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**A Brazilian health foreign policy?  
the role of health in Brazilian foreign affairs**

Aguilar Perez, Fernanda

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KING´S COLLEGE LONDON

Doctor of Philosophy in International Relations

Doctoral Thesis

**Author: Fernanda Aguilar Perez**

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role of health in Brazilian Foreign Affairs.**

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## **Abstract**

**PEREZ, F. A. A Brazilian Health Foreign Policy? The role of health in Brazilian Foreign Affairs.** 2018. 360 f. Thesis (Doctorate) – International Relations Institute, University of São Paulo/ King's College London. São Paulo, 2018.

Recently, health has become a point of interest for International Relations analysts. In terms of economics, security and social justice issues, health is being debated as part of countries' foreign policy formulation. Brazil, for example, recognizes the importance of health as part of its foreign policy, being a signatory of the Oslo Ministerial Declaration (2007) on Foreign Policy and Global Health, and having included the theme across various international negotiation contexts, both bilateral - for instance, in South-South Cooperation with African States - and multilateral - with the Union of South-American Nations or with the India, Brazil and South Africa Dialogue Forum. Moreover, since health is a constitutional right in Brazil, the country already possesses a legal framework which encompasses the development of international health cooperation. By establishing the concept of structured cooperation for health, Brazil emphasizes cooperation that strengthens the sanitary institutions of different countries. The main objective of this study is to analyze whether there is a specific foreign policy on health in Brazil, exploring the components, actors and principles of which it is made. Additionally, there will be an attempt to understand if Brazil's international action in the field of health converges with the principles of the country's own Unified Health System. Actors are mainly institutions part of either the MoH or MoFA. Regarding constituent elements and principles, certainly solidarity, universal health care, knowledge sharing and cooperation with global South countries were the bricks of all Brazilian actions in this Health Foreign Policy. There is also a deep commitment to the idea of structuring cooperation for health

**Keywords:** Foreign policy, International relations, International cooperation, Global health, Public health.

## Resumo (in Portuguese)

PEREZ, F. A. **A Brazilian Health Foreign Policy? The role of health in Brazilian Foreign Affairs.** 2018. 360 f. Tese (Doutorado) – Instituto de Relações Internacionais – Universidade de São Paulo/ King’s College London. São Paulo, 2018.

Cresce a relevância da saúde como tema das Relações Internacionais. Associada à economia, à segurança e à justiça social, a questão da saúde começou a ser debatida inclusive na formulação de política externa dos países. O Brasil reconhece a importância da saúde na política externa: é signatário da Declaração Ministerial de Oslo (2007) sobre Política Externa e Saúde Global, inserindo o tema em diversos âmbitos de sua ação internacional – como, por exemplo, na cooperação Sul-Sul com países na África - ou multilateral – como ocorre na União das Nações Sul-Americanas (UNASUL) ou no Fórum Índia, Brasil e África do Sul (IBAS). Por consagrar saúde como um direito em sua Constituição, o Brasil possui um marco regulatório que serve de base para o desenvolvimento de cooperação internacional com ênfase nesse assunto. O país criou a ideia de cooperação estruturante em saúde devido ao destaque que dá à cooperação que visa fortalecer instituições sanitárias de sistemas de saúde de outros países. Este estudo se propôs a analisar se houve uma política externa brasileira específica em saúde no período de 2003 a 2014, estudando quais componentes, atores e princípios a conformam. Da mesma forma, verificou se a ação internacional do Brasil em saúde se coadunou com os princípios do Sistema Único de Saúde (SUS). Constatou-se que os principais atores são o Ministério da Saúde, o Itamaraty e suas respectivas instituições. No que concerne elementos e princípios, solidariedade, acesso universal à saúde, compartilhamento de conhecimento e cooperação com países do Sul Global foram os pilares da atuação brasileira nessa Política Externa em Saúde. Houve também no período um profundo compromisso com a cooperação estruturante em saúde.

Palavras Chave: Política Externa, Relações Internacionais, Cooperação Internacional, Saúde Global, Saúde Pública.



## **List of Tables**

Table 01.	People contacted for interviews and subsequent outcomes	p. 44
Table 02.	Swiss Health Foreign Policy: Areas of Interest	p. 61
Table 03.	Health is Global: Areas of Action	p. 64
Table 04.	Realms of a Health Foreign Policy definition	p. 71
Table 05.	Strategic Planning 2011-2015 - Strategic Goal 14.	p. 89
Table 06.	FCTC Conference of Parties from 2003 to 2014	p. 105
Table 07.	MERCOSUR meetings taking place outside Brazil, concerning technical regulation harmonization from 2009 to 2013.	p. 136
Table 08.	Fiocruz international cooperation by country, 2011-2013 period	p. 146
Table 09.	CT 41 areas of cooperation and respective coordinators.	p. 148
Table 10.	Human Milk Banks partner countries	p. 154

## **List of Figures**

Figure 01.	MoH Budget (Executed)	p. 84
Figure 02.	More Health Program: axes of action	p. 85
Figure 03.	Thematic Group for International Cooperation in Health working structure.	p. 119
Figure 04.	Anvisa Budget (Executed)	p. 133
Figure 05.	Fiocruz Budget (Executed)	p. 147
Figure 06	MoFA Budget (Executed)	p. 196
Figure 07.	BCA's budget for implemented projects	p. 211
Figure 08.	BCA executed budget (world area)	p. 212
Figure 09.	Brazilian Contributions to CPLP (Formulated Budget)	p. 244

## List of Acronyms

ABIA	Brazilian Interdisciplinary AIDS Association / Associação Brasileira Interdisciplinar de AIDS
ABRASCO	Brazilian Association of Collective Health / Associação Brasileira de Saúde Coletiva
AFHSC	Armed Forces Health Surveillance Centre
AFHSC-GEIS	Armed Forces Health Surveillance Centre Global Emerging Infections Surveillance and Response System
AISA	Ministry of Health International Advisory Service / Assessoria de Assuntos Internacionais do Ministério da Saúde
Anvisa	National Agency for Sanitary Surveillance / Agência Nacional de Vigilância Sanitária
ART	Antiretroviral therapy
BCA	Brazilian Cooperation Agency / Agência Brasileira de Cooperação
BFP	Brazilian Foreign Policy
BHFP	Brazilian Health Foreign Policy
BNDES	Brazilian Development Bank / Banco Nacional de Desenvolvimento Econômico e Social
BRICS	Brazil, Russia, India, China, South Africa.
CGFOME	Coordination General of Humanitarian Cooperation and Actions against Hunger / Coordenação Geral de Cooperação Humanitária e Ações contra a Fome
CONICQ	National Commission for Implementation of the Framework Convention for Tobacco Control and its Protocols / Comissão Nacional para Implementação da Convenção-Quadro para o Controle do Tabaco
COOPEX	Foreign Cooperation Advisory / Assessoria de Cooperação Externa (HIV/AIDS)
COP	Conference of Parties
CPLP	Community of Portuguese Language Countries / Comunidade dos Países de Língua Portuguesa
CRIS	Fiocruz's Centre of International Relations - Global Health Centre / Centro de Relações Internacionais da Fiocruz.
CTs	Cooperation Terms
DATEC	Division of Technical Analysis / Divisão de Análise Técnica
DELBRASGEN	Brazilian Permanent Mission to the UN in Geneva / Missão Permanente do Brasil para as Nações Unidas em Genebra
DELBRASONU	Permanent Mission of Brazil to the UN / Missão Permanente do Brasil para as Nações Unidas
DoD	Department of Defense
DoD-GEIS	DoD Global Emerging Infections Surveillance and Response System
DPROJ	AISA Division of Projects / Divisão de Projetos da AISA
DTS	Social Affairs Division / Divisão de Temas Sociais
ECOSOC	United Nations Economic and Social Council

ECU	Emergency Care Unit
EMBRAPA	Brazilian Agricultural Research Corporation / Empresa Brasileira de Pesquisa Agropecuária
EU	European Union
FCTC	Framework Convention for Tobacco Control
FDFA	Federal Department of Foreign Affairs
FDHA	Federal Department of Home Affairs
FHC	Fernando Henrique Cardoso
Fiocruz	Oswaldo Cruz Foundation / Fundação Oswaldo Cruz
FPA	Foreign Policy Analysis
FUNASA	National Health Foundation / Fundação Nacional de Saúde
GATT	General Agreement on Tariffs and Trade
GHD	Global Health Diplomacy
GHI	Global Health Initiative
GHSA	Global Health Security Agenda
GIZ	German International Cooperation Agency
GTS-CPLP	CPLP Technical Group for Health
HFP	Health Foreign Policy
HR	Human Rights
IBSA	India, Brazil and South Africa Forum
IBSA Fund	Facility for the Alleviation of Poverty and Hunger
ICCR	International Cooperation on Cosmetics Regulation
ICP	International Cooperation Program
ICTC	MERCOSUR's Intergovernmental Commission for Tobacco Control
IFF	Fernandes Figueira Institute / Instituto Fernandes Figueira
IGEPE	Institute for Management of States Participation / Instituto de Gestão das Participações do Estado
IHP	International Health Program
IHR	International Health Regulations
ILO	International Labour Organization
IMDRF	International Medical Device Regulators Forum
INB	Intergovernmental Negotiation Body
INCA	Brazilian National Cancer Institute / Instituto Nacional de Câncer
INMETRO	National Institute of Metrology, Standardization and Industrial Quality / Instituto Nacional de Metrologia, Qualidade e Tecnologia
IO	International Organizations
IPEA	Institute for Applied Economic Research / Instituto de Pesquisa Econômica Aplicada
IR	International Relations
ISAGS	South American Institute of Governance in Health / Instituto Sul Americano de Governança em Saúde
JICA	Japan International Cooperation Agency
MAPA	Ministry of Agriculture, Livestock and Food Supply / Ministério da Agricultura, Pecuária e Abastecimento
MDGs	Millennium Development Goals

MERCOSUR	Southern Common Market
MINUSTAH	Mission des Nations Unies pour la Stabilisation en Haïti
MISAU	Mozambique's Ministry of Health / Ministério da Saúde de Moçambique
MoFA	Ministry of Foreign Affairs
MoH	Ministry of Health
MSPP	Ministry of Public Health and Population
NGOs	Non-governmental Organizations
NHS	United Kingdom's National Health Service
PAC	Growth Acceleration Program / Programa de Aceleração do Crescimento
PAHO	Pan-American Health Organization
PALOPS	Portuguese-Speaking African Countries
PEPFAR	President's Emergency Plan for AIDS Relief
POM	Plan of Objectives and Goals / Plano de Objetivos e Metas
PROFORSA	Project for the Strengthening of Angola's Health System / Projeto para o Fortalecimento do Sistema de Saúde de Angola
RIDESMAL – CPLP	Network for Research and Development in Health – Malaria – CPLP
SAMU	Emergency Care Mobile Unit / Serviço de Atendimento Móvel de Urgência
SARS	Severe Acute Respiratory Syndrome
SERE	Secretary of State for Foreign Affairs / Secretaria de Estado
SUS	Brazil's Unified Health System / Sistema Único de Saúde
TC-BCH	Tripartite Cooperation Brazil – Cuba – Haiti
TCDC	Technical Cooperation among Developing Countries
TRIPS	Trade-Related Aspects of Intellectual Property Rights
U.S.	United States
UFRGS	Federal University of Rio Grande do Sul / Universidade Federal do Rio Grande do Sul
UFSC	Federal University of Santa Catarina / Universidade Federal de Santa Catarina
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Program on HIV and AIDS
UNASUR	Union of South American Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNICAMP	University of Campinas / Universidade de Campinas
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
UNSG	United Nations Secretary General
UNSTAMIH	United Nations Stabilization Mission in Haiti
USA	United States of America
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization

WIPO	World Intellectual Property Organization
WS	Work Subgroup
WTO	World Trade Organization

## Summary

<b>1. Introduction .....</b>	<b>16</b>
<b>2. Research Methods .....</b>	<b>40</b>
<b>3. Health Foreign Policy: why it is necessary to define this new concept. .....</b>	<b>49</b>
3.1 The concept of foreign policy and the development of a thematic foreign policy. ....	53
3.2 Health Foreign Policy: what does it mean?.....	67
<b>4.Preludes: SUS, access to antiretroviral therapy, the anti-tobacco campaign and MoFA’s insulation .....</b>	<b>71</b>
<b>5.MoH .....</b>	<b>82</b>
5.1 HIV/AIDS Program.....	93
5.2 INCA .....	101
5.3 AISA .....	112
5.4 ANVISA.....	129
5.5 Fiocruz.....	139
5.6 The Antiretroviral Medicines Factory in Mozambique.....	159
5.7 Brazil-Cuba-Haiti Tripartite Project.....	177
<b>6.MoFA .....</b>	<b>191</b>
6.1 WTO, Doha and Public Health .....	197
6.2 Social Affairs Division.....	201
6.3 Brazilian Cooperation Agency .....	206
6.4 Global Health and Foreign Policy Initiative.....	221
<b>7. International Forums and Blocs .....</b>	<b>228</b>
7.1 MERCOSUR.....	231
7.2 UNASUR .....	236
7.3 CPLP .....	242
7.4 IBSA and BRICS .....	248
<b>8. Articulation within the Executive Branch and the influence of SUS .....</b>	<b>254</b>
8.1 SUS influence.....	264
<b>9. Evidence for the existence of a Health Foreign Policy .....</b>	<b>269</b>

9.1 The realms .....	270
9.2 Criticism.....	280
<b>10. Conclusion .....</b>	<b>283</b>
<b>11. References .....</b>	<b>286</b>
<b>12. Annexes .....</b>	<b>321</b>



## 1. Introduction

The topic of health is not new on the international arena. Epidemic outbreaks across borders, humanitarian issues, and international conferences on sanitary matters have been taking place for many years. However, only recently has the subject become a research topic for international relations (IR) analysts. Different authors suggest the same reasons for this change in understanding: for McInnes *et al.* (2012), the tipping point was the fact that health is no longer just a social issue, but also a matter of foreign policy and security – including bioterrorism concerns.

Likewise, for Kickbusch (2011), public health became part of the IR agenda because it affected important IR topics, highlighting, as McInnes *et al.* (2012), areas such as foreign policy and security. To this author, health is related to three realms (KICKBUSCH, 2011, p. 01):

- 1) Security: encompassing concerns with global pandemics, fears of international contagion as well as an increase in the number of conflicts that require humanitarian aid;
- 2) Economics: diseases might affect the economic development of countries. Moreover, there is a “global market in health goods and services”;
- 3) Social Justice: health is a human right and often a social value to some countries, and as such is included in one of the United Nations Millennium Development Goals.

Fidler (2009) concurs on this issue. To him, public health is immersed in a new reality, since it is now part of countries’ foreign policy strategies; it is therefore imperative to understand “how public health connects with the basic functions of foreign policy” (FIDLER, 2009, p. 53). Such a connection can be found in four different areas of this specific policy, all of which are engaged with by states to “fulfill four basic governance functions”. They are (FIDLER, 2009, p. 53):

First, through foreign policy, states seek to ensure their security from external threats. (...) Second, a country uses foreign policy to contribute to its economic power and prosperity. (...) Third, states use foreign policy to support the development of political and economic order and stability in other countries. (...) Fourth, states make efforts to promote

and protect human dignity through foreign policy, as evidenced by support for human rights and the provision of humanitarian assistance.

This reality he describes is a recent one that has only been observed since the end of the cold war, when public health became associated with these four functions. Fear of biological weapons and bioterrorism placed health on the agenda of national security; impacts of public health on a country's economic activity and social development have highlighted its association with economics; the increasing cost of health threatens to produce negative outcomes for global prosperity; and lastly, the recognition of health as a human right has linked public health to the protection of both first and second generation human rights (FIDLER, 2009).

Due to all these endeavors and recent changes, the way Universities and academics understand health has also been modified. As a result, research centers and foreign policy think-tanks that did not previously consider health a topic of relevance have begun to recognize its importance (FIDLER, 2009). Health has become so valuable in fact, that certain authors no longer consider it an issue of *lower politics* – as is the case for many social issues, such as humanitarian aid or education -, but rather a matter of *higher politics*, which includes topics that concern the existence of a State itself, such as power, security and economics (FRENK *et al.*, 2007).

Democracy is also on the list of issues affected by health. As Frenk and Gómez-Dantés (2007) highlight, both topics affect one another, not only because health is on the agenda of democratic countries, due to access to health care services, debates, or epidemic prevention, but also because research has demonstrated that countries which secure access to healthcare have more effective democracies (FRENK *et al.*, 2007). To the United Nations Development Program (UNDP), health is part of what they define as social citizenship, one of the dimensions of citizenship that relates to social inclusion and expresses the quality and strength of a given country's democratic regime (UNITED NATIONS DEVELOPMENT PROGRAMME, 2004).

These new interpretations of the role of health in IR are not unanimous in the academic community, neither are they exempt of criticism. For instance, Almeida (2017a) stresses that nowadays, disease is a subject of geopolitics, not health. Very few diseases, such as Malaria, Tuberculosis and HIV/AIDS, are truly at the center of the global health arena. Ingram (2005) goes even further, affirming that at the present time there is a

*Geopolitics of Disease*, framed by this association of health, security and foreign policy. The association has had some positive outcomes, since health has “gained much-needed resources and political commitment” (INGRAM, 2005, p. 525). However, managing health issues internationally from a security perspective could potentially be harmful, since the “current dominance of hard power and narrow visions of security may lend credence to suggestions that are fundamentally at odds with the principles of public health and its putative role in fostering global security” (INGRAM, 2005, p. 541).

A fundamental event that was crucial to this relationship between health and IR was the process of globalization. Globalization made International Relations a much more complex subject; it altered countries’ commercial relations, civil society connections, and even impacted peoples’ epidemiological profile and the organization of health care systems around the world (SACARDO *et al.*, 2013). A quantitative rise in international health legislation and the increased complexity of medical–industrial systems were also consequences of globalization which, according to Sacardo *et al.* (2013), further altered the relationship between health and IR.

The current debate is not limited to the reasons why health is a relevant matter to IR. It is equally concerned with why health came to be addressed within the foreign policy frame of so many countries. In 2008, during its 63<sup>rd</sup> session, the United Nations General Assembly recognized “the close relationship between foreign policy and global health and their interdependence” (UNITED NATIONS GENERAL ASSEMBLY, 2008, p. 02). Shortly after, in 2009, the United Nations Secretary General (UNSG) and the General Director of the World Health Organization (WHO) launched a joint report entitled “*Global Health and foreign policy: strategic opportunities and challenges*”, aiming to analyze “the interlinkages between health, poverty alleviation and development, as well as the role of health in the formulation and implementation of foreign policy” (UNITED NATIONS GENERAL ASSEMBLY, 2009, p. 02). The report underlines connections and interdependencies between health and foreign policy, listing the challenges of health that also concern foreign policy (such as pandemics, epidemics and access to medicines) as well as issues and problems of foreign policy that affect global health (such as financial crises, migration and international security). It also underlines that foreign policy can act as a catalyst when it comes to responding to sanitary problems.

The following year, in 2010, the UN Secretary General and WHO General Director collaborated once again to further analyze the interaction between Global Health and Foreign Policy. The report sheds light on topics such as institutional capacity building and discusses the management of existing regional and multilateral forums for better cooperation in both disaster reduction and risk management. Furthermore, the document reiterated the importance of health as a tool of foreign policy (UNITED NATIONS GENERAL ASSEMBLY, 2010).

By early 2011, the UNGA has addressed the issue again. During its 65<sup>th</sup> session, the countries of the General Assembly debated how health could offer cross-cutting approaches to other areas, such as development, education and foreign policy. The General Assembly's resolution acknowledged "the emergence of a growing worldwide movement in support of universal access to health care", which was interestingly the model of health service that Brazil had adopted with the Unified Health System (SUS, acronym in Portuguese for Sistema Único de Saúde) (UNITED NATIONS GENERAL ASSEMBLY, 2011).

The significant amount of attention the UN has paid global health and foreign policy is a response to countries themselves who have approached health in new ways. Fidler (2007) lists many "developments [that] over the last decade have forced public health experts and diplomats to think of health as foreign policy, namely public health as important to states' pursuit of their interests and values in international relations" (FIDLER, 2007, p. 53). Among these developments are the outbreaks of Severe Acute Respiratory Syndrome (SARS); H1N1 pandemics; anthrax attacks, bioterrorism and biosecurity issues; the Framework Convention for Tobacco Control (FCTC); medicine patent issues and debates regarding the World Trade Organization's (WTO) scope; the Millennium Development Goals (MDGs); revisions to the International Health Regulations (IHR), and even the establishment of the WHO Commission on Macroeconomics and Health, to name a few. Developments such as these explain why public health is no longer considered a domestic policy concern alone and has had to be included in foreign policy-making agendas.

The authors and International Organizations (IO) discussed so far have proven why health and foreign policy are so closely interwoven. However, they do not debate

whether there is a specific branch for what might be considered a “health foreign policy”, a particular policy predominantly delineated by states to address health issues internationally. A concept that is widely discussed in both Global Health literature and international negotiations about health is the idea of Global Health Diplomacy. However, this should not be confused with health foreign policy. Global Health Diplomacy is defined as a “processes by which government, multilateral and civil society actors attempt to position health in foreign policy *negotiations* and to create new forms of global health governance” (LABONTÉ *et al.*, 2010, p. 01. Emphasis by the author). The relationship between health and foreign policy is hence pivotal to this Diplomacy, but does not necessarily establish a specific foreign policy to target health. Instead, the main accomplishment for Global Health Diplomacy would be to involve health in negotiations. According to Drager *et al.* (2007, p. 162), such a relationship between foreign policy and health requires countries to reorient both their foreign and health policies, so as to “align their national interests with the diplomatic, epidemiological and ethical realities of a globalized world”.

In 2007 the WHO developed an initiative called Global Health Diplomacy, however both Drager *et al.* (2007) and Almeida (2017a) criticize its particular focus on trade and the lack of specification on how “to promote trade and protect health in ways that are politically feasible, economically attractive, epidemiologically informed and ethically sound” (DRAGER *et al.*, 2007, p. 162) .

Kickbusch *et al.* (2012) introduce a different rationale to the debate. To them, diplomacy is a method, a political activity, and a practice of conducting negotiations that countries use to pursue their own foreign policy goals. But as the world changes, so does diplomacy: with significantly more actors and new forms of interaction, diplomacy has acquired a double-standards responsibility, since national and global interests are now so closely interwoven. They illustrate their point by presenting a multiplayer game using the logic of Hudson (2012) and UNGA (2009), affirming that “foreign policy is no longer only about the ‘relation with external entities’, it is about achieving security, creating economic wealth, supporting development in low income countries, and protecting human dignity both at home and abroad” (KICKBUSCH *et al.*, 2012, p.02). Such changes to foreign policy have rendered health significantly more relevant on the international arena, with the former ultimately serving the goals of the latter.

Another consequence is Global Health Diplomacy, “that part of health diplomacy which deals with the negotiation processes that shape and manage the global policy environment for health”, which “can be considered as a method for reaching compromise and consensus” (KICKBUSCH *et al.*, 2012, p.02-03).

Whether a process or a method of negotiations, Global Health Diplomacy does not comprise the intricacies that foreign policy-making in health entails, since it focuses on *discussing and building consensus* on the topic in a given negotiation rather than developing a specific international strategy based on domestic decisions. Here we enter the realm of Foreign Policy Analysis (FPA). The skill with which Ruckert *et al.* (2017) produce a literature review on the issue is remarkable. Analyzing the definitions and theoretical frameworks of Global Health Diplomacy (GHD), they determine that diplomacy is a tool for foreign policy, thus, GHD operates within the reality of foreign policy. It is constituted of a three-level domain with the international, domestic and individual actor levels working in unison towards the common goal of making a difference in the political arena.

Not all concepts involving both IR and health address the development of foreign policy in the service of health, for example Medical Diplomacy and Disease Diplomacy. Medical Diplomacy is considered to be “the use of health care as an instrument for furthering policy goals” (LEE *et al.*, 2011, p.61). The idea of Disease Diplomacy is not new: as Fidler already explained in 1997, it began in 1851, when States understood “the need for international cooperation on infectious disease control” (FIDLER, 1997, p. 59). But since the emergence of an International Infectious Disease Control Regime, as well as various debates on Global Health Security, Disease Diplomacy has conformed to a more refined term, not far from the explanation offered by Fidler. He claims it is a “States’ attempt to negotiate ways to collectively strengthen the global system of disease surveillance and control” (DAVIES *et al.*, 2015, p. 01). Both definitions highlight a well-marked and restricted zone of action. The latter, for instance, focuses on diseases only. Some even consider that ideas such as Medical Diplomacy are just narrower approaches to diplomatic practices (RUCKERT, LABONTÉ, *et al.*, 2017).

Many countries, such as Switzerland and the United States of America, have used these narrow approaches to develop their own foreign policy and global health actions. Although Brazil has not adopted any pre-conceived terms to explain its international

actions in health affairs, the country certainly acknowledges the importance of health to foreign policy. Firstly, because Brazil strongly advocates for *soft power* predominance in international negotiations (LEE *et al.*, 2011), and there has recently been “a growing perception that health can be an effective “soft power” tool for foreign policy (in contrast to the “hard power” of military force)” (FELDBAUM & MICHAUD, 2010, p. 02).

But secondly, and most importantly, in 2007 Brazil officially recognized that global health and foreign policy were interwoven by signing the Oslo Ministerial Declaration, supported by the then Minister of Foreign Affairs, Celso Amorim, together with his counterparts in France, Indonesia, Senegal, Norway, South Africa and Thailand (the Declaration was signed on 20<sup>th</sup> of March 2007)<sup>1</sup>. This declaration was the main outcome of the Foreign Policy and Global Health Initiative, articulated by the Ministers of Foreign Affairs of the above-mentioned countries and felicitated by the WHO General Director, Ms. Margaret Chan herself, as an initiative that “seeks to promote the use of a health lens in formulating foreign policy to work together towards common goals” (CHAN, STØRE, & KOUCHNER, 2008, p. 498).

Another important aspect of this document, as noted by Feldbaum, Lee and Michaud (2010, p. 86) is that it declares that “health as a foreign policy issue needs a stronger strategic focus on the international agenda” and it demonstrates the countries’ commitments “to make health a point of departure and a defining lens (...) to examine key elements of foreign policy and development strategies”. During an event called Global Health and Diplomacy (that took place in New York in 2007), Ex-Minister Celso Amorim added to the significance of this Declaration by highlighting that “it is imperative that global health issues be placed high on the international agenda”, and “this is the main objective of the Oslo Declaration”. He also stressed that “Brazil [was] proud to have been associated to this initiative since its very beginning” (AMORIM, 2007a).

Recognizing health as a significant part of foreign policy by the Minister of Foreign Affairs is central to the debate, however, it was not the only Ministry that did so. Bearing in mind the following contributions from Pinheiro and Milani (2012a, p. 19), who affirm that “foreign affairs are more complex and multidisciplinary, thus the MoFA needs to pursue specialized knowledge in different instances”; of Badin *et al.* (2010),

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<sup>1</sup> There exists a similar declaration, albeit on a civilian scope, called the Istanbul Declaration for Global Health, from 1<sup>st</sup> of May 2009. Supported by local public health entities or associations, it discusses challenges to public health posed by globalization.

regarding the horizontalization process that occurred in the Brazilian Foreign Policy-Making (BFP); and of Milani *et al.* (2013, p. 19), who emphasize that “currently, ministries and other sub-state entities participate in foreign affairs”, we can easily see the popularity of the idea has spread beyond politicians. Adding to this the fact that the Ministry of Health (MoH) contributes considerably to the tenor of Brazilian Foreign Policy, it is possible to deduce that the literature on this issue already considers Ministries other than the MoFA central to BFP.

According to Badin *et al.* (2010), around 60% of MoH’s internal departments are now working at the international level, indicating that the MoFA no longer has exclusive competence in the process of internationalizing health. However, it should be stressed that understanding the reach and strength of these internal departments’ activity is vital to assessing whether the actions of the Ministry of Health are effective and if they can be considered part of the foreign policy decision making.

To analyze the relationship between the MoH and *Itamaraty* (as MoFA is better known in Brazil) is also to understand the different interests and powers driving BFP making. As McInnes and Lee (2012) underline, global health policy and foreign policy might have particular interests that overlap “but may at times pull in different directions, and that the way to understand some of the tensions in global health is to understand the different interests and priorities of health and foreign policy” (McINNES & LEE, 2012, p. 76). To them, this can be a problem as it “limits the establishment of global health diplomacy as a single policy arena”, but these tensions and disputed interests can “also [suggest] who the key players are in global health diplomacy and how to identify the key issues and intersections” (McINNES & LEE, 2012, p. 76).

Not only does Brazil recognize public health as a foreign policy matter, but the country also resorts to health to optimize its international affairs and reinforce cooperation efforts, in both bilateral and multilateral arenas. Health in the BFP would thus be what Pinheiro and Milani (2012a, p.20) categorize as *niche of action*, with actors that “promote new operational fields to the State abroad”.

Discussions regarding public health as a matter of BFP have increased quantitatively, though rather slowly. This said, the nature of those discussions has also changed qualitatively over time – and have improved considerably. Just over two decades



ago, health was considered a merely social matter by the MoFA, but it has slowly gained protagonism in the realm of foreign affairs, through both bilateral and multilateral cooperation projects developed by Brazil (RUBARTH, 1999). Other examples of this recently acquired significance are: Brazilian advocacy for the formulation of a regional health agenda; its support for activities with the Amazon Cooperation Treaty Organization; and its sponsorship of the establishment of a South American Institute of Governance in Health (ISAGS), and a South-American Health Council within the Union of South American Nations (UNASUR) – the Health Council and the Institute of Governance would later be denominated UNASUR Health (BUSS & FERREIRA, 2011).

Elucidating these circumstances, Buss and Ferreira (2012) make an effort to highlight health as a topic important to BFP. They note not only Brazil's relevant work at the WHO, the Pan-American Health Organization (PAHO), or at intellectual property negotiations, but also a crucial element of the country's legal system: "the fact that (...) health is constitutionally a right to all citizens and a duty of the State. This provides to the Ministries of Health and Foreign Affairs (...) a grounding political framework of utter relevance" (BUSS & FERREIRA, 2012, p.254). Milani (2012) also contemplates the Brazilian Constitution as an influence to the desconcentration of the BFP and to closer ties between domestic and foreign policies.

The Federal Constitution was not alone in encouraging the internationalization of health and the convergence of domestic and foreign policies. According to Pinheiro and Milani's (2012a, p. 13) inquiry, the "FPA itself started taking into account the domestic level, particularly decision-making processes, as an explanatory variable to the behavior of States at the international level". Moreover, BFP had been democratized - at the end of the country's dictatorship -, meaning that a wider variety of actors were involved in its formulation process. Thus, it can be understood that health is no longer confined to the domestic level; it has established an international agenda together with multiple different actors, meaning that the MoFA no longer has a monopoly over decision making.

This thesis further agrees with Pinheiro and Milani's (2012a, p. 20) understanding that health can be analyzed within a framework of foreign policy. They emphasize that new topics, such as health, should be seen as international relations issues with the potential of bringing about new kinds of both cooperation and conflict, consequently capable of altering relationships among states. There is a two-fold novelty to this case

(MILANI & PINHEIRO, 2013): diplomacy (as state affair) addressing non-traditional matters; and different agents (both internal and external to government structures) working as part of Foreign Policy decision making processes. However, the authors do not consider how these processes unfold, nor how non-traditional matters came to be part of the agenda. Additionally, they do not clearly define the conjuncture and context necessary for these novelties to take place. However, of significance to this thesis is these authors' emphasis on new topics being addressed by different actors in the foreign policy-making process, a process that can be duly seen in the Brazilian case.

The analysis introduced in this thesis understands “foreign policy as public policy, that is, the state and the government acting on the international level” (MILANI & PINHEIRO, 2017, p. 283). Milani and Pinheiro (2013, p. 24) define such an understanding as:

[the recognition] that its formulation and implementation is inserted in dynamics of governments choice-making, that, in their turn, are outcomes of coalitions, bargains, disputes, agreements among representatives with diverse interests who express, thus, the dynamics of politics themselves

For the authors, foreign policy as public policy deals with governments and the interaction between government institutions and multiple actors in society. Moreover, the “analysis of foreign policy as public policy implies, theoretically and methodologically, (...) to understand how and why governments choose particular activities” (SOUZA, 2006, p.22 *apud* MILANI *et al.*, 2013, p 25)<sup>2</sup>.

As public health is *per se* a public policy, its interaction with foreign policy is in fact an interaction between public policies. Recently, foreign policy has developed collaborative ties with other policies, as if in a synergic relationship; and in the Brazilian case, policies that were traditionally domestic, such as education and health, were pushed to international arenas (MILANI & PINHEIRO, 2013, p. 25). Brazil's process of re-democratization reinforced the perspective of BFP as public policy. Changes in the international conjuncture of the 1980's cannot alone explain modifications to the BFP; domestic disputes and demands were also modified in this interval and, as a result, BFP underwent a process of politicization (MILANI & PINHEIRO, 2013).

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<sup>2</sup> SOUZA, C. Políticas públicas: uma revisão da literatura. *Sociologias*, v. 8, n. 16, p. 20-45, 2006.

International variables cannot be ignored, however. The end of the Cold War and the 1980s Debt Crisis in Latin America (also known as the Lost Decade in this subcontinent) are key elements to this scenario. The combination of the two catalyzed domestic reforms as well as a certain level of trade openness that was needed for handling the economic crisis. As a consequence of this necessity, Brazil was keen to strengthening talks with international partners (such as Argentina) and had to accommodate domestic demands requiring a solution to the economic crisis. Itamaraty was, back then, an interlocutor among national actors and international connections (CASON & POWER, 2009).

Over the following decade, health became an integral part of the international debates for which Itamaraty was present. The 1990's were considered to be "The Decade of UN Conferences", when many social issues were discussed in a myriad of diplomatic gatherings organized by this IO. Brazil was regularly present and ensured that other countries were reminded of the topic of health across many discussions. For instance, in 1994, at the UN Conference on Population and Development, Brazil, G-77 and the Group of Latin-American and Caribbean Countries at the UN sought to adopt goals regarding life expectancy, maternal and infant mortality, and morbidity rates (RUBARTH, 1999). Thereby, "the Brazilian delegation supported (...) G-77 initiatives aiming to maintain donor-countries high-level commitments to projects related to reproductive health, education and combat to sexually transmitted diseases, including HIV/AIDS" (RUBARTH, 1999, p. 109).

Mr. Fernando Henrique Cardoso (FHC) was the Brazilian president at the time, and his administration (from 1995 to 2003) was relevant for its approaches to public health at both the national and international levels. Domestically, he reinforced policies to guarantee access to medicines essential to HIV/AIDS treatment, and internationally, more light was shed on public health within BFP. Mello e Souza (2012, p. 206) explains that Brazil's decision to provide HIV/AIDS medicines for free conditioned the:

country's behavior at regional and multilateral forums, forcing it to assume a leadership role in the defense of access to antiretroviral treatment in developing countries, [as well as] in the adaptation of patents rights law, required to assure access to cheaper generic medicines.

Additionally, Mello e Souza (2012) points out that Brazil's understanding of the situation was by no means narrow, because, it had not been restricted to advocating access

to generic drugs and changing patent laws before the World Trade Organization's (WTO) committees. To Brazil, it was a quest for the right to health, and consequently "this protection to the right to health was not restricted to trade negotiation at the WTO, it took place in forums as different as the UN Commission on Human Rights, WHO, UN General Assembly, and the Free Trade Area of the Americas talks" (MELLO E SOUZA, 2012, p. 206).

During Cardoso's administration, Brazil received and offered increasing international cooperation towards health projects, "mainly to developing countries in Latin America, Caribbean and Africa", and tried to "expand and diversify interlocution among different actors in this area, (...) such as Argentina, China, Cuba, Korea, India, Mexico and South Africa" (RUBARTH, 1999, p. 134).

However, it is during Luiz Inácio Lula da Silva administration (2003-2010) that a qualitative shift can be observed, resulting from Lula's emphasis on health as a subject of BFP practices. His government focused on an autonomous model of foreign policy, championing a vigorous policy for development and combining "a goal of international projection with the protection of certain degrees of flexibility and freedom [on the country's] foreign policy" (LIMA, 2005, p. 11). According to Vigevani and Cepaluni (2007, p. 296), FHC had already built connections with countries from the global South. An example of this is the alliance forged with South Africa and India regarding "HIV/AIDS medicines patents disputes (...) so that international prices of these medicines could be reduced". It was during Lula's administration that Brazil sought to further develop and strengthen these South-South alliances. As Lima (2010a) makes evident in her analysis, Lula's foreign policy tried to improve ties and enhance commercial and cooperation activities with non-traditional partners, establishing South-South relationships as a strategic move.

Likewise, Vigevani and Cepaluni (2007) consider that the main feature of BFP during Lula's years – when compared to FHC's - was what they defined as *autonomy through diversification*, since Brazil kept its multilateral relations, but with higher emphasis on national sovereignty. Lula's diplomacy made a significant effort to establish South-South coalitions and alliances with countries with similar goals, starting with South American neighbours. There was also a moral component in this foreign policy, represented by efforts to combat poverty and hunger (CERVO, 2010, p. 09).

Diplomatic activities developed during Lula's period sought, in all areas of international relations (such as trade, security, human rights and environmental protection), to establish reciprocal relationships (which means to assure that rules from this multilateral order benefit all countries), which is why this diplomacy is called "reciprocal multilateralism" (CERVO, 2010, p. 11). Thus, there was an endeavour to reform world order, pushing for change within many multilateral institutions, from the Bretton Woods system to the WHO itself. For Ventura (2013a), Brazil criticized WHO reform for its lack of attention to health and development in its working documents. The country also expressed its dissatisfaction when WHO's 2014 budget was under negotiation, affirming that Brazil would increase its contribution proportionally to the pressure it put on the WHO's openness to developing countries. Russia, India and China also accepted the increase to their contributions (CHADE, 2013).

In 2009, Brazil worked together with countries from the IBSA Dialogue Forum (India, Brazil and South Africa) and, backed by other developing countries, supported and approved resolution n°6/29 at the UN Human Rights Council, thereby gaining access to medicines recognized as a component of the right to health. In this instance, BFP demonstrated that its stances towards health was based on the understanding that access to medicines is a matter for human rights (MELLO E SOUZA, 2012, p. 224)

Brazil also collaborated with other developing countries on health-related topics across many different organizations, such as UNASUR. The South American Health Council, part of UNASUR's Sectorial Councils, aimed to help member states build agreements on certain topics, so that they could share common positions during international negotiations. This happened in April 2010, when the Health Council issued a "Position to the World Health Assembly (WHA) regarding Medicines and Intellectual Property" as part of its Resolution 10/2010. In the resolution, member states agreed to propose a single draft resolution to the 63<sup>rd</sup> WHA and ask for the establishment of "a permanent intergovernmental group as a sole instance on the WHO ambit to prevent and combat counterfeited medical products" (UNASUR HEALTH COUNCIL, 2010). The UNASUR Health Council had applied a similar approach to negotiations with the European Union in 2011, when member states negotiated a common position on public health cooperation between the two blocks, mainly in the area of health systems (UNASUR HEALTH COUNCIL, 2011).

UNASUR countries would negotiated in unison once again at the 65<sup>th</sup> WHA, in May 2012. The topic under debate was funding for the research and development of neglected diseases, for which UNASUR submitted its own proposal, recommending the establishment of a binding agreement for the research of neglected diseases. Although the final resolution did not adjudicate a binding agreement, WHA member states agreed to keep the topic on the following year's agenda (WORLD HEALTH ASSEMBLY, 2012a; WORLD HEALTH ASSEMBLY, 2012b; NEW, 2012).

Regarding the BFP principles of Lula's government, we note an addition to the traditional list: the principle of *non-indifference*. The principle was used as justification for Brazil's presence in Haiti, and its support to the United Nations Stabilization Mission in Haiti (UNSTAMIH, more widely known by the acronym for the mission's name in French, MINUSTAH - Mission des Nations Unies pour la Stabilisation en Haïti). However, the idea of non-indifference contradicted the principle of non-interference (very dear to Brazilian diplomacy) and demonstrated the BFP's concern with "matters of social justice" (HERMANN, B., 2011, p.20). The creation of this principle also suggests an increased awareness (on behalf of the Brazilian government) of the cost of collective action and its long-term benefits. According to Breno Hermann (2011, p. 22):

starting with Luiz Inácio Lula da Silva's administration, Brazilian foreign affairs were guided (...) by a feeling of global responsibility, where the principle of non-indifference expressed itself, [and this] constituted a base for actions in which the protection of the national interest is seen in a long-term perspective.

Another point of view is offered by Seitenfus, Zanella and Marques (2007, p. 22), to whom "non-indifference legitimizes an international behavior that had to be recreated to better answer the demands of a continent in crisis, where one can no longer ignore that there is no development possible amidst extreme poverty and desperation." The practical side of this principle is the concept of Diplomacy of Solidarity, characterized as "active solidarity from developing countries to less developed ones" which emphasizes the importance of sensibility to the challenges faced by humanity (SEITENFUS *et al.*, 2007, p. 20-21).

It is within this framework that Brazil's South-South Cooperation in health affairs operates. Firstly, Brazilian South-South Cooperation needs to be explained: to Brazil, South-South Cooperation is the same as horizontal technical cooperation, whose utmost

concern is “to contribute to the consolidation of [Brazil’s] relations with developing countries” (INSTITUTE FOR APPLIED ECONOMIC RESEARCH, 2011, p. 33). Technical cooperation, *per se*, is “a common effort, integrating donors and receiving [countries], in partnerships which previous experiences and strategic orientations are shared, aiming at joint planning and execution” and at the recipient country’s autonomy in the long term (BUSS & FERREIRA, 2017, p. 118)

So, combining these two ideas, horizontal technical cooperation as a whole is (INSTITUTE FOR APPLIED ECONOMIC RESEARCH, 2011, p. 33):

Inspired by a diplomacy of solidarity with other countries, making available the experiences and knowledge of specialized Brazilian institutions to other developing countries, in order to collaborate in propagating economic and social progress to other peoples. (...) horizontal technical cooperation in Brazil intends to share successful practices in areas demanded by partner countries, without impositions or conditionalities. Brazil’s ultimate goal is the integral development of partners, (...) [ensuring] social inclusion (...). The exchange of experiences and knowledge, which materializes the feeling of mutual solidarity among peoples, benefits not only partner countries, but also the Brazilian institutions involved, since everyone has always something to learn, as well as teach.

Due to the social and health needs of many developing countries, and the significant public health know-how of Brazilian experts that was assimilated during SUS’ establishment and development, Brazil is more than able to offer international cooperation in health (BUSS & FERREIRA, 2012).

The health cooperation offered is largely technical, typified by Almeida *et al.* (2010) and Buss and Ferreira (2012) as *structuring cooperation for health*, an idea of a cooperation that aims to train human resources in developing countries. The Brazilian structuring cooperation for health is focused on (ALMEIDA, CAMPOS, *et al.*, 2010, p. 28):

institutional strengthening of partner countries’ health systems, combining interventions with local capacity building and knowledge production; promoting too dialog among actors in a way that enables them to take responsibility in the leadership of processes in the health sector and promotes the autonomous development of an agenda for the future development of health.

In this sense, Brazilian cooperation is about training personnel and strengthening sanitary institutions in the countries receiving their support. The Oswaldo Cruz

Foundation (Fiocruz) coined this concept and started using it back in 2009, when the institution decided that their projects should be based on receiving-countries' needs and should intend to fully develop local health systems. This translated into programs that focused on individual long-term necessities (such as lasting structures and human resources) (BUSS & FERREIRA, 2017).

There are two geographical areas where Brazil concentrates most of the projects it has developed. These are South America and Africa (in the latter, projects are mostly concentrated across members of the Community of Portuguese Language Countries - CPLP, from *Comunidade dos Países de Língua Portuguesa* in Portuguese). As Buss (2011) explains, Brazilian South–South cooperation efforts that are concentrated in these two geographical areas work mostly with “the Health Council of the Union of South American Nations and its 2010–15 Quinquennial Plan, and (...) the Strategic Plan for Cooperation in Health of the Community of Portuguese Language Countries (CPLP)” (BUSS, 2011, p. 1723).

Brazilian South–South cooperation stands out for its marked claims of solidarity, as well as the multiplicity of domestic actors it involves. Noticeably, the Brazilian Cooperation Agency (BCA) is much more involved in South-South Cooperation than in other projects, and as Saraiva (2013) highlights, increasing participation from numerous domestic Ministries – predominantly the Ministries of Health, Agriculture and Science and Technology – and fomentation agencies – with special emphasis on the work developed by the Brazilian Development Bank (BNDES). All this rendered the organization and its cooperation planning far more complex, consequently expanding the debate on cooperation making. This increased agencies' and Ministries' participation had several outcomes: it is not by chance that Fiocruz, a public health institution connected to the MoH, opened a local office in Mozambique; and that the Brazilian Agricultural Research Corporation (EMBRAPA), an institution connected to the Ministry of Agriculture, Livestock and Food Supply (MAPA), opened offices in Ghana, Panama and Venezuela.

During president Dilma Rousseff's (2011-2014) administration, South–South Cooperation remained on the BFP agenda. Implemented programs focused on local human resources training, projects based on solidarity, and long-term goals to assist countries combating diseases and dealing with other regional issues, such as poverty



(PATRIOTA, 2011). Due to the particularities of this type of cooperation and considering it clearly constitutes a pivotal part of Brazilian activities developed abroad, South–South cooperation will be analyzed over the course of this thesis as a constituent part of the hypothesized Brazilian Health Foreign Policy.

The facts discussed so far raise doubts as to the relationship between BFP and health. In the words of Dr. Paulo Buss, director of Fiocruz’s Centre of International Relations (CRIS), and one of the most important figures of Brazilian technical cooperation, public health is a topic that would catapult Brazil into the world scenario (VENTURA, 2013b). This leads us to an important question: is health a mere utilitarian and practical element of BFP? A means – via South–South Cooperation or multilateral participation – to justify an end, being the greater international insertion of Brazil? If not, then why is health so meaningful to the BFP? Can it be considered a consequence of the emphasis given to solidarity in recent diplomatic practices, or just an offshoot of classic BFP interpretation, which claims foreign policy is meant to help Brazil’s socio-economic development?

Bearing in mind the historical background and these questions in the previous paragraph, the research aims are as follows:

Primary objective:

-To verify the existence of a Brazilian Health Foreign Policy, identifying its constituent elements, actors and principles.

Specific objectives:

- To identify the actors working with this Brazilian Health Foreign Policy;
- To identify the constituent elements of this Brazilian Health Foreign Policy;
- To verify whether health-related activities developed by Brazil at the international level respect the principles of its own Unified Health System.

The existence of a specifically health-oriented Brazilian Foreign Policy, with its own an agenda, values and goals, is the main hypothesis of this study. Should this

assumption be confirmed, a second hypothesis can be tested: does Brazilian Health Foreign Policy converge with the principles and values of SUS (i.e., universal and equitable access to health and comprehensive care).

Brazil's efforts to encourage international cooperation with countries from the Global South, as well as the high level of consideration the country has demonstrated for projects in the area of public health, have been the basis for the formulation of the main hypothesis of this study.

In the past, Brazil has developed foreign policies for specific topics, such as Human Rights (HR) and Disarmament, which work within very clear frameworks. In the case of HR, this refers to equality among countries in international law and the self-determination of peoples; and for Disarmament this refers to economic development and non-proliferation (AMORIM, 2009; MINISTRY OF FOREIGN AFFAIRS, 2010a). The country also tends to pursue very well-delineated goals and expect specific outcomes. Recently, the MoFA itself determined that South- South Cooperation has specific principles, among them knowledge exchange, emphasis on Human Resources training, employment of local workforces and recognition of each country's peculiarities (MINISTRY OF FOREIGN AFFAIRS, 2013a).

Should the main hypothesis be correct, it will be possible to analyze whether the principles of Brazilian Health Foreign Policy (BHFP) and SUS converge. It is assumed that this foreign policy indeed employs unique values and principles, and that these meet SUS ideology.

MoFA's own interpretation of health's role in foreign policy is unknown. It is of course possible that the Ministry understands health as a matter of technical cooperation, placing it in the same category as education or agriculture. However, it might also be considered that health has its own political agenda and long-term goals. Health is a potential asset to the "*soft power of credibility*", as Celso Lafer (2000, p. 264) puts it when describing Brazil's participation in the international debates of the post-Cold-War period. To him, Brazil invested in this soft power by engaging in the debate of new topics during the 1990's, refusing to be left out of global affairs deliberations. Pondering further,

we might ask whether Brazil developed a Health Foreign Policy *per se*, and, if the answer is yes, what the values guiding it are.

Regardless of the answer, an assessment of SUS's influence on BFP and its health projects is needed. There are many guiding principles to SUS operations; divided into *finality principles* (which are essentially ideals) such as universal care access, equity and integrality; and *strategic principles*, such as regionalization and social participation (TEIXEIRA, 2011). Such analysis is important in this case, since it provides subsidies to the idea that foreign policy and health policies, both guided by principles, can interact in a broader framework, contributing to people's access to health in countries cooperating with Brazil.

There is another parallel between SUS and foreign policy: if foreign policy has only been interpreted in terms of public policy since re-democratization, the end of the Cold War, and the Debt Crisis of the 1980's, then SUS is essentially a response – on behalf of the community of public health experts - to two of these historic events (the exception being the Cold War). It is by no coincidence that one of SUS' pillars is democratic participation and management pacts, which push the health agenda into public debates. However, unlike BFP, there were strong efforts to decentralize SUS in order to properly shape health care delivery to the specific needs of each particular area of the country (ANDRADE, PONTES & MARTINS JUNIOR, 2000).

Considering the nature of Foreign Policy, it might be difficult to envisage decentralization (although this is a controversial topic, since some cities have recently become international actors too). Nonetheless, it can certainly be democratized and prepared to work with different public policies. According to Milani and Pinheiro's analysis (2013), the insulation of BFP-making ended with re-democratization, and a synergic interaction between the BFP and other public policies was created. Bearing in mind this synergic interaction, it is reasonable to question whether SUS and BFP principles interacted to build a new goal in Brazil's international actions, or whether they simply influenced each other.

The approach employed for this study is distinct from what has been used in the literature so far, such as in Pires-Alvez, Paiva and Santana (2012). These authors highlight the convergences between the work of SUS and the Pan-American Health Organization, using their study to underpin cooperation for health and its main features. So far there is

no analysis of BFP *per se*, nor of its possible connections to SUS in a broader context – including, for example, cooperation practices outside that of South-South.

There is a strong interaction between SUS and BFP *rationales*, since both claim to be centered around ideals of solidarity (AMORIM, 2010; VENTURA, 2013b). And as Ventura clarifies (VENTURA, 2013b, p. 102):

it is the doctrine of the SUS, which advocates universal, equal and integral health coverage, that is the primary inspiration for the concept of “structural cooperation for health” developed by Brazil over the past decade. It is doubly innovative in relation to the paradigm of international cooperation.

From this stance, it is important that we understand whether SUS-BFP interactions are limited to acting as a structural base to cooperation for health, or if they influence foreign policy-making as a whole. For Frenk (2010), national health systems are fundamental to global health, to the achievement of the MDGs and to improving health outcomes. We must understand the goals of health systems, and they should be thought of “not only in terms of [their] component elements (like human resources, financing, hospitals, clinics, technologies, etc.) but most importantly in terms of their interrelations” (FRENK, 2010, p. 01). Moreover, domestic health matters and negotiations are extremely important to global health affairs, because (KICKBUSCH & IVANOVA, 2013, p.20):

Global health begins and ends “at home”. In a response to the increasing need to address the intersection between national and global health policy, countries are exploring new mechanisms for policy coherence. Consistency is sought in two directions. The first is across government sectors and the work of different ministries. The second is between national interests and global responsibilities.

We can consider all this interaction between foreign policy, health systems and various ministerial contributions as the input of a joint construction; a process with a global health outcome. All these interrelations are fundamental for what here is understood as Health Foreign Policy (HFP), a new concept derived from this intersection of global health, foreign policy and the approach of foreign policy as a public policy. Bearing in mind that global health is the main consequence of interactions between public health and international relations; and that foreign policy as public policy is the state and the government acting on the international level (MILANI & PINHEIRO, 2017), this thesis will also understand Health Foreign Policy as a construction, as the process through

which the state and the government act on the international level *on health affairs*. Affairs with clearly established aims and goals of their own, with actions and agendas that can be identified and analyzed.

Certain individual countries, and the European Union (EU), have claimed to have developed – or at least formally defined – a Health Foreign Policy. The United States of America (USA), The United Kingdom (UK), Switzerland, and the EU<sup>3</sup>, have engaged with global health affairs and have implemented many projects and programs abroad, but have they indeed developed a specific health foreign policy?

The goal of this thesis is by no means an in-depth verification of these four specific policies, let alone to observe if they have indeed established a Health Foreign Policy under our criteria. This is not a comparative study of five different approaches to global health and foreign policies; the aim here is to analyze BFP, its actors and elements, and Brazil is the only country being scrutinized. Nonetheless, knowing what other countries are doing and with which type of activities they engage can be helpful, especially if it is considered a fair description of what is currently being done by these three countries and the EU in health matters. This matter will be returned to later on in the text.

Lastly, the relationship between global health and foreign policy brings forth the intrinsic necessity to uncover who is responsible for BFP making and what these policy makers undertake as global health and health priorities (FIDLER, 2011). Thereby, ideas of Foreign Policy Analysis (FPA) must be looked upon so that such relationships can be properly understood.

This study understands that, in FPA, actors and structures are regarded as crucial to policy-making (CARLSNAES, 2012), but also that their interaction is complicated. Or, as Hill (2003, p. 28) summarizes:

Foreign policy making is a complex process of interaction between many actors, differentially embedded in a wide range of different

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<sup>3</sup> Labonté and Gagnon (2010) introduce Sweden as another country that established strategies to incorporate global health into the country's foreign policy. However, the strategies being discussed were part of global development plan that had health as one of its operative topics, which is the reason Sweden was not included on the list. Moreover, Buss (2011) only refers to USA, UK and EU as examples of countries with official global health and foreign policy strategies.

structures. Their interaction is a dynamic process, leading to the constant evolution of both actors and structures

Actors, agents and structures are a central part of FPA, but as Hudson introduces in her book (HUDSON, 2014), there is a quite effervescent debate not only between different understandings on how much leaders, bureaucrats and domestic structures matter to FP making; but also among different interpretations on FPA existing as a subject at all (many consider it a part of International Relations studies, not a field of study of its own).

This last debate aside, the ideas discussed above are important to this thesis because the interaction between MoH and MoFA, their understanding of each other, and their work dynamics are of immense significance to this study.

This study will analyze the period between 2003 and 2014, encompassing both the two terms of President Lula (2003-2006 and 2007-2010), and President's Dilma first term (2011-2014).

WHO, and any Brazilian activities attached to it, will not be included in this analysis. The simple and very specific reason for this is that when WHO was established, there was an agreement that health professionals would play a prominent role in the institution. The intention with this agreement was to emphasize technical studies and achievements, and combine them with diplomatic efforts to improve health conditions across the world; however, WHO never sought (at least according to its principles) to become yet another international institution ruled by diplomats. The WHO's objective was, indeed, to provide a space for health experts to collaborate at the international level<sup>4</sup>.

Given these intentions, WHO was meant to be a place where Ministries of Health were as present as Ministries of Foreign Affairs, where health experts were as important (and perhaps even more necessary) than diplomats. Brazilian participation in WHO is extremely relevant, but, bearing in mind the goals of this study, what matters more is Brazilian behavior in other forums as well as the MoH and MoFA's interactions with one another in various different contexts.

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<sup>4</sup> A lot of controversy surrounds WHO's work and the relationship it fosters between different countries, experts and the organization's bureaucrats. For further information, check Chorev (2012).

Even though negotiations with the WHO will not be taken into account, we must stress that it encouraged active cooperation from both MoFA and MoH with AISA (the MoH department responsible for the Ministry's International Advisory Service, and acronym in Portuguese for Assessoria de Relações Internacionais do Ministério da Saúde). In this, they became involved in discussing the WHA agenda that would be proposed by Brazil through the Brazilian Permanent Mission to the UN in Geneva (Delbrasgen) (MINISTRY OF FOREIGN AFFAIRS, 2006a). Brazilian Contributions to the WHO are also significant: in 2007, Brazil was the organization's 14th largest contributor (MINISTRY OF FOREIGN AFFAIRS, 2007a)

The *More Doctors* program will also be left out of our analysis. The program, which sought to increase the number of doctors in remote or less developed areas of Brazil through cooperation with Cuba and the Pan-American Health Organization, was the root of nationwide debates on doctors' education and access to health. Private institutions such as local Medicine Councils also engaged in these debates, making this a highly studied and popular topic in the country (a good example of this is the analysis carried out by Campos & Pereira Júnior, 2016). Additionally, More Doctors was established and carried out only in 2013, representing less than a year of the period covered by this thesis.

The thesis will develop as follows: chapter 02 focuses on research methods and data collection procedures, while chapter 03 begins by depicting the US, Swiss, UK and European Union initiatives that develop a global health and foreign policy approach. Through this, the chapter will then attempt to define what we understand as 'health foreign policy', and identify which features of foreign policy might serve to scrutinize its existence.

Chapter 04 explains how health became a prominent concern for Brazilian Foreign Policy, leading, in Chapter 05, to the analysis of the MoH's most important institutions engaging in projects abroad.

Chapter 06 highlights MoFa's understandings of the issue, with emphasis on the two of its institutions that work most closely with health: The Social Affairs Division and the Brazilian Cooperation Agency.

Chapter 07 scrutinizes the arenas within which Brazil has raised the question of health affairs. Finally, Chapter 08 introduces a debate on the above institutions'

cooperation, so that lastly, in Chapter 09, we can return to the main hypothesis and debate the existence of a Brazilian health foreign policy.



## 2. Research Methods

Based on the main objective at hand, the most adequate research method in its pursuit is a qualitative one. Qualitative research allows us to emphasize the particularities and details of a certain phenomenon, but is not limited to definitions. It is also about social organization and a serious attempt to “sort fact from fancy” (SILVERMAN, 2011, p. 04). It encompasses the myriad of social contexts and realities that conform to the social reality under investigation, making use of inductive strategies in order to understand new circumstances and use them to develop knowledge (FLICK, 2009).

Qualitative approaches emphasize the dynamic, evolutionary and constitutive nature of social realities, as well as stressing the importance of an interpretative epistemology and a comprehensive perspective when observing the world (DEVINE, 2002; KING *et al.*, 1994).

Importantly, institutions and arenas were chosen for analysis because the government itself highlighted their prominence when debating international cooperation in health (INSTITUTE FOR APPLIED ECONOMIC RESEARCH, 2016).

Sources of primary data include: documents (see below) from the MoFA and the MoH (as well as these ministries’ autarchies and organs), and Brazilian government reports and interviews with authorities and diplomats working on the topic during the period of time in question. A bibliography on subjects of BFP, Foreign Policy Theory and Analysis, public health, cooperation in health, South-South Cooperation and health diplomacy has also been fundamental to the development of this study.

The documents include: official letters and speeches, telegrams, notices, decrees, official ministerial communications and ordinances issued by any of the governments’ organizations. These are essential to the analysis because they are essentially texts that reproduce the culture, reality and action mode of an institution, or as Atkinson *et al.* (2011, p. 77) put it: “documents are not neutral, transparent reflections of organizational or occupational life. They actively construct the very organization they purport to describe”. Hence, when such documents are carefully scrutinized, one can “build the world behind the text” (PRIOR, 2011, p. 93).

Atkinson *et al.* (2011) further highlight that documents should not be taken as a way to validate interviews, as devices with complementary data. Documents instead reveal different sides to the same social reality, as if interviews and documents were observing the same geometrical form with a different lens. Therefore, for a comprehensive understanding of this social reality, data found in documents and interviews will be key.

Official documents were gathered in three distinct ways: first, most of the institutions considered here offer electronic documents and reports, which can easily be accessed through their websites. Second, materials were also sent by people contacted via e-mail (this is the case of the report of the Brazil-Cuba-Haiti trilateral project). Third, the researcher visited, in October 2016, the MoFA's Department of Communication and Documentation. Access to official documentation was previously requested and granted by this Department, and telegrams, notices and letters available at the Historical Archives Section were duly photographed and later categorized. All this material covers the interval proposed in this study (2003-2014).

In September 2016, a request was also made to the MoH International Advisory Service (AISA), soliciting access to this institution's archive. However, access was denied because AISA considered that the request did not properly specify which particular documents were being requisitioned. The solution to this problem was to look for AISA documents at the MoFA Historical Archives Section, in the form of official communications between the MoH and the MoFA. As suspected, documentation was plentiful and covered the time interval proposed.

Interviews were another method used to collect data. Ultimately, interviews are a process of learning from other people's stories and experiences; they are narratives of different practices that are delivered through language (SEIDMAN, 2006, p. 07 - 09). The interviews in this study can be divided in two cohorts: the first group's interviews were carried out during early 2016, in order to grasp Dilma Rousseff's appraisal for the MoFA and its endeavors. Because of its very specific goal, questions were straightforward and the surveys were short and simple. Questionnaires were randomly distributed to Brazilian diplomats with posts in different parts of the world as well as in Brasilia, for which written answers were requested. Informed Consent Forms, assuring anonymity and an explanation of what the data would be used for were provided in all cases. After a month,

ten questionnaires had been answered. Each survey contained four open-ended<sup>5</sup>, for which short answers were expected<sup>6</sup>. The characteristics of this part of the research allowed the selection of participants to be entirely random.

The second cohort is larger and the participants were carefully chosen according to their positions in public departments, workplaces or occupations. After a preliminary review of the literature, it was decided that members of the Civil Society, MoH, National Agency for Sanitary Surveillance (Anvisa), Brazilian National Cancer Institute (INCA), AISA, Fiocruz and MoFA should be contacted.

In total, 46 people working across these institutions were contacted. The content of email correspondence was always the same: a brief description of who the researcher was; a short explanation of what the research was about; some reasons why the contacted person was important to the research and why the interview would be of significance to the data collection; and, a final paragraph ensuring the contacted person that the interview would respect research ethics, and that the author was available for further clarifications should any doubts arise. When requested, questions were sent to participants prior to committing to the task.

To those who did not reply or who stopped replying after initial contact was made, three further attempts at contact were made. Following this, no other type of communication was endeavoured. To the ones who replied, an Information Sheet and Consent Form were sent, explaining that the collected data would be analyzed for PhD research, that it would involve a few open-ended questions to guide the conversation, and that the participant could choose not to be identified, if so they wished. Those who opted for anonymity were given the choice as to how they wished to be named for the purposes of the research.

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<sup>5</sup> The questions were: (1) Was there an abrupt change in BFP during Dilma Rousseff's first term (2011-2014) when compared to Luiz Inácio Lula da Silva's era (2003-2010)? If so, what are the reasons for this change in your opinion? If not, what continued to be the same, in your opinion?; (2) Do you believe that Dilma demonstrated a main idea/concept for BFP during the period of time in question?; (3) Cervo and Lessa (2014) use the word "decline" as a descriptor for BFP under Dilma's era. Would this word be the best one to describe the changes that took place during Dilma's first term?; (4) Can you highlight any differences in cooperation with Itamaraty between Lula's and Dilma's presidencies?.

<sup>6</sup> Results from this questionnaire were also used as a source of data for an article published in 2016 by my co-supervisor and myself. For further information, please see GOMEZ, E; PEREZ, F. Brazilian Foreign Policy in Health during Dilma Rousseff's administration. *Lua Nova*, v. 98, 2016. p 171 – 197.

This study was developed in compliance with Brazilian research ethics regulations. Even though social research conducted outside the scope of public health or medicine is not formally obliged to conform to strict ethic rules, the author of this research considered it mandatory to abide by Resolution 446/12 of the Brazilian National Health Council given her background in Public Health research. Thus, all participants were volunteers, informed about the research topic, introduced to an Informed Consent Form (which included the explicit option to be cited and identified or not), and asked if they wanted to read the research before it was made public in order to confirm that what they said was what they had meant.

In total, 27 interviews took place: six were sent in written form, and 21 conversations were conducted either in person, via Skype, on the phone, or via WhatsApp calling. During the latter more dynamic type of interviews, follow-up questions sometimes arose during the conversation, and were posed by the researcher when deemed appropriate, compatible with the methods of a semi-structured interview<sup>7</sup>.

All the material was transcribed by the researcher herself, with repetitive sounds or cacophonies being excluded from the conversation. The excerpts cited here are those that were deemed most important and relevant to the research objectives.

Table 01 depicts the contacted subjects in a more detailed manner, as well as the outcomes of the contact made.

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<sup>7</sup> During semi-structured interviews, the main questions were: 1) Was the place you work(ed) for autonomous in developing or implementing its own projects abroad? 2) How was the relationship with other Ministries / governmental entities? 3) Could other countries bring up their own demands in these projects? 4) Did SUS influence the initial concept of these projects or programs? 5) Bearing in mind BFP, could the country have developed a specific health foreign policy in recent years? These were the basic questions used during conversations, however, given the nature of a semi-structured interview, further questions varied depending on the subjects interviewed.

**Table 01.** People contacted for interviews and subsequent outcomes

Name	Institution	Professional Position	When Contacted	Outcome
Dr. Paulo Buss	Fiocruz	President Fiocruz 2001-2008, Diretor Cris	July/2017	Interview
Dr. Luiz Eduardo Fonseca	Fiocruz	Cris International Advisor	July/2017	Written Interview
Dr. José Roberto Ferreira	Fiocruz	Cris assistant manager	Aug/2017	Written Interview
Senador Humberto Costa	Ministry of Health	Ex-Minister of Health (2003-2005)	Aug/2017	No answer
José Gomes Temporão	Ministry of Health	Ex-Minister of Health (2007-2010)	Sept/2015 onwards	Interview
Alexandre Padilha	Ministry of Health	Ex-Minister of Health (2011-2014)	July/2017	Interview
Arthur Chioro	Ministry of Health	Ex-Minister of Health (2014-2015)	November/2017	Email response with a short answer
Amb. Santiago Alcázar	MoH-AISA	Ex-Diretor AISA	Sept/2015 onwards	Exchange of emails
Amb. Eduardo Barbosa	MoH-AISA	Ex-Diretor AISA	July/2017	Interview
Dr. Alberto Kleiman	MoH-AISA	Ex-Diretor AISA	Aug/2017	Interview
Dr. Ana Tapajós	MoH-AISA	Ex-Diretor DATEC - AISA	Aug/2017	Interview
Dr. Carlos Felipe A. Oliveira	MoH - Mercosur/UNASUR /Haiti	Ex-representative of the MOH to MERCOSUL/UNASUL Ex-diretor project Tripartite Haiti	Aug/2017	Interview
Luciano Queiróz	MoF - Technical Advisor	Reference person for the BCA inside the MoH	Sept/2017	No answer
Dr. Mariângela Simão	MoH-STD / AIDS Program	Ex- Diretor STD / AIDS Program (2004-2010)	Oct/2017	Interview
Dr. Luiz Santini	INCA	Ex-Diretor INCA (2005-2015)	Aug/2017	Interview

Dr. Tânia Cavalcanti	INCA	CONICQ Executive Secretary	July/2017	Interview
Dr. Vera Costa e Silva	INCA	Diretor Tobacco Free Initiative (2001-2005)	Sept/2017	Email response but no interview (Dr. Vera's schedule)
Patrícia Oliveira Tagliari	ANVISA	Chief Advisor for International Affairs	January /2017	Interview
Cammilla Horta	ANVISA	Advisor for International Affairs	January /2017	Interview
Amb. Celso Amorim	MoFA	Ex-Minister of Foreign Affairs (2003-2010)	Oct/2017	Interview
Amb. Antônio Patriota	MoFA	Ex-Minister of Foreign Affairs (2011-2013)	July/2017	Email response with referral to other diplomats to be interviewed
Amb. Luis Alberto Figueiredo	MoFA	Ex-Minister of Foreign Affairs (2013-2015)	July/2017	No answer
Brazilian Diplomat working at international multilateral organization	MoFA	International multilateral organization	July/2017	Interview
Sec. Juliana Gomes	MoFA - Division for Social Affairs	Ex-secretary in the Division for Social Affairs	July/2017	Interview
Cons. Tatiana Bustamante	MoFA - Division for Social Affairs	Substutive Chief Division for Social Affairs 2012-2013	Sept/2017	Email response with a short answer
Amb. Silvio Albuquerque	MoFA - Division for Social Affairs	Director Division for Social Affairs	Aug/2017	Email response but no interview (Ambassador's schedule)
Amb. Mariângela Rebuá	MoFA - Division for Social Affairs	Director Division for Social Affairs	Aug/2017	No answer

Cons. Carlos Cuenca	MoFA - Division for Social Affairs	Director Division for Social Affairs	July/2017	No answer
Amb. Guilherme Patriota	MoFA - UN	Ex-representative of Brazil at the UNSC	July/2017	Email response but no interview (Ambassador's schedule)
Sec. Maurício Fávero	MoFA - UN	Brazilian UN delegation at UN-NY	July/2017	Email response but no interview (diplomat felt he could not contribute to the issue)
Brazilian Diplomat at UN-NY delegation	MoFA - UN	Brazilian UN delegation at UN-NY	July/2017	Interview
Sec. Adriana Telles	MoFA - UN	Brazilian UN delegation at UN-NY	July/2017	Email response with relevant telegrams from the Brazilian Delegation
Sec. Fabio Farias	MoFA - UN	Brazilian UN delegation at UN-NY	Aug/2017	Email response but no interview (no email response after a certain point)
Amb. Maria Luisa de Moraes	MoFA - WHO	Head of negotiations of the <i>GH and FP Initiative</i>	July/2017	No answer
Sec. Lucas Sversut	MoFA - WHO	Brazilian representative working with the WHO	July/2017	Email response but no interview (no email response after a certain point)
Sec. Cristina Alexandre	MoFA - WHO	Brazilian representative working with the WHO	July/2017	Email response but no interview (no email response after

				a certain point)
Con. José Roberto A. Filho	MoFA - WHO	Brazilian representative working with the WHO	Oct/17	No answer
Min. Milton Rondó	MoFA - CGFOME	Diretor CGFOME	Aug/2017	Interview
Amb. Marco Farani	MoFA - BCA	Ex-diretor BCA (2008-2012)	July/2017	Interview
Amb. Luiz Fonseca	MoFA - BCA	Ex-diretor BCA (2006-2008)	July/2017	No answer
Amb. Lauro Silva Moreira	MoFA - BCA	Ex-diretor BCA (2005-2006)	July/2017	No answer
Amb. Fernando de Abreu	MoFA - BCA	Ex-diretor BCA (2012-2015)	July/2017	Email replied but no interview (Ambassador's schedule)
Paulo Lima	MoFA - BCA	General Coordinator Palop and East Timor	July/2017	Interview
Maria Augusta Ferraz	MoFA - BCA	General Coordinator Latin America and Europe	July/2017	No answer
Eduardo Suplicy	National Congress	Ex -President of the Foreign Affairs Commission at the Brazilian Senate	May/2017	Interview

Content analysis was not the approach of choice for this thesis. The analytical section therefore does not focus on the repetition of certain words, nor does it examine the intentions, representations, mood or state of mind of the subjects (AMADO, 2013).

Process-tracing methods were also considered to be unfit for the data scrutiny of this research. The aim here is to see whether Brazil built a framework; if it developed a matrix with different inputs that result in a specific outcome. Albeit an important method,



process-tracing is “[explicitly focused] on investigating causal mechanisms” on a single-case research design (BEACH & PEDERSEN, 2013, p. 04), and understanding the influence of an independent variable on a dependent one is not the intention of this inquiry. There is no “ambition to trace causal mechanisms” (BEACH & PEDERSEN, 2013, p. 04); but a will to witness the process of how ideas and projects were built and how different actors behaved.

This research has therefore used the qualitative data at hand to demonstrate how synergies occurred and relationships were built, considering whether such events culminated in a Brazilian Foreign Policy within the definition that was carefully developed in this thesis.

### **3. Health Foreign Policy: why it is necessary to define this new concept.**

There is a growing literature within International Relations (IR) that analyzes the links between health and foreign policy. Many studies (McINNES & LEE, 2012; RUCKERT, LABONTÉ, *et al.*, 2017) argue how essential joint IR theory and global health analyzes are to providing more comprehensive perspectives of diverse behaviours from different actors on health affairs McInnes and Lee (2012) detail the importance of risk (or the idea of risk) in this context, highlighting that *certain types of risk* (such as HIV/AIDS, SARS and H1N1 outbreak) were pivotal to the incorporation of health to IR. As countries devoted more attention to the issue, so academia followed suit, developing an agenda that (McINNES & LEE, 2012, p. 33):

can be summarized in three linked moves: that certain health issues led by bio-terrorism and merging infectious diseases pose new security risks; that the problems are global in scope and not limited to the local or national levels; and that collective action requires a political response going beyond the technical expertise of the public health community and thus engagement with the foreign and security policy community.

