Chapter 5
HEALTH AND INTERNATIONAL COOPERATION

The global commitment to work towards a world with enhanced social equity and reduced poverty that informs the Millennium Development Goals (MDGs) likewise drives the international cooperation agenda. In the Americas, international cooperation takes the forms of overseas development assistance, public/private partnerships, technical cooperation among countries, and subregional integration initiatives.

Official development assistance (ODA)—comprised of grants and loans from developed countries to developing countries that target the latter's economic development and welfare—is increasingly channeled toward sub-Saharan Africa and Southeast Asia (two-thirds of all ODA in 2005), with proportionately diminished assistance for Latin America and the Caribbean (less than one-tenth of all ODA in 2005). The volume of aid per capita shows comparable differences: in 2004, per capita ODA to Africa reached US$ 34, while it was US$ 13 for Latin America and the Caribbean. Actual aid flows to individual countries depend on how each is classified: low income and lower-middle income countries receive most ODA. In general, that portion of ODA that goes to health—basic health care, disease prevention and control, family planning, and health sector infrastructure, management, and administration—has been increasing. Of total ODA for health disbursed between 2002 and 2004, 17% (US$ 402.6 million) went to Latin America and the Caribbean—three-fourths of it furnished by bilateral agencies—mainly to combat sexually transmitted infections and to effect policies related to health, the population, and primary health care. A major portion of multilateral assistance for health aid to Latin America and the Caribbean came from development banks—the World Bank, Inter-American Development Bank, Andean Development Corporation, Caribbean Development Bank, and Central American Bank for Economic Integration. Philanthropic foundations and nongovernmental organizations (NGOs) contributed another significant portion of health aid to the region. Ideally, official development assistance targets each country's health priorities based on the "global burden of disease" indicator—an estimate of the magnitude of diseases, in-

juries, and risk factors as measured by disability-adjusted life years (DALYs); the aim is for health-related ODA to be consistent with health priorities. Notwithstanding, in Latin America and the Caribbean, the relationship between disease burden and allocated funding has been discrepant; for example, while noncommunicable diseases account for 60% of the burden, those diseases receive only 27% of ODA for health.

Public/private partnerships, a new form of health cooperation that brings together diverse stakeholders, have been on the increase over the past decade. The leading source of health aid since it was set up in 2002—the Global Fund to Fight AIDS, Tuberculosis, and Malaria brings together donor and recipient countries, NGOs, businesses, foundations, international development organizations, and impacted communities to fight three of the world's most devastating diseases; in Latin America and the Caribbean, that agenda has meant an allocation by the Global Fund of US$ 466 million. The Global Alliance for Vaccines and Immunization has raised nearly US$ 3.3 billion, has provided vaccination coverage to millions of previously uncovered children, and has averted an estimated 1.7 premature deaths worldwide. The Onchocerciasis Elimination Program for the Americas—a collaboration among Merck Sharp and Dohme, NGOs such as the Carter Center, the Centers for Disease Control and Prevention, endemic countries, and others—aims to eliminate the disease as a public health problem and interrupt its transmission by 2007. Finally, a major objective of numerous public/private partnerships has been cooperation in managing natural disasters in the Americas, for which more than US$ 21 million were raised between 2000 and 2005.

Technical cooperation among countries—a horizontal, reciprocal process in which two or more countries work together to build individual and collective capacity through cooperative exchanges of knowledge, skills, resources, and technology—includes more than 200 health projects approved by the Pan American Health Organization (PAHO) since 1998 in areas such as disease control, risk management, environmental health, family and community health, health care services, disaster mitigation and risk management, and humanitarian aid.

To assure the greater effectiveness of development assistance, ever more emphasis is being placed on "harmonization" (encouraging donors to dovetail their various efforts), "alignment" (assuring that donors' and recipient countries' priorities are in line with one another), and a United Nations reform process that targets the coordination of various U.N. agencies' operations in developing countries. A major initiative to address the hemispheric health challenges is the adoption by all the countries of the Region of the Health Agenda for the Americas, 2008–2017.

To enhance their political and economic advantages, countries in the Americas with common histories, cultures, and, in some cases, borders have formed regional integration processes. While their priority is trade,

these processes have also laid the groundwork for social and health-related cooperation. In the Southern Cone, the main regional integration scheme, MERCOSUR, is exploring the harmonization of health regulations. The Andean Community of Nations has a health sector integration process, the Hipólito Unánue Agreement, that bolsters individual and joint country efforts to improve their people's health. The Central American Integration System has established an Alliance for Sustainable Development and holds meetings of health ministers known as RESSCAD that incorporate a wide range of health sector institutions, including social security and water supply and sanitation agencies. The Caribbean Community has established a Caribbean Cooperation in Health Initiative that prioritizes strengthening health systems, developing human resources, and addressing family health, food and nutrition, noncommunicable and communicable diseases, mental health, and environmental health issues. The North American Free Trade Agreement between Canada, Mexico, and the United States includes provisions for cooperation in health among the three countries.

OFFICIAL DEVELOPMENT ASSISTANCE

Official development assistance (ODA) has become an increasingly important tool in furtherance of the MDGs (*1*). The Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD) defines ODA as nonreimbursable grants and subsidized loans to developing countries and territories on the DAC list of ODA recipients.

By definition, ODA must be furnished by the official sector of a donor country and geared to promoting the recipient country's economic development and welfare. Loans must have a grant element of at least 25%. The DAC's Credit Report System (CRS) and aggregate annual statistics (*2*) record and closely monitor trends in ODA. Both furnish data on aid commitments and disbursements by the 22 member countries of the DAC[1] and are the main source of data for this section of the chapter. ODA recipients are countries included on the list of developing nations first published by the DAC in 1962 to establish a comprehensive reporting system for ODA and other contributions by DAC member countries to developing countries. According to the DAC, the lists are published for statistical purposes only and are not designed to furnish guidance with respect to the geographic distribution of aid flows or country eligibility. Between 1993 and 2005, the DAC list was divided into two parts, with Part I of the list showing all countries and territories receiving ODA, which were referred to as developing countries. In 2005, the DAC decided to maintain a single list of ODA recipients, eliminating Part II altogether. The current DAC list includes four groups of countries eligible for ODA; namely, the least developed countries, low income countries, lower-middle income countries, and upper-middle income countries, with countries classified according to their per capita gross national income.

The Elusive 0.7% of GNP Aid Target

ODA flows reached a record US$ 106.5 billion in 2005, equivalent to 0.33% of the GNP of DAC member countries, up from 0.26% of the GNP of the same group of countries in 2004 (*3*). Projections based on aid commitments by DAC member countries put the volume of ODA at US$ 130 billion by the year 2010, nearly double the figure for the year 2000. Thus, only 0.33% of GNP was devoted to ODA in 2005 and, according to projections, ODA flows in the year 2010 will represent 0.35% of the GNP of DAC member countries. Figure 1 shows ODA trends over the past decade and a half and projections through 2010.

In 1970, the U.N. General Assembly recommended that each industrialized country step up its official assistance to developing countries and "exert its best efforts to reach a minimum net amount of 0.7 per cent of its gross national product at market prices by the middle of the decade" (*4*). The recommendation to the effect that donor countries allocate at least 0.7% of their GNP to ODA was reaffirmed at recent world summits of heads of state and government, the Millennium Summit in 2000, the In-

[1] The member countries of the DAC are Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Japan, Luxemburg, the Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, the United Kingdom, and the United States.

Classification of International Cooperation

There is no standard or universally accepted classification system for international cooperation. The conceptual framework for development aid varies according to the experiences, background, interests, and priorities of the countries and organizations involved. Thus, rather than having the discipline of a science, existing classification schemes are simply an empirical grouping of the different types of cooperation offered and received by participating countries.

Cooperation is defined as **bilateral** when originating in an agreement between two countries and their respective official financial or technical agencies. Government agencies channeling funding to developing countries are known as **bilateral agencies.** Cooperation is defined as multilateral when the relationship is between a country and **multilateral international organizations** (e.g., development banks, United Nations agencies). Cooperation is defined as **horizontal** (also known as **technical cooperation among countries, or TCC**) when the main players are two or more developing countries and it involves bilateral and multilateral relations among governments, institutions, corporations, individuals, and nongovernmental organizations (NGOs) in two or more developing countries. **Nongovernmental** cooperation refers to aid furnished by NGOs, philanthropic foundations, or other private organizations.

Source: Berro M, Barreiro A, Cruz A. América Latina y la cooperación internacional. Montevideo: Instituto de Comunicación y Desarrollo; 1997.

