Cooperation experiences in the health sector in Latin America and the Caribbean: Critical assessment and proposals for actions with a regional scope
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<td>AECID</td>
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<td>AIDS</td>
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<td>ARVs</td>
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<td>BHCPC</td>
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<td>Best Manufacturing Practices</td>
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<td>Best Prescription Practices</td>
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<td>CAN</td>
<td>Andean Community of Nations</td>
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<td>CAREC</td>
<td>Caribbean Epidemiology Centre</td>
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<td>CASE</td>
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<td>CDB</td>
<td>Caribbean Development Bank</td>
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<td>CECMED</td>
<td>Cuban Centre for State Control of Medicine Quality</td>
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<td>CISSCAD</td>
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<td>CMH</td>
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<td>COCISS</td>
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<td>Subregional Technical Commission for the Preparation of the Health Plan and Agenda of Central America and Dominican Republic</td>
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<td>FOCARD-APS</td>
<td>The Forum on Potable Water and Sanitation for Central America and the Dominican Republic</td>
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<td>GMC</td>
<td>Common Market Group</td>
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<td>Acronym</td>
<td>Description</td>
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<td>HERA</td>
<td>Health Research for Action</td>
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<td>HIS</td>
<td>Health Information System</td>
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<td>HIV</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IC</td>
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<td>INCAP</td>
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<td>INCOTERMFOB</td>
<td>International Commercial Terms Free-On-Board</td>
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<td>LAC</td>
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<td>PASAFRO</td>
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<td>PCU</td>
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<td>PPP</td>
<td>Puebla-Panama Plan</td>
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<td>PPS</td>
<td>OECS Pharmaceutical Procurement Service</td>
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<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<td>TCP</td>
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<td>UNASUR</td>
<td>Union of South American Nations</td>
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Experiences with cooperation in the health sector in LAC. Critical assessment and proposals for actions with a regional scope

**USAID**  
United States Agency for International Development

**VIGILA-SUR**  
South American Network for Health Monitoring and Response

**WHO**  
World Health Organization

**WSG**  
Work Sub-Group

**WTO**  
World Trade Organization
This document by the Permanent Secretariat of SELA analyzes cooperation experiences in the health sector within the framework of the various integration organizations with a subregional scope in Latin America and the Caribbean (LAC).

The study describes the evolution of the efforts to implement common policies and projects in the area of health by longstanding subregional integration organizations in LAC, such as the Central American Integration System (SICA), the Andean Community (CAN), the Caribbean Community (CARICOM), and the Common Market of the South (MERCOSUR). Secondly, the document summarizes the agreements adopted and the projects underway within the context of ALBA, the Mesoamerica Project and UNASUR, organizations that have defined the health sector as one of their fundamental fields of action to make strides towards integration. Finally, the study presents conclusions and some proposals aimed at advancing towards integration and convergence of the health sector in Latin America and the Caribbean.

This study will serve as the basis for the debates that will take place during the First Regional Consultation Meeting on Integration and Convergence for Health in Latin America and the Caribbean, to be held in late March 2010 in the headquarters of SELA.

The Permanent Secretariat wishes to thank Dr. Ariela Ruiz Caro, for her dedicated work as a consultant in charge of preparing this study.
EXECUTIVE SUMMARY

This document of the Permanent Secretariat of SELA provides an analytical review of the evolution of the efforts made by longstanding subregional integration organizations as well as the newly created ones – ALBA, the Mesoamerica Project and UNASUR – to implement common policies and projects in the area of health. All of these organizations have defined this sector as a priority within their lines of action. The three newest organizations push trade-related issues into the background of their action plans to promote integration, and attach top priority to social aspects, development of infrastructure and energy security. In the area of health, these new institutions favour a process of convergence on some issues, following guidelines from their highest political organs.

The effects of the current international crisis and the advances seen in new technologies, the enormous importance of the knowledge factor in the economy, and the fact that dealing with some health problems – such as certain epidemics that go beyond borders – by adopting an individual approach has proven to be ineffective, are bringing about changes in the way to address health development and in the type of solutions required to improve access to high-quality health goods and services for the population. In this context, governments in Latin America and the Caribbean (LAC) have assigned to integration organizations an increasingly important role in achieving the goal of guaranteeing health for all, by using such institutions as platforms for technical cooperation to facilitate communications and interaction among countries in joint initiatives in the health sector. Thus, political and institutional bodies have been promoted in order to address health issues in all relevant subregional integration and cooperation organizations in Latin America and the Caribbean.

In the attempt to strengthen actions in this area within the context of regional integration organizations, the sectoral reforms undertaken in most LAC countries during the 1990s have had some unexpected effects, such as a regressive shift in the role of the State, and the liberalization of market rules have led to privatizations in the financing and provision of health services. As stated by UNASUR’s Technical Commission on Human Resources for Health, there is consensus that in many countries the power of the State has weakened, which has had a negative impact on the quality of health care services. Furthermore, in some countries, this resulted in a reversal of the progress made as regards primary health care services.

However, the efforts to improve the population's access to health through various programmes supported by regional integration organizations have not achieved the expected results yet, despite clear progress at the political level, in particular. As a matter of fact, at regional integration forums, government authorities agree on the diagnosis and solutions to the problems faced by the health sector. For instance, they have all ratified the concept of the prevalence of public health over economic and commercial interests. In this regard, they have stated that medicines, vaccines, medical supplies and equipment required to treat diseases affecting public health must be considered to be global public goods. Similarly, they have signed joint declarations stating that intellectual property rights should not prevent party States from adopting measures to protect public health, or from exercising their right to resort to the flexibilities set forth in the WTO TRIPS Agreements, if necessary.

The limited progress as regards the expectations for progress in the development of the health sector is partly due to the fact that the actions aimed at improving access to health services through the promotion of intra-regional cooperation have been
developed mainly as a complement to the problems derived from the economic liberalization and deregulation processes experienced by most countries in Latin America and the Caribbean in recent times. It should also be taken into account that the decisions made at subregional organizations dealing with the area of health are not legally binding; that there are constraints in management capacities, and the various actors involved (regional and national, public and private actors) have an impact on the development of the health sector; and that there are restrictions as regards financing of common activities, which have to do, in some cases, with a shortage of resources and, in other cases, with the lack of political decision that favours financing for this type of actions, as noted by the Coordination of Forums and Meetings on the Health Sector of Central America.

Noteworthy among the numerous initiatives and programmes carried out by the subregional integration organizations are the joint negotiations on prices and purchases of medicines and medical supplies conducted by the Ministries of Health with international laboratories. One of the most important actions undertaken within the framework of ORAS-CONHU and MERCOSUR were the two negotiations and the agreements reached for the joint purchase of anti-retroviral medicines and diagnosis reagents for the treatment of patients with HIV in the region. They were conducted in 2003 and 2005, respectively, with results described by countries as successful from the political, economic and social development standpoints.

However, as stated by the Andean Health Agency, in some cases it was not possible to take advantage of the price reductions agreed upon due to difficulties with the domestic purchase mechanisms in the countries; in other cases, it was because the local industry refused to acknowledge the agreements reached by their parent companies in the negotiations, and yet in other cases, the heterogeneity in domestic trade regulations affected national purchase processes. PAHO explained that some anti-retroviral drugs that were covered in the negotiations were not even registered in all the countries participating in the negotiation of prices, which was conducted on a voluntary basis and without a formal commitment by the parties involved to comply with the agreements.

It must be noted that the existence of medicines whose production has been abandoned by the private sector and the emergence of the so-called orphan diseases1 have resulted in public production of medicines being regarded as a political tool. In this connection, within the framework of UNASUR, efforts are being made to identify industrial capabilities in the region to plan a regional policy for the production of medicines and other health supplies.

The Caribbean region has also had some experiences with joint purchases of medicines. As a matter of fact, CARICOM countries were the first ones to develop a regional approach for the purchase of anti-retroviral drugs to combat HIV/AIDS, a process that began in February 2002. While the negotiations between the PANCAP and six international pharmaceutical firms resulted in agreements in July 2002 and February 2003,

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1 "Orphan diseases" are defined as those affecting fewer than five people out of 10,000 inhabitants. They include the so-called 130 "rare" diseases, which are characterized by their low prevalence, as well as the "forgotten" diseases, which are transmissible and affect mainly people living in developing countries. They are "orphan" because no attention is paid to them in researches as their medical treatment lacks market interest, and they are not covered in public health policies. (European Organisation for Rare Diseases, EURORDIS). According to the World Health Organization, there are more than 5,000 diseases considered to be orphan diseases.
the problems faced to purchase medicines at the prices agreed upon are similar to those experienced in the South American region.

The Central American countries have also conducted joint negotiations for the purchase of medicines considered to be very costly but also of vital importance for most Central American nations, in compliance with the strategic objectives of the Health Agenda defined in June 2009. The countries already count on Regulations for Joint Negotiations on Prices and Purchase of Medicines, thereby establishing the judicial framework to ensure the legal viability of this process, which began in October 2006.

In general, drug policies established in integration organizations are governed by a series of principles which, among other things, recognize access to medicines as a human right, acknowledging that vital or essential medicines should be treated as public goods, that common good must prevail over individual good, and that access, monitoring of quality and safety of medicines are a responsibility of the State.

The problem is that the objectives of the productive sector and of marketing of drugs do not always coincide with public health interests, which results in: a) an absence of medicines in local markets for the treatment of diseases such as Chagas disease and dengue fever, among others; b) a shortage of suppliers of some medicines for priority diseases; and c) the fact that sometimes unethical practices are used to promote prescriptions of some medications.

Undoubtedly, joint negotiations are a political tool that increases the chances of getting lower medicine prices in comparison with the results obtained individually by countries. LAC countries have always faced the mammoth challenge of dealing with the international pharmaceutical industry, which has a great economic and political power, and obviously seeks to maximize its economic benefits.

Nevertheless, some of the key aspects to facilitate access to medicines are discussed in international organizations whose rules, in many cases, are of a legally binding nature. This is the case of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), the General Agreement on Trade in Services (GATS) and the forums debating the harmonization of sanitary and phytosanitary measures – all of them within the framework of the WTO.

All these issues are also addressed and regulated in the FTAs that several countries in the region have signed with the United States, the European Union and other nations outside the region. Of all of them, the aspects related to intellectual property rights have the strongest impact on access to public health.

This is due to the fact that when signing FTAs, countries accept regulations on intellectual property rights that are more restrictive than those foreseen under the multilateral framework of the WTO TRIPS Agreement. To a greater or lesser extent, the nations of the region that have signed such agreements have had to amend their national legislations and raise their standards of intellectual property protection beyond what is required by the TRIPS Agreement.

In this regard, PAHO officials have warned that patents may represent a barrier to access to medicines since they create a monopoly that slows down the introduction of generic versions that substantially help to reduce prices; in addition, patents benefit central countries because they consolidate the hegemony of transnational pharmaceutical companies, while increasing technological and economic dependence of peripheral countries. They also pointed out that, in view of the fact that these negotiations are
restricted per se, the Ministries of Health do not have enough power to have an influence on them; and in some specific cases, FTAs have been negotiated without the participation of Health Ministries, even though they affected the health sector. In addition, developing countries are not properly informed about the options available as regards intellectual property rights related to access to medications. Therefore, governments are not using the flexibilities foreseen in the TRIPS Agreement and the Doha Declaration.

In this connection, it is important to spread information, not only among government officials but also to all walks of society, about the scope and achievements of these negotiations and their impact on access to health services, and about the importance of making strides towards integration and convergence in the health sector. This is an area of action in which SELA could promote the conduction of forums to foster discussions and dissemination of information about this issue, with a view to strengthening the bargaining position of governments and subregional integration organizations in LAC and promoting a regional strategy for integration and convergence of the health sector in Latin America and the Caribbean, while fostering a strategy for integration and convergence of the health sector in the region by ensuring the participation of relevant political, economic and social actors.

In all these actions and efforts to devise coordinated responses at the regional level among Latin American and Caribbean countries, the participation of not only the main political actors, but also of various social players, would help to face in better conditions the consequences of building an international order that will probably not be based on a strictly multilateral arrangement, but on bilateral and plurilateral agreements.

Since the decisions adopted in the political institutions set up in regional organizations to address aspects affecting the health sector are not binding, it is necessary to develop a communication strategy to spread information about the issues related to the evolution of this sector and its determining political, economic and social factors. This will help to counteract the lack of political awareness about the benefits of integration and coordination in the area of health to achieve health-related goals in Latin American and Caribbean countries, the poor credibility existing in our region about the benefits of integration, the prevalence of economic interests over the social agendas of Latin American and Caribbean integration, and the still low priority attached to matters relating to integration in the region in terms of the national political agendas.

This document concludes with a summary of some proposals for action – mostly, medium and long-term actions – aimed at making strides towards integration and convergence of the health sector in Latin America and the Caribbean.
I. INTRODUCTION

Subregional integration organizations (SICA, CARICOM, CAN and, to a lesser extent MERCOSUR) included in their original treaties general goals in the area of health. Throughout their existence, they gradually created bodies that were entrusted with the specific task of dealing with this area of the integration process. That was the case of the Hipólito Unanue Convention, created in 1971, two years after the establishment of the Andean Community of Nations – which was then called the Cartagena Agreement.

Nevertheless, all of these organizations have created political bodies made up of the Meetings of Ministers of Health of the corresponding integration organizations, which are in charge of governing the sector, even though the resolutions adopted by these forums are not of binding nature (see Annex).

In collaboration with these political and institutional bodies, the regional integration organizations have designed and coordinated various initiatives and programmes in the area of health. Access to health goods and services for many sectors of the population, the reduction of malnutrition and infant and maternal mortality rates, as well as the reduction in the propagation of HIV/AIDS, malaria, tuberculosis and other serious diseases, are all goals and objectives of the programmes established in the declarations agreed upon by consensus at the highest political level by the various integration organizations in Latin America and the Caribbean.

Similarly, the actions undertaken as regards health care in border zones, monitoring epidemics, creation of binational networks of health services in border areas, conduction of prevention programmes and expansion of their coverage are also part of the programmes of the bodies in charge of the health sector in almost all the subregional integration organizations.

Many of these initiatives coincide, and often overlap, with the commitments assumed by the governments of the region individually in other international forums with broader scopes, such as those reached within the framework of the UN Millennium Development Goals, the Presidential Summits between Latin America and the Caribbean and the European Union, the Latin American Summits, and those established in the Health Agenda of the Americas: 2008-2017, of the Pan American Health Organization (PAHO).

In spite of the large number of commitments, health issues have not been subject to a community-wide binding legislation in subregional integration organizations. Generally speaking, community standards have not granted a differential treatment for health-related trade and/or investment in goods or services to be regarded as public goods and not just as mere merchandise. Neither have they standardized some aspects on patents that could be affected in international negotiations with industrialized countries. There are very few exceptions. One of them is the common regime of industrial property of the Andean Community, which deals with the issue of patents and the terms for the test data for medicines, and has a binding nature and precedence over national standards. It was changed in 2006 to ensure viability of the negotiations of the Free Trade Agreements of Peru and Colombia with the United States.

This means that fundamental aspects to ensure greater access to health services for the population, the regulations on trade in goods and services within the region (particularly, medicines and medical equipment), the rules on government procurements and investments, intellectual property rights legislations, which should grant goods, services and investments related to the health sector a "public good" treatment, have not been
sufficiently taken into account by most integration organizations when it comes down to defining their subregional cooperation objectives and programmes in the health sector.

Even though during the 1990s programmes and projects in the area of health were implemented with the support of international cooperation, in general, social issues lost relative importance in comparison with the priority given to trade liberalization and other economic matters. In the area of trade at the subregional level, not only significant strides were made in the reduction of tariff and non-tariff measures, but there was also a process of harmonization of regulations on sanitary and phytosanitary standards, transport, border crossings and other regulations to facilitate foreign trade. In addition, integration organizations were used as platforms to harmonize statistics in various economic and social areas which, in general, tended to adapt themselves to international standards aimed at facilitating the countries’ insertion into the international economic system.

Integration organizations reflected the economic reforms that were implemented in their member countries, which were influenced, in most of the cases, by the multilateral financial institutions and the agreements adopted in the World Trade Organization (WTO). This means that the standards of subregional integration groups were basically determined by the policies applied by their governments, which in many cases were in line with the interests of large corporations, including the pharmaceutical industry. To the extent that national authorities paid less attention to certain social issues, the integration organizations started to have less influence on the formulation of this type of policies, not to mention on the proposals on redistributive public policies.

The growing dissatisfaction with the results of the reforms implemented within the framework of the economic liberalization – mainly in the late 1990s – resulted in serious questioning of their soundness as an option to improve human development levels.

Within this context, social issues, particularly those related to health, started to gain weight in the integration agendas since the beginning of the new millennium. Since then, the commitments and activities in this sector have been increasing. The subregional integration organizations in Latin America and the Caribbean have been promoting political and institutional bodies, as well as joint programmes, intended to deal with the issue of health in a cooperative way and to achieve quality access to health services and medicines.

