

# Chapter 21

## Power Shifts in Global Health Diplomacy and New Models of Development: South–South Cooperation

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### Readers' Guide

**South–South cooperation** represents an alternative ideal to the model of rich northern countries providing aid to the poor countries of the southern hemisphere. It offers the prospect of mutual advantages for developing and emerging countries as well as a stronger voice in global diplomacy on social and economic issues. This chapter sets out to provide a balanced view of opportunities and challenges of **South–South cooperation**, outlining pertinent questions that emerge from this new dynamic of global governance. In the following sections, we briefly outline the history of **South–South cooperation** and describe its main mechanism and its application to health. We then discuss the paradigm shift from the former bipolar system during the Cold War to today's global multipolar system. We demonstrate how the consolidation of multipolarity is particularly reflected in the (re)formation of regional blocks, notably in terms of their spheres of coordination and their engagement in different **South–South cooperation** mechanisms. The African Union (AU), the Association of Southeast Asian Nations (ASEAN), and the Union of South American Nations (UNASUR in its official Spanish acronym) serve as key examples to illustrate both the current state of **South–South cooperation** and emerging challenges that need to be addressed if **South–South cooperation** is to be effective and viable in the long term.

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### Learning Points

- While **North–South cooperation** was characterized by an unequal relationship between donors and recipients, **South–South cooperation** is built on relationships between more equal partners with the objective of mutual exchange and development.
- The principles of **South–South cooperation** were forged at the first Asian-African Conference also known as the Bandung Conference in 1955.
- **South–South cooperation** in health is now seen by some commentators as a viable alternative model to the often highlighted difficulties of **North–South cooperation**.
- New regional platforms have begun to provide increasing opportunities to promote **South–South cooperation**; these include the ASEAN, the AU, and the UNASUR.

## Introduction: The History of South–South Cooperation

According to the United Nations Economic and Social Council's recent and most comprehensive report on **South–South cooperation**, Southern contributors are estimated to have disbursed between US\$9.5 billion and US\$12.1 billion in 2006, representing 7.8–9.8 % of total aid (United Nations Economic and Social Council 2008). While attention is increasingly paid to this model, the origins of development cooperation among developing countries can be traced back to the 1950s. At that time, **South–South cooperation** was an innovative practice established to foster economic cooperation among developing countries; it was influenced by an international system whose structures were shaped by the logic of the Cold War and growing independence movements in colonized developing countries. The two dynamics had a profound impact on the key rationale of **South–South cooperation**, primarily founded on the concepts and practices of “internationalist solidarity” of socialist countries. These countries portrayed **South–South cooperation** as “a mechanism through which countries of the (developing world) would be enabled to overcome dependence on the industrialized nations” (De la Fontaine and Seifert 2010, p. 2). Whereas **South–South cooperation** has a long history, it is only in this new millennium that we see an unprecedented upsurge of **South–South cooperation** on national, regional and global levels, and especially in the realm of global health governance (United Nations Economic and Social Council 2008).

While **North–South cooperation** was characterized by an unequal relationship between donors and recipients, **South–South cooperation** is meant to be different. It is built on relationships between more equal partners with the objective of mutual exchange and development (de Sousa 2010). It therefore presents a viable alternative to the dominant cooperation model that seeks to avoid the same historical mistakes in developing countries and to foster development and thus benefits for all countries

involved. Whereas **North–South cooperation** was primarily founded on the notion of “technical assistance”, **South–South cooperation** is based on the concept of “technical cooperation” to emphasize the joint effort of integrating partners in a genuine joint operation in which know-how and strategic orientations are shared in order to improve the work capacity and to foster equitable development (Buss 2009).

The political concept of **South–South cooperation** dates back into the 1950s, when the developing countries united for protection from the practices of the developed countries that were regarded as continuous exploiters and hegemonies of the South. At the height of the Cold War, the core principles of **South–South cooperation** were forged at the first Asian-African Conference also known as the Bandung Conference hosted by Indonesia in 1955 (see Bandung, 24 April 1955). These ten principles are set out in Box 1.

