[www.reciis.cict.fiocruz.br]
e-ISSN 1981-6286

Essay

Health diplomacy and South-South cooperation: the experiences of UNASUR Salud and CPLP's Strategic Plan for Cooperation In Health

DOI: 10.3395/reciis.v4i1.351en

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Abstract

This paper presents the main characteristics of the international cooperation in health recently carried out regionally that fits within the overall umbrella of South-South cooperation. Such cooperation schemes take place mostly among South American countries (UNASUL Saúde) and among lusophone countries including the Palop (Portuguese-Speaking African Countries), East Timor, Brazil and Portugal through the PECS/CPLP (Strategic Plan for Cooperation in Health of the Community of Portuguese-speaking Countries).

Keywords

international cooperation in health; health diplomacy; South-South cooperation; Unasul health; Unasur Salud; PECS/CPLP

South-South cooperation in social areas has been receiving greater and greater attention from developing countries in the southern hemisphere. This might be taking place due either to the limitations of the traditional North-South cooperation, which has been dominated by the centralizing perspectives and practices of developed countries, or to the emergence of middle-income countries in the sphere of international cooperation or even to a greater perception from poorer countries regarding the benefits of this 'cooperation between equals' (BUSS & FERREIRA, 2010).

On the other hand, after 30 years of the United Nations Conference on Technical Cooperation among Developing Countries (TCDC), which, in 1978, with the Buenos Aires Action Plan, produced the concept and the praxis of South-South cooperation, also, the United Nations, opened to the demands of Southern countries, revisited the agenda, having carried out in Nairobi, Kenya, on December 2009, the United Nations High Level Conference on South-South Cooperation, whose major theme was 'The Promotion of South-South Cooperation for Development' (SOUTH-SOUTH CONFERENCE, 2009).

This paper analyzes two different very recent South-South cooperation initiatives in the health field: the CPLP's Strategic Plan for Cooperation in Health (PECS/CPLP), which garther eight countries from this language-based group that extends throughout four continents; and Unasur Health, in the context of Unasur, the new regional bloc encompassing the twelve South American countries.

Since the highest levels of staff from both blocs consider cooperation in health a priority, we also listed those experiences in the area of "health diplomacy" (KICKBUSCH et al., 2007), which recently constituted as a field within the realm of international relations.

South-South cooperation: conceptual framework[1]

South-South cooperation is any kind of partnership (either economic, commercial, social, etc.) ideally established with multiple advantages for all partners, those being from the developing world, usually from the Southern Hemisphere.

The political concept around South-South cooperation was developed in the 1950s, at the height of the Cold War. The Asian-African Conference, carried out in Bandung, Indonesia, in 1955, can be considered its first political milestone. With the Non-aligned Movement, established in 1961 at the Belgrade Conference and, later on, with the institution of the Group of 77 in 1964 - which in actuality includes 130 countries - created with the UNCTAD[2], the basic framework for the development of political consensuses between developing countries was established.

In 1978, the United Nations Conference on Technical Cooperation among Developing Countries (TCDC), carried out in Buenos Aires, determined another essential landmark of the process, that is, that TCDC is an essential part of South-South cooperation. Still in the same year, the Special Unit for South-South Cooperation (SU/SSC), established by the United Nations General Assembly and organized within the United Nations Development Program (UNDP), began promoting, coordinating and supporting South-South and triangular cooperation schemes either globally or from within the UN.

In 1987, the South Commission, composed of 28 leaders from southern countries, among which included Brazilians Dom Paulo Evaristo Arns and Celso Furtado, was established to expand South-South cooperation schemes. Its report (THE SOUTH COMMISSION, 1990) became a classic and was turned into a global reference on the theme.

In the 1990s, but more pronouncedly in the first decade of this century, middle- or upper-middle-income countries appeared as relevant political actors in the international sphere and, therefore, in the world of South-South cooperation schemes. Stressing the ability to intervene positively in international politics, such emerging economies jointly developed investment funds, economic integration programs, development programs, projects regarding infrastructure, as well as programs for the internationalization of their companies.

Therefore, countries such as Brazil, China, India, Nigeria, South Africa and Venezuela, among others, began investing on production and cooperation in their regions or within poorer African and Asian countries, making use of the so-called 'soft power' (NYE, 2008) - that is, its human and technological resources in the cooperation with less developed countries, instead of the traditional schemes of political or military coercion - to impose their presence. This means that cooperation takes place between countries that are much more similar economically and politically than in schemes between rich/developed and poor countries. The areas of agriculture, health, education and the development of institutions are among the fields recently covered by the South-South cooperation.

The notion of "health diplomacy" (KICKBUSCH et al., 2007; BUSS, 2008) emerged to address health factors that transcend national borders and expose countries to global influences. The idea also made possible a better, more coherent coordination between the government's health and external relations sectors, not only pushing the acceptance of health-related goals in the Millennium Development Goals, but also assuring that those are incorporated to the countries' health and development plans.

Several countries have been salient in health cooperation as part of foreign policy schemes. Cuba, for instance, has been an important political actor in health diplomacy within the scope of South-South cooperation, having exported innovative technologies in biotechnology and health equipment, as well as making human resources (doctors and nurses, mostly) available for health systems that recognizably lack well-trained professionals.