Such reasoning, which emphasizes risk, is not the only existing explanation for this growing intersection between IR and global health studies. If so-called statist (experts who have a state-oriented approach focusing on “the place of health in national, foreign and defence policies” (DAVIES, 2010, p. 1170)) pay too much attention to risk, then a different perspective can be found in the globalist, who applies a more individual-centred approach (DAVIES, 2010, p. 1171)

It starts with individual health needs and then takes into account how global actors and structures impact on the individual, considering factors ranging from poverty and poor education to the actions of states and the health effects caused by international organizations, multinational corporations and others. The state remains a core actor in this perspective, but globalists see it as just one among a wide range of actors and situates the individual as the core referent.

Globalists still use words like ‘threats’ and ‘defence’, but with the aim of protecting vulnerable populations from health hazards, not to emphasize potential perils that might endanger the existence of the State *per se*. While statisticians are keen on securitization studies, globalists are more likely to develop their analysis in terms of human security (DAVIES, 2010).

Closer cooperation between global health and IR theory could be beneficial to both areas of knowledge. It produces a more systematic comprehension of global health trends and the networks of power behind them (Ruckert, Labonté, *et al.* [2017] introduce this idea in the context of Global Health Diplomacy), and claim that it could improve our understanding, for example, of the interaction between government and non-governmental institutions at the international level. However, the idea can also be applied to global health, since a more systematic understanding of global health actors is needed across the board).

When we zoom into a particular field of IR, in this case foreign policy, risk is still mentioned: global health was introduced to foreign policy experts due to concerns regarding the combination of health crises and threats to national security (BIRN, PILLAY & HOLTZ, 2017, P. xxvi). Labonté and Gagnon (2010) contribute to this debate by saying that there are six policy frames where health can influence foreign policy-making. These frames are: security, development, global public goods, trade, human rights, and moral/ethical reasoning. All have limitations and can overlap; for instance, in order to improve global health equity, countries might include global health goals into their foreign policy-making. However, whether these endeavours take place under a human rights scope, or within moral or ethical spheres, can change the policy framework significantly. The authors also point out that “politically, the security and trade frames are the most potent but remain the most problematic”. In this they assume that individuals are market actors, thus “[supporting], rather than [challenging], the social and economic assumptions that have driven the past three decades of neoliberal globalization” (LABONTÉ & GAGNON, 2010, p. 15).

In some cases, Foreign Policy and health have already been combined with international strategies, such as the USA, the UK and Switzerland, as well as by the European Union (BUSS, 2011). But have those strategies constituted a new thematic

foreign policy, or are they just what they claim to be, strategies developed within a larger framework? One thing is to have a foreign policy linked to health; another is to have a Health Foreign Policy, a specific foreign policy dedicated to the issue. Thus, there is a need to more deeply conceptualize what Health Foreign Policy is.

The aim of this chapter is to analyze what Health Foreign Policy (HFP) entails as a concept, and what its defining features and components are. When a concept of the social sciences is analyzed, there is a habit of linking a specific word / term to a particular phenomenon in the real world. This of course has its limitation, because no phenomena in the social world can be flawlessly or thoroughly explained by a single term. Parts of a concept can be missed or misinterpreted, mistakes that commonly accompany generalizations within the social sciences.

Moreover, it is impossible to consider creating a concept without first discussing its intentions; what it will be used for, and which epistemological position the researcher will take. And to take a position should also imply being aware of its weaknesses and strengths (FURLONG & MARSH, 2002). Consequently, concepts can be contested. As early as 1956, Gallie (1956) affirmed that different groups may dispute what would be “the correct” definition of concept based on what they interpret as true. What about concepts that seem to have a clear-cut definition, like *democracy*? What function does one give such concepts, based on one’s interpretation of them? Does one group’s long-term use of a concept redefine how others understand it? Are there ambiguities? Gallie demonstrates the intricate problems that can arise when a new concept is created.

For these reasons the author actually considers the concept introduced here as a methodological device, a definition built in order to assess the Brazilian case and properly test the hypothesis. The intention is not to introduce new theory or methodology to the investigation of possible Health Foreign Policies around the world. The concept we establish is a tool to assist us in the pursuit of our research goals.

The concept introduced here is intentionally *strongly based and heavily inspired* by Brazilian Foreign Policy practices. Since Brazilian institutions and actors are the unit of analysis, it is reasonable to build a *practical instrument*, a concept whose purpose is to serve as a tool for the study of the Brazilian case, upon those very Brazilian practices.

Four other countries' strategies will be introduced and briefly described over the course of this chapter. They will serve to demonstrate that Brazil is not the only country implementing health projects abroad and endorsing global health goals. This said, the exploration of these countries' cases will not include any exhaustive descriptions or judgements, nor will it comment on whether their strategies constitute a HFP. As already mentioned, the aim is to outline a concept linked to empiricism, not a philosophical universal concept that would be, "by definition, supra-empirical" (SARTORI, 1970, p.57).

Establishing a concept is not an easy task. The semantics of the word "Concept" is evident in dictionaries: as the Oxford Dictionary (2015) details, concept is defined as:

1. Something conceived in the mind; a notion, idea, image, or thought.
- 2.(...) a general idea or notion, a universal; a mental representation of the essential or typical properties of something, considered without regard to the peculiar properties of any specific instance or example.
3. An idea underlying or governing the design or content of a product, work of art, entertainment, etc.

Weber (1949)<sup>8</sup> introduces a narrower definition of concepts: to him, concepts are the result of attempts to order reality analytically (*apud* GERRING, 1999, p. 359). However, what constitutes a concept, its perimeters – essentially the outline of what it is about this new thing we are trying to define- are harder to clearly state. Goertz (2006, p.04) explains that semantics are not enough; a good concept "involves a theoretical and empirical analysis of the object or phenomenon referred to by the word. A good concept draws distinctions that are important in the behavior of the object." Therefore, concepts are closely linked to the matter ontology, since "they are theories about the fundamental constitutive elements of a phenomenon" (GOERTZ, 2006, p. 05)

Strictly speaking, in order to create a concept, it is necessary to go beyond the simple meaning of words, for such an approach is quite arbitrary. Words are symbols, and distinct symbols may be designated to specify the same object. Words by themselves do not specify a phenomenon. On the other hand, if a word or expression is linked to the

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<sup>8</sup> Weber, M. **The Methodology of the Social Sciences**. New York: Free Press, 1949.

object or the phenomena by empirical analysis and research, that word will also be linked to central components of the analyzed phenomenon. Thus, the attempt to establish a new concept is also an attempt to narrow down the object's boundaries of action, its main behaviours, constitutive elements and fundamental features (GOERTZ, 2006).

Bearing in mind the complexity of creating a universal concept of Health Foreign Policy, the author has instead opted for introducing the concept purely as a methodological tool, rather than an idea that encompasses all constitutive elements of the phenomenon.

### **3.1 The concept of foreign policy and the development of a thematic foreign policy.**

What *foreign policy* depicts as a concept is still debated in IR literature. As highlighted by Beach (2012), the problem in defining foreign policy is that definitions try to “understand key aspects of a very complicated reality”. As there is no limit to how narrow definitions can be, they are thus incomplete (BEACH, 2012, p. 02) .

Walter Carlsnaes (2002, *apud* SMITH, HADFIELD & DUNNE, 2012), for instance, introduces a very classic concept of foreign policy, devoting much attention to states. For this author, foreign policy is defined as (CARLSNAES, 2002, *apud* SMITH, HADFIELD & DUNNE, 2012, p.02):

actions which, expressed in the form of explicitly stated goals, commitments and/or directives, and pursued by governmental representatives acting on behalf of sovereign communities, are directed towards objectives, conditions and actors – both governmental and non-governmental – which they want to affect, and which lie beyond their territorial legitimacy.

Hill (2003) pushes the debate forward, bearing in mind that, nowadays, foreign policy analysis should go beyond the study of national diplomatic services. External relations are no longer a monopoly of states, so we must carefully consider who foreign policy makers really are. To Hill, the concept is succinctly defined as: “the sum of official

external relations conducted by an independent actor (usually a state) in international relations” (HILL, 2003, p.03).

Hill’s idea is also not exempt from criticism. As Beach (2012, p.02) clarifies, while Hill’s concept might be useful for understanding a State’s general behaviour or tendency when it comes to policy, but not its specific actions. Beach understands that “both the broad trends of behaviour and the particular actions taken by a state or other collective actor as directed toward other collective actors within the international system” is a good foreign policy concept (BEACH, 2012, p.03). By ‘particular actions’ the author refers to speeches, economic aid and even the use of military force.

Hence, if foreign policy can be interpreted as particular actions directed toward other actors, can a foreign policy on a specific issue, a thematic foreign policy, be understood as particular actions *in a specific topic* directed towards other actors? Apparently, such an idea is not enough. Just because there an action revolves around a certain topic, it does not necessarily mean that a country has drawn up a specific strategy to engage on the issue internationally. Particular health-related actions in the international system cannot alone constitute a health foreign policy, otherwise almost all countries in the world would qualify for having develop

Nonetheless, the question of how to define thematic foreign policy demands *per se* has gathered a considerable amount of attention in academia. Some themes have been more accepted than others when it comes to holding a foreign policy of their own, certainly more so than health. However, it is unclear if this is because of their nature, their particularities, or because of their longer presence in international debates. One example is the US Human Rights Foreign Policy. Historian Barbara Keys (2010) carefully explains how the US developed this specific foreign policy, *going beyond the idea that a thematic foreign policy is an international action on a specific theme*. US Human Rights Foreign Policy is a result of *domestic matters*, such as institutional disputes (between Congress, the State Department and the Bureau of Human Rights and Humanitarian Affairs); power disputes between the Legislative Branch of government and what Keys defines as “imperial presidency” (2010, p. 825), disputes among individuals (for instance among the then Secretary of State Henry Kissinger, Congressmen and the Assistant Legal Advisor for Human Rights); changes in national legislation (in the Foreign Assistance Act, for instance), changes in politicians’ behaviour, influence of NGOs and information

availability; and of *international matters*, as transnational activism and influence from abroad (mainly due to US relationships with Latin American countries under the rule of military dictatorships back in the 70s) (KEYS, 2010).

In a nutshell, US Human Rights Foreign Policy is the result of multiple actors engaging in Human Rights, bargaining and negotiating across multiple levels and multiple circumstances (Kissinger was against it, Carter was in favour, and international pressure mounted on the USA to get further involved in the issue) (KEYS, 2010).

One thematic foreign policy that often comes to mind is countries' commercial foreign policy. Like Keys (2010), Abreu (2002) begins his explanation of Brazilian Trade Foreign Policy by highlighting that domestic constraints and international issues greatly affect the policy. Protectionism and domestic infrastructural issues should always be considered when formulating this kind of foreign policy, such as Brazil's position as a major principle commodity exporter. Despite these domestic constraints, Brazil has long been active at the World Trade Organisation and MERCOSUR (Southern Common Market) and has redefined how government and private actors discuss the topic in a way that guarantees the interests of both parties. The country has a clear strategy for increasing its number of trade partners; as well as particular trade goals and a considerable number of actors involved: in government alone, the Ministry of Development, Industry and Foreign Trade and the Ministry of Foreign Affairs work together on the issue. Itamaraty also has four divisions specializing in trade, investments and trade promotion (ABREU, 2002; VEIGA & IGLESIAS, 2002; MINISTRY OF FOREIGN AFFAIRS, 2015a).

As mentioned, the case study of this research is Brazilian Foreign Policy and its health foreign policy-making. Nevertheless, it is important to highlight international strategies for health that have been developed by other countries. Based on notions of risk and threat, the USA has decided to pursue more health-related activities in their foreign policy. The United States has engaged in health activities abroad and funded various different programs for over a century (KAISER FAMILY FOUNDATION, 2011). As the connection between health and foreign policy became clearer, the more the US believed that diseases could become a major risk to their citizen's safety, thus dismissing the idea that health was a "soft factor in U.S. foreign policy" (KASSALOW, 2001, p. 07). The core of US rationale was that infectious diseases could threaten its citizens, whether at home or abroad, as well as "armed forces deployed overseas" , and that it could promote



“political instability in key countries and regions in which the United States has significant interests” (NATIONAL INTELLIGENCE COUNCIL, 2000, *apud* KASSALOW, 2001, p. 08).

To the National Academies of Sciences, Engineering, and Medicine, infectious diseases threaten not only American people and national interests, but also “the nation’s economic vitality and its very way of life” (NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE, 2017, p. 43). Bearing this in mind, the country concluded that one possible way to protect its citizens from emerging diseases and bioterrorists attacks was to increase the amount of funding towards improving infrastructure, training workforces and strengthening response systems in both the US and overseas. Unsurprisingly then, “U.S. funding for global health grew from \$1.7 billion in 2000 to \$8.47 billion in 2009” (NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE, 2017, p. 25 - 26)

The US approach to this topic was translated into greater involvement from the Department of Defense (DoD). The Department had long developed health research abroad, mainly due to the network of laboratories it had overseas (which were initially used for the protection of DoD personnel health) (RUSSELL, RUBENSTEIN, *et al.*, 2011). In 1996, realizing the need for a stronger response to infectious diseases, the U.S government established the DoD Global Emerging Infections Surveillance and Response System (DoD-GEIS), which later became part of the Armed Forces Health Surveillance Centre (AFHSC), known from 2008 onwards as AFHSC-GEIS (Armed Forces Health Surveillance Centre for Global Emerging Infections Surveillance and Response System). The basic goal is to train personnel and build capacity in partner countries, as well as providing surveillance of infectious diseases (mainly “respiratory, gastrointestinal, febrile and vector-borne, antimicrobial-resistant, and sexually transmitted infections”) (RUSSELL, RUBENSTEIN, *et al.*, 2011, p. 05).

However, it would be inaccurate to claim that DoD actions were the only global health and foreign policy activities developed by the US government. In May 2009, the Obama administration formulated the “Global Health Initiative” (GHI), an umbrella structure to accommodate most of the USA’s global health programs (KAISER FAMILY FOUNDATION, 2011). From 2009 to 2014, US\$ 63 billion would be invested in efforts

to combat tuberculosis, malaria, improve maternal and child health and strengthen health systems, among other goals (KAISER FAMILY FOUNDATION, 2010).

There are three characteristics of the American Global Health Initiative that deserve to be highlighted: first, despite being an umbrella enterprise, the GHI was still significantly focused on disease-specific efforts, to the point that 81% of its budget was earmarked to the President's Emergency Plan for AIDS Relief (PEPFAR, program that included projects to combat HIV/AIDS as well as malaria and tuberculosis); second, despite its health-oriented goals, the GHI's organizing structure comprised institutions such as the White House National Security Council and the Department of Homeland Security, suggesting that security was still vital to the US' global health approach; and third, the GHI's principles, to name a few, were country-ownership and sustainability through health systems strengthening, a feature that somewhat contrasts other programs developed by the United States (KAISER FAMILY FOUNDATION, 2010; KAISER FAMILY FOUNDATION, 2011).

The GHI was not the only US-established initiative to connect global health and foreign policy. In February 2014, the United States and other countries created the Global Health Security Agenda (GHSa), basically a strategy (KATZ, SORRELL, *et al.*, 2014, p. 231):

to address emerging and re-emerging infectious diseases, reflecting the growing recognition that disease outbreaks (...) not only threaten public health but can represent transnational security threats requiring new collaborative responses.

With member-states such as the United Kingdom, Canada, Germany and Australia, the GHSa seeks to encourage countries to meet International Health Regulation (IHR) obligations and commitments, providing funds so that partners can improve prevention and response capacities. During its first two years, the GHSa received US\$ 85 million to carry out its programs, however after the 2014-2016 Ebola outbreak, a further US\$ 1 billion was offered for the implementation of its goals (KATZ, SORRELL *et al.*, 2014; NATIONAL ACADEMIES OF SCIENCES, ENGINEERING AND MEDICINE, 2017, p. 61).

There are multiple instances in which GHSa and IHR goals or components overlap. This is evident across all GHSa actions: prevention, detection, and response. In

addition, the GHSA began to coordinate capacity building, technical assistance and commodity support strategies, further stressing that global health should receive due attention from high-level stances (KATZ, SORRELL *et. al.*, 2014; NATIONAL ACADEMIES OF SCIENCES, ENGINEERING AND MEDICINE, 2017, p. 61).

According to the National Academies of Sciences, Engineering and Medicine (2017, p. 63), the GHSA has had positive outcomes which they describe as “a valuable initiative that has been able not only to coordinate the vast array of U.S. programs in global health security but also to create transparent and mutually accountable means for countries around the world to assess their own capacities”. However, the National Academies also criticise the fact that without solid efforts to “[develop] resilient health systems in [low and middle income countries], capable of preventing and responding to emergencies, the risk of another Ebola-like epidemic remains a very real threat to all countries around the world” (NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE, 2017, p. 63)

Another country that has developed a strategy to Global Health as part of its Foreign Policy is Switzerland. Although the Swiss Armed Forces are involved in this strategy, it is for a very different reason to that of the US. In short, Switzerland relies on their Armed Forces for their knowledge on logistics (FEDERAL DEPARTMENT OF FOREIGN AFFAIRS, 2012).

Unlike the USA, whose strategy is permeated with a notion of risk, Switzerland ensures that ideals of human rights, rule of law, and democracy, as well as the interests of Swiss actors, prevail in the country’s approach to health and foreign policy. This approach was taken after consultations that began in 2006 with civil society, the private sector, government authorities and actors from the health system, and was endorsed by the Swiss Federal Council in 2012 (FEDERAL DEPARTMENT OF FOREIGN AFFAIRS , 2012)

Based on that, the Federal Department of Foreign Affairs (FDFA), along with the Federal Department of Home Affairs (FDHA), developed an Agreement on Health Foreign Policy Objectives. The document is responsible for harmonizing various national positions on health cooperation and for bringing further coherence and transparency to

Switzerland as a partner in international global health projects (FEDERAL DEPARTMENT OF FOREIGN AFFAIRS, 2012, p. 02).

With many actors involved – from Parliament and Executive departments, to NGOs and pharmaceutical companies -, this Swiss Health Foreign Policy claims that its values are (FEDERAL DEPARTMENT OF FOREIGN AFFAIRS, 2012, p. 06-08):

1. Good governance;
2. Justice and poverty focus;
3. Global responsibility (with people's health in both domestic and international spheres);
4. Safeguarding of interests and coherence (reconciling a liberal economic order with solidarity and global health);
5. Promotion of "Swissness" (by showing its health system strengths to the world and therefore serving as an example and as a partner to other countries).

Swissness can be understood as Switzerland's good practices and excellence in the area of public health, an acquired experience that the country believes can be shared with partners around the globe. Nonetheless, such ideas can be controverted, or minimally questioned, should the lack of further details be considered: by simply affirming that Switzerland shares its experiences and know-how, it is difficult to know whether the country develops vertical health cooperation projects, with an emphasis on a *one size fits all* approach, or if Switzerland builds projects along with other partners, focusing on shared learning and horizontal cooperation perspectives<sup>9</sup>.

In any case, based on these values, the country has developed what it defines as 'areas of interest', which are essentially topics that Switzerland feels are necessary to address for the sake of its population, national interests, and global responsibility. The areas of interest are very broad, and for this reason they are introduced in conjunction with their individual goals, in an attempt to both summarise and clarify. According to the Federal Department of Foreign Affairs (2012, p. 15-23), the areas and their respective goals are:

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<sup>9</sup> For further information on development models, poverty reduction and problems of single approaches to multiple problems, see Cornwall and Brock (2005); for critics of health-specific vertical programs, see Pfeiffer, Johnson *et. al.* (2008).

**Table 02.** Swiss Health Foreign Policy Areas of Interest

Area of Interest	Goals
<p style="text-align: center;"><b>Governance</b></p>	<ul style="list-style-type: none"> <li>• Swiss-EU relations (further collaboration with the EU, but under a consumer protection approach)</li> <li>• Role of the WHO (Strengthen the WHO)</li> <li>• Global Health Architecture (Improve all domains of Global Health structure)</li> <li>• Strengthening of health systems (bearing in mind not only their quality, but also their affordability)</li> <li>• Health Diplomacy (Further connect health to foreign policy)</li> <li>• “International Geneva” idea (arguably to officially turn Geneva into the health capital/hub of the world)</li> </ul>
<p style="text-align: center;"><b>Interaction with other policy areas</b></p>	<ul style="list-style-type: none"> <li>• Research</li> <li>• Economic interests (focusing on the promotion of free trade and the economic interests of Swiss actors in the area of health)</li> <li>• Protection of intellectual property (recognizing the importance of TRIPS flexibilization for emergency situations)</li> <li>• Health determinants (including the improvement of social determinants to health)</li> <li>• E-Health (the Federal Department of Foreign Affairs does not clarify if telehealth is encompassed, it just emphasizes the use of technology and social media with users and providers of the health service)</li> </ul>

<b>Health Issues</b>	<ul style="list-style-type: none"> <li>• Communicable diseases surveillance (strengthening of global surveillance and control systems, guaranteeing full employment of the IHR)</li> <li>• Health protection (in food safety and radio-chemical contamination, the Swiss government mentions that all measures taken to ensure such protection will be done so in business-friendly ways)</li> <li>• Health personnel (focusing both on shortage and unequal distribution of health professionals in the world)</li> <li>• Access to / quality of therapeutic products (including medicines but also health services)</li> <li>• Noncommunicable diseases (a broad conceptualisation of the issue, as the document mentions everything from mental health to the FCTC)</li> <li>• Drug policy (in cooperation with the EU)</li> <li>• Humanitarian aid</li> <li>• Human rights</li> <li>• Maternal and child health / sexual and reproductive health</li> </ul>
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Source: Federal Department of Foreign Affairs, 2012, p. 15-23. Elaborated by the author.

This Swiss Health Foreign Policy claims to be comprised of Swiss strengths in the area of health service, and also recommends that all these areas of interest and goals should be periodically revised. However, the document made available by the Federal Office of Public Health, which is a 2016 version of the goals and ambitions for the Health Foreign Policy, is in fact very similar (text-wise, it is identical) to the document released in 2012 by the FDFA (FEDERAL OFFICE OF PUBLIC HEALTH, 2017).

The last country to be mentioned here is the United Kingdom. Unlike Switzerland, the UK does not claim to have a health foreign policy, but a global health strategy, the result of cooperative work between various government departments hoping to “improve health in the UK and overseas” (DEPARTMENT OF HEALTH, 2011, p. 03). Many “consultation events held throughout the UK helped shape the strategy, [and] were jointly

run by government departments, the Lancet, the Royal Colleges and the London School of Hygiene and Tropical Medicine” (BANATVALA, GIBBS & CHAND, 2013, p. 270).

The British strategy was called *Health is Global and* was first outlined in September 2008. At the time, the UK released an analysis it defined as “a cross-Government strategy for global health, ‘*Health is Global - a UK Government strategy 2008-2013*’” (DEPARTMENT OF HEALTH, 2011, p. 03. Emphasis is ours).

In 2013 the world experienced immense change following economic crises and the rise of emerging powers. The British government itself detailed this as the UK released another document, this time entitled *Health is Global: An outcomes framework for Global Health 2011-2015* (DEPARTMENT OF HEALTH, 2011).

There were not many differences between this revised strategy and its predecessor. *Health is Global* was underpinned by ten fundamental principles, which included support of the MDGs; evaluating the consequences of UK domestic and foreign policy in global health; observing rules on environmental protection; and working in partnership with a multitude of international actors (such as IO and private business) in the pursuit of UK health goals (DEPARTMENT OF HEALTH, 2008; DEPARTMENT OF HEALTH, 2011).

Perhaps the only major change visible in the document was the reduction of areas covered by the action of this strategy. While in 2008 the government stipulated five areas, in 2011 it was decided they would be cut down to three, because, as the Department of Health explained (DEPARTMENT OF HEALTH, 2011, p. 06):

the five areas of work set out in the original strategy were useful as broad groupings for the (...) commitments made. However, if we are to embed an approach that is focused on achieving outcomes (...), we have to prioritize what we see as the three main areas for action.

Originally, these areas were (DEPARTMENT OF HEALTH, 2008, p. 18):

1. Better global health security;
2. Stronger, fairer and safer systems to deliver health;
3. More effective international health organizations;
4. Stronger, freer and fairer trade for better health;

5. Strengthening the development and use of evidence to improve policy and practice.

At first the British initiative included features that were reminiscent of the American approach – such as its emphasis on global health and security –, but also mixed with some of Switzerland’s ideas – such as emphasis and health and trade. These similarities became more evident in the second report, when areas of action were reduced to global health security, international development, and trade for better health (DEPARTMENT OF HEALTH, 2011).

**Table 03.** *Health is Global* Areas of Action

<b>Area for action</b>	<b>Outcomes to be achieved</b>
<b>Global Health Security</b>	<ul style="list-style-type: none"> <li>• MDGs - Food and water security</li> <li>• Climate change</li> <li>• Health and conflict (this element of the strategy is under the responsibility and management of the Ministry of Defense)</li> <li>• Emergency preparedness (defined as quick response to threats, such as epidemic outbreaks)</li> <li>• Research (in the following Global Health Security outcomes – climate change, food and water security, and conflict)</li> </ul>
<b>International Development</b>	<ul style="list-style-type: none"> <li>• MDGs – Health Systems and delivery (to tackle HIV/AIDS and tuberculosis, as well as to improve maternal and child health).</li> <li>• Noncommunicable diseases</li> <li>• Learning from other countries (this topic is particularly interesting, because the UK highlights how it wants to use the international experience to improve health standards in the UK itself).</li> <li>• Research (carried out in cooperation with the EU and developing countries)</li> </ul>



<b>Trade for better health</b>	<ul style="list-style-type: none"> <li>• MDGs – Access to medicines</li> <li>• Trade and investment (especially with emerging markets)</li> <li>• Research (to achieve universal health coverage)</li> </ul>
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Source: Department of Health, 2011, p. 07-09. Elaborate by the author.

Some evaluations of *Health is Global* have already been published, such as Benatvala, Gibbs and Chand’s analysis (2013). In their view, after just two years of its initial implementation, the strategy had achieved important results and concrete outcomes. Even though the world was facing severe economic turbulence in the years following its implementation, and “global health was not a high-level approach for many governments”, ministries came together to ensure that this UK strategy was able to adapt to the world scenario of the time (BANATVALA, GIBBS & CHAND, 2013, p. 276).

The UK’s NHS (National Health Service), one of the most well-known and admired national health systems in the world, was not forgotten by this strategy. Although *Health is Global* focuses heavily on building bridges abroad to improve British people’s health, the NHS’s involvement means that efforts are also made to “maximize the commercial value of its technologies, products and knowledge and to build its brand and reputation overseas” (BANATVALA, GIBBS & CHAND, 2013, p. 277). The authors further explain the importance of the NHS to the UK’s leading position in health-care management (in addition to its research abilities), highlighting NHS’s partnership with the Department for International Development on projects to support developing countries and share know-how.

For Benatvala, Gibbs and Chand (2013, p. 278), health is a form of soft power that promotes stability and security, an approach which, in their view, is evident in the UK strategy in that many government actors worked closely to “review preparedness plans and to insure the public was protected against the most significant risks” (BANATVALA, GIBBS & CHAND, 2013, p. 278). This is debatable, however, as such a link between soft power and ideas of risk and security is not commonly found in literature on the topic.

One particularly interesting independent review of *Health is Global*, published in June 2010, looks to the UK's foreign affairs with BRICS countries (Brazil, Russia, India, Russia, China, South Africa). Produced by a private consultancy company, Mott MacDonald, the review analyzes the relationship with each of the BRICS members separately, emphasizing the good rapport built between the UK and Brazil over the years (MOTT MACDONALD, 2010).

The UK's failure to engage SUS staff in locally developed joint projects is criticized in the report, further affirming that *Health is Global* is too focused on the British domestic realm, and that as a result misses a great opportunity to use local "skills and knowledge to progress in the action areas" (MOTT MACDONALD, 2010, p. 16). The report also criticizes the lack of a clear priority, or a strategy to develop programs' and countries' prioritisation ranking. Finally, it expresses some dissatisfaction with the way government departments work, as they appear to take care of their own activities before looking at the greater picture (MOTT MACDONALD, 2010, p. 21).

Another scrutiny of *Health is Global* was presented by Gagnon and Labonté (2013), who provide a categorical statement: "Health is Global was developed primarily to benefit the UK" (GAGNON & LABONTÉ, 2013, p. 16). In their view, this self-interest is best and most accurately observed when analysing "the strategy's focus on global health security, the priority the strategy places on capitalizing on global health as a business opportunity and the revelation that the strategy was likely developed in part to improve the UK's global reputation" (GAGNON & LABONTÉ, 2013, p. 16). By no means do they state that the strategy is debased, however, they do emphasize that *Health is Global* was used to achieve traditional foreign policy goals; the centrality of Britain's foreign affairs meant that they did not embrace health as a pivotal issue, but rather as a mean to old ends, and as "way to enhance the state's international reputation" (GAGNON & LABONTÉ, 2013, p. 17).

It is not only countries that have developed strategies for global health. Despite not being entirely explicit in its formative treaties, health also plays an important role in the European Union's relationship with other areas of the world. This is mainly due to its concerns for the strengthening of health systems and achieving universal health coverage (EMMERLIND & HEYDEMANN, 2013).

The European Union became involved with the FCTC's negotiations, and also sent representatives to the International Health Regulation debates of 2004-2006. It financially contributes with the Global Fund to Fight Aids, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunisation (GAVI) and was duly engaged in the achievement of the MDG's (EMMERLIND & HEYDEMANN, 2013).

This said, it is one thing to engage in foreign health-related activities, and another to develop global health policies embedded in a larger political framework. Bearing that in mind, the EU, aware of its relevance, opened a public consultation to better delineate its role on global health in 2009, publishing in 2010 a communication from the European Commission to the European Council, Parliament, Economic and Social Committee and Committee of the Regions. The Communication briefly explains how the EU could more emphatically engage in global health policies, either by sharing experience in good governance, by creating research networks, by supporting WHO leadership, or even by improving data collection in health systems (EMMERLIND & HEYDEMANN, 2013; EUROPEAN COMMISSION, 2010).

Perhaps due to its ambitious stance, perhaps because of the nature of the EU, interest in developing this Global Health strategy further soon decreased, and member states preferred to focus on controlling their own strategies (STEURS, VAN DE PAS, *et al.*, 2017, p. 756)

It would be untrue to say that the EU has removed global health from its discussions entirely, but its prominence has certainly been diminished. As Speakman, McKee and Coker (2017) demonstrate, the EU still develops global strategies. However, the most recently published Global Strategy for European Foreign and Security Policy, issued by the European External Action Service (EEAS), only mentions health, along with education, as an issue that is important to development. The authors wonder whether this perhaps reflects "the absence of health expertise within the [European External Action Service]" (SPEAKMAN, McKEE & COKER, 2017, p. 393).

The countries introduced so far share a common problem: they all make use of a fragmented notion of global health, in the sense that they place health into specific and well-known foreign policy frameworks: security, trade, and safeguarding national interests. In doing so, they subordinate health to these traditional foreign policy topics,

and attach them to strategies that do not necessarily ensure that the health goals prevail. By attaching health to security, the result is that the uppermost concern will be security itself, not health. As Alcázar (2013) points out, the major concern in bringing health to foreign policy should be a focus on health itself, thus “[instructing] foreign policy to broaden its perspective and to seriously consider issues and policies in the light of a discourse on human values previously unconsidered, ignored or simply not heard of” (ALCÁZAR, 2013, p. 334)

The classic FPA idea that international contexts and internal disputes matter is of considerable importance to our thematic foreign policy analysis (HUDSON, 2014). As perceived, the existence of responsibilities under the purview of a specific governmental department specialized in the topic withdraws the monopoly of foreign policy-making from countries’ Ministries of Foreign Affairs. This creates an intricate network of institutions and actors that researchers must bear in mind when analysing the existence of this particular foreign policy.

### **3.2 Health Foreign Policy: what does it mean?**

Global Health as a whole contains a myriad of concepts and definitions, which can sometimes be considered problematic for the field of study. For instance, there are so many different terms dealing with notions of health and governance, that one might get confused: Global Health Governance is different from Global Governance for Health, which is turn distinct from Governance for Global Health<sup>10</sup>.

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<sup>10</sup> Global Health Governance is defined by Fidler (2010, p.03) as “the use of formal and informal institutions, rules, and processes by states, intergovernmental organizations, and nonstate actors to deal with challenges to health that require cross-border collective action to address effectively.” Kickbusch *et al.* (2014), on the other hand, use a very restricted definition of the concept: “institutions and processes of governance that have an explicit health mandate, such as the WHO, hybrid organizations such as the Gavi Alliance (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), as well as health focused networks and initiatives and non-governmental organizations” (Kickbusch *et al.*, 2014, p.03). Global Governance for Health refers to institutions and processes whose work impacts health both directly and indirectly, despite the fact that health is not the core activity of such actors. The World Trade Organization and The International Labor Organization fit into this category. Governance for Global Health is about national and regional institutions and mechanisms contributing to the other two types of governance (Kickbusch *et al.*, 2014).

Circumstances are no different for health and foreign policy, for which academia has coined many terms with many different meanings. As mentioned earlier, there exists a definition for Global Health Diplomacy, which is understood as “processes by which state and non-state actors engage to position health issues more prominently in foreign policy decision-making” (LABONTÉ *et al.*, 2010, p. 01). Medical Diplomacy has a different meaning and is considered to be “the use of health care as an instrument for furthering policy goals” (LEE *et al.*, 2011, p.61). The idea of Disease Diplomacy is not new: as Fidler already explained in 1997, it has existed since 1851, when states understood “the need for international cooperation on infectious disease control” (FIDLER, 1997, p. 59). With the emergence of an International Infectious Disease Control Regime and debates concerning Global Health Security, Disease Diplomacy conformed to a more refined term, which is nonetheless very similar to Fidler’s own perception: “States attempt to negotiate ways to collectively strengthen the global system of disease surveillance and control” (DAVIES *et al.*, 2015, p. 01).

Regarding the case of Brazil, some have even claimed that what took place (recalling the Oslo Ministerial Declaration, technical cooperation projects on public health issues, and the efforts to discuss health in different international forums) was a process of *internationalization of domestic public policies*, such as health and education, which encouraged the increased participation of national actors (PINHEIRO & MILANI, 2012a). The country’s understanding of health was expanded to diplomacy, creating a new situation for the Brazilian Ministry of Foreign Affairs: a situation of cooperation with the Ministry of Health (even though no new term, such as Health Diplomacy, was coined to describe it). This Brazilian domestic dynamic is considered to be crucial for Brazil’s health-related activity abroad (ALCÁZAR, 2005).

All these terms or ideas are connected to foreign policy, and as Watt *et al.* (2013, p. 769) acknowledge, there is “a tension between foreign policy and health interests”, mainly because both topics are part of one single framework of government interests, and this can lead to competing interests. This framework of action involves security, economics and social justice – which again demonstrates that health is attached to classic foreign policy (KICKBUSCH, 2011; WATT *et al.*, 2013). However, as discussed earlier on, disputes in foreign policy are common, so competition should not prevent attempts to develop a Health Foreign Policy explanation.

A sharp and straightforward definition of what HFP is seems unlikely, due to the complexity of the issue. Global health reality is multilevel and multifold, with a considerable number of actors engaged. Switzerland, for instance, does not describe what HFG is, although the country self-claims to have developed such Foreign Policy, as already mentioned. Despite quite vague, Switzerland highlights that federal authorities *should work together* and that efforts should be centered on the pursuit of an improved health status worldwide. (FEDERAL OFFICE OF PUBLIC HEALTH, 2012).

On debating the concept of accountability, Rached (2013) points out that various aspects of a complex phenomenon are disregarded when a new definition is developed, mainly because new boundaries of action are explored. As such it is normal for criticism and doubts to arise, so they should not deter exploration. Since accountability is a complex phenomenon, Rached (2013) developed a framework to organize the dimensions and features of accountability that combine to form its rationale.

It is important to emphasise that by no means is this a case of “conceptual stretching”, as Sartori put it back in 1970. There is no attempt to broaden the meaning of foreign policy or increase its range of applications (nor to use the concept of accountability to define HFP, here Rached’s rationale (2013) merely serves as base). This is a methodological tool that serves as a mechanism of analysis to the thesis.

This research understands that such a framework reasoning can also be applied to HF. Keeping in mind the actors, instruments of action, strategies, arenas and agenda settings, a framework of analysis can be built to determine whether Brazil has a delineated HFP, or whether health is just another topic on the agenda of social subjects. Table 04 shows the ideas currently under consideration:

**Table 04.** Realms of a Health Foreign Policy definition

<b>Realm</b>	<b>Description</b>
<b>Legal / Legislation</b>	Are there domestic public health laws that influence the way a country deals with the theme internationally? Is there a specific law for international cooperation?
<b>Institutional</b>	Do other institutions cooperate? Do the Ministry of Health, Ministry of Foreign Affairs and other ministries work together to guarantee the best attainable level of health possible? Are there disputes? How are negotiations among institutions held?
<b>Agenda setting</b>	Is there a health-specific agenda in the country that set the topics of international priority?
<b>Arenas</b>	Is health debated only in health-specific arenas (such as the WHO)? Is the country able to debate health-related issues in different arenas, in non-health-related IOs, in bilateral and multilateral negotiations?
<b>Actors engagement</b>	Are the actors engaged in this international health action varied in nature (NGOs, government, private institutions)?
<b>Planning</b>	Are there health goals or international strategic health plans being implemented / formulated?
<b>Timing</b>	Are plans and actions long term? Or short term?
<b>Decision making structure</b>	Centralized (executive branch)? Or decentralized?
<b>Principles</b>	Is foreign policy principle-based? Is health policy? Are they consistent?

This table was formulated on base of ideas proposed by Rached (2013).

These are the different realms of a framework that seem to be important to thematic foreign policy, and the structure introduced here focuses specifically on policy-making. Thereby, based on this framework, an outlined definition of HFP could be:

*Health Foreign Policy is a branch of a given country's foreign policy, derived from a complex domestic structure and focused on the development of a well-delineated international strategy in Global Health. A complex domestic structure is interpreted as a legal and institutional arrangement that, together with a variety of actors, greatly*

*influences foreign policy making. A well-delineated international strategy in Global Health is one that is carefully planned with a feasible action / implementation timetable across different international arenas, which sets health goals in the long term.*

The following chapters will analyze Brazil's domestic structure and international strategies for health, so that this definition can be tested, and the hypothesis of this research can be confirmed or refuted.

#### **4.Preludes: SUS, access to antiretroviral therapy, the anti-tobacco campaign and MoFA's insulation**

Brazil's cooperation with health at the international level is no novelty. In fact, the country was one of the proponents of the World Health Organization (WHO) as early as 1945 (KIRCH, 2008)<sup>11</sup>. What has changed in recent years is, first, how health is interpreted by Brazil, and second, its motivations for advocating health globally.

As pointed out by Hill (HILL, 2003, p. 39), "foreign policy has its domestic sources, and domestic policy has its foreign influences", an affirmation that is equally true for the topic of health. In Brazil, health has undeniably become part of foreign policy because domestically, the process of democratization following years of dictatorship forced huge transformations upon the Brazilian health system. A new Federal Constitution was approved in 1988, stating that health is a right of all citizens and a responsibility of the State. As a result, the Ministry of Health (MoH) had its role expanded and its budget increased. Abroad, the end of the Cold War and innumerable Conferences held by the United Nations (UN) regarding a myriad of topics also shed more light on social issues, including health (ALCÁZAR, 2005; JEROME, 2015)

The epitome of Brazil's transformations in public health was the establishment of a new health care system, SUS (*Sistema Único de Saúde*, acronym in Portuguese for

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<sup>11</sup> The Brazilian doctor Geraldo de Paula Souza, along with Dr. Karl Evang and Dr. Szeming Sze, from Norway and China respectively, were the ones who proposed, in 1945, the creation of an international organization specialized in health. For further information, see Wilhelm Kirch, *Encyclopedia of Public Health* (New York: Springer, 2008).



Unified Health System). SUS was a result of a long-term process of changes in the way Brazil interpreted health. In the 1970's, still under military rule, a social movement advocated for the democratization of health, highlighting the menaces of health privatization and the benefits of an inclusive and solidary society, using the universal right to health as an instrument for increased social responsibility. This was the sanitarian movement, whose aphorism was *democracy is health* (SOUTO & OLIVEIRA, 2016).

The universal and equitable access to health care and comprehensive care (defined by SUS as integrality) were stated as SUS working principles. Moreover, SUS was a social project, with its origins in a political movement that wanted to make health care available to all. As a consequence, SUS would require more human resources for health, more knowledge creation and more learning in the field of public health (mainly to change Brazil's approach to health care, from tertiary care and hospitals to primary care and local clinics) (FEUERWERKER, 2005). To guarantee a steadily functioning health care system, the MoH itself had to change as it would become responsible for SUS management. More responsibilities also meant an increased budget, assuring thus that the Ministry would now have the resources to develop public health strategies. Local meetings open to the public were also created to discuss health goals, establishing democratic channels for people to express their demands (ALCÁZAR, 2005).

These changes to the Ministry of Health, as a consequence of SUS, are more important than we might appreciate. Before SUS was established, the Brazilian health care system was fragmented and divided, a situation that diminished the MoH's authority. Not only it was politically weak, but the divisions made the federal government perceive the MoH with some disregard, delegating it very little responsibility of the National Developments Plans formulated in the 1970's (ALCÁZAR, 2005).

With SUS, the MoH changed its working logic, becoming the central institution for public health in Brazil. With a decentralized organization such as SUS, the MoH was now present across different public spaces, closer to the population and open to the participation of different actors in the management and priority-setting of SUS policies. According to Alcázar (2005), the events responsible for bringing health and foreign policy closer to one another were: i) the Ministry of Health's stronger and more prestigious position in the eyes of the federal government; ii) meetings with the population as part of SUS decision-making, which brought more (and new) actors to the public health arena;

and iii) an understanding in Brazil that health was an independent topic and important *per se*, meaning that it did not need to be attached to trade, security, or any other issue to deserve due political attention. From this moment onwards, health was regarded as state policy, deemed crucial for the development of the country's strategy (ALCÁZAR, 2005).

In practical terms, and bearing in mind SUS' operating principles, it is fair to say that universal access to health does not necessarily also mean universal access to medication. However access to medication is precisely how public health became relevant to Brazilian Foreign Policy (ALCÁZAR, 2005, p. 69). Health was already being debated by the Ministry of Foreign Affairs (MoFA, also known as *Itamaraty*) during President Fernando Henrique Cardoso's administration (1995-2003). Health issues were negotiated through either bilateral agreements or multilateral forums, such as the UN Conferences and Summits of the 1990s. However, those negotiations, when analyzed with the tools provided by Alcázar (2005), demonstrate a fragmented understanding of health by BFP. Health only gained true relevance when Brazil had to deal with the international consequences of guaranteeing HIV/AIDS medication to all of its population (RUBARTH, 1999, p. 35 and 109).

The Brazilian Federal Constitution ensures that every citizen has the right to access therapies to his/her disease (medicines are comprised), making it mandatory for the State to provide such therapy. So, when HIV/AIDS incidence rates in Brazil grew to alarming levels, the government responded. Of course, this was no easy task: in 1983, São Paulo's organized homosexual community began working together with the city's Health Secretary; then, between 1985 and 1986, many Non-governmental Organizations (NGOs) appeared to help tackle the disease; and finally, in 1986, Brazil established its HIV/AIDS National Program. With SUS principles in mind, doctors began to prescribe new drugs to the general public that were not yet available in the country. As access to these drugs is a constitutional right, legal procedures were brought against the Health System, which should by law provide them to patients in need – even if this means importing them from abroad (REIS, VIEIRA & CHAVES, 2011).

Many studies detail how Brazil developed its HIV/AIDS National Program; how the country decided to provide antiretroviral therapy for thousands of patients, how it locally produced medicines with generic active ingredients, and the consequences this had on the country at the WTO and the Doha Round (see GALVÃO, 2005; NUNN, DA

FONSECA & GRUSKIN, 2009; MELO E SOUZA, 2012). The key point here is that, by virtue of all these events and the interaction of domestic demands and international engagement, the MoFA realized the importance of health to international affairs and most importantly, how it could be central to BFP (ALCÁZAR, 2005).

MoH and MoFA worked closely together at the World Trade Organization (WTO) when the intellectual property became a point of contest between pharmaceutical companies and countries, leading to what would eventually be an unprecedented recognition of the importance of public health in international trade (KICKBUSCH, SILBERSCHMIDT & BUSS, 2007). On 14th November 2001, during the Doha Ministerial Conference's Fourth Session, the *Declaration on the TRIPS agreement and public health* was adopted, ensuring the international community, in its fourth clause, that the "TRIPS Agreement does not and should not prevent members from taking measures to protect public health", as well as affirming "that the Agreement can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all" (WORLD TRADE ORGANIZATION, 2001a, p. 01). Brazil sponsored this declaration, along with other developing countries whose focus was mainly on access to healthcare rather than the protection of patent rights (WORLD TRADE ORGANIZATION, 2001b; SUN, 2004). Although agreed upon in 2001, only in 2003 would "a legal procedure for the importation of medicines under compulsory licenses [be] established" (MEINERS, 2008, p. 1471)

Following this case, Brazilian diplomacy began working with the proposition that people's health should have a significant place in diplomatic discussions (KICKBUSCH, SILBERSCHMIDT & BUSS, 2007). Ambassador Santiago Alcázar, Special Adviser to the Minister of Health for International Affairs and director of the MoH International Advisory Service from 2003 to 2008, declared that with the Doha Declaration, the relevance and value of SUS became clear to Itamaraty and health was inserted to BFP (ALCÁZAR, 2017).

An example of this was the country's effort to see resolution E/CN.4/RES/2001/33, "*Access to medicines in the context of pandemics such as HIV/AIDS*", approved in the Commission on Human Rights in 2001, rendering access to HIV/AIDS drugs a basic human right, a fact that can be considered a milestone for Brazilian Foreign Policy (ALCÁZAR, 2005; ALCÁZAR, 2007). The resolution,

sponsored by Brazil, clearly stated that countries should articulate safeguard access to HIV/AIDS medication from any limitation imposed by third parties (HELPER, 2003).

While the Doha Round summoned diplomats to discuss trade, agriculture and intellectual property, another important element of the Cardoso years was taking place: The Framework Convention for Tobacco Control (FCTC) negotiations. Since the late 1980's, Brazil had been developing national politics and programs for tobacco consumption control. The National Program for Tobacco Control was already underway when the World Health Organization (WHO) established its Intergovernmental Negotiating Body to discuss the FCTC, which secured Brazil leadership in the negotiation process (SAGOCIO, 2008).

In 1999, a National Commission for the Framework Convention Preparation was created in Brazil as an attempt to coordinate eight different Ministries' demands regarding tobacco control issues (the MoFA included)<sup>12</sup>. This contributed to *Itamaraty's* strong and coherent position abroad, to the point that the Peruvian delegation declared how impressed they were by the Brazilian delegation's "technical - diplomatic harmony" (SALDANHA, 2015, p. 85 - 86). Coherence and harmony are nouns that Lee, Chagas and Novotny (2010) also used to describe the relevance of this National Commission to the formulation of Brazilian policy on the matter and its behavior at FCTC negotiations. In their view (LEE, CHAGAS & NOVOTNY, 2010, p. 03):

This commission, including all pertinent stakeholders, ensured that tobacco control was embodied in consistent policies throughout government and not only as a health ministry issue. The close involvement of the Ministry of Foreign Affairs, in particular, backed by the highest levels of government, ensured a clear and unified endorsement of health goals within Brazilian foreign policy.

This domestic arrangement had consequences for the FCTC's Intergovernmental Negotiation Body (INB), a department established to negotiate the convention. The INB

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<sup>12</sup> This Commission was created by Presidential Decree (nº3136) in August 1999, and the ministries taking part were: the Ministry of Foreign Affairs, the Ministry of the Economy, the Ministry of Agriculture, Livestock, and Supply, the Ministry of Justice, the Ministry of Education, the Ministry of Labour and Social Welfare, the Ministry of Development, Industry and Foreign Trade and the Ministry of Agrarian Development. This last one was only added in 2001, by Presidential Decree nº 4001.

was chaired by Ambassador Celso Amorim and, after he withdrew to become Brazil's Ambassador in London, Ambassador Luiz Felipe de Seixas Correa. This high-level position awarded Brazil with leadership and prominence in the discussing sessions; and together with its robust foreign policy based on domestic support, Brazil was empowered enough to effectively challenge developed countries pressures and often pro-tobacco-industries positions (CAVALCANTE, 2007; LEE, CHAGAS & NOVOTNY, 2010).

Moreover, Brazil was one of the largest producers of tobacco in the world, so their chairmanship was offered not only because they were skilled diplomats, but also because, during the negotiations, it “helped to create a political bridge between countries that were tobacco producers and those that were not, and it exemplified the compatibility between producing tobacco and controlling tobacco use” (WIPFLI, 2015, p. 42)

Although the INB meetings took place prior to the period being dealt with in this thesis, it is worth highlighting that the FCTC was multidisciplinary, and being aware of this, Brazil took advantage. The country understood that for a successful negotiation to take place, everyone affected by tobacco control measures should be engaged in the debate. Even Gro Brundtland, WHO Director General at the time, praised Brazil for these efforts (SALDANHA, 2015).

Although a domestic institution, the National Commission used Itamaraty as a central actor, since it functioned as a bridge, a common element among the various Ministries involved. MoFA took what had been agreed domestically to the international level. All decisions made by the Commission were consensual, providing Itamaraty with considerable legitimacy to position itself abroad (SALDANHA, 2015)

The final draft of the convention was presented by the INB to the WHA in February 2003, and three months later, at the WHA's 56th session, the text was approved by member states. The convention then opened for signatures from 16<sup>th</sup> June 2003 to 29<sup>th</sup> June 2004, and officially came into force in February 2005, after 40 ratifications were processed (CAVALCANTE, 2007).

All this paved the way for health's stronger presence in Brazilian Foreign Policy, leaving Cardoso's successor, President Luis Inacio Lula da Silva (2003-2010) with the

conditions to further develop the topic. With president Lula, health gained elevated status in BFP, becoming a key feature of Brazilian South-South Cooperation (HIRST, 2012).

As the Minister of Foreign Affairs for the entirety of Lula's administration, Amb. Celso Amorim – in an interview with the author of this research – recalls that issues such as tobacco control and generic medicines would take up increasing space in his agenda, slowly rendering health a central feature of BFP (AMORIM, 2015a). In Amorim's view, three reasons can explain why health gained such prominence during Lula's administration. First, Amorim believes that the Brazilian experience in upholding its interests multilaterally (recalling HIV/AIDS and Tobacco Control) were crucial to Itamaraty's acquired familiarity with health. Secondly, he considers the country's health expertise (such as in vaccines and breast milk banks) important because it was shared through technical cooperation. Finally, Amorim stressed that President Lula added an element of morality to the equation with his ideals of combating poverty and hunger, he devoted attention to different needs of the population, and this in turn had an effect on foreign policy (AMORIM, 2015a).

Undoubtedly, these events played a significant role in modifying MoFA's engagement with health issues, but here we argue that changes *within* Itamaraty were also crucial for this shift to take place. Traditionally, MoFA was a sealed institution, in the sense that its staff and boards were always composed of highly-qualified personnel, consequently ensuring the Ministry a monopole on foreign policy-making, and most importantly, a certain degree of independence from the interference of national bureaucracy (PIMENTA DE FARIA, 2012)

It is very rare for a career diplomat in a key position of the Ministry's organizational framework to be replaced by a civilian – especially those appointed by national authorities external to Itamaraty. Pimenta de Faria (2012) adds to the mix the fact that, until the 1990's, Brazil's economic development strategy was import substituted industrialization<sup>13</sup>, an inward-oriented model that contributed to Brazil's increasing isolation from the rest of the world.

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<sup>13</sup> To understand in a greater degree what constitutes this economic model check BRAGA C.A.P. Import Substitution Industrialization in Latin America: Experience and Lessons for the Future. In: ESFAHANI H.S., FACCHINI G., HEWINGS G.J.D. **Economic Development in Latin America**. Palgrave Macmillan, London,

The end of military dictatorship was a watershed moment for the country, influencing changes in the health system, as mentioned, but also forcing Brazil to be more open to external influence. Domestically, the latter was translated into a broader scope of action for the executive branch, as the nature of internationally debated topics was far more diverse and specified (to the extent that it would impact domestic policy making) (BADIN & FRANÇA, 2010; PIMENTA DE FARIA, 2012).

According to Lima (2010b, p. 15 - 16), Brazil's expanded foreign policy agenda coupled with its domestic impact allowed national agents to mobilize and begin working on international affairs, which in turn increased the probability of conflict between agents. By agents, the author refers to the private sector, NGOs, and also governmental bureaucracy. From this, policy networks emerged, and consequently Interministerial Commissions were assembled. MoFA was regularly a member of said commissions, and sometimes even coordinating their work (LIMA, 2000, BADIN & FRANÇA, 2010). As a result, Itamaraty watched on as its leading role in foreign policy decision-making diminished and foreign policy as a whole became more politicized (LIMA, 2000).

Politicization is to render a certain issue the "subject of public discussion [that has] significant effects on the quality of political decision making" (ZÜRN, 2014, p. 48). Both health and foreign policy became politicized as new institutions were involved in their debates. For Brazilian Foreign Policy, this meant additional Ministries were now involved in policy-making; in the case of health, democratization made it necessary to embrace a much wider range of voices. (MILANI & PINHEIRO, 2013).

The outcomes discussed should not be interpreted as MoFA 'losing' its position as the main Brazilian Ministry responsible for foreign policy-making. The difference was that, now, more actors were engaged and were acting or negotiating internationally, leading to what Badin and França (2010) defined as *foreign policy horizontalization*. This means more institutions of the Executive Branch working on foreign affairs, dispersing the policy that was once dominated by the MoFA and testing Itamaraty's insulation.

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2010. To see how it affected Latin America, check SILVA, E. The Import – Substitution Model: Chile in Comparative Perspective. **Latin American Perspectives**, v. 34 n. 3 pp. 67 – 90, 2007.

This horizontalization, or *horizontal decentralization* as it is referred to by Silva, Spécie and Vitale (2010), is embedded in a legal problem: every department of the Brazilian government has had its responsibilities defined by the country's Federal Constitution. Developing projects abroad would therefore mean that, legally, such procedures need to be provided for in the Constitution. Officially, BFP is a monopoly of the *Executive Branch of government*, and the MoFA - by Presidential Decree<sup>14</sup> - is responsible for decision-making as well as advising the President on the implementation of diplomatic relations. By virtue of this monopoly, many Ministries under the Executive Branch have created International Secretaries or Foreign Affairs Advisory Agencies, many of which have appointed diplomats as directors or principle advisors (SILVA, SPÉCIE & VITALE, 2010).

Almost 60% of the Ministry of Health's internal departments or secretaries are legally considered competent to engage in either the formulation and/or implementation of foreign activities (SILVA, SPÉCIE & VITALE, 2010, p. 32). Many Presidential Decrees and executive ordinances authorize the institution to undertake international projects, and although AISA (Ministry of Health International Advisory Service) is responsible for the management of MoH international affairs, many other departments are, by decree, allowed to develop cooperative relationships with peers abroad – such as the Secretary of Health Surveillance, for instance (SILVA, SPÉCIE & VITALE, 2010).

Many of the Presidential Decrees dedicated to structuring the MoH were issued during the time period dealt with in this thesis. Despite being issued to regulate contracts with local management or at-will appointed positions, they all include instructions as to which type of foreign activity each ministry unit is allowed to engage<sup>15</sup>. As Silva, Spécie and Vitale (2010) stress, the key to understanding this legal puzzle is the fact that ministries outside MoFA are not only able to implement projects abroad but can also

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<sup>14</sup> Several Presidential Decrees were issued over recent years in order to define Itamaraty's competencies. During the time interval considered for this thesis, Presidential Decree numbers 4759 (2003), 5032 (2004), 5979 (2006), and 7304 (2010) were issued and revoked. Presidential Decree nº 8817 (2016) is the one currently in force. The core elements of MoFA have not been changed by any of them; Itamaraty is responsible for international politics, diplomatic and consulate affairs, international negotiations, international cooperation, promotion of the country's affairs (such as trade) and ceremonial support.

<sup>15</sup> From 2003 to 2014, Presidential Decree numbers 4726 (2003), 5678 (2006), 5841 (2006), 5974 (2006), 6860 (2009), 7135 (2010), 7336 (2010), 7530 (2011), 7797 (2012) and 8065 (2013) were issued and revoked. Presidential Decree nº8901 of November 2016 is the one currently in force.



*formulate* the policies that will culminate in those projects. Following the politicization and horizontalization of BFP, this ‘new’ Ministry of Health, receptive to social demands and an advocate of SUS, became a formulator of foreign policy. In fact, even subsidiary MoH institutions, such as the Oswaldo Cruz Foundation (FIOCRUZ) and the Brazilian Health Regulatory Agency (Anvisa), are now responsible for their own projects (VENTURA, 2013b).

To cope with all the extra demand of dealing with more complex and specific issues, MoFA appointed an additional General Secretary and established numerous Topic-Specific Divisions. A negative outcome of this was that “competency overlaps were inevitable”, because “there was not an explicit coordination of the division of labor” (SILVA, SPÉCIE & VITALE, 2010, p. 40).

The more incisive participation of Executive Branch institutions derives from the internationalization of a variety of issues which demanded specific expertise. Greater interconnections between domestic matters and international problems required different governmental institutions to develop noteworthy activities abroad, which in turn engaged with various sub-organizations in order to reach solutions. Milani (2012) argues, for instance, that the UN Conferences of the 1990’s acted as an incentive for the Brazilian State to internationalize, however Pinheiro and Milani (2012b, p. 335 - 336) draw a more assertive picture by affirming that:

We need to refer to a new face of public policies, such as what was developed by Brazil in the last years, a movement of internationalization of an extensive public policies agenda – from education to health (...), a continuous process of internationalization of public policies (...). By the way, it is mister to stress that this is not a case of exportation of public policies, but an internationalization movement. The difference between them is that the latter, unlike the former, assumes a high degree of acceptance and legitimacy, a practice in general stimulated due to real or built affinity among engaged actors; it is not an imposition of experiences from outside to within.

With this idea of South-South Cooperation, there was indeed an affinity among actors. In the process of health becoming important to foreign affairs, three characteristics should be highlighted: 1. The importance of SUS’ establishment and principles; 2. The

health debate being opened to the population and becoming state policy, as a result of the 1980's democratization (ALCÁZAR, 2005); and the fact that, particularly under Lula's administration, health was central to Brazil's foreign policy.

Now that we have sufficiently introduced the topic, we will focus on various actors of Brazil's Executive Branch in order to analyze whether they indeed engaged in international activity and, should the answer be positive, whether they formulated their own international agenda.

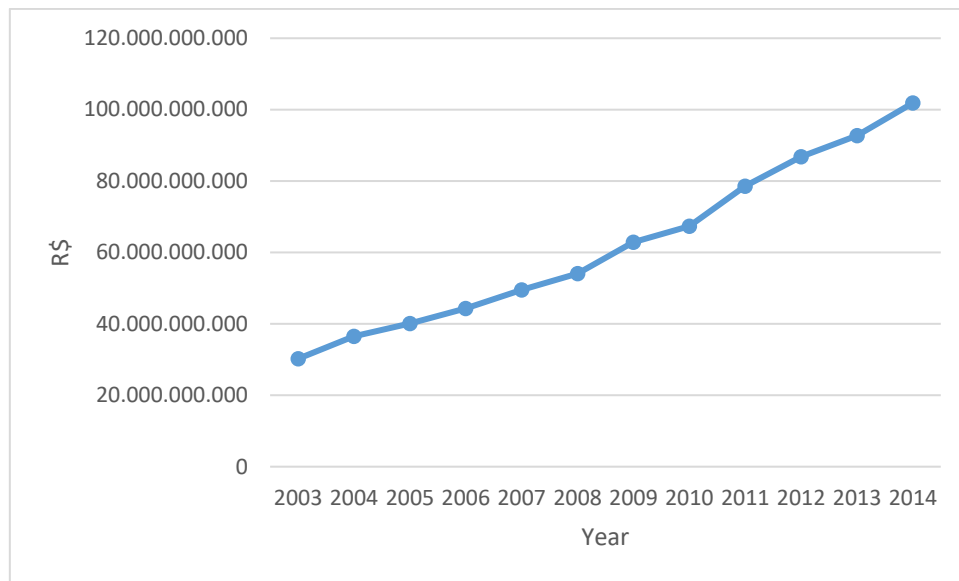
## 5.MoH

Before introducing our analysis, which is based on the suggested definition of a Health Foreign Policy, it is imperative that we present the complex domestic structure Brazil has built to achieve its international goals. This chapter aims to describe and analyze MoH's main institutions and their activities abroad, however, it is pivotal to firstly introduce what the ministry itself, as an institution, represented for the formulation and implementation of these goals.

As mentioned, the MoH became increasingly important following the advent of SUS, and this meant more financial resources and political prestige for the organization. When President Lula was elected, in 2002, he did not promise bold or daring changes to health, although his administration did try to “implement a new organization [frame] to the Ministry” to reform the institution (MENICUCCI, 2011, p. 524). With this restructuration, the *Pact for Health* was developed, a program that involved all federative stances of power and aimed to improve SUS's management (MENICUCCI, 2011).

The increased political will to improve health was not reflected in the resources available to the MoH or SUS. As seen in figure 01 below, the funding for the MoH increased steadily during both Lula's and Dilma Rousseff's administrations, without any plateaus, sharp increases or declines.

**Figure 01. MoH Budget (Executed)**



Source: Federal Senate of Brazil – Federal Budget (2003-2014) (2018). Elaborated by the author.

Nonetheless, the shift in political will became more apparent in 2007, when Dr. José Gomes Temporão was appointed as Minister of Health. With him, issues that were not necessarily new, but had lost emphasis on the governmental agenda, regained their political status and became more significant (MENICUCCI, 2011).

During Lula’s second term as president in 2007, the government launched what became known as Growth Acceleration Program (PAC, Programa de Aceleração do Crescimento in Portuguese), a set of strategies to improve Brazil’s economic growth. It was a very broad governmental plan, aiming to promote national development by investing in areas such as infrastructure, education, public security and health. PAC for Health was entitled *Mais Saúde* (More Health), and its policy goal was very straightforward: to boost social and economic development by improving people’s health (TEMPORÃO & MAZZOLI, 2009).

*More Health* was different from what had been done during Lula’s first term because it connected health policies to social determinants for health. It shifted SUS’s scope of action from mere reinforcement to intervening in social aspects of public health. Additionally, Temporão vehemently questioned SUS’s managerial structure, suggesting changes to the legal aspects of hospitals and federal institutes (MENICUCCI, 2011).

Projects’ management standards in the health system were also reviewed, and a result-based evaluation was implemented by the MoH (PORTAL BRASIL, 2010).

Pact for Health goals introduced many other ideas as well, such as strengthening Brazil’s Health Industrial Complex and addressing SUS underfunding issues. In order to implement *More Health*, MoH divided it into seven axes of action, one of which addressed international cooperation specifically, because the “program reveals an international dimension as it inserts health into Brazilian foreign policy, which is a consequence of its central role to cooperation among countries” (MINISTRY OF HEALTH, 2008, p. 09).

The MoH did not place these axes into any specific order or hierarchy, instead, they opt for a circle to emphasize how they converged and influenced each other. Figure 02 illustrates the program as it was depicted by the MoH.

**Figure 02.** More Health Program axes of action.



Source: Ministry of Health, 2008, p. 09.

Since international cooperation was an axis on its own, a specific directive and four goals were developed for this branch of the *More Health* program. According to the MoH (2008, p. 83 - 85), they were:

Directive: to strengthen Brazil's presence in the international health scenario, in close articulation with the Ministry of Foreign Affairs, expanding the country's presence in organs and health programs from the United Nations, and cooperating with the development of the health systems of South American countries, particularly with MERCOSUR, Central American, CPLP and African countries.

Goal 01: Contribute to the development of structures and health systems of Central and South America, CPLP and other African countries;

- Target 01: Support 20 National Public Health Institutes; support 25 Public Health Schools; and support 50 technical schools;
- Target 02: Establish Fiocruz's office with the African Union;
- Target 03: Establish an Antiretroviral Medicines Factory in Mozambique;
- Target 04: Technical Cooperation for the production of Interferon Peguilado with the Government of Cuba.

Goal 02: Support large scale training of technicians working on Health in CPLP countries, using Brazil's experience with the Professionalization Project for Nurse Professionals (PROFAE);

- Target 01: Support five countries (Angola, Sao Tome, Guinea-Bissau, Mozambique, Cape Verde), through technical cooperation, with pedagogic training for professionals, so that qualification courses for nursing assistants and health community agents are offered in a diffuse manner.

Goal 03: Insert the Program Health in the Borders in the scope of the South American Integration Strengthening;

- Target 01: Establish agreements with at least seven countries in the area, strengthening the regional bloc;
- Target 02: Improve health services from all 121 municipalities on borders.

Goal 04: Support the constitution of a Pan-Amazonian Science, Technology and Innovation Network;

1. Target 01: Support the constitution of the Pan-Amazonian Science, Technology and Innovation Network.

An initial budget of R\$58 million was made available for the accomplishment of these goals, and the program was set to last until 2011. An evaluation of *More Health* was made in 2010 by the MoH itself, and in what concerns the International Cooperation axis, we consider the evaluation quite vague. The Ministry praised the creation of UNASUR Health and its health plan; emphasized the importance of the humanitarian assistance Brazil sent to Haiti after the earthquake that devastated the country; highlighted Anvisa efforts to improve sanitary surveillance cooperation in Latin American and CPLP countries, and stressed Mozambique's importance to Brazilian Cooperation, since it was the recipient of eleven cooperation projects – for example, the ARV Medicines Factory required R\$13,6 million in Brazilian investments in 2008 alone (MINISTRY OF HEALTH, 2010a).

Nonetheless, the analysis did not inspect or introduce an audit of expenditures, nor did it detail which targets were achieved and what the outcomes of the proposed goals were. It also failed to demonstrate possible flaws, or solutions the Brazilian government developed for obstacles it faced. It focuses only on particular issues in a very descriptive way, with no analysis whatsoever.

However, this should not diminish the importance of *More Health*'s formulation to the MoHs role in BFP. As Dr. Temporão described in an interview given to the author of this thesis, when talking about the program (TEMPORÃO, 2016):

When I started in the Ministry, in 2007, for the first time international cooperation was put as one of the eight<sup>16</sup> structuring axes of the policy I implemented. This had never happened before. Why? Because it expresses somehow an important evolution of health's space within the Brazilian international cooperation. Of course, this was happening for a very long time, but in as unstructured and disorganised way (...).

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<sup>16</sup> Sanitation was under the responsibility of the Health National Foundation; however it was considered to be one of Mais Saúde axes by the MoH on its 2010 evaluation paper.

There was 100% of autonomy for the Ministry of Health. This was a policy developed by the Ministry, executed by the Ministry.

The autonomy of the Ministry of Health was a novelty, and in our view the most significant feature of the *More Health* program was the existence of a structured and well-delineated policy, with international cooperation as one of its basic pillars, as well as the fact that this policy was *developed and implemented* by the MoH. It demonstrated the MoH's intention to operate abroad, and more importantly, it positively influenced UNASUR and CPLP health agendas when they were established in consonance with the program (PAN AMERICAN HEALTH ORGANIZATION, 2015).

After Dr. Temporão left the Ministry, Dr. Alexandre Padilha was appointed as the new Minister of Health, remaining in office for almost the entire period of Dilma's first term (starting in 2011 and ending in February 2014). Under his supervision, another program, entitled "Ministry of Health Strategic Planning 2011-2015" was created. According to the MoH, there were too many planning and management mechanisms being used by the institution at the same time, thus, there it was necessity to harmonize these efforts with a new strategic plan (MINISTRY OF HEALTH, 2013).

In the new plan, sixteen strategic goals were developed, encompassing over one hundred targets and many more initiatives. With "perfecting SUS" as an institutional motto, these strategic goals aimed to improve (MINISTRY OF HEALTH, 2013, p. 20 - 24):

1. Primary and secondary health care delivery;
2. Health promotion and surveillance;
3. Women, infant and vulnerable populations' health;
4. Urgent and emergency care network;
5. Mental health care networks;
6. Chronic diseases treatment;
7. Native Brazilian populations' access to health;
8. Training of human resources for health;
9. Management mechanisms for the relationship between federative agents;
10. Mechanisms to increase effectiveness of federal actions;
11. Pharmaceutical assistance under SUS's scope;



12. Scientific, technological and innovative industrial complex;
13. Regulation and supervision of the Brazilian Supplementary Health Sector;
14. Promotion of Brazilian interests abroad, sharing SUS experiences in accordance with BFP;
15. Actions on sewage systems and environmental health;
16. Contribution to eradicate extreme poverty in the country.

Similar to *More Health*, Strategic Planning 2011-2015 also developed a specific goal for foreign affairs and health (defined by the MoH as SG 14), nevertheless, this time the MoH specified which of its institutions would be responsible for implementing each one of the targets. The following table was extracted from the original document introducing this Strategic Planning project (MINISTRY OF HEALTH, 2013, p. 146).

**Table 05.** Strategic Planning 2011-2015 - Strategic Goal 14.

Strategy 01	Promotion of international operations for strengthening / development of Science, Technology and Innovation of the Health Industrial Complex.		
	Outcome 01	Implementation of plans, agreements and cooperation / action / work projects for the for strengthening / development of Science, Technology and Innovation of the Health Industrial Complex.	Responsibility of: AISA
	Outcome 02	Inauguration of Mozambique's Factory, producing antiretrovirals and expanding potential access to medicines to the Mozambican population.	Responsibility of: Fiocruz
	Outcome 03	Cooperation for the local development of at least one biotechnological input for SUS usage, based on transfer of technology established from Cuba to Brazil.	Responsibility of: Science, Technology and Strategic Inputs Secretariat
Strategy 02	Strengthening of Regional Integration in Health		
	Outcome 01	Strengthened regional integration process, in health, at UNASUR, MERCOSUR and other regional forums.	Responsibility of: AISA
	Outcome 02	Integrated strategy of health in the borders fully established and implemented.	Responsibility of: AISA
Strategy 03	Strengthening of international cooperation and humanitarian assistance in health.		

Outcome 01	Implementing plans, agreements, and cooperation / action / work plans	Responsibility of: AISA
Outcome 02	Strengthening Haiti's sanitary authority	Responsibility of: MoH Executive Secretariat
Outcome 03	Strengthening actions on health humanitarian assistance.  Strengthening of MoH activities in various international	Responsibility of: AISA
Outcome 04	exchange actions for the reduction of racial disparities in health and for tackling institutional prejudice, within the framework of the Afrodecedents decade (2012-2022)	Responsibility of: AISA
Outcome 05	Maintain and strengthen cooperation projects to tackle sickle cell disease in Africa	Responsibility of: AISA
Strategy 04	Improve the management of international actions in Health	
Outcome 01	Creation and implementation of management tools and mechanisms.	Responsibility of: AISA

Source: Ministry of Health, 2013, p. 146. Elaborated by the author.

As can be inferred, this project is quite different from *More Health*. There were, indeed, many similarities and continuities, since both stress that Mozambique's ARV Medicines Factory, cooperation with Cuba, health on borders and regional integration are fundamental topics for Brazil. However, a major discontinuity that can be observed in this Strategic Planning 2011-2015 is the absence of any mention to CPLP countries or projects. Africa is not totally forgotten, since cooperation in sickle cell disease is acknowledged, but the emphasis given to *More Health* was by all means different. This fact is quite intriguing, since CPLP had its own strategic plan for health strengthening in the bloc due to last until 2016<sup>17</sup>; making us question why the Community was not included in the MoH's international plans. Additionally, it is worth underlining the apparent prevalence gained by the Ministry of Health International Advisory Service, responsible for 72% of the proposed outcomes in this new plan.

<sup>17</sup> CPLP projects will be further analyzed in a posterior section of this work.

Another continuity in this new Strategic Planning 2011-2015 was MoH's autonomy. As Dr. Padilha mentioned in an interview to the author of this thesis (PADILHA, 2017):

The Ministry had full autonomy, in the sense of defining what was priority in the agenda (...), execute the projects, decide on agreements, the Ministry had total autonomy for that, there has never been any sort of disrespect from the Ministry of Foreign Affairs to the Ministry's autonomy, or from any of the government's central organs. What there was in the Ministry... We had taken a very clear decision to build this international agenda with dialogue (...) following two paths: the first one, [the path] of all an agenda from multilateral health organizations, from the World Health Organization, and from the Pan American Health Organization.

(...)

And the second agenda was from the foreign policy of the Brazilian government.

Once again, we see that the MoH was able to independently *formulate and implement* its strategies abroad, demonstrating that BFP's horizontalization was real for the Ministry, which fully explored legislation on the matter, as discussed before. Nonetheless, Dr. Padilha highlights that the MoH was attentive to the BFP agenda and principles; suggesting that the Ministry understood the framework within which these international strategies would be developed.

One of the aspects of these processes that deserves to be stressed is the high regard the MoH held for the MoFA. Additionally, its autonomous behaviour should not be mistaken for a lack of Itamaraty's endorsement of its activities. As Dr. Temporão said (TEMPORÃO, 2016):

During my time as Minister, me and Celso Amorim, who was Minister of Foreign Affairs, we gathered regularly and periodically to discuss the global health agenda. This was something I believe had not happened before and certainly is not happening now.

