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Regionalism, activism, and rights: New opportunities for health diplomacy in South America

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Abstract. Tackling germs, negotiating norms, and securing access to medicines are persistent challenges that disproportionally affect developing countries' participation in global health governance. Furthermore, over the last two decades, the excessive focus on global pandemics and security in global health diplomacy, rendered peripheral diseases that usually strike the poor and vulnerable, creating situations of marginalisation and inequality across societies. However, as the importance of regions and regionalism increases in global politics, and integration ambitions and initiatives extend beyond trade and investment to embrace welfare policy, there are new opportunities to explore whether and how regional commitments affect health equity and access to medicine in developing nations. What, if any, are the possibilities for meso-level institutions to provide leadership and direction in support of alternative practices of global (health) governance? Can regional polities become international advocacy actors in support of global justice goals? This article addresses these questions by analysing regional health diplomacy in South America. The article argues that regional organisations can become sites for collective action and pivotal actors in the advocacy of rights (to health) enabling diplomatic and strategic options to member state and nonstate actors, and playing a role as deal-broker in international organisations by engaging in new forms of regional health diplomacy.

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Introduction

Regions as a structure of governance constitute important spaces for the socialisation of groups and individuals. Regions are spaces or arenas for action driven by different actors, motivations, and expectations about regional endeavours. At the same time, regional organisations can create an authoritative set of institutions based on normative principles that structure practices in member states and communities across the region. This makes sense, particularly, as some social harms are inherently cross-border, and are exacerbated or facilitated by regional developments. Regional rules can improve collective management while pulling together knowledge and material resources

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and thus reducing transaction costs. Yet, as domestic politics become more tightly coupled with regional normative and policy outcomes, regional institutions can also become a 'fulcrum of contention'.[1] Social mobilisation is likely to arise out of generalised perceptions of region building as an 'elite compromise', where regional policy and politics unduly favour national elites, and when pressures of market competition degrade regulatory protection in social areas.[2] These sources of contention have explained regionalism and its discontents in the Americas in the 1990s, and more recently in the Eurozone crisis. In both cases, economic and social regional projects unfolded at different speeds, where the search for efficiency and competitiveness, as a key driving force in the process of regionalism, decoupled from values like distribution, rights, and social justice.[3] But what, if any, are the possibilities for meso-level institutions to provide leadership and direction in support of alternative practices of global governance? Can regional polities become international advocacy actors in support of global justice goals? How can and do regional organisations mediate or transform transnational norms? These questions have received some attention among norm theorists and International Relations (IR) scholars with an interest in EU[4] and ASEAN regionalism,[5] but in the case of South American regionalism they have remained largely unaddressed. However, new political economic trends in Latin America, and new regionalist ambitions have given these questions increasing salience. This is most significantly illustrated, or so I will argue, as the Union of South American Nations (UNASUR) carves out a space for new forms of collective action within the region and of concomitant diplomacy to contest the existing order in the global governance of health.

Such developments challenge views of the transnationalisation of politics and norm diffusion that consider states of the global South, as individuals and as groups, simply as 'receivers' of global norms or norm-takers.[6] On such an understanding, regionalism in the South has been seen as an element of a global neoliberal strategy conducted at a regional scale, a process identified as 'meso-globalisation'.[7] This perception is now seriously challenged as the political and economic circumstances that

[1] Sidney Tarrow, 'Transnational Politics, Contention and Institutions in International Politics', *Annual Review of Political Science*, 4:1 (2001), pp. 1–20.

[2] Fritz Scharpf, 'Negative and Positive Integration in the Political Economy of European Welfare States', in Gary Marks, Fritz Scharpf, Philippe Schmitter, Wolfgang Streeck (eds), *Governance in the European Union* (London: Sage, 1996), pp. 15–39; Andrew Moravcsik, *The Choice for Europe* (Ithaca, NY: Cornell University Press, 1998).

[3] Mario Carranza, 'Clinging Together: Mercosur's Ambitious External Agenda, its Internal Crisis, and the Future of Regional Integration in South America', *Review of International Political Economy*, 13:5 (2006), pp. 802–29, 809; Fritz Scharpf, 'Economic Integration, Democracy, and the Welfare State', *Journal of European Public Policy*, 4:1 (1997), pp. 18–36.

[4] Charlotte Bretherton and John Vogler, *The European Union as a Global Actor* (London: Routledge, 1999); Trine Flockhart, *Socializing Democratic Norms: The Role of International Organizations for the Construction of Europe* (Basingstoke: Palgrave Macmillan, 2005); Mario Telo, *European Union and New Regionalism: Regional Actors and Global Governance in a Post-Hegemonic Era* (London: Ashgate, 2007).

[5] David Capie, 'Localization as Resistance: The Contested Diffusion of Small Arms Norms in Southeast Asia', *Security Dialogue*, 39:6 (2008), pp. 637–58; Amitav Acharya, 'How Ideas Spread: Whose Norms Matter? Norm Localization and Institutional Change in Asian Regionalism', *International Organization*, 58 (2004), pp. 239–75.

[6] Keohane Robert, 'Between Vision and Reality: Variables in Latin American Foreign Policy', in Joseph Tulchin and Robert Espach (eds), *Latin America in the New International System* (Boulder: Lynne Rienner, 2001), pp. 207–14.

[7] Nicola Phillips, 'Hemispheric Integration and Subregionalism in the Americas', *International Affairs*, 79:2 (2003), pp. 327–49, 329; Andrew Gamble and Anthony Payne (eds), *Regionalism and World Order* (London: Palgrave/Macmillan, 1996).

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gave substance to regionalism in the 1980s and 1990s no longer obtain and the contours of the regional arena are being defined by contentious politics in demand of responsive modes of governance beyond market-led integration.[8] This doesn't mean that capitalism, liberalism and trade related forms of integration are ceasing to be significant elements of the regional agenda, rather it seems that their centrality is being displaced as new valid social goals are being reclaimed and taking precedence in the politics of region-building and the practice of regionalism in the South. In this context, health is an appropriate field for an approach that focuses not only on social integration between states but also in the capacity of regional organisations to advocate more inclusive models of global health governance.

This article looks at the capacity of UNASUR to enable new policies for collective action in support of social development goals in South America, and to act as a broker of rights-based demands in global health governance. The human right to health is an established part of the international law structuring global health governance. However, critics of international institutions and health aid raised concerns about how issues of representation, transparency, accountability, and effectiveness undermine opportunities to enjoy attainable standards of physical and mental health in developing countries.[9] In this context, the article argues, the relevance of regional organisations such as UNASUR rests on the capacity to provide a framework that helps diffuse regulations, norms, and practices concerning national health regimes and, at the same time, to act as broker of health norms bridging domestic political concerns and global health governance, advancing demands for better representation and rights within the World Health Organisation (WHO) and *vis-à-vis* international pharmaceutical corporations. This argument does not assume that UNASUR advances a coherent foreign policy in all areas but, rather, that it has found in health diplomacy a niche area for contesting and reworking the *status quo* so that *regional* health diplomacy becomes a project of transformation, rather than an affirmation, of the current global order.

The article is organised as follows. Part One discusses controversies around what defines health and global health governance. It is argued that specific frameworks support policy agendas that open opportunities for policy engagement, contestation, and claiming. Part Two proposes a framework to analyse regional organisations as sites for collective action and pivotal actors in contending global (health) politics. Part Three contextualises the study by analysing the milestones defining global health diplomacy and its inequalities in Latin America. Part Four analyses how UNASUR, as an example of a regional organisation in the South, opens new opportunities for advocacy in support of access to medicines and health in the region and, through external engagement, as an actor contesting the *status quo* in global health governance. The article closes with a discussion about regional activism and rights followed by concluding remarks summarising theoretical and empirical implications for further analysis of regional organisations in global health governance.

[8] Diana Tussie, 'Latin America: Contrasting Motivations for Regional Projects', *Review of International Studies*, 35:1 (2009), pp. 169–88; Pía Riggirozzi and Diana Tussie (eds), *The Rise of Post-Hegemonic Regionalism: The Case of Latin America* (Netherlands: Springer, 2012).

[9] Paulo Buss, 'Brazil: Structuring Cooperation for Health', *The Lancet*, 377:9779 (2011), pp. 1722–3; Paulo Buss and Maria do Carmo Leal, 'Global Health and Health Diplomacy', *Cadernos da Saúde Pública*, 25:12 (2009), pp. 2541–41; Jonathan Wolff, *The Human Right to Health* (New York: W. W. Norton & Co, 2012).

