COMPARING SADC AND UNASUR REGIONAL HEALTH

GOVERNANCE AND POLICY

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Abstract

For many years regional organisations were regarded as entities driven mainly by the goals of trade liberalisation, market creation, and in certain instances security communities. After the 1990s many regional organisations widened their mandates to also incorporate elements of social policies including health. This is particularly significant as coordinated approaches are often needed within a given geographic space to address health challenges. This paper looks at these changes within the Southern African Development Community (SADC) and the Union of South American Nations (UNASUR). It is argued that these regional organisations, although distinctive in term of governance and practice, are examples of regional formations increasingly embedding new health mandates and pro-poor commitments in their normative frameworks, projects, forms of cooperation, and governance. The paper sheds light on regional health governance and policy as embraced by both UNASUR and SADC and on the different relationships, networks practices, and institutional and legal foundations by which regional arrangements hold competence in each region. In this respect, the analyses advanced here proposes 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.

Contents

1. Introduction

In the vast research field of regionalism that has flourished during the last two decades expectations of what regional governance can deliver have been evaluated primarily in terms of economic and security governance. While much has been written about economic integration, regional institutions and security communities, a discussion of how significant other regional projects have been in the process of regionalism has lagged behind. Specifically, a rather neglected policy domain in the account of contemporary forms of regionalism has been social policy (see Yeates, 2007; Deacon and Yeates, 2006; Deacon, et al 2010). As the literature shows, since the late 1990s, however, many regional organisations widened their mandates to incorporate elements of social policies including health. Regional groupings of countries are embracing new agendas and developing plans of action to achieve social goals. These are framing debates and agendas as to what the purpose of regional integration should be, what kinds of social policies are needed, what the respective roles of regional and national institutions should be in helping to achieve them (Riggirozzi, 2014). This is particularly significant in regions where poverty is a driving force behind ill health and under-development (United Nations, 2014). Poor populations in the developing world face the challenges of limited access to health care, weak systems of information about healthcare options, and social determinants of health related to living conditions that predispose them to many poverty related diseases and health inequalities (Hotez, 2011). The 2014 World Bank's World Development Indicators shows that 700 million fewer people lived in conditions of extreme poverty in 2010 than in 1990 and that extreme poverty rates have also fallen across developing regions. However, at the global level 1.2 billion people are still living in extreme poverty, while Sub-Saharan Africa is the only region in the world for which the number of poor individuals has risen steadily and dramatically between 1981 and 2010. There are more than twice as many extremely poor people living in Sub-Saharan Africa today (414 million) than there were three decades ago (205 million). The lives of people living in extreme poverty are continuously threatened by lack of food, the risk of disease, hazardous work and precarious living conditions. In many cases, this is aggravated by violence, including discrimination, attacks, harassment, humiliation and sometimes. This bleak canvas means that every day thousands of children, women and men die silently from easily preventable diseases associated with poverty - starvation, diarrhoea, malaria, tuberculosis, HIV and death in childbirth. In Latin America poverty has fallen by 15.7

percentage points since 2002, having declined virtually across the board since 2002, from over 40 million in 1980s to just under 28 million in 2014. Yet, around 80 million people in the region still live in extreme poverty with a further 40 per cent of Latin Americans at risk of falling back into poverty due to risks of economic shocks or the effects of climate change on the region (World Bank, 2014). Immediate circumstances such as poor housing and sanitation however are contributors to preventable deaths that are disproportionately affecting the poorest and most vulnerable, often neglected, populations. For instance, since the beginning of 2014, PAHO have reported almost 850,000 Dengue infections in the region, including 470 deaths, and more than 650,000 Chikungunya cases, many of which were also fatal (PAHO, 2010; UNASUR, 2010; ISAGS, 2013).

While neglected partners in global efforts to tackle poverty, regional organisations offer unique opportunities to strengthen actions on poverty reduction and health equity. This paper looks at the Southern African Development Community (SADC) and the Union of South American Nations (UNASUR) as examples of regional formations increasingly embedding new health mandates and pro-poor commitments in their normative frameworks, regional projects, forms of cooperation, and governance. The paper sheds light on regional health governance and policy as embraced by both UNASUR and SADC and on the different relationships, networks practices, and institutional and legal foundations by which regional arrangements hold competence in each region.

The aim of the paper is to compare the context, nuances and complexities of different systems, ethos, processes, and modalities of engagement of UNASUR and SADC in the area of health. The paper is divided in five parts. Part one traces the evolution of regionalism in South American and Southern Africa and the longer historical background that prompted health as part of a renewed agenda in each region. Part two turns the focus to the contemporary context to explore the place of health within a broader problematic of disease and poverty in the regions, and the socio-political-economic contexts in which SADC and UNASUR operate and are embedded. Part three offers an analysis of the constitutional and institutional structures, resources and the 'spaces' for governmental and non-governmental participation in regards to health policy in the regions. Part four concentrates on the scope and nature of regional commitments on health, exploring approaches to health, commitments, and programmes of action advanced by UNASUR and SADC. The paper closes with a cross-regional comparative framework assessing regional organisations

and interventions in light of what could be identified as 'broker' and 'forum' regional organisations.

2. Regionalism in a changing scenario

Social development and social policy considerations are gaining prominence in the debate about and practice of Southern regionalisms as countries attempt to address increasing poverty, unemployment and social inequality. At the same time, as globalisation creates greater risks to increasingly porous national borders, social protection becomes critical to managing and participating in processes of global political economic integration. Particularly since the late 1990s, there has been a growing consensus that, in an increasingly globalised world, new political thinking and new kinds of policies are necessary to achieve socially equitable development (Deacon et al 2010). This is the case of SADC and UNASUR as they are moving away from the traditional trade and financial drivers to address health in their programmatic agendas and institutional design. But besides the immediate context prompting the adoption of health in their institutional setting up, mandates and agendas, there is a longer historical background that links the need to take a 'social turn' to experiences marginalisation and social debt. While current conditions are favourable to embrace regionally social policies, the way health and commitments to health and poverty reduction are defined within SADC and UNASUR are not only context-dependent but shaped by historical struggles in societies that have suffered political instabilities and economic dependency of different sorts.

