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RESEARCH ARTICLE

Exploring the determinants of regional health governance modes in the Global South: A comparative analysis of Central and South America

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Abstract

What explains the variation in how states collectively deal with public health challenges across different regions? We tackle this puzzle by comparing the regional health governance efforts pursued within the Central American Integration System (SICA) and the Union of South American Nations (UNASUR). We show that Central America's health governance has been driven by external actors, whereas South America's was driven by states within the region, and remained insulated from external actors' influence. We argue that the explanation for such variation lies in the interplay of state capacity and regional leadership. In Central America, weak state capacity combined with the absence of a regional leader willing to provide governance resources. This opened up space for external actors to contribute actively to regional health governance, complementing the governance of Central American governments. In South America, Brazil's regional leadership mobilised neighbouring states' capacities by promoting a South-South cooperation agenda based on intra-regional exchanges among national health bureaucracies, which, however, proved vulnerable to intergovernmental conflicts. Through the comparison of Central and South America, the article bridges the gap between global health governance scholarship and comparative regionalism, providing new insights on the determinants and effects of regional health governance modes in the Global South.

Keywords: Regional Health Governance; State Capacity; Regional Leadership; Comparative Regionalism; Central America; South America

Introduction

What explains the variation in how states collectively deal with shared public health challenges across different world regions? The article tackles this puzzle by comparing regional health governance in Central and South America. To do so, we adopt the conceptual framework of *regional health governance modes* (RHGMs), which allows us to address institutional design issues (that is, how governance is institutionalised) while exploring the process of collective health policymaking that takes place within regional institutions (that is, how governance is enacted and by what types of actors). A key issue in the IR governance debate is the role of external actors, both state and non-state, in the provision of governance goods and services,[1] and this is at the heart of the article's findings. We show that Central America's health governance has been driven by external actors, whereas South America's health governance was driven by states and remained insulated from the influence of external actors. Drawing from the global health governance scholarship and comparative

[1]Markus Lederer, 'External actors', in Thomas Risse, Tanja A. Börzel, and Anke Draude (eds), *The Oxford Handbook of Governance and Limited Statehood* (Oxford: Oxford University Press, 2018), pp. 191–208; Stephen D. Krasner and Thomas Risse, 'External actors, state-building, and service provision', *Governance*, 27:4 (2014), pp. 545–67.

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regionalism, we argue that the explanation for such variation lies in the interplay of state capacity and regional leadership. In Central America, weak state capacity combined with the absence of a regional leader willing to provide governance resources. This opened up space for external actors to contribute actively to regional health governance, complementing the governance of actual governments. This resulted in the emergence of an *exogenously-driven governance mode*. In South America, the presence of states endowed with relevant capacities in the health sector interacted with Brazil's regional leadership, which supported regional institution building and promoted a South-South cooperation agenda based on intra-regional exchanges among South American health bureaucracies. This led to the emergence of an *endogenously-driven governance mode* autonomous from vertical North-South cooperation and resistant to external actors' influence.

To test our argument on the impact of state capacity and regional leadership on RHGMs, we conduct a comparative case study analysis of the regional health governance efforts pursued within the Central American Integration System (SICA) and the Union of South American Nations (UNASUR).[2] The member states of SICA and UNASUR equipped the two regional organisations (ROs) with bodies specifically devoted to public health: the Committee of Central American Health Ministers (COMISCA) and the Health Council of UNASUR (UNASUR Health). COMISCA and UNASUR Health are sector-based institutions headed by member states' health ministers, where decisions are made by consensus and formally subordinated to the approval of the intergovernmental political bodies of SICA and UNASUR. Despite these similarities, a closer look at COMISCA and UNASUR Health reveals significant variation in the two bodies' institutional design and policymaking, which is indicative of the different RHGMs developed in Central and South America. We explore such variation by comparing key dimensions of the two bodies' institutional design, as well as their policymaking in the field of access to medicines. This allows us to shed light on the determinants of RHGMs in the two regions.

The article provides the following contributions to the literature. It represents the first effort to compare RHGMs in Central and South America, whose variation is theoretically relevant for exploring the drivers of health governance in Latin America as well as in other world regions. By illuminating the impact of the interplay of state capacity and regional leadership on RHGMs, the article contributes to the comparative regionalism research agenda. Furthermore, the article contributes to the scholarship on global health governance by shedding light on the logic and effects of external actors' involvement in the provision of regional health governance solutions in the Global South.

The article is structured as follows. The first section bridges the gap between global health and comparative regionalism, introducing an innovative theoretical framework centred on state capacity and regional leadership as the determinants of RHGMs. Section two discusses research design and methodology issues. Section three presents empirical evidence relating to the differences in state capacity and regional leadership in Central and South America. Section four examines the variations in the institutional design of regional health governance in Central and South America. Section five analyses the variations in the two regions' health governance efforts in the field of access to medicines. The conclusion summarises how different configurations of state capacity and regional leadership determined variation in the modes and effects of health governance in Central and South America. In particular, the conclusion discusses how Central America's exogenously-driven RHGM has proven more resilient than South America's endogenously-driven RHGM. The former has not only delivered collective goods in the field of access to medicines but also responded to the COVID-19 pandemic. The latter succumbed to intergovernmental conflicts, which led to the dismantling of regional health institutions, the paralysis of health governance initiatives, and the subsequent lack of a regionally coordinated response to COVID-19.

[2]Since 2018, UNASUR has undergone a disintegration process caused by intergovernmental conflicts related to the Venezuelan crisis, which led nine out of twelve member states to withdraw from the organisation. In the conclusion, we discuss the impact of UNASUR's breakdown on regional health governance and South American states' capacity to respond to the COVID-19 pandemic.

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1. The determinants of RHGMs: Bridging the gap between global health and comparative regionalism

The concept of global governance emerged in IR scholarship to grasp the efforts to regulate interdependent transnational relations through the formulation of shared norms and rules, as well as through multilateral functional cooperation, in the absence of an overarching supranational authority.[3] Global governance can thus be defined as collective action aimed at managing cross-border issues and providing collective goods. This involves states as well as non-state actors such as international organisations (IOs), international non-governmental organisations (INGOs), and the market.[4]

Global health governance

The concept of global governance has been extensively applied to the field of public health, which has traditionally registered high levels of transnational cooperation in the areas of disease prevention and the promotion of well-being across societies. The relevance of public health in IR is due to the inherent characteristics of a policy sector marked by high levels of interdependence among states.[5] The complexity of transnational health challenges has stimulated a rich literature on global health governance, which maps the key actors involved in governance-making across the globe and analyses the challenges for legitimacy and effectiveness posed by transnational coordination.[6] This literature shows how the increasing globalisation of health challenges intensified the involvement of external state (for example, donor governments) and non-state (for example, the WHO or the Bill and Melinda Gates Foundation) actors in domestic health governance. This tendency has been particularly strong in developing countries with weak state capacity to provide basic health services and tackle cross-border health challenges. The literature investigated the influence of external actors on the decisions of policy-makers in weak states,[7] discussing the impact of external funding on those states' autonomy in and ownership of health policymaking.[8]

[3] Amitav Acharya, 'Rethinking demand, purpose and progress in global governance: An introduction', in Amitav Acharya (ed.), *Why Govern? Rethinking Demand and Progress in Global Governance* (Cambridge: Cambridge University Press, 2016), pp. 1–27; James N. Rosenau and Ernst-Otto Czempiel (eds), *Governance without Government: Order and Change in World Politics* (Cambridge: Cambridge University Press, 1992).

[4] Klaus Dingwerth and Philipp Pattberg, 'Global governance as a perspective on world politics', *Global Governance*, 12:2 (2006), pp. 185–203.

[5] Sara E. Davies, Stefan Elbe, Alison Howell, and Colin McInnes, 'Global health in International Relations: Editors' introduction', *Review of International Studies*, 40 (2014), pp. 825–34; Colin McInnes and Kelley Lee, *Global Health and International Relations* (Cambridge: Polity Press, 2012); Caroline Thomas, 'On the health of International Relations and the international relations of health', *Review of International Studies*, 15:3 (1989), pp. 273–80.

[6] Kent Buse, Wolfgang Hein, and Nick Drager (eds), *Making Sense of Global Health Governance: A Policy Perspective* (Basingstoke: Palgrave Macmillan, 2009); Chelsea Clinton and Devi Sridhar, *Governing Global Health: Who Runs the World and Why?* (New York: Oxford University Press, 2017); Richard Dogson, Kelley Lee, and Nick Drager, 'Global Health Governance: A Conceptual Review', WHO (Geneva, 2000); David Fidler, 'The Challenges of Global Health Governance', Council on Foreign Relations (2010); Sophie Harman, *Global Health Governance* (Abingdon: Routledge, 2012); Colin McInnes, 'Global health governance', in Colin McInnes, Kelley Lee, and Jeremy Youde (eds), *The Oxford Handbook of Global Health Politics* (New York: Oxford University Press); Jeremy Youde, *Global Health Governance in International Society* (New York: Oxford University Press, 2018).

[7] Anna Holzscheiter, 'Health', in Risse, Börzel, and Draude (eds), *Oxford Handbook*, pp. 438–58; John Kirton, Andrew Cooper, Franklyn Lisk, and Hany Besada (eds), *Moving Health Sovereignty in Africa: Disease, Governance, Climate Change* (Aldershot: Ashgate 2014); Amy S. Patterson, *Africa and Global Health Governance: Domestic Politics and International Structures* (Baltimore, MD: Johns Hopkins University Press, 2018); Marco Schäferhoff, 'External actors and the provision of public health services in Somalia', *Governance*, 27:4, pp. 675–95.

[8] Jeremy Shiffman, 'Has donor prioritization of HIV/AIDS displaced aid for other health issues?', *Health Policy and Planning*, 23:2 (2008), pp. 95–100; David Sridhar, 'Post-Accra: Is there space for country ownership in global health', *Third World Quarterly*, 30:7 (2009), pp. 1363–77.

