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COVID-19 in Latin America and the Caribbean: the visible face of a regional health cooperation in crisis

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Abstract

This article analyzes how the Covid-19 pandemic has been addressed in Latin America and the Caribbean, and how regional integration projects could have contributed to deal more effectively with this situation; it also intends to identify current limitations to advance cooperation efforts within regional integration mechanisms in the health sector. A qualitative methodology was conducted based on research and analysis of secondary data. The existing regional integration mechanisms in LAC have quickly sought to promote initiatives to face the pandemic. However, the results – being fragmented – have not been enough to prepare, through regional integration, more effective responses to Covid-19.

Keywords: COVID-19; Global Health; International Cooperation in Health; Latin America; Regional Integration.

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Introduction

January 30, 2020 marked a turning point in the history of global health, with the declaration from the World Health Organization (WHO) that the Covid-19 outbreak should be considered a Public Health Emergency of International Concern. At that time, 7,834 cases had been detected in 19 countries (only 98 of them outside China), and 170 people had died, all in Chinese territory. Fourteen months later, there are already more than 132 million cases worldwide, more than 2,860,000 deaths (WHO 2021), and an uncertain scenario regarding the future of the pandemic and the strategies to face it, especially considering access to vaccines and medicines.

In Latin America and the Caribbean (LAC), the situation is quite complicated and, so far, most countries have not yet managed

to flatten the curve. Since May 2020, the region has become the epicenter of Covid-19, with more than 25 million cases by the end of March 2021. In absolute terms, Brazil, Colombia, Argentina, and Mexico have the worst rates of infections and deaths at the time this article was written (WHO 2020). Around 800,000 Latin Americans and Caribbeans had already lost their lives due to the coronavirus since the first death was detected on March 7 in Argentina (WHO 2020).

At the regional level, countries face other health problems in addition to the pandemic. Due to the double burden of disease that is characteristic of many Latin American nations, communicable diseases and chronic-degenerative diseases overload already weakened and fragmented health systems, which must now face a greater weight from Covid-19 cases. Furthermore, the region continues to be the most unequal in the world, with poor regional non-economic cooperation, and decades of dismantling of public health and education, which have only increased this negative prospect (Vivares 2021). Even though it is true that the region was already facing economic and social difficulties before the pandemic – with the rise of unemployment to around 8% in 2018 and a significative drop in GDP growth in 23 out of the 33 Latin American and Caribbean countries (CEPAL 2019) – we are now dealing with one of the worst crises in decades. There was an even more dramatic increase in unemployment, informal work and millions of people pushed into extreme poverty (CEPAL 2020; CEPAL & OPS 2020), in a context that makes it difficult to control the pandemic and exposes how the disease impacts different countries unevenly (United Nations 2020).

In the last two decades, a regional integration model has taken place in Latin America, combining economic development with social development (Bianculli & Hoffmann 2016; Riggirozzi 2015). These changes helped to build new perspectives in the approach to regional governance towards health, economics, and education (Riggirozzi & Tussie 2018).

In the global health field, many authors have already mentioned the importance of regional integration mechanisms to develop cooperation actions in health, especially in the context of the pandemic (Buss & Tobar 2020; Davies & Wenham 2020; Rodrigues et al. 2020). Several studies have even shown the importance of regional organizations as central actors, not only in foreign policy, but also in the international health agenda (Herrero & Tussie 2015; Bianculli & Hoffmann, 2016; Riggirozzi 2015). With their roles and the pressure they exert at the different levels of intervention, they can, in fact, favor the emergence and consolidation of initiatives that contribute to the provision of sanitary sovereignty and health as a right, through new mechanisms of diplomacy (Riggirozzi 2015; Herrero & Tussie 2015; Herrero & Loza 2020). This leads us to reflect on the vital importance of regional integration mechanisms and cooperation to address Covid-19 and to tackle the impact on social determinants of health.

The Covid-19 pandemic seems to have caught countries and multilateral organizations off-guard, despite previous warnings about the risks of a pandemic and the need for countries to strengthen health systems to better respond to unprecedented demand, establish action plans and call donors and multilateral institutions to fund the development of vaccines and treatments (Board 2020; Buss et al. 2020). In the Latin American countries, the strategies to face the Covid-

19 pandemic have revealed a common thread: the responses have been unilateral and isolated, in the framework of a weakening of the (once promising) multilateral regional integration system and the consequent decline of the health program agenda.

The hypothesis of this study considers that a regional and concerted approach to the pandemic was not possible, despite the long history of regional integration and, more specifically, health cooperation in Latin America, and the fact that health is currently on the agenda of most, if not all, regional integration mechanisms. The pandemic erupted in a fragmented region, with a significantly weakened multilateral system, and also experienced the inability of regional projects to assume a more active and leading role to face the pandemic and to strengthen regional cooperation. In this regard, the health field, due to its characteristics and trajectory in the region, could illustrate some interesting points to think about this regional architecture in terms of integration and cooperation.

