

Latin American and Caribbean Regional Organizations Facing the COVID-19 Pandemic

Karina Mariano*

Regiane Bressan**

Guilherme Ferreira***

Abstract: The aim of this article is to analyse the responses of Latin American and Caribbean regional organisations to the pandemic caused by COVID-19 through a comparative analysis between the policies adopted by Mercosur, the Andean Community, and CARICOM. We have mapped the discussions, initiatives, and policies adopted by these regional organisations in order to understand the main elements that determined the adoption of regional co-ordination in the strategies to face the pandemic's effects. We argue that those organisations which had specific institutional channels dedicated to dealing with health issues and had already faced other health crises have had less difficulty in coordinating their member states' actions and adopting regional policies. Moreover, it can be affirmed that the level of economic interdependence and political convergence between member state governments played a significant role. Thus, this article seeks to contribute to a broader understanding of the current state of health co-operation in Latin American and Caribbean regional organisations, as well as to add to the discussion about its potential in coordinating and promoting regional health policies.

Keywords: regionalism; Latin America and Caribbean; pandemic; Mercosur; Andean Community; CARICOM.

Introduction

This article presents a comparative analysis of the performance of regional organisations in Latin America and the Caribbean in fighting the COVID-19 pandemic. By means of a comparative analysis between the Southern Common Market (Mercosur), the Andean

* São Paulo State University (UNESP), São Paulo-SP, Brazil. karina.mariano@unesp.br. ORCID 0000-0002-4559-918x

** Federal University of São Paulo (UNIFESP), São Paulo - SP, Brazil. regiane.bressan@unifesp.br. ORCID 0000-0002-7101-793X

*** Federal University of São Paulo (UNIFESP), São Paulo - SP, Brazil. guilhermegferreira@outlook.com. ORCID 0000-0003-3732-5661

Community (CAN) and the Caribbean Community (CARICOM), we seek to understand what were the determining elements for the co-ordination and/or adoption of regionalized strategies to fight the pandemic. These cases were chosen because they possess specific institutional structures to deal with health issues, making it possible to evaluate whether they were sufficient to construct regional responses to the COVID-19 pandemic. Although the Pan American Health Organization seems to be an obvious choice for the analysis, we discarded it as a case study since we are not focusing on co-operation organisations with an explicit and limited mandate for health issues. Other regional processes were not considered since they do not have institutional structures to deal specifically with health issues.

Considered a singular period in the history of contemporary international relations, the years 2020 and 2021 have been the stage for one of the most unique events of the present century. The global pandemic caused by a novel coronavirus (SARS-CoV-2), also known as COVID-19, has affected different spheres of society and strongly impacted the relations between countries. On 30 January 2020 the World Health Organization (WHO) declared a global emergency, insisting that efforts and attention from public authorities, states, world leaders, international institutions, and civil society organisations, be directed to the global health agenda. From the beginning, it was clear that confronting the COVID-19 pandemic and its consequences in the economic, social, and political spheres would require international co-operation.

The new context posed challenges and required quick responses, both in terms of health care and in combating impoverishment resulting from the social and economic fallout of the pandemic. In Latin America and the Caribbean this situation was aggravated by the well-known inequality and fragility of social protection and safety nets. This scenario represented, and still does represent, a challenge for the different mechanisms of co-operation and regional governance, which, in their varied political compositions and institutional formats, have faced a substantial increase in pressure and demands for action in the face of a problem that, by its very nature, does not stop at national borders.

Against this background, in order to understand the status of co-operation in health in regional organisations in Latin America and the Caribbean, we have mapped the discussions, initiatives and policies adopted within the scope of Mercosur, CAN and CARICOM. It was found that, as expected, regional organisations which had specific institutional channels dedicated to dealing with health issues and had already faced other health crises experienced less difficulty in coordinating the actions of their member states and in coming up with regional policies.

In addition to this introduction, the article is organised into three parts. The first contains a brief discussion on how the topic of health fits into the regionalism agenda in general, and the second part specifies how this unfolded in the Latin American and Caribbean cases during the pandemic. The conclusions are developed in the last part.

Regionalism and health

The recognition of health as a sector that requires international co-ordination has been present since the first discussions on public health strategies. As Fidler (2001) has pointed out, long before the very idea of globalisation, there were already important efforts towards the construction of co-operation and co-ordination strategies between different political communities to face health problems. In the 19th century, these initiatives gained the modern character of co-operation between states, with the International Health Convention of 1892 as an important initial milestone (Fidler 2001).

In contemporary times, studies dedicated to thinking about health as an international theme gave rise to the area of Global Health Governance, as shown by the works of Thomas (1989), McInnes and Lee (2012), and others. However, as pointed out by Agostinis and Parthenay (2021), such studies have been mostly dedicated to the work of international organisations with an explicit mandate for health issues, such as the World Health Organization (WHO), and transnational non-governmental organisations linked to the sector. At the same time, studies of Regionalism have historically paid little attention to the non-commercial dimensions of regional integration processes, given the predominance of concerns over the realisation of international economic integration. As a result, the role of regional organisations in the management of transnational health issues has been neglected.

