

# III

## SUBREGIONAL PROGRAMS

*This section is introduced for the first time as predicated by the PAHO Regional Program Budget Policy approved by the 45th Directing Council in 2005. This section represents the first iteration for the work of the Organization in support of the health agenda of the various subregional integration processes of the Americas. These plans will be refined in conjunction with CARICOM in the Caribbean, SICA in Central America, MERCOSUR in the Southern Cone, and CAN in the Andean Region. This section also includes resources devoted to the three subregional centers—INCAP, CFNI, CAREC—and to the United States/Mexico Border Health Office in El Paso. A more detailed explanation on the nature and criteria for the subregional program is included in Information Document CE136/INF/1.*

# ANDEAN

## ISSUES AND CHALLENGES

The countries of the Andean Community of Nations (CAN) have expressed their commitment to the process of integration as an essential tool for its development, complementing national efforts to ensure social and economic progress.

The process of integration in the Andean region received a strong boost towards the end of the 1980s, especially after the reform of the Cartagena Agreement. The agreement started the Andean Group with the goal of promoting balanced and harmonious development of the countries of the Andean subregion and facilitating their participation in the regional integration process, with a view to the gradual formation of a Latin American common market. In December 2004 the South American Community of Nations was formed, in an attempt to strengthen the integration of CAN and MERCOSUR, as well as several existing integration instruments and institutions.

In the health area, integration in CAN is implemented through the Hipólito Unanue Agreement (CHU), which includes Chile in addition to CAN. Its governing agency is the Meeting of Ministers of Health of the Andean Area (REMSAA). At the XXV REMSAA the ministers of health agreed to consolidate its work promoting access to drugs by preparing a work plan that includes a mass communication and public information strategy to give continuity to the process of joint negotiation for drugs to treat AIDS and others that are considered strategic.

It was also agreed to adopt policy guidelines for access to essential drugs, high-cost drugs, and strategic supplies in the subregional area.

REMSAA asked PAHO/WHO for technical strengthening of the CAN Health Forum, and they have cooperated in the following strategic areas: public health surveillance, epidemiological surveillance, Andean Border Health Plan, health promotion, access to drugs, macroeconomics and investment in health, chronic non-communicable diseases in the subregion, and disasters.

## PAHO OBJECTIVE

To contribute to strengthening the capacity of the institutions belonging to the Andean Community of Nations in managing the health agenda within the integration process.

### EXPECTED RESULTS

1. Existing health mechanisms strengthened in the entities that form CAN from an intersectoral perspective, for their incidences in the processes of integration.
2. The Health Agenda of CAN has been strengthened with the organization's technical cooperation in the creation of policies, projects, research, public

### INDICATORS

- The countries of the subregion have an intersectoral health entity that can study their incidence and standardize participation in subregional agreements, at the end of the two-year period.
- CAN entities involved in health establish formal coordination mechanisms, at the end of the two-year period.
- Network of actors in health and integration mapped, in the first year.
- Consensus proposal for a subregional health policy at the end of the two-year period.

health surveillance, epidemiological surveillance, Andean Border Health Plan, health promotion, access to drugs, macroeconomics and investment in health, control of chronic noncommunicable diseases, and disasters.

3. Follow-up and monitoring of the MDGs led by the integration entities of CAN in coordination with other cooperation agencies.
  - International health regulations in the national institutionalization process as a subregional agreement, in the first year.
  - Common indicators for health monitoring in CAN, by the end of the first year.
  - Health information and monitoring system in development, at the end of the two-year period.
  - Inventory of public assets for health and integration established at the end of the two-year period.
  - Inventory, monitoring, and systematizing of public health policies established, at the end of the two-year period.
  - Network of members who cooperate in building partnerships and mobilizing resources established, at the end of the two-year period.
  - The health agenda of CAN makes reaching the MDGs a priority, during the two-year period.
  - Mapping of health inequities and exclusion with emphasis on border areas, at the end of the two-year period.
  - Strategic plan for reaching the MDGs that focuses on care for indigenous peoples, migrants, and border populations, at the end of the two-year period.