Considering that regional cooperation in health can be a powerful epidemiological tool, it is estimated that, in the case of global emergencies such as the current one, it can act as an "epidemiological shield" to prevent their advance and contribute to their control, in a horizon of sanitary sovereignty.

The objective of this study is, in the first place, to analyze how the Covid-19 pandemic has been addressed in Latin America and the Caribbean region, and the contributions that regional integration projects could have made in the health field. Secondly, it proposes to identify the limitations of current integration mechanisms to advance in regional cooperation actions to deal with this health crisis, and to point out the tools that the health field could offer in this direction.

To achieve these objectives, this study applies a qualitative methodology. From a theoretical framework, it articulates different disciplines, such as international relations, collective health and social epidemiology. Thus, the aim is the investigation of public health policies and foreign policy, within the framework of the conceptual discussion of international cooperation and regional integration, especially considering post-hegemonic regionalism (Riggirozzi & Tussie 2012).

The empirical analysis includes secondary sources and consists of a qualitative assessment of official documents published by the regional integration mechanisms, high level declarations and regional plans and guidelines on Covid-19. Also, considering the process tracing method (Bennett & Checkel 2014), this qualitative analysis can help to identify the current limitations to advance with cooperation efforts within regional integration mechanisms in the health field.

The article is structured in three sections. After this introduction, the first section presents the conceptual and theoretical framework on regionalism in Latin America and the Caribbean and, then, an analysis of how health was included in the regional integration agenda, becoming one of the strategic tools of LAC cooperation. The second section develops the main national and regional initiatives to deal with Covid-19. The third part presents the analysis and discussion around the legacy and the gap left by regional integration mechanisms in LAC, as well as the impact of the subsequent crisis of multilateralism on the regional response to the disease. Finally,

by way of conclusions, this paper reflects on the importance of a regional cooperation based on principles of solidarity and mutual benefit, especially in contexts of health crises, as well as on the added value of regional integration projects.

By reflecting on the importance of regional integration and cooperation, based on solidarity and mutual benefits, it is expected that this analysis will contribute to identify the lessons learned in these processes, as well as their limitations and challenges. It could also provide some tools to overcome this pandemic and other (future) health crises, by rethinking the integration architecture and international cooperation from a Latin American perspective.

Regionalism and Cooperation in Health in Latin America

This section presents the conceptual and theoretical framework on regionalism in Latin America and the Caribbean, and an analysis of how health was included in the agenda of regional integration models, becoming one of the strategic tools of LAC regional cooperation.

Historically, from a neoliberal perspective, Latin America was conceived as part of an Americanized system, mainly looking north and linked to the economy of the other hemisphere (Grugel 1996). Regionalism was seen as manifestations of a world order conceived by hegemonic politics, and shaped by the need for countries to participate effectively in global market activity. The regional integration was conceived fundamentally as a commercial project.

The implementation of neoliberal policies increased socio-economic disparities, health inequities and social exclusion in Latin America. Inadequate access to medical care and drugs remains a problem, particularly among the most vulnerable population groups. At the beginning of the 21st century, the regional landscape became increasingly complex, challenging the notion of regionalism and the liberal governance led by the United States. By the new millennium, Latin America had witnessed a series of political transitions as left-leaning administrations had come into power in most South American countries, which could be understood, at that point, as a reaction against an excessive marketization that resulted from the financial reforms derived from the Washington Consensus. By force, the profound changes in the political-economic orientation in many countries called for redefining the dynamics in region-building. The move was not simply a domestic political turn to reach out to the excluded, but also a window of opportunity for new leaders to synchronize governmental policies in the search for greater autonomy vis-à-vis external actors (Riggirozzi & Tussie 2012).

In this context, South America became a platform for the emergence of a new regionalism that went beyond the patterns set by the US on trade integration. Hence, the "open regionalism" typical of the neoliberal economy and led by the United States, lost strength and dynamism and was faced with the gradual re-emergence of new nationalisms in the region (Riggirozzi & Tussie 2012). These new articulations of regional policy even reinvented principles of regional solidarity and collectivism, strongly differing from previous regionalist projects. Furthermore,

a more horizontal and solidary international cooperation among these countries has emerged as a strategy to increase power so that these countries may stop being mere receivers of the most traditional international cooperation and become cooperators in order to meet local social needs (Vance Mafla et al. 2016).

The rising regionalism adopted two principles: the management of tensions between political and economic autonomy in the face of external influences, and the search for cooperation for economic and social development (Riggirozzi & Tussie 2018).

It is also worth mentioning that, from this theoretical approach, the regional arena provides an emerging space above the states - a meso level between the national and the international one (Bianculli & Hoffmann 2020) - which is useful for debates, knowledge-sharing and the promotion of norms and methods of regional policy formation and practice (Riggirozzi & Ryan 2021). Regional organizations can effectively bridge regional and national policies and sustain the cross-border policy networks required to ensure efficient policy outcomes for citizens (Riggirozzi & Ryan 2021). This arena can also provide governments with some technical knowledge and financial support mechanisms to which actors can draw on when faced with internal and external pressures (Riggirozzi & Ryan 2021, 6).