**Box 1** The Ten Principles of Bandung (the Asian-African Conference, Bandung, 18–24 April 1955)

1. Respect for fundamental human rights and for the purposes and principles of the charter of the United Nations.
2. Respect for the sovereignty and territorial integrity of all nations.
3. Recognition of the equality of all races and of the equality of all nations large and small.
4. Abstention from intervention or interference in the internal affairs of another country.
5. Respect for the right of each nation to defend itself singly or collectively, in conformity with the Charter of the United Nations.
6. (a) Abstention from the use of arrangements of collective defence to serve any particular interests of the big powers. (b) Abstention by any country from exerting pressures on other countries.
7. Refraining from acts or threats of aggression or the use of force against the territorial integrity or political independence of any country.
8. Settlement of all international disputes by peaceful means, such as negotiation, conciliation, arbitration or judicial settlement as well as other peaceful means of the parties own choice, in conformity with the Charter of the United Nations.
9. Promotion of mutual interest and cooperation.
10. Respect for justice and international obligations.

The milestone Bandung conference of 1955 triggered talks between Indonesia, India, Egypt and then-Yugoslavia. The same group agreed to establish the Non-Aligned Movement (NAM) at the Belgrade Conference in 1961. Most of the NAM members also formed part of the Group 77 (G77), which was subsequently established in 1964, that actively sought to integrate **South–South cooperation** into its agenda to “promote developing countries’ interests in support of a proposed New International Economic Order” (Cabral and Weinstock 2010, p. 24). The call for the

revision of the dominant international economic system represented a culmination of the joint efforts of developing countries to overcome economic dependency and inequality that were—in the view of the developing countries—manifested in the Bretton Woods System. With these different Southern alliances, the basic framework for the development of political consensus between developing countries was established (Buss and Ferreira 2010). Their agglomerated influence played a critical role in the establishment of the United Nations Conference on Trade and Development (UNCTAD) in 1964. Following these developments, the United Nations General Assembly in 1972 initiated a Working Group on Technical Cooperation among Developing Countries (TCDC). In 1978, the United Nations Conference on TCDC, held in Buenos Aires, set another essential landmark in recognizing TCDC as an essential part of **South–South cooperation**. The Plan provided the conceptual basis and a practical guide for realizing the objectives that TCDC aimed to achieve (SU-SSC-UNDP 2010). Six years later it was institutionally supported by the UN Special Unit for **South–South cooperation**, whose mandate to this day is “to promote, coordinate and support South–South and triangular cooperation on a Global and United Nations systems-wide basis” (SSC-UNDP 2010). The establishment of this UN division reflected the increasing importance the UN gave to **South–South cooperation**. In 1987, the NAM convened a summit at which the **South Commission** was launched and which was later to become famous for its 1990 report “The Challenge to the South”. This highly cited work assessed the South’s achievements and failings in development and suggested directions for action, in particular with regards to how exactly developing countries could benefit from globalization. The report was critical in trying to establish a more pragmatic view on fostering more development within the South, elaborating how developing countries could in practice benefit from emerging global interdependencies.

## The Emergence of South–South Cooperation in Health

The establishment of the South–South institutions noted in the previous section often dates back decades into the past, but many of these organizations are still actively shaping today’s global policy-making processes. The bulk of Southern actors—particularly a large number of **rising states**—still claim to respect and apply the Bandung Principles. What has changed is that the early period of **South–South cooperation** primarily focused on the promotion of economic development, while the policy area of health was at best considered at the margins of Southern development cooperation. However, in but more recent years, approaches to international cooperation in health have evolved. This subsequent integration of policy issues that went beyond the initial primary objective of furthering economic development occurred gradually over time and through the evolutionary establishment of new institutions and/or strategies focusing on specific aspects of **South–South cooperation**.

Thus, while **South–South cooperation** had been increasingly pursued since the 1950s, it was only since the mid-1970s that the Southern countries started to pay more attention

to the component of health in their development cooperation schemes. By 1976, health representatives and coordinators from the non-aligned and developing countries met regularly to develop and discuss their activities in the field of health cooperation (Research Centre for Cooperation with Developing Countries 1987, p. 11).