Nevertheless, thus far, the situation in Latin America and the Caribbean as regards health security and access to high quality health services – despite some noticeable achievements – still shows clear signs of backwardness. In the document “Millennium Development Goals: Progress towards the right to health in Latin America and the Caribbean” (2008), a number of United Nations agencies, under the coordination of ECLAC, reported important achievements during the period 1990 to 2007, but at the same time they pointed to persistent shortcomings and imbalances in health standards and access to health services in our region. Large sectors of the population in Latin America and the Caribbean cannot fully enjoy their right to health. The document concludes that “in order to achieve higher levels of solidarity, avoid the selection of risks and make progress towards ensured equitable coverage, the health systems must overcome the segmentation that reflects the patterns of discrimination of their societies”. Furthermore, it states that “it is urgent to take on commitments with the principles of solidarity and universality, with social protection and tax progressivity”, and recommends “to make huge efforts to promote regional cooperation” in this area.
Experiences with cooperation in the health sector in LAC. Critical assessment and proposals for actions with a regional scope

All of this is directly related to the fact that high poverty rates still persist in our region, as well as a chronic trend to high levels of inequality in income distribution and access to public services, particularly access to education, health, and labour and social protection. Partly, this is the result of the economic policies that were applied in Latin America and the Caribbean during the 1990s, which – according to some analysts – reduced the margins in order to diminish social inequalities. The trend to privatization of the health sector, education and the social pension funds created first-class services for a few people and, simultaneously, excluded from them a significant segment of the population.

There is a widespread opinion that the current situation faced by the health sector – for instance, the problems with human resources – is largely due to the effects from the health sector reforms implemented by the region’s countries. In this connection, the UNASUR Technical Commission on Health Human Resources stated that “the sectoral reforms carried out in most South American countries during the 1990s – characterized by a diminished role of the State and the implementation or tightening of market rules that led to privatizations of health services financing and provision – produced undesired effects that seriously affected their health systems”. Even though such reforms and their impact varied from country to country, there is consensus that in many countries they weakened the State’s capacity to promote a suitable development and management of human resources, which had negative consequences on the quality of health care services. Furthermore, in some countries they even led to setbacks in the achievements already made as regards primary health care services.

Within this context in the new millennium, the social dimension in the health sector has become more relevant. This is evidenced not only in the political statements issued by the Presidential Summits and Meetings of Ministers of Health held by subregional organizations, but also in the creation of new integration and cooperation groups such as UNASUR, ALBA and the Mesoamerica Project. These new regional integration and cooperation projects have attached top priority to the health sector, and the government authorities of their Member States have undertaken initiatives and projects in the area of health as a commitment at the highest political level.

In those three recently-created organizations, trade issues are given less importance and top priority is attached to integration and social aspects, as well as infrastructure development and energy security. These new cooperation and integration organizations also take due account of the convergence process for social issues, particularly in the area of health.

Generally, in regional integration forums, government authorities coincide in their analyses and proposed solutions to the problems faced by the health sector. For instance, they all agree that public health must be given priority over economic and trade interests, and recognize that medicines, vaccines, as well as medical inputs and equipment required for public health care and disease treatment must be considered public goods at a global level. Similarly, they have signed joint declarations stating that intellectual property rights should not prevent Member States from adopting measures to protect public health, or from exercising their right to resort to the flexibilities set forth in the WTO TRIPS Agreements, if necessary.

These organizations also recognize that a strategy to reduce poverty and social inequities should not be limited to actions to palliate their consequences, but it rather should be aimed at eliminating the factors causing poverty, inequities and social exclusion. For this reason, all the strategic agendas of subregional integration organizations foresee the
creation of commissions to work on the determining social factors for the area of health. Nevertheless, while such determining factors are fundamental to achieve greater access to health services, due account must also be taken of the economic and political aspects that are at the very basis of those determining social factors.

The current international financial crisis and the characteristics of the globalization process are changing the nature of the problems and needs in the health sector, as well as the necessary actions to solve and meet such problems and needs. More often than not, the responses taken at the global level to offer better health services do not take due account of the complexity of the different realities in the countries and tend to standardize responses or to set objectives without considering the particular characteristics of the different regions.

On the other hand, individual approaches to tackle some public health problems caused by epidemics with a cross-border impact have proved to be ineffective. In this connection, experts think that in order to confront such public health problems, international initiatives on a regional and subregional scale can lead to much better results in combating international health problems.

Therefore, in order to curb down the effects of the international crisis on the health sector, it is fundamental to strengthen integration processes in Latin America and the Caribbean as a platform for technical cooperation that catalyzes communications and interaction among nations in joint initiatives that allow for solving problems with a transnational nature that also have an impact on the national reality of each member country.

This report describes the evolution of convergence efforts and the implementation of common policies in the area of health carried out by longstanding subregional integration organizations in Latin America and the Caribbean and by recently-created institutions (such as ALBA, the Mesoamerica Project and UNASUR), which have defined this sector as one of their fundamental fields of action. The document concludes by presenting some proposals to make progress towards integration and convergence of the health sector in the region.
II. INSTITUTIONAL FRAMEWORK AND COOPERATION EXPERIENCES IN THE HEALTH SECTOR

A. Traditional subregional integration organizations

1. Andean Community (CAN)

The Andean Community of Nations (CAN) has entrusted the Andean Health Agency - Hipólito Unanue Convention (ORAS-CONHU) with the task of dealing with the health sector. Its highest-level directive body is the Meeting of Ministers of Health of the Andean Area (REMSAA). In turn, the technical secretariat of the REMSAA is in charge of the ORAS-CONHU, which was created to implement the agreements adopted by the Ministers of Health with the top-priority objective of coordinating and supporting the efforts made by its member countries (See Box 1).

**Box 1: Andean Health Agency: Hipólito Unanue Convention**

The Hipólito Unanue Convention (CONHU) is a cooperation agreement signed in 1971 by the Ministers of Health of Bolivia, Colombia, Chile, Ecuador, Peru and Venezuela, with the purpose of contributing to improve health of the population and undertaking coordinated actions to confront common health problems.

It is directed by the Meeting of Ministers of Health of the Andean Area (REMSAA), which gathers on an annual basis, and has an Executive Secretariat created in 1974 with permanent headquarters in Lima.

Since 1998, CONHU is attached to the Andean Integration System, and during the XXIII REMSAA meeting, in 2001, a decision was made to attach its name to that of the Andean Health Agency (ORAS), and thus its current acronym is ORAS-CONHU.

ORAS-CONHU’s mission is to ensure compliance with REMSAA’s mandates, while promoting and facilitating harmonization of policies, exchange of experiences and capacity to respond to common problems, within the framework of Andean integration and the vision of health as a fundamental social right.

In addition, ORAS-CONHU coordinates and promotes actions for the aforementioned purposes, giving priority to the development of subregional systems and methodologies, and coordinating actions to this end with other subregional, regional and international bodies.

**Source:** ORAS-CONHU Web site.

In order to deal with health issues in the Andean area, there is a Strategic Plan 2009-2012, which was approved by the Ministers of Health at their XXII Special Meeting in December 2008. This medium-term Strategic Plan was drafted in accordance with the lines of actions for the health sector recommended by the Heads of State within the context of UNASUR.

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2 The XXIX REMSAA, held on 9 and 10 April 2008, issued Resolution 443 which entrusted the Executive Secretariat of the Andean Health Agency and the Coordinating Technical Committee with the task of preparing a medium-term Strategic Plan that includes management indicators. The plan was submitted for consideration in December 2008.
The Strategic Plan is aimed at promoting Andean and South American integration so as to guarantee the right to health for the population of the region. To this end, efforts should be made to harmonize policy-making, open up spaces for exchanges of experiences, and outline strategies to respond to common health problems, based on the principles of complementariness, equity, commitment, respect for diversity and solidarity.

In defining such plan, a series of problems were first identified, such as: inappropriate coordination of surveillance and response systems in Andean countries, limited access to medicines, difficulties to handle social determining factors in health policies in an operational way, quantitative and qualitative deficit as well as inadequate distribution of human resources for the health sector, and limited access to health systems.

In response to those prioritized problems, the following strategic objectives were set forth:

1) **Contribute to Andean and South American integration in the health sector**

To accomplish this objective, the Andean Community created in March 2003 the Andean Border Health Plan (PASAFRO), intended to set up binational health services networks in order to guarantee health care to people living in border areas or moving across borders (See Box 2). Such networks must meet specific needs and include financial, organizational and health care services. In this context, efforts are being made to continue with the implementation of the Project for “Malaria Control in Andean Border Areas: A Community Approach” (PAMAFRO), which is aimed at reducing the malaria mortality rate by 50% and the morbidity rate by 70% in border areas (See Box 3).

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**Box 2: Andean Border Health Plan (PASAFRO)**

Decision 541 of the Andean Council of Ministers of Foreign Affairs, dated 11 March 2003, approved the guidelines for the Andean Border Health Plan, with three specific objectives:

a) Attach priority to health problems in border areas and define joint actions to confront them.

b) Set up binational networks for health care services in border areas.

c) Outline, implement and evaluate binational cross-border health care projects.

The Executive Committee of the Andean Border Health Plan was especially created for the preparation, implementation and follow-up on the Plan. It is made up of officials of the offices for External Cooperation and International Relations of the Ministries of Health in the Andean Area. The Executive Secretariat of the Andean Health Agency-Hipólito Unanue Convention serves as technical secretariat of the Executive Committee of the Andean Border Health Plan, with the support of the General Secretariat of the Andean Community.
Box 3: Project for “Malaria Control in Andean Border Areas: A Community Approach” (PAMAFRO)

PAMAFRO is a project that joins the efforts made by Ecuador, Colombia, Peru and Venezuela to combat malaria in areas with greater incidence rates. Its objective is to reduce the morbidity rate by 70%, the mortality rate by 50% and the number of municipalities with IPA > 10 by 50% in border areas of participating countries with populations that can easily be affected by this disease due to their precarious living conditions.

The PAMAFRO Project was submitted for consideration of the Global Fund to Fight AIDS, Tuberculosis and Malaria and approved in July 2004, with a total funding of US$ 26 million and an implementation term of five years. Phase I of the project, which started in October 2005, has already concluded, and Phase II is scheduled to be completed by September 2010.

In order to accomplish the aforementioned goals, the following specific objectives have been set forth:

- To promote and strengthen society and community organization and active participation for planning and leadership to fight malaria.
- To increase access among the targeted population to malaria diagnosis and treatment services.
- To outline and implement a Health Information System (HIS) as well as epidemics surveillance, aimed at homogenous and integrated areas, to be harmonized with the already existing Andean System of Epidemics Surveillance and the national HIS. Its objective would be to significantly reduce subregional statistics, which indicate a 50% incidence of malaria cases in border areas.
- To develop a pilot project on information and voice communication networks among health centres in rural communities in remote locations along the Peru-Ecuador border.
- To conduct vital research whose results may be applied through decisions and actions for control and prevention of this disease in homogenous areas of the project.

Additionally, in order to enhance coverage and access, it was necessary to implement a strategy for joint purchases of medicines and medical inputs for the four countries participating in the project, so as to substantially decrease prices and their impact on general costs of medical treatment for affected populations.

The purchase of anti-malaria medicines and other medical products is being conducted with resources supplied by the Global Fund to Fight AIDS, Tuberculosis and Malaria. With the joint purchase strategy, unit prices decrease well below average prices obtained with subregional purchases.

Source: www.orasconhu.org.
2) Strengthen the Andean Network for Epidemics Surveillance and Response, with emphasis on border areas, and coordinate it with those networks existing in South America

To this end, it is necessary to efficiently use the instruments for data communication and analysis among countries, develop human resources specialized in epidemics control in public health systems, strengthen research on control and prevention of public health events in border areas, promote public health surveillance in South America, coordinate responses of Member States of the Andean network to sanitary emergencies through efficient detection and control, and create a network of national institutes and laboratories. All of these actions, as a whole, will contribute to building the so-called South American Epidemics Shield.

3) Promote and guarantee universal access to high-quality, safe and efficient medicines in the Andean subregion

For this purpose, the Andean Drug Policy (see Box 4) should be constantly updated. Similarly, a rational use of medicines should be made, developing Prescription Best Practices (PBP) and Dispensation Best Practices (DBP), suggesting the organization of a subregional pharmaco-surveillance programme and establishing an Andean Code of Ethics that rules the promotion and advertising of medicines.

Similarly, it is important to analyze the capabilities of the countries of the Andean subregion for the public production of medicines, analyze the management of supply systems in the countries of the subregion, and maintain and disseminate updated information on drug prices.

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1 With Resolution 447, the Ministers of Health in their XXIX Annual Meeting of April 2008 approved the creation of the Andean Network of Health Institutes, which plays a very important role in the epidemiological surveillance as it provides critical data on health issues being monitored in the Andean region.

2 The member countries of the ORAS-CONHU plus MERCOSUR and Mexico held two negotiations for the joint procurement of antiretroviral drugs and diagnostic reagents to treat HIV-affected patients in the region. The first one was held in Lima in June 2003 and the second one in Buenos Aires in August 2005, bringing about successful results from the political, economic and social view, as expressed by the countries. The results of the negotiations are explained in the chapter on UNASUR.
Box 4: Andean Drug Policy

The Andean Medicines Policy (PAM, Spanish acronym) was adopted by the Ministers of Health of the member countries in March 2009. This policy represents an update of the Andean Subregion Drug Policy, in force in the subregion since 1993, and is aimed at guiding and strengthening the management of medicines in the Andean countries to offer effective, safe and quality medicines, promoting their rational use and ensuring equitable access to the essential ones.

Some aspects worth mentioning in the PAM are as follows:

1) Reaffirms the importance of medicines as fundamental public goods under the Right to Health and must be guaranteed by health systems, making clear that economic interests should not be above collective interests and public health.

2) Emphasizes that drug selection and inclusion in the listings of essential medicines in each country must respond to the prevailing health and disease problems and not to the “fashion trends” arising from the industry interests and favoured by their influence on physicians.

3) Progress has been made on a proposal to create an Observatory on Drugs to provide Ministers with an updated instrument for monitoring and price control.

4) Stresses the issues of safety and pharmacosurveillance, remembering that no drug is totally harmless and big problems are created by improper use or prescription, and their rational use is a fundamental part of this policy.

5) Raises the issue of public drug production and the possibility of strategic alliances among countries to develop a regional production of drugs and biological products, and stresses the need to encourage national research in order to deal with prevailing and neglected problems.

6) Underscores the need for further harmonization of policies and standardization of criteria to make some headway in integration and turn health into a real space of encounter among Andean ministries, governments and peoples.


4) Establish policies for the comprehensive development and management of human resources in health

To fulfill this objective, it is necessary to implement the Andean Plan of Human Resources, approved in La Paz in November 2007 and comprised of the following scheduled activities:

- Operation of the Andean Observatory of Human Resources as a tool for boosting collective intelligence of human resources;
- Activation of the monitoring system, establishing the baseline for monitoring regional goals for human resource development raised in the six member countries; and
- Development of an Andean conceptual framework for health education with a view to linking training with the health needs of the population; migration management in the Andean region and articulation of the university with the health of the population through training and upgrading of human resources in management, research and teacher education (see Box 5).
Box 5: Andean Plan for Human Resources in Health

The Andean Plan for Health Human Resources refers to a set of actions to deal with common problems of the countries of the subregion, with measures that do not repeat or replace national actions aimed at looking for collective advances under the Regional Goals for Human Resources.

It proposes a plan of action for the year 2015 and a schedule for two-year periods, based on subregional planning schemes of the Pan American Health Organization.

Purpose and objectives

The actions and activities proposed in the Plan are designed for the strengthening of health service systems, particularly those related to Primary Health Care and Interculturalism, and from the integration view among countries.

Specific objectives

a) Support the creation or strengthening and development of the required capacity for policy definition, formulation of plans and adoption of strategies aimed at the development and management of policies for human resources in health in the countries of the Andean subregion.

b) Promote and support the organization or strengthening of the monitoring and assessment processes of achievements made in the countries of the subregion.

c) Contribute to the creation and development of common criteria for health human resource information systems.

d) Promote agreements among countries to guide the correction of distortions and restrictions in training and performance of the health personnel at the different categories and disciplines.

e) Support the establishment of agendas, spaces and opportunities for research and participation with a view to understanding migration of health personnel.

Source: ORAS-CONHU Web site.
5) Turn social determinants into the axis of public policies and health programmes in the Andean subregion

This objective entails, besides designing and implementing intersectoral programmes and projects aimed at strengthening capacities to deal with social determinants and health equity in the subregion with the participation of Andean countries, implementing the Andean Intercultural Health Plan. This plan aims, among other things, at incorporating traditional medicine and intercultural adaptation into health services and systems and formulating and implementing public health policies from an intercultural perspective. Also, according to the subregional HIV/AIDS plan for the health sector for 2007-2010, it has been considered to exchange successful experiences for the prevention of HIV and STDs among MSMs, including young MSMs, sex workers, persons deprived of liberty. Furthermore, the Teenage Pregnancy Prevention Plan is expected to be implemented, as well as the food security policy aimed at disseminating the Andean Plan towards the Eradication of Child Malnutrition among technical and financial cooperation agencies to obtain the necessary resources for its implementation.

6) Promote systems to ensure universal access to health

To meet this objective, it is necessary to have information on access to health investment and its impact on social development. Part of the activities required in the area of health is carried out within the framework of the Andean Commission on Health and Economy (CASE) (see Box 6). They are also related to actions arising from the strengthened Technical Committee for Health Technology Assessment and to the implemented work plan. The Work Programme of this Committee includes various activities, such as harmonization of regulation in the area of health technology assessment; diagnosis of the situation of health technology assessment; shaping of the information exchange network; and development and implementation of a subregional policy on health technology assessment.