In this sense, it is important to recognize the contributions of Bianculli and Hoffmann (2016), Nikogosian (2020), Greer et al. (2021), among others, in order to bring the studies of Global Health Governance closer to Regionalism. After all, there is a growing tendency in the negotiation agendas of regional organisations towards the inclusion of non-traditional themes. In Latin America, for example, contemporary studies, such as the contributions made by Riggirozzi and Tussie (2012), have sought to expand the analyses by adding the social dimension and the formulation of public policies pursued by the regional co-operation and integration agendas.

In the case of health policies, the COVID-19 pandemic has intensified such discussions, as it opened the intrinsic and multisectoral relationships between the traditional economic-commercial agenda, whose regulations and disciplines directly affect public health policies, and issues related to public health. However, the limitations imposed by theoretical models and the absence of robust empirical studies remain. After all, both traditional theories in the area, such as Neofunctionalism (Niemann and Schmitter 2009) and Liberal Intergovernmentalism (Moravcsik and Schimmelfennig 2009), as well as contemporary studies in the context of Comparative Regionalism (Börzel and Risse 2016), touched little on the subject of public health.

In an initial theoretical effort, Nikogosian (2020) proposes two aspects to understand the treatment given to the topic of health by regional organisations. On the one hand, he claims that it is necessary to identify how the health agenda is handled at the institutional level. This means verifying whether: i) there is an implicit or explicit reference to the promotion of health policies in the foundational treaties of regional organisations; ii) health objectives are included in the agendas and goals announced by organisations; iii) there are

regional and/or supranational health agencies or intergovernmental working groups dedicated to the technical discussion of this issue; and/or iv) the health theme is inserted in the activities of a certain regional organization only as an accessory agenda to trade issues (e.g., health regulations for trade). For the author, based on these findings, it is possible to understand whether a given organization has the potential to produce and implement regional health policies, to promote co-operation between member states and/or to co-ordinate the interactions between its member states and international health actors like the WHO and global players in the pharmaceutical industry.

Greer et al. (2021) initially argue that there are ‘three facets’ of action by regional organisations in the health issue from which it is possible to discuss the capacity of a regional organization to facilitate the development and/or implementation of health policies in its member states. The first facet concerns the explicit health actions implemented by regional organisations that hold some level of supranational authority, as provided for in their respective treaties. The second facet includes health actions that are implemented as an extension of economic and trade policies, such as health regulations and the health products market, sectors in which regional organisations traditionally have greater authority and pre-eminence. Finally, the third facet comprises the indirect impacts of fiscal and financial governance on the capacity of states to implement health policies.

In their conclusions, Greer et al. (2021) defend the need to consider, in addition to the three facets described above, that regional organisations can also partake in building collective action strategies of member states, which is particularly important for strengthening the bargaining power of countries with less relative power *vis-à-vis* the international complex of pharmaceutical industries. Moreover, they can co-ordinate the sharing and redistribution of resources (information, financial, material, human, etc.) among member states, both those from a country with greater relative capacity, and through co-operation with actors outside the regional organization.

Nikogosian (2020) and Greer et al. (2021) have offered comprehensive elements for understanding the role of regional organisations in health issues from a perspective linked to the institutional characteristics of each organization. However, they do not discuss which are the decisive power structures that may enable a regional organization to act.

From this perspective, Agostinis and Parthenay (2021) seek to understand the variation in the institutional design of regional organisations and their capacity to implement regional policies based on the characteristics of the member states and regional leadership. They argue that, on the one hand, regional organisations made up of states with greater material capacities in which there is leadership capable of mobilising and bearing the costs of co-operation tend to produce more robust and autonomous regional responses (called ‘endogenously-driven governance’). On the other hand, in regional organisations whose member states have low material capacities and no state with the political will or material capacity to lead the co-operation process, regional responses are subject to the existence of an external actor with the capacity to exert political influence and provide financial and technological resources (called ‘exogenously-driven governance’).

Furthermore, we consider it essential to understand whether there is a history of action in similar health crises and to what extent this impacted the performance of each regional organization. After all, one cannot disregard the dimension of ‘learning’ (Checkel 2005) and the effects of ‘path dependence’ (Pierson 2004) in co-operation processes and in the trajectory of regional organisations.

Based on the aforementioned, we have elaborated a reference framework on the variables that will be analysed in detail in the next section for each of the selected cases – Mercosur, the Andean Community and CARICOM. It will be demonstrated how each of these regional organisations have responded to the COVID-19 pandemic by adopting a comprehensive approach to the questions proposed by Nikogosian (2020), Agostinis and Parthenay (2021) and Greer et al. (2021).