(...) Health pulled this policy and developed it, surely, integrated with Itamaraty, precisely because my coordinator for international health was a diplomat, right? A career diplomat!<sup>18</sup>

In his interview, Dr. Padilha emphasised similar points, particularly when talking about the relationship between both Ministries and the policies developed at his time as Minister (PADILHA, 2017):

It was a collective construction, right? Yes, it was a collective construction, a mutual respect. For sure there was a political construction with a lot of identity, I mean, with Itamaraty's direction, with the Ministry of Foreign Affairs. There has never been, in any moment, Itamaraty coming to discuss a certain opinion, a certain position that was different from the Ministry ones, especially in some situations that could generate... Well, there are some topics in health which did not necessarily reach a consensus in the government. For instance, the tobacco issue. But the Ministry always had a very strong position, and Itamaraty always supported this position very well.

Ambassador Celso Amorim shared this perspective with Dr. Temporão and Dr. Padilha, because when asked about the relationship between these entities, his answer was (AMORIM, 2015a):

We had a very close relationship. Well, firstly, the international advisors [of the MoH] we had in these days we are talking about were diplomats (...).

When needed, they even spoke to me, with authorization of their Minister. I was personally interested in these topics. And like I said to you, this topic was very concerted in a given moment, because of all these matters of innovative financing sources, of hunger. We had special units to take care of this hunger issue...

[It was a gear] that worked well, I believe it still does.

Without a doubt the mutual interest and particular willingness both Ministries had to work on global health projects had positive consequences for Brazil's role abroad.

Itamaraty did not only support MoH projects. As discussed at the beginning of this chapter, budgetary allowances did not increase substantially enough to fully explain how the MoH was able to effectively expand its activities beyond borders. Thus,

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<sup>18</sup> Here Dr. Temporão was referring to Amb. Eduardo Barbosa, diplomat director of AISA during his time in office.

partnerships were built so that resources were available for the programs. This strategy is neither unusual nor new; for instance, international partnerships were already established with Germany in the early 2000s, for the implementation of HIV / AIDS projects in Bolivia and Paraguay together with German funding (BRAZILIAN INTERDISCIPLINARY AIDS ASSOCIATION, 2006).

Here we argue that the novelty was the fact that the Pan American Health Organization (PAHO) developed several international agreements with the MoH to strengthen and develop its institutions and departments in order to deliberately boost international cooperation. From 2004 to 2014, PAHO and MoH signed 31 Cooperation Terms (CTs), agreements in which the former generally provided financial resources for programs and the latter implemented them (PAN AMERICAN HEALTH ORGANIZATION, 2014a).

One particular agreement, Cooperation Term n° 41, specifically targeted international cooperation implemented by the MoH, and was understood as (PAN AMERICAN HEALTH ORGANIZATION, 2014a, p. 34):

A commitment established between PAHO / WHO and Brazil in 2005, aiming to strengthen an international cooperation program via experience, knowledge and technology sharing, [elements] available in public health institutions, among Brazil and PAHO / WHO member states, under South-South Cooperation Framework and prioritizing South America (UNASUR) and African Countries with Portuguese as Official Language (PALOPS).

Worth R\$43.995.000,00, Cooperation Term n° 41 was meant to last until 2015 and, due to its purposes and activities, Fiocruz became the main receptor of its resources. It would not be very coherent to introduce the main targets of this cooperation without first mentioning Fiocruz's important role in BFP. For the time being then, we will simply highlight that PAHO wanted Brazil to construct a cohesive South-South Cooperation strategy, because this would help to improve health standards in the developing world as a whole.

Other Cooperation Terms also endeavoured to enhance international cooperation by supporting Brazilian Institutions: CT 58 aimed to strengthen AISA, CT 64 focused on bolstering Anvisa's action, so that it could help to implement the International Health

Regulation, CT 66 worked with HIV / AIDS and Viral Hepatitis using South-South Cooperation principles as a framework. Even CTs that did not explicitly mention international cooperation on their targets ended up recognizing the importance this type of cooperation would represent for countries trying to address health problems, such as CT 54 on Networks for combating Cancer (PAN AMERICAN HEALTH ORGANIZATION, 2014a).

With institutional autonomy, a political agenda, well-delineated policies and strategies, and financial resources, the MoH had all the components needed to develop its international projects and implement them abroad. Given the complexity of its structure and the myriad of topics it worked with, the following subchapters are divided into either important programs of the MoH, or into its autarchic divisions - so each project can be carefully explained.

## **5.1 HIV/AIDS Program**

The Brazilian HIV/AIDS program was internationally praised for its excellency; and its know-how and expertise were highly desired by other developing countries and even international institutions and NGOs, who understood Brazil had to further engage in its projects to ensure universal access to antiretroviral therapy (ART) (MINISTRY OF HEALTH, 2002; PUENTE, 2010). The Brazilian example is well-known, and this been thoroughly analyzed by experts all over the world; therefore, this chapter will only discuss the particular aspects of the Brazilian HIV/AIDS program that matter to this thesis, such as the autonomy it granted to the MoH to negotiate HIV/AIDS medicines issues, and how influential the country became after signing various international agreements on the topic.

Inceded by this foreign recognition, Brazil developed specific programs to offer less developed countries means to tackle the epidemic. By Ministerial Order, published in May 2002, the Brazilian International Cooperation Program for Preventative and Control Actions against HIV/AIDS for Developing Countries was created as part of the Brazilian HIV/AIDS National Program. At first, ten pilot projects would be chosen to receive technical assistance and medicine donations for the HIV positive population, each

receiving US\$100,000 per year (MINISTRY OF HEALTH, 2002). It is remarkable that international cooperation became a constituent part of this Brazilian HIV / AIDS program, demonstrating MoH awareness of the importance of Brazil's engagement in the matter and its consequent international impact.

Although the International Cooperation Program was only established in 2002, Brazil had been offering technology transfers for the production of ART to developing countries since 2000. This said, in the two years of its existence no country had yet taken any initiative with regards to the proposal (MINISTRY OF HEALTH, 2002, p. 07) Thus Brazil changed the program's approach and started offering ART medicines<sup>19</sup> along with technical expertise<sup>20</sup>. There were certainly other cooperation projects which did not include technology transfer as a fundamental premise: Angola, Mozambique, Guinea Bissau, São Tomé and Príncipe, Namibia, South Africa, Zimbabwe, Kenya, Botswana, Cuba, El Salvador, and Peru, plus MERCOSUR, had been discussing prospective projects with MoH and the World Bank since 1999 (MINISTRY OF HEALTH, 2000).

A noteworthy feature of this International Cooperation Program (ICP) was the fact that it was completely coordinated by the MoH. A working party was appointed to analyze applications sent by governments, UN agencies, NGOs, Universities and even Official Cooperation Agencies offering bilateral programs. Brazil believed that a successful application should display political commitment to HIV control policies and long-term assurances of treatment availability for patients (MINISTRY OF HEALTH, 2002, p. 12 - 13). Over time, the MoH enjoyed a great amount of autonomy in the management of its HIV/AIDS projects abroad (PUENTE, 2010, p. 163).

After 2003 another component was added to Brazil's HIV / AIDS cooperation: President Lula's election and his desire to "export the recipe of the Brazilian model" (ROBINE, 2008, p. 124); in other words, exchanging technology with other developing countries and training personnel to work with this health issue. The President was rather proud of what was achieved by Brazil, pronouncing to world leaders at the 59<sup>th</sup> UNGA in

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<sup>19</sup> The medicines offered for donation were: Zidovudine capsule 100mg, Zidovudine Oral Solution, Zidovudine intravenous solution, Zidovudine + Lamivudine capsule 300+150mg, Didanosine capsule 25mg, Didanosine capsule 100mg, Didanosine powder, Zalcitabine capsule 0,75 mg, Lamivudine capsule 150 mg, Lamivudine oral solution, Stavudine capsule 30 mg, Stavudine capsule 40 mg, Stavudine powder, Indinavir capsule 400 mg, and Nevirapine pill 200 mg.

<sup>20</sup> Puente (2010) demonstrates that some classify the Brazilian HIV/AIDS cooperation as technical, while others describe it as humanitarian assistance by virtue of these medicine donations.

New York, on 21<sup>st</sup> September 2004, that HIV / AIDS was a priority and that cooperation projects with other countries on the matter were expanding (MINISTRY OF FOREIGN AFFAIRS, 2008a)

By 2004, the ICP had built 14 partnerships with other countries, nonetheless, this was not the only project in the MoH's portfolio (BRAZILIAN ASSOCIATION OF COLLECTIVE HEALTH, 2004). In the same year, Brazil signed an agreement with the Joint United Nations Program on HIV and AIDS (UNAIDS) to establish an International Technical Cooperation Centre in HIV/AIDS that aimed to share: (BRAZILIAN INTERDISCIPLINARY AIDS ASSOCIATION, 2006, p. 02)

knowledge, experiences and Brazilian technical resources, via formulation, implementation, evaluation and monitoring of horizontal technical cooperation programs among the Brazilian government and other developing countries to improve and strength national responses to the HIV/AIDS epidemics.

As a matter of fact, the use of a horizontal approach was peculiar because horizontal cooperation (ROBINE, 2008, p. 124):

is the most interesting because, unlike traditional technology transfer, it constitutes a balanced mode or acquisition of drug technology for developing countries. Rather than paying the full price for technologies developed in industrialized countries, skills can be exchanged in a fairer basis, each generic producer bringing their own technological knowledge to the table.

All these activities were managed by the Foreign Cooperation Advisory Office (COOPEX), a section of the Brazilian HIV/AIDS National Program that specialised in international negotiation and international cooperation (BRAZILIAN INTERDISCIPLINARY AIDS ASSOCIATION, 2006). The existence of such an Advisory subdivision inside a Department of the MoH demonstrates how autonomous the Ministry actually was to even negotiate cooperation agreements with different international actors.

Sometimes, the ICP was a plan within another plan. An example of this was the *Ntwanano*<sup>21</sup> Project, a partnership between Brazil and Mozambique under the South-

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<sup>21</sup> Ntwanano means agreement or alliance in Changana, a native Mozambican language,



South Cooperation scheme whose target was to prevent and combat HIV/AIDS epidemics. Although some of its activities were built under the ICP, it was broader than the Cooperation Program itself. Created in 2000, the *Ntwanano* Project was unique because it focused on strengthening the Mozambican response to this disease *and* the Brazilian ICP at the same time, promoting Brazilian technical expertise abroad. For instance, in 2003, Brazil was a participant at The Second Forum for HIV / AIDS Horizontal Technical Cooperation in Latin America and Caribbean, which was an attempt to share its knowledge with other countries (BRAZILIAN ASSOCIATION OF COLLECTIVE HEALTH, 2004).

Implemented by the Brazilian Association of Collective Health (ABRASCO), the Graduate Program on Epidemiology of the Federal University of Rio Grande do Sul, and MoH's National Program on Sexually Transmitted Diseases and HIV / AIDS, the *Ntwanano* Project counted on the Ford Foundation for its financial resources (BRAZILIAN ASSOCIATION OF COLLECTIVE HEALTH, 2004).

Itamaraty was not deeply involved in this project, however this did not mean the Ministry was completely absent. Many telegrams prove that MoFA was aware and was even responsible for communication between both States (which is, as a matter of fact, Itamaraty's legal duty). MoFA's Secretary of State for Foreign Affairs (SERE) – the Itamaraty department responsible for coordinating diplomatic mission work – sent several telegrams to the Brazilian Embassy in Maputo questioning how the Mozambican government was responding to draft agreements referred by Brazil. In one, SERE expressed its interest in knowing if Mozambique already had an opinion concerning the *Ntwanano* Project (MINISTRY OF FOREIGN AFFAIRS, 2003a).

Although it was already planned in 2000, it was only in 2003 that the project actually began. On 14<sup>th</sup> of July, changes in terms of the agreement were requested by Mozambique's MoH, so that it could more properly depict the state of HIV / AIDS in the country (MINISTRY OF FOREIGN AFFAIRS, 2003b). The Brazilian Cooperation Agency suggested some changes, and only in October that year would medicines begin to be distributed to Mozambican patients (MINISTRY OF FOREIGN AFFAIRS, 2003c; MINISTRY OF FOREIGN AFFAIRS, 2003d).

Around that same month, the idea of developing an ARV medicines factory in Mozambique was being debated at a higher diplomatic level, with a letter of intentions

and proposals under Mozambican scrutiny (MINISTRY OF FOREIGN AFFAIRS, 2003e). This project will receive due attention in a later chapter, since it is a central enterprise of BFP.

It was not only bilateral projects that were developed after Lula became Brazil's president in 2003: discussions concerning the MDGs, UNAIDS goals, TRIPS agreement and the Global Fund for HIV / AIDS, Malaria and Tuberculosis also received significant attention from the Brazilian government, and CPLP member states became eligible to receive cooperation from the ICP program (BRAZILIAN ASSOCIATION OF COLLECTIVE HEALTH, 2004; CEPIK & SOUZA, 2011). As a consequence of this multilateral approach, these international arrangements and the organizations involved saw Brazil as a potential partner. Or more significantly, as a leader.

Following the ICP's example and focusing on Portuguese and Spanish-speaking countries, the MoH, with UNAIDS support, created "Brazil + 7", a partnership with Bolivia, Cape Verde, East Timor, Guinea Bissau, Nicaragua, Paraguay and Sao Tome and Principe. The aim was to halt growing HIV / AIDS incidence rates. What started as a classical bilateral project in 2004 had by 2005 become a multilateral program with the United Nations Children's Fund (UNICEF), and its name was changed to South-South Ties Network. UNICEF contributed with action directed to women and children's health and helped to distribute medicine to the population. Later on, in 2007, the United Nations Population Fund (UNFPA) was also incorporated into the group, which introduced concerns about increasing civil society representation in the program (UNITED NATIONS CHILDREN'S FUND, 2016).

After ten years, the impact of South-South Ties Network is remarkable: in Guinea Bissau, for instance, this program was responsible for almost 100% of all ARV treatment available to the population, and in Nicaragua, country "representatives in the South-South Ties Network report that sharing information with Brazilian professionals has also been decisive for the adoption of best work practices in the LGBT community" (UNITED NATIONS CHILDREN'S FUND, 2016, p. 32). Brazil understood that the consequences of this South-South Ties Network to the country were significant: sharing know-how would bring, in return, new ideas and an ability to scrutinize its own actions and policies (UNITED NATIONS CHILDREN'S FUND, 2016).

After accumulating experience in multilateral discussions, technology transfer, and autonomous international arrangements, the MoH got involved in the creation of another multilateral group, the Network for Technological Cooperation on HIV/AIDS. The group was one of the outcomes of the 2004 XV International Conference in HIV, negotiated between China, India, Nigeria, Russia, Ukraine and Thailand. AISA was responsible for political aspects of this negotiation, inviting the Ministers of Health of the mentioned countries to debate an agreement, while Itamaraty undertook its usual role as the point of communication between diplomatic representatives (MINISTRY OF FOREIGN AFFAIRS, 2005a).

This Network for Technological Cooperation on HIV/AIDS was established on 17<sup>th</sup> May 2005, with two countries joining the founding members: Argentina and Cuba; and as Robine (2008, p. 126) describes, “this network constitutes an innovative modality of technology transfer in the pharmaceutical sector, since it involves only developing countries which have technological capacities in the pharmaceutical field”. The author questions the absence of India and South Africa in this agreement but praises the horizontal aspect of the cooperation initiative.

The meeting preceding the signing of this agreement was held concomitantly to 58<sup>th</sup> session of the WHA, which Mr. Humberto Costa, Brazilian Minister of Health at the time, attended personally. Countries agreed that cooperation for research and development in medicines; vaccines; laboratorial equipment and inputs; and condom production would serve to strengthen their manufacturing lines, as well as their quality and security control (MINISTRY OF FOREIGN AFFAIRS, 2005b)

Shortly after, in 2007, Brazil issued a compulsory licensing of Efavirenz 600g for non-commercial use. An important ARV drug, this medicine was produced by Merck Sharp & Dohme laboratory, who since 2006 was negotiating a reduction of each pills' individual price with Brazil. Laboratories charge countries differently based on their wealth and purchase power, and Brazil made it clear that they wanted the same price that had been offered to Thailand (RODRIGUES & SOLER, 2006, p. 555).

The Ministry of Health was responsible for triggering the process of compulsory licensing on 24<sup>th</sup> April 2007, by declaring it a medicine of public interest<sup>22</sup>, and on 4<sup>th</sup>

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<sup>22</sup> Ministerial Ordinance 886 (2007)

May of the same year, President Lula signed a decree to make the compulsory licensing official<sup>23</sup>. In 2001, 2003 and 2005, Brazil faced situations in which the country believed it would have to use this TRIPS resource, because negotiations with pharmaceutical companies were not showing results. However, they would only have to issue a decree to this effect in 2007 (RODRIGUES & SOLER, 2006).

Itamaraty was committed to standing with the MoH on this issue, by emphasizing that Brazil had been a pioneer as the only Latin American country to issue such licensing, reduce prices and purchase the generic active ingredient from India (MINISTRY OF FOREIGN AFFAIRS, 2010b). Also, Celso Amorim, invited by Minister Temporão, delivered a speech at the 60<sup>th</sup> WHA session, affirming that Brazil's decision was "unattackable, on either moral or legal basis", adding that "no consideration of economic nature can obstruct measures whose goal is to save millions of human lives" (AMORIM, 2015b, p. 235) .

The country was seen as a protagonist by its peers too. In 2010, at the Permanent Mission of Brazil to the UN (DELBRASONU), the then Ambassador to this mission, Ms. Maria Luiza Ribeiro Viotti, had a meeting with Mr. Michel Kazatchkine, who at the time was director of the Global Fund. Mr. Kazatchkine was very direct in his conversation, affirming that as a consequence of the 2008 economic crisis, the Fund was going through financial constraints, so he expected G20 countries to "assume greater responsibilities" (MINISTRY OF FOREIGN AFFAIRS, 2010c, p. 02).

His utmost goal was to convince China to increase its contribution, and after the Asian country questioned him on what the Brazilian position on the issue was, he effectively requested that Brazil exercise its leadership and financially contribute to the Fund, so that maybe not only China, but also Mexico and India, would follow suit (MINISTRY OF FOREIGN AFFAIRS, 2010c).

This recognized leadership abroad was translated into country representatives seeking MoFA or MoH for assistance with their domestic epidemics. Dr. Mariangela Simão, responsible for international cooperation and head of the Brazilian National HIV / AIDS program from 2004 to 2010, declared in an interview to the author of this thesis that countries came forward to develop joint projects on HIV / AIDS treatment. With the

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<sup>23</sup> Presidential Decree 6108 (2007)

support of Itamaraty and much more often, the BCA, demands from other nations would reach the National Program, and were quite diverse (ranging from medicine donation requests to interests in understanding Brazilian technological development in the issue) (SIMÃO, 2017).

Initiatives and programs in the area of HIV / AIDS are vast, from bilateral arrangements to projects with BRICS and CPLP (which will be addressed later on), there is a myriad of plans regarding access to medication and technology. Perhaps as a consequence of seeing HIV as being closely and perversely connected to poverty and hunger, President Lula held HIV / AIDS programs in high esteem, as he declared at the UNGA opening session on 21<sup>st</sup> September 2004 (MINISTRY OF FOREIGN AFFAIRS, 2008a).

President Dilma, on the other hand, never mentioned HIV (neither the disease nor Brazilian programs developed to address it) at any of the speeches she delivered at UNGA opening sessions (PRESIDENCY OF THE REPUBLIC OF BRAZIL, 2011; PRESIDENCY OF THE REPUBLIC OF BRAZIL, 2012; PRESIDENCY OF THE REPUBLIC OF BRAZIL, 2013; PRESIDENCY OF THE REPUBLIC OF BRAZIL, 2014). However, a lack of words does not translate to a lack of governmental policies.

During her first year in office, in 2011, Brazil and PAHO signed Cooperation Term n°66; a R\$10,980 million initiative to implement public policies to control HIV / AIDS and Viral Hepatitis in the framework of SUS principles and South-South Cooperation (PAN AMERICAN HEALTH ORGANIZATION, 2014a).

The term had a twofold goal: firstly, it aimed to strengthen the technical capacities of health professionals in the area across all three spheres of the Brazilian Federation (Union, States and Municipalities); and secondly, it wanted to use this enhanced capacity to “support experiences exchange among countries in the region, facilitating operational aspects of policy management to respond to HIV / AIDS and Viral Hepatitis” (PAN AMERICAN HEALTH ORGANIZATION, 2014a, p. 208). This CT was due to end in 2016, and was innovative in the sense that it represented an effort to improve national capacity as a means to train and harmonize regional capacities, demonstrating the MoH wanted to improve policies to HIV / AIDS with South-South Cooperation goals in mind.

The key aspect here is the MoH's prominence across these initiatives, and the fact that most of the time, Itamaraty merely acted as a bridge between international demands that arose after successful policies was implemented nationally and by the MoH. According to the works of Badin and França (2010) and Silva, Spécie and Vitale (2010), there was an active horizontalization and formulation of international affairs by the MoH as it signed agreements and established networks with other countries.

HIV / AIDS is just one of the topics that gained Brazil recognition within the realm of global health. However another, the Framework Convention for Tobacco Control, mentioned earlier, is equally important. Next, we will discuss what happened to Tobacco Control in the country from 2003 onwards.

## **5.2 INCA**

The Brazilian National Cancer Institute (INCA) is the institution of reference for formulation of anti-cancer policies in Brazil, as well as for the research and treatment of the disease. This chapter aims to describe INCA's national articulation and international leadership, shedding light on the complex structure supporting its decisions.

INCA is a branch of the MoH and is listed in its budget. It established a strong international presence following the success of its anti-tobacco policy and due to its decisive role in coordinating the National Commission for the Framework Convention Preparation. In an interview granted to the author of his thesis, Dr. Luiz Antônio Santini, director of INCA from 2005 to 2015, commented on how strong these anti-tobacco policies were (SANTINI, 2017):

What truly matters is that tobacco control initiatives in Brazil, emerging already in the 1990's, more substantially after 1995, were taken by INCA. INCA was the institution that brought to itself the commitment to tackle this tobacco issue as a cancer-leading factor.

(...) INCA took the initiative in these tobacco matters in such a way that when [it was time] to discuss the Framework Convention, the COP that defined the Framework Convention, Itamaraty resorted to INCA's information and experience, because (...) INCA did not only work as a communication institution, but it developed studies and researches.

When the Framework Convention for Tobacco Control opened for signatures in May 2003, this National Commission was extinguished and replaced by the National Commission for Implementation of the Framework Convention for Tobacco Control and its Protocols (CONICQ), for which INCA would be Secretariat. This meant it would maintain its original functions. That is, it would plan meetings, write reports and make sure communication among all members was effective – CONICQ is composed of 18 Federal Government institutions, and both the MoH and Itamaraty are members of CONICQ (PRESIDENCY OF THE REPUBLIC OF BRAZIL, 2003)<sup>24</sup>.

Intended to organize gatherings four times per year (or more, if necessary), CONICQ's mission was firstly to advise Brazil during the process of the FCTC's ratification; and, after this legal procedure was over, the Commission would promote the Convention and develop strategies to implement it. This Legislative appreciation of the FCTC only occurred on 27th October 2005, when the National Congress issued Legislative Decree n°1.012, ratifying the Convention almost a year and a half after its signature (RANGEL, 2011).

The ratification process was quite complicated, as Sogocio (2008) and Rangel (2011) explain in detail in their work. Given the complex nature of the topic, Brazil held six national public audiences to discuss the ratification and implementation process of the FCTC together with the members of public that it would affect, mainly tobacco producer associations, but also oncologists and doctor associations (RANGEL, 2011).

To understand more, we interviewed Mr. Eduardo Suplicy, Senator for the State of São Paulo from 1991 to 2015 and Chairman of the Commission of Foreign Affairs in the Senate during the ratification process being discussed. Mr. Suplicy recalled one of his announcements at the National Congress, stressing how unusual it was for the Senate to hold public audiences, and how they were not designed to prevent the country from

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<sup>24</sup> These institutions are: Ministry of Foreign Affairs; Ministry of Health; Ministry of the Economy; Ministry of Planning, Budget, and Management; Chief of Staff of the Presidency of the Republic; Ministry of Agriculture, Livestock, and Supply; Ministry of Justice; Ministry of Education; Ministry of Labour and Social Welfare; Ministry of Development, Industry and Foreign Trade; Ministry of Agrarian Development; Ministry of Communications; Ministry of Environment; Ministry of Science, Technology and Innovation; Secretary for Women-dedicated Policies of the Presidency of the Republic; National Secretary for Drug-control Policies of the Ministry of Justice; the Federal Attorney General's Office and the National Sanitary Surveillance Agency.

ratifying the document: what everyone involved actually wanted was to find a balance in the discussion (SUPLICY, 2017).

Given the nature of CONICQs secondary aim, civil society's access to CONICQ discussions continued even after the ratification had taken place. The FCTC periodically holds Conferences of the Parties (COP), meetings whose goal is to make decisions and agreements on technical and procedural aspects of the convention (NATIONAL CANCER INSTITUTE, 2017a). Civil society entities were not part of CONICQ, but they were heard by the Commission. INCA's efforts still focused on the construction of a harmonized domestic consensus, acquiring all the Ministries' support and exchanging as much information as possible with civil society. This allowed Brazil to champion a strong international position in the implementation of measures for tobacco control at COPs, for which CONICQ was in largely responsible, as Dr. Luiz Antônio Santini explained (SANTINI, 2017):

CONICQ success was the possibility of generating consensus via a strategic commitment and a commitment with transparency, with provision of information in a transparent fashion.

(...) it was a very cooperative relationship. And not only with Itamaraty, but also with all the ministries. With Itamaraty too. And Itamaraty was very important in international matters, at the COP representations.

Understanding the work behind these meetings is a pivotal quest of this thesis. Before diving in, we introduce Table 06, which demonstrates the venues and years of each COP that took place in the time covered by this thesis.



**Table 06.** FCTC Conference of Parties from 2003 to 2014

Year	COP Number	Venue
2006	COP 1	Geneva, Switzerland
2007	COP 2	Bangkok, Thailand
2008	COP 3	Durban, South Africa
2010	COP 4	Punta del Este, Uruguay
2012	COP 5	Seoul, South Korea
2014	COP 5	Moscow, Russia

Source: National Cancer Institute, 2017a

INCA, through CONICQ, held crucial roles at COPs and its preparatory pre-meetings alike. The Convention was still under the process of ratification in Brazil when then director of INCA, Dr. José Temporão, went to Geneva to partake in the Intergovernmental Work Group of the Convention. This was a gathering of social leaders who aimed to prepare the ground for the first COP, and discuss procedural matters, such as rules for the participation of civil society organizations. Brazil was invited because of its active role in the writing of the FCTC (NATIONAL CANCER INSTITUTE, 2005) .

During COP 2, Brazil volunteered to be part of a Working Group for article 8 (Protection from exposure to tobacco smoke) (NATIONAL CANCER INSTITUTE, 2017b). But perhaps the most significant event of COP2 to CONICQ was that, from 2007 onwards, “preparatory activities for the Brazilian Participation at the Conferences of the Parties involve open meetings to listen to those interested, including representations from the [tobacco] production sector”, to discuss COPs agendas (CONICQ, 2015a, p. 04). This demonstrates CONICQ’s interest in keeping the agenda-making process transparent.

In the following year, 2008, CONICQ organized: three seminars open to civil society; five meetings with the other ministries; went to Mexico and Peru to discuss the implementation efforts of specific articles of the FCTC; and participated in the COP 3, held in November in Durban, South Africa (NATIONAL CANCER INSTITUTE, 2008)

With time, preparation efforts for COP became more complex, as can be seen from COP 4. Seminars, as well as what INCA defines as “alignment meetings”, with member-Ministries, were used to prepare a guiding document written by the Institute (INCA chairs the Secretariat of CONICQ), and this document was used by the Brazilian delegation in Uruguay to orient negotiations (CONICQ, 2010a). In total, five seminars with civil society were organized: one was coordinated by Anvisa, another by the Ministry of Education, a third by the Ministry of Agrarian Development, a fourth by INCA and the last, by Itamaraty (CONICQ, 2010b).

Provided tobacco control is a multidisciplinary topic, MoH and MoFa were not alone in the delegation sent to Punta del Este: The Ministries of Agriculture, Livestock, and Supply; of Agrarian Development; of Development, Industry and Foreign Trade; of Education; of Labor and Social Welfare; the Chief of Staff of the Presidency of the Republic and the Federal Police were also present. As such Brazil had one of the largest delegations taking part in this COP (CONICQ, 2010a). At COP 4, Brazil was a member of the Working Group for Article n° 14 (Demand reduction measures concerning tobacco dependence and cessation) and helped settle an agreement on the matter (NATIONAL CANCER INSTITUTE, 2017b).

Besides Brazil’s multidisciplinary delegation, another significant event at COP 4 was the introduction of public hearings at COP venues, with representatives of tobacco producers also attending COPs (CONICQ, 2015a).

After COP4, Itamaraty, the MoH and the Ministry of the Economy participated in meetings for the negotiation of the FCTC Protocol, to be voted during COP 5. The MoH and the Ministry of Agrarian Development also held meetings with entities from all federative stances in Brazil, tobacco producer representatives, and health professionals, to discuss the country’s position on the COP 5 agenda (NATIONAL CANCER INSTITUTE, 2014a).

This agenda was quite sensitive to Brazil, one of the world’s largest tobacco producers, for it would discuss Articles 17 and 18 of the FCTC (respectively the provision of support for economically viable alternative activities, and the protection of the environment and peoples’ health). Since the first COP, Brazil had attempted to make Article 17 a priority on the international agenda, mainly because most countries who are

members of the convention are not tobacco producers; and Brazil did not want to encourage a debate on alternative economic activities (CONICQ, 2010b).

Other countries joined Brazil in this quest (these were Greece, India, Mexico and Turkey), and together they put together a study group that held talks in 2009 in India, 2010 in Ghana and 2012 in Geneva. Brazil was a protagonist of the Working Group because of the Ministry of Agrarian Development's plan for the diversification of tobacco production areas (demonstrating, once more, how multidisciplinary and diverse tobacco-related topics and actors were) (CONICQ, 2012).

The Brazilian delegation sent to Seoul was headed by a diplomat, Minister-Counselor Sérgio Luis Lebedeff, with representatives of the MoH; Ministry of Agrarian Development, of Economy; of Agriculture, Livestock, and Supply; Anvisa and the Federal Attorney General's Office (NATIONAL CANCER INSTITUTE, 2014a). This delegation suffered great pressures from the Legislative Branch. Because of the sensitive matters COP 5 was going to address, Congressmen from tobacco-producing states wanted to be official members of the Brazilian delegation. A governmental decision to only appoint representatives from the Executive Branch was necessary to prevent this from happening (CONICQ, 2013, p. 06).

MoFA had only sent two delegates to this COP (Mr. Lebedeff and Secretary Fabio Padro). The delegation divided itself according to the topic of each session, and CONICQ praised Mr. Fabio for his leadership and negotiation skills during the sessions (CONICQ, 2013, p. 12). CONICQ also highlighted how fundamental the quality of debates was to the diversity of the Brazilian delegation (CONICQ, 2013, p. 13):

The delegation (...) divided itself to participate on the informal groups on articles 6, 9, and 10, electronic cigarettes and smoke-free tobacco products. In this sense, it was very significative to have in the delegation (...) many different sectors from the Federal Government, so that different topics discussed could be covered for those indeed responsible for them.

There was a complaint, however; one which concerned the high level of pressure suffered by the official delegation. This pressure came from tobacco producers and politicians connected to tobacco who attended COP 5, who were concerned about possible restrictions to tobacco growth (CONICQ, 2013, p. 13):

Moreover, another complicating factor, that required a great effort from the delegation, concerned the demands and pressures it suffered from the tobacco-producers entourage, who attended COP5 from the hall of the building, since they were not authorized to have access to the activities of committee A and B. This entourage had members of parliament, mayors of tobacco-producing cities in Brazil, representatives from the union of the tobacco industry and associations of tobacco producers.

The delegation was not closed to their requests. Before going to Seoul, in August 2012, two meetings with the Minister of Agrarian Development, Mr. Pepe Vargas, and then Vice-President, Mr. Michel Temer, were scheduled by Congressman Alceu Moreira, so that an entourage of politicians for tobacco-producing areas, producers associations, and the tobacco industry itself could express their points of view on COP5's agenda (NATIONAL CANCER INSTITUTE, 2012a). At COP 5, Brazil agreed to diversify crops in tobacco-exclusive lands, but was against eliminating all tobacco plantations (NATIONAL CANCER INSTITUTE, 2014b)

Arrangements were not different for COP 6. In 2013 in Pelotas, a city in the Southernmost state of the country (Rio Grande do Sul), Brazil hosted the IV Meeting of the Working Group for articles 17 and 18 of the FCTC. In this gathering, tobacco producers and representatives from 18 countries were present, aiming to discuss economic alternatives to families whose income relied on tobacco production (NATIONAL CANCER INSTITUTE, 2013).

CONICQ also organized open meetings, in September 2013 and September 2014, to discuss sectorial demands for the upcoming COP 6, in Moscow, Russia. At the same time, INCA, AISA and the USA Department of State, with their National Cancer Institute, “met on three occasions [in 2013] to discuss and establish a bilateral cooperation project entitled “Brazil-USA Partnership for Tobacco Control” (NATIONAL CANCER INSTITUTE, 2015a).

In October 2014, COP 6 took place. This time, the Brazilian delegation had two Deputy Heads instead of only one main Head: one was Mr. Carlos Cuenca, from the MoFA and director of its Social Affairs Division, and the other was Mr. Alberto Kleiman, AISA's director at the time. This demonstrates how deeply the MoH was involved in Tobacco-related international negotiations. Also, Brazil was appointed at this COP to be

FCTC America's Regional Coordinator, with Mrs. Tânia Cavalcanti, from INCA, who was the Brazilian representative (NATIONAL CANCER INSTITUTE, 2015a).

Despite being given various opportunities to speak publicly in Brazil; tobacco industries, producers and politicians who had aligned with tobacco lobbyists still complained that they were not allowed inside COP sessions. In Moscow, the Association of Tobacco Producers of Brazil, the Union of Tobacco, and congressmen from traditional tobacco producing states (Rio Grande do Sul and Santa Catarina) criticized the fact that they were not allowed in the sessions' rooms, claiming there was an embarrassing emptiness in the FCTC – even though the Framework clearly states that members with any association to the tobacco industry are not to take part in negotiations (NATIONAL CANCER INSTITUTE, 2015b).

Despite complaints from the producers' association, the Brazilian delegation was able to find a middle-ground position in what concerned the protection of families of tobacco producers with public health interests. Tobacco relies significantly on family farming methods in Brazil, and these family farmers usually found themselves entangled in disadvantageous contracts with tobacco industries. Such families had their own association, the Federation of Workers of Family Farmers of the South Region (SAGOCIO, 2008). It was with great concern that they followed the formation of articles 17 (provision of support for economically viable alternative activities) and 18 (protection of the environment and the health of persons of the FCTC). However, during COP 6, the Ministry of Agricultural Development ensured them that production would not suffer with imposed restrictions, nor they would lose access to credit or loans: what the Ministry wanted was for them to start growing other crops on their land, and technical assistance would be provided so that they could diversify their production (CONICQ, 2014).

Perhaps CONICQ's biggest accomplishment was its openness to the public while it formulated public policy and represented Brazil abroad. Additionally, CONICQ was responsible for harmonizing the Brazilian delegation's diplomatic position. In an interview, Dr. Tania Cavalcanti, who is secretary-executive of CONICQ and has been working for INCA since 1993, told us what the working relationship between Ministries at CONICQ was like (CAVALCANTI, 2017):

All this preparation from the Brazilian delegation, it is done in harmony, in coordination with the Executive Secretariat, which is

INCA, (...), the Commission and the Ministry of Foreign Affairs. So, we always organize it, we take all these (...) documents that will be a base to the decision, we analyze, and discuss eloquently in the Commission so that we can take our positionings.

Obviously, when these positions are too sensitive, (...) too hard, these positions have to be go to the Ministries, so [the ministers] take their decisions. (...) We don't have problems concerning that.

Dr. Cavalcanti also highlighted the importance of listening to all interested parties during the implementation of the FCTC, even the ones that are not on the same page CONICQ is (CAVALCANTI, 2017):

The Commission is a government - only entity, but it has got the prerogative of establishing dialogs with the parties interested, thus every time we are to attend COPs, we open this seminar, it is part of this dialog [effort], of listening to all parties interested. Even the producers sector, we have tried to listen to them too. (...) afterwards, the commission itself, in a more closed fashion, with its members, we analyze the documents, analyze what was said by the civil society, including manufacturing sector, and this guides or decision making in the Conference of the Parties.

Actually, we don't have a direct relation with producers. We receive their representations. So, for instance, the Tobacco-producers Association of Brazil, the Sinditabaco, all these organizations express themselves at CONICQ. Also, the Federation of Family Agriculture workers, (...) organizations that deal with alternatives to tobacco plantation, so we listen to both sides.

Despite being open to dialogue, Dr. Cavalcanti (2017) affirmed that CONICQ is aware that most of the information presented by tobacco industries can be biased. Another crucial matter for the study presented here is to understand how autonomous CONICQ was during these COPs negotiations. While Itamaraty was concerned with diplomatic concertation, specialists addressed more technical issues. When asked about the relationship with Itamaraty and how discussions of more technical issues took place, Dr. Cavalcanti (2017) replied that:

For instance, at the conferences of the parties, we divide ourselves. Now, for sure we... For example, the Brazilian delegation, we always go with instructions, which are more substantive decisions'

details, which position Brazil is going to champion after a very long debate. Those are written decision details, we make an analysis of all the topics in the agenda, bearing in mind the documents, we discuss and we develop a position, this helps, because the diplomat, he is there to stand up to what was agreed, but sometimes unpredicted things happen, (...) [so] we sit down, we always hold delegation meetings, we listen to the civil society, and always in coordination with Itamaraty in what concerns concertation but we always try to bring the technical sector of the topics that will be addressed, exactly because of this possibility of having issues that are beyond our technical understanding. And there is always delegation of autonomy when the issue is specifically technical.

The interview with Dr. Cavalcanti highlights what was already observed in documents of the National Cancer Institute: INCA being a protagonist in anti-tobacco discussions, building bridges among civil society, the international community, and governmental institutions, and technical knowledge.

Another distinguished international organization of which INCA is a member and in which it actively participates is MERCOSUR's Intergovernmental Commission for Tobacco Control (ICTC). Fully functional since 2003, the ICTC even considered presenting a common MERCOSUR position during COP 4 (NATIONAL CANCER INSTITUTE, 2009). Country members meet every six months to assess FCTC implementation within the group (NATIONAL CANCER INSTITUTE, 2015a).

In 2010, INCA coordinated and prepared a study on the changes that happened in MERCOSUR members states after the FCTC was adopted, entitled "Report on the Evolution of Tobacco Control in MERCOSUR – 2004-2010" (NATIONAL CANCER INSTITUTE, 2011). In 2012, during COP 5, MERCOSUR was given the Orchid Award, a commendation for its efforts in implementing the FCTC, "for putting tobacco control in the development agenda and for prioritising health instead of trade" (CONICQ, 2013, p. 09)

INCA's international activities are not restricted to tobacco control. The institute has developed many programs related to cancer over the past few years, such as a Latin American and Caribbean Alliance for Integral Cancer Control, in order to build a network and strengthen the area's cancer policy management (NATIONAL CANCER

INSTITUTE, 2008). This Alliance was an outcome of the Second International Conference for Cancer Control organized by INCA, with active participation from Dr. Santini. He highlighted in our conversation that (SANTINI, 2017):

In this Congress a letter was prepared, which then became the Charter of Rio de Janeiro, which proposed directives for regional articulation and then, later, when UNASUR was created, [it was under] UNASUR's scope, so it was facing [inwards] to South America, [and from that] the Network of Institutes and National Institutions of Cancer Control was created. Why institutes and institutions? Because not all countries have institutes, and because not all institutes have a coordination role like INCA, Colombia, and some few others.

Thus, further responsibilities were yielded to INCA the following year, when the Network of Latin American National Cancer Institutes was created and aligned with UNASUR activities (NATIONAL CANCER INSTITUTE, 2011).

In 2009, INCA signed an agreement for international technical cooperation with Angola and Mozambique. This agreement had educational purposes, and that same year professionals from these countries were trained to improve their skills in radiotherapy, clinic cancerology and oncology nursing (NATIONAL CANCER INSTITUTE, 2009).

The following year, Brazil enhanced its cooperation with Cuba for cancer control programs and continued its educational programs in Angola and Mozambique for health staff training (NATIONAL CANCER INSTITUTE, 2011). The Latin American Network, under UNASUR's scope, held a meeting the following year, when INCA introduced its model for cancer registration management to other countries (NATIONAL CANCER INSTITUTE, 2012b).

As can be observed, and despite INCA's autonomy, most of its non-tobacco-related projects were developed in areas where Brazil was enhancing its international presence, such as South America and Africa. This can be inferred by its partnerships and networks with UNASUR and CPLP countries (in this case, Angola and Mozambique).

INCA's goal was to diminish tobacco consumption in Brazil. But its national campaign became a model for the world, to the point that Dr. Vera Costa e Silva, one of the people responsible for its implementation in Brazil, was appointed director of the



Tobacco Free Initiative (WHO's department supporting IGB's work) (SALDANHA, 2015).

In all areas, INCA exerted influence and leadership: for its substantial technical grounding in matters relating to cancer; for its great national influence; for its openness to civil society demands, even though they shared a different point of view; for its ability to share knowledge and good practice experiences; and for its ability to filter the different needs of diverse Ministries within CONICQ, providing MoFA a solid ground for their negotiations abroad. INCA is the one of the pieces of the puzzle created during the horizontalization of BHFP-making.

### 5.3 AISA

This chapter has no intention of describing all the projects implemented by the MoH International Advisory Service (AISA), nor does it aim to analyze these projects' effectiveness and outcomes. Bearing in mind the goals of this thesis, the main focus over the following pages will be to assess AISA's degree of autonomy, its relationship with other governmental entities, its international activism and its accessibility to other actors of society.

AISA was created quite a while ago by the MoH. In the 1970's, it established the Coordination for International Health Affairs, mainly to follow topics trending in the international scenario. Only in 1998 was its name reframed as it became an Advisory Service (MINISTRY OF HEALTH, 2017a).

Currently, the Service's main task is to advise the MoH on the implementation of its international programs, manage its projects with international partners and contribute, together with Itamaraty, to the area of health (MINISTRY OF HEALTH, 2017a). Moreover, the Ministry itself affirms that AISA should also “contribute to the *formulation of a Health International Policy*” and that its duty is to “coordinate actions together with programs and different Secretaries and areas from the Ministry of Health”, transforming AISA into the “*most important instance in the formulation*” of Health Foreign Policy (MINISTRY OF HEALTH, 2009a, p. 04-05. Emphasis is ours)

AISA endeavours have long been crucial to Brazilian international ambitions; however, we argue that there has been a watershed moment during the Advisory Service's work, a qualitative and quantitative shift which took place after a Cooperation Term (CT n°58) was signed with PAHO in 2009. The Pan-American Health Organization had, since 2008, advised its member states to strengthen relationships between public health, foreign affairs and international cooperation authorities; as well as to create institutional mechanisms through which health and foreign affairs could build a dialogue and negotiate matters of importance to global and regional health (MINISTRY OF HEALTH, 2009a, p. 05)

Before this, AISA had already been fundamental to government's plans for action abroad, as several official documents reveal. Nonetheless, after this Term was signed, we observe more official documents being issued and conclude that their content was more robust, depicting a stronger AISA engagement in international affairs. AISA itself affirmed that the CT with PAHO, aiming to strengthen the Advisory Service, served the purpose of consolidating "Brazilian Health [sector] interests in the international scenario" (AISA, 2009, p. 02).

Analysing official documents issued before 2009, we can see that MoFA required AISA's help for specific details on health matters, such as pieces of information concerning diseases (for instance, sickle cell disease), the participation of foreign companies providing health services to SUS (which MoH denied according to the Brazilian Constitution), and even information concerning the contents of a Brazilian Air Force cargo flight carrying ARV medicines to African countries (MINISTRY OF HEALTH, 2004a, MINISTRY OF HEALTH 2004b, MINISTRY OF HEALTH 2006a). There were also requests from AISA to the MoFA, more specifically to the Brazilian Cooperation Agency, asking them to analyze whether amended cooperation projects were in accordance with Brazilian standards (MINISTRY OF HEALTH, 2006b; MINISTRY OF HEALTH, 2006c). A very interesting event from this pre-PAHO-CT time was a request from the MoH to MoFA, after a seminar on Health Systems Financing in Luanda, where Angola called for further information on SUS and required "support to the development of a model of the Unified Health System, based on the enforcement of elementary principles of primary health care" (MINISTRY OF HEALTH, 2006d, p. 01).

We also need to consider that the volume of Brazilian projects from 2003 to 2009 increased substantially, but this CT with PAHO provided AISA with more means and tools to reach its goals and participate further in the negotiations. In an interview granted to the author of this thesis, Ambassador Eduardo Botelho Barbosa, AISA's director from 2008 to 2013, emphasized the importance of CT 58 to this Advisory Service, because (BARBOSA, 2017):

When I arrived, (...) [AISA] was facing a dramatic staff issue. You had a huge demand, President Lula used Brazilian public health a lot when offering South-South Cooperation, and we did not have ways of making it flow. And when I started, besides the overload of subjects demanded from this advisory service, there was virtually a daily problem because of staff [shortage]. The solution was found with PAHO's support. And PAHO is there exactly for that, to assist public health systems of countries. We signed this CT 58 (...), and this enabled a rearrangement of the advisory service, technicians were hired, you had a combination of public employees with consultants, and then, really, AISA developed considerably. When I left AISA, I had more or less 52 people working in the Service.

But this CT meant more than just resources made available for AISA. It introduced a more efficient administration method as well (BARBOSA, 2017):

(...) a Cooperation Term, as the name implies, is not only provision of resources, (...) with this, we started using other methods, management methods, and I must say, they've helped us a lot. Cooperation with PAHO was extremely good in this sense. We had to present reports on how we were arranged internally, how we were spending the resources, and that helped a lot our re-arrangement, our work administration. It was really a technical cooperation received from PAHO. In addition to the fact that it allocates resources for execution of activities agreed with PAHO. This allowed (...) an expansion of staff, but it was not extraordinary. Methods, methods improved a lot.

All this performance-enhancing relationship with PAHO did not affect AISA's priority setting, nor the requests it received from other sectors of the Executive Branch, as the Ambassador detailed (BARBOSA, 2017):

PAHO did not dictate what we should do. This must be clearly stated. PAHO advised us so that we could improve our performance, but who decided on goals and priorities was AISA, obviously, echoing priorities from the Ministry of Health, or demands we used to receive from other areas of the government, mainly the Presidency of the Republic or Itamaraty.

The cooperation with PAHO was initially intended to last until 2014 and provide around R\$ 3,6 million. It was later extended to be in force for a total of ten years (2009 to 2019), meaning that an extra R\$20 million was needed to re-organize and strengthen AISA (PAN AMERICAN HEALTH ORGANIZATION, 2010; PAN AMERICAN HEALTH ORGANIZATION, 2014). And PAHO, when developing this CT 58, openly declared that besides consolidating the Advisory Service, it aimed to strengthen health systems from South and Central America, CPLP nations and African countries, complying with the international agenda and, remarkably, aligning with the *More Health* program. Later on, it would be “*contributing to the goals of Brazilian Foreign Policy*”, and also “*contributing to the achievement of Strategic Goal 14, Promotion of Brazilian interests abroad, in accordance with the BFP directives*” (PAN AMERICAN HEALTH ORGANIZATION, 2010, p. 347; PAN AMERICAN HEALTH ORGANIZATION, 2014, p. 204. Emphasis is ours).

We therefore claim that the Brazilian government, on accepting PAHO’s conditions with this CT, demonstrated that enhancing AISA’s structure was part of a long-term plan embedded in the framework of MoH’s *More Health* project and also the Strategic Planning 2011-2015. The MoH had a purpose and most importantly, an *intention*; and with PAHO’s support, AISA became a means to achieve these goals.

The MoH understood its significant role in Brazil’s global health practices, thus for this institution, refurbishing AISA was a way to magnify and improve its participation in policy formulation and in the quality of its activities abroad. This “new” AISA should (MINISTRY OF HEALTH, 2009a, p. 31)

I – Promote, articulate and guide negotiations related to technical, scientific, technologic and financial cooperation with other countries, international organisms, and mechanisms for regional and sub-regional integration, in areas of Ministry’s competency;

II – Articulate collaboration between experts and international multilateral and bilateral missions, following instructions from the National Health Policy;

III – Advise the State Minister, domestically and internationally, in international matters of the Ministry’s interest.

These new responsibilities were in accordance with PAHO analysis, since to this international organization, AISA should coordinate Brazilian participation in international health forums and agenda setting, alongside the Ministry of Foreign Affairs. In order to comply with these responsibilities, four new divisions were created within the Advisory Service structure, as a way of grouping and organizing AISA's work into clusters. They were Divisions of: Projects, Technical Analysis, Multilateral Topics and Regional Integration (AISA, 2010).

Shortly after the CT was signed with PAHO, AISA presented its first Management Report, very likely as part of the new management methods bestowed by PAHO. The report carefully detailed all activities developed by AISA over the course of 2009, elaborating further on the activities of each one of the Divisions. The Division of Multilateral Topics, as the name itself depicts, is AISA's department responsible for the WHO and MDGs agendas, as well as bilateral cooperation and the Framework Convention for Tobacco Control affairs. The division is the element of AISA taking part in CONICQ meetings, both ordinary and extraordinary ones (AISA, 2010).

In charge of elaborating, analysing and negotiating projects, another department, AISA's Division of Projects (DPROJ), worked closely with the BCA and the MoH's more technical departments, mainly developing projects in Latin American and Caribbean countries (AISA, 2010).

Usually, when an international cooperation project is put forth, a planning and then an evaluation mission takes place in order to oversee the negotiation, development, implementation and assessment processes. There are two types of international missions Brazil resorts to: a political one, more focused on the negotiation of different aspects of future or on-going cooperation projects, which frequently answers to MoFA requests (the entity responsible for determining which partners are a priority according to the Brazilian Foreign Policy agenda); and a more technical one, meant to implement tasks and monitor whether proposed activities have the expected impact. The DPROJ is fully implicated in all these type of missions, and also uses them to build bridges between the MoH's and the MoFA's more technical areas (PAN AMERICAN HEALTH ORGANIZATION, 2010, p. 358-359; AISA, 2010).

It is important to highlight that for DPROJ, South America, Haiti and PALOPS (especially from Africa) were the top three priority areas, since this division respected

what had been defined by Itamaraty as the order of precedence for its international cooperation. Additionally, this division was also bound to what the MoH outlined as the *principles* of this Brazilian international cooperation in health affairs. This fact is of utter importance to this thesis, because not only does the MoH affirm that AISA is fundamental to Brazilian Health Foreign Policy, but it also states that it must comply with well-identified international cooperation principles. They are (AISA, 2010, p. 13 - 14):

- Commitment to life;
- Health is everyone's right and a State duty (Brazilian Federal Constitution art. 196);
- Cooperation amongst peoples for the progress of humankind (Brazilian Federal Constitution art. 4);
- Horizontal Cooperation, based on mutual respect, where actions are jointly defined in a non-vertical manner and based on a mutually-agreed agenda;
- Countries autonomy and sustainable actions;
- Integration and articulation;
- Resoluteness and efficiency;
- Preference for structuring actions;
- Team work;
- Development of Partnerships;
- Organization and modernization;
- Countries protagonism ([projects in] consonance with values, needs and strategic plans of countries themselves);
- Institutionalization and
- Social participation and control.

As in INCA's own analysis, this section will focus on DPROJ's articulation and interdependence with different entities and institutions, a situation that arose, for instance, when the Thematic Group for International Cooperation in Health was established in 2009, under DPROJ's management. Aiming to better delineate Brazilian strategies and priorities with partners in international cooperation in the realm of health, this Thematic Group reached out to other international partners so that more triangular cooperation projects could be developed; and sought stronger relationships with domestic counterpart institutions, such as Anvisa, Fiocruz and Funasa (National Health Foundation)<sup>25</sup> (AISA, 2010).

Still during the first year of its creation, the group held a meeting with over 120 participants, such as Unicef and Unaid, as well as many authorities from the MoFA,

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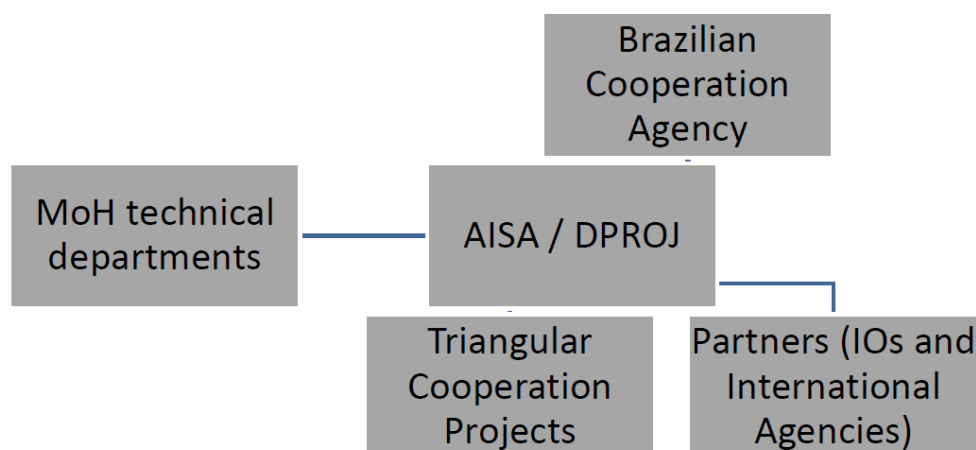
<sup>25</sup> This entity is responsible for the improvement of basic sanitation and sewage systems in Brazil, as well as environmental health (National Health Foundation, 2017).

largely in an effort to improve Brazil’s triangular cooperation without ignoring Itamaraty’s settled priorities and directives (AISA, 2010). However, despite convening different actors to discuss international cooperation, the Thematic Group was officially instituted as part of the MoH only in August 2010, with Ministerial Order nº 2.356 (AISA, 2011).

As can be interpreted from figure 03 below, DPROJ was at the centre of the Brazilian triangular cooperation structure, serving as a mediator between the BCA, other partners and MoH experts.

**Figure 03.** Thematic Group for International Cooperation in Health working structure.

Source: (AISA, 2011, p. 10)



Ambassador Barbosa, during his interview, mentioned how interesting AISA’s work with the German International Cooperation Agency (GIZ) was for technical cooperation with Uruguay. He also cited other international agencies (such as Japan International Cooperation Agency – JICA, and the United States Agency for International Development – USAID) as examples of agencies who worked closely with AISA for the implementation of triangular cooperation projects (BARBOSA, 2017; AISA, 2011).

JICA’s partnership was crucial for PROFORSA (Project for the Strengthening of Angola’s Health System), a strategy designed to reinforce primary health care in the country and train health care professionals in the delivery of secondary and tertiary care (MINISTRY OF HEALTH, 2010b; PAN AMERICAN HEALTH ORGANIZATION, 2010). At PROPORSA, Fiocruz was responsible for programs regarding primary health care, while UNICAMP (University of Campinas, a public university in São Paulo’s

countryside), was in charge of human resources training (BRAZILIAN COOPERATION AGENCY, 2012).

The triangular project developed with USAID was in Mozambique, and focused on its national response to HIV / AIDS epidemics. Since August 2003, USAID intended to develop a project with Brazil in the framework of the “US-Brazil Joint Venture on HIV / AIDS in Lusophone Africa”, an agreement between the countries respective presidents at that time, George W. Bush and Luiz Inácio Lula da Silva. The institution clearly stated its intention to provide financial support to public health strategies, “including HIV / AIDS” (MINISTRY OF FOREIGN AFFAIRS, 2003f, p. 01). By 2010, the project "Strengthening Mozambique's response to the HIV Epidemics" was in place, however, this triangular project was somewhat wearisome to the USA, since Mozambique did not indicate which national institutions would take part in the project, nor did it specify who would be responsible for its coordination locally. Nonetheless, USAID praised Brazil’s efforts in identifying tasks and future activities for the plan (MINISTRY OF FOREIGN AFFAIRS, 2010d).

Since it was established, the Thematic Group for International Cooperation in Health was crucial to coordination and articulation between the various different actors working on said triangular initiatives, especially in matters that implicated “diverse areas of the Ministry of Health concerning [its] actions in the international scope, broadening and strengthening partnerships with organisms and bilateral cooperation agencies” (MINISTRY OF HEALTH, 2010b, p. 02)

Besides this type of collaboration, DPROJ was also responsible for the supervision of CPLP and UNASUR projects, establishing plans with Fiocruz and working on the consolidation of networks (AISA, 2010). This area will be further analyzed in these international organization chapters.

Within AISA’s structure, there is another division whose goal is to deal with issues to which health is. It negotiates topics which, on the surface, might not seem directly connected to health, topics such as environment and disarmament policies: The Division of Technical Analysis (DATEC).

The Ministry of Health realized that it needed to be part of a myriad of negotiations, health-related or not. Due to this, its technical departments worked closely



with AISA in order to ensure that technical expertise would be explored in full to safeguard Brazilian health standards internationally (AISA, 2010).

Health and environment; biodiversity; biosecurity and the Cartagena Protocol; the ozone layer and the Montreal Protocol; chemical substances use; pollution and the Stockholm Convention; Kyoto Protocol; combat to drugs and even compliance to bioethics mechanisms were issues dealt with by DATEC (AISA, 2010).

When contacted by the author of this thesis for an interview, the DATEC director most active during the period covered by this thesis, Dr. Ana Maria Tapajós, sent a brief summary of this division's activities via email. In this document, Dr. Tapajós started to explain the importance of having a diplomat at the head of AISA, as well as DATEC's awareness of its role (TAPAJÓS, 2017a):

During almost all this period, bosses were from the MoFA originally, [they stayed in] the advisory service. The positive aspects of this fact were the understanding of the mechanisms of the Brazilian foreign policy making and of the international policy, associated with a smooth interaction among different sectors from Itamaraty.

DATEC's team was formed and transformed through all these years, being improved to understand, at the same time, the needs and the interests of the health sector, with tools to better deal with them internationally.

She also stressed that most of the international mechanisms and processes that DATEC followed, such as environmental protection, disarmament and climate, could make "decisions that could [potentially] be hazardous to health". These mechanisms were therefore under constant negotiation and implementation, and as a result, only what was actually written down in agreements or legal documents was considered to be legally binding (TAPAJÓS, 2017a). In a phone interview, she stressed that, undoubtedly, WHO's activities are crucial and pivotal for the improvement of health standards across the planet, but that more is needed (TAPAJÓS, 2017b):

WHO is important, but it is very limited to health, health. And for instance, when we went to (...) a discussion on access and division of benefits... it is a mechanism within the environment [protection]... But you know, access also concerns microorganisms, plants, animals, all those influence health, (...) mainly microorganisms.

And there was a huge effort on behalf of DATEC to introduce health not only to many different debates, but also into documents that could, in future, influence negotiations (TAPAJÓS, 2017b):

(...) when you make a statement, generally, you start with a document as foundation. (...) Starting with this document, people discuss, discuss. There were things we saw could be added as perambulatory clauses. They don't mean anything, but they allow you to, later (...) I mean, when you are able to insert health anywhere, you will also have posterior strategies to reinforce this presence [of health].

Another issue to catalyze debate in our email correspondence, which then continued in our phone interview ten days later, was the domestic negotiation process, which often took place before debates were taken to the international level. As Dr. Tapajós (2017a) described, negotiations started with a study of essential documents and proposals to be taken to discussions. Then (TAPAJÓS, 2017b):

[issues] were discussed internally. When all sectors agreed, (...), or made one or other suggestion, sometimes to make it better or to insert something of their interest, this became part of the Brazilian position. All of us, from the delegation, would have to stick to that position. So sometimes we even supported [what was] the position of Agriculture.

Generally, health, in this period you are analysing, health was more aligned with people from the environment than agriculture. Environment and agriculture had some clashes, but none of them was severe.

She emphasized that whenever an upcoming international debate was scheduled, Itamaraty made an effort to gather all sectors related to a certain topic under joint analysis. In these cases, even sectors with different or clashing interests tried to find common ground for negotiations. Paying closer attention, this is quite similar to INCA and CONICQ's work: bringing together all institutions implicated in a specific issue, solving their differences domestically, and delivering a strong diplomatic position to international negotiations.

In this sense, collaboration was not only among Ministries. As Dr. Tapajós puts it (TAPAJÓS, 2017b):

(...) during the period you are analysing, during a great part of this period, I'd say, during 2/3 of this period, we had a good collaboration in legal advice [with the Attorney General Office]. They were the ones who best knew about health legislation. (...) When there

were doubts, there was always someone from the legal advice to say “but according to the legislation, this is like this, this, and this. This helped us a lot to walk the paths. Because, if you say to Itamaraty, ‘this is against this law, or this respects that law, we can’t do this differently’, they wouldn’t argue.

Moreover, DATEC deeply understood what each different area of the MoH was working on, and what their particular interests were. It tried to channel these interests into more practical mechanisms, ways with which they could be exteriorized and translated into devices for the MoH. Concomitantly, AISA knew that MoH’s technical areas would only excel abroad should training and professional qualification be provided. Thus, this was another activity developed by DATEC: transforming interests into practical ideas or tools, and providing personnel training. Dr. Tapajós (2017b) also highlighted this, by saying that “AISA tried to see what was important for technical areas and attempted to translate that into tools. The other way around was done at the same time, [it used to] seat down with the technical areas and trained them”.

In a nutshell, DATEC’s ultimate goal was to ensure health protection across multiple areas, and its efforts could rely on MoFA support. The Division worked with very particular types of knowledge, and, just like CONICQ’s tobacco control experience, its technical approach meant that Itamaraty would provide support for the establishment of common domestic positions in exchange for this technical backing. In her email, Dr. Tapajós finishes the discussion with the following analysis (TAPAJÓS, 2017a):

As negotiations are made on the behalf of a country, and Itamaraty is not omniscient in all topics (some have very elaborated technical aspects), MoFA had got an efficient system to formulate its positions for negotiation, deducing [these positions] with specific documents from negotiations. [MoFA] arranged meetings with all sectors involved and analyzed agendas issue by issue, trying to find common positions.

Health has always been a sector seen with great sympathy. Internationally, it is a non-confrontational topic, that is, causes associated with health are usually well regarded. However, through time, DATEC had to carefully work this health insertion in some forums, and, in this matter, it has always had Itamaraty’s protocolary support

With a much more specific agenda, AISA's Division of Regional Integration worked with topics within MERCOSUR; UNASUR; Amazon Cooperation Treaty Organization; Itaipu Health (an agreement with Paraguay, within the Health in the Borders Program framework); a bi-national commission with Uruguay for the strengthening of health care delivered on Brazil and Uruguay's shared borders; and many other projects concerning health care delivery on the borders with Peru, Venezuela, French Guyana, Guyana and Colombia (AISA, 2010; AISA 2011).

The formerly mentioned international organizations, MERCOSUR and UNASUR, will both be duly considered in another chapter. For now, it is only necessary to highlight MERCOSUR's extensive work in the health arena, and bear in mind that much of this group's greatest achievements are a consequence of its long existence: MERCOSUR had time to develop and perfect its structure and institutionalize its organization. As Dr. Carlos Felipe D'Oliveira, AISA's General Coordinator for Regional Integration in Health from 2006 to 2010 puts it (D'OLIVEIRA, 2017):

MERCOSUR is a much older structure. (...) MERCOSUR has got a structured work story, (...) a more robust structure, because it is a structure that... since the decade of the 1990s, when it was established, it was being organized, so it had a much more complex organogram.

Besides developing projects with these South American regional organizations, AISA also provided assistance for the MoH to start bilateral programs with countries sharing borders with Brazil. Since 2007, working groups or public health commissions have been established or reactivated by this Ministry, with a goal of "facilitating health care delivery to populations in border zones" (MINISTRY OF HEALTH, 2009b, p. 03). There, working groups and commissions were very active, loaded with local demands and hence compelled to quickly introduce solutions to local problems (GADELHA & COSTA, 2007).

Issues concerning health on the borders encompass public powers from many different levels, spheres and branches, particularly because the MoH must closely cooperate with municipalities in this case. With Ministerial Order nº1.120, of July 2005, Brazil instituted what became known as the Integrated System for Health in Border Areas<sup>26</sup>, aiming to understand the epidemiological needs of each Brazilian border area

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<sup>26</sup> Sistema Integrado de Saúde das Fronteiras in Portuguese, know by the acronym SIS-Fronteiras.

and to establish strong collaboration methods among health systems' local facilities (MINISTRY OF HEALTH, 2005) .

The most recognized case of health on the borders is the project developed with Uruguay. However, cooperation with Uruguay began a few years before SIS-Fronteiras was even proposed. In 2003, two years before SIS-Fronteiras was established, the need for “constant negotiation between both governments and, on the Brazilian side, [the necessity] of integration among federal, states and municipalities domains” meant that the Complementary Adjustment for Health in the Borders was signed by Brazil and Uruguay, establishing the Advisory Bi-national Commission for Health in the Borders (PUCCI, 2010, p. 123).

Efforts of this Advisory Bi-national Commission were concentrated on epidemiological surveillance, as well as health care delivery integration. Fundamental to the analysis proposed by this study is the fact that, according to this Commission's rules of procedure, the Brazilian delegation would be composed of “representatives of Itamaraty, the Ministry of Health, Rio Grande do Sul State Health Secretary and Municipal Health Secretaries of all municipalities sharing borders with Uruguay, besides PAHO representation in Montevideo as observer” (PUCCI, 2010, p. 125).

Therefore, it was not only the MoFA and the MoH who were negotiating better strategies for health cooperation, but also Itamaraty and *all federative authorities* implicated in health care delivery on the border area with Uruguay.

In 2006, a strike of doctors at the *Santa Casa de Livramento*, a hospital on the Brazilian side, forced mothers undergoing labour to deliver their children in Rivara's hospital, a health care facility on Uruguayan territory. An emergency agreement was signed between the hospital and Livramento's city Health Secretary, allowing mothers to give birth in Uruguay and register their new-borns in Brazil. The money that was supposed to pay for procedures carried out by striking doctors were sent to Rivera's Hospital instead. Also, due to the lack of Brazil-educated doctors, local hospitals considered hiring Uruguayan professionals, and these two events brought about the displeasure of the Brazilian Medicine Regional Council (PUCCI, 2010, p. 169 - 170).

As a consequence of locals relying on the health care systems of both countries, as well as health professionals willing to work on either side, Brazil and Uruguay began

negotiations that culminated, in 2008, in the Complementary Adjustment for Reciprocal Health Care Services Delivery on the Borders, allowing inhabitants from the region to use the health systems of either South-American country. These agreements did not take place without complaint: the Rio Grande do Sul Regional Medical Council and a local Doctors Union formally protested, saying that Uruguayan professionals would cross the border and “invade” Brazil, without complying to Brazilian requirements for the work of health professionals (PUCCI, 2010, p. 172).

However, the MoH and Itamaraty joined efforts to prove the agreement would benefit many people and would not be hazardous to local employment dynamics. The efforts were not in vain, as the Brazilian National Congress approved the agreement for health on the borders in 2009, and interestingly, AISA has been offering support to its implementation ever since (PAN AMERICAN HEALTH ORGANIZATION, 2010). As we can see, even private entities were actors on the issue, with MoH and MoFA leadership proving essential to the protection of people’s right to health in this border zone.

When questioned on the issue, Dr. Carlos Felipe D’Oliveira, who closely coordinated projects to put this agreement into force, gave an extensive answer, emphasizing its importance not only to the local population but also to local governments (D’OLIVEIRA, 2017):

So, this agreement, it was an agreement that Itamaraty was developing for a very long time, because it involved many partnerships at the borders, and the health-related agreement, we managed to approve it. This agreement was on hold since 2004, and it was approved on 2008, thus, it was a stagnant agreement for around four years, and we were able to put it forth. Why? Itamaraty was interested on it, the Uruguayan Ministry of Foreign Affairs was interested on it, Ministries of Health from both countries were interested on it. Was there resistance? Yes, there was resistance. Mainly from the Brazilian side, I had to talk a lot, because they thought that Uruguayan people, the Uruguayan doctors would come to work in Brazil and this would take jobs away from Brazilian doctors. The agreement did not allow that.

So, there was resistance from the doctors’ union, from the Rio Grande do Sul Medicine Regional Council, but we also had a great support coming from Rio Grande do Sul Public Ministry, because what we were actually doing was to ensure the realization of a constitutional right, which was the provision of health care to those individuals. (...) and the fear was “well, these professionals will come here and take our jobs”. No! The agreement did not allow that.

I was able to demonstrate that this agreement would benefit all populations and that it would not fail on any Brazilian legislation in what concerned foreign professionals coming to work on the Brazilian side [of the border], the agreement did not allow that. This agreement would actually allow a Brazilian citizen to have a medical procedure done on the other side. In the same way a Uruguayan citizen would have a medical procedure [in Brazil]. And the agreement restricted the scope of action to those cities.

And Itamaraty was... because Itamaraty wanted this agreement, you see, Itamaraty was interested in several agreements concerning borders, because, this border... and I used to say, Itamaraty also shares this point of view, it is because it is a very specific border, one where citizens from one side and the other live together, let's put it this way. Firstly, it is a totally peaceful border where citizens live together. And many families, I visited many families [whose] husband was Uruguayan, the wife Brazilian, half the children were Brazilian, the other half, Uruguayan. That is, this was an agreement that would benefit nationals from both countries and would provide [health] resources to families from both countries.

This agreement was an intense effort that we made both from technical and political perspectives.

The interview with Dr. D'Oliveira pointed out that many actors were involved in the issue, as well as how great the results from this joint effort between Itamaraty, AISA, local Health Secretaries and even the local Public Ministry were. With a common agenda, and similar principles – universal access to health – all entities worked for the same goal: to safeguard locals and their right to health.

Unlike those mentioned so far, the last area AISA worked with was not a division, but a project that would become one of the most important international cooperation projects for health in Brazil. This was the Brazil-Cuba-Haiti Tripartite Agreement, signed after a severe earthquake afflicted Haiti and decimated most of the country's infrastructure, health facilities included, in 2010. Given this project's significance, an entire subchapter will be dedicated to it, however, for now, AISA's coordination efforts on this project should be noted. Although AISA worked with a range of partners of very different natures, such as Itamaraty; BCA; Fiocruz; international organizations such as the United Nations Development Program (UNDP) and even private companies such as the Brazilian private Hospital Albert Einstein; AISA managed this project's activities and guaranteed that all actors involved cooperated and engaged in their activities properly (AISA, 2011).

Another important accomplishment of AISA's during the period in question was the MoH's creation of a Permanent Commission for Health International Affairs within this Ministry's own structure. Established by Ministerial Order nº 1.496 on 18<sup>th</sup> July 2014, the creation of the Permanent Commission was based on a need for further coordination and working harmonization between the various entities working on health cooperation in Brazil. With this Commission the MoH also aimed to fulfil its strategic goal to "institutionalize a planning, monitoring and evaluation culture that integrates all different areas of the Ministry, emphasizing a collective construction" of cooperation (MINISTRY OF HEALTH, 2014a, p. 01).

AISA was responsible for the management of this Commission (such as scheduling meetings and forwarding relevant documents to participants), as well as its overall work coordination. Sixteen different secretaries and associated institutions from the MoH were members of this Permanent Commission: AISA; MoH Executive Secretary; MoH Attention to Health Care Secretary; INCA; National Institute of Traumatology and Orthopaedics Jamil Haddad; Science, Technology and Strategic Inputs Secretary; Work Management and Health Education Secretary; Health Surveillance Secretary; Participatory and Strategic Management Secretary; Special Secretary for Indigenous Population Health; National Health Council Executive Secretary; Fiocruz; National Health Foundation; ANVISA; National Regulatory Agency for Private Health Insurance and Plans; and the Brazilian Hemodynamic and Biotechnology Company (MINISTRY OF HEALTH, 2014a).

Despite its motivation and desire to improve its own international cooperation efforts, we cannot state that the Permanent Commission succeeded in achieving its goals: after 2010, AISA stopped producing Management Reports, and in the MoH Annual Management Report of 2014, there is no mention of the Commission whatsoever. Although it highlights the MoH's continuous commitment to "Strategic Planning 2011-2015" and further engagement with international programs; it only mentions the international meetings that Brazil took part in as well as a few projects it was developing in passing. Nothing is said on subjects regarding internal coordination (MINISTRY OF HEALTH, 2015).