Another scheme in vogue, in the scope of North-South-South cooperation, is the so-called 'triangulation', in which a developed country provides support for joint actions that promote the training of professionals, the strengthening of institutions and the technical interchange between two Southern countries. Worldwide data are still scarce, but the examples of Brazil and JICA (the Japanese agency for cooperation) both carrying out important triangulation schemes with African countries, and Brazil-U.S. Department of State with El Salvador and Mozambique might indicate a growth in triangular cooperation in health.

This growing importance of South-South cooperation can also be proved by three major high-level events carried out last year: the Pluriannual Meeting of International Cooperation Specialists, with a focus on South-South cooperation and regional integration, carried out on occasion of the UNCTAD meeting in February 2009, in Geneva (ICTSD, 2009); the United Nations High-Level Conference on South-South Cooperation (SOUTH-SOUTH CONFERENCE, 2009), carried out in Nairobi, in December 2009; and focusing specially in this field of policy and practices called health diplomacy, having mentioned the South-South cooperation specifically, the High-Level Meeting of the United Nations Economic and Social Council on Global Health, carried out in Geneva, in July 2009.

Cooperation in health within the CPLP: the strategic program of health cooperation (PECS/CPLP)

The CPLP (the Community of Portuguese-Speaking Countries) is composed of eight member-States: Brazil in the Americas; Portugal in Europe; East Timor in Asia and five countries in Africa (Angola, Mozambique, Guinea-Bissau; Cape Verde and St. Thomas and Prince), which form the Portuguese-Speaking African Countries (PALOP) (Box 1).

CPLP countries are greatly unequal among themselves not only in population, varying from 191.8 million in Brazil

BOX 1 – Community of Portuguese-Speaking Countries (CPLP)

The community of countries where Portuguese is the official language was created in 1996 in Lisbon, Portugal, by the heads of state of Angola, Brazil, Cape Verde, Guinea-Bissau, Mozambique, Portugal and São Tomé and Príncipe. With its independence in 2002, East Timor became the community's eighth member. Moreover, Equatorial Guinea, the Mauritius Islands and Senegal are observers.

The main objectives are to promote concerted political and diplomatic actions between member-States that strengthen their presence in the international community; to cooperate in all domains, including education, health, science and technology, defense, agriculture, public administration, communication, justice, security, culture, sports and social communication; and the promotion and dissemination of the Portuguese language.

The CPLP is composed of directing and executive units: the Conference of Heads of State and Government, the Council of Ministers of External Relations, the Permanent Steering Committee, the Executive Secretariat, the Meeting of Sectoral Ministers (such as the Health Ministers), the Meeting of Focal Points in Cooperation and the International Portuguese Language Institute (IILP). The Parliament gathers representatives from all Parliaments of the Community, which are formed according to the legislative elections in each respective country

The Conference of Heads of State and Government, CPLP's highest deliberative unit, is carried out every two years. Seven conferences have already been organized, the last of which was held in 2008, in Lisbon. The Council of Ministers gathers every year, represents the Presidents and coordinates CPLP's activities. The Steering Committee is formed by one high-level representative from each country and gathers every month to follow through with the implementation of the decisions taken by the other units in the Community.

The Meeting of Sectoral Ministers is formed by Ministers of different government sectors from all member-States. This Meeting is responsible for coordinating, at the sectoral/ministerial (or equivalent) level, concerted actions and cooperation schemes concerning their respective government sectors. The Meeting of Focal Points in Cooperation gathers the units responsible for CPLP's coordination of cooperation schemes within member-States.

The Executive Secretariat is CPLP's main executive unit. It is headquartered in Lisbon and headed by a Secretary with two-year terms, with the possibility of a two year reappointment. The current Secretary is from Guinea-Bissau and since 1996 the post has already been filled by important names from Angola, Brazil and Cape Verde. The Executive Secretary is aided by the Director-General, who, in turn, is recruited from citizens of member-States via a civil servant exam, for a three-year term, which can be renewed for three more years; the Director-General is responsible, under the guidance of the Executive Secretary, for the continuous administration of CPLP.

CPLP currently has 44 observers, including scientific, cultural and economic institutions of participating countries that collaborate with the Community in order for its goals to be met.

Despite having met informally before, the first official sectoral meeting between Ministers of Health from CPLP took place in Praia, Cape Verde, on April 2008, when the establishment of a Plan for Strategic Cooperation in Health was decided on for the period between 2010 and 2012.

In the international sphere, CPLP has also signed several agreements with various United Nations agencies, such as UNAIDS and, more recently, with the WHO, in the field of health. A specific agreement concerning the documentation of health in Portuguese - the e-Portuguese - was established with the WHO, under whom the project is housed.

Source: www.cplp.org, accessed on 11/18/2009.

to only 158 thousand in St. Thomas and Prince, but also concerning *per capita* income, which varies from US$ 18.950 in Portugal to only US$ 200 in Guinea-Bissau and US$ 320 in Mozambique. In 2005, Angola, Guinea-Bissau and East Timor had around 50% of their population living below the international poverty line (US$ 1.25 per day); and the percentage reached 75% in Mozambique (UNICEF, 2009).