When analysing the political and institutional aspects of each organisation to determine whether the institution dedicated to health has a consultative, supranational, or decision-making capacity, we focused on its institutional design. If the institution dedicated to health has autonomous decision-making capacity within the regional organisation, but the regional organisation does not possess supranational powers over its member states, it was classified as ‘decision-making capacity’. If it does not have autonomous decision-making capacity, it was classified as ‘consultative’. If it has autonomous decision-making capacity and the regional organisation does possess supranational powers over its member states, it was classified as ‘supranational’.

To the ‘health features on organisational agenda’ parameter, we verified whether and how the health agenda has been incorporated into the regional organisation. If there was an explicit reference to the promotion of health policies in regional organisation treaties and announced goals, we considered it as ‘specific mandate’. Alternatively, if the health agenda appears as a secondary theme, derived from trade discussions, regulations and agendas, it was considered as ‘derived from commercial agenda’.

The regional governance mode was defined through the analysis of leadership. If the response to the COVID-19 pandemic was headed by a member state, it was classified as ‘endogenously-driven governance’. If it was headed by a non-member state, as the case of CARICOM and its partnership with the European Union, it was classified as ‘exogenously-driven governance’. If there was no leadership, it was classified as ‘none’. Finally, we identified if the regional organization played an important role in the regional response in a similar health crisis during its history and to what extent this impacted the performance of each regional organisation.

Beyond these aspects, our analysis sought to identify if the regional organisations were able to co-ordinate a regional strategy to respond to the COVID-19 pandemic. To do that, we took into account four main parameters rated as low, medium, strong, or none. Each regional organisation was graded according to its relative protagonism compared to the isolated measures adopted by its member states’ governments. Firstly, we evaluated if the regional organisations built any kind of mechanism to monitor and exchange information about the evolution of the pandemic (such as medical data) and economic and social measures taken (such as changes in trade and tourism rules). Secondly, we look into the

regional organisations' role in coordinating the distribution of medical resources (trained medical staff, hospital equipment, medication, and vaccines). Finally, we also evaluated if regional organisations represented their member states in negotiations with third parties such as governments, international organisations, and/or the health private sector, as well as during vaccine purchase negotiations.

Regional organisations in Latin America and the Caribbean and the fight against the pandemic

Table 1 outlines each variable in the selected cases. In this section, data will be presented to corroborate the evaluation carried out, justifying the classification for each case while using the theoretical references indicated in the previous section as a parameter for analysis.

Table 1 – Regional organizations in Latin America and the Caribbean facing the COVID-19 pandemic: analysis of variables

	Mercosur	Andean Community	CARICOM
Political-institutional aspects			
Institutional organ dedicated to health	Consultative	Decision-making capacity	Decision-making capacity
Health features on organisational agenda	Derived from commercial agenda	Specific mandate	Specific mandate
Regional governance mode	None	Exogenously-driven	Exogenously-driven
Action history in health issues	Exists	Exists	Exists
Action regarding COVID-19 pandemic			
Regional strategy co-ordination	None	Strong	Strong
Information exchange	Medium	Strong	Strong
Co-ordination and redistribution of resources	None	Strong	Strong
Common dealings with external actors	None	Strong	Strong

Source: authors' elaboration.

Southern Common Market (Mercosur)

The theme of health was incorporated into Mercosur with the creation of the Meeting of Health Ministers (RMS) in 1995, and of the Work Subgroup 11 – Health (SGT 11) in 1996. During that period, it was a secondary agenda to trade disciplines, focused on discussions about the regulation of trade in health products, sanitary surveillance rules linked to the customs union, and other areas for the common market construction (Bianculli and Hoffmann 2016b; Queiroz and Giovanella 2011).

According to Bianculli and Hoffmann (2016) at the beginning these mechanisms did not represent a concise project of a regional health policy or an intention to promote some level of policy harmonisation. Instead, states still had different regulations and obligations in their health systems, and a very low level of co-ordination.

In 2000, with the approval of the Buenos Aires Charter on Social Commitment, and later in 2012 the Strategic Social Action Plan for Mercosur (PEAS), the health agenda gained clearer contours in terms of building governance mechanisms of health policies not limited to viewing the issue as a secondary aspect of trade liberalisation. Although structural limitations persisted (Bianculli and Hoffmann 2016b), efforts were made to enable Mercosur to operate as a political co-ordination institution in harmonising national health policies (Sacardo 2009). The RMS, for instance, has approved several harmonisation agreements related to drugs, tobacco and other issues associated with International Health Regulations.

Although the composition of health governance mechanisms within the scope of the Union of South American Nations (UNASUR) (Buss and Ferreira 2011) has restricted advances in this issue in Mercosur from 2008, it is noted that its institutional structure dedicated to health, with some history of regional co-ordination, could have been activated to handle the COVID-19 pandemic.