In the pursuit of further information on the Permanent Commission's work, we interviewed Mr. Alberto Kleiman, AISA's director from 2012 to 2015, who was



responsible for the institution's activities when the Commission was established. In an extensive conversation, Mr. Kleiman emphasized how complex AISA work was, and how much coordination effort was required by the MoH's international agenda, to the point that the Permanent Commission was created. As he explained (KLEIMAN, 2017):

The Ministry [of Health's] agenda was very fragmented. Very decentralised, and at the time pursued some sort of coordination. So, the challenge was to provide strategic orientation to an agenda that tended to grow, that had been growing for a while already, on different fronts. So, a concrete example, MERCOSUR, regional integration... UNASUR and MERCOSUR. Especially in the case of MERCOSUR, these were spaces created with great density and a very advanced [level of] "institutionality" from the offset, involving many sectors of the Ministry.

[It was an] outcome (...) of an intense agenda... that ended up involving many areas, many technicians, people and resources, and which encountered some difficulty in controlling all this. This is where the idea of the Commission comes from.

The goal of all this (...) was to exchange information and seek a strategic orientation for the agenda, which was already clearly defined in some concertations.

So, the Commission (...) was part of a roll of initiatives, in the sense of providing coordinated strategic guidance to the Ministry, organizing and managing the health international agenda, on all fronts, from the health industrial complex (...) to participation in multilateral forums, integration and cooperation, those were the Ministry's main axes [of action].

The Permanent Commission aimed to coordinate efforts and organize the health agenda. During our conversation, Dr. Kleiman recalled that the MoH had already had an international strategy for a long time, and the Brazilian health agenda had been in a crescent trend gaining international attention for quite a while. As a consequence (KLEIMAN, 2017):

We understood that the Permanent Commission (...) and many other actions would provide some coherence and strengthen our participation, (...) we could have more coordination (...) and optimize the agenda, create synergies.

Even though this commission headed by AISA was meant to coordinate MoH secretaries and associated institutions, we asked if there was any sort of participation from Itamaraty in the Commission's meetings. Provided the time between Mr. Kleiman's

departure from AISA and the day of the interview, he was not able to affirm with certainty in which meetings or when the MoFA participated. However, Mr. Kleiman explained that (KLEIMAN, 2017, emphasis is ours)

The Commission had few meetings (...) but I remember we brought [someone] to talk about (...) the integration process or [MERCOSUR's] Work Subgroups (...). The Ministry of Health *always had a fluid relationship with Itamaraty.*

(...) the Ministry was quite an autonomous entity, very important to the international agenda, so it was fundamental to coordinate [efforts] with Itamaraty on all fronts.

And the Permanent Commission was part of these efforts, further enhancing the number of forums in which Itamaraty and the MoH could work closely and refine their relationship.

AISA goals were clear: the institution sought to guide the MoH on its international insertion plans and was an effective coordinator between MoH and MoFA. It had a sumptuous budget, provided by CT 58, an agenda, and most importantly, could formulate and implement its own policies and projects. AISA was therefore a crucial actor for Brazilian health affairs.

## 5.4 ANVISA

The National Health Surveillance Agency of Brazil (ANVISA) was created in 1999<sup>27</sup>, with the main purpose of protecting the health status of the population, via “sanitary control of production and commercialization of products and services subject to sanitary surveillance, including environments, processes, inputs, and technologies to them related, as well as [sanitary control of] ports, airports and borders” (ANVISA, 2013, p. 31).

One of Anvisa's missions was to inspect products, materials and medicine manufacturing plants, regardless of the location of these factories and equipment, in order to issue commercialization authorizations (some of them are considered to be good practices certifications). Therefore, these so-called good practices certifications take place all over the world, since the goal is to verify whether products available to the

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<sup>27</sup> Law nº 9.782, 26th January 1999

Brazilian population respect the certain standard required by Brazilian authorities (ANVISA, 2013).

Moreover, Anvisa is also responsible for strengthening Brazil's capacity of emergency response as required by the International Health Regulation; and is the central reference for certain WHO compliance regimes, such as the International Program for Chemical Security and Codex Alimentarius (ANVISA, 2003; ANVISA, 2013). This National Health Surveillance Agency not only engages in activities with the WHO, the WTO, and other well-known international entities, such as the World Intellectual Property Organization (WIPO); but also, with less-known and very technically-oriented entities, such as the International Cooperation on Cosmetics Regulation (ICCR) and the International Medical Device Regulators Forum (IMDRF) (PEREIRA, 2014).

Because of all its duties, it is of Anvisa's nature to cooperate and engage in a myriad of activities abroad, consequently becoming one of the most widely functioning Brazilian institutions (TAGLIARI, 2017). As Pereira (2014, p.07) explains, "since its foundation, the Agency wanted to approach international initiatives correlated to its activities, [creating] a specific sector responsible for coordinating its international actions". This service is currently known as the Advisory Service for International Affairs, a department within ANVISA's structure responsible for taking care of its international activities.

Anvisa's inspections and commercialization authorization emissions are some of the agency's responsibilities determined by law. Anvisa is expected to advance on regulatory convergence and harmonization issues with its partners abroad. Also included in its long-term institutional goals, the Regulatory Agency also had the intention of becoming an international reference for regulatory matters. For this, Anvisa closely aligned its international goals with the MoH's *More Health* Strategy, signed cooperation terms with PAHO and the UNDP, and developed strategies for technical cooperation of its own (ANVISA, 2006; ANVISA, 2009; ANVISA, 2013).

In 2003, the first year Lula was in office and the start of the timeframe considered for thesis, Anvisa itself affirmed that its international achievements were small, considering everything the agency could have done under its scope of action (ANVISA, 2004, p. 09). International action began to increase in number by 2005 and skyrocketed from 2008 onwards. Based on analyzes of Anvisa's management reports from 2003 to

2014, institutional documents demonstrate that in 2006, for instance, Anvisa increased its international cooperation in health in a joint effort with AISA, elaborating or redefining international agreements with “several countries, including Technology Transfer Agreements” (ANVISA, 2007, p. 63). Most importantly, in the 2007 report, Anvisa clearly stated that increasing its international participation was a *political decision*, as can be read in the full sentence quoted below (ANVISA, 2007, p. 63. Emphasis is ours):

[The scope of] Anvisa’s international affairs group, *based on its political decision to align with its strategic definitions and the Brazilian foreign policy*, shifted to the prospection, formulation and negotiation of activities and projects in international cooperation, as well as to the follow-up of its implementation in technical areas.

Although it was only in 2006 that Anvisa announced the decision, years earlier, in 2004 and 2005, the agency signed cooperation terms with two different international organizations. In 2004, a partnership with the UNDP was launched, though it was a short-term endeavour for the establishment of sentinel health services<sup>28</sup> and was finished by 2008. In 2005, Cooperation Term n° 37 (CT 37) was signed with PAHO and this time it was a more ambitious project that aimed to strengthen the Brazilian health surveillance system in all three levels of the federative government, as a way of ensuring Brazil would reach the MDGs targets and would further consolidate SUS (ANVISA, 2009; PAN AMERICAN HEALTH ORGANIZATION, 2010).

With a total investment of R\$ 10.962.485,45, CT 37 was due to finish in 2010. PAHO understood that this CT could be part of the *More Health* program implementation, dealing with its international cooperation axis by strengthening and encouraging the exchange of experience at the international level (PAN AMERICAN HEALTH ORGANIZATION, 2010).

These cooperation terms were so significant to Brazil and the Agency that, over the following years, new ones were agreed upon: with the UNDP, a R\$ 28 million CT was signed in 2010; and with PAHO, a new CT worth R\$ 20 million began the same year (ANVISA, 2011; ANVISA, 2014; PAN AMERICAN HEALTH ORGANIZATION, 2014a).

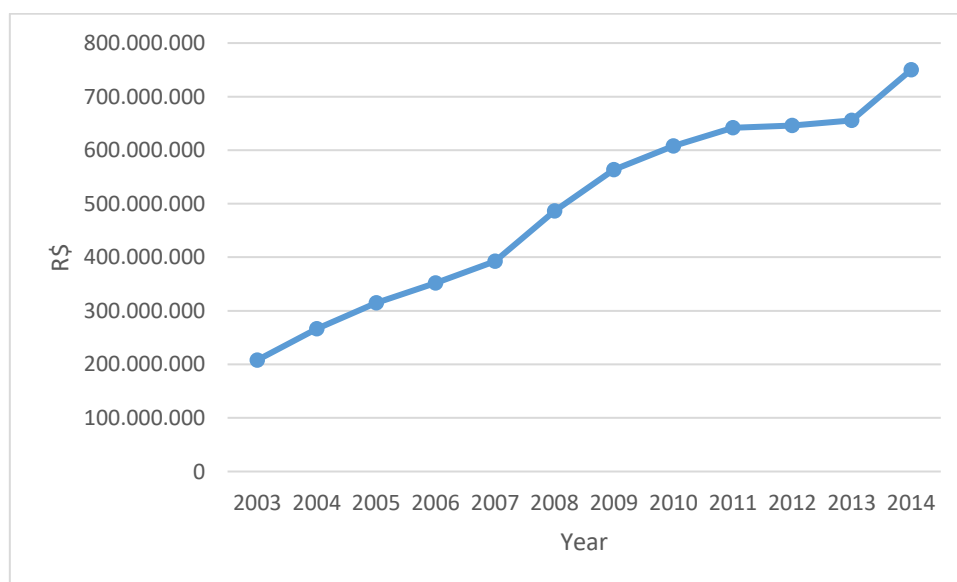
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<sup>28</sup> These services were meant to improve pharmacovigilance and surveillance professionals’ training.

In force until 2015, the renewed and renamed CT 64 was more complex, with outputs stretching beyond Brazilian borders. According to PAHO’s own evaluation, outcomes targeting pharmacovigilance should also include the protection of Latin American and Caribbean populations; as well as their laboratories’ scientific and technological development. Moreover, Anvisa should have its “institutional capacity strengthened for the implementation of the International Health Regulation in points of entry of Brazil, American Region and Countries of Portuguese Language”, referring to points of entry airports, ports and borders (PAN AMERICAN HEALTH ORGANIZATION, 2014a, p. 260).

Anvisa’s strengthening at national, and subsequently international, levels is not the result of contracts signed with international organizations alone. Anvisa was endorsed by *More Health* so for the MoH was just as essential to the achievement of its program goals. In 2008, the agency signed a contract with the Ministry of Health<sup>29</sup> to clearly set out Anvisa’s responsibilities with *More Health* and its strategies (ANVISA, 2009). Coincidence or not, in 2008 Anvisa’s budget demonstrated a sharp increase, maintaining the trend until around 2011, as we can see in figure 04 below.

**Figure 04.** Anvisa Budget (Executed)



Source: Federal Senate of Brazil – Federal Budget (2003-2014) (2018). Formulated by the author.

<sup>29</sup> Termo de Contratualização entre Ministério da Saúde e Anvisa, 9th July 2008.

Despite the rather flat level of investment from 2011 to 2013, Anvisa was also part of the MoH Strategic Planning 2011 -2015. Brazil did not conceal its interest in approaching regulatory agencies from other countries in order to strengthen Anvisa's work and learn from different experiences, and we argue that a strong Brazilian Surveillance in Health structure would be positive for parties benefiting from South-South Cooperation schemes (ANVISA, 2014).

In 2010, Anvisa announced that new internal strategic planning was under construction, mainly to change the institution's organizational structure and management style. By 2012, details of Anvisa's Strategic Planning 2010-2020 were released to the wider public in a document that details its reform plans from a managerial perspective. Improved communications within the organization; more efficient decision-making processes; modernized human resources management; improvement of Anvisa's image before the general public; and strengthening of the National Health Surveillance System were all actions that would be developed during the decade of 2010-2020. Nonetheless, for the purposes of this study, the most relevant initiative in this plan is "strengthening of Anvisa's institutional performance at the international level" (ANVISA, 2011; ANVISA, 2013, p. 50).

Anvisa therefore had a target; it had an obvious goal and purpose of action, a finality to its activities abroad. This initiative was broken down into three different parts (ANVISA, 2013, p. 50. Emphasis is ours):

1. Create opportunities for strategic approaches, increasing the roll of confidentiality agreements;
2. *Negotiate joint working plans and international cooperation actions;*
3. Establish a formal mechanism for the exchange of information, defining focal points.

So it was part of Anvisa's strategy to increase international cooperation actions, and it did not take long for them to get started. In 2014, 28 collaboration projects were in progress, and the international initiative, not even five years after the Strategic Planning had commenced, was already 84,20% accomplished (ANVISA, 2015, p. 245) . It was the highest percentage of all the initiatives on Anvisa's Plan.

International cooperation was very straightforward for this Brazilian National Sanitary Surveillance Agency: it focused on the institutional strengthening of similar

structures in other countries, “particularly with Latin American [ones], by taking part in Brazilian delegations in international missions, seminars and workshops” (INSTITUTE FOR APPLIED ECONOMIC RESEARCH, 2016, p. 56). In total, Anvisa took part in missions in 46 different countries, transferring technical expertise and implementing a “significant portion of Brazilian cooperation in sanitary and epidemiological surveillance” (INSTITUTE FOR APPLIED ECONOMIC RESEARCH, 2016, p. 57).

Beyond cooperation projects, international partnerships were developed with three countries: Argentina, to reinforce pharmacopoeia; Venezuela, to strengthen surveillance and control over contaminants and “products destined for human use and consumption”; and Mozambique, to strengthen the “country’s medicines regulatory agency and to regulate the pharmaceutical sector” (INSTITUTE FOR APPLIED ECONOMIC RESEARCH, 2016, p. 57).

The project with this African nation was praised by the Mozambican Minister of Health, Mr. Garrido. He demonstrated “extreme satisfaction with the cooperation provided by Anvisa, particularly the capacitation of Mozambique’s medicines regulatory agency, which, in his own words, ‘works as a clock’” (MINISTRY OF FOREIGN AFFAIRS, 2010e, p. 03). A few months later, Anvisa even sent a technical mission to help establish a pharmacology sector in the Mozambican medicines regulator office (MINISTRY OF FOREIGN AFFAIRS, 2010f).

Another significant international activity whose emphasis is significant is Anvisa’s lively participation in MERCOSUR Work Subgroups. Considering the Agency’s mission, MERCOSUR Subgroups 3 and 11 are the ones Anvisa engages with the most – technical standards and health, respectively. MERCOSUR’s level of regional integration and the existence of a customs union demands that Anvisa places efforts on harmonizing legislation and health standards, being one of the areas in which the agency is most active (PEREIRA, 2014). As can be seen in Table 07 below, from 2009 to 2013 a great number of employees of this Agency took part in several meetings within MERCOSUR’s structure (meetings are represented by the letter M, and the total number of employees present at these meetings, NE).

**Table 07.** MERCOSUR meetings taking place outside Brazil, concerning technical regulation harmonization from 2009 to 2013.

2009		2010		2011		2012		2013	
M	NE	M	NE	M	NE	M	NE	M	NE
18	79	15	53	11	71	06	33	07	49

Source: (PEREIRA, 2014, p. 68)

Brazilian cooperation in health with MERCOSUR will be further explored in a different chapter of this thesis, however, for now, we must stress that even CT 64, the cooperation term signed with OPAS, stressed the importance of this agency to MERCOSUR's pharmacopoeia strengthening (PAN AMERICAN HEALTH ORGANIZATION, 2014a).

In an attempt to develop a better understanding of Anvisa's activities abroad, the author of this thesis interviewed Ms. Patrícia Oliveira Pereira Tagliari, Chief-Advisor of Anvisa's Advisory Service on International Affairs; and Mrs Camilla Horta, Anvisa's Specialist in Surveillance and Regulatory Services.

As Patrícia Tagliari (2017) stated in her interview, Anvisa's international actions have various roots. One is Brazilian law: by national regulation, medical devices or medicine industries wishing to sell their products to the Brazilian population require international inspection. Besides this, two other types of overseas activities are developed by the agency: classical technical cooperation via the Brazilian Cooperation Agency; as well as what can be described as specific projects, with partners based on umbrella international agreements, such as Memorandums of Understandings. Tagliari (2017) explained this second category of cooperation with more detail in our interview:

[there are] other instruments signed with other countries that do not have a cooperation project with BCA, and they are usually umbrella agreements, they are memorandums of understandings, letters of intentions, agreements of confidentiality that anticipate many of the activities that can be properly developed. Some of them involve [use of] resources, others don't, but usually the praxis is that each part bears the costs related to their own employees. And then, in this bilateral relationship, which does not happen via BCA, most of our [bilateral] relationships are with countries with a greater degree of development,



so the United States, Japan, Australia, Canada, England, France, Portugal... several countries with which we have signed agreements and develop many activities. And in some of these agreements there are working plans, in others are an umbrella agreement that allows actions to be developed [only when] needed, each plan is very different and the way we consociate with each authority is very unique. We also have agreements signed with institutions, not with regulatory agencies *per se*, but with WHO, PAHO, or EDQM<sup>30</sup>...

For these memorandums, what do we do? We inform the Ministry of Health, at different stages, and Itamaraty as well, at different stages, not necessarily before we sign an agreement, sometimes we inform them after the agreement has already been signed, after certain activities are already being implemented, we write an informational report, [saying] that the Agency is developing actions with partners that are eventually considered strategic.

We argue, based on Tagliari's (2017) assertions, that in extremely technical issues, Itamaraty tends to get less involved. Some countries seek Anvisa for technical information or support for specific actions, and their pursuit goes straight to Anvisa's Advisory Service for International Affairs.

When asked questions concerning Anvisa's relationship with Itamaraty during daily negotiations activities, Horta (2017) answered similarly, explaining that in MERCOSUR, for instance:

[There are] groups composed mostly of regulatory authorities and Ministries of Health, the protagonist is technical and is hardly ever [discussions] accompanied by diplomats. This does not mean that diplomats are not aware of what is going on inside these groups, because [groups] report to the Common Market Group... which is, in MERCOSUR's structure, a group led by diplomats. [But] as a rule, they do not get involved in the day-to-day negotiations of these technical documents.

Thus Anvisa was fairly autonomous in discussions where topics were extremely technical. When it comes down to the relationship between Anvisa and Itamaraty during technical meetings, this approach is quite similar to that of AISA's DATEC former director, Dr. Tapajós: the MoFA is aware of discussions, but it is impossible for it to either

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<sup>30</sup> European Directorate for the Quality of Medicines and HealthCare.

hold or acquire all the technical knowledge required for the specificities of health-related negotiations.

Concerning international cooperation projects developed with BCA, Tagliari (2017) explained that they are either offered by Brazil or demanded by another country (who is sometimes already familiar with Anvisa's high-standard levels of work, and thus willing to receive its technical support). However, cooperation projects are always 'written by three pairs of hands', an analogy she used to say that Anvisa, BCA and the third country develop such documents together, "always trying to meet the necessities of the demanding country" (TAGLIARI, 2017).

Moreover, Anvisa is an organization that is aware of its role in the government and is fully conscious of what its own interests as an institution are – to improve its own best practices and increase the levels of protection of the Brazilian population. According to Tagliari (2017):

[Anvisa] works in a very collaborative fashion with other governmental organs, (...) and the Agency also bases its international actions with this concern for developing good relationships, understanding that the Agency has an important role to be fulfilled within the administration.

[Anvisa] is very technical (...). So, many actions are based on the agency's own regulatory interests, seeking to increase its expertise [level]; train its employees; and understand better practices accomplished by other countries.

In a commercial mission, for instance, let's suppose that Argentina and Brazil are discussing how to solve regulatory disagreements, Anvisa is called to help in what concerns the Agency [competencies], by either jointly analysing the regulatory framework, or settling doubts... (...) we answer the call of another governmental organ that is trying to reach legitimate and beneficial goals for the Brazilian society as a whole.

An interesting matter brought to discussion by Horta (2017), was the consideration that the nature of forums Anvisa participates in also influence how autonomous this Agency's actions can be. Again, we argue that this cannot be interpreted as Anvisa's acting without Itamaraty's endorsement, but as a governmental organ with a very specific

expertise working internationally and making decisions on the scope of its knowledge. As Horta (2017) puts it:

Let's say, the possibility of diplomats... in those super technical negotiations... even in places where diplomacy is the protagonist, such as MERCOSUR, they cannot keep track of all forums, MERCOSUR organogram is absurd... But they have control gates, for instance, meetings from working groups, they report to the Common Market Group... (...) so they receive minutes, information, so sooner or later diplomats will become aware of [what is going on] in this topic. Now, in those forums... I don't know how much this is particular or common, but with other institutions, in the health realm, there are many forums in which [health] authorities are protagonists and there is never any diplomatic tracking whatsoever. So, for instance, if you attend... the IMDRF, International Medical Device Regulators Forum (...). We were the secretariat of it; we've been participating for the last six years... You see there that governmental organs are aware of it, (...) they know we are part of this IMDRF, but there is no follow-up, no-one has ever been appointed to follow-up, no country comes with a diplomat. It is technical, technical.

Anvisa's international engagement exists for many different reasons. By law, it must inspect pharmaceutical industries and medical device companies abroad. Because of its formidable technical expertise, it develops, along with BCA, many cooperation projects to straighten Sanitary Regulation in a diverse range of countries. Also, it cooperates with more developed nations to learn and improve itself, investing in its employees training and knowledge-building skills.

From 2010 onwards, Anvisa came up with a strategy, a new organizational working style that has, as a target, the increase of its international cooperation: The Strategic Planning 2010-2020. Bearing in mind what was said by the Mozambican Minister of Health, apparently all these efforts are showing positive outcomes.

Anvisa's extreme technical expertise transformed it into a MoFA partner. Bearing in mind the documents and interviews quoted so far, both institutions clearly understood where each stood and how they could cooperate synergetically and become allies in Brazilian Health Cooperation.

## 5.5 Fiocruz

Established in 1900<sup>31</sup>, Fiocruz has long endorsed research and development in health-related areas (OSWALDO CRUZ FOUNDATION, 2012a). We argue that there is enough evidence to sustain that Fiocruz was one of the most significant institutions for both the formulation and implementation of cooperation projects abroad, given the partnerships and programs it developed with foreign counterparts. The institution itself claims for its protagonism, recalling that Fiocruz is “the main implementing agent of sectorial policy in international cooperation”. (OSWALDO CRUZ FOUNDATION, 2009a, p. 55 - 56)

Fiocruz is actually a fairly large institution, functioning as an umbrella organization for many other institutes, foundations and public pharmaceutical companies. The Fernandes Figueira Institute (for maternal and child health), Farmanguinhos (responsible for technology development in medicines), Bio-manguinhos (whose official name is the Institute of Technology in Immunobiological Materials, responsible for the production of vaccines) are among the institutions involved in Fiocruz’s international cooperation, as will be concluded from the documents analyzed for this study to be introduced later on in this chapter.

Despite the number of institutions under Fiocruz, coordinating efforts cannot be deemed precise before 2003. From 1995, the organization developed what was known as POMs (Plan of Objectives and Goals, in Portuguese)<sup>32</sup>, a strategy proposed by each based on their individual budgets and aims, as well as on yearly national health guidelines issued by the MoH. In 2003, discussions on the importance of having a proper institutional plan began (OSWALDO CRUZ FOUNDATION , 2004). Throughout 2004, a shift from POMs to a new planning and management system took place, and Fiocruz proposed a new strategic plan to be implemented from 2005 onwards (OSWALDO CRUZ FOUNDATION, 2005a).

As a consequence, Fiocruz produced the Pluriannual Plan 2004-2007, a more detailed plan of action for its entities. We could say that at the time, Fiocruz was already

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<sup>31</sup> The Oswaldo Cruz Foundation was officially created in 1974, when many other institutes and research centres merged and came under Fiocruz management (OSWALDO CRUZ FOUNDATION, 2012a).

<sup>32</sup> Plano de Objetivos e Metas.

undertaking international cooperation, but it was very focused and in few areas of action. Most of projects concerned biological research and cooperation with international laboratories; or educational projects with institutes and universities abroad. As such, actions were scattered and one-off, but not inexistent. It is from 2005 that we see the expansion of Fiocruz' international activities: that year, Fiocruz openly declared that it would focus on working with Latin American and Palop countries, starting with plans in Angola to build a “public health school and a structure for scientific information and communication” in the African nation (OSWALDO CRUZ FOUNDATION, 2006a, p. 49).

This shift in 2005 was noticed by the institution itself. As highlighted in Fiocruz's Management Report 2006, “Fiocruz activities in the consolidation of the Ministry of Health's international performance (...) were intensely strengthened in 2006, taking a prominent position in both the institution's strategic planning context and the country's international insertion” (OSWALDO CRUZ FOUNDATION, 2007, p. 41).

The Foundation's 2005-2008 Quadrennial Plan also demonstrated Fiocruz' awareness of the role it played in this Brazilian international insertion, highlighting, in its organizational strategy, particular action plans for its international cooperation programs. It explicitly mentioned that “international cooperation has grown and has become more relevant to Fiocruz” (OSWALDO CRUZ FOUNDATION, 2005b, p. 36). Thus, its main goals were described, back in 2005, as (OSWALDO CRUZ FOUNDATION, 2005b, p. 36):

- Implementing a strategy grounded on BFP and in accordance with AISA and BCA;
- Strengthening action on sub-region integration organizations, mainly in Latin America and Palops;
- Strengthening bilateral actions with equally or less developed states;
- Exchanging health-related technology and know-how;
- Strengthening cooperation with renowned international institutions.

Although embryonic, this Quadrennial Plan demonstrated Fiocruz' *strategy* – collaboration with the MoH and Itamaraty, focus on knowledge sharing and actions concentrated in Latin America and Palops – and, most importantly, its *intention* of broadening its international activities.

Another interesting fact found in this Plan is Fiocruz' recognition of problems resulting from the intention of being more internationally active. As the foundation puts it, "the lack of conceptual frameworks and institutional regulations that state what the profile of Fiocruz international cooperation is; unfamiliarity with the totality of cooperation activities implemented by the institution; and fragmentation of international cooperation activities" are pointed out as weaknesses that need to be solved in order for more efficient work to take place (OSWALDO CRUZ FOUNDATION, 2005b, p. 36).

Albeit conscious of this fragmentation, the Fiocruz Quadrennial Plan introduced six axes of action under which "all strategic goals and action plans from all units are distributed", and one of them explicitly included international cooperation as a topic (INSTITUTE OF DRUG TECHNOLOGY FARMAGUINHOS, 2014, p. 18. Emphasis is ours).

During this time, Fiocruz was advising increasing numbers of public health institutes from Latin American and Palop countries, and strengthening ties with Angola and Mozambique. Fiocruz clearly states that, as an institution, it is part of the *Ministry of Health's* strategy to increase *the Ministry's* international activity; it never claims that its actions are for its own benefit (OSWALDO CRUZ FOUNDATION, 2007). In 2008, when the Management Report 2007 was made available to members of the general public, Fiocruz' Pluriannual<sup>33</sup> Plan was explained in detail, and although the gist of the Plan is not quite clear (it is overly broad and the institution itself is aware of the diversity of its actions). Fiocruz marks out its own intention of "consolidating the international performance of the Ministry of Health" (OSWALDO CRUZ FOUNDATION, 2008, p. 13). At this stage it is crucial to bear in mind that this was the same year that the MoH had introduced its *More Health* strategy to society, with a clear project for its international insertion.

By 2007 Fiocruz seemed to have deepened its traditional international cooperation (collaborations with Laboratories abroad and agreements with educational and training institutions), and, as predicted in its Quadrennial Plan, these activities now focused on areas of interest to the MoH and Itamaraty, such as Angola and Mozambique. With the former, Fiocruz instituted a master's degree in public health and technical health training;

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<sup>33</sup> Quadrennial Plans are part of these Pluniannual Plans; and they tend to be broader and less precise since they indicate directions or trends for future actions of the institution.

and with the latter, conversations with Farmanguinhos regarding the establishment of a medicines' factory in Mozambique had begun (OSWALDO CRUZ FOUNDATION, 2008)

This diversification of activities continued to the point that Fiocruz claimed its position as the *main executor* of MoH's international projects. As stated in its 2007 Management Report (OSWALDO CRUZ FOUNDATION, 2008, p. 15):

Aligned with the modern concept of "Health and Diplomacy", the Ministry of Health strengthened its activities of international cooperation, either bilaterally or via the participation of international networks, with a special emphasis on the Community of Portuguese Language Countries – CPLP, other African and Latin American countries, in close articulation with policy directives from the Ministry of Foreign Affairs. In this context, Fiocruz is the main executor of this sectorial policy. Particularly in what concerns the strategy of Cooperation Among Developing Countries (CEPD), this institution expanded international cooperation actions with CPLP and has developed a prominent role in advisory projects on the re-organization of Public Health Institutes of African and Latin American member states of IANPHI (International Association of National Public Health Institutes). To further advance in this policy, Fiocruz started negotiating in 2007 with Itamaraty, [regarding the establishment], in 2008, of an [institutional] representation in Maputo / Mozambique, in order to intensify its cooperation activities in the African continent as a whole.

A new MoH Pluriannual Plan was in order for the 2008-2011 period, and it was very much attached to MoH strategic planning and its programs. Fiocruz became increasingly engaged in international actions: networks with Latin American and CPLP institutions and offers of technical cooperation were sharply on the rise (OSWALDO CRUZ FOUNDATION, 2009b).

This international engagement was so remarkable that, in 2008, Fiocruz indeed opened its office in Maputo, Mozambique, in order to offer support for its own activities on the African continent (OSWALDO CRUZ FOUNDATION, 2010)<sup>34</sup>. Also, given the amount of new activities and projects under Fiocruz leadership, the organization decided to extinguish its International Cooperation Advisory Service and replace it with a more robust institution: Cris/Fiocruz, which literally translates as International Relations in

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<sup>34</sup> The Brazilian Senate approved the functioning of the Fiocruz Mozambican Office in December 2011, with Legislative Decree nº 235/2011.

Health Centre, but which is usually referred to by its shorter name, Global Health Centre (FERREIRA, FONSECA, *et al.*, 2017, p. 610).

It is not that the Advisory Service was inefficient: what happened was simply that Fiocruz wanted to broaden the Service's scope of action. The Advisory Service endeavoured to promote international technical cooperation; was key in fundraising initiatives and was a bridge in communications with international organizations such as WHO, PAHO, CLPL and also Latin American countries, for instance (OSWALDO CRUZ FOUNDATION, 2004). The Global Health Centre; created in 2009, was actually an evolution of the International Cooperation Advisory Service that existed before (FERREIRA, FONSECA, *et al.*, 2017, p. 610).

Cris/Fiocruz developed its own approach to what cooperation projects should aim for, supporting that North-South relationships should target the “promotion of national values and [attract] high level technology”, whilst South-South cooperation should “respect demands from partners and promote their national values, at the same time (...) that technologies and practices suited to local needs are shared” (FERREIRA, FONSECA, *et al.*, 2017, p. 610).

Moreover, this Global Health Centre encouraged all Fiocruz units to deepen their engagement in international cooperation. When the Oswaldo Cruz Institute, the part of Fiocruz focused on biomedical research, analyzed all the organizational changes concerning Fiocruz' international work, it emphasized the endorsement of the Foundation's international cooperation directives, and that (OSWALDO CRUZ INSTITUTE, 2013a, p. 203. Emphasis is ours)

With the establishment, in 2009, of the International Relations in Health Centre (CRIS), the centralizing organ connected to Fiocruz' presidency and liable for the coordination of this Foundation's international actions; incentives for Units to establish cooperation sectors [within their own structures] were fomented. As a matter of fact, in the period of 2005 to 2012, (...) *cooperation was slowly raised to a strategic status, [with] programmatic actions and budget, supported by both the Foundation's institutional policy of national expansion and the Ministry of Health national policy of integration with the Ministry of Foreign Affairs and of solidary cooperation with Portuguese speaking countries of the Southern Hemisphere and Africa.*

Cris/Fiocruz was the epitome of a long process that began with the Fiocruz foundation, an outcome of a long tradition maintained by the institution, who had ties



with many other organizations abroad. As Dr. Paulo Buss, Cris director, emphasized in an interview to the author of this thesis (BUSS, 2017):

Circa 73, 75... When there was an outbreak of meningitis in São Paulo... Institute Merieux transferred technology for the production of vaccines against meningitis, including equipment donated from Mr. Merieux to Oswaldo Cruz Foundation, besides technology and technical training [for the staff]. So, we can say that in Fiocruz' rebirth, we've had technical cooperation as an important lever.

We believe that because Fiocruz already had connections abroad, with proper incentives and financial resources, Fiocruz projects had the chance they needed to flourish and gain strength. And even though during this 2005-2009 interval Fiocruz went through institutional changes to improve its internal management, it was already one of the most important establishments of Brazilian Technical Cooperation in Health. Of all the financial resources available for international technical cooperation in health between 2005 and 2009 interval, the Oswaldo Cruz Foundation was responsible for 20% (the MoFA invested 49% of the resources, followed by the MoH) (INSTITUTE FOR APPLIED ECONOMIC RESEARCH, 2011).

Moreover, most of its different technical organizations were involved in international cooperation. The Foundation established partnerships on a multitude of topics with 30 countries, more than half of which were Latin American or African, often with BCA support. All this information is summarized in table 08 below (INSTITUTE FOR APPLIED ECONOMIC RESEARCH, 2016).

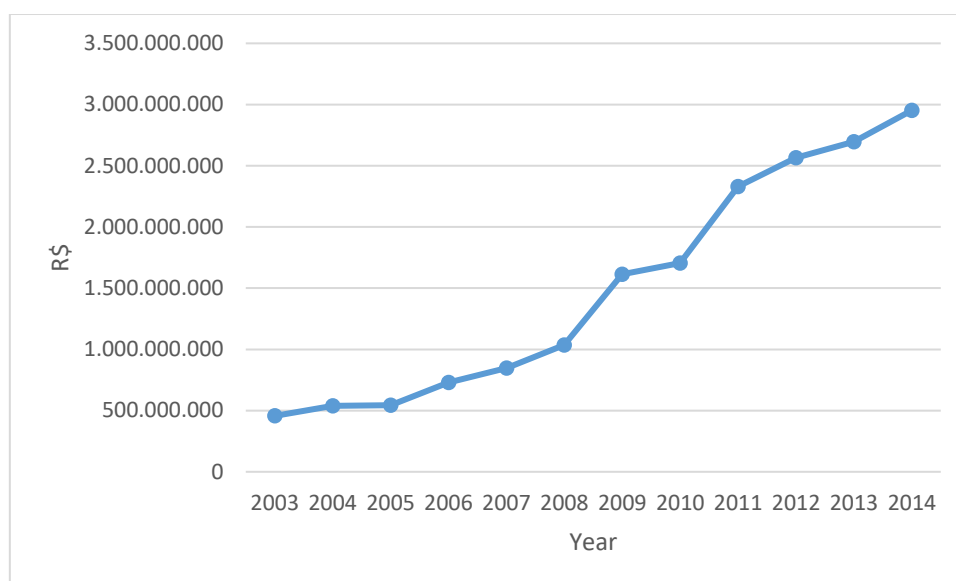
**Table 08.** Fiocruz international cooperation by country, 2011-2013 period.

Practices	Countries / Blocs
Nutritional Surveillance	Mozambique
Human milk banks	Bolivia, Cape Verde, El Salvador, Ecuador, Guatemala, Haiti, Mexico, Mozambique, Nicaragua, Paraguay, Peru, Ibero-American Network, Dominican Republic, Uruguay and Venezuela.
Tuberculosis	Palops
Maternal Health	Mozambique
Antiretroviral Medicines	Mozambique
Strengthening of Health Institutes	El Salvador and Venezuela
Public Health (Proforsa)	Angola
Strengthening of national laboratory	Cuba

Source: (INSTITUTE FOR APPLIED ECONOMIC RESEARCH, 2016, p. 55)

The expansion of Fiocruz' activities to the international level did not happen overnight, as observed, and did not take place without financial support either. The Foundation's income increased in two different ways: first, there was a sharp increase of resources made available to the institution during Lula's second term. The government intentionally enlarged Fiocruz' budget, mainly after 2007, as can be observed on figure 05 (this budget concerns investments in the Oswaldo Cruz Foundation as a whole, not only its international cooperation activities).

**Figure 05.** Fiocruz Budget (Executed)



Source: Federal Senate of Brazil – Federal Budget (2003-2014) (2018). Elaborated by the author

Concerning international cooperation *per se*, Fiocruz invested circa R\$ 750,000 from 2011 to 2013. Resources available for this purpose increased steadily, not so different to the trend observed in the institution’s budget as a whole (INSTITUTE FOR APPLIED ECONOMIC RESEARCH, 2016).

Second, in 2005, the MoH signed a Cooperation Term with PAHO that greatly benefited Fiocruz’s work. With a predicted investment of R\$ 43.995 million, this CT aimed to strengthen Brazil’s health cooperation with PAHO members – States (especially UNASUR countries), and Palops (PAN AMERICAN HEALTH ORGANIZATION, 2014a).

Entitled ‘Cooperation Term n° 41’, this agreement was originally due to remain in force until 2010 and receive R\$ 14,070 million from PAHO. Emphasizing the importance of South-South Cooperation, this CT coordination was under the joint responsibility of Fiocruz, the MoH and PAHO, and it aimed to train health professionals, establish networks and platforms for knowledge sharing, and contribute to the development of the MoH’s *More Health* strategy (PAN AMERICAN HEALTH ORGANIZATION, 2010).

The original CT (signed on December 31<sup>st</sup>, 2005 by Mr. Paulo Marchiori Buss (Fiocruz President), the then Minister of Health, Mr. José Saraiva Felipe, and Ms. Mirta Roses Feriago, PAHO director in Brazil) detailed that the collaboration should establish an International Health Program (IHP) aiming for local sustainable development and

improved life quality. The IHP would be under the responsibility of Fiocruz presidency, accountable for analysing and coordinating the program's development and implementation (BRAZIL, 2005).

In 2010 after CT 41 was extended, its goals became more ambitious. At that point, international projects were already on track and key Brazilian international cooperation programs, such as collaborations with Haiti and Mozambique, were in progress. Although it encompassed other MoH institutions, most of CT 41's projects were designed to be implemented by Fiocruz, as can be seen in table 09:

**Table 09.** CT 41 areas of cooperation and respective coordinators.

Projects	Coordination
1. Strengthening of Brazilian National Capacity for South-South Cooperation	
Support to Cris/Fiocruz	Cris/Fiocruz
Strengthening of a Study Centre on Bioethics and Health Diplomacy – NETHIS	Cris/Fiocruz
Masters in Global Health and Health Diplomacy	National School of Public Health (ENSP) /Fiocruz
Working Group for UNASUR Human Resources	Department of Health Education Management/ MoH
Support to Fiocruz's office in Africa	Cris/Fiocruz
2. Mobilization of National Collaborative Networks for South-South Cooperation	
International Network for the Training of Health Technicians (RETS)	Joaquim Venâncio Polytechnic Health School (EPSJV/Fiocruz)
Network of National Health Institutes	Cris/Fiocruz
Network of National Schools of Public Health (CLPL and UNASUR)	National School of Public Health (ENSP) /Fiocruz
3. Support to South-South Cooperation Projects on Development of Human Resources for Health	
Technical Cooperation Among Countries Brazil – CPLP	Cris/Fiocruz

Technical Cooperation Among Countries Brazil-Latin America	Cris/Fiocruz
Technical Cooperation Among Countries – Technical training Brazil - Haiti	Department of Health Education Management/ MoH

Source: Pan American Health Organization, 2014a, p. 37

As can be observed, one of the strengths that Fiocruz maintained with CT 41 was its international cooperation in education and training of human resources for health. According to PAHO, this cooperation term was also important for another reason (PAN AMERICAN HEALTH ORGANIZATION, 2014a, p. 44. Emphasis is ours):

Activities under execution with (...) CT 41 support facilitated the strengthening of bilateral/multilateral cooperation in health with emphasis on South American and Palop countries, in areas of professional education and training for *the development of SUS-like universal health systems*.

CT 41 proposals are perfectly aligned with [Brazilian] national foreign policy in what concerns the strengthening of Brazil's presence in the health international scene, and *finely tuned with the Ministry of Health and Ministry of Foreign Affairs joint actions, especially with directive 14 of the NHP 2012-2015, which aims for the international promotion of Brazilian interests in health, as well as for the sharing of SUS experience and knowledge with other countries, respecting Brazilian Foreign Policy directives*.<sup>35</sup>

The novelty here is that not only was there a strategy for Brazilian international insertion in health cooperation matters; and not only did Fiocruz, the MoH and the MoFA demonstrate the willingness to joint efforts and develop international projects: this time, sharing *SUS experience* and *SUS model* were explicitly quoted as pivotal variables for Brazilian activities abroad. The evidence of PAHO quoting these two as CT contributions to international cooperation is remarkable and deserves further attention.

PAHO's term of cooperation was fundamental to Fiocruz' daily activities. The author of this thesis interviewed Dr. Luiz Educardo Fonseca, doctor and public health specialist who has already worked on several Fiocruz international projects, including

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<sup>35</sup> NHS – National Health Plan, in this case. The plan for 2012 – 2015 does not change any premises from BFP or its international cooperation plans, provided it is part of the Strategic Planning 2011 – 2015 working framework. For further information, see MINISTRY OF HEALTH, **Plano Nacional de Saúde - PNS 2012 – 2015**. Brasília: Ministério da Saúde, 2015.

programs developed with East Timor and CPLP countries. Currently a researcher and advisor of the Foundation's Global Health Centre, Dr. Fonseca answered two different questionnaires by email, and in both of them the impact of CT 41 was emphasized. As he explained (FONSECA, 2017a; FONSECA, 2017b):

Cooperation Term 41, this financing, provided Fiocruz more autonomy to fund trips and institutional missions.

Some (...) projects [previously approved for implementation] are prepared with international agencies (UNDP, PAHO etc.) and receive funding, but these projects are formulated in the Ministry with outcomes that are interesting to the Ministry.

'Projects' from CT 41 were not all projects for activities already programd (there were, for instance, resources for two or three courses which were already planned by Fiocruz [and expecting] foreign students, but not as a project FOR a country), they were "projects-theme", let's say. For instance: Cooperation projects for structuring networks, projects for the maintenance of Maputo's office, [a] project to support Cris cooperating activities etc. This resource was essential to speed up specific projects, because we could finance a negotiating or planning mission, without relying on AISA or BCA management timeframe.

In a nutshell, CT 41 provided Fiocruz with the financial means to explore its capabilities to the fullest, and with more autonomy, but did not interfere in the Oswaldo Cruz Foundation's decision-making or priority setting. Nor did CT 41 become a tool for Fiocruz's complete independency or self-sufficiency: the foundation still needed support from different institutions to accomplish its tasks, and closely collaborated with the MoH and Itamaraty – particularly with the Brazilian Cooperation Agency. For instance, Fiocruz's technical cooperation projects with Angola and Mozambique, although formulated by its experts, were sent to BCA, via AISA, for the former to analyze the proposals and either provide its endorsement or suggest alterations to the latter (MINISTRY OF HEALTH, 2006e).

The Oswaldo Cruz Foundation even held conversations directly with Itamaraty's Social Affairs Division, which happened with BCA awareness rather than intermediation. In 2006, Dr. Paulo Buss, then president of the Foundation, met Ms. Ana Gentil Cabral, director of Itamaraty's aforementioned division, and after discussing Fiocruz' technical

activities in African and South American countries, the Social Affairs Division received “more detailed documentation on diverse projects that are being developed in these countries” directly from Fiocruz, not from AISA or BCA (OSWALDO CRUZ FOUNDATION, 2006b, p. 01)

Fiocruz had a MoH-based strategy to act internationally and had the resources to do so. But there was another significant feature of its projects: it had an idea, called *Structuring Cooperation for Health*. Most countries benefiting from international cooperation faced the same challenge: coordinating partners, public entities and national government organs to ensure the cooperation received was efficient (BUSS & FERREIRA, 2017). Mindful of this issue, and with South-South Cooperation at the foundation of its actions; the adoption of a structuring cooperation (meant to increase capacity building for development in other countries) was the Brazilian method of choice for collaborations abroad (BUSS, 2011).

Structuring Cooperation for Health was a new model, and according to Buss (2011, p. 1723), was:

... innovative in two ways – first, by integrating development of human resources with organisational and institutional development; and second, by breaking the traditional model of passive unidirectional transfer of knowledge and technology and mobilising each country’s existing endogenous capacities and resources.

Therefore, Structuring Cooperation for Health was a concept created by Fiocruz in 2009, and is basically a scheme for empowering recipient countries, strengthening health systems and guaranteeing operational sustainability of projects in the long term. Authors Ferreira and Fonseca (2017, p. 2130) explain that the actions performed with this concept seek to “combine concrete interventions (for) building local capacities and generating knowledge, promoting dialogue between actors to enable them to assume a leading role in health sector processes and promote the autonomous formulation of development agendas”.

It had its own guiding principles which were (BUSS & FERREIRA, 2017, p. 121):

1. Change the strategy of the cooperation towards a more shared cooperation style, always bearing in mind the specific need of partner countries;

2. Develop programs with a horizontal emphasis, emphasizing these countries' health systems;
3. Highlight long-term strategies: instead of only focusing on solving immediate problems, programs should plan to constitute long-lasting structures in these countries' health systems;
4. Incorporate social determinants of health in cooperation projects;
5. Prioritize public health programs.

In summary, the idea coined by Fiocruz intended to formulate international collaboration projects in joint efforts with authorities from other countries, whilst respecting their needs and willpower. In addition, it focused on training personnel and strengthening their own health systems' institutions (OSWALDO CRUZ FOUNDATION, 2012b, p. 34). These were defined as “structuring institutions”, or, as Ferreira and Fonseca (2017, p. 2130) define them, institutions capable of:

[transforming] health systems, include ministries of health, national health institutes, and training institutions, particularly those dedicated to providing advanced training and essential inputs, as well as model facilities, such as referral hospitals and exemplary primary care centres.

Structuring Cooperation for Health was present across different elements of Fiocruz' collaboration abroad. The institution often quotes Health Institutions Networks under CPLP and UNASUR scopes, for example, as well as Mozambique's antiretroviral medicines industry planning, as classical examples of this structuring cooperation. These will be duly regarded later. However, it is worth noting Fiocruz' efforts to create Networks of Human Milk Banks under this structuring cooperation framework. Although the Foundation did not see this as a core example, we understand that since these milk banks share know-how and a sense of long-term efforts common to structuring cooperation initiatives, they also sit within the framework of this type of cooperation.

Since the 1980's, Brazil had strived to improve its maternal and infant health indicators by investing in child nutrition. Under the leadership of the Fernandes Figueira Institute (IFF), a Fiocruz associated organization, the country championed breast feeding and human milk donations by establishing milk banks, and later on, creating a national network of human milk banks with units all over its territory. This strategy was so



successful that it was awarded with the Sasakawa Health Prize in 2001, as best public health project in the world (PITTAS & DRI, 2017, p. 2282).

All the knowledge on this topic was shared with whoever wanted it: an Ibero-American Network of Human Milk Banks was established in 2007, with IFF as headquarters for its executive secretariat. Argentina, Bolivia, Spain, Paraguay, Uruguay and Venezuela, plus Brazil, were all members of this network, and used the Brazilian model to “share knowledge and technology in the breast feeding and mother and child health fields” (OSWALDO CRUZ FOUNDATION, 2009a, p. 57).

Concerning CPLP member states, Brazil tried to build a common approach to the organization regarding breast feeding. The country even proposed a “Program for the Implementation of Human Milk Banks in CPLP countries”, however, countries’ particular needs and contexts prevented the program from going forward. Brazil thus decided to change its approach and start bilateral or trilateral negotiations, and by 2011, a Network of Human Milk Banks was active in Angola, Mozambique and Cape Verde (OSWALDO CRUZ FOUNDATION, 2012, p. 53; PITTAS & DRI, 2017, p. 2283).

This project was so dear to Brazil that, as can be seen on table 10 below, practically all South American countries were in the processes of implementing them during the period of time considered for this thesis – the exception being Venezuela, which had already developed a project with Brazil on this matter in 1996 (PITTAS & DRI, 2017, p. 2284).

**Table 10.** Human Milk Banks partner countries

<b>Country</b>	<b>Year of first contact for the implementation of</b>
<b>Uruguay</b>	2003
<b>Ecuador</b>	2004
<b>Argentina</b>	2006
<b>Cuba</b>	2006
<b>Belize</b>	2007
<b>Bolivia</b>	2007
<b>Colombia</b>	2007
<b>Costa Rica</b>	2007
<b>Spain</b>	2007
<b>Honduras</b>	2007
<b>Mexico</b>	2007
<b>Nicaragua</b>	2007
<b>Panama</b>	2007
<b>Paraguay</b>	2007
<b>Dominican Republic</b>	2007
<b>Cape Verde</b>	2008
<b>Guatemala</b>	2008
<b>Haiti</b>	2009
<b>Mozambique</b>	2009
<b>Peru</b>	2009
<b>Portugal</b>	2009
<b>El Salvador</b>	2010
<b>Angola</b>	2011

Source: PITTAS & DRI, 2017, p. 2284

These undertakings on milk banks are just one example of how Fiocruz operated the Structuring Cooperation for Health idea. They have been briefly introduced to demonstrate that the idea was established with a purpose. In an email received from Dr. José Roberto Ferreira (Cris/Fiocruz technical coordinator), it was underlined that the new approach to cooperation was also important to other institutions similar to Fiocruz (such as National Health Institutes or Public Health Schools in other countries) (FERREIRA, 2017). We argue that, given Fiocruz' accumulated experience and type of cooperation goals, analogous organizations from other countries could indeed benefit from Fiocruz' knowledge sharing.

Another Cris expert, Dr. Luiz Fonseca, was questioned by the author on the importance of Structuring Cooperation for Health for Fiocruz' work and for other countries' health system. As he answered (FONSECA, 2017a):

Structuring cooperation is an approach that guides our inter-institutional relations. Activities under this structuring cooperation approach do not improve health systems *per se*. Countries are different, share different histories that organize society and their power relations in distinct ways. Structuring cooperation seeks to strengthen cornerstone stances of countries health systems, so that people living and [having this] experience can modify their own institutions and systems. Vide the national health institutes of Mozambique, Guinea Bissau and Cape Verde, and how they have been dealing with health policies in their [own] countries.

Therefore, structuring cooperation cannot be considered as a specific type of cooperation meant to change health systems. It is an approach, a way of creating cooperation that *might* lead to change in those systems as a consequence. Dr. Paulo Buss, Cris/Fiocruz director, was also questioned about the approach. For him, structuring cooperation was a concept, upon which he further elaborated in our interview (BUSS, 2017):

Structuring Cooperation for Health was, basically, to support the development of health systems, providing to the health system of the cooperating country capacity for it to develop its organizing strengths; with a structure that would be able to develop tuberculosis programs, HIV/AIDS programs, hospitals (...), neonatal care programs, infant and maternal care programs, because if you are not proposing something that is structuring, that is, all the organization being capable of developing an integral health policy, comprehensive in English, comprehensive, equitable, universal, you have a distorted system.

(...) it is meaningless to develop cooperation on projects alone; you need a cooperation based on the development of the health system, to face the epidemiological reality of the country. So, who defined the configuration of the collaboration supposed to take place was the country itself (...). The big [developed] countries define what they think has to improve in developing ones. They do not ask the country if they need it, or if they want it that way. Instead of doing cooperation in this way, we developed the so-called structuring cooperation for health.

So, the idea of a structuring cooperation was established by us to guide Fiocruz and Ministry of Health foreign policy.

I think that, you see, when Proforsa<sup>36</sup> was established, what was its intention? It was to strengthen primary health care in all its aspects. Including human resources formation (...), able to continue,

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<sup>36</sup> Triangular cooperation with Jica, operationalized by the BCA and Fiocruz for the strengthening of Angola's health system.

sustainably, a project with a start, a middle and an end. But it was, typically, a structuring project. Part, therefore, of the structuring cooperation concept. The networks, same thing. The network of institutes, (...) institutes within the structure of the Ministry worked as a quality catalyzer in the whole health system, same thing as the Public Health School, the network of schools, the network of technical schools, that did not focus on [only] one problem or disease, or one [geographical] area, but aimed for the development of a systemic structure, an organizational structure of the ministry.

This is not a program focused on one disease, a program focused on one area, but [a program] concerned with institutional development, human resources formation, strengthening of the whole health system so it can comply with all the liabilities that epidemiological demands force health systems to undertake.

Summarizing, this structuring cooperation for health is a concept, an approach that works as guidance for, as Dr. Buss puts it, *Fiocruz and the MoH foreign policies*, and aims to work with the foundations, the most essential part of health systems, with action that consequently improves their quality. All member institutions of Fiocruz embraced this approach. The Oswaldo Cruz Institute, for instance, stated it “was actively part of this policy to strengthen health systems in developing countries, *contributing to the institutionalization of the structuring cooperation for health policy*” (OSWALDO CRUZ INSTITUTE, 2013a, p. 204. Emphasis is ours). Being a biomedical facility, the Institute’s activity included creating graduation courses in tropical medicine, parasitic medicine and cellular biology with Mozambique and Argentina.

Farmaguinhos, a public medicine laboratory owned by the Brazilian government and part of Fiocruz, established its own international cooperation centre to advise its board of directors. It was also part of the structuring cooperation for health approach, since the laboratory was responsible for providing pharmaceutical technology transfer and training Mozambican technicians in the production, storage and quality control of ARV medicines that were to be produced by the Mozambican Medicines Society, an industry of antiretroviral drugs built in this African country - another result of Brazilian international cooperation (INSTITUTE OF DRUG TECHNOLOGY FARMAGUINHOS, 2014)

This Farmanguinhos centre was connected to Fiocruz’ International Technical Cooperation Chamber, an institution created in 2013 to support Fiocruz’ presidency in

international cooperation matters. Coordinated by Cris/Fiocruz, this chamber was meant to help communication efforts between different Fiocruz units and ensure that institutional policies would be properly developed and assessed. Its first meeting was held on November 2013 (OSWALDO CRUZ FOUNDATION, 2014a)

For sure, not all cooperation activities under Fiocruz' responsibility were related to structuring. Some projects answered to different demands or were required for different reasons. In 2009, Africa was facing an outbreak of meningitis, after Sanofi-Pasteur, a branch of the French laboratory Sanofi that specialized in vaccines, was unable to maintain its supplies of the vaccine. WHO, then publicly called other producers to provide meningitis vaccines to the area, and a consortium of Latin American institutions answered the call: Brazil and Cuba, with Bio-Manguinhos and Finlay Institute, respectively (THORSTEINSDÓTTIR & SAÉNZ, 2012). Bio-Manguinhos is Fiocruz' immunobiology centre, with a facility where a great number of vaccines is produced for Brazil.

Regarding the WHO's public call, over 19 million doses of meningitis vaccines were distributed via WHO, UNICEF and other institutions to Africa, at a much cheaper price than the European-produced one. According to Thorsteinsdóttir and Saénz (2012), part of the success of this consortium is Brazil and Cuba's long-lasting cooperation in health, as they continue to invest time, efforts and resources in "affordable health products that serve local health needs" (THORSTEINSDÓTTIR & SAÉNZ, 2012, p. 1547).

The project was so important that Ambassador Celso Amorim, during his interview to the author of this thesis, spontaneously remembered the cooperation (AMORIM, 2015a):

I did not mention this to you, but it is connected to an important fact, this cooperation with Cuba.

When we were there... it was not... Oh, no, it was Temporão. Alongside Temporão... it was a visit from the president. It must have been around 2008. I went [there] with the president. In this event, there was me, the Minister of Health and Minister of Education, who back then was [Fernando] Haddad. [The visit] concerned health, we went there to visit a vaccines production unit in a Cuban Laboratory (...).

I have a feeling it was a meningitis vaccine<sup>37</sup> (...). There is a vaccine that Brazil and Cuba, jointly, were distributing to Africa

Nonetheless, not everything about the collaboration was positive. Anvisa did not agree to register the vaccine's active ingredient, as it was based on a chemical element that, according to Anvisa, produced a vaccine only suitable to teenagers over the age of 18. Additionally, and as a consequence of this issue, Bio-Manguinhos' exportation practices and payments made / received to / from Cuba were questioned by the Ministry of Transparency, Supervision and Control, an institution that analyzes public money expenditures and requires further information of authorities when expenditures are deemed incorrect. The Ministry of Transparency assessment indicated that Fiocruz did not collect money properly and disrespected national legislation together with Finlay (MINISTRY OF TRANSPARENCY, SUPERVISION AND CONTROL, 2014).

Another issue is the lack of social participation in Fiocruz' decision-making boards. To mention a case raised in a Brazilian newspaper by Mr. Pedro Villardi, one of Brazil's Interdisciplinary AIDS Association (ABIA) experts in intellectual property, Farmanguinhos created a consulting board with NGOs, but it never really played an important role. The board does not meet and information is hard to grasp, making civil society an actor with no influence in Farmanguinhos affairs, both nationally and internationally (MARINI, 2012).

To gather more information on the issue, an interview was conducted with Mr. Veriano Terto Jr., ABIA's vice president, in which he emphasized Farmanguinhos attempt to build a different relationship with civil society organizations. The idea was to create a consulting board, but this initiative did not last long due to changes in the board of directors of this institution (TERTO JR., 2018). Unfortunately, Farmanguinho's Reports on Social Affairs from 2009 to 2012 do not mention anything regarding consulting boards. They do mention a deliberative board, with the director and vice-director of the institution as heads along with 15 other employees as members, who would be responsible for giving a more democratic approach to the organization's decisions. But nothing is said on effective NGO or any other civil society organizations' participation or input to the institution's future projects (INSTITUTE OF DRUG TECHNOLOGY

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<sup>37</sup> During our interview, Ambassador Amorim was not sure if the vaccines was to immunize against meningitis or hepatitis.

FARMANGUINHOS, 2010; INSTITUTE OF DRUG TECHNOLOGY  
FARMANGUINHOS, 2011; INSTITUTE OF DRUG TECHNOLOGY  
FARMANGUINHOS, 2012; INSTITUTE OF DRUG TECHNOLOGY  
FARMANGUINHOS, 2013).

Despite being the most important institution to Brazilian international technical cooperation in health, Fiocruz' Quadrennial Plan for the 2011-2014 period can be described as quite modest. The document explains the institution's goals for the period, which remained largely unchanged from previous years' Quadrennial Plans. Moreover, the main action areas are still CPLP and UNASUR. Perhaps a change of tone can be noticed: instead of affirming its interest in consolidating Brazil's role in the international arena, this time Fiocruz uses the phrase "to consolidate Fiocruz as a State Institution in the Health Diplomacy and South-South Cooperation fields" (OSWALDO CRUZ FOUNDATION, 2011, p. 51). It is an ambitious approach but given the myriad of actions developed by this institution, it cannot be considered inappropriate.

Nonetheless, since the goals did not change, and a sense of continuity can be noticed, the analysis of this document alone cannot confirm whether that Fiocruz was claiming more space or recognition in the domestic arena. It does claim to be the most important actor in Brazilian Cooperation in Health Affairs, but we cannot say there was a great shift in the behaviour of this institution from the wording presented in its official documentation.

Fiocruz' importance to Brazilian international insertion in the area of health is nonetheless indisputable: it was a constant presence in the theoretical formulation of BFP: it formulated projects, established partnerships, implemented programs and shared know-how. The Foundation had goals, intentions, aims and strategies for reaching its objectives, features that are important in the analysis of the establishment of a Health Foreign Policy. Most importantly, Fiocruz coined a concept of its own, structuring cooperation for health, and used this idea to strengthen public health institutes all over Africa and South America.

In the next chapter we will continue to address Fiocruz participation in BFP, but this time we will emphasize a practical case: the ARV medicines factory in Mozambique.

## 5.6 The Antiretroviral Medicines Factory in Mozambique

During Lula's two terms of administration, Africa was considered a "privileged partner on [the Brazilian] foreign policy agenda", and, "in the words of the president himself, the boost in relations with Africa constitutes a historic duty and a strategic requirement [that] guide the Brazilian government" (MINISTRY OF FOREIGN AFFAIRS, 2003g, p. 02). African Portuguese-speaking countries were Brazil's priority, and among them, Mozambique was "the most important receiver of Brazil's technical assistance projects" (DE BRUYN, 2014, p. 17).

Agriculture, education and health were the areas receiving the most funding, and Mozambique was, by far, the country receiving the highest level of investments: for the 2011 to 2013 period, R\$ 19,744 million were spent by the Brazilian Federal government in this African country, more than double what was received by Sao Tomé and Príncipe, which was granted R\$7,674 million and ranked second for investments received (INSTITUTE FOR APPLIED ECONOMIC RESEARCH, 2016).

Health technical cooperation was diverse, and the main partner to Mozambique's Ministry of Health (MISAU) in Brazil for the development of such projects was Fiocruz. Collaboration in human resources for health training, high-level education schemes and health surveillance improvement were all in the portfolio of activities implemented by this Brazilian institution (ABDENUR, FOSENCA, *et al.*, 2014).

No wonder, therefore, that the Antiretroviral Medicines Factory in Matola, a city close to Mozambique's capital Maputo, became a symbol of Brazilian South-South Cooperation. Shortly after Luiz Inácio Lula da Silva's inauguration, in May 2003, the then Minister of Foreign Affairs, Ambassador Celso Amorim, paid an official visit to the country and signed a Memorandum of Understanding with Mozambique on HIV / AIDS cooperation, demonstrating Brazil's interest in developing programs other than the Ntwanano Project (MINISTRY OF FOREIGN AFFAIRS, 2003h).

The HIV / AIDS epidemic was a public health struggle for Mozambique, and Brazil had the experience and the technical know-how to assist Maputo (MINISTRY OF HEALTH, 2011a). Mr. Amorim understood how central, as well how hard, this project



would be for Brazilian diplomacy. To the author of this thesis, he claimed that (AMORIM, 2015a):

Lula's government gave more importance, really emphasized the importance of technical cooperation with poorer countries. And, in this technical cooperation, one of the things that always stood out was health.

Maybe, one of the most important and most celebrated projects, although up to today it has problems perhaps in its final execution, but anyway it is very important, is the idea of an antiretroviral medicines factory in Mozambique. On my first visit to Mozambique as Minister, I think it was in April, May 2003<sup>38</sup>, I noticed the project. I said "Ah, we will do it!". But one thing was me saying it. Another was when Lula went there, in December of the same year, and he committed to carrying it out. [This project] took a long time to develop, and still has some problems, including economy of scale [issues], because it was... it is an economic undertaking, but it shows our interest.

This factory was a Mozambican vindication; the country's authorities explicitly required its establishment (AMORIM, 2013). President Lula, on his first visit to the country, launched the idea of an ARV factory built with Brazilian assistance (MINISTRY OF HEALTH, 2011a). In June 2003, the country formally expressed its interest in creating the ARV factory on its territory with Brazilian technical assistance. In an official document from Itamaraty, we find a transcription of a letter sent from Dr. Avertino Barreto, the then National director of Mozambique's HIV / AIDS Program, to the Brazilian Ambassador in Maputo, Mr. Pedro Luiz Carneiro de Mendonça. The letter's content is partially reproduced in the following lines (MINISTRY OF FOREIGN AFFAIRS, 2003i, p. 02):

The Ministry of Health of Mozambique understands that South-South Cooperation is important and strengthens cooperation politics between both countries. In this sense, all transfer of technology to our country is welcome, but, in this particular moment, as we are facing the severe problems caused by the expansion of AIDS pandemics in our country, we understand that an initial assessment for the development of a program for local production of medicines for to combat HIV in this country is fundamental.

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<sup>38</sup> Ambassador Amorim paid an official visit to Mozambique in April 2003 (MINISTRY OF FOREIGN AFFAIRS, 2003i).

Under the conditions mentioned above, we express Mozambican interest in further developing cooperation bonds and, at the same time, we await a visit of a Brazilian mission in Mozambique to concretely initiate the definition of protocols and next steps to be taken in this process.

However, even before these assessment missions took place, Brazil was well aware of Mozambican problems with local infrastructure and institutions. Political problems in the 1990's had left a sense of frailty in the country (AMORIM, 2013). Moreover, in January 2003, when Mozambique was still analysing cooperation terms with Brazil on HIV/ AIDS assistance (that did not concern the factory), Brazil worried that these terms should have been signed in 2002, and that Mozambique “could not compromise and commit to the continuity of the project after the pilot phase was over” (MINISTRY OF FOREIGN AFFAIRS, 2003j, p. 01). In February, the Brazilian Ambassador to the country, Mr. Pedro Luiz de Mendonça, told Brasilia that (MINISTRY OF FOREIGN AFFAIRS, 2003k, p. 01):

The National Director of Health, Dr. Avertino Barreto, in a conversation with an employee of mine in a recent social gathering, mentioned, in not very appreciating terms, our cooperation in the HIV/AIDS area. He mentioned that he received around 70 million dollars from Bill Gates for seropositive people treatment, [money] he does not know how to use for lack of trained human resources in the country. He (...) clearly signalled that the Brazilian offer, in current terms, is far too modest in the face of the humanitarian crisis the country lives with due to the HIV/AIDS pandemic.

Thus, Brazilian authorities had always been aware of Mozambican fragilities and demands. Regardless of this awareness, it was decided in July 2003 that two technicians from Farmanguinhos were to be sent to Maputo to pick up information and prepare the factory project, and that consequently the Embassy should make arrangements for meetings with local authorities (MINISTRY OF FOREIGN AFFAIRS, 2003l). The idea of having a medicines industry on their territory pleased Mozambican authorities, and Brazil's willingness to transfer technology for medicines production was likewise well accepted. Mozambique understood that Brazil's enhanced South-South Cooperation would mean an improved bilateral cooperation as a whole (MINISTRY OF FOREIGN AFFAIRS, 2003m).

Former Minister of Health Dr. José Temporão also saw this initiative as an opportunity, but in a broader approach. For Dr. Temporão, this collaboration was an antonym to old-fashioned cooperation strategies, very much aligning his vision to Fiocruz's structuring cooperation for health guidance. According to him (TEMPORÃO, 2016):

The idea behind [the factory] was really a project of transfer of technology, in which Mozambique would have the know-how to produce medicines there, in its own country, and eventually develop a platform to other African countries. It was a very innovative and bold initiative, but also very complex from an operational perspective, bearing in mind the economic, conjunctural and organizational conditions of Mozambique, a poor country...

In Mozambique, 80% of the country's budget comes from donations... from international organizations' contributions. Only 20% of the country's budget are a result of its economic activity, so this is complicated. Why? Because each donor earmarks its donations to a certain project. So, you completely lose the broader vision. The Brazilian initiative is exactly a counterpoint to this process, right? It tries to see how to organize the national health institute, how to organize the national public health school, so that it can sustain itself and can walk with its own legs afterwards.

Brazil sees itself not as a donor, but as a partner in the development of international cooperation (DE BRUYN, 2014). Dr. Temporão words corroborate this vision.

In October 2003, Brazilian research and Farmanguinho's Mission resulted in a Protocol of Intentions that should be submitted for Mozambican authorities' scrutiny. Interestingly, SERE told the Embassy that the text of this protocol was, "*according to information from the Ministry of Health*", an outcome of the aforementioned mission. From this we can infer that the MoFA had little influence in the making of such an agreement in what concerns its content (MINISTRY OF FOREIGN AFFAIRS, 2003n, p. 01).

The MoH also instructed the MoFA on follow-up steps, as Itamaraty explains to its representative in Maputo: "still, according to explanations from the Ministry of Health, this protocol should be opportunistically followed by signature of a transfer of technology

contract, to be elaborated in common agreement by representatives of both countries” (MINISTRY OF FOREIGN AFFAIRS, 2003n, p. 01).

Therefore, we agree with De Bruyn’s analysis (2014, p. 17), in which he affirms that Itamaraty “formulates and designs the general policy, while the [BCA] coordinates the technical assistance programs, (...) the Ministry of Health designs the health cooperation policies, and the Oswaldo Cruz Foundation is the main implementing agency”. These telegrams from the early stages of factory negotiation are all also distributed to the BCA, and they demonstrate that the content of such negotiations is very much headed by the MoH.

All this is significant because it demonstrates the MoH’s leadership in the process. A week before Telegram 00416<sup>39</sup>, which contained MoH explanations and instructions, was sent to the Embassy, the MoH sent a telegram to Brasilia requesting further information on where the ARV factory project stood<sup>40</sup>, since the Ambassador was often questioned about it “by Mozambican authorities, foreign Ambassadors or local NGOs”, but could not provide any material to them (MINISTRY OF FOREIGN AFFAIRS, 2003o, p. 01). Mr. Pedro Luiz de Mendonça, Ambassador to Maputo’s Mission, stressed that (MINISTRY OF FOREIGN AFFAIRS, 2003o, p. 01):

I would much appreciate being updated on this matter. I remind you that the last event on record was a visit of the Ministry of Health’s technical mission, last July (...). This mission (...) should present a report to the Ministry of Health, in Brasilia, on 29th of July. I did not listen to any news on this issue, nor did I know the destination of the document "Proposal of Activities to be developed by each country", signed in Maputo.

Later that year, in November, President Lula paid a visit to Maputo to deepen talks on the matter, and with him as part of the official entourage, were the Minister of Health at that time, Dr. Humberto Costa, and AISA advisors (MINISTRY OF FOREIGN AFFAIRS, 2003p).

Nonetheless, despite all this initial arousal of emotions and activities, the actual project of the factory took a long time to get started. Postponement was so intense that

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<sup>39</sup> Telegram 00416 is here identified as Ministry of Foreign Affairs, 2003n.

<sup>40</sup> Telegram 00416 was sent on 29<sup>th</sup> October 2003, a week after Telegram 00692 was sent from Maputo to Brasilia on 22<sup>nd</sup> October 2003. This Telegram is attached to this study as Annex 02.

the Ambassador of Brazil in Maputo, now Ms. Leda Lucia Camargo, sent a telegram to Itamaraty asking for MoFA to take action and instigate the MoH so that negotiations could move, and faster. In this document the Ambassador explains, with a very personal tone, that (MINISTRY OF FOREIGN AFFAIRS, 2007b, p. 01. Emphasis is ours):

Only in July 2005, after considerable efforts from different areas of Itamaraty, I jointly signed with local Ministers of Health and Foreign Affairs the Memorandum of Understanding for the Analysis of Feasibility of an antiretroviral medicines factory, as promised by President Lula in his trip to Maputo in 2003. Although the memorandum fixed nine months for the end of this analysis, over a year and a half have passed and (...) I have just been informed that revision from the MoH is still awaited (...).

Bearing in mind the necessity of keeping [Brazil's] world in a topic of utter importance to this country, I would be thankful to be informed if high level meetings can be held *sadly, once more*, with that Ministry so that the process can be unblocked (...).

Our research indicates that two hindrances prevented this project having a major breakthrough earlier on: Brazil's lack of clear international cooperation legislation; and delays to the assessments and research carried out by Brazilian technical institutes to analyze the feasibility of the factory.

Regarding the legislation issue, there is no general law, ministerial order or robust legislation regarding international cooperation in Brazil. As a consequence, projects' development and actors' relationships need to be regulated case by case, without any general guidance. In the interview given to the author of this thesis, Dr. Paulo Buss (2017) highlighted that this fact indeed poses a problem, because it generates insecurity among the parts. It might be hard to precisely define what an international donation is, for instance.

In an institutional publication, AISA also signalled the lack of legal framework as an issue. In the Editorial of *Cooperação Saúde*, it claimed that (MINISTRY OF HEALTH, 2010b, p. 02)

An update in the legal framework is required, to accelerate the implementation of activities. The necessity of such an update has been demonstrated on several occasions, concerning [everything] from cooperation procedures to the donation of the Antiretroviral medicines

factory to Mozambique, decided by [the National] Congress in December 2009.

AISA used the factory to demonstrate how the lack of robust legislation can impact significant projects, such as Brazil's most important project with Mozambique. And we argue that legislation in this sense would be noteworthy because each institution would be able to begin with definitions of their individual responsibilities. That would make accountability checks easier to members of civil society or even to these institutions' peers.

Delays in bureaucratic procedures, local situation assessments and technical studies also took their toll. The technical and economic feasibility study for the establishment of the factory, for instance, was carried out with UNDP funding; thus, the accountability of the use of resources had to be audited, checked by the MoH and the BCA, and then checked by the UN agency. Therefore, the overall process was both long and slow (MINISTRY OF HEALTH, 2007a).

Sometimes, audit reports did not approve what was submitted for checks. In the technical and economic feasibility study case, the MoH General Coordinator for Logistical Resources deemed that the documentation submitted for analysis did not follow recommendations from the Guide for National Implementation of Technical Cooperation Projects with Developing Countries, so all institutions implicated in the project were notified to adjust to what was necessary to obtain approval (MINISTRY OF HEALTH, 2007b)

In 2006, there was still no agreement on which work proposal would be implemented. Fiocruz was in a technical mission in Maputo, and two options were put to the table: a partnership with *Final Farmacêutica*, using part of the industry's facilities, equipment and personnel; or the construction of a whole new laboratory, with first-hand equipment and freshly trained personnel. This also meant that MISAU would have to find a proper place to build the facility. Moreover, as Mozambique was a major recipient of international donations, an additional problem had to be discussed (MINISTRY OF FOREIGN AFFAIRS, 2006b, p. 02):

Considering that the majority of medicines purchase in Mozambique, is done with resources made available by donor countries, it was discussed with MISAU the urgent need to contact-these

agencies, for the establishment of procedures for their substitution with local production. Currently, seven European countries (Ireland, Netherlands, Belgium, Finland, Switzerland, Denmark and Norway) directly contribute to the medicines purchase fund; [therefore] a joint contract with the representatives of [these countries'] cooperation agencies must take place to verify there is no impediment for these resources to be used for the acquisition of products to be used in the future factory.