Moreover, health indicators and life expectancy vary greatly: in 2007, mortality of under-fives was 198 per 1,000 live births in Guinea-Bissau, 168 in Mozambique, 158 in Angola and only five in Portugal; life expectancy varied from 78 years of age in Portugal and 72 in Brazil to less than 45 in Angola, Guinea-Bissau and Mozambique. Improvements in health indicators that occurred since 1990 in the Palop and in East Timor are few when compared to those of countries with similar social and health conditions (UNICEF, 2009).

Nutritional conditions are also unfavorable taking into consideration indicators such as child malnutrition, low weight at birth among other indicators, as well as the access to basic health services, such as immunizations, prenatal care or births assisted by health professionals. The access to basic sanitation is also highly deficient in the Palop and East Timor, which contributes to the perpetuation of bad health conditions (UNICEF, 2009).

Health systems in the Palop and East Timor are extremely frail, with deficient coverage, insufficient number of service units, problems with governance, scarce and underpaid professionals and a technology standard that is inadequate for the countries' epidemiological profile. Health expenditure is minuscule and does not even cover basic primary healthcare needs. International technical and financial support is vital for even a minimum operationability of healthcare systems in the Palop and East Timor.

The difficult social and economic conditions faced by the Palop and East Timor - which have recently experienced serious internal conflicts[3], which, in many cases, have destroyed the infrastructure and hindered the development of efficient institutions and governance schemes (including those relative to the health field) - have led CPLP's member-countries to point the health field as suitable for solidary cooperation and exchanges of innovative experiences.

The choice of South-South cooperation between CPLP countries was a 'natural' alternative, facilitated by the language (the large majority of health professionals in the Palop, for instance, speak Portuguese and native languages exclusively), on the one hand, and political, ideological and cultural identities, on the other hand. Despite having scarce financial resources, health cooperation within the CPLP has been abundant in trained human resources and in the supply of graduate programs in critical areas for the health field, such as public health, women's and children's health and communicable diseases, in countries such as Brazil and Portugal.

The cooperation model adopted by the CPLP countries for the health field is based on the joint development of a *Strategic Plan of Health Cooperation* (PECS/CPLP), which is very serious in taking into consideration the social and health conditions of the countries, their respective abilities to respond to their major problems and their existing technical and financial resources that might be made available to other countries in a process committed to the principles of appropriation, alignment and harmonization.

After initial negotiations carried out by CPLP's Executive Secretariat, the Council of Health Ministers gathered in Praia, Cape Verde, in April 2008 and decided on the development of the plan. At the same instance, the so-called 'focal points of health', high-level officials of the countries' respective Ministries of Health - appointed and empowered by the ministers - were pointed out as those responsible for identifying the 'demands' of cooperation in health which each country could offer the others, as well as the cooperation 'needs', thus seeking to effectively develop each country's health systems, as well as that of the Community as a whole. That phase was carried out between April and September 2008 in a highly participative process that included technical visits to the countries where Fiocruz and the IHMT, institutions which were also responsible for the development of the first version of the PECS, are headquartered.

After two years of negotiations (2007-2009), carried out by means of meetings of the Council of Ministers (in Praia, in April 2008; and in Rio de Janeiro, in September 2008) and of the Technical Health Group (in Lisbon, in June 2007 and again in June 2008; and Recife, in March 2009) and strongly grounded on the concepts on appropriation, alignment and harmonization, the cooperation plan was completed as a great pact celebrated by the Ministers of Health of the eight countries and registered by the Estoril Declaration (CPLP, 2009), in May 2009. From then on, PECS/CPLP has been implemented by the countries along with CPLP's Secretariat.

Recognizing the connections between health and development and pointing out that health is a fundamental right and an obligation of the State, the Plan's main goal was established as "the improvement of the health systems of CPLP's member-States as to assure the universal access to quality health services". The major strategies used will be the training of human resources and the implementation of

structuring projects that strengthen the institutional capacity of health systems.

Among expected results are the reduction of child and maternal mortality, the universal access to integral healthcare with a focus on primary healthcare and reproductive health and the prevention and fighting of great endemic diseases - such as HIV/Aids, tuberculosis, malaria - and neglected and emerging diseases, such as influenza AH1N1, in all instances with a gender equality perspective (CPLP, 2009).

The Estoril Declaration (CPLP, 2009) emphasizes the need to act upon the social determinants of health in order for the Millennium Development Goals (which also serve the purposes of the Plan) to be attained. The Plan will be harmonized with and complementarily to the National Health Plans of each member country. Moreover, the Plan is keen in recognizing the importance of engaging, collaborating with and associating to the civil society of member States that carry out projects in the scope of health and development, as well as strengthening the relations between the CPLP, the international community and development partners acting in the field of health, thus broadening the presence of the CPLP and Portuguese-speaking countries in the international sphere.

CPLP's structure for cooperation in health is formed by the Council of Ministers of Health, CPLP's Technical Health Group - with focal points pointed out by the Ministers for the formulation, implementation, follow-up and evaluation of the PECS - and CPLP's Executive Secretariat, with technical support provided by the Oswaldo Cruz Foundation (Fiocruz) (Brazil) and the Institute of Hygiene and Tropical Medicine (IHMT) (Portugal).

The cooperation includes seven different areas for priority projects to be developed and goals to be attained (CPLP, 2009):

1) training and development of the workforce in health;
2) information and communication in health;
3) research for health;
4) development of a health industrial complex;
5) epidemiological surveillance and monitoring of health conditions;
6) emergencies and natural disasters;
7) health promotion and protection.

