The Impact of the Millennium Development Goals in Argentina, Brazil, and Chile

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The Millennium Development Goals have been a great initiative throughout many countries around the world since its creation in 2000. Among the countries of Argentina, Brazil, and Chile, this initiative has been one of the major factors that have contributed to their economic growth, social improvement, and health services and quality development during the first decade of the 21st Century. Regardless, there are other major factors that may be of either positive or negative influence to the development of the Millennium Development Goals in each country.

INTRODUCTION

During the month of September 2000, leaders from the United Nations were gathered in order to create an initiative with the purpose of promoting health and eradicating poverty throughout the world by 2015. This initiative was strategically planned and divided into goals, also known as The Millennium Development Goals (MDGs). The MDGs are composed of a total of eight goals that target the development and promotion of human rights and social determinants of health with the focus on coordinated efforts ranging from poverty, hunger, gender inequality and diseases reduction, along with the advancement in education, sustainable use of natural resources and the regulation of the cooperation between developed countries by 2015 (United Nations, 2012).

This initiative has obliged governments to elaborate strategic alliances between international health institutions and Non-Governmental Organizations (NGOs) in order to create the opportunity to fight poverty, hunger and diseases, stop environmental degradation, promote primary education and gender equality worldwide. Each developmental goal is designed differently by each UN country to meet its individual needs. The main objective of the MDGs is providing growth and improvement throughout the world as a common initiative between all countries.

Millennium Development Goals

Millennium Goal I seeks the eradication of extreme poverty and hunger. This goal has three aims or targets in order to end/lower poverty and hunger. The first target is to reduce by half the number of the

people whose income is less than $1 dollar a day between 1990 and 2015. This target is measured by the poverty gap ratio, share of poorest quintile in the national consumption and percentage of population below $1 (PPP) per day. The second target is to achieve full and productive employment and decent work for all, including women and young people. This target is measured by the growth rate of the Gross Domestic Profit (GDP) per person employed, employment-to-population ratio, and the percentage of employed people living below $1 (PPP) per day. Finally, the third target is to reduce by half the number of people who suffer from hunger between 1990 and 2015. This target is measured by the prevalence of underweight children under-five years of age, and the percentage of population below minimum level of dietary energy consumption.

Millennium Goal II seeks the achievement of universal primary education. This goal has only one aim or target in order to accomplish universal primary education. The main target is to ensure that every child around the world, boys and girls alike, complete a full course of primary schooling by 2015. This goal is measured by the net enrollment ratio in primary education, total percentage of pupils starting grade one who reach the last grade of primary education, and literacy rate of 15-24 year-olds, both woman and men.

Millennium Goal III seeks gender equality and women empowerment. This goal has only one aim or target in order to promote gender equality and empower women. The main target is designed to eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015. This target is measured by ratios of girls to boys in primary, secondary and tertiary education. It is also measured by the share of women in wage employment in the non-agricultural sector and the proportion of seats held by woman in national parliament.

Millennium Goal IV seeks the decrease of child mortality. This goal has only one aim or target in order to reduce the child mortality rate. The main target concentrates on reducing by two thirds the mortality rate among children under five between 1990 and 2015. This target is measured by both the under-five mortality and infant mortality rates along with the proportion of one year-old children immunized against measles.

Millennium Goal V seeks the improvement of maternal health. This goal has two primary aims or targets in order to improve maternal health. The first target is to reduce by three quarters the maternal mortality ratio between 1990 and 2015. This target is measured by maternal mortality ratio and the proportion of births attended by skilled health personnel. The second target is to achieve universal access to reproductive healthcare by 2015. This second target is measured by contraceptive prevalence rates, adolescent birth rates, antenatal care coverage, and unmet need for family planning.