It is also important to mention that regionalism in South America has not been conceived as a restriction to national autonomy, but as a set of institutions that empower rather than limit national decisions (Deciancio 2016). In this sense, Ferrer argued that regional integration is a tool to support and coordinate the construction of sovereignty (Ferrer 2013). The concept of sovereignty is quite traditional in the field of international relations, and refers to the centrality of the state in the international field. The contemporary debates on international relations and political science have reviewed some concepts and practices of sovereignty, considering a critical perspective that includes factors such as cooperations among States, global agendas and international and transnational actors (Cardozo da Silva 2007 apud Teixeira 2017).

Particularly in terms of regional cooperation and integration, Teixeira identifies that integration blocs can become conducive to the exercise of sovereignty in two dimensions: one internal and the other external, which are complementary and provide feedback to each other. In the internal dimension, within the national state, sanitary sovereignty is the ability to define public policies based on the conception that health is a human right and the person's needs should be met by sustainable health systems. Regarding the external dimension, at a regional level and strengthened by the integration between the countries, sanitary sovereignty is the ability to defend the health rights of their populations in multilateral spaces, against the transnational market interests. A sanitary sovereignty establishes a regional resistance mechanism as it reinforces the independence and autonomy of the states (Teixeira 2017).

Regionalism, understood as a common space for policy deliberation beyond and above states, is a structure of opportunities to obtain political statements and regulatory commitments, with very relevant windows of action for social activism (Riggirozzi & Tussie 2018; Bianculli & Hoffmann 2016). From this perspective, regionalism in Latin America

and the Caribbean has been able to promote a conglomerate of commercial, political and social projects around new principles of solidarity and regional autonomy (Riggirozzi 2015; Herrero & Tussie 2015).

In the context of post hegemonic regionalism, some practices and processes in social policy established new standards of political and social cohesion, which also helped "south-south" ties. The regional practices and processes in those decades laid new foundations for political and social cohesion in the construction of southern solidarity, and health became one of the most dynamic sectors, with the possibility of expanding public policy chains (Riggirozzi 2015; Herrero & Tussie 2015). This process helped countries to propose, from the health field, international cooperation initiatives for innovative actions that couldn't be successful if conducted individually (Herrero 2017).

Through consensual and collective actions, the countries promoted regional cooperation in health to deal with common problems, aiming to enhance its capacities in order to contribute to policy coordination. The experience of the Union of South American Nations (UNASUR) shows that some regional blocs can set up alternatives to unilateral and top-down transfer policies and, furthermore, that regional organizations have the potential to build new cooperative ties through health, to reduce asymmetries and to become actors in new forms of health diplomacy (Amaya & De Lombaerde 2019; Riggirozzi 2015). In this context, health has not only been the engine of regional integration in recent decades, but also one of the most active sectors of South-South Cooperation (SSC) (SEGIB 2017).

The presence of health on the regional agenda is not new. The region of the Americas has been a pioneer in cooperation in this field and has a wealth of experience and achievements in public policies as well as a history of mutual collaboration (SEGIB 2017). In fact, each of the regional processes, at different stages, defined health as a strategic area for cooperation among member countries (Teixeira 2017).

Although the forms of institutionalization are different and the levels of consolidation of each of the integration projects differ, what is remarkable is that all regional processes have bodies dedicated to the health issue. In this sense, health is also, in itself, a privileged field to build sovereignty, since it supports continental and global multilateral spaces for the negotiation and exercise of sovereignty, which other social areas do not have. At the same time, these regional integration processes with focus on social policies and regional health sovereignty, can also strengthen the national health sovereignty of its member countries.

This deployment of regional sanitary sovereignty strengthens a region in the external sovereignty scope, as well as, individually, each one of the countries that belong to the process of regional integration. In this way, it enhances the capacity of those countries to define their own health policies, with a lower level of external influence, thereby increasing their internal sanitary sovereignty (Teixeira 2017, 179).

Regional cooperation in health has become increasingly important in Latin America and the Caribbean, as well as a greater political and strategic interest. Nevertheless, even considering

the structure of cooperation in health already in place within Latin America, the pandemic breaks out in a context of disarticulation of its regional integration mechanisms, exposing pending debts and challenges.

Government reactions and regional health cooperation initiatives to address the pandemic crisis

The pandemic revealed that the region's health systems remain fragile, as well as highly heterogeneous, despite the increase in health spending and visible improvements in the last decade in many Latin American and Caribbean countries.