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The literature on global health governance has privileged the global level, analysing the role and performance of the WHO, global public-private partnerships like the Vaccine Alliance (GAVI) and transnational philanthropies and NGOs, and exploring their impact on domestic health governance, particularly in the developing world. As such, scholars have under-researched a key component of global health governance: the regional dimension.[9] Regions have emerged as a strategic policy space, located between the domestic and the global, in which to tackle shared challenges, govern interdependences, and provide collective goods.[10] This is particularly the case with respect to transnational health challenges, which produce severe negative externalities among neighbouring states.

Regional governance and public health

Governance-based approaches to the study of regionalism first appeared in scholarship on the EU, aimed at capturing the complexity of the interactions between European states, supranational bodies, and subnational actors.[11] Nonetheless, scholars of regionalism have increasingly identified in the concept of governance a tool for cross-regional comparison.[12] The comparative regionalism literature has investigated the role of ROs as catalysts for governance-making, exploring how regional institutions provide privileged arenas for the coordination between states, IOs, foreign governments, and external donors.[13] The tendency of states to engage in governance initiatives within ROs has been related to a set of demand and supply-side factors: tackling transnational challenges, signalling to external actors, and deflecting governance transfer by external actors, as well as other considerations relating to regional leadership and the normative diffusion of external models.[14]

The literature has paid particular attention to two supply-side drivers of regional governance: regional leadership and external actors. Scholars investigated how the presence of a state with leadership capacity affects the design and effects of regional governance.[15] Regional leaders can steer institution building and policymaking by use of material incentives[16] and/or by socialising neighbouring governments into their visions of how to articulate regional governance, and persuading them to follow their lead.[17] On the other hand, the literature analysed the impact of external actors (for example, the EU and other state and non-state donors) on the institutional design and policy orientations of regional governance, with a strong focus on sub-Saharan

[9]Those scholars who adopted a regional perspective focused on the relationship between specific regions and global health institutions, at the expenses of the analysis of regional health institutions. See Kelley Lee, Tikki Pang, and Yeling Tan (eds), *Asia's Role in Governing Global Health* (London: Routledge, 2012); Kirton et al. (eds), *Moving Health Sovereignty in Africa*; Patterson, *Africa and Global Health Governance*.

[10]Tanja A. Börzel and Vera van Hüllen (eds), *Governance Transfer by Regional Organizations: Patching Together a Global Script* (London: Palgrave Macmillan, 2015); Tanja A. Börzel and Thomas Risse (eds), *The Oxford Handbook of Comparative Regionalism* (Oxford: Oxford University Press, 2016).

[11]Gary Marks, Liesbet Hooghe, and Kermit Blank, 'European integration from the 1980s: State-centric vs. multi-level governance', *Journal of Common Market Studies*, 34:3 (1996), pp. 341–78.

[12]See Börzel and van Hüllen (eds), *Governance Transfer*.

[13]Andrea Bianculli and Andrea Ribeiro Hoffmann (eds), *Regional Organizations and Social Policy in Europe and Latin America: A Space for Social Citizenship?* (Basingstoke: Palgrave, 2016); Börzel and van Hüllen (eds), *Governance Transfer*; Bob Deacon, Maria C. Macovei, Luk Van Langenhove, and Nicola Yeates (eds), *World-Regional Social Policy and Global Governance: New Research and Policy Agendas in Africa, Asia, Europe, and Latin America* (London: Routledge, 2009).

[14]Börzel and van Hüllen (eds), *Governance Transfer*.

[15]Daniel Flemes (ed.), *Regional Leadership in the Global System: Ideas, Interests and Strategies of Regional Powers* (Burlington: Ashgate, 2010); Walter Mattli, *The Logic of Regional Integration: Europe and Beyond* (Cambridge: Cambridge University Press, 1999); Detlef Nolte, 'Regional powers and regional governance', in Nadine Godehardt and Dirk Nabers (eds), *Regional Powers and Regional Orders* (New York: Routledge, 2011), pp. 49–67.

[16]Mattli, *The Logic of Regional Integration*.

[17]Thomas Pedersen, 'Cooperative hegemony: Power, ideas and institutions in regional integration', *Review of International Studies*, 28:4 (2002), pp. 677–96.

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Africa and Southeast Asia.[18] Furthermore, scholars investigated the impact of external actors' involvement on the ownership and effectiveness of regional governance processes and institutions.[19]

Scholars of regionalism have conducted research specifically on regional health governance in and across different regions, with a focus on ROs such as the EU,[20] ASEAN,[21] UNASUR,[22] MERCOSUR,[23] ECOWAS, and SADC.[24] However, this scholarship has struggled to incorporate the theoretical insights generated by the IR literature on the drivers and modes of regional governance. As a result, there is little systematic comparative work on the conditions under which different RHGMs emerge across regions. This article fills this gap by developing a theoretical framework for the comparative analysis of RHGMs, which incorporates three key variables derived from the global health governance scholarship and comparative regionalism: state capacity, regional leadership, and external actors' involvement.

The theoretical framework

We argue that RHGMs are determined by the interplay of state capacity (SC) and regional leadership (RL). Such interplay explains the variation in the institutional design and policymaking of regional governance efforts. We define RHGMs as those institutionalised modes of coordination among state and non-state actors that produce shared norms and rules, and deliver regional collective goods in the public health area.

We posit that the interplay of weak aggregated SC in a given region and the absence of a state willing to exercise RL and capable of providing governance resources leads to the emergence of a RHGM driven by external actors, which influence governance-making through funding and

[18]Börzel and van Hüllen (eds), *Governance Transfer*; Stephen R. Buzdugan, 'Regionalism from without: External involvement of the EU in regionalism in Southern Africa', *Review of International Political Economy*, 20:4 (2013), pp. 917–46; Anja Jetschke and Philomena Murray, 'Diffusion regional integration: The EU and Southeast Asia', *West European Politics*, 35:1 (2012), pp. 174–91.

[19]Sören Stapel and Fredrik Söderbaum, 'Mapping and problematizing external funding to the African Union and the regional economic communities', in Ulf Engel and Frank Mattheis (eds), *The Finances of Regional Organizations in the Global South: Follow the Money* (Abingdon: Routledge, 2020), pp. 112–25.

[20]Scott L. Greer, Nick Fahy, Sarah Rozenblum, Holly Jarman, Willy Palm, Heather A. Elliot, and Matthias Wismar, *Everything You Always Wanted to Know About European Union Health Policies But Were Afraid to Ask* (WHO Regional Office for Europe, 2019); Elias Mossialos, Govin Permanand, Rita Baeten, and Tamara K. Hervey (eds), *Health Systems Governance in Europe: The Role of European Union Law and Policy* (Cambridge: Cambridge University Press, 2010).

[21]Ana Amaya, Vincent Rollet, and Stephen Kingah, 'What's in a word? The framing of health at the regional level: ASEAN, EU, SADC and UNASUR', *Global Social Policy*, 15:3 (2015), pp. 229–60; Marie Lamy and Kai Hong Phua, 'Southeast Asian cooperation in health: A comparative perspective on regional health governance in ASEAN and the EU', *Asia Europe Journal*, 10 (2012), pp. 233–50.

[22]Giovanni Agostinis, 'Regional intergovernmental organisations as catalysts for transnational policy diffusion: The case of UNASUR health', *Journal of Common Market Studies*, 57:5 (2019), pp. 1111–29; María B. Herrero and Diana Tussie, 'UNASUR health: A quiet revolution in health diplomacy in South America', *Global Social Policy*, 15:3 (2015), pp. 261–77; Pia Riggirozzi, 'Regionalism, activism, and rights: New opportunities for health diplomacy in South America', *Review of International Studies*, 41:2 (2015), pp. 407–28.

[23]Andrea C. Bianculli and Andrea Ribeiro Hoffmann, 'Regional integration and health policies: Regulatory governance challenges in Mercosur', in Bianculli and Ribeiro Hoffmann (eds), *Regional Organizations and Social Policy*, pp. 251–70; Andrea C. Bianculli and Andrea Ribeiro Hoffmann, and Beatriz Nascimento, 'Institutional overlap and access to medicines in MERCOSUR and UNASUR (2008–2018): Cooperation before the collapse?', *Global Public Health* (2021), available at: {DOI: 10.1080/17441692.2020.1867879}; Luisa G. Queiroz and Ligia Giovanella, 'Mercosur's regional health agenda: Architecture and themes', *Pan American Journal of Public Health*, 30:2 (2011), pp. 182–8.

[24]Erica Penfold and Pieter Fourie, 'Regional health governance: A suggested agenda for Southern African health diplomacy', *Global Social Policy*, 15:3 (2015), pp. 278–95; Keneilwe S. Mooketsane and Molefe Phirinyane, 'Health governance in sub-Saharan Africa', *Global Social Policy*, 15:3 (2015), pp. 345–48; Edefe Ojomo, 'Fostering regional health governance in West Africa: the role of the WAHO', in Leonie Vierck, Pedro Villarreal, and Katarina Weilert (eds), *The Governance of Disease Outbreaks: Lessons from the Ebola Crisis and Beyond* (Berlin: Nomos), pp. 273–300.