The factory needed resources for its establishment, only then could it become operational. Brazil wondered if funding from developed countries could alter their conditions in order to support Mozambique's future laboratory facilities.

Finally, the document suggests how intense the Brazilian Cooperation Agency workload was in this diplomatic post: in 2005, *BCA authorized a local employee to be hired by the Embassy*, assigned to be a technical assistant and support activities developed by Brazilian missions in the country. The Ambassador in Maputo, Ms Leda Lucia Camargo, praised this assistant's presence and dedication (MINISTRY OF FOREIGN AFFAIRS, 2006b).

So, it was not only Fiocruz, given its great workload, that needed operational support in Maputo. Although it was not a fully independent office, BCA also had to look for managerial support to better cope with demand.

The further demand increased, the closer Mozambique became with Fiocruz. MISAU and Fiocruz developed direct relationships, even though they were not analogous institutions. The organizations' association confirms what Kickbusch, Silberschmidt and Buss (2007) had introduced in theory: health negotiations implicate many actors on many different levels. Although Fiocruz as an entity is part of the Brazilian MoH, its close work with MISAU supervised by the MoH and Itamaraty demonstrate that relationships were not only horizontal; they happened in a multidimensional Cartesian plan.

Connections were so intense that in an official visit to Brazil in August 2007 the Mozambican Minister of Health, Dr. Paulo Ivo Garrido, did not go to Brasilia. Instead, he visited Fiocruz facilities in Rio de Janeiro, where, at the National Public Health School, he manifested the country's interest in having a partnership for human resources for health training (MINISTRY OF FOREIGN AFFAIRS, 2007c; NATIONAL PUBLIC HEALTH SCHOOL, 2008).

Later that same year, the Brazilian Embassy in Maputo was informed that Mr. Ivo Garrido intended to visit Fiocruz once again on January 17<sup>th</sup> and 18<sup>th</sup> to meet the president of Fiocruz *himself*, in order to bring negotiations to a close and open a Fiocruz office soon thereafter, in March 2008. The Brazilian Embassy was informed during an end-of-the-year reception offered by President Armando Guebuza, demonstrating a disconnection between MoFA and negotiations held between MISAU and Fiocruz (MINISTRY OF FOREIGN AFFAIRS, 2007d).

Actors' intentions and purposes were never disguised in such negotiations. Brazil never concealed how important this ARV factory in Maputo was to its foreign policy (MINISTRY OF FOREIGN AFFAIRS, 2007e). And Mozambique never hid its intentions of building a close relationship with the private sector regarding this laboratory matter. During another feasibility study of a Brazilian mission in 2006 (consisting of Fiocruz and Mr. Orlando Melembe, a local BCA employee), MISAU emphasized the importance of keeping apart "desires from reality", because similar feasibility studies were made in the past and none had been implemented. The Minister of Health, Mr. Paulo Ivo Garrido, highlighted that "whichever institutional model is adopted for the project, *it must privilege both the public and private sectors*". (MINISTRY OF FOREIGN AFFAIRS, 2006c, p. 02. Emphasis is ours) Moreover, it was suggested that triangulation with France or Germany should be considered for funding (MINISTRY OF FOREIGN AFFAIRS, 2006c).

In 2008, another Fiocruz / Farmanguinhos mission took place in Maputo, and official documentation indicates that *Final Farmacêutica* facilities in Matola, were then deemed suitable for future installations of the factory. However, this African nation still needed to decide which model of company would manage such factory (MINISTRY OF FOREIGN AFFAIRS, 2008b). *Final Farmacêutica* was already a pharmaceutical laboratory producing serum, and Brazilian experts had recommended the use of its facilities by MISAU. Maputo had also decided at the time that "the Mozambican state [would] have the majority of shares of the new company, which [would be] established to absorb the [medicines] production and the technology to be transferred by Farmanguinhos" (MINISTRY OF FOREIGN AFFAIRS, 2008c, p. 01).

Besides deciding to use *Final Farmacêutica's* infrastructure for the project, another important decision was made that same year: Mozambique decided to resort to



Brazil and appeal for Brazilian financial aid for the establishment of the industry. The Mozambican Vice-Minister of Foreign Affairs and Cooperation, Amb. Eduardo Koloma, sent a letter to the Brazilian Embassy in Mozambique saying that although he was fully aware of the importance and impact of such an enterprise, the country could not build the factory on its own. Consequently, it would have to resort to aid from international partners. Thereby, Mozambique asked Brazil to fund the construction of the factory, as well as “technical and material assistance for its initial operative phase” (MINISTRY OF FOREIGN AFFAIRS, 2008d, p. 01).

In 2009, Brazil approved a law “authorizing the donation of R\$13,600 million to this African country”; and this amount was due to be invested in the refurbishment of “the physical space of the factory and purchase of equipment and inputs for the production of (...) medicines” (MINISTRY OF HEALTH, 2010b, p. 06). This Brazilian donation authorized by National Congress was under Fiocruz’ responsibility (MINISTRY OF FOREIGN AFFAIRS, 2010e).

At a glimpse, all seems well at this point. The Feasibility Study was finished, Mozambique had made the necessary decisions on the matter, and resources had been made available by Brazil. Unfortunately, things were still turbulent. Mozambique complained that Fiocruz’ delays in handling the project’s specifications were preventing the country from calling for bids in public tenders for the construction of the factory (MINISTRY OF FOREIGN AFFAIRS, 2010e).

Additionally, Brazil was deeply concerned with Mozambique’s managerial approach to the project. The Mozambican Society of Medicines (MSM), the official name given to the ARV factory in Matola, was not part of MISAU’s structure. It was connected to the Institute for Management of State Participation (IGEPE), a state department linked to the Ministry of Finances. In early 2010 the first stage of the project, the planning stage, was complete. However, Brazil, realizing that the project’s scenario had changed because Mozambique had introduced a new management model, thought that perhaps new arrangements should be made (MINISTRY OF FOREIGN AFFAIRS, 2010g).

In the report of a Farmanguinhos mission to Maputo, the Brazilian Embassy informed that (MINISTRY OF FOREIGN AFFAIRS, 2010g, p. 03 - 04).

Among our main concerns is the fact that the supervision of the future factory was given to IGEPE (...), the department under the Ministry of Finance responsible for the management of public companies. Apparently, IGEPE's order is to clean up and eventually privatize state-owned companies. In this sense, the establishment of a state-owned company, (...) does not follow the logic of that institution. Problems have already arisen, such as: IGEPE has been vague with regards to the admission of a factory director and has given wrong information regarding the paycheck of technicians trained in Brazil.

On the one hand, at the time MISAU was not legally obliged to manage the factory, but on the other, handing supervision to IGEPE took away MISAU's ties to the industry (...) as well as its departments' motivation for the project. IGEPE is not subordinated to MISAU and does not communicate eventual problems or doubts concerning the factory management to it. At the same time, it expects MISAU to [provide] financial support to a great deal of costs and investments.

Still under IGEPE's logic, MSM must maintain itself, without [official] budget support. Thus, there are no investments forecast for refitting the current MSM (serum factory) into an antiretroviral [medicines] producing plant.

The long document continues with a description of the latest events in Mozambique, depicting MISAU's Minister Garrido as very committed to making everything work and overseeing MSM management. However, the telegram also highlights that "it was worrisome that all the tasks under Mozambican responsibility, even operational ones, to which departmental personnel are designated, are only performed if there is personal intervention from Garrido" (MINISTRY OF FOREIGN AFFAIRS, 2010g, p. 05).

Such concerns were explained to Mr Garrido, whose response emphasized that "the project has no precedent and the government has no experience in the management of a public company that produces medicines" (MINISTRY OF FOREIGN AFFAIRS, 2010g, p. 05). This led Ambassador Antonio Souza e Silva to suggest that the Brazilian government should advise MISAU and IGEPE to improve factory management by "trying to create a more efficient and agile *modus operandi* between the two institutions

– [which would be] key to the factory’s success” (MINISTRY OF FOREIGN AFFAIRS, 2010g, p. 05).

In mid-2010, following instructions from both Ministers Amorim and Temporão, Ambassador Eduardo Barbosa, the then director of AISA, was put in charge of a MoH assessment mission in Maputo in order to analyze which stage of development this international cooperation project was at. Joining him in the official entourage were specialists from Fiocruz, Farmanguinhos and AISA. During this visit he emphasized, in a meeting with Minister Garrido, that Lula wanted to inaugurate the first operational phase of the factory *personally* by November, during his official visit (MINISTRY OF FOREIGN AFFAIRS, 2010h).

At the time, the Memorandum of Understanding previously signed by both countries had expired, so Ambassador Barbosa had the additional task of negotiating the terms of a Complementary Adjustment to this memorandum. To this new agreement another Brazilian institution would be added: BCA, so that new technical cooperation projects could be done under this ARV factory idea.

This MoH mission also vocalized its apprehension with MSM management and the lack of communication between those involved. In a meeting at the Embassy together with IGEPE's manager, Mr. Santos Gonzaga Juque, and the project’s head at MISAU, Mrs Tania Siteo, Brazilian Ambassador Souza e Silva introduced the idea that MSM should emphasize public health, meaning the criteria applied to other commercial projects should not be used for this specific cooperation project (MINISTRY OF FOREIGN AFFAIRS, 2010h, p. 04). However, Mr. Garrido, the Minister of Health, was unaware of offers being made for the public tender regarding the reform of the serum factory, which made it clear that there were coordination issues between the two ministries as well as the Mozambican institutions involved.

IGEPE introduced Mr. Barbosa to its plans for a management hierarchy, a structure in which the technical director of the factory would be subject to a general director, who would in turn be subordinated to a management board. This board would be comprised of two representatives from MISAU and one from IGEPE, an arrangement that Brazilian representatives’ thought would not be nimble enough for decision making processes. Barbosa also observed that MSM sectorial supervision would be made by

MISAU, however that shareholders' supervision would be observed by IGEPE, creating "an ambiguity in the leadership of the project, confirmed during the time of the mission" (MINISTRY OF FOREIGN AFFAIRS, 2010h, p. 07).

There were additional problems. Barbosa observed that the MSM plant was divided into two parts, half dedicated to the production of serum and the other half, the one dedicated to the future ARV factory, had been used as a serum storage unit for the last seven months. The reason for this division was MISAU's suspension of domestically-produced serum purchases for those seven months, as the Ministry started buying the Chinese product, cheaper than the locally produced one. For MISAU, MSM is a private company - even though it is directly linked to IGEPE -, so MSM must offer public tender bids as does any other company that wants to sell their goods to the Mozambican government (MINISTRY OF FOREIGN AFFAIRS, 2010h, p. 07).

During his mission, Ambassador Barbosa was also informed that the MSM had (MINISTRY OF FOREIGN AFFAIRS, 2010h, p. 06 - 07):

28 employees, many of them functionally illiterate, a fact prohibited by international certification rules for obvious reasons, but whose existence constituted an obvious bottleneck that could not be ignored. According to Famanguinho's assessment, only 7 employees could be used in the new structure.

Domestically, troubles arose. Internationally, Mozambique had to convince developed countries, long-term providers of financial aid, that an ARV factory on its territory was a good idea. In a conversation with Ambassador Barbosa, the IGEPE's manager, Mr. Santos Gonzaga Juque (MINISTRY OF FOREIGN AFFAIRS, 2010h, p. 05 - 06):

(...) mentioned, multiple times, the constant pressure his government was under by western donors and some international organisms, [some] contributors of up to 60% of the public budget, who wanted the Mozambican State to be excluded from any production activity. I suggested thus that the Government should consider establishing, within its legal framework, a national plan for strategic medicines.

Mozambique approved Barbosa's suggestion, but we wonder whether a domestic legal framework would effectively prevent traditional donors from pressuring developing

countries and hindering their industrial efforts. How a strategic plan would work in this sense is unclear.

So much of this important document was heavily quoted that we can safely say *Itamaraty and the MoH (including AISA and Fiocruz) were aware of MSM's problems*. We agree that not all issues can be predicted in such an innovative project, but this ARV factory's obstacles were more than evident to the Brazilian government since its early developments.

Regardless of this awareness and in spite of all delays, President Luiz Inácio Lula da Silva officially visited Mozambique on November 10<sup>th</sup>, 2010, using this trip to inspect the MSM facilities. The original idea was for him to inaugurate the factory, but unfortunately this did not occur as the industrial unit was not ready to be launched (MINISTRY OF FOREIGN AFFAIRS, 2010i).

We argue that a key event took place during President Lula's: *a Brazilian private company, Vale, signed a Memorandum of Understanding with IGEPE*. In this agreement, Vale arranged to co-fund refurbishment works in the factory plant so that it would be fit for medicines production. The document was signed between Vale Mozambique's director-president, Mr. Galib Chaim, and the President of the IGEPE's Managing Board, Mr. Hipólito Hamela, with Brazilian Ambassador Mr. Antonio de Souza e Silva serving as witness (MINISTRY OF FOREIGN AFFAIRS, 2010i).

MSM was in a problematic situation and the project was not moving forward. So, President Lula took the lead and solved it by personally requesting Vale's financial support to ensure the construction of the plant. Moreover, this visit to Mozambique, which took place during the last month of his to-soon-end second term, was meant to "speed up the understandings" (MILANI & LOPES, 2014). Vale donated US\$ 4,5 directly to the project (RUSSO, OLIVEIRA, et al., 2014).

This Brazilian mining company was already doing business on Mozambican territory when the Memorandum was signed. The amount donated by Vale represented 75% of MSM refurbishment costs, and it was only after Vale's engagement with South-South Cooperation project that it really moved forward (MILANI & LOPES, 2014).

Vale's commitment was crucial to solving a deadlock in the project, but this private company did not only offer funding for the refitting of MSM plant: Vale hired "Mrs. Roberto Camilo, who was part of the Farmanguinhos mission", as an international advisor for worldwide funding<sup>41</sup>. He was appointed as technical director of the factory, commissioned by a short-term contract with Vale (MINISTRY OF FOREIGN AFFAIRS, 2010i, p. 03).

Neither the MoH nor Itamaraty opposed Vale's assertive presence in this South-South Cooperation project. Both Ministries were consulted prior to the signature of this memorandum, and neither objected. Itamaraty even stated that there were no restrictions to this collaboration, since without it the required adaptation of the factory infrastructure for the production line of medicines would not be possible. Also, MoFA did not identify any reason for a new trilateral agreement between Brazil, Mozambique, and Vale to be signed because the company could "offer its support directly to the Mozambican part", who was having issues fundraising for the project (MINISTRY OF FOREIGN AFFAIRS, 2010j, p. 01).

The MoFA in Brasilia even sent the Brazilian Embassy in Maputo instructions for a representative to speak to "Vale in Mozambique and inquire further details about the cooperation the company intends to offer in terms of resources, deadlines and warranties [necessary] to the continuation of [Vale's] commitment" (MINISTRY OF FOREIGN AFFAIRS, 2010j, p. 01).

Problems at MSM were mounting: there were not enough resources for the completing the restructure; MISAU and IGEPE had organizational and communication issues in their joint work; and there were also technical issues preventing the project from advancing. The ARV factory required constant support and incentives from Brazil, so much so that Ambassador Antonio de Souza e Silva praised Amb. Eduardo Barbosa's official visit to Mozambique; according to him, this AISA mission encouraged

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<sup>41</sup> Despite offering funding, exchange rates changes were an issue in Mozambique and imposed challenges to the maintenance of MSM, so Vale hired Mr. Camilo to continue the search for international partners who could further fund the project.

Mozambique to resume the decision-making process on its MSM-related agenda. (MINISTRY OF FOREIGN AFFAIRS, 2010k).

The Embassy provided all the assistance it could and attempted to interact as much as possible with Farmanguinhos', IGEPE's and MISAU's teams, even though technical features of the project gradually revealed increasing complexities as the project unfolded. The Ambassador therefore suggested "the permanency of a Brazilian technical team in Maputo, to follow up and offer guidance in this critical phase where operations are beginning" (MINISTRY OF FOREIGN AFFAIRS, 2010k, p. 03).

According to Russo, Oliveira, et al. (2014, p. 06), "besides the occasional Brazilian technical assistance necessary for training and setting up the operation" - and by occasional we imply they allude to technical missions coming back and forth to Maputo - "two key full time Farmanguinhos consultants [had] been appointed for the next two years with the objective of steering the factory towards sustainable production and WHO Quality Certification" (RUSSO, OLIVEIRA, et al., 2014, p. 06). The two Farmanguinho consultants and the Fiocruz office in Maputo, which was opened after the issue of the Ambassador's telegram, were therefore a fundamental support to Mozambique.

In November 2012, with Vale's support and Fiocruz' overseeing, the first locally-produced antiretroviral, Nevirapine 200mg, was delivered to the Mozambican Ministry of Health (OSWALDO CRUZ FOUNDATION, 2013b; MILANI & LOPES, 2014). However, by this time, Brazilian Foreign Policy had a new leader, Ms. Dilma Rousseff. President Rousseff's foreign policy ideas and instructions were remarkably different from her predecessor, with some saying that she did not emphasize personal abilities and simply allowed "strategies from the previous phase" to slowly continue (CERVO & LESSA, 2014, p. 134; VIEIRA DE JESUS, 2014).

President Dilma did visit Mozambique officially, but to discuss investment strategies with local investors, stressing mineral coal extraction by Vale, investments in energy, port and airport infrastructure, oil, paper and cellulose, and investments from the Brazilian Development Bank; and all this almost a year before the factory was ready to produce medicines (CERVO & LESSA, 2014; GÓMEZ & PEREZ, 2016).

The Brazilian government wanted to use Dilma's presence in Mozambique at the IX Conference of Chiefs of State and Government of CPLP to officially inaugurate MSM. However, not only did the local government not want to inaugurate the factory (because medicines were not actually being produced yet), but Dilma's plans were changed, and she did not go to Maputo. Instead, she was represented by Vice-president Michel Temer and the Minister of Foreign Affairs Patriota (MINISTRY OF FOREIGN AFFAIRS, 2012a; MILANI & LOPES, 2014, GÓMEZ & PEREZ, 2016).

MISAU authorities were not pleased with this formality as no official representative from the Ministry was appointed to be present at the inauguration. In their view, "if this ceremony was officially denominated an 'inauguration', (...) [then] they would have to [distribute] antiretroviral medicines to the population [the following month]" (MILANI & LOPES, 2014, p. 73)

Despite these conflicts, the technical part of cooperation continued, and the relationship between MSM and Fiocruz followed suit. In 2012, three representatives of the factory came to Rio de Janeiro in order to attend a medicines quality course. This training counted on resources from the Brazilian Cooperation Agency, and modules were organized by Farmanguinhos (OSWALDO CRUZ FOUNDATION, 2012c).

During 2014, technical and institutional support was not suspended: Fiocruz continued supporting MSM development by training their staff (OSWALDO CRUZ FOUNDATION, 2015). According to the Foundation, this was a continuous process, and multiple teams of MSM employees continued to be trained by this institution, with courses offered every year (OSWALDO CRUZ FOUNDATION, 2014b). Additionally, according to the MoH's own predictions, all technology transfer strategies were due to be complete by 2014 (MINISTRY OF HEALTH, 2011a).

One cannot say that the project stopped under Dilma Rousseff's government, nor that it had lost Brazilian support. Nonetheless, as mentioned before, without president Lula's willingness to make this cooperation work, and with Rousseff's approach to foreign policy (with a more staggered decision-making style), the ARV factory lost most of its drive. Because of its technical character, the relationship between MISAU and Fiocruz was not suspended, but clearly political will was no longer the same.



A reflection on the important features of this cooperation project must be made: first of all, *the strength of the MoH in this cooperation project*; and secondly, Brazilian lack of awareness on how Mozambican problems and political dynamics could impact the implementation of such a large cooperation project.

The Ministry of Health was fundamental to this process. Estimations indicate that “the factory’s overall setup costs [were around] USD 34.6 million, excluding the technical assistance by Brazilian officials who are setting up the operation, which Brazil does not report as cooperation expenditures” (RUSSO, OLIVEIRA, *et al.*, 2014, p. 06). From this total sum, the Brazilian MoH had planned to invest a total of R\$ 36 million, around US\$ 20 million at the currency rate of 2010<sup>42</sup>. Project implementation was also under MoH responsibility; it chose Farmanguinhos as the main executor, and AISA and Anvisa were of fundamental importance as well – mainly in training personnel and assessing the project implementation (MINISTRY OF HEALTH, 2011a).

The Brazilian Cooperation Agency had its role too, assisting the training of Mozambican technicians; and Itamaraty was crucial for logistical purposes. Both the Embassy in Maputo and the State Secretary in Brasilia scheduled meetings, organized official visits with the MoH for technical missions, and made local arrangements for these missions to take place. However, as can be observed in official telegrams introduced by this study, it was not Itamaraty’s duty to implement the project, but to take care of protocols, travel, and appointments, almost as an auxiliary institution to the MoH.

Regarding Mozambican local problems, Brazil was fully conscious of this country’s historical background and social turmoil. The unexpected part was how much progressions relied on Garrido’s personal pressures to the government; IGEPE and MISAU’s profound miscommunication issues; and even international pressures attempting to jeopardize this South-South Cooperation. As Russo, Oliveira, *et al.* (2014, p 07-06) explain,

The setbacks experienced so far in securing the factory’s financial, technical and political sustainability expose Brazil’s lack of familiarity with the complexities of development project implementation in a context that is very different from its own. Many risks have been taken

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<sup>42</sup> Currency rate on December 2010 was around R\$ 1,60. O GLOBO, **A linha do tempo do dólar em 2010**, 30 December 2010.

in this project, from underestimating the impact of government changes in political will, to the complexity of securing public sector's drugs purchases, and the conundrum of recruiting and retaining skilled personnel in Africa

On Mozambican territory, Brazil implemented one of its most important projects: the ARV medicines factory. Hopes were abundant, as well as problems. What deserves emphasis at this point is the MoH's and Fiocruz' willingness to cooperate and take the lead in the implementation of the factory, despite strong presidential agency and miscommunication matters. The MoH and Fiocruz fully embraced the project in all its aspects – from feasibility assessment to transfer of technology, to the point that, at certain moments, not even Itamaraty was aware of which stage of development the project was at.

We therefore argue that the AVR factory is another example of the MoH working with foreign policy, engaging in all stages of foreign policy-making – formulation, negotiation and implementation – without necessarily relying on MoFA for assistance or support in this South-South cooperation project. The next example introduced in this study is the Brazil-Cuba-Haiti Tripartite Project, and in its similarities can be perceived.

## **5.7 Brazil-Cuba-Haiti Tripartite Project**

On 12<sup>th</sup> January 2010, a 7.0 magnitude earthquake hit Haiti, destroying much of its infrastructure and severely affecting its already fragile health system. Over 3,500 million people were affected, and life quality was further deteriorated when a cholera outbreak quickly spread nine months later, killing over 8 thousand people and leaving public health in a very flimsy situation (ORATA, KEIM & BOUCHER, 2010).

Haiti was no stranger to Brazil: as leader of MINUSTAH (United Nations Stabilization Mission in Haiti), the country held significant knowledge on this island-nation's social, economic and political problems (GOULART & COSTA, 2015). Brazil was well aware of Haiti's turmoil and most importantly, of the rampant poverty and violence that hindered the country's development.

Consequently, after the earthquake, Brazil rapidly organized a response and by 27<sup>th</sup> January the country had issued Provisory Measure n° 480, bestowing R\$375,95 million for Ministries to develop projects in Haiti. According to Kastrup, Pessôa *et al.* (2017, p. 639), R\$ 205 million were allocated to the Ministry of Defence, so MINUSTAH could be reinforced; circa R\$ 35 million were assigned to MoFA, so humanitarian affairs and cooperation logistics issues could be addressed; and R\$ 135 million were given to the MoH, so that assistance in the reconstruction of Haiti's health system and disease combat expertise could be offered.

The following month, a mission was sent to the country to evaluate what had to be done, and on 27<sup>th</sup> of March 2010, Brazil signed a Memorandum of Understanding with Cuba and Haiti, with a clear goal: to strengthen this Caribbean country's health and epidemiological surveillance systems (MINISTRY OF HEALTH, 2014b).

This project, later known as Tripartite Cooperation Brazil-Cuba-Haiti (TC-BCH), was Brazil's biggest international cooperation project in public health. Officially called South-South Project for the Strengthening of Haiti's Sanitary Authority – PRODOC – BRA/10/005, its expenditures were included in the Brazilian National Budget and the trilateral collaboration was meant to last until 2014 (MINISTRY OF HEALTH, 2017b). Working closely with the Haitian Ministry of Public Health and Population (MSPP), as well as the Cuban Ministry of Health, was the Brazilian Ministry of Health, *leader of this project* (OSWALDO CRUZ FOUNDATION, 2014c).

AISA and the MoH Executive Secretary were the most engaged divisions of the Ministry, however, Fiocruz, the Federal University of Rio Grande do Sul (UFRGS) and the Federal University of Santa Catarina (UFSC) were also partners in this project. With a total cost of R\$ 92,700 million, the ultimate goal was to ensure “the institutional strengthening of Haiti's sanitary authority, the Ministry of Public Health and Population, and [the project] bases itself *on successful experiences of the Brazilian Unified Health System (...)*” (MINISTRY OF HEALTH, 2014b, p. 10. Emphasis is ours).

The responsibility for the management of this project fell into the hands of an AISA expert: Dr. Carlos Felipe Almeida D'Oliveira. He recalled, in an interview granted to the author of this thesis, that Brazil's presence in Haiti prior to the earthquake, as leader of the MINUSTAH, was fundamental for the Federal Congress's approval of this

extraordinary donation to this Caribbean country. Upon Minister Temporão's request, Dr. D'Oliveira travelled to Haiti, and was shocked by the devastation he found. He then described what happened afterwards, which we deem a demonstration of Brazil's respect to local ownership in international cooperation (D'OLIVEIRA, 2017, p. Emphasis is ours):

So, I travelled to Haiti 15 days after the earthquake, (...) with Itamaraty's staff, and I was received by the Brazilian Ambassador there, Amb. Igor Kipman, (...) I also contacted the Pan American Health Organization, who was already there (...); I said it would be important for us to talk about which would be the best way to spend those [financial] resources. Especially considering that, when I arrived in Haiti, I saw many organizations, many countries were already there, NGOs providing assistance...

Thus, although demand was high, many organizations were providing assistance. I mean, we would be another one only. So, I went to speak (...) I went to speak to the Minister of Health [of Haiti], and [he] said "look, *with the experience Brazil has, with the good relationship we have developed, with such a significant amount of resources, it'd be better if Brazil did not provide assistance, and use this resource for the medium and long terms. That is, [if Brazil] helped us to design a plan, something more structuring*". I thought this proposal was very interesting.

Thus, a long-term project aiming to improve Haiti's post-earthquake health system was a request of this partner country. Additionally, Dr. D'Oliveira described that he had made it clear to PAHO Brazil's unavailability of trained doctors for projects abroad, because Brazil was really interested in the training health personnel. To this, PAHO replied that there were already many Cuban doctors working on the island. This fact later triggered the idea of having a trilateral cooperation program (D'OLIVEIRA, 2017).

Headed by the MoH and inspired by SUS' positive experiences, this project entrusted different responsibilities to each one of the three countries involved. They were (MINISTRY OF HEALTH, 2014b, p. 11):

Government of the Federative Republic of Brazil:

1. Support the recovery and construction of hospital units;

2. Fund the purchase of equipment, ambulances and health products;
3. Make feasible scholarships for the training of Haitian health professionals;
4. Support the qualification of care management and epidemiologic surveillance in Haiti;
5. Support strengthening measures of Haiti's primary health care system.

Government of the Republic of Cuba:

6. Offer support and advice for operational logistics;
7. Cooperate with the provision of support and health professionals;
8. Support the training of Haitian health professionals.

Government of the Republic of Haiti:

9. Identify areas for health units to be built;
10. Identify health units to be refurbished;
11. Support definition of logistics;
12. Provide security to health units;
13. Identify health professionals to be trained;
14. Identify secondary-school youngsters to be trained in health technical areas;
15. Take full responsibility for all wages of Haitian personnel working in facilities considered by this Memorandum.

All this MoH leadership should not be understood as the absence of Itamaraty. The Brazilian Embassy in Port-au-Prince offered diplomatic and logistical support during each stage of the project, and the Brazilian Cooperation Agency (BCA) was crucial in this entire process, mainly because the TC-BCH was implemented with the United Nations Development Program's (UNDP) assistance, and an institution with experience and understanding of international cooperation and contracts was required to orchestrate all levels of this relationship. BCA was supposed to observe this "project development and its technical and managerial features, by analysing annual reports, missions and periodical missions with liable members and UNDP, so that accomplishment of goals, targets and outcomes [would be] verified" (MINISTRY OF HEALTH, 2014b, p. 14).

Each one of these actors had their responsibilities in this South-South Project: the Brazilian Ministry of Health was responsible for financing, executing and coordinating it, while the UNDP offered support, and the BCA, monitoring it (OFFICE OF THE COMPTROLLER GENERAL OF BRAZIL, 2015).

A tripartite committee was established to coordinate activities, with members from all countries' Ministries of Health, and so 17 meetings took place between April 2010 and August 2014. This Committee was divided into six technical committees (focusing on areas such as training human resources; epidemiological surveillance and immunization; and organization of health services), in order to optimize the technical cooperation of the project (MINISTRY OF HEALTH, 2014b). Such tripartite committee was considered to be an innovative model of management, being appointed as well as one of the reasons why the project goals were achieved (GOULART & COSTA, 2015).

Planning to build hospitals, train personnel and strengthen epidemiological surveillance, this project was so important to Brazil that both ex-directors from AISA, Ambassador Eduardo Barbosa and Mr. Alberto Kleiman; both ex-Ministers of Health, Dr. José Temporão and Dr. Alexandre Padilha, and even the ex-Minister of Foreign Affairs, Amb. Celso Amorim, *voluntarily brought the topic to the conversation*. During their interviews, all somehow mentioned, without even being asked, the importance of the project.

To Amb. Amorim (AMORIM, 2015a)

Well, also, in the health realm, for instance, perhaps today Brazil's biggest project in Haiti is in health, I think it involves even medical facilities building, but it is a Brazilian experience, [that] we had, more specifically after the earthquake, a trilateral cooperation with Cuba, with Cuba in Haiti.

According to his input, Ambassador Barbosa was aware of AISA's importance to TC-BCH, and mentioned that (BARBOSA, 2017)

Another project to which the Advisory Service was fundamental was the project with Haiti. President Lula was there after the earthquake, and he saw those... well, the scenes were really terrible, and he wanted to help. (...) so, we had to formulate a draft bill, justify, organize the project...

We built... we adapted the [Brazilian] Emergency Care Unit (ECU)<sup>43</sup> model, signed a cooperation term with Cuba, we had a Tripartite agreement, Haiti, Cuba, Brazil, with which Brazil built ECUs, Haiti provided land allotments and Cuba, medical personnel. We used the resources to train people from the health system. All this was... This entire project was orchestrated in the advisory service; we had a direct connection with it.

Another ex-AISA director, Mr. Alberto Kleiman, mentioned his role at AISA's Permanent Commission for International Affairs and Health, and while recalling activities with BCA, he talked about Haiti (KLEIMAN, 2017):

With BCA, regarding cooperation, for instance, with... Central America and Caribbean, for instance, we had a very flexible relationship because of... BCA as well as [more] political areas, because of the project with Haiti. (...) it is certainly the largest [project] of the Ministry, in terms of international cooperation, but also the biggest in Brazil, with over R\$ 100 million in financial resources<sup>44</sup>, for the cooperation of what was then the Tripartite Brazil-Cuba-Haiti project, for the construction of three hospitals, rehabilitation services...

It was bigger than the Mozambican project. (...) It was approved and had a budget of its own, I mean, it was approved by Congress. (...) it was a governmental decision, from the Brazilian Congress, and the Ministry of Health ended up being the main executor of this budget.

It is noteworthy to emphasize the 'AISA and BCA had a very flowing relationship' excerpt; because BCA was so present in the project that the Agency even attended tripartite meetings of the technical committees, which were in theory decision-making structures ready to address technical matters (MINISTRY OF HEALTH, 2014b). We can understand that, during Mr. Kleiman years, there was indeed institutional cooperation between AISA and BCA.

Ex-Minister Temporão expressed the significance of having a holistic international cooperation in health such as the TC-BCH, focusing on public health as a whole, not only on specific programs (TEMPORÃO, 2016):

Ah, I forgot to tell you something very important, the Haiti case!  
I mean, the Haiti case was the aftermath of the earthquake. Brazil was

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<sup>43</sup> Emergency care units in Brazil are known as UPAs, Unidades de Pronto Atendimento in English.

<sup>44</sup> Indeed, summing up all financial aid Brazil sent to Haiti – considering resources to both the TC – BCH and humanitarian assistance –, values add up to over R\$ 130 million (INSTITUTE FOR APPLIED ECONOMIC RESEARCH, 2016)

a fundamental actor, still is. Peacekeeping operation, etc. But in the partnership between Brazil and Cuba... (...) if I am not mistaken, Brazil funded something around US\$ 100 million in cooperation in the health field. From equipment recovery, donations, personnel training, primary health care recovery, to vaccines. (...) I think the presence of Brazil in Haiti itself in this health area, at that time, was the expression of the existence of this policy<sup>45</sup>. Because it was not only a fragmented initiative, “let’s donate vaccines”, or “let’s send a brigade of specialist to help”. Actually, it was a whole supporting program in the health field.

Lastly, Ex- Minister Padilha explained that he considered this Trilateral Cooperation with Haiti an example of the MoH efforts in strengthening Brazilian South-South Cooperation (PADILHA, 2017):

[There was] a great effort to strengthen South-South Cooperation, the South-South axis, which had important initiatives, for instance consolidation of BRICS Health, cooperation Brazil-Haiti... which was the largest bi... trilateral cooperation (...).

Brazil’s goals with the project were more than just training: construction of three community hospitals was also on the plans. Not only did they become a reality, but their completion was also on time. Located in the cities of Bon Repos, Beudet and Carrefour, these community hospitals were finished by August / September 2013 and ready for inauguration in May / June the following year. Equipment was inventoried, and a maintenance plan was developed by the MoH along with the MSPP and UNOPS, the United Nations Office for Project Services, responsible for supporting the countries involved and UNDP in the implementation of the project. After all was set, transferring terms to the government of Haiti were signed by MoH, MSPP, UNPOS and UNDP, and it was only after their signatures, in November 2014, that these documents were sent to the Brazilian Embassy (OFFICE OF THE COMPTROLLER GENERAL OF BRAZIL, 2015).

Because of TC-BCH, 1226 polyvalent communitarian health agents, 53 sanitary inspectors, and 276 nurse technicians were trained; and two public health laboratories, one in Les Cayes, and another one in Haitian Cape, were refurbished and re-equipped.

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<sup>45</sup> By this policy he meant a Brazilian Health Foreign Policy, as shortly before talking about TC – BCH, he was asked if he believed Brazil had developed a specific Health Foreign Policy.



Vaccines were also donated, and 30 ambulances were purchased and donated to Haiti (OFFICE OF THE COMPTROLLER GENERAL OF BRAZIL, 2015).

A state solemnity organized to symbolize this donation, and an official notice sent from Minister of Health Padilha to the then Minister of Foreign Affairs, Amb. Antônio Patriota, portrays the relationship between these two institutions. Dr. Padilha wrote to Amb. Patriota saying that the 30 ambulances were already on the island and that “the *Ministry of Health is drafting a cooperation proposal* with Haitian emergency services for the use” of these ambulances, a draft that would later be submitted to the tripartite committee (MINISTRY OF HEALTH, 2011b, p. 01. Emphasis is ours). By this we understand that the Ministry holding the proper knowledge on the issue and the main negotiator with Haiti was the MoH, not Itamaraty. However, this should not be understood as an indication of conflicting relations. In the same document, Dr. Padilha states that MoFA ceremonial suggestions for the donation were accepted, meaning that the ambulances would be given to Haiti on a Brazilian national holiday, September 7<sup>th</sup>; and that, given the significance of the event, Amb. Patriota should be present or appoint someone to attend the occasion on his behalf (MINISTRY OF HEALTH, 2011b).

Another part of this project, which was completed in 2014, was the establishment of a Haitian Institute for Rehabilitation, so that therapy, prosthesis and orthosis could be offered to people with physical disabilities. As mentioned, institutions other than the countries’ respective Ministries of Health participated in the project, and although the project only mentions public universities such as UFRGS and UFSC, a Brazilian private hospital was also present in Haiti to provide assistance specifically for the creation of this rehabilitation institute: the Albert Einstein Israelita Hospital. Despite being a private agent, this hospital sent experts to Haiti to train professionals to work in the Institute for Rehabilitation (MINISTRY OF HEALTH, 2014b). Contracts for collaborations with this actor were intermediated by the BCA (MINISTRY OF HEALTH, 2011c).

Documents suggest that there might have been issues such as the overlapping of efforts between these actors. The Brazilian Cooperation Agency, although part of TC-BCH, also partially financed projects in Haiti that were connected to projects developed by the Tripartite Agreement. To clarify, this meant that TC-BCH aimed to establish the Institute for Rehabilitation, and BCA financed a project whose goal it was to strengthen the Haitian state’s ability to integrate disabled people back into society. Project

BRA/04/043 -S159 was concluded in June 2013, and the BCA paid for 68% of all costs (BRAZILIAN COOPERATION AGENCY, 2015a).

Hospital Albert Einstein's participation was also connected to this rehabilitation institute, and in September 2011, the MoH asked BCA to provide further information on the project they had agreed on with this private hospital. This would facilitate the Ministry of Health's decision-making regarding upcoming activities and actions which needed to be coordinated within the Ministry of Health Working Group (MINISTRY OF HEALTH, 2011c).

Coordination issues were also identified by the Fiocruz team, and reasons are quite similar to the above: different institutions engaged in the same project performed activities that could have been complementary but ended up being fragmented. Fiocruz was responsible for providing training in epidemiology and was not notified when other Brazilian institutions provided Haiti with equipment for vaccine distribution. Had Fiocruz been warned, perhaps this equipment could have been better used, since professionals would have been properly trained to use them and store vaccines adequately (KASTRUP, PESSÔA, *et al.*, 2017, p. 650).

Despite pending issues which needed to be solved the following year, the Tripartite cooperation was considered concluded by 2014 (OSWALDO CRUZ FOUNDATION, 2015, p. 137). By Brazilian rules, governmental expenditures, regardless of their nature, must be audited, and with TC-BCH rules applied the same: the Office of the Comptroller General observed whether costs and completed tasks met standards and expected disbursements. Interestingly enough, the Comptroller General also analyzed whether the structure established by the MoH, BCA and UNDP was adequate to manage the project (OFFICE OF THE COMPTROLLER GENERAL OF BRAZIL, 2015).

Meetings between these three actors were periodical, and the Office of the Comptroller General reckoned the organizational structure of the project was suitable following the analysis of all its meetings and how they were assembled (OFFICE OF THE COMPTROLLER GENERAL OF BRAZIL, 2015, p. 10).

Despite the aforementioned communication issues, Dr. Carlos Felipe Almeida D'Oliveira, ex-director of the TC-BCH project and interviewee in this thesis, offered a long narrative of its successes. Some excerpts are translated below, highlighting the project's emphasis on structuring cooperation for health, and its relationship with Itamaraty (D'OLIVEIRA, 2017):

Regarding the idea of a structuring cooperation for health:

The project comprised many actions, such as strengthening the immunization system. I mean, it was not only about sending vaccines. It was about training teams, sending our teams there, to help and train professionals, set up services (...).

For the immunization project to work... because Haiti did not have energy supply, so how to keep and store vaccines in all cities? It was not a matter of taking vaccines and sending them over, no. You need a fridge, a fridge needs energy, but there is no energy supply there. "Ah, so use some fuel!" No, people, we don't have fuel! So, we ended up buying over one thousand solar-energy-run fridges.

(...) also [there was] a project for the training of community health workers, because we said "well, let's bring the [Brazilian] Family Health Program here! Let's train community health workers". So, we signed agreements with Brazilian universities, with experience in training these agents, and started a project for the training of community health workers.

Still regarding structuring cooperation for health, but this time including the provision of infrastructure for new hospitals in Haiti:

I had suggested we used a modular methodology, as UPAs<sup>46</sup> in Brazil, because I knew them, and it was faster, implementation costs would be lower, and these hospitals were effectively built. At the time, I said "well, for this treaty I now need to start signing agreements with entities". And then we had a covenant with the Oswaldo Cruz Foundation, to provide support on technical issues; we had a covenant with the Federal University of Rio Grande do Sul, with [its] health management school; (...) we had a partnership with the Pan American Health Organization, (...) the Federal University of Santa Catarina, who trained community health agents; and so, we were designing the project...

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<sup>46</sup> Emergency Care Units

Ah, the purchase of ambulances! Purchase of ambulances to put together an emergency response system, and then we took SAMU<sup>47</sup> technicians there [to Haiti].

Dr. D'Oliveira also mentioned AISA's relationship with Itamaraty, and as can be seen, MoFA's role was connected to logistics. The actual implementation of the project was MoH's responsibility, but Itamaraty provided support on many occasions:

Itamaraty helped us a lot, because we had many problems. Big problems. For instance, in December 2010, Haiti was problematic, elections were taking place (...) and there were political issues concerning elections and the cities... airports were closed...

All our teams, we had nurses there, teams from the Ministry... we were in a hotel and the hotel was surrounded, and violence from political groups was escalating, so we felt threatened. And at the same time, there was the cholera outbreak. Me, as the head of the mission, I was getting worried. At the time, Minister Temporão spoke to Minister Celso Amorim, and said "we need to take the teams from the Ministry of Health out of there". It was a war operation. The armed forces took us out, we left in tanks, buses, trucks with tanks protecting us until the borders with Dominican Republic, and then we came to Brazil. (...) but then I said "(...) when the situation is calmer we can come back". And we came back in February.

(...) We had personnel from the Ministry of Health living there, (...) we were training community health agents, providing education for these agents. We had public health nurses there, working and training these people. So, we had professionals living there at that time, we had to evacuate.

(...) there were moments when we had circa 50 technicians there, (...) when the agreement was signed, on March 2010, the Brazilian Minister of Foreign Affairs at the time went to the United Nations to say that Brazil was signing it. So, it was a very important project to Itamaraty, because Itamaraty also understood that "well, if you are doing this in Haiti, perhaps we can do it in different places, because of your experience". The experience we gave to Haiti was super rich! It wasn't easy, to deal with such great challenges, such as cholera, political-military issues... To Itamaraty, this was a project... if you

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<sup>47</sup> SAMU means Emergency Care Mobile Unit, or Serviço de Atendimento Móvel de Urgência, in Portuguese. SAMU is more than just an ambulance service for taking injured or ill people in severe emergency conditions to hospitals; it is a different approach to emergency care of which ambulances are only a segment. We clarify this as most people associate SAMU with ambulances. For further information on this project in Brazil, see: MACHADO, C.V.; SALVADOR, F.G.F.; O'DWYER, G. Serviço de Atendimento Móvel de Urgência: análise da política Brasileira. *Rev. Saúde Pública*, nº 45, v. 03, pp. 519 – 528, 2011.

... speak with people who followed the project from Itamaraty... (...) it was a very dear project, a project that could be introduced to other countries, with all this acquired experience of ours. It was very interesting work, you know, fantastic work, despite all difficulties. But I believe difficulties are part of it. We had professionals [who were] seriously engaged, people liked what they were doing, and they did a good job, it was a very good experience for Brazil, to the Ministry of Health, to the teams that were already working there...

[This project] had a great impact; it was very dear and important to Itamaraty, because Brazil was developing interesting work, and Itamaraty told it to the world, it publicized it, the United Nations knew [about this project].

There were also moments when a partnership with MINUSTAH was developed, usually with positive outcomes:

We did not want to build any hospitals in private areas, because we worried that after we had left the country, it would become a private hospital. In a private area. So, we got... guarantees on land documentation that those allotments were property of the government of Haiti, belonging to the Ministry of Health, and only then we settled the first stone, when we were sure the area was public and was a donation for the construction of a hospital.

When works got started, militias invaded the allotments. There were many militias in Haiti, very violent, and then, how to work if they were in the area? So, we had, again, to ask Itamaraty for help, help from the United Nations, from the armed forces that were there, from MINUSTAH. To watch the areas, so we could build the hospitals. And MINUSTAH was a great partner, (...) for instance, a battalion of engineers from the armed forces was there, and they helped us to drill for water wells. They also ensured our safety.

Additionally, Dr. D'Oliveira recalled the cholera outbreak the mission had to face:

In October, there was... the cholera outbreak in Haiti. Cholera had been brought by soldiers from the United Nations Mission (...). Our fear was very real: we had over one million people camping in open squares of Port-au-Prince. We needed to come up with an emergency plan to avoid cholera from spreading in Haiti. No-one could enter the country anymore. So, in Port-au-Prince... because if cholera arrived in Port-au-Prince in those conditions, with over one million people in the squares, with precarious sanitary conditions, without water, it would be chaos. It was chaotic already, we would have a very high mortality rate. So, at that time, we had to send to the Ministry... We had to purchase saline solution, send it to Haiti, we sent teams from the Ministry of

Health to train field epidemiologists, train teams there (...) The Pan-American Health Organization asked us to design a project to avoid cholera from arriving to Port-au-Prince, to isolate it in the area it already was. Afterwards cholera got to Port-au-Prince.

Dr. D'Oliveira eventually mentioned SUS and the importance of Brazil's experience in public health (D'OLIVEIRA, 2017. Emphasis is ours):

They did not know, but... I mean, they did not know exactly what they wanted. But they had an idea of *how the universal health system functioned*, they [also knew] that Haiti is a poor country. *They had an idea that Brazil could help them in this sense, help them to put together a structure, a health system that could [deliver] care to the population, not only and exclusively offer assistance.*

In the covenant with Fiocruz, for instance, we brought Haitian professionals to take courses and practical training inside Fiocruz. We identified the need, identified the potential partner in Brazil, and we set an agreement. So, the project funded the reception of Haitian professionals, and, in some cases, it funded a [mission] of technicians from here to Haiti. So that they could help organizing services, information (...) We took (...) the experience we had here and brought it [over to Haiti].

Perhaps because of less presidential agency, or because of its lack of outcomes that could directly impact the economy – Haiti was not going to produce medicines but receive training and humanitarian aid – this Project was not as highly praised as other MoH initiatives. However, the project demonstrates the MoH's great efforts to improve health standards in a developing country, further collaborating with the MoFA and BCA.

There are many aspects of this South-South cooperation initiative that are worth highlighting, mainly Haitian requests to develop a structure similar to SUS, and Brazil's emphasis on human resources for health training and infrastructure reconstruction. Brazilian leadership in the MINUSTAH undoubtedly provided the country information on Haiti's severe social issues, and once again, the idea of structuring cooperation for health shaped all the collaboration efforts set up by Brazil. We can observe in this cooperation the same pattern of behaviour observed in the ARV medicines factory in Mozambique: a strong leadership role played by the MoH, and logistical support provided by Itamaraty. The MoH and its agencies were responsible for formulating the agreement and implementing the project, while MoFA assisted the Ministry's actions.

This study so far introduced works from the MoH, its agencies, and examples of cooperation projects it developed. However, MoFA departments and works must be explained too, so that an assessment of BFP in the realm of health can be duly presented. This matter will be debated in the following section of this thesis.

## 6.MoFA

It is safe to say that the Brazilian Ministry of Foreign Affairs, also known as Itamaraty, was never unaware of how important health issues were to international relations. For example, in the Uruguay Round of the General Agreement on Tariffs and Trade (GATT), health was a key topic: this legal arrangement negotiated a Sanitary and Phytosanitary Agreement as an attempt to harmonize countries' legislation on the matter and diminish non-tariff barriers to trade (HOOKER & CASWELL, 1999).

However, as already explained in chapter six, the Ministry's approach towards health changed over time. A combination of the Doha round and intellectual property debates at the WTO and a greater MoH presence abroad changed the Ministry's perspective on how health could be inserted into foreign affairs debates. It was now regarded as a matter of state policy, not only a social affair (Alcázar S. L., 2005).

The international environment changed as well. Political programs from the United Nations, such as the Millennium Development Goals (MDGs), boosted health-related debates all over the world. And Brazil, hoping to become a major player in the field, not only achieved all MDGs targets before the stipulated time, but also brought the MDGs to the table of various forums, such as the High-Level Meetings For South-South Cooperation, at the UN headquarters in New York (VENTURA, 2013b). For Brazil, "South-South Cooperation was a useful mechanism for the achievement of MDGs" in topics such as HIV / AIDS and maternal mortality rates (Ministry of Foreign Affairs, 2005c).

Moreover, during Lula's administration (2003-2010) Brazil's domestic economy relatively stable. On the other hand, the world economy was expanding at unprecedented levels until it was eventually harshly struck by the 2008 crisis. Additionally, a re-arrangement of international orders occurred, which meant more space for so-called emerging countries, and more room for manoeuvre for new cooperation endeavours, such as the South-South Cooperation ventures (HIRST, LIMA & PINHEIRO, 2010; RICUPERO, 2010; ROBERTO DE ALMEIDA, 2012; VISENTINI, 2012).

Some authors, such as Hirst, Lima and Pinheiro (2010, p. 23), emphasize that Brazil, during the 2003-2010 period, "mobilized multiple State agents with foreign



agendas of their own or complementary to Itamaraty's road of action", bringing a new dynamism to Brazilian Foreign Policy. Others, such as Visentini (2012, p. 24), argue that what actually happened during Lula's administration was Itamaraty's return "to its central position (...) on the formulation and execution of the Brazilian Foreign Policy".

Given the MoH's extensive role and leadership in numerous foreign activity and projects abroad (explored over the last chapter), the rationality applied to this thesis seems to be in line with Hisrt, Lima and Pinheiro's (2010) analysis. This does not mean Itamaraty was no longer fundamental for the achievement of Brazilian international aspirations; if this was the case, as Visentini himself has stressed (2012), an increase in the number of Embassies across the world as well as the number of career diplomats hired in a relatively short space of time would not have the impact they did, further reaffirming Brazilian interest in becoming a global leader and a protagonist in international affairs.

Our goal in this chapter is to emphasize that Itamaraty has long been an important institution, and, similarly to the MoH, has had plans and projects to include health in its institutional strategies. The difference this time is that not only did the MoFA now have a myriad of other domestic ministries also working on their own international prevalence and agendas, but it also provided them with assistance and logistical support for their operations via institutions such as the Brazilian Cooperation Agency (BCA). Itamaraty was no longer the sole agent in foreign affairs, nor did it hold absolute control of the government's international agenda setting.

Under Lula, Brazil had its diplomatic goals: a permanent seat at the UN Security Council; an expansion of MERCOSUR with more state-members, in order to further integrate South America; and the conclusion of the Doha Round negotiations (Roberto de Almeida, 2012). However, while interviewing Dr. Padilha, ex-Minister of Health, a different perspective was brought forward (PADILHA, 2017. Emphasis is ours):

So, the Brazilian government, starting with President Lula, had a very clear foreign policy agenda. First, *to place social policies issues - connected to the rule of law, to the welfare state - at the centre of the foreign policy agenda. (...) and the Ministry of Health had a very important role. To help to bring social policies issues to the centre of the foreign policy.*

(...) second, a great effort to strengthen the South-South Cooperation.

For Itamaraty, health had long been considered a social affair (Rubarth, 1999). However, recognizing the centrality of social affairs in Lula's government was also in some ways a confirmation that health was crucial too. Indeed, the country accepted this position very earnestly, to the point that Minister Milton Rondó, ex-director of Itamaraty's Coordination General of Humanitarian Cooperation and Actions against Hunger (CGFOME), claimed that had Brazil become a "leader in nutrition. In food safety and nutrition. No doubt about that" (Rondó, 2017). The centrality that health acquired during this period was of great importance for the solidification of the idea that health was, now, a matter of state policy.

As mentioned in chapter five, ex-Minister of Foreign Affairs, Amb. Celso Amorim, also attributes the moral turn in foreign policy to Lula. With his ideals of combating poverty and hunger, he devoted attention to the different needs of the population which had an effect on MOFA's agenda (AMORIM, 2015a).

Unfortunately, Lula's successor did not hold Itamaraty in such high regards, at least not in the same way Lula did. After President Dilma Rousseff's inauguration, in 2011, the MoFA experienced a decline of its prestige and foreign policy was belittled. To grasp the events that led to this situation, the author of this thesis randomly distributed questionnaires to Brazilian diplomats, and their answers allowed us to conclude that there are four key reasons for this change in government<sup>48</sup>:

- 1) President Dilma and her close advisors' lack of personal interest in foreign affairs. Ms. Dilma Rousseff had an inward vision of national development, rather than a global one. She was more preoccupied with domestic issues and did not consider that foreign policy could act as tool in service of Brazil's development, as a device that could boost economic growth. The *priorities* of BFP had not changed: regional integration and South-South Cooperation were still the most significant. What had changed was the *emphasis* given to these priorities. One interviewed diplomat recalled a phrase used by a foreign policy

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<sup>48</sup> These research findings were published in the article written by Gómez and Perez, 2016.

journalist, Mr. Clovis Rossi, to summarize Dilma's relationship with Itamaraty: "Dilma's world is Brazil"<sup>49</sup>.

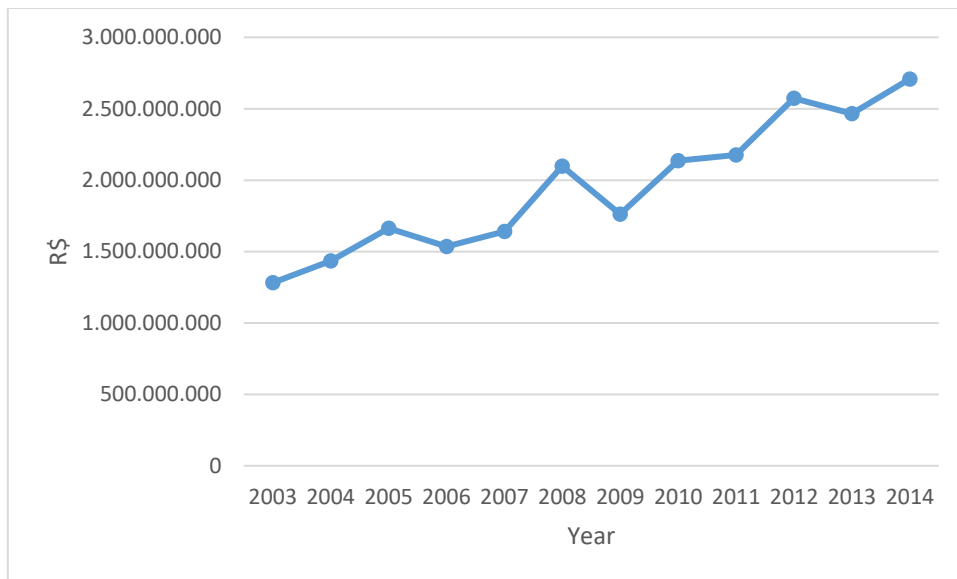
- 2) Budgetary cuts. From 2011 to 2014, the allotment of federal resources to Itamaraty was either practically the same as the previous year, or less. As can be observed in Figure 06, there was an increase in MoFA's Budget from 2011 to 2012, however, the following years did not present much of a change. If compared with other national institutions, such as Fiocruz and the MoH, it is evident how much fewer resources were allocated to the MoFA. Bearing in mind issues such as inflation and Real devaluation (the Brazilian currency) against the US Dollar, maintaining the sum of resources over such a significant period of time had negative effects on the institution's operations. The most evident consequence pointed out in our surveys was that the Ministry could not afford to send certain specialists to overseas negotiations. Budgetary contingency meant Itamaraty had to rely on diplomats working in nearby Embassies to engage in international negotiations, and this had a negative impact on Brazil's image abroad.

The Brazilian Cooperation Agency also suffered greatly from budgetary cuts, with fewer resources available for cooperation projects in other countries. Another issue raised was the fact that other Ministries, such as the Ministry of Economy and the Ministry of Planning, Budget, and Management, were hindering MoFA's autonomy and impacting resource flows to Embassies, International Organizations, and even cooperation projects. However, after checking Brazilian Budget files, we observed that this change had already taken place in 2009... contributions to the WHO and to CPLP were under scrutiny from the Ministry of Planning even before President Dilma was a candidate to national elections. We can infer from this that financial changes were more likely to be felt when resources were no longer abundant (i.e. under Dilma), even though they took place during Lula's term.

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<sup>49</sup> ROSSI, C. O mundo de Dilma é o Brasil. **Folha de São Paulo**. São Paulo, 22 September 2011. Caderno Mundo.

**Figure 06. MoFA Budget (Executed)**



Source: Federal Senate of Brazil – Federal Budget (2003-2014) (2018). Elaborated by the author.

- 3) A sense of separation and lack of leadership. On the one hand, President Dilma and her advisors did not understand Itamaraty and its importance; neither did they grasp how diplomacy could facilitate Brazil’s economic growth. On the other, the indifference and sometimes even apathy of Dilma’s administration towards foreign policy made Itamaraty unsure of what the presidency actually expected from it. Unaware of how to proceed, diplomats had difficulties in demonstrating how important their activities were to domestic policies. This created, therefore, a sense of separation between the two groups. Moreover, President Dilma did not introduce any particular ideals to BFP. What was the country supposed to pursue? What should diplomats work towards? What was the ultimate goal concerning foreign affairs? Keener on short-term strategies with more quickly perceivable results, President Dilma was not sensitive to diplomacy’s timing, and this further deteriorated the president’s relationship with Itamaraty. Additionally, without a clear set of ideas on which to base foreign affairs, Dilma was unable to bring civil society engagement and diplomatic efforts to the same table, creating a further obstacle to the establishment of a foreign policy agenda.
- 4) Itamaraty had problems of its own. For many years, Itamaraty had been led by Amb. Celso Amorim, a career diplomat considered not only brilliant, but a

clever interlocutor, someone able to negotiate with politicians in National Congress while also building a close relationship with President Lula (and, might we add, Minister Temporão). Amb. Celso Amorim's successors were nothing of the sort: Amb. Antônio Patriota, in office from 2011 to 2013, was also a brilliant and creative diplomat, but with no skills to play the games of National Congress. Amb. Luiz Alberto Figueiredo (2013-2015) experienced an insipid path to Itamaraty's most important position, and did not bring MoFA back to its old track.

Multiple definitions have been proposed by academics either to define or explain Dilma's period: systemic decline (CARLOS & LESSA, 2014); continuity by inertia (Kalil, 2014); benign multipolarity – a concept used by Amb. Patriota to explain that Brazil wanted to participate in world politics via a more multilateral decision-making process (Vieira de Jesus, 2014); and even “balance-sheet diplomacy”, a term coined by Casarões (2015) to highlight Dilma's *idée fixe* with short-term accomplishments.

This analysis of ex-President Dilma's foreign policy is not unanimous, though. To Vieira de Jesus (2014), Ms. Dilma understood foreign policy-making well, and a less personal approach allowed her to avoid emphasizing ideological identities; she was able to sustain a “clear institutional continuity of management” and bring “very few modifications in the institutional structure of the Executive branch”, since she belonged to the same political party of Lula, the Workers Party (Vieira de Jesus, 2014, p. 21).

Bearing all these difficulties in mind, the goal of the following subchapters is to demonstrate how MoFA sub-organizations dealt with health, or how this topic influenced this institution's work across different international arenas.

## 6.1 WTO, Doha and Public Health

The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) was responsible for placing public health on the MoFA's agenda. This was already made explicit during chapter 5 and subchapter 6.1., when the manufacture and provision of generic HIV / AIDS drugs were discussed. However, and considering the goals of this thesis, it is vital to demonstrate an alternative perspective, that is, MoFA's viewpoint and undertaking on the issue.

The TRIPS agreement came into force in 1995, concomitantly to the creation of the WTO creation, and was in summary, a “comprehensive multilateral agreement on [intellectual property rights] including patents, trademarks and copyright” (KERRY & LEE, 2007, p. 02). Despite its aim of protecting intellectual property rights and ensuring investments in development and research for health in forthcoming years, the TRIPS agreement did not take global inequalities and neglected diseases into consideration (Silva Lima, 2017). There was a concern that this agreement actually “enhanced the interests of transnational pharmaceutical companies and industrialised countries with large pharmaceutical industries (...) at the expense of access to affordable medicines by millions in genuine need” (KERRY & LEE, 2007, p. 02).

Bearing this and the HIV / AIDS issue in mind, it was decided during the IV WTO Ministerial Round in Doha, Qatar, to discuss how to protect public health and drugs provision in a TRIPS-protected environment. The result of this meeting was the 2001 Doha Declaration on the TRIPS Agreement and Public Health, a document sponsored by the WHO and in which countries agreed that patents and trade interests should come after health (Ministry of Health, 2009a, p. 15).

Two years later, in 2003, there was a second declaration, known as the Implementation of the Paragraph 6 Decision in 2003, which, combined with the Doha Declaration, set clear rules to the production and provision of generic drugs; and, most importantly (KERRY & LEE, 2007, p. 03):

[Stated] that a compulsory license can (...) be issued for primarily domestic use. [Article 31] precluded generic drug production for export to countries without their own domestic capabilities, leaving the poorest countries without access to generic medicines. The [Article 31] waiver

allowed a country to issue a compulsory license for either domestic use or export, on the basis of public health need. (...) the agreements appeared to distinguish drugs from other traded commodities, and to secure the right of WTO member states to uphold flexibilities contained within the TRIPS agreement for the purpose of protecting public health.

Hence, the Doha Declaration instated a new world order, where public health protection came before trade benefits. According to Alcázar (2013), this Declaration was very significant for developing countries, because it clearly expressed the idea that “nothing in the [TRIPS] Agreement [could now] prevent a member State to take measures to protect public health. It is in [this] context that is legitimate to say that the Declaration detaches health from trade.” (ALCÁZAR, 2013, p. 330).

To Itamaraty, these TRIPS waivers and Doha Round negotiations made the Ministry treat health differently; the discussions on intellectual property rights were translated into MoFA’s better understanding of public health’s importance to the international scenario and developing countries.

We inferred this fact after conversations with both Amb. Alcázar, who patiently replied to several emails sent by the author and affirmed that the Doha Declaration familiarized MoFA with SUS and BFP on health (ALCÁZAR, 2017), and Amb. Amorim, who explained how this Declaration became an important international tool to Brazil and its interests, as well as to African countries (AMORIM, 2015a):

At the UN itself there were some meetings... for instance, TRIPS and health, I was deeply involved, I would say that few people, at least [in the level of] Ambassadors, I was not Minister yet, were as involved as I was in this TRIPS and health matter. Diplomacy was very important for the settlement of a WTO agreement that did not introduce obstacles to our generic [medicines].

We had a very advanced policy regarding HIV / AIDS treatment and that involved generic drugs. We had to make sure that the old TRIPS agreement, negotiated at the Uruguay Round, and that presented some ambiguities which we introduced at the time, nobody believed that those would be very important; [we had to make sure that those ambiguities] were interpreted favorably towards us, and I think we got that (...) during the launch of the Doha Round... it was in 2001. The launch of the Doha Round was in late 2001, and after that it was complemented (...) I think in 2003, I do not know if it lasted until 2004,

extending compulsory licenses not only to local production but also to importation.

This was crucial to Brazil, (...) but was really significant to African countries and others that could not produce medicines but wanted to purchase cheaper drugs.

Given Brazil's extensive HIV / AIDS cooperation projects with numerous countries, this sort of international law provided the legal bases for Brazil to issue compulsory licenses and help any country in need upon request. The former would not be delayed any further: in 2007, Brazil declared the compulsory licensing of Efavirenz 600g, produced by Merck Sharp & Dohme laboratory, for non-commercial use. The Ministry of Health triggered the process on 24<sup>th</sup> April 2007, by declaring it a medicine of public interest<sup>50</sup>, and on 4<sup>th</sup> May of the same year, President Lula signed the decree authorizing this compulsory licensing<sup>51</sup> (RODRIGUES & SOLER, 2006).

To the Minister of Health at the time, Dr. José Temporão, all this, along with Brazil's family health and immunization programs, put the spotlight on Brazil internationally. He considered the compulsory licensing an important event (TEMPORÃO, 2016):

For the first time Brazil had triggered the compulsory licensing [process] of an antiretroviral drug, efavirenz, in May 2007 (...). This granted Brazil huge international visibility, because for the first time, a country with the dimensions of Brazil took this measure, [an] absolutely legal [measure] within the framework of law and international norms.

With all eyes on Brazil and with a deeper understanding of public health, Itamaraty's engagement in the issue went beyond the walls of the WTO. It moved to a different building in Geneva, where, invited by Dr. Temporão, Amb. Celso Amorim delivered a speech at the 60<sup>th</sup> WHA session, in 2007, and demonstrated MoFA's support to this public health cause (AMORIM, 2007b. Emphasis is ours):

It is, to me, a great pleasure to return to Geneva and address the World Health Assembly, on my behalf and on behalf of the Brazilian Minister of Health, José Gomes Temporão. *To Brazil, health promotion is a State policy that passes by different sectors. To be efficient, domestic policies and external actions must be complementary.*

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<sup>50</sup> Ministerial Ordinance 886 (2007)

<sup>51</sup> Presidential Decree 6108 (2007)



No consideration of economic nature can inhibit measures whose goal is to save dozens of human lives. As President Lula stressed, commercial considerations of whichever nature, including profits, cannot be prioritized over Brazilian people or any other people's health.

It is very significant for a Minister of Foreign Affairs to say that the promotion of health promotion is state policy, and that its efficiency relies on complementary national and international actions. It implies that Itamaraty is also liable for the successes and failures of health promotion activities, and that the Minister is aware of this institution's responsibility.

In the interview granted for this thesis, Amb. Amorim recalled this event and how important his speech at the WHA was for this compulsory licencing matter (AMORIM, 2015a):

I was in Geneva when Brazil had decided to issue the compulsory licensing of Efavirenz. And normally, the Minister of Foreign Affairs does not attend the World Health Assembly. Only the Minister of Health. And the Minister of Health was there, it was Temporão. He and I, obviously, I wrote with him the content of what the speech would be, and he said: no Celso, you deliver the speech (...)

The Minister of Foreign Affairs speaks on behalf of the Brazilian State. The Minister of Health speaks on behalf of the Ministry of Health. Of course he is a government representative etc., but people could always think "does everybody in Brazil think the same?"

I was with Temporão, sitting next to him. (...) this illustrates, it is a little bit anecdotal, but it illustrates thus how important it is for diplomacy to become interested in health and this growing fusion that happened between health and diplomacy matters.

The Doha round had many consequences for Brazil: domestically, it was essential for the country to comply with its commitments to the population and provide ARV therapy for those in need. Internationally, it allowed Brazil to import generic active ingredients for drugs should they be required. However, another consequence was a rapprochement between the MoH and Itamaraty, making the latter realize the importance of working on topics of the former.

The Doha Declaration was fundamental for making Itamaraty see health *per se* as an international affair, not only as a social matter. Alcázar (2013) considers this

declaration to be what he calls a *Copernican Revolution*, a change in perspective that detached health from trade. To him, the relationships between health and foreign policy have changed, and currently, “health instructs foreign policy to broaden its perspective and to seriously consider issues and policies in the light of a discourse on human values previously unconsidered, ignored or simply not heard of” (ALCÁZAR, 2013, p. 334). Hence, the Doha Declaration changed Itamaraty’s perception of health for good.

The next two sub-sections will discuss the role of two MOFA departments that were very active in the field of health: the Social Affairs Division, and the Brazilian Cooperation Agency (BCA). Part of the Undersecretariat General for Political Affairs, the Social Affairs Division provides instructions on negotiations and diplomatic meetings that deal with social issues (such as health). BCA, on the other hand, is linked to the Undersecretariat General for International Cooperation, Trade Promotion and Cultural Themes, and sponsors many South-South Cooperation projects that deal with health.

## **6.2 Social Affairs Division**

The Brazilian Ministry of Foreign Affairs is a complex organization with a fairly big number of secretariats and divisions. With three secretariats, seven different offices, and nine undersecretariats commissioned to observe international issues all over the globe, with their respective divisions, Itamaraty comprises an intricate structure that requires great communication efforts to function properly. The organogram of this organization can be seen in Annex 03 at the end of this thesis.

The decision to analyze the Social Affairs Division came after taking into consideration i) Rubarth’s study (1999), in which health is introduced as a social theme; ii) telegrams and official documents issued by Itamaraty and its representations abroad, for many of them display the information ‘distributed to the DTS’ (Social Affairs Division, in Portuguese); and iii) an interview conducted with a Brazilian Diplomat working at the country’s mission at the UN in New York. This diplomat described how this mission worked with the MoH, and according to his depiction, DTS had an important role to play in this communication channel (BRAZILIAN DIPLOMAT AT UN-NY DELEGATION, 2017):

This articulation with the Ministry of Health, in the health realm, this happens in the Social Affairs Division. It is usually via the Social Affairs Division that we receive what we call instructions. When we have a meeting, a specific negotiation, an event...

And these instructions are usually directives (...). Typically, they come in the following manner: Brazil might guard, or must favour alternatives that lead to this or that outcome. Piecing together this with the principles of the foreign policy and our profile as a negotiator, we already know how to translate these general instructions and apply them in the more specific context of a negotiation.

All topics deemed to have a more social content, such as health, work safety, human rights, childhood protection and elderly rights, are all part of Itamaraty's Social Themes Division agenda (MINISTRY OF FOREIGN AFFAIRS , 2015b). Thus, if DTS was responsible for intermediating communications between the MoH and representatives abroad, and vice-versa, was it just a bureaucratic stance? Or was it an active and important influence on Itamaraty's work in the health field? The answer, as can be observed by the forthcoming paragraphs, is a bit of both.

This Social Affairs Division was responsible for a plentiful number of documents and interministerial communication papers, and it was its duty to process information and offer guidance and directives to diplomats abroad. In an interview, Secretary Juliana Gomes, Brazilian diplomat who served at DTS for three years, explained that DTS used to receive reports of meetings or negotiations abroad and issue directives with instructions on health issues. According to Gomes, and emphasized by us (2017):

Those instructions were (...) suitable to the principles of our foreign policy, not only because you have diplomats on the missions who follow the meetings, who take part on it, but also because *our foreign policy, in the health realm, is very much based on the historical experience of the Ministry of Health and the Oswaldo Cruz Foundation, who always fought for Brazil to be autonomous in the production (...) of medicines, for instance, and also because of the Unified Health System, and the constitutional right to health that marks out (...) out international operations in this area.*

The key point in her speech was that instructions formulated and issued by DTS in health affairs were suitable to the principles of Brazilian Foreign Policy because it was done for diplomats, and also because *Brazil had foundations guiding this practice,*

*foundations built by SUS and the MoH pledge for affordable ARV therapy.* Therefore, SUS and MoH traditions meet MoFA ideas, they are not conflicting.

We asked Secretary Gomes if DTS directives also followed SUS principles, and the answer was brief and clear:

Yes. Since there is already a story (...) that Itamaraty keeps and that we use to act, our activity is totally based on SUS and constitutional principles. Maybe this is not expressed in a very clear way (...). For you to have a unified health system, with universal health coverage, something almost no country has, all of your foreign policy formulation and all of your actions are going to be based on it.

You will want to increase the access [to healthcare] and diminish the costs. So, what guides the Brazilian Foreign Policy in the health realm is this. It is to increase access and diminish costs. And this... Even though (...) you do not read SUS's principles every day, you also base your actions in public sectorial policies from the Ministry of Health. Policies for non-communicable diseases, tuberculosis, HIV, all this is based on SUS, so our actions are totally based on this as well.

Following Gomes' (2017) rationale, the MoFA bases its practices on the MoH public policies, and being that those are always grounded on SUS principles, the presence of SUS in Brazilian Foreign Policy is almost a consequence of a chain of events.

Bureaucracy was not out of the equation, but it did not have negative impacts on relationships between DTS and MoH. The author of this thesis also spoke to Counsellor Tatiana Bustamante, head of DTS in 2013, and she stressed that relationships with the MoH were good, with communications between the two institutions on a daily basis. All methods were used (phone calls, electronic messages, and official communication documents) regarding myriad issues in different forums. Counsellor Bustamante also emphasized AISA's constant availability to answer DTS consultations and information requests, and DTS efforts to provide AISA with the same quality of collaboration (BUSTAMANTE, 2017).

The same type of relationship was mentioned by Secretary Gomes. According to her there was constant feedback, with information exchanges and constant interactions, "a symbiotic relationship, one relies upon the other for basically everything" (GOMES, 2017).

Although there was a good relationship with the MoH, it was not the Social Affairs Division's role to supervise or inspect other institutions from the MoH that were working abroad: its activities concerned only provision of support. As Counsellor Bustamante explains, DTS did not oversee activities of other Brazilian institutions abroad, "the institutions themselves informed the MoFA, via DTS, about a trip of an authority and the reason of a mission, so that the network of posts abroad could provide logistical support" (BUSTAMANTE, 2017).