The reaction to the effects of the pandemic in LAC has been marked by a clear state focus supported by a sovereigntist and nationalist discourse (Riggirozzi 2020; Sanahuja 2020). Although other countries and regions have also adopted state-centric responses, in LAC the impact was quite intense: the weakness of regionalism and the debilitated cooperation and integration structures mentioned above, had implied a return to health nationalism to the detriment of coordinated actions and the logic of cooperation. Therefore, the unilateral measures adopted by the countries, with greater or lesser success, have been insufficient to contain the disease in most of the countries.

Some countries tried to deny the disease, presented miraculous medicines, and from the beginning, practically did not apply non pharmaceutical measures, such as Brazil. Brazil accounts for just over 40% of Latin America's GDP, and around 40% of its economically active population, which means that movements in the Brazilian economy strongly impact the averages of the region's indicators (Pereira da Silva 2018). Other countries implemented more structured measures, including prolonged social isolation and lockdowns: Paraguay, Argentina, Peru and El Salvador. Finally, some countries adopted measures gradually, initially disbelieving but applying increasingly harsh measures depending on the outcome of the disease in the territory, until many of them had to decree more drastic measures (Herrero & Belardo 2020).

In Latin America, where the epidemic arrived several weeks later, European experiences were not enough to alert some governments, whose health systems rapidly collapsed, such as Ecuador and Chile.

Such a difference in strategies indicates that there was not a concerted response, but what prevailed were isolated and individual measures, with varying degrees of success. The behavior of these countries contributed to further fragmentation of the region and hindered the possibility of agreements that could have reduced the social, political, economic and health impacts of the pandemic. The public health policies, if regionally integrated, could have had a key influence in the evolution of the pandemic in the region.

The analysis of the strategies initially adopted by the main regional integration mechanisms in Latin America allows us to identify some categories of response within the scenario of health cooperation. The following organizations were considered: Community of Latin American and Caribbean States (CELAC), Caribbean Community (CARICOM), Forum for the Progress of South

America (Prosur), Southern Common Market (MERCOSUR), Andean Health Organization-Hipólito Unanue Agreement (ORAS-CONHU), Amazon Cooperation Treaty Organization (ACTO), and the Central American Integration System (SICA) (Table 1). As selection criteria, the analysis considered the regional integration organizations composed only of Latin American and Caribbean countries which also have some kind of coordination mechanisms in the health area (Table 1). The analysis includes materials published between January 2020 and April 2021, such as high-level declarations, Action Plans, strategic guidelines and news published online.

Table 1. Integration mechanisms, member countries and dates of foundation

Regional Integration Organizations	Member countries	Date of foundation	Main objectives	Coordination mechanisms in the health field
CARICOM	Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Haiti, Jamaica, Montserrat, Saint Lucia, St, Kitts and Neves, St. Vincent and Grenadines, Suriname, Trinidad and Tobago	July 4, 1973	To promote and support a unified Caribbean Community that is inclusive, resilient, competitive; sharing in economic, social and cultural prosperity; driven by knowledge, excellence, innovation and productivity; where all citizens are safe and have the opportunity to realize their potential with guaranteed human rights and social justice.	Caribbean Public Health Agency (CARPHA) Council of Human and Social Development (COHSOD)
CELAC	Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Colombia, Costa Rica, Cuba, Chile, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Dominican Republic, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Saint Lucia, Suriname, Trinidad and Tobago, Uruguay and Venezuela	December 3, 2011	Mechanism of agreement and regional integration, created in response to the need to make efforts among the States of Latin America and the Caribbean in order to advance in unity and in political, economic, social and cultural integration; Also, it intends to increase social well-being, quality of life, economic growth in the region, and promote independent and sustainable development, based on democracy, equity and social justice.	Strategic Agenda for Regional Coordination in social matters Annual Work Plans
PROSUR	Argentina, Brazil, Chile, Colombia, Ecuador, Guyana, Paraguay, Peru	March 23, 2019	To build and consolidate a regional space for coordination and cooperation, without exclusions, to move towards a more effective integration that allows to contribute to the growth, progress and development of the countries of South America.	Health Axis

Continue

Continuação

MERCOSUR	Argentina, Brazil, Paraguay, Uruguay, Venezuela*	March 26, 1991	To promote a common space that generates commercial and investment opportunities through the competitive integration of national economies to the international market	Meeting of the Ministers of Health (RMS) Working Subgroup 11 on Health (SGT 11)
ORAS-CONHU	Bolivia, Colombia, Chile, Ecuador, Peru, Venezuela	December 18, 1971	To coordinate and promote actions aimed at improving the health level of member countries, giving priority to cooperation mechanisms that promote the development of sub regional systems and methodologies.	Meeting of Ministers of Health from the Andean Area (REMSAA)
ACTO	Bolivia, Brazil, Colombia, Ecuador, Guyana, Peru, Suriname and Venezuela	December 14, 1998	To coordinate the procedures within the framework of the Amazon Cooperation Treaty (ACT), and streamline the execution of its decisions, within the framework of the preservation of the environment and the rational use of the natural resources of the Amazon.	Regional Health Management
SICA	Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Dominican Republic	December 13, 1991	To carry out the integration of Central America, to constitute it as a region of peace, freedom, democracy and development	Council of Ministers of Health of Central America and the Dominican Republic (COMISCA)