Millennium Goal VI seeks to combat HIV/AIDS, malaria and other diseases. In order to achieve this, the goal was divided into three targets. The first target is to halt and begin to reverse the spread of HIV/AIDS by 2015. This target is measured by the HIV prevalence among population aged 15-24 years, condom use for high-risk sex, proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS, and the ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years. The second target is to achieve universal access to treat HIV/AIDS for all those who need it by 2010. This target is measured by the proportion of population with advanced HIV infection with access to antiretroviral drugs. The third target concentrates on halting and beginning to reverse the incidence of malaria and other major diseases. This target is measured by the incidence and death rates associated with malaria, the proportion of children fewer than five (5) sleeping under insecticide-treated bed-nets, the proportion of children fewer than five (5) with fever who are treated with appropriate anti-malarial drugs. As for tuberculosis, it is also measured by the incidence, prevalence and death rates associated with tuberculosis along with the proportion of tuberculosis cases detected and cured under directly observed treatment short course.

Millennium Goal VII seeks to ensure environmental sustainability. This goal is of severe complexity due to the fact that it has been divided into four targets. The first target aims at integrating the principles of sustainable development into country policies and programs, reversing the loss of environmental resources. The second target aims at reducing biodiversity loss by 2010. These first two targets are measured by the percentage of land area covered by forest, CO2 emissions per capita and per $1 GDP (PPP), the percentage of fish stocks within safe biological borders, the percentage of total water resources

used, the percentage of terrestrial and marine areas protected, and the percentage of species threatened with extinction. The third target addresses the number of people who are living without sustainable access to safe drinking water and basic sanitation with the objective of reducing the actual percentage of people without safe drinking water by half. This third target is measured by both the amount of population using an improved drinking water source and the amount of population using an improved sanitation facility. The last target of the seventh MDG is to achieve significant improvement in lives of at least 100 million slum dwellers by 2020. This last target is measured by the percentage of urban population living in slums.

Millennium Goal VIII promotes global partnerships for development. This last goal is divided into six targets. The first target aims to develop further an open, rule-based, predictable, non-discriminatory trading and financial system. This target also promotes the commitment to good governance, growth and poverty decrease; both nationally and internationally (United Nations, 2012). The second target addresses the special needs of the least developed countries. This target encourages the least developed countries' exports to be tax free along with an improved program of debt relief and cancellation of official bilateral debt (United Nations, 2012). The third target promotes the special needs of landlocked developing countries and small islands developing States through the Program of Action for the Sustainable Development of Small Island Developing States. The fourth target promotes dealing extensively with the debt problems of emergent countries throughout national and international initiatives with the purpose of making debt sustainable from a long-term perspective. The fifth target promotes the cooperation with pharmaceutical companies and the access to affordable essential drugs in developing countries. This target is measured by the percentage of the population with access to affordable essential drugs on a sustainable basis. Finally, the last target within the eighth goal aims at the cooperation with the private sector the availability of new technologies' benefits, such as information and communications. This target is measured by the number of fixed telephone lines per 100 people, the number of mobile cellular subscriptions per 100 people and the number of internet users per 100 people.

MILLENNIUM DEVELOPMENT GOALS' ACTUAL STATUS

The Continent of South America has three interesting sub-developed economies that are on their way to economic expansion and country growth as shown in Table 1. During the first decade of 21st Century, the Millennium Development Goals played a major role in the development of Argentina, Brazil and Chile's health profiles, as well as general economic progress since the planning and implementation of the MDGs within these countries in 2000.

Argentina

In the early 21st Century, Argentina, a vast country of natural resources, began the new millennium with a devastating economic and political crisis which led to a series of unfortunate events, including the rise of the poverty level within the Argentinean population.

Argentina's poverty level has been unstable throughout the last thirteen years. Due to the financial crisis in 2002, the poverty level increased from 6.1% in 1990 to 21.5% in 2002. Furthermore, from June 2007 to June 2009, the poverty level decreased 40.6% from 23.4% to 13.8% respectively, but not until 2010 in which it increased again to 30% and it has remain constant ever since (Central Intelligence Agency [CIA], 2013).

Since 1994 primary and secondary education has been obligatory. Argentina's universal education goal of obtaining 100% of literacy level among citizens is about to achieved. This percentage has increased from 91% in 2001 to 95% 2007. However, according to the Program for Development of the United Nations the lack of Argentina's ability to achieve their education goal is due to people living in rural areas (Programa de Naciones Unidas para el Desarrollo, 2009).