In Latin America the way regionalism unfolded has been something of a paradox; although the appeal to social and human development has been integral to the regional imaginary and even manifested in formal documents and declarations of regional agreements since the 1960s, in practice there has been very little dialogue between trade policies and issues of poverty and inclusion and thus collective action on social goals drifted away from the attention of authorities. In fact, delivering social protection, welfare and human development in Latin America 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 (Lewis and Lloyd Sherlock, 2009, p. 113). At the same time, the political economy of regionalism and development was dominated by debt crisis, austerity, and fundamentally by the influence of the United States (US) over regional politics across

Latin America (Gamble and Payne, 1996, p. 251–252; Phillips, 2003, p. 329). This was the case of the Southern Common Market (MERCOSUR) in 1991, grouping Brazil, Argentina, Uruguay and Paraguay; the North American Free Trade Agreement (NAFTA) signed by the United States, Canada and Mexico in 1994; and the renewed impetus from resilient projects, like the Community of Andean Nations created in 1969.

Notwithstanding the emphasis on market-led regionalism, some 'social clauses' were introduced in both the Andean Community and MERCOSUR, where the legacy of developmental welfare states steering development projects since the 1940s has been significant (Riesco, 2010). However, efforts to develop a social dimension in regional agreements were often sterilized by structural adjustment programmes, neo-liberal reforms, and elite politics (Draibe, 2007, p. 182). As the decade ended however alarming poverty indicators across the region, with nearly half of the total population living under poverty and a high percentage in extreme poverty (ECLAC, 2011, p. 11), led to episodes of resistance to neo-liberalism and social demands erupted in Latin America in early 2000. This context paved the way for the renewal of politics and policies at both national and regional levels. The rise of New Leftist governments across the region – in Venezuela (1998), Brazil (2002), Argentina (2003), Uruguay (2004), Bolivia (2005), Ecuador (2006), Paraguay (2008) and Peru (2011) – was not simply an expression of partisan and symbolic politics, but a more profound acknowledgement that economic governance could not be delinked from the responsibilities of the state to deliver inclusive democracy and socially responsive political economies (Grugel and Riggirozzi, 2012).

The Leftist governments not only developed a new attitude to state building and inclusion, but also to region building. This became evident in the aftermath of the Fourth Summit of the Americas, which took place in Buenos Aires in November 2005. The Summit declaration grounded opposing the new governments' views against the United States-led hemispheric regionalist project, the Free Trade Agreement of the Americas (FTAA) that declared themselves against a hemispheric trade agreement and refused to commit to future FTAA talks (Saguier, 2007). The defeat of the FTAA was an indication that the previously unquestioned association between regionalism and the trade/investment agendas was now open for review. In this context, South America became a ready platform for the reignition of regionalism incorporating the normative dimensions of a new era, at odds with both the neo-liberal core and defiant of US mentoring, redressing how integration projects should

respond to the legacies of poverty and create innovative mechanisms orientated to reduce Latin American's social debt. This was reflected in the UNASUR Constitutive Treaty, signed in Brasilia in May 2008, which explicitly declares 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 also specifically declared the 'right to health as the energetic force of the people in the process for South American integration' (UNASUR, 2009a, p. 14)

In the case of SADC, the point of departure for a deeper commitment with a social agenda should be seen not as a response to the legacy of neoliberalism unable to enact a project of capitalism with a human face, but from statist anti-apartheid movement. Interestingly, in both cases, the confluence of civil society mobilisation and leaders reclaiming the political space meant that regional politics also became a fulcrum of contention for what was perceived as a system reproducing political and economic marginalisation.

The origins of SADC must be traced to the formation of SADCC, established in 1980 to advance the cause of national political liberation in Southern Africa, and to reduce dependence particularly on the then apartheid era South Africa (Schoeman, 2002, Maleyek, Kabat, 2009). The region was seen as a platform for effective coordination, and strengths of, national independence and developmental goals. SADCC was formed with four principal objectives, namely: (1) reduction of member state dependence, particularly, but not only, on apartheid South Africa; (2) forging of linkages to create genuine and equitable regional integration; (3) mobilisation of member states' resources to promote the implementation of national, interstate and regional policies; and (4) concerted action to secure international cooperation within the framework of the strategy for economic liberation (SADC, 2014; also Penfold and Fourie, 2015).

As explored in Penfold and Fourie (2015) each of the 15 member states[2] in SADC took responsibility for a particular sector. The "sectoral responsibility approach" resulted in decentralisation of the structure in a highly state led institution (Schoeman, 2002, Ostergaard, 1990). By 1991 the members were only slightly less economically dependent on South Africa than in the beginning of the 1980s. Furthermore, as already indicated, SADCC did manage to attract large sums of donor funding, but mostly for national, and not

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[2] Angola, Botswana, the Democratic Republic of the Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, the United Republic of Tanzania, Zambia, and Zimbabwe

regional, development projects, considering the overwhelming national economic and political focus of most members. Furthermore, in line with a world-wide neoliberal trend in the 1980s, the SADCC countries started to pay more attention to promoting the private sector, foreign investment and trade. Within SADCC, members encouraged each other to reform their economies and liberalise trade in order to attract foreign investors. The creation of SADC should be seen in this light. The shift to SADC in 1992 and the signing of the Windhoek Treaty establishing SADC was undoubtedly economically motivated. Economic globalisation and liberalisation created "bloc formation", promoting regional integration to provide economic protection for SADC member states. The dramatic change in the global landscape following the end of the Cold War and the end of apartheid shifted focus to economic, societal and environmental security, instead of the more rigid military and political security of the Cold War era. Economic growth became priority at the expense of a coherent development policy (Pallotti, 2004). SADC has struggled to find a cohesive approach to regional integration and development. This is exacerbated by the lack of internal and external communication in the organisation. The competition between member states for private sector investment and development interventions, along with political internal struggles and economic imbalances has resulted in a regional imbalance (Pallotti, 2004). The level of conflict in certain states, the DRC and Mozambique in particular, has also resulted in a loss of resources and stable governance. This lack of integration has had repercussions for coordinated approaches to social policies; in many ways leaving a policy space to the support from international organisations and donors. As a consequence, the political economy of development and social policy in regional politics became largely influenced by donors from the global North.

3. Health and social development objectives in UNASUR and SADC

People living in poverty, particularly in poor areas in South America and Southern Africa, are particularly burdened by high rates of neglected, communicable, diseases, such as dengue, Chagas and parasitic diseases that, at the same time, tend to be marginalised by the health sector, private providers, and often the mainstream media as these are diseases that, unlike HIV, tuberculosis and malaria, do not lead to epidemiological emergencies. These diseases pose a major challenge to productivity and economic growth and development, and more critically to social well-being and inclusion of populations, often fuelling inequalities. In

addition, some of the most affected low- and middle-income countries in South America and Southern Africa are seriously limited in terms of state capacity to formulate and implement effective policies that strengthen their health systems. Their health systems are usually fragile, under-financed and under-resourced, which is compounded by migration of health professionals to urban areas or overseas in search of international training, job and career opportunities. This background defines profiles and modalities engagement of regional organisations.