* Venezuela is suspended in accordance with Article 5 of the Ushuaia Protocol

Source: own compilation

In the category of high-level declarations, there were manifestations in all regional mechanisms, with the exception of ACTO, which did not hold high-level meetings during the analyzed period. A common point in these declarations was the need to strengthen the Covax Facility mechanism to guarantee access to vaccines in LAC countries, but this in practice did not turn into concerted initiatives of great impact for the countries. Topics such as the importance of cooperation in health, the strengthening of national capacities, the exchange of information and health surveillance also appeared (Prosul 2020a; 2020b; 2021; MERCOSUR 2020a; 2020b; 2020c; 2020d; ORAS-CONHU 2020).

With regard to specific funding for Covid-19, the MERCOSUR, CELAC and SICA initiatives are worth mentioning. MERCOSUR approved an additional contribution of US$ 16 million for

the Plurinational project "Research, Education and Biotechnologies Applied to Health," to be fully allocated to the coordinated fight against Covid-19. The resources, financed through the Fund for Structural Convergence of MERCOSUR (FOCEM), should be used to purchase equipment, supplies, detection kits, and development of sero-diagnostic techniques (MERCOSUR 2020d).

SICA managed to approve the increase of resources to the bloc's Emergency Fund, with US$ 1 million for each of the 8 member countries. Besides internal financing, SICA approved external financial agreements with Taiwan, the European Union and Germany for financial support to micro, small and medium-sized companies in Central American countries, with contributions totaling more than US$ 350 million. Epidemiological surveillance strategies for the region were discussed with the North-American Centers for Disease Control and Prevention (CDC) and the President's Emergency Plan for AIDS Relief (PEPFAR), which led to the signing of development aid agreements.

Through the Central American Bank for Economic Integration (BCIE), SICA made donations of thousands of kits for Covid-19 detection to all member countries and also to Argentina and Colombia, which are extra-regional partners of the bank. As part of the Emergency Support and Preparation Program for Covid-19, created in March 2020, BCIE has allocated nearly US$ 4.2 million for the purchase and supply of diagnosis tests and medical equipment for early detection of the disease (BCIE 2020).

Within CELAC, Mexico and Argentina headed the signing of a financial agreement with the Slim Foundation - owned by Mexican billionaire Carlos Slim - signed in August 2020. The initiative should result in the regional production and distribution of between 150 and 250 million doses of the vaccine developed by the Oxford-AstraZeneca consortium. Production is in charge of Mexico and Argentina.

Additionally, ACTO proposed external financing – public or private – for the articulation of actions to combat the pandemic (ACTO 2020), but has not achieved concrete results so far.

In terms of regional monitoring, ORAS-CONHU, ACTO, SICA and CARPHA published detailed reports on the situation in the countries. CARPHA also published regional guidelines on various topics related to the pandemic and important to Caribbean countries, such as: prison visits, alerts for health professionals, communication strategies, and disinfection of tourist facilities, among others (CARPHA 2020). SICA managed to approve a Regional Contingency Plan (SICA 2020), aimed at complementing national efforts to mitigate the effects of the crisis generated by the pandemic. Also, the 2021 Work Plan of CELAC includes strategies on post-pandemic economic reactivation and the Regional Health Strategy against Covid-19, with regional initiatives of production and distribution of vaccines and medical supplies, and the consolidation of the Network of Experts in Infectious Agents and Emerging and Reemerging Diseases (CELAC 2021)

Some concrete results were also seen in terms of regional surveillance. CELAC managed to liaise with the United Nations Economic Commission for Latin America and the Caribbean (ECLAC) and the United Nations Food and Agriculture Organization (FAO), which resulted in the creation of the Covid-19 Observatory in Latin America and the Caribbean, with the aim of

tracking and monitoring countries' progress and the economic and social impact of Covid-19 in the medium and long terms (ECLAC 2020). CELAC also strengthened joint initiatives with SEGIB (Guadarrama Pérez and González Hernández 2020). SICA has also created a regional observatory, provided in its Contingency Plan, to issue improved and updated information on the pandemic to the countries.

In terms of extra-bloc articulation, other initiatives were developed with regard to the exchange of information and knowledge. Noteworthy is the articulation of ORAS-CONHU with MERCOSUR and ACTO to carry out online events and webinars on topics related to the fight against the pandemic. The initiatives were supported by the PAHO Subregional office for South America. It is worth mentioning that the events held by ACTO had an important focus on the health of indigenous populations, on combating Covid-19 in Amazonian regions, especially on the borders, and on access to vaccines and treatments for indigenous peoples (ACTO 2020).