Conversely, the primary level literacy is one of the goals that Argentina has already accomplished. According to the same report, the Program for Development of the United Nations, Argentineans achieved 100% primary level of literacy by 2008, meaning that all Argentineans are primary level

educated. This initiative promoted gender equality greatly since this achievement includes both sexes (Programa de Naciones Unidas para el Desarrollo, 2009).

The unemployment rate has also dropped over the years from 17.3 in 2003 to 7.2 in 2012. It is believed that the recent government interest and improvement of Argentina's social infrastructure after the 2002-2003 crises was cause of this positive outcome.

Argentina also aimed at decreasing their mortality rate by 2/3 by 2015. This goal helped decrease the mortality rate drastically during the first decade of the 21st century when Argentina's mortality rate decreased almost by half from 25.6 in 1990 to 13.3 in 2007 (per 10,000 population). This goal was achieved by 2010 when they reached a National Mortality Rate of 7.8 (Pan American Health Organization [PAHO], 2012). Although the goal was achieved, there was a slight change on Argentina's maternity rate since it decreased relatively slow during the period of 1990-2007 from 5.2% to 4.4% (Programa de Naciones Unidas para el Desarrollo, 2009). By 2012, this rate increased back to 7.7%. In addition, the goal to reduce maternal mortality by 50% in Argentina has not been achieved. Regardless, during 2010 the maternal mortality rate was 4.6% (per 10,000 populations) representing a decrease of 30% (United Nations, 2012).

Furthermore, some of the primary causes are Coronary Heart and Cerebrovascular Diseases, Influenza/Pneumonia and Lung Cancer as shown in Table 2.1. These diseases are also the primary causes of death in Brazil and Chile with the exception of Lung, Colon-Rectum and Breast Cancers which each of the rates are relatively high, 2.2, 1.7 and 2.5, respectively (per 10,000 populations). Both Colon-Rectum Cancers and Breast Cancer's rates are worrisome since their world comparison is ranked 22nd and 15th respectively by the WHO. Appropriately it is noted that although Argentina's Coronary Heart Diseases has the highest percentage (16.8%) of total causes of deaths between three countries, it is Brazil who has a higher rate with 8.1 *vis a vis* Argentina's 7.1 per 10,000 population. Also, Diabetes Mellitus and Hypertension are two of the primary causes of death in Argentina, their rates, 1.8 and 1.2 respectively, are lowest between the three compared countries.

The actual HIV prevalence rate, 0.5, was constant and barely decreased in the early 2000s. The goal, to decrease HIV prevalence rate by ¾ (0.37 per 10,000 populations), is the third goal that Argentina has already achieved since the rate reached 0.37 (per 10,000 populations) in 2007 (Programa de Naciones Unidas para el Desarrollo, 2009). Moreover, as the second decade of the 21st starts, the HIV prevalence rate continues to slightly decrease reaching a 0.3 in 2010 (PAHO, 2012). Although there are 110,000 Argentineans living with HIV/AIDS, this disease is not one of the primary causes of death

Brazil

Brazil's rise to power and its potential of becoming the new emerging economy in South America was halted during the last four years when the Gross Domestic Product growth decreased from 7.5% in 2010 to 1.3% in 2012. Still, Brazil is one of the few countries that might achieve all of their goals in time by the year 2015.

The percentage of the population living on less than a US $1 per day has decreased from 9.9% to 5.7% over a period of 13 years (1990-2003). According to the Pan American Health Organization (PAHO), if this percentage of living on less than a $1 was considered, Brazil would accomplish the first MDG by 2015 (Pan American Health Organization [PAHO], 2008). Furthermore, the population below the poverty line has also decreased in the last two years from 26% in 2010 to 21.4% in 2012. Regardless, due to the vast population of 201,009,662 it is estimated that there are at least 43 Million people living below the poverty line.

Access to education and gender equality has also been increasing within the population of Brazil. From 1992-2003, the rate of primary school attendance increased from 81.4% to 93% respectively and gender equality within middle schools also increased from 15.1 Males & 21.3 Females to 38.1 Males & 48.2 Females. Also, child mortality decreased from 1996 to 2004 with rates of 332 to 226 respectively (per 10,000 live births).