In the case of UNASUR, its official documents placed a strong rhetorical on 'rights' and within it the right to health since its very creation. UNASUR's mission is, above all, to address social development and deepen democracy, as well as establishing economic complementarities in order to support poverty reduction (UNASUR 2009a: article 3.1). Health became path-breaking in the regional agenda and is defined as 'the energetic force of the people in the process for South American integration' (UNASUR, 2009a: 14). In this context, UNASUR speaks of a new morality of integration linked to a right-based approach to health that is considered as a transformative element for societies, and a vehicle for inclusion and citizenship (UNASUR, 2011)

That health became a locus for an alternative modality of regional integration is not surprising. Health has been roots of the long struggle for social equity, inclusion and justice in Latin America, since the mid-1950s (Birn and Nervi, 2014). The story of Latin American health justice is in fact a long story of the struggle for enhancing social entitlement and citizenship rights. Throughout the mid-20th century, as Latin America became heavily unionised and workers pressed for a range of social security benefits, health and security became bastions of welfare state provisions for better living conditions and inclusive political systems. In Chile, intense working class and socialist claims for social justice were played out as part of the social medicine movement, led by medical activist Salvador Allende since the 1940s. In Brazil demands for social medicine and the right to health was embraced by the *movimiento sanitarista* (health movement), an activist movement that played a key role in the process of redemocratisation in Brazil and its Constitutional reform in 1988, leading to the adoption of the universal public health system (Shankland and Cornwall, 2007). In this case, the realisation of universal and equitable access to quality health care must be understood not as a function of pragmatic policy making, but as the result of social movements demanding decent living, working, and social conditions under the slogan 'Salud

es Democracia' (health is democracy) (Melo in Shankland and Cornwall, 2007). Likewise, across the region, ideas and practices around social medicine, collective health, and citizen inclusion, were resilient to repression, dictatorship, and neoliberal policies.

Despite poverty rates falling by more than 14 per cent between 2000 and 2013 (ECLAC, 2014), the region's poor are still at risk from the (re)emergence of infectious diseases such as Dengue, Chagas, and parasitic diseases. In parts of the region, such Bolivia, Paraguay and Peru, communicable diseases still determine the quality of life and life expectancy, while only limited access to basic medicines is still common (Holveck et al., 2007). This bleak situation is worsened by reduced technical expertise and inefficient national health regulatory structures affecting as a consequence accessibility, quality, and equity in health services delivery. Not surprisingly, government failures to deliver decent health care figured as part of the anti-neoliberal protest across the region through the 1990s and first years of the new millennium, as spending on public health plummeted as a consequence of neoliberal reforms and budgetary cutbacks as the privatisation of health insurance directly reduced access to healthcare and rights (Birdsall and Lodoño, 1998).

But health is also a policy area where expert knowledge is valued and one where the region has some experience of successful cooperation to build on through PAHO. MERCOSUR and the Andean Community also worked together to put in place trans-border epidemiological control and surveillance in response to, and support of, increased traffic of trade and people (SELA, 2010), meaning that UNASUR can build on an existing legacy of cooperation. The focus on health also means that there is potentially a 'deliverable' that can be attached to region-building – better health outcomes as measures through indicators. Moreover, better and more effective health policy-making features as part of the demands of the New Left. The shift to the Left at the level of member states has opened up an opportunity to promote rights based ideas about health and as part of the concept of '*buen vivir*' (wellbeing) which has found a place in new constitutions of Bolivia and Ecuador, amid discussions about what 'universal' health care might look like in South America. In short, Health for UNASUR is about addressing a longstanding social debt as much as enhancing rights and inclusion through (post-hegemonic) regionalism. This is an issue-area where UNASUR can make a difference and it has been careful to link the focus on health to the idea of democratically responsive regionalism, particularly as UNASUR embraced social policies in a different

political and economic context in respect to predecing regional formations such as Mercosur and Andean Community (Buss, 2011; Riggirozzi 2014).

In the case of SADC, the region is in a politically and economically difficult space. The majority of countries in the region are at face value liberal democracies, with the exception of Swaziland, recognised as an absolute monarchy and non-party state (Penfold and Fourie, 2015: 9). Despite this, there are low levels of institutionalisation and fragmented state institutions in the SADC region. SADC states have not institutionalised the governance process – this is evident by the high levels of violence used to maintain state power in a number of states (for example, Mozambique, Angola, South Africa, the DRC, Lesotho, Madagascar and Zimbabwe, and Zambia and Zanzibar to a smaller extent) (*Ibid*).

Tracking pro-poor discourse and development in the SADC region is thus a difficult task, considering the vast economic imbalances, political tension, varying levels of poverty and donor assistance in the region (Hurt, 2012). Nonetheless, SADC has clearly declared objectives to promote sustainable and equitable socio-economic development and growth (Penfold and Fourie 2015: 7). SADC's mandate is to provide strategic planning, management and coordinating decisions through the Secretariat. In practice, there is a large emphasis on trade and economically oriented goals. Yet, there is an implicit need to address the economic consequences of health for economic production and growth across the region (SADC, 2009). The role of South Africa is central as a dominant economic power, accounting for 80% of SADC's GDP, and setting the political tone for cooperation. Notwithstanding this, the political economy of health in the region is largely donor influenced. This is evident by the large amounts of aid organisations responsible for coordinating, amongst others, HIV/AIDS plans and projects, which could be informing government policies and protocols. Donor countries encouraged SADC institutional reforms (SADC 2012; Lenz, 2012, Gray, 2013). External finance and foreign aid encouraged transformation within SADC (with support in particular from the EU, Finland, the United Kingdom, Germany and Switzerland (*ibid*). External funding in the SADC region amounted to USD$67 600 000 for a total of 58 projects (Gray, 2013). The Regional Integration Strategic Development Plan is said to emulate EU policies of integration and development and is conditioned by the material dependence of SADC on the EU (Lenz, 2012).

There is something of a risk here: considering how middle powers have risen to confront health issues as part of a foreign policy agenda, SADC, as an emerging regional organisation, should prioritise health as part of the regional policy agenda. However, donors and international organisations have played more of a role in assisting with healthy policy and programme implementation than SADC does. Donors contribute to development within the region and consequently have an important role in agenda setting and decision making for development policies, technical working groups and subsequent policies and protocols that are implemented. Donors and governments work together to develop SADC specific policies and protocols, which are the foundations for regional health governance in Southern Africa.