<b>Resources US\$</b>	<b>Regular Budget</b>		
	<b>2004-2005</b>	<b>2006-2007</b>	
Support to Subregional Health Agenda	0	877,200	
<b>Total</b>	<b>0</b>	<b>877,200</b>	
<b>2006-2007 Budget Breakdown by Area of Work</b>			
	<b>Post</b>	<b>Non-Post</b>	<b>Total</b>
Human Resources for Health	350,400	0	350,400
Country Cooperation Leadership and Coordination	0	526,800	526,800
<b>Total</b>	<b>350,400</b>	<b>526,800</b>	<b>877,200</b>

# CARIBBEAN

## ISSUES AND CHALLENGES

The Caribbean, as served by PAHO/WHO, comprises Independent English-speaking countries (IESC)<sup>1</sup>, Cuba, Dominican Republic, Haiti, Suriname, the Dutch Overseas Territories<sup>2</sup>, the French Departments in the Americas (FDAs)<sup>3</sup>, and the United Kingdom Overseas Territories (UKOTs)<sup>4</sup>. However, the Caribbean subregional program encompasses only the CARICOM Member and Associated States namely; the ESC, Suriname, Haiti and the UKOTs.

This multi-lingual, multi-cultural, and multi-ideological subregion has a number of political integration processes and a history of cooperation in trade and health. The oldest of the integration processes is the Caribbean Community (CARICOM), which has a commitment to the Caribbean Cooperation in Health (CCH), the main health agenda for the subregion. CARICOM is moving toward full implementation of the CARICOM Single Market and Economy (CSME) before the implementation of the Free Trade in the Americas Agreement (FTAA), and the CSME will have implications not only for the movement of goods and products, but also for the movement of human resources, including those for health. It will be important for the subregion's health sector to increase participation in global processes and prepare for their influence at the country and regional level. The efforts to ensure that quality of health is protected through the registration of properly trained doctors must be brought to a conclusion and similar steps should be taken for other professional areas.

The epidemiological and demographic transition in the countries imposes a significant burden of non-communicable diseases, even as communicable diseases, new and re-emerging, cause illness and death, prime among them HIV/AIDS. Injuries, mental disorders, and substance abuse, among other health issues, threaten development gains, and the countries are struggling to reform their health sectors and re-tool their health systems to deal with the changing health situation in an equitable manner. In response to some of the subregional health priorities, the Caribbean is also able to draw upon the support of two subregional institutions that are also specialized PAHO/WHO Centres, the Caribbean Food and Nutrition Institute (CFNI) and the Caribbean Epidemiology Centre (CAREC).

The concept of the Caribbean Cooperation in Health (CCH) Initiative, introduced by the CARICOM Ministers of Health in 1984, continues to provide the framework for collaborative priority setting in the region. The CARICOM Heads of Government in their July 2001 meeting issued the Nassau Declaration in Health for Development which mandated that particular emphasis should be placed on moving the health and development agenda forward. The Declaration indicates that priority should be given to the strengthening and/or development of regional strategic plans for HIV/AIDS, Mental Health and Non-Communicable Diseases. These conditions were identified as placing the greatest economic burden of disease on the community.

During the Caribbean Cooperation in Health Phase II (1999-2003) the Member States of the Caribbean Community collectively focused action and resources towards the achievement of agreed objectives in the following priority areas: Strengthening Health Systems, Human Resource Development, Family Health, Food and Nutrition, Non-Communicable Diseases, Communicable Diseases, Mental Health and Environmental Health. Although improvements have been realized in these areas, the real challenge remains the capacity of the countries to translate subregional objectives into concrete policy formulation and sustainable programs. The major limitations are the human resource and health leadership capacities and the deficiencies in management systems.

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<sup>1</sup> Antigua & Barbuda, The Bahamas, Barbados, Dominica, Grenada, Guyana, Jamaica, Saint Lucia, St. Kitts & Nevis, and St. Vincent & the Grenadines, and Trinidad & Tobago.

<sup>2</sup> Aruba and the Netherlands Antilles (Bonaire, Curacao, Saba, Sint Eustatius, and Sint Maarten).