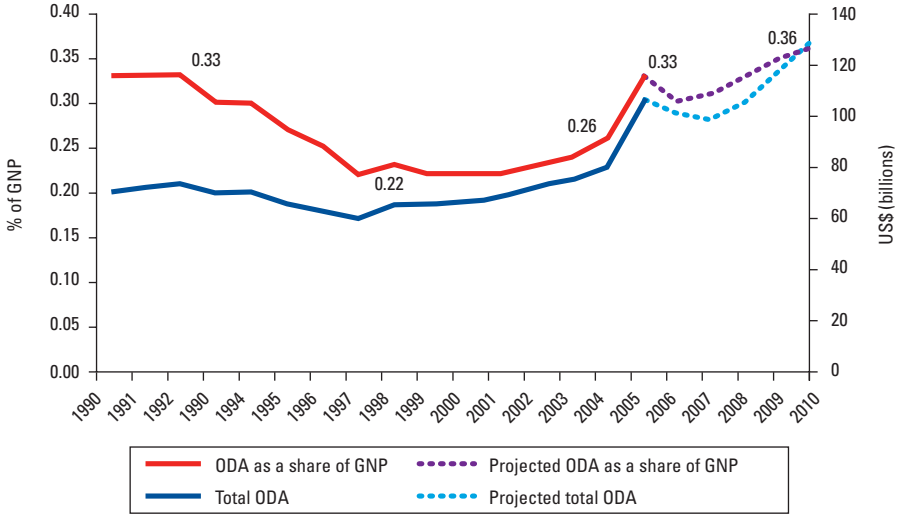
ternational Conference on Financing for Development (Monterrey, 2002), and the 2005 U.N. General Assembly High-Level Dialogue on Financing for Development. Only five countries have surpassed this target: Denmark, Luxemburg, the Netherlands, Norway, and Sweden (*2*).

ODA for Latin America and the Caribbean

In 2005, there were 150 ODA recipients in different parts of the world, but with a somewhat irregular pattern of ODA distribution. From a geographic standpoint, the top priorities for ODA in 2005 were sub-Saharan Africa and Southeast Asia, with 66% of all ODA going to these two regions and a mere 9% being allocated to Latin America and the Caribbean. A look at trends over the period 1998–2004 shows a steady increase in aid flows to Africa and a relatively stable or diminishing flow of aid to Latin America and the Caribbean (Figure 2).

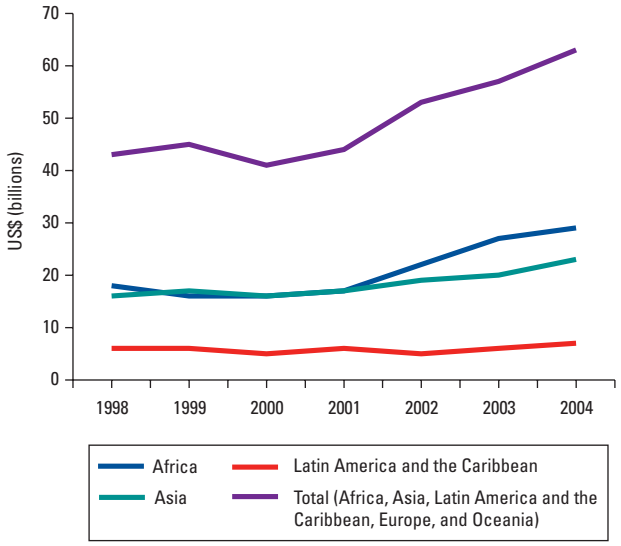
There are three ways of measuring ODA. One is in total U.S. dollars; a second is as a share of GNP; and a third is in terms of aid per capita, which shows the volume of aid received by a given

FIGURE 1. Official development assistance, 1990–2005 and estimates through the year 2010.



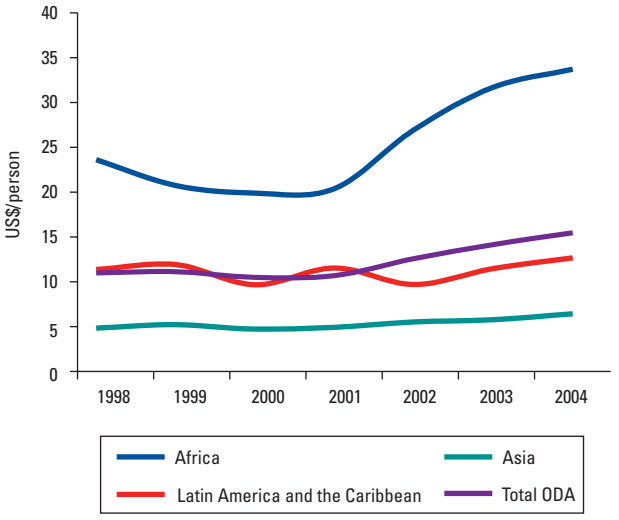
Source: Organization for Economic Cooperation and Development. Adapted from DAC members' net ODA 1990–2005 and DAC Secretariat simulation of net ODA in 2006 and 2010. Available at http://www.oecd.org/dataoecd/57/30/3530618.pdf.

FIGURE 2. Official development assistance, by region, in constant 2004 US dollars.



Source: Organization for Economic Cooperation and Development. Online CRS database on aid activities and DAC online database on annual aggregates (http://www.oecd.org/dac/stats/idsonline).

FIGURE 3. Official development assistance per capita, by region, 1998–2004.



Source: Organization for Economic Cooperation and Development. Online CRS database on aid activities and DAC online database on annual aggregates (http://www.oecd.org/dac/stats/idsonline).

region or country per person and helps to standardize aid measurements by adjusting for the population factor. For example, the level of total ODA went from US$ 10 per capita in the year 2000 to nearly US$ 15 per capita in 2004. However, a breakdown by region puts the level of ODA to Africa at US$ 34 per capita in 2004, compared with US$ 13 per capita for Latin America and the Caribbean, which is below the global average, albeit above the figure for Asia, which was US$ 6 per capita. While the Asian and Latin American regions rank second and third among ODA recipients in total U.S. dollars, in terms of aid flow per capita, they rank third and second, respectively (Figure 3).

Within Latin America and the Caribbean, most ODA has gone to low and lower-middle income countries which, in 2004, took in US$ 27 and US$ 14, respectively, in aid per capita. The level of aid for upper-middle income countries in Latin America and the Caribbean (US$ 2 per capita in 2004) is below the region-wide average and below the figure for aid flows to both low and lower-middle income countries (Figure 4).

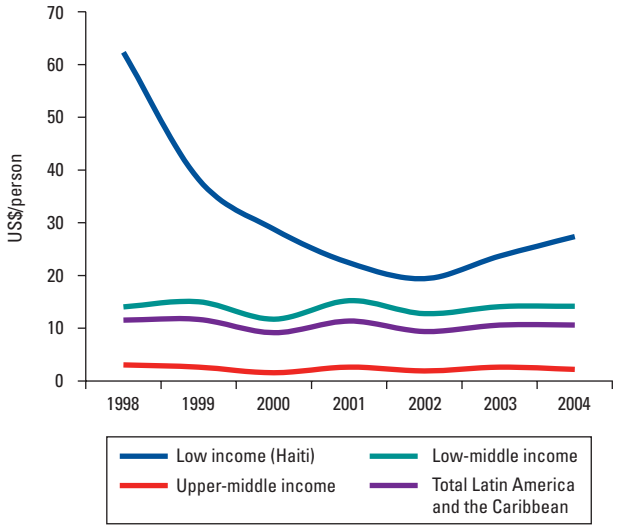
Classification of World Economies

According to the World Bank classification of world economies, low income countries are those with a gross national income (GNI) per capita at or below US$ 905. Countries with a GNI per capita of between US$ 906 and US$ 3,595 are classified as lower-middle income countries, and countries with a GNI per capita of between US$ 3,596 and US$ 11,115 are classified as upper-middle income countries. High income countries have a GNI per capita of over US$ 11,115. The only country in Latin America and the Caribbean classified as a low income country is Haiti, while Antigua and Barbuda, Aruba, Bahamas, Barbados, Bermuda, the Netherlands Antilles, and Trinidad and Tobago are classified as high income economies.

Argentina, Belize, Brazil, Chile, Costa Rica, Dominica, Grenada, Mexico, Panama, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Uruguay, and Venezuela are classified as upper-middle income economies. All other Latin American and Caribbean nations—Bolivia, Colombia, Cuba, the Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Jamaica, Nicaragua, Paraguay, Peru, and Suriname—are classified as lower-middle income countries.

Source: World Bank. Data and statistics, country classification.

FIGURE 4. Official development assistance per capita to Latin America and the Caribbean, by income level, 1998–2004.



Source: Organization for Economic Cooperation and Development. Online CRS database on aid activities and DAC online database on annual aggregates (http://www.oecd.org/dac/stats/idsonline).

In general, aid is the main component of foreign capital flows to low-income countries (representing 2.8% of their GNP), while middle-income countries have a much larger flow of private capital, with aid representing only 0.2% of their GNP (*5*).

Official Development Assistance for Health

ODA for health is the portion of assistance going to the health sector into such areas as basic health; basic health care; basic health infrastructure; control of infectious diseases; general health; medical services; training and research; health policy administration and management; population; population policy administration and management; reproductive health and health care; family planning; the control of sexually transmitted infections (STIs), including HIV/AIDS; and health and population (*2*).

According to recent OECD data, ODA for health grew at an average annual rate of 5.4% during the 1990–2005 period (*6*). The share of bilateral versus multilateral aid held steady over the 1996–2004 period, with two-thirds of health aid in the form of bilateral aid and one-third in the form of multilateral aid. Bilateral aid commitments for health by DAC member countries over the 1973–2003 period totaled US$ 66 billion, with another US$ 18 billion in loan commitments by development banks coming to the health sector during that same period.