4. Institutionalisation of Health in UNASUR and SADC

SADC and UNASUR have both developed institutional competences in health policy and poverty reduction, although their policy development practices and methods may take quite different forms.

4.1 *Institutional Structure Health in UNASUR*

As an inter-governmental body, UNASUR is made up of the Ministers of Health of the twelve member states that form the UNASUR Health Council. The role of the Council is to set policy priorities, working in conjunction with Technical Groups set up around some health themes and networks to help policy delivery. UNASUR headquarters and the General Secretary are located in Quito. The President Pro Tempore (PPP) alternates between member states on a yearly basis.

In 2009 UNASUR Health Council approved a Five Year Plan (*Plan Quinquenal*), which outlines actions on five areas: (1) surveillance, prevention and control of diseases; (2) development of Universal Health Systems for South American countries; (3) information for implementation and monitoring health policies; (4) strategies to increase access to medicines and foster production and commercialisation of generic drugs; and (5) capacity building directed at health practitioners and policy makers for the formulation, management and negotiation of health policies at domestic and international levels (UNASUR 2009b). Needless to say, the themes were not chosen at random. They make sense both epidemiologically in that some of these are areas where cooperation would be of direct benefit to the region's population (disease control, for example, or the prospect of

greater availability of cheap generic drugs) whilst others correspond closely to the political demands of post-neoliberal governments and their grassroots supporters, the development of a universal health system, for example. Once the agreement to focus on the areas set out in the Five Year Plan was agreed, delivery required the introduction of some system for knowledge-sharing and dissemination. This led to the creation of a regional health think tank, the South American Institute of Health Governance (Instituto Sudamericano de Gobierno en Salud, (ISAGS), under the auspices of the Health Council and reporting directly to it. ISAGS tasks are to provide policy-oriented and informative research, training and capacity building for member states.[3]

UNASUR Health Council agreed ISAGS to: (1) identify needs, develop programmes and capacity building for human resources and leadership in health; (2) organise existing knowledge and carry out new research on health policies and health governance as per request of the South American Health Council or member states; (3) systematise, organise and disseminate technical-scientific information on regional and global health, with the intention of supporting the decision-making process of the conduction centres, of strengthening society processes and of giving information about the processes of government and governance in health; (4) support the formulation of UNASUR's common external policies to back up negotiations in global and regional international agendas; and (5) provide technical support to national health institutions.[4]

The most active level of health governance within UNASUR falls undoubtedly to ISAGS, where health professionals have been able to establish a space of technical know-how and been given room to act. The Health Council – or the Ministries of Health –benefit in a number of ways, from being more effectively briefed at international meetings to have regional expertise to support national health targets.

ISAGS has quickly become the key level of activity where policies are being made and delivered. Located in Rio, ISAGS is able to capitalise on the leadership of Brazilian diplomats and health experts in international negotiations on the provision of medicines and the right to health (Buss and Do Carmo Leal 2011; Nunn 2009). ISAGS has also been closely linked to the *movimiento sanitarista*, and the Brazilian health research institution, the Oswaldo Cruz Foundation, which was instrumental in setting up ISAGS itself (interviews with ISAGS Chief

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[3] For detailed information about UNASUR Thematic Groups, networks and ISAGS, see {http://isags-unasul.org/site/sobre/?lang=es}
[4] Resolución CSS 05/2009 Sede y creación ISAGS abril 2009

of Cabinet, 10th November 2014; and with former Officer at the Pan-American Health Organisations, 12 June 2012). ISAGS is, almost inevitably, more radical than the Health Council itself. Its core philosophy is that health cannot be left to the market or commodified and it is the source of much of the rhetoric about rights that shape UNASUR's health policies. It gives UNASUR an aura of technical know-how in relation to health and conveys the message that this is not just a matter of politics and, at the same time, it provides UNASUR with access to genuine expertise.

4.2 Institutional Structure Health in SADC[5]

The SADC Declaration and Treaty signed in Windhoek; Namibia (SADC, 1992) defined the SADC institutions, but did not specify objectives and functions for these institutions. The Declaration stipulates the need for poverty reduction, self-sustaining development and a harmonised approach to political and socio-economic profiles and plans for each member state. Led by market concerns the SADC Trade Protocol was signed in 1996 in support of the removal of trade barriers. The purpose of promoting regional trade flow is to encourage economic strengthening and development. However, the nature of the Trade Protocol is such that it has created political differences between states. This influences political standing on other development issues, including health. The polarisation of political and economic relations among member states means that there is minimal agreement on a regional development strategy. No structural formations are promoted, negatively influencing efforts to coordinate regional development protocols, or improving upon regional development protocols, including for health, education and infrastructure. The SADC states are still heavily reliant on donor interventions and external assistance for development strategies. Economic liberalisation in the region has been heavily dependent on foreign assistance, since the introduction of economic conditionality through structural adjustment programmes in the 1980s (Penfold, 2015).

Pallotti (2004) describes SADC as being a development community without a development policy. This description is fairly accurate in policy circles, considering the fact that since 1992, the regional body has struggled to find cohesive regional integration and development coordination. The competition between member states for private sector investment and development interventions, along with political internal struggles and

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[5] This section builds from Penfold and Fourie (2015) and the PRARI research they carried out in support of that working paper

economic imbalances has resulted in a regional imbalance (ibid). This lack of total integration has had repercussions for coordinated approaches to developmental needs in the region, including health and medicine.

Political and economic stability is seen as baseline for the development, and achievement, of health targets. The SADC Protocol on Health is the driving document behind health objectives in the SADC region. It was signed on 18 August, 1999. SADC recognises that "a healthy population is a pre-requisite for the sustainable human development and increased productivity in a country" (SADC, 1999). Member states acknowledge that regional cooperation for health is indispensable for controlling communicable and non-communicable diseases, to address common concerns in the region.

The SADC Protocol outlines country commitments to coordinating regional efforts on epidemic preparedness, prevention mapping, control and possible eradication of communicable and non-communicable diseases. Additional discussions in the Protocol centre on education, training, effective laboratory services and common strategies for the health needs of women, children and vulnerable groups. The Protocol does not have a pro-poor agenda and makes no mention of the poor, poverty or the impoverished (SADC, 1999). The Protocol does, however, encourage the development of an institutional response and institutional mechanisms to effectively implement the Protocol (ibid). In short, unlike UNASUR where a complex institutional structure helps scaling policies from the region to the national settings, and vice versa; in SADC, there is a more informal institutional set up made of protocols that act as normative framework to structure the practice of different stakeholders.