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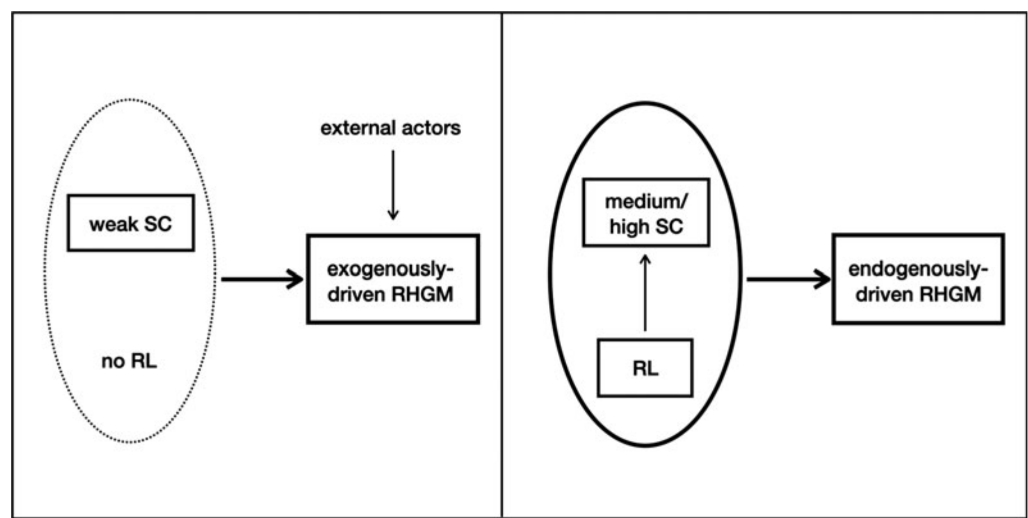

Figure 1. The theoretical framework.
Source: Authors' own elaboration.

technical assistance. We define this mode of governance as an *exogenously-driven* RHGM (see Figure 1). On the other hand, we argue that the interplay of medium/high aggregated SC plus the presence of a state willing and able to exercise RL by sustaining institution building and mobilising neighbouring countries' SC leads to a RHGM centred on intra-regional exchanges, and less dependent on external actors. We define this mode of governance as an *endogenously-driven* RHGM (see Figure 1).

2. Research design, methodology, and data

This article investigates the variation in the RHGMs of Central and South America. We argue that such variation results from the interplay of SC and RL in the two regions.

Operationalisation of the dependent variable

We operationalise the dependent variable RHGM in a dichotomous manner: a RHGM can be *exogenously driven* or *endogenously driven*. The former is driven by external actors, which shape the design of regional institutions and influence regional policymaking through funding and expertise. The latter is driven by states, which design regional institutions, finance their activities through national quotas, and autonomously formulate regional policies, keeping external actors at the margins of the process. We dichotomise the dependent variable because our interest is to explain the variation in the principal driver of health governance in the two regions.

Operationalisation of the explanatory variables

Following an organisational approach, we define state capacity (SC) as 'the bureaucratic, managerial, and organisational ability to process information, implement policies, and maintain governing systems'.[25] Four indicators for assessing SC have emerged from the literature: resources,

[25]Miguel A. Centeno, Atul Kohli, and Deborah Yashar, 'Unpacking states in the developing world: Capacity, performance, and politics', in Miguel A. Centeno, Atul Kohli, and Deborah Yashar (eds), *States in the Developing World* (Cambridge: Cambridge University Press, 2017), p. 9.

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presence of the state, quality of bureaucracy, and coherence of mandates.[26] To operationalise SC in the public health sector, we adopt the first two indicators.[27] The first of these refers to the resources that a state has at its disposal to provide public health services to its population. We operationalise this indicator as a function of: (1) domestic general government health expenditure per capita and (2) external health expenditure as a percentage of total health expenditure. The second indicator, presence of the state, refers to a state's infrastructural capacity to penetrate its surrounding society and territory. We operationalise this indicator as a function of: (3) the number of doctors per 10,000 population; (4) the number of hospital beds per 10,000 population; and (5) the capacity to ensure treatment coverage across the population, which we measure through the antiretroviral therapy coverage among people living with HIV. The aggregated SC of a group of countries can rank high, medium or low based on how they score against these indicators, relative to the OECD average. We take the latter as the benchmark for high SC.

We define regional leadership (RL) as a relational concept that entails not only the material capacity to provide regional collective goods, but also the willingness to do so, as well as the capacity to articulate a persuasive idea of collective action that elicits the backing of neighbouring states.[28] As such, RL is present when a state (1) has the capacity to drive regional institution building and policymaking; (2) is willing to bear the costs of leadership, and (iii) has the following of other states. We adopt an issue-specific approach to RL, whereby RL can be exerted in a specific issue area without necessarily being projected in others. This means there can be multiple leaders in a given regional governance initiative.

The comparative case study method

This article employs comparative case study analysis to address the following question: What explains the variation in how states collectively deal with shared public health challenges across different world regions? Comparative, cross-regional studies of the logics of regional governance have focused on security[29] and economic integration.[30] Less attention has been devoted to explaining cross-regional variation in RHGMs. We conduct the first systematic comparison of regional health governance in Central and South America by focusing on the institutional design of SICA's COMISCA and UNASUR Health and their governance efforts in the area of access to medicines. An innovative comparison of this nature affords a prime opportunity to explain empirical variation in external actors' influence on regional health governance, which in turn allows for new insights to be generated on the determinants shaping RHGMs across the Global South.

Case selection responds to a most similar cases design, whereby the two cases take on similar values of relevant confounding variables, but different values of the two independent variables of interest (that is, SC and RL) during the periods under investigation (2001–20 for Central America and 2008–20 for South America). Both Central and South America have a dynamic history of regional cooperation, which accelerated in 1950s–1960s and led to the emergence of formal regional institutions that dealt with economic integration, as well as with a variety of other policy sectors, including, prominently, public health.[31] In 1956 the Central American states launched the Meeting of Health Ministers of Central America and Panama (REMCAP). Since then, Central American health authorities have continued to pursue regional health cooperation,

[26]Ibid., p. 10.

[27]The analysis of health bureaucracies' quality and institutional mandates' coherence would require an investigation of the multilevel interactions that take place within each state, which goes beyond the scope of this article.

[28]Flemes (ed.), *Regional Leadership*; Nolte, 'Regional powers'; Pedersen, 'Cooperative hegemony'.

[29]Emanuel Adler and Patricia Greve, 'When security community meets balance of power: Overlapping regional mechanisms of security governance', *Review of International Studies*, 35:1 (2009), pp. 59–84.

[30]Mattli, *The Logic of Regional Integration*.

[31]Paulo Buss and Sebastián Tobar, 'Health diplomacy in the political process of integration in Latin America and the Caribbean', *Oxford Research Encyclopedia of Global Public Health* (26 April 2018).

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which – starting from the 1990s – got embedded into the institutional framework of SICA. South American states have been cooperating in the field of public health since the 1970s in the sub-regional frameworks of the Hipólito Unanue Agreement on Health Cooperation between Andean Countries (CONHU) and the Amazon Cooperation Treaty. Throughout the 1980s, both regions experienced a democratisation process (which in Central America was accompanied by a peace process) that stimulated the emergence of new regional institutions – SICA, MERCOSUR, the Andean Community (CAN), and the Amazon Cooperation Treaty Organization – and the intensification of the regional social agenda, with an emphasis on health. In South America, the member states of MERCOSUR created the Meeting of Health Ministers and the Technical Sub-Group on Health, while the members of CAN inserted CONHU into the Andean Integration System, leading to the emergence of the Andean Health Body (ORAS-CONHU). In Central America, the member states of SICA established the Central American Social Integration System, which provided the legal framework for the emergence of multiple sectoral councils, including COMISCA.[32] As such, historical precedents of regional cooperation were present in the two cases under investigation.

The two regions take on similar values also of a key domestic variable for the study of foreign policy decisions: the ideology of presidents.[33] In fact, the ideological orientations of the heads of state in power in Central and South America during the periods under investigation were relatively heterogeneous in both regions. They ranged from left wing (for example, Hugo Chávez in Venezuela and Mauricio Funes in El Salvador) and left-of-centre (for example, Lula da Silva in Brazil and Álvaro Colom in Guatemala) to right wing (for example, Álvaro Uribe in Colombia and Antonio Saca in El Salvador) and right-of-centre (for example, Sebastián Piñera in Chile and Oscar Arias in Costa Rica).[34] Although South America was populated by multiple left-wing or left-of-centre presidents when the region's RHGM emerged between 2009 and 2011, there were some relevant exceptions to this trend (for example, Piñera in Chile and Uribe and Manuel Santos in Colombia). This shows how South American presidents' ideological orientations were far from being homogeneous even during the region's 'left turn'. If we take the data set provided by Federico Merke and Diego Reynoso, we can observe variation in the location of both Central and South American presidents in the analytical spectrums ideology driven versus pragmatic foreign policy, and South versus North geopolitical orientation.[35] This confirms that presidents' political orientations were relatively heterogenous in both regions. As a consequence, we posit that the comparison of Central and South America allows testing our hypothesis on the impact of SC and RL on RHGMs.

We investigate the mechanism through which the independent variables of interest that differ between the two cases affect their outcomes. In so doing, we show how the interplay of different configurations of SC and RL led to the emergence of different RHGMs in Central and South America.

Data

To generate the empirical evidence needed to prove the impact of SC and RL on RHGMs in Central and South America, we utilised a combination of qualitative and descriptive quantitative

[32] Alejandra C. Roa and José P. Santana, 'Regional integration and South-South cooperation in health in Latin America and the Caribbean', *Rev Panam Salud Publica*, 32:5 (2012), pp. 368–75.

[33] There is a wide consensus that much of the foreign policy of Central and South American states can be explained through the analysis of presidents' ideological orientations due to the fact that all those countries adopt a presidential system, with the exceptions of Guyana (semi-presidential) and Belize (parliamentary). See Federico Merke and Diego Reynoso, 'Latin America: Experts' perception of foreign policy dimensions', *Estudios Internacionales*, 48:185 (2016), pp. 107–30.

[34] A comprehensive ideological classification of Latin American heads of state can be found in Manuel Alcántara (ed.), *Proyecto Élites Latinoamericanas* (PELA-USAL). Universidad de Salamanca (1994–2018).

[35] Merke and Reynoso, 'Latin America', pp. 118–20.

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Table 1. Indicators of aggregated SC in the public health sector (2000–14).