Brazil may look like the most ideal country to follow but they are lacking implementation of some major MDGs objectives. One of these objectives is the maternal mortality rate, the one that has remained

inconstant for the last thirteen years since it increased from 5.16 to 7.61 per 10,000 live births from 1996 to 2004 and reached its peak during 2010 at 11 per 10,000 of population and by 2012, suddenly decreased to 5.6. There is little or no evidence on why these statistics are vastly varied.

Another ongoing issue in Brazil that distinguishes Brazil from Argentina and Chile is the Violence Rate as one of the Primary Causes of Death as shown in Table 2.2. The violence rate in Brazil has been a continuous issue that represents almost 6% of the total deaths in the country, making it the 5th Primary Cause of Death in the Country. This percentage ranks number 19th worldwide and since the targets and objectives from Brazil's Millennium Development Goals do not address this issue, there is little or no information/data to report. It is important to note that Brazil also has the highest death rate of Coronary Heart Diseases (8.1), Cerebrovascular Diseases (7.4), Diabetes Mellitus (3.8), and Hypertension (3.2) per 10,000 populations, among others, between these three countries.

The number of people living with HIV/AIDS in Brazil has increased from 600,000 (1998) to 730,000 (2007), the HIV/AIDS adult prevalence rate has been constant from 1996 to 2010 at 0.6%. This percentage of HIV/AIDS occurrence within Brazil has been the result of a synergetic work effort between international organizations and both the private and public industry in Brazil. None the less, by 2012 this rate increased to 1.8 but, regardless of Brazil's prevalence, HIV/AIDS is not one of the primary causes of death as noted previously.

Chile

In the last decade, Chile has served the world as an economic role model. Inspired by change and political crisis, Chile's economy has been aimed at a superior level for foreign trade throughout the last twenty years. By 2010, exports were already responsible for at least 25% of their total GDP. In addition, Chile has a total of 57 joint regional trade agreements throughout the world (including US, China, India, Mexico, among others), making them one of the countries with the highest level of regional trade agreements. Moreover, while Argentina's and Brazil's GDP Real Grow Rate halted by the end of the last decade (2.6% and 1.3% respectively), Chile's has barely decreased since 2010 from 6.1 to 5.0% in 2012. Not to mention that Chile's GDP Per Capita is also the highest with $18,400 compared with Argentina and Brazil which are $18,200, $12,000 respectively (CIA, 2013).

Within a period of 10 years, Chile has greatly decreased poverty from 12.9% (1990) to 4.7% (2003). By 2005 it was the only country in America that had already cut the poverty level in half. In addition, their goal of having a 1.7% proportion of the population with an income of less than one dollar a day has already been achieved by 2006 when they reached 1.1% (Chili Ministry of Planning, 2008). And although the population below the poverty line has increased from 11.5% to 15.1% in the last three years (2010-2012), Chile still has the lowest Poverty Rate between the compared countries.

Unlike other countries, Chile has a very small proportion of malnourished children less than 6 years old. They have also achieved their 0.5% goal of decreasing malnourished children when the rate decreased from 0.7% in 1994 to 0.5% in 2000. By 2006, this rate was already 0.3%. Obesity within the same age category, on the contrary, is vaguely an issue in Chile. During 1996, 6.2% of children younger than 6 suffered from obesity and by 2000 this percentage increased to 7.2%. Their actual goal is to reach 6% obesity percentage by 2015 (Chile Ministry of Planning, 2008).

During a period of ten years (1990-2000), Chile was able to slowly increase access to primary school for children from 88% to 91% (respectively) until 2006 when the rate decreased to 88%. Primary level literacy rate has also increased slowly within the same period of time from 98.4% to 98.7% and, although it has not been enough to achieve their goal of 99.8% by 2015, it has promoted gender equality within Chile since same genders have the same percentage of alphabetization. The country's literacy rate by 2002 was 95.7% and it is estimated that this number will increase to 99.1% by 2015 (Chile Ministry of Planning, 2008).