The Health Protocol is a strategic framework outlining specific objectives to addressing HIV, TB and Malaria Programmes in its Article 9 (Communicable Disease Control); Article 10 (Control of HIV/AIDS and Sexually Transmitted Diseases); Article 11 (Malaria Control); Article 12 (Tuberculosis Control) (SADC, 1999).

The SADC Health Protocol establishes the following regional bodies responsible for coordinating and delivering on the protocol objectives:

- The Health Sector Coordinating Unit (HSCU)
- The Health Sector Committee of Ministers (HSCM)
- The Health Sector Committee of Senior Officials (HSCSO)

- Technical Sub-Committees

As such, a number of declarations, plans and strategies have developed from the protocol, detailing specific goals to combatting the disease burden in the SADC region (see Table 1).

Table 1: SADC Health Policies, Plans and Strategies

SADC Health Policies, Plans and Strategies
The SADC Protocol on Health (1999)
The Regional Indicative Strategic Development Plan (2001)
Maseru Declaration on the fight against HIV and AIDS (2003)
SADC Draft Strategic Plan for the Control of Tuberculosis (2007-2015)
SADC HIV and AIDS Strategic Plan (2010-2015)
SADC Malaria Elimination Framework (2010)
SADC Malaria Strategic Framework (2007-2015)
SADC Minimum Standards for the Prevention, Treatment and Management of Tuberculosis (2013-2017)
SADC Pharmaceutical Business Plan (2007 - 2013)
SADC Regional Minimum Standards for the prevention of Mother to Child Transmission of HIV (2009)
SADC Regional Minimum Standards for the Prevention, Treatment and Management of Malaria (2010)
SADC Sexual and Reproductive Health Business Plan (2011-2015)
SADC Strategic Framework for Control of Tuberculosis in the SADC Region (2012)
Sexual And Reproductive Health for SADC (2006-2015)
The Draft Declaration on Tuberculosis in the Mining Sector (2012)
The Health Policy Framework (2003)
The Minimum Standards for HIV Testing and Counselling (2009)
The SADC Minimum Standards for Child and Adolescent HIV, TB and Malaria Continuum of Care (2012)

Additional commitments to promoting regional health governance include the *Health Policy Framework*, approved by the SADC Council of Ministers in 2000. It proposes policies strategies and priorities on the following health related concerns: research and surveillance,

information systems, health promotion and education, HIV/AIDS and sexually transmitted diseases, communicable and non-communicable disease control, disabilities, reproductive health, health human resources development, nutrition and food safety and violence and substance abuse (SADC Health Policy Framework, 2001). Likewise, the Code on Social Security and the Charter of Fundamental Social Rights include social protection objectives addressing poverty reduction, quality of life and support for the social disadvantaged through regional integration (SADC, 1992).

The Code provides guarantee for rights to social security, social insurance and social assistance. It guides other social protection mechanisms, including healthcare, maternity, paternity, death and survivor benefits, retirement and old age, unemployment, underemployment, occupational injuries, diseases, political conflict and natural disasters. The Code focuses specifically on vulnerable persons, including women, people with disabilities, families, children, youth, migrants, foreign workers and refugees (SADC, 2008). The Charter of Fundamental Social Rights in the SADC Region (Social Charter) promotes a minimum social protection floor, emphasising the need for social protection for the unemployed, vulnerable, the youth, the elderly and the disabled. The Charter specifies that member states are responsible for creating an "enabling environment" for every worker to have the right to social protection and adequate social security benefits. Individuals unable to work and with no means of income are entitled to resources and social assistance (SADC, 2003). Finally, SADC adopted a Pharmaceutical Programme under the Southern Africa Regional Programme on Access to Medicines and Diagnostics, sponsored by UK Aid. This programme supports access to medicines information, facilitates understanding of intellectual property, and helps build SADC member state capacity for pharmaceutical policy reform (SADC 2015).

The constitutional and institutional make up of UNASUR and SADC suggest that while both are inter-governmentalist regional organisations, with limited supranational elements, the way they are organised institutionally significantly differs. SADC works at a policy level (declarations and protocols) and there are less visible channels clear of interaction with national actors – what could be seen as a distance between levels of governance and even more fundamental a gap between policy declaration and practice. UNASUR is an institution that 'belongs to the member states' but has in place key 'intermediary instances' that facilitate the policy nexus between the region and the national policy arenas as well as the

engagement of different stakeholders. For instance UNASUR has created theme-specific networks of country-based institutions to implement projects to combat HIV/AIDS; a Network of Public Health Schools of UNASUR (RESP-UNASUR), composed of institutions committed with human resources training for health systems, national health policies, and production of new technologies across the region; and the Network of National Institutions of Cancer (RINC), which coordinate cooperation amongst national public institutions across UNASUR member countries to develop and/or implement cancer control policies and programs and research in South America. Supporting these developments, the ISAGS, acts as a think tank and hub for five thematic working groups each led by two member states. These intermediary instances help closing the regional/national divide creating bridges between policy makers, practitioners and epistemic communities for the creation, dissemination and cross learning of best practices.

Notwithstanding, when it comes to spaces for civil society organisations engagement, SADC seems to offer more effective institutional 'spaces' for non-governmental participation in regional policy debate. SADC Partnership Forum, a platform for consensus building, brings together major players in the HIV/ AIDS-sector, civil society organisations formalised through the Regional African AIDS NGOs (RAANGO), and donors. It convenes twice a year to discuss the strategic planning of the SADC Secretariat. In 2008, for example, civil society was extensively consulted on the next strategic plan for HIV/AIDS thorough RAANGO, which was used as a referral body for SADC in the process (Godsater, 2014). If strengthened, these types of regional partnerships can support advocacy initiatives in the area of health.

5. Scope and nature of regional health governance: approaches to, and commitments on, health

Approaches to the right to health are comprised of a basic set of guarantees for all, namely horizontal dimension, and gradual implementation of higher standards or vertical dimension (Graph 1). There is a debate on whether a vertical approach (promoting disease specific and targeted specialised clinical services) or a horizontal approach (tackling interrelated health issues while aiming at strengthening health systems)are more effective means of effective provision of healthcare. Vertical programmes are more dominant, and often compete with one another for funds and professional recognition (Braveman P., et al 2005). William Easterly argues that 'which *rights to health* are realised is a political battle'. This is

contingent on a political and economic reality that profits on the margins of (poor) health and thus we cannot downplay the role of politics in healthcare.

Figure 1: Approaches to the right to health

Source: author's elaboration based on WHO (2008). Also Riggirozzi (2014b).