In 2020, during the exercise of the pro tempore presidency of Mercosur by the Government of Paraguay, a meeting was held between the Health Ministers which resulted in the 'Declaration of the Presidents of Mercosur on regional co-ordination for the containment and mitigation of the coronavirus and its impact' (2020). At the meeting, actions were agreed upon to facilitate the return of nationals residing in Mercosur member states, the regulation of restrictive measures for circulation in Twin Cities, actions of tariff exemptions and the facilitation of importation and transport of medical and hospital supplies. However, as emphasised by Neves and Costa (2020), there has been no progress in establishing regional co-ordination mechanisms to face the pandemic.

In addition, Mercosur contributed US\$16m from the Fund for Structural Convergence of Mercosur (FOCEM) to the Research, Education and Biotechnologies applied to Health program. Although directed to combating COVID-19, this concerned a redirection of FOCEM's budget as an extra contribution to a program in operation since 2011. Finally, Mercosur acted as a platform for sharing information on the epidemiological situation among member states.

Therefore, unlike the central role played by Mercosur in regional efforts to fight contagious diseases such as Dengue, Zika Virus and Chikungunya, as shown by Kuhn and

Damasceno (2016) and Melo and Papageorgiou (2021), in the case of COVID-19 the bloc was limited to being a platform for some dialogue between its members.

The lack of dialogue was due to both the political differences between the governments of the Mercosur countries, as well as the crisis in the commercial sphere. In the first case, since the electoral campaign in Argentina in 2019, when the Brazilian president openly positioned himself in favour of the re-election of then president Mauricio Macri, who ended up losing the election, the dialogue between the two countries has deteriorated.

On the trade side, there were also setbacks, with a significant reduction in intra-regional trade – with China becoming Argentina's main trading partner – and open conflicts over the negotiating agenda. On the one hand, Brazil and Uruguay started to defend a greater tariff reduction and expansion of free trade agreement negotiations, especially with Asian countries. Meanwhile, the government of Alberto Fernández has shown its commitment to maintaining the Common External Tariff (TEC) rates and strengthening the internal market, before opening new negotiations.

In this sense, we agree with the observation by Briceño-Ruiz (2021) and Neves, Junqueira and Ribeiro (2021) that the main impediment to Mercosur's performance occurred in the political sphere. Political fragmentation, especially the well-known divergences between the governments of Argentina and Brazil, has made it impossible to build a regional strategy to fight the pandemic and compromised the potential for a more efficient regional response. Furthermore, as Riggirozzi (2020) pointed out, with the dismantling of UNASUR there was a lack of co-ordination in health co-operation in South America which, in the case of Mercosur, revealed the difficulties, impasses and bottlenecks that had plagued the bloc even before the pandemic.

Andean Community (CAN)

In the countries of the Andean Community – Bolivia, Colombia, Ecuador, and Peru – contamination proliferated exponentially throughout the pandemic, with recognized underreporting due to the forms of death registration in each country. Not all governments have been able to implement effective isolation measures, given that just over half of the work force in the Andean countries is active in the informal sector and unable to stay at home in the face of economic difficulties. Therefore, isolation policies did not contain the spread of the disease in the region (Bressan 2020).

Compared to Latin America and the Caribbean, the Andean countries faced greater difficulty in caring for the most serious cases of the disease as a result of the precarious condition of their health systems. There were several obstacles to the purchase of supplies, medicines, and oxygen bottles, which affected the treatment of more complex cases and led to the death of a significant number of infected patients (Bressan 2021).

The economic and social difficulties triggered by the isolation policies – albeit limited – aggravated the domestic situation of the CAN countries. Domestically, political instabilities occurred even in 2020, like the revolts against the police in Colombia and electoral instability in Bolivia. In turn, Peru and Ecuador experienced crises in their health systems,

with serious accusations of corruption due to the diversion of health resources by local authorities in overpriced purchasing schemes related to the acquisition of devices, medications and contracts, further aggravating the pandemic crisis.

However, efforts have multiplied within CAN to face the pandemic (Pedraza 2020). Aiming to overcome economic losses, CAN members sought to reactivate their economies and achieve greater unity during this global problem. New economic measures and more contemporary regulations were established to facilitate and foster intra-community trade. Furthermore, the signatories' bureaucracies engaged in the digitization of procedures to reduce costs and operational times in the export process (Declaración de los Ministros de Relaciones Exteriores y de Comercio Exterior de la Comunidad Andina respecto a la propagación del coronavirus (COVID-19) 2020).

As for sanitary prevention measures throughout the pandemic, new procedures were established to facilitate control in customs transit operations, avoiding physical contact, the handling of documents and the spread of the virus at border crossings. Furthermore, new protocols were established to avoid the risk of contagion in rural and indigenous areas. In the April 2020 declaration, still at the beginning of the pandemic, the Ministers of Foreign Affairs and Foreign Trade announced common measures. Among them, the following stood out: strengthening regional health promotion mechanisms; real-time exchange of epidemiological information and diagnoses of the evolution of the disease for official decision-making; exchange of successful approaches in mitigating the spread of the virus; joint purchase of medical supplies; and the commitment of resources from the Latin American Development Bank (CAF) for non-reimbursable technical co-operation. In addition, meetings and virtual meetings co-ordinated by the Ministries of Foreign Affairs were scheduled to discuss the regional fight against the pandemic (CAN 2020).