Table 2. Health cooperation initiatives of regional integration mechanisms in response to Covid-19, by categories

	CARICOM	CELAC	PROSUR	MERCOSUR	ORAS-CONHU	ACTO	SICA
Epidemiological surveillance	✓			✓	✓	✓	✓
Production / purchase / distribution of medicines / supplies / vaccines	✓	✓		✓			✓
Periodic regional reports	✓				✓	✓	✓
Formal/Informal exchange of information among countries	✓	✓		✓	✓	✓	✓
Regional Action Plans/ Regional Guidelines on Covid-19	✓	✓					✓
High-level political statements	✓	✓	✓	✓	✓		✓
Virtual events on topics related to the pandemic	✓	✓		✓	✓	✓	✓
Articulation with other regional integration mechanisms within LAC				✓	✓	✓	
Articulation with other international organizations or external actors	✓	✓				✓	✓

Source: elaboration of the authors

As can be seen in Table 2, in almost all the blocs of Latin America and the Caribbean, the main strategies were related to high-level political statements, publication of reports with epidemiological data and the holding of virtual events on the pandemic. Some made progress

with other more specific initiatives. Thus, it is not that the region is not active in the context of the pandemic. However, the initiatives of the different regional blocs have been detached from each other, which hindered the possibility of effectively building a joint response to the problem.

Cooperation in health and regional integration: where are we?

When examining the initiatives as a whole, from a regional cooperation perspective, it is evident that each of the analyzed organizations has developed strategies to face the pandemic, but establishing partial alliances. Consequently, they have put instruments in place that, in a context of fragmentation or individual responses to the outbreak of the pandemic, run the risk of being short-term and temporary, limiting the ability to build a health agenda at the regional level, with a view to coping with eventual health crises in the future.

Acting at the regional level in Latin America is a challenge due to specific limitations of the regional arena as a field of social policy making, but also due to some weaknesses of regional integration processes in this specific region. Literature in the field of international relations discusses and argues that these are valid and fundamental spaces for collective action and construction of regional policies, especially in the field of social policies (Bianculli and Hoffmann 2016; 2020; Riggirozzi & Tussie 2012; Riggirozzi 2015; Herrero 2017). However, this action is often limited by the political will of countries, by the reduced credibility of regional policy making and, in many cases, by the lack of institutional continuity that is often present in regional spaces, especially in Latin America. For this reason, it is often difficult to identify the social effects of these regional policies (Riggirozzi & Ryan 2021).

According to Riggirozzi and Grugel (2015) this skepticism is identified as the "credibility gap" of regional integration bodies, explained by "the proliferation of weak and sector-based regional organizations, and often overlapping regional organizations, which only supported erratic implementation of regional policies across Latin America" (Riggirozzi & Ryan 2021, 10). Skeptics tend to overlook the gains made by regional spaces, as well as their potential, which ends up widening the gap. In this scenario, it is possible therefore to observe that, on the one hand, the dissolution of UNASUR left an institutional vacuum that has not been filled yet, in a context that is already complex due to the stagnation – and even the withdrawal – of South-South Cooperation actions and the crisis of the multilateralism. However, on the other hand, UNASUR also left certain capacities that could undoubtedly be an added value in addressing the pandemic and, above all, the post-pandemic scenario.

At this point, it is interesting to make visible the legacy of UNASUR beyond the significant gap left by its dissolution, also considering that it was one of the most active and effective regional mechanisms in the health area, especially concerning the defense of democratic values and the promotion of social participation in the construction of health policies. At the regional level, the actions of UNASUR promoted the health agenda towards successful strategies of south-south

and horizontal cooperation, regarding common actions against the H1N1 influenza pandemic, dengue epidemics, other emerging and re-emerging communicable diseases, and the collective preparation for an eventual arrival of the Ebola virus (Buss et al. 2018). Moreover, UNASUR had the ability to articulate not only the actions of the countries, but also the actions of other regional mechanisms, through the complementation of agendas that appeared both in activities and in official documents. That in practice resulted in the carrying out of joint activities promoted and financed by UNASUR. And this is particularly important when addressing a crisis of such magnitude as this one.

Due to unsatisfied demands and given the systemic scope of the crisis, the pandemic has shown that the articulation and coordination of actions at 3 levels is essential: national, regional and global. The national one with a view to underpinning local capacities and especially the strengthening of health systems to meet the demand and cover the need for supplies and medical equipment, something that has been lacking in many countries in the region (García et al. 2020). At the regional level, aiming at articulating and strengthening cross-border cooperation, exchanging data and promoting joint mechanisms for the acquisition of medicines and, even more, of vaccines (Riggirozzi 2020), whose race jeopardizes the capacity of some countries to acquire them. In other words, hoping to reduce regional asymmetries, which have undoubtedly been evident in this pandemic crisis. Finally, at the global level, in order to join forces to act together and negotiate as a bloc, understanding and defending health as a right.

