

MINISTRY OF HEALTH OF BRAZIL

# Health and Foreign Policy:

20 years of the International  
Health Affairs Office of the  
Ministry of Health of Brazil  
(1998-2018)



Brasília - DF  
2019



MINISTRY OF HEALTH OF BRAZIL  
International Health Affairs Office

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2019. Ministry of Health of Brazil.



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Edition: 1<sup>st</sup> edition – 2019 – 200 copies printed

Translation of the original in Portuguese language "Saúde e Política Externa: os 20 anos da Assessoria de Assuntos Internacionais de Saúde (1998-2018)", published in September 2018 and available at: <<http://pesquisa.bvsalud.org/bvsms/resource/pt/mis-39839>>. The articles were finished in June 2018.

*Preparation, distribution, and information:*

MINISTRY OF HEALTH OF BRAZIL  
International Health Affairs Office  
Esplanada dos Ministérios, bloco G,  
Ed. Sede, 4<sup>o</sup> andar  
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*Standardization:*

Delano de Aquino Silva – Editora MS/CGDI

*Layout:*

All Type Assessoria Editorial EIRELI

Impresso no Brasil / Printed in Brazil

Cataloging-in-Publication Data

Brazil. Ministry of Health. International Health Affairs Office.

Health and Foreign Policy: 20 years of the International Health Affairs Office of the Ministry of Health of Brazil (1998-2018)/  
Ministry of Health, International Health Affairs Office. Brasília: Ministério da Saúde, 2019.  
350 pages

ISBN 978-85-334-2698-6

1. Foreign Policies. 2. Advisory. 3. International Cooperation. I. Title.

CDU 614(4/9)

Cataloging in source – General Coordination of Documentation and Information – Editora MS – OS 2019/0065

Title for indexing:

Health and Foreign Policy: 20 years of the International Health Affairs Office of the Ministry of Health of Brazil (1998-2018).

# LIST OF ABBREVIATIONS

**ABC** – Brazilian Cooperation Agency (*Agência Brasileira de Cooperação*)  
**ABRASCO** – Brazilian Association of Post-Graduation in Collective Health (*Associação Brasileira de Pós-graduação em Saúde Coletiva*)  
**ACTO** – Amazon Cooperation Treaty Organization  
**ADD** – Acute Diarrheal Diseases  
**AECID** – Spanish Agency for International Development Cooperation (*Agencia Española de Cooperación Internacional para el Desarrollo*)  
**AESA** – Special Health Affairs Office (*Assessoria de Assuntos Especiais de Saúde*)  
**AFD** – French Development Agency (*Agence Française de Développement*)  
**AIDIS** – Inter-American Association of Sanitary and Environmental Engineering (*Asociación Interamericana de Ingeniería Sanitaria y Ambiental*)  
**AIDS** – acquired immune deficiency syndrome  
**AISA** – International Health Affairs Office of the Ministry of Health (*Assessoria de Assuntos Internacionais de Saúde*)  
**AMR** – antimicrobial resistance  
**ANDIFES** – National Association of Federal Higher Education Institution Leaders (*Associação Nacional de Dirigentes de Instituições Federais de Ensino Superior*)  
**Anvisa** – National Health Surveillance Agency (*Agência Nacional de Vigilância Sanitária*)  
**ART** – antiretroviral therapy  
**ARV** – antiretrovirals  
**ASA** – Africa-South America Summit  
**ASSE** – State Health Services Administration, Uruguay (*Administración de los Servicios de Salud del Estado*)  
**BRICS** – Brazil, Russia, India, China and South Africa  
**CAESA** – General Coordination of Special Health Affairs (*Coordenação Geral de Assuntos Especiais de Saúde*)  
**CAIS** – Coordination of International Health Affairs (*Coordenadoria de Assuntos Internacionais de Saúde*)  
**Caisan** – Interministerial Chamber for Food and Nutrition Security (*Câmara Interministerial de Segurança Alimentar e Nutricional*)  
**CAMS** – National Committee for Articulation with Social Movements (*Comissão Nacional de Articulação com Movimentos Sociais*)  
**CAN** – National Ambulance Center of Haiti (*Centre Ambulancier National*)  
**CARICOM** – Caribbean Community  
**CBERS** – China-Brazil Earth Resources Satellite Program  
**CCM** – Mercosur Trade Commission (*Comisión de Comercio del Mercosur*)  
**CDC** – Center for Disease Control and Prevention in the USA  
**CDC China** – Center for Disease Control and Prevention in China  
**Cebes** – Brazilian Center for Health Studies (*Centro Brasileiro de Estudos de Saúde*)  
**CEEC** – Committee of European Economic Co-operation  
**CEWG** – Consultative Expert Working Group on Research and Development: Financing and Coordination  
**CF** – Federal Constitution (*Constituição Federal*)  
**CGAN** – General Coordination of the Ministry of Health for Food and Nutrition (*Coordenação Geral de Alimentação e Nutrição do Ministério da Saúde*)  
**CGFOME** – General Coordination for International Action Against Hunger of the Ministry of Foreign Affairs (*Coordenação Geral de Cooperação Humanitária e Combate à Fome do Ministério das Relações Exteriores*)  
**CICT** – International Center for Technical Cooperation (*Centro de Informação Científica e Tecnológica*)  
**CIDA** – Canadian International Development Agency  
**CIDT** – Intergovernmental Commission on Donation and Transplantation of the Mercosur (*Comissão Intergovernamental de Doação e Transplantes do Mercosul*)  
**CIES-OAS** – Inter-American Economic and Social Council of the Organization of American States (*Conselho Interamericano Econômico e Social*)

**CIRSI** – Mercosur Intergovernmental Commission for the Implementation of the International Health Regulations (*Comissão Intergovernamental para a Implementação do Regulamento Sanitário Internacional*).

**CISAN** – Mercosur Intergovernmental Commission for Food and Nutrition Security (*Comissão Intergovernamental para a Segurança Alimentar e Nutricional*)

**CIVIH** – Intergovernmental Commission on HIV/AIDS (*Comissão Intergovernamental de HIV/AIDS*)

**CMC** – Board of the Common Market (*Comissão do Mercado de Capitais*)

**CNAIDS** – National Committee for STI, HIV/AIDS and Viral Hepatitis (*Comissão Nacional de IST, HIV/Aids e Hepatites Virais*)

**CNBB** – National Council of Brazilian Bishops (*Conferência Nacional dos Bispos do Brasil*)

**CNIg** – National Immigration Council (*Conselho Nacional de Imigração*)

**CNPq** – National Council for Scientific and Technological Development (*Conselho Nacional de Desenvolvimento Científico e Tecnológico*)

**CONARE** – National Committee for Refugees (*Conselho Nacional de Refugiados*)

**Conasems** – National Council of Municipal Health Secretaries (*Conselho Nacional de Secretários Municipais de Saúde*)

**Conass** – National Council of State Health Secretaries (*Conselho Nacional de Secretários de Saúde*)

**CONICQ** – National Commission for the Implementation of the Framework Convention on Tobacco Control (*Comissão Nacional para Implementação da Convenção Quadro para o Controle do Tabaco e de seus Protocolos*)

**Conjur** – Legal Consultancy of Ministry of Health (*Consultoria Jurídica*)

**Consea** – National Council for Food and Nutrition Security (*Conselho Nacional de Segurança Alimentar*)

**COSBAN** – China-Brazil High-Level Coordination and Cooperation Committee (*Comissão Sino-Brasileira de Alto Nível de Concertação e Cooperação*)

**CPC** – Communist Party of China

**CLPL** – Community of Portuguese-speaking Countries (*Comunidade dos Países de Língua Portuguesa*)

**CPTG** – Clinical Protocols and Therapeutic Guidelines

**CRM** – Regional Medical Board (*Conselho Regional de Medicina*)

**CUT** – Unified Workers' Central (*Central Única dos Trabalhadores*)

**DAA** – direct action antivirals

**DAB** – Department of Basic Health Care of the Ministry of Health (*Departamento de Atenção Básica do Ministério da Saúde*)

**DATEC** – Division of Technical Analysis (*Divisão de Análise Técnica*)

**Delbrasgen** – Permanent Mission of Brazil to the United Nations Office and other international organizations in Geneva (*Missão permanente do Brasil junto à Organização das Nações Unidas e demais organismos internacionais em Genebra*)

**DESID** – Office for Health Economics, Investment and Development of the Ministry of Health (*Departamento de Economia da Saúde, Investimentos e Desenvolvimento do Ministério da Saúde*)

**DFID** – Department for International Development of the United Kingdom

**DIAHV** – National Department of Surveillance, Prevention and Control of Sexually Transmitted Infections (STIs), HIV/AIDS and Viral Hepatitis (*Departamento de Vigilância, Prevenção e Controle das Infecções Sexualmente Transmissíveis, do HIV/Aids e das Hepatites Virais do Ministério da Saúde*)

**DINEPA** – National Directorate for Potable Water and Sanitation of Haiti (*Direction Nationale de l'Eau Potable et de l'Assainissement*)

**DNDi** – Drugs for Neglected Diseases Initiative

**DONASUR** – Mercosur Registry on Organ Donation and Transplantation

**DOTS** – Directly Observed Treatment, Short-course

**DTM** – Office of Multilateral Affairs (*Divisão de Temas Multilaterais*)

**EB** – Executive Board of the World Health Organization

**ECLAC** – United Nations Economic Commission for Latin America and the Caribbean

**ECOSOC** – United Nations Economic and Social Council

**EEC** – European Economic Community

**EFTA** – European Free Trade Association

**ENSP** – National School of Public Health (*Escola Nacional de Saúde Pública*)  
**EOCs** – Public Health Emergency Operations Center  
**ERP** – European Recovery Program  
**ESF** – Family Health Strategy (*Estratégia Saúde da Família*)  
**EU** – European Union  
**EWG** – WHO Expert Working Group on Research and Development: Financing and Coordination  
**FAO** – Food and Agriculture Organization of the United Nations  
**FCES** – Mercosur Economic and Social Consultative Forum  
**FCTC** – Framework Convention on Tobacco Control  
**Fiocruz** – Oswaldo Cruz Foundation (*Fundação Oswaldo Cruz*)  
**Fiotec** – Foundation for Scientific and Technological Development in Health (*Fundação para o Desenvolvimento Científico e Tecnológico em Saúde*)  
**FPGH** – Foreign Policy and Global Health  
**Funasa** – National Health Foundation (*Fundação Nacional de Saúde*)  
**G20** – Group of 20  
**G77** – Group of 77  
**GARDP** – Global Antibiotic Research & Development Partnership  
**GASP** – Gonococcal Antimicrobial Surveillance Program  
**GAVI** – Global Alliance for Vaccines and Immunization  
**GDP** – gross domestic product  
**GHD** – Global Health Diplomacy  
**GIZ** – German Agency for International Cooperation (German Acronym for *Deutsche Gesellschaft für Internationale Zusammenarbeit*)  
**GLASS** – Global Antimicrobial Resistance Surveillance System  
**GMC** – Common Market Group (*Grupo Mercado Comum*)  
**GSD** – Brazil–China Global Strategic Dialogue  
**GSPA** – Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property  
**GTS** – Technical Health Group of the CPLP (*Grupo Técnico da Saúde da CPLP*)  
**GTZ** – German Technical Cooperation Agency (*Deutsche Agentur für Technische Zusammenarbeit*)  
**HCR** – Community Reference Hospitals, Haiti (*Hôpital Communautaire de Référence*)  
**HCV** – hepatitis C virus  
**HDI** – Human Development Index  
**HIV** – human immunodeficiency virus  
**HMB** – Human Milk Bank  
**HRF** – Haiti Reconstruction Fund  
**HTCG** – Horizontal Technical Cooperation Group of Latin America and the Caribbean on HIV/AIDS  
**IACG** – Interagency Coordination Group on Antimicrobial Resistance  
**Ibase** – Brazilian Institute for Social and Economic Analysis (*Instituto Brasileiro de Análises Sociais e Econômicas*)  
**IBRD** – International Bank for Reconstruction and Development  
**ICD** – International Classification of Diseases  
**ICN2** – Second International Conference on Nutrition  
**ICP** – International Cooperation Program for Other Developing Countries  
**ICTC** – International Center for Technical Cooperation  
**IDB** – Inter-American Development Bank  
**IFAD** – International Fund for Agricultural Development  
**IHMT** – Institute of Hygiene and Tropical Medicine of Portugal (*Instituto de Higiene e Medicina Tropical de Portugal*)  
**IHR** – International Health Regulations  
**IMF** – International Monetary Fund  
**INAMPS** – National Institute of Medical Care and Social Security (*Instituto Nacional de Assistência Médica da Previdência Social*)

**INASA** – National Institute of Public Health of Guinea-Bissau (*Instituto Nacional de Saúde Pública da Guiné-Bissau*)

**INC** – National Institute of Cardiology (*Instituto Nacional de Cardiologia*)

**INCA** – National Cancer Institute (*Instituto Nacional do Câncer*)

**Inesc** – Institute for Social and Economic Studies (*Instituto de Estudos Socioeconômicos*)

**INS** – National Institute of Health of Mozambique (*Instituto Nacional de Saúde de Moçambique*)

**INSP** – National Institute of Public Health of Cape Verde (*Instituto Nacional de Saúde Pública de Cabo Verde*)

**Interfarma** – Pharmaceutical Research Industry Association (*Associação da Indústria Farmacêutica de Pesquisa*)

**IPEA** – Institute for Applied Economic Research (*Instituto de Pesquisa Econômica Aplicada*)

**Ipespe** – Institute for Social, Political and Economic Research (*Instituto de Pesquisas Sociais, Políticas e Econômicas*)

**ITG-IHA** – Inter-Ministerial Thematic Group on International Humanitarian Assistance

**JICA** – Japan International Cooperation Agency

**KEI** – Knowledge Ecology International

**KfW** – German Development Bank (*KfW Entwicklungsbank*)

**Losan** – Organic Law of Food and Nutrition Security (*Lei Orgânica de Segurança Alimentar e Nutricional*)

**MAPA** – Ministry of Agriculture, Livestock and Food Supply (*Ministério da Agricultura, Pecuária e Abastecimento*)

**MCTIC** – Ministry of Science, Technology, Innovation and Communication (*Ministério da Ciência, Tecnologia, Inovações e Comunicações*)

**MDG** – Millennium Development Goals

**MDS** – Ministry of Social Development (*Ministério do Desenvolvimento Social*)

**Mercosur** – Southern Common Market

**MIF** – Multilateral Interim Force

**MINUJUSTH** – United Nations Mission for Justice Support in Haiti (*Mission des Nations Unies pour l'appui à la Justice en Haïti*)

**MINUSTAH** – United Nations Stabilization Mission in Haiti (*Mission des Nations Unies pour la stabilisation en Haïti*)

**MMA** – Ministry of the Environment (*Ministério do Meio Ambiente*)

**MPAS** – Ministry of Social Security and Social Assistance (*Ministério da Previdência e Assistência Social – 1974-1990*)

**MRE** – Ministry of Foreign Affairs (*Ministério das Relações Exteriores*)

**MS** – Ministry of Health (*Ministério da Saúde*)

**MSF** – Doctors Without Borders (*Médecin sans frontières*)

**MSP** – Ministry of Public Health of Uruguay (*Ministerio de Salud Pública*)

**MSPP** – Ministry of Public Health and Population of Haiti (*Ministère de la Santé Publique et de la Population – Haïti*)

**NAFTA** – North American Free Trade Agreement

**NATO** – North Atlantic Treaty Organization

**NDP** – National Drug Policy (*Política Nacional de Medicamentos*)

**NGO** – non-governmental organization

**NHFP** – National Health and Family Planning Commission

**NRCMS** – New Rural Cooperative Medical Scheme

**NTCP** – National Tobacco Control Policy (*Política Nacional de Controle do Tabaco*)

**OAB** – Brazilian Bar Association (*Ordem dos Advogados do Brasil*)

**OAS** – Organization of American States

**OCHA** – United Nations Office for the Coordination of Humanitarian Affairs

**OECD** – Organization for Economic Co-operation and Development

**OEEC** – Organization for European Economic Co-operation

**OIE** – World Organization for Animal Health

**PAC** – Joint Action Plan Brazil-China (*Plano de Ação Conjunta Brasil-China*)

**PAHO** – Pan American Health Organization

**PALOP** – Portuguese-speaking African countries (*Países Africanos de Língua Oficial Portuguesa*)

**PAN-BR** – National action plan on prevention and control of antimicrobial resistance (*Plano Nacional de Prevenção e Controle da Resistência aos Antimicrobianos*)

**Parlasur** – Mercosur Parliament (*Parlamento del Mercosur*)

**PCB-UNAIDS Program Coordinating Board**

**PCMM** – Cooperation Project to More Doctors Program (*Projeto de Cooperação para o Mais Médicos*)

**PCDT** – Clinical Protocols and Therapeutic Guidelines

**PCI** – Program of International Cooperation for other developing countries

**PEAS** – Strategic Plan for Social Action (*Plano Estratégico de Ação Social*)

**PECS** – Strategic Plan in Health Cooperation of the CPLP (*Plano Estratégico de Cooperação em Saúde da CPLP*)

**PHEIC** – Public Health Emergency of International Concern

**PHENC** – Public Health Emergency of National Concern

**PIS** – Cuba Integrated Health Program (*Programa Integral de Salud*)

**PLANSAN** – National Plan for Food and Nutrition Security (*Plano Nacional de Segurança Alimentar e Nutricional*)

**PLHIV** – people living with HIV

**PMMB** – More Doctors Project for Brazil (*Projeto Mais Médicos para o Brasil*)

**PPP** – purchase power parity

**PPT** – pro tempore presidency (*Presidencia pro tempore*)

**PrEP** – prophylaxis for pre-exposure to HIV

**PROMESS** – National Program for Essential Drugs of PAHO/WHO (*Programa de Medicamentos Esenciales*)

**Provab** – Primary Care Professional Valorization Program (*Programa de Valorização do Profissional da Atenção Básica*)

**PSAC** – Portuguese Speaking African Countries

**R&D** – research and development

**ReLAVRA** – Latin American Network for Antimicrobial Resistance Surveillance (*Red Latinoamericana de Vigilancia de la Resistencia a los Antimicrobianos*)

**Rename** – National Relation of Essential Medicines (*Relação Nacional de Medicamentos Essenciais*)

**Renezika** – National Network of Specialists of Zika and Related Diseases (*Rede Nacional de Especialistas em Zika e Doenças Correlatas*)

**Revalida** – Brazil's National Exam for the Revalidation of Medical Diplomas Issued by Foreign Higher Education Institutions (*Exame Nacional de Revalidação de Diplomas Médicos Expedidos por Instituições de Educação Superior Estrangeira*)

**RINSP** – Network of the National Institutes of Health of the Community of Portuguese Language Countries (*Rede de Institutos Nacionais de Saúde Pública da CPLP*)

**RMS** – Meeting of Mercosur Ministers of Health (*Reunión de Ministros de Salud*)

**SAM** – Administrative Secretariat of Mercosur (*Secretaría Administrativa del MERCOSUR*)

**SAMU** – Mobile Emergency Care Service (*Serviço de Atendimento Móvel de Urgência*)

**SAN** – food and nutrition security (*Segurança Alimentar e Nutricional*)

**SAS** – Secretariat of Basic Health Care of the Ministry of Health (*Secretaria de Atenção à Saúde do Ministério da Saúde*)

**SCTIE** – Secretariat of Science, Technology and Strategic Inputs of the Ministry of Health (*Secretaria de Ciência, Tecnologia e Insumos Estratégicos de Saúde do Ministério da Saúde*)

**SDG** – Sustainable Development Goals

**SGT** – Sub Working Group of the GMC (*Common Market Group*)

**SIAB** – Primary Care Information System (*Sistema de Informação da Atenção Básica*)

**SIMM** – Integrated Information System on More Doctors (*Sistema Integrado de Informação Mais Médicos*)

**Sisan** – National System for Food and Nutrition Security (*Sistema Nacional de Segurança Alimentar e Nutricional*)

**SMART** – Specific, Measurable, Assignable, Realistic and Time-related

**SNFA** – National Yellow Fever Service (*Serviço Nacional de Febre Amarela*)  
**STAG-AMR** – Strategic and Technical Advisory Group on antimicrobial resistance  
**STI** – sexually transmitted infections  
**SUS** – Unified Health System (*Sistema Único de Saúde*)  
**SVS** – Secretariat of Health Surveillance of the Ministry of Health (*Secretaria de Vigilância em Saúde do Ministério da Saúde*)  
**TCM** – Traditional Chinese Medicine  
**TDR** – Special Program for Tropical Diseases Research and Training  
**TG** – technical group / working group / thematic group  
**TRIPS** – Agreement on Trade-Related Aspects of Intellectual Property Rights  
**TSA** – Antimicrobial susceptibility testing  
**UBS** – Basic Health Units (*Unidades Básicas de Saúde*)  
**Udelar** – *Universidad de la República*, Uruguay  
**UEBMI** – Urban Employee Basic Medical Insurance in China  
**UFMG** – Federal University of Minas Gerais (*Universidade Federal de Minas Gerais*)  
**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*)  
**UN** – United Nations  
**UNAIDS** – Joint United Nations Program on HIV / AIDS  
**UNAIDS TG** – UNAIDS Thematic Group  
**UNDP** – United Nations Development Program  
**UNESCO** – United Nations Educational, Scientific and Cultural Organization  
**UNFPA** – United Nations Population Fund  
**UNGA** – United Nations General Assembly  
**UNICEF** – United Nations Children's Fund  
**UNILA** – Federal University for Latin American Integration (*Universidade Federal da Integração Latino-Americana*)  
**UNITAID** – International Drug Purchase Facility  
**UNMIH** – United Nations Mission in Haiti  
**UNOPS** – United Nations Office for Project Services  
**UPA** – Emergency Care Unit (*Unidade de Pronto Atendimento*)  
**URBMI** – Urban Resident Basic Medical Insurance in China  
**USA** – United States of America  
**USAID** – United States Agency for International Development  
**USAN** – Union of South American Nations  
**USSR** – Union of Soviet Socialist Republics  
**WFP** – World Food Program  
**WHA** – World Health Assembly  
**WHA** – World Hepatitis Alliance  
**WHO** – World Health Organization  
**WTO** – World Trade Organization

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# Foreword

## The 20 years of AISA in the milestone of 30 years of SUS

*Ministry of Health*

2018 is a milestone to be celebrated not only by the Ministry of Health but by all Brazilians.

The reason to celebrate is the thirtieth anniversary of the Brazilian Unified Health System (SUS), the largest free and universal public health system in the world. In thirty years, SUS has experienced achievements, permanent challenges and, above all, pride for having a participatory, egalitarian, solidary public policy that reflects the wishes of our society as established by the Federal Constitution. SUS is an inheritance that belongs to the State of Brazil and its population, and it reveals the national realization that health care is a right that belongs to the population and a necessary condition for the sustainable development we so strongly seek to achieve.

The International Health Affairs Office (AISA) celebrates 20 years of operation in 2018. This is not a less important celebration. Throughout the past two decades, AISA has had an essential public role, contributing not only to the international projection of health-related interests of Brazil and the Ministry of Health, but also to strengthen principles that are imperative to SUS, both nationally and internationally, such as health universality, equity and integrality.

AISA currently counts on a specialized technical team focused on activities that include advising the Minister of Health on international affairs, as well as guiding the actions of the Ministry on a multilateral level, in international forums, regional mechanisms and border integration activities, bilateral relations and international initiatives for technical and humanitarian cooperation in health.

In close coordination with the Ministry of Foreign Affairs, the international activity of the Ministry of Health has contributed to strengthen the public dimension of Brazilian foreign policy. As a public policy, a country's foreign policy seeks to reflect the wishes and the needs of its population, aiming at the sustainable development across its multiple dimensions. In the 2030 Agenda for Sustainable Development, health is considered an essential component of the effort to accomplish several of the Sustainable Development Goals transversally established. Health is, therefore, a fundamental condition to achieve the values that are so dear to Brazil and its society and for its global projection.

In the multilateral scope, AISA coordinates the participation of the Ministry of Health in more than twenty international organizations and mechanisms; in addition, it

monitors more than thirty multilateral treaties and agreements with a direct or indirect impact on health issues. By promoting positions such as the strong defense of the access to medicines as a human right in multilateral forums, Brazil is strengthening the principles that guide the constitutional right to health in our country. Consequently, our national policies in this matter are also being strengthened.

In the field of international technical cooperation, AISA monitors projects developed by the Ministry of Health on various themes in partnership with other countries and international organizations. Today, it has over one hundred health cooperation projects and activities under execution in every continent, mainly on issues such as the implantation of human milk banks, human resources training, primary care improvement, HIV/AIDS and viral hepatitis control programs, strengthening of epidemiological surveillance, food and nutritional security and health management. These international cooperation projects carried out and monitored by the Ministry of Health denote the establishment of good national practices for global reference in the health field. In addition, we have the opportunity to learn from the exchange of experiences and, consequently, improve our national health policies.

In humanitarian cooperation, AISA also plays an outstanding role in articulating with the Ministry of Foreign Affairs to meet international demands for donations of vaccines, medicines and health supplies aimed at addressing emergency needs, both in other countries and in Brazil. Besides the moral duty to assist countries and people in situations of basic health needs, humanitarian cooperation efforts also reinforce Brazil's institutional commitment to international cooperation. The spirit of solidarity of other partner countries that consider health as a human right has also been beneficial and helpful to us during these emergencies.

The twenty years of AISA are a great opportunity to share the achievements we have had so far and to demonstrate how we have prepared ourselves to face global health challenges in the future. This book aims to present some of the prominent activities of AISA throughout its two decades of existence. Besides bringing information about Brazil's international action concerning health-related issues in a manner that has not been done so far, this work also serves the purpose of enhancing accountability and social control of governmental actions, bringing the Ministry of Health closer to scholars, academia, civil society, and the population in general.

As public policies, health and foreign policy have the unavoidable social function of translating our society's worldview both at national and international settings. The proficiency and commitment of the work performed by AISA for the past twenty years have played, certainly, a fundamental role in strengthening not only Brazil's international protagonism but also Brazilian public health as a whole.

# Introduction

The International Health Affairs Office (AISA) celebrated its 20th anniversary in 2018, and the publication *Health and Foreign Policy: 20 years of the International Health Affairs Office* of the Ministry of Health of Brazil is intended to present the history of activities carried out throughout this period and inscribe practical aspects of the work done by the Office, its main challenges, the multiplicity and extent of topics, and the performance of its technical staff, who has contributed to the protagonist role of the Brazilian Ministry of Health on the international scene.

AISA is an organizational unit institutionally linked to the Minister of Health Office, with competence to deal with international issues concerning the Ministry of Health and to advise the Minister on topics of international concern. This book shows that AISA has focused on issues of strategic relevance to the Ministry of Health and Brazil, contributing to the strength of Brazilian foreign policy, the defense of the Unified Health System's (SUS) guiding principles and the promotion of health care, both nationally and abroad.

In order to implement its activities, AISA has a very experienced staff with a high technical level, fully conscious of the importance of their contribution to the Ministry of Health, Brazil and our society. While approaching the celebration of AISA's twenty years and SUS's thirty years of existence, we proposed the organization of this commemorative book, aware of the importance of the work performed by AISA and the proficiency of its technical staff. The methodology used consisted in the production of articles by professionals directly involved in activities developed within the International Health Affairs Office, sharing their personal experiences, perspectives, and technical opinions, which we consider to have enriched the publication even further. The themes proposed do not cover the entirety of AISA's activities, but provide an important overview of a significant portion of its work.

With this book, we also seek to report the actions carried out by the Ministry of Health on the international agenda closer to the academic world. In partnership with Dr. Rodrigo Pires de Campos, a renowned professor dedicated to the study of multilateralism, international cooperation and global health, of the Institute of International Relations of the University of Brasília (IREL/UnB), we organized seminars in the subject of Contemporary Foreign Policy in the Undergraduate Program of International Relations at UnB, supervised by the authors in this book. The seminars were held from March 26 to June 25, 2018. This initiative allowed us to accomplish our goal of strengthening integration between government and civil society, building a profitable dialogue between the academic world and the management of public health policies. We would like to thank all the students for their participation in

these seminars. Their attendance represented a favorable opportunity for dialogue on contemporary health-related issues in Brazil and globally. The seminars have also contributed to a reflection about AISA's work process and the activity of the Ministry of Health in the international scenario. Final versions of the articles were reviewed based on considerations and debates raised during the seminar presentations.

This publication implies much more than the edition of a commemorative book. We seek to instigate research and knowledge on the relationship between health and foreign policy, and to improve the activities developed by AISA. We truly hope that the multiplicity of the selected themes will contribute to bring forth greater interest in Brazilian health-related foreign policy by the most diverse readers. We aim to support the institutional commitment to transparency, social control and the availability of information to all interested audiences, thus contributing to strengthen the role of AISA. We also hope that this initiative may give rise to other opportunities of partnership between AISA and civil society, reinforcing the bond between Brazilian society and the process of creation and execution of Brazilian health foreign policy, in an effective expression of what we define as public policy.

# **HEALTH IN THE BRAZILIAN FOREIGN POLICY AGENDA**



# Brief history of the International Health Affairs Office of the Ministry of Health

*Igino Rodrigues Barbosa Filho<sup>11</sup>*

## Abstract

This article contextualizes Brazil's international activity in health and it presents the institutional structures dedicated to this topic within the Ministry of Health, since its establishment. The International Health Affairs Office (AISA) stands out as the longest-lasting unit among those analyzed. Its persistence and institutional strengthening contribute, in general terms, for the success of the international activity of the Ministry of Health and for the accomplishment of the Brazilian public health and foreign policy interests.

**Keywords:** Brazilian foreign policy. Health. Ministry of Health. International Health Affairs Office. History.

The International Health Affairs Office (AISA), established in 1998, is the responsible unit at the Brazilian Ministry of Health for its international topics, through the preparation of guidelines, the coordination of positions or also through the implementation of the international policy of the Ministry of Health. AISA formulates the Brazilian position on health topics in the international scenario, always according to the orientation of the Brazilian foreign policy and in connection with areas within the Ministry of Health that have the technical knowledge on the most diverse issues. Moreover, it provides advisory to the Minister of State for Health on international matters.

The two decades of existence of AISA represent an important – although relatively new – experience of the history of Brazil's international relations in health. This history started, however, decades prior to the establishment of AISA in 1998. In Brazil, since the 1950s, there has been a division of the Ministry of Health dedicated to international topics. However, this structure has undergone frequent institutional changes due to internal transformations of the Ministry and to modifications concerning the overall administration at the Executive level.

Several authors attribute the beginning of the international sanitary cooperation to the 19<sup>th</sup> century, driven by the concern with issues related to hygiene, epidemics

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containment, and transportation technologies (ALMEIDA et al., 2010; CHAVES, 2013; LIMA, 2002; PIRES-ALVES et al., 2012). The First International Sanitary Conference of 1851, was held in Paris, and it is a milestone in international relations in health. The creation of the Pan-American Sanitary Division in 1902 – which would become the Pan American Health Organization (PAHO) – and the establishment of the World Health Organization (WHO) in 1948 are additional milestones in this history.

The Brazilian, participation in health related international conferences dates back to the Second Empire – especially two Latin American sanitary conferences held in the second half of the 19<sup>th</sup> century: in Montevideo, in 1873, and in Rio de Janeiro, in 1887, with the participation of representatives of the Empire of Brazil and the Republics of Uruguay and Argentina in both occasions (CHAVES, 2013). Although the Brazilian participation in the main international forums on health topics – such as the International Office of Public Hygiene (OIHP, French acronym), the League of Nations Health Organization, PAHO, and WHO – only in the 1950s an institutional structure for the coordination of the topic in the Brazilian government was set, prior to the establishment of the Ministry of Health. The International Health Committee was created within the former Ministry of Education and Health through Directive No. 94, of April 20, 1950<sup>2</sup> comprised by the agency's own staff.

The Ministry of Health, as currently known, was only established on July 25, 1953, by Law No. 1,920, being thus separated from the Ministry of Education and Culture, also created on this occasion (BRASIL, 1953). Even though the Act establishing the Ministry of Health did not create a structure dedicated to international topics, through Directive No. 101 of February 26, 1954, new members of the International Health Commission were nominated, which shows that there were continuity in actions of the former Commission's activities established in the previous Ministry of Education and Health (GAUDÊNCIO, 2014).

In 1964, Decree No. 55,041 set the Commission for International Affairs (CAI, acronym in Portuguese), within the Ministry of Health, to advise the Minister of Health through collective deliberation (BRASIL, 1964). CAI was formed by the national directors of the ministry and by representatives from WHO and PAHO, as well as from the Ministry of Foreign Affairs. In 1969, Decree No. 65,253 changed the commission into a coordination, by establishing the Coordination for International Affairs, keeping the same acronym, CAI, without a deliberative character (BRASIL, 1969). With Decree No. 66,623, of 1970, CAI became the Coordination for International Health Affairs (CAIS), as an “agency for international support”, connected to the formerly called

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<sup>2</sup> Before the Commission,, still within the Ministry of Education and Health there was also the Board for International Sanitary Protection and for the Capital of the Republic, responsible for ports and airports inspection; it was extinct in 1937, when the Borders Anti-Venereal Service was established (GAUDÊNCIO, 2014).

General Secretariat<sup>3</sup> of the Ministry of Health. It had then a more administrative role, and the responsibility of “advising the Ministry in matters concerning projects or programs that have technical or financial participation of foreign or international entities” (BRASIL, 1970).

In 1977, Decree No. 81,141 transformed CAIS into an agency providing direct and immediate assistance for the Minister of State to “promote, coordinate, monitor, and evaluate technical cooperation, in the field of health, with international bodies, governments, or foreign entities”, shifting its designation to ‘Coordination’ of International Health Affairs, and keeping the same acronym (BRASIL, 1977). Directive No. 83 of February 20, 1978 returned the competence of advising in decision-making activities to CAIS (GAUDÊNCIO, 2014). CAIS represented a higher coordination of the Ministry of Health to institutionally follow up international topics of its interest (TAPAJÓS, 2014).

Throughout the decade of 1980, CAIS maintained unchanged its structure. On March 21, 1990, in the context of the administrative reform undertaken by Fernando Collor administration (1990-1992), all international areas of the Ministries, including CAIS, were extinct by means of Provisional Decree No. 150, inclusively CAIS. As set forth then by Article 27, “[are] extinct [...] VI – the General Secretariats and the current Secretariats or International Offices of the Civil Ministries or equivalent bodies of the Presidency of the Republic” (BRAZIL, 1990).

Despite this institutional reorganization, projects that had been started or that were about to start, as well as international requests of interest of the Ministry of Health and administrative procedures related to international affairs would still generate work demands. In this context, it was necessary to establish informal arrangements to fulfill previously commitments and demands related to the international context. For this purpose, a special adviser to the Minister of Health was appointed to deal with international affairs and to continue the work that, until then, was performed by CAIS, although without establishing a unit formally responsible for the issue within the institutional structure of the ministry. This situation lasted until the establishment of the General Coordination of Special Health Affairs (CAESA), through Directive GM No. 382, of May 3, 1991. CAESA, connected to the Office of the Minister, even though it did not formally have international competence, it assumed the responsibility over the topic. – which became explicit by the Directive No. 1,157, of November 9, 1992, which set the Coordination Council of International Projects and attributed to CAESA the Executive Secretariat of the Council (GAUDÊNCIO, 2014).

In July, 1993, Directive GM No. 778 changed CAESA into the Office for Special Issues in Health (AESA, acronym in Portuguese), connected to the Minister’s cabinet.

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<sup>3</sup> It is currently called the Executive Secretariat of the Ministry of Health.

In spite of that, between September 1993 and 1994, AESA was linked to the Executive Secretariat of the Ministry (TAPAJÓS, 2014). Since 1995, career diplomats became responsible for AESA leadership<sup>4</sup>, which facilitated the interaction between the international work of the Ministry of Health and the Ministry of Foreign Affairs.

In 1998, the Ministry of Health underwent another institutional restructuring when the International Health Affairs Office (AISA) was established by Decree No. 2,477, of January 28, 1998, which is its current designation.

For the past two decades, AISA has acted on extremely relevant topics for the Ministry of Health and for Brazil. Some of them are: generic drugs and the defense of compulsory licensing as a valid instrument for the promotion of access to health care; Brazil's protagonist role in regional and global response to HIV; technical cooperation among developing countries; support to regional integration within the scope of Mercosur and in other integration mechanisms; support to cooperation in the More Doctors Program; participation in multilateral forums; monitoring International Health Regulations, such as tobacco control, among many other topics that represent important achievements of the Brazilian society and the Brazilian public health.

In its twentieth year, AISA is already the longest-lasting institutional structure in charge of international affairs in the history of the Ministry of Health. Its maintenance and institutional strengthening contribute, in general terms, for the success of the Ministry of Health international activity and for the achievement of the Brazilian public health and foreign policy fundamental interests.

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# The International Health Affairs Office of the Ministry of Health: its affairs and challenges

*Fabio Rocha Frederico<sup>1</sup>*

## Abstract

This article seeks to present the main themes, attributions, and challenges of the International Health Affairs Office of the Ministry of Health (AISA), highlighting its growing importance in the field of health in the international scenario and emphasizing practical aspects of its work. The routine activity of AISA faces significant challenges, especially given the multiplicity, the extent and the complexity of its matters and attributions, the amount and diversity of groups it interacts with, as well as the current characteristics of the international context.

**Keywords:** Brazilian foreign policy. Health. Ministry of Health. International Health Affairs Office.

## 1 AISA and the international landscape in the field of health

The International Health Affairs Office of the Ministry of Health (AISA) is the bureau in charge of international affairs in the Ministry. Since AISA's creation in 1998<sup>2</sup>, health issues have become even more important in the international front, and the responsibilities of the Office have also grown in volume and complexity.

Over the last decades, the health field has attained significant prominence as a foreign policy issue. As mentioned by Fidler (2007), health has become an important topic in all of the main functions of a state's foreign activity: boosting economic development; the promotion of security; advocacy of stability in the international order; and the support for human dignity, including the provision of humanitarian aid. Therefore, the health field becomes increasingly relevant for the achievement of the State's goals and interests, before the international landscape (FIDLER, 2007).

There are several reasons for the increase in the importance of the health field in each of those functions aforementioned; most of them related to the intensification

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<sup>2</sup> About this topic, refer to the article "Brief history of the International Health Affairs Office of the Ministry of Health", by Igino Rodrigues Barbosa Filho.

of the globalization phenomenon (CUETO, 2015). Some of the reasons consist in the massive transit of travelers and immigrants, the increment of goods exchange, the emergence of new diseases, and the upgrowth of the health industrial complex.

The industrial complex in the field of health is one of the largest in the world, comparable only to the arms and the oil sectors. In the United States, for example, the health sector is the largest one in the country in terms of revenue. The economic implications of the health sector are even greater, considering, for instance, that decisions and regulations from the sector can have significant impacts on other areas of the economy, such as in the tobacco industry and the food industry. Moreover, in many countries, including Brazil, the development strategy of the sector is a fundamental part of the country's industrial policy as a whole.

In reflecting upon the increasingly higher economic relevance of health, entities, forums, and institutions of primarily economic character have acted more intensely in the sector, such as the World Bank, the Organization for Economic Co-operation and Development (OECD)<sup>3</sup> and the G20.

The intensification of interconnections between the health area and both the international economic agenda and the security sector is particularly challenging for the international actions of the Ministry of Health, traditionally oriented by the defense of health as a fundamental human right, which surpasses economic or security considerations. In contrast, in today's landscape, the increase in the flow of immigrants and the rise of new diseases, in particular, reinforce an increasingly common view, especially among developed countries, that health issues should be tackled from the security perspective.

The growing importance of health has been accompanied by a process of fragmentation and progressive complexity of the sector in the international arena. Over the last two decades, AISA has operated within a setting marked by a multiplication of actors, by the rise of non-governmental organizations (NGOs), transnational companies, public-private partnerships, and global initiatives, in addition to the increase in the number of regional and sub-regional organizations, oftentimes creating overlapping integration layers, where the health topic has also gained progressive importance.

In this scenario, AISA also maintains at the national level, a permanent dialogue with several governmental and non-governmental actors that are fundamental for the successful execution of Brazilian foreign policy in the field of health. First of all, the International Health Affairs Office coordinates with the technical departments of the Ministry of Health that possess substantial knowledge in the related areas, which are themselves highly specialized in many cases, for determining positions and priorities

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<sup>3</sup> About this topic, refer to the article "Brazil's process of access to OECD and the prospects for a discussion on health", by Rafaela Beatriz Moreira Batista.

for Brazil's external activities. Among the units of the Ministry of Health that are in direct contact with AISA to coordinate international actions, the Department of Strategic Programmatic Actions (DAPEs), the Department of Primary Care (DAB), the Department of Science and Technology (DECIT), the Department of Planning and Regulation of the Provision of Health Care Professionals (DEPREPS), Department of Health Surveillance of Non-communicable Disease and Health Promotion (DANTPS), Department of Communicable Disease Surveillance (DEVIT), and the Department of Surveillance, Prevention and Control of sexually transmitted diseases (STIs), HIV/AIDS and Viral Hepatitis<sup>4</sup> (DIAHV) stand out.

Furthermore, AISA also works in close coordination with entities linked to the Ministry of Health that also have specialized technical knowledge of its matters, and, in many cases, their own international actions. Among the main institutions in close ties with AISA for the coordination of positions and the establishment of actions for international cooperation are the National Health Surveillance Agency (Anvisa), the Brazilian Cancer Institute (INCA), the National Institute of Cardiology (INC), the National Health Foundation, and Oswaldo Cruz Foundation (Fiocruz).

The contact with representatives of non-governmental institutions, international organizations, foundations, and multilateral programs acting in the field of health is also quite frequent. With issues such as non-communicable diseases, tobacco control, health promotion, food and nutritional security<sup>5</sup>, among many others, there is a significant diversity of national and international actors involved, with varied agendas and actions. AISA is responsible for establishing the ties and actions between the Ministry of Health and these institutions, with a view to subsidizing the production of national roles and promoting cooperation actions of public interest.