The United States has been the leading bilateral donor for health aid in absolute terms, although Ireland has furnished the most health funding in relative terms (35% of health aid for the 2002–2004 period). The volume of multilateral aid has increased since 1999, and particularly since 2002 with the establishment of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, which furnished some US$ 3.7 billion in aid over the 2002–2006 period.

Worldwide disbursements of ODA for health during the 2002–2004 period totaled US$ 8.58 billion, of which 45% went to Africa and 17% was allocated to Latin America and the Caribbean (US$ 402.6 million). These funds were used mainly to combat STIs, including HIV/AIDS, and for the implementation of health and population and primary health care policies (*7*).

However, aid to Latin America and the Caribbean for the control of STDs and HIV/AIDS accounted for only 7% of worldwide ODA for health (Figure 5). In contrast, funding for medical services and training and research in the region accounted for 14% of worldwide health-related ODA allocated to this area. A breakdown of ODA flows over the 1990–2004 period by sector shows a slight upward trend in aid to the health and population sector, whose share of the total went from 4% in 1990 to 7% in 2004 (Table 1).

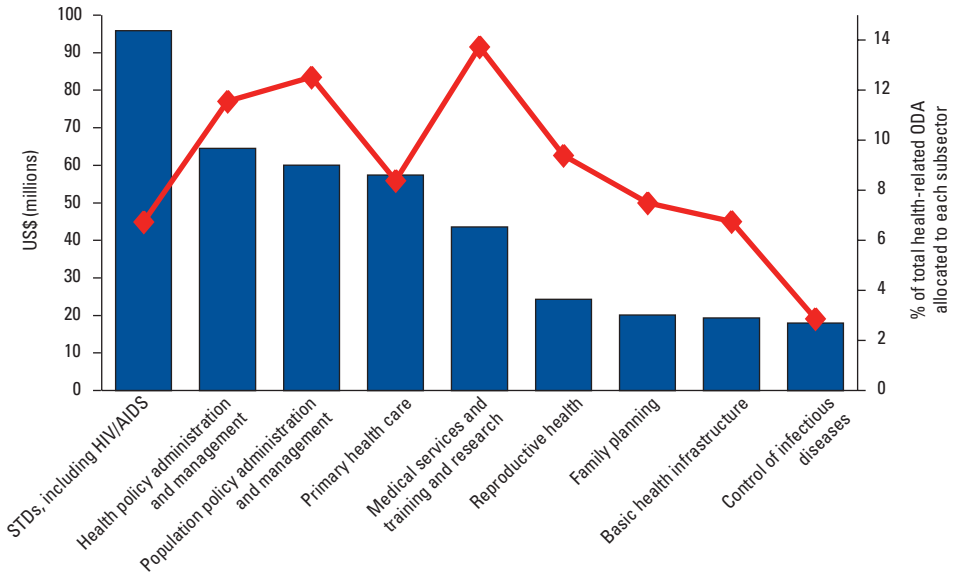
ODA for Health in Latin America and the Caribbean

Health funding accounted for 13% of total worldwide ODA for the 2002–2004 period (*6*), up from 8.7% for the period 1996–1998. The 11% share of total ODA allocated to the Latin American and Caribbean region in 1998 had declined to 8.7% by 2004. While there is clearly an upward trend in worldwide aid for health, the level of aid going to Latin America and the Caribbean is declining, which took in US$ 402.6 million in health aid over the period 2002–2004 from bilateral, multilateral, and private sources (*7*) (Figure 6).

Bilateral agencies furnished 75% of all health aid for Latin America and the Caribbean over the period 2002–2004. The five leading donor countries were the United States, Japan, Spain, France, and Canada, with France and Canada earmarking the largest share of aid funding for the health sector and allocating at least 10% of all health aid to Latin America and the Caribbean (Table 2). The largest donor of cooperation funding for health in Latin America and the Caribbean in absolute terms was the United States, which furnished more than US$ 135 million.

Multilateral organizations furnished 22% of all health aid for Latin America and the Caribbean over the period 2002–2004, with 8% of all health aid disbursements for the Latin American and Caribbean region by multilateral organizations during this period made by development banks, in the form of reimbursable financial cooperation. The *World Bank Group* provided more than US$ 5.3 billion in assistance for Latin America and the Caribbean in fiscal year 2004 (*8*), including US$ 5 billion in the form of International Bank for Reconstruction and Development loans and US$ 338 million in International Development Association credits. As of June 2004, its ongoing project portfolio in Latin America and the Caribbean totaled US$ 19.3 billion. In fiscal year 2003, the World Bank channeled 27% of its loans (US$ 1.57 billion) into the funding of health projects and crucial social services in Latin American and Caribbean nations. World Bank-financed health-related projects have buttressed policies in Latin

FIGURE 5. Official development assistance for health to Latin America and the Caribbean, amounts and percentage, by sector, 2002–2004.



Source: Organization for Economic Cooperation and Development. Online CRS database on aid activities and DAC online database on annual aggregates (http://www.oecd.org/dac/stats/idsonline).

American and Caribbean countries designed to improve health and nutritional conditions and population outcomes for the poor.

The volume of *Inter-American Development Bank* lending in 2005 topped US$ 7 billion (*9*), up 17% from the previous year. Loan disbursements increased by nearly 20%, totaling US$ 5.3 billion.

The *Central American Bank for Economic Integration* approved a total of US$ 2.45 billion in loans during 2004 and 2005, with US$ 2.43 billion in disbursements (*10*), representing a quarter of the value of all loans approved and disbursed in the entire history of the Bank and making it the main source of multilateral development financing for Central America. There were important breakthroughs in 2005 in the Bank's three strategic areas of globalization, integration, and poverty alleviation (*11*), with large numbers of loans being approved for the social sectors, including health. The Bank furnished US$ 13.6 million in nonreimbursable cooperation funding in 2004 and 2005 in support of various projects, including fire prevention and training programs and rehabilitation for burned children in Central America and initiatives designed to strengthen social integration.

The *Andean Development Corporation* approved approximately US$ 43 billion in financing in 2005 (*12*), with more than US$ 30 billion in disbursements and a total loan and capital investment portfolio of over US$ 8 billion. In its 35 years of operation, the Corporation has become the leading source of multilateral financing for Andean Community nations and an important alternative source of financing for its other shareholders.

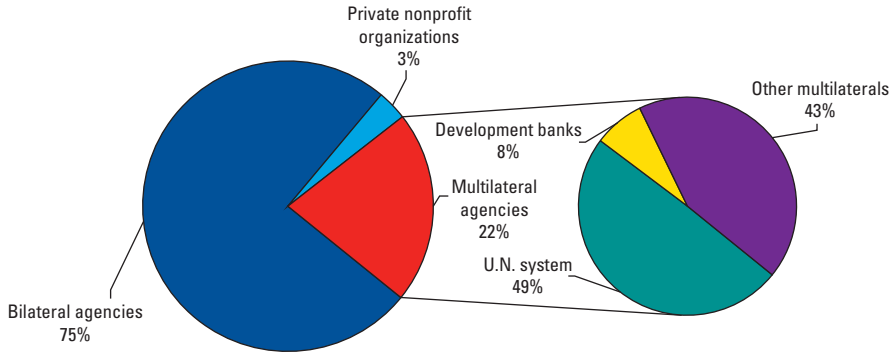
The *Caribbean Development Bank* approved 15 loans in 2005 (*13*) totaling US$ 146 million and another US$ 14 million in

TABLE 1. Official development assistance to Latin America and the Caribbean, by sector, 1990–2004.

Sector	1990–1992	1993–1995	1996–1998	1999–2001	2002–2004
Education	4%	3%	6%	7%	8%
Health and population	4%	8%	8%	6%	7%
Water supply and sanitation	5%	9%	9%	7%	4%
Other social sectors	22%	23%	21%	35%	38%
Economic infrastructure	21%	13%	14%	8%	5%
Production	13%	11%	12%	8%	10%
Multisector	12%	14%	8%	12%	11%
Other	19%	19%	22%	17%	17%
Total	100%	100%	100%	100%	100%

Source: Organization for Economic Cooperation and Development. Online CRS database on aid activities and DAC online database on annual aggregates (http://www.oecd.org/dac/stats/idsonline).

FIGURE 6. Official development assistance for health to Latin America and the Caribbean, by type of source, 2002–2004.



Total ODA for health: US$ 402.6 million

Source: Organization for Economic Cooperation and Development. Online CRS database on aid activities and DAC online database on annual aggregates (http://www.oecd.org/dac/stats/idsonline).

grants for member countries of the Caribbean Community. Approximately 12% of all financing approved by the Bank was for the health and disaster mitigation and risk management sectors.

Private organizations (philanthropic foundations and NGOs) supplied 3% of all health aid for Latin America and the Caribbean during the 2002–2004 period. According to independent reports on private aid flows (*10*), some 68,000 corporate, community, or independent foundations made US$ 33.6 billion in grants to countries around the world in 2005, 5.5% above the level of funding furnished by these same sources in 2004. The Latin American and Caribbean region and Africa rank third and fourth among recipients of philanthropic foundation funding, after the Asian Pacific and Eastern Europe. U.S. foundations contributed US$ 3.2 billion in 2002, US$ 3.0 billion in 2003, and US$ 2.8 billion in 2004.