There is a body in the CAN institutional structure in charge of dealing with the health issue, which is the Andean Health Organization (ORAS - CONHU), derived from the Hipólito Unanue Agreement. It was created to address the need for co-operation in the health area, thus providing the CAN with an organ for this agenda since its inception. Encompassing six countries of the Andean region: Bolivia, Chile, Colombia, Ecuador, Peru and Venezuela, the agency celebrated its fiftieth anniversary in 2021. Against the background of the COVID-19 pandemic, member countries intensified their work within the scope of ORAS-CONHU and made an effort to strengthen health systems, share technologies and health practices, in addition to improving, preventing, and promoting isolation and health measures in accordance with international protocols, among other measures (ORAS – CONHU 2020).

The CAN's National Health Authorities meet frequently to present advances and outline joint efforts, with the presentation of information on the epidemiological situation of the COVID-19 pandemic. They also report on the progress of vaccination against COVID-19 and the mechanisms put in place to achieve the proposed goals.

After the reorganisation of the work in a virtual way, the advance of the institutional co-ordination of the ORAS-CONHU body culminated in three virtual meetings between the Ministers of Health and in the monthly meetings of the National Health Authorities

of the Andean Region, with the aim to carry out an exchange and analysis of the strategies, challenges, and lessons in order to deal with the pandemic. Additionally, specific meetings were held to address access to vaccines against COVID-19, with the Directorate of Immunizations and Directors of Epidemiology of the six member countries. Meetings also took place among those responsible for information systems and statistics to guide the evolution of the pandemic.

ORAS-CONHU adopted an agenda of diverse activities with experts, authorities, and technicians to discuss common strategies. Until August 2021, there were 84 webinars with 25 000 participants from 31 countries, 231 000 reproductions and 263 panellists. In addition, the organ organised 42 technical meetings between experts, members of the Andean Committees, the ORAS-CONHU team and social organisations, deepening analyses on priority issues in the search for alternative solutions to the pandemic and its consequences on public health. The summaries of each webinar and technical meeting are available in the *Boletín Notisalud Andinas*, published monthly and fully disseminated in the region (ORAS – CONHU 2021a).

To work on these fronts, ORAS-CONHU worked in close collaboration with the Ministries of Health of the Andean countries, the Andean Integration System, and other organisations and mechanisms of Andean integration, as well as agencies of the United Nations (UN). Among the achievements are the Community Directive ‘Andean Strategy on Medical Devices’ of the Andean Parliament (ORAS – CONHU 2021b), the articulation in processes related to health at the borders with the respective Ministries of Health, involving institutions operating at the borders like entities of the Treaty Organization for Cooperation in the Amazon (ACTO) and Mercosur.

There is a commitment to continue the joint work between the Andean countries to control the expansion of the COVID-19 pandemic, with complementary actions taken by each of the countries in the region as bilateral actions at common borders are reinforced. Agreements established with PAHO and WHO, through the COVAX¹ mechanism, have guaranteed access to COVID-19 vaccines in all CAN countries. Finally, there is a regional commitment to the production of innovative medical technologies, aimed at the treatment, prevention, and containment of COVID-19 (NOTISALUD ANDINAS 2021).

As such, the Andean Community, through ORAS-CONHU, has promoted the institutional strengthening of the health agenda in Andean countries through the exchange of experiences, ongoing training, articulation of policies and plans, all of which were elaborated from strategies of the Andean Member States’ Ministries of Health. Action was taken to train health professionals, improve access to medicines and health technologies, and to combat the erroneous ‘health versus economy’ dilemma widely heard throughout the pandemic. Thus, strategies, articulation and complementary mechanisms were designed, in addition to the presentation of results in specific aspects of health management like access to services with a focus on rights, promotion and prevention.

Caribbean Community (CARICOM)

The health performance of the Caribbean Community member states and associated territories (CARICOM)² was substantially above the world average. Data published on 23 September 2021 indicate, up to that date, the occurrence of approximately 400 000 confirmed cases of COVID-19 in a population of approximately 19 million people, of which 7198 resulted in death (CARPHA 2021). Parthenay (2021) has pointed out three hypotheses that could possibly explain these results. The first concerns the predominantly insular characteristic of the region which, in a scenario of low tourism flow, would have operated as a ‘natural barrier’ to the spread of the virus. The second refers to the knowledge and experience that the states of the region have acquired during other health crises faced by the region, which made it possible to apply a quick and efficient strategy to prevent the spread of the virus. Finally, the author argues that the support and financing of extra-regional actors strengthened the response capacity of governments in the region.