Besides the health field, AISA has played a role in the articulation and permanent contact with other players in the Brazilian government, especially with the Ministry of Foreign Affairs, and, the Brazilian Cooperation Agency (ABC) for setting up positions and strategies, as well as for implementing international actions related to health. Other ministries of the Federal Government are also frequent partners, such as: the Ministry of Social Development (MDS), in areas related to food and nutritional security; the Ministry of the Environment (MMA), as in the issue of chemical waste management and environmental health; and the Ministry of Agriculture, Livestock, and Supply (MAPA), on issues concerning inter-ministerial coordination for smoking

<sup>4</sup> About this topic, refer to the article "International technical and humanitarian cooperation and the Brazilian role in the regional and global response to HIV", by Mauro Teixeira de Figueiredo.

<sup>5</sup> About this topic, refer to the article "The Decade of Action on Nutrition: Commitments, Challenges, and the Health Strengthening in the Agenda of Food and Nutrition Security", by Lorenza Longhi.

prevention, and prevention from antimicrobial resistance<sup>6</sup>, for instance. In many cases, these actors have put forth points of view that are dissimilar from the ones of the Ministry of Health, and at times, even conflicting interests. In those circumstances, the equalization of positions for the achievement of a consensus and the construction of a Brazilian governmental perspective is also part of the Office's daily responsibilities. AISA's activity, therefore, consists not only of the full mastery of topics related to health, but also of the capability to establish communication and coordination with the various relevant actors, inside and outside the Ministry of Health, with a view to identifying and pursuing the international interests of Brazil in this area.

In summary, AISA's main goal concerns the creation of guidelines for the coordination and execution of international actions by the Ministry of Health in lasting articulation with other areas of the Ministry, with related entities and other agencies of the Brazilian government, with frequent dialogue with other countries, with international institutions and with the organized civil society, acting in accordance with the guidelines and the goals pertaining the national foreign policies.

## **2 Matters and Duties**

Without failing to acknowledge that AISA's matters and realms of activity are multiple and interconnected, not easily definable into schemes or simplified representations, it is possible to classify AISA's duties into seven basic thematic groups.

### **2.1 Bilateral activity**

AISA coordinates Brazil's bilateral relations in the health field in permanent liaison with the Ministry of Foreign Affairs. For the past two years, one of AISA's priorities has been the intensification of bilateral relations, especially around the development of concrete cooperation projects and activities in the health field that are mutually beneficial, from both the financial and the human resources perspective.

The cooperation projects generate meaningful benefits not only for the countries "receiving" the cooperation, but also for those willing to "offer" it. In practical terms, referring to the country that "provides" or "receives" the cooperation sounds simplistic. It is, after all, a mutually beneficial exchange. The professionals involved have the chance for personal improvement, by getting to know other realities and challenges, reflecting upon their own actions, trying solutions, and foreseeing hardships. The mutually beneficial nature of cooperation is even more evident in the South-South

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<sup>6</sup> Refer to the article "Antimicrobial Resistance: Multilateral approach and the Brazilian response", by Tatiana Silva Estrela for further information on this topic.

cooperation, which is the one established between developing countries, which allows an even more intense exchange of experiences and knowledge.

In the context of South-South cooperation, in particular, the positive image of the Unified Health System (SUS) and of some national programs, such as the ones for HIV/AIDS control, tobacco control and breastfeeding<sup>7</sup>, as well as the international recognition of the competence and professionalism of Brazilian professionals, in these and other health-related matters, have stimulate international demands for Brazil's cooperation (BUSS, 2018).

AISA currently takes part, at different levels, in financial and human resources commitment, in over one hundred cooperation projects or activities, especially with countries in Latin America and Africa, and almost always in partnership with the technical areas of the Ministry of Health.

In line with Brazilian foreign policy, in the health area, relations with South American countries are a priority<sup>8</sup> and they are reinforced by common challenges in border areas. Brazil maintains 16 bilateral mechanisms for work on health at the borders, among these are commissions, subcommittees, committees and working groups, linked to neighboring commissions or originated in specific bilateral agreements. In the border regions, the Ministry of Health promotes projects for building up and renovating primary care units, training activities for health professionals, joint vaccination campaigns and donations of health supplies, among others.

In border regions, an efficient coordination between the Ministries of Health of the countries involved and other subnational entities is paramount, considering the importance of the matter for the populations of most Brazilian border regions, with intense exchange of professionals in the health area, with people searching for health services and health products, services and tourists, which entails several challenges in terms of sanitary surveillance. However, in border areas, the challenges for AISA's activities are particularly complex, involving difficulties resulting from the coordination between two or more different national health systems (with different legal and health regulatory regimes, customs, and others), and coordination with states and cities, from eventual logistics deficiencies, among others.

Besides South-American neighbors, and aligned with Brazilian foreign policy, over the past decade, relations in the health field with countries in Central America and the Caribbean have also been intensified, especially with Haiti<sup>9</sup>. Along with Mozambique, Haiti, given the reach and the quality of operative projects is currently

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<sup>7</sup> For further information on this topic, refer to the article "Health, foreign policy and public diplomacy", by Bruno Pereira Rezende.

<sup>8</sup> For more information on this topic, refer to the article "Health in the Brazil-Uruguay border and the Brazil-Germany-Uruguay cooperation project", by Rafael Gomes França.

<sup>9</sup> About this topic, refer to the article "Health cooperation with Haiti", by Douglas Valletta Luz.

one of the main partners of the Brazilian cooperation in health. In Central America, Brazil has developed partnerships with El Salvador and Honduras in the areas of human milk, strengthening of the blood system and blood products, among others.

The Portuguese-speaking African countries (PALOP) are also important partners bilaterally or within the scope of the Community of Portuguese-speaking Countries (CPLP)<sup>10</sup>, and in addition to Mozambique, Brazil also has significant projects in health with Angola, Cape Verde, and São Tomé and Príncipe. The main cooperation areas with the PALOP are the implementation of human milk banks, cancer prevention and control, fight against HIV/AIDS and food and nutritional security. Some of the highlights in the regions are the projects to install a medicines manufacturing plant in Mozambique, the largest cooperation project ever implemented by the Brazilian government, and the laboratory structuring project for diagnosis and treatment of tuberculosis in São Tomé and Príncipe, inaugurated in 2018.

Over the past years, AISA has sought to boost relations in the health area with BRICS countries, especially China<sup>11</sup> and India, both bilaterally and in the context of the BRICS mechanism<sup>12</sup>.

In addition to strengthening the bonds with traditional partners, such as the United States, France, and the United Kingdom, AISA has also sought to enhance and establish concrete cooperation projects with developed countries that are particularly advanced in certain sectors, such as Australia, Canada, and Denmark.

By and large, besides the prominence in the set of cooperation programs with the ABC, health issues have also had an increasingly important role in Brazilian foreign policy, fundamentally contributing to intensifying or establishing bilateral relations with some countries. For the past two years, it's possible to emphasize the importance of the More Doctors Program originated in the relations with Cuba<sup>13</sup>, the efforts of humanitarian cooperation in health, set forth with Venezuela, or the Brazilian donations of goods and medicines in the context of the Syrian Civil War.

In addition, the Ministry of Health engages in humanitarian cooperation actions with countries found in emergency situations arising from natural disasters, armed conflicts or momentary shortages, mostly through the donation of medicines or health

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<sup>10</sup> About this topic, read the article "Health cooperation with Portuguese-speaking African countries", by Luciano Ávila Queiroz and Layana Costa Alves.

<sup>11</sup> Refer to the article "Brazil and China: cooperation in health and perspectives", by Mariana Darvenne for further information on this topic.

<sup>12</sup> Refer to the article "Political coordination and cooperation in health within the BRICS ", by Eduardo Shigueo Fujikawa for further considerations on this topic.

<sup>13</sup> Refer to the article "The More Doctors Program and the Brazil-PAHO-Cuba cooperation for the strengthening of primary care at SUS", by Jorge Eliano Ramalho Filho and Anna Elisa lung Lima for more information on this topic.

supplies<sup>14</sup>. The main receptor partners in this case are, once again, countries in South America and in Africa.

Brazil also receives a significant amount of donations, which contributes to alleviating emergency issues of medicines shortage or shortage risks facing unforeseen circumstances, for example. Between June 2016 and early 2018, Brazil carried out 46 international donations of medicines, and received 28, most of them with the support from Latin American countries and from the Pan American Health Organization (PAHO/WHO).

## 2.2 Actions in multilateral and regional organizations

AISA coordinates the participation of the Ministry of Health in several multilateral and regional organizations in the field of health, promoting national interests in different fronts. In the multilateral scenario<sup>15</sup>, the main organizations specialized in health care are the World Health Organization (WHO), with headquarters in Geneva, and its regional branch, the Pan American Health Organization (PAHO), with headquarters in Washington, USA. The main governing bodies of WHO are the Executive Board and the World Health Assembly – which is attended by all members of the organization. In the regional setting, PAHO's main governing bodies are the Executive Committee and the Pan American Sanitary Conference – which also congregates all member States.

WHO was created in 1948 as an organization within the United Nations (UN) program, and is the main global governance institution in the health area. Within the scope of WHO, the guidelines and the International Regulations of the sector are defined. AISA has a close relationship with areas within the Ministry of Health responsible for the most varied issues approached within the scope of WHO and relationships with the Ministry of Foreign Affairs aimed at setting forth Brazilian positions and promoting national interests inside the institution. Particularly over the last three decades, Brazil has maintained a high profile of actions in both organizations, in line with the protection of multilateralism in the international system. In May 2018, for instance, Brazil became a part of the Executive Board of WHO and of the Vice-Presidency of the PAHO Executive Committee simultaneously.

AISA, along with other areas of the Ministry of Health, also takes part in multilateral discussions on other aspects of the international system, such as intellectual property standards and patent regulations, both in the multilateral bodies framework<sup>16</sup>

<sup>14</sup> See the article “Humanitarian cooperation in health”, by Raquel Machado and Tatiane Lopes Ribeiro de Alcântara.

<sup>15</sup> For further information on this topic, refer to the article “The International Health Affairs Office of the Ministry of Health (AISA): the history towards multilateral activity”, by Indiara Meira Gonçalves.

<sup>16</sup> About this topic, refer to the article “The international action of the Ministry of Health in the issue of access to medicines”, by Roberta Vargas de Moraes.

and within the scope of commercial negotiations, as in current negotiations between Mercosur and other blocs and countries, such as initiatives at different stages of negotiations with the European Union, the European Free Trade Association (EFTA) and Canada.

AISA is also responsible for coordinating the Brazilian participation in the health area in several regional organizations and coordination mechanisms, including Mercosur<sup>17</sup>, the Union of South American Nations (USAN), the Amazon Cooperation Treaty Organization (ACTO), the Organization of Ibero-American States (OEI), the Community of Portuguese-speaking Countries (CPLP) and the BRICS. Recently, under the leadership of the German government, a group in the health field was also established within the scope of G20, with its first ministerial meeting held in Berlin in May 2017.

The organization of ministerial meetings within the scope of regional bodies or international mechanisms is the responsibility of the country holding its own *pro tempore* presidency (PPT). In the latter case, in coordination with the Ministry of Foreign Affairs, AISA is responsible for organizing the Brazilian PPT in the health area, which includes ministerial meetings, in addition to technical meetings and high rank meetings, which involves a significant demand for human and financial resources. Moreover, with the multiplication of regional bodies with Brazilian presence, an accumulation of PPTs is common. In the second semester of 2017, for example, Brazil accumulated PPTs of the CPLP and the Mercosur and AISA organized meetings with Ministers of Health of the CPLP in Brasília, in October, and with Mercosur, in the city of Foz do Iguaçu, in December. Likewise, in the second semester of 2019, Brazil is to accumulate PPTs of BRICS, of USAN and of the Mercosur. The overlap of PPTs represents an overload also for the technical units involved, and complicates matters in their operations, even for a country with a specialized technical body in international health, like Brazil; this is the reason why it is necessary to make adequate planning efforts in order to obtain successful outcomes.

Over the past two years, besides prioritizing the development of cooperation projects and activities within the scope of the regional organizations, AISA has also promoted greater coordination of integration mechanisms within the scope of multilateral institutions, especially with BRICS and CPLP countries, in addition to fostering the traditional articulation with Latin American neighboring countries.

Brazil's active presence in multilateral health forums is fundamental to ensure that international decisions and regulations are in line with the principles of SUS, especially with universal access, health integrity and social participation: elements

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<sup>17</sup> On this topic, refer to the article "Regional Integration to strengthen health systems: the case of Mercosur", by Wesley Lopes Kuhn and Sonia Maria Pereira Damasceno.

that are fundamental for the understanding of health as a constitutional right in Brazil, in that the latter elements are also reflected on the country's international performance in this realm.

## 2.3 International Organizations

In addition to multilateral activities, especially in the scope of WHO and PAHO, AISA also maintains strong ties with international organizations and initiatives in the health area. Differently from the multilateral activities previously described, which focus on dialogue and negotiation with governments, the contact with international organizations and initiatives already takes place within a bureaucratic structure of its own, not within a state structure, which has different traits and interests.

In this respect, the main entities in contact with AISA are organizations related to the UN system. The intensification of globalization and the multi-sectoral nature of fields in health, as well as the broadness of its actions, have also led to a greater engagement of the Ministry of Health with UN organizations not focused on health specifically. Besides WHO and PAHO, the main organizations in contact with AISA within the scope of the United Nations are the following: the United Nations Office for Project Services (UNOPS), the United Nations International Children's Emergency Fund (UNICEF), the United Nations Population Fund (UNFPA), the Food and Agriculture Organization of the United Nations (FAO), the United Nations Development Program (UNDP), and the World Food Program (WFP).

Within the UN system or even in the WHO context, there are several sectoral initiatives in which the Ministry of Health also plays its roles constantly. Those include the Framework Convention on Tobacco Control (FCTC), the Global Antibiotic Research & Development Partnership (GARDP), the Partnership Stop TB and the Joint United Nations Program on HIV/AIDS (UNAIDS).

For the past two decades, particularly, the number of international initiatives in health, many of them geared towards specific themes, has gone through considerable expansion. AISA also maintains a constant dialogue with several of such initiatives, many of them created with support from the Brazilian government. Some of them are the Global Alliance for Vaccines and Immunization (GAVI), the Global Fund to Fight AIDS, Tuberculosis and Malaria and the UNITAID. Moreover, many non-governmental organizations operate in the health field, in that, among them are the Bloomberg Philanthropies and the Bill & Melinda Gates Foundation, which have important ongoing projects with the Ministry of Health.

The increase in the number of initiatives certainly reflects the growing relevance of international problems in the health area, and may provide more human and financial resources so as to face such challenges. This increment, on the other hand,

presents difficulties for coordination and transparency, and also reflects the growing interest of economic actors in the health area, which not necessarily are aligned with national and international needs in public health.

Furthermore, the creation of new bureaucratic structures frequently entails administrative costs, which has intensified the competition for state or private resources in the international health scenario. In some cases, despite the fundamental contributions that some of these initiatives may offer in their several strands of activity, the need to collect funds and support for the maintenance of their own existence invariably becomes one of their core objectives. The balance between these different priorities not always leans towards the strengthening of health in the global setting. As the institution mediating the contact between the Ministry of Health and these multiple organizations, AISA seeks to assign coherence and efficiency to actions implemented by them in partnership with the Brazilian government.

## **2.4 Advisory to the Minister of Health**

Advisory to the Minister of Health in the international scenario is, perhaps the primary goal of the creation of international offices within the ministries. AISA, as well as most of the international offices, is directly tied to the Minister's Office and is responsible for advising the Minister's international actions by organizing bilateral meetings, preparing subsidies, speeches, and presentations, as well as keeping record and providing support and counseling during the meetings, dealing with logistic aspects, and coordinating both the Minister's international travels and the visits of international health authorities to Brazil.

The multiplicity of entities and initiatives in the health area has led to an exponential increase in the number of regular ministerial meetings, as well as in the amount of events and extraordinary seminars requiring ministerial in-person attendance. Brazil's Minister of Health, for instance, is invited to annual ministerial meetings at WHO, always in the month of May, in Geneva; at PAHO, in September, in Washington; at the Union of South American Nations (USAN); at Mercosur (twice a year); as well as at annual meetings of the BRICS and the G20; besides the CPLP meetings, every two years.

## **2.5 Logistic and Administrative Tasks**

AISA also carries out several logistic and administrative tasks in multiple areas of intersection between the Ministry of Health and the international arena. This support consumes a significant part of AISA's human resources and is essential for the good performance of the Ministry.

For instance, AISA verifies the legal compliance of all international travel processes of the Ministry of Health and the related institution's staff. In addition, it participates both in the analysis of documents provided by international candidates of the More Doctors Program and in meetings comprised by the three different parties for negotiation within the scope of the program. It also supports issues concerning the organization of international conferences, seminars, and events; it took part in the actions of the Ministry of Health in the 2014 World Cup and in the Rio 2016 Olympic and Paralympic Games, when actions on health surveillance, medical care to visitors, and arrangements for several health-related situations were developed. Additionally, it acts as a focal point in the contact with the Ministry of Foreign Affairs and with foreign embassies located in Brasília.

## 2.6 Action in health emergencies

One of the newest roles of AISA's activities, which deserves a separate analysis, is the support in cases of emergencies directly related to public health or that have a significant impact on it<sup>18</sup>. As for the first case, it is important to highlight the need of a broad international dialogue during the period of declaring the Zika virus a public health emergency by the WHO, in 2016, and the consequences associated to it, and also in the context of the increase of yellow fever cases in the country between late 2017 and the first quarter of 2018.

Both cases raised concerns among the neighboring countries and international health institutions and demanded intense communication with international actors, besides the mechanisms traditionally used within the framework of the International Health Regulations.

In both situations, AISA acted in cooperation with other areas in the Ministry of Health, in the articulation with WHO and PAHO, and served as an important communication hub with the Ministry of Foreign Affairs, providing official information about the events and about actions implemented by the Brazilian government in order to subsidize the performance of the Brazilian units abroad and to inform the foreign embassies located in Brasília. In addition, AISA also took part in transferring information within the scope of regional entities, such as Mercosur, and worked to foster cooperation activities aimed at contributing with efforts against the outbreak.

Another emergency situation that required active participation of the Ministry of Health happened with the expressive arrival of Haitian immigrants, especially through the border region in Acre and Amazonas in 2013. More recently, the current

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<sup>18</sup> Refer to the article "The International Health Regulations (IHR 2005) on the Mercosur health cooperation agenda and the Zika virus emergency", by Bárbara Frossard Pagotto, for more on this topic.

immigration wave from Venezuela in the Northern border of Brazil has also demanded inter-ministerial actions for admittance and care, and the Ministry has given special attention to the issue. In the latter cases, AISA has followed up with the emergency measures taken by the Ministry of Health in the regions receiving the immigrants, and it has ensured a permanent dialogue with the Ministry of Foreign Affairs and other government bodies in this matter, also monitoring eventual occasional implications in bilateral or sub-regional relations.

## **2.7 Representation of the Ministry of Health in government mechanisms**

AISA often also participates as a representative of the Ministry of Health in mechanisms of the Brazilian government that are focused on governance and monitoring of international issues. Members of AISA participate, for instance, in the National Committee for Refugees (CONARE), in the National Immigration Council (CNIg), in addition to other special domestic mechanisms of inter-ministerial coordination about health-related issues in the international context, many of them conducted by the Presidency of the Republic.

## **3 Challenges**

International action in the health area is conditioned by an extremely complex scenario, characterized by the intensification of the globalization phenomenon, among others factors, which facilitate the transit of human beings and entails a greater feasibility of circulation of diseases and potential epidemics. In addition, the multiplication of actors and the increase of initiatives and organizations contribute to the fragmentation of the international scenario in the health area, as discussed above. The new international conjuncture has also promoted a greater intertwinement between matters pertaining to health and the global economy, making it even harder to identify the objectives and interests of the various actors involved (ALMEIDA, 2017).

Facing problems in the health area, especially in the international context, calls for coordinated and inter-sectoral actions, and the multiplication and fragmentation of actors and initiatives hinder the attainment of this goal. The multiplicity of forums also favors countries with more financial and human resources and with greater capacity for international action, also from the logistic point of view. In this scenario, one of the main challenges is to prevent AISA's activity from being mostly reactive, given the high number of commitments, meetings and documents, and from compromising its capacity of creating and pursuing projects and goals of interest for Brazilian international affairs in the area of health.

AISA has been boosting its efforts to promote cooperation activities, also within the scope of regional organizations, seeking to avoid that the meetings only serve for sharing ministerial statements with low practical outcomes. Another relevant challenge is to carry out actions drawing from such forums, especially during PPTs, so as to achieve solid results that will be beneficial for the countries and their populations, and that justify the human and financial efforts employed in the action.

The achievement of successful outcomes demands intense coordination with several national and international actors, in addition to planning, organization, and a clear definition of goals, as well as the support and involvement of the main authorities of the ministry, especially the Minister of Health. In this case in point, AISA must be able to provide elements to the Minister to define a broad and coherent international action, with clear goals and in accordance with the national priorities of public health and with the guidance put forth in the Brazilian foreign policy.

In this context, the features of the national political scenario also impose difficulties to AISA's actions, given the frequent changes in the conduction of the Ministry of Health. Over the past thirty years, for instance, Brazil has had 21 Ministers of Health<sup>19</sup>, an average period of one year and four months for each Minister. The maintenance of specialized structures with qualified technical professionals in the structure of the Ministry that allows the work developed to be carried on, despite occasional changes is, therefore, fundamental in order to ensure continuity of the policies developed. In this regard, AISA has had an outstanding role.

International cooperation in the field of health yields tangible outcomes, with direct and relatively fast benefits for the populations and the countries involved. Projects in the area of human milk banks, for instance, one of the most fruitful and successful in Brazilian cooperation in the health area,<sup>20</sup> have the potential to significantly reduce childhood mortality at low cost, which often represents a fraction of the resources invested in the organization of a large international seminar, for example.

In the context of humanitarian cooperation, specific donations with no expressive cost may save lives. This is what frequently happens through the donation of anti-venom serum ampoules<sup>21</sup> produced by the Butantan Institute and frequently requested from the Ministry of Health by other Latin American countries.

By means of multifaceted actions, for the past twenty years AISA has had an increasingly relevant role in the international projection of the Ministry of Health

<sup>19</sup> In the period, Adib Jatene was the Minister in two occasions.

<sup>20</sup> International cooperation in the sector is conducted by the Fernandes Figueira National Institute of Women, Children and Adolescents Health of Fiocruz.

<sup>21</sup> It is also important to mention the requests for donation of anti-arachnid, anti-lonomia and snake antivenom serum, which are provided whenever the donation does not compromise the national supply.

and in the health agenda within the context of Brazilian foreign policy. Consequently, Brazil's international projection and the principles of SUS are mutually strengthened.

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# Health, foreign policy, and public diplomacy

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“Health is the right of all and a duty of the State (...).”  
(1988 Federal Constitution, art. 196)

## Abstract

The purpose of this paper is to discuss the relationship between public policies and Brazil's international performance in health-related matters since the creation of the Unified Health System (SUS) in 1988. Based on a historical analysis, we attempt to identify the common elements present in the declarations made by Brazilian foreign policy authorities on health-related matters over the last three decades, particularly at the World Health Assembly, as well as the actions relative to internal and foreign policies associated to them.

In relation to the main characteristics of Brazil's international performance in health-related themes in this period, we verify the permanence of stances related to the advocacy of development, universality and the right to health. Case studies on the national policies for HIV/AIDS, access to medicines, tobacco control, and the installation of human milk banks are analyzed, discussing their impacts on the formulation of Brazilian foreign policies in the area of health during the period of the study. Brazil's international performance in the health field over the last thirty years, as it reflects domestic emphasis and priorities based on participative public policies, comes close to the Brazilian concept of “public diplomacy”.

**Key words:** Health. Brazilian foreign policy. Public diplomacy. Unified Health System (SUS). Multilateralism. International cooperation. Public Policies. Social Participation.

## 1 Introduction: health on the international agenda

Public health policies are essential to promote development. The preamble of the Constitution of the World Health Organization (WHO) states that “health is a

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state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1946). Because of its inter-sectoral nature, health has an interface, not only with other social arenas, but also with various other sectors of governmental performance. Consequently, progress in health affects and is affected by a number of economic, social, cultural and environmental determinants (WHO, 2015), as recognized in the World Conference on Social Determinants of Health, held in Rio de Janeiro, in 2011 (BRASIL, 2013a).

The international health system began to be structured in the 19<sup>th</sup> century, when the I International Sanitary Conference was held in Paris, in 1851. In 1902, beginning of the 20<sup>th</sup> century, the International Sanitary Bureau was established in Washington, and is the predecessor of the Pan-American Health Organization (PAHO). In 1907, the International Office of Public Hygiene was installed in Paris. After World War I, the League of Nations’ Health Organization was created and its attributions included the elaboration of technical reports and epidemiological intelligence, as well as the establishment of international commissions on diseases (BROWN et al., 2006).

In relation to the United Nations, health has been a component of the activities developed, since the creation of this organization in 1945. In its preamble, the United Nations Charter highlights the intention of Member States to “promote social progress and better standards of life in larger freedom” and, to that end, “to employ international machinery for the promotion of economic and social advancement of all peoples”. The third paragraph of article 1 of the Charter lists, among the purposes of the organization, “to achieve international cooperation in solving problems of an economic, social, or humanitarian character [...]” (UN, 1945). Although the word “health” is not mentioned directly, the UN’s founding treaty draws attention to this social dimension as one of the focuses of its performance. In the San Francisco Conference (1945), occasion in which the UN Charter was signed, the Brazilian delegation pointed out that health issues should be among the topics that the Organization should attempt to solve, a stance that would influence the evolution of how this theme has been approached in the multilateral scenario since then. (BRASIL, 1988b).

The three main UN organizations – the UN General Assembly (UNGA), the United Nations Economic and Social Council (ECOSOC), and the Security Council (UNSC) – address health from various perspectives. The social concern, inherent to the UN’s profile, has also led to the establishment of institutions and programs within the UN, with an interface with health. Some examples are the United Nations Children’s Fund (UNICEF), created in 1946, the World Health Organization (WHO), established in 1948, the United Nations Population Fund, instituted in 1969, and, more recently, the Joint United Nations Programme on HIV/AIDS (UNAIDS), created in 1996.

The Universal Declaration of Human Rights, approved by the UN General Assembly in 1948, provides, in article 25, that “everyone has the right to a standard of

living adequate for the health and well-being of himself and his family” (UN, 1948). Also, the International Covenant for Economic, Social and Cultural Rights recognizes, in article 12, “the right of everyone to the enjoyment of the highest standard of physical and mental health” (UN, 1966).

The multilateral approach to health topics has had, therefore, an interface with the very evolution of international, inter-governmental organizations since the mid-1800's. However, the creation of WHO represents the constitution of an entity with a specific focus on sanitary conditions, with a global mandate and world action capability.

Soon after the San Francisco Charter was signed, Brazil and China proposed calling an international summit to create an organization that would exclusively address health topics (RUBARTH, 1999; BRASIL, 1988b). WHO, created by a treaty signed in 1946, and in effect since 1948, was devised as a directive and coordinating authority for international works in the health domain<sup>2</sup>. The main purpose of the organization, articulated in article 1 of its Constitution, is the acquisition, by all peoples, of the highest attainable standards of health. WHO's constitutive treaty recognizes health as a fundamental right, and considers it an essential component to reach international peace and security (WHO, 1946).

During the Cold War, the ideological disputes of a bipolar world greatly influenced international debates around social themes. On the one hand, the main global discussions centered on security and disarmament issues; on the other, there were few opportunities for players directly involved with social themes to participate in the corresponding international forums. In 1949, as a result of the tensions created by this systemic bipolarity, the Union of Soviet Socialist Republics (USSR) and other countries under their influence<sup>3</sup> withdrew from WHO, criticizing the prominence of the United States of America (USA) in the Organization and in UN agencies, in general. It was only after Josef Stalin's death and the ascension of Nikita Khrushchev to power in 1953, that a change in the USSR's stance changed towards a peaceful co-existence with the USA, leading to the return of the Soviet Union and its allies to WHO in 1956.

Brazilian Marcolino Gomes Candau occupied the position of WHO's Director-General between 1953 and 1973, being the director with the longest term in the Organization's history. He was the first Brazilian to head a specialized UN organization, having been re-elected three times. Under his administration, WHO expanded its visibility, achieved financial stability and administrative coherence, and strengthened its regional offices<sup>4</sup> worldwide (FEE; CUETO; BROWN, 2016). While directing an

<sup>2</sup> According to art. 2(a) of the World Health Organization's Constitution (WHO, 1946).

<sup>3</sup> In 1949, besides the USSR, the following member states withdrew from WHO: Albania, Bulgaria, Hungary, Poland, Byelorussian Soviet Socialist Republic, Ukraine, Romania, and Czechoslovakia (FEE, CUETO and BROWN, 2016).

<sup>4</sup> Art. 44(b) of the Constitution of the World Health Organization permits the establishment, by WHA, of regional organizations integrated to WHO (WHO, 1946). Today, WHO has six regional offices, in the following regions:

international organization does not mean representing the interests of one's country of origin, his perspectives influenced the guidelines of the organization's activities. Therefore, this was a position of great visibility and importance, both technically and politically.

During its first years, WHO developed qualification programs for healthcare professionals and promoted standardization efforts in sectors such as the international classification of diseases<sup>5</sup>, the Pharmacopoeia<sup>6</sup>, and the International Health Regulations<sup>7</sup>. Throughout the 1950's and 1960's, changes in biology, in economy, and in global policies altered public health and international relations, causing WHO to change its focus – previously limited to ending infirmities and standardizing health-related matters – to a broader interest in the development of healthcare services and health promotion. Regionally, the Special Meeting of the Inter-American Economic and Social Council at the Ministerial Level (IAESC-OMS) was held in 1961. The Charter of Punta del Este, approved on that occasion, recognized “the mutual relationships that exist between health and development and the need to promote coordinated economic and social development” (PIRES; ALVES; PAIVA, 2006, p. 23).

In the 1970's and 1980's, WHO developed the concept of “primary health care” (FEE; CUETO; BROWN, 2016). In 1978, the commitment to seek “Health for All by 2000” was signed during the I International Conference on Primary Health Care, held in Alma-Ata, Kazakhstan, in which Brazil did not participate<sup>8</sup>. The Alma-Ata Declaration has advanced the ideas of universality and health as a right, recognizing their inter-sectoral nature (WHO, 1978). Despite Brazil's absence at the Alma-Ata Conference, the adoption of these principles by the national sanitary reform movement would influence the construction of the public health system in the country.

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Africa (AFRO), Americas (AMRO), Europe (EURO), Eastern Mediterranean (EMRO), Western Pacific (WPRO), and South East Asia (SEARO). The Pan-American Health Organization (PAHO), whose origin dates back to the beginning of the 20th century, was integrated into WHO as a regional office for the Americas through an agreement signed in 1949 (WHO, 1949).

<sup>5</sup> The sixth version of the International Classification of Diseases (ICD) was published by WHO in 1948, and approved by WHA in the following year (resolution WHA2.93, 1949). Earlier, the International Institute of Statistics had been in charge of the Classification since 1893. From the 1920's on, the League of Nations' Health Organization also joined its efforts to update the ICD, which was called, at that time, the “International List of Causes of Death” (WHO, 2018).

<sup>6</sup> The first edition of the International Pharmacopoeia was approved by WHA in 1950 (resolution WHA3.10, 1950), and its first volume was published by WHO in the following year.

<sup>7</sup> The first version of the International Health Regulations (IHR) was adopted by WHA in 1951 (Resolution WHA4.75, 1951), and came into effect the following year. It was applicable to six diseases: cholera, yellow fever, recurrent fever, the black plague, typhus, and smallpox.

<sup>8</sup> Although Brazil did not participate in the Alma-Ata Conference, the discussions greatly impacted Brazilian health policies. The Alma-Ata Declaration stated that governments are responsible for their people's health, “which can be fulfilled only by the provision of adequate health and social measures” (WHO, 1978). Thus, it established that primary health care is key to meet the goal of all peoples of the world having a high standard of health by 2000.

The 1988 Federal Constitution, complying with the deliberations of the VIII National Health Conference, created the Unified Health System (SUS)<sup>9</sup>, recognizing health as a social right to be guaranteed by the State. The social movement for a sanitary reform in Brazil, initiated in the second half of the 1970's<sup>10</sup>, influenced the inclusion of a universal system that ensured health as a social right<sup>11</sup>. According to the Federal Constitution:

Art. 196. Health is a right of all and a duty of the State and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illnesses and other hazards and at the universal and equal access to actions and services for its promotion, protection and recovery (BRASIL, 1988a).

The constitutional health-related precepts adopt a broad and inter-sectoral concept of health which is not limited to treating diseases, in the same way as it is established in the preamble of WHO's constitution. The Brazilian constitution establishes health as a State policy. Similarly, the recognition of health as a right, and the provision of universal access to health in the constitution, reflect the principles incorporated into the Alma-Ata Declaration and go beyond, when it states that it is the duty of the State to ensure the right to health.

In the World Health Assembly (WHA), held in 1988, the Minister of Health, Luiz Carlos Borges da Silveira, gave a speech highlighting the definition of the basic principles to re-structure Brazil's public health system, achieved after broad consultations with various sectors of society, which include the importance of society's control and the participation of states and municipalities in the development of the new system (BRASIL, 1988b). In the following year, Minister Seigo Tsuzuki pointed out, during the 42nd WHA, the broad process and discussion that preceded the proclamation of the 1988 Constitution, which for the first time, dedicated an exclusive section<sup>12</sup> to health (BRASIL, 1989). SUS's decentralized model, with a division of competencies among federal, state and municipal governments, was highlighted by Minister Jamil Haddad, in 1993, as a model of organization that "meets the needs of equity, preserves administrative autonomy, and strengthens control by society" (BRASIL, 1993).

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<sup>9</sup> Held in Brasília, between March 17 and 21, 1986, the VIII National Health Conference is viewed as a landmark for the proposal of the institutional framework of SUS, which would become the basis of the discussions in the National Constituent Assembly (CONASS, 2011).

<sup>10</sup> This historical context also encompasses the creation of the Brazilian Center for Health Studies (Cebes), in 1976, and the Brazilian Association for Graduate Studies in Collective Health (Abrasco), in 1979 (PAIVA and TEIXEIRA, 2014).

<sup>11</sup> According to Art. 6 of the 1988 Federal Constitution, "education, health, work, leisure, security, social security, protection of motherhood and childhood, and assistance to the destitute, are social rights, as set forth by this Constitution" (BRASIL, 1988a).

<sup>12</sup> Chapter II, Section II of the Federal Constitution (BRASIL, 1988a).

Therefore, SUS was structured based on concepts and principles that aim at promoting the effective democratization of health. As a consequence of this structure, today Brazil has the world's largest universal health system with free access to health, ensuring universal health coverage as a social right for all<sup>13</sup> in the Brazilian territory (BRASIL, 2013a). According to data from the Ministry of Health, approximately 150 million Brazilians depend exclusively on SUS today, which is equivalent to over 70% of the national population (BRASIL, 2018a).

The Magna Carta establishes, as some of the principles that govern Brazil's international relations, the "prevalence of human rights" and "co- operation among peoples for the progress of mankind"<sup>14</sup>. Until the beginning of the 1990's, however, Brazil's international performance in the social arena was restricted, due to the limited space dedicated to those themes on the work agenda of the Ministry of Foreign Affairs and to the "novelty of the international approach to issues which had been previously seen as exclusive of the internal affairs of each country" (RUBARTH, 1999, p.153).

In the beginning of the 1990's, as tensions in the post-bipolar scenario began to ease and debates about the role of the State in the provision of development advanced, social topics started to draw renewed international attention, as they were understood as being an intrinsic component of countries' national strategies for development, with a growing plurality of players, issues, and specialized forums. The progressive changes in the concept of development, recognizing the economic, social and environmental dimensions of sustainable development<sup>15</sup>, contributed to update the view that social advances would be a natural consequence of economic progress. As a result, proposals were made to adopt policies integrating the three dimensions. The so-called "decade of conferences" was marked by an increasing dissemination – through multilateral meetings organized by the UN to address social agendas – of debates, declarations and action programs that would make references, directly or indirectly, to health<sup>16</sup>.

<sup>13</sup> Besides the provisions of the Constitution, the New Migration Law (Law 13,445, dated May 24, 2017) ensured "access to public health services (...) of migrants, under the terms of the law, without discrimination due to nationality or migratory condition" (article 4, item VIII).

<sup>14</sup> Article 4, items II and IX (BRASIL, 1988a).

<sup>15</sup> The "Our Common Future" report (also known as the "Brundtland Report"), published in 1987, dealt with the relationship between economic development and environmental issues, and defined the concept of sustainable development as one that meets the needs of current generations, without compromising the capability of future generations to meet their needs. In this new concept, the eradication of poverty is viewed as a critical condition to construct sustainable ecologic development. The United Nations Conference on the Environment and Development (Rio de Janeiro, 1992), confirmed the understanding of sustainable development as a combination of three dimensions: economic, social and environmental.

<sup>16</sup> As part of this landmark of "the decade of conferences", the following are included: The World Summit for Children (New York, 1990), the United Nations Conference on the Environment and Development (Rio de Janeiro, 1992), the World Conference on Human Rights (Vienna, 1993), the International Conference on Population and Development (Cairo, 1994), the World Summit for Social Development (Copenhagen, 1995), The World Conference on Women (Beijing, 1995), and the United Nations Conference on Human Settlements (Istanbul, 1996). In 2001, the World Conference against Racism, Racial Discrimination, Xenophobia, and Related Intolerance was also held in Durban.

The 1988 Constitution and the adoption of new stances by Brazil in relation to the international regime of human rights influenced the reformulation of the Brazilian approach to multilateral social themes in the federal sphere of public administration. Parallel to the multilateral conferences held in the 1990's, and to demonstrate the beginning of transformations in the approach to multilateral social topics in the country, institutional and administrative reforms were made within the Brazilian government to incorporate measures to address social themes in the federal public administration. Among these innovations, we highlight the creation, in 1995, of the Department of Human Rights and Social Issues, subordinated to the Ministry of Foreign Affairs<sup>17</sup>, and the re-creation, in 1998, of a unit responsible for international issues in the Ministry of Health<sup>18</sup>, now called International Health Affairs Office (AISA). The institutionalization of a unit to permanently follow international issues in the Ministry of Health allowed not only for better coherence in the international performance of Brazil in this area, but also strengthened a cooperative dialog with the Ministry of Foreign Affairs, with the presence of career diplomats heading the international affairs office<sup>19</sup>.

With greater intensity from the beginning of the 2000's, a plurality of governmental and non-governmental agencies with an interface with the health sector was created or had their scopes expanded. The role of WHO as "directive and coordinating authority of international works in the domain of health", as provided in its constitution, has been tested through the growing participation of institutions, groups, mechanisms, and coalitions, with diverse objectives and interests, adding a challenge to the coordination, effectiveness, and sustainability of the activities developed<sup>20</sup>.

Over the last three decades, Brazil has increased its participation in WHO's agencies and deliberations through the presentation of proposals and development of activities. In the World Health Assembly<sup>21</sup> (WHA) – WHO's decision-making arena in

<sup>17</sup> Created by Decree 1756, dated December 22, 1995 (CASTRO, 2009).

<sup>18</sup> In the Ministry of Health, the Coordination for International Health Issues (CAIS) was created on Dec. 12, 1977 and closed on Mar. 21, 1990, during the administrative reform conducted in March 1990, in the period of the presidency of Fernando Collor de Mello, when other agencies, such as international advisories were dissolved. Due to the need to give continuity to international matters, CAIS was substituted, in the Ministry of Health, by an informal Special Advisory, connected to the Ministry's Cabinet. On May 3, 1991, the General Coordination for Special Health Matters (CAESA) was created and then replaced, on July 15, 1993, by the Special Health Advisory Division (AESA). On January 28, 1998, AESA was replaced by the International Health Affairs Office (AISA), a title that identifies, until today, the unit of the Minister's cabinet that addresses the international themes of interest to health. In this respect, please see the articles "Brief history of the International Health Affairs Office of the Ministry of Health", written by Igino Rodrigues Barbosa Filho, and "The International Health Affairs Office of the Ministry of Health (AISA): the history towards multilateral activity", authored by Indiara Meira Gonçalves.

<sup>19</sup> The international area of the Ministry of Health was headed by diplomats from March 1995 to April 2012. In June 2016, the unit was again led by career diplomats.

<sup>20</sup> In relation to this, please see the article "The International Health Affairs Office of the Ministry of Health: its affairs and challenges", by Fabio Rocha Frederico.

<sup>21</sup> Among WHA's competencies are: to promote research, approve guidelines and regulations, make recommendations to Member States, and determine the Organization's policies. WHA's ordinary sessions are held annually (as provided in art. 13 of the Constitution of the World Health Organization), in the month of May.

which all members of the organization have a seat –, Brazil has consistently advocated themes that are important to the national health agenda. Despite the sequence of governments and Ministry of Health's managers, it is possible to verify a predominance of coherence and continuity, to the detriment of well-defined ruptures, in the content of some macro-themes related to Brazil's participation in WHA over the last three decades, such as issues related to universal health coverage and access to medicines.

This article seeks to identify patterns of continuity in Brazil's international health performance since the creation of SUS and to correlate them with the broad lines of the discourse adopted by the country in international forums, particularly in WHA. As examples, brief case studies on the international insertion of health issues in the Brazilian foreign affairs agenda are also presented.

This paper is divided into two parts, besides the introduction and conclusion. First, we briefly discuss some theoretical-conceptual aspects related to patterns of continuity in Brazilian foreign policies and the inter-relationship between the Ministry of Foreign Affairs and other governmental agencies for the development of foreign policy positions. In the second part, we present, from a historical perspective, the main elements of the Brazilian participation in WHA since the creation of SUS, including case studies on its national performance relative to HIV/AIDS treatment and access to medicines, tobacco control, and the installation of human milk banks, three iconic and pioneering initiatives of Brazil's international participation in health-related matters. As we examine Brazil's statements in health-related matters over the last three decades, we try to correlate them to factors which have, somehow, influenced the most-adopted international positions of Brazil. As a common line, we identify principles, such as universality, transversal approach to health, and the importance of cooperation for development.