The end of the Cold War marked a turning point, not only for collective action in the area of health, but also for **South–South cooperation** in general. Developing countries' movements suffered a serious political setback in the context of the end of the bipolar world. A number of developing countries were dealing with financial crises that forced them to approach the Bretton Woods institutions for assistance, "which generally came with the conditionality of binding them firmly with the Washington Consensus" (Kumar 2008, p. 2). Developing countries became progressively interwoven into an increasingly complex international system, but in heterogeneous ways. The consequence for the formerly rather united stance of Southern countries, based on common objectives critical of the developed world, was suddenly no longer shared by all developing countries. Yet, despite these substantial changes, the interest of developing countries in engaging in new ways in **South–South cooperation** was not extinct and was revived with an unprecedented enthusiasm as the dynamics of globalization became apparent in the twenty-first century. The new zeal of Southern countries also captured a vivid interest in development cooperation in areas that previously had been of less interest to these countries. Health now received unprecedented levels of attention in Southern development agendas, a trend that also reflects the **power shift** of health as it gained recognition as an issue of global concern (Alcazar 2008). **Global health**, due to its complex character that touches many governance levels and policy fields (e.g. trade, security, development), has been the focus of a plethora of development initiatives. Many of these still follow the traditional logic of the "rich" industrialized countries seeking to help the "poor" developing countries. But this long-standing dichotomy is changing remarkably in today's world where a considerable number of those countries formerly regarded as "poor" or "third world" have become new regional and global centres of power and influence, both economically and politically (see Khanna 2008; Kickbusch 2009; Alexandroff and Cooper 2010). **South–South cooperation** is reviving to match these geopolitical **power shifts**, to generate better development outcomes for all the partners involved.

The factors leading to an increasing focus on South–South health cooperation were manifold. Economic crisis, debt payment, implementation of structural adjustment programmes and significant political shifts worsened the situation of poverty and inequality for many people in the Southern countries (Almeida et al. 2010). Additionally, the health systems of many developing countries were disproportionately burdened as they struggled with the emerging HIV/AIDS epidemic as well as other fatal diseases (Almeida et al. 2010, p. 25).

Many academics and policy makers have praised today's model of **South–South cooperation** in health, portraying it as a viable alternative model in contrast to the often highlighted difficulties of **North–South cooperation**. This long-time dominant model of international health cooperation has been exclusively provided by multilateral organizations and national agencies from developed countries, and

more recently has been increasingly influenced by philanthropic foundations, celebrity opinion leaders and a myriad of other nongovernmental organizations. All these actors from the industrialized countries have been keen to help poor people in “recipient” countries; despite having the best intentions to help poor populations in the poorest countries in the world, very often these actors impose their own world views, agendas and predefined objectives. On the other hand, some developing countries are frequently seen as unable to organize their national demands, given the lack of coordination between Ministries of Health, Foreign Affairs and other key public and private institutions. As a result of both situations, developing countries often suffer from the highly fragmented and ineffective use of the limited resources available (Buss 2007, 2008a, b).

**South–South cooperation** in health now aims to achieve four clear objectives, all of them representing a substantial move away from the traditional features of the dominant North–South model, highlighting (Buss and Ferreira 2010):

- A move away from vertical (disease-focused interventions) to the comprehensive development and thus strengthening of the health system.
- An emphasis on long-term instead of short-term needs, i.e. by strengthening key institutions to acquire true leadership, promoting the development of a future-oriented agenda and balancing specific actions with the generation of knowledge.
- A move away from programmes based on a single global orientation towards strategic planning centred on the reality of the “recipient” country by broadly incorporating the social determinants of health.
- A prioritization of population-based (public health-oriented) programmes and activities strictly focused on individuals.

The fourth ministerial meeting of the NAM ministers of health during the 64th World Health Assembly in Geneva in 2011 represents a further step forward. Together, the NAM member states issued a declaration on “Strengthening the International Health System”: “Reinforcing global solidarity against pandemics, addressing health systems financing and universal coverage and combating non-communicable diseases” (Non-Aligned Movement 2011). A fifth meeting of NAM Ministers of Health took place during the 65th World Health Assembly in Geneva in May 2012.