	OECD area	Central America[38]	South America[39]
Domestic general government health expenditure per capita (in PPP international $)	**1941.93**	**274.53**	**376.45**
External health expenditure as a % of total current health expenditure	**0.08**	**4.18**	**2.58**
Number of doctors (per 10,000 population)	**29.1**	**12**	**16**
Number of hospital beds (per 10,000 population)	**52.6**	**11.6**	**20**
HIV Antiretroviral treatment coverage (%)	**47.4**	**17**	**21**

Source: Authors' own elaboration based on data from the OECD, PAHO, and WHO. (The entire dataset, including data disaggregated per country, is available in the online supplementary material.)

data. First, we conducted 15 semi-structured interviews with decision-makers and bureaucrats from the member states of SICA and UNASUR, as well as with external donors and regional experts from different Central and South American health institutions. The appendix lists the interviews. We selected interviewees by applying a positional sampling strategy, whereby individuals' direct participation in the initiatives under investigation determined their inclusion in the sample. Positional sampling ensures the reliability of the evidence generated through interviews.[36] We carried out our fieldwork in Brasilia, Buenos Aires, Rio de Janeiro, Quito, and San Salvador, between May 2011 and March 2020. When we were unable to conduct our interviews in person, we conducted online interviews. Second, we generated an original dataset on Central and South American countries' SC in the health sector, drawing from existing datasets elaborated by the WHO, the Pan-American Health Organisation (PAHO), and the OECD. (The complete dataset is available in the online supplementary material). Finally, secondary literature and official documents issued by national, regional, and multilateral institutions provided additional sources of empirical evidence that served the purpose of testing the reliability of the evidence gathered from primary sources. The adoption of such a triangulation strategy increases the credibility of findings.[37]

3. SC and RL in Central and South America: Exploring the determinants of RHGMs

In this section, we present the empirical evidence relating to SC and RL in the health sector in Central and South America.

SC in the public health sector in Central and South America

An asymmetry exists between Central and South American states in terms of the capacity to provide public health services to their populations, with the South American region displaying, on average, higher aggregated SC than Central America across the board (Table 1).

The Central American region has traditionally been characterised by state weakness, the pervasive involvement of external actors, and repeated attempts to pursue regional cooperation.[40] Multilateral agencies and external donors have substituted for Central American states' lack of economic and technical capacities to foster development and regulate their societies.[41] The health

[36] Oisín Tansey, 'Process tracing and elite interviewing: A case for non-probability sampling', *Political Science and Politics*, 40:4 (2007), pp. 765–72.

[37] Ibid.

[38] The Central American states comprise Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama, and the Dominican Republic.

[39] The South American states comprise Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Guyana, Paraguay, Peru, Suriname, Uruguay, and Venezuela.

[40] Olivier Dabène, *The Politics of Regional Integration in Latin America* (New York: Palgrave Macmillan, 2009).

[41] Martin Mowforth, *The Violence of Development: Resource Depletion, Environmental Crises and Human Rights Abuses in Central America* (New York: Pluto Press, 2014).

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sector is subject to this general trend. Central America remains below the OECD and South American averages in terms of both public health spending and infrastructural capacity to provide public health services. This explains why Central American states have relied heavily on the support of external actors, as evidenced by the large share of external resources within total health expenditures, which reaches 4.18 pe cent in Central America compared to 2.58 per cent in South America and 0.08 per cent in OECD countries. Weak public health spending has impinged on Central American states' human resources (for example, number of doctors), infrastructural capacities (for example, hospital beds), and ability to provide treatment coverage in the fight against deadly transmissible diseases like HIV (see Table 1). Data disaggregated by country show deep intra-regional asymmetries. In particular, Costa Rica and Panama have performed significantly better than the regional averages across all indicators. Costa Rica spent, on average, more than 6 per cent of its GDP on health, whereas Guatemala spent little more than 1 per cent. Likewise, in 2014 Costa Rica and Panama spent US $850 and US $907 on health per capita, respectively, whereas Honduras and Guatemala spent US $142 and US $166, respectively (see online supplementary material).

The limited resources of most Central American states have hampered the development of medicine production capacities and of the regional pharmaceutical market.[42] This has been exacerbated by the small size of Central American states' population and GDP, which inhibited the development of healthcare industries capable of sustaining an inward-oriented strategy in strategic fields like medicine production. Central America represents the seventh largest pharmaceutical market in Latin America, ranking behind Chile, and relies heavily on imports of medicines from extra-regional markets. The largest importers of the region are Costa Rica and Guatemala.[43] Furthermore, most of the pharmaceutical manufacturing infrastructures of Costa Rica and Panama – Central America's economic powerhouses – belong to multinational pharmaceutical laboratories like AstraZeneca, Bayer, and Roche. Costa Rica is the only Central American state with indigenous pharmaceutical companies (for example, Gutis and Speratum), whereas Panama has focused on becoming a hub for transnational healthcare companies rather than on developing medicine production capacities.[44]

South America is also marked by intra-regional asymmetries in the area of public health, with Bolivia, Guyana, and Suriname ranking considerably lower than the regional average across multiple indicators. This is particularly evident with regard to dependence on external resources – 5.63 per cent, 1.14 per cent and 4.58 per cent of total public health expenditure, respectively – and the number of doctors per 10,000 population: 5.75, 4.44, and 7.69, respectively. On the other hand, Argentina, Brazil, Chile, and Uruguay perform above the regional average across the board (see online supplementary material). In any case, South American states display, on average, higher levels of government health spending and a higher number of doctors and hospital beds than Central American states. This allows South American states to be less dependent on external aid, and to ensure higher treatment coverage for deadly transmissible diseases such as HIV, than their Central American counterparts (see Table 1).

A case in point is medicine production. Several South American states – above all, Argentina and Brazil[45] – developed the capacity to produce medicines through public and private

[42]José L. Valverde, 'Latin American pharmaceutical overview', *Pharmaceutical Policy and Laws*, 16 (2014), pp. 179–206.

[43]Central American Data, 'Pharmaceutical Products: Central American Market Figures', available at: {https://www.centralamericadata.com/en/article/home/Pharmaceutical_Products_Central_American_Market_Figures} accessed 20 October 2020.

[44]Chameleon Pharma Consulting, 'Unveiling the Promising Growth of Central America's OTC and Pharma Industry – Panama', available at: {https://www.chameleon-pharma.com/unveiling-the-promising-growth-of-central-americas-otc-and-pharma-industry/} accessed 20 October 2020; The Central American Group, 'Pharmaceutical Industry Overview, Costa Rica's story', available at: {https://www.thecentralamericangroup.com/pharmaceutical-manufacturing-costa-rica/} accessed 20 October 2020.

[45]Núria Homedes and Antonio Ugalde, 'Improving access to pharmaceuticals in Brazil and Argentina', *Health Policy and Planning*, 21:2 (2006), pp. 123–31.

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laboratories.[46] Argentina is a pioneer in the production of medicines in South America and counts 160 domestic enterprises and 210 laboratories that produce for the national market (accounting for 50 per cent of the domestic pharmaceutical market).[47] Brazil is the largest market for pharmaceuticals in Latin America (sixth in the world), and its capacity to produce drugs is unparalleled in the region, with 241 laboratories active in the country (60 per cent of them Brazilian-owned). This is the result of a systematic state effort to build up a domestic pharmaceutical industry, starting in the 1950s, when Brazil became a major exporter of antibiotics. This trend accelerated in the early 1990s when the Brazilian government invested heavily into Brazil's manufacturing capacity in order to tackle the HIV-AIDS epidemic and sustain the country's newly established universal healthcare system.[48] The administrations of Fernando Henrique Cardoso (1994–2002) and Lula da Silva (2002–10) further stimulated the production of generic medicines, which now account for one-third of Brazil's medicine market.[49] Two of Brazil's largest pharmaceutical laboratories are public: the Drug Technology Institute (Farmanguinhos) and the Immunobiological Technology Institute (Biomanguinhos), which every year manufacture several million doses of vaccines (for example, for yellow fever and polio), diagnostic tests (for example, for HIV and dengue fever), and pharmaceutical units (antiretrovirals plus medication for malaria, Chagas disease, hepatitis, and diabetes).[50] Both laboratories belong to the Oswaldo Cruz Foundation (FIOCRUZ), a public health agency that provides 40 per cent of the drugs purchased by the health ministry. This has allowed Brazil to gain bargaining power and technological autonomy *vis-à-vis* international laboratories.[51] Differently from Central America, the size of the population and the economy of some South American states – Brazil and Argentina, in particular – created a higher potential for inward-oriented strategies based on the development of endogenous medicine production capacities.

RL in Central and South America

The Central American region has traditionally lacked a regional leader, but not necessarily because of the lack of states endowed with superior material, ideational, and/or entrepreneurial capacities. Indeed, Costa Rica and Panama have displayed higher SC than their Central American neighbours, not only in the health sector, but across all the main indicators of socio-economic development.[52] Additionally, Costa Rica played a central role in the 1980s Central American peace process. However, both states have consistently eschewed regional leadership ambitions at the Central American level, privileging instead the global multilateral level. Panama has sought to establish itself as a 'global hub' – particularly in the fields of logistics, transport and finance – while refusing to play such a role for Central America. Following the same logic, in May 2020 Costa Rica launched the 'COVID-19 Technology Access Pool' (C-TAP)[53]

[46]Domestic production in Argentina, Brazil, Chile, Colombia, and Venezuela accounted respectively for 9.3, 42.5, 3, 4.3, and 14.6 per cent of those countries' total pharmaceutical markets in 2010. See Maruja N. Crisante, 'Mercado Farmacéutico y Acceso a Medicamentos en el Perú', available at: {https://www1.paho.org/per/images/stories/FtPage/2013/Mercado_farmaceutico-acceso_medicamentos-Peru.pdf} accessed 26 October 2020.

[47]CILFA, 'La Industria Farmacéutica Argentina: Su Carácter Estratégico y Perspectivas', available at: {http://cilfa.org.ar/wp1/wp-content/uploads/2018/10/Presentación-institucional-CILFA-2018-VF-ns.pdf} accessed 18 April 2020.

[48]Markus Fraundorfer, *Brazil's Emerging Role in Global Governance: Health, Food Security and Bioenergy* (London: Palgrave Macmillan, 2015).