<sup>3</sup> French Guiana, Guadeloupe, and Martinique.

<sup>4</sup> Anguilla, Bermuda, the British Virgin Islands, Cayman Islands, Turks and Caicos and Montserrat.

In most instances national technical officers who work at the policy level are multi-tasked and both time and financial resources restrict the amount of travel they could undertake at the expense of the daily operational tasks. The proliferation of donors for HIV/AIDS has brought with it a considerable number of meetings and other international engagements placing many demands on the staff who work on issues relating to HIV/AIDS. This is requiring special efforts of the sub region to coordinate improved delivery and address absorptive capacity. Taking this and other global issues into consideration, the next iteration of CCH should pay particular attention toward addressing the specific details within the Millennium Development Goals and more focused on selected conditions causing greatest mortality and morbidity.

The Caribbean Environmental Health Institute (CEHI), the Caribbean Regional Drug Testing Laboratory (CRDTL), the Caribbean Health Research Council (CHRC), and the various institutions of the University of the West Indies are partners, collaborators, and beneficiaries in the subregional health initiatives. They form a vital link in the chain of Technical Cooperation among Countries (TCC) and the implementation of the Caribbean Cooperation in Health. All of these entities work within the rubric of the CARICOM governance machinery and, in the case of health, report to the Council for Human and Social Development (COHSOD) for policy direction. The March 2005 report of the review of the Caribbean Regional Health Institutions (RHI) provides options for the rationalization of the Centres, including CFNI and CAREC. PAHO/WHO will collaborate with CARICOM in this effort.

Among other critical organizational issues for the subregion is the need to support and sustain the Caribbean Commission for Health and Development (CCHD), which has already produced a report that will be presented to CARICOM Heads of Government in mid-2005. The report of the Commission should contribute toward positioning the PASB to influence transnational and global issues, including definition of positions on the World Trade Organization and food security, climate change and health in Small Island Developing States, and Roll Back Malaria.

#### EXPECTED RESULTS

1. Plans for increased cooperation for health development at the subregional level strengthened and implementation initiated.
2. Increased capacity of the CARICOM Secretariat in the health sector.

#### INDICATORS

- Caribbean Cooperation in Health III (CCH III), derived from collaborative priority setting in the subregion, approved by the Ministers of Health and shared with all partners nationally and internationally.
- Joint plans of action for the achievement of selected CCH objectives developed with CARICOM and other partners and implemented in collaboration with subregional institutions.
- Joint PAHO/CARICOM development and implementation of plan to strengthen the CARICOM Secretariat's capacity to plan, monitor and report on health agenda.
- Support provided to CARICOM in implementation of the approved option for the rationalization of the Regional Health Institutions.

3. Improved PAHO participation in collective action for health in the Caribbean

- Support for implementation of approved recommendations of the Caribbean Commission on Health and Development.
- Framework for PAHO's cooperation with and in the Caribbean subregion defined.
- PAHO Pan Caribbean Cooperation Strategy used to plan 0809 BPB.

<b>Resources US\$</b>	<b>Regular Budget</b>		
	<b>2004-2005</b>	<b>2006-2007</b>	
Support to Subregional Health Agenda	7,054,600	6,588,600	
CFNI	2,522,800	2,585,800	
CAREC	1,539,200	1,364,200	
<b>Total</b>	<b>11,116,600</b>	<b>10,538,600</b>	
<b>2006-2007 Budget Breakdown by Area of Work</b>			
	<b>Post</b>	<b>Non-Post</b>	<b>Total</b>
Communicable Disease Prevention and Control	1,272,000	154,000	1,426,000
Surveillance, Prevention and Management of Chronic, Non communicable Diseases	309,600	65,000	374,600
Nutrition	1,972,800	593,000	2,565,800
Health Promotion	619,200	0	619,200
Health and Environment	309,600	0	309,600
Food Safety	309,600	20,000	329,600
Reproductive Health	309,600	0	309,600
Essential Health Technologies	292,800	0	292,800
Human Resources for Health	309,600	50,000	359,600
Health Financing and Social Protection	309,600	0	309,600
Health Information, Evidence and Research Policy	619,200	65,000	684,200
Emergency Preparedness and Response	0	68,200	68,200
Country Cooperation Leadership and Coordination	988,800	323,000	1,311,800
Country Office Operations	739,200	838,800	1,578,000
<b>Total</b>	<b>8,361,600</b>	<b>2,177,000</b>	<b>10,538,600</b>

# CENTRAL AMERICA

## ISSUES AND CHALLENGES

Central America is the subregion with the greatest inequalities in the Americas, characterized by the exclusion of large sectors of the population.