Foundations around the world allocated approximately US$ 3.4 billion to health projects in 2004, which translates into an annual growth rate of 1.3% for the 2001–2004 period. This increase in funding was attributable to a US$ 750 million contribution by the Bill & Melinda Gates Foundation to the GAVI Alliance (formerly known as the Global Alliance for Vaccines and Immunization). The Bill & Melinda Gates Foundation made 112 grants for health totaling US$ 1.2 billion in 2004.

The Pan American Health and Education Foundation (PAHEF) is an especially important philanthropic foundation for the Region of the Americas. PAHEF administers health-related grants and presents international awards recognizing excellence in inter-American health, community service, health literature, veterinary public health, and bioethics.

TABLE 2. Health aid for Latin America and the Caribbean, by funding source, 2002–2004.

Donor	Health aid (US$ million)	Share of total health aid (%)	Aid to all sectors (US$ million)
United States	135.2	33.6	1776.0
Japan	44.0	10.9	944.0
GFATM	37.2	9.3	37.2
Spain	34.5	8.6	537.4
UNFPA	33.0	8.2	33.0
France	24.7	6.1	243.5
Canada	13.0	3.2	131.1
Netherlands	11.4	2.8	265.8
Germany	10.5	2.6	737.2
Switzerland	9.8	2.4	124.7
Other sources	49.3	12.3	624.2
All donors	402.6	100	5,454.1

GFATM: Global Fund to Fight AIDS, Tuberculosis and Malaria.
UNFPA: United Nations Population Fund.
Source: Organization for Economic Cooperation and Development. Online CRS database on aid activities and DAC online database on annual aggregates (http://www.oecd.org/dac/stats/idsonline).

"Over the past decade, the most important accomplishment in the field of public health in the Americas has been the rapid increase in international collaboration to solve health problems in the hemisphere and the sustained improvement in the coordination of activities of the various official entities participating in this work."

Fred Soper, 1958

Global Burden of Disease and Official Development Assistance for Health

The purpose of ODA for health is to help developing countries meet their health goals as a way of promoting the population's development and well-being. These health goals are set based on each country's health priorities, generally using health situation indicators showing the types of diseases and injuries responsible for the deterioration in human health.

The use of health measurements based on health-adjusted life expectancy estimates has become increasingly common in the last 30 years. Generically, when such measurements are based on a population approach, they are referred to as synthetic or summary measures of population health. One of the most useful such measures is the global burden of disease, a new indicator used to estimate and compare the magnitude of diseases, injuries, and risk factors in different parts of the world through a joint assessment of their lethal and nonlethal effects, referred to as disability-adjusted life years, or DALYS. By looking at flows of health aid within the framework of national health priorities, it is possible to establish their degree of consistency with these priorities.

The OECD has already highlighted discrepancies between health priorities as reflected by the burden of disease and health-related ODA (*14*). According to a 2002 World Health Organization (WHO) study on the global burden of disease (*15*), although HIV/AIDS accounted for only 2.3% of the total global burden of disease in Latin America and the Caribbean, 25% of all health aid received by Latin America and the Caribbean during the 2002–2004 period was allocated to combating HIV/AIDS. Likewise, even though noncommunicable chronic diseases accounted for 60% of the total burden of disease during the same period, this health category was allocated only 36% of all health aid (Figure 7). Finally, injuries accounted for 16% of the burden of ill health but were allocated only 10% of aid funding.

Figure 7 also provides similar information at the country level for Bolivia, Guyana, Haiti, Honduras and Nicaragua, the five leading recipients of health-related ODA in the Latin America and Caribbean region. These five countries all qualify for the World Bank/International Monetary Fund Highly Indebted Poor Countries (HIPC) initiative, a debt relief program assisting numerous countries around the world.

PUBLIC/PRIVATE PARTNERSHIPS: A NEW FORM OF HEALTH COOPERATION

While ODA is channeled through official government agencies in donor and recipient countries, over the past few years, an effort has been made to strengthen different types of partnerships between the public and private sectors. More than 70 health partnerships were formed over the 1995–2005 period involving many different types of stakeholders and achieving important gains (*16*).

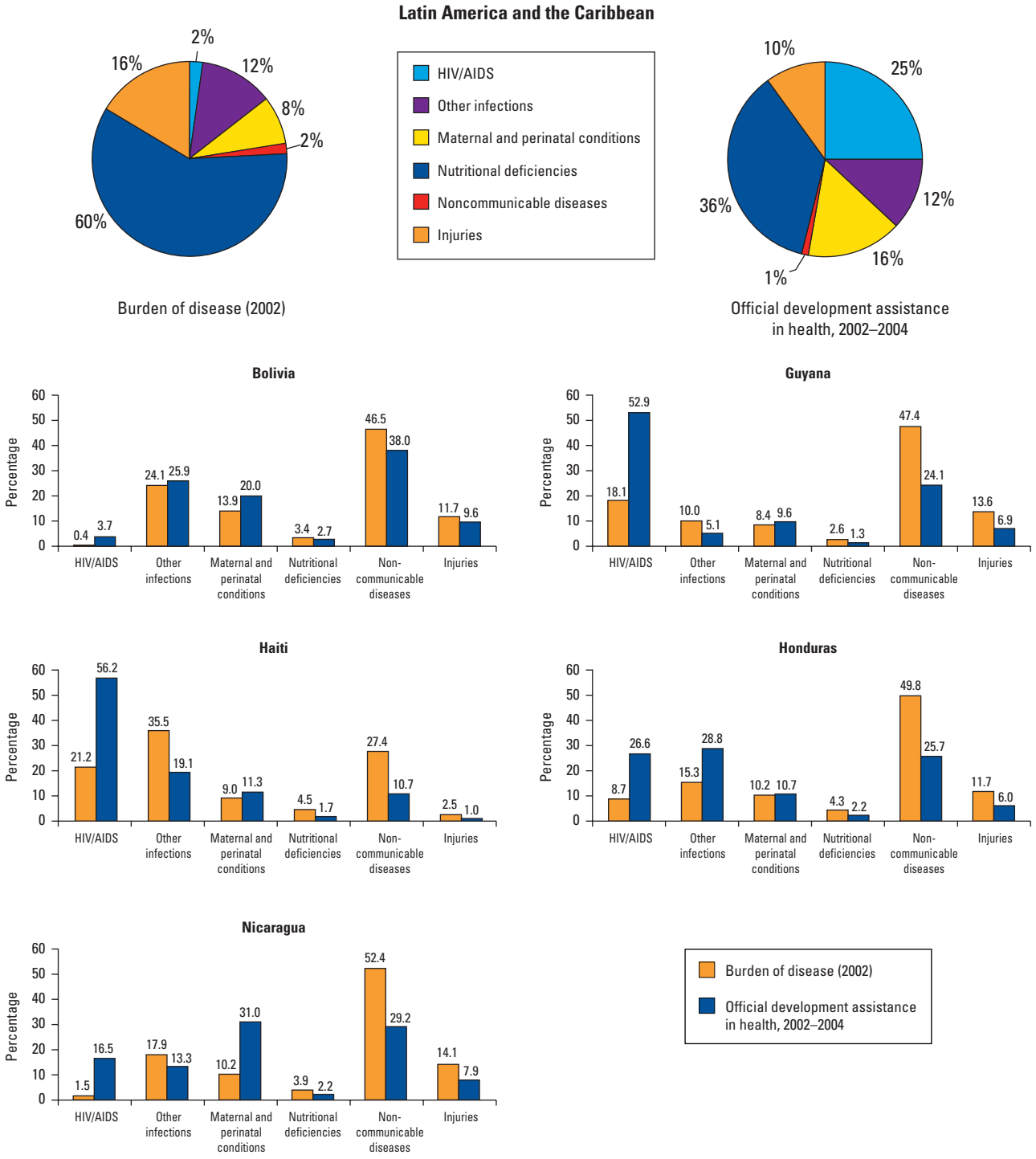
The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) has been a leading source of health aid funding since its inception in 2002. The Global Fund is a public/private partnership, whose board of directors consists of representatives of the governments of donor and recipient countries, NGOs, businesses, foundations, and impacted communities, as well as of key international development partners, including WHO, the Joint United Nations Program on HIV/AIDS, and the World Bank. The Global Fund was created specifically for purposes of radically increasing funding for combating three of the world's most devastating diseases and steering this funding into areas with the greatest needs. As a partnership of different governments, civil society, the private sector, and impacted communities, the Global Fund is an innovative approach to international health financing.

In five rounds of grant-making between 2002 and mid-2006, the Global Fund approved 350 program grants in 131 countries for a total of US$ 4.9 billion, with the largest share of funding going to Africa (Figure 8).

The Latin American and Caribbean region has been allocated a US$ 466 million share of all funding supplied by the Global Fund since its formation (*17*). Figure 9 shows grants and disbursements for Latin America and the Caribbean in all proposal rounds by the Global Fund.