[49]Fraundorfer, *Brazil's Role in Global Governance.*

[50]FIOCRUZ, 'Production and Innovation', available at: {http://portal.fiocruz.br/en/content/production-and-innovation} accessed 20 April 2020.

[51]Author's interviews with José Gomes Temporão.

[52]Victor Bulmer-Thomas, *The Political Economy of Central America since 1920* (Cambridge: Cambridge University Press, 2010).

[53]WHO, 'COVID-19 Technology Access Pool: Commitments to Share Knowledge, Intellectual Property and Data', available at: {https://www.who.int/emergencies/diseases/novel-coronavirus-2019/global-research-on-novel-coronavirus-2019-ncov/covid-19-technology-access-pool} accessed 30 January 2021.

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in partnership with the WHO. It is worth noting that Costa Rica never took similar leadership initiatives at the regional level, and that its global leadership bid via C-TAP did not meet with a general consensus among Central American states – Guatemala and Nicaragua declining back it. In sum, despite their superior material and entrepreneurial capacities, Costa Rica and Panama have never pursued RL in Central America. The RL vacuum in Central America has been filled by external actors such as the EU, and the cooperation agencies of countries such as Spain and the US.[54]

South America has had in Brazil a state with the capacity to exercise RL. Particularly since the end of the Cold War, Brazil has driven regional governance efforts by launching the idea of South America as an autonomous geopolitical region.[55] Health cooperation became a pillar of Brazil's RL under the Lula administrations, as evidenced by the substantial increase in the federal resources earmarked for regional cooperation projects, which went from 2.78 million reais in 2005 to 13.8 million in 2009.[56] The pivotal role of public health in Brazil's foreign policy did not start with Lula, but rather with Cardoso in the late 1990s, when Brazil displayed a remarkable activism in global health negotiations in support of the production of generic antiretroviral drugs.[57] Brazil's health diplomacy turned decisively to the region during the Lula administrations, which regarded health cooperation as instrumental in the consolidation of Brazil's RL in South America.[58] Under the leadership of Health Minister José Gomes Temporão (2007–10), Brazil exploited its diplomatic clout, economic power and superior capacity in the health sector to become the agenda setter of South America's health governance, and to promote its South-South health cooperation project at the regional level.[59]

Besides Brazil, the South American region has had in Argentina a secondary power with the capacity to exercise RL, particularly in the Southern Cone.[60] Despite declining clout, in the early 2000s the Argentine government (under the leadership of Health Minister Ginés González García) coordinated joint meetings of all South American health ministers, and drove the first joint purchases of medicines by South American states.[61] In so doing, Argentina showed its capacity to exercise RL at both the diplomatic and the technical level, particularly in the area of access to medicines.

4. The institutionalisation of RHGMs: Exploring the variations in the institutional design of COMISCA and UNASUR Health

In 2001 Central American governments formally created COMISCA, a regional institution devoted to public health cooperation, and inserted it within the institutional framework of SICA.[62] The establishment of COMISCA was a response to the severe public health crisis caused

[54]Olivier Dabène and Kevin Parthenay, 'Regionalism in Central America: An "all-in" strategy', in José Briceño-Ruiz and Isidoro Morales (eds), *Post-Hegemonic Regionalism in the Americas: Toward a Pacific-Atlantic Divide?* (London: Routledge, 2016), pp. 159–73.

[55]Sean W. Burges, 'Consensual hegemony: Theorizing Brazilian foreign policy after the Cold War', *International Relations*, 22:1 (2008), pp. 65–84; Tullio Vigevani and Gabriel Cepaluni, 'Lula's foreign policy and the quest for autonomy through diversification', *Third World Quarterly*, 28:7 (2007), pp. 1309–26.

[56]SAE/PR and IPEA, *Cooperação brasileira para o desenvolvimento internacional: 2005–2009* (Brasilia, 2010), p. 38, available at: {http://www.ipea.gov.br/portal/images/stories/PDFs/Book_Cooperao_Brasileira.pdf} accessed 18 April 2020.

[57]Fraundorfer, *Brazil's Role in Global Governance*.

[58]Deisy Ventura, 'Public health and Brazilian foreign policy', *SUR International Journal On Human Rights*, 10:19 (2013).

[59]Paulo Buss, 'Brazilian international cooperation in health in the era of SUS', *Ciência & Saúde coletiva*, 23:6 (2018), pp. 1881–90; Ventura, 'Public health'.

[60]Laura Gomez-Mera, *Power and Regionalism in Latin America: The Politics of MERCOSUR* (South Bend: University of Notre Dame Press, 2013).

[61]Author's interview with Sebastián Tobar.

[62]Although Central American states' health authorities continued to meet throughout the 1990s, COMISCA formally emerged only in March 2001, when the members of SICA approved COMISCA's internal regulations.

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by Hurricane Mitch in October 1998, which pushed Central American governments to intensify regional cooperation to consolidate national health systems.[63] External actors played a key role in the institutionalisation of COMISCA by providing external funding and technical assistance that compensated for the limited capacities of Central American states.[64] In so doing, external actors gained a central role in the design of COMISCA, and in the setting of the regional health agenda. South American states subsequently created UNASUR Health in December 2008, on the back of a Brazilian government proposal under Lula; this aimed to consolidate pre-existing health cooperation initiatives that had been pursued at the level of subregional ROs such as CAN, MERCOSUR, and the Amazon Cooperation Treaty Organization. To make this a reality, Brazil proposed the creation of a regional institution specifically devoted to public health governance within the newly created institutional framework of UNASUR.[65] COMISCA and UNASUR Health were both envisioned as strategic platforms for articulating regional governance responses to shared health challenges. However, the two bodies' institutional designs differed in terms of objectives, organisational structure, and sources of funding. Analysis of these differences allows us to uncover the variation in the RHGMs that have emerged in Central and South America.

The objectives of COMISCA and UNASUR Health

Analysis of the objectives enshrined in the constitutive treaties of these two regional bodies shows an interesting variation (Table 2). Central American governments designed COMISCA as a policymaking platform for redefining the priorities of regional health governance through the external support of international cooperation. On the other hand, South American governments designed UNASUR Health as a tool for reinforcing horizontal exchanges among member states and consolidating national health systems. As a result, UNASUR Health emerged as an inward-oriented institution focused on intra-regional cooperation, whereas COMISCA was designed as an outward-oriented governance platform focused on attracting resources from external actors.

The organisational structure of COMISCA and UNASUR Health

In 2007, the Central American health ministers agreed to create the Executive Secretariat of COMISCA (SE-COMISCA). SE-COMISCA is a permanent technical body in charge of facilitating the coordination and implementation of intergovernmental initiatives. SE-COMISCA has acted as the driver of Central America's health governance, providing policy inputs, participating in the implementation phase, facilitating coordination among member states' health authorities, and representing them at the hemispheric and global multilateral levels. COMISCA also comprises eleven technical commissions and two working groups composed of issue-specific experts from member states' health ministries, which deal with issues like obesity prevention, teenage pregnancy, the control of transmissible diseases, and access to medicines. COMISCA's technical commissions were created on the basis of a proposal formulated by SE-COMISCA, which acts as their technical coordinator.[66] SE-COMISCA thus exercises a tangible agenda-setting power, which results from member states' delegation of authority to it.[67]

[63]Parthenay and Dabène, 'Regionalism in Central America'.

[64]As pointed out by regional bureaucrats from SICA's institutions, external funds are often grabbed by member states to meet basic administrative needs at the domestic level (for example, computers and cars). Author's interviews with Ondina Castillo and with Omar Orozco.

[65]Paulo Buss and Sebastián Tobar, 'Health diplomacy'; Riggirozzi, 'Regionalism, activism'.

[66]Julio C. Valdés Díaz, Nelson Guzmán Mendoza, and Ligia Carmona Barrios, *Pensamiento regional en Salud 10 años de la Secretaría Ejecutiva del Consejo de Ministros de Salud de Centroamérica y República Dominicana* (El Salvador: COMISCA, 2017).

[67]Author's interviews with Pedro Caldentey del Pozo and Rolando Hernandez.

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UNASUR Health lacked a permanent executive secretariat with the characteristics of SE-COMISCA. In 2011 the member states created the South American Institute of Governance in Health (ISAGS), which acted as a consultative agency of UNASUR Health (see Table 2).[68] Member states occasionally delegated to ISAGS task-specific authority to carry out policy-oriented research and data gathering, yet they carefully avoided endowing it with agenda-setting power. ISAGS thus acted as a think tank at the service of member governments,[69] which were exclusively entitled to full ISAGS membership, while external actors could only apply for observer status. ISAGS was an outcome of the RL exercised by the Brazilian government, which envisioned it as a space for sharing knowledge, training officials, and establishing regional networks of national health institutions. The Lula administration's vision of regional health cooperation was predicated on the idea that South American states had to move away from vertical North-South cooperation in favour of horizontal exchanges of knowledge among national health authorities.[70] UNASUR Health also encompassed five technical groups and six structuring networks. The former were made up of experts from national health ministries, and developed cooperation initiatives in areas such as access to medicine, the social determinants of health, and health surveillance. The latter were formed by member states' specialised health institutions, and dealt with issues such as the fight against cancer and public health education. The networks were set up on the back of a proposal from Brazil's health ministry, which rested on the idea of building a structure for health cooperation that would stretch across member states' health authorities, as a tool for promoting endogenously-driven capacity building.[71]

Sources of funding for COMISCA and UNASUR Health

COMISCA – like all regional institutions in Central America – gets the bulk of its funding from external actors. Member states are expected to pay an annual quota of US $15,700, yet many have been delaying payments or missing them altogether, making SE-COMISCA heavily dependent on extra-regional funds. SE-COMISCA's 2016 Management Report shows that 90.74 per cent of its budget was financed by external actors, such as the cooperation agencies of Spain, Taiwan, and the US.[72] On the other hand, UNASUR Health did not count on an autonomous budget, but rather received project-specific funds from the UNASUR general budget, which was financed through national quotas. Consequently, South American states financed health cooperation activities by drawing on national budgets. ISAGS was UNASUR Health's only body to get regular funding (US $2.5 million annually) from the UNASUR budget. Yet ISAGS was created in a phase of institutional transition in which national quotas for financing UNASUR's budget had yet to be defined. Thus between 2011 and 2013, the Brazilian government fully financed ISAGS.[73] More broadly, the UNASUR General Regulations establish that contributions from third-party donors must be approved by UNASUR's political bodies by consensus.[74] This severely limited member states' capacity to attract external resources for financing specific cooperation projects developed within UNASUR's sectoral councils.[75]

[68]ISAGS was endowed with legal personality and headquartered in the city of Rio de Janeiro, where it operated on the basis of a Headquarters Agreement between UNASUR and the government of Brazil.