Today, South–South development cooperation activities in health have a large portfolio of different mechanisms, including, for example, institution-building, capacity-building, the dispatch of human resources and technology, foreign aid or foreign direct investments. This range of cooperative tools stands in contrast to traditional **South–South cooperation** projects in health, which had been mainly driven by ideological reasons (e.g. China, Cuba, Soviet Republic), whose main **South–South cooperation** activities consisted of the dispatch of medical personnel to developing countries or graduate training of thousands of health professionals (Feinsilver 2008; see Huang 2010). Today we can observe an enlarged scope of development cooperation mechanisms reflecting **South–South cooperation** of a pragmatic nature, with partners seeking to foster economic, political and social objectives. Currently about 20 % of development assistance from Southern

contributors—especially from **rising states**, such as Brazil, China, India, Indonesia or South Africa—has been allocated to the health and education sectors in developing countries (Chahoud 2008; United Nations Economic and Social Council 2008). And yet, although a growth can be observed in the acknowledgement of health within **South–South cooperation**, it is striking that relatively little literature has been published that specifically focuses on South–South health cooperation. While Brazil has recently published academic articles that sketch out how the country understands and implements its guiding concept of “structuring cooperation for health” (Buss 2011; Almeida et al. 2010), only a few historical and mostly descriptive narratives have been published that broach the issue of South–South health cooperation (see: Ruger and Ny 2010; Bliss 2010; Huang 2010).

## **Multipolarity, Rising States and Its Implications for South–South Health Cooperation**

The recent increase in **South–South cooperation** reflects the changing dynamics of today’s multipolar global system. This multipolarity can be seen in the substantial redistribution of power that is taking place among different centres of power, with many of them being geographically located in the Southern hemisphere (Khanna 2008; Fidler 2010; Lesage and Vercauteren 2009). As portrayed in the report “Global Trends 2025” of the U.S. National Intelligence Council, the world’s environment is characterized by a gradual diffusion of power away from the West, a decay in multilateral institutional governance and the growing influence of new power centres that are increasingly orchestrating global affairs (National Intelligence Council 2008).

It has become common practice to denominate these new power centres as “emerging countries” or “emerging economies”, alluding to these countries’ accelerated economic growth that is increasingly overtaking many OECD countries. On the other hand, the academic disciplines with a less emphasis on economics find it hard to work with such confined terms. In the social sciences, the most popular attempt so far has been to define these countries as “**rising states**”. As Alexandroff and Cooper (2010) suggest, the term “rising state” does not deny the distinctive economic characteristics of these countries but specifically focuses on socio-economic and political features. Khanna (2008) has offered to define these states as second world countries. This term was formerly used to describe socialist countries during the Cold War, but today’s second world countries are defined by their common hybrid nature, in that they are both, rich and poor, developed and underdeveloped, post-modern and pre-modern, cosmopolitan and tribal, all at the same time. Such conceptualizations account more accurately for the hybrid realities and the countries’ individual experience of self-development, which, these countries suggest, gives them greater insight and legitimacy as partners than countries from the industrialized world.

The rise of **South–South cooperation** has also to be seen in the context of the traditional donors of **North–South cooperation** who welcome this trend, perceiving

the increasing number of Southern development initiatives as acknowledgment from **rising states** of the need to take more global responsibility. The United Nations target is for countries to give at least 0.7 % of their gross national income to official development assistance projects. However, this only applies to states that are full members of the OECD's Development Assistance Committee (DAC) and of these only five countries meet the target.

**rising states** such as Argentina, Brazil, India, Malaysia, South Africa, Thailand and recently also China have concluded trilateral agreements with traditional donors belonging to the DAC. This is the first example of DAC and non-DAC partners jointly implementing development projects in developing countries. The Development Assistance Committee (OECD) has increasingly sought to strengthen its relations with emerging donors, generating a number of occasions to increase communication and collective action by both traditional and emerging partners. In 2005, a Forum organized jointly by the DAC of the Organization for Economic Cooperation and Development (OECD) and the UNDP brought together for the first time members of OECD/DAC and a wide range of non-OECD governments involved in South–South initiatives, seeking to promote greater dialogue and mutual understanding among the world's principal providers of development cooperation. In addition, in 2009, a Task Team on **South–South cooperation** (TT-SSC), a Southern-led multi-sectoral platform hosted at the Working Party on Aid Effectiveness (WPAEFF) at the OECD/DAC, was created to bring partner countries together with the aim of mapping, documenting, analysing and discussing evidence on the synergies between the principles of aid effectiveness and the practice of SSC (Cabral and Weinstock 2010).

Despite all these developments, we still lack data showing the concrete results of Southern countries' engagement in such development partnerships. Greater documentation of successful development cooperation outcomes could help to answer criticisms of **South–South cooperation** that have recently emerged. For example, critics have noted that the world is experiencing a rising Global North within the Global South (Sotero 2009), speculating that **South–South cooperation** would primarily be guided by **rising states** and their interests. While it is important to respond to such emerging critics, it is also important to note that the different **South–South cooperation** models are very diverse. This is the case not only for the engagement of individual **Rising states**, for example, but also for the various regional blocks worldwide, where integration processes now go beyond the traditional regional cooperation areas of security and economics, to increasingly include other sectors, such as health.