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Health as a defining lens of governance

Like most terrains of social policy, public health has traditionally been a sensitive area where the dominant form of political organisation and provision has been the state. However, in recent years health has risen as a strategic policy area with transboundary implications. There is increasing evidence that many determinants of health extend beyond the commonly understood area of public policy and health sector activities, and are associated with transnational pandemics and diseases that trespass national boundaries and migrate from countries to country through porous frontiers and interdependent economies. While the state still exercises undoubted and indisputable regulatory power over public health decisions over societies in their own territorial boundaries, both the reach and scope of health governance has become central to the understanding and practice of global foreign policy. Policymakers and researchers are now familiar with the term 'global health diplomacy', which has developed as a field of research and policy action over the last two decades as health is becoming a core feature of global negotiations, whether they relate to trade, economic growth, or social development.[10]

Collective attempts to combat diseases that cross national borders are not new. In fact, health was one of the first transboundary issues to employ multilateral diplomatic mechanisms during the nineteenth century.[11] But it was only at the end of the twentieth century when health became recognised, academically, as a 'global' issue. The HIV/AIDS epidemics in the 1980s, and more recently the outbreaks of severe acute respiratory syndrome (SARS) in China and Canada, and the spread of pandemic influenza A (H1N1) between Mexico and the United States, demonstrated little regard for state borders or notions of sovereignty. In an increasingly globalised world, disease can spread more quickly and more easily than before. In addition to the impact in terms of morbidity and mortality caused by communicable diseases, their capacity to interfere with economic activity and population movement means that communicable diseases fall subject to international coordination.[12] Similarly, the terrorist and bioterrorist attacks of September and October 2001 in the United States directed the focus of infectious disease to national security.[13] Such events have increased global political concerns about emerging infectious disease threats and deliberate epidemics, and have highlighted the important connection between global public health and security, what Ingram identifies as a new 'geopolitics of disease'.[14]

[10] See Ilona Kickbusch, Gaudenz Silberschmidt, and Paulo Buss, 'Global Health Diplomacy: the Need for New Perspectives, Strategic Approaches and Skills in Global Health', *Bulletin of the World Health Organization*, 85 (2007), pp. 161–244; David Fidler, 'The Globalisation of Public Health: 100 Years of International Health Diplomacy', *Bulletin of the WHO*, 79 (2001); David Fidler, 'Germs, Norms and Power: Global Health's Political Revolution', *Law, Social Justice & Global Development Journal* (2004), available at: {http://www2.warwick.ac.uk/fac/soc/law/elj/lgd/2004_1/fidler/} accessed 28 March 2013

[11] Ilona Kickbusch and Margarita Ivanova, 'The History and Evolution of Global Health Diplomacy', in Ilona Kickbusch, Graham Lister, Michaela Told, and Nick Drager (eds), *Global Health Diplomacy: Concepts, Issues, Actors, Instruments, Fora and Cases* (New York: Springer, 2013), pp. 11–26.

[12] Vanessa Rossi and John Walker, *Assessing the Impact and Costs of Public Health Risks: the Example of SARS*' (Oxford: Oxford Economic Forecasting Group Report, 2004).

[13] Gary Cecchine and Melinda Moore, 'Infectious Disease and National Security: Strategic Information Needs', available at: {http://www.rand.org/content/dam/rand/pubs/technical_reports/2006/RAND_TR405.pdf} accessed 14 July 2013

[14] Alan Ingram, 'The New Geopolitics of Disease: Between Global Health and Global Security', *Geopolitics*, 10:3 (2005), pp. 522–45. Also Colin McInnes and Kelley Lee, *Global Health and International Relations* (London: Polity, 2012).

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The nexus between health crisis and health security increasingly provided new grounds for international policymaking as well as an important entry-point for analysing the politics of health. In practice, health was recognised as a security threat at the turn of the century by a United Nations Security Council (Resolution 1308, 2000) and subsequently awarded a place in numerous national security documents – particularly in relation to infectious diseases and HIV/AIDS.[15] This has particularly been so in the case of US policy responses and the subsequent creation of the President's Emergency Plan for AIDS Relief (PEPFAR) and other funding mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria; bilateral programmes; NGOs and civil society groups; and private foundations such as the Bill and Melinda Gates Foundation. The General Assembly's Millennium Summit in September 2000 also brought further attention to the HIV/AIDS pandemic by devoting Goal 6 of the Millennium Development Goals (MDGs) to combat the disease, as well as other prevalent infectious diseases such as malaria and tuberculosis.[16] To be clear, the WHO has promoted broad debates about global responses to HIV since the late 1980s. But the identification of health as a global security issue, underpinned by the UN Security Council, demarcated rhetorical and disciplinary boundaries in International Relations. Theoretically, this gave substance to three main approaches framing the study of international health politics: (i) a realpolitik approach that suggests that the global scope of health poses security risks to states and citizens and thus defending, as well as advancing, national interests becomes the primary motivation for international health politics;[17] (ii) an institutional approach which stresses that unintended consequences of global health, and social action, leads to cooperation between formal global international institutions, states and nonstate actors, particularly if states fail to address (state and human) insecurity; and (iii) normative and rights-based approaches claiming that a complementary aspect of realpolitik should reorient global health architecture to the recognition of the morality of health and the right to health.[18] Despite this range of approaches, the challenge of International Relations, in theory and as foreign policy practice, is 'to galvanise existing actors and structures into acting on behalf of the voiceless and vulnerable, without succumbing to the logic of securitisation'.[19]

If imperatives of state, social, and economic security exert pervasive influence over the discourses, institutions, policies, and practitioners of public health, the risk is that health moves away from the realm of rights, as 'right to health',[20] to that of 'securitisation'. This is not to say that the securitisation of health denies the right to health. But it rather *delimits* the subject of rights, *prescribes* policy obligations, and

[15] Simon Rushton, 'AIDS and International Security in the United Nations System', *Health Policy and Planning*, 25:6 (2010), pp. 25, 495–504.

[16] See Rushton, *AIDS and International Security*, p. 499.

[17] See David Fidler, 'Architecture amidst Anarchy: Global Health's Quest for Governance', *Global Health Governance*, 1:1 (2007), available at: {http://ghgj.org/Fidler_Architecture.pdf} accessed 1 April 2014. Also, Ronald Labonté and Michelle L Gagnon, 'Health and Foreign Policy: Lessons for Global Health Diplomacy', *Global Health*, 6:14 (2010), pp. 2–19.

[18] For a comprehensive analysis of these perspectives, see McInnes and Lee, *Global Health.* Also Jennifer Prah Ruger, 'Global Health Justice and Governance', *The American Journal of Bioethics*, 12:12 (2012), pp. 35–54, and Kay and David Williams, *Global Health Governance*

[19] Sara Davies, 'What Contribution can International Relations Make to the Evolving Global Health Governance', *International Affairs*, 86:5 (2010), pp. 1167–90, 1182. Also Paul Farmer, *Pathologies of Power* (Berkeley, CA: University of California Press, 2005) and Prah Ruger, *Global Health Justice*

[20] For a discussion about 'right to health' and recognition, see Patrick Hayden, 'The Human Right to Health and the Struggle for Recognition', *Review of International Studies*, 38 (2012), pp. 569–88.

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steers the allocation of human and material resources.[21] It can also create a tension between existing *normative and legal* instruments supporting rights-based approaches to social development and citizenship and the *practice* of global (health) governance.[22] In other words, that certain infectious diseases become a matter of security and global threat also means that actors' responses may drift away from an ethos of human dignity to one of self-interest of cost-effective calculations.[23]

Who frames what and why depends on how the actors in global health governance, including government officials, nongovernmental organisations (for example, Medicins Sans Frontieres, Oxfam, the Gates Foundations), institutions (for example, the WHO, World Bank, UNICEF, UNAIDS), public-private partnerships (for example, GAVI), define their goals and objectives, institutional mandates and rationales, and exercise use of material and knowledge resources to support actions accordingly.[24] As argued by Fidler, the ways *germs* are tackled, *norms* addressed, and *power* exercised, are linked to both moral responsibilities as well as a more pragmatic understanding of powerful actors' interests.[25] From this perspective, the linkages between global health, aid, trade, diplomacy, and national/global security motivates foreign policy based on strategic calculations – economic (protecting trade), diplomatic (preventing epidemics), strategic (preventing bioterrorism) – as much as by a desire to promote health equity and wellbeing.[26] As such, it is expected that the donor community, advocacy organisations, wealthy countries, and the UN system, for instance, strategise not only on the basis of moral principles, but also driven by their understandings of what constitutes 'problems', 'solutions', and 'best' practices. These considerations are often filtered by what is considered *globally relevant* and *cost-effective* in health cooperation and technical assistance programmes.[27] These interests are salient even in current times of rising development aid for health and groundbreaking global health treaties increasingly addressing the *right to health*.[28] The risk is that what is 'visible' and 'urgent' leads over what is 'marginal'; that so-considered high politics in health prevails over low politics; or simply that global pandemics render peripheral diseases that disproportionately strike the poor and vulnerable, creating situations of marginalisation and inequality across societies.[29]

[21] Colin McInnes, 'HIV/AIDS and Security', *International Affairs*, 82 (2006), pp. 315–26; Melissa Curley and Jonathan Herington, 'The Securitisation of Avian Influenza: International Discourses and Domestic Politics in Asia', *Review of International Studies*, 37:1 (2011), pp. 141–66.