Child mortality has decreased by more than half. During 2005 the rate was 79 (per 10,000 populations) live births compared to the year 1990 in which the rate was 160 (per 10,000 populations). The goal to reduce it to 53 by 2015 and has still not been achieved. Also, the maternal rate goal of 10 (per 10,000 populations) has not been achieved. Regardless, it has decreased drastically since its peak of 40

(per 10,000 populations) in 1990 to 19.8 in 2005 (Chili Ministry of Planning, 2008). By 2012 the mortality rate increased once again to 26.

Additionally, Road Traffic Accidents is not a Primary Cause of death in Chile compared to Argentina and Brazil. Chile also has the lowest rates of Coronary Heart Disease (5.1) and Influenza/Pneumonia (2.1) as a cause of death per 10,000 populations, but what truly distinguishes Chile is Dementia being one of the primary causes of death as shown in Table 3.3. By 2010, there were 4,059 deaths related to dementia (including the Alzheimer's disease) which represented a rate of 2.0 per 10,000 populations, ranking number 8th in the World. Stomach Cancer also distinguishes Chile from Brazil and Argentina since 4.3% of the total deaths in 2010 were cause by it, ranking 17th worldwide.

Chile's estimated HIV prevalence cannot be compared to Argentina or Brazil because their rates have been constant. Chile's rate has slightly increased over the past years from 0.25% in 2000 to 0.4% in 2009. In addition, the number of people living with HIV has also increased from 20,000 in 1998 to 40,000 in 2009 (CIA, 2013). Surprisingly, in order to calculate this HIV/AIDS increase, Chile utilizes other measures, HIV prevalence not being one of them. According to the Central Intelligence Agency, Chile had an HIV prevalence rate of 0.4 and 40,000 people were living with HIV/AIDS by 2010 as shown in Table 3. Regardless of Chile's prevalence, HIV/AIDS is not one of the primary causes of death.

MITIGATING FACTORS

Political Factor

The political factor has been the major contributor to most of the Millennium Development Goal's success within the countries of Argentina, Brazil and Chile. These three governments strategically prioritized social development as a primary target since the MDGs' implementation planning.

Within these countries, Argentina may be seen as the greatest example since they had to overcome political and economic crisis during 2002-2003 while other countries already started their MDGs' implementation. This achievement was caused by the adoption of aggressive policies that obliged both private and public entities either to perform vast layoffs or to decrease salaries in order to keep Argentina's workforce employed and with full compensation. This political initiative stopped the development of the economic crisis in Argentina. Increasing access to health care was also another aggressive initiative from the Argentinean government. This supplementary policy favored the access of both health and essential medicines to the population, consequently reducing the infant mortality rate (Programa de Naciones Unidas para el Desarrollo, 2009).

Similarly, Chile aimed at social policies as part of their political planning. By 2002, their government created a new Health Reform in order to promote access to health and raise health quality within the country. By 2008, Chile's government created a Provisional Reform with the purpose of providing pensions to previous citizens that did not have the right to own personal pensions. Moreover, their new social priority from a political perspective is to promote equality within citizens, regardless of their social or economic class, and most importantly, to eliminate risk opportunities that might threaten low income families (Chile Ministry of Planning, 2008).

Economic Factor

The economic factor has also played a major role in the development of the Millennium Development Goals of these three countries. Evidently, as shown in Table 1, these countries have an actual positive Gross Domestic Product (GDP) and Growth Per Capita Rate. These indicators clearly represent the capability of investing in both social and health development. Regardless of the fact, these countries have their own political priorities.

The political priority in Argentina was social development and by 2003 the Argentinean government invested 20% of their GDP in order to put a stop to the economic and political crisis of 2002-2003. This political initiative succeeded due to the economic planning and investment within the year 2003. By 2008, social development represented 23.7% of their GDP expenditure (Programa de Naciones Unidas para el Desarrollo, 2009). This percentage assisted the country of Argentina in regaining stability.