By approximating Brazil's foreign policies in the area of health to the interests and needs of its society, the international performance of the Ministry of Health has contributed, over the last three decades, to materialize the public dimension of the national foreign policy, a practical evidence of the Brazilian concept of “public diplomacy”.

## **2 Foreign policy as public policy**

The construction of a substantial and lasting foreign policy is related to the existence of an accumulated history and of international participation principles which are enduring over time. The recurrent academic debate about the elements of continuity and rupture in the history of Brazilian foreign policy has led to an evaluation of its nature as a “State policy” or “Government policy”. The former would be “relatively immune to changes and interferences from governmental agendas”, “associated to alleged national

interests that are self-evident and/or permanent, protected by circumstantial dictates of political-partisan nature” (MILANI and PINHEIRO, 2013), while the latter would be its opposite, that is, it would represent the direct interference of the government’s political interests over the priorities, directions, and general guidelines of the national foreign policy.

The establishment of guidelines for the conduction of Brazil’s foreign policy is, by constitutional force, an attribution of the President of the Republic. The 1988 Federal Constitution determines, in Art. 84, that it is the prerogative of the President of the Republic to “maintain relations with foreign States and to accredit their diplomatic representatives” (item VII), and “conclude international conventions, treaties and acts, *ad referendum* of the National Congress” (item VIII). All the previous republican constitutions had similar texts<sup>22</sup>. The apparent contradiction or coincidence between the conduction of foreign affairs by the President of the Republic translates into periodic alternation of power and the permanence of continuity on the Brazilian foreign policy agenda over the last century, especially from the Rio Branco Chancellery (1902-1912), and have motivated academic discussions in the area of the analysis of Brazil’s international relations.

According to Celso Lafer (2000), the explanation for the continuity patterns in the international participation of Brazil would be related to historical, geopolitical, and socio-cultural factors. The continental dimension of the country and its position in South America, the use of a single language, the absence of significant international tensions since its independence, and the challenge to seek development as the traditional vector of national foreign policy would have contributed, according to the author, to construct a Brazilian international identity that would be reflected in the country’s foreign activities. The traditional guidelines for national foreign policy, characterized by Amado Cervo (2008) as the “accumulated history” of the Brazilian foreign policy, were embodied in article 4 of the 1988 Federal Constitution, which provides the principles that guide Brazil’s international relations<sup>23</sup>.

<sup>22</sup> The 1891 Constitution established as private competency of the President of the Republic to “maintain relations with foreign States” and “engage in international negotiations, sign agreements, conventions and treaties, *ad referendum* of the Congress(...)” (Art. 48, §14 and 16). Concurrently, the 1824 Constitution also assigned these corresponding competencies to the Emperor. In the 1934, 1937, 1946, and 1967 Constitution and the Constitutional Amendment 1, 1969, the items regarding the private competencies of the President of the Republic are all practically identical, including the topics “maintain relations with foreign States” and “conclude international treaties and conventions *ad referendum* of the National Congress”.

<sup>23</sup> “Art. 4. The international relations of the Federative Republic of Brazil are governed by the following principles: I – national independence; II – prevalence of human rights; III – self-determination of the peoples; IV – non-intervention; V – equality among the states; VI – defense of peace; VII – peaceful settlement of conflicts; VIII – repudiation of terrorism and racism; IX – cooperation among peoples for the progress of mankind; X – granting of political asylum. Sole Paragraph. The Federative Republic of Brazil shall seek the economic, political, social and

One area that shows the patterns of continuity of the Brazilian diplomacy is the multilateral sphere. Iconic speeches in international arenas, such as “the speech of the three Ds”, by Chancellor Araújo Castro at the UN, in 1963, represent an authentically Brazilian perspective on international relations. Even though the current domestic and international circumstances are quite distinct from those in the early 1960’s, the actuality of this intervention is based on principles such as autonomy, universalism, and the strengthening of multilateralism, as strategies to seek solutions for key issues, both for the country and for the world. As advocated by Celso Lafer (2000, p.229, our translation), “given the interaction of shifting alliances forged in a world of undefined polarities, the multilateral forums constitute, for Brazil, the best arenas for the country to exercise its competency in the defense of national interests.”

Topics previously restricted to the domestic sphere of States have been increasingly addressed in international forums, ensuing an approximation between what is discussed in the multilateral arena and what effectively impacts the life of the ordinary citizen. Similarly, domestic political debates in democratic societies have also started to influence, more pronouncedly, the international performance of these States. Concurrently, it is possible to verify, in the governmental arena, a bigger opening to the participation of other organizations besides chancelleries in the conduction of the nation’s foreign policy.

In Brazil, beginning in the 1970’s and gaining momentum in the following decades, the movement to incorporate the topic of foreign policy in other governmental organizations and the transfer of diplomats to other agencies outside the Ministry of Foreign Affairs, led to the questioning, according to Milani and Pinheiro (2013), of the “relative autonomy and bureaucratic insulation of Itamaraty in the process of formulation and conduction of foreign affairs.” In the 1980’s, the Brazilian re-democratization process permitted overcoming the military stances which, during the military regime, had reduced the capability of Brazil’s international performance in matters such as the environment, peace and security, human rights, and nuclear non-proliferation. Since then, changes in the domestic scenario have allowed the country to act with more conviction and credibility in the multilateral scene and, similarly, encouraged a greater approximation between the topics of foreign affairs and domestic issues.

In the foreign scenario, from early 1990’s, the new realities in the post-Cold War order also contributed to further the engagement of Brazil in multilateral forums, rescuing the traditional principles and guidelines of its foreign affairs. This domestic movement was also driven by the renewed dynamics of the Brazilian foreign policy

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cultural integration of the peoples of Latin America, viewing the formation of a Latin-American community of nations”.

after re-democratization, in a context described by Ambassador Gelson Fonseca Jr. as a “renovation of credentials”, marked by the positive participation of the country in the international system, especially in normative multilateralism:

[...] the heritage of a positive participation, always based on the criteria of legitimacy, opens the door to a series of attitudes which have given a new profile to the Brazilian diplomatic work. Autonomy today no longer means “distance” of polemic issues to protect the country against undesirable alignments. On the contrary, autonomy is translated into “participation”, driven by a desire to influence the open agenda with values that express the diplomatic tradition, and the ability to see the directions of the international order with one’s own eyes, from original perspectives. Perspectives that correspond to our national complexity (FONSECA JR., 1998, p.368, our translation).

The plurality and diversification of players and agendas in the Brazilian foreign policy, and the new configuration of its formulation process over the last three decades, have raised questions about the existing relationship, not only between domestic policy and foreign policy, but also between the latter and society. For Milani and Pinheiro (2013), the expansion of the participation of public agents, outside the chancellery, in topics regarding the international agenda, with the growing qualification of the public machine and mastery of technical aspects related to the international performance, would have promoted a “politicization of foreign policy” movement, understood as “the intensification of the debate around ideas, values, and preferences on policy choices” (MILANI; PINHEIRO, 2013, p.339).

This movement is also related to changes experienced in the performance in international forums and in the activities of technical cooperation connected to other ministries and governmental institutions. From various points of view, the international participation of these institutions has grown, while also requiring an increasingly specialized presence in the corresponding international forums. The need to adapt to an environment that requires increasing technical knowledge, linked to the country’s realities and national policies, makes it imperative to promote an effective transversal intra-governmental coordination, with the purpose of providing a more coherent and legitimate international position.

Carlos Aurélio Pimenta de Faria (2012) refers to this growing process of players and agents as the “horizontalization of Brazilian foreign affairs”. Similarly, the formulation of foreign policy began to promote what Silva, Spécie and Vitale (2010, p.31) refer to as the “new institutional arrangement between the [Ministry of Foreign Affairs] and other ministries.” This movement has contributed to qualify Brazil’s technical participation in international forums and to approximate foreign policy to national society, democratizing both their access and guidelines. When this movement

occurs through a dialog with participative national policies, like the ones that will be later described in this article, foreign policy strengthens its role as public policy and, as such, should be close to the interests of the society it democratically represents.

Ernesto Otto Rubarth (1999), in his dissertation about the emergence of treating social themes on the international policy agenda after the Cold War, argues that the performance of national diplomacy in social themes may serve as a tool to be used by governments to modify internal social situations and to identify possibilities for international cooperation that can be added to their national efforts in these areas. For the author,

Foreign affairs and social policies are both public policies and, as such, naturally have convergence points that deserve to be explored in an integrated manner, so that the institutions in charge may perfect their performances and maximize the results they intend to achieve while fulfilling their attributions (RUBARTH, 1999, p. 8. Our translation).

The original formulation of the concept of “public diplomacy” refers to “the mechanisms used by an international player with the purpose of managing the international environment through engagement with an external public” (VILLANOVA, 2017, p.28). Therefore, it refers to initiatives to promote the profile of a country internationally, in an attempt to influence its foreign audience. Its effectiveness relates to the compatibility between the image that is being promoted and the national reality. The Brazilian perspective on public diplomacy, however, encompasses other dimensions. As defined by the Ministry of Foreign Affairs,

[in] Brazil, “public diplomacy” is understood, not only based on this traditional concept, but also in the sense of a bigger opening of the Ministry of Foreign Affairs and of the Brazilian foreign policies to civil society, in an effort to enhance the democratization and the transparency of national public policies (MRE, 2018. Our translation).

In his inspiring text about the Brazilian perspective on public diplomacy, Minister Antonio de Aguiar Patriota states that,

as a public policy, foreign affairs must represent, in a trustworthy manner, the interests of the Brazilian citizen for development and peace, in harmony with the global desires for a fairer and more stable world. (...). The advocacy of democracy is a common plea in our society, and a foreign policy that translates the true national objectives should be, inescapably, increasingly participative. (PATRIOTA, 2013, p. 13. Our translation).

It is, thus, possible to observe a two-way movement in the formulation and conduction of national foreign affairs. On the one hand, there is a diversification of players influencing the formulation and execution of the country's foreign policies; on the other hand, there is a demand for greater approximation of foreign affairs to domestic policies and society. It is, therefore, a two-way road, in a synergetic game. The country's international performance becomes more representative of society's real interests – which are dynamic – while, at the same time, these foreign experiences and the evolution of international debates around domestic issues also influence the elaboration of the country's public policies.

The opening of national foreign policies to the contributions of other governmental agencies, and the approximation to society and themes that directly affect them, are, therefore, paramount both for pragmatic efficiency and for democracy. In this respect, Celso Lafer and Gelson Fonseca Jr. state that:

the process of formulating diplomatic positions in the democratic stage starts to integrate the logic of the gains and costs apportioned to social groups affected by concrete diplomatic options; some of the manifestations of this process are the movements required by the public opinion agenda, which, if they create embarrassment in certain cases, in others they may mean an expansion of a range of maneuvers for the diplomat. (LAFER; FONSECA JR., 1997, p. 73. Our translation).

By inviting, voluntarily or involuntarily, the participation of new players, Brazilian foreign policies are influenced by perspectives that could, hypothetically, change the traditional patterns of the country's performance abroad. This greater inter-relationship between Brazilian foreign affairs and themes arising from day-to-day concerns of national citizens could also produce greater susceptibility to alterations in Brazil's position in international arenas, when faced with domestic and priority changes, with the potential to harm the continuity of the country's profile in international forums dealing with these issues. This fear, however, has proven unfounded up to now. Despite the increasing diversification of themes, agendas, players, and modes of action, the principles that traditionally govern Brazil's participation worldwide have been preserved and reiterated. Thus, the permanence of values and common objectives on the country's and society's foreign agenda, and the effective harmony between guidelines and traditional principles observed by Brazilian foreign policies become evident, including those issues viewed as emanating from national interests.

No matter how much the day-to-day reality of themes – such as the multilateral prioritization of strategies to control tobacco, the negotiation of commercial agreements, or the advocacy of access to drugs in multilateral debates on intellectual property –, become more distant, the country's international position regarding all these issues must be guided by principles and values shared by the ordinary citizen. Foreign affairs

must, in the end, be justified as a public policy that is concerned with the aspirations of the population they represent. Translating the real impact of these positions on the life of society is the attribution of public agents engaged in international themes, and should be the foundation of the very notion of democracy and representation.

In the area of foreign policies related to health<sup>24</sup>, there is a growing integration between Brazil's international actions and the formulation of domestic public policies, which give legitimacy to the Brazilian government's performance inside and outside the country, and ensure greater correlation between national priorities and foreign performance. Brazil's declarations on health-related matters in international forums have thus replicated the consensus, the capabilities, and the general guidelines of domestic health policies, effectively expressing national public diplomacy.

### 3 Brazil and its foreign policy in health-related matters

Until the creation of SUS, in 1988, the Ministry of Health's internal activities were dedicated, primarily, to controlling endemic diseases. The National Institute of Social Welfare (INAMPS), linked to the Ministry of Social Welfare and Assistance (MPAS), was in charge of managing public medical-hospital assistance in the country. Although the leadership role in formulating health policies was the responsibility of the Ministry of Health<sup>25</sup>, MPAS received the largest share of the budget allocated to this area (FLEURY; CARVALHO, 2018). In the international scenario, until the end of the 1980's, the actions of the Ministry of Health in specialized international organizations, such as WHO and PAHO, were limited to institutional activities (e.g., participation in conferences and assemblies, or offering support to the election of candidates) (ALCÁZAR, 2005).

The promulgation of the 1988 Constitution occurred in the context of a movement from a reactive position to a more proactive performance in the country's international participation in health-related matters. Brazil began to dictate and lead the international health agenda on topics such as the response to HIV/AIDS, tobacco control, breastfeeding, and health promotion. According to Alcázar (2005), the effective incorporation of health issues into the Brazilian foreign affairs agenda resulted from the political, budgetary, and institutional strengthening of the Ministry of Health in the domestic arena, allied to a proposition of open, independent, universal and integral health policies, encompassing the economic and social determinants of health. This universal position, which resulted from that movement, informed the intrinsic nature

<sup>24</sup> Recently, in national academic publications, we have also registered the use of the terms "health diplomacy" and "global health diplomacy", in reference to the incorporation of health as a foreign policy tool (v. BUSS, 2018).

<sup>25</sup> Law 1,920, dated July 25, 1953, establishes in art. 1: "The Ministry of Health is created, and all problems related to human health are under its responsibility" (BRASIL, 1953).

of Brazil's international performance from then on. Unlike what happened in other countries, where public health interests were, and often are, subordinate to economic-commercial priorities, "the position towards health, with its universal and integral characteristic – viewed as the conquest of a right – is the guarantee of free-of-charge access to all health services [...], as well as to all medicines" (ALCÁZR, 2005, p. 9) and constitutes a real State policy.

With the implementation of SUS, health care no longer presents the assistance-based and welfare nature that characterized the previous model (MONTEIRO; VILLELA, 2009). The creation of the System was followed by the establishment of decision-making arenas open to social participation<sup>26</sup>, which have contributed, in an open, plural, and democratic way, to the elaboration, execution, and strengthening of public health policies on themes such as HIV/AIDS, tobacco and breastfeeding. Consequently, Brazil assumes a position of leadership in the international stage, presenting the domestic successes achieved in this area as a validity argument. The inclusion of health-related matters on Brazil's foreign affairs agenda results from the practical demonstrations of the national concept of public diplomacy.

Since the mid-1990's, we have registered various Brazilian cooperation initiatives towards developing countries in the area of health. In 1994, at the 47<sup>th</sup> WHA, Minister Henrique Santillo announced the organization, in Brazil, for that same year, of a meeting with the Health Ministers of Angola, Brazil, Cape Verde, Guinea-Bissau, Mozambique, Portugal, and São Tomé and Príncipe. This was an initial effort to define the priority areas for health cooperation, and was later expanded with the creation of the Community of Portuguese-Speaking Countries (CPSC), in 1996<sup>27</sup>. Regionally, we point out the creation, within Mercosur, of the Meeting of Health Ministers, in 1995, and the Work Subgroup # 11 (Health), in 1996<sup>28</sup>.

From the 1990's on, successful Brazilian experiences in the area of health have been recognized worldwide, especially the initiatives of the National Program for the Control of Sexually Transmitted Diseases and AIDS, created in 1988, the National Program for Tobacco Control, established in 1989, and the National Network of Human Milk Banks, instituted in 1998. Formulated with the support of SUS's guidelines and

<sup>26</sup> In compliance with article 198, item III, of the 1988 Federal Constitution, which establishes community participation as a guideline for the constitution of SUS (BRASIL, 1988a), Law 8.142, dated December 28, 1990, provides for community participation in SUS management, recognizing the role played by collegiate instances such as the Health Conference, Health Council, National Council of Secretaries of Health (Conass), and the National Council of Municipal Secretaries of Health (Conasems) (BRASIL, 1990a).

<sup>27</sup> In relation to this, please see the article "Health cooperation with Portuguese-speaking African countries (PALOP)", by Luciano Ávila Queiroz and Layana Costa Alves.

<sup>28</sup> The Meeting of Health Ministers of Mercosur was created by Decision 3/95 of the Common Market Council, on August 05, 1995. The Work Subgroup #11 "Health" was created through Resolution 151/96 of the Common Market Group, on December 12, 1996. Please see the article "Regional Integration to strengthen health systems: the case of Mercosur", by Wesley Lopes Kuhn and Sonia Maria Pereira Damasceno.

its universal principles, these initiatives were conceived, executed, and improved with the active participation of civil society. These successful experiences accredited the country to act as an engaged player in various international forums related, directly or indirectly, with health.

The choice of the three above-mentioned experiences, which will be discussed below, results from their importance as iconic episodes of the Brazilian international performance in multilateral and technical cooperation projects. Based on these first initiatives, conceived and expanded during the first decade after the creation of SUS, Brazil appears in the international health arena as an unquestionable leader in health-related matters. More recently, other areas have stood out as spaces for multilateral performance and international cooperation on the Brazilian foreign agenda, all stemming from the previous experience gained with these initiatives.

### 3.1 Brazil in the World Health Assembly: a new position

Between the end of the 1980's and the beginning of the 1990's, common elements in the speeches of Brazilian representatives at the World Health Assembly (WHA)<sup>29</sup> recognized the economic and social crisis faced by the country, and the nature of the new public health system in the construction of a governmental response to the challenges of materializing health as a fundamental human right. In 1989, Minister Seigo Tsuzuki criticized, at the 42nd WHA, the deterioration of the currency exchange terms, blaming them for the economic and financial crisis faced by Brazil and for the adverse effects on the health system. He argued that they were compromising the goal of achieving “Health for All by 2020”, in accordance with the Alma-Ata commitment (BRASIL, 1989). In 1991, Minister Alcení Guerra drew the attention of the 43rd WHA to the “inherent relationship” between internal social debt and external debt, an alarming problem for Latin America and the Caribbean at that time, stating that it was imperative to rethink the relationship between the integration of economic growth and social development in developing countries. In this regard, he said that “health is an enormous and urgent social debt to our peoples, and cannot be neglected in the course of negotiations on external debt” (BRASIL, 1991).

From the 1990's on, the Brazilian participation in WHA would also be influenced by its advocacy for the reduction of inequalities (RUBARTH, 1999). Similarly, the universalism of the national public health system would also provide elements for an increasingly active international participation. Since then, the theme of reducing inequalities in the access to health has been a constant component of the Brazilian

<sup>29</sup> The World Health Assembly is WHO's decision-making body and represents the plurality of its 194 member states. All of UN's 193 member states are also members of WHO, except for Liechtenstein, Niue, and the Cook Islands.

position in international forums dealing with this issue, especially at WHO. As Minister Gilberto Occhi synthesized during the 71st WHA, in 2018, “there is no universal health without the adoption of policies directed at overcoming gender, ethnic-racial, economic, regional, and social inequalities in the access to health” (BRASIL, 2018c).

In his speech at the 43rd WHA, the executive secretary of the Ministry of Health, Luis Romero Farias, talked about the importance of promoting access of all to health, without socio-economic, geographic, or cultural distinction (BRASIL, 1990b). A similar perspective was presented in Minister José Carlos Seixas’s speech, during the 48th WHA, in 1995. In his words, “the main idea involved in the promotion of equity and health solidarity [...] is not only the fight against inequality, but [also] an attempt to end unacceptable injustices still existing in many societies” (BRASIL, 1995).

During the 50<sup>th</sup> WHA, in 1977, Minister Carlos Albuquerque stated that it was necessary to review the “abusive usage of technological resources, in order to allow the expansion of their social function, promoting equity [...] [and] contributing for the reduction of inequalities” (BRASIL, 1997). In 1998, during the 51<sup>st</sup> WHA, Minister José Serra drew special attention to women’s health as part of the commitment to end discrimination in the access to health and also to recognize “the essential role of women in the promotion of sustainable development” (BRASIL, 1998). In the following year, Minister Serra reiterated “the importance of gender issues in the development process and their close connection to health” (BRASIL, 1999).

The Brazilian declarations in multilateral health forums started to incorporate, in the mid-1990’s, elements that gave coherence to the traditional positions defended by Brazil in the international stage. The principles that began to guide the positions adopted by Brazil in health- related matters were greatly reflected in the evolution of national public policies after the creation of SUS.

### 3.2 The response to AIDS and access to medicines

The beginning of Brazil’s outstanding international performance in the area of health relates to the response to AIDS, an important banner of public health policy in the country during the 1990’s<sup>30</sup>. The AIDS epidemic was firstly identified in Brazil in 1982. By the end of the 1980’s, civil society mobilization had contributed to expand their participation in and control of public policies, through instances such as the National Health Council<sup>31</sup> and the National Commission on STIs, HIV/AIDS and Viral

<sup>30</sup> Please see the article “International technical and humanitarian cooperation and the Brazilian role in the regional and global response to HIV”, by Mauro Teixeira de Figueiredo.

<sup>31</sup> Instituted in 1937 as an advisory agency of the Ministry of Health, it began to assume, in 1990, a deliberative nature, integrating the basic structure of the Ministry of Health (Decree 99,438, dated Aug. 07, 1990).

Hepatitis (CNAIDS)<sup>32</sup>, whose purpose was to strengthen the government's response to the epidemic.

One of the main dimensions of the Brazilian AIDS program is the universal and free-of-charge distribution of antiretroviral drugs by the public health network, subsidized by the Ministry of Health. In 1988, the Ministry of Health started distributing these drugs through the public system to treat opportunistic infections in AIDS patients. In 1991, antiretroviral therapy was also dispensed through the public network (BRASIL, 1999). Law 9,313, dated November 13, 1996, established the free distribution of all the needed medication to treat people living with HIV/AIDS in the country (BRASIL, 1996). As a result, in 1997, the Ministry of Health's expenses with antiretroviral drugs increased seven-fold when compared to the previous year (BRASIL, 1999). Concurrently, a logistics network to distribute the medicines promoted the qualification of human resources in diagnosis and assistance, strengthened the public laboratories, and defined, with the support of advisory committees, treatment criteria and recommendations (GALVÃO, 2002).

This expansion of treatment in Brazil promoted a reduction of AIDS-related deaths, a decline in the costs with hospitalizations, the improvement of patients' quality of life, the continuity of productivity of people living with HIV, and a reduction in the dissemination of the disease (CARDOSO, 1998; BRASIL, 2001; BRASIL, 2002b). Minister José Serra stated, during the 52nd WHA, in 1999, that the provision of free medicines to all people living with HIV/AIDS was a priority of public health management in Brazil (BRASIL, 1999). In 1988, the First-lady and president of the Solidarity Community Program<sup>33</sup>, Ruth Cardoso, gave a speech in the opening ceremony of the 12th World AIDS Conference, in Geneva. On that occasion, she said that she believed that

the most distinct aspect of Brazil's mobilization against AIDS has been the dynamic interaction between community-based initiatives and policies. (...) As a result, Brazil has recognized the value of working together with civil society. (...) [The] National Program to Fight AIDS is based on the concepts of openness, decentralization, multi-sectoral partnerships, and innovative initiatives directed at communities (CARDOSO, 1998, p.3-4. Our translation).

<sup>32</sup> Instituted in 1986, CNAIDS's purpose is to "provide advisory services to the Ministry of Health in the definition of technical-operational mechanisms to control AIDS, coordinate the production of technical and scientific documents, and aid the Ministry of Health in the evaluation of the performance of the various components of the actions to control AIDS" (BRASIL, 2018b).

<sup>33</sup> Created by Decree 1,366, dated January 12, 1995, with the purpose of "coordinating governmental activities directed at assisting population groups who do not have the means to provide for their basic needs and, in special, fighting hunger and poverty."

The Brazilian program for the free distribution of antiretroviral drugs was considered a model by WHO and was recognized as the most advanced and far-reaching program in the developing world (BRASIL, 2001). At WHO and other multilateral forums, in compliance with the principles that govern the National HIV/AIDS Program, as well as with the country's position in other United Nations forums, Brazil began to advocate the recognition of the universal right to medicines at fair and reasonable prices as a component of the human right to health (BRASIL, 2003c).

The Brazilian criticism of the high drug prices had already been expressed by Minister Adib Jatene in his speech at the 45th WHA, in 1992, when he stated that it was necessary to “adjust the prices of medication to the economic realities of developing countries, especially in cases where these products are being used in governmental programs for low-income populations”, striving to strengthen “ethics among nations” and justice (BRASIL, 1992). In 1995, Minister José Carlos Seixas reported, at the 48th WHA, that “the medical practice had become a mere business”, claiming that drug prices were being determined according to the interests of pharmaceutical companies which did not take into account the purchasing power of the population, contributing to expand social exclusion (BRASIL, 1995). As a tool to create political will and to ensure that prices were compatible with the economic realities of developing countries, Minister Seixas proposed the creation of a fund established through taxations of international financial operations. The idea, however, did not prosper at that time. Eleven years later, in 2006, UNITAID, subordinated to WHO, was created as a result of a proposal presented jointly by Brazil, Chile, France, Norway, and the United Kingdom. It is an innovative funding mechanism, conceived to promote drug, diagnosis, and prevention inputs procurement for HIV/AIDS, malaria and tuberculosis in developing countries with high concentrations of these diseases.

In the 2001 WHA, Minister José Serra pointed out the importance of free-of-charge distribution of medicines to people living with AIDS as a policy guaranteed by Brazil's legislation. He also discussed the need for inter-sectoral articulation, involving other international organizations, to deal with this issue, in order to ensure access to treatment and reduce costs and drug prices in developing countries (BRASIL, 2001). During the Special Session of the United Nations General Assembly on HIV/AIDS, held in 2001, the understanding that the fight against the global pandemic required global actions in the areas of prevention, assistance, treatment and human rights, prevailed. (BRASIL, 2002b).

The domestic production of generic antiretroviral drugs has also been encouraged as a strategy to reduce costs. The Brazilian law on intellectual property<sup>34</sup> provides, in art. 68, for the possibility of compulsory licensing of patents due to abusive practices

<sup>34</sup> Law 9,279, dated May 14, 1996.

of economic power. In the beginning of the 2000's, the restrictions imposed by the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) to the development of a universalist position in health – as it allowed pharmaceutical processes and products to be patented<sup>35</sup> –, and these company's adoption of pharmaceutical practices that limit the capability to access drugs, especially in developing countries, led Brazil to defend a balance between respect to the commitments made with the World Trade Organization (WTO) and the legitimate concerns in encouraging and reinforcing access to essential medicines<sup>36</sup>. This position was reflected in multilateral forums such as UNGA<sup>37</sup>, the extinct UN Human Rights Commission and its successor, the UN Council on Human Rights<sup>38</sup>, UNSC<sup>39</sup>, WTO<sup>40</sup> and, naturally, WHO.

At WTO, based on the proposal submitted by the African group, Brazil led the negotiation process which would conclude with the approval, in 2001, of the Doha Declaration on TRIPS and Public Health, stating that TRIPS “can and should be interpreted and implemented in a manner supportive of WTO members’ rights to protect public health, and, in particular, to promote access to medication for all” (WHO, 2001). This allowed for the maintenance of generic drugs production programs such as the Brazilian one, which provides for the possibility of compulsory licensing. Brazil's performance in the advocacy of ample access to medicines culminated with the preponderance of the national thesis that public health interests may trump commercial issues (BRASIL, 2002b).

At WHO, in 2003, the approval, by consensus, of the resolution “Intellectual Property Rights, Innovation and Public Health”<sup>41</sup>, proposed by Brazil, received the support of several developing countries and led to the establishment, in that same year, of the Commission on Intellectual Property Rights, Innovation, and Public Health (BERMUDEZ; OLIVEIRA, 2004). Thus, it was recognized that, although intellectual

<sup>35</sup> In compliance with article 27 of TRIPS.

<sup>36</sup> In 2001, the high prices charged by foreign pharmaceutical laboratories for medication used in AIDS treatment, led the Ministry of Health to mention the possibility of resorting to compulsory licensing in order to guarantee price reductions; this ensued the request, by the United States, to open a panel against Brazil at WTO, which led to the renegotiation and reduction of the prices charged by the companies. The USA argued that Art. 68 of the Brazilian law on intellectual property rights would violate WTO's TRIPS Agreement. A few months later, the USA withdrew its complaint from WTO. Please see the article “The international action of the Ministry of Health in the issue of access to medicines”, by Roberta Vargas de Moraes.

<sup>37</sup> Resolution A/RES/58/179, 2003.

<sup>38</sup> Resolution E/CN.4/RES/2001/33, 2001; Resolution E/CN.4/RES/2002/31, 2002. The latter established the mandate of the Special Rapporteur on the Right of All to Enjoy the Highest Attainable Standards of Physical and Mental Health, with the substitution of the Human Rights Commission for the UN Human Rights Council. In 2006, the mandate was endorsed and successively extended by the Human Rights Council. In 2016, Resolution A/HRC/RES/33/9 extended the rapporteur's mandate for an additional period of three years.

<sup>39</sup> Resolution S/RES/1308, 2000.

<sup>40</sup> Declaration WT/MIN(01)/DEC/2, 2001.

<sup>41</sup> Resolution WHA56.27, 2003 (WHO, 2003a).

property rights are relevant for innovations in public health matters and for access to medication, these are not the only important factors.

The same position was observed in the Brazilian declarations in later governments. In 2005, during the 58th WHA, Minister Humberto Costa pointed to the intention of the Brazilian government to use all the flexibilities possible in the TRIPS Agreement and in the Doha Declaration, including compulsory licensing, if necessary, to ensure the sustainability of the Brazilian policy to guarantee universal access to antiretroviral drugs<sup>42</sup> (BRASIL, 2005). Minister Alexandre Padilha, in his speech at the 64th WHA in 2011, highlighted the importance of equal access to prevention and treatment to face the HIV/AIDS challenge (BRASIL, 2011). Similarly, in the 69<sup>th</sup> WHA, in 2016, Minister Ricardo Barros reminded everyone of the fact that Brazil had been the first developing country to offer universal antiretroviral therapy and stated that access to treatment remained a pillar of the Brazilian response to the AIDS epidemic (BRASIL, 2016). Corroborating Brazil's historical position in this area, Minister Gilberto Occhi said, in his speech during the 71<sup>st</sup> WHA in 2018, that "there is no universal health without access to medication, vaccines, technologies and healthcare services" (BRASIL, 2018c).

In relation to the fight against HIV/AIDS and the defense of access to medication, it is possible to observe that the domestic advances in this area have allowed Brazil to act as an international reference and to influence multilateral debates around the issue of ensuring the right to health. Eventual limitations imposed on WHO's performance by external interests with great capability to influence the positions of major players of the Organization have made this issue the object of constant debates. In consonance with its historical performance in this theme, both domestically and internationally, Brazil continues to be engaged in the defense of access to drugs as a priority dimension in its public health policies.

### 3.3 Tobacco Control

The national advances in the area of tobacco control have also allowed, over the last decades, for a prominent performance of Brazil in the international arena. Brazil is the second largest producer and the largest exporter of tobacco leaves in the world (WHO, 2017). Despite the political, agricultural, and industrial lobbies around this topic, the National Tobacco Control Program has been effective in its adoption of legislative, fiscal, regulatory, publicity-related, work-related, economic, agricultural, sanitary, and public awareness-raising measures which have led to the reduction in the prevalence of smoking among the Brazilian population, from 34.8%, in 1989, to

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<sup>42</sup> In 2007, the Brazilian government determined, for the first and only time, the compulsory licensing of patents related to the antiretroviral drug Efavirenz, using the flexibilities provided in the TRIPS Agreement.

10.2%, in 2016 (BRASIL, 2017; BRASIL, 2018a). The program to fight smoking has been viewed as a model by WHO (BRASIL, 2003c).

The efforts to control tobacco use in Brazil started in the 1960's and advanced over the following decades with State actions to restrict and respond to smoking, culminating, in 1986, with the creation of the National Program to Fight Smoking, whose management was shared with INAMPS and the Ministry of Health (PORTES et al., 2018b). In 1989, The National Tobacco Control Program was created, coordinated by the National Cancer Institute (INCA) and linked to the Ministry of Health.

Since 1995, when discussions about the adoption of an international tool to control tobacco within WHO started<sup>43</sup>, Brazil has been actively engaged in this matter and has conducted its own negotiation process (BRASIL, 2003b). In 2000, during the 53rd WHA, Minister José Serra stated that Brazil would have a “pioneering role in the process to elaborate a future convention on tobacco control and its protocols” (BRASIL, 2000b). As reported by PORTES et al (2018b),

Brazil had a central role from the very beginning of the [Framework Convention on Tobacco Control (FCTC)]'s negotiations (1999-2003). Since Brazil was a tobacco-leaf producing country and already had a robust tobacco control program, it was nominated as vice-president of the work group, open to WHO's member states. Besides presiding FCTC's Inter-Governmental Negotiation Agency, Brazil led the work group, which organized the first Conference of the Parties, a structure formed by all interested parties of the treaty and which guides the work of the Secretariat and negotiates the implementation terms of the treaty in bi-annual meetings. The country maintained its international leadership role on tobacco control over the following years, and one of the highlights was the nomination of a Brazilian woman to preside FCTC's Secretariat in 2014 (PORTES et al, 2018b, p.1838. Our translation).

The conclusions of the National Commission for the Control of Tobacco Use (CNCT), an inter-ministerial agency presided by the Minister of Health<sup>44</sup>, provided the guidelines for the Brazilian delegation's performance during the negotiation of the treaty (BRASIL, 2000a). FCTC, signed in 2003, was the first international treaty on public health in the history of WHO, expanding the field of operations of the Organization to the normative sphere<sup>45</sup>.

With the signature of the FCTC by the Brazilian government, in 2003, CNCT added an executive role to its advisory attributions, started implementing the treaty's

<sup>43</sup> Resolution WHA 48.11, 1995.

<sup>44</sup> CNCT was created by Decree 3/136, dated Sep. 13, 1999.

<sup>45</sup> Although article 19 of WHO's Constitution provides for the possibility of adopting “conventions or agreements with respect to any matter within the competence of the Organization” (WHO,1946), this provision had never been applied before.

obligations in the country, and changed its name to National Commission for the Implementation of the Framework Convention on Tobacco Control (CONICQ)<sup>46</sup>. CONICQ gathers representatives from various ministries, organizations, and governmental agencies, and one of its competencies is to “establish a dialog with institutions and national entities whose objectives and activities may offer relevant contributions to issues within their competency scope” (BRASIL, 2003a). In 2006, national anti-smoking inter-sectoral actions were integrated into the so-called National Tobacco Control Policy (PNCT) (PORTES et al, 2018a).

The interactions and exchange of experiences with civil society organizations, such as the Alliance for Tobacco Control, medical associations, scholars, and associations for the defense of family farmers and consumers, have been essential to strengthen concrete actions developed along with society and governmental representatives within PNCT. Therefore, a substantive dialog has been promoted, contributing to the formulation of public policies towards meeting the obligations of FCTC, as well as to construct the Brazilian position in the Conference of Parties, held every two years.

During the 56<sup>th</sup> WHA, in 2003, Minister Humberto Costa highlighted the creation of FCTC as a first step towards effective control of tobacco use, which is a moral obligation of all States (BRASIL, 2003d). Minister Alexandre Padilha pointed out, during the 65<sup>th</sup> WHA, in 2012, the importance of developing legislation and adopting fiscal and regulatory measures to control smoking (BRASIL, 2012). In 2016, Minister Ricardo Barros talked about the national legislation that prohibits smoking in public spaces, and highlighted the data showing the significant reduction in the prevalence of tobacco use in Brazil (BRASIL, 2016).

The Sustainable Development Goals include, among the objectives relative to health, the strengthening of FCTC<sup>47</sup>. The three dimensions of sustainable development have close relationship with the positions adopted by Brazil in international forums regarding the fight against smoking, being characterized by the balance of concerns regarding economic, social, and environmental issues. During FCTC’s 7<sup>th</sup> Conference of Parties, held in New Delhi in 2016, a decision project for FCTC’s articles 17 and 18, presented by Brazil and India, was approved. It refers to economically sustainable alternatives to the farming of tobacco and to the protection of the environment as well as of human health (WHO, 2003b), a theme of special interest to the Brazilian civil society organizations engaged in this area.

The importance of organized civil society’s participation to reach the objectives of FCTC is recognized in article 4, paragraph 7, of the Convention (WHO, 2003b).

<sup>46</sup> CONICQ was created by decree on Sep. 01, 2003.

<sup>47</sup> Objective 3 aims at “ensuring a healthy life and promoting well-being for everyone, of all ages,” and goal 3.a has the purpose of “strengthening the implementation of WHO’s Framework Convention on Tobacco Control in all countries, where appropriate” (BRASIL, 2015a).

Similarly, CONICQ defends a dialog and cooperation with non- governmental organizations to meet the objectives of offering informed advice to the Brazilian government<sup>48</sup>. By engaging civil society in the organization and implementation of the inter-sectoral governmental agenda, with the purpose of fulfilling the FCTC's obligations, the public policy dimension of Brazil's foreign policy is equally promoted, strengthening and giving legitimacy to the country's international activities in this area.

### 3.4 Human Milk Banks

The establishment of the human milk banks as an effective strategy to reduce infant morbidity and mortality rates<sup>49</sup> is another example of Brazil's international performance in health-related matters. The program promoted major advances internally, encouraged society's engagement and participation, and motivated the country's participation in foreign arenas. Although they began to be implemented in the 1940's, human milk banks had little relevancy until the 1980's, and were dedicated to providing assistance in emergency situations, fulfilling a commercial function. The National Breastfeeding Program, launched in 1981, was conceived to increase the rates of breastfeeding. Since 1985, there has been a significant expansion of human milk banks in Brazil, leading to the need of regulating their operations. In 1988, an ordinance issued by the Ministry of Health<sup>50</sup> provided norms for the installation and operation of human milk banks. (ALMEIDA, 1999; PITTAS and DRI, 2017).

The organization of debate forums and the sharing of experiences – such as the National Meetings of Human Milk Banks, in 1992 and 1995, and the I Brazilian Conference on Human Milk Banks, in 1998 – instituted a participative planning and management model. In 1998, the Ministry of Health, through the National Reference Center of the Oswaldo Cruz Foundation (Fiocruz), created the National Network of Human Milk Banks. This new operational logic of working with networks contributed to scaling up the activities of the human milk banks throughout the national territory (MAIA et al., 2006). Today, Brazil has the largest and most complex network of human milk banks worldwide. There are 220 human milk banks in the country and 199 collection points. In 2017, 215,000 liters of human milk were collected and distributed to almost 100,000 newborns (FIOCRUZ, 2018).

Besides preventing infant malnutrition, the milk banks are also an essential strategy to protect the health of children born to HIV-positive mothers, avoiding the vertical transmission of the virus. In 2001, during the 54th World Health Assembly,

<sup>48</sup> Decree dated Sep. 01, 2003, article 2, items VII and VIII.

<sup>49</sup> Morbidity refers to the amount of disease within a population. Mortality refers only to the cases where diseases lead to death.

<sup>50</sup> Ordinance MS 322 , dated May 26, 1988.

WHO awarded the Network with the Sasakawa Health Prize, which recognizes innovative works for the development of health. In his speech at WHA that year, Minister José Serra highlighted the success of breastfeeding to fight infant malnutrition in Brazil and the potential for its promotion globally (BRASIL, 2001). In 2002, based on a Brazilian proposal, the 55<sup>th</sup> WHA endorsed the Global Strategy for Infant and Young Child Feeding<sup>51</sup>, recognizing breastfeeding as a global public health recommendation for the first six months of life.

The success of the implementation of human milk banks, as a strategy to strengthen infant health in Brazil, brought international recognition to the country and allowed the use of this experience as an instrument for foreign policy and international cooperation. The first official contact with the Brazilian government – made by Venezuela – for the establishment of international cooperation in the implementation of human milk banks occurred in 1996 (PITTAS and DRI, 2017). In the mid-2000's, with PAHO's support, a systematic effort was made to scale up and roll out the network of human milk banks to other countries in the American continent. In 2008, the international cooperation work conducted by Brazil in this area was expanded to members of CPLC, an initiative that culminated with the approval, in 2017, of the establishment of the Community Network of Human Milk Banks (BRASIL, 2017). Through this initiative, coordinated by the Brazilian Cooperation Agency, in partnership with the Ministry of Health and Fiocruz, Brazil has provided technical support to implement human milk banks in 19 American countries, 3 African nations and one European country. (ALMEIDA et al., 2017; FIOCRUZ, 2018).



Over the last three decades, Brazilian public policies in the health sector have incorporated SUS's concept of universality as a guide for their development, implementation, and improvement, and have included mechanisms to foster civil society's participation and control, providing greater transparency and administrative accountability. In this period, Brazil's international performance in health-related matters has been directly influenced by its domestic capabilities and experiences, observing the same principles of universality and equality that characterize the right to health in the country. By reflecting the national view on health as a human right and social right<sup>52</sup>, Brazilian foreign policies ensure greater legitimacy to its position and greater efficacy of its international actions, which allows for the reinforcement and

<sup>51</sup> Resolution WHA 55.25, 2002.