[22] Jean Grugel and Nicola Piper, 'Do Rights Promote Development?', *Global Social Policy*, 9:1 (2009), pp. 79–98, 92.

[23] Christian Enemark, *Disease and Security: Natural Plagues and Biological Weapons in East Asia* (London: Routledge, 2007).

[24] Jennifer Prah Ruger, 'Global Health Governance as Shared Health Governance', *Journal of Epidemiology and Community Health*, 66:7 (2012), pp. 653–61, 658.

[25] Fidler, *Germs, Norms and Power.*

[26] See for example, Harley Feldbaum, Kelley Lee, and Joshua Michaud, 'Global Health and Foreign Policy', *Epidemiologic Reviews*, 32:1 (2010), pp. 82–92.

[27] Asuncion St Clair and Desmond McNeill, *Global Poverty, Ethics, and Human Rights: The Role of Multilateral Organisations* (New York and London: Routledge, 2009); Andrea Cornwall and Celestine Nyamu-Musembi, 'Putting the 'Rights-Based Approach' to Development into Perspective', *Third World Quarterly*, 25:8 (2004), pp. 1415–37.

[28] Hayden, *Human Rights to Health.*

[29] Farmer, *Pathologies of Power*; Simon Rushton and Owain Williams (eds), *Partnerships and Foundations in Global Health Governance* (Basingstoke: Palgrave Macmillan, 2011); Wolff, *Human Right to Health.* For further discussion, see Colin McInnes, Adam Kamradt-Scott, Kelley Lee, David Reubi, Anne Roemer-Mahler, Simon Rushton, Owain David Williams, and Marie Woodling, *Framing Global Health: The Governance Challenge*. *Global Public Health*, 7:2 (2012), pp. 83–94.

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This is even more the case as many deliberations and declarations about rights, development aid, and the right to health take place in global institutions with limited participation of right-bearers – rural and indigenous community leaders, migrants, etc.– in those deliberations or within the institutional structure of the relevant organisations. Lack of participation in the structure of health governance closes the political opportunity, in the words of Tarrow,[30] for 'rights bearers' and activists to set up political agendas and to contest how subjects of rights are defined, their needs established, and problems of poverty and marginalisation addressed.[31] Harman argues that the highly centralised nature of decision-making and delivery in global health governance, led by a statecentric and hierarchical mode of organisation, has the effect of 'pigeon-holing issues and prescribing interventions' while reproducing a power gap between international institutions and donors (that is, the World Bank, the Bill and Melinda Gates Foundation, states within the G8) and the governments and civil society actors within developing countries. The latter have less opportunity to influence terms of agenda-setting and decision-making, priorities of research, and delivery of services.[32] According the Lancet-University of Oslo Commission on Global Governance for Health, power asymmetries between actors with conflicting interests, as well as reduced spaces for policy dialogue in contemporary global governance, are political determinants of health, marginalised diseases, and populations.[33]

In recognition of this, a puzzling question arises: can regional normative and institutional frameworks structure practices in support of broader equality and rights to healthcare and access to medicines? Relatedly, can regional organisations become activist in support of the right to health in developing countries? Constructivist scholarship in International Relations and the literature on contention politics and social movements have acknowledged the dynamic role of NGOs and transnational advocacy networks seeking to alter existing political structures, particularly in relation to human rights.[34] According to these perspectives, when communication between domestic actors and the state are blocked, NGOs can search out international partners who will pressure the state from the outside. Risse, Ropp, and Sikkink, for instance, argue that the referential point for policy change is at the intersection of macro and micro relations of power where international institutions are key to the policy impact of transnational actors; not only because they facilitate the formation of transgovernmental coalitions but also because transnational actors working in international institutions gain visibility and influence, gaining access to the governments of member states.[35]

[30] Sidney Tarrow, *Power in Movement: Social movements and Contentious Politics* (Cambridge: Cambridge University Press, 1998).

[31] Hayden, *The Human Right to Health*, p. 588.

[32] Sophie Harman, *The World Bank and HIV/AIDS: Setting a Global Agenda* (London: Routledge, 2010), p. 117

[33] The Lancet-University of Oslo Commission on Global Governance for Health, 'The Political Origins of Health Inequality', *The Lancet*, 383 (2014), pp. 630–67; Harman, *The World Bank*, p. 20; Farmer, *Pathologies of Power.*

[34] See Margaret E. Keck and Kathryn Sikkink, *Activists Beyond Borders: Advocacy Networks in International Politics* (Ithaca, NY: Cornell University Press, 1998); Thomas Risse, Steven Ropp, and Kathryn Sikkink, *The Power of Human Rights: International Norms and Domestic Change* (New York: Cambridge University Press, 2013 [orig. pub. 1999]). Also Amitav Acharya, 'How Ideas Spread: Whose Norms Matter? Norm Localization and Institutional Change in Asian Regionalism', *International Organization*, 58:2 (2004), pp. 239–75.

[35] Risse, Ropp, and Sikkink, *The Power of Human Rights.*

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Furthering these arguments, yet with a focus on regional organisations, this article argues that regional organisations have a crucial role providing opportunities and incentives for individuals or groups to undertake collective action, contesting, reworking and spreading (human rights) norms, and fundamentally engaging as 'regional actors' in (health) diplomacy. Little has been speculated about the opportunities for multilateral and regional organisations (that is, G-20, IBSA, ASEAN, SADC, MERCOSUR, and the Community of Portuguese Speaking Countries) to act as norm sponsors championing alternative practices and viewpoints on global health. Some empirical work on the ways Southern in support of health cooperation has been produced,[36] however current scholarly writings tend to emphasise diplomatic interactions led by singular 'regional powers', primarily Brazil, South Africa or China, in international diplomacy and within the WHO. While important global players in health diplomacy, the challenge is not depicting how member states' interests play out in the global system, or the role of NGOs – mainly operating from major Western countries, but rather to explain how regional organisations can become political structures providing opportunities and incentives for individuals or groups to undertake collective action, and fundamentally how a regional polity can *itself* become a policy entrepreneur brokering demands and reworking (global) rights to health.

Advocacy and regionalism in health governance

Activism and advocacy of civil society groups and networks have been corrective devices and moral vectors in global (health) governance.[37] Similarly, increasing South-South cooperation and alliances are said to strengthen less developed countries collective bargaining position, influence, and negotiation outcomes in critical areas in global health politics.[38] High economic growth rates in emerging economies such as Brazil, Russia, India, and China have certainly increased their presence and political influence in global governance, and thus their political willingness to challenge traditional structures of power and norms in strategic areas such as the Trade Related Intellectual Property Rights Agreement (TRIPS) regime, curtailing the interests of traditional powers while introducing new international normative, such as the Framework Convention on Tobacco Control.[39] Similarly, but with a focus on social actors, Jönsson and Jönsson show how firm advocacy of NGOs fighting against HIV/AIDS profoundly changed impacted on global health institutions in terms of mobilising

[36] Katherine Bliss (ed.), *Key Players in Global Health: How Brazil, Russia, India, China, and South Africa are Influencing the Game* (Washington, DC: Centre for Strategic and International Studies, 2010); also Kickbusch, Silberschmidt, and Buss, *Global Health Diplomacy*; and William Onzivu, 'Regionalism and the Reinvigoration of Global Health Diplomacy: Lessons from Africa', *Asian Journal of WTO & International Health Law and Policy*, 7:1 (2012), pp. 49–77.