The first theme regards the *training and development of the workforce in health*, a fundamental element in every system, whose situation is dramatic in Africa, due to the low number of professionals, low wages, the lack of training schools and continued education programs, as well as the 'brain-draining', which displaces the few professionals who have already graduated. One of the most critical aspects of this situation is the ignorance towards the true state of things and, therefore, the creation of country-based Observatories of Human Resources in Health - as well as a network of these observatories within the CPLP - was determined. The training of medium level technicians (nursing, laboratory, radiology and imaging technicians, as well as community health agents) - which are fundamental for the health systems in Africa - has been incremented by the implementation of Schools of Health Technicians in all CPLP countries. In November 2009, in a meeting at the Polytechnic Health School at Fiocruz, in Rio de Janeiro, CPLP's Network of Health Technicians Schools was created and its first triennial Work Plan was approved (EPSJV, 2009). On the other hand, the training of high-level professionals to work within the health system and provide health services is planned under a strategy to strengthen the National Schools of Public Health, which will also gather in a network. Specialized medical doctors in priority areas will also be trained by means of the Center for Specialized Medical Training in the Lusophonic Countries, which will be created in Cape Verde, whose new University will also receive incentives. Living examples of cooperation projects that have been applying this strategic line of work are the Masters in Public Health and Health Sciences that Fiocruz has been developing, respectively, in Angola and Mozambique, with the objective of providing onsite training for future high-level professionals that will staff the health system as well as for the development of quality health systems and services (SAVINO et al., 2009).

Such initiatives to train human resources, as well as the continued education of professionals, need financial resources, scientific references and documentation, which are often unavailable in Africa and East Timor. Therefore, PECS/CPLP has defined *information and communication in health* as its second theme/priority. The creation of a CPLP Saúde (CPLP Health) Web Portal and the Network of Virtual Libraries and the Health Libraries in each country - including the establishment of a scientific journal on health for the CPLP, including an internet version - are priorities that provide support for the development of health systems and health professionals based on high-quality scientific information. Moreover, the WHO (in 2008) created the *e-Portuguese*, a platform to support the development of human resources in health in Portuguese-speaking countries by strengthening the fields of information, documentation and training in health.

Health research also plays an important part. It is the only way of producing knowledge with original/local evidence. The third area of PECS is the development of studies and research

projects focusing on health surveillance, management of health systems and biomedical research. The Community already has numerous high-quality institutions such as Fiocruz and other Brazilian public research and development (R&D) institutes, besides an extraordinary network of Universities in Brazil and Portugal that include institutions such as the Institute of Hygiene and Tropical Medicine, the Ricardo Jorge National Health Institute, the Gulbenkian Institute of Sciences and both the traditional and new Portuguese Universities. Angola and Mozambique already have high-level Universities, while Guinea Bissau, Cape Verde, St. Thomas and Prince and East Timor are currently walking towards - with the support of the other countries - establishing Universities that will be part of the effort of producing science and innovations that are adequate to the demands of CPLP's health systems and health as a whole.

It is possible that, in the mid-term, this network of research institutes produces innovations that render it a community-based *health production complex*, which will seek to reduce the dependency on foreign products and equipment, accelerate the economy of the health sector, expand the access of the population to these critical inputs, as well as, more specifically, develop a national industry. This is the fourth area in PECS/CPLP and an example of this kind of cooperation is the Brazilian support to the implementation of a public facility for the production of basic medicines and antiretroviral drugs (as well as the respective technology transfer), which took place between Fiocruz and the Ministry of Health of Mozambique. Also in the same area is the implementation of a network of Technical Centers for the Installation and Maintenance of Equipment (CTIME), a vital matter for CPLP's health systems, since many medical equipment that are donated end up turning into garbage due to an absolute lack of maintenance.

Another essential function of public health – *health surveillance*, the fifth theme area in PECS/CPLP – includes the monitoring of health conditions, as well as of the Millennium Development Goals (MDG), and is considered a field mutual interest by all countries. A symbol of an 'intersectoral pact' (which assuredly have great outcomes for health, demonstrated in many different conjectures and social settings), MDG unquestionably represent a step forward in contexts of poverty and inequality such as in the Palop and East Timor and should, therefore, have their progression monitored. However, in a recent evaluation concerning three major health-related MDG in Africa, the WHO pointed out that, if nothing is done, not even minimum health and quality of life indicators will have been attained. Moreover, the areas of epidemiological, sanitary and environmental surveillance require not only adequate management technologies and technologies regarding tools and instruments, but also the creation of laboratories (such as the National Public Health Reference Laboratories) that are capable of producing timely and reliably diagnostics and treat diseases of greater prevalence, as well as tackle sanitary and environmental risks. Currently, one approach is to transcend the idea of 'isolated laboratories dedicated to specific diseases or disease groups' and, thus, favor the construction of 'National Institutes of Public Health' that are broad in scope and function, such as those which Fiocruz, in cooperation with the International Association of National Public Health Institutes (IANPHI, 2010), provides support for in Mozambique and Guinea-Bissau.