Anvisa and Fiocruz efforts were praised by Secretary Gomes, because, as she put it, they do work a lot. She clarified that (GOMES, 2017)

Anvisa, because there are career employees [working there], and employees who understand well this relationship among different organs; Anvisa has always been very careful in informing Itamaraty of all missions it engages with, in most cases sends reports, and also participates in positions concertations. A very emblematic case, for instance, in the area of antimicrobial resistance, which Anvisa [always has debated], most times leading processes (...). Besides, many bilateral memorandums of understanding in health, or BRICS, for instance, regard regulation issues. And on that Anvisa has got a primordial role. So Anvisa has always been very present in the international scenario, but we never really coordinated or oversaw their work. Their work was coordinated and oversaw, let's say, by AISA. We did not have such a relationship; we still do not have this direct relationship with them. In the case of Fiocruz, we do not have any relationship with Fiocruz. At DTS, you develop a certain understanding, especially because of the work of UNASUR and ISAGS, which are very connected to Fiocruz, as well as in the tobacco area, we are part, DTS is part of the National Commission for the Implementation of the Framework Convention for Tobacco Control, and Fiocruz has got a great expertise in this area. But, let's say, Itamaraty does not hold them accountable.

This is another significant piece of evidence that the MoH had full autonomy to formulate, implement and assess its international projects. Itamaraty was aware of official visits and meetings and could also be aware of events and outcomes. Nonetheless, oversight services and inspections were not part of MoFa's responsibility in MoH subsidiary organs case. Such a circumstance is observed in studies on other Ministries as well, as indicated by Papi and Medeiros (2015). The Brazilian Ministry of Social Development, "as emphasized by a manager working at the Ministry of Foreign Affairs' Social Affairs Division, (...) [held] a great autonomy in the development of its

cooperation activities, being MoFA's participation just an intermediation of this process" (PAPI & MADEIROS, 2015, p. 82)

The Social Affairs Division was a key intermediary actor for institutional communications and issuance of directives for diplomats working in representations all over the world. Nevertheless, DTS was central at negotiations that require a more robust political position.

For instance, during negotiations that preceded the signature of the Oslo Ministerial Declaration, which later became known as the Foreign Policy and Global Health Initiative, MoFA's Social Affairs Division appointed Minister Mariangela Rebuá, then-director of the DTS, to take part in workshops and brainstorming sessions in order to formulate a draft proposal. Min. Rebuá was to be accompanied by Dr. Paulo Buss (Fiocruz director) in those meetings in New York, and although suggestions of topics to be debated in these workshops were to be formulated by the MoH, Itamaraty was interested in engaging DTS on the issue to ensure that interests of developing countries would be respected. As MoFA expressed, to Brazil, because of "the growing interdependence between health issues and the international political agenda", health became a sensible topic to social development, but this association concerning health and diplomacy was "recent and object of careful scrutiny", highlighting that interests of developing countries should be taken into consideration (MINISTRY OF FOREIGN AFFAIRS, 2007f, p. 02 - 03) .

When the actual meeting took place, Min. Rebuá, Dr. Buss and Amb. Santiago Alcázar, AISA's director at the time, were part of the Brazilian delegation. Thus, the country's representatives were a diplomat, a diplomat highly specialized in public health, and a doctor. Over the course of several days, participants were expected to introduce their expertise, concerns and wishes for the international initiative, and in the Brazilian delegation's introductory speech, "*the country's ongoing experience of a joint effort between the Chancellery and the Ministry of Health, and [this experience] contribution in handling this topic in the international arena*" was highlighted (MINISTRY OF FOREIGN AFFAIRS, 2007g, p. 04. Emphasis is ours).

Still regarding the Foreign Policy and Global Health Initiative, Minister Mariangela Rebuá also took part in preparatory meetings scheduled to take place before

UNGA encounters, so that country members of this joint endeavor could harmonize their positions. Brazil was an active participant, submitting draft papers and strongly standing up for its decisions in controversial issues, such as the use of ‘global public goods’ in global health governance, a concept Brazil strongly opposed to (MINISTRY OF FOREIGN AFFAIRS, 2007h).

Itamaraty’s Social Affairs Division worked closely with AISA and based itself on the MoH activities when formulating guidance and instructions for Brazilian representations abroad. Moreover, this institution granted great autonomy for organizations like Anvisa and Fiocruz to pursue their own goals, being more present when topics on the floor required more political action. Yet, DTS recognized the importance of MoH and MoFA collaborations in negotiations abroad and understood the importance of SUS in Brazilian Foreign Policy.

### **6.3 Brazilian Cooperation Agency**

The Brazilian Cooperation Agency (BCA), established in 1987, is part of Itamaraty’s Undersecretariat General for International Cooperation, Trade Promotion and Cultural Themes, and is responsible for (MINISTRY OF FOREIGN AFFAIRS, 2011a, p. 06):

Planning, coordinating, approving, implementing, following and assessing, within national scope, programs, projects and cooperation for development activities in all areas of knowledge, received from other countries and international organisms and performed by Brazil in developing countries.

In a less comprehensive definition, BCA is in charge of coordinating technical cooperation projects implemented within Brazilian territory by third parties, or implemented abroad by Brazil. And despite introducing its work with a clear emphasis on the importance of technical collaborations, BCA was aware of its political role in the Brazilian Foreign Policy chessboard, since technical cooperation can bond countries together and project “a modern image of the country” to international audiences (MINISTRY OF FOREIGN AFFAIRS, 2005d, p. 01)

Moreover, BCA also recognized that cooperation was a tool to Brazilian Foreign Policy, used both to develop the country and to “*promote [Brazil] to the condition of global player in international relations*” (MINISTRY OF FOREIGN AFFAIRS, 2005d, p. 01. Emphasis is ours).

This agency is at the centre of Brazilian technical cooperation and South-South Cooperation, whose official designation is Technical Cooperation among Developing Countries (TCDC), its most predominant operation (MINISTRY OF FOREIGN AFFAIRS, 2005d). As health is a key component of Brazilian international cooperation (HIRST, 2012), one would expect to see BCA formulating and planning several projects concerning health cooperation, as this entity did. For example, with BCA support, 62 Human Milk Banks were implemented in 18 Latin American and Caribbean countries, from Argentina to Mexico (MINISTRY OF FOREIGN AFFAIRS, 2014a).

However, despite health being a crucial topic, to BCA it was just as important as other matters, such as agriculture, for instance. As already stated, cooperation was regarded as a tool for the achievement of different foreign policy goals, and the agency was clear about it. This approach is quite practical and very close to the Brazilian Foreign Policy tradition of pragmatism on its relationships with other countries. Ambassador Marco Farani, director of BCA from 2008 and 2012, granted an interview to the author of this thesis, in which he expressed this connection very deeply (FARANI, 2017. Emphasis is ours):

The Ministry of Health was the executing organ, AISA was the executing organ.

Cooperation in health, specifically, does not distinguish itself from other areas. It was the *Brazilian Cooperation* that was in health, agriculture, and many other things. So, the philosophy behind it (...) was to contribute to international peace and security. It was to contribute to a better world, to a fairer world and etc. It was not a project for three, five, ten years. It was a project for a century. But you have to be engaged, to participate, (...) you take responsibilities to yourself, challenges from the international community. So this was the idea, to be truly active, not only through words, in the international order. [Be] active on the field (...). This explained cooperation.

In the eyes of the BCA, health was therefore conceived as one of its most important endeavors: Brazilian International Cooperation. And there are certainly many



types of collaboration: bilateral, multilateral, or via triangulation; all are varieties of the cooperation BCA undertakes and are not excluded from BCA's portfolio. As an example, triangular collaborations with Japan's International Cooperation Agency or the Spanish Cooperation Agency for International Development have benefited other developing countries (PUENTE, 2010).

Nevertheless, all this prestige is recent. The BCA used to be a "strange body inside Itamaraty" (MILANI, 2017, p. 26); only during President Fernando Henrique Cardoso administration were necessary reforms made, reorganizing MoFA's structure and providing more competencies and power to this agency. Those changes continued during Lula's era. However, Puente (2010) deemed they were not enough to suppress old legal flaws that brought considerable consequences to BCA's work. Despite all difficulties, from 2003 onwards TCDC became central to the MoFA, to the point that new criteria and priorities were established for technical cooperation and further attention to the issue was paid by high-ranked diplomats, "endowing BCA with further human and financial resources" for it to accomplish Itamaraty goals in technical cooperation programs (PUENTE, 2010, p. 113)

One international organization was fundamental in this whole process: the United Nations Development Program (UNDP). Since BCA's creation, the UNDP has supported its activities and granted extra resources to international cooperation projects (MILANI, 2017). Throughout Lula's administration this practice continued; UNDP and BCA signed two umbrella agreements, BRA 04/043 and BCA 04/044, in order to finance technical cooperation programs in developing countries. They are defined as umbrella agreements because within their scope a myriad of other cooperation sub-agreements were signed: for instance, Brazilian cooperation with Angola, for the strengthening of its health system, was classified as project BRA/04/043 -A157; and training courses to improve technical capabilities of Mozambique's Ministry of Health staff in Brazil was categorized as BRA/04/044 -A647 (MINISTRY OF FOREIGN AFFAIRS, 2010i; BRAZILIAN COOPERATION AGENCY, 2015b).

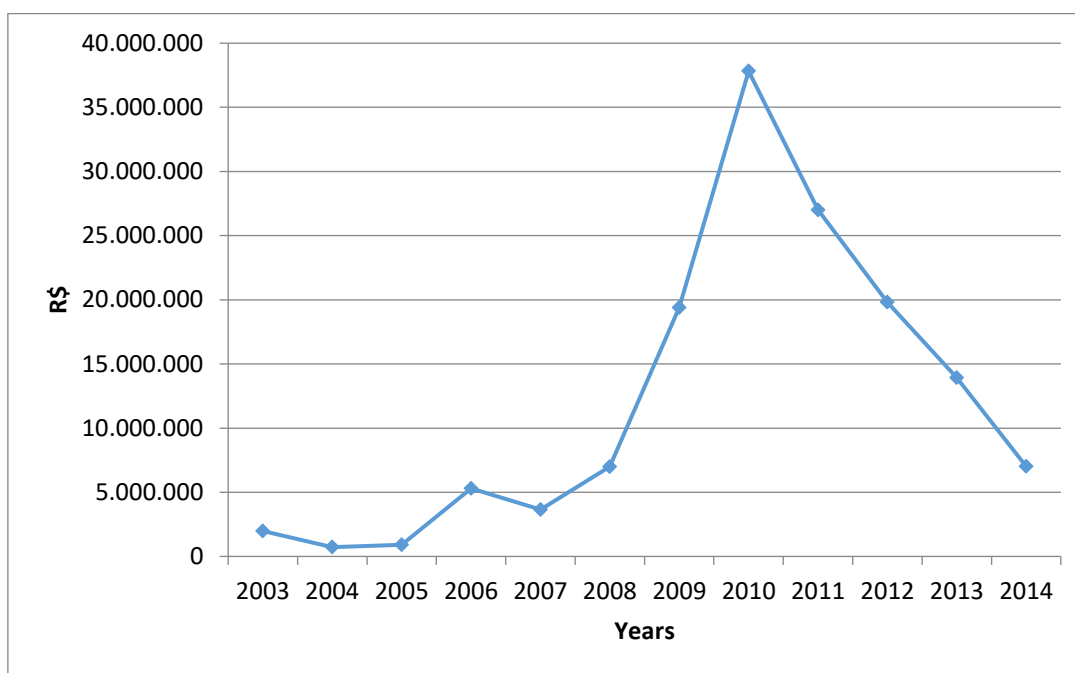
BRA 04/043 and BCA 04/044 had budgets of US\$21,411,387.70 and US\$47,847,150.80 respectively (MINISTRY OF FOREIGN AFFAIRS, 2010i; MINISTRY OF FOREIGN AFFAIRS, 2012b). Transferring such large sums can cause some contentiousness: 84% of all resources managed by BCA come from donations made

by either UNDP (with 49%) or International Labour Organization (ILO, with 35%), and because of their origin, they are not subject to management audits (Ministry of Foreign Affairs, 2014b, p. 02). Although the Office of the Comptroller General of Brazil audits international technical cooperation projects by sampling, we question the accountability and transparency of these projects and accounts (MINISTRY OF FOREIGN AFFAIRS, 2014b). Provided they are a considerable volume of resources, UNDP and BCA should be held accountable for their expenditures.

Given the nature of these resources, their audits reports find legal preclusions, and BCA itself is preoccupied with such matters. Because it is part of Itamaraty's framework, BCA is not autonomous: it cannot hire cooperation experts abroad; neither can it acquire any sort of possessions. Contracts with UNDP allow BCA to at least hold some control on its activities, even though it is not fully autonomous (SAO PAULO CHAMBER OF COMMERCE, 2012).

Despite questionable transparency processes, it is indubitable that from 2003 onwards there were a political project and financial resources to provide BCA with all means required for a TCDC expansion that lasted until 2011. As can be observed in Figure 07, there is an exponential growth in funding for projects for the 2007-2010 period, and the same staggering trend can be seen in the opposite direction for President Dilma's first term period (2011-2014).

**Figure 07.** BCA's budget for implemented projects<sup>52</sup>



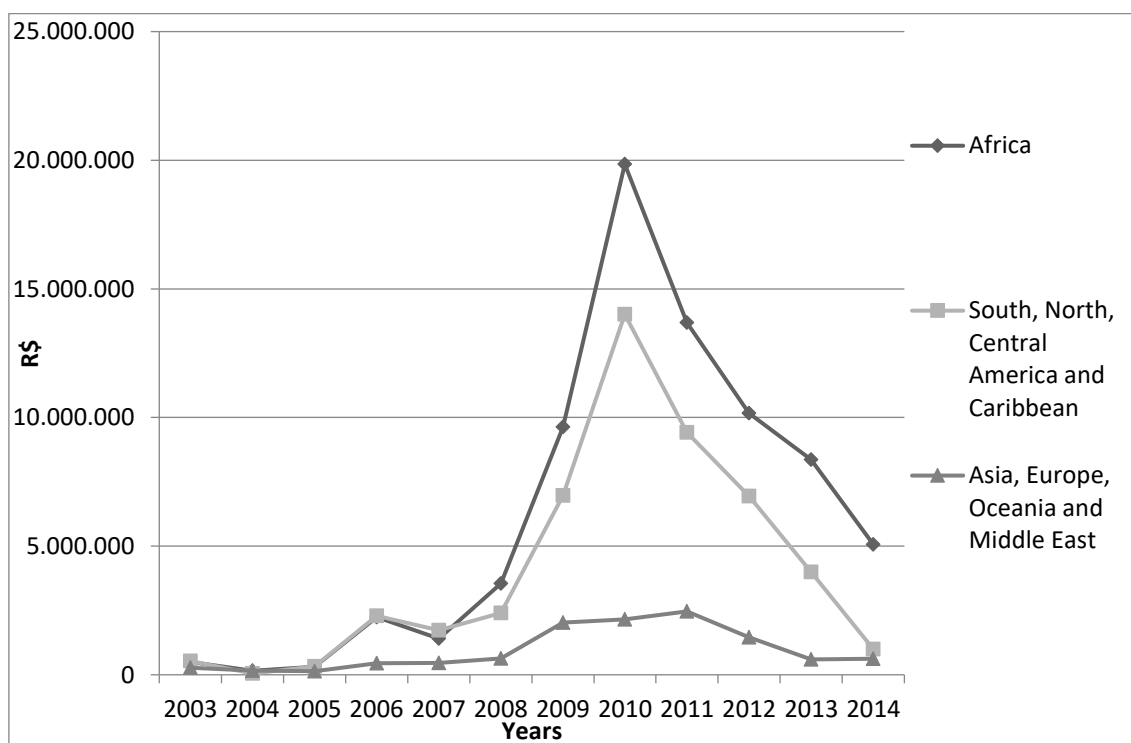
Source: Brazilian Cooperation Agency, 2017a. Elaborated by the author.

The same trend was seen when we analyzed funding spent per area of the world. As Figure 08 demonstrates, Africa was by far the territory with the most investments, followed by the American Hemisphere and the rest of the world. Provided that Brazil stated clearly that its priority in Foreign Policy was Portuguese Speaking Nations of Africa, as well as South American countries, these curves translate political discourse into financial terms. Most of these investments went to projects in agriculture, health and education.

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<sup>52</sup> This includes contributions from International organizations.

**Figure 08.** BCA executed budget (world area)



Source: Brazilian Cooperation Agency, 2017b; Brazilian Cooperation Agency, 2017c; Brazilian Cooperation Agency, 2017d. Elaborated by the author.

The Brazilian Cooperation Agency, with rare exceptions, does not implement projects directly. It serves as a connecting institution, linking third countries' demands to organizations with technical expertise and ability to transfer technology and know-how. The BCA's role was mainly to articulate actors and to provide funding, which could be made available by developed countries cooperation agencies, UNDP or the Brazilian Government itself (PUENTE, 2010).

As mentioned, the author of this thesis interviewed Ambassador Marco Farani, director of BCA from 2008 and 2012. His years as head of BCA are considered to be a period of entrepreneurial management, and Amb. Farani himself found the occupation to be "quite rewarding", since it was a "very positive activity to [Brazil]" (MILANI, 2017, p. 50). He demonstrated concern in seeing projects delivering feasible outcomes within a pre-determined time frame (FARANI, 2017):

Basically, it used to work in the following way: we used to receive, via embassies, cooperation requests. So we debated the possibility of cooperating, depending on the solicitation received, with the matching Brazilian Agencies, the ones that could deliver that (...). Once this was

clear, BCA then confirmed Brazilian government availability to offer that cooperation, and sent technicians from the Brazilian organization to that country, to discuss with local technicians and formulate a cooperation project. This project, when ready, was once again analyzed by BCA, a BCA technician was always present in these trips and was part of the project formulation, which was done accordingly to our pattern for projects. (...) if it was approved politically and financially, then it was implemented... we signed the projects, then implemented. In my years, I asked for projects (...) to have a beginning, middle and an end. (...) that they were not too long, [so we would not] lose control and all technicians engaged would have a sense of work accomplished. Projects would last two years, maximum, some projects, if [more time] was needed, we would formulate a new complementary project, to continue the [previous] one.

The official documents from MoFA demonstrate just how much paper work was involved in the relationship between BCA and other Brazilian Organizations as they dealt with international demands and mission planning. For instance, BCA was responsible for mediating the exchange of documents regarding the implementation of Cape Verde's Human Milk Banks between Cape Verde's government and AISA, basically intermediating communications among them (MINISTRY OF FOREIGN AFFAIRS, 2008e). Another example is a visit from a Burkina Faso delegation in 2008. This official entourage was meant to come to Brazil so that its members could have a glimpse of SUS functioning and undertake a course on this health system. It was BCA's responsibility to organize this mission along AISA. BCA's diplomat in charge of this visit formally required AISA to enable her to answer to the African authorities, demonstrating either how little authority BCA had or how little knowledge on MoH activities this agency held (MINISTRY OF FOREIGN AFFAIRS, 2008f).

What we might consider a problem could also be understood as BCA simply working within its competence. For this thesis, BCA's General Coordinator for Palop and East Timor was interviewed. Mr. Paulo Roberto Barbosa Lima was asked about health and BCA work, to which he answered (BARBOSA LIMA, 2017. Emphasis is ours):

*BCA does not have to understand, at least for now, now it is still being structured (...), it does not have to understand health. It has to understand technical cooperation. How I take a health issue and transform it into a development project. And then tools to facilitate and tools to formulate the projects, projects management, of course, we will always count on (...) our partners. We will always count with the thematic Ministries, institutes and Brazilian institutions, to support*

BCA in the formulation of a project on each theme. So, we have to know a lot about foreign policy, we have to know a lot about technical cooperation, to support these partners to formulate actions and cooperation initiatives in [other] countries.

Thus, we can assume that BCA *was not meant* to influence or to have a say in the content or substantive matters of cooperation, as according to Mr. Barbosa Lima it was not its responsibility. This would, as a consequence, assure great levels of autonomy to MoH institutions, since BCA's unique role was to confer if agreements respected legal aspects of technical cooperation.

Many interviews confirm this feature of BCA work. For instance, Ms. Patricia Tagliari, director of Anvisa's international affairs office, explained that prior to negotiations, the BCA and the Brazilian Embassy request technical cooperation to organize an official visit to identify what the actual needs of the demanding country are. After that, BCA invites Brazilian institutions with the necessary technical expertise to a meeting, in order to put together a cooperation project and a plan of action. Anvisa assessment considered the technical expertise it could transfer, its availability to be in the project and amount of funding for these activities, which most of the time counted on BCA resources. Also, Anvisa and BCA's relationship was considered, by Ms. Tagliri, to be very good (TAGLIARI, 2017).

A similar relationship was developed with the Brazilian STD / HIV / AIDS Program from the MoH. As Dr. Mariangela Simão highlighted in her interview to the author of this thesis, the HIV / AIDS program (SIMÃO, 2017):

(...) did have a solid cooperation base with other countries, and we used to do this alongside BCA. We used to contact BCA in a direct fashion. (...) we had, of course, a formal relationship with MoH's International Advisory Service, but it was more like a pro forma contact. I used to inform them when a new cooperation project [was approved], via BCA. So, it was not independent, it was something from the Brazilian government, but was not tied to the Ministry of Health structure.

The HIV / AIDS program formulated its agenda. But we answered as well to BCA requests, so, for instance, when we were supposed to establish a technical cooperation network with Portuguese speaking countries, we did it with BCA. There was cooperation, a technical cooperation group among HIV /AIDS [program] directors of the

Community of Portuguese Language Countries, and we did it jointly with BCA.

Fiocruz also claims to have developed, over the course of several years, a positive relationship with BCA. Both Dr. Paulo Buss and Dr. Luiz Eduardo Fonseca emphasized BCA's support to this foundation's international endeavours, even though its priority setting structure was quite autonomous, as the former explains (BUSS, 2017. Emphasis is ours):

To Fiocruz was requested for to support the foreign policy, the president, support the expanded-Brazilian-presence-abroad policy. So, how would this happen? We were free to propose, from the contact sent to us or from a demand stemming from a country, we were free to propose to the government project A, project B, project C. We were supported, on one hand, by BCA, from the Ministry of Foreign Affairs, (...) and on another, by resources from the Ministry of Health itself. And let's say, we had human capital (...), technical capital.

It has always been very easy, very flowing, very cooperative this collaboration with AISA. AISA provided funding for some things, Fiocruz provided funding too, (...) and *another very important agency, with the same (...) consistency, vision and convergence was BCA (...)* [it] also worked very aligned with Brazilian Foreign Policy.

Hence, under Dr. Paulo Buss' scrutiny, BCA was consistent and shared the same values with both Fiocruz and the BFP. Apart from all the positive highlights, Dr. Luiz Eduardo Fonseca remarked on some communication issues which were more common when there was a significant spike in international demand, but which did not compromise the quality of this relationship. Moreover, because of Cooperation Term n° 41, with PAHO, Fiocruz had resources of its own to pursue some of its goals and implement projects without being held accountable by BCA, though its activities were reported all the same (FONSECA, 2017a):

[TC 41] made Fiocruz more autonomous to fund trips and institutional missions. In this sense, when this funding existed, we were able to foment activities without being accountable to BCA or AISA, yet these activities were always reported to these spheres and shared (...) in the health realm.

Our relationship with MoFA has always been one of mutual respect and courtesy, nonetheless, our institutional relationship happens via BCA. During Minister Celso Amorim's management, who personally

(...) reinforced Brazilian international cooperation, this relationship with BCA was more institutionalized, likewise with AISA (...).

[Relations with BCA were] always very good. For the (...) first years of this decade, relations among BCA, AISA and Fiocruz had to be lubricated, since cooperation demands increased and sometimes, communication with different stances did not keep the same pace. Sometimes uncomfortable surprises were created, as AISA knowing about an activity between Fiocruz and BCA after it [had already been] negotiated.

However, given the considerable number of international projects implemented by all these institutions, these communications issues did not prevent Brazil from strengthening its role as supplier of technical cooperation.

There is an interesting convergence of working rationale between BCA and Fiocruz, making us wonder whether such common thought was developed after intense periods of collaboration among MoH institutions and BCA. Fiocruz is well-recognized for coining the idea of structuring cooperation for health, and circa 2009, while BCA was experiencing a staggering increase on its resources and expanding Brazilian South-South Cooperation programs to over 55 countries, this agency adopted a new approach to its cooperation model (MINISTRY OF FOREIGN AFFAIRS, 2010l, p. 33):

Aiming to print a new status and a new dynamic to the Brazilian Cooperation, BCA adopted an approach to the Brazilian South-South cooperation, based on 'structuring' actions, which have offered many advantages to the Brazilian cooperation and, principally, to recipient countries: the social and economic impacts of this cooperation to target audiences have increased, and sustainability of outcomes from this Brazilian Cooperation have been ensured.

We are implying, in this case, that given MoH strength and Fiocruz authority in South-South Cooperation, perhaps their actions might have inspired BCA to consider the importance of training local personnel and ensuring that projects would continue in spite of Brazilian absence after its technicians' departure in all areas of international cooperation, not only health.

Although crucial to Brazil and BCA, the UNDP was not the only partner providing funding to Brazilian projects. Triangular cooperation was quite a common method used



by Itamaraty, relying thus on external money transfers coming from developed countries to answer to developing nations' demands. Features of this type of cooperation were usually similar in all projects: cooperation agencies from developed countries would provide financial means; Brazil would be responsible for know-how sharing and technology transfer; and recipient countries would outline their needs. The Ministry of Health itself emphasized how relevant triangular cooperation was to the world, since it reduced the likelihood of analogous institutions from different countries to develop parallel projects at the same place. However, this same Ministry stated clearly that, to Brazil, triangular cooperation could not "lose its horizontal cooperation nature, neither assume a 'technical assistance' approach" (MINISTRY OF HEALTH, 2009a, p. 29).

MoFA engaged in a series of triangular cooperation, and more interestingly, for a time Brazil allured foreign partners so much that many developed countries offered to formulate triangular cooperation projects with Brazil. Denmark, Italy, Norway and USA are examples of nations willing to support Brazilian Technical activities in Africa, especially in Mozambique. The consistency of this approach made the Brazilian Ambassador in Maputo, Mr. Pedro Luiz Carneiro de Mendonça declare, in 2003, that "in recent times, the interest of third countries / international organizations to work with Brazil in Mozambique has increased considerably" (MINISTRY OF FOREIGN AFFAIRS, 2003q, p. 01).

Indubitably, not all programs with developed countries followed this pattern: for instance in 2003 Brazil and the USA signed an agreement entitled *U.S. - Brazil Joint Venture on HIV/AIDS in Lusophone, Africa*, in which "President Bush stressed that the program will take advantage of Brazil's expertise in creating a national program for HIV/AIDS prevention, care, and treatment, and benefit from the cultural and linguistic advantages that Brazil brings to programs in Lusophone Africa" (U.S. DEPARTMENT OF STATE, 2003, p. 01). In this program, Brazil and USA contributed equally with their technical expertise.

Probably one of the most well-known international collaborations in health under Palop's scope, and certainly the most renowned cooperation with Angola, happens to be a triangular initiative: Proforsa, or Project for the Strengthening of Angola's Health System, which receives financial support from JICA, Japan's International Cooperation Agency (FONSECA, ESTEVES & GOMES, 2015).

Angola had already demonstrated, in 2006, interest in operational aspects of SUS and in the consolidation of a primary health care system in the country. The following year, the Ministry of Health sent to BCA a proposal of an international project for its scrutiny, named Developing Primary Health Care Services in Angola. Amb. Santiago Alcazar reminded BCA of how cooperation with Angola had always been “a priority in partnerships between MoH and this agency [BCA]”, also recapping all the successful programs both countries had jointly assumed on issues such as malaria and nutrition (MINISTRY OF HEALTH, 2007c, p. 01).

Angolan interest in Brazil was evident as well. In an official visit, this nation was intrigued by programs such as Family Health Program and pediatrics’ plans, a situation which led to a formal cooperation request in these areas by the Angolan Vice-Minister of Health (MINISTRY OF HEALTH, 2007c, p. 01).

Proforsa was a three-year-long project entailing BCA, Fiocruz, UNICAMP and JICA participation. Signed in 2011, it was a project with well-defined tasks, so each participant had full understanding of which areas they should engage with (ESTEVES, FONSECA & GOMES, 2016, p. 169. Emphasis is ours):

*Fiocruz*, through Joaquim Venâncio Polytechnic School of Health (EPSJV/ Fiocruz) and Sergio Arouca National School of Public Health (ENSP/Fiocruz), became the lead institution in the project’s primary health component. The tertiary component, led by *UNICAMP*, particularly through Hospital Sumaré in Brazil, and *JICA*, focused on improving the organization of hospital services and nursing care, in areas such as neonatal and women’s health, at both Josina Machel Hospital and Lucrécia Paim Maternity.

Despite being coordinated by BCA, Fiocruz commanded country missions and project planning, defining Proforsa as another project strongly based on “structuring cooperation for health” ideals, therefore “seeking to strengthen local institutions and to jointly build [the health system] with Angolan authorities” (PAN AMERICAN HEALTH ORGANIZATION, 2014b, p. 215).

Fiocruz was praised by locals for being “very apt in promoting understanding of basic issues related to Angola’s health system among sectorial stakeholders”, and the project had mechanisms to “guarantee (...) national ownership and context sensitivity” (FONSECA, ESTEVES & GOMES, 2015, p.28).

However, Proforsa had a great misfortune, and that was having commenced its activities in the year of 2011. As demonstrated in Figure 07, BCA had a sharp increase in resources available for its projects from 2008 to 2010, followed by a similarly intense decline from 2011 onwards. In 2014, the year Proforsa was concluded, BCA saw itself with the same levels of investments of 2008.

In its management report, the Agency admitted the existence of this problem, disclosing a decrease in the number of new South-South initiatives and further relying on resources from developed countries via Triangular cooperation to fulfill its commitments, even if the project was not originally triangular, but bilateral (Brazil – another developing country) (MINISTRY OF FOREIGN AFFAIRS, 2011a). As the institution itself explained, BCA accomplished some results with its bilateral cooperation (MINISTRY OF FOREIGN AFFAIRS, 2011a, p. 08):

Regardless of budgetary cuts determined by the Federal Government, whose impacts reverberated in new commitments to be made throughout this period, diverse missions for prospection and cooperation projects negotiations, as well as working groups meetings, to be held in the first semester, were postponed, and new demands, particularly for structuring projects, were renegotiated or reformulated, so that they could meet BCA's new [budget] execution expectations.

Proforsa was no exception in this case: as a consequence to these budget cuts, “there had to be a restructuring of responsibility for Proforsa's third year project expenses. Most cuts were absorbed by JICA, while a smaller yet significant amount was allegedly absorbed by Angola's Ministry of Health” (ESTEVEES, FONSECA & GOMES, 2016, p. 171).

This project was also greatly impacted by inconsistencies in its implementation, such as delays in works for improvements of infrastructure and lack of human resources with the required ability to fulfill certain tasks. Moreover, the Brazilian Ministry of Health, as Esteves, Fonseca and Gomes (2016) explain, failed to fulfill all of its duties.

Additionally, there were cultural and political challenges that posed constraints to the project (ESTEVEES, FONSECA & GOMES, 2016). Maybe in this case, a parallel with the analysis of Russo, Oliveira *et al.* (2014) of Mozambique can be traced: different perceptions of public health and managerial styles among Brazil, Angola and Japan

influenced negatively the implementation of Proforsa, although this did not prevent the project from being fully executed.

The project with Angola was important. However, BCA was only the coordinator and responsible for part of its funding, performing exactly as it was supposed to. BCA's institutional competence is to coordinate the Brazilian Cooperation Policy, but nonetheless these efforts are sometimes diluted by numerous other institutions, such as the Ministry of Health and Fiocruz, who also develop cooperation projects abroad independently from BCA (SAO PAULO CHAMBER OF COMMERCE, 2012). As Mr. Barbosa Lima (2017) emphasized, this might lead to miscommunications and future problems.

Ex-Director of the BCA, Amb. Marco Farani, did not understand that BCA scope of action was limited: its employees had specific roles, and, under Amb. Farani scrutiny, they successfully achieved goals. As he explained (FARANI, 2017, p. Emphasis is ours):

Each technician [from BCA] was responsible for a certain number of projects. *What this technician (...) had to do was basically to hold control of schedules and follow the performance of the cooperation service, to ensure [technology] was being properly transferred, if the institution was executing cooperation (...) in a way that the soliciting country was pleased (...), that is, to make assessments.* We had a spreadsheet with all the projects (...), each one's activities, how they were being implemented, what was missing (...). I had a great overall control of everything. In my days, no project was stopped, all projects were executed within deadlines, more or less, sometimes we had issues... sometimes issues with Brazilian technical organizations, because they were involved with other things in Brazil and could not travel on specific dates, but we resettled it for next month and deadlines were met.

Additionally, Amb. Farani demonstrated a great respect for BCA's employees and institutional achievements, since they were highly-skilled hard working professionals. This matter was brought about after he was asked if SUS influenced Brazilian international cooperation projects, and emphasis are ours (FARANI, 2017):

No, not SUS specifically, because our cooperation was not influenced by an institution or another. The principles and motivational

aspects of this cooperation, political and human aspects, humanitarian aspects [influenced] (...). Now, a Brazilian program like SUS, this Brazilian project, such as HIV / AIDS combat, when it works well in Brazil, it can be easily... abroad, transferred to other countries. *We have fantastic technicians, brilliant people in all areas. Very dedicated people, committed on technical standards*, I mean.

And they also have good academic education, a lot of people with good academic education. And there was also great enthusiasm, (...) with Brazil, I mean, we thought we were building a new Brazil, a more egalitarian [country] (...).

International technical cooperation could have been a great tool for the establishment of a more effective foreign policy, (...) for the obtainment of more responsibilities on Brazil's behalf (...). Cooperation would contribute as well to our development.

The Brazilian Cooperation Agency was not depriving other institutions from their autonomy to formulate, implement and assess projects abroad. It was BCA's competence and responsibility to negotiate, fund, formulate projects *with technical organs* and make assessments on the effectiveness of each one of these projects. As Mr Paulo Barbosa Lima (2017) expressed:

We cannot cooperate without our partners. We have as principle the participation of them all, horizontality in our relationships. (...) BCA does not formulate projects on its own. That is why I said we do not need to understand health. Who understands health issues are the ones in the Brazilian government who execute health projects.

This agency had goals of its own, but BCA was much more concerned with the quality of these cooperation projects and respect to deadlines than *their content*. BCA should ensure deadlines were respected and recipient countries were satisfied with the cooperation outcomes, however the technical knowledge was not part of its roles and duties. MoH and Fiocruz were independent and BCA could only impose budgetary constraints to projects jointly developed: considerations on what was significant health-wise were discretionary to health institutions.

## 6.4 Global Health and Foreign Policy Initiative

Launched in September 2006, as part of Norway and France's efforts to discuss connections between health and foreign affairs, the Global Health and Foreign Policy Initiative wanted to place health as a strategic matter to the international agenda. Supported by Brazil, Indonesia, Senegal, South Africa and Thailand, this Initiative wanted to provide health a special role in the international arena by: "exploring how foreign ministers and foreign policy could add value to health issues of international importance, and by showing how a health focus could harness the benefits of globalisation, strengthen diplomacy and respond to new thinking on human security" (AMORIM, DOUSTE-BLAZY, *et al.*, 2007, p. 01).

The following year, countries involved agreed that a more ambitious step should be given in order to demonstrate to the world how this interconnection was significant, and as a consequence, they signed, on March 2007, the Oslo Ministerial Declaration (AMORIM, DOUSTE-BLAZY, *et al.*, 2007). This document was a benchmark to governments willing to demonstrate how health was noticeable in their international agendas (LABONTÉ & GAGNON, 2010).

The Oslo Declaration wanted to organize the international agenda around three axes: capacity for global health security, threats to global health security and making globalization work for all. Although countries did not reach an agreement on a definition for global health security, with this declaration all these nations proved that health and foreign policy are interwoven, with some issues requiring international cooperation to be solved (such as emerging infectious diseases) (AMORIM, DOUSTE-BLAZY, *et al.*, 2007).

The aim of this subchapter is not to describe what the Oslo Declaration is and its outcomes in detail. Brazil's role and performance in this initiative will be scrutinized, in order to understand Itamaraty's undertakings in this whole process.

Brazil was present at the very first meeting of this initiative, which took place in Paris, in November 13<sup>th</sup>, 2006. In the beginning, countries wanted to estimate how "cooperation among countries interested in promoting common strategies to deal with

health challenges of global reach” could be structured (MINISTRY OF FOREIGN AFFAIRS, 2006d, p. 01).

Dr. Paulo Buss, then director of Fiocruz, and Amb. Santiago Alcázar, then AISA’s director, were also invited to this meeting. By 2006 Fiocruz was considered by the Brazilian government as a fundamental actor for health international cooperation and deemed as a “privileged focal point for such cooperation” (ALMEIDA, CAMPOS, *et al.*, 2010, p. 26). In an interview with the author of this thesis, Dr. Paulo Buss explained that Brazil had become an important country for this initiative because of all the accumulated know-how this nation already had in public health (BUSS, 2017):

The Oslo Declaration, I was part of the initial work, it was the [acquired] knowledge of the Brazilian government after 5 years of Lula’s government. He started in office in 2003, and (...) soon Brazil discovered that health... The Oslo Declaration, called attention upon the importance of serious sanitary issues the world was facing, [wanted] health to be part of each one of those countries’ foreign policies; and the UN (...) I think in 2010, made a declaration on health and foreign policy.

Nonetheless, despite the presence of the MoH representatives, Itamaraty and all other countries involved were aware that letting the Ministers of Foreign Affairs take the lead in discussions would embed public health in foreign policy strategies, and this would be of pivotal significance for future global health negotiations. Dialogue between public health experts and diplomats was encouraged, since each field could complement each other’s work. However, countries understood the relevance of addressing global health issues with an approach other than that of security and health. (MINISTRY OF FOREIGN AFFAIRS, 2006d).

Brazil was open to discuss a range of issues, from health actions in war-torn territories to communicable diseases surveillance, as well as innovative funding mechanisms for international assistance and health research. The country also wanted to bring to the table debates concerning access to drugs and intellectual property, mainly because medicines production in developing countries was a very dear topic to Brazil at that moment (the ARV medicines factory in Mozambique was already under implementation in 2006, so perhaps this motivated Brazil to put forth this issue in different stances) (MINISTRY OF FOREIGN AFFAIRS, 2006d).

Itamaraty also wanted South-South Cooperation, research and development and the link between health and development to be on the floor, and the Ministry of Health proposed some suggestions on which the diplomats could base their work (MINISTRY OF FOREIGN AFFAIRS, 2007f).

One matter proposed by this initiative, and a reason of great apprehension for the delegation, was the concept of global health security. In March 2007, now at a working group in Oslo, Brazil reiterated its interest in focusing on TRIPS flexibility, South-South Cooperation and associations between health and development, and *not* global health security, since the definition of the concept had yet to be negotiated. For this country, health and security could overlap in specific situations, such as an increase of vulnerabilities in populations affected by unsafe circumstances. However, Brazil understood the existence of a definition *per se* to be excessively problematic. The eventual solution was to add a footnote in this Oslo working group's final document, expressing that (MINISTRY OF FOREIGN AFFAIRS, 2007j, p. 02 - 03. Emphasis is ours):

The concept of global health security has yet to be defined. *The reference to security should not be understood in terms of threats to the maintenance of peace and security enshrined in the UN Charter.* In the context of this initiative, global health security is used to mean protection against public health risks and threats that, by their very nature, do not respect borders. Global health security depends on critical capacity in all countries, combined with a commitment to collaborate, as spelled out in the International Health Regulations. It is our expectation that a definition for global health security will be agreed at the World Health Assembly.

Associations of health and security have always been a source of major apprehension for Brazilian diplomats. Brazil is not fond of the idea of securitization<sup>53</sup>,

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<sup>53</sup> Securitization is the use of speech to transform "political challenges and challengers (...) into existential threats to the community" (HANRIEDER & KREUDER – SONNEN, 2014, p. 333). Securitization creates friend – foe antagonisms that may pose threats to democracy and the rule of law, and in a scenario of a communicable disease outbreak, this connection of health and security / disease securitization can have negative consequences for international organizations and countries' responses. For further information, see HANRIEDER, T. & KREUDER – SONNEN, C. WHO decides on the exception? Securitization and emergency governance in global health. *Security Dialog*, vol 45, nº 04, pp. 331 -348. 2014.



and has always avoided, even at the United Nations Security Council, any assertion that could imply connections of topics which were not threats to peace and security, as the UN Charter understands it. In an interview with a Brazilian diplomat, this person clearly affirmed that (BRAZILIAN DIPLOMAT WORKING AT A MULTILATERAL INTERNATIONAL ORGANIZATION, 2017):

Securitization was a permanent preoccupation. (...) there were many different issues, even issues we understand that should indeed be on the (...) security agenda, such as protection of civilians; women, peace and security...

HIV / AIDS, climate change (...) they were topics we deemed important, (...) topics in which we even felt we could have some leadership and be proud of, but I had to stay there, hammering “no, it cannot be done, it is not a threat to peace, it is securitization” ...

But securitization of global health was avoided at this point of negotiations, and after this working group, Brazil demonstrated it was very pleased with the results of discussions, since in the Oslo Declaration access to medicines and health and development were included in the final text. Brazil also committed to bringing more Latin American countries to this initiative (MINISTRY OF FOREIGN AFFAIRS, 2007j).

After the Oslo Declaration was approved, international efforts to take this initiative to the UN General Assembly began and signatory meetings continued. On September 2007, a preparatory meeting to the 62<sup>nd</sup> UNGA took place in Paris, where Brazil again shared its concerns on France and Norway’s insistence on focusing on an approach to health and security that emphasized threats to peace and collective security. Brazil had several reservations to this idea, and sustained its position of a ‘cooperation enthusiast’ (MINISTRY OF FOREIGN AFFAIRS, 2007h).

The same criticism applied to the WHO. When the 62<sup>nd</sup> UNGA started, Brazil demonstrated a deep concern on what would be discussed ahead, and worried that this association of health and security could actually broaden up WHO’s fields of action. The country already understood that Dr. Margareth Chan, this IO’s General Director, focused on holding health and security close together, which led to further support from the European Union and the United States. Thus, clear instructions were issued for diplomats to not support any language not found in the Millennium Summit framework, and most importantly, to prevent “any initiative willing to trace causal and necessary relationships

amongst concepts such as combat to health threats, humanitarian intervention and responsibility to protect” (MINISTRY OF FOREIGN AFFAIRS, 2007k, p. 03)

MoFA and South Africa were responsible for ensuring that emphasis would be given to links between health and underdevelopment problems, true causes of violence and instability in their interpretation. Brazil also convinced others that there was no consensual definition on the concept “global health security” (MINISTRY OF FOREIGN AFFAIRS, 2007k).

Unfortunately, all these efforts did not render health a high-level meeting at the UNGA, but a draft resolution was written and later on the then-officially published resolution became an important document to most countries wanting to prove how health and foreign policy affect one another (MINISTRY OF FOREIGN AFFAIRS, 2008g).

Ideas and problems from this Global Health and Foreign Policy initiative extrapolated to other UN forums. During a preparatory meeting before the 2009 United Nations Economic and Social Council (ECOSOC) sessions, Itamaraty disclosed to its diplomats that during a high-level seminar of this Initiative at the WHO, a clash of interests between developed and developing countries had erupted, mainly because the former group sustained a security approach, and the latter, a social-economic development one. Additionally, Brazil was uncomfortable with private funding and earmarked donations in the global health governance system, a practice remarkably supported by developed nations. Hence, the country asked for its diplomats to take part in this ECOSOC preparatory meeting “to focus on interrelations between health and development” (MINISTRY OF FOREIGN AFFAIRS, 2009a, p. 04).

And indeed, this happened. To France’s dismay<sup>54</sup>, ECOSOC declared that global health and foreign policy were intertwined in a myriad of different topics, such as human rights, poverty, nutrition, gender equality and women’s roles, access to medicines, work-place conditions and even the strengthening of health systems. Moreover, the countries were asked to closely work with WHO General Director and UN General Secretary to

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<sup>54</sup> France did not want the scope of the initiative to broaden up in these different UNGA resolutions because the country considered they could become “new Oslo Declarations” instead of only UN resolutions.

write a report and another draft resolution to be introduced at the 64<sup>th</sup> UNGA session (MINISTRY OF FOREIGN AFFAIRS , 2009b).

All these efforts resulted in countries committing to at least debate Foreign Policy and Global Health relationships, and in the UN releasing studies and joint declarations with the WHO. Every single year, from 2008 to 2013, there were resolutions on Foreign Policy and Global Health approved at the UNGA, documents in which we can identify an evolution in the debate: Security is still present, but this time as a consequence of promotion of health equity – considered to be “essential to sustainable development and to a better quality of life and well-being for all, which, in turn, can contribute to peace and security” (UNITED NATIONS GENERAL ASSEMBLY , 2013, p. 03).

At the margins of this very same UNGA meeting in 2003, the original signatories of this initiative issued a Ministerial Communiqué, reiterating their commitment to this debate and asking the UN, in the formulation of the post-2015 development agenda, to consider the centrality of health (PERMANENT MISSION OF THE REPUBLIC OF INDONESIA, 2013).

There are two matters we understand should be highlighted: the first one, the Brazilian leadership in preparatory meetings, meetings and conferences, always tried to push the topic away from securitization and emphasize how much health and development were interwoven. Itamaraty’s delegation was so successful in this endeavor that not only did ECOSOC support this idea, but also, we can observe how UNGA’s 2013 resolution on the matter did not underscore much security.

The second topic is to observe a more active role of Itamaraty. This Global Health and Foreign Policy Initiative had a more political approach and was also discussed in much more politicized arenas, such as UNGA and ECOSOC, being thus deliberated in places where MoFA was naturally more prominent. The Ministry of Health was certainly present in the early days of this initiative, for both Fiocruz and AISA representatives were invited to take part in working groups. Nonetheless, bearing in mind the arenas (UN and WHO), type of negotiations (for instance, wordings in resolutions) and features of analogous actors Brazil was negotiating with (other diplomats and MoFAs), it is

understandable why Itamaraty was the head of all this process, with MoH serving a more auxiliary role.

## 7. International Forums and Blocs

Brazil has been an active participant of International Organizations for a long time, and after its redemocratization process, the country also started to strongly advocate regional integration and cooperation with developing countries. Health was an important issue on its international agenda too: when the League of Nations Health Organization was established, Brazil was one of the few South American countries welcomed as a member, contributing to debates on leprosy, infant mortality and yellow fever. Interestingly enough, from 1922 to 1934, Dr. Carlos Chagas, then director of the Oswaldo Cruz Institute, was involved in the Health Organization's Leprosy as well as Malaria commissions (WEINDLING, 2006). When the League of Nations was dissolved, and the United Nations were suggested, Brazil took the lead, with China, to consistently help in WHO's creation (KIRCH, 2008).

When the Military Dictatorship was over, in the early 1980s, the then president Mr. José Sarney (1985-1989), realized that South America was part of a strategy for a worldwide Brazilian insertion, therefore fomenting the creation of a regional integration mechanism with Argentina. This mechanism would later become the Southern Common Market, a.k.a MERCOSUR (VISENTINI, 2008).

During Lula's years as President, other initiatives were encouraged. Lula sought to build stronger South-South bonds, forging alliances with developing countries whose foreign policy goals were similar (CERVO, 2010). This trend can be observed with the creation of IBSA Dialogue Forum, a tripartite grouping of countries created by India, Brazil and South-Africa in 2003, by the Brasilia Declaration, aiming to change global political economy and "to construct strategic partnerships between three of the world's big emerging markets" (TAYLOR, 2009, p. 47).

The South-South movement was not changed by Ms. Dilma Rousseff's administration. Between 2011 and 2014, Brazil still wanted to establish a regional zone of influence and improve its relationships with China and Russia, although in both areas a decline in the intensity of efforts was observed (CERVO & LESSA, 2014).

This chapter's purpose is to demonstrate how these different international forums and blocs had their agendas influenced by actions perpetrated by the Ministry of Health,

and how sanitary issues became a key topic to bring these different countries closer together. Moreover, we want to describe Brazil's intention to operate in international arenas other than WHO and PAHO. The historic creation of these forums and blocs are not object of scrutiny, as the aim is to debate how health discussions were pushed by the Brazilian government in these organizations.

Brazil's commitment to emphasize cooperation with other countries from the global South was visible in the MoH's *More Health* initiative. Due to what this Ministry defined as an "active partnership with the Ministry of Foreign Affairs" (MINISTRY OF HEALTH, 2009a, p. 16), it was agreed that the *More Health* strategy would, at its international agenda, include contributions for the "development of structures and of health systems of South and Central American countries, CPLP and other African countries", as well as to support formation of African technicians in nursery subjects and enhance health in the borders program (SIS-Fronteira) with neighbouring countries (MINISTRY OF HEALTH, 2009a, p. 17).

This rationale of cooperation was kept unchanged when the Strategic Planning 2011-2015 was formulated, since its Goal 14 also focused on strengthening the regional integration process in health, at UNASUR, MERCOSUR and other regional forums (MINISTRY OF HEALTH, 2013, p. 146). According to Dr. Padilha, there was a clear intention of this Ministry to strengthen South-South cooperation during his years as Minister, encompassing institutions, such as MERCOSUR and UNASUR, as well as initiatives, such as BRICS (PADILHA, 2017).

We argue that, as a result, the Ministry of Health had a project and a strategy for its international insertion in these regional blocs and international arenas. That implied provision of autonomy and resources to its organizations (as Fiocruz and AISA), and also an *enlargement of the geographical scope of the actions of these organizations*, providing them with the means necessary to put into practice their own political goals in South America and Africa, for instance.

The MoH clearly states in its cooperation assessment that MoFA was a partner, so its subsidiary entities (AISA, Fiocruz, Anvisa, STD / HIV Coordination, among others) should establish operational collaborations with the BCA and local Brazilian embassies (MINISTRY OF HEALTH, 2013). However, as already debated in previous chapters,

MoH was autonomous to formulate and implement international technical cooperation projects, leaving to Itamaraty the role of an intermediary agent.

The Pan American Health Organization was a fundamental entity throughout this entire process, for its financial and managerial support bolstered AISA and Fiocruz capabilities to provide international technical assistance. Singularly, it was PAHO's political goal, in Brazil, to “support international health activities defined by the government” (PAN AMERICAN HEALTH ORGANIZATION, 2007, p. 49). In the release of its 2008–2017 strategy, entitled “Health Agenda for the Americas”, this organization expressed its interest in (PAN AMERICAN HEALTH ORGANIZATION, 2007, p. 50. Emphasis is ours):

following Brazilian international participation in initiatives, spaces and health political processes, boosting partnerships based on *shared principles of equity, universality, integrity and social participation, as well as strengthening of public health*; contributing with (...) Brazilian capacity of cooperating for *the development of health systems of America*<sup>55</sup> and with *Portuguese Language Countries in Africa, under the South–South Cooperation framework*.

Therefore, Brazil had international incentives to collaborate with other countries using the principles SUS underpins. And this support, via signature of Cooperation Terms, became indeed a mechanism used by most of MoH institutions to broaden their scope of action to different arenas.

Bearing in mind the Brazilian strategy of focusing mainly in Latin America and Caribbean countries – especially South American ones – as well as Portuguese speaking nations of Africa, it becomes quite obvious why these three blocs retained most Brazilian cooperation efforts: MERCOSUR, UNASUR and CPLP were international arenas in which Brazil engaged the most. Two other informal political blocs were also regarded with due attention by Itamaraty and MoH, because of their features: the India, Brazil and South Africa dialog forum (IBSA) and BRICS group (Brazil, Russia, India, China and South Africa) were places where so-considered emerging powers could work together and debate issues of global order with a different perspective. All these arenas will be debated in the following sections.

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<sup>55</sup> Here understood as American hemisphere.

## 7.1 MERCOSUR

The Southern Common Market, MERCOSUR, is a regional integration institution not unfamiliar with health regulations, nor international cooperation in health matters. With Brazil, Argentina, Uruguay, Paraguay and Venezuela as full members, and Chile, Peru, Ecuador and Colombia as associate members, MERCOSUR's organizational structure includes specific sectors for health-related debates.

Since 1995, a Meeting of Health Ministers – as an institutional organ – was created to suggest strategies for health policy coordination among the member-states to the Common Market Council. Moreover, a Work Subgroup (WS) for health-specific debates was created: WS-11, responsible for coordinating common actions among countries as well as assisting them in harmonizing their health surveillance systems (AISA, 2011).

Brazil's attention to health themes in MERCOSUR is not new: by 1998, MoH had created the National Health Coordination in MERCOSUR, a commission working within AISA's structure to optimize health coordination efforts in the bloc (AISA, 2011). And in MERCOSUR, discussions of causes dear to Brazil were always brought forward: for instance, in 2007, Ministers of Health asked the Common Market Council to prioritize health projects due to their “potential impact (...) in diminishing existing inequalities among Health Systems and care delivery”, both within and among countries<sup>56</sup> (MINISTRY OF HEALTH, 2009a, p. 24).

The following year, the Ministers of Health group decided to develop a public health and intellectual property strategy for all member states (including associated countries), to ensure the right to health would come before commercial interests in all of MERCOSUR territory (MINISTRY OF HEALTH, 2009a, p. 16). And in 2009, this institution decided to establish a Health Systems Observatory<sup>57</sup>, with clearly set goals: improvement of human resources for health training, harmonization of concepts and data collection methods, improved communication among health professionals and population, among others (AISA, 2010).

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<sup>56</sup> Ministers of Health of MERCOSUR Agreement nº 10/07.

<sup>57</sup> Ministers of Health of MERCOSUR Agreement nº 18/08.



Despite its importance, this regional organ faced many challenges. President Lula tried to revitalize MERCOSUR in 2004, given his interest in increasing Brazilian leadership in South America (LIMA, 2005; OLIVEIRA, 2008). But MERCOSUR had its political influence diminished, according to Veiga and Rios (2001): Brazilian and Argentinian economic crises, in addition to increasing difficulties in negotiating the commercial agenda, resulted in domestic policies that did not prioritize MERCOSUR. Initiatives with a more politically inclined agenda, such as UNASUR, were prioritized to the detriment of MERCOSUR's strengthening.

Political initiatives within the bloc's structure still existed, though: for instance, the Ministers of Health agreed to work as a bloc during the international conference called 'Health for Development: Buenos Aires Declaration 30-15, from Alma-Ata to the Millennium Declaration', further committing themselves to know-how sharing and primary healthcare (MERCOSUR - RMS, 2007).

But it was in the technical realm that MERCOSUR and the Brazilian MoH really excelled. One of the reasons for that was PAHO's institutional support: in 2006, a Cooperation Term was agreed with AISA, in order to strengthen the National Health Coordination in MERCOSUR. This CT, whose full denomination was Cooperation Term number 48, aligned ideas from PAHO's strategy for South America and the *More Health* initiative with the aim of "bolstering Brazilian participation in the institutionalization process of MERCOSUR, in what concerns integration of public health policies" (PAN AMERICAN HEALTH ORGANIZATION, 2010, p. 244).

Meant to last until 2011 and with a budget of R\$ 2,323,850.00, CT 48 also endorsed Brazil and Uruguay health in the borders initiative, and assisted the Itaipu Health Working Group, a set-up organized by Brazil and Paraguay because of the Itaipu Bi-national hydropower plant, aiming to further connect both countries and their civil societies in health events (PAN AMERICAN HEALTH ORGANIZATION, 2010).

These resources and political incentives were not granted to MERCOSUR. They were contracted *between the Brazilian MoH and PAHO*, so that AISA knowledge and political strength were used as means to make MERCOSUR health structures more solid.

MERCOSUR and its significance were also mentioned by our interviewees, such as Dr. Tania Cavalcanti. This regional institution was honoured with the Orchid Award, a symbolic prize awarded to all whose efforts in tobacco control are deemed exemplary. Brazil spread this news to other countries and emphasized which regional strategies to confront tobacco industries and implement the FCTC existed within MERCOSUR's framework, thus helping this institution to be recognized internationally. Moreover, MERCOSUR had also put together a Regional plan of Intergovernmental Commission on Tobacco Control (CONICQ, 2013). In this regard, Dr. Tania Cavalcanti explained that MERCOSUR member states indeed came together to exchange experiences, exalting the existence of a Commission on Tobacco Control in this bloc (CAVALCANTI, 2017).

AISA was deeply involved in MERCOSUR: not only was the National Health Coordination dealing with MERCOSUR matters within its structure, but Brazil's health actions coordinator was also an AISA expert: Dr. Carlos Felipe Almeida D'Oliveira. Before being appointed to lead Brazilian efforts on the tripartite agreement in Haiti, Dr. D'Oliveira was responsible for coordinating and representing Brazil in this regional stance. In his interview, he mentioned some key aspects of this assignment: how technical negotiations in MERCOSUR could get; how independent the MoH was in these technical negotiations; and Itamaraty's support to the MoH activities.

Some excerpts of the interview were separated according to the subject being debated. For instance, concerning technical negotiations and MoH autonomy (D'OLIVEIRA, 2017):

MERCOSUR is a much older structure. There is (...) a much more structured work story (...). (...) MERCOSUR is a structure with important political and technical features.

Its structure stems from the 90s, it was organized, had a more complex organogram. All this structure was supported with Itamaraty efforts, I mean, Itamaraty was the organ responsible for foreign policy, responsible for MERCOSUR policy, but it needed all the other governmental structures as well.

I coordinated both the Meeting of Ministries (...) and WS-11. I coordinated, but there were within WS-11 many other work subgroups. And some of them were specific. I'll give you one example... for instance, cosmetics. Cosmetics are products under Anvisa competence, they define rules, approve norms... This subgroup was coordinated by

technicians, by an Anvisa technician. There was a person, Anvisa representative, a coordinator of Anvisa to all this subarea. But the general coordination was [under] MoH [responsibility], I was the coordinator.

The Meeting of Ministers was a political – technical structure, because it negotiated agreements, and agreements are always political. But those agreements were based on technical attributes. WS-11 was an exclusively technical structure.

[it was important because WS-11] always tried to elevate countries' technical capacity. We had (...) many groups for medicines, for surveillance, for products like cosmetics (...). Usually, Anvisa participated actively in these groups. Anvisa [was] apt to formulate rules and (...) harmonize norms on products [and goods], or medicines, whichever they were, or protection of ports and airports (...). To elevate the technical level of these structures, considering international parameters. This was indeed important, because it allowed a product commercialized under MERCOSUR's scope to respect norms considered to be standard-norms by the World Health Organization. Thus, MERCOSUR equalized its products [quality standards], facilitating, therefore, commercialization processes (...) with other countries. Because they obeyed a given standard, one considered to be golden. That is, they comprised with international norms.

Regarding MoH autonomy and collaboration with Itamaraty:

(...) technical groups would work, work, work... until they reached a conclusion. (...) barriers would exist, in a technical point of view, because of asymmetries among countries.

WS-11, (...) essentially technical groups performed very well, under my conception. There was no (...) specific participation from Itamaraty. Itamaraty, for sure, monitored our duties, because it wanted to observe... (...) the approval of technical norms and the internalization process of these norms in countries domestic legislation, it was important, no doubt about that, to the Ministry of Foreign Affairs.

Itamaraty considered the MoH performance good, they were important to Itamaraty, the works the Ministry of Health was developing, since MERCOSUR was created they took part... they used to attend [meetings] as observers, and sometimes, when we wanted to get important agreements approved, like when (...) ... this was in 2007 or 2008, Brazil was interested in... and Itamaraty supported us entirely, to create a health secretary under MERCOSUR auspices in Montevideo.

Itamaraty supported us because this was a significant political matter. On strictly technical issues, we retreated from their [help]. They

monitored, we produced reports, but Itamaraty would strongly act when we required political assistance. This would happen mainly in the Meeting of Ministers, when we had to thoroughly negotiate, so then Itamaraty, as a foreign policy organ, with their experience, would provide us with great support.

All these excerpts demonstrate, once again, that the nature of what is being discussed influences how MoH and MoFA divide their work. More technical topics are under MoH responsibility, provided it possesses the know-how required by negotiations. When issues have a broader scope or are more political, Itamaraty is the institution in action.

Dr. Carlos Felipe Almeida D'Oliveira also briefly mentioned SUS, by affirming that all undertakings took SUS legislation into consideration. As he said (D'OLIVEIRA, 2017):

In the scope of the Meeting of Health Ministers, we produced agreements bearing in mind what was interesting (...) for the countries' public health. And for sure we, Brazil, always stood for positions that were consensus in Brazil, always taking into consideration the Unified Health System too. We had as guidance our legal system, our legislation, and undoubtedly, what was included in SUS [legislation].

This technical versus political realm was also discussed with Ms. Cammillah Horta, Anvisa international affairs specialist. During her interview, given to the author of this thesis, Ms. Horta emphasized Anvisa collaboration with the Brazilian National Institute of Metrology, Standardization and Industrial Quality (INMETRO) to negotiate food quality and control within a MERCOSUR working subgroup. In these extremely technical discussions, diplomats do not monitor strictly what is happening, however (HORTA, 2017)

This does not mean diplomats do not know what is happening in these groups, because we report [what happened] to the Common Market Group, which, in MERCOSUR's organogram, is controlled by diplomats. (...) They are not involved in the negotiation of these technical documents on a daily basis [though].

Nonetheless, the technical and political might cross at some point. When a topic is politicized, or when its negotiation reaches a sort of a blockade, diplomats are invoked

to support debates, so this distinction could become a little blurred. As Horta (2017) clarified:

When there is an issue whose negotiation is a little more complicated, as the diplomatic stance is hierarchically superior in MERCOSUR to the technical stance, we elevate... the jargon is to elevate, we elevate the issue to be discussed in the Common Market Group, because this is the political arena.

This event denotes an interesting level of collaboration between both Ministries. Itamaraty understood what its boundaries of action were, however, when solicited; it was ready to assist technical organs to solve negotiation problems. The same rationale explains MoH (in this case, Anvisa) actions. Anvisa was completely aware of its capability, and did not step into MoFA's territory. In what was highly technical, there was no Itamaraty involvement, however, there was no hesitation in request for assistance should more political events take place.

Despite being well-structured and complex, MERCOSUR was not the only South American regional organization to be considered strategic by the Brazilian Foreign Policy. So was the Union of South American Nations, UNASUR, an institution that also considered health an important issue for regional integration efforts.

## **7.2 UNASUR**

President Luiz Inacio Lula da Silva promised, in his inauguration speech, to prioritize, in Brazilian foreign policy, the establishment of a prosperous and united South America (VISENTINI, 2008). In 2004, the Community of South American Nations was created, providing countries with a political arena that optimized political coordination among all these countries. As a result, in 2007, the Union of South American Nations (UNASUR) was proposed, becoming operational in 2011<sup>58</sup> (CARVALHO, 2009).

UNASUR was created as a regional organ with a more political scope of action, focusing less on trade or commercial agreements and more on issues such as regional

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<sup>58</sup> Only on March 2011 this institution's Constitutive Treaty had the minimum number of signatures required to be put into force.

defence and health. Within its structure UNASUR Health was created, comprised by a Health Council with Ministers of Health, and ISAGS, the South American Institute of Government in Health, focused on promoting events and supporting the strengthening of health systems in member states. Promotion of universal access to health services and the establishment of a South American Health Agenda were sanitary goals of this enterprise as well (BRAZIL, 2010).

ISAGS had a special status to Brazil, since the country offered to host this institutional headquarters in Rio de Janeiro. Moreover, approximately US\$ 6 million were donated by this country's government to the Institute in 2011, providing to ISAGS resources for its initial budget (BUSS, TOBAR, *et al.*, 2017, p. 440). Also, the MoH supported Fiocruz with a project, named PRO-ISAGS, so that this institution could be created in Rio (AISA, 2011). However, although the Institute was created in 2011, it was only in 2015 that the Brazilian National Congress approved a document officialising its existence and activities in the country, therefore finally solving myriad bureaucratic issues that were starting to hinder its proper functioning (GÓMEZ & PEREZ, 2016).

In 2010, with resolution 02/2010 of this Health Council, a Five-Year Plan for Health was agreed upon. In this plan, countries decided on the development of universal health systems in state-members and promotion of social determinants on health, as well as training of human resources for health (LATIN AMERICAN AND CARIBBEAN ECONOMIC SYSTEM, 2010).

Emphasis on human resources training and education was indeed a relevant theme to UNASUR. From 2009 onwards, this institution's Health Council started approving many resolutions authorising the interconnection of public health institutions, schools and offices. Five of these networks are already operational, and a special coordination effort from Fiocruz can be observed in most of them. They are (BUSS, TOBAR, *et al.*, 2017, p. 439. Emphasis is ours):

1. RETS-UNASUR: Network of Technical Health Schools, established by UNASUR's Health Council resolutions 09/2009 and 07/2010. Coordinated by Joaquim Venâncio Polytechnic Health School (EPSJV/Fiocruz).

2. RINS-UNASUR: Network of National Institutes of Health, created by UNASUR's Health Council resolution 07/2009. Although Peru's National Health Institute is in charge of its management, Fiocruz is part of the RINS secretariat.
3. RENSP-UNASUR: Network of Public Health Schools, enacted by UNASUR's Health Council resolutions 07/2009 and 06/2011. Though coordinated by Paraguay, its secretariat is run by Fiocruz's National School of Public Health.
4. RINC-UNASUR: Network of Cancer Institutes. UNASUR's Health Council resolution 04/2011 established it. INCA is responsible for its management.
5. REDSURR-ORIS: Network of International Relations and International Health Cooperation Offices. Enacted by UNASUR's Health Council resolution 10/2009, it is coordinated by Chile.

All of Fiocruz' efforts to intensify a structure of networks of institutions within the UNASUR framework was a reaction to MoH's deep interest in this regional organization, we argue. Obviously, international reassurance was present too, with PAHO's CT 41 injecting resources to Fiocruz's budget, so that this institution could continue developing programs with UNASUR's member states; and CT 58 bolstering AISA's capability of enhancing its participation in activities concerning regional integration (PAN AMERICAN HEALTH ORGANIZATION, 2014b).

But there was also a *political understanding* in the Ministry of Health that considered UNASUR pivotal to the Brazilian strategic planning for the time interval considered in this thesis. Both ex-Ministers of Health, Dr. José Temporão and Dr. Alexandre Padilha, highlighted the central role this integration endeavour and its health-related goals had to the MoH internal arrangements. To Temporão, who would later become ISAGS director, after leaving the MoH (2017):

A very important matter I want to shed light on was the creation of UNASUR. (...) UNASUR is a political agreement, and within its

Ministers of Health Council, a Five-Year Plan was discussed, agreeing on 5 topics: universal systems, social integration, formation of strategic human resources, universal access to medicines and other technologies, and sanitary and epidemiological surveillance. All [done] by Brazilian initiative. (...) we also proposed at that time the establishment of an institute.

ISAGS. In the beginning, (...) the idea of this institute was closely tied to [the idea of] personnel training. But that changed afterwards. (...) ISAGS is currently an international public entity.

Dr. Padilha also mentioned MoH efforts to implement ISAGS, but did not specifically fixate on this institution (PADILHA, 2017):

Another important thing was the participation of the Ministry of Health in some articulations for the succession of directors in these organs. In the case of BRICS forum and UNASUR, the creation of UNASUR Health and BRICS Health... For UNASUR, in South America, we appointed ex-Minister Temporão to assume ISAGS for a while.

Ex-director of AISA, Amb. Eduardo Barbosa did not focus his interview on this topic either, nevertheless, he appraised Fiocruz for its support to AISA in UNASUR matters (BARBOSA, 2017):

At UNASUR, effectively, we organized meetings with international health advisory services, seeking further regional coordination. That, I did with a lot of support from Fiocruz. With the international health centre from Dr. Paulo Buss.

Fiocruz leadership in this process was evident when we interviewed directors of different stances of the foundation. For instance, to Dr. Paulo Buss, these institutionalized networks of health schools are a significant endeavor for the improvement of local health standards, since through collaboration, best practices can be shared. According to Dr. Buss (2017):

Fiocruz proposed... by late 2008, we proposed the establishment of a network of national health institutes, that is, [a network of] “fiocruzes”, in quotation marks. That already existed in the 12 South American countries. So, in April 2009, we had our first health cooperation meeting, in Chile, and Brazil submitted an official document (...), there we created a network of national health institutes, led, since then, by Fiocruz.



We proposed to the Brazilian government [the idea of] taking to UNASUR this suggestion of institutionalizing a network of national health institutes. Through collaboration with these institutes, we could avoid diseases outbreaks from spreading, make faster diagnosis, and cooperate in the case, for instance, of a disease threat, as could have been used for Ebola (...) The network of national public health schools, for human resources formation, was also a Fiocruz proposal to the Brazilian government, and it was institutionalized within USANUR [‘s structure].

In addition to Fiocruz’s importance in the conception of these networks, Dr. Paulo Buss highlighted as well this foundation’s role in the genesis of ISAGS (BUSS, 2017):

We also suggested the creation of a South American Institute of Governance in Health, ISAGS, which was created upon Brazilian proposal and became... it is an institute of UNASUR, but created upon Brazilian proposal.

ISAGS was established inside Fiocruz. The endowment, who got the funding for (...) who suggested the Brazilian government to firstly provide funding grants [to ISAGS] was exactly Fiocruz (...) to Minister Temporão. R\$10 million were endowed, that was, back then US\$5 million. Something like that.

In this case specifically, Fiocruz and the MoH were setting the agenda, were listing the priorities of the Brazilian government for regional integration and health at UNASUR structures. Fiocruz was so deeply engaged with ISAGS creation that even this institute’s inauguration was organized by Oswaldo Cruz Foundation. When the MoH invited MoFA diplomats for the reception, replies confirming attendance should be directly sent to Dr. Buss institutional email or to another Fiocruz employee, demonstrating how engaged Cris-Fiocruz was with ISAGS implementation (MINISTRY OF HEALTH, 2011d).

Despite being the coordinator of these networks and an ISAGS enthusiast, Fiocruz maintained good relations with MoFA. Moreover, these networks were used to intensify the formulation of projects based on the idea of structuring cooperation for health. When asked about these cooperation arrangements, Dr. Luiz Fonseca, one of Cris-Fiocruz directors, answered in a very comprehensive fashion (FONSECA, 2017a):

Most of Fiocruz Cooperation activities happen under the scope of structuring networks (public health schools, health institutes and milk banks). Fiocruz is the coordinator of these networks, not [the coordinator] of specific actions (which usually take place with BCA

and/or AISA). Brazil is a member state of different organizations, within which these networks are (UNASUR, MERCOSUR, CPLP), and in this sense coordination efforts with MoFA are thorough.

The case of Networks of National Health Institutes is relevant for the enhancement of what we call structuring cooperation, either in Africa or South America. All trainings and cooperation activities aspire to reinforce these institutions, their health systems and the cooperation network which are established around these efforts. The response of this network to epidemic outbreaks such as Ebola, Dengue, Zika and Yellow Fever is very positive.

He continued in the conversation, explaining that these networks were actually tools for bolstering relationships and deepening sharing of know-how (FONSECA, 2017b):

These networks are structuring [tools] to health systems, not constructing, of either activities (...) or materials. Maybe they could be constructing, [in the sense of building] a relationship between institutions and health system ideas with other institutions supporting that. Health Institutes (or public health laboratories, depending on the size of the institution) are essential to providing scientific support to health policies; and centres for education in public health are essential for the formation of managers, influencing as well policy making and decision making.

Despite MoH efforts to further connect South American public health institutions, UNASUR Health *per se* had many issues hindering its implementation process. For instance, its Five-Year Plan was superimposed on other regional institutions projects, and interestingly enough, it did not take into consideration these networks so dear to Fiocruz, leaving them out of the strategy. In 2013, three years after this Plan was agreed by member states, 0% of all activities to assist countries in the development of universal health systems were implemented. If on one hand UNASUR's Five-Year Plan was too ambitious, on the other countries had different priorities in their agendas. Moreover, changes in conjectures and political - economic scenarios also impacted the achievement of these health goals (GARRÓN, FARIA, *et al.*, 2013).

UNASUR was an important arena to Brazil: South America became one of BFP's strategic zones, and the country sought to further engage in health cooperation with

regional partners. Fiocruz was a key actor in this whole project, influencing the creation of networks and advocating for enhanced education for human resources for health. Unfortunately, because of political and economic reasons, as stated above, projects did not develop in full capacity, what cannot be translated into lack of leadership from Fiocruz.

One might question whether MERCOSUR's robust structure or Brazil's cooperation ties with other South American countries (which existed long before the creation of UNASUR), might have negatively impacted UNASUR's work in public health. Another possibility is lack of a further political commitment by member countries. As can be observed, what required technical cooperation flourished, such as the networks. But even ISAGS' legal authorization to have its headquarters in Brazil, a political process, took a considerable amount of time to be issued.

The next subchapter debates another special Geographic zone to BFP as well: the community of African countries who speak Portuguese language, or CPLP.