[37] Michael McCubbin, Ronald Labonté, and Bernardette Dallaire, 'Advocacy for Healthy Public Policy as a Health Promotion Technology', *Centre for Health Promotion* (2001), available at: {http://www.utoronto.ca/chp/symposium.htm} accessed 19 August 2013.

[38] For a literature review on the place of BRICS in global health governance, see Andrew Harmer, Yina Xiao, Eduardo Missoni, and Fabrizio Tediosi, 'BRICS without straw? A Systematic Literature Review of Newly Emerging Economies Influence in Global Health', *Globalization and Health*, 9:15 (2013), pp. 2–11.

[39] Kelley Lee, Luis Chagas, and Thomas Novotny, 'Brazil and the Framework Convention on Tobacco Control: Global Health Diplomacy as Soft Power', *PLoS Medicine*, 7:4 (2010), pp. 1–4. Also Celia Almeida, Rodrigo Campos, Paulo Buss, et al., 'Brazil's Conception of South-South "Structural Co-operation" in Health', *Review Global Forum Update on Research for Health*, 6 (2009), pp. 100–7.

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unprecedented amount of funds and framing the discourse about HIV as a matter of human rights and socioeconomic inclusion, downplaying medical and security emphasis that particularly defined the issue in the 1990s.[40] Furthermore, changes in the international regulatory framework with the multilateral adoption of the Millennium Development Goals under the umbrella of the UN system, catalysed the activism of transnational advocacy groups endorsing the framing of HIV as human rights also within domestic contexts, particularly in Africa.[41] As the WHO recognised NGOs as legitimate partners promoting and protecting rights, HIV/AIDS activists have been able to make use of global opportunity structures granting access to important governance institutions, mainly within the UN system, but also in public-private partnerships like the Global Fund to Fight AIDS, Tuberculosis, and Malaria. While these developments do not mean that power asymmetries and exclusionary decision-making have been reverted, they are important steps towards transformations in the multilateral policymaking. This may also explain the unprecedented focus on health as a foreign policy, confirmed in a special issue of the Bulletin of the WHO and the 'Oslo Declaration'.[42]

However, not all countries or social organisations are able to craft (influential) health foreign policies, in the same way that not all diseases generate the same level of interest in health diplomacy and global health responses. In this regard, communicable diseases, such as HIV/AIDS, tuberculosis, and malaria tend to receive a disproportionate share of attention and resources compared to other communicable diseases such as dengue, chagas, and parasitic diseases that do not lead to global epidemiological emergencies.[43] This is also the case in relation to the corridors of research and development funding. While nonstate actors and funders, whether the Gates Foundation, the Welcome Trust, private charity or international organisations, may be led by noble and ethical considerations, pursuing a human rights agenda may concentrate resources on dealing with one disease while delinking the problem from the political economic environment affecting societies' access to health systems and medicines in many developing countries. Likewise, the US President's Emergency Plan for AIDS Relief (PEPFAR) or the Gates' initiatives to eradicate polio and malaria often support laboratory research and work in the field, setting up clinics, treatment centres, home visits, and so on, but their money, effort, and good intentions do not always have a significant effect on the lack of technical expertise, professionalisation of health workers and health policy makers; or the different capacity and leverage of developing countries in health negotiations within international organisations and *vis-à-vis* international pharmaceuticals.[44] Despite a recognition that transnational alliances and advocacy efforts of NGOs, and global rights-based regimes can

[40] Christer Jönsson and Kristina Jönsson, 'Global and Local Health Governance: Civil Society, Human Rights and HIV/AIDS', *Third World Quarterly*, 33:9 (2012), pp. 1719–34; also Laurie Garrett, *HIV and National Security: Where are the Links?* (New York: Council on Foreign Relations, 2005).

[41] Jönsson and Jönsson, *Global and Local Health*, p. 1723.

[42] Foreign Ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand, 'Oslo Ministerial Declaration: A Pressing Foreign Policy Issue of Our Time', *Lancet*, 369:9570 (2007), pp. 137–8

[43] Roger Magnuson, 'Non-Communicable Diseases and Global Health Governance: Enhancing Global Processes to Improve Health Development', *Globalization and Health*, 3:2 (2007), available at: {http://www.globalizationandhealth.com/content/pdf/1744-8603-3-2.pdf} accessed 28 March 2013; Peter Navario, 'HIV Dollars? Boon or Black Hole?', *Council on Foreign Relations Expert Brief* (2009), available at: {http://www.cfr.org/publication/18845/hiv_dollars.html} accessed 28 March 2013.

[44] Ronald Labonté, 'Health Activism in a Globalising Era: Lessons Past for Efforts Future', *The Lancet*, 381:9884 (2013), pp. 2158–19.

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make a difference in terms of pro-poor development and rights,[45] political considerations, institutional mandates, private interests, and distributional consequences may create perverse incentives making it difficult to address and advance (international-led) responses to tackle poverty, hunger, gender, discrimination, and production/consumption habits.[46]

In view of that, the hypothesis proposed here is that there is a new kind of political opportunity structure emerging if we consider that the *regional space* represents a critical platform to enhance visibility and recognition of marginalised societies (and neglected diseases) in global politics. I therefore propose to look at both the opportunities institutions of regionalist governance allow for collective action within the region, and activism of regional institutions advanced through diplomacy as a unified actor. These are different ways through which regional actors can actually promote health policies and practices, from framing public policy debates to providing different set of incentives for actors involved in the domestic and global policymaking process. That is, regional organisations can become sites for collective action and pivotal actors in contending (global) politics, in three main different ways: (i) providing a normative framework structuring new practices in support of rights-based development governance; (ii) facilitating the (re)allocation of material and knowledge resources and creating new institutions in support of claims making and advocacy of actors; and (iii) enabling representation and claims-making as a unified regional actor in global governance. In short, regional actors can change policymaking and the policymaking arena. They can also play the role of deal-broker and mediator between developing countries and international organisations by engaging in new forms of regional health diplomacy.

Latin American health inequalities

It is now commonplace to assert that Latin America has begun to move away from strictly neoliberal models of growth as a consequence of an unprecedented economic boom, based on global demand for the region's abundant natural resources. Despite important differences in current economic conditions within the region strong external demand (especially from emerging economies like China), in combination with vigorous internal demand, resulted in an average annual GDP growth rate of almost 5 per cent during 2003–8 and an average of 4 per cent during 2011–13 for the entire region.[47] New economic opportunities intersected with the rise of populist Leftist governments across the region, redefining projects of economic and social development.[48]

[45] Ken Conca, *Governing Water: Contention, Transnational Politics and Global Institution Building* (London: Routledge, 2005); Kathryn Hochstetler, 'Fading Green: Environmental Politics in the MERCOSUR Free Trade Agreement', *Latin American Politics and Society*, 45:4 (2003), pp. 1–33; Deborah Yashar, 'Globalisation and Collective Action: A Review Essay', *Comparative Politics*, 34:1 (2002), pp. 355–75. Also, Jean Grugel and Nicola Piper, *Critical Perspectives in Global Governance* (London: Routledge, 2007)

[46] For further discussion, see McInnes, Kamradt-Scott, and Lee, *Health: The Governance Challenge*.

[47] Economic Commission for Latin America and the Caribbean (ECLAC), *Panorama Social de America Latina* (Santiago: CEPAL, 2012).

[48] Laura Macdonald and Arne Ruckert, *Post-Neoliberalism in the Americas* (Basingstoke: Palgrave/Macmillan, 2009); Jean Grugel and Pia Riggirozzi, 'Post-neoliberalism in Latin America: Rebuilding and Reclaiming the State after Crisis', *Development and Change*, 43:1 (2012), pp. 1–21.