Along the same lines, Knight and Reddy (2020) and Chattu and Chami (2020) have pointed out that the fight against the COVID-19 pandemic within the scope of CARICOM must be understood in light of structural and historical characteristics of the Caribbean. On the one hand, it is a region that has historically suffered from epidemics, pandemics, and natural disasters. These have decisively impacted health systems, because the destruction of health and medical care infrastructure creates ideal conditions for the spread of contagious diseases (viral and per vector) (Chattu and Chami 2020). On the other hand, they are states and territories that present low levels of development and economies heavily dependent on tourism, which, according to data from the Economic Commission for Latin America, is responsible for 25% of the GDP and 35% of jobs in the region (ECLAC 2020). In countries like Antigua and Barbuda these numbers reach 45% and 90%, respectively.

According to the authors, these characteristics boosted regional co-operation on health issues. First, because the interdependence generated by the ‘Caribbean tourist circuit’ imposed the need for sanitary and health co-operation mechanisms, given that although most CARICOM members are islands there is still a high flow of people. Secondly, political, and economic weaknesses have rendered the region dependent on foreign aid and therefore on an increased need for joint action to deal with the international community.

In line with what was presented, it is important to emphasise the role of CARICOM in this process. The theme of health has been incorporated into CARICOM’s activities since the Treaty of Chaguaramas, which gave rise to the institution in 1973. In article 6 of the aforementioned treaty, which establishes the objectives of CARICOM, it is foreseen that the Community should promote functional co-operation in the health sectors. Furthermore, the treaty established in articles 17 and 75 that CARICOM should act to promote the development and organization of efficient and cost-effective health services, as well as promote measures to establish and improve institutions and facilities for the provision of health services. It is noteworthy, as Ferreira and Melo (2020) have pointed out, that concerns over the health issue were already present in the constitution of CARICOM, unlike

other initiatives in the region, such as the Caribbean Free Trade Association (CARIFTA), which is limited to the trade liberalisation agenda.

From an institutional point of view, since 2011 the health agenda within the CARICOM framework has been under the responsibility of the Caribbean Public Health Agency (CARPHA)³, which concentrated on activities previously carried out within the framework of the Caribbean Institute of Environmental Health (CEHI), the Caribbean Epidemiology Center (CAREC), Caribbean Food and Nutrition Institute (CFNI), Caribbean Health Research Council (CHRC), and Caribbean Regional Drug Testing Laboratory (CRDTL).

For these reasons, even before the start of the COVID-19 pandemic there was an explicit provision that CARICOM should promote co-operation in health and, given the fragility of domestic health systems and the various environmental and health crises experienced in the region, an extensive historical experience of co-operation in the area was embodied in the creation of CARPHA.

The existence of a regional structure dedicated to health enabled CARICOM to begin the preparation of a regional strategy to combat COVID-19 as early as January 2020. Given the evolution of contagion in Asia, the Management Team Emergency Response (IMT-ER) and the Regional Coordinating Mechanism for Health Security (RCM-HS) were activated. With the registration of the first confirmed case of COVID-19 on 10 March 2020 in Jamaica, CARICOM convened the 9th Special Emergency Meeting of the Conference of Heads of State, an opportunity in which member states and Associated Territories agreed on the need to create a Common Public Health Policy to face the pandemic.

Therefore, based on CARPHA's technical leadership and the willingness of CARICOM member states and associated territories, a regional strategy for combating the COVID-19 pandemic was built, which involved regional co-ordination in key sectors like tourism, epidemiological surveillance, and the mobilisation of human resources for health and medical supplies (CARPHA 2020).

In the area of tourism, the regional response took shape in the creation of a 'Travel Bubble', co-ordinated within the scope of CARICOM. Regional criteria were established to identify risks associated with the rate of contagion by COVID-19, in addition to a regional protocol for tourism activities. Next, CARPHA set up a course aimed at training workers in the tourism sector in order to ensure sanitary safety within the 'Travel Bubble'. At the end of the course, companies in the sector were certified with the Caribbean Travel Health Assurance (CTHA) seal, a regional certification that aimed to offer greater health and safety guarantees to tourists.

Within the scope of health surveillance, all activities were led by CARPHA and implemented regionally. CARPHA was responsible for the reference laboratory in performing the PCR tests, the preparation of medical, laboratory and health protocols, and for the gathering of all information in a regional database. Such initiatives were and continue to be important, especially when considering that the technical and financial weaknesses of domestic health systems have made it impossible for many CARICOM member states and

associated territories to maintain up-to-date databases that could support the development of public policies to combat the COVID-19 pandemic.

Finally, it is necessary to highlight the leading role played by CARICOM and CARPHA in mobilising human resources for health and medical supplies. In addition to offering training to health professionals in the region, regional institutions played a key role in working with foreign actors and international institutions, especially with regard to technical co-operation, obtaining financial aid and medical supplies. It is worth highlighting CARPHA's role in technical co-operation with the WHO and the Pan American Health Organization (PAHO), the negotiation of funds with the European Union (EU) and the Inter-American Development Bank (IDB), the co-ordination of reception and distribution of medical supplies donated by the People's Republic of China, and co-ordination of the participation of member states and associated territories in the COVAX Facility for vaccine acquisition (CARPHA, 2020).