Regional institutions have developed as a response to global challenges that nation-states are no longer capable of addressing on their own. This has led to new modes of regional governance. Such regional platforms have also begun to provide increasing opportunities to promote **South–South cooperation** (Sridhar et al. 2008/2009). The ASEAN, the AU and the UNASUR are illustrative examples; and especially with regards to the latter two institutions, it can be observed that **rising states**, such as Brazil or South Africa, have been particularly active in strengthening regional integration and development through **South–South cooperation** initiatives.



## The Association of South East Asian Nations

The ASEAN was founded in 1967 by Indonesia, Singapore, Philippines, Malaysia and Thailand signing the Bangkok Declaration (ASEAN Declaration). The organization was constructed as a political regional organization with an overall aim of ensuring their member states' security and political stability (see Stevenson and Cooper 2009). Since then, ASEAN has expanded to include the countries of Brunei, Burma (Myanmar), Cambodia, Laos and Vietnam. Together, the ten countries have committed themselves to accelerate economic growth, social progress and cultural development and to promote regional peace and stability, to mention but a few primary objectives outlined in the ASEAN Declaration.

Although not explicitly referred to, ASEAN's objectives—especially its aim of maintaining regional security—provided the basis for health to emerge on the organization's agenda first in response to the HIV/AIDS and then in 2003, in response to the immediate public health threat of the SARS pandemic. ASEAN's health security agenda also had a significant impact on what Curley and Thomas (2004) describe as an unprecedented change of the "ASEAN Way". While the traditional regional approach was governed by the belief in non-interference and consensual decision making, there has been a growing recognition in the more recent past that non-traditional security issues can also threaten the stability and prosperity of the ASEAN region. ASEAN member states suddenly had to go beyond their traditional security concepts and consider their response to human security issues (Curley and Thomas 2004). ASEAN responded to the daunting SARS epidemic through a number of high-level meetings and several action points to confront the global public health threat, including the ASEAN+3 (ASEAN plus China, Japan, South Korea) Ministers of Health Special Meeting on SARS, or the Special ASEAN Leader's Meeting on SARS, which also included the non-member states China, Japan and South Korea, as well as the Hong Kong region of China.

While health security has been an important focus, this approach is too narrow and fails to capture the region's health threats that are not directly linked to the security of state and society. As *The Lancet* recently noted "Southeast Asia is a microcosm of global health" (Health in South East Asia 2011), with the region "hosting complex animal-human interactions, which has borne the brunt of several emerging and re-emerging infections, coupled with several strains of multi-drug resistant microbes that not only threaten health in the region, but also globally" (Acuin et al. 2011). All these challenges are linked to the need to strengthen the countries' health systems and to formulate and implement cooperation agreements that cover the health-related challenges that are of a cross-border and often regional nature.

The region's growing awareness of the need to include health issues in their cooperation frameworks also reflects the dynamic interface of global health and foreign policy. Several ASEAN countries have become active in global health governance applying sophisticated diplomatic strategies in what has been coined global health diplomacy. Illustrative examples include Thailand's brave declaration on compulsory licensing to produce and import essential medicines and Indonesia's refusal to share samples of H5N1 influenza viruses with WHO, which sparked

heated diplomatic debates about how to balance national with global interests (Pitsuwan 2011; Kuek et al. 2010; Sedyaningsih et al. 2008).

Looking at ASEAN's engagement in regional health cooperation today, the main document that guides its member states is the ASEAN Socio-cultural Community Blueprint (ASCC), which was approved at the 14th ASEAN Summit held in March 2009 in Thailand (Association of South-East Nations 2011). To guide the achievement of the strategic objectives set out in the Blueprint, the member states agreed to establish the ASEAN Strategic Framework on Health and Development (2010–2015) (Association of South-East Nations 2011). This policy reaffirms ASEAN's vision of "Healthy ASEAN 2020" adopted at the 5th ASEAN Health Ministers Meeting, which was held in April 2000 in Yogyakarta, Indonesia. It promoted the vision that by 2020 "health shall be at the centre of development and ASEAN cooperation in health shall be strengthened to ensure that our peoples are healthy in mind and body, and living in harmony in safe environments" (ASEAN 2010). In addition, various ASEAN Working Groups on Health Cooperation have been set up and tailored ASEAN Health Programmes are planned that focus on capacity-building activities, including institutional capacity, laboratories, surveillance, preparedness and rapid response. All these actions are in pursuance of the strategic objectives of health development in ASEAN, including the enhancement of food security and safety, and ensuring access to adequate and affordable healthcare, medical services and medicine, and to promote healthy lifestyles (ASCC Blueprint, 2009: B3, B4).