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Notwithstanding this, around 168 million still live in poverty, that is almost 30 per cent of the population subsists with less than two dollars a day, while 66 million live in extreme poverty earning less than one dollar per day.[49] The most economically and socially vulnerable populations, that is indigenous, rural poor, slum residents, migrant workers, the elderly, women and children, face unfavourable conditions and the greatest burden of infectious diseases and disabilities.[50] Many studies have reported the close links between tuberculosis, infectious diseases, malnutrition, and other communicable diseases, and the lack or insufficient access to drinking water, sanitation, adequate housing, education, and health services across Latin America.[51] The poverty-health link is also manifested in reduced learning capabilities and socio-economic and income earning capacity opportunities. Some alarming figures show that in low-income countries, such as Bolivia, Paraguay, and Peru communicable diseases exert the most important influence on quality of life and life expectancy. In Haiti, the incidence of tuberculosis is seven times that of the region; while dengue and HIV, although a significant and growing problem across the region, disproportionately affects Brazil. Malaria is endemic in 21 countries.[52] This bleak situation is worsened by low levels of social service delivery and limited access to medicines particularly affecting populations in rural and tropical areas and, significantly, women in the region. Deeper levels of poverty have been associated with distortions and transformations caused by the manner in which many countries in Latin America have been integrated into a globalising world economy with high rates of poverty and inequality in income distribution and access to public services accentuated by a legacy of neoliberal reforms in the 1990s that reduced public spending in welfare policies and state participation in the provisions of health, education, and social security.[53] Additionally, access to medicines has been hampered by unfavourable trade negotiations with developed countries and exporters of high-value patented drugs. Numerous public health experts, academics, and practitioners have expressed concerns about the impact of TRIPS, part of the normative order of the World Trade Organisation, limiting availability and increasing prices of drugs in favour of the pharmaceutical sector.[54] Although the TRIPS Agreement allows developing countries to override drug patents by issuing 'compulsory licenses' to manufacture generic drugs in exceptional cases, for instance when drugs are not sufficient or affordable domestically, these flexibilities have sometimes been curtailed.[55] Restrictive bilateral

[49] ECLAC, *Panorama*, p. 14.

[50] Ibid., p. 9.

[51] John Holveck, John Ehrenberg, Stephen Ault, et al., 'Prevention, Control and Elimination of Neglected Diseases in the Americas: Pathways to Integrated, Inter-programmatic, Intersectoral Action for Health and Development', *BMC Public Health*, 7 (2007), available at: {http://www.biomedcentral.com/1471-2458/7/6/} accessed 10 March 2013; Annette Pruss, Robert Bos, Fiona Gore, and Jamie Bartram, *Safer Water, Better Health: Costs, Benefits and Sustainability of Interventions to Protect and Promote Health* (Geneva: WHO, 2008).

[52] Sandhi Barreto, Jaime Miranda, Peter Figueroa, et al., 'Epidemiology in Latin America and the Caribbean: Current Situation and Challenges', *International Journal of Epidemiology*, 41:2 (2012), pp. 557–71.

[53] Ibid. For a discussion about health inequalities and neglected populations, see Peter Hotez, *Forgotten Diseases, Forgotten People: The Neglected Tropical Diseases and their Impact on Global Health and Development* (ASM Press, 2008).

[54] Maria A. Oliveira, Jorge Zepeda Bermudez, Gabriela Costa Chaves, et al., 'Has the Implementation of the TRIPs Agreement in Latin America and the Caribbean Produced Intellectual Legislation that Favours Public Health?', *Bulletin of World Health Organization*, 8:11 (2004), pp. 815–21.

[55] Anthony So, 'A Fair Deal for the Future: Flexibilities under TRIPs', *Bulletin of the World Health Organization*, 82:11 (2004), pp. 811–90.

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frameworks have been applied to a number of US and EU-sponsored FTAs with Central America, Chile, Peru, and Colombia curtailing the flexibilities for compulsory licensing and parallel imports of medicines at lower prices from other countries, circumventing the WTO framework.[56]

In the struggle for the right to health and access to medicines, South American countries started collectively bargaining for price reductions in the procurement of pharmaceuticals needed for national health programmes, particularly in response to the escalation of HIV in Brazil in the 1990s and the mobilisation of social actors demanding rights honouring the Constitution of 1988.[57] In fact, attempts to embed social issues in relation to health, education, and labour regulations within regional frameworks, particularly in the Andean Community and the Common Market of the South (MERCOSUR) have been significant.[58] Nonetheless, in practice collective action on social goals drifted away from the attention of authorities and consequently regional mechanisms had limited or no influence on policymaking in regards to such issues. In the end, these initiatives remained rather *ad hoc* and severely limited by the realities and pressures of economies highly dependent on international cooperation and conditional loans demanding fiscal austerity and 'less state' through privatisation and deregulation of markets, including health.[59] Delivering social protection, welfare, and human development remained seen as the responsibility of (seriously constrained) domestic spending choices, often to mitigate the effects of market reforms or to secure political support of citizens. In this context, South American nations failed to build fixed and effective regional institutions protecting and promoting health rights, and creating opportunities for individuals and groups to access, enjoy, and reproduce those rights.

By 2000, renewed attitudes to tackling the critical state of global health saw a proliferation of players, resources, and policy frameworks such as the Millennium Development Goals, with health as an issue cutting across its eight objectives; the Global Health Initiatives for the increase of funds for infectious diseases, such as AIDS, Tuberculosis and Malaria, and for immunisation; the Commission on Social Determinants of Health (2005–8) defining health not simply as a sanitary problem but one determined by socioeconomic conditions; and the Oslo Ministerial Declaration (2007) which called for more attention to health as a foreign policy issue and a stronger strategic focus on the global health agenda. These new frameworks intersected with the changes in the political economy of Latin America where more confident and resourced nationalist governments have been highly consequential for a new cycle of contention politics – in the language of Sidney Tarrow – through government-sponsored welfare policies and a significant change in the regional agenda to respond to the legacy of past neoliberal policy reforms. Indeed the commitment with the integration process was reaffirmed in the early 2000s by the new South

[56] Ibid., p. 813; Oliveira et al., *Has the Implementation of the TRIPs Agreement in Latin America.*

[57] SELA (Sistema Economico Latinoamericano), 'Cooperation Experiences in the Health Sector in Latin America and the Caribbean', available at: {http://www.sela.org/attach/258/EDOCS/SRed/2010/05/T023600004086-0-Cooperation_experiences_in_the_health_sector_in_LAC.pdf}, p. 56, accessed 2 August 2013.

[58] SELA, 'Bulletin 150 on Regional Integration in Latin America and the Caribbean', available at: {http://www.sela.org/attach/258/EDOCS/SRed/2010/07/T023600004239-0-Boletin_150__MAYO_2010_Ingles__.pdf} accessed 15 March 2014.

[59] Celia Almeida, Rodrigo Campos, Paulo Buss, et al., 'Brazil's Conception of South-South "Structural Cooperation" in Health', *Review Global Forum Update on Research for Health*, 6 (2009), pp. 100–7.

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American governments who saw the regional space a platform for redefining consensuses around autonomous development through regional social policies in health, the management of natural resources, and infrastructure integration.[60] The creation of UNASUR in this context was manifestation of a new model of development and a political platform to strategically place South America in a stronger and unified position to address health issues and promoting new rights in global governance, and creating opportunities for policy coordination for the access and enjoyment of those rights.

Contesting norms, brokering rights: Regional health diplomacy in UNASUR

UNASUR crystallised as a model of governance in 2008, yet its origins must be traced back to the beginning of the decade when Brazilian president Fernando Henrique Cardoso called in the first Summit of South American Presidents, in 2000. The aim was an ambitious integration project beyond notions of market expansion with renewed commitments on democratic principles and a broader sense of development. The creation of UNASUR was the result of a combination of national level statecraft and the reshaping of the regional political economy based on new commitments for social development principles, and rights together underpinning institution-building, and giving new impetus to ambitious projects focusing on inclusion and human rights. Its Constitutive Treaty established a broad acceptance of social policy as an important catalyst for new models of integration and the need to institute a Health Council to coordinate effective governance.[61] UNASUR official documents speak of a new morality of integration linked to a right-based approach to health as it is considered a transformative element for societies, a vehicle for inclusion and citizenship, and an active aspect in the process of South American integration.[62] Health from this perspective became a 'locus for integration' and a new framework to advance historically constituted claims of social and rights-based medicine, as well as innovative legal paradigms linking citizenship and health. Although these commitments materialised in the late 2000s, the seeds of these developments must be traced to Brazilian activism around HIV/AIDS, tobacco control, and the promotion of policies concerning the impact intellectual property rights on access to medicines.[63] Furthermore, rights claims in relation to HIV/AIDS treatment in Brazil were developed in a setting where the country was transiting from authoritarian rule to democracy. The repertoire of protest unfolded as a struggle for democratisation and social rights combined demands for political reform and the universalisation of social insurance, in a context of pubic campaigns against discrimination of AIDS patients.[64] These

[60] Riggirozzi and Tussie, *The Rise of Post-Hegemonic Regionalism.*

[61] UNASUR (2009), *Constitutional Treaty* (Tratado Constitutivo de la Unión de Naciones Sudamericanas), available at: {www.comunidadandina.org/unasur/tratado_constitutivo.htm} accessed 3 July 2012.