Geographic Factor

The geographic factor also plays a major role in the development of the Millennium Development Goals. Although most of the population of these three countries lives within urban areas, access to health in rural areas is a major issue since there is little or no health workforce or facilities. Areas such as el *Chaco Sur Americano* (South-American Chaco) which includes Argentina, Bolivia, Paraguay and Southwestern Brazil, and some other regions in Western Brazil, lack health professionals and schools since most of health professionals, shown in Table 4, work within urban areas. The majority of the population living in these areas is indigenous and during the years these people have been marginalized by governments. Since there is little or no government involvement within these places, there is a lack of quantitative data in order to properly analyze these regions.

In order to address this issue, in 2006 the Pan American Health Organization lunched an initiative called *Faces, Voices and Places* with the purpose of accelerating progress toward the achievement of the Millennium Development Goals. The initiative focuses its efforts on the most vulnerable communities in different regions in the Americas and the Caribbean including Argentina, Brazil and Chile, from a perspective of health and development (Pan American Health Organization [PAHO], 2011)

Education Factor

Argentina's geographical factor has also affected the education in the country since it has not been able to obtain 100% level of literacy within the population. This is a result of having 5% of children or people fewer than 17 years of age living in unfavorable rural sectors (Programa de Naciones Unidas para el Desarrollo, 2009). Their actual national literacy rate, for people of age 15 and over who can read and write, is 97.2% and they are expected to reach their goal regardless of the effect of the geographical factor on their education system. Still, 97.2% is a decent number for an emerging economy and, actually, Argentina has the highest literacy rate between the three compared countries and their government expends 4.9% of their Gross Domestic Product (GDP) on Education (CIA, 2013).

Chile, on the contrary, has a lower Literacy rate of 95.7%, compared to Argentina. There is little or no information regarding the reason as to why Chile does not have 100% national literacy rate. It could be assumed that the main reason is due to the geographical factors and regions of indigenous population, same as Argentina and Brazil. Furthermore, by 2010 the Chile's government expended only 4.0% of their GDP on education, making it the country with the lowest contribution on education between the compared countries (CIA, 2013).

Unfortunately, Brazil has an even lower literacy rate than Argentina and Chile. By 2010 their literacy rate was only 88.6%, which makes it the lowest literacy rate between the three compared emerging economies, and as same as Chile and Argentina, the reason may be due to the vast rural area that Brazil has to the West which makes it impossible for children to travel to schools, or even to build schools. Although it has the lowest literacy rate between the three, Brazil has the highest government expenditure on education with 5.08% of their GDP, raking number 55th worldwide (CIA, 2013).

Wealth Inequity Factor

According to the World Factbook from the Central Intelligence Agency, Brazil and Chile are within the top 20 wealth inequity countries. Calculated with the Gini Index, a tool that measures the degree of inequality in the distribution of family income in a country, Brazil has the highest rate of wealth inequity between the three compared countries with 53.9 (CIA, 2013). This coefficient has increased from 49.6 (2004) to their actual 53.9 (2009) and ranks number 13th worldwide. This creates a worrying issue in Brazil since 26% of their citizens are already below the poverty line and may increase the percentage of the population living on less than a US $1 in the years to come if this coefficient does not stop increasing. One of the major reasons for this inequity in Brazil is the different salaries between professionals from urban and rural areas. These salaries create a direct threat to Brazil's Health System since most health professionals are only willing to work in urban areas leaving the rural areas without competent staff or adequate health professionals, and making it impossible to compete with other private health institutions located in urban areas (Pan American Health Organization [PAHO], 2008).

By 2009 Chile also had a high Gini Index Coefficient with 52.1, making it the 16th highest wealth inequity region of the World (CIA, 2013). Unlike Brazil, this coefficient, for Chile was 52.0 in 2003, has barely increased but it may still affect the total population who are below the poverty line (11.5%) and increase the population living on less than a US $1.

Argentina has the lowest Gini Index Coefficient in the whole South-American Region with 45.8. Compared to Brazil and Chile, Argentina is the only country whose coefficient decreased from 48.8 in 2007 to their actual 45.8 in 2009, making it the 36th country with the highest wealth inequity and it is also estimated that by 2010 their Gini Coefficient decreased to 41.1 according to the World Factbook (CIA, 2013). Although there is not a concrete report explaining these events in Argentina, it is speculated that the previous political corruptions, the last economic crisis, and their actual 30% of population living below the poverty line are some of main factors that are decreasing this coefficient.