Very poor countries have great problems in dealing with the unforeseeable and the unexpected in the field of health. Therefore, PECS/CPLP has identified *emergencies and disasters* as a priority for cooperation and solidarity between countries in the Community. Epidemic diseases, earthquakes, floods, droughts – to name a few of the complications climate change and other alterations to the environment have been causing – demand coordinated actions and quick, joint and solidary responses from member States, especially in the Palop and East Timor. In its sixth theme area, PECS included the establishment of national quick and coordinated response units and the development of a community-based plan for mutual support in the case of *sanitary emergencies* (which include sanitary crises after natural disasters; serious drug shortages; outbreaks; lack of human resources, etc.).

Finally, the seventh priority regards *health promotion and protection*, including the support for vaccinations in CPLP countries, the implementation of pilot 'healthy communities' projects and the locally based development of intersectoral actions to tackle the social determinants of health. Health promotion is also a recent source of concern not only for health authorities, but also, and especially, for the population as a whole. Different from the prevention of diseases and risk factors or treatment after diseases have stricken, health promotion is the field in which the social determinants of health are tackled (WHO, 2008), which requires coordinated actions between the health sector and other public policy fields, such as sanitation, the environment, housing, education, employment and labor and the equitable distribution of income. Brazil has implemented a National Commission on Social Determinants of Health (CNDSS, 2008), following recommendations of the WHO, and is able to contribute with ideas and experience regarding the actual implementation of intersectoral policies and actions within the CPLP countries.

Within the same theme area of cooperation, the so-called traditional or alternative resources, such as healers, wizards, midwives and other "professionals", which are very important in certain African countries, are also considered.

As guidance for the development of the theme areas for cooperation, the Health Ministers determined that the plan should emphasize the support towards the full development of Ministries of Health as national health authorities and the strengthening of primary healthcare (WHO, 2008a) as their major political guideline, as well as the buttressing of the so-called 'structuring institutions of health systems'[4]: National Institutes of Public Health, National Schools of Public Health, Schools of Health Technicians, other National Institutes - such as those related to Women's and Children's health, for instance - and undergraduate schools that train health professionals (medicine, nursing, etc.).

Moreover, several health problems are managed collectively by CPLP countries through its thematic networks concerning malaria, tuberculosis, HIV/Aids and sickle-cell disease. Other areas might be included later, including health diplomacy and health and migration, for example.

The last step taken towards the implementation of PECS was the meeting of 'partners for the development of PECS/CPLP' (Lisbon, October 2009), in which Brazil and Portugal announced initial donations of US$ 250 thousand each and the World Bank committed to allocating a US$ 500 thousand grant, which are all now part of CPLP's Health Fund, created by the Ministers and the Secretariat to finance actions under PECS. In a touching gesture of profound trust in the process, the small East Timor made a self-entitled 'symbolic' contribution donation of US$ 25 thousand to help implement PECS.

The countries' excelent welcome to PECS/CPLP - expressed by the Focal Points in Cooperation - is leading CPLP to apply similar models to other areas of social cooperation, such as education and the environment, among others.

The perspective is that every wide-ranging action directed at strengthening health systems in the Palop and East Timor by means of the strategy of 'structuring cooperation in health' (ALMEIDA et al., 2009; BUSS & FERREIRA, 2010), in the context of South-South cooperation, contributes to improve the health and life conditions of millions of people in Africa and Timor that not only speak Portuguese, but also are linked by history, culture and solidarity.

Health diplomacy and South-South cooperation in South America: UNASUR salud

Previously organized in two separate regional blocs (Mercosur and the Andean Community of Nations), the twelve South American countries are now united under the Union of South American Nations (or Unasur) (see Box 2), which was formally created in May 2008, in Brasília, in a moment of assertion of democratic values and the emergence of popular governments in most countries of the region. Some analysts consider this regional political bloc the first true balance to the political power of the United States in the hemisphere.

UNASUR did not appear, at the dawn of the 21st century, by chance. On the contrary, it was preceded by several initiatives that include: the constitution of ALALC (Latin American Free Trade Association) (1960), which was later converted into ALADI (Latin American Integration Association) (1980); the creation of the Andean Pact (1969), changed into the Andean Community of Nations (CAN) (1996); the Amazon Cooperation Treaty Organization (OTCA) (1978); the Rio Group (in the 1980s); the constitution of Mercosul, by means of the Treaty of Asuncion (1991) and its expansion in the following years, with the incorporation of Bolivia, Chile and Venezuela (the latter in 2006); the constitution of CASA (The South-American Community of Nations) gathering Mercosul and CAN, by means of the Cuzco Declaration (2004), which was converted into the Unasur (2007); and, finally, the signature of Unasur's Constitutive Treaty in a meeting of Heads of State, in Brasília, in May 2008.