It should be noted, therefore, that CARICOM's role was central in the regional co-ordination of policies to combat the COVID-19 pandemic in the Caribbean region, especially given that the regional nature of economic activities aggravated the need for multilateral action. The prior existence of an institutional apparatus specialised in the health agenda, with experience in the regional co-ordination of responses to sanitary emergencies and natural disasters, CARPHA enabled a rapid deployment of regional co-ordination and co-operation efforts. This, despite the economic and technical limitations of national health care systems, enabled CARICOM member states and associated territories to respond more adequately to the COVID-19 pandemic.

Final considerations

The bibliographical review presented in the first section of this article allowed us to identify how the theme of health has been approached by the specialised literature on regionalism. From it, it was possible to list variables for the analysis of regional organisations in Latin America and the Caribbean, summarised in Table 1, both regarding the way in which the health agenda is inserted into the institutional apparatus, and with regard to capacity building co-operation to face the COVID-19 pandemic. These variables are important because they offer an analytical framework that makes it possible to identify which were the determining elements for co-operation to occur.

When looking at regional organisations from the perspective of health co-operation, we observe a quite different panorama from the one found in the commercial sphere. Neither CARICOM nor CAN involve strong economies, they have not promoted insertions in value chains or industrial development processes among their members. Nonetheless, the fact that they have been able to realise institutional co-operation on some issues throughout their existence enabled them to react more adequately to the COVID-19 pandemic.

A first aspect to be highlighted is the existence of organs focused on health with decision-making capacity. Here, the case of Mercosur slightly differs, for it has bodies that deal

with health but of a mere consultative nature. This distinction is fundamental in coming up with more efficient responses because it gives the relevant organs more autonomy to act without the need for political agreement between governments and, as such, the possibility of taking decisions and implementing policies in a more agile manner.

The CAN and CARICOM cases show how the existence of an institutional organ with a specific mandate to develop health policies, deal with external actors, and stimulate co-operation, has made it possible to adopt a regional strategy to fight the pandemic, especially given the economic fragility and weak domestic health systems of member states. We highlight the performance of ORAS – CONHU in the CAN, and CARPHA in CARICOM. Both were relatively successful in co-ordinating health strategies, promoting technical and financial co-operation, determining regional protocols for medical and economic activities, articulating Community participation in the COVAX consortium, as well as coordinating the capture and distribution of financial resources and external medical supplies. In the CAN, the financial resources from CAF and the EU stand out; in CARICOM, resources from the EU and the IDB, as well as input donations from the Chinese government.

Contrarily, Mercosur was paralyzed by friction between its member states' governments, which were incapable of agreeing on joint actions. The political divergence between the presidencies of Brazil and Argentina was decisive for the bloc not to succeed in building a regional response to the pandemic. Despite being derived from the trade agenda, there is an important trajectory in the treatment of the health agenda in Mercosur within the scope of SGT 11 and the Meeting of Health Ministers, the history of which points to a great potential for co-operation. However, political differences over how the fight against the pandemic should be structured, in particular the strategy based on denial adopted by the Brazilian government, made it impossible for Mercosur to build a regional strategy. In this lack of co-ordination, it is important to consider the fundamental importance of the Brazilian government's contribution to the construction and financing of regional policies within Mercosur since the absence of Brazilian initiative left a gap in the bloc's capacity to encourage co-operation.

Another interesting aspect is the purpose of regional processes as an important element for co-operation. Only in those that aim for integration is it possible to observe agendas and organs that go beyond commercial aspects. Even though the existence of dedicated organs in itself is insufficient, as was demonstrated in the Mercosur case, such channels are necessary for the mobilisation of member states and co-operation, even if they lack proper decision-making competences.

In the case of Mercosur, despite its institutional structure, the regional integration process is heavily dependent on decisions made by national Presidents. It should be noted that their current interest in the integration process is quite limited and divergent as a result of political-ideological differences and personal disagreements, which makes it difficult to co-ordinate actions to fight the pandemic between the countries of the bloc.

The manufacturing of a social consensus to make integration processes sustainable depends on the ability to generate a perception of benefit for the societies involved.

Otherwise, they tend to increase pressure and support for abandoning integration. Perhaps this perception of benefit is an interesting element in CAN's continued existence, despite its meagre economic results in recent decades. Hence, regional structures without some degree of autonomy in relation to governments are subject to inconsistencies present in domestic policies. This affects the capacities of Latin American regional organisations to respond to challenges that arise, especially in such adverse circumstances as in the case of a global pandemic. The current Latin American situation has clearly demonstrated this weakness. Additionally, the characteristics of the domestic health systems of the member states of each of the analysed regional organisations, as well as the levels of economic interdependence and political convergence between their respective member states, are aspects that should be part of a future research agenda, especially in light of the structural characteristics of regionalism in Latin America, which is marked by a low interdependence between states and a leading role played by heads of governments.