7) Strengthen the management system by ORAS-CONHU results to comply with the mandates issued by REMSAA

This objective entails generating and improving human, technical and financial capacities of the ORAS-CONHU Secretariat to ensure compliance with the objectives outlined in the Strategic Plan and the resolutions adopted by the Ministers of Health of the Andean Region. To this end, it is necessary to strengthen the management of human resources and make a proper use of technologies that facilitate the financial and administrative processes of the institution.

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5 The Andean Committee for Intercultural Health, made up of one representative from each country, developed the Intercultural Andean Health Plan with the cooperation of the ORAS-CONHU and PAHO/WHO (resolution REMSAA/438-2000).

6 The Work Plan of the Technical Committee for Health Technology Assessment was approved by the XXIX REMSAA.
Box 6: Andean Commission on Health and Economy (CASE)

The Andean Commission on Health and Economy (CASE, Spanish acronym) was established in February 2006 and includes a Technical Secretariat made up of Ministers of Health and Finance of the member countries.

The 2008-2009 Work Plan of the CASE covers various activities, such as economic analysis and assessment in the health area; training of health and economy critical mass; conduction of national and Andean forums to underscore the importance of investment in health and capacities of health systems to respond to the requirements of economic growth and social development. It also entails the standardization of methodologies for the health sector accounts in South America with a view to moving towards harmonization of financing amounts and public and private expenditures on health, looking for methodological and technical agreements to improve regional comparisons.

Based on the lines of action, information spaces on CASE’s findings should be promoted in the legislative and executive powers of the countries of the subregion, as well as the opportunities for analysis and discussion on topics of the CASE in national forums with the participation of academic institutions, scientific societies, professional associations and civil society organizations.

In November 2008, the first South American Forum on Health and Economy was held in Quito. It was organized by the Andean Health Agency - Hipólito Unanue Convention (ORAS-CONHU) and the Andean Commission of Health and Economy (CASE).7

2. Caribbean Community (CARICOM)

The Caribbean Community (CARICOM), originally the Caribbean Community and Common Market, was established on 4 July 1973 by the Treaty of Chaguaramas with a view to creating a common market. In that treaty, the concern for social issues was expressed in the introduction of the project itself. In fact, full employment, improvement of working and life conditions, and the effective use of established institutions for the economic, social and cultural development of peoples, are aspects mentioned in the considerations for its creation. However, the goals explicitly stated in the text are of economic nature.

The institutional structure foreseen in its founding treaty did not set the creation of a Secretariat to be responsible for social issues. However, as part of the institutions of CARICOM in the area of health, the Conference of Ministers of Health8 was established. This would be responsible for formulating policies and tasks necessary to achieve the objectives of the Community in this area. The Conference of Ministers of Health, as an institution of CARICOM, could dictate their own procedures and establish subsidiary committees, agencies and other bodies it deemed necessary for the efficient performance of its functions, and decide to admit observers to its deliberations.

7 Under the sponsorship of the Ministry of Public Health of Ecuador and the cooperation of the Andean Development Corporation (CAF), the Pan American Health Organization and the World Health Organization (PAHO / WHO), and the auspices of the National Health Council of Ecuador.

8 Similar mechanisms were applied in different social, economic and political areas.
representatives of non-member States and other organizations. One example was the adoption of the Caribbean Charter for Health Promotion (See Box 7).

**Box 7: Caribbean Charter for Health Promotion**

In 1994, CARICOM member states adopted the Caribbean Charter for Health Promotion upon a mandate from the 13th Meeting of the Ministers Responsible for Health in the Caribbean. Since the adoption of this charter, a variety of initiatives has been implemented to promote the health sector development in the region. The implementation of these initiatives has been done in three phases, with possible overlaps. The first phase referred to awareness of the relevance of the principles set forth in the mandate for the well-being of the population in the Caribbean.

The second phase (1997-2001) considered health promotion a central implementation strategy. The six strategies of the mandate were used to identify actions aimed at achieving the goals in eight priority areas. The efforts also tended to seek synergies between the health sector and other sectors. Initiatives such as School Health and Family Life Education Project, Project Lifestyle for Schools, Healthy and Health Hotels and Tourism Projects, Healthy Communities were launched during this phase.

During the third phase, interest was kept in health promotion and capacity building was emphasized to accelerate the implementation of the established proposals.

**Source**: SELA, Social Dimension of Integration: Guidelines for an Action Plan in the areas of health, education, housing and employment, Regional Seminar for consultation on the Social Dimension of Integration in Latin America and the Caribbean, Caracas, Venezuela 16 and 17 July 2008, and PAHO, Report on Eastern Caribbean: Achievements in Health Promotion with respect to the commitments in the Mexico Declaration, Chile Workshop, PAHO/CPC 2002.

Throughout its history, the Treaty has been amended by the protocol mechanisms to adjust the terms of the agreement to fit in with the international political and economic reality. In 2001, these protocols were approved by the Member States, resulting in a new text which represents the revised Treaty of Chaguaramas.

In the objectives set out in the revised Treaty, explicit reference is made to social goals as opposed to the previous text. It also establishes a new institutional structure by creating four Ministerial Councils to support the Council of Heads of State, which replaces the so-called Conferences of Health Ministers or Committees of Ministers in charge of each area. The Council that addresses the issue of health is the Council for Human and Social Development (COHSOD), which also must promotes social and human development, not only through the development of health but also education and sports. (see Box 8).


10 Caribbean Charter for Health Promotion.

11 The other three include: the Council for Trade and Economic Development (COTED), which promotes trade and economic development of the Community; the Council for Foreign and Community Relations (COFCOR), in charge of coordinating the foreign policies of their Member States and, where possible, of achieving joint positions of the Community on international affairs; and the Council for Finance and Planning (COFAP), responsible for coordinating economic policy and financial and monetary integration.
Box 8: Council for Human and Social Development (COHSOD)

The COHSOD is made up of the Ministers designated by the Member States and is responsible for promoting human and social development of CARICOM. In particular, the COHSOD is aimed at:

(a) promoting greater access to health, including the development and organization of efficient and accessible health care services;

(b) promoting educational development through efficient organization of educational and training services in the Community, including the basic and advanced technical and training services;

(c) promoting and developing policies and programs to improve living and working conditions of the population, as well as taking necessary measures to facilitate the organization and development of a harmonious relationship of the workplace;

(d) establishing policies and programmes to promote youth and women development in the Community to strengthen their participation in social, cultural, political and economic activities;

(e) promoting and establishing programmes for the development of culture and sports in the Community;

(f) promoting the development of special focus programmes for the establishment and maintenance of a healthy human environment in the Community; and

(g) performing any function specified by the Conference related to the Treaty.


Also in July 2001, the Heads of State of CARICOM issued a statement with the slogan "The health of the region is the wealth of the region" in Nassau. In this connection, they committed themselves to raising initiatives and objectives that would improve health conditions of the population in the following five years, emphasizing leadership, strategic planning, management, implementation and mobilization of resources in the context of the reform processes of the health sector that were then underway.

To promote the issue of health as the core of the development process and achieve the goals set forth in the Nassau Declaration, the Heads of State decided to create a special group to design a set of strategies for these purposes. This group was established in 2003 under the name of the Caribbean Commission on Health and Development (CCHD) within the framework of COHSOD. The Heads of State also committed themselves to implementing Phase II of the Caribbean Cooperation in Health (CCH). This would be the framework under which all health sector plans would be considered at the regional, subregional and national levels (see Box 9).
Box 9: Caribbean Cooperation in Health (CCH) Phase II and Background

The concept of Caribbean Cooperation in Health was presented in 1984 at a meeting of the Conference of Ministers of Health (CMH) of CARICOM and adopted by the Heads of Government in 1986. They considered that health could be dealt with through increased collaboration and promotion of technical cooperation among countries in the Caribbean, particularly in seven priority areas.

In 1996, the CMH decided to reformulate the Initiative for the period 1997-2001, with a view to benefiting the Member States through: a) reducing costs associated with doubling of services or mobilization of extra-regional support; b) optimizing national and external resources to deal with priority health problems; c) identifying and implementing appropriate projects and programmes in collaboration with regional institutions; d) exchanging experiences with other Caribbean countries facing similar problems; e) creating mechanisms for the ongoing participation of social partners in all stages of development and programme implementation; f) planning for the future of regional health; g) obtaining resources for countries to benefit from economies of scale; and h) implementing the regional integration policy in the health sector.

The priority areas addressed at the regional level were: environmental health, strengthening of health systems, chronic diseases, mental health (substance abuse), family health (prevention and control of transmissible diseases), food and nutrition, and human resource development.

The new phase of the CCH initiative is aimed at ensuring that activities are focused on critical areas to improve the health conditions in the region and actively involve all countries in the Caribbean, as well as regional and international agencies, in a proactive communication network dedicated to improving health in the region. It would also broaden participation to other sectors and participants.


As regards the management of Phase II of the Caribbean Cooperation in Health (CCH), a decision was made to create a Secretariat of the CCH, made up by officials of the CARICOM Secretariat and PAHO. The CCH Secretariat would act as facilitator to ensure the identification of country needs, and promote technical cooperation among nations, agencies, institutions and public and private organizations, and volunteers associated to this subject.

It was also decided that the Pan Caribbean Partnership against HIV/AIDS (PANCAP) serves as a model for mobilizing resources to implement the Regional Strategic Plan against HIV/AIDS. Since the PANCAP became a trusted tool for donors, its expansion was highly recommended to include other priority areas of health and promote donor support (see Box 10).

As for the strategic planning of health, the Heads of State of CARICOM set forth in the Declaration of Nassau that sharing of services and a comprehensive approach for managing and programming health information was an urgent need. They also stressed
that the Regional Strategic Plan against HIV/AIDS should include the Pharmaceutical Procurement Service (PPS) of the Organization of Eastern Caribbean States (OECS) as a mechanism for the purchase of antiretrovirals.

In fact, the first countries to develop a regional approach for the purchase of antiretroviral drugs to combat HIV/AIDS were those of CARICOM. The process began in February 2002 with the Declaration of the Ministers to implement a Regional Plan with the following approaches: to negotiate uniform prices for AZT, 3TC, NVP, EFV, and IDV; to establish a Regional Plan to develop clinical and system health capacity for a comprehensive health care at the regional and national levels; to develop a joint purchasing system through PAHO as well as a framework for negotiations among member countries.

In May 2002, representatives of CARICOM presented the Initiative to ARV suppliers during the World Health Assembly. A month later, in June, a technical meeting was held in Barbados to complete the Framework Document of the Regional Plan, an instrument that provided information about supply and demand at that time, the potential demand, the purchase price and the current legal framework which provided the theoretical coverage of the different countries. In July 2002, the PANCAP and six international pharmaceutical industries agreed packages of drugs for the Caribbean worth US$ 1,000 per person per year.

However, CARICOM governments considered that price still high after the drop in raw material prices and the sharp decline of the tourism market after the attacks of 11 September in the United States. Negotiations continued, and in February 2003 negotiators established a lower price than the one agreed with pharmaceutical industries in July last year, as a result of the combination of research and development of medicines with generic drugs.
Box 10: Pan Caribbean Partnership against HIV/AIDS (PANCAP)

PANCAP was created in February 2001 during the Meeting of Heads of State of CARICOM and approved by the Nassau Declaration on Health in 2001.

PANCAP member countries are: Anguilla, Antigua and Barbuda, Bahamas, Barbados, Belize, Bermuda, British Virgin Islands, Cayman Islands, Cuba, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Montserrat, Netherlands Antilles, Puerto Rico, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, Turks and Caicos Islands, U.S. Virgin Islands.

The Partnership is aimed at expanding the response to HIV/AIDS in the region. Its specific mandate is:
- To promote issues related to HIV/AIDS at the government level
- To coordinate regional activities and mobilize resources at both regional and international levels
- To increase human and financial resources for countries to overcome the epidemic.

The PANCAP structure consists of four elements:
- The PANCAP Membership
- A Steering Committee
- A Coordinating Unit
- Technical Working Groups

The Partnership supports the priority areas for action specified in the Regional Strategic Framework.

The Membership includes member countries, United Nations agencies, bilateral and multilateral organizations, regional and international organizations, networks of people living with HIV/AIDS, academic institutions, the private sector, and faith-based organizations.

The PANCAP Coordinating Unit (PCU) is located at the CARICOM Secretariat in Georgetown, Guyana, and supported by PANCAP partners. Project activities of the PCU include resource mobilization, coordination and promotion of a law on ethics and human rights with a view to assessing national policies so as to avoid non-discrimination practices for persons infected and affected by HIV, and a project to promote exchange of information among partners.

The last (ninth) Annual General Meeting of the PANCAP was held in October in Grenada under the slogan "Towards Universal Access: Strengthening the multisectoral response to HIV/AIDS in the Caribbean." The implementation of the Caribbean Regional Strategic Framework (CRSF) on HIV/AIDS is underway for the period 2008-2021.

In general, governments have recognized that although the Caribbean has implemented aggressive HIV prevention strategies, they have not yet reached all citizens. Therefore, the PANCAP must now take the initiative to organize a movement of political leaders, businessmen, religious persons, athletes and artists to release these initiatives to the people.12

Source: [http://www.pancap.org](http://www.pancap.org)

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12 Opening speech by Mr. Leslie Ramsammy, Minister of Health of Guyana, during the XIII Meeting of the Regional Coordinating Mechanism of the PANCAP, held on 17-18 November 2009 at the General Secretariat of CARICOM in Georgetown.
It is important to emphasize that CARICOM countries face not only the treatment of HIV/AIDS cases, but also a growing number of non-transmissible chronic diseases, for which a treatment should be ensured. In this context, the Technical Advisory Group established at the tenth meeting of the COHSOD recommended the preparation of a study on the existing regulatory systems for drugs in the member countries in order to establish adequacy of resources and ensure timely supply of safe, effective and quality drugs. Aware that the market and human and financial restrictions can lead to a potential barrier to effective and efficient regulation of medicines in each country, they agreed upon the design of strategies and an action plan for the development of a harmonized system for the regulation of drugs in the region.

Since July 2009, CARICOM has a regional assessment of drug registration and regulatory systems in the Member States and the Dominican Republic. As regards the characteristics of the regulatory systems of CARICOM countries, they can be divided into three groups: the first one is made up of five countries, which have a more comprehensive regulatory system, including the registration of medicines. About 91% of the population of CARICOM is concentrated in these countries. The second group includes two countries, where the registration of medicines is scheduled to be implemented in the near future. The third group includes eight countries with limited regulatory systems and where no plans have been made to introduce soon the registration of medicines. Seven of these States are part of the Organization of Eastern Caribbean States (OECS).

In general, the countries believe that harmonization of drug regulations in the context of the Caribbean region will bring benefits. Those who do not have a registration system consider it particularly favourable to establish a central body aimed at assessing applications for marketing authorization. The main causes usually taken into account by countries are the lack of experience and financial and human resource capacity. Most of these countries are stocking up on pharmaceuticals for the public sector of the Pharmaceutical Procurement Service of the Organization of Eastern Caribbean States (OECS/PPS) (see Box 11). However, there is concern about the lack of control of drugs circulating in the private market.

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14 The OECS is made up of Anguilla, Antigua and Barbuda, British Virgin Islands, Dominica, Grenada, Montserrat, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines.
Experiences with cooperation in the health sector in LAC. Critical assessment and proposals for actions with a regional scope

Box 11: Pharmaceutical Procurement Service of the Organization of Eastern Caribbean States (OECs/PPS)

The PPS is an instrument of the Organization of Eastern Caribbean States which pools procurement of drugs and finances itself to cover its operating costs at a rate of 15%. It consists of nine countries of the region: Anguilla, Antigua and Barbuda, British Virgin Islands, Dominica, Grenada, Montserrat, St. Kitts and Nevis, Saint Lucia and Saint Vincent and the Grenadines, with a total population of approximately 550,000 inhabitants.

In 1986, the Prime Ministers of the OECs agreed to establish the PPS, and the initial project was funded by the USAID. The countries deposited third of the annual budget of their pharmaceutical accounts in individual accounts in the Eastern Caribbean Central Bank (ECCB), in order to ensure timely payment to suppliers and maintain a revolving fund for drugs. In 1989 the mechanism achieved financial self-sufficiency.

The products offered by the OECs/PPS are acquired only through annual contracts. The PPS operates a centralized and restricted tendering system, with all approved providers being pre-qualified through a vendor registration questionnaire. Prices are offered in U.S. dollars. The selection of suppliers has a profound impact on quality and cost of medicines. Inadequate quality assurance in the selection process may result in the purchase of ineffective and unsafe drugs.

In addition to the joint purchase, the PPS provides countries with a wide range of related services, such as training and technical support, forms of common drugs, drug utilization studies and quality assurance. In this connection, the PPS has launched a comprehensive quality assurance programme to ensure that each imported drug is effective and acceptable. The quality assurance programme includes the pre-qualification of the selected suppliers, purchasing agreements, and regular testing of priority drugs in three laboratories.