CONCLUSION

It is evident that the Millennium Development Goals have been a fundamental factor for the development of the countries of Argentina, Brazil and Chile from a macro perspective. Most of the goals set up by the governments are on their way to being achieved by 2015 while others have been already achieved. Regardless, it is because of these goals that these three countries are emerging as potential power economies.

Although, the recent economic and political crisis in Argentina proved that these are vulnerable countries, the MDGs' indicators have been of great assistance and guidance by creating awareness and promoting social and health development within the countries' governments. Nevertheless, some factors such as the geographical factor are impeding the development and the successful achievement of some of these goals. It will be interesting to see if these three countries do reach and achieve all of their eight goals by 2015 and are able to identify the reasons that enabled these achievements.

REFERENCES

Central Intelligence Agency. (2013). *World Factbook*. Retrieved from https://www.cia.gov/library/publications/the-world-factbook/index.html

Chile Ministry of Planning. (2008). *Millennium Development Goals Executive Summary.*

Pan American Health Organization. (2008). *Health Systems And Services Profiles: Brazil.*

Pan American Health Organization. (2011). *Faces, Voices and Places*. Retrieved from http://www.paho.org/english/mdg/MDGs32p2.pdf

Pan American Health Organization. (2012). *Basic Indicators: Health Situation in the Americas.*

Programa de Naciones Unidas para el Desarrollo. (2009). *Objetivos de Desarrollo del Milenio.* Consejo Nacional de Coordinación de Políticas Sociales.

United Nations. (2012). *The Millennium Development Goals Report 2012.* New York: United Nations.

World Health Organization. (2011). *Countries.* Retrieved from http://www.who.int/countries/en/

World Health Organization. (2012). *Argentina: Health Profile*. Retrieved from http://www.who.int/gho/countries/arg.pdf

World Health Organization. (2012). *Brazil: Health Profiles*. Retrieved from http://www.who.int/gho/countries/bra.pdf

World Health Organization. (2012). *Chile: Health Profile*. Retrieved from http://www.who.int/gho/countries/chl.pdf

APPENDIX A

TABLE 1
COUNTRY INDICATORS

	Total Population (20013 est.)	% Living Urban Area in 2010-2012	GDP Per Capita 2010-2012	GDP Real Growth Rate 2010-2012	GDP % Expended in Healthcare 2009-2010	Unemployment Rate 2009-2012	Population Below Poverty Line in 2010-2012
Argentina	**42,610,981**	**92%-92%**	**$16,700-$18,200**	**9.2%-2.6%**	**10.1% - 8.1%**	**8.7%-7.2%**	**30%-30%**
Brazil	**201,009,66**	**87%-87%**	**$11,700-$12,000**	**7.5% - 1.3%**	**7.5% -9.0%**	**8.1%-6.2%**	**26%-21.4%**
Chile	**17,216,945**	**89%-89%**	**$16,800-$18,400**	**6.1%- 5%**	**8.2% -8%**	**9.6%-6.4%**	**11.5%-15.1%**

Source: Central Intelligence Agency, 2013

TABLE 2.1
PRIMARY CAUSES OF DEATH IN ARGENTINA

Causes of Death	Deaths in 2010	Rate Per 10,000 population 2010	Total Distribution (100%)	World Rank (2010)
Coronary Heart Disease	**36,415**	**7.1**	**16.8%**	**154**
Cerebrovascular Disease	**22,859**	**4.4**	**10.5%**	**151**
Influenza & Pneumonia	**20,366**	**3.6**	**9.4%**	**90**
Lung Cancer	**10,033**	**2.2**	**4.6%**	**51**
Diabetes Mellitus	**8,911**	**1.8**	**4.1%**	**133**
Colon-Rectum Cancers	**8,575**	**1.7**	**4.0%**	**22**
Kidney Disease	**7,807**	**1.2**	**3.6%**	**102**
Breast Cancer	**6,702**	**2.5**	**3.1%**	**15**
Hypertension	**6,487**	**1.2**	**3.0%**	**151**
Road Traffic Accidents	**4,880**	**1.2**	**2.3%**	**116**
Other (Rest)	**-**	**-**	**38.6%**	**-**

Source: World Health Organization, 2011. Note: This table includes both sexes.