[62] UNASUR (2011), *Report of the Pro Tempore Secretariat* (2011), available at: {http://isags-unasul.org/site/wp-content/uploads/2011/12/Informe-2011.pdf} accessed 28 July 2012.

[63] Amy Nunn, Elize Da Fonseca, and Sofia Gruskin 'Changing Global Essential Medicines Norms to Improve Access to AIDS treatment: Lessons from Brazil', *Global Public Health: An International Journal for Research, Policy and Practice*, 4:2 (2009), pp. 131–49; Kelley Lee, Luiz C. Chagas, and Thomas E. Novotny, 'Brazil and the Framework Convention on Tobacco Control: Global Health Diplomacy as Soft Power' (2010), available at: {http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000232} accessed 12 June 2013.

[64] Amy Nunn, *The Politics and History of AIDS Treatment in Brazil* (Netherlands: Springer, 2009); Buss and do Carmo Leal, *Global Health.*

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campaigns were advanced by an alliance between activists and health professionals, *movimento pela reforma sanitária* (movement for health reform or public health movement), known as *sanitarista* movement, which emerged in the 1980s across Latin America carving out a public space reclaiming rights to health as part of democratic rights. The *sanitarista* movement framed health reform as a 'key demand of the popular sectors'.[65] The inclusion of representatives of the *sanitarista* movement in key posts in the Ministry of Health during the process of redemocratisation in Brazil, allowed the right to health to become a constitutional right in the Constitutional reform in 1988, which led in turn to the adoption of the universal public health system in Brazil. In this case, social activists and practitioners in the health sector acted upon the opportunities created by the imminent HIV risk and the context of democratisation in Brazil, linking, or 'brokering' in the language of McAdam et al.,[66] two 'sites' of contentious politics – HIV patients' rights and demands for democracy – framing the claims for health under the slogan 'Democracy is Health', creating a 'meta narrative' that also shaped subsequent interpretations of the right to heath across the region.[67] In tandem, health as rights, as advocated by UNASUR, also grew from the notion of 'wellbeing' (*buen vivir* or *sumak kawsay* in the Quechua language) included, as a right, in new constitutions of Bolivia and Ecuador, two influential countries in the construction of UNASUR and its plan of action on health. It is not coincidence that UNASUR headquarters are based in Quito, Ecuador, while UNASUR's health think tank, the South American Institute for Health Governance (*Instituto Sudamericano de Gobernanza en Salud*, ISAGS) is in Rio de Janeiro, Brazil. The UNASUR Constitutive Treaty, signed in Brasilia in May 2008, explicitly declared human rights as a core value of integration, expressing the need to foster an integrative process in support of social inclusion and poverty eradication. Within this framework, it is also specifically declared the 'right to health as the energetic force of the people in the process for South American integration'.[68] In short, the experience of previous regional formations such as MERCOSUR and the Andean Community in addressing regional health governance issues was determined by a political economic environment marked by financial dependency, austerity, and reduced social spending. In contrast, UNASUR embraced health in a different political and economic environment. As a consequence, health took centrality in regional politics not only to address sanitary problems of transborder relations but fundamentally to redress equity and wellbeing as a right to be sought in intraregional relations and in global governance diplomacy.

Institutionally, UNASUR set up a Health Council that works at the ministerial level to consolidate South American integration in the health field through policies and an agenda proposed by members in combination with thematic Technical Groups and thematic networks. In 2009, UNASUR Health Council approved a Five Year Plan (*Plan Quinquenal*) outlining actions towards the implementation of projects

[65] Marcus Melo, 'Anatomia do fracasso: Intermediação de interesses e a reforma das políticas sociais na Nova República', *Dados – Revista de Ciências Sociais*, 36:1 (1993), pp. 119–63, quoted in Alex Shankland, and Andrea Cornwall, 'Realising Health Rights in Brazil: The Micropolitics of Sustaining Health System Reform', in Anthony Bebbington and Willy McCourt (eds), *Development Success: Statecraft in the South*, (London: Palgrave, 2007).

[66] McAdam, *Dynamics of Contention*, p. 142.

[67] Author's interview with Mariana Faria, ISAGS Chief of Staff, Rio de Janeiro, 29 September 2012.

[68] UNASUR (2009), 'Constitutional Treaty' ('Tratado Constitutivo de la Union de Naciones Sudamericanas' available at:{http://www.comunidadandina.org/unasur/tratado_constitutivo.htm} accessed 3 March

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and regulatory frameworks, allocation of financial resources, and capacity building on five programmes:

(1) Coordination of surveillance, immunisation, and networks for prevention and control of noninfectious diseases and dengue fever;
(2) Creation of Universal Health Systems in South American countries;
(3) Generation and coordination of information for implementation and monitoring of health policies;
(4) Coordination of strategies to increase access to medicines and foster production and commercialisation of generic drugs, including harmonisation of medicines' surveillance and registries for members; coordinated policy for pricing of medicines for the purchase from, and external negotiations;
(5) Development of mechanisms for capacity building and human resources management directed at health practitioners and policymakers for the formulation, management, and negotiation of health policies at domestic and international levels.[69]

Based on these areas, UNASUR engaged in a new type of diplomacy in a twofold strategy: (i) intraregional diplomacy, focusing on intraregional cooperation; and (ii) transversal or extraregional diplomacy seeking to redefine North/South divide in health negotiations and strategies. These forms of diplomacy are not mutually exclusive but rather reinforce the role of UNASUR in health governance. While horizontal diplomacy reflects the formation of a new consensus in the region about social inclusion and rights, framing new terms of cooperation and mobilisation of human and financial resources; extraregional diplomacy concerns interventions of UNASUR as a bloc in the WHO and World Health Assembly (WHA), and *vis-à-vis* international pharmaceuticals.

Intraregional diplomacy is led by Technical Groups, which are responsible for analysing, preparing and developing proposals, plans, and projects according to the Five Year Plan. The Technical Groups report to the South American Health Council and are directed by two member countries in charge of setting up and observing projects on the ground. In addition, networks of national health institutions and public health schools promote technical education, research, and exchange for the development of public health workforce across the region. Particularly relevant in this regard has been the Network of Public Health Schools, which aims to create educational infrastructure for health workers and decision-makers; and the Network of National Institutions of Cancer (RINC), which coordinates cooperation among national public institutions across UNASUR member countries to develop and/or implement cancer control policies and programmes and research in South America. Supporting these developments, the South American Institute of Health Governance is an innovative regional institution, under the umbrella of UNASUR, which provides policy-oriented and informative research, training and capacity building.[70] ISAGS capitalised on the international role of Brazil, which over the past decade has taken an increasingly protagonist position contesting global norms regarding access to medicines and right to health in various United Nations bodies and South-South

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[69] UNASUR, *Plan Quinquenal* (2010–15), available at: {http://www.ins.gob.pe/repositorioaps/0/0/jer/rins_documentosunasur/PQ%20UNASUR%20S alud.pdf} accessed 20 March 2012.

[70] For detailed information about UNASUR Thematic Groups, networks and ISAGS, see {http://isags-

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cooperation.[71] This activism turned to the region and was articulated by a leading Brazilian research institution, the Oswaldo Cruz Foundation, which proposed, in the first instance, the creation of ISAGS to UNASUR health ministers. ISAGS philosophy is that health not simply an issue of public policy but also a problem of governance. From this perspective, it was proposed that a new institution helped improving the quality of policymaking and management within the Ministries of Health in UNASUR members through regional networking activities, policy training and capacity building.[72] For instance, echoing the Five Year Plan, ISAGS plays a key role as 'knowledge broker' gathering, assessing and disseminating data on health policies of countries; benchmarking health policy and targets; and establishing effective mechanisms of diffusion through seminars, workshops, capacity building, and special meetings in support of policy reform by demand of member states.[73] For instance, UNASUR's Technical Group on Human Resources Development and Management, in collaboration with ISAGS, have offered technical support and capacity building activities for the creation of new institutions such as Public Health Schools in Peru, Uruguay, Bolivia, and Guyana.[74]

Similarly, as a '*training hub*' ISAGS engages policymakers that fill in ministerial positions, negotiators that sit in the international fora, and practitioners that liaise with the general public, providing technical assistance and capacity building, strengthening skills and institutional capacity through a range of activities in support of professionalisation and leadership.[75] For instance, ISAGS supported Ministry of Health officials in Paraguay and Guyana for the implementation of national policies regarding primary attention and preparation of clinical protocols in these poor countries, and more recently echoing the challenges of creating universal health systems, ISAGS supported reforms towards the universalisation of the health sector in Colombia, Peru, and Bolivia.[76] The politico-institutional framework fostered by UNASUR is also manifested in its support of theme-specific networks of country-based institutions to implement projects on noncommunicable diseases, such as cancer and obesity; to combat the propagation of HIV/AIDS, and to undertake extensive vaccination programs against H1N1 influenza and Dengue Fever across the region, and addressing counter-cholera efforts in Haiti after the earthquake in 2010.[77] ISAGS also leads theme-specific networks of country-based institutions to implement projects on noncommunicable diseases, such as cancer and obesity, and to combat the propagation of HIV/AIDS, malaria, dengue, tuberculosis, chagas, and other serious communicable diseases through health surveillance, access to vaccinations and medicines.[78]

unasul.org/site/sobre/?lang=es} accessed 2 April 2013.