It is important to underscore that, at a Conference held in Barbados in 2006, nine countries of CARICOM\textsuperscript{15} and the Dominican Republic had already discussed the possibility of harmonizing the regulation of medicines. During that meeting, participants determined that the regulatory function of the assessment of records submitted for registration should be done at the regional level. “There could be a regional registry, but the licenses for use in the countries should be under the jurisdiction of each Member State. As regards other regulatory functions, participants agreed to establish regional (and international) guidelines on inspection and licensing for pharmaceutical businesses. A regional body could play an important role in the inspection and licensing for

\textsuperscript{15} Bahamas, Barbados, Belize, Guyana, Jamaica, St. Lucia, St. Vincent, Suriname, and Trinidad and Tobago.
manufacturers, while the regulation of the supply chain was considered a national responsibility based on harmonized guidelines.”

Recently, CARICOM countries have proposed to create the Caribbean Public Health Agency (CARPHA), which came into operation in early 2010 with location of headquarters yet to be confirmed in Trinidad and Tobago. CARPHA became the entity under which the five existing Caribbean entities in the area of health would operate: the Caribbean Epidemiology Centre (CAREC), established in 1975 and based in Trinidad and Tobago; the Caribbean Food and Nutrition Institute (CFNI), founded in 1967 and based in Jamaica; the Caribbean Environmental Health Institute (CEHI), established in 1988 in Santa Lucia; the Caribbean Health Research Council (CHRC), based in Trinidad, which dates from 1955; the Caribbean Regional Drug Testing Laboratory (CRDTL), based in Jamaica since 1974.

Finally, it is important to emphasize intra-subregional cooperation efforts in the area of health. One of them is underscored in the Joint Declaration of the Second Summit of Heads of State and Government of SICA and CARICOM, held in Belize in May 2007. It reiterates the interest of strengthening cooperation in the area of health, particularly through the exchange of experiences in managing non-transmissible chronic diseases and programmes to combat HIV/AIDS, tuberculosis and malaria.

There have been also experiences of bilateral cooperation of countries such as Argentina and Cuba with CARICOM.

3. Common Market of the South (MERCOSUR)

Unlike other integration organizations where the social dimension has been a constant feature since their corresponding foundation, the Treaty of Asunción establishing the MERCOSUR in 1991 – the last integration body created to make up a common market – failed to establish a specific body for the treatment of social issues of integration or health.

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17 The CHRC was originally called Standing Advisory Council (SAC). It was created in order to provide advisory in the area of medical research. In 1972, it was transformed into the Commonwealth Caribbean Medical Research Council (CCMRC), and in 1998 it incorporated the Caribbean countries that did not form part of the British Commonwealth, changing its name to Caribbean Health Research Council (CHRC).

18 The actions underway to conduct CARPHA include an estimate of function, infrastructure and staffing costs; the establishment of a marketing strategy Ahmed at public health specialists in the United Kingdom, in collaboration with specialists of the region; and the planning of a donors’ meeting coordinated by the Caribbean Development Bank (CDB) and the Pan American Health Organization (PAHO). Funding for the preliminary work so far has been supported by the Canadian Public Health Agency of Ottawa and PAHO, while the CARICOM Secretariat, in conjunction with the Office of Caribbean Programme Coordination of PAHO in Barbados, has been responsible for administrative and logistic arrangements.
In 1994, the Ouro Preto Protocol, which sets the current institutional structure of MERCOSUR, creates the Economic and Social Consultative Forum (FCES), which started operations in 1996 and became the representative body of the economic and social sectors of the Member States. However, it has been questioned as a restricted space which is largely outnumbered by actors of social organizations. Moreover, it is hardly consulted by the Common Market Group and its views are not often taken into account.

In 1995, the political body in charge of dealing with the issue of health in the subregion was created: the Meeting of Ministers of Health of MERCOSUR. A year later, in 1996, the Working Subgroup No. 11 in charge of health was created as a technical body of deliberative nature dealing with the harmonization of national regulations governing health and sanitary control systems among Member States.

Within the framework of such political and technical bodies, the issue of health in MERCOSUR has been subject of an ongoing debate that covers several issues, such as ensuring the health of the population, intellectual property, production and access to medicines, social determinants of health, universal health systems, ensuring inclusion of citizens in health policies, implementation of the International Health Regulations, regional surveillance of transmissible diseases, health policy at the borders, strengthening the primary health care, technological innovation policy, among other issues that are being discussed and incorporated into the regional agenda.

The Meetings of Ministers of Health, as a political forum, depend on the Common Market Council (CMC), the highest body of the Common Market, which drives the integration process. It is made up of the Heads of State, Ministers of Foreign Affairs and Economy of the Member States. In this connection, the role of the Meetings of Ministers of Health is "to propose the CMC measures aimed at coordinating policies in the area of health for MERCOSUR. Its objective is the joint prioritization of policy issues in areas identified as priorities by the ministers." To meet its goals, this forum is made up of Intergovernmental Committees (IC) which deal with various issues from a technical perspective, proposing draft agreements that are submitted for consideration of the Ministers of Health (see Table 1).

**Table 1: Intergovernmental Committees that make up the Health Policy Forum in MERCOSUR**

<table>
<thead>
<tr>
<th>IC: Information Systems</th>
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<tbody>
<tr>
<td>IC: Tobacco Control</td>
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<tr>
<td>IC: Dengue Control</td>
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<tr>
<td>IC: HIV/AIDS</td>
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<tr>
<td>IC: Sexual and Reproductive Health</td>
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<tr>
<td>IC: Health and Development</td>
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<tr>
<td>IC: Drug Policy</td>
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<tr>
<td>IC: Risk Management and Vulnerability Reduction</td>
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<tr>
<td>IC: Environmental and Worker Health</td>
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<tr>
<td>IC: Implementation of the International Health Regulations (IHR)</td>
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<tr>
<td>IC: Donation and Transplantation</td>
</tr>
</tbody>
</table>

19 Since its creation to the present, 26 meetings have been conducted, with about a hundred agreements being approved.

20 Common Market Council Decision No. 03/95.
The Intergovernmental Committees meet at least once a year. Given the increased number of committees, it has been considered the incorporation of virtual work methods, avoiding the delay in implementing the work plans.

The main agreements have been reached on dengue-related issues, drug policy, tobacco policy, articulation subgroups and information about health, sexual and reproductive health and HIV/AIDS. Thus, the Meetings of Ministers of Health of MERCOSUR have become a forum that promotes research and policy studies to facilitate the decision-making process of full members and associated countries. In this connection, Tobar (2006) considers that the Meetings of Ministers of Health should conduct studies on the subregional economic evaluation of diseases such as HIV/AIDS, malaria, dengue, Chagas disease, tuberculosis, among others. He also considers of the utmost significance to estimate the gap among Member States, as well as costs to control these diseases; to make annual calculations of proportion of GDP for selected public health problems; to estimate knowledge and health care requirements; and to assess the support requirements of other agencies. To deal with these issues, the Intergovernmental Committee on Health and Development was created in July 2004 in the context of the Meeting of Ministers of Health.

Some progress has been made in the field of coordination in international forums, agreeing on a common position regarding several issues, such as the adoption of the International Health Regulations and the Declaration of the Ministers of Health of South America on Health, Innovation and Intellectual Property, positions that have also extended to the South American area.

As regards the technical body in charge of health in MERCOSUR, SGT No. 11 “Health” is one of the Working Groups of the Common Market Group (GMC), executive body of the Common Market Council (CMC), consisting of the Ministries of Foreign Affairs of the Member States, which aim at promoting measures for the Trade Liberalization Programme, the coordination of macroeconomic policies and the negotiation of agreements with third parties. The work of SGT No. 11 “Health” is organized according to a Negotiating Guideline, of common interest, based on issues prioritized by the Member States and agreed upon and approved by the GMC.

The SGT No. 11 carries out the following actions: harmonizing and reconciling legislations in the area of health in order to remove obstacles to trade flows within the subregion; reconciling the sanitary control systems of partner countries to ensure mutual recognition at the subregional level; defining the relationship with other bodies of MERCOSUR, in order to complement and integrate activities; proposing procedures for the organization of information on health among members and promoting the integration of national systems and structures, related primarily to improving the quality and safety of products and services in the area of health (Tobar, 2009).

As regards the organizational structure, the SWG No. 11 is made up of three specific committees:

- Committee on Health Products (covering psychotropic and drug products; blood and blood products; medical products, cosmetic health products);

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21 MERCOSUR/CMC/ACTN0 01/04.

22 It was created by Resolution GMC No. 151/96.
Committee on Health Care Services (professional development; evaluation and use of technologies in health care services); and
Committee on Health Surveillance

They work together with their subcommittees and ad-hoc groups. The subcommittees function as working groups made up of representatives of the Member States who discuss topics in the light of national health policies, building regional consensus.

The progress made by the Committees has been uneven. The Committee on Health Care Services has reported the least progress in the harmonization of standards. On the contrary, the Committee on Health Products has harmonized the majority of rules. However, MERCOSUR legislation has had little impact, since the industry has adapted to the national laws of the countries and has no incentives to adopt MERCOSUR rules.

Like the other regional integration bodies, MERCOSUR agreed on a Drug Policy and a Plan of Action for its implementation. The drug policy for MERCOSUR, Bolivia and Chile (PMM, Spanish acronyms) was adopted in 2000 and contains a wide and comprehensive approach. The purpose of this policy is to improve the State action, particularly in relation to four topics identified as key objectives for the countries of the region in the area of medicines:

a. increase the population access to drugs, considering the needs of the different social groups;
b. ensure the quality, safety and efficacy of drugs circulating in the region;
c. promote the culture of rational drug use;
d. create a research and development environment in the sector to promote integration of countries in the domain of sectoral technology.

The drug policy is also based on a fundamental choice in favour of the generic drug policy and the essentiality criteria established by the World Health Organization.

The Plan of Action for the implementation of the PMM was approved three years later, in 2003, by the Meeting of Ministers. The aspects covered by such plan are shown in the following box (see Box 12).

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Box 12: Plan of action for the implementation of the drug policy of MERCOSUR

The Plan of Action includes the following aspects:

1) **The selection of essential drugs** to enable better access to medicines and promote their rational use.

2) **Generic Drug Policy as a strategy to promote access to medicines**, for which the harmonization of the various design approaches in generic drugs is required, giving priority to different issues according to the local situations.

3) **The development of a common strategy as regards patent requirements and its effect on access to essential medicines.** This is probably one of the problems that increasingly challenge the procurement systems of the public sectors and the possibility of supporting access to medicines for the treatment of high-cost diseases such as HIV/AIDS, among others.

4) **Improving Public Procurement Systems and generating greater market transparency.** This is another area dealt with by the PMM where there is enough room to develop a joint strategy that covers from the exchange and dissemination of best practices and the introduction of mechanisms that increase transparency, to the possibility of conducting joint negotiations of certain inputs, multiplying efforts and ensuring economies of scale.

5) **The promotion of research and development activities** to guide and increase efforts of each State and to support joint ventures - such as research funds -

6) **Promoting rational drug use.** A series of regulatory and educational strategies is proposed and identified as being of high priority, namely: developing rules of prescription for rational use of drugs, based on international scientific consensus; promoting the practice of pharmaceutical care; developing educational activities aimed at the population; promoting the organization of public and private drug supply systems, in a scheme of health facilities integrated into national health systems; developing strategies for integration of drug information centres; controlling more effectively the advertising and promotional activities; and continuously evaluating the drug utilization profile in the region. A highly necessary support to the implementation of the items identified as priorities of the PMM is related to educational activities aimed at all professionals and agencies working in the drug chain, at all levels of promotion and action.

7) **Regulatory actions to ensure the quality and safety of the drug chain.** To ensure a joint regulation in the region, negotiations on harmonization of specific topics in the technical forums of MERCOSUR should be a priority.

*Source*: MERCOSUR/ XIV RMS/Agreement No. 04/03.

It is important to underscore that MERCOSUR has a Price Database for the member countries, Bolivia and Chile since 2000 which, at the time of its creation, was based on government procurements, health services and consumer services. The body was designed to encourage a periodic survey on consumer prices in each of the Member and Associate States from a common list of products. It regained impetus in 2007, as it will be seen below.

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24 Created by Agreement RMS No. 2/00.
The existence of this Bank facilitated the negotiation of joint procurement of antiretroviral drugs held with the countries of the Andean Health Organization, Hipólito Unanue, in 2003 in Lima. In fact, during the XVI Meeting of Ministers of Health of MERCOSUR, Bolivia and Chile in June 2004, participants acknowledged the reduction in ARV drug prices after the abovementioned negotiation in Lima. However, they also noted that in many cases the drug prices were financially inaccessible for some countries in the region.

To address this difficulty, Resolution MERCOSUR/XVI Agreement No. 104 was adopted, in order to promote and facilitate a government analysis on different joint strategies for negotiation with pharmaceutical companies to increase accessibility to antiretroviral drugs.

Similarly, in the XXVI Regular Meeting of Ministers of Health of the Andean Area held in March 2005 in Santiago de Chile, the Ministers of Health and Social Protection adopted the Resolution REMSAA XXVI/399 approving the work plan of the Subregional Technical Committee for Drug Access Policy, stressing the need to continue the joint negotiation process and take actions to achieve the expected impact on the subregional strategies and negotiations of drugs and drug inputs.

A day later, in that city, the same authorities met within the framework of the IV Meeting of Ministers of Health and Social Protection in South America to make some progress in searching for shared solutions, such as promoting access to ARV drugs and reagents for HIV in the region. In its Statement 11 issued on 1 April 2005, the Ministers of Health and Social Protection in South America highlighted the importance that countries have adequate access to drugs and drug inputs in terms of timeliness, quality and prices. They reaffirmed the joint negotiation as an effective tool to get lower prices, improve accessibility and increase the coverage, and agreed to hold a second round of joint negotiations from 3 to 5 August 2005 in Buenos Aires, Argentina.25

Although joint negotiations of drugs have not continued, some progress in another area has been made, particularly during the XXIII Meeting of Ministers of Health of MERCOSUR and Associated States, held in Punta del Este in November 2007. At that time, participants defined joint strategies to promote the Drug Price Bank of MERCOSUR and Associated States.26 This means that the Ministries of Health will have a bank of drug prices at their disposal, with which they assess how much it is paid at the regional level for the least prevalent and “high cost” medicines. Thus, they may set a price ceiling for its purchases nationwide. This information will enable them to require providers a price in line with the international value.

At first, the bank will have information on prices paid by each State for antiretroviral drugs, cancer and some immunosuppressants. However, the list of drugs is expected to be extended to any treatment in the short term. Since Brazil already has a system of this type, the headquarters of the regional bank will be located in that country, and the other countries may have on line access to this information, expected to be updated on annual basis. Agreements signed by participants include one aimed at regulating the promotion and advertising of drugs at the regional level (Agreement No. 11/07) and

25 The details of the negotiations conducted in Buenos Aires in 2005 are available in the chapter on UNASUR.
26 Agreement No. 14/07, XXIII Meeting of Ministers of Health of MERCOSUR and Associated States, held in Punta del Este (Uruguay), on 30 November 2007.
another that will join efforts in combating counterfeit drugs and illegal drug trade (Agreement No. 12/07).

Furthermore, in November 2008, the Ministers of Health agreed to implement the MERCOSUR Observatory on Health Systems, under the Coordinating Committee of the RMS. It was created with a view to developing an instrument for disseminating information to health systems and exchanging experiences among Associate and Member States, based on the analysis of the organization, financing and social participation practices in the context of these systems. It is also aimed at analyzing institutional concepts and guiding principles in the case of countries which have undertaken reforms in their health systems and identifying the role of major social actors in the development and management of health systems. Each country will propose a public academic institution to provide technical support to the Observatory.27

Dealing with social issues, including health, has gained increasing importance in MERCOSUR. During the last regular meeting of the Common Market Council,28 held in Asunción in July 2009, the authorities issued a Statement on Mechanisms for Coordination and Articulation of Common Problems in the Areas of Social Development and Health. They stressed the need to strengthen the social aspect as one of the cornerstones of the regional integration process and incorporate the social determinants of health in the design, implementation and monitoring of sectoral and intersectoral public policies at the regional level.

MERCOSUR authorities agreed that comprehensive actions help reduce exposure to social risks and vulnerabilities as determinants of the health conditions of the population, particularly the most vulnerable sectors. In this connection, they decided to establish a joint agenda for Social Development and Health, which will take into account advances in these areas in the integration process, promotion of new policies for social protection in health and social development as well as the contribution of other Meetings of Ministers, specialized meetings and other forums of MERCOSUR dealing with social issues.29

It is also important to underscore that on the same occasion, the authorities and associated countries of MERCOSUR said that the organization, if required, should activate the mechanisms related to the flexibilities provided by the Agreements on Trade-Related Aspects of Intellectual Property Rights (TRIPS), in connection with the manufacture of drugs against influenza A (H1N1). MERCOSUR also requested WHO to “coordinate efforts to expand production capacity for vaccines, antivirals and diagnostic drugs at affordable prices. Participating countries agreed to strengthen the network of laboratories for detection, early warning, and research for vaccine development “with a new regulatory approach to ensure their access to the population.” They undertook to coordinate between ministries of health in the region with all the agencies related to innovation, technology transfer and productive capacity, in order to encourage regional production of vaccines, antivirals and other drugs against the influenza A (H1N1).