In the case of UNASUR it is possible to identify the three levels in which it had operated and through which norms had been promoted (the national level, the regional level and the global level). It is possible to call UNASUR an "intermediary" that moves through the three levels of governance that reinforced themselves - national, regional and international – showing the capacity to generate broad consensus (Riggirozzi 2015). Influence at the national level is perceived to the extent that integration processes with focus on social policies and regional health sovereignty are considered to also strengthen the national health sovereignty of its member countries. South American countries frequently presented important themes for their national health systems in the multilateral space of UNASUR, which served as a space to jointly search for common solutions.

UNASUR's aforementioned health actions were led by its South American Health Council, with the explicit support of the Heads of State. Many actions were implemented by hundreds of technicians from the ministries of health of the Member States (Buss *et al.* 2018). Moreover, UNASUR not only articulated the actions of the countries, but also acted in coordination with the different regional blocs by complementing agendas. This is an added value of the bloc that even anticipates those articulations in its documents and normative regulations.

The ability to articulate with other regional mechanisms – that was the fundamental characteristic of UNASUR in both all its activities and documents – is the first great loss for the region. As a consequence, it also resulted in a loss of capacity to enforce regional health sovereignty, leading to a global disarticulation. In the area of access to medicines, for example, projects

such as the Medicines Price Bank - launched at the end of 2016 - and the joint negotiation of prices for high-cost medicines – started in 2015 – demonstrated the importance of articulation with MERCOSUR, in a scenario of institutional overlap that was beneficial to the countries (Oliveira 2019; Bianculli, Hoffmann and Nascimento, 2020).

At the global level, UNASUR contributed to building a new arrangement of health diplomacy. Among its important contributions in this field are the common positions presented at the World Health Assembly. Between 2010 and 2016, there were 35 common positions, on various topics, always focused on the principles defended by UNASUR: health as a fundamental human right, universal access to medicines, the valuation of public health over intellectual property rights, the strengthening of human resources in health, social determinants of health and the agenda of the Sustainable Development Goals (SDG) (Vance Mafla 2020).

A special characteristic of UNASUR was to propose the construction of a regional identity without the need for member countries to delegate part of their sovereignty to supranational mechanisms. Thus, it placed itself, in an innovative way, as a regional integration organization in which health interests at the regional level are valued more highly than the power of the supervisory body while being superior to that of individual members. In this sense, the regional policy process and its results in terms of health diplomacy are another interesting point in the analysis of UNASUR. Through new diplomacy mechanisms, the region strengthened and broadened its capacity to negotiate and defend its interests in multilateral spaces, thus generating greater autonomy for the countries that belong to the process to define its own policies, with less external influence (Teixeira 2017). Health is itself a privileged field to build sovereignty at international and multilateral levels, since it offers a negotiation space within continental and global multilateral bodies, which other social areas do not have.

In such a situation of several open fronts, the experience of UNASUR has taught us that it is essential to have mechanisms and spaces of regional coordination that could allow the exchange of information and good practices, define joint prevention and containment actions, and propose the adoption of incentives for technological innovation, negotiation and joint purchase of vaccines and treatments for Covid-19. Above all, it would be fundamental to provide a contextualized epidemiological strategy according to the realities and priorities of the health systems of Latin American and the Caribbean countries.

The development of the vaccines against Covid-19 takes place in the context of countries that face second and third waves of the epidemic. According to the WHO, humankind will need around 2 billion doses of vaccines available to immunize health personnel and high-risk populations alone. However, the 27 member states of the European Union, together with five other rich countries, have reserved approximately the amount of vaccines that should be available, while these countries represent only 15% of the world population. Furthermore, of the 700 million doses applied worldwide in the first 6 months of global vaccination, more than 87% have gone to high- or upper-middle-income countries and only 0.2% to low-income countries. And of the vaccines produced, Latin America has, by contract, only 11% while Africa has 4%. These figures

contrast with those of countries such as the United States and the European Union, which cover 199% of their population, or Canada, 532%.

In this context, in spite of some initiatives on the part of different governments, such as the proposal for the temporary exemption of patents – led by India and South Africa to the World Trade Organization (Prabhala et al. 2020) – and the claim before the WHO to guarantee equitable access – such as the initiative promoted by Costa Rica (OMS 2020) – , the countries that paid the most are having privileged access to the vaccines, prioritizing the market criterion and the purchasing power over the criterion of public health needs.

So, the race of the wealthy countries to ensure anticipated doses has compromised the ability of the majority of the states – where more than 80% of the world population is – to acquire them (Herrero & Nascimento 2020).

The UNASUR continuity would be very valuable in this pandemic context as a factor of articulation to more effectively coordinate production and expand access to vaccines and treatments for Covid-19: not only because of the importance of access to them as a right, but also because this path can become a facilitator to wider margins of health policies and reinforced regional integration regarding the influence of the actors involved.