TABLE 2.2
PRIMARY CAUSES OF DEATH IN BRAZIL

Causes of Death	Deaths in 2010	Rate Per 10,000 population	Total Distribution (100%)	World Rank
Coronary Heart Disease	**133,992**	**8.1**	**13.8%**	**134**
Cerebrovascular Disease	**123,034**	**7.4**	**12.6%**	**117**
Diabetes Mellitus	**61,987**	**3.8**	**6.4%**	**84**
Influenza & Pneumonia	**60,951**	**3.6**	**6.3%**	**91**
Violence	**56,841**	**2.8**	**5.8%**	**19**
Hypertension	**53,466**	**3.2**	**5.5%**	**68**
Lung Disease	**43,373**	**2.7**	**4.5%**	**83**
Road Traffic Accidents	**42,071**	**2.2**	**4.3%**	**57**
Lung Cancer	**22,747**	**1.4**	**2.3%**	**104**
Breast Cancer	**12,573**	**1.4**	**1.3%**	**102**
Other (Rest)	**-**	**-**	**37.2%**	**-**

Source: World Health Organization, 2011. Note: This table includes both sexes.

TABLE 2.3
PRIMARY CAUSES OF DEATH IN CHILE

Causes of Death	Deaths in 2010	Rate Per 10,000 population	Total Distribution (100%)	World Rank
Coronary Heart Disease	**9,799**	**5.1**	**12.6%**	**177**
Cerebrovascular Disease	**8,757**	**4.5**	**11.3%**	**149**
Influenza & Pneumonia	**4,364**	**2.1**	**5.6%**	**132**
Dementia	**4,059**	**2.0**	**5.2%**	**8**
Diabetes Mellitus	**3,784**	**2.0**	**4.9%**	**123**
Hypertension	**3,681**	**1.8**	**4.8%**	**131**
Lung Disease	**3,378**	**1.7**	**4.4%**	**116**
Stomach Cancer	**3,351**	**1.8**	**4.3%**	**17**
Liver Disease	**3,058**	**1.7**	**3.9%**	**44**
Lung Cancers	**2,587**	**1.4**	**3.3%**	**87**
Other (Rest)	**-**	**-**	**39.7%**	**-**

Source: World Health Organization, 2011. Note: This table includes both sexes.

TABLE 3
HEALTH INDICATORS BY COUNTRY

	Life Expectancy by male and female 2010-2012	Infant Mortality (per 10,000 live births) 2010-2012	Maternal Mortality (per 10,000 live births) 2010-2012	Total Fertility Rate 2010-2013 (est.)	HIV/AIDS Adult Prevalence Rate 2010-2012	People living with HIV/AIDS 2012 (est.)
Argentina	**72/79-74/81**	**111.1-105.2**	**4.6-7.7**	**2.33-2.27**	**0.5 – 0.3**	**120,000**
Brazil	**69/76-69/76**	**211.7-205**	**11-5.6**	**2.18-1.81**	**0.6 – 1.8**	**730,000**
Chile	**74/81-75/81**	**73.4-74**	**16-25**	**1.88-1.85**	**0.4 – 0.4**	**40,000**

Source: Central Intelligence Agency, 2013

TABLE 4
HEALTH PROFILE

	Contraceptive Prevalence 2010-2012	Births attended by skilled health personnel 2010-2012	Measles Immunization in 1-year-olds 2010-2012	Number of Physicians (per 10,000 population) 2010-2012	Number of Nurses & Midwives (per 10,000) 2010-2012	Obesity by Male & Female (2008)
Argentina	65%-75%	99%-98%	99.6%-99%	31.6-20	4.8-7.25	27.4/29.7
Brazil	88%-80%	98%-99%	99%-99%	17.2-17.6	65-64.2	16.5/22.1
Chile	64%-64%	100%-100%	96%-93%	10.9-10.3	6.3-1.4	24.5/33.6

Source: World Health Organization, 2012