27 Taken from MERCOSUR/RMS/AGREEMENT No. 18/08.

28 Participants also included the Ministers of Social Development and the Ministers of Health of MERCOSUR and Associated States on 23 July 2009 on the occasion of the Expanded Session of the Thirty-Seventh Regular Meeting of the CMC.

29 Taken from the Declaration on Mechanisms for Coordination and Articulation of Common Problems in Social Development and Health of MERCOSUR and Associated States, meeting in Asuncion on 23 July 2009, during the Expanded Session of the XXXVII Regular Meeting.
One of the tasks still to be carried out by MERCOSUR in the area of health is their treatment in border zones. Some institutions consider it necessary to make comprehensive studies on the status of the various health systems in the border area (infrastructure, coverage area, installed capacity) with a view to facilitating coordination of services and identification of strengths and weaknesses. Proposals also included the establishment of border committees to jointly treat health emergencies (dengue, malaria, disease, H1N1, among others) and an assessment of the infrastructure (telecommunications, networking and public-health infrastructure) available to MERCOSUR at the borders, defining priorities and lines of action, such as that conducted by SIS BORDERS of the Brazilian Ministry of Health.30

4. Central American Integration System (SICA)

The area of health in the Central American Integration System is responsibility of the Council of the Central American Ministers of Health (COMISCA). Its activity is legally and institutionally in line with the Declaration of San Salvador, which established it in 1991; the Tegucigalpa Protocol, signed in December 1991 to create SICA31; and the Treaty on Central American Social Integration (TISCA), signed in 1995 to establish the Social Integration Council (CIS), the Secretariat for Social Integration and the legal framework for the sector councils of the Social Subsystem.

The COMISCA is the political body of the Central American Integration System (SICA) in the area of health. Its responsibilities include being the rector body of the regional health sector; identifying and prioritizing health regional problems which, given their importance, should be addressed through an agenda and a Central American health plan in order to have a greater impact than the one expected if they were dealt with individually; identifying health problems that, due to multiple causes and economic implications, should be submitted for consideration of the Summit of Presidents for intersectoral solutions; promoting regional health initiatives that require international cooperation channelled through SICA; and implementing and evaluating the agreements and resolutions arising from the Summits of Presidents.32

The health sector, of which COMISCA is the rector body, is made up of the following bodies: (See Box 13)

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30 Suggestions on public policies for cross-border integration in MERCOSUR, a document drafted by participants of the Seminar-Workshop on Cross-border Integration and Cooperation in MERCOSUR, held in the Spanish Cooperation Training Centre in Montevideo on 21 to 25 September 2009. The activity is in line with the MERCOSUR Subregional Programme of the Spanish Agency for International Development Cooperation (AECI), which in turn also supports the three-year Border Integration in MERCOSUR project (2009-2011), aimed at defining lines of action for the design and management of public policies on border integration in MERCOSUR.

31 The Tegucigalpa Protocol, signed by six Central American Presidents on 23 December 1991, updates the judicial framework of the Organization of Central American States (ODECA), signed in Panama in December 1962.

Box 13: Bodies making up the regional health sector of SICA

- **Meeting of the health sector in Central America and Dominican Republic (RESSCAD)** is a sectoral forum aimed at promoting the exchange and development of experiences and knowledge. It also tries to achieve a commitment among the Member States for the solution of common health and environmental problems that require joint and coordinated efforts of countries, in order to have a greater impact than the expected if they were dealt with individually, in the context of the Central American integration.

There have been multiple subregional meetings with the participation of Ministers of Health and general directors in the sector for 39 years.33

The RESSCAD has a coordinating function and represents the forum by which COMISCA can effectively play its leading role in the sector, governing several key actors, such as technical and financial cooperation agencies.

- **Council of Social Security Institutes in Central America and Dominican Republic (CISSCAD).** The CISSCAD, created in September 2007 to replace the Central Council of Social Security Institutions (COCISS)34, established in 1992, preserves the objective of promoting projects and actions aimed at achieving the extension of social security benefits to all countries of the region, without discrimination of any kind, according to national programmes for economic and social development.

33 Since 1956, the forum was known as REMCAP (Meeting of Ministers of Health of Central America and Panama), and since 1971 it adopted the name of RESSCAP (Meeting of the Health Sector of Central America and Panama). In 1985 the Social Security agency joined the group, and in 1988 it was renamed RESSCA (Meeting of the Health Sector of Central America) and Belize joined in. From 1998 to the present, it is referred to as RESSCAD, with Dominican Republic joining the group, and the sectors of Water and Sanitation, and Social Security in the Region are included, thus increasing membership. Since the first RESSCAD, the OPS, which participated in the Meetings of Ministers of Health, became the Technical Secretariat of the meetings.

34 The COCISS implemented important projects, namely: Multilateral Central American Agreement on Emergency Medical Attention for Foreign Patients insured by Social Security Institutions; Agreement on Training of Human Resources in Hospital Management; Project for Training in Neonatal Resuscitation; Project for Early Detection of Cervical Cancer; Quality of Medicines; and in 2005, the Multilateral Agreement on Health Protection of Foreigners while in Transit insured by Social Security Institutions in Central America, including the member countries of the COCISS.
Experiences with cooperation in the health sector in LAC. Critical assessment and proposals for actions with a regional scope

35 - Central American and Dominican Republic Forum on Drinking Water and Sanitation (FOCARD-APS). This regional forum was created in February 2006 and brings together the eight major bodies in charge of public policies, plans of action, master plans and investment plans in this sector in the countries of SICA, making it possible to achieve a common regional position of the drinking water and sanitation sector and making up an important platform for cooperation among countries to promote actions in support of public health and well-being of the population of Central America.

35 - Board of Directors and Advisory Council of the Institute of Nutrition of Central America and Panama (INCAP). This body, a centre of PAHO/WHO specializing in nutrition and institution of SICA, was established in September 1949. It is aimed at supporting, within the framework of Central American integration, the Ministries of Health of the Member States and the COMISCA in playing its leadership role in nutrition for health and development with a view to preparing and harmonizing local, national and regional agendas to achieve Food Security and Nutrition (SAN) and strengthening the capacity of key social actors responsible for their implementation.

It is worth noting that other regional bodies support the leadership role in areas that are not directly related to health activities, but complement them and play an important role in the process of social production of health. One is the Central American Commission on Environment and Development (CCAD).

The COMISCA includes an Executive Secretariat since September 2007, which is aimed at strengthening and ensuring the smooth functioning of the Council and assuming the Technical Secretariats of the REESCAD and Directing and Advisory Councils of INCAP. The Executive Secretariat of COMISCA has also the mission to support the COMISCA in consolidating its leadership role in managing regional health, coordinating it with the integration bodies and institutions that directly or indirectly affect the health of the population, with emphasis on those from the Regional Health Sector. The objective is to lead them towards a more coordinated, integrated, harmonized, effective and efficient management based on a regional health agenda that ensures the protection and improvement of health of the population.

Moreover, it is the body that considers the recommendations made by the international health organizations related to the COMISCA and particularly those from the bodies and institutions of Central American Integration System, SICA; it entitles the President Pro Tempore and Technical Secretariat to conclude agreements with international agencies in order to achieve the objectives of the COMISCA; it creates the number of advisory

35 The FOCARD was recognized as a mechanism of regional institutionality by the Presidents of Central American Integration System at their Summit held in June 2005 in Tegucigalpa, Honduras. The Convention was signed in the context of the "Workshop on Unification of Basic and Fundamental Concepts for the Drinking Water and Sanitation Sector and Strategic Plan of Central American and Dominican Republic Forum on Drinking Water and Sanitation (FOCARD-APS)", held in Guatemala.

36 The Executive Secretariat of COMISCA was created within the framework of the Special Meeting of COMISCA in San Salvador on 10 September 2007. The provisions replace the contents set forth in the Act of Antigua, Guatemala, adopted at the XIII Meeting of the Council of Ministers of Health of Central America on 18 August 1999, when the Secretary of the Central American Social Integration (SICA) was designated as Technical Secretary of COMISCA.
committees it deems necessary for the fulfillment of the purposes of the COMISCA, among others.

The Regional Health Agenda is the instrument by which the COMISCA plays its leadership role in health at the regional level. During the XXIX Regular Meeting of the Council of Ministers of Health of Central American Integration System, held in late January 2009 in Tegucigalpa, participants adopted the Agenda of Health for Central America and Dominican Republic: 2009-2018. It represents the political instrument with an integrationist approach established by the governments of the region and includes some strategic objectives (see Box 14).

Box 14: Strategic objectives of the Health Agenda for Central America and Dominican Republic

1. Strengthen the social integration of Central America and Dominican Republic through the definition and implementation of regional health policies.
2. Strengthen the leadership role of the national health authority within the framework of Central American integration.
3. Strengthen and extend social protection in health by ensuring access to quality health services.
4. Reducing inequalities and social exclusion in health within and among countries.
5. Reduce risks and burden of transmissible and non-transmissible diseases, gender and social violence, as well as those related to the environment and lifestyles.
6. Strengthen the management and development of health workers.
7. Promote scientific research and development of science and technology in health and use/application of evidence in public health policies.
8. Strengthen food security and nutrition and reduce malnutrition with the support of the specialized institution in the region, the Institute of Nutrition of Central America and Panama (INCAP).
9. Establish mechanisms to increase coverage in the provision of safe water for human consumption, and the protection and improvement of human environment, with the support of the Central American and Dominican Republic Forum on Drinking Water and Sanitation (FOCARD-APS).
10. Reduce vulnerability to natural disasters, anthropic emergencies and effects of climate change.

Source: Health Agenda for Central America and Dominican Republic, Tegucigalpa, 30 and 31 January 2009.
The Agenda is based on the principles of integration, right to the highest possible level of health, solidarity and participation, equality of men and women, respect for ethnic and socio-cultural diversity and primary health care. It lines up with the Health Agenda for the Americas, launched by the Ministers of Health of the Americas in Panama in June 2007, and the Social Strategic Agenda for Central America, which was adopted by the Heads of State and Government of SICA in December 2008 in San Pedro Sula, Honduras.

The development of the Health Agenda was the result of a participatory process, led by the health authorities of the countries who appointed the Subregional Technical Commission for the Preparation of the Health Plan and Agenda of Central America and Dominican Republic (COTESAS), in charge of coordinating the different stages of development of the agenda. Intersectoral national consultations were conducted in the eight countries, as well as consultations with regional bodies.

In compliance with the strategic objectives of the Health Agenda during the XXX COMISCA Regular Meeting held in Managua in June 2009, the Ministries of Health and Social Security Institutions in the countries of Central America and Dominican Republic committed themselves to carry out in 2009 the joint negotiation of 37 products considered of high cost and importance for most countries, since they are intended to treat health problems such as cancer, treatment for kidney failure, immunodepressants in kidney transplant, treatment for liver failure, diabetes and treatment for cardiovascular diseases.

On that occasion, the Ministers of Health adopted the Regulations of the Joint Negotiation of Drug Prices and Procurement, which provides the legal framework that gives the legal recognition to the process. Moreover, drug manufacturers were called to participate in this process.37

This joint negotiation is primarily aimed at obtaining better prices in the procurement of drugs, with an estimated cost reduction of up to 46%, which means a saving of approximately US$ 37 million.38 This draft joint negotiation on procurement prices was launched in October 2006. In 2008 began the process of joint negotiation on prices of drugs included in the Subregional Harmonized List, based on a review of the legislation applicable in each country.

The negotiation process has been led by the Subregional Technical Commission on Drugs (CTSM)39 with the technical and financial support of the Pan American Health Organization (PAHO), the Spanish Agency of International Cooperation for Development (AECID) and the IDB. The preparation of the joint negotiation and purchase of drugs will be in the hands of the COMISCA Executive Secretariat, in coordination with the General Secretariat of Central American Integration System (SG-SICA).

Negotiations for joint purchasing of drugs also tally with the regional drug policy adopted by SICA and developed by the CTSM. This policy is based on the following general principles:

37 Information on this matter is available at the Web site www.ocamed.org

38 Source: Noticias del SICA, 16 June 2009.

39 In December 2006 in San Salvador, the Subregional Technical Commission on Drugs (CTSM) was officially installed to develop proposals, strategies and a work program aimed at formulating the Drug Policy for Central America and Dominican Republic. This body is made up of representatives of the Ministries of Health and social security institutions in the region.
1. Access to medicines is recognized as a human right.
2. A vital or essential medicine should be treated as a public good.
3. Common good should prevail over individual good.
4. Access, quality surveillance and safety of medicines are a state responsibility.
5. Incorporation of the Drug Policy for Central America and Dominican Republic in the health policy of each country in the subregion.

The strategic objectives of the policy are aimed at revising and updating the legal framework for the implementation of the Drug Policy in Central America and Dominican Republic; improving access, availability and equitable provision of medicines to the population of the countries of the subregion; ensuring quality, safety and efficacy of drugs to protect public health; managing the supply of drugs on an efficient and timely basis; and promoting the rational use of them to ensure that people receive the appropriate treatment according to their needs, doses that meet their individual needs and for an appropriate period of time. To comply with these strategic objectives and to implement this policy, five components have been suggested (see Box 15).

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**Box 15: Components of the Regional Drug Policy for Central America and Dominican Republic (Summary)**

**First component: Legal framework**
Strategic lines:
1. Analysis of the legal framework related to the topic of drugs

**Second component: Access, availability and provision**
Strategic lines:
1. Encourage access and availability to drugs
2. Promote the use of generic drugs
3. Use of mechanisms to limit costs (through joint negotiation)

**Third component: Quality, security and efficacy**
Strategic lines:
1. Quality assurance of drugs
2. Research

**Fourth component: Drug supply management**
Strategic lines:
1. Efficient supply systems
2. Timely supply management

**Fifth component: Rational use**
Strategic lines:
1. Promote rational use of drugs
2. Pharmaco-surveillance

*Source: Regional Drug Policy in Central America and Dominican Republic, AECID, PAHO, SISCA and SICA.*
Price negotiations for the joint purchase of five drugs (out of 37 that will be purchased in the coming months) between Central America and Dominican Republic with international laboratories began in early October 2009 in San Salvador. The first negotiation, which lasted two days, is a first effort under a plan that includes the acquisition of high-cost drugs not produced by laboratories in the region. The purchase of drugs will be negotiated in various meetings with representatives of the laboratories by March 2010.

The products to be acquired are produced by "the only manufacturers in the world", and thus no competition concerns are expected to be raised by laboratories established in the Central American countries that produce them. The countries plan to negotiate the best market price and generate savings, which should be invested in "extending coverage" of state health systems. The Central American Integration System (SICA), to which COMISCA reports, said in a statement that countries plan to invest about US$ 12 billion in the purchase of these five drugs.40

Participants in this first negotiation include Roche, Abbott and Schering Plough laboratories, said SICA. Drugs that are traded in this first phase are prescribed to treat two "cancers of the immune system", such as rheumatoid arthritis or lupus. In addition, two drugs that stimulate the battle of cancer cells and a substance that helps premature babies in respiratory infections. The expanded list of 36 drugs include "antibiotics and others of common use" in the region. Priority is being given to the non-regional production of drugs, which are exported by a single manufacturer and have different prices throughout the Central American area when purchased separately.

It is important to underscore that SICA has an Observatory on Drugs aimed at: organizing and consolidating information on drugs that are available in Central America and Dominican Republic; gathering and disseminating information in a structured and systematic way; having at one’s disposal information on drugs for decision making, encouraging the exchange of information among professionals and providing a space for sharing experience and knowledge, among others.

Moreover, SICA carries out a series of health programmes promoted by the international technical cooperation as the socialization and institutionalization process of national plans to eradicate chronic child malnutrition in the context of national nutrition policies; coordination of a regional response to human influenza H1N1 pandemic; projects to slow down progression of diseases such as HIV/AIDS, malaria, dengue, tuberculosis, among others; and the training of human resources in primary health care.

B. Recently created integration and cooperation organizations

5. Bolivarian Alliance for the Peoples of the Americas (ALBA)

ALBA was formally established in December of 200441 through an agreement between Caracas and Havana that includes offset trade agreements and exchanges of goods and services according to the needs and capacities of both countries. Afterwards,

40 Executive Secretary of the Council of Ministers of Health in Central America and Dominican Republic (Comisca), Rolando Hernández.

41 It was initially proposed as an alternative to the Free Trade Area of the Americas (FTAA), and hence its initial name Bolivarian Alternative for the Americas, which later became the Bolivarian Alternative for Latin America and the Caribbean and now is the Bolivarian Alliance for the Peoples of the Americas.

This initiative started from complementarity principles in the context of an own (endogenous) multidimensional (economic, political, social and cultural) perspective based on the reciprocal cooperation aimed at overcoming asymmetries among its members.

According to some analysts (Oliva, 2007), ALBA includes 5 axes:

- Energy: main oil resource for financing.
- Human development: includes health, education and sport programmes.
- Infrastructure.
- Communications: TELESUR’s role is of great significance.
- Finances: strategies for financial cooperation and, more recently, the creation of the Bank of ALBA.

Actually, efforts have been made to implement state control policies on economy that influence the development of the member states. Therefore, strategic alliances are preferably established through public and joint management enterprises.