While ASEAN's attempts to further health in its region are undoubtedly laudable, it is hard to obtain objective and systematic information about implementation cycles of ASEAN's **South–South cooperation** projects, their outputs and their impacts on health development in the region. Scholarly literature has so far been rather loath to identify and analyse ASEAN's different policies and instruments of health cooperation. In an academic account on challenges emerging from state sovereignty and its implications for global health governance in Asia, scholars have suggested that "ASEAN's historic strength as a regional organisation lies in its commitment to political stability, which has been informed by the norm of non-interference by member states. Yet this norm is also its inherent weakness when forced to confront threats to public health rooted in poor governance by the organisation's members" (Stevenson and Cooper 2009, p. 1390). Against this background, it remains to be seen to what extent present and future aspirations for ASEAN's health cooperation policies can be realized.

## The African Union

The AU was founded in 1999 by the Agreement of the Sirte Declaration with the objective of accelerating the process of integration on the African continent, to enable Africa to play its rightful role in the global economy, while addressing multifaceted social, economic and political problems (African Union 2009; 2011). As a result, the organization covers health amongst a vast range of other issues that fall

under these broad objectives. AU-agreements on health include: the Abuja Declaration (2001) calling for its 53 Member States to allocate 15 % their national budgets to health; the Abuja Summit on HIV/AIDS in 2005 to reaffirm that commitment; the AUC Strategic Framework 2005–2007, or the Maputo Declaration on Strengthening of Laboratory Systems (2008). One of the recent health milestones has been the Africa Health Strategy 2007–2015 that addresses the main challenges faced by African health systems and outlines a broad strategic framework for African nations to achieve the health Millennium Development Goals. It thereby complements existing national and sub-regional strategic documents (African Union 2007). The broader goal of this strategic document is to contribute to Africa's socio-economic development by improving the health of its people and by ensuring access to essential health care for all Africans, especially the poorest and most marginalized, by 2015. Strengthening the health systems of the African countries is particularly necessitated by the fact that many of their health systems are overwhelmed by the high disease burden and confronted with inadequate human and financial resources. Funding targets both from international assistance and from AU countries themselves are being missed and reflect a long-time priority challenge that was already recognized in the Abuja Declaration 10 years ago, when the importance for AU member states was highlighted to give greater weight to health in the allocation of government revenues (World Health Organization 2010).

Besides the numerous declarations and commitments of the AU member states to improve the state of health in their countries, one remarkable institutional development that has steadily embraced health as a key point of action stands out: the New Partnership for Africa's Development (NEPAD). A development strategy established by Africans for Africans in 2001, the initiative represents a pledge by African leaders to eliminate poverty and to achieve a sustainable path of economic growth and development. Set out as an explicit development strategy, health was initially not a primary focus of NEPAD. The AU/NEPAD strategy entitled "Strengthening of Health Systems for Equity in Development in Africa: Africa Health Strategy 2007–2015" represents a milestone in recognizing the importance of health and its essential links with NEPAD's paramount objective on economic growth and development. This strategic document highlights what is known as the "triple burden" of communicable and non-communicable diseases as well as violence and traumatic injuries and their social consequences in retarding Africa's development (Iluyemi and Briggs 2008). The strategy is formulated as a comprehensive health systems approach, through which improvements in health care and health status are expected to be delivered largely at the country level (Buch 2003).