Central America has had a long process of integration, which achieved notable advances in the 1990s. In 1991, the Tegucigalpa Protocol created and implemented a new institutional framework, whose principal entity is the Central American Integration System (SICA)—Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama, in addition to the Dominican Republic as an associated member state, and Mexico as a regional observer.

Beginning in the 1990s, the regional agenda has had a rapid and complex evolution. The regional forum “Rethinking Central American Integration: Recommendations for the Renewal of Its Institutions” concluded that the agenda was overloaded, since it includes hundreds of subjects whose undeniable urgency does not necessarily reflect the strategic priorities of the subregion in the current context.

PAHO/WHO and the social integration secretariat of SICA have agreed that it is important to cooperate on the following subjects: (a) Central American social policy; (b) forum on social protection; (c) social information systems; (d) strengthening institutions; and (e) regional public assets and MDG.

The countries of Central America and the Dominican Republic gave their complete support to the Declaration of the Millennium Summit and have adopted the goals expressed in it to contribute to their development and to the eradication of poverty. Central America sees its integration process as an essential tool for development and as a complement to the countries’ efforts to ensure social, economic, and environmental progress.

Furthermore, in light of the institutional analysis and the complex and varied social agenda of SICA and RESSCAD, PAHO/WHO proposes to renew, concentrate, and strengthen its technical cooperation in this subregion through the subregional entities in SICA and the RESSCAD to contribute to the harmonization of efforts in the social area in a complementary and synergistic way with the technical cooperation activities developed in each country.

## PAHO OBJECTIVES

The general objective is to help strengthen the health-related institutions of the Central American Integration System, buttressing the processes that it has been supporting and assisting new strategic initiatives in the renewed health agenda of the subregion. This framework includes three specific objectives:

- . Strengthen the existing health mechanisms in SICA entities from an intersectoral perspective
- . Support development of the health agenda in SICA in terms of the following: policies and projects, research, human resources development, information systems, and monitoring
- . Promote follow-up and monitoring of the MDGs in coordination with other cooperation agencies.

### EXPECTED RESULTS

1. Health-related institutional capacity of SICA strengthened for policy-making, programs, and subregional health projects with an intersectoral perspective.

### INDICATORS

- . Proposed subregional policy of social protection approved.
- . Coordination mechanism among RESSCAD, COMISCA, and FOCARF-PHC approved.
- . The SISCA will have coordinated all meetings of RESSCAD,

- COOMISCA, and FOCARD-PHC.
- Central American Health Objectives 2020 approved.
  - There will be at least one annual meeting between PAHO/WHO and SISCA, CABEL, and one joint meeting to follow up on joint projects and prepare joint activities.
2. The institutional ability of SICA to advocate for and monitor the MDGs in coordination with other agencies for strengthened cooperation.
- The Central American health agenda reviewed and focused on the fulfillment of the MDGs.
  - Mapping of inequities in health and their determinants with emphasis on the border areas.
  - Strategic plan for mobilization of resources approved and implemented.