The regional level linked to integration initiatives presents great opportunities for cooperation in health, through collective action, in order to contribute to face challenges such as the pandemic and other global public health events (Buss & Tobar 2020). Conceiving international cooperation as an epidemiological tool implies the need to discuss what type of health cooperation is most effective and efficient to deal with health issues that affect our people.

At this point, we consider that the concepts of "epidemiological shield" and "sanitary sovereignty," as a UNASUR legacy, broadly contribute to an articulated Latin American and Caribbean regionalism, where cooperation and integration become a benefit that strengthens the region and have a favorable impact within each Latin American nation, reinforcing the respective socio-sanitary policies. The whole is superior – or at least it should be – to the sum of its parts.

In the field of emergency response, the human security concept presented by Chen and Narasimhan (2003) and instrumented by Panisset (2018) could be useful in the construction of a regional epidemiological shield concept, to the extent that it facilitates the understanding on the diverse role of authorities and institutions of public health and safety areas, to prepare and carry out the necessary response actions to face potentially devastating health crises (Panisset 2018).

Mechanisms for formulating policies and practices based on solid scientific evidence and information correctly analyzed can, therefore, represent a more operational component of intelligence for health, improving the quality of health management, with positive impact on the population wellness (Panisset 2018, 161).

The conceptualization of this South American epidemiological shield – in the words of Buss and Tobar (2009) – can be considered a regional public good, that is, those results or products whose benefits go beyond borders, and are available for all population groups of the region. In fact,

as Rovere (2020) argues, during the pandemic, what could have acted as an epidemiological shield was not activated, but each country made the decisions it believed were most appropriate.

In this sense, the creation of an "epidemiological shield" with a south-south focus could become a regional-interregional institutional tool, aimed to provide adequate and politically supported epidemiological responses to epidemics and priority diseases in the global south, in accordance with each health context. This device must be constituted in an interdisciplinary and multidimensional way, structured around a regional surveillance and response network, for the building of mechanisms to exchange information and protocols, as well as the systematization of statistical databases for coordinated action in the different instances of the political-diplomatic sphere.

In the current context of political realignments, other regional integration paradigms are beginning to gain force, even with overlapping agreements. There are the alliances most linked to the interests of the United States that have sought to have a greater role in the political changes in the region, without major achievements in terms of institutional frameworks, such as the Pacific Alliance or Prosur. Others, meanwhile, have sought to survive the conflicts and disputes of the member states, such as the Bolivarian Alliance for the Peoples of Our America (ALBA). The triumph of the Front of All (*Frente de Todos*) in Argentina and of the Movement to Socialism (*MAS*) in Bolivia, as well as the overwhelming majority approval of changing the Pinochet Constitution and the recent election of a leftist president in Chile, could be a landmark concerning the path that the region should take in terms of regional integration. In the midst of the pandemic the world is experiencing, health has once again the possibility of becoming the engine of renewed regional cooperation, and an opportunity to strengthen (and rebuild) sovereign spaces in terms of integration in LAC: neither more nor less than one of the legacies that the integration process supported by UNASUR has achieved to build.

Conclusion

The increasingly globalized and interconnected world shows that there are urgent health issues that must be addressed collectively. This also implies activating urgent actions for the most vulnerable populations. Although diseases know no borders, once they cross them, they find specific ways to spread and circulate, marked by strong inequalities, manifestly in Latin America, the most unequal region in the world. The different regional mechanisms have quickly sought to promote initiatives to face the pandemic. However, the results – being fragmented – have not been enough to create, through regional integration, more effective responses to Covid-19.

The dissolution of UNASUR left an institutional gap at the regional level, with an impact on SSC actions in the health area, in a complex regional scenario that also faces a broader crisis of multilateralism. However, crises can also be opportunities. The trajectory of the health field in LAC, its experience in integration matters, and the legacy left by UNASUR can be a chance

for a more effective approach to health issues in the region. The pandemic therefore could be addressed through more inclusive models and collective sovereignty strategies.

In the current context of a health emergency, it would be necessary to move forward to the creation of a South-South Epidemiological Shield, which could strengthen regional capacities within LAC countries. The global shortage of vaccines also opens up a new opportunity for regional collective action. Vaccines must be a global public good and, for that to happen, regional mechanisms must be established and strengthened in order to avoid market interests, disputes and the "vaccines nationalism". In this panorama, Latin America and the Caribbean have a new opportunity to make efforts to face the Covid-19 jointly, through a common development around production, purchase and distribution of vaccines, health and epidemiological surveillance.

Health cooperation has shown that it can be a paradigmatic channel for regional consensus, as a tool and framework for action to expand the margins of public policies in other fields. The region, with its long history of integration and cooperation in health, is expecting to rebuild those favorable spaces for discussion and to develop or recreate institutional mechanisms for action. The inclusion of health in the regional cooperation agenda can generate a favorable environment for agreement among countries, thus promoting a structure of opportunity toward new models of development that are more inclusive and socially just, arising from the region and for the region.

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