Africa's poor state of health continues to represent one of the most pressing challenges of the continent to reach NEPAD's overall objective of accelerated economic growth and sustainable development. Whereas NEPAD initially recognized the importance of health improvement only marginally in its development approach, this philosophy has certainly changed. NEPAD has given unprecedented recognition to the state of health in general and health systems strengthening in particular in relation to overall goals of social and economic development. While this strategic development is admirable, it remains uncertain whether and how the causes of

poverty and inequity will be addressed by the AU/NEPAD members in the future (see Labonté et al. 2004). Despite the numerous pledges and discourses that have emerged around health as a prerequisite to the achievement of sustainable development for Africa, tangible evidence of results is still lacking. Academic research and review is required to examine whether and how AU/NEPAD's health strategies have produced measurable improvements in health care and health status at country level.

## The Union of South American Nations

The UNASUR represents the most recent regional organization of the South American continent resulting from the merger of the previously separate regional blocks Mercosur and the Andean Community of Nations. In a way, UNASUR can be seen as the result of an incremental process dating back to the initial proposals of a South American Free Trade Organization (SAFTA) and the South American Community of Nations (SACN) in 2000 (Briceño-Ruiz 2010). UNASUR's formal establishment traces back to December 8, 2004, when the Heads of State of 12 South American nations gathered in Cusco, Peru to promote further integration of the continent (Union de Naciones Suramericanas 2011). Two years later, in 2006, this goal was further elaborated in the Cochabamba Declaration, in which the member states pledged to establish solidarity and cooperation in their common search for greater equity, reduction of poverty, curtailed asymmetries and strengthened multilateralism to better assert themselves in international relations (UNASUR Health 2010). At that time, the group was known as the South American Community of Nations (CSN), but renamed on April 17, 2007, as UNASUR—the Union of South American Nations.

The aim of UNASUR is to build, in a participatory and consensual manner, an integration and union among its peoples in the cultural, social, economic and political fields. It prioritizes political dialogue, social policies, health, education, energy, infrastructure, financing and the environment, among other objectives, with a view to eliminating socio-economic inequality, achieving social inclusion and participation of civil society, strengthening democracy and reducing asymmetries within a framework of strengthened sovereign and independent states (Buss and Ferreira 2010). Some analysts consider this regional political bloc the first true balance to the political power of the USA in the hemisphere (Buss and Ferreira 2010, p. 104).

A milestone in establishing health as a focus for UNASUR was achieved on December 16, 2008, when the Heads of State gathered in Salvador de Bahía and created the South American Health Council. Its purpose was to build a common platform for integration on matters of public health, incorporating the efforts and achievements of other regional integration mechanisms, and promoting common policies and coordinated activities among UNASUR member states (UNASUR Health 2010). One year later, their Health Ministers successfully formulated a Five Year Plan (2010–2015) for the South American Health Council, which is composed by the Health Ministers of the twelve UNASUR

member states. The Council's health agenda prioritizes five work areas of common action, consisting of the establishment of a South American Health Vigilance & Response Network, the development of universal health systems, the provision of universal access to medication, the promotion of health and to tackle its social determinants, as well as the development and management of human resources in the field of health.

Another essential initiative aimed at fostering **South–South cooperation** in health was the agreement of the UNASUR member states to establish the first South American Institute of Health Governance (ISAGS in its Spanish acronym). Since all initiatives outlined in the UNASUR Health Agenda depend on management capacities, leadership skills, the quality of advanced training, knowledge production capabilities and health and intersectoral policies, ISAGS was developed to help South American countries train the future heads of health systems (Buss and Ferreira 2010, p. 107; Instituto Suramericano de Gobierno en Salud 2012). Another important mission of the new institution is to manage the existing knowledge, as well as to produce the new knowledge necessary to fulfil its goals, jointly with relevant social and political actors of the social and health spheres of the region (Buss and Ferreira 2010). The Institute is owned by all UNASUR member states and is headquartered in Rio de Janeiro, Brazil (see [www.isags-unasul.org](http://www.isags-unasul.org)).

The UNASUR Health agenda and structures present unprecedented opportunities to improve health and health systems in the Latin American region. Most UNASUR countries have been exposed to a new approach to health that sees it as a product of local and global social determinants and locates health at the interface of domestic and foreign policy. Brazil has been particularly active in the field of global health and foreign policy through other **South–South cooperation** mechanisms (e.g. IBSA, CPLP, see Buss and do Carmo 2009; Almeida et al. 2010), alliances (Oslo Declaration Group 2007) and in global health negotiations (e.g. FCTC, see Alcazar 2008; Lee et al. 2010). These experiences have reinforced Brazil's understanding of health as a complex, intersectoral good that transcends the traditional concept of public health, being seen as increasingly relevant in former non-health governance areas such as: security, trade and development. Such perspectives and experience can be shared with other UNASUR members to eventually consolidate a shared South American understanding of public health as contributing to everyone's well-being and development.