ALBA is considered a recently created mechanism with a marked social content thanks to the participation of social organizations and actors. Nevertheless, according to the current structure of ALBA, a parliamentary body is not expected to be created soon.

The Social Commission of ALBA is in charge of health and education matters. In this connection, the grand-national plan for the development of the Health Mission in the countries of ALBA takes into account the recovery and implementation of public health systems, as well as the provision of instruments for research and development of biodiversity resources in the region. The training of medical science and health specialty professionals is also taken into account under the guidelines of ALBA-TCP (Bolivarian Alliance for the Peoples of the Americas-People’s Trade Agreement).

Furthermore, ALBA is responsible for the so-called Miracle Mission (free eye operations), which is supported by Cuba and has treated more than a million patients in Bolivia, Nicaragua, some Central American and Caribbean countries and South America, offering also services to population sectors that require medical diagnoses, medicines, vaccines, prosthesis, physical and gynecological treatments and geriatric care, among others.

In the “Barrio Adentro” Mission implemented in Venezuela, more than 23,000 Cuban doctors provide health care to more than 17,000 million people.

One important integration project of ALBA-TCP in the area of health is the Centre for Drugs Regulation of ALBA, which is designed as a single Sanitary Registry aimed at facilitating access to effective, safe and quality medicines. It represents a new and additional body to the national authorities for drugs regulation in each country, which will continue acting within the scope of their current obligations. This Centre will issue a sanitary registration certificate to be valid in all member countries of ALBA and carry out duties related to the drugs regulation system, inspections, laboratory analyses, lot release and post-registration surveillance, in order to guarantee drug quality, safety and efficacy, as well as the availability of appropriate information on drugs.
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At the first stage, Bolivia, Cuba, Honduras, Nicaragua and Venezuela joined the project. The body in charge of coordinating it is the State Centre for Drug Quality Control of Cuba (CECMED).

This project will last four years (from May 2009 to May 2013) and be implemented in three stages:

- **Pre-investment**: From May 2009 to November 2010 (18 months). At this stage, the legal framework and regulations are expected to be developed for the operation of the Centre.
- **Investment**: From December 2010 to December 2012 (24 months). A headquarters is expected to be built for the Centre, which requires the construction, fitting out, recruitment and preparation of specialists.
- **Operation**: January 2013 to May 2013 (6 months). In this period, the Centre for Drugs Regulation of ALBA will work in its headquarters, under protection of this Project, after which the Centre will be officially created and work will still be done through the already established mechanisms and identified resources. It will stop being a project to become a body of ALBA - TCP.

Its goals include:

a) To create the grand-national mechanism Centre for Drugs Regulation of ALBA for a single and centralized sanitary registration, including the actions taken before and after negotiation, as a regional scheme of the countries of ALBA. As regards the actions taken before negotiation, the Centre will be in charge of assessing quality, safety, efficacy and information on Essential Medicines of ALBA, based on the requirements that to this end have been developed. To carry out such assessment, the fulfillment of good practices in manufacture by the manufacturer and distribution by the distributors are verified. As regards actions taken after negotiation, once the medicine is approved and consequently granted the Single Registration Certificate of ALBA, a permanent surveillance of its performance will be carried out to determine any potential negative effect, quality problem, withdrawal from the market, warning of falsification and others. This type of registration requires a constant update of information in view of any change and renewal;

b) To develop and implement the legal system of the sanitary registry created by this Centre, with the recognition and participation of the member countries of ALBA;

c) To develop the structure and functions of the Centre, based on transparency, communication and interrelationship with the member countries of ALBA;

d) To organize knowledge transfer through an instrument that strengthens capacities for the sanitary regulation in each country.

The project is expected to contribute to access to essential medicines with high standards, which are necessary to guarantee health programmes in the countries of ALBA; it will also contribute to a decrease in costs of medicines, strengthening, for the common benefit, the use of capacities of the member countries of ALBA as a regional integration mechanism; it will rationalize efforts, avoid unnecessary duplicates and make it possible to accomplish increasingly efficient and complicated processes with high quality levels; enable the assessment of medicines with high standards and transparent, updated and agreed mechanisms; update the information on high-priority medicines for
the health systems, as a contribution to its rational use; contribute to the accountability
and efficiency of the licensing system for pharmaceutical products in the member
countries and make it possible to transfer specialized knowledge on medicine assessment,
allowing national authorities and increasing the experience of specialists through the
exchange based on the current strengths and joint development.

It will also serve as model for the increase of capacities and strengthening of the sanitary
drugs regulation through the development and implementation of best practices for
control and regulation and the development of a joint legal and administrative system for
the smooth running of the Centre with a pharmaceutical regulation reached by
consensus and set forth in a legal instrument of ALBA.

6. Mesoamerica Integration and Development Project (Mesoamerica Project)

The Mesoamerica Project was launched in the X Summit of the Tuxla Mechanism for
Dialogue and Coordination, held in July 2008. At that time, the Mesoamerica Project was
institutionalized to replace the former Puebla Panama Plan (PPP), created in 2001. It has
basically the same institutionality and objectives of the PPP, but makes more emphasis on
the social area, particularly on the health sector. At the present, the Project is made up of
the members of SICA, Mexico and Colombia.

PPP’s background dates back to November 2000, when the government of Mexico
announced a development strategy for the South-East of this country. At that time, the
president of Mexico invited the Central American nations to coordinate actions aimed at
extending this strategy to the Mesoamerican region to create the PPP. This strategy was

With the approval of the PPP, some initiatives have been adopted as regards sustainable
development, prevention and mitigation of natural disasters, promotion of tourism,
provision of trade exchange, integration of roads and telecommunication services,
energy interconnection and human development.

In the area of human development, the Mesoamerican Initiative for Human Development
(IMDH) was adopted and, in this context, memoranda of understanding on health,
education and culture were signed. In 2004, the Mesoamerican Human Development
Council (CMDH) was established with a view to coordinating and monitoring efforts for
the implementation of projects from a multisectoral view and preservation of the
transversal character of human development in other PPP initiatives. A Technical
Secretariat was also created.

In the area of health, the CMDH recognized the Council of Central American Ministers of
Health (COMISCA), through the Follow-up and Evaluation Technical Commission (COTSE)
of the health component of the PPP, as the body in charge of coordinating the Plan of
Action of the health component of the IMDH. Technical representatives of the Central
American Ministries of Health and the Health Secretariat of Mexico approved the
Operations Regulations and elected Mexico to assume for one year the Presidency Pro
Tempore of COTSE.

In the Plan of Action approved by this mechanism, involved parties decided to give
priority to the Mesoamerican Programme on Epidemiological Surveillance and the
Mesoamerican Project for the Comprehensive Care of Mobile Populations with HIV/AIDS.
With these options, besides those dealing with the education and culture areas, the CMDH of the PPP was initially aimed at reducing poverty, improving access to the essential social services for the most vulnerable population and contributing to the development of the Mesoamerican peoples. The CMDH was also aimed at promoting regional strategies for social development that would enable the governments of the region to fulfill the Millennium Goals established by the United Nations.

After the PPP turned into the so-called Mesoamerica Project, the general goals of the first one as regards health, education and culture remained unchanged and, in some cases, have gained relevance. The new project is expected to strengthen the institutionality and reach more coordination with other regional mechanisms.

The Mesoamerica Project includes an area that was not part of the social area of the PPP: the Mesoamerican Social Housing Programme. The objective is to develop a long-term housing financing market in the region that is sustainable, deals with the housing backwardness and meets the future housing needs.

In the area of health, the Mesoamerican Programme on Epidemiological Surveillance, which was developed within the framework of the PPP, has evolved to become a Mesoamerican Public Health System (MPHS). In fact, the ministers of Health of Mexico, Central America and Colombia and nine Mexico's south-south-eastern states agreed in April 2009 to create the MPHS and the Mesoamerican Public Health Institute (MPHI) to fight against the so-called backwardness and vector-borne diseases, thus guaranteeing quality health conditions to 197.5 million people who lack them. This programme is devised as a regional plan to effectively respond to the common challenges of the region in the area of health.

The MPHS will focus on the production of regional public goods and incorporate and develop projects, such as the Central American Programme on Epidemiological Surveillance, the Central American Network for Information on Health and Communication and the Central American Network of Emerging and Re-emerging Diseases. It will work in coordination with the information and epidemiological surveillance systems and the public health laboratory network in Mesoamerica.

In the medium term, a Mesoamerican Health Agenda will be developed in addition to the Central American Health Agenda and a Strategic Plan of the Mesoamerican Public Health System.

In addition, the created Mesoamerican Public Health Institute (MPHI) will be aimed at strengthening the technical-scientific capacity of human resources in the region for the comprehensive care of health needs through research, evaluation, teaching and public health service. Among the specific objectives of this MPHI are: contributing to the development of the governance of MPHS providing technical support for the development of the Mesoamerican Health Agenda; strengthening the technical capacity of regional health programmes that are part of the MPHS; supporting inclusion of regional health programmes in national health systems; and improving the health of the population through the production and use of regional public goods.

The MPHI is made up of a virtual network of high-level academic and research institutions in the Mesoamerican region. It would be funded with contributions from the Carso foundations, and Bill and Melinda Gates, who pledged an amount of US$ 102 million. This institute also would provide contributions to the Inter-American Development Bank (IDB),
the Pan American Health Organization (PAHO), the Spanish Agency of International Cooperation for Development and the European Union.\textsuperscript{42}

In July 2009, a meeting of Ministers of Health of the Mesoamerican Public Health System (MPHS) was held in Cancun with a view to presenting to the advances made in establishing the Mesoamerican Public Health Institute (MPHI), which will act as a technical coordination body of the MPHS.

To meet its objectives, the Institute has set out three operational programmes: the Mesoamerican Programme for Training and Update of Public Health Professionals; the Mesoamerican Programme for Capacity Strengthening and Institutional Development; and the Mesoamerican Programme for Technical Support and Knowledge Management, through which human resources will be will trained and developed in Mesoamerica through master and diploma courses.

The MPHI will give primary attention to regional strategies in the common areas identified as priorities in the MPHS: vector-borne diseases like dengue and malaria, maternal mortality, malnutrition and vaccination coverage.

The Act and Statute of the MPHI was signed by the founding members of the Board of Directors of the Institute, made up of the National Public Health Institute of Mexico; the University of Costa Rica; the Centre for Research and Studies in Health (CIES) of the National Autonomous University of Nicaragua; the University of El Salvador; the Gorgas Memorial Institute for Health Studies in the Republic of Panama; the Faculty of Medical Sciences of the University of San Carlos of Guatemala; the College of the Southern Frontier of Mexico; the Mesoamerica Integration and Development Project and the Executive Secretariat of the Council of Central American Ministers of Health (COMISCA).

It should be noted that a process has begun to identify the academic institutions in Belize and Honduras to be incorporated into the Institute in the future. In addition, the Dominican Republic, which has been participating as an observer, formally requested to join this regional effort led by the Mesoamerica Project.

7. Union of South American Nations (UNASUR)

The social area, particularly the health issue, was the main topic of the Declarations of South American presidents since they first met in 2000 until they established UNASUR through a constitutive treaty in May 2008 in the city of Brasilia.

The Constitutive Treaty of UNASUR is aimed at creating, by means of participation and consensus, an integration and partnership space in the cultural, social, economic and political areas for their peoples, giving priority to political dialogue, social policies, education, energy, infrastructure, finance and environment, among others, with a view to eliminating socioeconomic inequality, achieving social inclusion and citizen participation, strengthening democracy and reducing asymmetries within the framework of the defence of sovereignty and independence of States.

The priorities are set out in the guidelines for an Action Plan of UNASUR, agreed for the period 2008-2009. The defined areas include the following:\textsuperscript{43} a) Financial Integration b)
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In the field of social policies, particularly in the field of health, governments committed themselves to completing the process of building a South American policy in this area, making emphasis on identifying the measures needed to implement the following initiatives:

- South American Epidemiological Shield,
- Development of universal health systems,
- Universal access to medicines,
- Health promotion and action on social determinants,
- Human resources development and management for health.

Most of the elements of these initiatives making up the Health Agenda for UNASUR are in accordance with the commitments and regional agreements already signed by the South American countries in the multilateral arena, and complement them.

Governments also undertook to develop, in coordination with the Ministers of Health, a proposal to strengthen the coordination and cooperation efforts of integration organizations specializing in health, such as the Andean Health Organization - Hipólito Unanue Convention (ORAS-CONHU), the Working Sub-group on Health Issues of MERCOSUR, the Amazon Cooperation Treaty Organization (ACTO), PAHO/WHO and other organizations of the United Nations, with a view to formulating a Five-Year Plan for Health Integration.

In the framework of UNASUR, Ministerial Councils have been created in areas considered of greater importance by governments. One of the first to be established was the Health Council on 21 April 2009, when a work plan was defined for the agenda in this area.

a) Background. Actions by South American Health Ministers before the creation of UNASUR

Importantly, the Health Ministers of the Member States of the ORAS-CONHU and those of MERCOSUR have been meeting since 2001 within the framework of the Meetings of Ministers of Health and Social Protection in South America (REMSUR).

43 In order to advance in the integration of UNASUR, the Council of Delegates pledged to deal with other issues, some of which refer to the social area, in order to identify the mechanisms for inclusion in the Action Plan: Environment, Food Security, Innovation, Research and Development, Regional Network of Telecommunications and Culture.

44 These had already been identified by both the ORAS-CONHU and MERCOSUR.

45 The first one was the Energy Council, established in 2007, before even the establishment of the Treaty of UNASUR. Next to be established was the Defence Council in March 2009. During the Presidential Summit of UNASUR in Quito in August 2009, new Councils were created, namely: Infrastructure and Planning; Fight against Drug Trafficking; Education, Science, Technology and Innovation; and Social Development.

In the search for topics of common interest and shared and coordinated solutions, participants have highlighted, among others, the following issues: nutrition, promotion of healthy lifestyles, development of health communication for integration (with a view to spreading the cross-cutting nature of communication in the proposals formulated to face the challenges in this area), strengthening of South American joint position on the revised international health regulations, intellectual property, access to medicines and health (see Box 16).

**Box 16: Summary of the Declaration of Ministers of South America over Intellectual Property, Access to Medicines and Public Health**

Considering that:

Access to medicines and critical raw materials is an integral part of the right to health, which is a basic human right of every individual and a fundamental prerequisite that governments have a duty to ensure.

The provision of patents in the pharmaceutical sector has gained increased relevance in the region since the enforcement of the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPs) in the World Trade Organisation.

Significant price increase is being recorded in the area of government programmes related to pharmaceuticals and in the direct costs to consumers, as well as in the market prices; this is a consequence of the patent system which concerns health products that are essential for the prevention and/or the treatment of serious public health conditions, leading to a deterioration of access to essential drugs.

Our countries have in different ways adopted all the flexibilities and safeguards in our national legislations, as provided by the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPs), and as reiterated in the Doha Declaration on Intellectual Property Rights and Public Health signed in Doha, Qatar, on 21st November 2001.

Both in the Andean countries and in the MERCOSUR, Ministers of Health have developed their work on the issue of access to essential medicines, thereby considering aspects of intellectual property and public health.

A continued dialogue must be fostered at the regional level concerning the impact of intellectual protection on access to drugs, leading to the adoption of concerted measures in order to ensure the supremacy of the public interest over commercial concerns.

WE DECLARE OUR COMMITMENT TO:

Promoting the implementation of the Doha Declaration on Intellectual Property Rights and Public Health in our own countries, and particularly the decision of the TRIPs Council (Decision IP/C/W/405, dated 30/08/2003), in relation to the provisions regulating paragraph 6 of the Declaration mentioned above - granting of compulsory licences and use of parallel importing mechanisms.

Maintaining the flexibilities provided in the TRIPs Agreement in bilateral and regional agreements, while seeking to: a) facilitate the use of compulsory licences, parallel importing and “Bolar exceptions”; b) avoid the broadening of the scope of patentability
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and the extension of patentable areas (for example: therapeutic methods, plants and animals), and second uses; c) avoid the linkage between the granting of the patent and the granting of the marketing approval, in addition to avoiding any other clause that may include “TRIPs plus” arrangements.

Seeking the active role of our Ministries of Health in the negotiation of bilateral trade agreements, in the negotiation among regional groups as well as in the process of modification, updating and consolidation of national intellectual property rights norms, by means of:

a) affirming the needs of the health sector with technical supports, based on the Doha Declaration on Intellectual Property Rights and Public Health, and the declaration of the UN Millennium Development Goals;

b) training health professionals in the domain of intellectual property rights, including their current and future repercussions with regards to access to essential medicines. Promoting and supporting the continued international dialogue on the impact of patent protection on access to essential medicines and critical raw material, by means of research initiatives and exchanges of experiences.

Recommending the promotion of studies allowing the monitoring of drugs prices and the effects of the TRIPs Agreement in the domain of public health in our countries, with the intent of identifying alternatives to the current system that may contribute to the promotion of innovation and the transfer of technology, while favouring social appropriation at accessible costs.