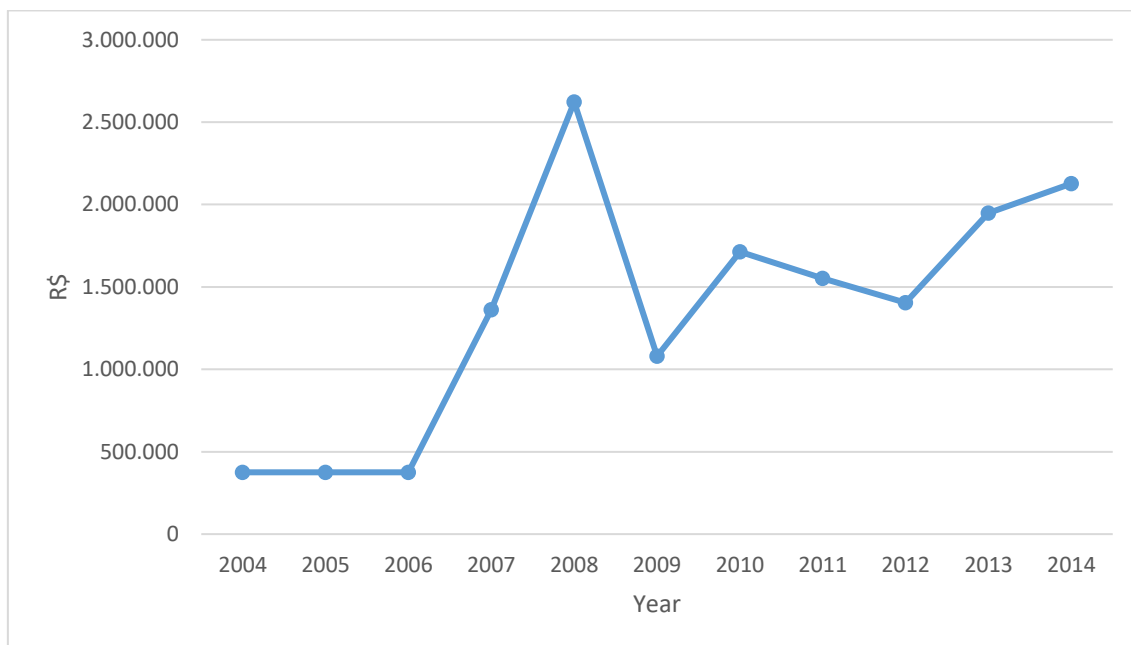
### **7.3 CPLP**

The Community of Portuguese Language Countries (CPLP) resorted to a common language as justification for the establishment of its institutional space: sharing in common Portuguese language and usually a historical presence of Portugal as colonial ruler, member-states of CPLP go from South America to Asia. And, coincidence or not, all Portuguese-Speaking African Countries (PALOP) are members of this Community. Thus, Brazil already had a multilateral arena to accommodate its plans and build stronger relationships with these PALOPs, using CPLP as platform (VENTURA, 2013b).

Two of the most important projects with Portuguese speaking countries, the AVR medicines factory in Mozambique and Proforsa, in Angola, were already introduced in this thesis. This section will not mention them; it seeks to briefly introduce CPLP works in the health realm and MoH activities in this Community.

Brazil's interest in CPLP can be observed in different aspects of this country's behaviours. Firstly, Brazilian contributions to this Community increased five-fold in a very short period of time: in only two years, donations skyrocketed, going from around R\$500,000 to R\$2.5 million. As demonstrated on the figure below, albeit inconstant, this financial support continued throughout the period analyzed.

**Figure 09.** Brazilian Contributions to CPLP (Formulated Budget)



Source: Federal Senate of Brazil – Federal Budget (2003-2014) (2018). Elaborated by the author

Another aspect of this interest was Brazil's efforts to enlarge and invigorate the CPLP's structure, creating strategic plans and technical groups. In April 2008, in Cape Verde, Ministries of Health from all member states met for the first time, formulating a Strategic Plan for Cooperation in Health (PECS, as it is known by its acronym in Portuguese). Meant to be in force for the 2009-2012 period, PECS were created to "contribute to the enhancement of health systems from CPLP member states, in a way that universal access to health and quality health care [services] are granted" (AISA, 2010, p. 16). Again, just as in the case of UNASUR, the idea of universal access to health appears in another health strategy of a multilateral stance.

To this Strategic Plan, a "modest budget of 14 million euros [was] allocated" and "seven strategic topics, [among them] creation and development of a 'workforce in health', which receives 67% of the total PECS budget" were also agreed upon by CPLP member states (VENTURA, 2013b, p. 99).

A year after this meeting in Cape Verde, countries were summoned up again in Portugal, and in this event, the Ministries of Health decided to put together a CPLP Technical Group for Health (GTS-CPLP) whose aims were to coordinate the execution of the PECS project. The CPLP Technical Group for Health was the first technical group *formally constituted within CPLP institutional framework*, and for it to operate in full capacity, Brazil and Portugal promised to donate US\$200,000 and €200,000, respectively. Resources were also made available by the African Development Bank and the German Cooperation Agency (AISA, 2010).

The Brazilian MoH and Fiocruz were crucial to the “formulation, approval and creation of GTS-CPLP” (AISA, 2010, p. 18). And similar to what happened at UNASUR, Fiocruz took the lead in the establishment of networks with analogous institutions in CPLP countries. By 2009, a Network of Technical Health Schools of CPLP was created, with the Joaquim Venâncio Polytechnic Health School of Fiocruz responsible for its constitution. A Network of Public Health National Schools was structured as well, with Brazil and Angola trying to work together and use structure already in place to advance a project, that is, use resources already available to design a joint project (AISA, 2010).

Still in 2009, Ministers of Health met once again and agreed upon the institutionalization of a Health Sector Fund – CPLP, so that resources could be mobilized. In 2010 the Community decided to jointly create a technical network for malaria response, called Network for Research and Development in Health – Malaria – CPLP (RIDESMAL-CPLP) (AISA, 2011). Another network, this time for STD/HIV/AIDS was established shortly thereafter, with a similar goal of sharing know-how and expertise to combat these diseases (this network was also known as RIDES IST VIH SIDA) (COMMUNITY OF PORTUGUESE LANGUAGE COUNTRIES, 2011)

By the time these networks and structures were being considered, Fiocruz was already an advisory observer to CPLP, proving technical assistance to member countries of the Community and going on missions abroad, on behalf of CPLP, to find focal points in member states that could implement PECS. Mozambique and Sao Tome and Principe were under this Foundation’s map of places to offer technical support (COMMUNITY OF PORTUGUESE LANGUAGE COUNTRIES, 2010).

The Strategic Plan for Cooperation in Health was also formulated under Fiocruz's concept of structuring cooperation for health, and this Foundation was completely aware of its importance to this enterprise: Fiocruz itself acknowledged to be a leader in four of this plan's axes of action, them being: work force development, health communication services, health research and promotion, epidemiological surveillance and health condition monitoring (OSWALDO CRUZ FOUNDATION, 2010).

Unfortunately, PECS-CPLP did not present the expected outcomes. Upon self-analysis, CPLP drew attention to the fact that some strategies proposed by this plan had not advanced on any level whatsoever, while others presented only a few accomplishments. Irregular frequency of meetings; changes in national political agendas; changes of Ministries of Health command; and issues with lack of personnel and adequate technology unavailable were all to blame, according to CPLP, for this Plan's lack of tangible results (EXECUTIVE SECRETARIAT CPLP, 2013).

Even the networks were criticized by CPLP Secretariat: RIDESMAL and RIDES IST VIH SIDA were both accused of not being properly operational and having a very narrow reach. Nonetheless, and despite all negative outcomes, it was decided that the Strategic Plan for Cooperation in Health should be extended, thus PECS would no longer be finished by 2012, but by 2016 (EXECUTIVE SECRETARIAT CPLP, 2013).

Some might argue that CPLP suffered from a chronic lack of resources, preventing it from having the necessary means to transform ideas into reality. However, we argue that perhaps lack of enthusiasm also delayed this Community's plans. In an official ministerial communication from 2007, regarding a CPLP preparatory meeting for its first ever Meeting of Ministers of Health, Itamaraty reported to AISA that initially, the meeting had to be cancelled, because many Ministers of Health were to be absent. Instead, only the aforementioned preparatory meeting took place, leaving the Cape Verde Health Minister clearly upset and disappointed. A Brazilian delegation with the Minister of Health did not attend either; nor did they send any notice of or reason for their absence. According to Ms. Maria Dulce Silva Barros, Brazilian Ambassador in Cape Verde, two Fiocruz experts, already on a mission in the country for educational matters, received recommendations to extend their stay and participate in the preparatory meeting. Therefore, we conclude that Brazil did not send specific personnel to this meeting, but

instead took advantage of Fiocruz staff who were already in the field (MINISTRY OF FOREIGN AFFAIRS, 2007l).

If on one hand countries were maybe not so enthusiastic, on the other CPLP was certainly interested in increasing its activities in the health realm. So interested in fact, that the Community appointed a Goodwill Ambassador for Health Affairs, Dr. Jorge Sampaio, ex-President of Portugal. We argue that this Goodwill Ambassador's role is quite unclear though, since his responsibilities are not specified or listed (MINISTRY OF FOREIGN AFFAIRS, 2007m).

Even though CPLP health strategy did not deliver results as expected, both MoH and MoFA saw in this institution a strategic partner and attempted to develop many cooperation projects with CPLP state-members (AISA, 2010). This fact also appeared in most of our interviews during the gathering of data for this thesis. Dr. Temporão recalled in his interview that the ARV medicines factory was built in a CPLP partner, Mozambique, and that this was a major cooperation project (TEMPORÃO, 2016).

One of the reasons CPLP received considerable attention from AISA was because PAHO's Cooperation Term number 41 supported technical cooperation with PALOPs. CT 41 was strategic to PECS-CPLP, and together with Fiocruz, AISA, as representative from MoH, should develop tactics to implement such technical cooperation in health (PAN AMERICAN HEALTH ORGANIZATION, 2014b). Amb. Eduardo Barbosa added another comment, declaring that there was also a personal engagement from Minister Temporão to ensure health would be introduced to CPLP agenda (BARBOSA, 2017):

CPLP, we... we made efforts to include health as a theme on CPLP. It was not [a theme before]. And we were able to include it [on the agenda].

It was an action, a direct presence from Minister Temporão, talking to CPLP Executive Secretary; we were supported by Portugal's Ministry of Health, because actually the Community started as a language community, but in current days it also focuses on topics [such] as development, cooperation... So, naturally this health issue is included too. But we were in the beginning of this process.

CPLP was decidedly a strategic international arena for the Brazilian Cooperation Agency. Many of the technical cooperation projects signed with PALOPs took place

based on this Community agenda; however, CPLP was used as a space to share ideas only: agreements and memorandums of understanding were still all bilateral. BCA's ex-director, Amb. Marco Farani, explained that (FARANI, 2017):

We encouraged this 'CPLP speech', CPLP was well constituted, had formal meetings, so we, speech-wise, used CPLP. But cooperation was bilateral. The speech was there. CPLP as a political organization. But cooperation was from country to country, Brazil to Guinea Bissau, to Angola, Mozambique, to countries.

CPLP had visibility, and was more institutionalized, too. CPLP, I would say, certainly there was a discourse there. This discourse was incorporated by countries in their own domestic and foreign speeches.

Responsible for BCA's cooperation with African nations, Mr. Paulo Barbosa Lima also mentioned the bilateral nature of CPLP cooperation, however, according to his analysis, CPLP added a different character to this cooperation, since there were common pillars sustaining CPLP members relationship. As he puts it (BARBOSA LIMA, 2017):

[There is] a CPLP representation inside BCA. BCA is CPLP's focal point here in Brazil. So, for instance, we have meetings with Ministers of Foreign Affairs, in which the relationships among chancellors and focal points for cooperation are observed. Every six months.

CPLP, actually, is not purely bilateral in nature; it tries to develop projects with a more multilateral attribute, assisting the community. There are the pillars that are observed, diffusion of the Portuguese language, technical cooperation is one of the pillars...

He also emphasized the importance of developing a strategy to jointly implement technical and educational cooperation, similar to what Fiocruz, with its National Public Health Schools, does: implement a project and provide training to local personnel.

Despite being considered a strategy area to BFP, actions developed within the CPLP's institutional scope were rather weak. Both MoFA and MoH signed projects in member states and pretty much worked by the book in their plans, meaning MoH offered its technical knowledge and Itamaraty, its diplomatic services. Parallel to UNASUR, networks of technical institutes working with specific topics functioned fairly well, while other projects that required a more political stage did not go forward. We could also question whether the CPLP's institutional weakness had a negative impact on its multilateral projects.



President Lula promised to use the ties between Brazil and Africa to contribute to African development (MINISTRY OF FOREIGN AFFAIRS, 2008a), and CPLP was the platform chosen for these efforts to take place. Similar to UNASUR, there was an attempt to connect educational centers or institute projects with analogous topics to tackle down problems. Unfortunately, CPLP struggled with lack of resources and insufficient engagement on countries' behalf, facts that really prevented this Community from reaching its full potential.

#### **7.4 IBSA and BRICS**

The India, Brazil and South Africa Dialog Forum (IBSA); and Brazil, Russia, India, China and South Africa (BRICS) grouping are two different cooperation mechanisms with a common feature: their level of institutionalization is quite low. Because of this, their analysis in this thesis was aggregated.

Both are political groups of global South countries (although Russia might contest this information) aiming to increase development levels around the world by using South-South Cooperation. However, some believe that because of Chinese and Russian presence at BRICS – two countries with veto power in at the UN Security Council and nuclear weapons in their territories – this group tends to be considered by international analysts as somewhat more important (ARRUDA & SLINGSBY, 2014).

Their origins are rather concomitant: the idea of BRICS was conceived in 2003, when a working paper from investment bank Goldman Sachs originally referred only to Brazil, Russia, India and China (South Africa is not a founding member) as “emerging economies with great demographic and geographic dimensions” (BAUMANN, ARAUJO & FERREIRA, 2010, p. 09).

BRICS as a group was conceived under a purely economic approach: because of their potential in the production of agriculture and industrial goods, as well as their service industry and large domestic consumption markets, these countries were considered as candidates for more powerful roles in the international scenario (BAUMANN, ARAUJO & FERREIRA, 2010). It is precisely due to these considerations that Jim O'Neill, the

economist who coined the acronym, opposed the inclusion of South Africa in 2011, affirming that this country “does not have the same potential for growth that characterizes Brazil, Russia, India and China” (ARRUDA & SLINGSBY, 2014, p.01).

IBSA was also established in 2003. Understood as an informal alliance of prominent global South countries, this alliance reflected these three countries’ “inherent frustration with the results of WTO negotiations for key exporting states from the global South”, as well as their demands for a reconsideration of power asymmetry in this globalized world (TAYLOR, 2009, p. 45). It had more of a political approach, but as a consequence, was less centralized as an organization (ARRUDA & SLINGSBY, 2014).

Regarding international cooperation for health, these institutions adopted different approaches to cooperate on the issue. IBSA decided to emphasize 16 different sectorial cooperation zones, health being one of them. The countries quickly identified a common interest in the TRIPS agreement and combat to HIV/AIDS, concluding then that exchanges of experience and best practices would be the focus of this cooperation effort (MOKOENA, 2007).

During IBSA’s 2<sup>nd</sup> Summit Declaration, its leaders called for the development of an Action Plan in the sector of health (IBSA DIALOG FORUM, 2007a), and in 2007, a working group (WG) on the topic was put together. However, WG Health had held only three meetings before 2014 (ROA, 2014). In October of the same year, the three countries signed a Memorandum of Understanding on Cooperation in the field of Health and Medicine, in which they planned to develop programs against HIV/AIDS, Tuberculosis, Malaria, and work together to improve pharmaceutical assistance, vaccines, medical research and development, and intellectual property rights, among other topics (IBSA DIALOG FORUM, 2007b).

Perhaps the most active stance in the IBSA was its Facility for the Alleviation of Poverty and Hunger, or more simply the IBSA Fund. Created in 2004, this Fund was a financial tool for development promotion. Managed by UNDP, each country should endow US\$1 million per year for projects with great impact in the development of other global South territories all over the world. From Burundi, Cape Verde and Haiti, to Palestine, Cambodia and Laos, all these global South countries had projects funded by the IBSA Fund in their nations (ROA, 2014).

Burundi, Cape Verde, Cambodia and Palestine were countries receiving funding for health-specific projects. President Lula himself, in his speech at the 59<sup>th</sup> UNGA, introduced the IBSA Fund to the world as a fund of solidarity (MINISTRY OF FOREIGN AFFAIRS, 2008a).

Although less formal, Brazil performed in this forum the same way it did in more institutionalized organizations, which means that the MoFA coordinated efforts and the MoH negotiated and offered technical cooperation. Negotiations with the IBSA Dialog Forum were considered part of AISA's Multilateral Themes responsibilities (Ministry of Health, 2009a), and indeed, there were collaborative efforts across both Ministries. For instance, when a Framework Agreement for Cooperation in Technologies and Communications was under negotiation, Itamaraty sent the Indian draft proposal to AISA, asking for this organization to comment and add suggestions to the text. AISA was required to collaborate because this agreement was also considering cooperating in e-health initiatives, aiming to (MINISTRY OF FOREIGN AFFAIRS, 2005e, p. 03):

increase telemedicine infrastructure to enable patients to receive health care services, such as medical diagnoses and advice, [services] which they would not ordinarily have access to due to distance and/or limitation in the availability of specialists.

During a negotiation previous to the signature of IBSA's Memorandum of Understanding on Cooperation in the field of Health and Medicine, delegates of the Work Group for health were summoned in India. The MoH sent two representatives to assist Itamaraty with solutions to strengthen this WG and grasp what could be offered by the country in this Memorandum (MINISTRY OF FOREIGN AFFAIRS, 2007n).

In the analysis introduced by Roa (2014), she debated how central Itamaraty was to health negotiations at IBSA forum meetings, guiding the foreign policy and pushing other Ministries' agendas, as well as mediating IBSA demands with these other Ministries. However, we argue that this was MoFA's role: similar events happened with BCA, for instance, with Itamaraty depicting the Brazilian Foreign Policy abroad and later filtering demands for cooperation with domestic entities.

Regarding BRICS, not only its nature differs from IBSA: so do its levels of centralization and institutionalization. BRICS structure was slowly built upon countries'

requirements, thus being considered more functional and active (ARRUDA & SLINGSBY, 2014). Within the loosely organized structure of the BRICS forum, each topic, of which there are many, has its own place for discussion, and health is no exception. The difference with IBSA is that, on BRICS forum, the Ministers of Health of each member state are present and take part in rounds of negotiations.

In 2011, these Ministers of Health had already issued a declaration, focusing on TRIPS and affordability of medicines (BRICS HEALTH MINISTERS, 2011). On a parallel meeting to the 65<sup>th</sup> WHA, in 2012 in Geneva, Ministers of Brazil, Russia, South Africa and India met to express their commitment to engage in international health collaborations (NATIONAL CANCER INSTITUTE, 2015a).

The next meeting took place in New Delhi, India, and on this occasion, they focused on the BRICS motto at the time (BRICS Partnership for Global Stability, Security and Prosperity) to specifically develop joint efforts in knowledge sharing and information exchange (NATIONAL CANCER INSTITUTE, 2015a).

BRICS Ministers of Health Meetings take place twice a year: as a parallel event to WHA sessions, and as a formal meeting in one of the countries that are part of the initiative. 2014 was no different, and countries promised, as outcomes of these meetings, to guarantee efforts would be made to combat Tuberculosis, continue to combat HIV/AIDS, and ensure the Framework Convention for Tobacco Control's full implementation. This last assurance caught INCA's attention, since "among the BRICS countries, we have the three largest producers of tobacco leaves (China, Brazil and India), the two largest consumers (China and Russia) and the largest exporter (Brazil). All are member states of the FCTC/WHO" (NATIONAL CANCER INSTITUTE, 2015a, p. 142).

During interviews with authorities from the Ministry of Health, the author of this thesis asked about cooperation with BRICS countries and about the decision-making process in these meetings with other Ministers of Health. Mr. Kleiman (2017), AISA ex-director, debated how important these joint efforts were to, for example, combat tuberculosis, and further added that:

BRICS brought to their agenda tuberculosis, countries with different interests but [yet] complementary interests. Brazil took global

responsibilities in global debates on health, took responsibilities and lead the processes.

In the case of BRICS, (...) of course<sup>59</sup>! The Ministry of Health was always autonomous to formulate its positions, but evidently, we articulated with Itamaraty. Because this is BRICS, BRICS are a bloc encompassing heads of governments, the State, involves the presidents. So all the themes, they are discussed in this atmosphere, under the Brazilian diplomacy command. You feed, and you are fed. In MERCOSUR it also happened like this: always a direct articulation with Itamaraty, feeding, asking for help, offering help... but the technical-political formulation of health issues [negotiations] were always from the Ministry. (...) in coordination with Itamaraty.

Minister Padilha was present in most of these meetings, since he was in office from 2011 to 2014. He explained that BRICS indeed held two meetings per year, one parallel to WHA, with the support of WHO's Director General Margaret Chan, and another at the country holding BRICS presidency at the time. When asked about the MoH autonomy to decide what would be discussed, Dr. Padilha highlighted that (PADILHA, 2017. Emphasis is ours):

Generally, the agenda was formulated by the Ministry, and Itamaraty always supported the Ministry agenda. Our agenda with BRICS had three big axes: First, strengthening of the idea of national public health systems. (...) China, Russia, India, and South Africa, among all these countries Brazil is the only one with a structured national public health system.

The second dimension was technical cooperation, mutual technical cooperation, deal with common issues and all. The third, and this we introduced, but it was their interest as well, which were discussions on productive development, the health industrial complex. (...) We had a lot to learn from China and India, in regards to what they did to their pharmaceutical industry.

Another Minister of Health that emphasized this cooperative component of MoH and MoFA at BRICS was Dr. Arthur Chioro, Brazilian Minister of Health from 2014 to 2015. Although his time in office is not completely within the time interval considered in this thesis, Dr. Chioro was present at the 2014 Brasilia meeting. In an interview by email, when asked about this BRICS encounter, he explained that (CHIORO, 2017):

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<sup>59</sup> Mr. Kleiman was asked if the MoH had autonomy to formulate the discussion agenda of BRICS meetings.

BRICS agenda was agreed among Ministries of Health from each country, always supervised by their respective Ministries of Foreign Affairs.

The technical exchange of information has always existed, aiming to converge actions and especially, to exchange information considering common challenges or interests. Spaces for technical dialog were promoted in areas of common interest to most countries. This multilateral articulation also anticipated positions in topics concerning the Framework Convention for Tobacco Control, access to medicines, [tackle down the issue of] neglected diseases, combat obesity etc. Likewise, there was an attempt to promote, nationally, the integration of the health group with some [other groups] (...).

In this sense, works aimed to encompass many topics, in a coordinated fashion among different national actors, focusing on the establishment of a positive and purposeful agenda to the countries.

Even though all these interviewees claimed that the meetings had positive outcomes, BRICS suffers from a slow pace and lackluster results. Implementation of projects has been slow, and topics and affirmations constantly repeat themselves in these Ministers of Health Communiqués and Declarations (GOMÉZ & PEREZ, 2016).

Yet, we conclude that what happens in coordination efforts for these meetings is the same that occurs in IBSA, but this time with high lever authorities. MoH and MoFA cooperating, with the MoH taking the lead in specific discussions while MoFA performed more organizational tasks and observed whether the principles of the BFP were respected by the MoH institutions.

## 8. Articulation within the Executive Branch and the influence of SUS

The purpose of this chapter is to demonstrate how deep collaborations established between MoFA, MoH and its subsidiaries were, emphasizing the institutions and reasons for their determination in building a health agenda in the foreign policy arena.

It goes without question that the MoH and the MoFA, throughout the period of time analyzed here, enhanced their relationship and took their inter-institutional collaboration to new different level. Even these Ministries recognized their closer ties as a remarkable accomplishment: in December 2006, the MoH invited Amb. Celso Amorim for the inauguration of a commemorative plaque at this Ministry's building in order to celebrate the intense cooperation of these two organizations (MINISTRY OF HEALTH, 2006f).

The Brazilian Federal Constitution explicitly stresses that foreign policy-making is an exclusive competency of the Executive Branch. However, as demonstrated in chapters 06 and 07, this activity was not under the responsibility of one single institution within this branch, but many, each with their own priority and objectives. Most institutions, from AISA to Anvisa, affirmed to act respectfully of the *priorities settled* by MoFA, but when debates concern health policy or technical cooperation in health, MoH regains authority and implements an agenda of its own.

Deliberations in foreign policy-making also entail discussions of level of analysis, not only institutions encompassed on its formulation. As Hudson (2014) elucidates, international influences and domestic disputes, as well as the individual decision maker, group dynamics, and organizational processes matter to foreign policy-making.

In the Brazilian case, the individual decision maker is undoubtedly crucial, given the strong roles presidents play in the country. But President Lula added value to this role. His willingness to combat hunger and poverty and the solidarity purport of his speech added a new layer of principles, and this was brought up by Mr. Celso Amorim (2015a) in his interview. In his interview, Dr. José Temporão (2016) highlighted Luiz Inácio Lula da Silva's understanding, his vision for "the Brazilian presence in the international scene".

This president's efforts were also commended by Dr. Padilha (2017), because, in his opinion, changes were implemented by Lula in the form of an equation, balancing social and foreign affairs:

The Brazilian government, starting with president Lula, had a very clear foreign policy agenda. First, to put social affairs at the centre of the foreign policy agenda. So, since the campaign to combat hunger, for instance, a [funding] agreement which is an achievement of Lula's government... So, in this the Ministry of Health was really influential. Helping to bring social affairs to the centre of foreign policy. And second, a great effort in strengthening South-South cooperation, the South-South axis, [with many] important initiatives.

Nonetheless, a leader alone cannot operate miracles. As Hudson (2014, p. 73) puts it:

no matter how influential (...), a single leader cannot make and implement foreign policy by himself or herself. (...) foreign policy decisions are made in a group setting. And these policies are (...) carried out by particular organizations or arrays of organizations (bureaucracies).

Thus, the group of people and organizations involved in this foreign policy-making matter. Groups tend to focus on addressing the issue that caused them to become a group in the first place, and "organizations exist to provide capabilities that otherwise would not exist" (HUDSON, 2014, p. 85).

We argue that Brazil had put together a team whose synergy had positive outcomes for Brazilian Foreign Policy. Both Mr. Celso Amorim (2015a) and Dr. José Temporão (2016) remembered, in their respective personal interviews, their meetings to discuss concerted policy action on health affairs. Amorim emphasized Temporão's consciousness of the role of health to international relations, while Temporão debated that after the program *More Health* was developed and its execution had started (TEMPORÃO, 2016):

We reached the conclusion that there were so many interfaces [with each other's work] that we had to periodically sit down to discuss.

It was a direct relationship between me and Celso Amorim. Actually, there was not any other sort of filter or channel. I prepared an agenda,



sent it in advance to him, if he had any other topic to include, we would include it, we discussed and made decisions there.

As an empirical example of what he meant, Brazil's ex-minister of health remembered the moment Brazil asked for the compulsory licensing of Efavirenz 600g for non-commercial use. At this moment, "and during all this period, evidently, my relationship with Celso Amorim was on a daily basis. We were speaking all the time" (TEMPORÃO, 2016).

Other authorities, this time from MoH organizations, also praised President Lula and Amb. Celso Amorim for their efforts in improving this Ministry's work. Dr. Paulo Buss, Fiocruz ex-Director and coordinator of this institution's Global Health Centre, called attention upon the fact that "the state policy, which is developed by Lula and by Celso Amorim [was to] open many embassies in new countries. (...) this was intensely criticized (...) but it was a concept of political affirmation. Fiocruz was always triggered by President Lula, mainly [after] each one of his [official] visits as president" (BUSS, 2017). But President Lula was not the only name recalled by our interviewees: so was Minister Temporão. Ex-director of the Brazilian Program for HIV / AIDS, Dr. Mariangela Simão, emphasized that Dr. Temporão was "a great Minister of Health" (SIMÃO, 2017).

But we consider that leaderships in other positions were also crucial to support Lula in these international enterprises. From 2003 to 2006, all during the period of President Lula's first term, AISA could rely on now-Ambassador Santiago Alcázar, not only an experienced and skilful diplomat, but also a profound *connoisseur* of SUS and of public health systems theory. Six years after Rubarth (1999) published his works explaining that Itamaraty understood health as a social affair, Amb. Alcázar presented his analysis of the influence of different public health rationales on MoH's power-structure, and how important the idea of universal access to health was for the insertion of public health in foreign affairs (ALCÁZAR, 2005). An expert in both foreign policy and health affairs must have had a strong influence in AISA's activities.

Another important leadership, this time within Itamaraty's structure, was Amb. Marco Farani, ex-director of the BCA. With a more entrepreneurial and managerial spirit, this diplomat reckoned that the Brazilian Cooperation Agency was crucial for the

implementation of Brazilian Foreign Policy. And more importantly, he understood how people working in this agency were fundamental for its success (MILANI, 2017).

Finally, we also argue that Dr. Paulo Buss's full comprehension of what Fiocruz was and what it could offer to the Brazilian technical cooperation greatly influenced this organization's leadership in Brazilian collaborations abroad.

Most of these institutions are public facilities with career personnel, and as Amb. Farani described in his interview, there were good people working for international cooperation programs. Amb. Farani saw a positive symbiosis in the relationship between public employees and international consultants, and one can consider that this ensured policy continuation after presidential changes, since inertia played its role and actions persisted despite President Dilma's lack of interest in foreign themes (CERVO & LESSA, 2014).

As fundamental as this relationship among different authorities was to a smooth process in foreign policy-making, the matrix of governmental organizations cannot be overlooked (HUDSON, 2014). And in Brazil, this matrix was complex due to MoH's intricate structure, which oversaw foundations that had organs of their own (such as Fiocruz). Cris/Fiocruz and Farmanguinhos had established relationships with AISA and the BCA; Anvisa signed bilateral programs with many countries but also was well connected with BCA; and the BCA had over 300 partners in the Brazil to deliver South-South cooperation, some of them being Federal Universities helping in health-related projects (BARBOSA LIMA, 2017).

Unlike living organisms, organizations are "a simpler form of life", as Hudson (2014, p. 86) puts it, yet they are entities with goals of their own, with their particular working styles and institutional relationships. Governments use these organizations to act, so there are some critical organizational features that Hudson (2014, p. 86) deems crucial when analysing their participation in Foreign Policy-making:

1. Their essence: "the organization's self-understanding of what it is and does"; their particular identity, mission and vision;
2. Their domain of practice: the area which one organization claims to be the leader of, with its influence and expertise;

3. Their budget and personnel: organizations' sizes and the amount of resources made available for them is a strong indicator of how strong they are domestically;
4. Their influence: who they have access to, who they can reach;
5. Their morale: how respected they are domestically, in other words, who holds them in high regard within the national bureaucracy;
6. Their autonomy to act: how independently each organization can operate.

### **1. Their essence**

How an organization perceives itself brutally impacts its working capability. An institution aware of its goals and field of action is more likely to develop specific skills that will make it influential within the State bureaucracy. Add this to the fact that many of these institutions manage their own budget and have many employees; the result is a quite autonomous entity working for the executive branch (HUDSON, 2014).

The Ministry of Health and most of its entities understand their mission inside state bureaucracy. MoH's goal is to improve the quality of life of Brazilian people, via strong health service delivery and a well-structured Health System. Efforts to do so made MoH an institution with such a robust set of domestic policy health programs that they even called international attention (MINISTRY OF FOREIGN AFFAIRS, 2007i).

For example, INCA is a research institution aiming to reduce cancer incidence rate in Brazil. The National Cancer Institute uses health promotion, education or health care approaches to implement its mission, defined as "integrated national actions to prevent and control cancer" (NATIONAL CANCER INSTITUTE, 2012b, p. 14). INCA is essentially the most important national cancer organization in the country, and its awareness of this fact helped the country to formulate one of the most recognized Tobacco Control policies in the world, transforming Brazil into a world leader in the area.

With PAHO's financial assistance, many institutions already had clear missions and goals, and were able to hire more experts and gain autonomy. This was the case of AISA, as explained in subchapter 6.3: with proper funding and more personnel, AISA shifted into a major institution in MoH.

And most importantly, the MoH, with More Health and the Strategic Planning strategies, had itself a set of goals and missions; as well as an agenda and core values that would assist this Ministry with its international insertion. The MoH understood which elements it was seeking for in its international endeavours, and what it wanted to accomplish with such insertion. The MoH understood its essence, and this was fundamental for its role in Brazilian Policy-making.

## **2. Their domain of practice**

According to Hudson (2014, p. 87), essence and domain of practice are directly linked, since the skill domains of an organization will shape its claims for influence and authority, and institutions develop skills based on their understandings of self.

The Brazilian case is singular because, domestically, there is a well-defined legal framework for the description of its Executive Branch competencies, explaining what is under each institution's responsibility, to whom they are held accountable and what their sets of activities are. Most MoH institutions have presidential decrees and ministerial ordinances delineating their scopes of action. INCA is organized under one presidential decree and two ministerial ordinances (NATIONAL CANCER INSTITUTE, 2012b, p. 14). Anvisa was created by a Federal law, and its activities are regulated by 35 other laws, decrees and ordinances (ANVISA, 2013).

We claim that not all this legislation is negative. Anvisa has a clear legal mandate to observe compliance of sanitary surveillance standards, and it has built skills to fulfil this role. Anvisa became such an international reference on this matter that it became the only representative of developing countries to be part of the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use, as Horta (2017) said, an important international consideration for the high-level sanitary regulation Brazil developed throughout these years.

The same process to take place in the case of Anvisa can also be seen in the experience of the Fernandes Figueira Institute (IFF). Part of Fiocruz, specialized in maternal and infant health, IFF championed human milk banks in the country, and later used this skill to cooperate with other nations. Its domain of practice is exclusively maternal and infant health, and it was indeed a leader in this area.

### **3. Budget and personnel**

As Hudson (2014) explains, an organization's prestige within a government structure can be measured by its budget and staff sizes: they are directly proportional variables.

By analysing Figures 04 (Anvisa Budget) and 05 (Fiocruz Budget), we can observe a steady increase of resources in the period analyzed, which, under Hudson's (2014) theory, suggests continuous governmental support to these institutions. In turn, the Brazilian Cooperation Agency (as indicated in Figures 07 and 08) demonstrated a staggering increase followed by a drop in the same proportion. Despite some authors' claim that it was President Dilma who was the authority responsible for BFP decline (CARLOS & LESSA, 2014; KALIL, 2014; CASARÕES, 2015), this trend started in 2009, still under President Lula's administration.

Agreements with PAHO also had a huge impact in this sense. With Cooperation Term nº 58, AISA had an extra R\$23,063,883 to build capacity and strengthen its work. As Amb Barbosa highlighted, more staff was hired, helping this institution to boost its activities.

One issue attached to this particular feature is that economic crisis can hit institutions differently, impacting their budgets negatively. In 2014, Brazil had a deficit of 0.6% of its Gross Domestic Product (CARLEIAL, 2015), and the country faced difficulties in handling the international economic conjecture as well (SARAIVA, 2014). An economic crisis together with President Dilma's lack of interest in foreign policy brought about severe difficulties to Itamaraty and its subsidiary institutions, even though MoH's budget remained on its upward trend.

MoFA, whose budget share was 0.5% in 2003, went down to 0.28% in 2013. There were cases of Itamaraty not being able to afford rent and other expenses for its Embassies. Moreover, the number of diplomats hired from Lula's second term to Dilma's first term was diminished by 74% (SARAIVA & GOMES, 2016). Hiring new personnel was another problem Itamaraty had to face during President's Dilma term. While President Lula was still in office, he allowed this Ministry to hire and form more diplomats and chancellery staff, an initiative that was not continued by his successor.

#### **4. Influence and morale**

Influence here is to be understood as an institution's impact on domestic bureaucracy for foreign policy-making, in terms of access to policymakers and domestic recognition. Morale encompasses less tangible events and is connected to how respectful an institution is domestically and how it is regarded by its own personnel (HUDSON, 2014)

As can be inferred from chapters 06 and 07, these two features depended on the topic considered for debate. INCA was unquestionably very influential during all COPs negotiations, and CONICQ was regarded as a high authority in this stance, even coordinating Itamaraty actions itself. Similar events happened to Anvisa in negotiations at MERCOSUR, and to AISA in the Tripartite Cooperation Brazil-Cuba-Haiti.

These institutions were so recognized for their activities, domestically, and their programs were so respected, internationally, that it is quite straightforward to understand why they took the leadership in these arenas.

Concerning morale, we argue that two diplomats (Amb. Alcázar and Amb. Barbosa) as heads of AISA, demonstrate how both institutions held one another in high regards: MoH saw in this an opportunity to better navigate in foreign affairs realms, and MoFA understood it as an opportunity to monitor MoH actions and ensure all of its activities abroad were in compliance with BFP directives.

INCA's director for 10 years, Dr. Santini recalled in his interview that a diplomat as head of AISA facilitated its works. As he declared, when asked about ministerial relationships (SANTINI, 2017):

Very cooperative. It had always been a very cooperative relationship, very... and facilitated also because the Ministry of Health had, from a certain moment on, I mean, from 2003, 2004, I do not remember exactly the date, but in this period (...) there was a career diplomat in the Advisory Service of the Ministry of Health. So that helped a lot in communications, priority setting and all that.

Bearing in mind the institutions, both saw each other as organizations with high levels of influence that were highly respected in the execution of their competencies.

## 5. Autonomy to act

To the author on whom we are basing our analysis, institutional autonomy is a consequence of the difficulties of “jointly planning an operation” (HUDSON, 2014, p. 90). However, we do not take this assertion to be true in the Brazilian case. To us, institutional autonomy stems from institutional expertise in certain affairs, expertise which allows this particular institution to become an authority on the issue, hence, an agent in the national political framework, capable of conducting negotiations on its own.

The HIV/AIDS National Program, Fiocruz and Anvisa are probably the epitome of this rationale. Their level of knowledge endorsed them to formulate, negotiate and sometimes even implement international cooperation programs. As observed in most interviews of chapter 06, most demands for cooperation from international partners were mediated by Itamaraty, but this does not diminish MoH institutions’ autonomy: as Pinheiro and Milani (2012a) emphasize, MoFA had to seek specialized knowledge within state organizations elsewhere, in part due to the more complex nature of modern diplomacy.

Badin and França’s (2010) ideas of foreign policy horizontalization also make sense in this case: foreign policy-making, once so concentrated on MoFA, was dispersed, with other entities being able to negotiate their own interests as well.

At times Itamaraty played the role of mediator. When the Ministry of Health considered it important to carry out a technical mission in another country, it was up to MoFA to check with local authorities the most convenient dates, venues for these meetings to take place and sometimes, even accommodation was sorted by Itamaraty (MINISTRY OF FOREIGN AFFAIRS, 20031) .

There is a predominance of Itamaraty in certain arenas. For instance, the United Nations Headquarters, in NY, deals only with political issues in health discussions. A Brazilian Diplomat working at the UN mission told the author of this thesis, in a personal interview, that should there be any demand from Anvisa or Fiocruz, it would not be sent straight to the Brazilian UN Mission. All would be processed in Brasilia, by the Social Affairs Division, to then be reported to this mission abroad. For sure there was *informal communication* among diplomats and MoH employees, but they were all off record and

useful for occasional doubts or one-off questions (BRAZILIAN DIPLOMAT AT UN-NY DELEGATION, 2017).

Autonomy, though, cannot be understood as lack of inter-institutional communication and cooperation. Within MoH and between MoH and MoFA, most interviewees emphasized that relationships between institutions were always based on collaborative foundations. Of course, this was not flawless: both Barbosa Lima (2017) and Fonseca (2017a) described how somewhat inconvenient it was for Fiocruz to start negotiations abroad without BCA awareness, likewise when Fiocruz and BCA had already agreed upon something without AISA cognizance.

When asked about this relationship between institutions, Dr. Paulo Buss emphasized cooperative events, and recalled the establishment of AISA's Permanent Commission for International Affairs in Health, saying that (BUSS, 2017)

[Relationships with] AISA had always been extremely collaborative. In a given moment, even (...)... it was established, formalized a coordination for international cooperation and health, uniting all these parts in one commission. But this did not last long.

[Relationships with AISA] were always very easy (...). AISA used to fund things, Fiocruz provided funding as well, and another very important agency, the Brazilian Cooperation Agency from the Ministry of Foreign Affairs, also worked very much aligned with the Brazilian Foreign Policy.

I think it had always been very fluid, with the foreign policy per se and with [policy] executors within the ministry.

When asked if relationships between these two ministries were positive, Dr. Buss promptly answered: "no doubt" (BUSS, 2017). Dr. Buss's interview excerpt was brought to the debate to emphasize that an autonomous MoH is not the same as a ministry that ignores another ministry's directives.

Both Itamaraty and MoH had all the features introduced by Hudson (2014) during Lula's years in office: the essence and domains of practice were well-defined, and institutions had the budget, personnel, influence and autonomy to act. Some of these are



debatable during Dilma's administration, but provided that "inertia is a strong force within organizations" (HUDSON, 2014, p. 91), most of their prestige was still in place.

## 8.1 SUS influence

*SUS is the big backbone of this international policy.*

Mr. Alberto Kleiman, AISA's Director from 2013 to 2014.

*It is SUS's very nature and its social base that allow this vanguardism in health at the international scenario [to exist], as well as [SUS's] "natural" insertion in foreign affairs, reflected in the international recognition of several of its programs.*

Ambassador Santiago Alcázar, AISA's Director from 2003 to 2006.

These epigraphs were not chosen by chance: Dr. Kleiman's response when questioned about SUS's influence on BFP's making was so categorical, that it very well represents what most of interviewees from the MoH replied when asked about SUS's influence in BFP (KLEIMAN, 2017). Amb. Alcázar provided a more theoretical approach, focusing on SUS more as a democratic foundation and the success of its programs to explain why it became so important to BFA (ALCÁZAR, 2017).

Throughout this thesis, various examples of SUS influence have been provided: how its principle of universal access to health care impacted the Brazilian National HIV/AIDS program; how it provided a grounding for MoFA's Social Affairs Division to issue directives; and how Brazil used the idea of universal access to establish cooperation plans with MERCOSUR, UNASUR and CPLP member states.

Even PAHO emphasized SUS's importance: to this institution, CT 41 was in accordance with BFP directives and was willing to share "SUS experiences and knowledge with other countries" (PAN AMERICAN HEALTH ORGANIZATION, 2014a, p. 44).

This section will summarize interviewees' thoughts on SUS's influence in Brazilian Foreign Policy-making, debating how deeply the health system influenced BFP's interest in healthcare. Starting with Fiocruz's Global Health Centre director, Dr. Paulo Buss (2017), when asked if he considered that SUS principles could indeed serve as inspiration to the BFP:

No doubt. I think it is the food, the source; this inspiration could not be different. How are we going to cooperate, act externally with cooperation, with foreign policy, based on what? Based on the experience Brazil accumulated since its Constitution, the Unified System Law, and then practices and know-how developed within SUS.

Dr. Fonseca (2014a), also from Fiocruz, provided a similar answer to the same question:

Yes, absolutely. Health as a right and State obligation is a strong rudder of the vision that Brazilian public institutions not only stand up for but also share. So, does MoFA, showing itself to be a defender of SUS. This is something that people from other countries have always admired, (...) the coherence of Brazil's health discourse across different levels of [health] care and health institutions in Brazil.

AISA ex-directors also emphasized the importance of SUS to Brazilian international affairs. As Amb. Barbosa (2017. Emphasis is ours) answered:

For sure, I mean, [SUS principles] were always present. [In] everything we have done in the health realm in the international sphere. I even think that we had an international action of this amplitude, and I repeat, the golden years for me, under Lula's presidency, Lula and Minister Celso Amorim, to people very sensitive to this issue. And within SUS you have the principle of universality, values of generosity, equality, all this certainly helped us, *because what we did was always with the intention of reinforcing public health systems from other countries*. And, in multilateral forums, to defend, obviously, Brazilian interests, but avoiding, for instance, that private interest could disfigure policies backed by WHO. *The goal is always the promotion of public health*.

Besides the affirmation that became the epigraph of this subchapter, Mr. Kleiman (2017) highlighted other aspects of SUS influence in this policy:

The Ministry's international agenda already had strategic guidance, during Temporão's years, even before, the Ministry of Health was taking responsibilities (...) the international agenda in health that Brazil was developing was growing, was gaining international space, I mean, Brazil was becoming a protagonist (...)... Brazil was in a moment of a

highlighted foreign policy, a prominence in all means, and health, because of SUS itself, SUS experiences, the maturity SUS acquired, the model was being projected.

SUS also served as guidance to Anvisa's missions abroad. Its International Advisory Service director, Ms. Patricia Tagliari (2017), explained to the author of this thesis that:

The Agency is absolutely sensible [to SUS principles]. (...) 3 years ago, the agency had a very strong understanding, very solid, that did not mention SUS specifically but mentioned the importance of ensuring the population's access to medicines, medical devices, access to health as a whole.

Even in our participations at WHO and regulation forums, international forums to formulate guides, Brazilian discourse (...). Brazil promotes development.

Ex-Minister Temporão (2016) recalled his years at ISAGS, when “this issue of health as a right and universal systems appeared in a very comfortable fashion within the Ministers of Health Council at UNASUR”. He continued by quoting Sérgio Arouca, a Brazilian doctor who used to advocate for public health and who understood “SUS as a civilizing process”, and shed light on the importance of the *More Health* program in this whole process:

For sure, it was one of the axes of my policy, back then, More Health. In the specific field of international cooperation, for the first time we added this area as a priority area within the Federal Government. I think it was a benchmark, something remarkable.

The last representative of MoH to have his interview discussed in this subchapter is Dr. Padilha (2017). Unlike the others, this ex-Minister of Health mentioned how interested and even curious other countries were in understanding what SUS was:

There is an undeniable, direct and permanent influence, because it is bold, a country like Brazil, 200 million inhabitants, middle income, to have a free national public health service. No other country is so bold. (...) and many countries sought to know... SUS... even countries with national public systems, bilateral cooperation with Canada, England, Spain, Portugal, all very strong cooperation (...) They want to support Brazil and also learn from us.

This enthusiasm for SUS's influence on Brazilian Foreign Policy was not shared by all diplomats from MoFa. Areas working directly with health on a daily basis, such as the Social Affairs Division or during the negotiations of the Global Health and Foreign Policy initiative, as mentioned on chapter 07, were aware of this connection. But this understanding is not shared by Amb. Farani (2017), for instance. To him, SUS was not an influence, what was a true influence were programs part of SUS (Emphasis is ours):

No, SUS specifically, no, because our cooperation was not influenced by one institution or another. Now, *a Brazilian program with SUS, a Brazilian project like combat to HIV/AIDS, this can be more easily transmitted to other countries.*

Mr. Paulo Barbosa Lima (2017) shares a similar understanding. Under his scrutiny, SUS projects such as combat to HIV/AIDS, Malaria and primary health care are the ones demanded by countries. Countries do not seek to develop a health system similar to SUS, he explained, but want to implement analogous health programs. As he put it:

I don't remember any explicit demand for a universal health system. But all the demands in health had, somehow, connections with SUS implementation on Brazil. So, the HIV/AIDS program, tuberculosis program, public health program... All was related, but demands were... specific. They did not want to create a health system, but to use what we offer within the system.

SUS is part of [this] cooperation. I can tell you (...). Our programs, are programs that work within SUS. (...) Demands are very specific, not for the establishment of a SUS [over] there.

Both BCA authorities see SUS programs as possible cooperation projects. But to them, SUS as a whole, as a health system, cannot be shared with other countries.

As can be observed, not all of SUS's principles were debated. Most of the authorities considered universal access to health to be the most influential principle of SUS, and as debated in chapter 05, this was indeed the idea that most influenced the insertion of health in Brazilian Foreign Affairs. But other principles, such as integrity, were not remembered in conversations held with authorities, nor were they found in the documents analyzed.

One of the objectives of this thesis was to analyze whether international activities implemented by Brazil respected SUS principles. As can be observed, Brazil based its

entire international health cooperation on the SUS programs that were recognized for their excellency, such as Human Milk Banks, access to ARV therapy or health promotion (such as tobacco-use prevention).

We can infer that if national SUS programs were always developed using SUS principles as a base, and all Brazilian foreign actions in health were based on SUS programs, that indirectly, all Brazilian Foreign Policy on the issue was based on SUS principles.

SUS allowed Brazil to build know-how and expertise in public health, and later on, all this acquired knowledge was demanded by other developing countries. And this is a consensus among all interviewees, including the ones working for MoFA: SUS programs were pivotal for Brazil to become such an important cooperation partner. Thus, we conclude that one of the hypotheses of this study is confirmed: Brazilian actions in international cooperation for health were based on SUS programs and its principles, especially universal access to health care.

However, this thesis wanted to scrutinize if not only Brazilian cooperation, but also Brazilian Health Foreign Policy, was also SUS inspired. To be able to extrapolate this analysis, first we need to analyze if indeed Brazil developed a specific foreign policy for health affairs.

## 9. Evidence for the existence of a Health Foreign Policy

One of the goals of this thesis was to propose a definition for a Health Foreign Policy as a methodological tool to assist us in the pursuit of our research goals, a practical instrument, very much based on the Brazilian case. Because of that, the concept here introduced is intentionality *strongly based and heavily inspired* by Brazilian Foreign Policy practices. Since Brazilian institutions and actors are the unit of analysis, it is reasonable to build a *practical concept*, a concept whose purpose is to serve as a tool for the study of Brazil. We thus propose that:

*Health Foreign Policy is a branch of a country's foreign policy deriving from a complex domestic structure focused on the development of a well-delineated international strategy in Global Health. A complex domestic structure is interpreted as a legal and institutional cooperation arrangement that, with different types of actors engaged, greatly influences foreign policy making. A well-delineated international strategy in Global Health is considered to be precise plan with a feasible action/implementation timetable in different international arenas, setting health goals in the long term.*

To the untrained eye, this definition suggests that two processes need to be analyzed: the existence of a complex domestic structure with many actors involved in foreign policy-making; and a clearly outlined international strategy in global health. Brazil developed both processes. Many institutions from the Executive Branch were involved in health activities abroad, with some, such as INCA and Anvisa, enjoying considerable levels of autonomy due to their level of expertise. They also established their own plans to execute cooperation tactics in other countries. Moreover, the MoH itself, with *More Health* and the Strategic Planning, stated its own strategy for international insertion.

However, we question if this is enough, if this can be considered all that it takes to development of a Health Foreign Policy: a complex domestic structure and a strategy. Foreign policy-making is more intricate and knotty. To say there are many institutions with a plan is one thing. But to affirm there are myriad institutions, with different interests, developing collaborative or quarrelsome relations to formulate and implement policy, is another. Thus, we propose, instead of a plain definition, a structure detailing all

the features that, in our view, are crucial to foreign policy-making and should be taken into consideration when an analysis of health foreign policy is proposed.

## 9.1 The realms

As already introduced in chapter 04, we propose 9 realms, or as Rached (2013) calls them, prisms, lenses breaking reality into smaller pieces so that it can be thoroughly analyzed. As mentioned before, in Table 04, and reproduced again here, the realms and their descriptions are understood as:

**Table 04.** Realms for Health Foreign Policy Analysis.

<b>Realm</b>	<b>Description</b>
<b>Legal / Legislation</b>	Are there domestic public health laws that influence the way a country deals with the theme internationally? Is there a specific law for international cooperation?
<b>Institutional</b>	Do other institutions cooperate? Ministry of Health, Ministry of Foreign Affairs and other ministries work together to guarantee the best attainable level of health possible? Are there disputes? How are negotiations among institutions held?
<b>Agenda setting</b>	Is there a health-specific agenda in this country, setting the topics that become an international priority?
<b>Arenas</b>	Is health debated only in health-specific arenas (as the WHO)? Is the country able to debate health-related issues in different arenas, non-health-related IOs, and bilateral and multilateral negotiations?
<b>Actors engagement</b>	Are the actors engaged in this international action in health different in their nature (NGOs, government, private institutions)?
<b>Planning</b>	Are there health goals, international strategic health plans being implemented / formulated?
<b>Timing</b>	Are plans and actions long term? Short term?
<b>Decision making structure</b>	Centralized (executive branch)? Decentralized?

<b>Principles</b>	Is foreign policy principle-based? Are there principles in health policies as well? Are they consistent?
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Source: inspired by Rached (2013)

Individually analysing each realm, we have:

Legal / Legislation

Perhaps, this legal area is one of Brazil’s Achilles heels. There is not a general law or legal ordinance regimenting Brazil’s international cooperation (and this concerns cooperation as a whole, not only cooperation in health affairs). This fact was highlighted by some of the interviewees, who stressed that its existence could be beneficial to the country, because it would clearly outline institutions and people’s duties, obligations, and terms of law infringements. This would make it easier for civil society to hold actors accountable and would bring legislative security to Brazil and its partners. We also argue that a general law could bring more clarity to the international system, since partners abroad would already be aware of what to expect from their relationships with Brazil.

What does exist in Brazil is a web of over 302 Memorandum of Understandings, Complementary Adjustments, Protocol of Intentions and Agreements in health issues with many countries and international organizations, such as the CPLP. This means that great effort is required for every new negotiation: new cooperation projects or relations with new partners need to be negotiated individually, as there is no general law orchestrating them. Annex 04 is a summary of signed Brazilian cooperation agreements in health. As can be seen, sometimes even with only one country there are over ten documents signed with Brazil (such as Haiti).

This may be a cause of hindrances to Brazilian institutions. Dr. Paulo Buss, from Fiocruz, complained about this lack of a larger legal framework regarding international cooperation (BUSS, 2017):

International cooperation activities happen... under legal insecurity. It is hard to donate an asset from Brazil to another country, because there is no legal framework.



Regarding the MoH and SUS, the Unified Health System has two main structuring laws, Law 8080 from 19<sup>th</sup> September 1990, and Law 8142, from 28<sup>th</sup> of December of the same year, and only the former mentions that entities part of the Federation can sign health-related international agreements. There is no specific detail or further explanation on what could be developed by SUS internationally.

Once more, it is not the case of a legal breach, or legislative gap. There is legislation on the issue, but it is diffuse, disperse and is presented as single-case-based laws, with time-demanding formulation process and consuming a lot of energy from both MoH and MoFA. A general guide is needed.

#### Institutional:

Most interviewees highlighted the cooperative spirits of all institutions engaged in Health activities abroad. From INCA and CONICQ sessions to Fiocruz and its relationships with MoFA and BCA, there was a true commitment to making these international cooperation work.

There were problems, which were mainly communication issues, such as the Brazilian Ambassador to Maputo not being forwarded news about the ARV factory, or the BCA not being told about technical cooperation projects being developed abroad and only made aware of them the moment MoFA was questioned by a third party involved. Still, institutional harmony was the rule.

Institutions were very aware of each other's areas of expertise and there was a good level of autonomy and no interference in the formulation of cooperation programs. Itamaraty issued directives and observed whether all MoH institutions were respecting BFP principles, but perhaps, aware of these institutions' great technical expertise, it only interfered in matters of protocol under its scope.

### Agenda Setting:

Brazil did not develop one single international agenda for Health. What did happen was health was listed as a priority by MoFA, and the MoH set international cooperation as part of its axis of action in both the *More Health* and Strategic Planning strategies. From this, each institution individually set their goals and tactics for international actions, such as Fiocruz, with plans of its own.

INCA also had its own COPs implementation agenda, as did Anvisa, with cooperation projects via BCA or even via country-country partnerships, providing this institution with its own health regulatory service agenda. BCA also had priorities of its own (although they were very much aligned with Itamaraty's agenda, since it is one of its subsidiary organizations).

However, although there seems to be no final or unique agenda for Brazil, there are undertakings common to them all: a focus on developing countries, training of local personnel, and strengthening of local health capacities. Bearing in mind the different natures of all institutions engaged in health foreign affairs, we argue that Brazil was able to harmonize these institutions' agenda setting, using three ideas as basis in i) health as a priority, ii) focus on the global South, iii) commitment with the idea of structuring cooperation for health.

### Arenas

Brazil was not only able to debate health-related issues in different arenas, as the country intended. By virtue of AISA's Technical Analysis Division—whose activities included bringing health topics to climate change forums—and Anvisa—which was very active on MERCOSUR and even part of the International Conference on Harmonisation of Technical Requirements—we understand that Brazil expanded its operations to many different centres.

However, MoFA defined its *strategic* arenas, the ones that would be prioritized by BFP: South America, Haiti, Africa – mainly PALOPs – and East Timor (as a way of saying that CPLP member states would receive due attention as well), and the rest of

Latin America and the Caribbean (AISA, 2010). Nonetheless, most of the efforts concentrated on South American and PALOPs nations.

Moreover, debates in groups such as IBSA and BRICS were not fortuitous. Declarations were issued, and common proposals constructed. Although not an actual arena, the global South was a sort of political space where Brazil truly sought to become leader, mainly during President Lula's years in power. As analyzed in this thesis, many of these global South arenas such as MERCOSUR, UNASUR, CPLP and these two informal forums were all listed as priorities by Brazil.

Brazil also attempted to establish collaborative arenas even for specific matters: networks of public health schools, public health institutions and milk banks were spaces that connected and offered training for UNASUR and CPLP countries. Thus, it is very significant that Brazil was willing to bring health debates to so many different arenas.

### Actors engagement

Actors engaged in this international action on health are very different in nature. There are NGOs, government organizations and private institutions. Governmental institutions, because of their ability to implement programs, are much more prominent. SUS is a governmental institution, and, as brought up by Mr Barbosa Lima (2017), most of Brazil's international cooperation was done by technicians already working for these institutions. In other words, Brazil used the already existing employees of its organizations to implement its technical cooperation program.

If governmental actors are so prominent, the same cannot be said of civil society actors. On one hand, Itamaraty and its extremely slow opening process has placed several hindrances in the path of NGOs willing to influence foreign policy-making (PIMENTA DE FARIA, 2012). In an interview with the author of this thesis, Terto Jr (2017) explained that the lack of institutional mechanisms for third sector participation has negative impacts on engagement of actors other than governmental organizations. On the other hand, Amorim himself explains that, whenever needed, Itamaraty would debate with

NGOs topics deemed sensible to the country, in a dynamic that he understood to be very positive (AMORIM, 2015b).

Analysis of private participation is equally hard. Regarding projects, we had the case of the Albert Einstein Hospital in Haiti, and in Mozambique the Brazilian Society of Paediatrics was having conversations with both Itamaraty and MISAU to implement a cooperation project for infant health. Nevertheless, there is not much information on the monetary values of such cooperation, and in neither period of time would it be under implementation (MINISTRY OF FOREIGN AFFAIRS , 2006e). Regarding other types of participation, there is the case of Vale funding for the ARV medicines factory in Mozambique. And there are some characteristics of this funding that make it a very atypical case for analysis. It was not humanitarian aid, but was made, as already mentioned, on request of President Lula. We wonder if more debates concerning the accountability of this relationship between Vale and Mozambique should have existed.

### Planning

Were there international strategic health plans being formulated or implemented? In this case, the answer to the proposed question is positive: there were health goals and international strategic health plans being implemented or formulated by both MoFA and MoH organizations. All engaged institutions did develop strategies and signed contracts for planning of health-related activities and negotiations abroad, no matter how specific the topic.

The most important examples of strategies and plans can be found in the MoH's *More Health* and Strategic Planning 2011–2015. Because they operated as umbrella strategies, being used by others, such as Fiocruz and Anvisa, as guidelines for their own goals. Even CT 41 with PAHO was influenced by those strategies.

Itamaraty also had a clear strategy for health: the Oslo Initiative, or the Global Health and Foreign Policy Initiative. Moreover, BCA and all of its activities and projects

had a strategy to increase the number of technical cooperation projects where health was the main topic of collaboration.

### Timing

The duration of projects varies greatly based on project type. There are some long-term projects, such as Brazil's tripartite cooperation with Cuba and Haiti, and there are many short-term ones, since it was BCA's preferred type of contract for some time (two-years long projects, with a possible two-year extension, as Amb. Farani explained). Contracts with PAHO were also usually long term, given that some Cooperation Terms were meant to last 10 years.

And there were many commitments which did not clearly specify how long they would last, leading us to conclude that they were all long term. For instance, MoH projects with MERCOSUR and UNASUR, INCA's presence at the COPs and Anvisa presence in international regulatory committees, all demonstrate intense activity throughout the time interval considered in this thesis (2003 – 2014). Moreover, these institutions developed goals and strategies to be implemented in the long term, such as Anvisa's Strategic Planning 2010 – 2020, and CONICQs strategy for the enactment of the FCTC.

Therefore, projects can be both long term and short term. They vary according to the cooperation contracts signed and the intention of the institution responsible for that particular activity.

### Decision-making structure

Decision-making structures change according to the nature of topics under the spotlight. Holding more political negotiations or organizations naturally requires more engagement from Itamaraty. For instance, when Global Health and Foreign Policy strategy was discussed in the UN General Assembly, Itamaraty and its Social Affairs Division took the lead in negotiations.

In more technical arenas, MoH and its institutions share a great deal of autonomy, significantly for their attributes such as high-expertise. Although receiving guidance from Itamaraty and discussing previous Brazilian Foreign Policy positions in their areas of work, INCA and Anvisa, for example, are very independent in the negotiation *per se*.

So, we can say that this decision-making structure is decentralized, depending upon the themes considered. But, we must emphasize it is decentralized *within the Executive Branch*, since other branches of the federal governance and institutions other than governmental ones might find it hard to have access to it.

### Principles

The idea of a principle of non-indifference in Brazilian Health Foreign Policy did not voluntarily appear in our interviews. What did appear was an idea that Brazil had something that could be shared with others: Brazil, a developing country, had an immaterial product, its knowledge, that could be shared with other developing nations.

It was almost an ideal of communion, of unity among developing nations and empathy towards their populations. Likewise, SUS universalism was considered to be a fundamental piece of this structured puzzle.

An idea that appeared in many documents, speeches and in the literature is Fiocruz's concept of structuring cooperation for health. It was a beacon for Fiocruz activities, but other entities, such as BCA, and even multilateral organization, such as CPLP, use this concept to justify actions and develop programs.

There are two possibilities in this case: either Fiocruz became so deeply engaged in international affairs that it imposed its agenda and strategy to other areas; or structuring cooperation for health as a concept was so effective that other institutions applied it on their own. Either way, we argue that this concept performed as an important guide to Brazilian Foreign Policy formulation, remarkably more than the idea of no-indifference.

A possible criticism of this realm's structure is that it is too heavily inspired by the domestic arena, and too closed to international influences. Nonetheless, once more, this structure is proposed for the analysis of the Brazilian case, and it was its domestic structure, with SUS, MoH and MoFA, that provided a good base for many of these international events to happen.

When bearing in mind all these realms and their analysis, we conclude that some realms and some domains are better explored than others. We must consider that some goals or some of the questions we have asked in each one of the realms have been respectively answered or achieved. Bearing this in mind, we have:

- Legislation: partially achieved;
- Institutional: totally achieved;
- Agenda setting: totally achieved;
- Arenas: totally achieved;
- Actors engagement: partially achieved;
- Planning: totally achieved;
- Timing: totally achieved;
- Decision making structure: totally achieved.

Thus, according to the realms we proposed, Brazilian policy-making structures allows us to consider that all events taking place in the country tick all the boxes for the existence of a Brazilian Health Foreign Policy.

When asked directly whether Brazil developed a proper Health Foreign Policy, some interviewees categorically answered yes. Others just emphasized Lula's influence on the issue, questioning if during Rousseff's term this had continued. Some denied the existence of any Health Foreign Policy whatsoever, describing that what actually had happened was a case of a branch of BFP for international development gaining more attention, since health *per se* would be an extremely technical issue, not well-known by diplomats.

To Amb. Celso Amorim (2015a), health was an important topic, but “social affairs in general are quite a new thing”. Amb. Alcázar (2017) explained that health should be understood under the paradigm of social determinants for health, a broader approach, an idea loosely shared by Dr. Paulo Buss (2017), with whom Brazil developed a foreign policy of support to other countries under South-South Cooperation ideas, not a specific foreign policy for health affairs.

Both ex-Ministers of Health disagree with their analysis. For Dr. Temporão (2016), “for the first time Brazil dealt with the topic in a structured fashion, within a framework planned by the Ministry. And this was done in partnership with the Ministry of Foreign Affairs”. To Dr. Padilha (2017), there was a structure that allowed all these initiatives to take place, and this structure was a Health Foreign Policy. And to him, there was a political decision to build this agenda, closely linked to the national development plan. In a nutshell, to Dr. Padilha, despite being a technical issue, to place health in the international agenda was a political decision. In his own words (PADILHA, 2017):

There can be a government with an effective foreign policy agenda, with a degree of protagonism and importance to the government, and the construction of this agenda is necessarily political, it has connections with the national development project of a country, how this country wants to be inserted in the world. When you have this, and we had this during this period, you build a highly political agenda, connected to your national development project, and technical organs, they offer technical support to this agenda. Sometimes, what happens, is that the government has not got a clear foreign policy, because there isn't a national project of development (...). This has happened to Brazil before. (...) [As a consequence] technical organs sometimes develop a specific foreign policy of many bilateral cooperation projects, [each] answering to interests of these technical organs themselves, and not the national development project. It's a tension that has always existed.

I have no doubt that a foreign policy is built by political actors. The Ministries, the tensions with National Congress, with civil society, with subnational governments, and with what you think about your country. What you consider a national development project and how you want to position your country in the world. And health has this feature, of being offered... [it is a technical offer] it thickens, enhances foreign policy.

With all the material analyzed and interviews carried out for this study, we conclude that what can be observed in Brazil is indeed a Health Foreign Policy. There



was a structure, there was knowledge and technical know-how, there were resources ready to spread its experience to partner countries, and most importantly, there was the intention and political strategy to do so. Some areas need further development, such as legislation and access to civil society actors, so that the BHFP can be considered a well-structured thematic foreign policy. But the framework is ready.

## 9.2 Criticism

Some issues concerning Brazilian activity abroad still need to be highlighted before the closure of this thesis. First of all, one issue that needs to be debated is the Brazilian idea of South-South Cooperation, based on altruistic principles, “respect for sovereignty and nonintervention in the domestic affairs of other nations” as well as not seeking “profit and disconnect from commercial interests” (INSTITUTE FOR APPLIED ECONOMIC RESEARCH, 2011, p. 33).

There is evidence in the literature that this might not be exactly the case. Data found by Esteves, Fonseca and Gomez (2016, p.163) suggest that:

Angola is (...) a relevant destination for Brazilian private companies' investment. In fact, Angola concentrates the highest number of Brazilian small and medium enterprises in Africa. Furthermore, BNDES has disbursed US\$2.8 billion for private investments in Africa since 2007, of which Angola has received 96%

Evidence of a correlation between trade and cooperation was also found by Hirst (2012, p. 34), as the author describes that, “in 2008, African countries absorbed 52% of all Brazilian exports destined to the developing world, and 53% of BCA activities”.

We also found evidence of such a connection between international cooperation and the activities of Brazilian private companies abroad. According to a telegram issued by Brasemb Maputo in 2010, ex-President Lula, Mr. Marco Aurelio Garcia (Foreign Policy Advisor to President Lula) and the Ambassador to Mozambique at that time (Amb. Antonio J. M. de Souza e Silva) had a meeting with representatives of Brazilian companies working in this African country (MINISTRY OF FOREIGN AFFAIRS, 2010m).

Those companies were: Vale, Odebrecht, Camargo Correa, Fidens, Galvão, Queiroz Galvão and Andrade Gutierrez. Vale's president, Mr. Roger Agnelli, was also present. Worried about the fact that mining activities at the Moatize Mine would start in July 2011, producing exports of around US\$2 billion/year, mainly to Brazil, he complained about the work of the Indian company RITES, that was supposed to improve infrastructure in Mozambique, mainly "*corredor sena*" for exportations. Vale lost to RITES the government public bid to refurbish and improve this Sena railway (MINISTRY OF FOREIGN AFFAIRS, 2010m).

Andrade Gutierrez's vice president group attended the meeting too. In partnership with Fidens, they wanted to build the Moamba Major Dam, increasing water supply to Maputo. This project was supported by the World Bank and was considered to be public health-related because 70% of the population still relies on water wells. Andrade also demonstrated interested in the telephone communications market of Mozambique. The state-owned company Mcel needed capital to expand its services and wanted to establish operational partnerships with other companies. This all was said by president Guebuza in a private meeting (MINISTRY OF FOREIGN AFFAIRS, 2010m).

To Odebrecht, the Moatize mine was "the biggest project in the history of the country" and also warned that Brazil should provide "adequate funding, in case it wants to ensure, regarding competitiveness with other countries, the exportation of capital goods and services to Africa. In their evaluation, the funding guarantor to exportations *could not* be BNDES, but the government" (MINISTRY OF FOREIGN AFFAIRS, 2010m, p. 05. Emphasis is ours). President Lula, in turn, emphasized the necessity of Brazilian Banks coming to Africa, to help diminish financial costs.

Not all authors had negative interpretations on this matter. To some, South-South structuring of cooperation for health "[demonstrated] that it is possible to combine altruism with self-interest in the support of improved health conditions in partner countries on health diplomacy initiatives", emphasizing as well the existence of a "Brazilian self-interest in increasing its international political capital", and "with health as a fundamental question to South-South cooperation, health diplomacy became a foreign policy strategy" (PANISSET, 2017, p. 110).

The true nature of Brazilian Cooperation is questioned by some authors. However, with all the data collected for this thesis, we must say we agree with Panisset (2017), in the sense that Brazil had a self-interest, but that there was a true intention of sharing SUS know-how with other countries. There is no space in this study to analyze whether, in all the outcomes of these cooperation projects, the self-interest prevailed over the altruistic facet of Brazilian activities, and neither is this within the time interval proposed in this thesis. But a study in this regard is quite urgently needed.

## 10. Conclusion

Health in international relations has been categorized by its links to either Security, Economics or Social Justice. Brazil chose to stay closer to the latter, by associating it to South-South Cooperation efforts and providing what was defined as structuring cooperation for health, an “institutional strengthening of health systems of partner countries” (ALMEIDA, CAMPOS, et al., 2010, p. 28).

To do so, many actors got involved, especially institutes and organizations belonging to the MoH and to the MoFA. The former counted on its HIV/AIDS National Program, INCA, AISA, Anvisa and Fiocruz to implement its strategy. The latter was supported by its Social Affairs Division and the Brazilian Cooperation Agency to assist and fund Brazilian health actions abroad.

HIV/AIDS and INCA programs brought Brazil under the spotlight of the international arena, and with the evolution of SUS in its domestic domain, Brazil was ready, during the period of time considered for this thesis, to export its most essential good in health cooperation: know-how and expertise.

The concept of Health Foreign Policy introduced by this thesis was a methodological tool to analyze the country’s actions during the period considered. In Brazil, there was a very complex structure of interconnected institutions aware of their essence, with budget, personnel and morale to influence foreign policy-making.

There were also Brazilian efforts to multiply the number of arenas in which the topic was debated, though there were problems: lack of a clear legislation for cooperation and difficulties for non-state organization actors are negative aspects of this foreign policy. Most institutions, from AISA to Anvisa, affirmed to act respecting *priorities settled* by MoFA, but when debates concern health policy or technical cooperation in health, MoH regains authority and implements an agenda of its own.

Itamaraty had to learn how to cooperate with new demands, and MoH had to understand that sometimes, programs that are effective in Brazil might face problems in other areas, as was the case with the Mozambique ARV medicines factory and Angola/Proforsa.

This Health Foreign Policy fits completely into the idea of “foreign policy as public policy, that is, the state and the government acting on the international level” (MILANI & PINHEIRO, 2017, p. 283). State ideas, in this case SUS, with a government prone to emphasizing social matters (President Lula’s first and second terms), transformed this into an effective tool to improve levels of development mainly in South American and PALOP countries.

SUS’s idea of universal access to healthcare and Fiocruz’s concept of structuring cooperation for health were the beacons leading Brazilian Health Foreign Policy. They cannot be considered principles, but are certainly ideas which brought MoH and MoFA together in efforts to structure Brazilian international cooperation.

Dilma Rousseff might not be able to claim the same political will as Lula (ALMEIDA, 2017b), and some projects continued because of institutional inertia. However, after all the evidence introduced by this thesis, we can affirm that the pillars and structure for a Brazilian Health Foreign Policy were solidified from 2003 onwards.

The goals of this thesis were to identify actors, constituent elements and principles of this BHFP. Actors are plentiful. Undoubtedly, they are mainly institutions part of either the MoH or MoFA, but this prominence of organs from the Executive Branch poses a problem to the agenda setting, since this centralization leaves civil society, private entities and other branches of government quite excluded from the agenda setting.

Regarding constituent elements and principles, certainly solidarity, universal health care, knowledge sharing and cooperation with global South countries were the bricks of all Brazilian actions in this Health Foreign Policy. Prioritizing health, engagement in the global South, and a deep commitment to the idea of structuring cooperation for health were the compasses of agenda setting.

Our first proposed hypothesis, the existence of a Health Foreign Policy with an agenda, values and settled goals, is confirmed. Both MoH and MoFA had their agendas and goals (respectively *More Health* and Strategic Planning 2011-2015, and the Oslo Initiative), while each one of their organs and institutions had agendas and goals of their own. Agents had the intention of acting internationally, and could, autonomously, formulate, develop and implement their projects and plans.

We can also question whether there was a national intention, a Brazilian attempt to increase its presence in the international political arena. Regarding values, we cannot affirm that Brazil has already established specific principles to this foreign policy, however, we claim that an idea, the idea of structuring cooperation for health, was a guide to this process.