[69]ISAGS was run by a small group of experts selected by the UNASUR member states upon the proposal of ISAGS' director (who was also chosen by member states for a two-year mandate).

[70]Author's interviews with Mariana Faria and Felix Rigoli.

[71]Author's interviews with José Gomes Temporão and Henri Jouval. On the Brazilian concept of structuring health cooperation, see Paulo M. Buss, 'Structuring cooperation for health', *Lancet*, 377:9779 (2011), pp. 1722–3.

[72]SE-COMISCA, XLIV Reunión Ordinaria del COMISCA, Informe de Gestión Financiera (2016), available at: {https://www.sica.int/busqueda/Centro%20de%20Documentaci%C3%B3n.aspx?IDItem=111623&IdCat=12&IdEnt=143&Idm=1&IdmStyle=1} accessed 23 September 2020.

[73]Author's interview with José Gomes Temporão.

[74]UNASUR, Reglamento General de UNASUR (2012), Art. 52, available at: {http://www.itamaraty.gov.br/images/ed_integracao/docs_UNASUL/RES16.2012ANEXOI.pdf} accessed 20 April 2020.

[75]Author's interview with David Álvarez.

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Table 2. Variation in the institutional design of COMISCA and UNASUR Health.

	UNASUR Health	COMISCA
Objectives	(1) To strengthen the capacities of national health ministries to respond to health challenges; (2) to facilitate horizontal exchanges of knowledge among member states; (3) to advance in the harmonisation of national norms.[76]	(1) To identify and prioritise the region's health challenges in coordination with external actors (PAHO, donors); (2) to promote regional health initiatives through international cooperation funds to be channelled through SICA.[77]
Organisational structure	No permanent executive secretariat, only a consultative technical body (ISAGS). ISAGS's tasks: (1) identifying the needs of member states' health systems and supporting domestic capacity-building; (2) carrying out policy-oriented research; (3) disseminating scientific information on regional/global health; and (4) promoting shared UNASUR positions in global health negotiations.[78]	Permanent executive secretariat (SE-COMISCA). SE-COMISCA's tasks: (1) formulating COMISCA's cooperation agenda, taking into account member states' requests; (2) monitoring the implementation of COMISCA's resolutions and ensuring member states' compliance; (3) implementing regional rules in coordination with SICA's General Secretariat and external cooperation agencies; and (4) establishing partnerships with other international institutions involved in Central America's health sphere.[79]
Budget	No permanent regional budget (except ISAGS between 2013 and 2018) ⇒ activities financed individually by member states.	Permanent regional budget financed predominantly by external actors.

Source: Authors' own elaboration.

The comparative analysis of the institutional design of COMISCA and UNASUR Health reveals a significant variation in the involvement of external actors therein, and in the delegation of authority to technical regional institutions. We argue that such cross-regional variation is explained by the interplay of SC and RL in Central and South America. Central American countries' limited SC in the health sector interacted with the absence of a state willing to exercise RL in support of regional health governance. As a consequence, external actors drove the institution-building process, shaping COMISCA's design and paying for the bulk of its budget. This is particularly evident in the genesis of SE-COMISCA, which can be considered the product of external actors' pressure on Central American states to create a permanent technically-oriented body in charge of coordinating interstate cooperation and monitoring implementation, and capable of interfacing effectively with external donors.[80] On the other hand, the design of UNASUR Health was the result of the interaction between Brazil's RL and South American countries' SC in the health sector. The Brazilian administration of Lula pushed forward both materially (for example, financing the establishment of ISAGS) and ideationally its South-South cooperation project, whereby it was envisaged that horizontal cooperation between South American states would replace vertical North-South cooperation driven by external donors. This proposal interacted with the presence of other South American states endowed with relevant capacities in

[76]UNASUR, 'Decisión para el Establecimiento del Consejo de Salud Suramericano de la UNASUR', available at: {http://www.itamaraty.gov.br/images/ed_integracao/docs_UNASUL/DEC.2008.CSS.PDF} accessed 20 April 2020.

[77]COMISCA, 'Reglamento del Consejo de Ministros de Salud de Centroamérica', available at: {https://www.paho.org/resscad/index.php?option=com_docman&view=download&alias=24-reglamento-comisca-4&category_slug=comisca-665&Itemid=192} accessed 18 April 2020.

[78]UNASUR Health, 'Estatuto del Instituto Sudamericano de Gobierno en Salud', available at: {http://www.itamaraty.gov.br/images/ed_integracao/docs_UNASUL/DEC02.2012ANEXO.pdf} accessed 20 April 2020.

[79]COMISCA, 'Resolución de la Reunión extraordinaria del Consejo de Ministros de Salud de Centroamérica y República Dominicana', available at {https://www.sica.int/documentos/resolucion-de-la-reunion-extraordinaria-del-consejo-de-ministros-de-salud-de-centroamerica-y-republica-dominicana-san-salvador-el-salvador-10-de-septiembre-de-2007_1_106950.html} accessed 20 April 2020.

[80]Valdés, Guzmán, and Barrios, *Pensamiento regional*.

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specific areas of public health, such as Argentina in the field of access to medicines. This led to the establishment of a regional institution characterised by issue-specific platforms for intra-regional exchanges among national health bureaucracies. UNASUR Health remained largely insulated from external actors' influence, and firmly under the grip of member states' national executives, due to the strictly intergovernmental design of UNASUR.

5. RHGMs in action: The variations in COMISCA and UNASUR Health's governance efforts in the field of access to medicines

To grasp the differences between the RHGMs of Central and South America, we need to explore how regional governance works in practice within COMISCA and UNASUR Health. We do so by analysing the initiatives undertaken by two regional bodies in the field of access to medicines, which allows us to uncover the differences in the patterns of agency underlying health governance in the two regions.

The articulation of a regional pharmaceutical policy in Central America

Broadening access to medicines is one of the most daunting challenges faced by Central American states, which have traditionally displayed an insufficient capacity to acquire essential medicines due the high costs of local manufacturing and the high prices set by external providers.[81] In response to this situation, in December 2006 SICA's health ministers created the Technical Commission for Medicines (CTSM), bringing together specialists from the different member states. The CTSM became a platform for the coordination of an interstate joint negotiation strategy for the purchase of medicines (the so-called 'Joint Negotiation COMISCA'), whose aim is to obtain lower prices from international laboratories.

In 2008 the CTSM held a first negotiation round, which resulted in the definition of a list of medicines for which member states negotiated a harmonised price. The prime movers behind the initiative were three external actors: PAHO, AECID, and the Inter-American Development Bank (IADB). PAHO provided financial and technical resources that facilitated regional coordination within the CTSM. A representative of PAHO was granted permanent membership status within the CTSM, alongside that of member state officials. AECID provided external funding in support of the joint negotiation initiative, which was channelled through PAHO (using the Spain-PAHO Cooperation Fund) and SE-COMISCA (through the Spain-SICA Cooperation Fund). In particular, AECID funded the development of the software used by SE-COMISCA for prequalification and negotiation, and the organisation of workshops aimed at strengthening member states' capacity to assess and regulate medicine provision according to international best practice. The IADB provided financial and logistical support in the operational phase.[82] The articulation of Central America's pharmaceutical policy was thus the outcome of a triangulation strategy carried out by three external actors in collaboration with SE-COMISCA (Table 3).

Between 2009 and 2019, the COMISCA member states held ten joint negotiations, which made significant progress in terms of access to medicines in Central America – lowering prices, rationalising regional purchases, and improving medicinal quality. The joint negotiations allowed Central American states to pay between 25 and 30 per cent less for a list of 68 medicines – and for some drugs up to 600 per cent less – generating regional savings of US $61 billion over the period

[81]COMISCA, 'Health Plan for Central America and the Dominican Republic 2010' (2015), available at: {https://www.paho.org/blz/index.php?option=com_docman&view=download&alias=66-health-plan-for-central-america-and-the-dominican-republic-2010-2015&Itemid=250} accessed 6 November 2020.

[82]COMISCA, 'Informe Comisión Técnica Subregional de Medicamentos', available at: {https://www.sica.int/documentos/2-ctsm-xxxiv-comisca-junio-2011_1_60652.html} accessed 10 April 2020.

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Table 3. External support to Central America's regional pharmaceutical policy.

	Instrument	Financial support (US$)
AECID	Spain-SICA Fund	691,000 (2006–09)[83] 627,976 (2010–13)[84]
IADB	Regional Protocol for Joint Procurement of Medicines in Central America (RG-T1272)	1,057,600 (2007–12)[85]
PAHO	Regional Revolving Fund for Strategic Public Health Supplies	Technical support

Source: Authors' own elaboration.

2009–16.[86] COMISCA's joint negotiations have also helped to align Central American states with higher international standards, improving the quality of medicines circulating in the region. This was illustrated by the 2017 decision of the International Organization for Standardization to award COMISCA's joint procurement mechanism the ISO 9001:2015 Quality Management System standard. The improvement in purchasing procedures has benefited a wider public at the domestic level, especially those who cannot afford private health services. Indeed, the medicines procured through joint negotiation are not for sale in pharmacies, but distributed through public health institutions. At the same time, the joint negotiations have proven attractive for pharmaceutical companies, which benefit from a higher predictability of sales and stronger guarantees on purchasing commitments from Central American governments.