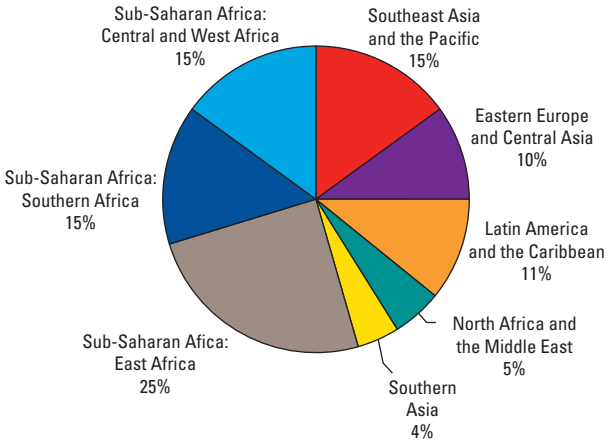
The Global Fund is the main donor for HIV/AIDS prevention and control interventions in Latin America and the Caribbean, with a total of 22 programs with approved GFATM funding for a five-year period. This funding was an important factor in meeting the target set by heads of state at the Special Summit of the Americas in Monterrey, Mexico (2004), which was to provide at least 600,000 individuals in the Americas living with HIV/AIDS with access to antiretroviral therapy by the year 2005. By the end of June of that year, there were an estimated 622,275 individuals in the Americas receiving treatment. Over the 2002–2005 period, 108,415 new courses of therapy were started in Latin America and the Caribbean, and the number of individuals receiving treatment grew from 196,000 to 304,415. Data for the sixth funding round published in November 2006 showed 85 new programs in 62 countries worldwide totaling US$ 846 million, with four Latin American and Caribbean nations (Cuba, Guatemala, Paraguay, and Peru) receiving US$ 48 million in funding.

FIGURE 7. Global burden of disease and official development assistance in Latin America and the Caribbean and in Bolivia, Guyana, Haiti, Honduras, and Nicaragua, 2002–2004.



Source: Organization for Economic Cooperation and Development. Online CRS database on aid activities and DAC online database on annual aggregates (http://www.oecd.org/dac/stats/idsonline).

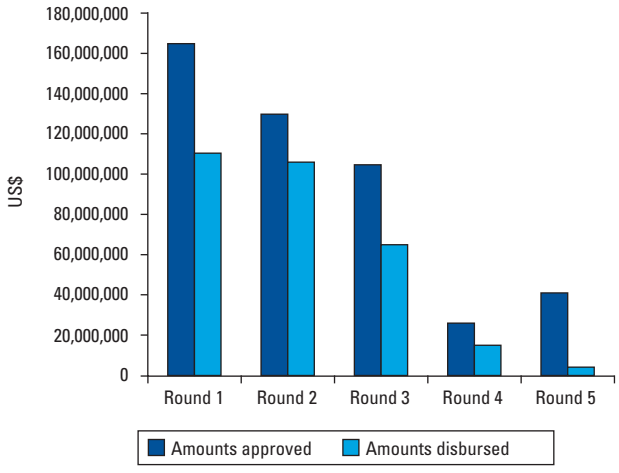
FIGURE 8. Aid disbursements by the Global Fund to Fight AIDS, Tuberculosis, and Malaria, by region, 2002–mid-2006.



Source: The Global Fund to Fight AIDS, Tuberculosis and Malaria. Funds committed and disbursed. (http://www.theglobalfund.org)

The Global Alliance for Vaccines and Immunization (now known as the *GAVI Alliance)* was formed in 2000 to help the poorest countries provide enough vaccines to immunize their entire child populations. This public/private partnership builds on the strengths of various immunization partners, including governments, the United Nations Children's Fund (UNICEF), PAHO/WHO, Bill & Melinda Gates Foundation, World Bank, vaccine manufacturers, NGOs, and research centers. As of 2005, the Alliance had raised nearly US$ 3.3 billion in traditional financing from governments and private donors and collected more than half this sum (*18*). As of the end of that same year, GAVI had successfully vaccinated millions of children previously without access to this coverage, administering the combination diphtheria-pertussis-tetanus vaccine to close to 13 million children and vaccinating 90 million children against hepatitis B, approximately 14 million children against *Haemophilus influenzae* type b, and some 14 million children against yellow fever. Estimates put the number of premature deaths prevented through the assistance furnished by GAVI as of the end of 2005 at over 1.7 million. Some of these deaths would have involved infants, while others (deaths from vaccine-preventable diseases such as hepatitis B) would have cut short the lives of adults during their most productive years.

FIGURE 9. Amounts approved and disbursed by the Global Fund to Fight AIDS, Tuberculosis, and Malaria, Latin America and Caribbean region, 2002–mid-2006.



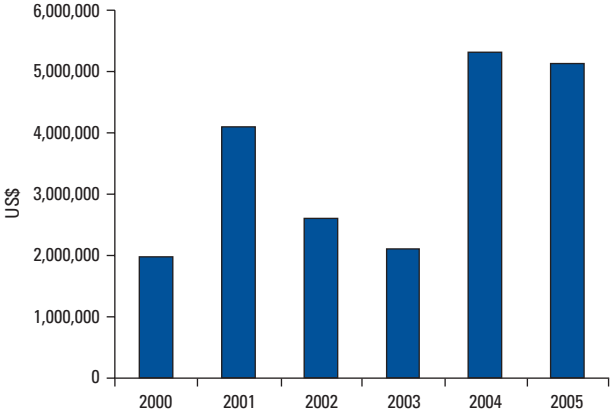
Source: The Global Fund to Fight AIDS, Tuberculosis and Malaria. Funds committed and disbursed. (http://www.theglobalfund.org)

The Onchocerciasis Elimination Program for the Americas (OEPA) is the product of a decision made in 1987 by the international pharmaceutical firm of Merck Sharp & Dohme to provide supplies of the drug ivermectin to onchocerciasis control programs free of charge. The OEPA was created in 1991 as a multinational partnership of various types of entities, endemic countries, NGOs, the U.S. Centers for Disease Control and Prevention, academic institutions, lending agencies, and PAHO. The OEPA is supported by the River Blindness Foundation and the Carter Center in the United States. It has marshaled the necessary political, economic, and technical support to work towards the goal of eliminating all morbidity from onchocerciasis from the Region of the Americas by the year 2007 through the mass distribution of ivermectin (*19*). The goal of the OEPA is to interrupt the transmission of river blindness in six endemic countries in the Region of the Americas: Brazil, Colombia, Ecuador, Guatemala, Mexico, and Venezuela. In 2002, national programs in these countries administered 749,182 ivermectin treatments, reaching 65%–85% of the affected population.

The Western Hemisphere countries stepped up their *cooperation in the management of natural disasters* over the 2001–2005 period, including national disaster programs in the health sector, by forging better working relations with various international organizations such as UNICEF, the United Nations Development Program (UNDP), and the United Nations Office for the Coordination of Humanitarian Affairs; NGOs such as the International Federation of Red Cross and Red Crescent Societies, the International Committee of the Red Cross, and Doctors Without Borders; and donor countries, particularly Canada, the United Kingdom, and the United States.

A total of US$ 21,195,085 in funding was raised over the 2000–2005 period from various donors to meet Region-wide needs for controlling and mitigating the effects of emergencies and disasters in the Americas. This was achieved by strengthening alliances and partnerships with bilateral and multilateral cooperation agencies and private organizations, with 85% of this aid coming from bilateral cooperation agencies. The United Kingdom furnished the largest volume of funding through the Department for International Development, its official cooperation agency, followed by the European Commission's Humanitarian Aid Office. The five leading recipients of this assistance dur-

FIGURE 10. Emergency and disaster management aid to Latin America and the Caribbean, 2000–2005.



Source: Pan American Health Organization (PAHO), Emergency Preparedness and Disaster Relief.

ing 2000–2005 were Colombia, El Salvador, Guatemala, Haiti, and Nicaragua. The volume of disaster aid going to Latin America and the Caribbean increased from nearly US$ 2 million in 2000 to more than US$ 5 million in 2005 (Figure 10).

TECHNICAL COOPERATION AMONG COUNTRIES

As the supply of cooperation funding in the form of ODA for Latin America and the Caribbean has dwindled, the developing countries have looked for new types of cooperation to complement ODA, such as Technical Cooperation among Countries (TCC). TCC is, basically, a process in which two or more countries work together to build individual or collective capacity through cooperative exchanges of knowledge, skills, resources, and technology. The main characteristic of TCC is the sharing of specialized skills and successful experiences in health among countries in a more horizontal, reciprocal, and comprehensive relationship than that of classic official development assistance, which tends to be unidirectional. TCC, also known as horizontal cooperation or South-South cooperation, was originally designed to complement ODA and help offset the dwindling supply of cooperation resources from traditional donors who, with worldwide pressure from economic reforms and current political phenomena, have changed their aid priorities in terms of both the geographic regions targeted and the issues addressed.

Unlike the case of ODA, in which aid flows are monitored by the OECD through a detailed database, there is no single source of consolidated, standardized data on TCC.

PAHO, in particular, approved a total of 175 TCC projects over the 1998–2003 period, or 51 projects (29%) in the two-year 1998–1999 period, 56 projects (32%) in the two-year 2000–2001 period, and 68 projects (39%) in the two-year 2002–2003 period. The five countries in the Americas qualifying for the HIPC initiative—Bolivia, Guyana, Haiti, Honduras, and Nicaragua—are all actively participating in TCC projects sponsored by PAHO. Of a total of 44 projects approved in the two-year 2004–2005 period, 18 (41%) involved one of these five countries (*20*).