<sup>52</sup> Although they are often used interchangeably and present significant inter-relationship, the terms "human rights" and "social rights" differ, from a legal point of view. Human rights refer, in this distinction, to those recognized as universal within public international laws. Social rights (or fundamental rights), on the other hand, are those that

dissemination, in the international community, of principles deeply cherished by Brazil and its society.

#### **4 Final considerations: health, foreign policy and society**

The domestic support for Brazil's foreign performance has given the country the necessary credibility to transform internal potentialities into assets for foreign affairs. Consequently, Brazilian foreign policy positions, and the very capability of the country's agency in international arenas, are strengthened. Similarly, this foreign performance also enhances national policies as it confirms the national perspectives on the global challenges of public health.

The pillar for the validity of a country's public policy resides in its capacity to translate the needs and aspirations of society into concrete and effective governmental actions. As public policy, foreign affairs must express the values of the society they represent. Brazil, a country with a pacifist tradition, which views the promotion of development as the main vector of its foreign performance, participates in world arenas as a player engaged with the promotion of peace, equality, cooperation, and human rights values<sup>53</sup>.

In the area of health, Brazilian international performance in the last three decades has demonstrated a convergence between domestic priorities and actions, and the country's foreign policies. In consonance with the constitutional determination of a universal model for public health, the defense of universal access to health, as a social right and the duty of the State, has been a recurrent topic in the Brazilian position in international forums. Similarly, Brazil's international cooperation activities in health-related matters have contributed to fortify the health systems of developing countries, showing sensitivity to local priorities and complying with the constitutional principle of cooperation with peoples for the progress of mankind<sup>54</sup>.

The above-mentioned examples of Brazil's performance in relation to the development of policies for HIV/AIDS, tobacco control, and human milk banks, represent successful practices in the use of public diplomacy as groundwork for the country's foreign policy position. As a two-way road, national public policies in the area of health are equally invigorated as they enshrine principles, values and policies defended by Brazil in the international arena.

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are included in the Constitution of a State and represent the ethical and normative basis of the national judicial system (COMPARATO, 2007; SARLET, 2006).

<sup>53</sup> In compliance with article 4 of the 1988 Federal Constitution, which defines the principles that govern Brazil's international relations (BRASIL, 1988a).

<sup>54</sup> According to article 4, item IX of the 1988 Federal Constitution (BRASIL, 1988a).

This connection between domestic health policies and Brazil's international positions has led, in recent years, to the expansion of the scope of its activities. During the celebration of the 40th anniversary of the Buenos Aires Action Plan (UN, 1978), a document that establishes a comprehensive conceptual and operational framework for the promotion of the South-South cooperation, the Ministry of Health greatly contributed to strengthen the construction of capabilities, encourage a joint response to public health challenges, and promote development in the world. In topics related to food and nutritional security, for example, Brazil has led the engagement of American countries within the scope of the United Nations Decade of Action on Nutrition (2016-2025), while simultaneously building, internally, one of the most advanced policies for food and nutrition. On another front, the Ministry of health launched, in 2017, the National Plan to End Tuberculosis as a Public Health Problem, elaborated with the participation of state and municipal managers, scholars, and civil society, and based on the recommendations of WHO's Strategy to End Tuberculosis. In that same year, BRICS's Tuberculosis Research Network was established. The Brazilian experience in fighting cancer, sickle cell disease, and malaria have also informed the scaling up of international cooperation projects conducted by Brazil, especially benefitting Latin-American and Caribbean counties as well as Portuguese-Speaking African Countries, in a broad framework of capability construction and strengthening of local health systems. These examples corroborate the perspective that the inter-relationship between domestic capabilities and foreign action in health-related matters, whether in multilateral forums, whether through cooperation actions, is beneficial both to enhance Brazil's international profile and to consolidate national policies.

In 2018, when the 70<sup>th</sup> anniversary of the World Health Organization, the 40<sup>th</sup> anniversary of the Alma-Ata Declaration, and the 30<sup>th</sup> anniversary of SUS were celebrated, it is symbolic that WHO chose universal health coverage as the theme for the World Health Day, celebrated on April 7. The human right to health, constitutionally guaranteed in Brazil, substantiates the position of national foreign policy, which becomes more legitimate, efficient, and democratic as it incorporate these values.

Rescuing the words of Chancellor San Tiago Dantas,

[we] know, by virtue of our democratic convictions, that democracy is a regime that is only established effectively, enduringly, and validly, when it arises from the population's feelings and aspirations; when it is not the result of external influences, but the product of an internal evolution rooted in the maturity of the people's will (DANTAS, Francisco Clementino de San Tiago apud FRANCO, 2007, p.161. Our translation).

Brazil's foreign policy in health-related matters benefits from the experience and technical competency of the Ministry of Health and SUS (including other spheres of the

federation and participative arenas) in the elaboration and implementation of effective, democratic, and participative public policies.

Over the twenty years of its existence, AISA has also contributed, acting as liaison between, on the one hand, the position and the reality of Brazil's public policies and, on the other hand, the elaboration of foreign health policies that take into account the real national interests. In the future, it should continue to advance in its mission to prospect areas and policies of excellence that can guide the country's international actions, and to capitalize on the exchange of experiences, perspectives and international debates towards perfecting domestic policies and improving the life and health of the Brazilian society. Thus, public diplomacy and national health policies complement each other directly, strengthening the Brazilian position as a nation engaged with health and development, inside and outside the country.

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<sup>56</sup> All the speeches from the plenary sessions of the World Health Assembly mentioned in this paper are available at: <<http://portalmhs.saude.gov.br/noticias/aisa/42660-discursos-do-brasil-na-assembleia-mundial-da-saude>>. Accessed on: 10 Jul. 2018.

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# **INTERNATIONAL COOPERATION IN HEALTH**



# International technical and humanitarian cooperation and the Brazilian role in the regional and global response to HIV\*

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## Abstract

Brazil has advanced in its response to HIV, particularly in relation to the offer of universal and free-of-charge treatment to infected people, and to the government's work in partnership with civil society and people living with HIV. This has translated into Brazil assuming a leading international role, rarely conferred to the country, in forums and international arenas related to the epidemic. The country has acted, in various opportunities, as a key player in the definition of policies, strategies and goals, agreed upon and implemented both regionally and globally.

In this context, technical and humanitarian cooperation has fulfilled a fundamental role. The international recognition of the Brazilian success, ensued – from the 1990's on – a growing demand for technical and humanitarian support, resulting in a broad international agenda, implemented through formal projects as well as specific activities, which in turn have enhanced Brazil's international profile, effectively allowing it to influence the directions of regional and global policies to face the epidemic.

Key words: access to ARV drugs; social participation; human rights; international technical and humanitarian cooperation on HIV/AIDS; Brazilian leading role.

## 1 Context

Communicable diseases are not limited by national borders; therefore, effective responses must equally extrapolate these borders by combining players, efforts and resources towards a common goal. Brazil has experienced this reality with the AIDS epidemic: it detected the HIV within its borders shortly after its discovery and started receiving from and providing support to other countries, also within a short time frame.

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I would like to thank the collaboration of Adele Benzaken, Juliana Givisiez, Clarissa Barros, Josi Paz, Fábio Sartori, Michele Dantas, Simone Vivaldini, Angela Martinazzo, Alicia Krüger, Karim Sakita, Bruno Rezende, and Anna Elisa Lima, all of whom have greatly contributed to the consistency of the analyses and data of this article.

AIDS, which appeared in the 1980's, rapidly spread to all five continents and is viewed, even today, as one of the main challenges to global health. The response, thus, has been global, involving a large number of governments, non-governmental organizations, multilateral institutions, private and public companies, scientists and researchers, and people living with HIV (PLHIV), among others, all contributing with distinct and often divergent views and interests, making it difficult to construct a consensus around the best policies and practices to control the disease.

Brazil has – and continues to exercise – a strong leadership in this debate, assuming, in several different opportunities, a key role in the definition of the response, both regionally – Latin America and the Caribbean – as well as globally, participating in HIV-related forums and international arenas.

The technical and humanitarian cooperation has played a critical role in the consolidation of Brazil's leadership. As a result of the international recognition of Brazil's successful interventions – viewed by UNAIDS (Joint United Nations Program on HIV/AIDS) as a case to be replicated by other countries –, in the 1990s, the former National Program for STDs and AIDS started receiving demands to provide technical and humanitarian support. A vast international agenda took place through the implementation of formal projects as well as specific cooperation activities, which enhanced the country's profile and allowed for many of the policies, principles and guidelines of the Unified Health System (SUS) to be incorporated into the regional and global responses to HIV.

This article focuses on two significant areas of Brazil's participation, through which the country has effectively influenced regional and global policies to fight the epidemic: access to AIDS drugs, and social participation and human rights.



The Brazilian response to HIV was relatively early when compared with most countries, particularly in comparison to other developing nations. The first cases were diagnosed in 1982, which motivated the creation, in the following year, of the first State Program for HIV/AIDS, in the state of São Paulo. In 1985, the “AIDS Control Program” was structured at the federal level (BRASIL, 1985).

Over the following years, there were many advances and this resulted in a growing demand for technical and humanitarian cooperation in this field. During this process, a number of experiences developed in Brazil in several areas – care, treatment, articulation between government and civil society, human rights, prevention, epidemiological surveillance, antiretroviral (ARV) drug logistics, monitoring and evaluation, communication, among others – were and continue to be shared and incorporated into the national response of different countries, especially in Latin

America and the Caribbean, and in the African continent, mainly in Portuguese-speaking African States.

The Ministry of Health's area in charge of this topic underwent several restructurings. Today it is part of the Health Surveillance Secretariat (SVS) and is called Department of Surveillance, Prevention and Control of Sexually Transmitted Infections, HIV/AIDS and Viral Hepatitis (DIAHV)<sup>2</sup>. Led by this Department – in coordination with the International Health Affairs Office (AISA) of the Ministry of Health; and the Brazilian Cooperation Agency (ABC), of the Ministry of Foreign Affairs (MRE) –, the Brazilian technical cooperation on HIV has played, in these last years, a triple role: contribute to strengthen the national response in several partner countries, from a perspective of international solidarity and responsibility towards global health; validate the policies adopted internally through demonstration effect while improving the visibility of these policies; and strengthen the stances advocated by Brazil in relation to better practices and policies to face the epidemic.

As part of this effort in advocating SUS's principles and guidelines beyond its national borders, Brazil has proactively participated in various forums and multilateral arenas related to HIV, such as UNAIDS's Programme Coordinating Board (PCB), the World Health Assembly (WHA) of the World Health Organization (WHO), and the Special Session of the UN General Assembly on HIV/AIDS, among others. Thus, Brazil has been recognized as a leading player and, on several occasions, the theses defended by the country were incorporated into the global agenda and strategies to fight the epidemic in the two above-mentioned areas, as described below.

## 2 Access to antiretroviral therapy

Since HIV first appeared in the early 1980's, Brazil has been committed to offer treatment to people infected, according to the eligibility criteria established internationally. This commitment was ratified through the approval of Law 9,313, dated November 13, 1996, whose article 1 states that "HIV (Human Immunodeficiency Virus) carriers and people with AIDS (Acquired Immune Deficiency Syndrome) are entitled to receive from the Unified Health System (SUS) all the needed free-of-charge medicines for their treatment." This law has proven to be an effective tool to respond to the enormous challenge faced by the country, as it regulated, within this specific

<sup>2</sup> Throughout its history, the area in charge of the response to STIs, HIV/AIDS, and, later, viral hepatitis, has enjoyed distinct status, being subordinated to different instances and receiving different names: AIDS Control Program; Division of Sexually Transmitted Diseases/AIDS; National STDs and AIDS Coordination; National STDs/AIDS Program; Department of Surveillance, Prevention and Control of STIs, HIV/AIDS and Viral Hepatitis, among others (v. GALVÃO, 2000).

epidemic, two fundamental rights guaranteed by the 1988 Federal Constitution as well as by the organic laws that govern SUS<sup>3</sup>: the right to health and the right to life.

As reported by Chequer and Simão (2008, p. 170), “this stance faced a number of criticism raised by renowned scientists and researchers from national and international organizations, who believed that Brazil, on that occasion, did not have sufficient capability to manage a decision of such magnitude, both technically and operationally [provide treatment to all people who needed it], especially due to the therapy’s innovative and relatively unknown nature, with sophisticated technical and technological requirements.”

Chequer and Simão (2008) also observed that the success of the national policy could be seen in the first year of its implementation: a significant decline in deaths from AIDS, in hospitalizations, and in the occurrence of opportunistic infections.

Hence, the incorporation of HIV assistance and treatment has been a strenuous and complex process, involving productive debates and active advocacy in a number of forums and international arenas, until the decision to offer antiretroviral therapy (ART) to people living with AIDS reached a consensus, both because it was a human rights issue and because controlling the epidemic was cost-effective. Universal assistance and treatment means reduction of financial resources to health systems nationwide because it prevents new infections while reducing the increasing costs with hospitalizations as the disease evolves to more serious conditions.

Technical and humanitarian cooperation has played a leading role in the process of scaling up access to ART. As knowledge was shared, experiences and technologies were developed and implemented nationwide; medicines, diagnosis, and prevention inputs were also donated, to name just a few examples. Brazil became a reference in the fight against AIDS, effectively influencing the definition of guidelines regarding best practices and strategies to confront the epidemic at both regional and global levels.

By the end of the 1990’s, Brazil had signed HIV technical cooperation projects with Angola, Guinea-Bissau, Mozambique, and São Tomé and Príncipe. Care, treatment and access to drugs were topics addressed in all of them. These projects, negotiated and implemented through AISA/Ministry of Health and ABC/Ministry of Foreign Affairs, were initially limited to training and qualifying healthcare professionals on clinical management and other aspects related to people living with HIV. Later, evaluations showed that these activities presented limited results in contexts where inputs, such as medicines and tests, were not available. From then on, Brazil began to invest in projects and programs which, together with technical cooperation, included the supply – in the form of donations – of ARV drugs as well as prevention or diagnostic inputs such as tests, condoms and lubricant gels, among others.

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<sup>3</sup> Law 8,080/1990 and Law 8,142/1990.

From this perspective, the Brazilian government launched, in 2001, the Program of International Cooperation for other Developing Countries (PCI) with pilot projects in 10 countries<sup>4</sup>. Brazil offered to donate treatment inputs to patients living with AIDS by supplying ARV drugs produced in Brazil<sup>5</sup>, besides technical cooperation in various related areas, especially those relative to managing the infections as well as input and drug distribution logistics. The purpose of this initiative was to boost treatment in countries where it was scarce and draw the international community's attention to the importance of ensuring access to ART.

An evaluation of these pilot projects showed positive results in some countries, mainly in those with a relatively small number of people in need of treatment. In the other countries, with generalized epidemic, the one hundred treatments offered did not make a significant difference. The second phase, called "South-South Bonds", was launched in 2004, in partnership with the United Nations Children's Fund (UNICEF), with the purpose of scaling up the number of treatments in some countries<sup>6</sup> and enhancing universal access.

Again, the topic of care, treatment and access to ARV drugs has been present in the projects developed with almost every country with which Brazil has cooperated, such as: Bolivia (2002 and 2008, in partnership with the Department for International Development – DFID/UK – and the Pan-American Health Organization – PAHO/WHO); Burkina Faso (2010); Cuba (1999 and 2002); El Salvador (2001 and 2006); Ecuador (2005); Guatemala (2002); Honduras (2005); Nicaragua (2007); Paraguay (2004 and 2008, in partnership with German Cooperation Agency – GTZ); Peru (2004); Uruguay (2005, in partnership with GTZ); in specific cooperation activities with English-speaking African Countries (late 1990's); among others. According to the COBRADI Report (IPEA-ABC, 2013, p.35), by the end of the second half of the 2000's, the cooperation agenda on HIV represented the second thematic area with the highest number of projects in the area of health (following the area of human milk bank projects conducted by the Fernandes Figueiras Institute/FIOCRUZ), having, at one point, over 20 projects being implemented. A large number of these projects were developed under the coordination of the International Center for Technical Cooperation (ICTC), in partnership with the German Cooperation Agency (GTZ) and the British Department for International Development (DFID), with the purpose of providing better organization and agility to the enormous HIV/AIDS cooperation demands received by Brazil.

<sup>4</sup> The following countries were contemplated in this first phase: Bolivia, Burkina Faso, Colombia, El Salvador, Mozambique, Paraguay and the Dominican Republic. Due to different reasons, the projects for Burundi, Namibia and Kenya – which integrated the initial list of ten countries – were not implemented.

<sup>5</sup> Donated drugs were produced by Farmanguinhos/FIOCRUZ.

<sup>6</sup> This initiative included Bolivia, Paraguay, Cape Verde, Guinea-Bissau, São Tomé and Príncipe, and East Timor.

Concurrently, the Ministry of Health, through AISA and DIAHV, in articulation with the political area of the Ministry of Foreign Affairs, actively participated in the discussions with WTO (World Trade Organization) about using the flexibilities of the TRIPS Agreements (Agreement on Trade-Related Aspects of Intellectual Property Rights) to address issues related to intellectual property. In 2001, WTO accepted the Brazilian thesis that international agreements on trade-related aspects of intellectual property cannot prevent the implementation of public health policies. On this occasion, as well as on many others, AISA had a decisive role in the negotiation process, which resulted in great advances towards increasing access to antiretroviral drugs in the country.

Internally, Brazil approved, in May 2007, the compulsory licensing of Efavirenz, a drug whose patent belonged to the Merck Sharp & Dohme laboratory. This measure was greatly relevant to reduce prices and ensure the sustainability of offering this drug, considering that it was the most-used imported medicine, recommended by the treatment protocols adopted at that time.

Aware of the importance of its role as a regional leader, Brazil was a key player in the I Latin-American and Caribbean Forum on the Continuum of HIV Care, held in the Mexico City in 2014. On this occasion, the 90-90-90 goals were defined (reach, by 2020, 90% of people living with HIV knowing their status; 90% of these on antiretroviral treatment; and 90% of these with suppressed viral load, that is, less than 1,000 copies/mm<sup>3</sup>) and established as intermediate goals for the target 3.3 of the Sustainable Development Goals (SDG), which aims at reaching the end of AIDS as an epidemic by 2030, among other goals. In 2016, Brazil estimated that 84% of people living with HIV knew their status; of these, 72% were on ART; and 91% of them had suppressed viral loads (BRASIL, 2017a, p. 23).

Similarly, Brazil participated proactively in the definition of the set of prevention and stigma/discrimination reduction goals to reflect the characteristics of the epidemic and the responses for each one of the Latin American and Caribbean sub-regions. This debate occurred during the Second Latin-American and Caribbean Forum on the Continuum of HIV Treatment, held in Rio de Janeiro, in 2015. On this occasion, participants also agreed that the combination prevention strategy should become the main approach to meet the 2020 and 2030 prevention goals.

The advances and challenges to meet the 90-90-90 goals<sup>7</sup> nationally and internationally were evaluated during the III Latin American and Caribbean Forum,

<sup>7</sup> It refers to the intermediate goals of the objectives defined in the Sustainable Development Goals (SDG) to end the HIV/AIDS epidemic by 2030 (Goal 3.3). This goal establishes that, by 2020: 90% of all people living with HIV will know their serologic status; 90% of all people diagnosed with HIV will be on antiretroviral therapy, uninterruptedly; and 90% of people on antiretroviral therapy will have suppressed their viral load. Available at: [https://unaids.org.br/wp-content/uploads/2015/11/2015\\_11\\_20\\_UNAIDS\\_TRATAMENTO\\_META\\_PT\\_v4\\_GB.pdf](https://unaids.org.br/wp-content/uploads/2015/11/2015_11_20_UNAIDS_TRATAMENTO_META_PT_v4_GB.pdf)

held in Porto Principe, Haiti, in 2017. During the forum, participants discussed strategies to maintain the sustainability of the HIV response on the short and long term and recognized the need to improve health system efficiency as a main issue, including an increase of the national investments to the fight against HIV.

Still in the regional arena, Brazil fostered and integrated, along with Latin America and the Caribbean, some joint ARV drug price negotiation processes. It should be pointed out, though, that the results of many of these processes had results below the expectation. Anyway, in 2015, Brazil led the first joint procurement of ARV medicines – with Mercosur countries – through PAHO's Strategic Fund, which meant a significant reduction in the prices of these drugs. In 2016, also through PAHO's Fund, Brazil, together with Argentina, Bermuda, Chile, El Salvador, Ecuador, Guatemala, Paraguay, Suriname, Uruguay, and Venezuela purchased the ARV Darunavir, which represented a reduction of over 50% in the price of this product for Brazil and 83% for the other countries.

Concerning humanitarian cooperation, Brazil has donated ARV drugs and diagnostic and prevention inputs to several countries, particularly to those in Latin America, the Caribbean and the African continent. In the last few years, besides antiretroviral drugs, donations have included condoms, rapid tests and lubricant gels to numerous countries such as Cape Verde, El Salvador, Guinea-Bissau, Haiti, Paraguay, Peru, The Dominican Republic, São Tomé and Príncipe, and Suriname, among others. Donations are always made as long as they do not jeopardize the stocks needed to meet Brazil's internal demands.

In the multilateral scenario, Brazil has also played a significant role in various opportunities. In 2001, the UN General Secretary accepted a proposal advocated by Brazil to create the Global Fund to Fight AIDS, Tuberculosis and Malaria. Later, this Global Fund accepted a proposal presented by developing countries, led by Brazil, to promote equitable participation in the management of available funds. Brazil was chosen to represent Latin America and the Caribbean in the Global Fund's Board of Directors (BRASIL, 2018).

In 2006, Brazil, together with Chile, France, Norway, and the United Kingdom was one of the founding members of the International Drug Purchasing Facility (UNITAID), which contributed to reduce the price of medicines and diagnostic inputs for AIDS, tuberculosis and malaria. UNITAID offers long-term support to beneficiary countries by providing planned and sustainable funding that are mobilized through innovative fund-raising mechanisms such as the solidary contributions over air ticket prices and programmed budget contributions (BRASIL, 2008, p. 100).

In the end of 2013, Brazil was the third country in the world (and the first developing country) to recommend "Treatment as Prevention" to all people living with HIV, even before WHO incorporated this recommendation into its protocols. Since

then, people diagnosed with HIV have been able to initiate treatment regardless of their white blood cell count (CD4). Besides the individual benefits to the health of people living with HIV, early treatment also offers broader benefits because, when properly conducted, it results in undetectable viral load, that is, the chances of transmission are very low, close to zero. The recommendation for treatment for all is very important in the fight against the HIV epidemic, not only because it influences other countries to adopt the strategy, but also because of Brazil's large population. Ever since this recommendation was published, in 2013, the country has been able to rapidly increase the number of people on ART. Today, there are over half a million Brazilians on ART (BRASIL, 2017b, p. 69).

In June 2017, Brazil promoted and organized, in Brasilia, the “Technical consultation on antiretroviral treatment optimization and strategies for access to Dolutegravir in Latin America and the Caribbean”, from a public health perspective. The purpose of the event was to discuss the benefits of introducing Dolutegravir, a drug that was incorporated into the treatment protocols in 2016<sup>8</sup> and began to be distributed by SUS, free-of-charge, in January 2017. This drug is more efficient for HIV control and has less adverse effects, thus contributing to increase treatment adherence, one of the challenges to meet the 90-90-90 goals to end the AIDS epidemic by 2030.

Aiming at scaling up HIV combination prevention, Brazil incorporated, in 2017, the offer of Pre-Exposure Prophylaxis (PrEP), being one of the first countries worldwide and the first developing country to recommend the distribution of free-of-charge PrEP as a public health measure. By incorporating this strategy, Brazil is in line with WHO's recommendation of combination prevention, which includes: regular HIV testing; Post-Exposure Prophylaxis; prenatal care for HIV-positive pregnant women; harm reduction for alcohol and other drug users; timely testing and treatment for other sexually transmitted diseases; incentives to use female and male condoms as well as lubricant gel; and antiretroviral treatment to all PLHIV.

Brazil has been at the forefront of the response to HIV, having incorporated, in a timely manner, the so-called “new technologies” to fight the epidemic. Similarly, it has channeled its efforts to face the global challenge of scaling up HIV diagnosis, particularly among key populations (gays and other men who have sex with men, transvestites and transgender people, people who use alcohol and other drugs, people deprived of freedom and sex workers), in an endeavor to meet the 90-90-90 goals by 2020, and end the AIDS epidemic by 2030.

The scientific and medical advances have allowed us to glimpse, in the near future, the end of the AIDS epidemic as a global health issue, as advocated by the SDG with

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<sup>8</sup> Brazil was the first country in Latin America and the Caribbean to introduce Dolutegravir in the public health system.

which Brazil is committed. This commitment is not limited to reaching the national goals, but also to join efforts globally around this pledge.

### **3 Participation of civil society and the guarantee of human rights**

Another area related to the response to the HIV in which the Brazilian participation has been decisive to define the regional and global agenda refers to the joint work between government and civil society in the field of human rights advocacy and the respect for the diversity of some of the most affected groups. Community participation, viewed as one of SUS's principles and guidelines, involves engaging representatives from non-governmental organizations (NGOs) and people living with HIV, not only in the execution but also in the formulation, monitoring, and evaluation of activities and policies.

The appearance of HIV in the first years of the 1980's coincided with a critical moment in Brazil's history: the re-democratization process after more than twenty years of military dictatorship, which ended in 1985. This process was marked by the strengthening of social movements that aspired for political and social changes, including in the area of health, demanding what was called the Sanitary Reform. This process culminated with the VIII National Health Conference, held in 1986, one of the landmarks of the fight for a universal and democratic health system in Brazil. The Conference's final report was the groundwork for the formulation of Section II of the 1988 Federal Constitution (BRASIL, 1988), which governed the area of health. This Section included two articles that represented a radical change in the concept of health held until then: article 196 established health as a right to all and a duty of the State; and article 198 included community participation as one of SUS's guidelines, integrating a regionalized and hierarchical network of health actions and services.

Social participation in Brazil occurs at all government levels and across the various stages of the process of formulation and implementation of public policies. Therefore, representatives from civil society have a seat in the National STIs, AIDS and Viral Hepatitis Commission (CNAIDS), in the Articulation with Social Movements Commission (CAMS), and in UNAIDS's Theme Group (GT-UNAIDS), among others. The engagement of these players in all the stages of elaboration and implementation of public policies has been essential to bring the reality and the daily routine of people directly affected by the HIV closer to managers and decision-making arenas. This fact has made a significant difference in improving the quality of the implemented policies nationally.

Respect for human rights constitutes one of the cornerstones of the Federative Republic of Brazil, as defined in the 1988 Federal Constitution:

Art. 1º The Federative Republic of Brazil, formed by the indissoluble union of the states and municipalities and of the Federal District, is a legal democratic state and is founded on:

(...) III – the dignity of the human person. (BRASIL, 1988)

In the specific case of HIV, since the beginning of the epidemic, this constitutional precept has had specific outlines favoring some advances, particularly in relation to law-making instances, declarations and political documents relative to non-discrimination and to respect for diversity, as well as the very issue of universal and free-of-charge access to medicines and treatment.

A law<sup>9</sup> was passed in 2004 establishing a sentence of one to four year in prison and a fine to those who express discriminatory attitudes towards people living with HIV.

Concerning gender identity, in 2016, a Presidential Decree<sup>10</sup> was enacted allowing the use of the social name and the recognition of the gender identity of transvestites and transsexual people in Federal organizations, autarchies and foundations.

With the same purpose, Decree 9,278, dated 2018 – which regulates procedures and requirements for the issuance of the Identity Card by State and Federal District Identification Agencies (Law 7,116, dated August 29, 1983) – provides, in article 8, item XI, the possibility of applying for the use of the social name in the new unified national identification document, without the need for the interested party to provide supporting documentation<sup>11</sup>.

Similar to what happened in the field of care and treatment, the joint work themes between government, civil society and human rights organizations have been present in practically all international cooperation projects implemented by Brazil around this issue. They have also appeared constantly in public declarations and Brazilian initiatives in the various international instances of governance.

These topics have also been a component of technical cooperation projects implemented with Angola, Bolivia, Cuba, El Salvador, Ecuador, Guatemala, Guinea-Bissau, Honduras, Mozambique, Nicaragua, Paraguay, Peru, Sao Tome and Prince, Uruguay, as well as Portuguese-Speaking African Countries (PSAC) and English-Speaking African countries, among others. They have also been part of technical and scientific cooperation projects implemented by Brazil and France. In various opportunities, since the 1990's, Brazil has encouraged the engagement of representatives from NGOs and people living with HIV in the implementation of technical cooperation activities developed in several countries, similar to what happens internally in the

<sup>9</sup> Law 12,984, dated June 2, 2014.

<sup>10</sup> Decree 8,727, dated April 28, 2016.

<sup>11</sup> Decree 9,278, dated February 5, 2018.

country. Also, NGOs representatives from and PLHIV of the African Portuguese Speaking Countries – PALOP have been invited to learn about the Brazilian experience in loco.

Brazil's international leadership, both regionally and globally, has been widely recognized due to some of its actions and interventions. The country has had a prominent and continuous presence, acting to define directions and to change attitudes regarding these themes.

In this sense, in October 1998, during the I Latin American and the Caribbean Conference in HIV/AIDS for Horizontal Technical Cooperation, organized by the Latin America and the Caribbean Horizontal Technical Cooperation Group for HIV/AIDS (HTCG)<sup>12</sup>, held in Querétaro, Mexico, it was possible to see a change in the stance of the region's countries towards governments working jointly with civil society. Representatives from NGOs and people living with HIV from several countries were invited to participate in the event, organized by the directors of HIV/AIDS government programs. On that occasion, Brazil was one of the few countries developing a truly articulated work involving government and civil society. During the conference, situations of confrontation and disarticulation between governmental and non-governmental arenas could be observed and verified through the number of protests against the lack of medicines in some countries or against the policies adopted to face the epidemic. Governments, on the other hand, adopted stances that were sometimes defensive, other times accusatory, arguing that the demands from those organizations were radical or absurd due to the specificities and capabilities of each country. The environment, therefore, was one that hindered the possibility of thinking about and implementing joint solutions, as in Brazil.

Shortly after the Conference, Brazil, supported by other countries such as Argentina and Chile, proposed the creation of a work group to discuss the possibility of strengthening joint work within the HTCG. As a consequence of this work group, the HTCG incorporated representatives from seven NGO networks as full members of the Group; another decision was to jointly organize the I Latin American and the Caribbean Forum on HIV/AIDS, held in Rio de Janeiro in November 2000. Unlike the Querétaro Conference, representatives from NGOs were not only invited, but also integrated the organization and implementation of the Forum, including participation in the event's Directive and Thematic Committees. From then on, civil society representatives have participated in various processes in partnership with governments, including the organization of other regional forums and conferences as well as the formulation

<sup>12</sup> <sup>20</sup> The HTCG is composed of directors/coordinators of STIs, HIV/AIDS programs in Latin America and Caribbean countries, in partnership with non-governmental networks and people living with HIV/AIDS, with the purpose of promoting technical and humanitarian cooperation among this region's countries and to discuss and implement policies and strategies to more effectively address the epidemic in the region.

and implementation of activities in the Latin American and Caribbean region. In the Special Session of the UN General Assembly on HIV/AIDS held in 2001, the HTCG presented a consensus document elaborated by governments and civil society on the stand of Latin America and the Caribbean on the priorities and guidelines for the fight against AIDS.

This stance has been defended in various international and inter-governmental arenas. As a result of this position, equally advocated by some governments and multilateral organizations, the international community has incorporated the participation of representatives from civil society in large-scale meetings, such as the Special Session of the UN General Assembly on HIV/AIDS, since 2001, and other meetings held on the scope of the United Nations or other mechanisms for international coordination.

The contribution of these new players in the search for innovative solutions is unquestionable. Today, it is inconceivable to construct responses and define policies without the participation of representatives from these population groups, which is the case of specific social organizations and people living with HIV, who have a vested interest in finding solutions for their daily challenges. This experience has served as a parameter in the response to other epidemics such as tuberculosis, malaria and viral hepatitis, which has greatly benefited from the new ways of acting and from the advances in the fight against HIV.

Partnerships with international organizations and cooperation agencies have also played a relevant role in many of these processes, both in strengthening the national response to HIV and fostering triangular cooperation, through which Brazil provides technical or humanitarian cooperation in partnership with other countries or international organizations.

In relation to triangular cooperation, some organizations should be pointed out: UNAIDS Joint United Nations Programme on HIV/AIDS, UNICEF (United Nations Children's Fund), UNESCO (United Nations Educational, Scientific and Cultural Organization), UNFPA (United Nations Population Fund), GTZ/Germany (German Technical Cooperation Agency), DFID/UK (United Kingdom Department for International Development), JICA (Japan International Cooperation Agency) and USAID (United States Agency for International Development), among others.

Internally, since the 1990's, Brazil has worked in partnership with the World Bank through loan agreements (AIDS I, II, III, and AIDS SUS agreements), which have allowed advances in the implementation of prevention and treatment actions, facilitated the structuring of alternative care networks, and fostered the participation of civil society.

Even though these resources have accounted for only around 10% of the total national budget allocated to HIV – with percentages declining over the years –, they

were strategic to scale up the funding of the partnership agreements with states and municipalities and to support prevention, information, education, and communication (IEC), human rights advocacy and health promotion projects, among other programs developed in partnership with non-governmental organizations.

Other organizations and agencies have equally supported activities, projects, and programs implemented in Brazil, according to the type of activity and the mandates and specificities of each one of the institutions.



In the last few years, the Brazilian leadership has also expanded to the area of viral hepatitis, incorporated into DIAHV in 2009. Consequently, in 2010, during the 63<sup>rd</sup> World Health Assembly in Geneva, Brazil played a relevant role by presenting and obtaining the approval of the first WHO resolution for viral hepatitis (WHA63.18)<sup>13</sup>, which recognized hepatitis as an important public health issue worldwide and instituted July 28 as the World Hepatitis Day, one of the four days dedicated to drawing the world's attention to a specific health problem within WHO. In 2013, during the 66<sup>th</sup> World Health Assembly, a parallel meeting on viral hepatitis was held with the purpose of, among other objectives, analyzing the progress of the adoption of that resolution.

In the 67th World Health Assembly, in 2014, Brazil led the elaboration of the new WHO resolution (WHA63.18)<sup>14</sup>, which urges countries to develop and implement national coordinated and multi-sectoral strategies to prevent, diagnose, and treat viral hepatitis. Also, this resolution appealed to WHO to analyze the feasibility of ending hepatitis B and C through the establishment of global goals.

In 2015, in partnership with PAHO/WHO, Brazil held and co-sponsored the WHO's Latin America and the Caribbean Consultation on Global Health Strategies for HIV, STIs and Viral Hepatitis as well as PAHO's Action Plan for Viral Hepatitis, with the purpose of establishing an agenda for post-2015. The objective of the Regional Consultation was to promote a discussion on the priorities, strategies for action, interventions and global actions in the American Continent, as well as to review and validate the Action Plan proposed by PAHO to prevent and control viral hepatitis in the period between 2016 and 2019.

Also in 2015, Brazil incorporated new hepatitis treatments using direct-acting antivirals. That was also when HIV/HCV<sup>15</sup> co-infected patients were offered priority access to treatment, regardless of the degree of liver damage (BRASIL, 2015). Up to now, approximately 65,000 hepatitis C treatments have been distributed. Those drugs

<sup>13</sup> Available at: [http://apps.who.int/gb/ebwha/pdf\\_files/WHA63/A63\\_R18-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R18-en.pdf). Accessed on February 22, 2018.

<sup>14</sup> Available at: [http://apps.who.int/gb/ebwha/pdf\\_files/WHA63/A63\\_R18-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R18-en.pdf). Accessed on February 22, 2018.

<sup>15</sup> HCV, ou vírus da hepatite C.

have revolutionized the therapy worldwide because they show cure rates above 90%, few reports of adverse effects, and high treatment tolerance (BRASIL, 2017c).

During the 69th World Health Assembly, held in May 2016, Brazil committed itself to end hepatitis B and C as a public health problem by 2030, as part of WHO's Global Strategy for the Health Sector on Viral Hepatitis.

In recognition of the ongoing national initiatives and the international leadership in the field of viral hepatitis, Brazil was chosen to host the "World Hepatitis Summit 2017", held in São Paulo, in November 2017, in partnership with WHO and the World Hepatitis Alliance (WHA). This event, which had the participation of over 900 representatives from 110 countries, has been viewed as a landmark for the country. On that occasion, the "National Plan to end Hepatitis C by 2030" was announced and includes the offer of treatment to all patients, regardless of the degree of hepatic fibrosis<sup>16</sup>. The expectation is to treat over 650,000 people in the next few years.

In 2017, the Brazilian Clinical Protocols and Therapeutic Guidelines (PCDT) for hepatitis B and C were reviewed to include vertical transmission of syphilis, HIV and hepatitis B and C.

Similar to the history of HIV, from the beginning of the 1990's, Brazil has assumed a key role in the fight against viral hepatitis, regionally and globally. The legacy of the Brazilian experience in the response to HIV contributes to confront other challenges in public health.

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<sup>16</sup> Available at: [http://conitec.gov.br/images/Consultas/Relatorios/2018/Relatorio\\_PCDT-HepatiteC\\_Coinfeccoes\\_CP11\\_2018.pdf](http://conitec.gov.br/images/Consultas/Relatorios/2018/Relatorio_PCDT-HepatiteC_Coinfeccoes_CP11_2018.pdf). Accessed on February 28, 2018.

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# Health cooperation with Portuguese-speaking African countries (PALOP)

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## Abstract

In this article, the relationship between Brazil and Portuguese-speaking African countries (PALOP) is analyzed in regards to technical cooperation in health in the bilateral and multilateral scenarios. Initially, agreements in the health sector signed by Brazil with African countries between 1998 and 2018 are presented. Then, bilateral projects signed with PALOP derived from those agreements are described, and the history of cooperation in health in the scope of the Community of Portuguese-speaking Countries (CPLP) is reviewed. Finally, the main challenges and perspectives of bilateral and multilateral cooperation with those countries are discussed.

**Keywords:** Health. Africa. PALOP. CPLP. International Cooperation. South-South Cooperation.

## 1 History of Brazil's Cooperation with PALOP

The beginning of the 2000s marked a new perspective in the relations between Brazil and African countries. In the decade of 1990, an effective approximation between the two sides of the Atlantic was relatively restricted, and a few specific initiatives were more prominent, such as the creation of cooperation projects against HIV/Aids, and the approximation with Portuguese-speaking African countries (PALOP)<sup>3</sup>, which would culminate in the creation of the Community of Portuguese-speaking Countries (CPLP), in 1996. At the turn of the century, the priority conferred to the relationship with developing countries brought Africa to an outstanding position in the Brazilian foreign affairs agenda, based on several initiatives of political approximation and bilateral cooperation.

The significant economic growth of African countries throughout the decade of 2000 was driven by the rise in global *commodities* prices. The significant increase of the economic-commercial exchange between Brazil and the countries of the African

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<sup>3</sup> Angola, Cape Verde, Guinea Bissau, Equatorial Guinea, Mozambique and Sao Tome and Principe.

continent in that period, from US\$1.3 billion in 2000 to a record US\$12.2 billion in 2011, was accompanied by the intensification of political ties and bilateral cooperation. Based on initiatives such as the creation of the Africa-South America Summit (ASA), whose first edition was held in 2006, based on a joint proposal by Brazil and Nigeria, the approximation between the countries of the two regions enabled the establishment of an unprecedented platform of political dialogue and cooperation. As the Minister of Foreign Affairs, Celso Amorim, stated in his discourse,

Itamaraty, in coordination with several government areas, relies on the private sector and the civil society to transform the bonds of friendship that connect us to the peoples of Africa in economic and social progress, for mutual benefit. The routes to Africa reopen and point to a solidary reunion between Brazilians and Africans, in tune with the motivations and aspirations of our society (AMORIM, 2003).

One of the main aspects of the political rapprochement between Brazil and Africa in that period was characterized by South-South Cooperation, conceived as a joint development instrument between developing countries that share common challenges. Through initiatives coordinated by the Brazilian Cooperation Agency (ABC)<sup>4</sup>, working with several government segments, the strengthening of South-South Cooperation was incorporated to the Brazilian foreign policy agenda as an instrument of its global projection.

The Brazilian South-South Cooperation is based on principles such as horizontality, non-conditionality and solidarity. In addition, it aims to take to other developing countries successful and consolidated national experiences in a wide range of fields, such as agriculture, education, justice and health, in partnership with several Brazilian governmental bodies and, in some cases, with the private sector. Following these precepts, initiatives include the sharing of knowledge and technologies and the training of human resources, aiming at the sustainable strengthening of the institutions of the countries involved.

In the area of health, the dialogue on cooperation with the PALOP started in 1994. From the initiative of Oswaldo Cruz Foundation (Fiocruz), in that year, a meeting of Ministers of Health was held at the institution's main office in Rio de Janeiro, seeking to discuss common cooperation interests. However, the lack of resources allocated for this purpose prevented concrete advances at the time. Only in 1997, with a project financed by the Pérez-Guerrero Fund of the United Nations Development Program (UNDP),

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<sup>4</sup> The Brazilian Cooperation Agency (ABC), which is part of the structure of the Ministry of Foreign Affairs (MRE), is responsible for negotiating, coordinating, implementing, and monitoring the Brazilian technical cooperation programs and projects executed based on agreements signed by Brazil with other countries and international institutions.

Fiocruz carried out the first mission to the PALOP, where the situation was assessed, and recommendations were outlined for future projects.