With the establishment of ISAGS, UNASUR has achieved one of its most promising institutional initiatives for South–South health cooperation. In order for health development to flourish within and between its member states, current challenges in the UNASUR region, particularly on country level, still need to be addressed. For example, one challenge that has been highlighted in a recent publication is: “(t)o further improve Brazilian international cooperation in health, many of its institutions need to be harmonized and a law is needed for international cooperation by the National Congress that can define new concepts and provide mechanisms to improve the country's international efforts” (Buss 2011). National efforts to address similar barriers in other countries of the region are therefore more important than ever if South–South health cooperation is to succeed in the UNASUR region.

## Conclusions: Opportunities and Challenges in South–South Health Cooperation

Over the last decades, and most notably in this twenty-first century, **South–South cooperation** has evolved into a more comprehensive development structure that not only seeks to foster economic benefits within the South but also contributes to social and political development. While a number of **rising states** are increasingly becoming engaged in South–South development cooperation projects in developing countries, regional integration processes have also provided support for **South–South cooperation** to flourish in defined regional spaces. Countries have adopted more integrated policy approaches to health and development in response to emerging concepts and as a product of **South–South cooperation**. Cross-country collaboration and regional structures usually emerged with the aim of addressing high disease burdens or to improve inadequate health systems.

The recent increasing attention the international community has allocated to health especially on the global level due to its cross-sectoral character has also positively influenced countries to promote health integration through institutions at the regional level. **Rising states** such as Brazil, Indonesia or South Africa have been notably active in this trend, while even countries without a current membership status in the most prominent regional organizations have approached such institutions in order to ensure health for its citizens, as the case of China in its closer engagement with ASEAN demonstrates. Many regional institutions have expanded their health agenda to embrace initiatives that go beyond immediate threats to health, promoting for example, structural cooperation for health through better health infrastructures. But many commitments to such initiatives still need to be implemented, so it remains difficult to analyse their impact. While these developments are potentially fundamental to improving health for all, we also observe that to date there has been a lack of active civil society involvement in such initiatives (see [Buss and Ferreira 2010](#)).

While **South–South cooperation** is thriving in international development practice, it is a concept that most scholars find difficult to grasp. Most recently, scholars have pointed out that the contemporary South–South geography includes asymmetries of economic and political power that have so far not been adequately taken into consideration when discussing the respective collaboration between **rising states** and developing countries (De la Fontaine and Seifert [2010](#)). Such a discussion must be avoided as **South–South cooperation** undoubtedly represents a foreign policy instrument (Betancourt and Schulz [2009](#)).

As signatories to the Oslo Ministerial Declaration, **rising states** such as Brazil, Indonesia, South Africa and Thailand joined with other developed country partners to stress the essential links between health and foreign policy. These countries commit themselves to ensure that foreign policy serves health objectives (Oslo Declaration Group [2007](#)). According to its signatory states, foreign policy should actively seek to further health for all. **South–South cooperation** is undergoing an exciting revival among **rising states** and developing countries; it represents a new

way of integrating foreign policy with health goals that promises to generate considerable socio-economic benefits for the all partner countries involved. This provided the basis for several consecutive UN General Assembly Resolutions on Global Health and Foreign Policy (<http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N08/472/77/PDF/N0847277.pdf?OpenElement>; <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N09/468/31/PDF/N0946831.pdf?OpenElement>; <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N10/518/24/PDF/N1051824.pdf?OpenElement>; <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N11/465/72/PDF/N1146572.pdf?OpenElement>) which were adopted during the last four years. This represents a significant step forward in the field of global health governance and raises expectations for increasingly concrete achievements in the future.

### Questions

1. What is the connection between foreign policy and health in **South–South cooperation**? What consequences does it have?
2. Is it useful to make a distinction between developing countries and **rising states** when discussing the topic of **South–South cooperation**? Why?
3. What factors can explain the re-emergence **South–South cooperation**?
4. What impact will **South–South cooperation** have on **North–South cooperation**?
5. Do you think that the increasing importance **South–South cooperation** represents only a passing phase that is bound to diminish eventually?

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