclists by promoting the use of helmets and reflective vests, and has experienced a decline in traffic-related deaths over the past decade. Initiatives are under way in South America to control drinking and driving and to improve information systems and civil society's involvement in road safety promotion activities. NGOs are working actively in the Region to improve road safety. There are examples of this from several countries, including Argentina, Brazil, United States, Mexico, Uruguay, and Venezuela.

8. Financial implications of this Agenda item:

Total cost–5 years: US$ 2,850,000

(For further details see Annex B of this document)

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