<b>Resources US\$</b>	<b>Regular Budget</b>		
	<b>2004-2005</b>	<b>2006-2007</b>	
Support to Subregional Health Agenda	0	819,500	
INCAP	2,698,400	2,225,200	
<b>Total</b>	<b>2,698,400</b>	<b>3,044,700</b>	
<b>2006-2007 Budget Breakdown by Area of Work</b>	<b>Post</b>	<b>Non-Post</b>	<b>Total</b>
Nutrition	439,200	1,786,000	2,225,200
Human Resources for Health	292,800	0	292,800
Country Cooperation Leadership and Coordination	0	526,700	526,700
<b>Total</b>	<b>732,000</b>	<b>2,312,700</b>	<b>3,044,700</b>

## SOUTHERN CONE

### ISSUES AND CHALLENGES

The purpose of the South American Summit of 2004 was to strengthen the integration of the MERCOSUR and CAN blocs. It demonstrates growing political will on the part of the countries of South America and the expansion of possibilities of consensus building and cooperation in South American integration. The South American Community of Nations was established as a result of this summit. It emphasizes the necessity of strengthening channels of contact between the OTCA, MERCOSUR, CAN, LAIA, and CARICOM and other South American integration initiatives.

The health agenda is led by the ministers of health of MERCOSUR, who have worked hard on the process of harmonizing various subjects, such as health in border areas, environment, drugs policy, antismoking policy, Millennium Development Goals, disasters, primary health care, epidemiological surveillance (malaria and dengue), sexual and reproductive health, HIV/AIDS, and review of the International Sanitary Code in the context of integration.

### PAHO OBJECTIVE

To contribute to strengthening the capacity of institutions belonging to MERCOSUR in the management of the health agenda within the integration processes.

#### EXPECTED RESULTS

1. Existing health mechanisms strengthened in the entities that form MERCOSUR from an intersectoral perspective, for their incidence in the integration process.
2. The health agenda of MERCOSUR has been strengthened with technical cooperation of the organization, in the creation of policies, projects, research, human resources development, drugs, information systems, environment, disasters, and epidemiological surveillance.

#### INDICATORS

- The countries of the subregion have an intersectoral health entity that studies their incidence and standardizes their participation in subregional agreements, at the end of the two-year period.
- MERCOSUR entities involved in health establish formal coordination mechanisms, by the end of the two-year period.
- Network of actors in health and integration mapped, in the first year.
- Consensus proposal for subregional health policy, at the end of the two-year period.
- International health regulations in the national institutionalization process as a subregional agreement, in the first year.
- Common indicators for health monitoring in MERCOSUR, by the end of the first year.
- Health information and monitoring system in development, at the end of

the two-year period.

- Inventory of public assets for health and integration established at the end of the first year.
  - Inventory, monitoring, and systematizing of public health policies established, at the end of the two-year period.
  - Network of members who cooperate in building partnerships and mobilizing resources established, at the end of the two-year period.
3. Follow-up and monitoring of the MDGs led by MERCOSUR integration entities in coordination with other cooperation agencies.
- The health agenda of MERCOSUR makes reaching the MDGs a priority, during the two-year period.
  - Mapping of health inequities and exclusion with emphasis on border areas, at the end of the two-year period.
  - Strategic plan for reaching the MDGs that focuses on care for indigenous peoples, migrants, and border populations, at the end of the two-year period.

<b>Resources US\$</b>	<b>Regular Budget</b>		
	<b>2004-2005</b>	<b>2006-2007</b>	
Support to Subregional Health Agenda	0	814,800	
<b>Total</b>	<b>0</b>	<b>814,800</b>	
<b>2006-2007 Budget Breakdown by Area of Work</b>	<b>Post</b>	<b>Non-Post</b>	<b>Total</b>
Human Resources for Health	288,000	0	288,000
Country Cooperation Leadership and Coordination	0	526,800	526,800
<b>Total</b>	<b>288,000</b>	<b>526,800</b>	<b>814,800</b>

## FIELD OFFICE: UNITED STATES / MEXICO BORDER

### NATIONAL PRIORITIES FOR PAHO TECHNICAL COOPERATION

The US-Mexico border is one of the most traveled and dynamic regions in the world. Migration continues to be a priority bilateral issue and, although the border is characterized by economic inequality and unequal development, there is considerable economic interdependence. More than 13 million people live along the border (53% on the U.S. side, and 47% on the Mexican side). This figure is expected to double by 2020 or 2025. There are profound differences between the two countries in terms of their health systems. The US-Mexico Border Health Commission, which has its own budget, is responsible for defining the bilateral health agenda. It should be borne in mind that the US-Mexico Border Health Association (USMBHA) separated from PAHO, which had been its Executive Secretariat for over 60 years. An agreement has been signed between the two entities, stating that PAHO will continue to provide technical cooperation to USMBHA until it is fully consolidated and independent.