[71] Buss and do Carmo Leal, *Global Health*; Nunn et al., *Politics and History of AIDS.*

[72] Author's interview with Mariana Faria, ISAGS Chief of Staff, 29th August 2012.

[73] UNASUR, *Plan Quinquenal.*

[74] Agencia Fiocruz de Noticias, 'UNASUR Promotes Health Systems in South American Nations', available at: {http://isags-unasul.org/noticias_interna.asp?lang=2&idArea=2&idPai=4387} accessed 27 April 2013.

[75] Author's interview with Dr Hugo Noboa, Ministry of Health, Quito, Ecuador, 30 July 2012, Quito, Ecuador.

[76] ISAGS, *Report* (January 2013), available at: {http://issuu.com/isagsunasur/docs/informe_ing} accessed 13 March 2013.

[77] PAHO, 'UNASUR's Role in the Vaccination Against Pandemic Influenza', *Pan-American Health Organisation Immunisation Newsletter*, 32:4 (2010); UNASUR, 'Bulletin: Ecuador and Dominican Republic Agree to Cooperate in the Reconstruction of Haiti' (4 November 2010), available at: {http://www.pptunasur.com/contenidos.php?id=1100&tipo=27&idiom=1website} accessed 28 March 2012.

[78] UNASUR, *Salud, Report of the Pro Tempore Secretariat* (2011), available at: {http://isags-unasul.org/

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More recently, UNASUR has been instrumental, as '*industrial coordinator*', in the establishment of two projects to promote harmonisation of data for public health decision-making across the region: a 'Map of Regional Capacities in Medicine Production' approved by the Health Council in 2012, where ISAGS, is identifying existing industrial capacities in the region to coordinate common policies for production of medicines; and a 'Bank of Medicine Prices', a computerised data set revealing prices paid by UNASUR countries for drug purchases, and thus providing policymakers and health authorities a common background and information to strengthen the position of member states in purchases of medicines *vis-à-vis* pharmaceuticals. Based on this, joint negotiation strategies, as a purchase cartel, are also in place to enhance the leverage *vis-à-vis* pharmaceutical companies. UNASUR Health Council is also seeking new ways of coordinating industrial capacity for the production of generic medicines, potentially in coordination with the Defence Council. This was confirmed in a seminar organised by UNASUR and the Ministry of Defence in Argentina, in April 2013, where a proposal for the creation of a South American Program of Medicine Production in the field of Defence, was discussed.[79]

These practices are not only oriented to generate conditions for better access to health and efficient use of public resources within the regional space but are also reaching outside the region through South-South cooperation and UNASUR leadership in health diplomacy. In terms of extraregional diplomacy, UNASUR is establishing as a legitimate and proactive actor advancing a new regional diplomacy to change policies regarding representation of developing countries in the executive boards of the WHO and its regional branch the Pan-American Health Organisation (PAHO). The leadership of Brazil in the region is undoubtedly critical for these developments as it has been instrumental in promoting an international presence of UNASUR, yet policy positions for international discussions concerning the impact intellectual property rights on access to medicines or the monopolist position of pharmaceutical companies on price setting and generics have been particularly driven by Ecuador and Argentina, echoing new regional motivations for redistribution and rights.[80] UNASUR also led successful discussions on the role of the WHO in combating counterfeit medical products in partnership with the International Medical Products Anti-Counterfeiting Taskforce (IMPACT), an agency led by Big Pharma and the International Criminal Police Organisation (Interpol) and funded by developed countries engaged in intellectual property rights enforcement. Controversies focused on the legitimacy of IMPACT and its actions seen as led by technical rather than sanitary interests, unfairly restricting the marketing of generic products in the developing world.[81] At the 63rd World Health Assembly in 2010, UNASUR proposed that an intergovernmental group replaced IMPACT to act on, and prevent, counterfeiting of medical products. This resolution was approved at the 65th World Health Assembly in May 2012. The first meeting of the intergovernmental group was

site/wp-content/uploads/2011/12/Informe-2011.pdf} accessed 28 March 2012.

[79] UNASUR's Centro de Estudios Estrategicos de Defensa (CEED), *Action Plan 2013*, Centre for Strategic Studies: UNASUR Defense Council (2013), available at: {http://www.ceedcds.org.ar/English/09-Downloads/Eng-PA/ENG-Plan-de-Accion-2013.pdf} accessed 2 June 2013

[80] Author's interviews with Patricia Betancourt and Paula Gonzalez, International Cooperation Office, Ministry of Health in Ecuador, 30 July 2012. Author's interview with former UNASUR Health Council delegate from Ecuador, 6 August 2012; and with Lorena Ruiz, former Coordinator of UNASUR's Technical Group for Access to Medicines, 2 August 2012.

[81] Author's interview with Fausto Lopez, Senior Official at UNASUR Health Council, 30 July 2012; and

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held in Buenos Aires, Argentina, in November 2012. In the course of this meeting, UNASUR also lobbied for opening negotiations for a binding agreement on financial support and research enhancing opportunities in innovation and access to medicines to meet the needs of developing countries. More recently, led by Ecuador, UNASUR presented for discussion an action plan for greater recognition of rights of disabled people within the normative of the WHO, a normative that was successfully taken up in the WHA Assembly in May 2013.[82] Finally, UNASUR entered into capacity building partnerships with other regional organisations, such as the Pan-American Health Organisation, and is seeking recognition to act through regional, rather than national, delegates at the World Health Assembly, just as the EU negotiates as a bloc across a wide range of agenda items.[83]

The presence of UNASUR in this type of health diplomacy, and its coordinated efforts to redefine rules of participation and representation in the governing of global and regional health, and production and access to medicine *vis-à-vis* international negotiations, are indicative of a new rationale in regional integration in Latin America based on international leadership and policymaking. These actions create new spaces for policy coordination and collective action where regional institutions become an opportunity for practitioners, academics, and policymakers to collaborate and network in support of better access to healthcare, services, and policymaking. For negotiators, UNASUR structures practices to enhance leverage in international negotiations for better access to medicines and research and development funding, as well as better representation of developing countries in international health governance. For advocacy actors, UNASUR represents a new normative platform for claiming and advancing the right to health within the region while at the same time attempting to establish itself as a broker between national needs and global norms, a political pathway that differs from the position held by Latin America in the past.

Regional activism and rights

The regional experience of UNASUR opens an unprecedented opportunity to evaluate and compare the ways and extent to which regional organisations address rights-based concerns affecting ordinary people. It was argued here that regional organisations should be seen as both a space redefining cooperation on social policies within a geographical space, as well as transborder practices reworking and contesting norms. In the first, place, the evidence in the preceding sections highlights the importance of political and economic contexts driving new forms of regional cooperation. The regional space facilitates new corridors of knowledge exchange, reallocating resources in support of not only claims making and advocacy of actors but also of better policymaking. Regional organisations, such as UNASUR, can enable the exchange and networking of actors and epistemic communities for addressing neglected issues and for research and development of medicines. Unlike previous regional integration experiences in Latin America where building fixed and effective social regional institutions remained a rhetorical aspiration, UNASUR Health facilitates opportunities

with Senior Official at the Ministry of Health in Ecuador, 30 July 2012.