The South American integration process has not been absolutely devoid of internal conflicts or conflicts between participant nations. Internally, in most countries, Unasur is the project of a few heads of State, which is not known (and even less supported) by national populations (RIVAROLA, 2009). To other analysts, the large economic, social and political-ideological disparities between countries - not to mention a few historical border disputes - are at the root of the difficulties faced by countries in implementing the South-American integration. The integration policy supported by Brazil, for instance, is often seen as 'imperialist', that is, that the country would be willing to promote the expansion of its own territorial, cultural and economic domains, as well as defend a model of integration based on the interests of Brazilian executives (BAVA, 2009; OUALALOU, 2010), of the agribusiness (SILVA E MELO, 2009), of infrastructure projects (TAUTZ, 2009) and related to military presence (GONZÁLES, 2009), and not on an agenda of fulfilling rights (BAVA, 2009). The Bolivarian Alliance for the Peoples of Our America (Alba) includes only three of the twelve South-American countries (Bolivia, Ecuador, and Venezuela) and proposes the creation of a regional currency, the Sucre (the Unified System for Regional Compensation) - which, according to

Box 2 – Union of South-American Nations (UNASUR)

The Union of South-American Nations (USAN) (Dutch: Unie van Zuid-Amerikaanse Naties – UZAN; Portuguese: União de Nações Sul-Americanas – Unasul; Spanish: Unión de Naciones Suramericanas - UNASUR) is an intergovernmental union integrating two existing customs unions: Mercosur and the Andean Community (CAN). It is part of a continuing process of South-American integration. Its Constitutive Treaty was signed on May 23rd, 2008, in Brasilia, Brazil, by twelve heads of state. It is modeled after the European Union.

According to the Treaty, the Union's headquarters will be in Quito, Ecuador. The South-American Parliament will be located in Cochabamba, Bolivia, while its bank, the Bank of the South, will be housed in Caracas, Venezuela.

Unasur is structured as follows:

- The Council of Heads of State and Government will be the top political actor;
- The Council of Ministers of Foreign Affairs will formulate concrete proposals and make executive decisions;
- The Council of Delegates will be composed of high-level government officials dedicated to organizing the work of the two above-mentioned Councils and to implement their decisions;
- A Secretary-General will be elected to establish a permanent secretariat in Quito, Ecuador;
- Presidents will summon sectoral Ministerial Meetings that will be carried out according to Mercosur and Andean Community procedures.
- The Pro Tempore Presidency will be held for a year and will rotate between member States. Between July 2009 and July 2010, the Presidency will be held by Ecuador.

The twelve South-American countries have thousands of miles of shared land borders, cover 10.99 million square miles of land, house around 385 million people (2008) and are touched by both the Atlantic and the Pacific Oceans. They extend through a long stretch of the American Continent, from the Equator to Antarctica, and encompass the entirety of the Amazon Forest – the largest and best-preserved forest on the planet. Moreover, they have the major fresh water reserves of the world and vast tracts of land suitable for agriculture and cattle ranching.

The Presidents convened to create the South-American Health Council, composed of the 12 Ministers of Health, in Bahia, Brazil, on December 2008.

Source: www.unasur.org; accessed in 01/18/2010.

Cassen (2009), in response to liberalism, would break the monopoly of the IMF -, but is not supported by the other countries, who discuss the expansion of the use of national currencies in international negotiations carried out inside the bloc (CARVALHO, 2009). The implementation of the Bank of the South, an important part of Unasur's structure - created by the leaders of the bloc - is advancing slowly due to a few points raised by Brazil (CASSEN, 2009).

Despite all the mentioned conflicts, Unasur managed to be politically implemented in a world in which, although increasingly globalized and regionalized, broader regional organizations committed to the development of each country and the region as a whole (and that clamor for equity) define the implementation of multilateral agreements.

Due to its geography and history, Brazil has been prioritizing South America in its External Relations ever since the Empire, a trace that remained unchanged in the Republic - although there have been substantial changes in the economic and political relations between the country and the other South American nations throughout the 20th century. As was emphasized, the results obtained and the meaning of these policies varied according to the historical context and the heterogeneity of the neighbor countries (SANTOS, 2009).

Simões (2009) summarized the positive outlook of the Brazilian diplomacy towards integration by writing that *Unasur starts an unprecedented phase in South American international relations [...], which represents a 'paradigm shift' in the relations between South American nations, a real opportunity to accelerate the economic and social*

development of member countries with a genuine possibility for the region to project itself in a multipolar world.

The objective of Unasul is to *build, in a participatory and consensual manner, an integration and union among its peoples in the cultural, social, economic and political fields, prioritizing political dialogue, social policies, health, education, energy, infrastructure, financing and the environment, among others, with a view to eliminating socioeconomic inequality, in order to achieve social inclusion and participation of the civil society, to strengthen democracy and reduce asy*mmetries within the framework of strengthening the sovereignty and independence of States (UNASUL, 2008).

The Union's first meeting of Heads of State and Government in Brazil was carried out in Costa do Sauípe, in the Brazilian state of Bahia, between December 16th and 18th, 2008 (UNASUR, 2008), and resulted in many political declarations and the constitution of the South-American Health Council, which demonstrates the priority of the matter and of the health agenda for South American political leaders.

The Council is composed by the Ministers of Health of the twelve member States. UNASUR Salud is intended to consolidate the South American integration in the health field by means of the establishment of policies based on mutual agreements, coordinated activities and cooperation efforts between countries (UNASUR Salud, 2009).

The structure of the Council includes a Coordinating Committee, constituted by representatives from the Ministries of all countries; a Technical Secretariat, composed by the country currently holding Unasur's *Pro Tempore* Presidency plus the country that held it previously and the country that will hold it immediately after - which should instill continuity in the process; and Technical Groups, which will be dedicated to developing the Agenda.