Central American states have sought to further institutionalise and extend the scope of COMISCA's joint procurement mechanism. In 2017 health ministers decided to devote 0.5 per cent (increased to 2 per cent in 2019) of the regional savings accumulated between 2009 and 2017 to financing the joint negotiation process.[87] Furthermore, Central American governments reached an agreement to extend the negotiations' scope to medical devices and other sanitary products. Finally, in COMISCA's last round of joint negotiation in June 2019, member states agreed upon a list of pharmaceutical companies to invite to the table, and added ten new medicines to the collective purchase list.[88] Overall, according to SICA's General Secretary, COMISCA's joint procurement mechanism saved Central American states US $11.9 million in 2019.[89]

In sum, COMISCA's joint negotiation has become a success story. The initiative confirms the relevance of external actors (Spain's AECID, PAHO, and IADB) in Central America's RHGM. External actors drove COMISCA's joint negotiations by providing funding and expertise that helped Central American states build up their capacity to broaden access to essential medicines. This contributed to the provision of a regional collective good in the health sector. Interestingly, the case of COMISCA's joint procurement mechanism also reveals the key facilitating role of SICA's technical regional bureaucracy in Central America's health governance-making.

[83]Fondo España-SICA, 'Memoria de Labores 2006–2009', available at: {https://www.sica.int/documentos/memoria-de-labores-2006-2009_1_58793.html} accessed 10 March 2020.

[84]Fondo España-SICA, 'Evaluaciones del Fondo España-SICA 2010-2013', available at: {https://documentop.com/queue/informe-final-evaluacion-rev-19-11-cooperacion-espaola_598439f51723ddb404626f82.html} accessed 10 March 2020.

[85]IDB, 'RG-T1272: Central American Protocol for Procurement and Quality Control of Medicines', available at: {https://www.iadb.org/en/project/RG-T1272} accessed 18 April 2020.

[86]María Campos de Murillo, 'Negociación conjunta de precios y compra de medicamentos para Centroamérica y República Dominicana – Una mirada desde la perspectiva de salud internacional', SE-COMISCA (2016), available at: {https://www.paho.org/els/index.php?option=com_docman&view=download&alias=1733-negociacion-conjunta-comisca-plsi-final&Itemid=292} accessed 20 April 2020;

[87]During the XLVII Ordinary Meeting of COMISCA (held on 5 December 2017), member states approved a regulation on the self-sustainability of the Joint Negotiation Mechanism.

[88]COMISCA, 'Acta adjudicación Ev 02-2019', available at: {https://www.sica.int/noticias/se-comisca-informa-resultados-del-evento-de-negociacion-conjunta-de-precios-de-medicamentos-2-2019_1_118331.html} accessed 18 April 2020.

[89]{https://twitter.com/sg_sica/status/1276570767757651973} accessed 26 October 2020.

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SE-COMISCA helped member states work together to identify a shared list of priority medicines and bring international laboratories on board.[90] We posit that the *exogenously-driven* RHGM underpinning Central America's pharmaceutical policy resulted from the interplay of Central American countries' weak SC in the field of access to medicines, and the lack of RL in that area. This opened a policy space for external actors to contribute to the provision of governance resources, in collaboration with a technically-oriented regional institution (SE-COMISCA), thus pushing Central American states towards a coordinated response to a shared public health challenge.

Regional coordination in the field of access to medicines within UNASUR Health

South America is marked by significant asymmetries in states' capacity to access essential medicines, which are conditioned by economic issues such as market size and GDP per capita. To address this challenge, South American states developed three regional initiatives within the scope of UNASUR Health's Technical Group for Universal Access to Medicines (GAUMU): (1) mapping the differences in prices paid by member states for essential medicines imported from outside the region; (2) mapping member states' capacity to produce medicines; and (3) the coordination of shared positions in the WHO Assembly. The first two projects aimed at providing policy-oriented information that could be used to define price-negotiation strategies *vis-à-vis* international laboratories, and at constituting a regional production network for generic drugs. The leading actors behind the two initiatives were the health ministries of Argentina and Brazil, which shared a strategic interest in the development of a regional market for the production and commercialisation of generic drugs.[91] Since the 1990s, the Brazilian state has developed a medicine production capacity that is strong by the standards of the region – part of the country's autonomy-oriented development strategy.[92] Under Health Minister Gomes Temporão, the Brazilian government invested heavily in strengthening public laboratories' production capacities, with the objective of achieving technological autonomy.[93] Within UNASUR Health, Minister Temporão promoted the idea of a 'regional health industrial complex', seeking to socialise the other South American states into the strategic relevance of increasing the region's autonomy in medicines production. Brazil's proposal received the active support of Argentina's health ministry. Since the early 2000s, Argentina had displayed a strong interest in regional coordination, as well as remarkable leadership capacity, in the field of access to medicines.[94] This drove the first joint medicine procurement effort conducted by South American states in 2003.[95] Argentina continued to exercise RL in the area of access to medicines within UNASUR Health, taking on the coordination of GAUMU and pushing forward two cooperation projects: the price database and the mapping of medicine production capacities. The two proposals interacted positively with South American governments' growing interest in widening access to essential medicines, leading South American health ministers to finance the projects in 2013. The other actors involved in the initiatives were ISAGS and UNASUR's General Secretariat. Member states selected ISAGS as the projects' technical administrator, to which they delegated administrative and executive tasks.

[90]Campos de Murillo, 'Negociación conjunta'.

[91]Author's interviews with Tomás Pippo, Sebastian Tobar, and José Temporão.

[92]Author's interview with Celso Amorim.

[93]Author's interview with José Temporão.

[94]Author's interview with Oscar Feo.

[95]The 2003 CAN-MERCOSUR joint negotiation involved representatives of pharmaceutical laboratories producing generic and patented antiretrovirals (for example, Bayer, Glaxo Smith, Roche, etc.), resulting in a reduction of the cost of antiretroviral therapy between 30 and 93 per cent depending on the country. See ORAS-CONHU, 'Un Ejemplo de Integración Exitosa: Proceso de negociación conjunta para el acceso a medicamentos antirretrovirales en la Subregión Andina, Argentina, México, Paraguay y Uruguay', Organismo Andino de Salud (2003), pp. 30–1, available at: {http://www.oras-conhu.org/documentos/medica_antirre.pdf} accessed 10 April 2020.

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UNASUR's General Secretariat signed an agreement with ISAGS for the disbursement of US $300,000 to finance the implementation of the price database and the mapping of production capacities.

The UNASUR price database project started in 2014 with the negotiation of a list of essential medicines for price mapping. The negotiation was coordinated by Argentina with ISAGS's support.[96] In 2015, Brazil's health ministry shared with the other South American states the software it had developed for creating its national price database. In December 2016, member states launched a new software application designed to collect and systematise data on medicine prices in the region, based on the Brazilian software. In 2017, member states agreed on a list of 34 medicines to subject to price monitoring for one year. Drawing on the information gathered, ISAGS conducted a preliminary study that detected significant asymmetries in the prices paid by different member states. According to the study, South American states could save US $1 billion per year by collectively negotiating with international laboratories on the basis of the lower prices recorded for each of the prioritised medicines.[97] However, after a promising start, the price bank project suffered a sudden setback caused by the severe political and institutional crisis that hit UNASUR in 2018,[98] which led to the paralysis of all cooperation activities within UNASUR Health.

The second project was the mapping of production capacities of medicines in South America. The project's long-term objective was to increase South American states' autonomy from multinational economic actors by stimulating the emergence of a regional network of medicine production based on Argentina and Brazil's productive capacities.[99] In 2018 ISAGS started to coordinate the mapping of member states' public and private production capacities, which was expected to provide inputs for the coordination of a regional medicine production strategy. However, as in the case of the mapping of medicine prices, the project experienced a sudden paralysis caused by UNASUR's institutional breakdown.

The third regional governance initiative pursued by South American states within GAUMU concerned the coordination of a set of common positions at the WHO Assembly in the domain of access to medicines.[100] In particular, between 2010 and 2014, the UNASUR member states articulated eight joint positions relating to issues such as the impact of intellectual property rights on states' access to medicines, the production of generic (particularly biogeneric) medicines, research and development on 'neglected diseases', and the setting of standards against counterfeiting.[101] Several of the joint UNASUR initiatives succeeded in eliciting a revision of existing global regulations and standards, shifting the focus from intellectual property considerations to sanitary ones – particularly the need to ensure broader access to essential medicines in developing countries.[102] The prime movers behind UNASUR's health diplomacy were, once more, the health ministries of Argentina and, to a lesser extent, Brazil.[103] They used GAUMU to socialise the other member states into their global health agenda relating to access to medicines. Argentina exercised a firm leadership within GAUMU, exploiting its capacities in the production of generic medicines and the coordination of regional price negotiations to drive the promotion of joint UNASUR

[96]Author's interview with Tomás Pippo.

[97]ISAGS, 'Compra Pública de Medicamentos en los Países de UNASUR', available at: {https://www.academia.edu/36322422/COMPRA_PÚBLICA_DE_MEDICAMENTOS_EN_LOS_PAÍSES_DE_UNASUR} accessed 10 March 2020.

[98]Bianculli et al., 'Institutional overlap'.

[99]Author's interviews with Tomás Pippo and José Gomes Temporão.

[100]Herrero and Tussie, 'UNASUR Health'; Riggirozzi, 'Regionalism, activism'.

[101]For a detailed analysis of UNASUR's joint positions, see Andrea Ribeiro Hoffmann and Jana Tabak, 'Discussing global health and access to medicines in the UN system: the case of the Union of South American Nations (UNASUR)', in Karen Smith and Katie Laatikainen (eds), *Group Politics in UN Multilateralism* (Leiden: Brill, 2020), pp. 219–40.

[102]Riggirozzi, 'Regionalism, activism'.

[103]Brazil pursued its own global health diplomacy, which extended beyond South America to include South-South cooperation with African and Asian countries. See Fraundorfer, *Brazil's Role in Global Governance*.