Still in the 1990s, driven by the international projection of the Brazilian policy in response to HIV, Brazil started to develop its first actions on this topic with African countries<sup>5</sup>. In 2002, the Ministry of Health launched the International Cooperation Program (PCI, Portuguese acronym for Programa de Cooperação Internacional), which included, in its first phase, Burkina Faso and Mozambique, in addition to five Latin-American countries. The initiative anticipated the donation of antiretrovirals (ARVs) produced by Brazilian public laboratories and the training of human resources in clinical management and drug distribution logistics. Thus, the Department of Surveillance, Prevention and Control of STIs, HIV/Aids and Viral Hepatitis (DIAHV) was the first area of the Ministry of Health to act systematically with the ABC in the establishment of technical cooperation projects (BRASIL, 2002). Paulo Roberto Teixeira (2002), who was then the national coordinator of the “STD/Aids Program”, stated that Brazil was ready, in the beginning of the 2000s, to share the experience acquired in facing the Aids epidemics with other developing countries.

With the expansion of Brazil's engagement with countries in the African continent, other areas, such as malaria, human milk banks and sickle cell disease, have also become part of the cooperation agenda in health. According to the ABC's publication on the Brazilian technical cooperation, health is a prevailing theme in the international technical cooperation agenda in multilateral and bilateral levels.

Given the successful and dynamic partnership developed between the Ministry of Foreign Affairs and the Ministry of Health, Brazil is one of the main actors in the dissemination of the technical cooperation in health within the developing world. Important factors contributing to this are the tradition and the recognized experience of institutions of world excellence, in the case of the Oswaldo Cruz Foundation, as well as the national programs developed by the Ministry of Health, for which the STD/Aids Program already implemented in African and Latin American countries became a reference (BRASIL, 2007).

In recent years, despite the economic crisis faced by Brazil and the management changes in the Ministry of Health and the Ministry of Foreign Affairs, the cooperation agenda in health with the PALOP has been maintained, and in some cases, even extended, showing the renewed commitment of the country with the constitutional principle of cooperation among peoples for the progress of humanity.

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<sup>5</sup> At the time, technical cooperation projects were signed with Angola, Guinea Bissau, Mozambique and Sao Tome and Principe focusing on the training of health professionals. About this topic, refer to article “International technical and humanitarian cooperation and the Brazilian protagonist role in regional and global response to HIV”, by Mauro Teixeira de Figueiredo.

## 2 Bilateral Cooperation with PALOP

Between 1998 and 2018, several bilateral cooperation actions in health were established with African countries, especially with Portuguese-speaking countries. This section contextualizes international agreements<sup>6</sup> signed in the period with countries from the African continent in terms of health, and compares them with agreements signed with PALOP, showing the prioritization of these countries for the Brazilian cooperation in health. Then, the recent situation of bilateral cooperation with the PALOP is presented and some of its perspectives are discussed.

Through database research on international agreements of the Ministry of Foreign Affairs and in the files of the International Health Affairs Office of the Ministry of Health (AISA) for the period from 1998 to 2018, 69 agreements signed between 2000 and 2012, in the area of health, with 23 African countries were identified. The countries are South Africa, Angola, Algeria, Benin, Botswana, Burkina Faso, Burundi, Cape Verde, Cameroon, Ethiopia, Gabon, Ghana, Guinea Bissau, Equatorial Guinea, Libya, Mozambique, Namibia, Nigeria, Kenya, Republic of Congo, Sao Tome and Principe, Senegal and Zambia. Among these, 44 complementary agreements, 13 protocols of intentions, five memorandum of understanding, four executive programs, one joint declaration, one letter of intentions and one work program were identified – table 1.

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<sup>6</sup> As discussed ahead, the development of international cooperation actions faces several challenges, such as the lack of legal framework, the risk of project discontinuity and difficulties related to monitoring the assessment. It is difficult to establish a historical sequence of all cooperation projects developed with the African continent for the past 20 years. Therefore, in this article, we decided to quantify the agreements established, given the possibility of establishing a historical series for the period analyzed. However, this approach presents a few limitations: when agreements on merits concerning the topic focused on cooperation actions already exist, it is common that the following projects do not demand the registration of new agreements. Thus, the agreement indicator is not directly related to the intensity of the cooperation actions, as it will be clarified at the end of this section. Then, we decided on the presentation, in sequence, of the data presented, of the current situation of cooperation with each African country with Portuguese as the official language.

**Table 1** – International agreements signed by Brazil with African countries, per type of agreement (1998-2018)

Type of agreement	Amount
Complementary agreement	44
Protocol of intentions	13
Memorandum of understanding	5
Executive program	4
Joint declaration	1
Letter of intentions	1
Work program	1
Total	69

Source: own preparation based on search in the Concórdia database and the database of the Ministry of Foreign Affairs (BRASIL, 2018a), as well as in AISA's files.

The majority of documents were associated to the following areas: HIV/Aids (18), public health (15), malaria (9), and sickle cell disease (5). The PALOP had the highest number of agreements signed during the period analyzed, with a total of 38 documents, being 30 of them still in effect, followed by French-speaking countries (17), English-speaking countries (12), and others. Table 2 presents details on international agreements signed with PALOP.

**Table 2** – International agreements signed by Brazil with PALOP, per type of agreement (1998-2018)

Type of agreement	Amount
Complementary agreement	28
Memorandum of understanding	2
Work program	1
Executive program	4
Protocol of intentions	3
Total	38

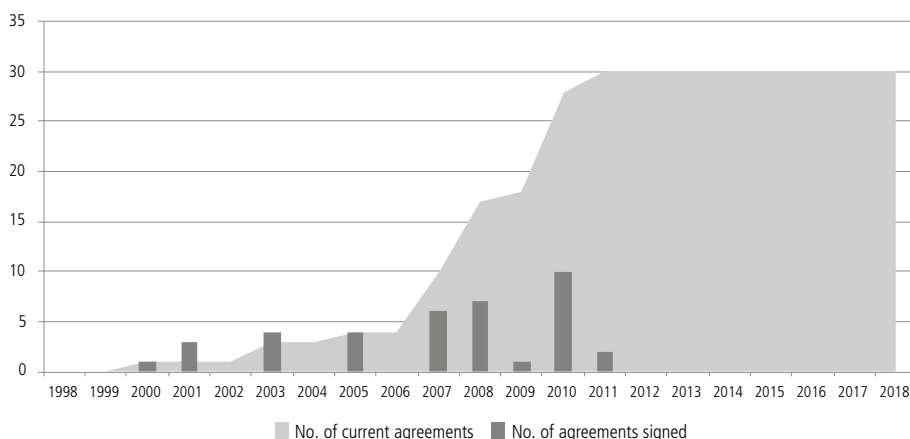
Source: own preparation based on search in the Concórdia database and the database of the Ministry of Foreign Affairs (BRASIL, 2018a), as well as in AISA's files.

The above-mentioned agreements gave rise to 48 technical cooperation projects throughout the African continent, 32 of which with PALOP. Among the different types of agreement used, only the complementary agreement and the executive program generate the legal support necessary for the implementation of concrete

actions. Instruments such as memorandums of understanding, protocols of intent and declarations are mostly used at times of greater political visibility, such as at presidential visits and ministerial meetings, as an expression of the interest of the countries involved in enhancing bilateral relations and promoting cooperation.

In the chart below, information is compiled on the number of international health agreements currently in effect signed by Brazil with African countries per year in the period analyzed.

**Graph 1** – International agreements signed by Brazil with PALOP and current international agreements per year (1998-2018)



Source: own preparation based on search in the Concórdia database and the database of the Ministry of Foreign Affairs (BRASIL, 2018a).

Among the PALOP, Mozambique is the main destination of cooperation in health from Brazil, which is confirmed not only by the number of agreements signed, but also, and above all, by the volume of financial resources used. There are 17 agreements between the two countries in the areas of HIV/Aids, cancer, food and nutrition, oral health, public health, maternal and child health and regulation and pharmaceutical manufacturing, totaling five projects in execution and eight projects completed. Among the projects, it is worth highlighting the initiative to implement a pharmaceutical plant, one of the most emblematic cooperation projects ever conducted by the Brazilian government, in which over R\$ 40 million have already been invested in a joint effort of the two countries. Another remarkable initiative is the action to build the human milk bank (BLH) and a lactation center at Maputo Central Hospital, to be open in the last quarter of 2018.

Next on the list is São Tomé and Príncipe, with which five agreements have been signed in the areas of HIV/Aids, public health, malaria and tuberculosis, with 3 projects concluded and one in execution. One of the largest Brazilian health cooperation

projects was developed with that country: the project “Support to the Program Against Tuberculosis”, which also appears as one of the largest projects in the Brazilian cooperation in health, which had financial support from the ABC and technical support from the Ministry of Health for its execution. The initiative contemplates all areas of the DOTS Strategy<sup>7</sup>, including decentralization in the treatment for all health districts in the country and extension of the diagnosis capacity, with strengthening of laboratory support and implementation of sputum culture tests. The project includes structuring a national reference laboratory at Ayres de Menezes Hospital (“Hospital Central”), according to international quality standards. This hospital might be used in the future as a hospital for the training of other PALOP. The laboratory was inaugurated in January 2018.

Five agreements were signed with Cape Verde in the areas of HIV/Aids, malaria, health surveillance, human milk banks and primary care, with three projects completed and two in execution. One of the highlights among them is the cooperation in human milk banks, with the establishment of the first bank in the African continent, in the year of 2011. The bank, located in the maternity of Agostinho Neto Hospital, in the capital Praia, has contributed for the reduction of neonatal deaths in the country. As part of the project, 90 technicians from Cape Verde were trained. Given the success of the initiative, a new project was agreed upon in 2018 for the establishment of the second human milk bank in the country, which will be located at Baptista de Sousa Hospital, in São Vicente Island (IBERBLH, 2018; RBLH, 2018). Moreover, the two countries negotiate the possibility of establishing a cooperation initiative in the area of tobacco, with the goal of supporting the Cape Verdean government in the process of comprehensive implementation of the Framework Convention on Tobacco Control<sup>8</sup>.

Cooperation with Guinea-Bissau includes five agreements in the areas of HIV/Aids, malaria and women’s health<sup>9</sup>. Three projects were concluded, being worth mentioning a triangular cooperation project involving the United Nations Population Fund (UNFPA), which aimed to improve health care for women and adolescents exposed to gender-based violence, between the years 2010 and 2011. In 2012, two bilateral projects were signed in the area of HIV/Aids, but due to Guinea-Bissau’s political instability that year, cooperation actions were suspended until the institutional normalization of the country, in 2014. This was a practical example of the eventual susceptibility of cooperation actions to situations of political or economic instabilities,

<sup>7</sup> From *Directly Observed Treatment, Short-course*. It is the strategy for tuberculosis treatment recommended by the World Health Organization (OMS).

<sup>8</sup> The Framework Convention on Tobacco Control (FCTC), signed in 2003, is the first international public health treaty in the history of the WHO. It represents an instrument of response by the member states of the Organization to the growing smoking epidemic worldwide.

<sup>9</sup> It is common that there is more than one agreement for the same thematic area. In the case of Guinea-Bissau, there were three agreements in the area of HIV/Aids signed in 2001, 2005 and 2010.

for example. Currently, Brazil and Guinea-Bissau negotiate a new project in the area of HIV/Aids, which aims at increasing the efficiency of the National Secretariat Against Aids (Secretariado Nacional de Luta contra o SIDA) of Guinea-Bissau in HIV prevention health services and in epidemiological surveillance. The training activities are expected to start in 2018.

Finally, four agreements were signed with Angola, with projects already concluded in the following areas: malaria; training of human resources for the Josina Machel Hospital, in a triangular project with Japan; sickle cell disease; implementation of a Master's program in Public Health, in partnership with Fiocruz. Currently, the only project under execution of cooperation in health with Angola is the project for the implementation of a human milk bank unit at the Lucrecia Paim Maternity Hospital in Luanda. Two new projects in the areas of oncology and sickle cell disease are being negotiated between the two countries.

International cooperation agreements in the area of health between Brazil and PALOP were signed between 2001 and 2011, according to the figures in Chart 1. Even though there are no agreements signed after 2011, this is not an indicator representing – by itself – the intensity of international cooperation actions implemented. Most part of international agreements signed in the period are still in force – a total of 29 agreements – and continue to serve as legal backing for new projects developed thereafter. Similarly, some projects started in this period are still in execution.

For the past few years, the joint efforts by AISA and the ABC have enabled the continuation of the robust agenda of international cooperation in health with the PALOP. It is only in 2018 that five new bilateral cooperation projects are expected to be established in health, as mentioned above. By promoting the exchange of experiences and the construction of public health policies that express the universal emphasis of the Brazilian Unified Health System, the Ministry of Health and the Ministry of Foreign Affairs reinforce Brazil's commitment to promote development and respect for human rights.

Besides bilateral cooperation, Brazil develops multilateral health cooperation with the PALOP within the scope of the CPLP. Seen as an important element in the foreign policy agenda of its member-States, cooperation in health is one of the pillars of the Community. It has significant relevance to development, as well as to strengthening the bonds of solidarity that guide relations between the countries in the bloc (CPLP, 2006a).

### 3 Multilateral cooperation: CPLP

Soon after the formal constitution of the CPLP<sup>10</sup>, cooperation in the area of health started in the bloc, mainly through thematic meetings of specialists. The main topic in the health agenda at the time, especially in African countries, was the HIV/Aids epidemics. At the 3<sup>rd</sup> Conference of Heads of State and Government of the Community of Portuguese Speaking Countries (CPLP), held in Maputo, in 2000, the member states agreed to undertake efforts and resources in actions and projects for disease prevention and control (CPLP, 2000).

In the following years, other topics related to the health area, such as the Millennium Development Goals (MDGs) and the malaria epidemics impact, existing in several countries in the African continent, were treated in political settings, such as summit meetings, and in technical meetings with researchers from the member states. In 2006, during the 6<sup>th</sup> Conference of Heads of State and Government of the Community of Portuguese Speaking Countries (CPLP), it was defined that the MDGs should guide all cooperation actions on the bloc. The CPLP should therefore be involved in the coordination of actions among its member countries with a view to eradicating hunger and poverty and promoting sustainable development, education, gender equality and the health of the population. In relation to health, the goal was to reduce child mortality by two-thirds, improve access to reproductive health, reduce maternal mortality by three quarters, and fight HIV/Aids, malaria, tuberculosis and other endemic infectious diseases (CPLP, 2006b).

However, it was only with the First Meeting of Ministers of Health of the CPLP – held in 2008 in the city of Praia – that health cooperation began to be discussed institutionally in the Community. On the occasion, the ministers assigned to Oswaldo Cruz Foundation (Fiocruz) and to the Institute of Hygiene and Tropical Medicine (IHMT) of Portugal the task of coordinating the preparation of the proposal for the Strategic Plan in Health Cooperation of the CPLP (PECS), document that should guide all actions of cooperation in health within the Community. It is worth mentioning that both institutions already had an important history of cooperation with the PALOP, especially in training human resources in health (CPLP, 2008). In the following year,

<sup>10</sup> The CPLP was founded in 1996 with the goal of promoting the dissemination of the Portuguese language, political-diplomatic coordination among member states, as well as cooperation in different fields. Endowed with the principles of peace, democracy and the rule of law, human rights, development and social justice, and based on the common language and history, the Community was initially composed of seven countries: Angola, Brazil, Cape Verde, Guinea Bissau, Mozambique, Portugal and Sao Tome and Principe. In May 2002, after its independence, East-Timor joined the Community. In 2014, Equatorial Guinea was accepted as a full member state. Currently, besides the nine member states, the CPLP also has ten Associate Observers: Slovakia, Georgia, Hungary, Japan, the Czech Republic, Mauritius, Namibia, Senegal, Turkey and Uruguay. Headquartered in Lisbon, the CPLP has legal personality and administrative and financial autonomy. The non-interference in each State's internal affairs and the promotion of mutually advantageous cooperation guide the relations between member states (CPLP, 2018).

during the 2<sup>nd</sup> Meeting of Ministers of Health of the CPLP, in Estoril, the first version of the Plan was approved; it would remain effective until 2012 – Chart 1. The health area was the first one to create a sectoral plan within the CPLP. The Executive Secretary of the Community at the time, Ambassador Murade Murargy, stressed in his speech at the 2<sup>nd</sup> Meeting of Health Ministers (Estoril, 2009) that the Plan could serve as an inspiration to other areas of activity within the Community.

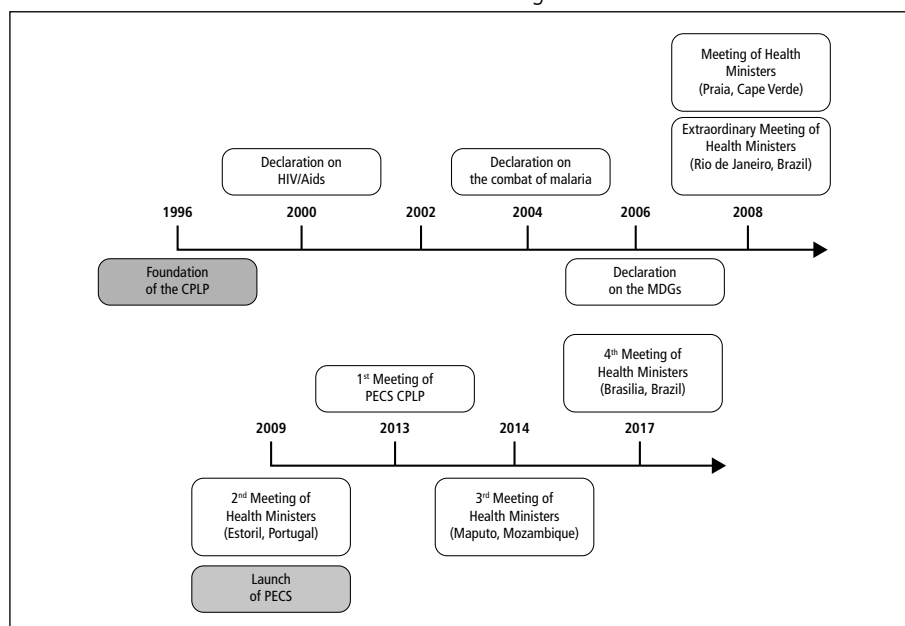
**Chart 1** – Chart summarizing the ministerial meetings of the CPLP in the health sector

Meeting	Location	Date	Main decisions
1 <sup>st</sup> RMS	Praia, Cape Verde	Apr 11 and 12, 2008	Approves the resolution for the creation of PECS/CPLP
1 <sup>st</sup> REMS	Rio de Janeiro, Brazil	Sep 20, 2008	Presentation of the proceedings of the PECS/CPLP and discussion
2 <sup>nd</sup> RMS	Estoril, Portugal	May 15, 2009.	PECS approval
3 <sup>rd</sup> RMS	Maputo, Mozambique	Feb 12, 2014	Monitoring of PECS
4 <sup>th</sup> RMS	Brasília, Brazil	Oct 26, 2017	Revision of PECS

Source: own preparation based on search in the CPLP health portal (CPLP, 2018).

Chart 2 below summarizes the evolution of the approach to health in the scope of the CPLP.

**Chart 2** – Timeline of the CPLP and ministerial meetings of the health sector



Source: own preparation based on data obtained in the CPLP health portal (CPLP, 2018).

The main purpose of PECS is to contribute to the strengthening of the health systems of the member states in order to guarantee universal access to quality health care, contributing to the reduction of child mortality, the improvement of maternal and child health and to the fight against HIV/Aids, malaria and other endemic diseases. Based on these provisions, PECS was constituted with axes that served to define the priority projects, which were revised and updated in 2018, for the version of the document that will be effective until 2021. The current edition of PECS is organized around six axes: 1) Training and development of work force in health; 2) national health systems; 3) information and communication in health; 4) investigation in health; 5) monitoring and analyzing the health situation and compliance with the Sustainable Development Objectives (SDOs); and 6) surveillance and response to emergencies in public health.

Regarding the Plan's governance mechanisms, the Ministers approved the creation of the Technical Health Group (GTS) and the Sectoral Health Fund of the CPLP. The GTS is composed of health experts appointed by the Ministries of Health of the member states and aims to formulate, coordinate and monitor projects, initiatives and cooperation networks established within the scope of PECS. The CPLP Sectoral Health Fund is made up of contributions from member states, other states, international organizations and agencies, and public and private entities, from inside or outside the Community, to finance cooperation initiatives in the area of health aligned with the priority axes of the PECS.

After five years of its launch, during the III Meeting of Ministers of Health of the CPLP, held in February 2014 in Maputo, a review of the implementation of the PECS was carried out. At the time, it was seen that the financial sustainability was one of the major bottlenecks for the implementation of the activities and projects foreseen in the Plan, since there would be no mechanism to guarantee the minimum investment needed by the member states to the Sectoral Health Fund. Despite these difficulties, PECS was able to advance in the axes of training and development of human resources and research, with the Network of the National Institutes of Health (RINSP) and on the axis of information and communication, with the Network ePORTUGUÊSe (CPLP, 2014).

Implemented in 2005 and managed by the World Health Organization, (WHO), the project ePORTUGUÊSe was built as an information network on health that aggregates the countries of the CPLP with the aim of strengthening collaboration between health institutions and professionals in the community. In addition, there was a proposal to subsidize training for health professionals, through access to information and technical training in Portuguese, as well as to foster the production of knowledge in Portuguese. ePORTUGUÊSe activities were discontinued in 2015.

At the 11th Conference of Heads of State and Government of the CPLP, held in November 2016, the rotating presidency of the Community was transferred to Brazil for a period of two years. For the Brazilian presidency, the following motto was chosen: “The CPLP and the Agenda 2030 for Sustainable Development” (CPLP, 2016). After more than three years of gap since the Maputo meeting, the Brazilian Ministry of Health has reinvigorated the cooperation in health with the countries of the Community during the pro tempore presidency.

On October 26, 2017, the 4<sup>th</sup> Ordinary Meeting of Ministers of Health of the CPLP was held in Brasília. The background of the meeting was the revision of PECS, aiming at its financial sustainability. On the occasion, Brazil made a commitment to technically and financially support the following initiatives: the creation of the human milk banks network of the CPLP; the establishment of the permanent Working Group of the CPLP in Telemedicine and Telehealth; the creation of the Network of focal points for restructuring ePORTUGUÊSe; the reinforcement of the Network of the National Institutes of Public Health of the CPLP (RINSP) (CPLP, 2017).

The human milk bank (BLH) network of the CPLP is intended to be a forum to promote the continuous interchange of good practices and information of professionals from the BLH, in order to increase the chances of success and the sustainability of new initiatives within the countries of the bloc. The successful implementation of the first BLH in Cape Verde, product of the bilateral cooperation with Brazil, has a potential catalyzing effect to the other initiatives of installation of human milk banks in PALOP countries, since it shows, in practice, the possibility of overcoming common technical and cultural challenges of different countries in the region, with proven positive results. This is a good example of the complementarity between technical cooperation initiatives in health developed within bilateral and multilateral scopes.

The Permanent Working Group on Telemedicine and Telehealth aims to coordinate efforts to disseminate these strategies in the member countries of the Community. In September 2017, the First Telemedicine and Telehealth Meeting of the CPLP was held in the city of Praia, from which recommendations emerged to promote the use of telemedicine and telehealth as means to reduce health inequities and to facilitate access and quality of health services to the populations of the member states.

The Network of focal points for restructuring ePORTUGUÊSe responds to the interest, shared by several member states, in resuming the initiative as a tool to strengthen the use of Portuguese as the language of work and research in health. With a mandate to define the models that will be used in the new phase of ePORTUGUÊSe, the Network will bring together CPLP specialists to ensure the quality and suitability of the initiative to the current needs of the member countries.

The support for the establishment of National Institutes of Public Health in CPLP member countries has been one of the main goals of RINSP, since its creation,

in 2011. Some of the main advances of the network are the support in the creation of the National Institute of Public Health (INASA) of Guinea-Bissau, the creation of the National Institute of Public Health (INSP) of Cape Verde, and the approval of its executive plan, in addition to opening a new building of the National Health Institute (INS) of Mozambique. Moreover, several initiatives for the training of health professionals have been conducted to train institutes to formulate strategic responses for the development of national health systems.

Among the main achievements of Brazil's multilateral CPLP work in health matters are the understandings held on the margins of the World Health Assembly (WHA). In a Brazilian initiative, the Minister of Health of Brazil gave a speech at the 71st plenary session of WHA on behalf of CPLP countries, an unprecedented initiative in the history of the Community. In his speech, he highlighted the importance given by Brazil, as pro tempore president of the CPLP, to the Agenda 2030 for sustainable development as the guiding direction for actions developed in the most varied areas of political cooperation and coordination, including in the health agenda. In the words of the Minister, "we, the CPLP countries, give special attention to the strengthening of our health systems and to universal quality health care as means for the construction of capacities and promotion of development" (OCCHI, 2018).

The Brazilian initiative to strengthen cooperation with the member states of the CPLP in matters of health is timely and beneficial for all parties. The network cooperation structure, adopted in different technical cooperation initiatives of the CPLP in health, allows the feedback between the parties, promoting the development of capacities and the reduction of inequities within and among the member states of the Community. As a unit of the Ministry of Health responsible for articulating possibilities for international cooperation and converting them into concrete achievements, AISA fulfills the fundamental role of contributing, in partnership with the ABC, to the implementation of a policy of solidary and humanist cooperation.

#### **4 Challenges and cooperation perspectives in health with PALOP**

The lack of a legal framework that supports Brazilian cooperation is a factor that affects the implementation of activities in the scope of international technical cooperation projects in all areas, whether bilateral or multilateral initiatives. Concerning cooperation arrangements in partnership with international organizations such as the Pan American Health Organization (PAHO) and the UNDP – which today support the financial execution of the cooperation provided by Brazil – there are enormous challenges in the daily conduct of these initiatives. From simpler actions, such as sending a technician from the Ministry of Health abroad to participate in an activity, to purchase equipment, as in the case of projects involving the development of a health

service – such as a milk bank, operationalization difficulties are also important factors in conducting international cooperation initiatives.

Management changes also often impact on the execution of projects. It causes interruptions for long periods, or even the cancellation of some initiatives. In addition, there are challenges related to difficulties in matching intense work routines of technical areas of the Ministry of Health, which have limited human and financial resources, with the technical and logistic demands related to an international cooperation project.

Despite the difficulties, which are common in initiatives of this nature, the Ministry of Health has sought to improve its *modus operandi* in international cooperation matters, as a means to ensure the establishment of projects that may contribute for the development of capacities with a view to strengthen national health systems through human resources training and the improvement of sectoral public policies.

This improvement is reflected, for example, on the need of a more thorough analysis of Brazil's capacity and other partners' capacity to operationalize the intended cooperation prior to the establishment of new initiatives. Thus, there has been more investment in the development phase of cooperation projects, with the development and use of tools that favor a previous diagnosis. This exercise takes place through a participatory process, in which the dialogue between the various actors involved in cooperation is fostered, both during the prospecting mission and later, by means of distance meetings. The improvement of this diagnosis, which includes the analysis of problems, solutions and risks, has made project execution more efficient, also increasing its sustainability chances.

Another factor that has been improved is the monitoring and assessment of cooperation initiatives. For that, new projects contemplate the establishment of a managing committee that periodically brings together focal points of all institutions involved to monitor the development of the project and propose eventual adaptations that become necessary throughout its execution. As far as assessment is concerned, only a small portion of the projects that were completed has gone through this process. Now there is an ongoing effort of the ABC to institute that practice in the routine of the new technical cooperation projects developed by the country, which contributes to knowledge accumulation and to future projects. This effort is made explicit in the publication of the Manual of South-South Technical Cooperation Management, by the ABC, in 2013, which suggests assessment as an essential part in the technical cooperation process.

The priority conferred to the establishment of horizontal cooperation initiatives seeks to obtain mutual benefits, among other aspects. It can be important for the engagement, at the political and technical levels, of areas in the Ministry of Health, as a means to ensure the sustainability of cooperation actions involved. AISA and ABC have had an extremely important role in achieving these objectives.

Regarding multilateral cooperation, Brazil made efforts, during its pro tempore presidency of the CPLP 2016-2018, to strengthen the PECS, encouraging the progress of initiatives that were already under way and launching new projects with concrete purposes, such as Networks of Human Milk Banks, Telemedicine and Telehealth, which have promising prospects for the coming years. To ensure the long-term sustainability within the timeframe, it is necessary to guarantee financial predictability and effective participation of the member states, favoring the autonomy of the Networks and the PECS projects.

The cooperation between Brazil and the PALOP on health matters has advanced on different fronts over the last twenty years, both bilaterally and multilaterally. In addition to the expansion of the themes and policies contemplated in the projects and the number of partner countries, it is possible to notice that the cooperation structures and processes involved become more complex and improved. In its twenty years of history, AISA has contributed to foster and give coherence to international cooperation actions in health matters developed by Brazil. In doing so, the Ministry of Health contributes for the improvement of health policies not only among the partner countries, but also in the Brazilian Unified Health System, which reinforces the perspective of solidarity and mutual benefits, which characterizes Brazilian international cooperation.

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## APPENDIX – List of agreements between Brazil and Portuguese-speaking African countries, and international technical cooperation projects signed between 1998 and 2018

Country	Type	Area	Year of signature	Status of agreement	Affiliated project	Project title	Project status
Angola	Complementary agreement	Malaria	2007	Ongoing	Yes	Support to the Program for Malaria Prevention and Control	Canceled
Angola	Complementary agreement	Public health	2007	Ongoing	Yes	Improvement of the health system in the Republic of Angola – I (master's program)	Completed
Angola	Complementary agreement	Public health	2007	Ongoing	Yes	Improvement of the health system in the Republic of Angola – II (master's program)	Completed
Angola	Complementary agreement	Sickle cell disease	2010	Ongoing	Yes	Pilot project in sickle cell disease	Completed
Angola	Work program	Public health	2011	Ongoing	Yes	Support in the implementation of human milk bank	In execution
Cape Verde	Complementary agreement	HIV/Aids	2005	Expired in 2008	Yes	International Cooperation Program of the Ministry of Health	Completed
Cape Verde	Complementary agreement	Malaria	2008	Ongoing	Yes	Support to the Program for Malaria Prevention and Control	Canceled
Cape Verde	Complementary agreement	Sanitary surveillance	2008	Ongoing	Yes	Consolidation of ARFA as a regulation agent	Completed
Cape Verde	Executive program	Primary care	2008	Ongoing	Yes	Strengthening of primary care in Cape Verde	Completed
Cape Verde	Executive program	Human milk banks	2008	Ongoing	Yes	Support in the implementation of human milk bank	Completed
Guinea-Bissau	Complementary agreement	HIV/Aids	2001	Expired in 2003	Yes	Strengthening of combating HIV/Aids program in Guinea-Bissau	Completed
Guinea-Bissau	Complementary agreement	HIV/Aids	2005	Expired in 2008	Yes	International Cooperation Program of the Ministry of Health	Completed

Country	Type	Area	Year of signature	Status of agreement	Affiliated project	Project title	Project status
Guinea-Bissau	Complementary agreement	Malaria	2007	Ongoing	Yes	Support to the Program for Malaria Prevention and Control	Interrupted
Guinea-Bissau	Complementary agreement	HIV/Aids	2010	Ongoing	Yes	Strengthening of combating HIV/Aids program in Guinea-Bissau – phase II	Completed
Guinea-Bissau	Complementary agreement	Women's health	2010	Ongoing	Yes	Strengthening of actions: women and teenagers victims of violence	Completed
Equatorial Guinea	Memorandum of understanding	Basic sanitation	2009	Ongoing	No		Not applicable
Mozambique	Complementary agreement	HIV/Aids	2001	Expired in 2003	Yes	Strengthening of combating HIV/Aids program in Mozambique	Completed
Mozambique	Complementary agreement	HIV/Aids	2003	Ongoing	Yes	International Cooperation Program of the Ministry of Health	Completed
Mozambique	Complementary agreement	Science and technology	2005	Expired in 2007	Yes	Feasibility study for the installation of a drug manufacturing plant	Completed
Mozambique	Complementary agreement	Food and nutrition	2007	Ongoing	Yes	Strengthening of food and nutrition actions in Mozambique	Completed
Mozambique	Complementary agreement	Public health	2007	Ongoing	Yes	Strengthening of the National Institute of Health of Mozambique	Completed
Mozambique	Complementary agreement	Science and technology	2008	Ongoing	Yes	Installation of a manufacturing plant producing antiretroviral and other medication	In execution
Mozambique	Complementary agreement	Sanitary surveillance	2008	Ongoing	Yes	Institutional strengthening of the medicines regulation agency	Completed
Mozambique	Complementary agreement	Human milk banks	2010	Ongoing	Yes	Implementation of a human milk bank at Central Hospital	In execution
Mozambique	Complementary agreement	Oncology	2010	Ongoing	Yes	Strengthening of actions for cancer prevention and control	Completed

Country	Type	Area	Year of signature	Status of agreement	Affiliated project	Project title	Project status
Mozambique	Complementary agreement	Oral health	2010	Ongoing	Yes	Support to the System of oral care in Mozambique: oral health research	In execution
Mozambique	Complementary agreement	Oral health	2010	Ongoing	Yes	Support to the system of oral care in Mozambique: dental prosthesis	In execution
Mozambique	Complementary agreement	Mental health	2010	Ongoing	Yes	Implementation of pilot project in community therapy	Completed
Mozambique	Complementary agreement	Women's health	2010	Ongoing	Yes	Implementation of the center for women and children at Central Hospital	In execution
Mozambique	Complementary agreement	Science and technology	2011	Ongoing	Yes	Project for training in the production of antiretroviral medicines	In execution
Mozambique	Memorandum of understanding	HIV/Aids	2003	Ongoing	No		Not applicable
Mozambique	Protocol of intentions	Public health	2001	Expired in 2004	No		Not applicable
Mozambique	Protocol of intentions	Science and technology	2003	Expired in 2009	No		Not applicable
São Tomé and Príncipe	Complementary agreement	HIV/Aids	2000	Ongoing	Yes	Strengthening of combating HIV/Aids program in São Tomé and Príncipe	Completed
São Tomé and Príncipe	Complementary agreement	HIV/Aids	2005	Ongoing	Yes	International Cooperation Program of the Ministry of Health	Completed
São Tomé and Príncipe	Executive program	Malaria	2008	Ongoing	Yes	Support to the Program for Malaria Prevention and Control	Completed
São Tomé and Príncipe	Executive program	Tuberculosis	2010	Ongoing	Yes	Support to the Program Against Tuberculosis in São Tomé and Príncipe	In execution
São Tomé and Príncipe	Protocol of intentions	Public health	2003	Expired in 2005	No		Not applicable

Source: own preparation based on search in the Concorórdia database and the database of the Ministry of Foreign

# Health cooperation with Haiti

*Douglas Valletta Luz<sup>1</sup>*

## Abstract

This article briefly contextualizes the relations between Brazil and Haiti, the Haitian health system, and it presents the activities and the international technical cooperation projects between the two countries in the realm of health, which count on the support of the International Health Affairs Office of the Ministry of Health of Brazil.

The international technical and humanitarian cooperation activities and projects started in early 2004, when Brazil assumed the military command of the United Nations Stabilization Mission in Haiti (MINUSTAH, acronym in French), in a perspective to support the country's stabilization by means of strengthening its institutions in several areas, acknowledging public health as a core part of the country's development. From 2010 onwards, after the earthquake that devastated a considerable part of the Haitian public health infrastructure, the cooperation activities were intensified and acquired significantly higher volume and amplitude, especially the Tripartite Cooperation Brazil-Cuba-Haiti and the Project for Strengthening the Management of Services and the Health System in Haiti. It is shown that the projects were important to strengthen Haitian institutions and to support the development process proposed for the stabilization of Haiti, as well as it revealed learning experiences and challenges for the Brazilian side.

The original article was completed in June 2018 and published in Portuguese in September 2018.

**Keywords:** Health. Brazil-Haiti. Cooperation.

## Contextualization

One of the main achievements and peculiarities in the Haitian history is that its independence was the successful result of a slave revolt. In 1804, Haiti was the second

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I would like to thank Everaldo Torres, Isaac Vergne, Isabela Coelho Moreira, João Aprígio Guerra de Almeida, Mauro Figueiredo, Maria Augusta Ferraz, Mercedes Goldmann, Michelle Rodrigues Correia, Ricardo Barcelos, Tomás Werner Seferin and Virgínia Valiate Gonzalez, who kindly provided information on activities and projects, and Anna Elisa Lima, Bruno Rezende and Rodrigo Campos, for textual contributions.

colony of the Americas to conquer its independence, the first country in the American continent to abolish slavery, and the first black republic in the world.

After the Haitian revolution (1791-1804), the history of the country was marked by military regimes, authoritarian dictatorships, such as the Duvalier (known as Papa Doc and Baby Doc, in power between 1957 and 1986), political instability, as well as foreign interventions, and peace missions (VALLER FILHO, 2007). According to Verenhitch (2008, p. 19), “the crisis of Haiti comes from two centuries of independent history in which the country underwent 34 coups and enacted 23 constitutions in a long and uninterrupted cycle of dictatorial governments”.

According to Valler Filho (2007), between its independence and 1820, Haiti went through what would be its “foundational phase”, in which the exporting agriculture was replaced by subsistence farming. In the following period, until 1915, its economy was geared towards exporting of primary products, with successive military governments and political instability. In 1915, a North American intervention started – when the country became a United States protectorate until 1934. In 1946, there was a general strike demanding better conditions of life and employment.

In 1957, François Duvalier, who also became known as *Papa Doc*, was elected president with the US support, and in 1964 he declared himself President for life, establishing a dictatorial government. Upon the death of *Papa Doc*, in 1971, his son, Jean-Claude Duvalier, known as *Baby Doc*, assumed his father’s position. The Duvalier dictatorship was marked by episodes of disrespect of human rights and by a terror atmosphere, sponsored by the regime’s own militia. In 1986, demonstrations against the dictatorship spread out across the country. According to Louidor (SANTIAGO, 2013, p. 21-22),

the discontent, particularly in rural areas in popular neighborhoods, grew against the Duvaliers’ repressive regime. The means of communication, the public university and the Catholic Church, especially the Basic Ecclesial Communities (*Ti Legliz*, in Creole), appeared among the first forces (though not the only ones) that channeled and articulated the social protests against the Duvalier regime. [...] In view of a large social movement, the dictator Jean-Claude Duvalier had to be exiled, ending a terrible dictatorship that lasted about 30 years. The date of February 7, 1986 marked a new stage in the country’s history: “the second independence of Haiti”, as it was named. In the following year, a new Constitution, democratic and according to people’s will, was drawn up and unanimously accepted by the population, who solemnly proclaimed it to “guarantee their inalienable and imprescriptible rights to life, to liberty and to the pursuit of happiness; in accordance with their Act of Independence of 1804 and with the Universal Declaration of Human Rights of 1948”, to “constitute a Haitian nation, socially fair society, economically free and politically independent”, and to “implant

democracy, which implies ideological pluralism, and political alternation, and to affirm the inviolable rights of the Haitian people”, according to the preamble of the country’s Constitution.

The Constitution of the Republic of Haiti (1987) aimed at ensuring social rights to its population, in a context of a large social mobilization after the overthrow of a perverse dictatorial regime. Education, health, housing and social security are social rights of Haitians, despite the State difficulty to ensure them and even the difficulty of Haitian citizens in claiming them in the judicial system.

After the end of the dictatorship, between 1986 and 1990, there was major political instability, with two transitional governments, one disrespected election and two coups d’état. In February 1991, the Catholic priest Jean-Bertrand Aristide, adept of the Liberation Theology and an emblematic figure in the Haitian politics until today, assumed the presidency, elected with 67% of the votes.

After seven months his mandate had started, Aristide was ousted by another coup d’état and sought asylum in the United States. In 1993, the Organization of American States (OAS), in partnership with the United Nations Organization (UN), set the International Civilian Mission in Haiti, comprised by international observers to monitor the denounces on human rights violations presented by the deposed president, and it would remain in the country until mid-1994, when it was expelled. Still in September 1993, the UN Security Council approved the first military mission in the Americas, the United Nations Mission in Haiti (UNMIH), which supported, in an unprecedented manner, the reinstatement of the deposed president to power and monitored his term until the succession. Aristide was able to elect his successor, René Préval, for the 1996-2001 term. During Préval’s term, there was a rupture between Aristide’s groups and the group in power, and the political scenario led to a new wave of instabilities.

In the 2000 election, whose fairness was questioned by the international community, Aristide was elected again for a term until 2006 and established the majority in Congress. This episode yielded a new cycle of instabilities, which included a parallel opposition government, human rights violations, gathering of civil society segments calling for a new social contract in the country for its pacification, in addition to the escalation of street violence, violent repression of the opposition and the disintegration and politicization of the National Police. The legislative elections foreseen for 2003 did not happen and the parliamentary mandates ended in January 2004, when the Executive started to legislate by means of decrees.

In early 2004, the Caribbean Community (CARICOM) and the OAS offered to support the mediation of the conflict, unsuccessfully, as the opposition was not willing to negotiate and demanded presidential deposing. In February, an armed revolt started

in Gonaïves<sup>2</sup> spread to other cities, including Cape Haitian, the second largest city in Haiti, and the rebel movement dominated the northern part of the country. The revolt threatened to take over Port-au-Prince. With the alert of a civil conflict and after a meeting with ambassadors from France and from the United States, Aristide resigned, on February 29, 2004, and flew into exile.

The provisional government was assumed by the president of the Supreme Court of Justice, whose first measure was to request international support for the maintenance of the order, besides establishing a Council of the Wise. On February 29, the representative of the UN for Haiti submitted the claim to the UN Security Council, which approved it on the same night, creating a Multilateral Interim Force (MIF), composed by North American, French, and Chilean troops.

On April 30, 2004, the UN Security Council approved Resolution No. 1,542, which originated the United Nations Stabilization Mission in Haiti (MINUSTAH), whose military command was taken by the Brazilian Armed Forces. The provisional government and the MINUSTAH had the responsibility of promoting political conciliation calling for new elections – initially planned for 2005 and held in 2006–reestablishing security and public services, strengthening the country's political and economic governance and promoting the institutional development, the economic recovery, and improving the access to public services.