Despite having the best intentions, programmes from international non-governmental and philanthropic organisations including the Gates Foundation, PEPFAR, private charities may be guided by specific views, agendas and objectives. Treatment campaigns for diseases, including HIV, malaria and tuberculosis (which account for over 90 per cent of the global disease burden), despite having substantial resources to tackle these diseases, have done little to strengthen weak healthcare systems, which are in many cases unreachable or distrusted by the people they are designed to help. Undoubtedly, Global Fund and the Global Fund and the Global Alliance for Vaccines and Immunisation (GAVI), the Vaccine Alliance, amongst other funders and philanthropies, have had success in slowing the rate of HIV infection, tuberculosis, and malaria and providing vaccines and immunisation against diseases such as pneumococcal disease and meningitis worldwide. However, it less evident how they contribute to a more effective integrated and comprehensive health care solution in the long term (Pendfold and Fourie 2014). Furthermore, other diseases, such as dengue, Leishmaniasis, Chagas and Chikungunya, that also add to the increasing toll of human life and to the poverty-disease burden, receive little attention, owing to the focus on the more prevalent global diseases. The risk is that what is *visible* and *urgent* takes priority over what is deemed *marginal.* Actions targeted to the poor, which ignore the social factors that cause poverty and exclusion, also risk discriminating positively, not only affecting a full realisation of health equity but also normalising and even reproducing inequities.

This discussion helps to put in perspective the way UNASUR and SADC approach health and poverty reduction through health as well as the place of donors and their approaches to regional health policy. For instance, SADC tends to follow a disease-led, vertical, strategy to address poverty reduction through tackling HIV, malaria, TB. UNASUR defines health as a right and thus a structural notion of poverty reduction addressing social determinant of health defines its policy approach.

This characterisation also reflects the types of policies advanced by the regional organisations, who is engaged and how actors are mobilised. For instance, UNASUR's focus is on universalisation of health, rather than on disease or vulnerable populations, emphasising social determinates of health inequality and reform of health systems. The narrative of UNASUR does not link with definitions of neglected diseases or populations but rather with approaches to the right to health, equality and universalisation as drivers of policy definition. Consequently, rather than targeted interventions to address specific

diseases or populations, UNASUR seeks to reform national governance and policy processes related to the delivery of health and protocols towards the goal of universalisation of health. *Access* to universal health and governance are key words in UNASUR's approach to poverty reduction and this manifests in its programmatic agenda, its institutional complexity, active involvement in capacity and consensus building, and innovative health diplomacy vis a vis pharmaceuticals and at the level of WHO.

In Southern Africa, the commitment to upholding social protection and a coordinated regional response to health issues have become increasingly urgent and mainly led by what is considered priority on the region: the high prevalence of HIV/AIDS, tuberculosis (TB) and malaria. In 2009, nine member states were experiencing adult HIV infection levels in excess of 10%, with three of those states with an HIV prevalence of above 20%. SADC member states account for approximately 42% of the 2.1 million AIDS related deaths globally (WHO, 2011, UNAIDS, 2010, SADC, 2009; also Penfold and Fourie, 2015).

The region is also vulnerable to the increasing impact of climate change, high prevalence of poverty, pre-existing disease burden, weak health services and increasing water and food insecurity (Young et al, 2010). Political and economic stability is essential to achieving development health targets, considering the intrinsic relationship between politics, economic stability and the capacity of regional governments and the SADC Secretariat to provide essential health services for SADC citizens.

There is a need to reinforce child specific problems related to specific diseases; for instance, strengthening child and adolescent HIV testing, counselling, screening for TB and insect treated nets to protect against malaria. There is a lack of human resources and restrictions in specific skills needed to treat patients in the region. There are also major gaps in the HIV, TB and Malaria strategic frameworks and plans, regarding the integration of HIV/Malaria and TB/Malaria programmes and the integration of TB and Malaria programmes to basic child services. The HIV and TB programmes are vertical and need to be integrated into decentralised health systems. Strategy integration for major diseases are relatively limited overall. Policies and programming frameworks on HIV are not harmonised across the region. There are different PMTCT programmatic options being implemented, different first-line treatment regimens and different provisions of child universal access to anti-retroviral treatment.

Despite numerous drafted strategies and work to achieve control over the major health issues in the region, there is little evidence to suggest that the SADC itself is making in-roads as a regional health organisation. Donor funded endeavours and social protection platforms appear to be the most effective programmes available.

At the 33rd SADC Summit held in Lilongwe, Malawi in 2013, SADC leaders emphasised the need to find ways to augment domestic resources to control the spread of the disease. Leaders also agreed to find ways to work together to share responsibility for HIV, TB and malaria responses in Africa (UNAIDS, 2013). The need for regional production and procurement of medicines and commodities for HIV/AIDS, TB and malaria and the need for the SADC region to make a greater effort to unify regional policies, technology transfer and build capacity for SADC countries to produce medicines and pharmaceutical supplies (UNAIDS, 2013). The SADC region has seen an increase in antiretroviral coverage, but the SADC region remains the most affected by HIV. Poverty in the region exacerbates this problem, as millions of people lack access to treatment and care, as they do not have the resources.

5.1 Regional responses to health

SADC leaders acknowledged the need to scale up access to testing and treatment. Additional structural, financial, human resource and human rights challenges have prevented universal access to ARVs (UNAIDS 2013). The Global Fund has currently granted USD$14 million to the SADC region specifically for HIV/AIDS prevention and treatment (Global Fund, 2014). Health access and services in the SADC region, particularly for HIV/AIDS is largely donor-funded, with some government support. This reflects again on the idea that donors play a large role in determining the political economy of health in the region.

Tuberculosis is one of the major challenges in the region, as a standalone disease and because of its prevalence in HIV positive people in the region. The SADC Draft Strategic Plan for the Control of Tuberculosis (2007-2015) outlines current challenges posed by Multi-Drug Resistant (MDR) and Extensively Drug Resistant (XDR) tuberculosis, in an effort to control the spread of the disease in the region (SADC, 2007). A number of SADC states form part of the "high burden countries" that contribute more than 80% of global TB cases (World Bank, 2012).

A SADC led partnership with the World Bank, the Stop TB partnership and the International Organisation for Migration is trying to address issues of concern regarding the high prevalence of TB in the region (World Bank, 2012). The major problem in the region is the prevalence of TB amongst miners in the region. The SADC Declaration on TB in the Mining Sector, signed at the SADC Summit Meeting in 2012, shows the start of regional coordinated efforts to tackle the effects of this disease in the mining community. This is arguably one of the better movements made by SADC to leading pro-poor responses to TB, considering that miners are considered to be low income workers (Stop TB, 2012, SADC, 2012, World Bank, 2012). The driving force behind this initiative are high profile current and former Ministers of Health in the SADC region (Stop TB, 2012). The declaration was endorsed by SADC Ministers of Health, Labour and Justice. This is a critical step for SADC, considering the number of poverty-stricken citizens who are susceptible to the disease and are unable to access health services to combat the disease.