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positions in the WHO. Argentina's RL was a consequence of its national interest in overcoming the limitations posed by intellectual property rights to the production of and access to essential medicines, which was actively supported by the governments of Bolivia, Ecuador and Colombia.[104] But once again, South American states' health governance efforts suffered a setback due to the breakdown of UNASUR, which led to the dismantling of GAUMU and the abandonment of regionally coordinated health diplomacy initiatives in the WHO.

In sum, within UNASUR Health, South American states pursued three governance initiatives that led to the adoption of shared methodologies for the harmonisation of national data on medicine prices and production capacity, and to the coordination of joint positions in global health negotiations. Differently from the Central American case, external actors did not play any relevant role in the initiatives, which were designed, financed, and implemented by member states under the RL of Argentina and Brazil, and with ISAGS's technical support. Argentina and Brazil's RL interacted with the existence of SC for medicine production in other South America states: Chile, Colombia, and – before the economic crisis – Venezuela. This resulted in an *endogenously-driven* RHGM in the field of access to medicines. However, the strictly intergovernmental dynamic underlying South America's RHGM made it vulnerable to intergovernmental conflicts, which led to the breakdown of UNASUR and the subsequent paralysis of regional health governance efforts.

Conclusions

This article investigated the variation in the RHGMs of Central and South America. We compared the institutional design and policymaking of COMISCA and UNASUR Health in order to identify the drivers of health governance in the two regions, focusing particularly on the issue of access to medicines. The empirical evidence shows that Central America's health governance has been driven by external actors that provided funding, gave technical assistance that consolidated COMISCA's institutional design (equipping it with a permanent executive secretariat), and influenced its policymaking. Central America's *exogenously-driven* RHGM delivered significant results in the area of access to medicines, producing a joint procurement mechanism that allowed Central American states to increase their access to essential medicines for chronic diseases such as HIV, diabetes, and cancer. External state (AECID) and non-state (IADB and PAHO) actors drove the initiative, financing the development of COMISCA's joint negotiation platform through the regional channel of SE-COMISCA, which sustained interstate coordination and provided technical assistance.

On the other hand, the paper shows that South American governments constructed a RHGM based on intra-regional exchanges among national health authorities, insulated from external actors' influence. South America's *endogenously-driven* RHGM was led by the health ministries of Brazil and Argentina, which drove regional institution building and policymaking. Through UNASUR Health, South American states conducted an innovative mapping of medicine prices and production capacity in the region, with the objective of facilitating joint procurements and the establishment of a regional production network. After a promising start, both projects suffered a setback due to UNASUR's institutional breakdown in 2018, which led to the paralysis of the governance activities pursued within UNASUR Health, and to the dismantling of ISAGS. Likewise, the disintegration of UNASUR caused the disarticulation of South American states' regional coordination efforts at the global WHO level.

We showed that the variation in the RHGMs of Central and South America is explained by the interplay of SC and RL in the two regions. Central American states have traditionally suffered from weak SC in the health sector, which affected their ability to deal with public health challenges. Despite the existence of intra-regional asymmetries – Costa Rica and Panama rank

[104]Author's interview with Tomás Pippo.

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significantly higher than their neighbours across all health indicators – no Central American state was willing to exercise RL in support of health governance. As a consequence, Central American governments sought the help of external actors, who invested in strengthening regional health institutions and interstate policy coordination. External actors enlisted a regional technical body, SE-COMISCA, to help them coordinate Central America's health governance, particularly in the area of access to medicines.

On the other hand, South America's RHGM resulted from the interaction between the RL of Brazil and Argentina and the presence of several South American states endowed with relevant SC in the public health sector. The Brazilian administration of Lula drove the institution-building process, promoting the establishment of UNASUR Health's structuring networks and financing the creation of ISAGS, and pushed forward an intergovernmental South-South cooperation agenda that mobilised the SC of other South American countries. Argentina drove both politically and technically the elaboration of a regional policy on access to medicines, which built on Argentina and Brazil's medicine production capacities. Furthermore, Argentina persuaded its neighbours to join its effort to promote changes in global health regulations regarding access to medicines, leading the coordination of a set of joint UNASUR positions within the WHO.

Interestingly, South America's *endogenously-driven* RHGM proved vulnerable to the breakout of intergovernmental conflicts, such as those triggered by the Venezuelan crisis, which led to the institutional breakdown of UNASUR. In response to UNASUR's paralysis, nine member states including Brazil withdrew from the RO, prompting the disintegration not only of UNASUR, but also of South America's regional health governance architecture. Concretely, the disintegration of UNASUR resulted in the dismantling of UNASUR Health and ISAGS, which were subordinated to and dependent on the political decision-making bodies of UNASUR. The intergovernmental logic underlying South America's RHGM thus made it vulnerable to the traditional weakness of South American regionalism: states' persistent reluctance to delegate authority to technical regional institutions, which makes governance efforts dependent on unstable intergovernmental dynamics.[105]

The dismantling of the regional institutions underpinning South America's RHGM has severely hindered South American states' ability to develop a coordinated strategy for containing the spread of the COVID-19 virus in the region. UNASUR's breakdown precipitated sub-regional fragmentation, pushing South American states to try to address COVID-19 within existing ROs like CAN and MERCOSUR. However, these efforts have fallen short of South America's need for common strategies in relation to quarantine protocols, the deployment of testing and tracing technologies, and the joint purchase of essential medicines (for example, vaccines) and medical equipment. South America's situation stands in contrast to how Central American states have responded to COVID-19. With the support of SICA's General Secretariat and the Coordination Centre for Disaster Prevention in Central America and the Dominican Republic (CEPREDENAC), Central American states have developed a regional contingency plan against COVID-19[106] based on the data generated by SICA's COVID-19 Information and Coordination Platform,[107] and with the financial backing of the Central American Bank for Economic Integration (CABEI). CABEI also provided a specific credit line (worth US $50 million) to each member state for the purchase of vaccines against COVID-19. The responsiveness of Central America's RHGM confirms the importance of regional institutions – technically

[105]Andrés Malamud, 'Latin American regionalism and EU studies', *Journal of European Integration*, 32:6 (2010), pp. 637–57.

[106]UNDRR Regional Office for the Americas and the Caribbean, 'Central America Allied against the Coronavirus COVID-19', available at: {https://www.undrr.org/publication/central-america-allied-against-coronavirus-covid-19} accessed 10 March 2020.

[107]CEPREDENAC, 'Plataforma de Información y Coordinación SICA COVID-19', available at: {https://plataformaregional.cepredenac.org/portal/apps/webappviewer/index.html?id=ebfc9c26673b44f6a9ca5a8e215b90fd} accessed 10 March 2020.

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oriented ones in particular – for the coordination of shared responses to severe transnational health challenges.

From a theoretical point of view, the article contributes to comparative regionalism by shedding light on the impact of SC and RL on regional health governance structures and processes. The generalisation scope of our findings is limited to Latin America. That said, we posit that the theoretical framework developed in this article could be used for investigating the determinants of RHGMs in other world regions. Additionally, the article contributes to the literature on global health governance by providing an in-depth comparative analysis of the drivers, modes, and effects of health governance in two regions, which complements the literature's traditional focus on global health institutions and dynamics. More specifically, the article illuminated the driving role of external actors (state and non-state) in the articulation of regional governance responses to transnational health challenges in the Global South. Furthermore, through the comparison of the RHGMs of Central and South America, the article highlighted the limits of purely intergovernmental governance arrangements, like UNASUR, whose vulnerability to domestic political changes and intergovernmental conflicts can jeopardise the sustainability of regional health governance. On the other hand, the case of SICA-COMISCA in Central America shows how the proactive involvement of external actors, coupled with the establishment of regional technically-oriented institutions, increases the effectiveness and sustainability of health governance efforts, particularly in world regions marked by limited state capacity.

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Supplementary material. To view the online supplementary material, please visit: https://doi.org/10.1017/S0260210521000206

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Appendix

List of interviews

Name	Position	Nationality	Date	Place
Álvarez Veloso, David	Director of Citizen Security and Justice, UNASUR's General Secretariat	Chile	8 May 2017	Quito
Amorim, Celso	Foreign Affairs Minister of Brazil (2003–10)	Brazil	7 April 2015	Rio de Janeiro
Caldentey del Pozo, Pedro	Principal Adviser, Fund Spain-SICA	Spain	11 May 2011	San Salvador
Castillo, Ondina	Planning Director, SICA's Secretariat for Social Integration	El Salvador	12 May 2011	San Salvador
Faria, Mariana	Head of the Political and Strategic Office of ISAGS	Brazil	30 March 2015	Rio de Janeiro
Feo, Oscar Feo	Executive Secretary of ORAS-CONHU (2006–10)	Venezuela	14 June 2015	Skype
Gomes Temporão, José	Director of ISAGS (2011–2016); Minister of Health of Brazil (2007–10)	Brazil	2 April 2015	Rio de Janeiro
Hernandez, Rolando	COMISCA's Executive Secretary	El Salvador	16 May 2011	San Salvador
Jouval, Henri	Technical Coordinator of ISAGS	Brazil	30 March 2015	Rio de Janeiro
Mata Amaya, Estéfany	Strategic Analysis Coordinator, SICA's General Secretariat	El Salvador	24 March 2020	Email
Orozco, Omar	International Cooperation Director, SICA's General Secretariat	El Salvador	20 May 2011	San Salvador
Pippo, Tomás	Coordinator of UNASUR Health' GAUMU; Director of the Department of Health Economics, Ministry of Health (Argentina)	Argentina	27 March 2015	Buenos Aires
Recinos, José Angel	Technical Consultant, COMISCA's Executive Secretariat	El Salvador	20 January 2019	San Salvador
Rigoli, Felix	Regional Advisor, PAHO-Brazil	Uruguay	15 April 2015	Brasilia
Tobar, Sebastián	Director of the International Relations Department, Ministry of Health (Argentina)	Argentina	17 March 2015	Buenos Aires

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