MINUSTAH was the fifth<sup>3</sup> UN mission aimed at reestablishing the order in the country and it sought to be different from the previous ones by ensuring a greater presence of developing countries and with a broad range of activities, such as electoral assistance, public security, economic development, humanitarian cooperation, human rights protection, and preservation of the environment. The international community was urged to offer cooperation and resources to support the Haitian stabilization and its development movement. MINUSTAH had the presence of several countries, as demonstrated by Valler Filho (2007, p. 170):

[...] with over 6,700 soldiers and about 1,600 policemen, and its international feature would be shaped by the origin of its components. Thus, the countries that contributed with military personnel, in addition to Brazil, were Argentina, Bolivia, Canada, Chile, Croatia, Ecuador, France, Guatemala, Jordan, Morocco, Nepal, Pakistan, Paraguay, Peru,

<sup>2</sup> According to Valler Filho (2007, p. 152), the “fourth Haitian city and symbolic for the country’s history as it was the headquarter of the victorious revolt against the French colonizer and of the movement that culminated with the end of the Duvalier’s dictatorship, in 1986”.

<sup>3</sup> Since this is a brief overview, the text above presented only the first mission and MINUSTAH. The four missions prior to MINUSTAH were the following: UNMIH (*United Nations Mission in Haiti*), joint mission of the UN and the OAS, Sep, 1993-Jun, 1996; UNSMIH (*United Nations Support Mission in Haiti*), Jul, 1996-Jul, 1997; UNTMIH (*United Nations Transition Mission in Haiti*), Aug, 1997-Nov, 1997; and MIPONUH (*United Nations Civilian Police Mission in Haiti*), Dec, 1997-Mar, 2000 (VERENHITACH, 2008, p. 35-36).

the Philippines, Sri Lanka, the United States and Uruguay. The police contingent would consist of personnel from Argentina, Benin, Bosnia and Herzegovina, Brazil, Burkina Faso, Cameroon, Canada, Chad, Chile, China, Colombia, Egypt, El Salvador, France, Grenada, Guinea, Yemen, Jordan, Madagascar, Mali, Mauritius, Nepal, Niger, Nigeria, Pakistan, the Philippines, Romania, Russia, Senegal, Sierra Leone, Spain, Togo, Turkey, the United States, Uruguay, Vanuatu and Zambia.

On January 2010, an earthquake hit the region of Port-au-Prince causing major destruction, which intensified the country's poverty and vulnerability situation and it extended the mission's mandate. MINUSTAH remained in Haiti until October 2017, standing criticism related to the long period of its presence, complaints of human rights violations, and the introduction of the cholera epidemic<sup>4</sup>.

After MINUSTAH's withdrawal, in October 2017, the United Nations Mission for Justice Support in Haiti (MINUSJUSTH, acronym in French) started, without the military component, to provide political support to the strengthening of the National Police of Haiti, as well as the legal institutions, and human rights. The mission is comprised by a team of over 300 civilian staff and one thousand Police Officers, and it had an initial term of six months, currently extended to April 2019 (ONU, [2017]).

Haiti occupies one third of the western portion of the Hispaniola island, in the Caribbean. Its territory is approximately 27,750 km<sup>2</sup> – comparable to the state of Alagoas in Brazil – and its population was estimated at 11 million people in 2015 (HAITI, 2015), been essentially young, with average age of 22 years (OMS, [2017]). Haiti is among the poorest countries in the world, being the poorest in the Americas, with the lowest Human Development Index (HDI) of the continent (0.493, considered low). In a list of 185 countries, it is in position 163th in the HDI, and presents the forth higher GINI index (60.8), an indication of a wide income inequality (PNUD, [2016]). It is a country in urbanization process, with 52% of the population living in urban areas in 2010. In 2015, life expectancy was 62 years for men and 66 for women. Infant mortality rate, in 2015, was 52.2 per 1,000 live births, and the maternal mortality ratio was 359 per 100,000 live births (OMS, [2017]). In addition to the high infant and maternal mortality rates, the country has a high prevalence of infectious diseases, such as malaria, tuberculosis and HIV/AIDS (BRASIL, [2017]a).

Haiti is a country dependent on foreign assistance and on international cooperation. In 2011, 60% of the national budget came from official development assistance, but only 10% went to the country's national accounts and institutions, which indicates

<sup>4</sup> Cholera would have been introduced into Haiti by Nepalese serving in MINUSTAH troops. In August 2016, after the political distress caused by the incident, the United Nations Secretary-General made the organization accountable for the cholera epidemic outbreak in Haiti, although maintaining its immunity to legal procedures seeking award for damages. The organization established a fund in 2017 to combat cholera in Haiti and it has been urging countries to donate to this fund.

that foreign assistance is not necessarily strengthening the Haitian state (BARANYI, 2012). Many publications mention Haiti as a “Republic of NGOs”, given the proliferation of organizations operating in its territory, including governmental, religious, charitable, and philanthropic. According to Jerome (SANTIAGO, 2013), the harsh social situation in Haiti is also due to humanitarian aid, which had turned the country into one of the main sources of funds for thousands of NGOs, working in the country for decades, without, nevertheless, improving the general situation of the population. In some cases, these organizations assumed, inclusively, services that are of the state competence, and, in some cases, have a higher budget than institution, which should regulate them. There is a poor coordination or regulation of their actions. There are accusations related to deviation or misapplication of funds and criticisms on diffused works not necessarily related to public interest by those organizations are common, which would be, often, more focused on their own maintenance than in the Haitian people’s emancipation and improvement of quality of life.

It is also noted the frailness of the official information available by the Haitian State on its territory and population. The last census was conducted in 2003, prior to the earthquake and the Haitian diaspora occurring after the 2010 earthquake, which makes it difficult for managers’ planning and decision-making.

Frequently, frailness is also presented related to the Haitian mountainous territory, to climate deriving from annual tropical storms and hurricanes, and to geographic phenomena, such as those leading to the 2010 earthquake – which combined with poverty, social vulnerability, and disorganized urbanization, tend to be more devastating in Haiti than in other countries in the region.

## **1 Relations between Brazil and Haiti**

The beginning of the diplomatic relations between Brazil and Haiti happened in 1928, with the onset of the diplomatic missions, at the time called as “legations”, in both countries – raised to the condition of embassies in 1953. Up to 2004, the countries had only sporadic and incipient relations. As noted by Sá e Silva (2016), Brazil and Haiti were not outstanding trade partners, do not have geographical proximity, do not share the same language, and had different colonial backgrounds. Valler Filho (2007) registers that there has been some exchange between the countries through relevant connections established by intellectuals and diplomats, more than through trade or systematic relations. The Basic Agreement on Technical and Scientific Cooperation, signed on October 15, 1982, during the visit of the Minister of Foreign Affairs from Haiti to Brasília only became effective in November 2004, when Brazil ratified it by means of a decree (BRASIL, 2017a).

Since 2004, Haiti became a priority in Brazil's international relations. For Regina (2016), this was due mainly to two events: the MINUSTAH military leadership from 2004, and the response to the earthquake that devastated the country in 2010. In addition, in the last two decades Brazil assumed a position of greater approximation with developing countries and started to put greater emphasis on South-South relations in its foreign policy.

The Brazilian decision to assume the military command of a peacekeeping mission showed the emergence of a foreign policy guidance that shifted the principle of nonintervention to non-indifference, since it was an operation to support a country in a situation of lack of control and institutional collapse, with a discourse focused on the issue of solidarity and mutual development (HIRST, 2007). As the Brazilian Minister of Foreign Affairs, Celso Amorim, exposed to the National Congress, on May 12, 2004 (BRASIL, 2004c, p. 112),

Brazil is a country that has a very active foreign policy today, a foreign policy recognized by everyone, which often makes people uncomfortable. It is a foreign policy that recognizes the responsibility of a country like Brazil. Peace is not a free good. When people say, why do we have to get in here or there? Peace does not exist for free. Peace has a price and we have a responsibility, especially in this region of the world; if we do not exercise these responsibilities, others will. It is not of the Brazilian interest that this intervention happens in moments in which peace may be achieved by other means, even if the action is based on full legitimacy, not only politically, but also in the judicial, legal, and we have always defended this point. [...] This is an action that is approved and supported by the Security Council. I also would like to say, as complement, that this mission will have an important civil component. We are studying and discussing how to work on this component. For example, Haiti is a country frail by illiteracy and by diseases such as AIDS. Therefore, Brazil is also studying how to participate – of course, this will also have a cost – on the humanitarian component, the civilian component, and also, from a more strictly diplomatic part.

The Brazilian action assumed a position of not only ensuring the country's political stability, but also to support it towards the improvement of the quality of life of its population. It was emblematic, from a symbolic standpoint, the friendly soccer match between the Brazilian and Haitian national teams, in the Haitian territory, as an expression of friendship and promotion of the country's positive values, in the onset of the MINUSTAH mandate (PERDIGÃO; IPOLITO, 2017).

In the field of Brazilian cooperation for international development, Haiti has also gained priority. The years of 2004 and 2010 are historic milestones in the technical cooperation profile between the two countries: from 2004, the activities and developed projects were more related to policies of fighting hunger and poverty, and from 2010

onwards, they were focused on the reconstruction of the country and on humanitarian cooperation, mainly in the health and food sectors. The Brazilian cooperation itself had to be adapted to provide post-earthquake emergency support, with bulkier projects and with more flexibility to assume activities related to the reconstruction of the country (REGINA, 2016). In 2010, 47.4% of Brazil's expenditure with technical cooperation for international development was targeted to Haiti (IPEA, 2013).

The projects and technical cooperation activities developed by Brazil have focused on the horizontality of actions, highlighting the principle of “joint actions” as a condition for the development of projects. As Perdigão and Ipolito (2017: 112) note, since 2004, “Brazil has not shown any notable restrictions to joint initiatives in Haiti in any area”, and the bilateral and multilateral projects and activities have been carried out not only in health, but also in food security, agriculture, education, professional training, sports, police training, environmental preservation, among others, like the support itself in organizing the electoral process.

## 2 The Haitian national health system

As afore mentioned, the 1987 Constitution of Haiti, drawn up in maintenance context of social mobilization in the end of the Duvaliers' dictatorship, aimed at ensuring social rights to its population. In its articles 19 and 23, respectively, it sets forth that the state has as its obligation to guarantee the right to health and to provide for all citizens the appropriate means the maintenance, protection, and restoration of health – despite the State difficulty to ensure them, as well as the difficulty of Haitian citizens to claim them in the judicial system (HAITI, 1987). Lamaute-Brisson (2013) argues that, opposed to what many would presuppose, the Haitian State assumes actions and positions of social protection and fight against poverty, but there are coverage constraints, both in terms of territory extension and magnitude, which leads to the formation of “islands” with access to social policies and deficiencies of coverage of services in the other areas. Until 2010, those “islands” were highly concentrated in the country's capital, reason why the earthquake was so devastating to the public health system.

From the perspective of the organization of public health services, according to the guidelines of the document *Organisation des soins de santé communautaire* (HAITI, 2016a), from the Ministry of Public Health and Population of Haiti (MSPP), the Haitian national health system is organized in three levels of health care, according to the territorial distribution of services and with community basis, guided by primary care, with decentralized services and of increasing complexity. The following chart summarizes the organization of services according to the levels of care.

**Chart 1** – Organization of public health services in Haiti

Health care level	Services	
Primary	Sublevel 1	Community Health Center – community level Family Health Teams (1 physician, 2 nurses, 4 nursing assistants) Multipurpose Community Health Workers
	Sublevel 2	Health Centers – municipal level
	Sublevel 3	Community Reference Hospitals – district level
Secondary	Departmental Hospitals – departmental level	
Tertiary	University and Specialized Hospital Institutions	

Source: Author's own organization based on HAITI (2016).

Despite the legal and normative provisions, access to health services is limited. In practice, Haitian health services are offered by the following instances: the public sector (MSPP and Ministry of Social Affairs and Labor); the private for-profit sector; the mixed nonprofit sector – private institutions or religious entities; by the private non-profit sector – non-governmental organizations (NGOs), foundations, associations; and by the traditional health system (HAITI, 2016a; MISOCZKY et al., 2015). However, 40% of the population only has access to traditional health. According to the document *Organisation des soins de santé communautaire* (HAITI, 2016a, p.2, own translation), in practice, the public health situation in the country shows that

most families are in a situation of precarious health; and the provision of essentially curative, of insufficient quality, discontinuous and fragmented health services covers only 60% of the population and is not adapted to the needs of the population [...] The organization of services is based on vertical programs and on hospitals (Community Reference Hospitals). Inadequate and irregularly distributed human resources were trained in accordance with this regime and, therefore, performance does not meet the actual health needs of the population.

The difficulty of financial, human and infrastructure resources and service coverage that the MSPP faces also leads to the need to count on the support of NGOs and international partners for the provision of health services. These entities do not always submit to state coordination to maximize coverage and access to services in the country. As noted by Meneghel et al. (2016), there are also difficulties in the production of health information and for epidemiological surveillance, as many of these players and organizations develop their activities based on their own data, and they do not necessarily share it with the Haitian sanitation authority.

Another challenge in the Haitian health system is that the public health services charge fees from users for most part of procedures. Even though it consists of a “sym-

bolic” charge; that there are programs such as vaccination, HIV/AIDS, and malaria are free; that the charge represents only 10% of the costs of a service, and that, in case of evidenced incapacity of payment, the user is exempted from the fee, the charge is a barrier to health care access given the poverty conditions of the population (BORDIN; MISOCZKY, In: MISOCZKY et al., 2015).

### **3 The Brazilian Ministry of Health Cooperation with Haiti**

Since 2004, the Ministry of Health has been one of the main players in Haiti of the Brazilian cooperation for international development. Just like Haiti, which ensured public health as a citizen’s right and a duty of the State in the 1987 Constitution, in Brazil, these features were ensured in 1988, with the establishment of the Unified Health System (SUS) – a universal system of health care, setup after broad social mobilization led by the health reform movement that, differently from the Haitian system, ensures access to the entire population for free, and is guided by the integrality of its actions. The regulation and the actions and policies adopted for the implementation of SUS, starting in 1988, were important decisive steps for the institutionalization of a universal and public health system. As pointed out by Pires-Alves et al. (2012, p. 444), “from an international point of view, the achievements of the Brazilian health reform, although partial, make the health system in Brazil a unique experience, especially in the Latin American context”, generating great respectability and interest in sharing experiences with the Ministry of Health of Brazil.

The international cooperation activities and projects that will be presented in this article had focus on the development of the public health system and on the strengthening of the State as promoter of social development. Furthermore, they were in line with the principles of technical cooperation for international development set forth by the Brazilian Cooperation Agency (ABC), focused on the development of state capacities, strengthening local autonomy for the design and joint implementation of endogenous solutions to development challenges, based on sharing of experiences and approaches to similar challenges (BRASIL, 2013).

The International Health Affairs Office (AISA) has been directly involved with the projects listed in this text, and its action has been strategic for the implementation of the health cooperation with Haiti. Its activities involved negotiating and articulating projects, identifying national and international partners, approving and designing projects, monitoring their implementation by partner institutions – or by other departments and entities linked to the Ministry of Health – or, still, financing activities. Since it has knowledge and expertise in international projects, AISA assumed an important role as coordinator of several activities that have taken place, facilitating the execution of the projects listed. AISA, representing the Ministry of Health, has also maintained a

constant dialogue with the ABC and the Ministry of Foreign Affairs (MRE, acronym in Portuguese), fundamental partners in the activities and projects identified herein. It is understood that activities and projects have brought a positive visibility to the Ministry of Health and to the achievements of SUS and provided valuable learning experiences to the Brazilian health system.

Still in the health area, other institutions developed international technical cooperation and projects activities with Haiti without the direct involvement of the Ministry of Health. ABC, for instance, coordinated projects that had, as Brazilian counterparts, entities such as *Hospital Sírio-Libanês* (Syrian-Lebanese Hospital), for talks on hygiene and formation of multipliers in health education in the context of cholera combat, and the *Pastoral da Criança* (Child's Pastoral), to support initiatives on child's protection (BRASIL, [2017]b). In addition, within the scope of MINUSTAH, Brazilian military health professionals acted in Haitian medical and dental centers, or in campaign facilities, with the goal of bringing together the military and the local population, creating ties of trust and caring for the health of the population, besides supporting the humanitarian response in tragedy situations, such as hurricanes and the 2010 earthquake (PERDIGÃO; IPOLITO, 2017).

### 3.1 Activities and projects in the period 2004-2009

The period from 2004 to 2009 was marked by trilateral technical cooperation projects in which Brazil shared technical knowledge with Haiti, with technical and financial support provided by developed countries or international organizations. The projects focused on strengthening vaccination and breastfeeding, on setting up a human milk bank and on fighting against gender-based violence. It is observed the Presidency of the Republic of Brazil's activism on engagement in the health projects listed below.

#### *Multidisciplinary mission to identify areas of cooperation*

At the time MINUSTAH's mandate started, in July 2004, at the International Donors' Conference for Haiti, held in Washington, Brazil assumed the commitment to contribute with technical cooperation projects in Haiti and to mobilize donors to support these activities (VALLER FILHO, 2007).

On August 18, 2004, in a visit to Haiti, the President Luiz Inácio Lula da Silva issued a joint statement with the Haitian Prime-Minister, Gérard Latortue, in which they announced a multidisciplinary mission, for the following week, for the identification of areas in which the countries could develop cooperation projects.

The multidisciplinary mission was comprised by technical experts in health from the Ministry of Health, as well as experts in sanitation, agriculture, justice, civil defense, infrastructure, education, sports and social development areas (BRASIL, 2005b). It was identified the possibility of working in a mass vaccination program or in capacity-building in combating malaria and tuberculosis – which, later, led to the project to strengthen the Haitian Immunization Program, in partnership with Canada (VALLER FILHO, 2007).

### *Strengthening of the Haitian Immunization Program*

In November 2004, President Luiz Inácio Lula da Silva and the Canadian Prime-Minister Paul Martin, in his visit to Brazil, issued a joint statement in which they expressed the willingness of jointly cooperating to the benefit of a third country, Haiti (BRASIL, 2004d, p. 454):

Continuing the cooperation that Brazil and Canada have been providing to Haiti, the two leaders decided to urgently send a joint mission of technical cooperation in the field of public health to that country and they determined that other areas of partnership with Haiti should be analyzed.

According to ABC, cooperating with a developed country for the benefit of a third developing country was, until then, an unprecedented experience for the Brazilian technical cooperation for international development (BRASIL, 2005b).

In February 2005, there was a mission to Haiti with experts from both countries to prospect, with the Haitian entities, a project to be implemented through trilateral cooperation. The mission identified public health system organization, epidemiological surveillance, immunization, and sanitary engineering, as priority areas. At the end of the mission, experts from the three countries prepared a work plan proposal in support of the Haitian immunization program, with some sanitation engineering and health system organization activities (BRAZIL, 2005b). In July, a mission with immunization technicians from the Ministry of Health of Brazil went to Haiti with the goal of presenting a proposal of technical cooperation, with emphasis on human resources capacity-building, cold chain restructuring<sup>5</sup> and implementation of information system

<sup>5</sup> According to the Cold Chain Manual (*Manual de Rede de Frio*) (BRASIL, 2001, p. 11), “cold network or cold chain is the process for storage, conservation, handling, distribution and transportation of immunobiologicals (...) and should have suitable refrigeration conditions from the producing laboratory until the time the vaccine is administered. The Cold Chain target is to ensure that all administered immunobiologicals keep their initial characteristics to ensure immunity, considering that they are thermolabile products, that is, they deteriorate after a certain time when exposed to temperature variations unsuitable for their preservation. Heat accelerates the inactivation of immunogenic components”.

for managing vaccines and pharmaceutical supplies, in addition to supporting mass vaccination against hepatitis B and rubella. The mission met with technicians from the Haitian government and the Canadian International Development Agency (CIDA) besides visiting health units (BRASIL, 2005a).

In May 2006, in an international meeting held in Brasilia for coordinating the works by countries and international agencies operating in Haiti, Brazil, Canada and Haiti entered into agreements to enable the implementation of a trilateral project (VALLER FILHO, 2007). On the Brazilian side, the “Subsidiary Arrangement to the Technical-Cooperation Agreement between Brazil and Canada, in order to Implement the Project ‘Strengthening the Haitian Immunization Program’” was signed, and the “Subsidiary Arrangement to Technical-Cooperation Agreement between Brazil and Haiti, to Implement the Project ‘Strengthening the Haitian Immunization Program’” was signed with Haiti (BRASIL; CANADÁ, 2006; BRASIL; HAITI, 2006).

The project document between the three parties was signed in April 2007, with a budget of USD 2.1 million, approximately USD 700 thousand from Brazil<sup>6</sup>. The Canadian side paid for part of technicians’ daily allowances and tickets and undertaking most of the procurement and logistic activities in the project, in addition to the acquisition and donation of 425 thousand doses of vaccine against rubella. Haiti provided human resources and facilities to support the project implementation. A technical committee for project management, with participants from the three parties, met periodically to monitor the progress of the activities until the project was completed, in December 2008.

As activities, Brazil promoted the exchange of experiences – with arrival of a team of five Haitians to get acquainted with the Brazilian National Immunization Program, in July 2008, and with the presence of Brazilian focal points of technical support in Haiti, between October 2007 and December 2008, being uninterrupted between May and December 2008. Other activities consisted of training on cold chain, supporting the development of vaccination campaigns and information system, as well as supporting the preparation of manuals for vaccination facilities and technical specifications for the Program, and training of 11 multipliers and 42 nursing assistants. The Canadian side assumed most of the logistic activities in the project. Four computers were purchased for the implementation of information systems, in addition to thermometers, refrigerators and freezers to improve storage capacity and control of the cold chain.

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<sup>6</sup> USD 650,000 from the Secretariat of Health Surveillance of the Ministry of Health were used to pay for staff technical hours, daily allowances and plane tickets, supporting the development of information system and acquisition and donation of 1.2 million doses of hepatitis B vaccine, for a mass vaccination campaign; and USD 32,000 from ABC, for daily allowances and plane tickets, in addition to preparation of manuals and teaching materials.

### *Human Milk Bank*

In December 2008, the French First-Lady Carla Bruni Sarkozy, in a visit to Rio de Janeiro, visited the Fernandes Figueira Institute's human milk bank, of the Oswaldo Cruz Foundation (Fiocruz). At the visit, Fiocruz proposed a joint action between Brazil, France, and Haiti to establish a human milk bank in Haiti, meeting a Haitian demand (BRASIL, 2008a).

In July 2009, there was a technical mission from the Ministry of Health and Fiocruz to Haiti, to carry out a technical diagnosis in institutions indicated by the Haitian government, aiming at developing a cooperation project to implant human milk banks in the country, in a triangular partnership between Brazil, France and Haiti (BRASIL, [2012]).

On September 7 of that same year, President Luiz Inácio Lula da Silva and the President of France, Nicolas Sarkozy, who was visiting Brazil, issued a joint statement on a project to set a human milk bank in Haiti in a partnership between ABC and the French Development Agency (AFD) for Haiti. On the 18th of the same month, during a visit to Haiti, the Brazilian and the French Ministers of Foreign Affairs, Celso Amorim and Bernard Kouchner, signed, in Port-au-Prince, a declaration of intent concerning the installation of a human milk bank in Haiti (BRASIL, 2009).

The earthquake in January 2010 was an obstacle to continue ongoing actions, as the destruction shifted the priorities of the Haitian government to the reconstruction of their health system. Nevertheless, in September 2010, was signed the "Subsidiary Arrangement to the Technical-Cooperation Agreement between Brazil and Haiti to Implement the Project 'Support in the Implementation of a Human Milk Bank in Haiti'" (BRASIL; HAITI, 2010).

In June 2011, there was a technical mission from the Ministry of Health and Fiocruz to Haiti, to design a project for the installation of a human milk bank at a university hospital (BRASIL, 2011b). The mission promoted the exchange of experiences, but the project to implement a human milk bank was not continued.

### *Prevention of violence against women in Haiti*

In 2005, ABC organized a mission to identify possibilities for establishing a project to prevent gender violence in Haiti. In May 2008, Brazil and Haiti signed the "Subsidiary Arrangement to the Technical-Cooperation Agreement between Brazil and Haiti to Implement the Project 'Prevention of violence against women in Haiti'" (BRASIL; HAITI, 2008). The project, also signed in 2008, in partnership with the United Nations Population Fund (UNFPA), OXFAM, and Haiti, through the Ministry of Women's Affairs, proposed to support the treatment of women victims of violence,

the strengthening of healthcare services, as well as legal and medical assistance, in addition to the implementation of pilot police stations for women in Haiti (BRASIL, 2008b).

On the Brazilian side, it had the participation of ABC, the Secretariat of Policies for Women of the Presidency of the Republic, and the Ministry of Health. In the field of health, there was exchange of experiences and, in order to strengthen the operational network for assistance and reference for women victims of violence, a training was offered to over 70 health professionals in Haiti (UNFPA, 2011).

### *Humanitarian Cooperation*

Within humanitarian cooperation<sup>7</sup>, between 2006 and 2009, 2.1 million doses of canine and human rabies vaccine were donated in support to the program to eradicate rabies in Haiti. Between 2007 and 2008, in response to the hurricanes, 1.8 ton of basic medicines were donated, in addition to antifungal medicines, diuretics and drugs against malaria and tuberculosis.

## **3.2 Tripartite Cooperation Brazil-Cuba-Haiti (2010)**

On January 12, 2010, the earthquake caused a big devastation in Haiti, with over 200 thousand casualties, one million unsheltered, and 300 thousand buildings destroyed in a country whose population was estimated at 10 million people at that time (HAITI, 2009). Bordin and Misoczky (MISOCZKY et al., 2015, p. 38) point out that the earthquake of 2010 generated, among other situations, the following impacts and repercussions in the health sector:

[...] in the three departments affected, 60% of the hospitals were severely damaged or destroyed; [... there were] 10,000 people with several disabilities, over 4,000 amputations were performed, 400 became quadriplegics and a large number of people developed mental health problems after the earthquake; economic disruption and destruction of infrastructure and public services [...]; reduction in the supply of health services, due to the destruction of installed capacity or decrease in the total number of health professional (wounded as consequence of the earthquake or by exodus), leading to a full disorganization of public health services; worsening of the management capacity of the Ministry of Health, which was already low, either in coordination, infrastructure, equipment, or human resources.

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<sup>7</sup> The article in this book “Humanitarian cooperation in health”, by Raquel Machado and Tatiane Lopes Ribeiro de Alcântara, details the donation mechanism of medicines, supplies and vaccines by the Ministry of Health.

In response to this situation, and to strengthen its health system, the Haitian government opted for two strategies: emergency care to the population affected by the earthquake, and reconstructing and restructuring the national health system, through an increment in health services coverage.

Immediately after the earthquake, the Brazilian government set a Crisis Security Cabinet, coordinated by the Institutional Security Office, with the participation of the of the Presidency of the Republic, the Ministries of Defense, Planning, Foreign Affairs and Health, and the Civil Defense. The Cabinet evaluated the emergency actions and determined to send financial aid to Haiti in support of its reconstruction strategy. It has also requested the Ministry of Health to send a mission to assess the epidemiological risk and the setup of a working group to define the scope of supporting the country in the realm of health.

The Institutional Security Cabinet coordinated the release of funds to an extraordinary credit line to Haiti, on January 27, 2010, through Provisional Measure No. 480, later converted into Law No. 12,239 of May 19, 2010, assigning the amount of BRL 375 million, being BRL 135 million for the Ministry of Health (MoH) to develop emergency actions and technical cooperation projects to strengthen the Haitian Ministry of Public Health and Population (MSPP). Additionally, BRL 205 million were assigned to the Ministry of Defense and BRL 35 million to the Ministry of Foreign Affairs (BRASIL, 2010). The resources distribution shows the prioritization given by the Brazilian government to health in the activities to support the reconstruction of Haiti. There is, also, a peculiarity that deserves to be highlighted in this project, which is the fact that funds were directly released to the MoH – and not through ABC, as it usually occurs in the technical cooperation flow – in view of the emergency.

In the context of emergency response to the earthquake, the MoH quickly articulated with international organizations, such as the Pan-American Health Organization (PAHO/WHO) and other UN agencies acting in the response to the disaster, especially the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), that coordinated the emergency response, and the task forces from other countries. Besides the mission to assess the epidemiological risk, the MoH organized the registry of volunteers<sup>8</sup> for humanitarian help in the realm of health, and it sent the donation of 400 tons of medicines<sup>9</sup>. A group of Brazilian physicians and nurses, from the Conceição Hospital Group, linked to the MoH, and to the Mobile Emergency Care Service (SAMU) from the Brazilian state of Ceará, worked on an Italian hospital ship for about a month providing emergency healthcare to the population. Two experts from the National Health Foundation (Funasa, acronym in Portuguese), linked to the MoH, were also sent to the

<sup>8</sup> The Health Hotline (Disque Saúde) included “option 7” in the Audible Response Unit as electronic message informing on the catastrophe and opening space for donations or registration of volunteer health professionals.

<sup>9</sup> Donations from the Ministry of Health and other institutions or from volunteers.

country to support water quality assurance in the context of the Brazilian response to the earthquake, as well as to train the Brazilian battalion serving in Haiti to install water treatment equipment (OLIVEIRA JUNIOR et al, 2011).

For the strategy of restructuring the health system, the Haitian government defined as priority areas (MISOCZKY et al., 2015, p. 27):

(a) the definition of the model to be implemented; (b) strengthening the leadership of the Ministry of Health on the components of the health system and essential public health functions; (c) massive investment in human resources; and (d) strengthening logistics in transportation, communications and essential materials and medicines.

Aiming to support the Haitian strategy of restructuring the health system, the MoH coordinated one of the largest projects of international technical cooperation in the history of Brazilian cooperation in volume of financial resources. As suggested by Haiti, the project happened in a partnership between the Ministries of Health of Brazil, Cuba, and Haiti, considering that Cuba had been working in Haiti for over ten years<sup>10</sup> through its Medical Brigade, with around 700 health specialists and technicians financed by the Cuban government. In addition, there were other points of approximation between Brazil and Cuba, such as the experiences and techniques in the health sector and in sharing the conception of universality in the health systems.

On March 27, 2010, the Ministers of Health from the three countries, José Gomes Temporão, José Balaguer Cabrera and Alex Larsen, and the President of the Haitian Republic, René Préval, signed the Brazil-Cuba-Haiti Memorandum of Understanding for the “strengthening of the system and of public health services and epidemiological surveillance in Haiti”, which established the “Tripartite Cooperation Brazil-Cuba-Haiti”. Through the document, each country assumed the following commitments:

- Brazil: to support the recovery and construction of hospital facilities; to contribute in the procurement of equipment, ambulances and health supplies; provide scholarships to train Haitian health professionals; to support the qualification of assistance management and epidemiological surveillance in Haiti; and to support measures for strengthening the basic healthcare system in Haiti.
- Cuba: to provide support and advise on operations logistics; to collaborate with the availability of health and support professionals; and to support the training of Haitian health professionals.

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<sup>10</sup> In 1998, after hurricane George hit Haiti, Cuba resumed its diplomatic relations with the country – after 36 years of interruption, which started in the Duvalier dictatorship – and it sent physicians and other health professionals to work in the country providing support to the healthcare of the Haitian population, keeping them in activity until the present time (KASTRUP et al, 2017).

- Haiti: to identify areas for the setup of health units; to identify health units to be rehabilitated; to support the identification of logistics; to provide safety to health units; to identify health professionals to be qualified; to identify young high school students to be trained in the health technical sector; and to be accountable for the full salary of the Haitian professionals who will work in the facilities stated in the Memorandum.

The Memorandum established the Tripartite Steering Committee, an instance of dialogue and decision-making among project coordinators from each country. The Committee has had quarterly meetings and it is still in operation<sup>11</sup>. It was responsible for the harmonization of proposals and by the solution of challenges identified throughout the project. It has also strengthened MSPP coordination role. The project activities were also defined within the Tripartite Steering Committee throughout their execution – as an example, the project “BRA/10/005 – Project of South-South Cooperation for Strengthening the Health Authority of Haiti”, instrument through which Brazil accomplished most of its commitments, was only signed in November 2010, after four deliberative meetings of the Committee.

Differently from the trilateral agreements held prior to 2010, in which the Ministry of Health carried out activities in Haiti, in this project the MoH assumed in addition to technical support, the role of greater provision of funds, including for logistics, construction, and reform issues. The operationalization of the partnership between the three countries came through the individual commitments that each of them assumed, with its implementation harmonized in the Steering Committee, in which the three countries equally discuss the technical and political issues of the cooperation.

In addition to the Steering Committee, technical working groups were established, involving players from the three countries, according to specific and defined topics as priorities for the project execution – health care, rehabilitation of physical disabilities, urgency and emergency, training of human resources in health, epidemiological surveillance and immunization, organization of the health services network, mental health and communication in health<sup>12</sup>. There was an intense technical exchange and exchange of experiences between the three countries, and diagnoses were produced of the Haitian health system, of its operation, needed human resources, primary health-care, epidemiological surveillance, mental health, among other topics.

To comply with the commitments made in the Memorandum of Understanding, Brazil developed actions “having as basic principle the strengthening of Haiti’s health authority, [...] with] focus on institutional strengthening for restructuring of the Haitian health system” (BRASIL, 2014b) involving domestic institutions with wide experience

<sup>11</sup> In June 2018 the 35th Meeting of the Tripartite Management Committee was held. Note for the English version: the last Meeting (the 36th) was on November 2018, after the conclusion of this article (June 2018).

<sup>12</sup> For more information, see BRASIL (2014b) and other publications mentioned herein.

in the agreed work areas. On the Haitian side, MSPP cooperated and, on the Cuban side, the Cuban Medical Brigade.

On the Brazilian side, The Ministry of Health in Brazil is the coordinator and responsible for project financing and execution in partnership with the ABC, which monitors the fulfillment of agreed goals, targets and outcomes. The project coordination, initially carried out by AISA, is currently under the responsibility of the Department of Health Economics, Investments and Development (DESID, acronym in Portuguese), of the Ministry of Health Executive Secretariat.

The following education and research institutions also participated through agreements: the Oswaldo Cruz Foundation (Fiocruz), the Federal University of Rio Grande do Sul (UFRGS, acronym in Portuguese) and the Federal University of Santa Catarina (UFSC, acronym in Portuguese). In addition, partnerships with the following international organizations were established for the implementation of activities: the United Nations Development Program (UNDP), the Pan American Health Organization (PAHO/WHO), and the United Nations Office for Project Services (UNOPS).

The agreement with Fiocruz involved training activities in healthcare, health surveillance, general training in vocational education, health communication, as well as laboratory techniques, work processes, educational technologies and maintenance of health equipment. The agreement with UFRGS was responsible for developing processes and activities to strengthen the organization of the health services network in Haiti. The agreement with UFSC predicted the support on training in primary care and education of health community workers, nursing assistants, and sanitary inspectors. The technical action of these institutions was coordinated in the MoH, by its secretariats, according to working areas.

The “BRA/10/005 – South-South Cooperation Project for Strengthening the Health Authority of Haiti” was signed with the UNDP, which was responsible for the constructions and reforms undertaken, for the procurement of ambulances, vehicles, equipment, and inputs, for the maintenance of the Community Reference Hospitals (HCR, acronym in French) and for the logistic support in trainings carried out. Two partners were included in the BRA/10/005 project: the UNDP transferred some activities, through an Agreement Letter, to the UNOPS, which implemented the physical structures of the project and monitors the maintenance of the HCR; and to the PAHO/WHO, which supported the implementation of the procurement and distribution of medical supplies and medicines activities with its Program for Essential Drugs (PROMESS, acronym in French). It was also signed, in 2014, the “Community Reference Hospitals Maintenance Plan”, as complement to BRA/10/005, for the allocation of funds remnant from Law No. 12,239 of May 19, 2010, for the maintenance of the HCRs.

There was also a cooperation agreement directly with PAHO/WHO to support the organization activities of the health system and services, the training and qualification program of community health workers and other health professionals, and the Haitian program for immunization and epidemiological surveillance, in activities such as technical and logistical support to the 2012 vaccination week, selection and training of professionals for the task force on immunopreventable diseases, supporting the development and launching of the cholera contingency plan and facilitation of strategic planning of cooperation activities (MISOCZKY et al., 2015). The following chart summarizes the main projects executed by Brazil in the scope of the Tripartite Cooperation Brazil-Cuba-Haiti, indicating partners, object, and total amount in BRL.

**Chart 2** – Projects established by the Ministry of Health with funds from Law No. 12,239 of May 19, 2010, targeted to the Tripartite Cooperation Brazil-Cuba-Haiti, according to partnership, object, and total amount

<b>Partner and partnership term</b>	<b>Object of the project</b>	<b>Total amount (BRL)</b>
Project document with the UNPD (partnerships with UNOPS and PAHO/WHO)	BRA/10/005 – Project of South-South Cooperation for Strengthening the Health Authority of Haiti	92,727,366.00
Project document with the UNPD (partnerships with UNOPS and PAHO/WHO)	Sustainability of the BRA/10/005 Project through the Implementation of a Maintenance Support and Operation Supply Program (Community Reference Hospitals Maintenance Plan)	12,507,358.06
Term of Cooperation with PAHO/WHO	Strengthening of Epidemiological Surveillance and Support to the Haitian Immunization Program	10,044,540.00
Agreement with UFSC	Education of human resources in Primary healthcare	6,500,000.00
Agreement with Fiocruz	Development of activities in epidemiology, immunization, information and communication in health areas	5,750,000.00
Term of Cooperation with PAHO/WHO	Support to the Haitian Immunization Program	4,180,743.71
Agreement with UFRGS	Management and organization of Health services in Haiti and Preparation of Assistance Management Protocols	2,015,600.00
Direct acquisitions through the Ministry of Health	Procurement of supplies and medicines	924,946.57

Source: DESID/SE/MS, May 2017.

Notes: In total amounts, there is variation due to exchange rate fluctuation during the period. All projects are concluded, except the projects in partnership with the UNPD, to be completed in July 2018, according to Substantive Review 6 of BRA/10/005 (BRASIL, 2016)<sup>13</sup>.

<sup>13</sup> Note to the English version: these projects were concluded on November 2018, after the publishing of the original version of this article.

Considered the dimension of the project being discussed, it would be risky to survey all activities and outcomes in an article, such as this. For further information, refer to existing studies for overall information on the tripartite cooperation and meeting minutes of the Tripartite Steering Committee (BRASIL, 2011a, 2012b, 2014b); support in setting up health services networks (MISOCZKY et al., 2015); communication in health (GOMES; OLIVEIRA, 2015); relation between the Tripartite cooperation, Brazilian foreign policy, and the activism of President Luiz Inácio Lula da Silva (REGINA, 2016); education activities in epidemiological surveillance (MENEGHEL et al., 2016); ethnographic approach of practices and perspectives of the players involved with the program (ESTEVEZ, 2016); training of human resources in health (KASTRUP et al., 2017); Brazilian action in the Haitian health as a means of foreign policy (PERDIGÃO; IPOLITO, 2017); and strengthening of State capacities, project BRA/10/005 and its complementary Community Reference Hospitals Maintenance Plan (LUZ, 2018).

The main activities implemented are presented next, with emphasis on the deliveries carried out and normally disseminated by the Ministry of Health on its institutional texts about the Tripartite Cooperation.

### *Human Resources in Health*

There was a great effort in training human resources in health, as demanded by the Haitian government and foreseen within the working group on this issue. The training was provided to 1,237 multipurpose health community workers<sup>14</sup>, 310 multipurpose nursing assistants, and 53 sanitary inspectors. There was also the undertaking of training or courses in other areas, such as epidemiology of non-immunopreventable diseases (malaria, dengue and HIV); management of physical and technological resources in the health area; production of audiovisual material for health promotion; training of journalists about health; and specific trainings for the implementation of two regional public health laboratories in Haiti, among others.

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<sup>14</sup> Interviews with Haitian interlocutors revealed that the health community workers were already an existing figure in the Haitian community health since 1980s, in a scattered manner, due to the influence of the 1978 Alma-Ata Declaration. The Tripartite Cooperation Brazil-Cuba-Haiti was the opportunity to strengthen this policy: the current national curriculum for the training of community health workers is mostly inspired on the one proposed by the cooperation; the impressive dimension of the action also strengthened the community health policy in the MSPP; finally, this activity was an opportunity for defining the functions of professionals in the family health team (physicians, nurse, nursing assistant and community health workers), which until then was diffuse and poorly determined in the scope of the national policy. Additionally, the relationship between workers and community has revealed a social demand and a constant need of institutionalizing community participation in the health units, and according to consulted interviewees, the MSPP studies a means to implement a social participation policy in health (LUZ, 2018).

## *Support in restructuring the health system*

Three Community Reference Hospitals (HCR, acronym in French) were built in the metropolitan region of Port-au-Prince, in Bon Repos, Beudet e Carrefour<sup>15</sup>, inspired by the Brazilian model of the 24h Emergency Care Units (UPA), enlarged with other services related to the HCR service in Haiti. Furthermore, in Bon Repos, the Haitian Institute for Rehabilitation and the Orthotics and Prosthetics Factory were built<sup>16</sup>.

The HCR were inaugurated in May 2014, in a ceremony with the presence of the Brazilian Minister of Health, Arthur Chioro. Since then, the Ministry of Health has foreseen, through the project BRA/10/005 and its complementary project “Community Reference Hospitals Plan”, the maintenance and funding of certain activities of built hospitals, such as hiring physicians and local health professionals, the provision of propane for the maintenance of electric power generator, the regular provision of goods and services, and global activities of maintenance and trainings (BRASIL, 2014b; MISOCZKY et. al, 2015). Currently, the three hospitals are integrated to the Haitian public health system, acknowledged as a model of service organization – the MSPP considers, inclusively, transforming them into a practice field for university education for health professions (LUZ, 2018).

The Haitian Institute for Rehabilitation<sup>17</sup> was the first and largest public structure in the country to assist disabled people and it has been considered as a model to foster physical rehabilitation in the country. The report of the United Nations Economic Commission for Latin America and the Caribbean (ECLAC) about the physical disability in Haiti (VALENCIA, 2015), for example, highlights the innovation and the importance of this structure for the disabled people health.