More than half of all available TCC resources from PAHO during the 1998–2003 period went to the Andean area and Central America, helping to promote the active exchanges of skills and experiences among the countries in these subregions in areas such as disease control and risk management, environmental health, family and community health, health care services, intersectoral action, disaster mitigation and risk management, and humanitarian aid (*21*).

TCC Project Helps to Improve Health Conditions of South American Chaco Residents

The Chaco is a remote region with an inhospitable climate spanning parts of Argentina, Bolivia, and Paraguay. Its inhabitants are various ethnic and indigenous groups whose rights to health and an adequate standard of living have long been overlooked. In 2000, the residents of the Chaco joined efforts to improve their living conditions, using a health approach as the principal integrating focus.

The Confederation of Indigenous Peoples of the South American Chaco Region (COPICHAS) mounted a project over the 2000–2003 period, with assistance from PAHO/WHO, whose goal was to develop and strengthen the Confederation's institutional capacity to implement strategies and carry out programs to improve health conditions and the quality of life of Chaco residents. The main components of the project were geared to strengthening communications among the different indigenous groups of the area, training the local leadership in social project management, and capacity-building for analysis of health situation and living conditions. Project outcomes include the establishment by COPICHAS of an organizational infrastructure for mounting long-term, sustainable cooperation initiatives in conjunction with other indigenous organizations.

HARMONIZATION, ALIGNMENT, AND COORDINATION OF INTERNATIONAL COOPERATION RESOURCES FOR HEALTH

One of the main challenges in terms of international cooperation for health in the Americas is the need to achieve harmonization, alignment, and the most effective coordination of resources possible.

The leading multilateral development banks, international organizations, bilateral agencies, and representatives of recipient countries gathered in Rome in February 2003 for the First High-Level Forum on Harmonization. The Paris Declaration on the effectiveness of development assistance, approved by delegates to the Second High-Level Forum in March 2005, made a change in the aid effectiveness program, turning the general consensus forged in Rome into more specific commitments to step up harmonization, alignment, and coordination efforts, and established mechanisms for monitoring progress in this direction (*22*).

The Rome Declaration (*23*) spelled out the commitment of its signatories to ensure that harmonization efforts were tailored to circumstances in recipient countries and that development assistance was aligned with the priorities of the partner/recipient country and in keeping with the good practices agreed upon by the international community at that meeting.

The participants in the Second High-Level Forum in 2005 evaluated progress in this area. In addition to representatives of all bilateral and multilateral cooperation agencies active in the Region of the Americas, the meeting was also attended by representatives of Bolivia, Guatemala, Guyana, Honduras, Jamaica, and Nicaragua.

As new modalities of technical cooperation, alignment and harmonization are clearly the new trend in assistance provision. "Harmonization" refers to donor efforts to synchronize their respective operations, while "alignment" is the synchronization of donor priorities with priorities in the recipient country, which are given precedence. The main goal of aid alignment and harmonization efforts is to build leadership in recipient countries and country ownership of the goals of the foreign assistance and to avoid duplication of efforts and structures for the delivery and monitoring of such aid, which not only increases the transaction cost of aid, but places more of a burden on the recipient country.

The harmonization and alignment agenda includes all types and modalities of aid and is designed, among other things, to ensure that a larger share of aid is delivered through mechanisms promoting program-based approaches such as budget support and sector-wide approaches (SWAPs), in which all major funding allocated to a particular sector goes to support a single spending program and policy and the government is the sole implementation and distribution agency for these funds.

In the Americas, discussions of initiatives such as the Poverty Reduction Strategy and SWAPs as part of the aid alignment and harmonization process are beginning to pick up momentum. An evaluation of budget support as an aid disbursement mechanism in 2001 revealed what were clearly positive outcomes in five of the seven countries studied: Burkina Faso, Malawi, Mozambique, Nicaragua, Rwanda, Uganda, and Vietnam (*24*).

In the Americas, Bolivia, Brazil, the Dominican Republic, Ecuador, Guyana, Honduras, Jamaica, Mexico, and Nicaragua have all mounted aid harmonization and alignment efforts (*25*) tracked as a part of monitoring activities by the World Bank. However, though such processes are already underway in the countries of Latin America and the Caribbean, efforts in this respect in the health sector remain somewhat limited to date.

Along these same lines, the United Nations reform process is designed to improve the efficiency and effectiveness of the operations of various U.N. agencies in developing countries. The United Nations Development Group is using two tools to achieve its goals in this reform process: Common Country Assessments and the United Nations Development Assistance Framework, both of which are designed to better synchronize inter-agency operations in developing countries, while at the same time serving as an opportunity to promote intersectoral action in the Americas.

THE FUTURE OF INTERNATIONAL COOPERATION IN THE AMERICAS

The most important challenge for Latin America and the Caribbean with respect to ODA is, at the very least, to sustain the share of aid for health in the Americas at its current level in the face of the priority accorded other parts of the world in recent years.

On one hand, the number of Latin American and Caribbean nations eligible for official bilateral aid from donor countries is steadily decreasing with the reported progress in the indicators of poverty and well-being used by such countries, despite the persisting gaps and inequities in this region. Moreover, there is an urgent need to make the use of ODA resources more effective by aligning aid flows with country interests and priorities and by better synchronizing the operations of the different bilateral and multilateral agencies and organizations supporting work in the health sector in these countries.

Without question, one of the greatest challenges facing the Americas is the implementation of the Health Agenda for the Americas 2008–2017 endorsed by the Governments of Western Hemisphere countries as a framework for joint action by national and international stakeholders with an interest in helping to improve the health of the peoples of this Region over the next decade.

TCC is an option for addressing the likely rollback in future financial aid to the Americas. The countries of this Region have developed adequate and, in some cases, mutually complementary capacities and skills for the attainment of health and development goals in Latin America and the Caribbean. Nevertheless, it is important that such projects take a long-range view. Exchanges within the framework of TCC activities need to be viewed

as the first step in a longer-term, sustainable process that will require time and additional funding as well as the establishment of mechanisms to help countries define the expected outcomes of TCC activities, bearing in mind their long-term impact, including corresponding monitoring and evaluation methods and procedures.

More specifically, the Americas have gained a considerable amount of experience in disaster management, with international cooperation playing a pivotal role in strengthening disaster mitigation, preparedness, and response systems. The Region has learned to share its experience and capabilities with other parts of the world, surmounting geographic barriers and establishing a virtuous cycle global cooperation in coping with disasters. In the wake of natural disasters such as the powerful earthquake striking Bam, Iran, in 2003; the devastating Indian Ocean tsunami of 2004; and the major earthquake hitting Pakistan and India in 2005, experts from various Latin American and Caribbean nations quickly responded with invaluable assistance and solidarity, thereby providing a model for efficient and effective international cooperation.

> *"International organizations in general need to accept the fact that they confront fundamental demands for change. The prospects for such change are under way, including the implementation of a series of new approaches for the 1990s. These approaches encourage subregional initiatives by groups of countries, favor closer relation between national priorities and initiatives and technical cooperation efforts, press for realizing the full potential of available national resources, support decentralization and regionalization of national health systems, and favor concentrating efforts on the most critical areas in need. Beyond that, we are also pressing for acknowledgment of the major impact that political decisions have on health activities, for application of the "health for all" principles and primary care strategy, for integration of health into the socioeconomic process, and for better application of science and technology to meet people's basic needs."*
>
> **Carlyle Guerra de Macedo, 1990**

HEALTH AND INTEGRATION PROCESSES IN THE AMERICAS

Today's world is shaped by two parallel, mutually complementary phenomena: globalization and regional integration. On the one hand, globalization promotes interdependence by placing all countries in a single arena in which they are forced to compete for markets and capital while, on the other hand, regionalization seeks to create integration blocs of countries with a shared history and culture and, in some cases, common borders to improve their development opportunities and options in a globalizing environment.

Regional integration processes in the Americas are principally motivated by political and economic goals, with countries seeking to protect their autonomy and identity while at the same time positioning themselves in a stimulating albeit hostile and competitive globalized environment. Regional integration processes in the Americas have their own development dynamics, with periods of stagnation and development, in which trade issues are given top priority. However, such processes have all helped lay the groundwork for progress in social areas, including those related to health.

Integration in the Southern Cone

The Southern Cone countries of South America—Argentina, Brazil, Chile, Paraguay, and Uruguay—are members of several subregional integration or cooperation blocs simultaneously and have forged subregional alliances in the area of health, which in some cases have been incorporated into economic integration processes.

The Southern Cone is a heterogeneous subregion in terms of its social, economic, demographic, epidemiological, and health situation characteristics and the responsiveness of its health systems, which vary not only from one country to another, but within different geographic areas of the same country. In terms of population, Brazil is the largest nation, with more than 186 million inhabitants, while Uruguay accounts for the smallest share of the subregion's population, with more than 3 million inhabitants. Brazil (21.8%) and Uruguay (19.6%) have the highest population densities, while Paraguay (15.1%) and Argentina (13.9%) have the lowest population densities. Looking at the population's age structure, Paraguay (at 70.5%), with its more youthful population, and Uruguay (at 60%), with the steady growth in its older adult population, have the highest dependency ratios of the five Southern Cone countries. All of the countries have a predominantly urban population, with the sole exception of Paraguay. According to population data for 2005, Argentina (at 26.4%) and Uruguay (at 24.3%) were two of the four Latin American and Caribbean countries (along with Cuba and Chile) with the smallest share of youths under the age of 15 (*26*).