Notes

- 1 COVAX is a WHO initiative for the acquisition and subsequent distribution of vaccines against Covid-19 to the poorest countries on the planet.
- 2 CARICOM comprises 15 member states (Antigua and Barbuda; Bahamas; Barbados; Belize; Dominica; Grenada; Guyana; Haiti; Jamaica; Montserrat; Saint Lucia; Saint Kitts and Nevis; Saint Vincent and the Grenadines; Suriname; and Trinidad and Tobago) and five associated territories (Anguilla; Bermuda; British Virgin Islands; Turks and Caicos Islands; Cayman Islands).
- 3 In addition to the member states and associated territories, CARPHA counts on the participation of Dutch islands and territories: Aruba, Bonaire, Saint Eustatius, Saba, Curaçao and Saint Martin.

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About the authors

Karina Lilia Pasquariello Mariano is an Associate Professor at the São Paulo State University (UNESP), School of Humanities and Sciences/Araraquara Campus and at the Graduate Program in International Relations San Tiago Dantas (São Paulo State University - UNESP, State University of Campinas – UNICAMP and Catholic University of São Paulo - PUC/SP). She is Coordinator of GEICD (Group of Interdisciplinary Studies on Culture and Development) and the Network DIPP (Development, International Politics and Peace) sponsored by CAPES and researcher at the Regionalism Observatory (ODR). Since 2013 she is a National Council for Scientific and Technological Development (CNPq) scholarship holder. Her latest publications include: 'El regionalismo sudamericano y el giro a la desintegración: algunas reflexiones' (*Foro Internacional*, 2022) and 'Liquid Regionalism: a typology for regionalism in the Americas' (*Revista Brasileira de Política Internacional*, 2021).

Regiane Nitsch Bressan is a Professor at the Federal University of São Paulo (UNIFESP) and at the Graduate Program in International Relations San Tiago Dantas (São Paulo State University - UNESP, State University of Campinas – UNICAMP and Catholic University of São Paulo - PUC/SP). She is a researcher at Regionalism Observatory (ODR) and a member of the Research Network on Foreign Policy and Regionalism (REPRI); the Grupo de Reflexión sobre Integración y Desarrollo en América Latina y Europa (GRIDALE); the Fórum Universitário Mercosul (FoMerco); and the Brazilian Network for Latin American and Caribbean Research (BLAC Network). Her latest publications include: 'Para além do Comércio: Mercosul, Democracia e Segurança Regional' (*Lua Nova*, 2021) and 'Liquid Regionalism: a typology for regionalism in the Americas' (*Revista Brasileira de Política Internacional*, 2021).

Guilherme Augusto Guimarães Ferreira is a Professor at the Federal University of São Paulo (UNIFESP). He holds a Ph.D. and a Master's degree in International Relations at the Graduate Program in International Relations San Tiago Dantas (São Paulo State University (UNESP), State University of Campinas (UNICAMP) and Catholic University of São Paulo (PUC-SP)), and a bachelor's degree in International Relations at São Paulo State University (UNESP). He is a researcher at the Regionalism Observatory (ODR). His areas of research include International Institutions, Regional Integration and Regionalism. His latest publications include: 'Estatuto da Cidadania do Mercosul' (*Brazilian Journal of International Relations*, 2021) and 'A reunião especializada sobre agricultura familiar do Mercosul (REAF): expansão ou aprofundamento da integração regional?' (*Conjuntura Austral*, 2019).

Organizações regionais latino-americanas e caribenhas enfrentando a pandemia da COVID-19

Resumo: O objetivo deste artigo é analisar as respostas das organizações regionais da América Latina e Caribe à pandemia causada pelo Covid-19, através de uma análise comparativa entre as políticas adotadas pelo MERCOSUL, Comunidade Andina e CARICOM. Mapeamos as discussões, iniciativas e políticas adotadas por essas organizações regionais a fim de compreender os principais elementos que determinaram a adoção da coordenação regional nas estratégias para enfrentar os efeitos da pandemia. Argumentamos que aquelas organizações que tinham canais institucionais específicos dedicados a lidar com questões de saúde e já tinham enfrentado outras crises de saúde, tiveram menos dificuldade em coordenar as ações de seus estados membros e adotar políticas regionais. Além disso, pode ser afirmado que o nível de interdependência econômica e convergência política entre os governos dos estados membros desempenhou um papel significativo. Assim, este artigo procura contribuir para uma compreensão mais ampla do estado atual da cooperação em saúde nas organizações regionais da América Latina e do Caribe, bem como para acrescentar à discussão sobre seu potencial na coordenação e promoção de políticas regionais de saúde.

Palavras-chave: Regionalismo; América Latina e Caribe; pandemia. Mercosul; Comunidade Andina; CARICOM.

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