## *Epidemiological Surveillance and Immunization*

The epidemiological surveillance sector was strengthened by the exchange of experience, training of specialists and technical, operational, financial and material support. Brazil supported the reconstruction of two laboratories specialized in epi-

<sup>15</sup> Bon Repos and Beudet are new hospitals, built in regions that became more densely populated after 2010 earthquake due to migration to the surroundings of Port-au-Prince. The Carrefour HCR was rehabilitated in the same site where the previous hospital had been destroyed by the earthquake.

<sup>16</sup> Its conception had the support of the Rehabilitation Technical Working Group for the activities related to the construction, implementation and operation of the Institute and the Factory, which had the partnership with the National Secretariat for the Promotion of the Rights of Disabled People (SDH/PR) and the Institute of Social Responsibility of Albert Einstein Hospital, in projects coordinated by ABC.

<sup>17</sup> In September 2010, the “Subsidiary Arrangement of Technical-Cooperation Agreement between Brazil and Haiti to Implement the Project ‘Haiti-Brazil Institute for the Rehabilitation of Disabled People’” was signed (BRASIL; HAITI, 2010). The implementation of the institute, which initially was a project of ABC, ended up incorporated to the Tripartite Cooperation activities.

miological surveillance in Cape Haitian and in Les Cayes, through the rehabilitation of physical structures and procurement of equipment. The laboratories allow for epidemiological surveillance exams and surveillance of water quality and of biological environmental factors (vectors, hosts, reservoirs and venomous animals). There was also an exchange of experiences and training in epidemiology, in addition to completion of the training program for 53 sanitary inspectors, as mentioned above.

Activities in the field of health communication were carried out to support and publicize campaigns and to increase awareness and health education of the population. This activity involved also a partnership with local community radios to broadcast the information.

The MoH also supported the Haitian Immunization Program, contributing for the immunization of three million children in oral vaccination campaign against poliomyelitis (children 0-9 years old) and double viral vaccine against measles and rubella (children from 9 months to 9 years old).

Furthermore, there was also the construction of three vaccines storage facilities, support in the maintenance of refrigerators to preserve vaccines (with the installation of solar power panels and acquisition of propane for electric power generators), and the purchase of three trucks with cooling system for vaccines transportation. Until then, the storage of medicines, vaccines, and supplies for the country was done essentially by PAHO/WHO at the storage facility in Port-au-Prince, in the central-western region of the country. The storage facilities built by the project in Jérémie, Port-de-Paix and Fort-Liberté – in the southwest, northwest and north regions of the country, respectively – were donated to the MSPP and allowed for setting up a logistic network in strategic points to deepen the immunization policy and enable vaccination campaigns and medicines and supplies storage at those locations, enabling the decentralization of storage.

### *Urgency and emergency*

The project acquired thirty ambulances to support the urgency and emergency service in the country. Moreover, it promoted the exchange of experiences with the Brazilian Mobile Emergency Care Service (SAMU, acronym in Portuguese), with a Haitian technical mission in Brazil and the deployment of Brazilian technicians to Haiti to support the institutionalization of the Haitian National Ambulance Center (CAN, acronym in French).

### *Current Status*

The Ministry of Health accomplished all commitments assumed by the project, remaining in the execution the HCR activities and maintenance. The period of

maintenance, which started in 2014, planned for 24 months, was extended until July 2018 (BRASIL, 2016)<sup>18</sup>. However, there were some constraints for the Haitian government to fully assume the maintenance activities of these hospitals, upon completion of this project, which has been assured until 2020 by the “Project for Strengthening the Management of Services and the Health System in Haiti”, signed in 2017, with funds from Brazilian donation to the Haiti Reconstruction Fund in 2010, as discussed below.

### 3.3 Haiti Reconstruction Fund (2017)

After the 2010 earthquake, the Haitian government established the Haiti Reconstruction Fund (HRF), in partnership with bilateral and multilateral donors, to support financing the recovery, reconstruction, and development of the country. The HRF is managed by the World Bank Group and is supported by a Steering Committee chaired by the Haitian government and comprised by the World Bank, the UN, and the main donors of the fund, who have a minimum contribution of USD 30 million – in addition to Brazil, Canada, Spain, the United States, Japan, and Norway. Brazil participates on the Steering Committee, with a representative appointed by the Ministry of Foreign Affairs.

Brazil was the first country to contribute with the Fund, with a donation of USD 55 million, announced by the Secretary-General of the Ministry of Foreign Affairs, Antonio de Aguiar Patriota, in a ceremony at the World Bank, in Washington, on May 11, 2010 (BANCO MUNDIAL, 2010). The Brazilian donation would have two destinations: USD 15 million were allocated to support the budget of the Haitian government that year, and USD 40 million would be used to support the construction of a dam and hydroelectric plant Artibonite 4C, which would be the first hydroelectric plant in the country and it already had a technical study carried out with Brazilian support in 2008 (BRASIL, 2011c). Between 2011 and 2013, Brazil sought to enable, with possible international partners, the availability of additional resources required by the Artibonite 4C project, estimated in over USD 100 million. In the beginning of 2014, the Haitian government informed the Brazilian government that they had been in contact with a Chinese group to finance and build the hydroelectric plant.

Therefore, in May 2014, the Steering Committee of the HRF decided to allocate USD38.6 million of the funds donated by Brazil to bilateral projects of technical cooperation in health, education (vocational training), and agriculture, with USD 20 million for health, USD 17 million for education and USD 1.6 million for agriculture (FRH, 2014). In August 2014, negotiations of the new health project started, involving ABC

<sup>18</sup> Note to the English version: Tripartite Cooperation projects were concluded in November 2018, after the publication of the original version of this article. At the conclusion of the project, the Ministry of Health released the documentary “Haiti – Janvier 12”, available at <<https://www.youtube.com/watch?v=jhEI55Ys7ck>>.

and the MoH on the Brazilian side. According to the rules of the HRF and the World Bank, the project must be carried out by a UN agency. The UNPD Brazil was then chosen, due to the successful partnership of the Tripartite Cooperation Brazil-Cuba-Haiti.

After intense negotiation between Brazil and Haiti, the “BRA/17/018 – Project for Strengthening the Management of Services and the Health System in Haiti” was designed. The project was signed in June 2017, during the visit by the Minister of Health, Ricardo Barros, to Haiti, to participate in the ceremony when the Community Reference Hospital of Bon Repos, built with Brazilian resources in the scope of the Tripartite Cooperation, was named “Community Reference Hospital Dr. Zilda Arns”, as an homage to the illustrious Brazilian who died during the Haitian earthquake. The signature took place in a joint ceremony at the Dr. Zilda Arns HCR, with the presence of the Brazilian Minister of Health, Ricardo Barros, the Haitian Minister of Public Health and Population, Marie Greta Roy Clément, the UNDP Resident-Representative in Brazil, Niky Fabiancic, and the Brazilian Ambassador in Port-au-Prince, Fernando Vidal de Melo (PNUD, 2017; BRASIL, 2017c).

The management arrangement of the project foresees that the UNPD Brazil be the managing agency and responsible for project implementation- differently from the Tripartite Cooperation, whose execution was national and responsibility of the MoH – with technical coordination of actions by the Ministry of Health and the ABC. At the MoH, the Ministerial Ordinance SE No. 780 of July 20, 2017 assigned the coordination of the activities to the Department of Health Economics, Investments and Development (DESID), of the Ministry of Health Executive Secretariat.

The project has two strategic axes. The first axis is intended to support and strengthen the urgencies and emergencies system of Haiti. The project document foresees the following activities for this axis: system diagnosis; support to the constitution of an organizational structure targeted to MSPP urgencies; definition of flows, referencing, protocols, manuals and good practices of the urgency system; training in related topics; continued education; physical structuring of services to be identified; and updating and reintegrating community health workers into the health system. For the physical structuring activities, the UNDP Brazil has signed an Agreement Letter with the UNOPS Haiti; for activities concerning training, continued education, and updating and integrating community health workers into the health system, it signed an agreement letter with PAHO/WHO Haiti, which will implement all activities, including in the technical component.

The second axis foresees the continuity of the HCR maintenance, built by the Tripartite Cooperation for three years and it includes, furthermore, the costs of a structure not yet included in the 2014 Maintenance Plan, the Haitian Institute for Rehabilitation. It also includes the designing of a sustainability plan to transfer the ser-

vices and completion of maintenance in 2020. For the implementation of the activities in this axis, the UNDP Brazil signed an Agreement Letter with UNOPS Haiti.

Differently from the Tripartite Cooperation, in which there was an intense technical exchange between the institutions from Brazil and Haiti, in the project of the Haiti Reconstruction Fund, priority is given to the allocation of funds in UN agencies, which implement, inclusively, the technical activities through their consultants, benefiting the strengthening of Haitian institutions.

In January 2018, the Minister of Health, Ricardo Barros, visited Haiti again to take part in the inauguration ceremonies of the Surgical Center of Hospital Saint-Antoine and the vaccines and supplies storage facility in Jérémie; to announce the beginning of the maintenance of the Haitian Institute for Rehabilitation; to visit the National Ambulance Center; and to participate in the ceremony in memory of Dr. Zilda Arns (BRASIL, 2018b).

By the time this article was concluded<sup>19</sup>, the project had started funding the structures of the Tripartite Cooperation and it had supported the rehabilitation of a surgical center in Jérémie. It also provided support to the rehabilitation of the National Ambulance Center headquarters, the procurement of new ambulances, and to the renewal of ambulances donated by the Tripartite Cooperation. Trainings on issues related to mobile emergency care are also foreseen (BRASIL, 2018b). Finally, the MoH project coordination negotiated activities that will be implemented by PAHO/WHO in Haiti. The project is available for public consultation (PNUD, 2017), in order to allow for following-up its execution by the involved institutions.

### 3.4 Other activities and projects after 2010

In the aftermath of the earthquake, other smaller scale activities or projects were carried out. They were related to the strengthening of national policies linked to combating cholera and the improvement of the water quality, as well as related to the issue of HIV detection.

Cholera is a waterborne disease that became epidemic in Haiti after the earthquake, supposedly introduced in the country in 2010 by Nepalese troops serving in MINUSTAH. It spread rapidly, due to the poor sanitation conditions and access to potable water in the country, besides the aggravated condition of social vulnerability after the disaster. The UN objective responsibility for the introduction of cholera in the country was recognized by the UN Secretary-General Ban Ki-Moon, only in December 2016. In 2017, the United Nations urged countries to cooperate in combating cholera in Haiti.

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<sup>19</sup> June 2018.

The cholera epidemics has had, since 2010, approximately one million confirmed cases and ten thousand deaths, according to information provided by the Ministry of Public Health and Population (HAITI, 2018b). According to the National Directorate for Potable Water and Sanitation of Haiti (DINEPA), 58% of the population in the country has access to potable water and 20% has access to basic sanitation (HAITI, 2018a).

### *Regional Coalition for Water and Sanitation to Eliminate Cholera*

The National Health Foundation (Funasa), linked to Ministry of Health of Brazil, joined, in 2012, the “Regional Coalition for Water and Sanitation to Eliminate Cholera in Hispaniola”, a PAHO/WHO initiative in partnership with Funasa, the United Nations International Children’s Emergency Fund (UNICEF), the Center for Disease Control and Prevention in the USA (CDC), the Spanish Agency for International Development Cooperation (AECID), the Inter-American Development Bank (IDB), the World Bank, the Inter-American Association of Sanitary and Environmental Engineering (AIDIS), and the Organization of American States (OAS) (OPAS, 2012).

In 2014, Funasa promoted the sharing of water analysis techniques through the production of the “Practical Handbook of Water Analysis” in French and Spanish and provided two thousand copies in French to the Haitian government. In 2015, it produced and made available in Spanish and French, the virtual course “Water Safety Plan”. The activities were carried out in partnership with PAHO/WHO, responsible for the local implementation and for the use of materials produced by Funasa.

### *Water quality*

In Haiti, combating cholera is under the responsibility of the Ministry of Public Health and Population of Haiti (MSPP) and the National Directorate for Potable Water and Sanitation of Haiti (DINEPA). According to information from these institutions, currently there are eight priority areas in the country where the incidence of cholera is higher. Access to safe, quality water is one of the country’s key strategies for combating cholera, especially in these priority areas (HAITI, 2018a).

In August 2017, Funasa experts accompanied a Brazilian mission to participate in the 31st Meeting of the Tripartite Steering Committee and presented the areas of activity of the Foundation to the Minister of Public Health and Population of Haiti, Marie Greta Roy Clément (BRASIL, 2017b). In September 2017, the MSPP requested Brazilian support to strengthen the policy of the quality of water in the country.

In May 2018, a mission composed by Funasa, the Ministry of Health (technicians from AISA and from the Secretariat of Health Surveillance) and the ABC carried out a prospection visit in Haiti on the topic of water quality. Among other activities, the

mission visited the communities of Village des Pêcheurs and Petit-Bois, both located in the commune of Croix-des-Bouquets, which is one of the priority areas to combating cholera.

The mission concluded that the communities visited had problems related to access to potable water, and health services visited reported that acute diarrheal illness (ADI) and other waterborne diseases are among the main complaints presented by users. Problems related to surveillance and monitoring of water quality in the country have also been identified. The development of a project for technical cooperation in water quality among the two countries is under discussion (BRASIL, 2018a).

### *HIV Detection in key-population*

According to information from the MSPP, Haiti has a situation of generalized HIV epidemic, with prevalence of 2.0% among the population between 15-49 years old, for 2016-2017 (HAITI, 2017), being concentrated on key-populations: men who have sex with men (12.9%), sex workers (8.7%), people deprived of freedom (4.6%), and pregnant women (2.3%) (HAITI, 2016b).

In August 2016, a mission of the Ministry of Health, composed by technicians of the Department of Surveillance, Prevention and Control of STIs, HIV/AIDS and Viral Hepatitis (DIAHV) and from AISA, was established to negotiate a project for technology transfer from Brazil to Haiti, on the strategy for quick HIV/AIDS testing with key populations, based on the “Viva Melhor Sabendo” (Live Better Knowing) success strategy developed by the Ministry of Health of Brazil. In December of the same year, Brazil donated one thousand rapid oral fluid tests to Haiti, in support to the national protocol validation process for the use of those tests, with a view to achieve project viability. Brazil awaits the completion of this process to continue the negotiations.

### *Humanitarian Cooperation*

In the scope of humanitarian cooperation, in 2010, 400 tonnes of medicines were donated in support of earthquake victims, in addition to the donation of one hundred thousand doses of Hepatitis B vaccines and four tonnes of anti-cholera medicines. In 2013, 150 thousand doses of anti-rabies vaccine were donated. Between 2016 and 2017, after Hurricane Matthew, Brazil donated to Haiti four thousand anti-cholera vaccine doses, twenty thousand drugs for calamity situations, 49 filters and 87 water reservoirs. In 2017, fifteen thousand doses of human anti-rabies vaccine were donated.

### 3.5 Final Considerations

Haiti is a peculiar case of Brazilian cooperation, which has acquired a central status since Brazil assumed the leadership of the military component of MINUSTAH. Also, Brazil assumed the task of supporting initiatives for the social and sustainable development of the Caribbean country, in order to strengthen stabilization and promote sustainable development. The Brazilian government considers peace, security, and development as interconnected issues, so it has added the multidimensional character to the military command of the mission, intensifying technical and humanitarian cooperation with Haiti, aiming at the development of the country.

The history of two centuries of political instability, social inequality, poverty, and social vulnerability of Haiti has led to a situation of major need for public services provision by the state or even to a difficulty in coordinating actions carried out by a multiplicity of NGOs and international players acting on the most varied areas, including health. This situation was worsened by the earthquake of 2010, which destroyed several structures related to the provision of public health in the country – besides causing the death of health professionals and starting a new period of diaspora, in which a considerable number of people emigrated searching for better conditions of life.

The Ministry of Health has been one of the most important players in the Brazilian cooperation with Haiti. The focus on the strengthening of the Haitian state happened based on the principle that the social development encompasses the strengthening of the state as an institution able to promote public health in an integral perspective. The Ministry of Health has also prioritized the development of the Haitian health system and has sought, by means of the activities developed, to establish the relationship between such activities with the good operation of the whole health system, besides broadening the access the Haitian population has to public health care.

The period from 2004 to 2009 was marked by trilateral technical cooperation projects in which Brazil shared technical knowledge with Haiti, with financial support provided by developed countries or international organizations. The projects were focused on strengthening vaccination and breastfeeding, setting up a human milk bank and fighting against gender-based violence. The Brazilian Presidency of the Republic was highly involved in the projects during the period. It became evident through the statements and high-level commitment signed by the President Luiz Inácio Lula da Silva in relation to the projects and activities presented herein.

From 2010, the projects were more related to the reconstruction of the country, the strengthening of its health system, the strengthening of HIV detection, and combating cholera. It is also noticeable, that from 2010 onwards, the projects had more funding from the Brazilian Government. It is important to highlight, though, that the two largest projects, the Tripartite Cooperation Brazil-Cuba-Haiti and the project with

financial resources from the Haiti Reconstruction Fund, refer to resources provided to Haiti from Brazil in 2010, still within the context of the earthquake, as a result of a major political movement at the time to support Haiti. The project BRA/10/005, developed within the scope of the Tripartite Cooperation, is still in force until the date this article is written, with completion foreseen to July 2018<sup>20</sup>; and project BRA/17/018, that counts with financial resources from the Haiti Reconstruction Fund, was only signed in 2017 and will be implemented until 2020.

In the period post-2010, it is possible to notice the importance given by the Ministers of Health to the partnership with Haiti. Since 2010, four Ministers of Health have visited Haiti: José Gomes Temporão, in 2010, when he signed the Tripartite Memorandum of Understanding Brazil-Cuba-Haiti (BRASIL, 2011a); Alexandre Padilha, in 2012, with the entourage of President Dilma Rousseff<sup>21</sup> (BRASIL, 2012a); Arthur Chioro, in 2014, for the opening of Community Reference Hospitals (BRASIL, 2014a); and Ricardo Barros, in 2017, for the signature of the project Haiti Reconstruction Fund and to participate in the ceremony when the Community Reference Hospital of Bon Repos was named Community Reference Hospital Dr. Zilda Arns (BRASIL, 2017c) and, in 2018, to take part in the inauguration ceremonies of the Surgical Center of Hospital Saint-Antoine and the vaccines and supplies storage facility in Jéremie, in addition to other agendas described in the session concerning the project of the Haiti Reconstruction Fund (BRASIL, 2018b).

Throughout the entire period, there were humanitarian cooperation actions for the donation of medicines, vaccines and supplies, which were also intensified after 2010.

The international technical cooperation of the Ministry of Health of Brazil with Haiti was, in some aspects, innovative for the Brazilian cooperation for international development experience itself. As mentioned above, the project “Strengthening of the Haitian Immunization Program” was an unprecedented initiative of trilateral cooperation in the Brazilian government, in partnership with a funding country cooperating in benefit of a third country (BRASIL, 2005b). The action of the Ministry of Health in the Haitian earthquake also meant a significant learning for the immediate response in a public emergency, involving also other actors, such as the civil society and organizations that sent donations and volunteers to the country.

<sup>20</sup> Note to the English version: Tripartite Cooperation projects were concluded in November 2018, after the publication of the original version of this article. At the conclusion of the project, the Ministry of Health released the documentary “Haiti – Janvier 12”, available at <<https://www.youtube.com/watch?v=jhEI55Ys7ck>>.

<sup>21</sup> President Dilma Rousseff visited Haiti in February 2012 for the ceremony to introduce the Brazilian contingent of the MINUSTAH. During the visit, she stressed the importance of the cooperation and included the health agenda in the relevant bilateral topics. The Minister of Health, Alexandre Padilha, was part of the entourage (BRASIL, 2012c).

The Tripartite Cooperation Brazil-Cuba-Haiti also brought several innovations. Firstly, because Brazil assumed the role of main funding of the project through the Ministry of Health, and not through ABC. Moreover, the difference between its activities in relation to the technical cooperation projects traditionally carried out by Brazil is remarkable, especially concerning the strengthening of state capacities, as they had a significant share of its resources intended for the construction, reform, and maintenance of physical structures, as well as for supporting the payment of scholarships. There was a massive strengthening of issues related to the territorial coverage capacity of the state and to access to public health in Haiti. In addition, these activities were permeated by the South-South cooperation principles of horizontality, flexibility and, especially, of “joint initiatives” seeking to add knowledge transfer activities, human resources training, and organization of services in the Haitian health system aiming at the sustainability of actions. These activities were inspired by the experiences developed by the institutionalization and by the implementation of the Brazilian Unified Health System (SUS) and the challenges to its development<sup>22</sup>.

For the Brazilian side, this approach has also brought considerable learning experiences, with the need to strengthening the institutionalization of the Brazilian cooperation itself, in order to allow for more diversified international activities that consider the complexity of executing projects in different contexts and with legal frameworks different from the Brazilian one, favoring logistics, procurement and implementation of activities abroad, being able to adopt projects of medium and long term, without interruptions due to management changes.

Specifically for the Ministry of Health of Brazil, one of the main current challenges is to support the joint development and the execution of a sustainability plan foreseen by the project of the Haiti Reconstruction Fund, aiming at provide conditions for the Haitian government to fully assume, from 2020, the maintenance activities of the health services built by the Brazilian cooperation, when the project is supposed to be concluded. Also, there is the challenge of improving the technical exchange among the countries in order to strengthen the technical aspect of the international cooperation. Differently than the Tripartite Cooperation, initially foreseen for two years and that already has eight years of cooperation, the rules of the Haiti Reconstruction Fund

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<sup>22</sup> Even though the impact assessment foreseen by the project is not yet available, interviews carried out with Haitian partners revealed that the activities of the Tripartite Cooperation generated “positive collateral effects” in the country, such as the development of strategies of coordination and management that have been continuous since 2010, strengthening of community health in the scope of the national health policy, the creation of a national curriculum for the training of health community workers, the organization of the attributions of the family health team, the recognition of the organization of the services implemented as a model and as a practice field for university education, the creation of a pioneer service for the rehabilitation of physical disabilities and even a possible policy of social participation being conceived (LUZ, 2018).

do not allow the extension of projects, so the BRA/17/018 is supposed to finish its activities in 2020.

Furthermore, the perspectives for cooperation between Brazil and Haiti in strategic fields will continue, such as the strengthening of HIV detection among key populations and water quality projects, focused on the strengthening of the Haitian state and on the technical exchange between the countries, both in institutional dialogue with the organized civil society and the community. This variety of cooperation activities may contribute not only to strengthen the Haitian health authority, one of the goals of the above-mentioned projects, but also for the effective improvement of the health and the quality of life of the Haitian people, in a multidimensional perspective.

In a true practical expression of the constitutional principle of cooperation among peoples for the progress of mankind, the health cooperation with Haiti strengthens the action of Brazil abroad, extends the capacity of implementation of great international cooperation projects by the Ministry of Health, and celebrates the base principles of the South-South cooperation and of the Unified Health System (SUS).

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# Political coordination and cooperation in health within the BRICS

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## Abstract

This article analyzes political coordination and cooperation in health within the BRICS, a group formed by Brazil, Russia, India, China and South Africa, in light of the need to conceive innovative forms of interaction between the countries of the group that may translate in political commitments for practical activities of common interest, which are still not very frequent in the field of health. In order to do that, by means of literature review and based on the author's practical experience, this paper considers impressions about the role of BRICS in global health, cohesion factors for the unit of the group and, finally, proposes a reflection on the conception of the BRICS Tuberculosis Research Network as an example of a favorable trajectory from political coordination to technical execution.

The study found that the international expectation remains current, considering the individual capacity of BRICS<sup>2</sup> countries of promoting collaboration of potential impact for global health. In addition, there are approximation factors for these countries that include the possibility of playing a protagonist role in global health governance, of using complementary capacities for domestic benefit, and the possibility of coordinating a common agenda of cooperation for developing countries. The research identified a gap between discourse and practice, even though the interest of BRICS countries in intensifying collaboration within the group is evident. To fill this gap, the findings indicate that a joint effort will be necessary to give a new sense to BRICS multilateralism and to promote a structural change in the dialogue mechanisms that favor decisions geared towards the implementation of technical and scientific activities.

**Keywords:** BRICS. Political coordination. Global health. Multilateralism.

## 1 Introduction

Created by market analysts as an acronym to guide international investors in the beginning of the decade of 2000, the BRICS took a step towards political coordination

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<sup>2</sup> As far as the use of the terminology "BRICS", this article adopts the guidelines of Manual de Redação Oficial e Diplomática do Itamaraty (Official and Diplomatic Writing Manual by Itamaraty) (2016). When referring to the group, the singular in Portuguese is used as "o BRICS" (the BRICS group). When referring to the countries that are part of it, the plural "os BRICS" (the BRICS countries) is used in Portuguese.

as of 2006, being constituted as a mechanism sustained by the political will of its participants, Brazil, Russia, India, China, and South Africa<sup>3</sup>, which share positions and perspectives related to global governance reform. The first summit meeting of the group was held in 2009, in Yekaterinburg, Russia. Since then, heads of state and government have convened annually, and a series of parallel meetings is organized by the country that holds the pro tempore presidency of the group.

Cooperation in the field of health was included in the BRICS agenda starting from the Sanya Declaration and Action Plan from the 3rd Summit of the BRICS, in 2011, motivated by the need to identify topics of common interest that could generate beneficial collaboration for the countries. Since then, the Ministers of Health and the high staff of the group have met on a regular basis, in order to debate cooperation initiatives in matters of health.

Seven years after the Sanya Declaration and after several meetings of BRICS Health Ministers<sup>4</sup>, issues related to the means to accomplish intra-BRICS cooperation and concerning the protagonist role expected by the international community facing the challenges of global health are still reasons for vivid debate.

In the search for evidence that may contribute to this discussion, the political coordination and the health cooperation in the BRICS is proposed as the topic of investigation of the present article. Based on literature review and, especially, on the author's experience at the International Health Affairs Office of the Ministry of Health of Brazil in the dialogue promoted by the BRICS, we seek to raise arguments on the means to establish relations geared towards practical actions that are coherent with the political decisions taken by the group.

Aiming to offer a new reflection perspective and contribute with the existing literature, we proposed a discussion based on three guiding questions: what are the impressions about the role of BRICS countries in global health? What are the cohesion factors for cooperation in health within the BRICS? What are the means to connect the political and technical health agendas within the BRICS?

The present article aims at contributing with long-lasting and recurrent discussions. We do not intend to provide definite arguments, but on the contrary, we aim to foster non-exhaustive reflections that may promote new perspectives of analysis.

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<sup>3</sup> South Africa was incorporated to the mechanism in 2011.

<sup>4</sup> Beijing in 2011, New Delhi in 2013, Cape Town in 2013, Brasília in 2014, Moscow in 2015, New Delhi in 2016, Tianjin in 2017 and Durban in 2018. The Ministers of Health have also met routinely since 2012 at the sidelines of the World Health Assembly of the World Health Organization (WHO), held annually in Geneva.

## 2 Impressions about the role of the BRICS in global health

Since it was established, the international community has created high expectations about the protagonist role of the BRICS facing the challenges of global health. For the Director-General of the World Health Organization (WHO) at the time, Margaret Chan (OMS, 2011), the new high level political coordination of the BRICS represented a rising power of diplomatic and economic influence on global health. Harmer et al. (2013) point out that the expectation was of a group able to lead emerging topics, coordinate regional efforts, and at the same time, individually benefit from opportunities arisen from intra-BRICS relations.

The bibliographic research for this article has allowed to infer that there has been significant production of information on the potential impact of the BRICS in global health between 2011 and 2015, suggesting, to a certain extent, a relation with the level of expectation of the international community in the period. An expressive example of this interest was the publication of the special edition of the WHO monthly bulletin (2014) with the topic *BRICS and global Health*.

Despite the political will demonstrated by the governments, materialized in the summit meetings, in the chancellors and ministers of Health meetings and by their respective joint declarations, the health *momentum* in the BRICS is still awaited. There is a consensus in relation to the existing gap between political commitments and actions implemented within the BRICS. Larionova et al. (2014) note that, even though the discourse concerning health has been intensified in the group, the political rhetoric has not yet been translated into substantive results. Jim O'Neill, the creator of the term "BRICS", asserted, in an interview to BBC News (2017), "I would like to see the leaders of the BRICS doing something more tangible, such as a joint fund for tuberculosis research, to show their efficacy". Only from practical collaborations, which have been incipient so far, it will be possible to evaluate the real impact of the BRICS on global health, and any previous analysis would be merely a speculative one (STUENKEL, 2012; TYTEL, 2012). Indeed, Harmer et al. (2013) concluded that there is little evidence contributing to the assertion that the group has an influence on global health, though its prominent potential<sup>5</sup>.

If, on the one hand, the finding seems to be valid, on the other the expectation remains sustained by the individual contributions and by the active participation of the BRICS on topics related to issues that, since the creation of the group, have received the attention of the global community. In this perspective, Buss et al. (2014) mention, for

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<sup>5</sup> The literature review of the study comprised an initial analysis of 887 documents on the topic. Based on criteria established by the author, the search was limited to 71 articles and 23 reports, and later, on a new selection, to seven documents. Most of them, according to the researchers, concentrated their analysis on the individual capacities of the countries, and only one document presented a sustainable analysis on the collective influence of the BRICS.

example, the involvement of India, Brazil, and South Africa on multilateral discussions about the access to antiretroviral medicines, intellectual property, and the production of generic medicines, while Harmer et al. (2013) highlight the leadership of BRICS on the topic of universal health coverage, especially within WHO.

It thus makes evident the need to reflect about the means of interaction of the BRICS that may translate such individual capacities into synergies to deliver tangible results for the group and for global health, as a consequence.

Yu (2008 apud Harmer et al., 2013) describes the coordination of the BRICS as a new perspective of international relations, in contrast with the western approach of assistance for health development. With certain cohesion, Kickbusch (2014) believes that the BRICS tend to prioritize bilateral and multilateral collaborations; besides, they would be less interested in fostering financial contributions for the development of global health. Even though Kickbusch's argument is valid, and a factual one up to the moment, the establishment of the BRICS New Development Bank (NDB) of BRICS, in operation since 2015, is presented as an unexplored opportunity for the financing of health projects. This circumstance would not be inconsistent with the bank's mission to promote infrastructure and sustainable development in the BRICS and in emerging countries. Due political convergence in the definition of a common agenda of priority themes on health, preferably confirmed by the heads of state would be necessary for that.

Gautier (2014) believes that the role of the BRICS in global health governance should not happen in the scope of the United Nations, but within their own "South-South" cooperation structure<sup>6</sup>, based on experience sharing and technologies at low cost. Callahan and Tytel (2012, p.6), also assert that:

The BRICS emphasize South-South cooperation and favor models based on domestic programs and their own political and social philosophies. This cooperation often includes bilateral capacity and infrastructure building and the identification of lessons learned by BRICS *policymakers* in addressing their own internal challenges (own translation).

It is important to mention that, contrary to Gautier's argument, the BRICS Ministers of Health, during the 6th Meeting of Ministers of Health of the BRICS, in

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<sup>6</sup> It is worth noting that the BRICS have different perceptions and not necessarily at the same extent on such models. Characteristics of the South-South cooperation would be more clear in the IBSA grouping, which includes India, Brazil, and South Africa (HARMER et al., 2014).

Tianjin (2017), reasserted their interest in acting in a more determinant way in the multilateral scope<sup>7</sup>. Specifically, the Ministers agreed to:

(...) promote dialogue among BRICS countries to jointly assess issues of common interest for convergence participation in multilateral fora, and strengthen the role of BRICS countries in global health governance, especially at the World Health Organization and United Nations Organization (CHINA, 2017, our translation).

This is, undoubtedly, a strong message from the BRICS about their intention to explore their renowned capacity to exercise political influence at the regional and global levels. In the broader multilateral scope, this alignment prior to the meetings of the G20, for example, has been more expressive in comparison with previous agreements between countries that compose regional groups (LIMA, 2015). Within the scope of the G20 Health Working Group, established during the German presidency of the G20 (2017), the International Health Affairs Office, as a representative of Brazil in the group, has sought to promote the coordination of the positions of the BRICS countries in topics of common interest in health, such as antimicrobial resistance, investment and research in health, health emergencies, among others. If this coordination becomes stronger in the health forums, new political arrangements should rise from multilateral negotiations for the strengthening of the positions traditionally defended by Brazil on these matters.

Besides the possible protagonist role on the global health agenda, there is a broad space for the exchange of knowledge on successful health policies within BRICS (BUSS et al., 2014). Larionova et al. (2014) state that “without avoiding the responsibility of participation of global governance in health, the BRICS could give a larger contribution to global public health by ensuring national health systems that are efficient, innovative, and inclusive”<sup>8</sup>. Effectively, more than any other group of countries, whenever promoting the improvement of the health of their citizens, the BRICS contribute for the development of global health, as the population of the countries of the group represents, jointly, over 40% of the world population.

The perception captured by the literature review is that it consists of a highly influential group on multilateral discussions, which is, at the same time, able to promote health development of the BRICS and of other countries, based on horizontal cooperation models. These possibilities suggest a broad scope of work opportunities inside and outside the group.

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<sup>7</sup> Brazil, through the International Health Affairs Office of the Ministry of Health, headed the proposal to intensify the political coordination of the BRICS in the multilateral health forums.

<sup>8</sup> Own translation

### 3 Cohesion factors for cooperation in health within the BRICS

The economic development similarities pointed out in the precursor study of Jim O'Neill (2001) consolidated the term BRICS as a broad multisectoral political forum. Larionova et al. (2014) note that similar socioeconomical processes within the BRICS countries have indeed defined a certain development standard and common health challenges.

Over a decade after its formation as a political mechanism, it is necessary to reflect upon the reasons that have maintained the unity of the group beyond the almost dogmatic understanding of justifications based on exclusively economic affinities, as if those, in isolation, were enough to sustain the relations consolidated in the most varied sectors<sup>9</sup>. Harmer et al. (2014), mention the need of studies that allow for an ontological understanding to explain the approximation of the BRICS countries and of other groups. It is necessary to acknowledge that the BRICS do not maintain the same characteristics brought by O'Neill, surpassing the initial dimension of the exclusively financial-economic acronym (FLÔRES JR., 2015).

Seven years after the Sanya declaration, it would be natural to see a decrease in the political discussion in the health forum, if the initial interest of the BRICS had turned into frustration throughout the dialogue process. The meetings would have become *pro forma*, at a minimum, merely supporting the agenda of heads of state and government. However, the dialogue on health was strengthened by the regular meetings among high level representatives and advanced in the practical setting with the establishment, for example, of the BRICS Tuberculosis Research Network, as discussed later herein.

It is also worth mentioning that BRICS acts in a volunteer character and does not have binding agreements, institutional structure<sup>10</sup> with secretariat or fixed funds dedicated to carrying out activities. These properties reinforce the spontaneous interest of BRICS in political coordination and in technical cooperation among its countries, even after almost a decade after its first summit meeting<sup>11</sup>.

<sup>9</sup> Other sectors that have established forums are: finance and central banks, science and technology, agriculture, environment, and labor. In addition, other forums are regularly organized by business councils, *think tanks*, parliaments, cultural segments, among others (AYRES, 2017).

<sup>10</sup> Even though there is not an institutional structure, it is interesting to notice that in the 9th paragraph of the Beijing Declaration resulting from the 1st BRICS Health Ministers Meeting, the following is stated: "(...) we agree to institutionalize, on a permanent basis, the dialogue among Ministers of Health, as well as among Permanent Representatives in Geneva, to follow-up and implement the health related outcome of the BRICS summit (UNIVERSITY OF TORONTO, 2011). In a similar sense, Larionova et al. (2014) use, recurrently, the term "institutionalization", as they consider it to be reflected on the regularity of the BRICS meetings and in their resulting products. *Stricto sensu*, "the first institution with its own legal personality created by the initiative of the mechanism is the New Development Bank" (BAUMANN et al., 2015).

<sup>11</sup> The first summit meeting of BRICS (called "BRIC" at the time) was held in Yekaterinburg, Russia, in 2009.

The similarity in the economic growth path would have not been enough motivation for the permanence of the articulation efforts among the countries if there had not been compatibility among common challenges and respective opportunities. Larionova et al. (2014) consider that these challenges would be related, for example, to the iniquity of access and of quality health services, and to the incidence of chronic non-communicable diseases and HIV/AIDS. Buss et al. (2014) also include in this list the communicable diseases and access to medicines. Also related to these challenges are difficulties concerning the deficit of public health financing, the complexity of the mixed public-private administration of health, demographic varieties, and health determinants (MARTEN et al., 2014).

The common challenges of BRICS are a consistent basis to consolidate cooperation for the benefit of sustainable health systems. They can be taken as opportunities for the improvement of domestic policies in their respective health systems, which can be leveraged by the dialogue and the cooperation with other countries in the group.

It is equally important to recognize the existence of rhetorical differences among the BRICS countries when referring to political and diplomatic macro agendas and to socio-cultural demands that have shaped the peculiar concept of health in each of the countries. There are, for instance, different discourses from the BRICS countries when dealing with topics such as tobacco and alcohol control, mental health, and food and nutrition (Kickbusch, 2014; Li, 2012 and Shidhaye and Kermode, 2013, apud BUSS et al., 2014). Those differences do not prevent collaboration, though. On the contrary, they are supposed to foster collaboration for the conception of innovative models, which can be adapted to the context of each country. For this purpose, flexibilization of BRICS would be necessary so that seemingly divergent topics could be included in a joint agenda, if not from the perspective of political coordination, at least within the scope of intra-group technical cooperation.

Even with a certain degree of plurality, the political decisions have reached a successful level of consensus. Three main reasons could explain the BRICS interests in coordination in health: (i) the potential influence and protagonist role of these countries in global and regional health governance; (ii) the possible consolidation of a joint agenda of cooperation for developing countries; (iii) the opportunities for technical and scientific collaboration among the BRICS countries.

The first reason would be related to the interest of the countries in the group in reflecting their sovereign national interests in global health governance as a tool of international politics. It would also be connected to economic advantage factors, regional stability, construction of reputation, altruism, and a consequent regional and international projection (HARMER et al., 2014). These advantages would not require political friction or higher costs for the countries, and would have motivated governments to set an autonomous agenda, even without apparent influence of

divergent positions on their bilateral relations (AYRES, 2017; FLORES JR., 2015). The expressive population ratio of the BRICS is also a strong argument for the group to seek greater representativeness in multilateral forums. In relation to the presumed regional projection, there are controversial understandings regarding the capacity of the group to use political influence or to transfer the benefits generated by their collaborations in the perspective of regional integration, at least in the current conjuncture<sup>12</sup>.

The second related reason would be the ability of BRICS to converge efforts to provide solutions and models of cost-effective technology and innovation for developing countries. Concerning this matter, the former Director-General of WHO, Margareth Chan, during the 1st BRICS Health Ministers Meeting, highlighted the industrial capacity of BRICS for pharmaceutical production, as well as production of vaccines and health technology, also for exporting purposes (OMS, 2011). This role would be unlikely in the current BRICS stage, though naturally possible in the long term. Individual collaborations should continue the cooperation agenda of each country, with potential for evolution to joint cooperation in a context of an evolutionary process of the dialogue mechanisms or eventual institutionalization<sup>13</sup> of the group toward that purpose.

The third reason would be related to the motivation based on opportunities of technical and scientific collaboration between the BRICS group, especially due to the countries' productive capacity. There would be, however, a better definition of the common agenda for this scope of activity.

In theory, the joint Communiqués resulting from the BRICS Health Ministers Meetings would fulfill the goal of highlighting priority topics and actions. However, even though they reinforce the political will for the coordination, they have not activated the operative mobilization around the highlighted topics. This inconsistency refers again to the reflection about a possible need for institutionalization that allows, at the same time, the organization of the executive agenda and the preservation of the fluidity of dialogue, a characteristic in the group.

Assuming a natural and understandable resistance to this process of institutionalization, a reasonable solution would be the adoption of work documents defined based on political decisions and, above all, the convergence to establish flexible

<sup>12</sup> The challenges would exceed the health agenda in the group and would be related to geopolitical divergences, such as, for example, between India and countries in South Asia, such as Pakistan and Bangladesh (FLORES JR., 2015). On the other hand, Baumann (2015) notes that the inclusion of South Africa in the former BRIC would be, in itself, an effort to promote a stronger contact of the group with other African countries. For no coincidence, the first office of the NBD is headquartered in South Africa, with a view to potential project funding to developing countries on the continent.

<sup>13</sup> The BRICS institutionalization is a controversial theme. For Flores Jr. (p. 149, 2015), for example, "efforts of a more vigorous institutionalization may compromise the flexibility of the good relations, leading to weakening the cohesion, while aiming for the opposite". Abdenur and Folly (2015) offer a consistent discussion on possible effects of BRICS normative and bureaucratic platform, based on the NBD conception.

and efficient mechanisms to follow up with the planned activities. A previous effort would be that of ensuring a structural change in the status quo, in the search of a dialogue that promotes coherence and connection between the political and technical agendas.

The effort in the search of solutions in this aspect cannot be disregarded. An example of it was the establishment of thematic working groups coordinated by each one of the countries<sup>14</sup> at the 1st BRICS Health Ministers Meeting, in Beijing, in 2011. Another important highlight is the adoption, in 2013, of the BRICS *Framework for Collaboration on Strategic Projects in Health* and the *Monitoring Framework*<sup>15</sup> with the goal of monitoring the progression of the countries towards universal health coverage. Despite the efforts, the references produced to guide the collaboration ended up being discontinued, even though the topics remain present in multilateral discussions and become increasingly more relevant for the BRICS, individually.

It is important to highlight that the arguments do not entice the definition of a new structure of governance and health, as this role belongs to the World Health Organization, but the intention to coordinate an agenda of common interests for the BRICS which may result in practical collaboration according to defined global guidelines, in a representative manner, within the scope of WHO.

#### **4 From political coordination to technical conformation: the case of the BRICS Tuberculosis Research Network**

Despite the lack of historical evidence, the BRICS political-technical coordination is not only viable, but also promising. A tangible example was the establishment of the BRICS Tuberculosis Research Network in 2017.