The Southern Cone has a fairly small indigenous population. In Brazil, 52.2% of the indigenous population lives in urban areas, compared with a mere 8.4% of the indigenous population of Paraguay. There are large differences in national averages for the Southern Cone countries in terms of per capita income, as well as in the income ratios for the top and bottom 20% of their respective populations (*26*).

MERCOSUR is the principal regional integration process for the Southern Cone countries, all of which hold either full or associate membership status. These countries are also members of the Union of South American Nations. Brazil is a member of the

Amazon Cooperation Treaty Organization, while Chile is a member of the Andean Health Agency-Hipólito Unánue Agreement on Health.

MERCOSUR is the customs union (a free trade area with a common trade policy) for Argentina, Brazil, Paraguay, and Uruguay. Thus far, Chile (1996), Bolivia (1997), and Peru (2003), and Colombia, Ecuador, and Venezuela became associate members (2004), with Venezuela later becoming a full member (2006).

MERCOSUR has three decision-making bodies: the Common Market Council, the Common Market Group, and the MERCOSUR Trade Commission, which is a technical body. There are 15 Working Subgroups for the coordination of macroeconomic and sector policies, including groups on the Environment, Agriculture, Labor Issues, Employment and Social Security, and Health. MERCOSUR also includes other advisory bodies, such as the Joint Parliamentary Commission, the Economic and Social Consultative Forum, and the Commission of Permanent Representatives to MERCOSUR. Its Secretariat is permanently headquartered in Montevideo, Uruguay.

Meetings of MERCOSUR health ministers deal with the harmonization of health policies, while Working Subgroup 11 (Health) deals with the harmonization of health regulations. As an integration process, the health challenges addressed by MERCOSUR all have to do with sustaining ongoing efforts to harmonize regulations as the basis for free trade in health products. The main needs are to improve the institutional performance of regulatory agencies and the harmonization of corresponding regulations, including provisions relating to good manufacturing practices and quality control for the pharmaceutical industry, blood and blood products, medical supplies, household health supplies and chemicals, information and epidemiological information processing systems, and technology evaluation, among others. According to the MERCOSUR agenda, the focus of this subregional integration and cooperation process is on access to timely information; organ, tissue, and cell donation and transplants; implementation of the International Health Regulations; a health surveillance system for dengue and other diseases; improving health conditions in border communities; developing an integrated policy for controlling the HIV and STD epidemics; sexual and reproductive health; an integrated tobacco control policy, oversight in the management of natural disasters and incidents with hazardous materials; an environmental and occupational health policy; public health research; and equitable access to knowledge as a health-related regional public good within the framework of MERCOSUR.

Integration in the Andean Area

The Andean area consists of Bolivia, Chile, Colombia, Ecuador, Peru, and Venezuela. Colombia has the largest population (with 41,242,948 inhabitants), and Bolivia has the smallest population (with 9,182,000 inhabitants). Ecuador has the highest population density, while Bolivia has the lowest population density. A look at the age structure of the Andean area's population shows Bolivia with the highest dependency ratio due to its large child population and steadily growing older adult population.

Bolivia and Ecuador and, to a lesser extent, Peru have primarily rural populations. These same countries have a large indigenous population, generally concentrated in sparsely populated rural areas.

International migration is one of the most complicated and challenging phenomena for the Andean area countries, where patterns of migration in terms of points of origin and destination are constantly changing. However, there are certain more or less typical interregional and intra-regional migratory movements. In general, the main type of migration is labor-related, tied to the deep-seated economic imbalances between the area countries. Another major cause of migration is the displacement of entire groups as a result of political violence and internal strife, such as in the case of Colombia. The Office of the United Nations High Commissioner for Refugees estimates the number of internally displaced persons in Andean area countries at somewhere between 2 and 3.3 million, many of whom seek refuge in other area countries.

The integration movement in this area began in 1969, culminating with the official establishment of the **Andean Community of Nations** in 1996, whose General Secretariat is headquartered in Lima, Peru. The Andean Community currently consists of Bolivia, Colombia, Ecuador, and Peru, with Argentina, Brazil, Chile, Paraguay, and Uruguay serving as associate members.

The counterpart of the Community's political and trade integration process in the health sector is the Meeting of Andean Area Health Ministers (REMSAA, for its Spanish acronym) of signatory countries to the Hipólito Unánue Agreement for Cooperation in Health in Andean Area Countries. This agreement, officially referred to as the Andean Health Agency-Hipólito Unánue Agreement (ORAS-CONHU, for its Spanish acronym) since 2002, is designed to synchronize and bolster individual and joint efforts by member countries to improve their population's health. It coordinates and promotes activities geared to improving health conditions in member countries, giving top priority to cooperation mechanisms fostering the development of subregional systems and methodologies. To this end, it coordinates efforts in furtherance of this goal with those of other subregional, regional, and international organizations. The governing body for the ORAS-CONHU is REMSAA.

REMSAA has made some progress in improving access to drugs, and the Subregional Technical Commission for a Drug Access Policy has developed a work plan for carrying on joint negotiations with respect to HIV/AIDS medications.

To address border health issues, ORAS-CONHU is implementing the PAMAFRO Project aimed at controlling malaria in border zones of the Andean countries, and, specifically, lowering the dis-

ease's incidence in the highest-incidence areas. The project has received funding from the Global Fund to Fight AIDS, Tuberculosis, and Malaria and technical cooperation and logistical assistance from PAHO/WHO, as the product of an initiative among Andean area ministers of health and coordinated efforts by Ecuador, Colombia, Peru, and Venezuela (*27*).

Malaria and dengue are still major public health problems in all Andean area countries with the exception of Chile. In the case of malaria, the magnitude of the problem is further compounded by the resistance of *Plasmodium falciparum* to cloroquine and other antimalarial drugs. All four dengue virus serotypes are in circulation in the Andean area, producing outbreaks of dengue hemorrhagic fever in the past few years. While human rabies transmitted by dog bites is in the process of being eliminated, there are still bat-transmitted wild rabies outbreaks in the Amazon region, affecting mainly resident indigenous communities. The HIV/AIDS epidemic is still concentrated among high-risk population groups. Its prevalence rate in adults aged 15–49 is 0.5%, compared with rates of over 10% among men who have sex with men, with a large margin of fluctuation according to the city and population group in question. The principal transmission mode is through sexual contact, although in Chile, parenteral transmission by intravenous drug users is also an important mode of transmission. Stepped-up trade and free trade agreements have created a need for the incorporation of plant and animal health regulations into existing food safety legislation, as well as for the establishment of laboratory networks to inspect and certify the quality of food products earmarked for domestic consumption and export.

Integration in Central America

The Central American area includes the countries of Belize, Costa Rica, the Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, and Panama, with a population of approximately 50 million inhabitants. As far as its cultural diversity is concerned, Guatemala puts the share of its indigenous and/or native population at 48%, compared with 19% for Belize, 10% for Panama, 8% for Nicaragua, 7% for Honduras, 2% for Costa Rica, and an estimated 11% for El Salvador in 2006 (*26*). According to a UNDP report, there are a total of approximately 6,100,000 members of indigenous groups in this subregion (which account for 12% of the total population of Central America and the Dominican Republic) (*28*). This same source reported a total of 506,753 immigrants in all Central American countries combined in 2001, with close to 70% coming from within the Central American subregion, and 59% of the immigrants going to Costa Rica and 16% to Panama.

There were roughly 1,300,000 emigrants from Central American countries in or around 1990, whose main country of destination was the United States. By the year 2000, this figure had jumped to close to 1,800,000.

There are large divides between the rich and poor in Central America in terms of their means and opportunities. The wealthiest 20% of the population of El Salvador, Guatemala, Honduras, and Panama has 20–25 times more income than the poorest 20%. The wealthiest 20% of the population of Costa Rica and the Dominican Republic has 10–12 times more income than the poorest 20%. Nicaragua has the largest income gap, which could potentially cause a regression in health and development indicators (*26*).

All area countries are part of the **Central American Integration System (SICA)**, in which the Dominican Republic is an associate state and the other countries are member states. The Central American countries have been involved in integration processes for more than 40 years, achieving a number of major breakthroughs in the 1990s. The Tegucigalpa Protocol of 1991 created and implemented a new institutional framework based on SICA and established a basic program platform known as the Alliance for Sustainable Development.

The SICA General Secretariat is permanently headquartered in San Salvador, El Salvador, although several SICA entities are based in other countries. The Central American Parliament, for example, is based in Guatemala City, and the Central American Court of Justice is located in Managua, Nicaragua. ICA's top decision-making body is the Meeting of Heads of State and Government of its member countries. Other SICA bodies include the Executive Council of Foreign Ministers and Ministerial-Level Sectoral Councils, including the Council of Health Ministers. SICA also includes intersectoral bodies, such as the Meeting of Ministers of Agriculture, the Environment, and Health. It has a Consultative Committee and a Social Integration Secretariat, which operates as a specialized sectoral body. Other institutions include the Nutrition Institute of Central America and Panama, the Central American Higher University Council, the Regional Coordinating Committee for Water Supply and Sanitation Agencies, and the Regional International Organization for Plant Protection and Animal Health.