Another area of joint actions between both subregions was the boost for the strategy of joint negotiations on the purchase of medicines, since the government recognized it as an effective tool to obtain fair prices, improve accessibility and increase coverage. In fact, the South American countries represented in the Andean Health Organization - Hipólito Unanue Convention and MERCOSUR (without Brazil), plus Mexico, jointly conducted two negotiations on access to antiretroviral drugs and diagnostic reagents for the management of patients affected with HIV in the region. The first one was held in Lima in June 2003. The negotiation arose from an agreement among the participating countries set out in the Final Declaration of the Second Meeting of Ministers of South America (REMSUR) and the resolution of the XXIV Meeting of the Ministers of Health of the Andean Area (REMSAA), both in November 2002.

The results of the negotiations were considered by all countries as a political and social success. Of the 37 traded products, quotation proposals on 15 of them were below the existing lowest price in the 10 countries of the region. In September 2004, a year after the

47 For additional information, see chapter on the Andean Community.

48 Cost of treatment decreased by 30-93% for first-line triple therapy and 9-72% for second-line triple therapy. As regards all matters dealt with during negotiation, quality requirements were agreed upon based on compliance with Good Manufacturing Practices (GMP), the availability of health registry and quality standards related to identity, purity, potency and bioequivalence, the latter where appropriate. As for reagents, a decrease was also reported in the range of maximum and
first round of negotiations, the 10 countries participating in the negotiations initiated a process of assessing the impact of the negotiation.

However, according to a report by the ORAS-CONHU, during the year after negotiations, participating countries recognized different degrees of benefits from the agreements and prices reached among them, due to the obstacles they faced to assert negotiations when making their purchases effective. “In some cases, it was not possible to use the agreed upon prices due to difficulties with the internal procurement mechanisms of the countries; in other cases, the local industry refused to acknowledge the agreement signed by their head offices in the negotiation; and in others, the heterogeneity in national trade regulations affected national procurement processes.”

PAHO (2006) adds that the agreements were not always compatible with policy and regulations on trade, intellectual property and contracts of the countries participating in the negotiation; a part of ARV drugs, subject to negotiation, was not registered in all countries participating in price negotiations; bidding processes for drugs made in the various countries did not follow the requirements established in the negotiation, and price negotiation was not based on a formal commitment to comply with the agreements signed by the parties.

As a result of this situation, parties of subsequent negotiations considered initiatives to take further into account the transnational integration agreements among member countries of regional and subregional health organizations, so as to allow, as stated by the ORAS-CONHU (2007):

“- Optimizing the coordination of the agreements reached in negotiations on regulations and policy in the areas of health, trade, intellectual property and contracts of the participating countries.

- That countries can benefit from those ARV drugs subject to negotiation that do not have registration in their countries, provided that this does not conflict with their national legislation and policy.

- That the drug bidding processes carried out after negotiations in the various countries take into account the requirements set out in the negotiation.

- Improving the mechanisms by which the national representative offices of multinational laboratories comply with the prices agreed by their corresponding head offices.”

In August 2005, South American Ministers of Health, this time with the participation of Brazil and Mexico, met in Buenos Aires to carry out the second joint negotiation of drug and reagent prices for the treatment of HIV/AIDS (see Box 17).

The second round of negotiations, held among the abovementioned governments and 26 pharmaceutical companies, showed a significant reduction of 15% to 55% in prices for minimum prices, which varied according to the type of reagents: rapid tests (62% to 1%), EUSA tests (13 to 33%), CD4 (5 to 70%) and CV (22 to 82%). (PAHO, 2006).


50 Ibid 49.
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most used therapeutic schemes in the region. The reduction was such that the basic therapeutic scheme cost US$ 241, compared to the price suggested by the pharmaceutical industry in 2003 of US$ 350 per year per patient. For one of the most complicated therapies, the annual cost of US$ 2,489 decreased by 55% to US$ 1,123 per patient.

It is important to underscore that of the 26 companies summoned to the round of negotiations, 14 met with the Negotiating Committee. Prices of antiretroviral drugs made by 11 manufacturers were received, including generic drugs, an original drug (Abbott Laboratories), and antiretroviral drugs from a public association of manufacturers in Brazil. The 11 countries signed a letter of intent with 10 manufacturers of antiretroviral drugs and 7 reagent manufacturers.

The Negotiating Committee stressed that the main result of the Joint Negotiation strategy was to obtain reference and regional top prices to be applied in the public sector, which would remain in force for a period not less than two years from the date the letter of intent was signed.

In March 2006, the ARV Negotiation Monitoring Group (GAN/ARV) was created with a view to helping countries have access to the prices agreed upon at the Second Negotiation and systematically following up on them, based on the implementation of agreements.

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51 Merck & Co., Boehringer Ingelheim and Bristol Myers Squibb did not present their offers with a single regional price. Therefore, the Negotiating Committee did not consider their offers.

52 Cipla, Cristalia, Elea, Iqueño-Lafepe-Famanguinhos, Filaxis, Gadop, Humas, Kampel Marten, Ranbaxy and Richmond S.A. The agreement with Abbott Laboratories would be signed after the negotiation.

53 Bayer Diagnostico, Beckman, Becton Dickenson, Biomerieux, Biorad, Roche Diagnostico, Weiner.

54 The group was made up of representatives of the Horizontal Technical Cooperation Group, of the Government of Argentina (country hosting the Second Negotiation), representatives of civil society and UNAIDS. Members of the group include also representatives from PAHO.
**Box 17: Criteria used during the Second Negotiation**

1. **Manufacturers**
   Manufacturing plants should comply with Good Manufacturing Practices (GMP) certified by one of the countries participating in the negotiation or through one of the countries belonging to the International Conference on Harmonization (ICH).

2. **Medicines**
   - Having approved the corresponding records in the participating countries or in the National Regulatory Authorities (NRAs) of the countries that are part of the ICH at the time of marketing. In return, participating countries will facilitate and speed up those records. They also would monitor continuously that companies disclose the documents required to process a sanitary registration certificate.
   - Complying with the requirements of identification, purity, potency and bioequivalence when this appropriate, in order to guarantee their quality, certified by the negotiating countries or through the WHO prequalification for ARVs.

3. **Prices**
   - Offers should be submitted in U.S. dollars, INCOTERMS FOB (Free On Board).
   - Top price would consist of the lowest price available in the region or the First Negotiation (Lima 2003) for each item traded (brand or generic item) from the list.
   - Companies should provide a single price for each item traded, so that all countries may purchase it at that price.
   - The countries would use as reference price the lowest price negotiated in the national procurement processes.
   - The local representatives of international companies should comply with the negotiated prices. If not, the participating countries could provide the means to purchase products directly from the head offices or through international procurement mechanisms, such as the PAHO Strategic Fund.

4. **Validity of negotiation**
   No less than two years, except for a new negotiation.

5. **Implementation, Monitoring and Follow-up**
   - The participating countries would establish a Monitoring and Follow-up Group, with the technical support of PAHO.

   - The Monitoring and Follow-up Group will coordinate the dissemination of results to all actors involved in the negotiation, establish a framework to assess the relationship of the regional process with national registration and procurement processes, identify and propose solutions to difficulties faced in implementing the terms of trade. The Group will present two reports to the participating countries and companies on the impact of the second negotiation, one at the end of the first year and the other at the end of the period of negotiation.

b) The South American Health Agenda

During the Second Summit of Heads of State of the South American Community of Nations, held in Cochabamba, Bolivia, in December 2006, the South American Ministers of Health were instructed to develop a Regional Health Agenda with the collaboration of the Andean Health Organization - Hipólito Unanue Convention, the Health Subgroup II of MERCOSUR, the Amazon Cooperation Treaty Organization (ACTO) and other relevant regional organizations. The aim was to achieve a South American commitment for equity and social inclusion which would ensure universal access to health services for all inhabitants of the region. Its development should ensure an ongoing dialogue with social movements.

Since then, the ORAS-CONHU, in coordination with the MERCOSUR countries, has taken advantage of all international meetings where South American Ministers of Health have come together to move forward in the preparation of the South American integration health agenda. \[\text{55}\]

At present, within the framework of UNASUR, a work plan is already underway for the South American Health Agenda, as well as a statute which sets forth the makeup, objectives and operation of the South American Council on Health. In fact, the functions of the Coordinating Committee, the Technical Secretariat and the Technical Groups in charge of each thematic area identified in the Plan of Action 2009-2010 of UNASUR are already established.

The Coordinating Committee is a body aimed at boosting, facilitating and promoting the achievement of the objectives of the South American Council on Health (CSS). Its functions include: following up progress in South American integration in health; coordinating and monitoring the technical groups; preparing draft agreements and resolutions to be submitted for consideration by the CSS; coordinating and developing common stances on health issues in international forums and negotiations; proposing innovative processes through which the South American integration in health could be reached, going beyond the convergence of existing processes; developing and implementing a strategic media plan to spread information on the existence and performance of UNASUR-Health; and promoting dialogue spaces that encourage citizen participation in South American integration processes in health, among others.

As regards the Technical Secretariat, it is made up of the country currently holding UNASUR’s Pro Tempore Presidency (PPT) (since 10 August 2009, it is held by Ecuador) plus the country that held it previously and the country that will hold it immediately after. Among its responsibilities are to convene regular and special meetings in coordination with the Presidency of the Council and the Coordinating Committee; act as Minutes Secretary in meetings of the Council and the Coordinating Committee; manage mechanisms for the holding of virtual meetings; prepare a Newsletter of the South American Council on Health, create a web site, and coordinate media coverage through a Press and Communications mechanism, among others.

\[\text{55}\] World Health Assembly, Geneva, May 2007; Ibero-American Conference of Ministers of Health, Iquique, July 2007; International Conference on PSA, Buenos Aires, August 2007; Pan American Sanitary Conference, Washington, October 2007, when a Working Group (made up of Brazil, Bolivia and Chile) was created to develop the proposal for the Ministers of Health.
Technical Groups are in charge of analyzing, creating, prepare and developing – under technical and scientific criteria – proposals aimed at achieving the South American integration in health, based on the Work Plan and the South American Health Agenda. Technical Groups have a coordinator represented by a country and an alternate coordinator represented by another one, with a term of two years, during which they alternate their responsibilities after having completed their first year (see Box 18).

**Box 18: Objectives of the five Technical Groups of the South American Council on Health**

**Epidemiological Shield** (Coordinated by Paraguay, alternate coordinator is Uruguay)

- Establish a record of standardized regional morbidity and mortality indicators, based on the Millennium Development Goals.
- Promote the work and joint efforts in disease surveillance and control in border areas.
- Create, strengthen, consolidate and coordinate networks for South American epidemiological surveillance and control.
- Prepare a report on the priority attention diseases in South America.
- Promote the South American Immunization Programme.

**Development of Universal Health Systems** (Coordinated by Chile, alternate coordinator is Bolivia)

- Promote the development of initiatives for monitoring and assessment of health systems in South American countries.
- Exchange experiences to expand coverage and improve quality in health care, giving priority to the comprehensive primary care strategy.
- Facilitate the exchange of experiences on health systems of the member countries of UNASUR, including its financing.
- Strengthen the harmonization of health accounts.
- Design and share experiences in providing services to migrants in the region, so as to guarantee access to health.
- Support the reform of health systems and strengthening of the steering role of the Ministries of Health.

**Universal Access to Medicines** (Coordinated by Argentina, alternate coordinator is Suriname)

- Establish a map of South America’s capacity to produce medicines and other health inputs.
- Exchange experiences to establish mechanisms aimed at overcoming obstacles that limit access to essential and high-cost medicines.
- Develop a proposal for South American policies of universal access to drugs, considering the South American health production complex.

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56 During the First Regular Meeting of the Epidemiological Shield Technical Group of UNASUR, held on 18 June 2009 in Asuncion, the delegates suggested that the name of the strategic axis should be modified, since the term “epidemiological shield” does not reflect the integration of surveillance and response systems being implemented in the Americas. It has been considered relevant to rescue the initial conception of the thematic area proposed in Cochabamba, 2006, which points to the general objective: South American Health Surveillance and Response Network (VIGILA-SUR).
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- Establish a risk communication area on the quality control of drugs, as well as on counterfeiting and smuggling of drugs.

**Health Promotion and Action on Social Determinants** (Coordinated by Venezuela, alternate coordinator is Colombia)

- Establishment of the South American Commission on Social Determinants of Health, considering the recommendation of the Commission on Social Determinants of WHO.
- Creation of exchange mechanisms in the fields of training and research on social determinants of health.
- Take actions aimed at making reduction of health inequities viable in South America.
- Exchange inspection and monitoring experiences as regards social determinants of health.

**Human Resources Development and Management in Health** (Coordinated by Brazil, alternate coordinator is Peru)

- Produce knowledge with a view to creating a policy on sustainable development of human resources to provide capacity, taking into account the challenges of the region. This includes the creation of a database of training institutions for human resources in health and preparation of a report on the impact of migrations of health staff, so as to formulate strategies to mitigate their negative effects in South America.
- Identify research priorities and speculation on health human resources.
- Develop mechanisms for encouraging training of health human resources through a UNASUR - Health scholarship programme and the creation of the South American School of Health Governance (see Box 19).
- Promote the reduction of inequity gaps in the distribution of health human resources. Source: UNASUR/South American Council on Health/Agreement N. 01/09-21/04/2009.
Box 19: South American Institute of Health Governance - ISAGS

The South American Institute of Health Governance (ISAGS) shall operate as a centre for higher studies and political debate, governance and health management. The actions of the institute are conceived as part of a work process, and are directly Ahmed at strengthening health systems.

Through the Oswaldo Cruz Foundation (FIOCRUZ) – an organ of the Ministry of Health – the Government of Brazil, in cooperation with the Ministry of Foreign Affairs, assumes the role of facilitator for the implementation of the institute. Thus, advantage is taken of the experiences gained since 1998 with Brazil’s School of Health Governance, which involved a substantial reorientation of training and human resource development programmes, as well as research in this field, seeking to support the expansion of capacities and the quality of health governance in Brazil based on the challenges posed by the Unified Health System.

ISAGS will be a communal, public institution, and will belong to all the signatory countries of UNASUR. It will have a small and flexible structure, and its work programme will be agreed to in coordination with the national institutions in UNASUR countries and multilateral centres for training and research. Its mission will not overlap or replace those of the existing national training institutions, as the ISAGS will contribute to encourage the development of leadership and support both the improvement of leadership capacities of countries at local and national level, as well as their management of social integration processes, particularly in the health sector in South America.


It is important to underscore that Paraguay, Brazil, Chile, Colombia and Peru have reported on their focal points, while the rest (Argentina, Bolivia, Ecuador, Guyana, Suriname, Uruguay and Venezuela) have not done it yet in any of the technical groups.

During the Special Meeting of the South American Health Council, held in Quito in August 2009, Ministers specializing in the area issued a Declaration to raise a common voice against the difficulties of the Member States to have equal access to resources they need to confront the H1N1 influenza pandemic and other public health challenges faced by the region.

Among other things, they endorsed the concept of public health prevalence over economic and commercial interests. In this connection, they said that drugs, vaccines, supplies and equipment required to combat diseases of public health importance should be considered global public goods. Moreover, intellectual property rights should not prevent Member States from taking measures to protect public health and the right to make use of the foreseen flexibilities, if necessary.

In the Declaration, they also decided to carry out a strategic plan for innovation, regional development and production that prioritizes and ensures access to biological resources and medical supplies for the South American population to combat the new influenza and other diseases of public health interest. Finally, they endorsed the PAHO Revolving Fund as a strategic mechanism for regional negotiations, urged involved authorities to
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prioritize the purchase of drugs made by producers of the region and strengthen health surveillance.

III. CONCLUSIONS AND PROPOSALS FOR INTEGRATION AND COOPERATION IN THE HEALTH SECTOR IN THE REGION

Various attempts have been made to improve people’s access to health care services by promoting several cooperation programmes within the framework of regional integration organizations in Latin America and the Caribbean. While huge efforts have been made in this connection in recent years, despite the progress achieved at the political level, in particular, results have not been as expected.

This is partly due to the fact that the actions aimed at increasing access to health through the promotion of intra-regional cooperation have been developed mainly as a complement to the problems derived from the economic liberalization and deregulation processes experienced by most countries in Latin America and the Caribbean in recent times.

Similarly, other factors explain this gap between objectives and concrete results, including: a) the objectives and plans to guarantee access to health goods and services undertaken by regional integration groups are often hindered by actions that are defined in the “economic and trade areas” of such subregional integration groups, b) the fact that the decisions that are taken at subregional organizations dealing with the issue of health are not legally binding, c) there are constraints related to management capacities and the various actors involved (regional and national, public and private actors) have an impact on the development of the health sector, and d) there are restrictions as regards financing of common activities, which have to do, in some cases, with a shortage of resources and, in other cases, with the lack of political prioritization for health-related projects, as noted by the Coordination of Forums and Meetings on the Health Sector of Central America.

In addition, some analyses reveal a lack of systematic coordination and coherence among efforts in the region, a deficit in the mechanisms for monitoring and evaluating the programmes agreed upon, and a lack of effective instruments to measure achievements as regards the goals and objectives in the health sector in subregional integration and cooperation mechanisms.

The multiplicity of agencies and institutions with limited and little known results in some subregions, the absence of a culture of accountability, the prevalence of economic interests over social interests in political decision-making, and conflicting interests in some cooperating agencies are common traits in almost all subregional integration organizations.