Through the Border Health Commission, the Governments of Mexico and the United States have set health priorities as part of the Healthy Border 2010 initiative. The main objectives are:

- To improve the quality of life and increase years of healthy living.
- To eliminate health disparities.

Within the framework of these priorities, PAHO/WHO technical cooperation will focus on the following actions:

- Facilitate transborder work in order to jointly solve common problems requiring bilateral action.
- Ensure that regional and global initiatives are reflected in health efforts on the border.
- Support the attainment of the objectives of Healthy Border 2010 within the framework of the Millennium Development Goals (reduction in inequity, prioritization of vulnerable groups, especially migrants, indigenous people, and adolescents).
- Support the Border 2012 initiative: Mexico-United States Environmental Program.
- Support the Epidemiological Surveillance System of the Uniform Information Platform for the border and disseminate information and knowledge.
- Devise indicators for the surveillance system, information dissemination, and advocacy for incorporating this subject into the Healthy Border 2010 agenda.
- Promote intersectoral work and support the institutional development of USMBHA.

## PROJECTS

### INFORMATION AND COMMUNICATING FOR HEALTH

#### PURPOSE

To improve diagnostic and evaluation capabilities for characterizing environmental and public health on the US-Mexico border.

#### EXPECTED RESULTS

- Health information systems that make it possible to characterize health on the US-Mexico border are strengthened and/or developed.
- Access to information on health problems and determinants are facilitated.

#### **ENVIRONMENTAL HEALTH**

- PURPOSE** To preserve and rehabilitate the environment and reduce the greatest risks to public health.
- EXPECTED RESULTS**
- Environmental health indicators on the border will be identified, tested, collected, and disseminated.
  - Capacity of communities on the US-Mexico border to prevent, mitigate, and respond to disasters will be improved.

#### **PARTNERSHIPS FOR BORDER HEALTH**

- PURPOSE** To increase social participation and intersectoral approaches in the development, implementation, and evaluation of interventions aimed at reducing the years of potential life lost due to causes identified in Healthy Border 2010.
- EXPECTED RESULTS** Forging and strengthening of interinstitutional partnerships promoted between local governments, academic institutions, and sectors other than the health sector to achieve the Healthy Border 2010 objectives.

#### **HEALTH PROMOTION AND CONTROL OF NONCOMMUNICABLE DISEASES**

- PURPOSE** To make health promotion a priority strategy for meeting the objectives of the Healthy Border 2010 program.
- EXPECTED RESULTS**
- A bilateral border work plan for health promotion and disease prevention strengthened and/or developed.
  - CARMEN strategy would implemented on the US-Mexico border.
  - Diabetes pilot projects will be executed to reduce complications in diabetes patients and reduce risk factors among their relatives.

#### **INTERPROGRAMMATIC COORDINATION AND PROJECT MANAGEMENT**

- PURPOSE** To strengthen interprogrammatic coordination and project management.
- EXPECTED RESULTS**
- Technical skills and well-being of staff improved in the Field Office.
  - Contribution made in developing health on the border through teamwork, the search for strategic partnerships, mobilization of resources, and negotiation.

<b>Resources US\$</b>	<b>Regular Budget</b>		
	<b>2004-2005</b>	<b>2006-2007</b>	
Field Office: United States/Mexico Border	1,510,700	1,400,700	
<b>Total</b>	<b>1,510,700</b>	<b>1,400,700</b>	
<b>2006-2007 Budget Breakdown by Area of Work</b>	<b>Post</b>	<b>Non-Post</b>	<b>Total</b>
Health Promotion	0	91,500	91,500
Health Information, Evidence and Research Policy	0	280,000	280,000
Country Cooperation Leadership and Coordination	619,200	110,000	729,200
Country Office Operations	0	300,000	300,000
<b>Total</b>	<b>619,200</b>	<b>781,500</b>	<b>1,400,700</b>