The South American Health Agenda was approved by the Council, is currently under development by the Technical Groups with representatives from all countries and encompasses an array of issues which include the following critical ideas (UNASUR Salud, 2009):

1. to develop a South American Policy for the Surveillance and Control of Health Events, previously called 'South American Epidemiological Shield';
2. develop universal health systems;
3. promote the universal access to medications and other health inputs and develop a South American health production complex;
4. promote health and jointly address its social determinants;
5. develop human resources for the health field.

The social reality and health conditions in South America legitimizes this agenda. The countries are very unequal in terms of their economic and health indicators, where Bolivia and Guiana should be pointed out with the highest mortality rates of under-fives. Life expectancy at birth also greatly vary (from 64/68 years of age in Bolivia, to 76/82 in Chile and 73/80 in Uruguay). Variations in population and *per capita* GDP are also significant: Brazil and Argentina hold around 60 percent of the population; the income varies from US$ 2,580 in Guiana to more than US$ 12,000 in Argentina, Chile and Venezuela.

Chronic non-communicable diseases are also predominant in South America. However, communicable diseases (such as malaria in the Amazon, dengue fever and tuberculosis - which are still important problems -, and pockets of Chagas disease and leishmaniasis) linger on. Diseases that can be controlled via immunizations have received great attention from the Ministries of Health and, thus, currently show acceptable indexes.

The first component of the Agenda is referred to the *South American Policy for the Surveillance and Control of Health Events* seeks to standardize all morbidity and mortality records in the region; to foster joint actions concerning the surveillance and control of diseases near borders; to create, strengthen, consolidate and coordinate the networks of epidemiological surveillance and control; and identify diseases that should be prioritized. Cooperation between countries will seek to strengthen the national public epidemiological surveillance services by providing them with adequate technical/scientific and managerial tools, as well as mobilizing the national and subcontinental resources from various sources for such. According to the Technical Group on Surveillance (UNASUR Salud, 2010), gathered in Asunción, Paraguay, in July 2009 and February 2010, the South American policy on epidemiological surveillance - developed and implemented in respect to the International Sanitary Regulations - will be dedicated to those situations depending on national and regional efforts, such as communicable diseases, chronic non-communicable diseases (neoplasias and cardiovascular problems, among others), those most commonly developed by women and children, those occurred due to violence or other external causes, etc. Another important component in the agenda is strengthening a South American Immunization Program

so as to cover the whole population with vaccines that are adequate to the countries' current epidemiological profile.

The second item in the South American Health Agenda is the development of 'universal and equitable health systems', which addresses the recognized insufficiency of South American health systems. Universal health systems are those that, through various means, provide populations with the access to all public health and individual healthcare services. Having assured such a right, high-quality social welfare and public health actions gain importance and are implemented according to social and health needs. The subregional aspect of the Agenda is complemented by the development of 'health in the borders', as well as by assuring the so-called "portability", that is, the access to national South-American health services to nonresidents that seek assistance – which will be regulated in the future. The harmonization of 'health accounts' is also among the Technical Group's priorities, which has been defined in a meeting carried out in Santiago, Chile, in October 2009 (UNASUR Salud, 2009a).

However, health systems are complex technological structures: they depend on medical/surgical equipment, drugs, vaccines, diagnostic kits, orthoses, prostheses, blood, blood-derived products, consumables and inputs, as well as increasingly specialized facilities. Not only do health systems face challenges such as the access to new products and the regulation of pharmaceutical markets in face of the new fields of biotechnology, genomics and proteomics, but also the access to such technologies should be considered from within the framework of health, industrial and science & technology policies. These resources are produced by what is usually called the 'health productive complex' (GADELHA, 2006), that is, by the set of companies and institutional (governments, health service providers, hospitals, etc.) and individual consumers of health goods and services, besides institutions that develop innovations (universities and companies). This is the complexity that the third component in the South American Health Agenda, developed by the Technical Group in Buenos Aires, in February 2010 (UNASUR Salud, 2010), seeks to address. The region has a huge trade deficit regarding health inputs and services. The proposal implies that the health inputs necessary for the South American population should be produced, within reasonable means, by the health productive complex installed in the subcontinent, which points to the establishment of public-private partnerships at the regional level that harmonize industrial and S&T policies in the complex.

Scholars, politicians and social activists recognized today, consensually, that health is a social product, more than the exclusive result of biological processes. The approach of the social determinants of health as a guideline toward the solution of numerous problems faced on a global scale was raised by the World Health Organization (WHO, 2008), and Brazil followed in the same steps, having established its National Commission on Social Determinants of Health. Within the scope of Unasur Salud, the Ministers understood that there is also a subregional dimension that, all at once, is a part of and influences the social determinants of health. The Technical Group specific for the theme gathered in Caracas, Venezuela, in February 2010 (UNASUR Salud, 2010b), when the development of a process to identify the major social determinants in the regions - as well as the development of public policies based on an analysis of the current situation and of previous successful experiences in intersectoral actions - was proposed to better tackle them both nationally and regionally.

Lastly, considering that the health issue is very intensive in and extremely dependent on the quality of the workforce, the specific Technical Group for the theme proposed several initiatives in the field of development of human resources in health for the Agenda in a meeting carried out in September 2009, in Rio de Janeiro (UNASUR Salud, 2009b). Among its recommendations is the creation of the South American Institute of Governance in Health (ISAGS), which was approved by the Ministers in a meeting in Guayaquil, in November 2009 (UNASUR Salud 2009c).