One of the most complex problems in the region is the insufficient capacity to meet the growing demand for medicines to address major health problems affecting the population. It is widely known that access to medicines and other health supplies plays a central role among the many factors that contribute to improve health care. For this reason, the pharmaceutical industry – which has a growing international presence in the region - is a key area in pricing of medicines and supplies for this sector. This characteristic in medicine supply, as recognized in various joint political statements made by government officials in integration organizations, requires States to assume an active role with well-defined functions of coordination, regulation and promotion of the drug industry.
In order to reduce prices and ensure access to the medicines needed for national health programmes, in recent years, the Health Ministries under the umbrella of integration organizations have conducted joint negotiations with international pharmaceutical laboratories. As a matter of fact, the two negotiations and agreements for the joint purchase of anti-retroviral drugs and diagnosis reagents for the treatment of patients with HIV in the region are among the most important ones carried out within the framework of the joint actions between ORAS-CONHU and MERCOSUR. They were conducted in 2003 and 2005, respectively, with results described by countries as successful from the political, economic and social development standpoints.

However, according to a report by ORAS-CONHU, during the year following the first negotiation, participating countries were benefitted by the agreements and the price reductions to different degrees due to the obstacles they faced to enforce the terms of the negotiations at the moment when they were effectively going to purchase the medicines. "In some cases it was not possible to take advantage of the prices agreed upon due to difficulties with the domestic purchase mechanisms in the countries; in other cases, it was because the local industry refused to acknowledge the agreements reached by their parent companies in the negotiations, and yet in other cases, the heterogeneity in domestic trade regulations affected national purchase processes".57

PAHO (2006) added that the agreements were not always compatible with the regulatory and commercial policies, intellectual property rights and contracts in the countries participating in the negotiations. Furthermore, some anti-retroviral drugs that were covered in the negotiations were not even registered in all the countries participating in the negotiation of prices, which was conducted on a voluntary basis and without a formal commitment by the parties involved to comply with the agreements.58

In view of this situation, it was decided that future negotiations should consider initiatives that delve deeper into integration agreements among member countries of regional and subregional health organizations, so as to: "Optimize the coordination of the agreements reached in negotiations on health regulations and policies, trade policies, intellectual property rights and contracts of participating countries, so that all countries can benefit even from those anti-retroviral drugs under negotiation that do not count on a registration in their territories; and to improve the mechanisms to make national offices representing multinational laboratories comply with the prices agreed upon by their corresponding parent companies, among other things".59

The second negotiation, conducted in 2005, obtained better results, but many of the problems identified in the first negotiation continued to be a stumbling block. For this reason, the Health Agenda of UNASUR, which groups together the agendas of the Andean integration organization and MERCOSUR, foresees in its programme for access to medicines, not only price negotiations and joint purchases of vital drugs as part of their respective legal frameworks, but also the development of a pharmaceutical and biotechnological industry within the region.


As a matter of fact, in view of the existence of medicines whose production has been abandoned by the private sector and the emergence of the so-called orphan diseases, public production of medicines is now regarded as a political tool. In this connection, within the framework of UNASUR, efforts are being made to identify industrial capabilities in the region to plan a regional policy for the production of medicines and other health supplies.

The Caribbean region has also had some experiences with joint purchases of medicines. As a matter of fact, CARICOM countries were the first ones to develop a regional approach for the purchase of anti-retroviral drugs to combat HIV/AIDS, a process that began in February 2002. In the 2001 Presidential Declaration of Nassau, whose focus was on health, the Heads of State of the Caribbean integration organization said that the regional strategic plan against HIV/AIDS should include the Pharmaceutical Procurement Service (PPS) of the Organization of Eastern Caribbean States (OECS) as the main mechanism for the purchase of anti-retroviral drugs for the entire region.

While negotiations between the PANCAP and six international pharmaceutical firms resulted in agreements in July 2002 and February 2003, the problems faced in the Caribbean to purchase medicines at the prices agreed upon are similar to those experienced in the South American region.

The Central American countries have also conducted joint negotiations for the purchase of medicines considered to be very costly but also of vital importance for most Central American nations, in compliance with the strategic objectives of the Health Agenda defined in June 2009. The countries already count on Regulations for Joint Negotiations on Prices and Purchase of Medicines, thereby establishing the judicial framework to ensure the legal viability of this process, which began in October 2006.

In general, drug policies established in integration organizations are governed by a series of principles which, among other things, recognize access to medicines as a human right, acknowledging that vital or essential medicines should be treated as public goods, that common good must prevail over individual good, and that access, monitoring of quality and safety of medicines are a responsibility of the State.

The problem is that the objectives of the productive sector and of marketing of drugs do not always coincide with public health interests, which results in an absence of medicines in local markets for the treatment of diseases such as Chagas disease and dengue fever, among others; and in a shortage of suppliers of some medicines for priority diseases – not to mention that sometimes unethical practices are used to promote prescriptions of some medications.

Another related factor that sometimes hampers availability of drugs is the negotiation and subsequent entry into force of FTAs with industrialized countries, because the standards set forth in these agreements are legally binding and include more restrictive legislations in the area of intellectual property rights than those agreed to within the framework of the World Trade Organization.

Among the elements that hinder access to quality health services in the region are the problems related to human resources in this sector, not only because of the low number of professionals, but also and most importantly because of their inadequate geographical distribution. Within the framework of the integration organizations, but also individually, the countries have adopted various strategies to correct these situations.
ORAS-CONHU highlights the progress made by several regional experiences, such as the model of family health care in Cuba, the Family Health Program in Brazil, the guarantees of the right to health in Chile, the Barrio Adentro Mission and the programme to train integral community doctors in Venezuela, and the Medical Residency in Comprehensive Intercultural Family Health in Bolivia, among others. These projects, developed in the last decade, combine a new form of distribution of human resources with massive on-the-job training programmes, based on the notion that health is a citizens’ right.

However, as noted by the Andean Health Agency, the problems of geographical distribution and lack of adaptability persist and have worsened. In addition, the reforms implemented in some countries of the region in the areas of education and health have led to new difficulties, such as the emergence of an oversupply of medical training and an excessive number of professionals graduated in disciplines that do not always respond to the health care needs of the majority of the population.

It should also be noted that, in recent years, some countries in the region have suffered a reduction in their availability of qualified and specialized human resources in the health sector, due to the fact that a growing number of health professionals and technical staff are migrating to developed countries.

Proposals

1. As described above, within the context of regional integration organizations in Latin America and the Caribbean, access to medicines is a fundamental aspect with a direct impact on the health sector. In this connection, it is necessary to make further strides in the discussions, exchange of information and the implementation of the following four lines of action aimed at expanding access to medicines in our countries:

   a) development of a coherent policy on generic medicines;
   b) national and regional strategies for cost containment, with an emphasis on pricing and regulations on protection of intellectual property rights;
   c) strengthening of national and regional systems for supply of basic inputs for public health; and
   d) regional mechanisms for joint purchase of medicines, as defined by the PAHO Directing Council in October 2004.

Political and technical authorities of regional integration organizations in charge of the health sector, as well as national authorities responsible for that sector in each one of the countries, have taken due note of these four lines of action. However, it is absolutely necessary to continue to make further progress with the exchange of information and experiences among Latin American and Caribbean nations in this connection. In addition, the resolutions and decisions adopted as part of the monitoring and implementation of such actions should be gradually incorporated into the national regulations, legislations and economic practices.

2. Another long-term objective to make progress towards integration and convergence of the health sector in LAC is to improve the mechanisms for joint negotiations between the Ministries of Health and international laboratories aimed at increasing access to medicines that have an impact on our countries, and to try to undertake such negotiations at the regional level.

As noted before, joint negotiations are a political tool that enhances the possibilities to get lower medicine prices, as compared to what individual countries can obtain.
However, as evidenced by developments thus far, in order for these joint negotiations with international pharmaceutical companies to yield the expected positive results, it is essential to make progress – within the framework of integration and cooperation among LAC countries – in terms of the following aspects:

a) the gradual harmonization – at least in the context of the various subregional integration organizations – of the regulations governing internal mechanisms for purchase and distribution of health goods and services at the national level;
b) the possible standardization of the regulations governing national registries of vital medicines that have a direct impact on health for most of the population;
c) to the greatest possible extent, and as part of these harmonization efforts, progress should be made towards medium-term convergence of regulations on government procurements of vital goods and services related to the development of the health sector in Latin American and Caribbean countries.

3. However, as evidenced in this document, some of the key aspects to facilitate access to medicines are discussed in international organizations whose rules, in many cases, are of a legally binding nature. This is the case of the TRIPS and GATS Agreements and the Sanitary and Phytosanitary measures of the WTO. It should be recalled that the Doha Declaration of November 2001 reaffirmed the right of WTO members to use, to the greatest possible extent, all the flexibilities of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPs) so as to protect public health and promote access to medicines for all. Such flexibilities include exempting the repetition of test data of new drugs, because it suffices to prove that the generic drug is bioequivalent.

This is also related to the disciplines agreed to in the FTAs that several countries in the region have signed with the United States, the European Union and other nations outside the region. Of all of them, the aspects related to intellectual property rights have the strongest impact on access to public health.

As some PAHO officials have warned, patents may represent a barrier to access to medicines since they create a monopoly that slows down the introduction of generic versions that help to reduce prices. In addition, patents benefit central countries because they consolidate the hegemony of transnational pharmaceutical companies, while increasing technological and economic dependence of peripheral countries.

For all the above reasons, within the framework of SELA’s actions – together with ECLAC, PAHO and the various subregional cooperation and integration organizations in LAC – since the adoption of Decision No. 512 of the American Council, permanent efforts should be made for consultation and coordination at the regional level to achieve greater exchange of information, analysis and preparation of proposals on these issues among the countries and Latin American and Caribbean integration organizations. Progress should also be made – if possible – towards a consensus-based position of LAC in the multilateral negotiating forums or organs whose rules affect access to health goods and services for Latin American and Caribbean peoples. In this regard, it should be borne in mind that, in view of the characteristics of this type of negotiations which are restricted in practice, the Ministries of Health do not have enough power to have an influence on them, in most cases. In addition, as noted by PAHO, developing countries in general have no tradition of negotiating trade agreements and are not properly informed about the

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options available as regards intellectual property rights related to access to medications. Therefore, governments are not using the flexibilities foreseen in the TRIPS Agreement and the Doha Declaration.\(^{61}\)

4. In this connection, it is important to spread information, not only among government officials but also to all walks of society, about the scope and achievements of these negotiations and their impact on access to health. It is also essential to ensure the participation of academics, professional associations, institutions related to scientific and technical development and health, and other relevant social organizations in the discussions, evaluation and preparation of strategic proposals aimed at making progress in terms of development with social inclusion and integration and convergence of the health sector in Latin America and the Caribbean. This is an area of activity in which SELA - along with ECLAC, PAHO and other agencies specialized in health integration and cooperation in LAC - could promote the conduction of forums to foster discussions and dissemination of analyses, with a view to not only strengthening the bargaining position of governments and subregional integration organizations in multilateral negotiations, but also to effectively designing a regional strategy for integration and convergence of the health sector in Latin America and the Caribbean. In this regard, the experience gained by the Permanent Secretariat of SELA during past meetings on the social dimension of integration in LAC and the Regional Seminar on this issue – held in July 2008 with the participation of regional social organizations – could serve as a starting point for these actions.

This is obviously relevant if we bear in mind that the general objective of the project “Integration and Convergence for Health in Latin America and the Caribbean – INCOSALC” is “to contribute to the reduction of social inequities in the health sector in Latin America and the Caribbean, by impacting on its determining factors through coordinated action of different economic and social sectors in the context of the processes of regional integration and cooperation”.

5. Either in the medium or the long term, integration and convergence of the health sector in Latin America and the Caribbean necessarily requires developing a medical-pharmaceutical and biotechnological industry within and for the region. For this purpose, one of the actions that should be undertaken within the framework of SELA’s INCOSALC project – along with ECLAC, PAHO and other subregional integration and cooperation agencies – is to identify industrial capacities in the region as a first step for designing a strategic proposal to develop a Latin American and Caribbean medical-pharmaceutical industry to ensure the production of medicines and other essential supplies for health in the region.

6. The strengthening of inter-sectoral partnerships, as well as the promotion and expansion of South-South cooperation in the area of health among LAC countries is a must, if we are to make progress towards integration in this area and achieve social development in our region. In this connection, some Latin American and Caribbean countries have taken important actions and have had positive experiences in the area of South-South Cooperation, not only as recipients but also as donors and participants in triangular cooperation. Cuba, Brazil, Mexico, Argentina, Chile and Venezuela have played prominent roles in the area of cooperation for health, but there is still much more potential to explore in the region. Gaining knowledge and better understanding of the experiences lived in Latin American and Caribbean nations and of the cooperation offers

\(^{61}\) Ibidem 59.
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from those countries would allow us to move forward in that direction. SELA should become a forum for discussion, debate and exchange of experiences in this field.62

In all these actions and efforts to devise coordinated responses at the regional level among Latin American and Caribbean countries, due account must be taken of the issues related to training of human resources in the area of health, both at the professional and technical levels. In this connection, some of the issues to be taken into consideration are: best practices for capacity building, exchange of knowledge and skills in the area of health, use of new Information and Communication Technologies for the health sector in LAC, the gradual recognition of qualifications and professional degrees among member countries of subregional integration groups, and the incorporation of health care workers who have migrated to developed countries so as to contribute promote national and regional strategies for improvement and advancement of the health sector in Latin America and the Caribbean.

7. In order to better face the consequences of building an international order that will probably not be based on a multilateral arrangement, but on bilateral and plurilateral agreements, and to incorporate all social, economic and political actors into the efforts to promote integration and convergence of the health sector, it is necessary to develop a communication strategy to spread information about the issues related to the evolution of this sector and its determining political, economic and social factors. This will help to counteract the lack of political awareness about the benefits of integration and coordination in the area of health to achieve health-related goals in Latin American and Caribbean countries, the poor credibility existing in our region about the benefits of integration, the prevalence of economic interests over the social agendas of Latin American and Caribbean integration, and the still low priority attached to matters relating to integration in the region in terms of the national political agendas.

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62 Taken from SELA/PAHO/ECLAC “Towards convergence and integration in Latin America and the Caribbean for health development: The INCOSALC Project”, October 2009.
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ANNEX: POLITICAL AGENCIES DEALING WITH HEALTH MATTERS IN LATIN AMERICAN AND CARIBBEAN INTEGRATION ORGANIZATIONS

<table>
<thead>
<tr>
<th>Organizations</th>
<th>Cooperation bodies in health matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andean Community (CAN)</td>
<td>The Council of Health Ministers was established in 1972. In the initial stage of the Andean process, health was associated with the definitions of security and health at the workplace, as a contribution to social equity and protection of workers. As the Hipólito Unanue Convention turned into the Andean Health Agency in 2000, the Andean Health Ministers’ meetings became the policy maker and priority defining agency, responsible for the follow up of decisions and mandates.</td>
</tr>
<tr>
<td>Caribbean Community (CARICOM)</td>
<td>It groups Health Ministers in a specific conference focused on the development of strategies on health for this region. Nowadays, the Council for Human and Social Development (COHSOD) is the organization responsible for the promotion of human and social development in the community. With the motto, “the health of the region is the wealth of the region”, this entity agreed to establish functional cooperation areas so that health helps achieve other objectives of the Chaguaramas Treaty, using regional health institutions and other associated agencies.</td>
</tr>
<tr>
<td>Central American Integration System (SICA)</td>
<td>The Council of Central American Health Ministers (COMISCA) is the political branch of the Central America Integration System for health matters. Its purpose is to lead the Regional Health Sector, as well as the identification and prioritization of the regional health issues.</td>
</tr>
<tr>
<td>Common Market of the South (MERCOSUR)</td>
<td>The Meetings of the Health Ministers of MERCOSUR and Associate States (RMSMEA) is the political body in charge of harmonizing health policies and determining priority issues for the region. Such issues are dealt with through technical groups, grouped together into the so-called Work Subgroup Nº 11, which includes three commissions: Commission on Products for Health, Commission on Health Care Services, and Commission on Health Watch (non-transmissible diseases).</td>
</tr>
<tr>
<td>Union of South American Nations (UNASUR)</td>
<td>It created a Council of Health Ministers in May 2009. A Coordinating Committee for this Council and five Technical Groups have also been created to coordinate UNASUR’s priority topics regarding health matters.</td>
</tr>
</tbody>
</table>
The project ALBA-salud “Grand-National Company and Medicine Regulatory Centre of ALBA” is an initiative created at a technical meeting in July 2007 in Caracas. Its goal is to achieve a centralized distribution of medication drugs in order to ensure access to essential medicines to the population of the Great Latin American Homeland.

Similarly, regional cooperation mechanisms have been strengthened so as to train technical and professional health care providers for the Member States and other countries in the region.

The Mesoamerican Public Health System was created in 2008 by virtue of this project. Its purpose is to target common public health problems and strengthen national health systems through selected interventions and the creation of the Mesoamerican Institute of Public Health. It pursues regional cooperation and the reinforcement of horizontal technical cooperation among the countries of the region in an organized manner complementing the initiatives of COMISCA.

**Source:** Summary prepared by the Permanent Secretariat of SELA based on official information issued by the subregional integration bodies in Latin America and the Caribbean.