SADC Members states have endeavoured to reduce child mortality, as a result of HIV/AIDS, TB and malaria in the region. Child survival and development are key problems in the SADC region. In 2009, more than one million children under the age of 15 years were estimated to be living with HIV in SADC member states. Rates of mother to child transmission (MTCT) in 2010 resulted in 176 000 new infant infections. Percentages of MTCT in the SADC region range from 3% to 37%. TB remains high, with five member states classed among the 22 global high burden TB countries. 35 million children under five are estimated to be at risk of contracting malaria. These epidemics render children susceptible to malnutrition and other diseases (SADC, 2012).

SADC member states have committed to regional and international goals to reducing child mortality, because of these diseases, including the Millennium Development Goals 4 and 6. These targets are unlikely to be met by 2015. However, the SADC Protocol on Health has ensured commitment from member states to addressing communicable diseases, in particular HIV, TB and malaria. The Protocol and additional regional frameworks do not, however, sufficiently address children and adolescents. The SADC Secretariat is mandated to develop the *SADC Minimum Standards for Child and Adolescent HIV, TB and Malaria Continuum of Care* (SADC, 2012). This document establishes the minimum packages of services that member states should have, to create a common response in the region. Considering the bi-directional links between HIV, TB, malaria and child vulnerability, access

to health, education, social and child protection, food security and nutrition and psychosocial services must be integrated as part of this response – as is established in the SADC Strategic Framework and Programme of Action for Orphans and Vulnerable Children and Youth (SADC, 2012).

Treatment campaigns for diseases such as HIV, malaria and tuberculosis (which together account for over 90 per cent of the global disease burden) are substantially resourced, yet they have done little to strengthen weak healthcare systems, which are in many cases unreachable or mistrusted by the very people who need them most. Undoubtedly, the Global Fund and GAVI, amongst other funders and philanthropies, have had success in slowing the rate of HIV infection, tuberculosis, and malaria and providing vaccines and immunisation against diseases such as pneumococcal disease and meningitis worldwide. At the same time, it is less evident how they contribute to the development of effective, integrated, comprehensive and sustainable health care solutions. Global vertical health initiatives focused on a disease, a group of diseases, or a special topic could be better integrated with ongoing horizontal initiatives whose primary purpose is to contribute to the strengthening of health systems.

While SADC has a policy based on the three big diseases that undoubtedly affect the region and their societies in many different ways, UNASUR engaged in professionalisation and policy change on the ground. In the case of UNASUR, its commitments and understanding of tackling health and poverty reduction manifest in an agenda that is largely oriented to governance and policy reforms, especially in the area of primary care, Public Health Schools professionalization, and policies on medicines. From this perspective, it was proposed that a new institution helped improving the quality of policy-making and management within the Ministries of Health in UNASUR members through regional networking activities, policy training and capacity building.[6] 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 (UNASUR 2010). In practice, in collaboration with the UNASUR's Technical Group on Human Resources Development and Management, for instance, ISAGS activities have been significant for the creation of new institutions such

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

as Public Health Schools in UNASUR countries such as Peru, Uruguay, Bolivia and Guyana (Agencia Fiocruz de Noticias, 2012).

Similarly, ISAGS through training and capacity building programmes with policy makers 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.[7] 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 (ISAGS 2013). 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 non-communicable diseases, such as cancer and obesity; to combat the propagation of HIV/AIDS, and to undertake extensive vaccination programmes against H1N1 influenza and Dengue Fever across the region, and addressing counter-cholera efforts in Haiti after the earthquake in 2010 (PAHO 2010). ISAGS also leads theme-specific networks of country-based institutions to implement projects on non-communicable 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.[8]

More recently, UNASUR has been instrumental, as '*industrial broker*, 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 policy-makers and health authorities a common background and information to strengthen the position of member states in purchases of medicines vis-à-vis

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[7] Author's interview with Dr Hugo Noboa, Ministry of Health, 30 July 2012, Quito, Ecuador
[8] *Report of the Pro Tempore Secretariat* (2011) at {http://isags-unasul.org/site/wp-content/uploads/2011/12/Informe-2011.pdf} accessed 28 March 2012

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 (UNASUR CEED, 2013).

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. 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.[9] UNASUR is establishing as a legitimate and pro-active 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 Organisations. 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.[10] 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 held in Buenos Aires, Argentina, in

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[9] Author's interview 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, 2August 2012

[10] Author's interview with Fausto Lopez, Senior Official at UNASUR Health Council, 30 July 2012; and with Senior Official at the Ministry of Health in Ecuador, 30 July 2012

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.[11] Finally, UNASUR 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.[12]

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 long-term policy-making. These actions create new spaces for policy coordination and collective action where regional institutions become an opportunity for practitioners, academic and policy makers to collaborate and network in support of better access to healthcare, services and policy-making; for negotiators, UNASUR structure 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.

More recently, led by the Ecuadorian delegation, UNASUR presented an action plan for discussion at the WHO which aims to improve the health and wellbeing of people with disabilities.[13] This action plan was successfully taken up at the 67th session of the World Health Assembly in Geneva, in May 2014, when the WHO's 2014-2021 Disability Action Plan was approved. This plan focuses on assisting regional WHO member countries with less-advanced disability and rehabilitation programs and will be carried out by the WHO in conjunction with regional organisations such as: Caribbean Community (CARICOM), Central American Integration System (SICA), MERCOSUR and UNASUR. This is not a minor issue in countries that bear a 'double burden' of epidemic communicable diseases and chronic non-

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

[12] *Ibid.*

[13] For details, see UpsideDown News at http://upsidedownworld.org/main/ecuador-archives-49/4875-ecuador-pushes-for-greater-south-south-cooperation-and-stronger-public-disability-assistance-policies

transmissible diseases. These developments, and the creation in 2008 of the first regional health think tank, the South American Institute of Health Governance, provides evidence that UNASUR can become pivotal actor in the promotion of health and the right to health in light of the post-2015 Development Agenda.

6. *Broker* and *forum* organisations

Based on the above analysis, we could think of two types of regional interventions and types of organisations: brokers and forum regional organisations. The case of UNASUR seems to suggest that in the course of policy change, particularly in middle-income countries where financial resources are not reduced to the multilateral donors and equally important where there is a vibrant and politically influential local/regional network of experts informing policy-making (epistemic communities and networks), regional organisations are almost compelled to engage with the local conveyors of knowledge and policy ideas and become 'brokers' by engaging in pro-reform networks with local actors for the definition of both the problem and the solution in the promotion of (health) projects.