[82] Author's interview with Gustavo Giler, Senior Government Official from Ecuador's Presidency and former delegate of UNASUR Health, 29 August 2012

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for policy change through training and capacity building activities directed at the professionalisation of policymakers and international health negotiators, enhancing leadership for national policymaking. Likewise, it provides technical and policy support fostering approximation of laws conducive to similar legal provisions in primary health, and the universalisation of health systems. The article illustrates this interplay between regional institutions/regulations and implementation of health policies at the national level in Paraguay and Guyana where UNASUR's think tank was key supporting the implementation of national policies regarding primary attention and preparation of clinical protocols, as well as reforms towards the universalisation of health sector in Colombia, Peru, and Bolivia. The creation of new institutions such as Public Health Schools across UNASUR members is a manifestation of positive regional/national synergies in health.

Yet regionalism should also be seen as more than an instrumental mechanism aiming at the maximisation of regulatory capacity in different policy domains. Regional organisations can become sites for collective action and pivotal actors in contending (global) politics by means of providing an alternative normative framework and rescaling practices in support of rights-based and social development governance. Undoubtedly, the most innovative aspect of UNASUR is its global activism. Playing global politics under a unified umbrella, UNASUR means that representation of less powerful and resourced countries in the region enhance their visibility, voice, and claims-making capacity in global governance. UNASUR's regional logic is not reduced to an institutional expression of market liberalisation, as previous regional formations in South America anticipated, and many scholars claimed,[84] but to new symbolic and practical aspects of social rights. In other words, health, as a social component of the regional normative and institutional structure, downplays the excessive emphasis on trade in the study and practice of regionalism in the South, suggesting also that there are new opportunities for linking leadership and regional governance to advocacy and claims-making. As the previous section demonstrated, national governments and policy makers turned to UNASUR to set up new institutions; support new policies and policymaking; advocate access to health and medicines, rights of disabled people; broaden representation of developing countries in the institutions of global health governance; and contest the power of pharmaceuticals. Likewise, the relevance of UNASUR must be seen in the opportunities it opens to redefine the terms of engagement of developing countries in South America in relation to sensitive issues of rights and representation global health governance.

Based on this, it can be claimed that regional organisations can become sites for collective action and pivotal actors in the advocacy of rights (to health) enabling diplomatic and strategic options to member state and nonstate actors. At the same time, regional organisations can play a role as deal-broker in the international arena by engaging in new forms of regional diplomacy. This is not a minor issue given that international frameworks pushing for universal human rights in relation to social and economic development have significantly filtered the normative discourse of the UN System, yet international agencies have been quite conservative in turning the rhetoric into practice, acknowledging and affecting bearers of rights in different ways. In the

[83] Ibid.

[84] For instance, Fritz Scharpf, *Governing in Europe: Effective and Democratic?* (Oxford: Oxford University Press, 1999); Wolfgang Streeck and Philippe C. Schmitter, 'From National Corporatism to Transnational Pluralism: Organized Pluralism: Organized Interests in the Single European Market', *Politics*

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case of UNASUR diplomacy, advancing goals of social justice entails acting as a corrective to the sidelining of rights on account of security concerns in international health politics.

Conclusion

The presence of regional organisations in public policymaking is an increasing subject of North-South and South-South development agendas, and an intriguing entry-point for research into the benefits of regional integration for public goods provision and combating the sources and effects of poverty. There is growing recognition that regional integration ambitions and initiatives extend beyond commercial trade and investment to embrace health and welfare policy, but little is known about whether and how regional organisations' commitments are being implemented in these domains or about the ways in which regional policy processes can be conducive to broadening rights (to health, but not only health) in national and international spheres. To repair this epistemic lacuna, this article investigated regional health policy and diplomacy by undertaking an analysis of UNASUR's regional health agenda and global ambitions. It was argued that regional organisations such as UNASUR can provide frameworks structuring practices and shaping, normatively and institutionally, national health regimes projecting, at the same time, goals through regional health diplomacy.

Empirically, the analysis of synergies between regionalism and welfare through health contributes to studies rooted in the field of comparative regionalism, substantiating the claim that 'regions other than Europe are thinking of regionalism as a way of addressing the most pressing challenges that these societies faced'.[85] In the case of UNASUR, this is exemplified by the expansion of regional cooperation and strategies of regionalism, and the new impetus it gives to the goal of tackling poverty through its focus on regional health policy processes and institutions. Likewise, a focus on Southern regional institutions as sites of policymaking and as international actors adds geographical nuance to scholarly work on the foreign policy dynamics of regional formations that have, to date, largely focused on the European Union. In keeping with the rapid growth of global (health) governance literatures, the present analysis brings new evidence about how social relations of welfare are being (re)made over larger integrative scales and how regional actors may initiate new norms to improve health rights in international arenas engaging in new forms of 'regional' diplomacy beyond traditional spheres of trade, finance, and investment.

Theoretically, the message is that, in the light of the new modalities of mobilisation, diplomatic and strategic options, regional organisations and identities must be considered important keywords in advocacy and contention politics, as well as in the academic analysis of who acts, who frames and who contests global (health) policies. In many ways the argument developed here points to the need to investigate the relations of the regional level of analysis *between* the state and the globe, and the processes that connect regional and national politics *within* the regional space if we are adequately to analyse contemporary forms of power, activism, and cooperation

and Society, 19:2 (1991), pp. 133–64.

[85] Amitav Acharya, 'Comparative Regionalism: A Field Whose Time has Come?', *The International*

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on health and other social issue areas. Accepting that states pool rather than cede sovereignty to play out externally pressing shared dilemmas the analysis settles on three variables specific to regional structures: (i) regional normative frameworks structuring practices in support of rights-based governance; (ii) regional norms and practices creating opportunities for (re)allocation of material and nonmaterial resources and thus for inclusion; and (iii) regional formations as unified representative actors in global political space enabling representation and claims-making, contesting, and reworking global governance in support of global justice goals.

For scholars concerned with the study of regionalism, this framework encourages new forms to assess, normatively, the capacity of regional institutions to diffuse regulations, norms, and practices for more inclusive and responsive national and global regimes, moving away from mere assessments of regions and regionalism on the basis of material indicators such as free trade or levels institutionalisation (that is, hard institutionalism) through the presence of – often supranational – institutions. Similarly, for those concerned with International Relations and health, the analysis of the role and opportunities for meso-level institutions mediating transnational norms through new forms of diplomacy sheds new light on what so far has been a theoretical 'blind spot'. The way IR looks at health has been mainly rooted in theorisations of health as *threat*, and health as a matter of *international cooperation*. These approaches generated different conclusions about what (global) health entails, shaping the main ways in which health has featured in International Relations; namely, as *realpolitik* responses by states to transborder disease risks, and as collective humanitarian commitments and modalities of intervention by multilateral institutions and nongovernmental actors to reduce inequalities within and across societies.[86] It is only with the emergence of the alternative theorisation provided by new normative right-based approaches emphasising the *right* to health that the topic has acquired its contemporary salience. The last two decades have seen rapid advances in political economy and right-based approaches denouncing health inequities between different populations, within and between countries, and fostering debates about social determinant of health.[87] However, this rights-oriented scholarship has largely remained focused on the role of states and nonstate institutions in the making and shaping of global health politics, disregarding other formations such as regional organisations. This has been the consequence of theoretical idiosyncrasies rather than a problem of irrelevance of regional organisations affecting opportunities for social development and rights. Addressing these limitations, this study casts new light on the synergies between regionalism and social development, and between modalities of regional activism, health diplomacy, and rights, suggesting that regional organisations can provide opportunities and incentives for individuals or groups to undertake collective action in support of rights-based governance, and engage as 'regional actors' in support of rights-based global governance.

The present study should be taken as a starting point of this broader research agenda; it claims only to have established a *prima facie* case for the importance of this area of enquiry. It is, of course, the case that future difficulties faced by regional groupings in the South may affect the political and social foundations of regional activism, in health and other social areas. Latin America in particular has a long

Spectator: Italian Journal of International Affairs, 47:1 (2012), pp. 3–15, 4.

[86] McInnes and Lee, *Global Health.*

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history of truncated regional aspirations. Nevertheless, the advancements in regional health, as an area of diplomacy in South America, not only marks an important difference, in symbolic, practical and institutional terms, in relation to experiments of the past, but also illustrates how policymaking can be made over larger policy scales. In this respect, the argument advanced here establishes at least the value of devoting more attention to the linkages between regionalism and poverty reduction through effective, context-specific, policy interventions, as well as for further analysis of the role regional organisations play as actors in global (health) politics.

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