The second hypothesis, a possible convergence of BHFP with SUS principles and values, is partially confirmed. The idea of Universal Health Care is strong in all projects and cooperation programs Brazil has developed from 2003 to 2014, and no doubt universal access to health care created a window of opportunity for health to become a foreign policy issue. However, we consider this hypothesis to be partially confirmed because other principles, such as equitable access to health care, were not mentioned by interviewees or documents. SUS's other principles were not denied, refuted or diminished. They were simply not mentioned or recalled. By analogy, we can consider they were important because, provided that SUS was considered to be the spine of Brazilian international cooperation in health, so were its principles. It is just a matter of these other principles not being properly cited by authorities or documents.

There is a Brazilian Health Foreign Policy. Some might still consider it to be quite embryonic: different from trade, a topic to which Itamaraty dedicates 4 different divisions, health still needs to fight for its space within MoFA's structure. However, as our interviewees demonstrated, they are well aware of its existence and importance. Nonetheless, international actions are totally developed in the MoH framework of organizations, to the point that some, such as Anvisa, have become an international reference in their topics of expertise.

We thus conclude that a Brazilian Health Foreign Policy has been developed. There is a network of domestic institutions that, basing themselves on SUS experience and knowledge, have built a new array of relationships using health as the topic of action. Further research is required, now, to see if the outcomes of this new BHFP were positive for the country and its partners.

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## 12. Annexes

Annex 01 – MoH reporting to MoFa medicines donations.

  
**MINISTÉRIO DA SAÚDE**  
Assessoria de Assuntos Internacionais  
Divisão de Projetos

**URGENTE**  
SIPAR - Ministério de Saúde  
25000-055 955/2006-29  
10 / 04 / 06

Ofício nº 192 /2006/MS-AISA-GM

Brasília, 07 de Abril de 2006

A Senhor:  
Ministro João Inácio Oswald Padilha  
Chefe da Divisão de África II  
Ministério das Relações Exteriores  
Esplanada dos Ministérios – Bloco H, Anexo I, Sala 322  
70170-900 – Brasília – DF

**MRE - DCA**  
**DISTRIBUIÇÃO**  
DAF-II /  
10 ABR 2006  
**CLASSIFICAÇÃO**  
SAPS BRAS CABO

**Assunto: Doação a países africanos.**

Senhor Ministro,

Em resposta a comunicação dessa Divisão, datada de 28 de março passado, relativo ao voo especial FAB/MRE para Cabo-Verde, Costa do Marfim, Guiné-Bissau e Senegal, informo que este Ministério enviará a título de doação:

**Cabo-Verde**

- 167 frascos de Zidovudina 100mg;
- 006 frascos de Neviradina 200mg;
- 275 frascos de Zidovudina Sol. Oral;
- 100 ampolas de Zidovudina injetável;
- 001 kit de farmácia básica ( 3 caixas, total: 88kg).

**Costa do Marfim**

- 001 Kit de farmácia básica ( 3 caixas, total: 88kg).

**SEM ANEXO  
NA CARTEIRA  
DE ENTRADA**

Esplanada dos Ministérios, Bloco G, Ed. Sede, 4º andar, sala 423, CEP: 70058-900 BRASÍLIA – DF  
Telefone: 315-2700/2138 – Fax: 224-0014 – E-mail: dproj@saude.gov.br

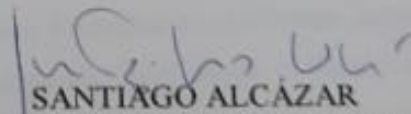
**Guiné-Bissau**

- 150.000 cápsulas de vitamina A 200 UI;
- 50.000 cápsulas de vitamina A 100 UI;
- 1 Kit de farmácia básica ( 3 caixas, total:88kg);
- 14.760 comprimidos de Nevirapina 200mg;
- 5.040 comprimidos de Estavudina 30 mg;
- 1.200 cápsulas de Estavudina 40 mg;
- 1.680 cápsulas de Ritonavir 100 mg.

**Senegal**

- 1 Kit de farmácia básica ( 3 caixas, total:88kg);

Respeitosamente,



SANTIAGO ALCÁZAR

Assessor Especial para Assuntos Internacionais de Saúde

Annex 02

Brazilian Ambassador to Mozambique requiring further information on the establishment of an ARV factory in this African Country

De : BRASEMB MAPUTO

Recebido em: 22/10/2003 18:59 No.: MG00692

De Brasemb Maputo para Exteriores em 21/10/2003 (GGMP-AFJ<J8EKFJ8)

CARAT=Ostensivo  
PRIOR=Urgentíssimo  
DISTR=DAF II/ABC/DTS  
DESCR=Etec-BRAS-MOÇA  
REF/ADIT=TEL 445  
CATEG=MG

//  
Brasil-Moçambique. Visita  
presidencial. Cooperação em  
DST/AIDS. Projeto da fábrica/  
laboratório de ARVs. Missão do  
Ministério da Saúde.  
//

Nota da DCA: Redistribuído para DAF II/ABC/DIPI/DTS/ACS em 22/10/2003  
Nr. 00692

RESUMO=

Informo e solicito providências. Pede atualização do tema do apoio brasileiro à instalação de fábrica de ARVs em Moçambique, sobre o que com frequência consultam a Embaixada e que será, certamente, uma das perguntas a serem feitas ao Senhor Presidente da República.

Um dos temas mais abordados com a Embaixada é o da disposição brasileira de apoiar a instalação de um laboratório/fábrica de anti-retrovirais em Moçambique. Sou, com frequência, perguntado sobre o assunto, seja por parte de autoridades moçambicanas, Embaixadores estrangeiros ou ONGs locais. No dia de hoje, 21 de outubro, tanto o Diretor da USAID, como a Dra Graça Machel, com quem me encontrei em reuniões separadas, perguntaram-me a respeito.

2. Essa indagação será, com toda a certeza, feita ao Senhor Presidente da República quando aqui estiver.

3. Muito agradeceria ser atualizado sobre o assunto. Recordo que o último desdobramento registrado foi a vinda de missão técnica do Ministério da Saúde, em julho último, no contexto da preparação da visita presidencial prevista para agosto. Essa missão, que efetuou o primeiro levantamento concreto das condições locais relativamente ao projeto, ficou de apresentar relatório ao Ministério da Saúde, em Brasília, em 29 de julho. Não mais tive notícia do assunto, nem tampouco do destino que terá tido o documento "Proposta de Atividades a serem desenvolvidas por cada país", assinado em Maputo.

Distribuído em : 22/10/2003 20:00:00

Impresso em : 01/02/2008 15:42:04

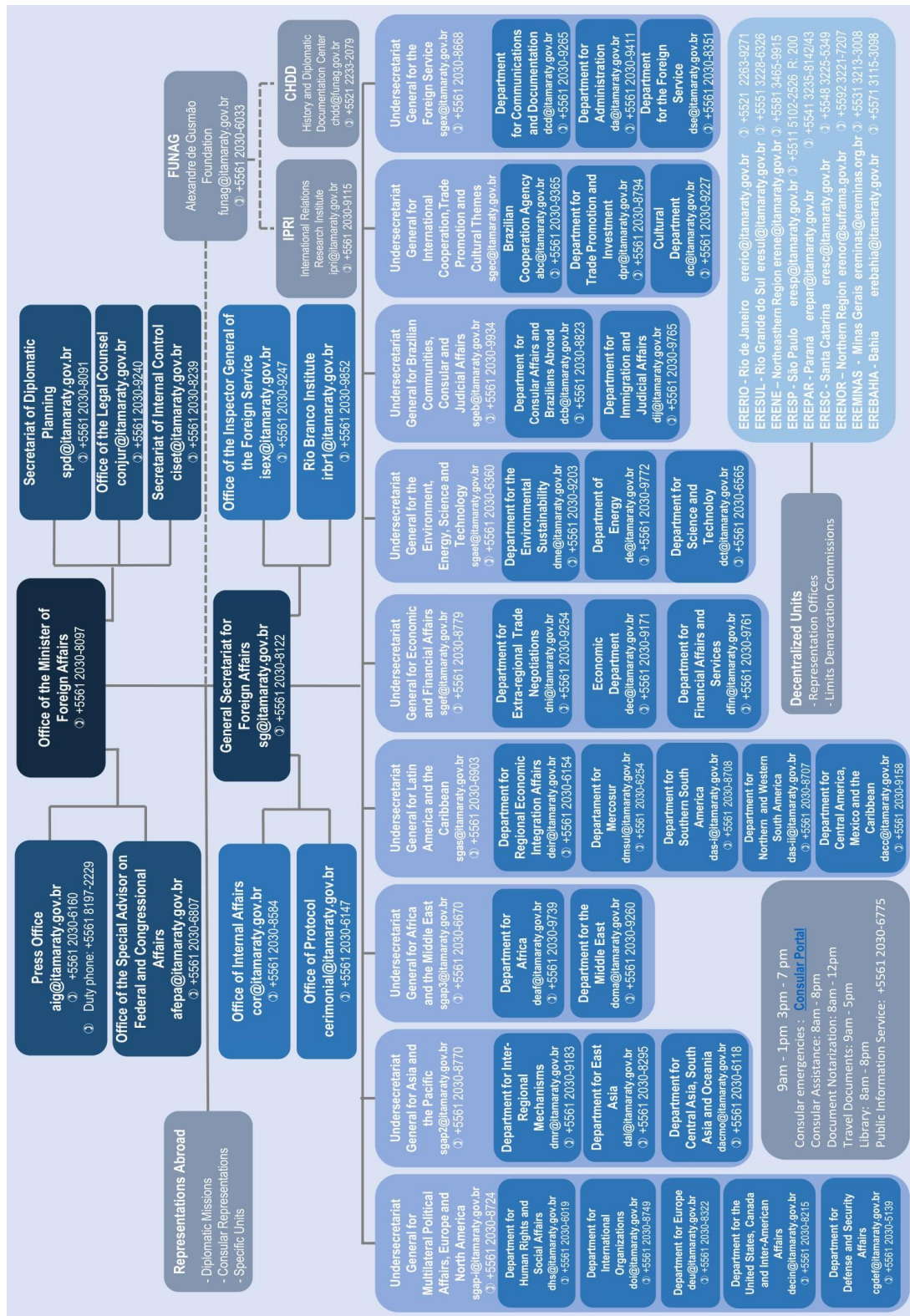
De : BRASEMB MAPUTO

Recebido em: 22/10/2003 18:59 No.: M300692

PEDRO LUIZ CARNEIRO DE MENDONÇA, Embaixador

PLCM

# Annex 03 – Itamaraty organogram



Annex 04 – International Agreements in health affairs signed by Brazil

Country	Agreements (names in Portuguese)	Signed on
Germany	Ajuste Complementar, por troca de Notas, ao Acordo de Cooperação Técnica, de 17/09/1996, sobre o Projeto “Fortalecimento do Programa Nacional de DST/AIDS”.	15/08/2001
Germany	Declaração Conjunta de Intenção entre o Ministério da Saúde do Brasil e o Ministério Federal da Saúde da República Federal da Alemanha nos campos: doenças transmissíveis e não transmissíveis; economia da saúde; gestão da saúde; educação em saúde; gestão da qualidade; atenção primária à saúde; práticas regulatórias e pesquisas relacionadas a questões de saúde.	20/08/2015
Germany	Declaração Conjunta de Intenção entre a Agência Nacional de Vigilância Sanitária-ANVISA e o Ministério Federal da Saúde da República Federal da Alemanha.	20/08/2015
Germany	Ajuste Complementar sobre o Projeto Pesquisa e Desenvolvimento na Área Biomédica.	19/02/1993
Germany	“Prosseguimento à cooperação prestada ao Instituto Nacional de Controle de Qualidade em Saúde – INCQS, da Fundação Oswaldo Cruz – FIOCRUZ, no Rio de Janeiro, com o objetivo de apoiá-lo para que este exerça, de forma qualificada, suas funções de laboratório nacional de referência para o controle de medicamentos e gêneros alimentícios”.	19/02/1993
Angola	Ajuste Complementar ao Acordo de Cooperação Econômica, Científica e Técnica entre o governo da República Federativa do Brasil e o Governo da República Popular de Angola para Implementação do “Projeto Piloto em Doença Falciforme”.	23/06/2010
Angola	Ajuste Complementar ao Acordo Básico de Cooperação Econômica, Técnica e Científica para a Implementação do Projeto “Apoio ao Programa de Prevenção e Controle da Malária”.	18/10/2007
Angola	Ajuste Complementar ao Acordo de Cooperação Econômica, Científica e Técnica para Implementação do Projeto “Formação de Docentes em Saúde Pública em Angola”.	09/07/2007
Angola	Ajuste Complementar ao Acordo de Cooperação Econômica, Científica e Técnica para Implementação do Projeto “Capacitação do Sistema de Saúde da República de Angola”.	09/07/2007



Algeria	Ajuste Complementar ao Acordo de Cooperação Científica, Tecnológica e Técnica entre o Brasil e a Argélia para a Implementação do Projeto Capacitação Técnica em Procedimentos Cirúrgicos Cardíacos Pediátricos	23/06/2008
Algeria	Ajuste Complementar ao Acordo de Cooperação Científica, Tecnológica e Técnica entre o Brasil e a Argélia para a Implementação do Projeto Gestão e Normatização do Atendimento a Pacientes Portadores de Queimaduras	23/06/2008
Argentina	Memorando de Entendimento entre o Ministério da Saúde da República Federativa do Brasil e o Ministério da Saúde da República Argentina em Matéria de Saúde, Transplante Multivisceral.	18/05/2015
Argentina	Memorando de Entendimentos entre o Ministério da Saúde da República Federativa do Brasil e o Ministério da Saúde da República da Argentina sobre a cooperação para inclusão social, o acesso à saúde e a formação de Recursos Humanos em saúde.	17/07/2013
Argentina	Ajuste Complementar ao Acordo de Cooperação Científica e Tecnológica entre a República Federativa do Brasil e a República Argentina para a Pesquisa, Desenvolvimento Tecnológico e Produção de Insumos, de Medicamentos e de Recursos para Diagnóstico.	30/11/2005
Argentina	Protocolo de Intenções entre o Ministério da Saúde da República Federativa do Brasil e o Ministério da Saúde e Ambiente da República Argentina sobre Cooperação da Área da Saúde sobre Medicamentos.	22/08/2005
Barbados	Ajuste Complementar ao Acordo Básico de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo de Barbados para a Implementação do Projeto “Fortalecimento do Combate ao HIV em Barbados”	26/04/2010
Belize	Memorando de Entendimento entre o Governo da República Federativa do Brasil e o Governo de Belize na Área da Saúde, estabelecer as bases e mecanismos para a colaboração científica e técnica entre as Partes e criar a plataforma para empreender iniciativas e atividades comuns, designadas a promover e a realçar o setor saúde e a atenção à saúde nos respectivos países.	15/10/2009

Benin	Ajuste Complementar ao Acordo de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República do Benim para Implementação do "Projeto Piloto em Doença Falciforme".	13/03/2009
Benin	Protocolo de Intenções sobre Cooperação Técnica para Prevenção e Tratamento da Malária.	10/02/2006
Bolivia	Acordo Interinstitucional Internacional subscrito entre o Ministério da Saúde da República Federativa do Brasil e o Ministério da Saúde do Estado Plurinacional da Bolívia em matéria de Cooperação de Saúde na zona fronteira Brasil – Bolívia.	06/10/2017
Bolivia	Ajuste complementar ao acordo básico de cooperação técnica, científica e tecnológica entre o governo da república federativa do Brasil e o governo do estado plurinacional da Bolívia para a implementação do projeto “Fortalecimento em atenção integral e vigilância epidemiológica em DST/HIV/Aids na Bolívia”.	25/09/2009
Bolivia	Ajuste Complementar ao Acordo Básico de Cooperação Técnica, Científica e Tecnológica entre o Brasil e a Bolívia para Implementação do Projeto “Fortalecimento da Capacidade Institucional do Ministério de Saúde e Esportes da Bolívia em Sistemas de Vigilância em Saúde Ambiental”	12/03/2009
Bolivia	Ajuste Complementar ao Acordo Básico de Cooperação Técnica, Científica e Tecnológica entre o Brasil e a Bolívia para Implementação do Projeto “Apoio à Implementação do Banco de Leite Materno”	12/03/2009
Bolivia	Ajuste Complementar ao Acordo Básico de Cooperação Técnica, Científica e Tecnológica para a Implementação do Projeto Estruturação do Centro de Referência para Queimados em La Paz.	18/11/2003
Bolivia	Ajuste Complementar ao Acordo Básico de Cooperação Técnica, Científica e Tecnológica para Implementação do Projeto Prevenção e Controle de Doenças Sexualmente Transmissíveis, Vírus de Deficiência Imunológica Humana e a síndrome de Imunodeficiência Adquirida (DST/HIV/AIDS).	28/04/2003
Bolivia	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica na Área do Controle de Endemias.	02/08/1988

Bolivia	Ajuste Complementar ao Acordo Básico de Cooperação Técnica Científica entre a República Federativa do Brasil e a República da Bolívia no Campo da Saúde, com o propósito de identificar problemas similares de saúde, tais como a alta mortalidade infantil, desnutrição proteico-calórica, alta incidência de doenças transmissíveis, difícil acesso aos serviços de saúde e alto custo dos medicamentos básicos.	08/02/1984
Bolivia	Acordo sobre Cooperação Sanitária entre a República Federativa do Brasil e a República da Bolívia.	08/06/1972
Botswana	Ajuste Complementar ao Acordo de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República de Botsuana para Implementação do Projeto “Fortalecimento do Plano Nacional Estratégico para HIV/Aids 2003-2009”	05/05/2009
Botswana	Memorando de Entendimento sobre Cooperação Técnica na Área de HIV/AIDS	11/02/2006
BRICS	Declaração de Moscou – 5ª Reunião de Ministros de Saúde do BRICS. Cooperação entre o Grupo para a Promoção da Saúde.	30/10/2015
Burkina Faso	Protocolo de Intenções entre o Governo da República Federativa do Brasil e o Governo do Burquina Faso Sobre Cooperação Técnica na Área de Saúde.	15/10/2007
Burkina Faso	Protocolo de Intenções no Âmbito do Programa de Cooperação Internacional do Ministério da Saúde do Brasil, que tem como objeto a implementação de "Projeto de Assistência de Prevenção do HIV/AIDS", no âmbito do "Programa de Cooperação Internacional para Ações de Controle e Prevenção do HIV para Países em Desenvolvimento" contribuindo com os esforços do Burquina Faso em promover uma resposta efetiva para o controle da epidemia do Vírus da Imunodeficiência Humana (HIV) e AIDS, bem como estabelecendo os parâmetros de sua execução.	03/09/2003
Burundi	Protocolo de Intenções no Âmbito do Programa de Cooperação Internacional do Ministério da Saúde do Brasil.	28/01/2003
Cape Verde	Programa Executivo Relativo ao Acordo Básico de Cooperação Técnica e Científica entre o Brasil e Cabo Verde para Implementação do Projeto “Fortalecimento da Atenção Primária à Saúde em Cabo Verde”.	27/06/2008

Cape Verde	Programa Executivo Relativo ao Acordo Básico de Cooperação Técnica e Científica entre o Brasil e Cabo Verde para Implementação do Projeto “Apoio Técnico para Implantação de Banco de Leite Humano em Cabo Verde”	27/06/2008
Cape Verde	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Governo da República Federativa do Brasil e o Governo da República de Cabo Verde para Implementação do Projeto “Consolidação da ARFA como Agente Regulador dos Setores e Farmacêutico e Alimentar Visando ao Fortalecimento de sua Capacidade Institucional”.	12/03/2008
Cape Verde	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Governo da República Federativa do Brasil e o Governo da República de Cabo Verde para Implementação do Projeto “Apoio ao Programa de Prevenção e Controle da Malária em Cabo Verde”.	12/03/2008
Cameroon	Ajuste Complementar ao Acordo de Cooperação Técnica para Implementação do Projeto “Apoio ao Programa de Prevenção e Controle da Malária”.	10/04/2007
Cameroon	Protocolo de Intenções sobre Cooperação Técnica na Área da Saúde Pública.	11/04/2005
Canada	Memorando de Entendimento entre o Ministério da Saúde do Brasil, o Ministério da Saúde do Canadá e a Agência de Saúde Pública do Canadá para Cooperação Mútua em Saúde.	25/09/2017
Canada	Carta de Intenção entre o Ministério da Saúde da República Federativa do Brasil e o Departamento de Saúde do Canadá e a Agência de Saúde Pública do Canadá sobre Colaboração no Setor de Saúde.	22/05/2017
Canada	Memorando de Entendimento Brasil – Canadá e a Agência de Saúde Pública do Canadá, para colaboração no setor da saúde.	21/05/2012
Canada	Memorando de Entendimento entre o Ministério da Saúde da República Federativa do Brasil e o Departamento de Saúde do Canadá para colaboração no setor saúde.	19/05/2009

Canada	Ajuste Complementar ao Acordo de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo do Canadá para Implementar o Projeto Aprimoramento do Programa Haitiano de Imunizações”.	23/05/2006
Canada	Ajuste Complementar ao Acordo de Cooperação Técnica, para o Aperfeiçoamento de Especialistas Brasileiros na Área Médica em Tratamento de Câncer.	23/04/1986
Caricom	Memorando de Entendimento Entre a Agência Caribenha de Saúde Pública e o Ministério da Saúde da República Federativa do Brasil.	
Chile	Memorando de Entendimento entre o Ministério Da Saúde Da República Federativa Do Brasil e o Ministério da Saúde da República Do Chile, enfoque no acesso a medicamentos estratégicos e de alto custo.	13/11/2015
Chile	Protocolo de Intenções entre o Governo da República Federativa do Brasil e o Governo da República do Chile para a Criação de Grupo de Trabalho de Cooperação em Matéria de Saúde.	17/08/2010
China	Intercâmbio de informações e o fomento à cooperação entre o Brasil e a China em suas áreas de responsabilidade.	01/11/2017
China	Plano de Ação entre o Ministério da Saúde da República Federativa do Brasil e a Comissão Nacional de Planejamento Familiar e de Saúde da República Popular da China no campo da saúde para o período 2018-2020.	01/09/2017
China	Plano de ação conjunta Brasil-China em Saúde 2011-2014.	20/10/2011
China	Ajuste Complementar sobre Saúde e Ciências Médicas ao Acordo de Cooperação Científica e Tecnológica.	24/05/2004
China	Ajuste Complementar sobre Vigilância de Medicamentos e Produtos Relacionados à Saúde.	24/05/2004
Colombia	Ajuste Complementar ao Acordo Básico de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República da Colômbia para a Implementação do Projeto “Pesquisa e Desenvolvimento para a Fabricação e o Controle da Qualidade de Produtos Biológicos na Colômbia”	31/05/2012

Colombia	Ajuste Complementar ao Acordo Básico de Cooperação Técnica para Implementação do Projeto “Apoio Técnica para a Implementação de Bancos de Leite Humano na Colômbia”.	21/08/2007
Colombia	Ajuste Complementar ao Acordo Básico de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da Colômbia para Implementação do Projeto “Fortalecimento no Diagnóstico Molecular e Tipificação das Espécies de Leishmania, sua Georreferenciação e Análise Espacial.	10/11/2009
Colombia	Ajuste Complementar ao Acordo Básico de Cooperação Técnica para Implementação do Projeto “Fortalecimento Institucional das Assessorias Internacionais dos Ministérios da Saúde do Brasil e da Colômbia”.	07/05/2007
Colombia	Ajuste Complementar, por troca de Notas, ao Acordo Básico de Cooperação Técnica de 13/12/72, para Saúde na Fronteira.	22/03/2005
Colombia	Ajuste Complementar ao Acordo Básico de Cooperação Técnica para Implementação do Projeto Assistência e Tratamento a Pessoas Vivendo com HIV/AIDS na Colômbia.	17/10/2003
Colombia	Memorando de Entendimento no Âmbito do Programa de Cooperação Internacional do Ministério da Saúde do Brasil.	18/12/2002
Congo	Ajuste Complementar ao Acordo Básico de Cooperação Econômica, Técnica, Científica e Cultural para a Implementação do Projeto “Apoio ao Programa de Luta contra a AIDS na República do Congo”.	16/10/2007
Congo	Ajuste Complementar ao Acordo Básico de Cooperação Econômica, Técnica, Científica e Cultural para a Implementação do Projeto “Apoio ao Programa de Prevenção e Controle da Malária no Congo”.	16/10/2007
Congo	Memorando de Entendimento entre o Governo da República Federativa do Brasil e o Governo da República do Congo na Área da Saúde.	15/03/2007
Coreia	Memorando de Entendimento entre o Ministério da Saúde da República Federativa do Brasil e o Ministério da Saúde e Bem Estar da República da Coreia no Campo da Atenção à Saúde e Ciências Médicas.	24/04/2015

Costa Rica	Ajuste Complementar ao Acordo de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República da Costa Rica para Implementação do Projeto “Vigilância da Saúde e Sistemas de Informação para a Vigilância”.	08/12/2010
Costa Rica	Ajuste Complementar ao Acordo de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República da Costa Rica para Implementação do Projeto “Incorporação de Terapias Não-Convencionais e Complementares nos Serviços de Saúde de Atenção Direta às Pessoas e Desenvolvimento de Estratégia de Saúde Mental de Base Comunitária”	29/11/2010
Costa Rica	Ajuste Complementar ao Acordo de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República da Costa Rica para Implementação do Projeto Fortalecimento Institucional das Assessorias Internacionais dos Ministérios da Saúde do Brasil e da Costa Rica.	19/11/2008
Costa Rica	Ajuste Complementar ao Acordo de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República da Costa Rica para Implementação do Projeto Intercâmbio de Conhecimentos sobre os Sistemas de Saúde Pública do Brasil e Costa Rica.	19/11/2008
Costa Rica	Ajuste Complementar ao Acordo de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República da Costa Rica para Implementação do Projeto Apoio Técnico para Implantação/Implementação de Bancos de Leite Humano na Costa Rica.	19/11/2008
Costa Rica	Ajuste Complementar ao Acordo de Cooperação Técnica na Área da Saúde.	04/04/2000
CPLP	Carta da Cidade de Praia, Cabo Verde – I Reunião de Telemedicina e Telessaúde da CPLP.	15/09/2017
CPLP	Declaração Conjunta: aprofundar a concertação político-diplomática em saúde entre os membros da comunidade, fortalecendo o Plano Estratégico de Cooperação em Saúde (PECS/CPLP).	22/05/2017
CPLP	Plano Estratégico de Cooperação para o Fortalecimento dos Sistemas de Saúde dos Países Membros.	2009-2012

Cuba	Carta de Intenção entre o Ministério da Saúde do Brasil, Ministério da Saúde Pública e o Grupo das Indústrias Biotecnológica e Farmacêutica, BioCubaFarma, ambos da República de Cuba, que estabelece as bases de cooperação para a inovação e desenvolvimento conjunto de Biofármacos.	27/01/2014
Cuba	Ajuste Complementar ao Acordo de Cooperação Científica, Técnica e Tecnológica entre o Governo da República Federativa do Brasil e o Governo da República de Cuba para a Implementação do Projeto “Apoio Técnico para a Expansão e Consolidação da Rede Cubana de Bancos de Leite Humano”.	31/01/2012
Cuba	Ajuste Complementar ao Acordo de Cooperação Científica, Técnica e Tecnológica entre o Governo da República Federativa do Brasil e o Governo da República de Cuba para a Implementação do Projeto “Fortalecimento da Odontologia no Brasil e em Cuba - Fase 3”.	31/01/2012
Cuba	Ajuste Complementar ao Acordo de Cooperação Científica, Técnica e Tecnológica entre o Governo da República Federativa do Brasil e o Governo da República de Cuba para a Implementação do Projeto “Fortalecimento da Organização da Pesquisa Clínica sobre Câncer”.	31/01/2012
Cuba	Ajuste Complementar Ao Acordo de Cooperação Científica, Técnica e Tecnológica entre o Governo da República Federativa do Brasil e o Governo da República de Cuba para a Implementação do Projeto “Estabelecimento de Substâncias de Referência para o Controle da Qualidade dos Medicamentos”.	31/01/2012
Cuba	Ajuste Complementar ao Acordo de Cooperação Científica, Técnica e Tecnológica entre o Governo da República Federativa do Brasil e o Governo da República de Cuba para Implementação do Projeto “Fortalecimento Institucional dos Laboratórios Nacionais de Vigilância Sanitária do Brasil e de Cuba”.	24/02/2010
Cuba	Protocolo Complementar ao Memorando de Entendimento entre o Governo da República Federativa do Brasil e o Governo da República de Cuba na Área da Saúde.	24/02/2010



Cuba	Ajuste Complementar ao Acordo Básico de Cooperação Científica, Técnica e Tecnológica para Implementação do Projeto “Fortalecimento Institucional do Centro para o Controle Estatal de Qualidade dos Medicamentos e da Agência Nacional de Vigilância Sanitária na Área de Vigilância Sanitária de Medicamentos”.	15/01/2008
Cuba	Ajuste Complementar ao Acordo Básico de Cooperação Científica, Técnica e Tecnológica para Implementação do Projeto “Fortalecimento Institucional das Assessorias Internacionais do Ministério da Saúde do Brasil e do Ministério de Saúde Pública de Cuba”.	15/01/2008
Cuba	Ajuste Complementar ao Acordo de Cooperação Científica, Técnica e tecnológica Desenvolvimento Tecnológico para Implementação do Projeto “Apoio Técnico para Implementação de Bancos de Leite Humano em Cuba”.	13/12/2007
Cuba	Ajuste Complementar ao Acordo de Cooperação Científica, Técnica e tecnológica Desenvolvimento Tecnológico para Implementação do Projeto “Controle de Qualidade de Produtos de Risco Submetidos à Vigilância Sanitária”.	13/12/2007
Cuba	Ajuste Complementar ao Acordo de Cooperação Científica, Técnica e Tecnológica para Implementação do Projeto “Fortalecimento da odontologia no Brasil e em Cuba - Fase I”.	27/10/2006
Cuba	Ajuste Complementar ao Acordo de Cooperação Cultural e Educacional para o Reconhecimento de Títulos de Medicina Expedidos em Cuba.	
Cuba	Ajuste Complementar ao Acordo de Cooperação científica, Técnica e Tecnológica para Implementação do Projeto Fortalecimento do Programa Nacional de DST/AIDS de Cuba-Fase II.	29/10/2004
Cuba	Protocolo de Intenções sobre Cooperação Educacional na Área de Saúde.	26/09/2003
Cuba	Protocolo de Intenções na Área de Educação, Saúde e Trabalho com Vistas ao Reconhecimento Recíproco de Diplomas de Graduação e de Pós-Graduação "Stricto Sensu" na Área da Saúde.	23/09/2003
Cuba	Memorando de Entendimento na Área de Saúde entre a República Federativa do Brasil e a República de Cuba.	26/09/2003

Cuba	Ajuste Complementar ao Acordo de Cooperação Científica, Técnica e Tecnológica para Implementação do Projeto Fortalecimento do Programa Nacional de DST/AIDS de Cuba-Fase II.	08/11/2002
Cuba	Memorando de Entendimento na Área de Transferência de Tecnologia na Produção de Medicamentos.	04/12/2000
Cuba	Protocolo de Intenções sobre Cooperação Técnica na Área de Saúde da Família.	19/10/1999
Cuba	Ajuste Complementar ao Acordo de Cooperação Científica, Técnica e Tecnológica para Implantação do Projeto. O presente Ajuste Complementar visa à implementação do projeto "Fortalecimento do Programa Nacional de DST/AIDS".	19/10/1999
Cuba	Ajuste Complementar ao Acordo Básico de Cooperação Científica, Técnica e Tecnológica em Matéria de Saúde Relativo ao Município de Caxias.	08/05/1996
Cuba	Acordo por Troca de Notas, Relativo à Compra de Medicamentos Cubanos.	08/04/1993
Denmark	Carta de Intenções entre o Ministério da Saúde do Brasil e o Ministério da Saúde do Reino da Dinamarca	03/09/2014
El Salvador	Ajuste Complementar ao Acordo de Cooperação Técnica, Científica e Tecnológica entre o Governo da República Federativa do Brasil e o Governo da República El Salvador para a Implementação do Projeto "Apoio Técnico para a Consolidação da Rede de Bancos de Leite Humano".	27/08/2014
El Salvador	Ajuste Complementar ao Acordo de Cooperação Técnica, Científica e Tecnológica entre o Governo da República Federativa do Brasil e o Governo da República de El Salvador para a Implementação do Projeto "Apoio às Ações de Atenção à Saúde e Formação de Conselhos dos Povos Indígenas de El Salvador"	27/04/2011
El Salvador	Ajuste Complementar ao Acordo de Cooperação Técnica, Científica e Tecnológica entre o Governo da República Federativa do Brasil e o Governo da República de El Salvador para a Implementação do Projeto "Apoio Técnico para Criação do Instituto Nacional de Saúde de El Salvador"	26/04/2011

El Salvador	Ajuste Complementar ao Acordo Básico de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República de El Salvador para a Implementação do Projeto “Apoio Técnico para Implementação de Bancos de Leite Humano em El Salvador”	02/07/2010
El Salvador	Ajuste Complementar ao Acordo de Cooperação Técnica, Científica e Tecnológica entre o Governo da República Federativa do Brasil e o Governo da República de El Salvador para a Implementação do Projeto “Apoio ao Fortalecimento e Desenvolvimento do Sistema Nacional de Sangue e Hemoderivados de El Salvador”	26/02/2010
El Salvador	Ajuste Complementar ao Acordo de Cooperação Técnica, Científica e Tecnológica para Implementação do Projeto “Fortalecimento da Resposta à Epidemia de HIV/AIDS em El Salvador”	09/06/2006
El Salvador	Memorando de Entendimento no Âmbito do Programa de Cooperação Internacional do Ministério da Saúde do Brasil.	18/12/2002
El Salvador	Ajuste Complementar ao Acordo de Cooperação Técnica, Científica e Tecnológica para Implementação do Projeto Assistência e Tratamento a Pessoas vivendo com HIV/AIDS em El Salvador.	05/02/2004
El Salvador	Ajuste Complementar ao Acordo de Cooperação Técnica, Científica e Tecnológica para Implementação do Projeto "Apoio ao Programa de Doenças Sexualmente Transmissíveis e AIDS.	02/02/1999
Ecuador	Memorando de Entendimento entre o Ministério da Saúde Pública do Equador e o Ministério da Saúde da República Federativa Do Brasil	15/07/2014
Ecuador	Ajuste Complementar ao Acordo Básico de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República do Equador para Implementação do Projeto “Fortalecimento Tecnológico da Rede de Bancos de Leite Humano do Equador”.	06/09/2012
Ecuador	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Governo da República Federativa do Brasil e o Governo da República do Equador para a Implementação do Projeto “Apoio ao Fortalecimento da Promoção da Saúde no Equador”	06/09/2012

Ecuador	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Governo da República Federativa do Brasil e o Governo da República do Equador para a Implementação do Projeto “Consolidação dos Modelos de Atenção à Saúde Aplicados aos Povos Indígenas”	06/09/2012
Ecuador	Ajuste Complementar ao Acordo Básico de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República do Equador para Implementação do Projeto “Apoio Técnico para a Expansão e Consolidação da Rede de Bancos de Leite Humano no Equador”.	18/02/2011
Ecuador	Ajuste Complementar ao Acordo Básico de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República do Equador para Implementação do Projeto “Apoio Técnico para o Fortalecimento das Funções Regulatórias de Pré e Pós Comercialização de Medicamentos no Equador”	18/02/2011
Ecuador	Ajuste Complementar ao Acordo Básico de Cooperação Técnica para Implementação do Projeto “Fortalecimento Institucional da Assessoria Internacional do Ministério da Saúde do Equador”.	04/04/2007
Ecuador	Ajuste Complementar ao Acordo Básico de Cooperação Técnica para Implementação do Projeto entre o Governo da República Federativa do Brasil e o Governo da República do Equador "Políticas Públicas de Desenvolvimento Social, de Combate à Fome e de Segurança Alimentar e Nutricional no Equador".	04/04/2007
Ecuador	Ajuste Complementar ao Acordo Básico de Cooperação Técnica para Implementação do Projeto ``Fortalecimento dos Modelos Nacionais de Promoção e Proteção da Saúde dos Povos Indígenas do Brasil e do Equador``	04/04/2007
Ecuador	Ajuste Complementar ao Acordo Básico de Cooperação Técnica para a Implementação do Projeto “Fortalecimento do Sistema de Vigilância Epidemiológica no Equador”.	29/11/2005
Ecuador	Ajuste Complementar ao Acordo Básico de Cooperação Técnica para a Implementação do Projeto “Apoio à Implementação do Banco de Leite Humano Isidoro Ayora”.	29/11/2005

Ecuador	Ajuste Complementar ao Acordo básico de Cooperação Técnica para a Implementação do Projeto Intercâmbio para Fortalecimento dos Sistemas Nacionais de Saúde do Brasil e do Equador.	25/08/2004
Ecuador	Memorandum de Entendimento entre o Governo da República Federativa do Brasil e o Governo da República do Equador sobre Cooperação para a Implementação de Banco de Leite Humano	25/08/2004
Ecuador	Protocolo de Intenções entre o Governo da República Federativa do Brasil e a República do Equador na Área de Saúde	06/05/2004
Ecuador	Ajuste Complementar ao Acordo Básico de Cooperação Técnica para Implementação do Projeto “Fortalecimento da Capacidade de Resposta do Programa de Prevenção e Controle de Doenças Sexualmente Transmissíveis, Vírus de Deficiência Imunológica Humana e a Síndrome de Imunodeficiência Adquirida (DST/HIV/AIDS) do Equador”.	27/05/2003
Ecuador	Memorando de Entendimento sobre Políticas Sociais no Âmbito do Programa de Cooperação Técnica.	27/05/2003
Ecuador	Ajuste Complementar ao Acordo Básico de Cooperação Técnica, de 09/02/1982, na Área da Saúde.	08/10/1999
Spain	Carta de Intenção entre o Ministério da Saúde do Brasil e a Consejería de Saúde e Bem-Estar Social da Junta de Andaluzia (Espanha).	mar/13
Spain	Acordo Administrativo entre o Ministério da Saúde do Brasil e o Ministério da Saúde, Serviços Sociais e Igualdade do Reino da Espanha para colaboração no campo dos transplantes.	11/11/2014
Ethiopia	Protocolo de Intenções sobre Cooperação Técnica na Área de Saúde - Áreas de: vigilância epidemiológica; prevenção de doenças; participação da sociedade civil; informação em saúde; formulação e implementação de políticas de saúde pública; capacitação de recursos humanos de ambas as partes para o desenvolvimento técnico; e em outras áreas que as partes julguem adequadas à realização de seus interesses.	08/03/2005
USA	Memorando de Entendimento em Saúde e Ciências Médicas entre o Departamento de Saúde e Recursos Humanos dos Estados Unidos da América (HHS) e o	30/09/2015

	Ministério da Saúde da República Federativa do Brasil.	
USA	Ajuste Complementar, por troca de Notas, ao Acordo de Cooperação em Ciência e Tecnologia para o Controle Biológico do Mosquito Aedes Aegypti.	29/02/2000
USA	Contrato de Prorrogação do Programa de Cooperação em Matéria de Saúde, de 27/12/1950, e do Acordo sobre Saúde e Saneamento, de 14/03/1942.	31/12/1959
USA	Acordo Suplementar ao Acordo para a Realização de um Programa de Cooperação em Matéria de Saúde (1950) e ao Acordo de 14 de março de 1942 entre o Ministério da Educação e o “Institute of Inter-American Affairs”.	08/02/1955
USA	Plano de Cooperação em Saúde Brasil-Estados Unidos. “Plano de Cooperação em Saúde Brasil-Estados Unidos para o enfrentamento ao Zika e suas complicações”.	fev/16
USA	Carta de Intenções com a Cooperação Universidade do Texas UTMB (Inst. Privada) firmado em 2016 – Cooperação para o desenvolvimento de vacina contra o vírus zika com o Instituto Evandro Chagas (IEC). Previsão para testes clínicos até novembro de 2016.	02/04/2016
USA	Carta de Intenções entre CDC/HHS e SVS/MS para Cooperação em Saúde Pública e Vigilância em Saúde.	11/05/2012
USA	Carta de Intenções entre NIH/HHS, MCTI e MS para pesquisa em saúde firmado em 2014.	
USA	Acordo de Confidencialidade entre ANVISA e FDA firmado em 2010.	
France	Declaração de Intenção entre o Ministro da Saúde do Brasil e a Ministra dos Assuntos Sociais e da Saúde da República Francesa para o Estabelecimento de uma Parceria Estratégica em Matéria de Saúde.	19/05/2014
France	Memorando de Entendimento entre o Governo da República Federativa do Brasil e o Governo da República Francesa em Matéria de Cooperação de Saúde na Zona Transfronteiriça Brasil-Guiana Francesa	15/02/2012

Bill & Melinda Gates Foundation	Memorando de Entendimento entre o Ministério da Saúde da República Federativa do Brasil e a Fundação Bill & Melinda Gates para Tratar da Saúde Global e das Necessidades de Desenvolvimento em Países em Desenvolvimento	06/04/2017
Ghana	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Governo da República Federativa do Brasil e o Governo da República de Gana para Implementação do Projeto “Centro de Hemoterapia e Doença Falciforme de Kumasi “.	09/02/2011
Ghana	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica Entre o Governo da República Federativa do Brasil e o Governo da República de Gana para Implementação do Projeto "Apoio A Estruturação do Programa Nacional de Atenção Integral à Pessoa com Doença Falciforme da República de Gana"	07/07/2009
Ghana	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Brasil e Gana para Implementação do Projeto “Fortalecimento das Ações de Combate ao HIV/AIDS em Gana”	19/04/2008
Granada	Memorando De Entendimento Entre o Governo da República Federativa do Brasil e o Governo de Granada sobre Cooperação Técnica a Área da Saúde Pública.	26/04/2010
Guatemala	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República da Guatemala para a Implementação do Projeto “Apoio Técnico para a Expansão e Consolidação da Rede de Bancos de Leite Humano da Guatemala”.	15/04/2013
Guatemala	Ajuste Complementar ao acordo Básico de Cooperação Científica e Técnica entre o Brasil e a Guatemala para Implementação do Projeto “Apoio Técnico para Implementação de Bancos de Leite Humano na Guatemala”.	04/04/2008
Guatemala	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica para Execução do Projeto “Apoio ao Programa Nacional de Prevenção e Controle de DST/HIV/AIDS da Guatemala”.	12/09/2005

Guatemala	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica para Implementação do Projeto Apoio ao Programa Nacional de Prevenção e Controle de DST/HIV/AIDS da Guatemala.	22/08/2002
Guyana	Ajuste Complementar na Área de Saúde ao Acordo Básico de Cooperação Técnica Brasil-Guyana - Visa à implementação da Comissão Binacional Assessora de Saúde na Fronteira Brasil – Guyana.	15/02/2005
Guyana	Protocolo de Intenções na Área de Saúde. – Recebimento de 24 pacientes guianenses, incluídos os casos de emergência, para tratamento médico em hospitais brasileiros.	04/10/1989
Guyana	Acordo de Cooperação Sanitária. – Áreas: epidemiologia tropical; patologia tropical; ecologia tropical; profilaxia e terapêutica; recursos institucionais; formação de recursos humanos; e pesquisa.	08/06/1981
Guinea-Bissau	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Governo da República Federativa do Brasil e o Governo da República da Guiné-Bissau para Implementação do Programa de Combate ao HIV/SIDA na Guiné-Bissau	25/08/2010
Guinea-Bissau	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Governo da República Federativa do Brasil e o Governo da República da Guiné-Bissau para Implementação do Projeto “Fortalecimento e Capacitação Técnica das Instituições de Saúde para Atendimento às Mulheres e Adolescentes Vítimas de Violência Baseada em Gênero e Promoção de Saúde”.	25/08/2010
Guinea-Bissau	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica para Implementação do Projeto “Apoio ao Programa de Prevenção e Controle da Malária na Guiné-Bissau”.	14/11/2007
Haiti	Declaração Conjunta bilateral assinada entre o Ministério da Saúde do Brasil e o Ministério da Saúde Pública e da População do Haiti para reafirmar a continuidade da cooperação na área da saúde.	14/01/2018
Haiti	Declaração Conjunta entre o Governo da República Federativa do Brasil e o Governo da República do Haiti sobre o Fundo de Reconstrução do Haiti (2017).	23/06/2017



Haiti	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Governo da República Federativa do Brasil e o Governo da República do Haiti para Implementação do Projeto “Apoio à Implantação de Banco de Leite Humano no Haiti”.	29/09/2010
Haiti	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Governo da República Federativa do Brasil e o Governo da República do Haiti para Implementação do Projeto “Instituto Haiti-Brasil de Reabilitação de Pessoas com Deficiência”	29/09/2010
Haiti	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Brasil e o Haiti para Implementação do Projeto “Combate à Violência contra as Mulheres no Haiti”.	28/05/2008
Haiti	Ajuste Complementar ao Acordo Básico de Cooperação Técnica entre o Brasil e o Haiti para Implementar o Projeto “Aprimoramento do Programa Haitiano de Imunizações”.	23/05/2006
Haiti	Memorando de Entendimento entre o Governo da República Federativa do Brasil, o Governo da República de Cuca e o Governo da República do Haiti para o fortalecimento do sistema e dos serviços públicos de saúde e de vigilância epidemiológica no Haiti.	17/03/2010
Honduras	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Governo da República Federativa do Brasil e o Governo da República de Honduras para Implementação do Projeto “Fortalecimento da Saúde Mental de Honduras”.	19/07/2012
Honduras	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República de Honduras para Implementação do Projeto “Apoio ao Fortalecimento e Desenvolvimento do Sistema Nacional de Sangue e Hemoderivados de Honduras”.	23/04/2012
Honduras	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República de Honduras para Implementação do Projeto “Apoio Técnico para Implantação/Implementação de Bancos de Leite Humano”.	07/08/2007

Honduras	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República de Honduras para Implementação do Projeto “Intercâmbio de Conhecimentos sobre os Sistemas de Saúde Pública de Brasil e Honduras”.	07/08/2007
Índia	Memorando de Entendimento sobre Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República da Índia.	30/03/2012
Índia	Memorando de Entendimento entre o Governo da República Federativa do Brasil e o Governo da República da Índia em Cooperação na Área de Biotecnologia	30/03/2012
Índia	Acordo entre a República Federativa do Brasil e a República da Índia em Cooperação Científica e Tecnológica	12/09/2006
Índia	Ajuste Complementar ao Acordo de Cooperação nos Campos da Ciência e Tecnologia, na Área de Saúde e Medicina.	05/05/1998
Índia	Ajuste Complementar ao Acordo de Comércio entre o Governo da República do Brasil e o Governo da República Índia sobre Medidas Sanitárias e Fitossanitárias	02/07/1997
Índia	Declaração Conjunta sobre a Agenda Brasil-Índia para Cooperação Científica e Tecnológica	27/01/1996
Iran	Marco de Ação em Promoção da Saúde e Nutrição entre o Ministério da Saúde da República Federativa do Brasil e o Ministério da Saúde e de Educação Médica da República Islâmica do Irã	18/10/2017
Iran	Memorando de Entendimento para Cooperação Mútua em Saúde entre Ministério da Saúde da República Federativa do Brasil e Ministério da Saúde e de Educação Médica da República Islâmica do Irã.	23/05/2017
Israel	Acordo entre o Governo da República Federativa do Brasil e o Governo do Estado de Israel sobre Cooperação nos Campos da Saúde e de Medicamentos	19/06/2006

Italy	Memorando de Entendimento entre o Ministério da Saúde da República Federativa do Brasil e o Ministério do Trabalho, da Saúde e das Políticas Sociais da República Italiana sobre Cooperação no Campo da Saúde e das Ciências Médicas	11/11/2008
Italy	Acordo de Seguridade Social. O presente Acordo aplica-se: ao Sistema Unificado de Saúde (SUS), no qual se refere à assistência médica, farmacêutica, protética, odontológica, ambulatorial e hospitalar;	26/06/1995
Japan	Memorando de Cooperação no campo da Saúde entre o Ministério da Saúde do Brasil e o Ministério da Saúde, Trabalho e Bem Estar Social do Japão.	01/08/2014
Libya	Protocolo de Intenções entre o Brasil a Líbia sobre Cooperação Técnica na Área da Saúde	19/02/2009
Mexico	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Governo da República Federativa do Brasil e o Governo dos Estados Unidos Mexicanos para a implementação do Projeto “Apoio Técnico para a Expansão e Consolidação da Rede de Bancos de Leite Humano no México”.	11/06/2012
Mexico	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Governo da República Federativa do Brasil e o Governo dos Estados Unidos Mexicanos para a Implementação do Projeto “Aplicação das Práticas Integrativas e Complementares em Áreas Específicas de Saúde”.	11/06/2012
Mexico	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Governo da República Federativa do Brasil e o Governo dos Estados Unidos Mexicanos para a Implementação do Projeto “Fortalecimento da Vigilância em Saúde Ambiental Relacionada a Desastres e População Exposta – Fase II”.	11/06/2012
Mexico	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Governo da República Federativa do Brasil e o Governo dos Estados Unidos Mexicanos para Implementação do Projeto “Intercâmbio de Experiências e Conhecimentos entre Brasil e México sobre Práticas Integrativas, Complementares e de Competência Intercultural na Oferta de Serviços de Saúde”.	11/08/2009

Mexico	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Governo da República Federativa do Brasil e o Governo dos Estados Unidos Mexicanos para Implementação do Projeto “Fortalecimento da Vigilância em Saúde Ambiental Relacionada a Desastres e População Exposta”.	11/08/2009
Mexico	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Governo da República Federativa do Brasil e o Governo dos Estados Unidos Mexicanos para Implementação do Projeto “Intercâmbio de Experiências e Conhecimentos entre Brasil e México sobre Práticas Integrativas e Complementares e Competência Intercultural na Oferta de Serviços de Saúde”.	11/08/2009
Mexico	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica entre o Governo da República Federativa do Brasil e o Governo dos Estados Unidos Mexicanos para Implementação do Projeto “Apoio ao Processo de Implementação de Bancos de Leite Humano no México”.	11/08/2009
Mozambique	Ajuste Complementar ao Acordo Geral de Cooperação entre o Governo da República Federativa do Brasil e o Governo da República de Moçambique para o Projeto de Instalação da Fábrica de Antirretrovirais e Outros Medicamentos em Moçambique.	22/12/2011
Mozambique	Ajuste Complementar ao Acordo Geral de Cooperação entre o Governo da República Federativa do Brasil e o Governo da República de Moçambique para Implementação do Projeto “Implantação de Banco de Leite Humano e de Centro de Lactação em Moçambique”.	09/11/2010
Mozambique	Ajuste Complementar ao Acordo Geral de Cooperação entre o Governo da República Federativa do Brasil e o Governo da República de Moçambique para Implementação do Projeto “Apoio à Implantação do Centro de Telesaúde, da Biblioteca e do Programa de Ensino à Distância em Saúde da Mulher, da Criança e do Adolescente de Moçambique”	09/11/2010
Mozambique	Ajuste Complementar ao Acordo Geral de Cooperação entre o Governo da República Federativa do Brasil e o Governo da República de Moçambique para Implementação do Projeto “Apoio ao Sistema de Atendimento Oral de Moçambique –	05/10/2010

	Implementação de Laboratório de Referência em Prótese Dentária em Maputo”.	
Mozambique	Ajuste Complementar ao Acordo Geral de Cooperação entre o Governo da República Federativa do Brasil e o Governo da República de Moçambique para Implementação do Projeto “Apoio ao Desenvolvimento da Política Nacional de Saúde Oral em Moçambique: Pesquisa em Saúde Oral - Maputo”	05/10/2010
Mozambique	Ajuste Complementar ao Acordo Geral de Cooperação entre o Governo da República Federativa do Brasil e o Governo da República de Moçambique para Implementação do Projeto “Implantação de Projeto Piloto de Terapia Comunitária em Moçambique, como Recurso de Promoção da Saúde	16/07/2010
Mozambique	Ajuste Complementar ao Acordo Geral de Cooperação entre o Governo da República Federativa do Brasil e o Governo da República de Moçambique para Implementação do Projeto “Fortalecimento das Ações de Prevenção e Controle do Câncer em Moçambique”.	16/07/2010
Mozambique	Ajuste Complementar ao Acordo Geral de Cooperação entre o Governo da República Federativa do Brasil e o Governo da República de Moçambique para Implementação do Projeto “Capacitação em Produção de Medicamentos Antirretrovirais e outros Medicamentos”.	04/09/2008
Mozambique	Ajuste Complementar ao Acordo Geral de Cooperação entre o Governo da República Federativa do Brasil e o Governo da República de Moçambique para Implementação do Projeto “Fortalecimento Institucional do Órgão Regulador de Medicamentos de Moçambique como Agente Regulador do Setor Farmacêutico”	04/09/2008
Mozambique	Ajuste Complementar ao Acordo Geral de Cooperação para Implementação do Projeto “Fortalecimento das Ações de Alimentação e Nutrição”.	06/07/2007
Mozambique	Ajuste Complementar ao Acordo Geral de Cooperação para Implementação do Projeto “Fortalecimento do Instituto Nacional de Saúde de Moçambique”.	23/04/2007

Mozambique	Ajuste Complementar ao Acordo Geral de Cooperação para Implementação do Projeto PCI-NTWANANO no Âmbito do Programa de Cooperação Internacional do Ministério da Saúde do Brasil.	05/11/2003
Mozambique	Memorando de Entendimento no Âmbito do Programa de Cooperação Internacional do Ministério da Saúde do Brasil. (HIV e AIDS).	02/05/2003
Mozambique	Ajuste Complementar ao Acordo Geral de Cooperação para Implementação do Projeto “Apoio ao Programa Nacional de Controle às DST/SIDA”.	20/06/2001
Namibia	Memorando de Entendimento no Âmbito do Programa de Cooperação Internacional do Ministério da Saúde do Brasil.	19/03/2003
Nicaragua	Ajuste Complementar ao Acordo Básico de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República da Nicarágua para Implementação do Projeto “Apoio Técnico para Implantação de Bancos de Leite Humano na Nicarágua”.	30/08/2010
Nicaragua	Protocolo de Intenções na Área de Saúde	08/08/2007
Nigeria	Acordo de Cooperação sobre o Combate à Produção Ilícita, Consumo e Tráfico de Drogas e Substâncias Psicotrópicas e Lavagem de Dinheiro	06/09/2005
Nigeria	Protocolo de Intenções sobre Cooperação Técnica na Área de Saúde	03/03/2004
UN	Memorando de Entendimento entre o Ministério da Saúde da República Federativa do Brasil e o Secretariado do Programa Conjunto das Nações Unidas sobre HIV/AIDS (UNAIDS) para Constituição do Centro Internacional de Cooperação Técnica em HIV/AIDS (CICT/AIDS).	27/07/2005
PAHO	Ajuste Complementar ao Convênio Básico entre o Brasil e a OMS e ao Acordo entre o Brasil e a RSP para o Funcionamento do Escritório de Área da OPAS/OMS.	16/03/2000
PAHO	Ajuste Complementar para Adesão do Fundo Rotatório Regional para Insumos Estratégicos de Saúde.	27/09/1999
PAHO	Convênio para Realização de um Programa de Erradicação da Malária no Estado de São Paulo.	24/06/1958

PAHO	Convênio com o Ministério da Educação e Saúde do Brasil para Cooperação no Problema Continental da Febre Amarela.	06/05/1950
Palestine	Memorando de Entendimento entre o Governo da República Federativa do Brasil e a Organização para a Libertação da Palestina, em Nome da Autoridade Nacional Palestina, na Área da Saúde.	17/03/2010
Panama	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República do Panamá para Implementação do Projeto "Fortalecimento do Programa de Combate da Dengue".	25/05/2007
Panama	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República do Panamá para Implementação do Projeto "Fortalecimento do Programa de Combate à Hantavirose".	25/05/2007
Panama	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República do Panamá para Implementação do Projeto "Fortalecimento do Sistema de Informações em Saúde".	25/05/2007
Panama	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica para Implementação do Projeto "Implementação de Bancos de Leite no Panamá".	25/05/2007
Panama	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República do Panamá para Implementação do Projeto "Vigilância Epidemiológica e Ambiental em Saúde".	25/05/2007
Paraguay	Declaração conjunta entre o Ministério da Saúde da República Federativa do Brasil e o Ministério da Saúde Pública e Bem-Estar Social do Paraguai.	15/06/2017
Paraguay	Memorando de Entendimento entre o Ministério da Saúde da República Federativa do Brasil e o Ministério de Saúde Pública e Bem-Estar Social da República do Paraguai.	

Paraguay	Ajuste Complementar ao Acordo de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República do Paraguai para Implementação do Projeto “Fortalecimento da Vigilância em Saúde, com Ênfase no Combate à Dengue e na Implementação do Regulamento Sanitário Internacional”.	21/05/2007
Paraguay	Ajuste Complementar ao Acordo de Cooperação Técnica para Implementação do Projeto “Fortalecimento Institucional das Assessorias Internacionais dos Ministérios da Saúde do Brasil e do Paraguai”.	23/11/2006
Paraguay	Ajuste Complementar ao Acordo Básico de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República do Paraguai para Implementação do Projeto “Fortalecimento Institucional da Divisão Nacional de Vigilância Sanitária do Ministério da Saúde Pública e Bem Estar Social da República do Paraguai”.	24/05/2012
Paraguay	Ajuste Complementar ao Acordo de Cooperação Técnica para Implementação do Projeto “Apoio à Implantação e Implementação de Banco de Leite Humano no Paraguai”.	23/11/2006
Paraguay	Ajuste Complementar ao Acordo de Cooperação Técnica para Implementação do Projeto Assistência e Tratamento a Pessoas Vivendo com HIV/AIDS no Paraguai.	14/10/2003
Paraguay	Ajuste Complementar ao Acordo Sanitário de 16 de julho de 1971, sobre Cooperação e Intercâmbio de Tecnologia de Saúde	21/07/1992
Paraguay	Acordo Sanitário - Acordo que tem por objeto eliminar ou diminuir os danos que gravitam sobre as comunidades da referida região geográfica bem como promover medidas capazes de melhorar os respectivos índices de saúde;	16/07/1971
Peru	Memorando de Entendimento entre o Ministério da Saúde da República Federativa do Brasil e o Ministério da Saúde Pública e Assistência Social da República do Peru na Área da Saúde.	24/04/2013
Peru	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Projeto “Fortalecimento Institucional da Direção Geral de Medicamentos Governo da República do Peru para a	31/10/2011



	Implementação do , Insumos e Drogas - Digemid do Peru na Área de Vigilância Sanitária”	
Peru	Ajuste Complementar ao Acordo Quadro entre o Governo da República Federativa do Brasil e o Governo da República do Peru para o Estabelecimento de uma Zona de Integração Fronteiriça Brasil – Peru para a Criação do Subgrupo de Trabalho sobre Saúde na Fronteira.	16/06/2010
Peru	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República do Peru para Implementação do Projeto “Apoio à Implementação de Bancos de Leite Humano no Peru”.	11/12/2009
Peru	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Brasil e o Peru para Implementação do Projeto “Fortalecimento do Processo de Implementação da Vigilância Sanitária Internacional em Portos, Aeroportos e Fronteiras do Peru”.	17/05/2008
Peru	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica para Implementação do Projeto “Fortalecimento da Regulamentação e Fiscalização em Saúde Pública no Processo de Descentralização dos Ministérios da Saúde do Brasil e do Peru”.	09/11/2006
Peru	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica para Implementação do Projeto “Fortalecimento da Capacidade de Resposta dos Serviços de Saúde Frente a uma Pandemia de Influenza”	09/11/2006
Peru	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica para Implementação do Projeto “Implementação e Adequação das Normas Técnicas da Estratégia Sanitárias Nacional de Combate à DST/HIV/AIDS”.	09/11/2006
Peru	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica para Implementação do Projeto “Fortalecimento Institucional das Assessorias Internacionais dos Ministérios da Saúde do Brasil e do Peru”.	31/05/2006

Peru	Ajuste Complementar ao Acordo Básico de Cooperação Técnica e Científica para Implementação do Projeto Prevenção e Controle de Doenças Sexualmente Transmissíveis, Vírus de Deficiência Imunológica Humana e a Síndrome de Imunodeficiência Adquirida (DST/HIV/AIDS) no Peru.	25/08/2003
Peru	Ajuste Complementar ao Acordo Sanitário de 16 de julho de 1965, para o Combate à Epidemia da Cólera.	15/05/1991
Peru	Acordo Sanitário para o Meio Tropical. - Patologia tropical; Ecologia tropical; Recursos de instituições; Formação de recursos humanos, e Pesquisa.	05/11/1976
Peru	Acordo Sanitário - prioridade os seguintes: A erradicação da varíola; O programa de erradicação da malária; A febre amarela silvestre e outras transmitidas por artrópodes; A lepra, pela existência de um número elevado de formas lepromatosas na região geográfica em referência; e A tuberculose, as enfermidades venéreas e outras enfermidades, que necessitam de ação coordenada por parte dos Governos de ambos os países, para facilitar seu controle;	16/07/1965
Portugal	Memorando de Entendimento entre o Ministério da Saúde da República Federativa do Brasil e o Ministério da Saúde da República Portuguesa em Matéria de Saúde.	22/05/2017
UNAIDS	Memorando de Entendimento entre o Brasil e o UNAIDS sobre o Apoio Continuado ao Centro Internacional de Cooperação Técnica em HIV/AIDS (CICT/AIDS) do Ministério da Saúde da República Federativa do Brasil	21/05/2008
Kenya	Ajuste Complementar ao Acordo de Cooperação Técnica entre o Brasil e o Quênia para Implementação do Projeto “Fortalecimento das Ações de Combate ao HIV/AIDS no Quênia”.	15/08/2008
Kenya	Ajuste Complementar ao Acordo de Cooperação Técnica entre o Brasil e o Quênia para Implementação do Projeto “Apoio ao Programa de Prevenção e Controle da Malária”.	15/08/2008
United Kingdom	Memorando de Entendimento entre o Governo da República do Brasil e o Governo do Reino Unido da Grã-Bretanha e Irlanda do Norte para Colaboração entre o Ministério da Saúde do Brasil e o Ministério da Saúde da Inglaterra e seus respectivos equivalentes nas administrações regionais.	18/10/2011

United Kingdom	Ajuste Complementar ao Acordo de Empréstimo de 1973, Relativo ao Projeto Hospitalar do Estado do Piauí.	21/05/1974
United Kingdom	Ajuste Complementar Relativo a um Projeto de Cooperação Técnica de Suporte à Reforma do Sistema de Saúde no Brasil.	29/01/1996
United Kingdom	Memorando de Entendimento para colaboração no Campo de Saúde entre o Ministério da Saúde do Brasil e o Ministério da Saúde da Inglaterra - Em particular na área de sangue e segurança do sangue.	07/03/2006
Dominican Republic	Memorando de Entendimento no Âmbito do Programa de Cooperação Internacional do Ministério da Saúde do Brasil - tem como objeto a implementação do "Projeto de Assistência de Prevenção do HIV/AIDS", no âmbito do "Programa de Cooperação Internacional para Ações de Controle e Prevenção do HIV para Países em Desenvolvimento".	30/01/2003
Dominican Republic	Ajuste Complementar ao Acordo Básico de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República Dominicana para a Implementação do Projeto "Apoio ao Fortalecimento da Autoridade Sanitária Dominicana nas Áreas de Registro de Medicamentos, Farmacovigilância e Inspeções Sanitárias".	05/02/2010
Dominican Republic	Ajuste Complementar ao Acordo Básico de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República Dominicana para a Implementação do Projeto "Apoio à Implementação do Programa de Redução da Morbimortalidade Materno-Infantil na República Dominicana.	09/02/2012
Dominican Republic	Ajuste Complementar ao Acordo Básico de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República Dominicana para a Implementação do Projeto "Apoio Técnico para a Criação da Rede de Bancos de Leite Humano da República Dominicana".	15/06/2012
Dominican Republic	Ajuste Complementar ao Acordo Básico de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República Dominicana para a Implementação do Projeto "Apoio Técnico para a Implementação do Banco de Leite Humano no Hospital Materno Infantil San Lorenzo de Los Mina".	10/04/2015

Sao Tome and Principe	Protocolo de Intenções sobre Cooperação Técnica na Área de Saúde - executar programas, projetos e atividades específicas de cooperação técnica na área de Saúde, com particular ênfase na luta contra o HIV/SIDA e o paludismo.	02/11/2003
Sao Tome and Principe	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica para Implementação do Projeto “Apoio ao Ministério da Saúde de São Tomé e Príncipe na Prevenção às DST/AIDS”.	02/12/2000
Sao Tome and Principe	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República Democrática de São Tomé e Príncipe para a Implementação do Projeto Ações de Prevenção e Controle do Vírus da Deficiência Imunológica Humana e Síndrome da Imunodeficiência Adquirida (Hiv/Aids) em São Tomé e Príncipe.	18/08/2005
Sao Tome and Principe	Programa Executivo ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República Democrática de São Tomé e Príncipe para Implementação do Projeto “Apoio ao Programa de Luta Contra a Tuberculose em São Tomé e Príncipe”.	04/03/2010
Syria	Memorando de Entendimento entre o Governo da República Federativa do Brasil e o Governo da República Árabe da Síria sobre Cooperação na Área da Saúde.	30/06/2010
Suriname	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República do Suriname para a Implementação do Projeto “Fortalecimento da Resposta à Epidemia Do HIV/AIDS no Suriname”.	26/04/2010
Suriname	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República do Suriname para a Implementação do Projeto “Fortalecimento de Ações de Vigilância e Prevenção da Doença de Chagas no Suriname”.	26/04/2010
Suriname	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República do Suriname para a Implementação do Projeto “Fortalecimento do combate ao HIV/AIDS em populações-chave no Suriname”.	01/03/2016

Suriname	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República do Suriname para a Implementação do Projeto “Cooperação Transfronteiriça para Erradicação da Malária”	01/03/2016
Suriname	Governo da República Federativa do Brasil e o Governo da República do Suriname para a Implementação do Projeto “Fortalecimento do combate do surgimento da Leishmaniose no Suriname”	01/03/2016
Suriname	Governo da República Federativa do Brasil e o Governo da República do Suriname para a Implementação do Projeto “Fortalecimento ao combate do surgimento da Doença de Chagas no Suriname”	01/03/2016
Suriname	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República do Suriname para a Implementação do Projeto “Uso, Armazenamento e Distribuição de Materiais de DST/HIV/AIDS”.	10/09/2009
Suriname	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República do Suriname para a Implementação do Projeto “Prevenção da Transmissão Vertical da Sífilis e do HIV”.	10/09/2009
Suriname	Protocolo de Intenções na Área de Saúde - Mineração/Mercúrio; DST/AIDS; Malária e outras.	16/02/2005
Ukraine	Memorando de Entendimento entre o Ministério da Saúde da República Federativa do Brasil e o Ministério da Saúde da Ucrânia sobre Cooperação no Domínio da Saúde e Ciências Médicas.	25/10/2011
UNASUR	Acordo de Sede entre a República Federativa do Brasil e a União de Nações Sul-Americanas (Unasul) para o Funcionamento do Instituto Sul-Americano de Governo em Saúde (Isags).	20/04/2012
UNICEF	Ajuste Complementar entre o Governo da República Federativa do Brasil e o Fundo das Nações Unidas para a Infância e o Brasil, de 28/03/1966, para Ampliar Ações de Prevenção e de Atenção Integral a Mulheres Grávidas, Crianças e aos Adolescentes na Área do HIV/AIDS e outras DST no Brasil e em	06/12/2006

	outros Países com os quais o Brasil Mantenha Acordos de Cooperação Técnica Aplicáveis.	
Uruguay	Memorando de Entendimento entre o Ministério da Saúde da República Federativa do Brasil e o Ministério da Saúde da República oriental do Uruguai para a constituição de um marco institucional para estimular os esforços de coordenação e cooperação entre os Partícipes na área de saúde.	07/12/2017
Uruguay	Cooperação Financeira Oficial entre a Alemanha e Brasil – Contrato de Empréstimo/Contribuição Financeira/Execução do projeto KFW: Apoio ao combate internacional à epidemia de AIDS – projeto Triangular de Cooperação Financeira Brasil-Alemanha-Uruguai.	10/08/2017
Uruguay	Memorando de Entendimento entre o Governo da República Federativa do Brasil e o Governo da República Oriental do Uruguai na Área da Saúde	30/05/2011
Uruguay	Ajuste Complementar ao Acordo de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República Oriental do Uruguai para Implementação do Projeto “Apoio Ao Fortalecimento do Sistema Nacional Integrado de Saúde do Uruguai com Ênfase em Localidades com Menos de Cinco Mil Habitantes”.	30/05/2011
Uruguay	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República Oriental do Uruguai para Implementação do Projeto “Consolidação da capacidade Institucional do Ministério de Saúde do Uruguai e Ampliação do Diálogo Regulatório entre as Autoridades Sanitárias de Brasil e Uruguai”.	30/05/2011
Uruguay	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República Oriental do Uruguai para Implementação do Projeto “Apoio Técnico para a Expansão e Consolidação da Rede de Bancos de Leite Humano do Uruguai”.	03/12/2010

Uruguay	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República Oriental do Uruguai para Implementação do Projeto “Fortalecimento das Políticas de Enfrentamento à Epidemia de DST/AIDS no Uruguai.”	25/05/2009
Uruguay	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica entre o Governo da República Federativa do Brasil e o Governo da República Oriental do Uruguai para Implementação do Projeto “Apoio ao Fortalecimento do Sistema Nacional de Sangue e Hemoderivados do Uruguai.”	25/05/2009
Uruguay	Ajuste Complementar ao Acordo para Permissão de Residência, Estudo e Trabalho a Nacionais Fronteiriços Brasileiros e Uruguaios, para Prestação de Serviços de Saúde.	28/11/2008
Uruguay	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica para Implementação do Projeto “Fortalecimento Institucional da Secretaria de Saúde Pública do Governo Uruguaio na Área de Vigilância Sanitária”	24/07/2007
Uruguay	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica para Implementação do Projeto “Apoio Técnico para Implementação de Bancos de Leite Humano no Uruguai”.	22/11/2006
Uruguay	Ajuste Complementar ao Acordo Básico de Cooperação Científica e Técnica para Implementação do Projeto “Fortalecimento Institucional das Assessorias Internacionais dos Ministérios da Saúde do Brasil e do Uruguai”.	22/11/2006
Uruguay	Ajuste Complementar ao Acordo de Cooperação Técnica, Científica e Tecnológica para Saúde na Fronteira.	31/07/2003
Uruguay	Memorando de Entendimento no Âmbito da Troca de Experiência em Transplantes de Órgãos e Tecidos.	18/06/2003
Uruguay	Acordo para a Melhoria das Condições Sanitárias na Região da Fronteira Brasileiro-Uruguaia.	10/05/1969
Uruguay	Convênio Relativo à Luta Contra as Enfermidades Venereosifilíticas na Fronteira Comum aos dois Países.	13/02/1928

Venezuela	Memorando de Entendimento entre a República Federativa do Brasil e o Governo da República Bolivariana da Venezuela para o Fortalecimento e Integração das ações para alcançar a eliminação da Oncocercose na área Yanomami.	20/05/2014
Venezuela	Ajuste Complementar ao Convênio Básico de Cooperação Técnica, para Implementação do Projeto "Capacitação dos Recursos Humanos do Serviço Autônomo da Controladoria Sanitária da República Bolivariana da Venezuela em Vigilância e Controle dos Produtos de uso e Consumo Humano".	13/12/2007
Venezuela	Ajuste Complementar ao Convênio Básico de Cooperação Técnica, para Implementação do Projeto "Apoio Técnico para Implantação e Implementação de Bancos de Leite Humano na Venezuela".	13/12/2007
Venezuela	Ajuste Complementar ao Convênio Básico de Cooperação Técnica, para Implementação do Projeto "Desenvolvimento Institucional do Instituto de Altos Estudos em Saúde Doutor Arnaldo Gabaldon".	13/12/2007
Venezuela	Acordo sobre Cooperação Sanitária Fronteiriça. - medidas preventivas e de controle, de acordo com suas possibilidades, tendentes a resolver os problemas de suas zonas fronteiriças, no que diz respeito à malária, tripanosomíase, febre amarela, oncocercose, hanseníase, leishmaniose, doenças venéreas, tuberculose, hepatites e saneamento ambiental.	19/02/1982
Venezuela	Convênio Complementar ao Convênio Básico de Cooperação Técnica de 20 de fevereiro de 1973, Referente à Cooperação em Matéria Sanitária para o Meio Tropical.	17/11/1977
Zambia	Ajuste Complementar ao Acordo de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República da Zâmbia para Implementação do Projeto "Treinamento e Capacitação dos profissionais da Saúde do University Teaching Hospital".	08/07/2010
Zambia	Ajuste Complementar ao Acordo de Cooperação Técnica entre o Governo da República Federativa do Brasil e o Governo da República da Zâmbia para Implementação do Projeto "Fortalecimento do Plano Nacional Estratégico para HIV/AIDS".	08/07/2010