Since all initiatives in the Health Agenda depend on management capacities, leadership skills, the quality of advanced training, knowledge production capabilities and health and intersectoral policies, as well as other aspects related to performing essential public health functions (PAHO, 2002) – which includes the new field of health diplomacy –, ISAGS was developed to help South American countries train the future heads of health systems. Another important mission of the new Institution will be to manage the already existing knowledge, as well as produce the knowledge necessary to fulfill its goals, jointly with relevant social and political actors of the social and health spheres of the region.

ISAGS will not only be owned by the community (that is, it will belong to all member-countries of Unasur) but also be public, with its headquarters in the city of Rio de Janeiro. The Institute will have a small and flexible structure and will coordinate its work program with national institutions and equivalent training and research centers in the region through integration with the networks of the so-called 'structuring institutions of health systems' (see below).

At the same meeting in Guayaquil (UNASUR Salud, 2009c), the Council of Ministers decided on the development of UNASUR's Quinquennial Health Plan (2010-2015), by consolidating the recommendations of the five Technical Groups - each corresponding to one point in the South American Health Agenda -, thus, determining the Coordinating Committee to present it in the Council meeting to be carried out in April 2010, in Ecuador. Moreover, the meeting also formally established various very important initiatives - that had been referred to in the Agenda - (UNASUR Salud, 2009c) for the development of health systems in the region, among which joint actions for the control of Dengue Fever and Influenza A H1N1, the Unasur Salud Scholarship program and the development of networks of structuring institutions of health systems.

The concept of 'structuring cooperation' (ALMEIDA et al, 2009) implies the establishment of South American networks of National Institutes of Public Health, of National Schools of Public Health Schools of Health Technicians, as well as networks of undergraduate schools that train professionals for the main health functions, of healthcare institutes, such as those in the fields of women's and children's health, cancer and others, and of international departments of Health Ministries. These networks will be part of Unasur Salud and able to contribute to the training of human resources, to research and technology development and the rendering of reference services in the region.

Also in South America, but outside the realm of Unasur, the Pan Amazonian Pact in Health Research should also be mentioned. Scientific institutions from the Amazon countries (Bolivia, Brazil, Colombia, Ecuador, Guyana, Peru, Suriname, and Venezuela) created the Pan Amazonian Health Research Network with the objective of jointly carrying out relevant projects for the specific and defying situation of this vital region for the planet. As everyone knows, the Amazon is the largest tropical forest in the world and is essential for reducing global warming. The region's population is relatively scarce, but exhibits health problems directly connected to the social and environmental situation of their surroundings. Brazil will participate though the (Brazilian) Amazon Health Research Network – headed by Fiocruz and composed of 21 institutes of the region, among which eight Federal Universities and prestigious scientific institutions such as the National Institute of Amazonian Research (Inpa) and the Goeldi Museum. Major projects currently being implemented are the Research Networks regarding malaria, hemorrhagic fevers (including dengue fever) and health systems.

This large intergovernmental array called UNASUR Salud is a great example of 'South-South cooperation' (FERREIRA & BUSS, 2010) and 'health diplomacy' (KICKBUSCH et al., 2007; BUSS, 2008) which the South American countries and their Ministers of External Relations and Ministers of Health offer the world, that is, one which associates technical guidance in the field of health and the support of the external relations sector in order to address issues that transcend national borders and expose countries to global influences.

With political and conceptual approaches under implementation, Unasur Salud is able to identify the issues that are better addressed regionally - as opposed to exclusively at the national level -, that is, the situations in which integration facilitates solving problems - since not all socio-sanitary issues benefit from a regional approach and each integration process should be able to identify its own needs and the adequate mechanisms and resources to address them.

However, more than the desire of national governments - a first and fundamental step that has already been implemented -, in order to be materialized as a true "union" of "nations" - and not simply an intergovernmental treaty -, UNASUR will need, as pointed out by Rivarola (2009), "*the active involvement of what is normally called the civil society - which the Andean Community of Nations and Mercosur currently lack - is what is going to allow a transition from a "integration of markets", with no shared memory, to a 'Union', based on identities, cultures and 'transcitizen' rights".*

Notes

1. For a broader discussion concerning South-South cooperation in the health field, see Buss and Ferreira (2010).

2. In the meeting in which it was created, in 1964, UNCTAD defended strategies towards greater industrial autonomy in Southern countries, under public control, such as the policy of substituting imported goods from developed countries for locally produced goods (RUIZ-DIAZ, 2005).

3. In 2010, the 35 years of independence of all PALOPs, a process that was completed in 1975, immediately after the Carnation Revolution, in Portugal, was celebrated.

4. Structuring institutions of health systems are those capable of operationalizing health systems and services effectively, efficiently and sustainably, especially by means of its officialdom, its management capacity and its ability to render health services (such as the Ministries o Health) and its aptitude in training health professionals and generating useful data for decision-making, through Research & Development and the training of essential human resources for the health field (the National Institutes of Health, the Schools of Public Health, the Technical/Vocational Health Schools and other institutes and schools that train professionals in the field of health, for instance) (BUSS, 2008 - unpublished).

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