There have been Meetings of Central American Health Ministers since 1956. Since 1985, these meetings have been referred to as Meetings of the Health Sector of Central America and the Dominican Republic (RESSCAD) to reflect their expansion to include other health sector agencies and institutions, such as social security and water supply and sanitation agencies. The Dominican Republic became a full-fledged member in 2000 after attending the meetings as an observer for more than a decade. PAHO/WHO serves as the technical secretariat for RESSCAD under the provisions of Article 3 of the RESSCAD Regulations approved at the XVI RESSCAD Meeting held in 2000.

Other integration bodies helping to further the social agenda include the Central American Bank for Economic Integration; the Central American Public Administration Institute; the Central American Institute for Industrial Research and Technology; the Coordination Center for the Prevention of Natural Disasters in Central America; the Regional Water Resources Commission; the

"While new and reemerging diseases represent a threat, there are other worries too. Natural disasters, chemical and nuclear accidents, climate change and its consequences, and bioterrorism all have the potential to affect international public health security. However, the same forces of globalization that allow pathogens to move freely around the world, can also be used to build multinational partnerships to help us expand access to drugs and vaccines, improve public health infrastructure in developing countries, and launch better public health workforce education programs worldwide."

Mirta Roses, 2007

Permanent Central American Commission for the Eradication of Illegal Drug and Psychotropic Substance Production, Trafficking, Consumption, and Use; and the International Organization for Plant Protection and Animal Health.

In addition, there are a number of ad hoc intergovernmental secretariats, such as the Central American Council of Social Security Agencies, the Central American Electricity Board, the Central American Council for Sports and Recreation, the Central American Commission on Housing and Human Settlements, and the Science and Technology Commission of Central America and Panama.

Integration in the Caribbean

The Caribbean subregion includes the nations of Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, and Trinidad and Tobago; the British overseas territories of Anguilla, Bermuda, the British Virgin Islands, the Cayman Islands, Montserrat, and the Turks and Caicos Islands; the French overseas departments of French Guiana, Guadalupe, and Martinique; and the Netherlands Antilles autonomous territories of Bonaire, Curaçao, Saba, Saint Eustatius, and Saint Maarten.

The subregion is made up of small islands and mainland states with areas of anywhere from 13 km^2 (Saba) to 214,970 km^2 (Guyana) and populations ranging in size from approximately 1,400 inhabitants (Saba) to as many as 2,651,000 inhabitants (Jamaica). This multilingual, multiethnic, multicultural area is marked by wide gaps in socioeconomic development levels, health conditions, health needs, and available resources.

The framework for technical cooperation in this subregion is somewhat complex. The Caribbean countries are members of various subregional integration processes, some of which also include Latin American countries, such as the Amazon Cooperation Treaty Organization and the Association of Caribbean States (ACS). Moreover, all independent countries have bilateral agreements and relations with other countries, some with Cuba and others with multilateral financial institutions such as the World Bank and the International Monetary Fund. The GFATM, the President's Emergency Plan for AIDS Relief (a U.S. Government initiative created in 2003), and the William J. Clinton Foundation also fund health projects in this subregion. There are a number of powerful NGOs, trade associations, and private enterprises operating at the subregional and country levels marshalling resources that in many cases outstrip the volume of government funding. United Nations and Inter-American System agencies and organizations are also cooperation partners in this subregion.

The main subregional cooperation agency is the **Caribbean Community** (**CARICOM**), whose Secretariat headquarters are located in Georgetown, Guyana. The PAHO/WHO Office of Caribbean Program Coordination entered into an agreement with CARICOM in 1978 and is also involved in cooperation initiatives with the Organization of Eastern Caribbean States and the ACS. The Caribbean Epidemiology Center and the Caribbean Food and Nutrition Institute are specialized PAHO/WHO centers and CARICOM regional health institutions. Other health institutions within the CARICOM system include the Caribbean Environmental Health Institute, the Caribbean Health Research Council, and the Caribbean Drug Research and Testing Laboratory.

The Eastern Caribbean Cooperation Strategy for 2006–2009 crafted in 2005 by PAHO/WHO established the following five strategic directions: enabling the health systems to ensure equitable access and improve quality of services; strengthening public health leadership; reducing preventable mortality, avoidable morbidity, and disability in priority health areas; reducing vulnerability and threats to health arising from environmental and economic causes, including natural and other hazards; and enabling optimal use of global, regional, and subregional collective agreements for national health development (*29*).

The main health challenges for this subregion are reflected in the priorities set by CARICOM's strategic framework for cooperation in health known as the Caribbean Cooperation in Health (CCH) Initiative. The priorities for Phase II (1999–2003) of the Initiative were strengthened health systems, human resources development, family health, food and nutrition, chronic noncommunicable diseases, communicable diseases, mental health, and environmental health. Health promotion was viewed as a cross-cutting strategy. Among other things, the Nassau Declaration of 2001 by CARICOM Heads of Government endorsed CCH Phase II commitments as "the framework under which all regional and subregional, national, and institutional sector plans for health will be considered" and focused on HIV/AIDS, chronic noncommunicable diseases, and mental health as work priorities (*30*). A subsequent evaluation of Phase II of the CCH Initiative conducted at the request of the Heads of Government highlighted a number of achievements, along with a few weaknesses. Phase III, covering the period 2007–2015, whose design is nearly finalized, will address the findings of the Phase II evaluation.

Integration in North America

In January 1994, the **North American Free Trade Agreement (NAFTA)** was established among Canada, Mexico, and the United States. The NAFTA Secretariat headquarters are located in Ottawa, Mexico City, and Washington, D.C.

The three nations of North America, while they do share some similarities, are for the most part very different in social, economic, demographic, and epidemiological terms, as well as health conditions and the response capacity of health care systems. The population of the North American subregion is approximately 442 million (49% of the total population of the Region of the Americas as a whole). In each of the three countries, the majority of the population resides in urban areas; only 21% are rural inhabitants. Mexico has the highest crude birth rate (19.6 per 1,000 population), compared to 13.9 per 1,000 population in the United States and 10.1 per 1,000 population in Canada. The average dependency ratio is 49.9% for the three countries as a whole, with Mexico having the highest rate (56%) (*26*).

The North American subregion has a high migration rate and number of border crossings. Along the U.S.-Mexico border alone, there are an estimated 400 million border crossings a year (*31*). According to the International Organization for Migration, in 2006 approximately 450,000 undocumented persons emigrated from Mexico to other parts of the world, principally the United States and Canada (*32*). **A**ccording to U.S. immigation authorities, there are an estimated 11 million undocumented persons currently residing in this country, with 6 million of these coming from Mexico (*33*).

Trade between the three NAFTA partners has grown considerably over the past dozen years, standing at US$ 297 billion in 1993 and US$ 810 in 2005. One indication of the commercial interdependence between the three countries is the fact that Canada and Mexico have become the first and second largest markets, respectively, for the United States. Furthermore, Mexico has tripled the volume of its agricultural exports to the United States, which stood at US$ 3.6 billion in 1993 and US$ 9.3 billon in 2005 (*34*).

During the signing of NAFTA, the three partners also signed the North American Agreement on Labor Cooperation and the North American Agreement on Environmental Cooperation. The Commission on Labor Cooperation and the Commission for Environmental Cooperation were established for the implementation of the respective agreements. Additionally, Mexico and the United States established the Border Environmental Cooperation Commission and the North American Development Bank.

In a 2006 publication, the Commission for Environmental Cooperation analyzed data obtained from national pollutant release and transfer registers in North America and emphasizes the reporting of chemical carcinogens, developmental toxicants, and neurotoxicants. Although data were available only for the United States and Canada, the report discusses in specific terms the potential impact of these substances on the health of children in North America (*35*).

Even while NAFTA's primary focus is on economic integration, various health-related aspects are addressed through its aforementioned labor and environmental agreements. PAHO has collaborated with the Commission for Environmental Cooperation in the provision of technical assistance in environmental health issues and in consensus-building within the context of the International Health Regulations, whose latest revision (2005) was unanimously adopted by WHO member countries at the World Health Assembly in May of that year and which entered into force in June 2007.

Additionally, PAHO maintains a permanent presence along the Mexico-United States border through its Field Office located in El Paso, Texas. Established in 1942 at the request of the two Governments, the Office coordinates and oversees a variety of health-related technical cooperation activities along the border area, interacting with the federal government officials of Mexico and the United States, as well as the political leaders of the area's 10 border states (Arizona, California, New Mexico, and Texas in the United States and Baja California, Chihuahua, Coahuila, Nuevo León, Sonora, y Tamaulipas in Mexico) and with their respective public health authorities. The Field Office's work focuses on developing and implementing effective responses to the unique health situation characterizing this multicultural and multilingual geographic area and building a consensus among government and public health authorities at the local, state, and federal levels regarding the need for collective, well-integrated health promotion and prevention programs. Among its priorities are the development of information systems enabling the comparability of core health data and improved informational exchanges, surveillance and control of such communicable diseases as tuberculosis and HIV/AIDS, and, more recently, situation and risk factor analysis of various chronic noncommunicable diseases, particularly diabetes.

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