The ability of the regional organisation to translate (knowledge and material resources) into instruments of policy reform depends on their capacity to act as a 'broker', engaging with local actors and establishing common grounds for the implementation of policies. This can also be seen at the global level as the regional actor can act as broker of ideas/consensuses in global governance (through regional diplomacy)

The choice of 'broker' here does not denote the 'neutral' intervention of an impartial arbiter. Rather, 'broker' is associated with the idea that the regional organisation may engage with local experts for the amalgamation and compromise of ideas and policy positions, empowering certain actors who can carry through a project and implement change. There is an instrumental purpose in engaging with local experts: this is related to the ability to generate a broader consensus, ensuring that the norms and institutional practices supported by the regional organisations (seen in mandates or Constitutive charters for instance) are not only taken up by governments, but also implemented on the ground. After all these are inter-governmental organisations without supranational binding mandate.

Broker organisations may engage with or create policy (reform) networks bringing actors from diverse backgrounds together, even involving those who might have conflicting views of the world or contradictory interests. A broker may 'crafts consensus' and support certain actors to carry through politically sensitive projects on the ground, as well as represent collective interests in the international fora.

Another way of assessing the role of regional organisations in health policy is as 'forum organisation'. While regional broker organisations may provide regional and global leadership in translating global goals into regional context-specific priorities, and vice versa, regional organisations, forum organisations are associated to activities, ranging from an exchange of views to the negotiation of binding legal instruments. Organisations acting as forum can identify and discuss rising problems and effectively coordinate development partners nationally and internationally around goals, supporting pro-poor partnership work through. Rather than concentrating on technical cooperation and acting as a bloc in global diplomacy, forum organisations may concentrate on agenda-setting, analysis, policy implementation, and evaluation, in coordination with member states, non-state actors and donors (see Tussie and Riggirozzi, 2001; Steffek and Kissling, 2006). This is particularly significant to analyse how SADC coordinates approaches to health, particularly in relation areas and programmes such as HIV and Malaria, addressing health challenges in the region. As Penfold (2015) acknowledges, despite having an established presence, SADC is heavily reliant on the intervention of donors in assisting to curb the spread of disease, develop adequate healthcare systems and horizontal approaches to tackling communicable and non-communicable diseases in each region. Nonetheless, it may provide donors and partners with a single point of contact for discussions relating to member countries, while acting as channel through which to disburse development aid (Yeates, 2014). For social and advocacy actors, this type of forum can provide a distinctive platform for consensus building and for civil society organisations to engage in common initiatives and implementation of programmes such as the SADC Partnership Forum, a platform for consensus building which brings together major players in the HIV/AIDS-sector, civil society organisations formalised through the Regional African AIDS NGOs (RAANGO), and donors (Godsater, 2014).

Although in practice the boundaries between organisations acting as broker and forum are undoubtedly blurred, the distinction between secretariat-oriented (forum) and programme-oriented agencies (broker), it may be helpful as a heuristic device that helps identify not

only the differences in terms of modalities of involvement, and supporting institutional architecture, in health promotion but also to depict different policy processes and opportunities for regional organisations to affect policy thinking, policy capacities and regimes at national and global levels. As the paper analysed, regional health governance and policy as embraced by both UNASUR and SADC differ in term of legacy, approaches to health, relationships, networks practices, and institutional foundations and competences in each region and in global governance (see Table 2).

Table 2. SADC and UNASUR health governance and policy compared

	SADC	UNASUR
Approach to health	Disease led, as part of specific focus on poverty, prevalence of pro poor focus	Systemic, not linked to specific populations, disease or pro poor policies. Health conceived as universal right
Where the push on health/ right to health come from	Governments and donors	Governments and epistemic communities
Where mandates come from	Governments Donors have a distinctive influence	Governments
Modality of intervention in health areas and programmes	Vertical interventions, disease led, focus on HIV, Malaria and Tuberculosis. Strong pro-poor language	Horizontal approach, aimed at reforming health systems towards universal healthcare and *access* to medicines (as opposed to universal *coverage*). Strong equity language
Institutional regulatory framework for the discussion, negotiation, and decision making process regarding health policies	SADC Secretariat, Social And Human Development and Special Programme Directorate Key frameworks: SADC Protocol on Health	Health Council, pro Tempore Presidency, ISAGS, 5 thematic working groups (coordinated by two member countries each); thematic networks Key frameworks: UNASUR Constitutional

	(1999) Health Policy Framework (2000) Regional Indicative Strategic Development Plan (2001)	Treaty (Art 3) (2008) Five Year Plan (2010) ISAGS programmatic plan (2010)
Area of action/intervention	Regional-national National-regional	Regional-national, National-regional, Regional-global (through active regional health diplomacy)
Institutional mechanisms that engender and facilitate engagement with state and non-state actors	Strong relationship between governments and donors defining programmatic agenda of SADC. More permeable to NGOs through SADC Partnership Forum, bringing together major players in the HIV/AIDS-sector, civil society organisations formalised through the Regional African AIDS NGOs (RAANGO), and donors.	States are the master of regional organisations and gate-keep access to international decision-making processes. But permeable to civil society organisations through 'intermediary instances of engagement' such as ISAGS, working groups, thematic networks
Regional space	Forum organisation	Broker organisation
Sources of funding	Donors, multilaterals, philanthropies	Quota from members (based on size of economy)
Type of impact	Mainly through the creation of normative frameworks structuring practices	Creating normative frameworks structuring inter-governmental and expert networks model of regional governance; Facilitating the re-allocation of material and knowledge resources in support of public policy and policy implementation; and Acting as a bloc in global governance

Regional policy as advanced by UNASUR and SADC is about setting new parameters as much as creating spaces of cooperation for the design and implementation of policies. This is a clear distinction from previous regional integration experiences in Latin America and Southern Africa and suggests that the potential of regional action relies on the ways regional organisations: (i) create normative frameworks structuring inter-governmental and expert networks model of regional governance; (ii) facilitate the re-allocation of material and knowledge resources in support of public policy and policy implementation; and (iii) enable representation and claims-making of actors in global governance (see also Riggirozzi, 2014). In this respect, the argument advanced here establishes the value of devoting more attention to the linkages between regionalism and poverty reduction through effective, context-specific, policy interventions, as well as the necessity of further analysis of the role of regional organisations in global health politics and policy.

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