It would be misleading to say that negotiations for the conception of the network have been easy and homogeneous, but they have not been tense or problematic either. Just like in any multilateral dialogue process, it is necessary to accommodate different perspectives and interests around common objectives. This is possible when convergent priorities are materialized in a common agenda.

Even though it is still early to assert that the process of construction of the network is a model for future action within the BRICS, it is relevant to reflect about the trajectory for its conception, which, certainly is one of the most tangible activities in the group in the area of health. In general terms, its conception permeated fundamental stages of identification of mutual interest matters, political convergence for defined

<sup>14</sup> Brazil: WG health strategies for communicable diseases; Russia: WG medical technologies; India: WG health surveillance; China: WG discovery and development of new medicines; South Africa: WG risk factors of non-communicable diseases, prevention and universal coverage (UNIVERSITY OF TORONTO, 2011).

<sup>15</sup> Communiqué of the III Meeting of BRICS Health Ministers (BRASIL, 2013).

action within a defined deadline, establishment of a framework and technical-executive coordination. It is worth noting, during this trajectory, the Brazilian leadership in the dialogue with the other governments of BRICS, through the International Health Affairs Office of the Ministry of Health of Brazil, with support from the General Coordination of the National Tuberculosis Control Program of the Ministry of Health.

The identification of tuberculosis as a common interest topic was not based on the benefit of just one country within BRICS, neither was it motivated by financial advantages or enabled to accommodate assets in other sectors. It consists of an illness that statistically presents a significant concern for all BRICS countries.

The WHO Global Tuberculosis Report (2017) informs that almost 50% of all estimated cases of the disease are in the BRICS countries. The tuberculosis burden is so significant within the group that a good portion of the comparative analysis presented in the WHO report is divided between two groups: “BRICS countries” and “countries outside BRICS”. While China, Russia, and India are strongly affected by drug-resistant tuberculosis<sup>16</sup>, Brazil still needs to improve strategies to prevent the discontinuation of tuberculosis treatment and mitigate regional differences of incidence of the disease (BRASIL, 2017).

If the challenges are robust, the capacities for research, funding<sup>17</sup> and response<sup>18</sup> are also significant, which reinforces the importance of the intra-BRICS cooperation agenda to fight the disease. The five countries have knowledge of technologies that, combined, are able to promote a significant impact on facing the disease at the global level.

The political convergence around the topic became evident in 2014, when the BRICS Ministers of Health approved the development of a Cooperation Plan on Tuberculosis. In 2015, despite little advances<sup>19</sup>, the Ministers reinforced the importance of the conception of a Plan to be adopted during the 6th Meeting of Health Ministers in New Delhi, in 2016. In the following year, the Ministers of Health announced that the first activity of the BRICS cooperation plan would be the establishment of the

<sup>16</sup> China, Russia, India account for 45% of total cases of drug resistant tuberculosis in the world in 2016 (STOP TB PARTNERSHIP, 2016).

<sup>17</sup> BRICS have been responsible for 46% of the total funding to fight tuberculosis in the world in 2017. Among these resources, 95% came from domestic sources (OMS, 2017).

<sup>18</sup> Brazil is a reference in the treatment of drug-sensitive tuberculosis related to social protection policies, while India and China have a great capacity for the production of medicines. South Africa has a successful experience for the control of TB/HIV co-infection, and Russia has expanded its diagnostic capacity in the past few years (INSTITUTE OF MEDICINE, 2014).

<sup>19</sup> In 2015, Brazil hosted, in Brasilia, the only technical meeting with BRICS representatives for a preliminary discussion on the BRICS Tuberculosis Cooperation Plan. It is important to highlight the Brazilian insistence, in 2016, in resuming the political agenda, and the favorable *momentum* for the discussion, in view of the 1st WHO Global Ministerial Conference on Tuberculosis, in Moscow, in 2017.

Tuberculosis Research Network<sup>20</sup>. Brazil had a fundamental role in the development of these negotiations. The International Health Affairs Office maintained the dialogue, proposing that the topic appeared highlighted in the joint approved communiques, and presented the basic proposals of the BRICS Cooperation Plan and Tuberculosis Network.

Two aspects on this political coordination process should be evidenced. Firstly, even though the Brazilian government assumed a leadership position in proposing the agenda, it would probably not have thrived if there was no adhesion of the other countries according to their own motivation, for the same reasons previously discussed. Secondly, BRICS maintained coherence in their action concerning this topic by connecting specific political positions among the Declarations of Brasilia, Moscow, New Delhi and Tianjin, when respectively declared the intention of conceiving the plan, confirmed the interest in the maintenance of efforts for its development, approved it, and defined specific activities within its scope. It is important to note that this type of language geared towards the technical-practical reaction of the governments is different than the general references concerning political coordination that inform about the collective position but do not necessarily suggest the development of intra-group collaboration.

From the political coordination, BRICS advanced in the definition of a framework and executive technical coordination, motivated, again, by the Brazilian initiative. Thus, it held the first meeting of the BRICS Tuberculosis Research Network, in Rio de Janeiro, in September, 2017. The meeting had the participation of representatives of the governments and the academia of all BRICS countries, in addition to representatives from the Pan-American Health Organization (PAHO) and from WHO. The participants defined, through a terms of reference, the mechanisms of operation and the schedule of activities of the Network (BRASIL, 2017). The second meeting of the Network happened approximately three months later, in Moscow, when the priorities for the BRICS action were defined, such as research for timely diagnosis.

About the development of collaboration in the technical aspect, some elements should be pointed out. In addition to the political instruction, the BRICS got ready for the operationalization of the Network. The creation of the terms of reference on its operation, even though it does not represent a constitutive document or does not generate obligations among the participants, has allowed the coordination of efforts to organize strategies and activities to be developed. More than that, its joint conception has promoted a sense of ownership and a collective responsibility of BRICS in relation to this agenda. Approaches of this type may represent a balance between the

<sup>20</sup> As reflected in the joint communiques of the 4th, 5th, 6th and 7th BRICS Health Ministers Meetings (BRASIL, 2014; BRASIL, 2015; BRASIL, 2016; CHINA, 2017).

institutionalization rigidity, in its strict sense, and the mere declaratory character that exempts the fulfillment of activities by BRICS.

Also noteworthy is the fact that all countries have sent representatives of government and academia to Brazil for the first meeting of the Network, which challenges the argument that geographical distancing imposes barriers to cooperation among BRICS, while proving the mutual interest for collaboration. The participation of PAHO and WHO is also representative, as it reinforces the due consideration of BRICS towards multilateral efforts of global health. The Brazilian action on the political and technical fronts, led, respectively, by the International Health Affairs Office and by the National TB Control Programme of the Ministry of Health of Brazil, were preponderant for the mobilization of their counterparts in other BRICS countries.

Other positive developments have risen from the technical to the political aspect on the tuberculosis fight agenda. The BRICS Tuberculosis Research Network was formally presented to the international community during the first WHO Global Ministerial Conference on Tuberculosis, held in Moscow, in November 2017, and was approached during the first meeting of the BRICS working group on Biotechnology and Biomedicine (BIOMED)<sup>21</sup>, reinforcing its intersectoral character. The interest in the topic from the audience has also led to the unprecedented initiative of coordination among the BRICS governments for a joint intervention on tuberculosis, which was done by Brazil during the 142<sup>nd</sup> session of the WHO Executive Board, held in Geneva, in January, 2018 (BRASIL, 2018). In May 2018, South Africa also gave a speech at the 71<sup>st</sup> World Health Assembly, the first discourse on behalf of BRICS, held in the WHO plenary session. In the near future, new initiatives of political coordination and cooperation are prospected that may deepen the coordination of BRICS in health matters and reinforce the recognition of the mechanism as a fundamental player in global health.

## 5 Final Remarks

The expectation generated around the economic and productive capacity for global health within BRICS continues to be strong in the international community. The group, however, needs to transform the political rhetoric in practical collaborations that may prove its potential. The words of the Chinese leader, Xi Jinping, could represent this mission within the group: “BRICS *is not a talking shop, but a task force that gets things done*”<sup>22</sup>.

<sup>21</sup> The working group is part of the ministerial agenda of the science and technology sector of the countries. In Brazil, it is coordinated by the Ministry of Science, Technology, Innovation and Communication.

<sup>22</sup> Speech delivered at the opening ceremony of the *BRICS Business Fórum* (BRICS, 2017).

One premise for BRICS collaboration is the indissociability between global health and domestic health, justified by the fact that their demographic proportion concentrates almost half of the world population. This premise reinforces the need of intra-group cooperation that may make use of complementary capacities to mitigate common challenges.

BRICS also has the capacity for the development of a common cooperation agenda in health, aimed at developing countries. The perception, however, is that this kind of collaboration would lack a process of developing the dialogue mechanisms of the group, which could be the object of further studies in the future.

Concerning political coordination, there is clear demonstration of interest of the BRICS in acting more forcefully in global health governance, as expressed in the Tianjin Joint Communiqué, in 2017. A positive sign was the implementation, for the first time, of BRICS joint interventions at the 142<sup>nd</sup> session of the WHO Executive Board, in January 2018, and at the 71<sup>st</sup> session of the World Health Assembly, in May, 2018. This articulation should be more recurrent and will certainly influence the decisions made in the health multilateral forums.

The health ministers meeting, even though they may signal a broad collective positioning at the highest political level, were not conceived for the purpose of promoting specific thematic consensus to be expressed in multilateral forums, neither they seem to dispose of form and time for this goal up to now. These efforts demand additional mechanisms of regular coordination between the Ministries of Health and country missions at the UN and WHO.

Institutionalization processes will continue to permeate discussions on the BRICS operation. Its voluntary character allows fluidity in negotiations, which should alleviate the burden in the accomplishment of the commitments announced. Besides expressing political coordination, the joint declarations resulting from BRICS ministerial meetings should be linked to the implementation of tangible activities. If the declarations are restricted to political coordination, other action frameworks shall be conceived towards this goal. It would not be enough to inform a joint position if the intention is also to promote technical collaboration among the countries.

Regarding the Brazilian dialogue in health topics in the scope of BRICS, the International Health Affairs Office has been fulfilling an important role in the identification of areas and topics that allow joint action, both on cooperation agendas and on multilateral action themes. The International Health Affairs Office, in a constant articulation with the other areas of the Ministry of Health, works on the promotion and engagement of the growing involvement of Brazil with BRICS countries in the health area, with a view to advance in common interests in this agenda.

The BRICS Tuberculosis Research Network is an example of it. According to the findings of the present study, it was the only activity that presented coherence between

political decision and technical coordination. The success factors are related to the identification of a common problem, the political coordination based on time, and the joint construction of operational mechanisms, which has generated a sense of collective ownership in the BRICS initiative.

It is also necessary to value the history of the BRICS relations, without disregarding previously made decisions. It is necessary to reflect upon means to monitor the commitments and the activities according to coherence and continuity principles that reassert the credibility of the decisive and executive process of the group. The meetings of high level staff, which generally happen prior to ministerial meetings, could be used for this purpose.

Finally, we can conclude that above all, it is fundamental to promote structural change in the BRICS dialogue, which happened, for a certain time, with a certain degree of automatism. In this perspective, it is necessary to bring a new sense to the BRICS multilateralism, and make it different than the multilateralism of the UN, of Mercosur, or other regional groups. BRICS is a unique mechanism, able to promote improvements in the health of their countries and in the world and, at the same time, to have a significant influence on health global governance based on compatible, if not homogeneous, interests. Based on the latest events, the scenario is highly promising.

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# Brazil and China: cooperation and perspectives in the health sector

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## Abstract

This paper presents a brief description of health public policies in China, reviews the bilateral relations between Brazil and China, focusing on the health sector, and, finally, highlights the importance of the dialogue between Brazil and China within the scope of BRICS, and the perspectives for advancing the bilateral interests in health issues.

The study shows that the relation with China in the health sector has gradually progressed in the past decade, strengthened with the creation of the Sub-commission on Health of the High-level Sino-Brazilian Commission for Concertation and Cooperation (COSBAN). However, even though the political-diplomatic understanding is fluid and recent progress have been registered in the bilateral political dialogue, cooperation in health still has unexplored potentials with possible benefits to both partners. This article analyzes the challenges that hinder the cooperation on this issue and outlines its perspective for the following years.

**Keywords:** China. Foreign Policy. Brazil-China relations. International Cooperation. Health.

## 1 Introduction

China has extended its political presence in the world over the past decades, in parallel to the expressive growth of its economic weight. This has been reflected not only on the increasingly more active participation in debates on major global themes, on the defense of the global governance reform, and on the multiplication of channels of political consultation with other countries, but also on the expansion of its engagement with international cooperation.

In 1980, China was ranked tenth among the largest economies of the world, behind the United States, the Soviet Union, France, Brazil, India, among others. In just over two decades, China became the second largest world economy in nominal terms, and the largest global economy in purchasing power parity<sup>2</sup> (BANCO MUNDIAL, 2018a).

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<sup>1</sup> Bachelor's degree in International Relations, specialized in Political Science from the University of Montreal, and Specialization Certificate in International Cooperation from the University of Montreal.

<sup>2</sup> The methodology for calculating a country's gross domestic product in terms of purchasing power parity (PPP) uses as reference the average prices in the economies and assesses the relationship between domestic and international prices.

Ernesto Otto Rubarth<sup>3</sup>, in a thesis about the emergence of the approach of social themes, health in particular, in the Brazilian diplomatic agenda (RUBARTH, 1998), refers to international cooperation in health with the so-called “new partners”, Russia, India and China, (RUBARTH, 1999, pp. 217-223), as an emblematic case of the new role played by social issues in Brazilian foreign policy. In the late 1990s, China was still emerging progressively as an eminent hub of political and economic power in the developing world. Twenty years later, the transformations seen both in the international order and in the dynamics of China’s domestic and foreign actions raised the country to the condition of an indisputable global player and Brazil’s fundamental partner in the international scenario. The present article aims at analyzing the challenges and potentials of the Brazil-China relation in the health sector. Twenty years after Rubarth’s thesis, it is worth questioning if China would have already surpassed the condition of Brazil’s “new partner” in the health area, or if the concrete results of this relation would still fall behind their potential. This article has the objective of gathering information that, although does not answer this question - which, due to its complexity, would require more in-depth analyzes whose scope escapes the purpose of this text - may contribute with introductory elements to the discussion of the issue.

The most populous country in the world, with 1.37 billion people (BANCO MUNDIAL, 2018b), the People’s Republic of China has stood out, over the last four decades, for the robust and sustained economic growth registered since the implementation of the reforms initiated by Deng Xiaoping in 1978, with average real growth rates of about 10% annually during this period, a unique case in modern economic history. By combining expressive real economic growth rates with the country’s demographic and economic size, China has gone from the tenth economy of the world in 1980, the equivalent of less than 10% of the United States’ gross domestic product (GDP) that year – and, lower than the Brazilian GDP, ranked ninth in the global ranking of economies in 1980, to become the second global economy in 2010, surpassing the Japanese economy. In 2017, the nominal Chinese GDP represented more than 60% of the North-American product (NONNENBERG, 2010; FMI, 2018). According to the International Monetary Fund (IMF) data, China became, in 2014, the world’s largest economy in terms of GDP for purchasing power parity, reaching the position that had belonged to the United States since 1872, and should surpass the nominal North-American GDP before 2030 (BARBOSA, 2017).

Government relations between Brazil and China on health issues derive from relatively recent initiatives. The formalization of the bilateral relation in the health sector occurred in 2011, with the signature of the Health Joint Action Plan. Nevertheless, the

<sup>3</sup> Ernesto Otto Rubarth, diplomat, was the head of the Advisory Office for Special Issues in Health (AESA), from 1995 to 1998. He was the first diplomat to lead the unit responsible for international issues of the Ministry of Health.

two countries have a history of bilateral approximation in the health sector, dating back to the 1980s, under the Scientific and Technological Cooperation Agreement, signed in 1982. Throughout the 1990s, there were sporadic and unsystematic attempts of bilateral approximation in health (RUBARTH, 1998). From the early 2000s, the Brazil-China relationship in the health sector expanded and gained greater institutionality. More recently, bilateral relations in the area of health have strengthened with the establishment, in 2015, of the Sub-commission on Health of the High-level Sino-Brazilian Commission for Concertation and Cooperation (COSBAN). The first meeting of the COSBAN Sub-commission on Health was held in São Paulo, in November 2017.

In the following section of this article, the health situation in China will be briefly analyzed. In the sequence, the Sino-Brazilian bilateral relation will be comprehensively presented in general terms, and then, specific emphasis will be given to the relationship in the health sector. Finally, the challenges and perspectives of this cooperation will be analyzed.

## **2 Health in China: a brief analysis**

Since the establishment of the People's Republic of China in 1949, the Chinese government has been working to ensure access to health care for its population. The Social Security Law currently in effect in China was formally enacted in July 2011 and it includes three basic health insurance plans: the Urban Employee Basic Medical Insurance (UEBMI), the Urban Resident Basic Medical Insurance (URBMI), and the New Rural Cooperative Medical Scheme (NRCMS). The transition from the Chinese health system to universal coverage has been gradual and can be divided into four phases (SUN, 2017).

The first, from 1949 to 1983, focused on the establishment of a Rural Cooperative Medical System in rural areas where doctors working in small communities provided basic health services. In urban areas, people who worked for the government or private companies had most of their medical expenses paid by their respective employers. In the late 1970s, the medical cooperative system collapsed after economic reforms in China, leaving most of the rural population without health care.

In the second phase, from 1984 to 2002, Chinese people living in urban areas were affected by the economic crisis context, so that, in 1999, only 49% of the people were covered by some sort of health insurance, compared to two thirds of the population in 1993. During the crisis, free health care for urban workers became economically unfeasible, both for government and companies, which demanded the reform of the system. In 1994, the State Council issued a decision on the establishment of a basic medical insurance system that would provide all urban employees with medical insurance financed through a combination of public or private funds (which depended

on the individual being hired by the government or by a private company) and individual funds. The Social Security Law, applied by the Ministry of Human Resources and Social Security, sets forth that all companies and employees must participate in the Urban Employee Basic Medical Insurance (UEBMI).

The third phase began between 2002 and 2003, when the Central Committee of the Communist Party of China and the State Council, seeking to further strengthen rural health care, created the New Rural Cooperative Medical Scheme (NRCMS), managed by the Ministry of Health. At the end of 2011, the program had 832 million beneficiaries, and the coverage rate was above 95%. Funding for this program was achieved through a combination of individual contributions, financial support from collective companies, and government subsidies.

In 2007, the State Council issued an opinion about the implementation of pilot studies for an Urban Resident Basic Medical Insurance (URBMI), which was implemented across the country in 2009. URBMI is managed by the Ministry of Human Resources and Social Security and it covers urban residents who are not covered by UEBMI, including students in basic and primary education, children, adolescents, seniors and other groups in need of social assistance. According to statistics published by the Ministry of Human Resources and Social Security, the total number of participants in this program increased from 43 million in 2007 to 221 million in 2011.

Finally, the fourth phase establishing the current Chinese health system started in 2009, when the Central Committee of the Chinese Communist Party and the State Council issued a set of guidelines on reforming the medical and pharmaceutical system along with a notice of the State Council on an implementation plan to promote reforms in the period between 2009 and 2011. The five main actions proposed were: (1) acceleration of the establishment of a basic health insurance system; (2) preliminary establishment of a national system of essential medicines; (3) improvement of the primary health care services; (4) constant improvement of access to basic public health services; and (5) greater expansion of public hospitals services. In that period, the central government invested USD 65.2 million in health facilities across the country, an amount higher than the sum of all investments made by the Chinese government in the previous thirty years, since the economic reforms of the late 1970s. In 2011, the government announced its intention to increase the investments in the sector to USD 175 billion for a three-year plan. In 2009, the Chinese government also started to implement a reimbursement system for outpatient care of NRCMS and URBMI. Additionally, individual copayments for outpatient and hospital care were significantly reduced.

In general, health care in China is managed through three systems: hospitals, primary health care units, and public health institutions. Official data indicates that, in 2011, China had a total of 21,979 hospitals, including 14,328 general hospitals (65.2%),

2,831 traditional Chinese medicine hospitals (12.9%) and 4,283 special hospitals (19.5%). Most hospitals are public (13,539 in 2011, corresponding to 61.6%), and there were 8,440 private hospitals (38.4% in total) in that year.

The health scenario in China presents complex challenges related not only to the size of its population, but also to internal inequities arising from social, geographic, economic, and political issues. Currently, 57.9% of the Chinese population lives in urban areas, with an estimated annual growth of urbanization of 2.3% between 2015 and 2020 (OMS, 2018). Life expectancy at birth rose from 35 years in 1949 to 75.7 years in 2017, and infant mortality dropped from 300 deaths per thousand live births in 1950 to twelve per thousand live births in 2017. Maternal mortality decreased from 80 in 1991 to 25 in 2012 per 100,000 live births, and neonatal mortality dropped, in the same period, from 33 to 7 per 1000 live births (BANCO MUNDIAL, 2018a, BANCO MUNDIAL, 2018b).

Despite significant advances in health and the construction of high-level medical facilities, the country deals with emerging public health problems, such as infectious diseases, like HIV/AIDS, and chronic diseases, notably the growth of obesity among young people who live in urban areas. Furthermore, there has been a significant increase in cases of respiratory diseases caused by air and water pollution and by smoking, affecting approximately 760,000 individuals per year. Since 2007, China has surpassed the United States as the world's largest carbon dioxide emitter, and currently about 90% of Chinese cities suffer from some level of water pollution (LUK, 2017).

To address this problem, President Xi Jinping launched, in 2014, the “National Plan for a New Urbanization Model”, which presents the goal of increasing urban population from just over 50% to 60% by 2020. The plan also includes an urban infrastructure program, focusing on the expansion of mobility, on housing construction, on the overall improvement of quality of life in the cities, and on fighting pollution (BRASIL, 2015).

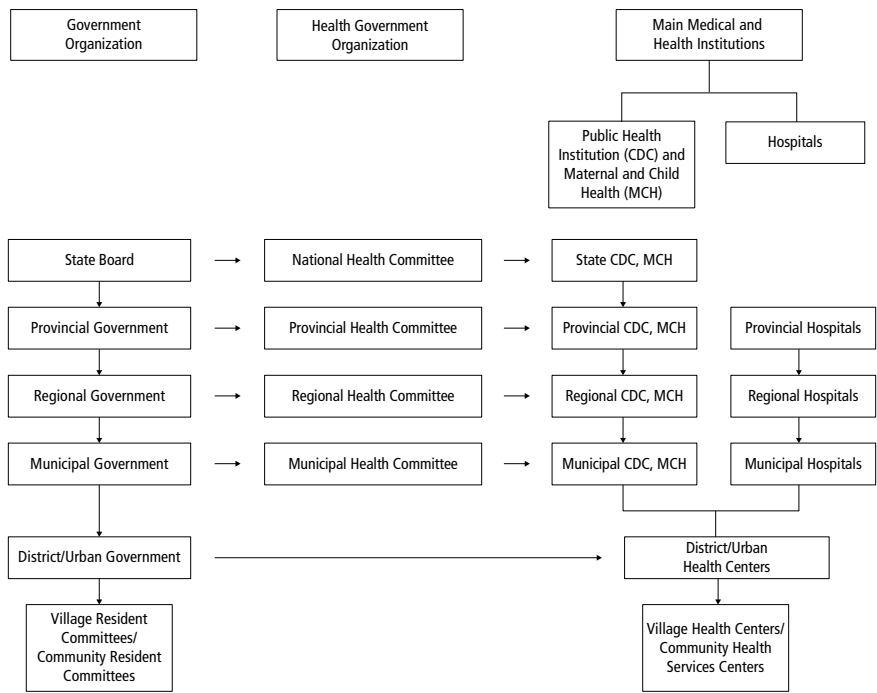
The National Health and Family Planning Commission (NHFPC), along with provincial health offices, supervises the medical needs of the population. The Commission is also responsible for providing information, raising awareness and educating the population on health topics, providing family planning, ensuring accessibility of health services, and monitoring the quality of health services provided to citizens, and the country's populational planning. This agency replaced the Ministry of Health, Family and Populational Planning in 2013 and has been led since then by the Minister of Health and Family Planning, Li Bin (CHINA, 2018).

The NHFPC reports directly to the CPC Council of State and has functions and responsibilities that include, for example: drafting of laws, regulations, plans and policies related to public health; supervision of disease prevention and treatment; supervision of medical education; formulation of policies for maternity and child care

programs; control of epidemics outbreaks; supervision of state hospitals; population control; family planning; development of scientific projects and medical technology; definition of quality standards for food and cosmetics; and supervision of the State Administration of Traditional Chinese Medicine (CHINA, 2018).

The Chinese health system is organized according to government administration, which includes the following levels: central, provincial, regional, municipal and district (Figure 1). Each district is responsible for taking care of several cities, and each government unit at the municipal level has a functional health department under double control: the corresponding government and the health department of a higher administrative level.

**Figure 1** – Organization Chart of China Health Care System



Source: Author’s own preparation based on data from SUN, 2017

Health services provision in China can be divided into three main segments. The first is comprised by specialized public health services, which are provided by the Center for Disease Control and Prevention (CDC), an institution managed by the Chinese government and by other specialized health agencies for women and children

at the provincial, municipal, and district levels. In 2014, there were 3,490 CDCs and 3,098 health agencies for women and children in China.

The second type of service is targeted to primary care, carried out in rural and urban areas, at the district and municipal levels. In 2014, the total number of primary health care institutions reached 917,335, including 595 sub-district health centers, 34,238 community health service centers, 36,902 municipal service centers, 645,470 municipal clinics and 200,130 outpatient departments.

The third segment of health services provision in China is aimed at curative health care, offered by hospitals, categorized as a public or private service and accredited at levels from one to three. Category one hospitals are generally at the municipal level for primary public health care and clinics introduced in the primary care section. There are district hospitals that provide comprehensive health services in category two. At level three, public or private provincial or regional hospitals working with curative care and that provide comprehensive or advanced health services. Hospitals at each level are classified as A and B, based on their functions, size, technical skills, equipment, and quality of service. A hospital classified as A in level three, for example, is considered of high quality. In 2014, China had 16,524 general hospitals, 3,115 traditional Chinese medicine hospitals, and 5,478 specialized hospitals.

China has managed to achieve universal health insurance coverage by implementing three different health insurance schemes, the NRCMS, which covers the rural population, the UEBMI, which guarantees the health of people employed by the government or the private sector, and the URBMI, which covers non-employed individuals living in urban areas. In addition, the Chinese government has built a database with its citizens' health information, including electronic medical records. Currently, China faces challenges to maintain and complete the complex health reform. International cooperation initiatives may, therefore, contribute to the sharing of successful and efficient experiences that will allow to strengthen health care in the country.

Traditional Chinese medicine (TCM) has existed for more than two millennia and since its creation has used characteristics and practices of other neighboring civilizations. TCM was popular in many bordering countries, already in Qin and Han dynasties (221 BCE-220 AD), with wide use in disease treatment and prevention. From 1911 to 1949, TCM was discouraged and the country sought to establish a medical system based only on western biomedicine. After the establishment of the People's Republic of China, in 1949, TCM was reestablished in the public health system, as one of the ways to reassert the value and the authority of the Chinese culture. The Constitution of the People's Republic of China sets forth that the state promotes modern medicine and TCM to protect people's health. The practices include several forms of phytotherapy, acupuncture, massage, physical exercises, and dietary therapies aiming

at the prevention and treatment of diseases and at the improvement of people's quality of life (RPC STATE COUNCIL, 2016).

In 1978, the Central Committee of the Communist Party of China (CPC) transmitted across the country the "Report on the Implementation of Party Policies Concerning TCM and the Training of TCM Professionals", providing support of human resources, finance and supplies areas. In 1986, the State Council established a relatively independent administration of the TCM, and all provinces, autonomous regions and municipalities established their respective administrations of traditional medicine. More recently, in 2003 and 2009, the State Council issued the "People's Republic of China Regulation on Traditional Chinese Medicine" and the "Opinions on Supporting and Promoting the Development of Traditional Chinese Medicine", gradually forming a quite robust TCM political system.

Since the 18<sup>th</sup> National Congress of the CPC in 2012, the Party declared that it desired to give greater importance to the development of TCM and reiterated the need to pay equal attention to the development of both traditional Chinese medicine and Western medicine. At the National Conference on Health and Hygiene, in 2016, President Xi Jinping emphasized the importance of revitalizing and developing traditional Chinese medicine. In the same year, the Central Committee of the CPC and the State Council published the draft of the Strategic Plan for the Development of traditional Chinese medicine (2016-2030), which raised the development of TCM to the national level, with specific goals and guidelines.

A few decades ago, TCM represented the most widely used method by the Chinese population that lived mainly in rural areas. In 1980, the Chinese rural population represented 81% of the total population (BANCO MUNDIAL, 2016c). With the country's modernization and economic development, China adopted several methods of Western medicine, which were implemented as a public health system. Currently, the public health system in China provides both types to the population. It is important to highlight, however, that the significant rural population that represented, in 2016, 43% of the Chinese people still uses TCM as the main method for disease prevention and treatment (BANCO MUNDIAL, 2016c).

In the international scope, China has exported its technology and expertise in TCM as a model for several countries. Within the scope of BRICS, China promoted, during its *pro-tempore* presidency, in 2017, the BRICS High-level Meeting on Traditional Medicine, as part of its government strategy of disseminating and extending the use of TCM practices also in other countries.

### 3 Brazil-China Bilateral Relations

Diplomatic relations between Brazil and the People's Republic of China were established in 1974. Starting in the mid-1980s, the two countries engendered on bilateral cooperation initiatives in technology-intensive sectors, such as nuclear energy and satellite construction. The first major bilateral cooperation project was implemented in 1988, with the CBERS Program (China-Brazil Earth-Resources Satellite), created with the goal of constructing and launching satellites for land monitoring, being one of the first cooperation projects between developing countries in a highly intensive technology sector (BRASIL, 2016b).

In 1993, the Brazil-China strategic partnership was established – the first one of both countries – and in 2014, during the visit of President Luiz Inácio Lula da Silva to China, the High-level Sino-Brazilian Commission for Concertation and Cooperation (COSBAN) was established as an institutional framework for bilateral relations. COSBAN, led by the Vice-President of Brazil and by the Vice Prime-Minister in charge of economic, commercial, and financial issues in China, is the permanent instance of cooperation and bilateral dialogue of highest level between the two countries (BRASIL, 2016b).

Since 2009, China has been Brazil's main trade partner. The Asian country has also been consolidated as one of the main sources of investment in the country. Between 2001 and 2017, the bilateral trade flow increased over twenty times, from USD 3.2 billion to USD 74.8 billion (BRASIL, 2018b). Since 2003, Chinese investments in Brazil have added up to more than USD 54.1 billion, mostly concentrated in the oil, gas, and energy sectors (BRASIL, 2018c).

In 2010, the two countries signed the Brazil-China Joint Action Plan (PAC 2010-2014), which defined targets, goals and guidance for bilateral relations. In May 2015, during the visit of the Prime Minister Li Keqiang to Brazil, the updated version of the PAC was signed, valid until 2021. The PAC aims at broadening and deepening cooperation in the bilateral, plurilateral, and multilateral dimensions, with specific purposes for the Global Strategic Dialogue and for the subcommissions of the COSBAN, the mechanism responsible for monitoring the implementation of the plan (BRASIL, 2016b).

In June 2012, the Prime Minister, at that time, Wen Jiabao, visited Brazil and, during the visit, three new frameworks on the bilateral relation were established. The bilateral relation was raised to the category of "Global Strategic Partnership". The Global Strategic Dialogue (GSD) was implemented at the Chancellors' level, in recognition of the growing strategic and global influence of the two partners. The Ten-Year Cooperation Plan was signed for the period 2012-2021 – which is less comprehensive than the PAC –, focusing on five priority areas of the bilateral relation: (i) science,

technology, innovation and space cooperation; (ii) mines, energy, infrastructure and transport; (iii) investments and industrial and financial cooperation; (iv) economic and trade cooperation; (v) cultural, educational and exchange cooperation between peoples (BRASIL, 2012, BRASIL, 2016b).

## 4 Bilateral relations in the health sector

Until the early 2000s, the relationship between Brazil and China in the health sector was marked by isolated initiatives, with an overlap of actors and scarce institutionalization or centralization of actions within the federal government (RUBARTH, 1999). The recent bilateral relationship in the health sector still suffers from this pulverization of actions. However, the direct engagement between the two governments in this matter has shown signs of maturation, with concrete potential for the execution of joint projects in the coming years.

The institutionalization of bilateral relations in the health sector advanced after the visit of the Minister of Health, José Gomes Temporão, to Beijing in 2009. At the time, the ministers of health of both countries agreed that a specific bilateral instrument for health would be developed. In 2011, the Health Joint Action Plan was signed, an instrument that guided the cooperation for the sector for the four upcoming years and established the control of infectious diseases as one of the priority areas for bilateral cooperation in this topic (BRASIL, 2015).

In 2014, the NHFPC Deputy Minister, Sun Zhigang, visited Brazil to get acquainted with the national experience in providing health services to the population. The Brazilian Minister of Health presented the government programs, such as *Mais Médicos* (More Doctors, in english), *Farmácia Popular* (Popular Pharmacy, in english), and the construction of Emergency Care Units (UPAs), since the Chinese government was interested in knowing more about the Brazilian experience in the implementation of the Unified Health System (SUS) (BRASIL, 2015).

The Prime Minister of the State Council of the People's Republic of China, Li Keqiang, visited Brazil in May 2015 and met with President Dilma Rousseff. The authorities had discussions and exchanged experiences based on the Health Joint Action Plan, signed in 2011, and on the new Brazil-China Joint Action Plan 2015-2021. At the time, the leaders stated the commitment to advance in the cooperation on health, determining the establishment of the Sub-commission on Health, as one of the twelve sub-commissions<sup>4</sup> within the scope of COSBAN (MOREIRA LIMA, 2016). The

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<sup>4</sup> Besides the Sub-commission on Health, COSBAN also includes the following Sub-commissions: Economic-Financial; Inspection and Quarantine; Educational; Political; Space Cooperation; Economic-Trade; Agriculture; Cultural; Science and Technology; Energy and Mining; Industry and Information Technology.

effective implementation of the Sub-commission on Health, however, would still take over two more years.

In July 2017, during the BRICS Health Ministers Meeting, carried out in Tianjin, China, the Brazilian Executive-Secretary of the Ministry of Health met with the Deputy Minister of the NHFPC and expressed Brazil's interest in progressing with concrete actions, through the exchange of successful experiences in the health sector. At the time, both agreed with the proposal to hold the first High-Level Meeting of the Sub-commission on Health, still in 2017, in Brazil, and they agreed to sign, in that same year, the Terms of Reference for the operation of the Sub-commission and the renewing of the the Action Plan in Health, signed in 2011, which had expired in 2015.

Following this meeting, the International Health Affairs Office of the Ministry of Health of Brazil (AISA) and the International Cooperation Department of the NHFPC established a direct communication channel, which allowed fast and effective progress in the bilateral negotiations. Within a short time, the Brazil-China Action Plan in the health sector for the period 2018-2020 was negotiated and approved between the parties, which allowed its signature, in September 2017, in the context of the State visit of President Michel Temer to China (BRASIL, 2017d; BRASIL, 2018e).

In November 2017, during the World Hepatitis Summit – organized by the Ministry of Health of Brazil, in partnership with the World Hepatitis Alliance (WHA) and the World Health Organization (WHO), in São Paulo – the first meeting of the COSBAN Sub-commission on Health was held, with the participation of the Minister of Health of Brazil, Ricardo Barros, and the Chinese Deputy Minister of Health, Wang Guoqiang (BRASIL, 2018a). During the meeting, the discussions focused on the bilateral relation in health and on cooperation perspectives in several areas, such as research and development, traditional medicine, control and prevention of diseases, health within BRICS, antimicrobial resistance, and innovative ways for fighting the *Aedes aegypti* mosquito. On that occasion, representatives of both countries also signed the Terms of Reference of the COSBAN Sub-commission on Health, which establishes the overall parameters for its operation, and the Memorandum of Understanding for International Cooperation in research and development between the Oswaldo Cruz Foundation (Fiocruz) and the Chinese Center for Disease Control and Prevention (CDC China). The document signed between Fiocruz and CDC China aims to promote the prevention and control of diseases and to invest in innovative ways to fight the *Aedes aegypti* mosquito (BRASIL, 2017c, BRASIL, 2018a).

In the Brazilian perspective, with the establishment of the Sub-commission, the Brazilian-Chinese cooperation in health reached a new level, since both countries now dispose of an established forum and a consistent plan to advance in an agenda of practical cooperation activities. The Brazilian government has also shown interest in identifying common positions that could be reinforced in the multilateral forums,

in which the two countries participate, such as WHO and BRICS. In an international context characterized by several initiatives often overlapped in a variety of topics, in the health sector, the effective coordination of positioning may bring higher coherence and strength to Brazil's international action. Due to its economic and population dimensions, as well as political and geopolitical relevance and the role played by China in the contemporary international order, the task of coordinating positions for a country like Brazil presents additional challenges. Nonetheless, since the two countries share common public health challenges, there is room for identifying possible convergences.

In the topic of research and development, the Brazilian government has shown interest in cooperating with China in the area of epidemics, both in those that have significantly hit Brazil in recent years, such as Zika, dengue and chikungunya, and those that have presented a growing public health challenge to China, such as influenza A-H7N9 and avian influenza (BRASIL, 2017c). The Chinese government has expressed interest in learning from the Brazilian experience in tropical disease management and in the prevention of epidemics.

The Brazilian Ministry of Health has prioritized the adoption of integrative and complementary practices of the traditional medicine within SUS. Several practices pertaining to the traditional Chinese medicine, such as acupuncture, Chinese phytotherapy, auriculotherapy, cupping therapy and Tai Chi Chuan. In 2017, over 1.4 million of these procedures were offered to the SUS users. Traditional medicine practices represented more than 150 000 sessions annually. In 2018, new integrative practices have been incorporated to the SUS, with a total of 29 practices that became available in the Brazilian Unified Health System (BRASIL, 2018d). Cooperation with the Chinese government in this matter is a priority for Brazil, which has shown interest in exchanging experiences and in training of professionals.

Within the scope of BRICS, in July 2017, the High-Level Meeting on Traditional Medicine was held, and the Xiamen Declaration, adopted by BRICS leaders in September 2017, commended the establishment of a long-term mechanism for traditional medicine exchanges and cooperation, to promote mutual learning of traditional medicines and pass them down to future generations (BRASIL, 2017e). The promotion of the traditional medicine among BRICS countries may, therefore, constitute a promising area of cooperation in the coming years, as it was shown in Brazil's recent engagements with China and India.

Sexually transmitted infections (STI) also represented a promising area in the bilateral relation. The Brazilian government has sought to strengthen the prevention strategy of these diseases, promoting the use of condoms, focusing on the more vulnerable populations (BRASIL, 2017b). The Chinese government signaled interest in exchanging experiences with Brazil on prevention and control of STI, considering the Brazilian experience on the matter, especially in the treatment of viral hepatitis.

Brazil also seeks to strengthen cooperation with China for the acquisition of penicillin, which is used in the treatment of several STI, as China is the world's leading supplier of this antibiotic. Penicillin, in its various forms, is classified by WHO as a drug vulnerable to supply crises because it is an old drug, its patent has expired, it is cheap, and few pharmaceutical companies are interested in its production.

The bilateral health relation between Brazil and China has ahead of it the challenge of transforming significant potentials into concrete cooperation and learning initiatives with practical effects on the public health of the two countries. The areas already identified by the two governments may represent an important starting point to leverage other future cooperation modalities. Beyond the geographical, cultural and organizational distances, as well as the lack of knowledge about capabilities and interests by both sides, mutual knowledge generated within the scope of the bilateral approach seen in the health could raise the Brazil-China relationship in this area to a new level.

## 5 Brazil and China in the scope of BRICS

BRICS has represented a space for approach and discussion on several topics in the international agenda, as it is the case of health (MOREIRA LIMA, 2016). In the Chinese perspective, BRICS has been converted into a strategic element for its insertion in global economy (BRASIL, 2016b). In the health sector, China and India have used their *pro tempore* presidencies in the grouping to organize high-level meetings on traditional medicine in 2016 and 2017. Beyond the possible commercial interest on the subject, the Chinese and Indian governments have used traditional Chinese medicine and Ayurveda as platforms to broaden their own vision of health, and its relations with society, passing from the rationale diseases healing to health promotion and prevention.

The recent multilateral coordination of the BRICS<sup>5</sup> countries within the scope of WHO, agreed at the 7<sup>th</sup> BRICS Health Ministers Meeting (TIANJIN, 2017), reflects the political coordination initiatives from COSBAN. During the 4<sup>th</sup> Plenary Session of COSBAN in 2015, chaired by the Chinese deputy Prime Minister and the Brazilian Vice-President, the authorities of both countries reiterated the importance of cooperating in multilateral forums and stressed that the promotion of reforms of global mechanisms of political and economic governance is of great importance to try to adapt them to the new demands of the international reality, especially by increasing the participation of developing countries (MOREIRA LIMA, 2016).

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<sup>5</sup> Refer to article "Political coordination and cooperation in health among BRICS nations", by Eduardo Shigueo Fujikawa for further considerations on this topic.

The existence of common needs and challenges to developing countries in the area of health provides space of joint action that allows the promotion of shared goals and interests. By using their participation in international mechanisms and organizations such as the platform for the coordination of positions and promotions of their interests as developing countries, Brazil and China have leveraged the bilateral approximation in the scope of health.

## **6 Concluding remarks: challenges and perspectives**

The bilateral relation between Brazil and China has advanced at a fast pace in the past three decades, driven, mainly, by the growing importance of the bilateral economic agenda since the beginning of the 2000s. In the field of health, however, even though the political-diplomatic understanding is fluid and recent progresses have been registered, this cooperation is not yet thoroughly explored in practice.

Even for an emerging country with the political dimension and weight of Brazil in the international scenario, the coordination of positions and the identification of areas for possible cooperation with a country such as China is not an easy task. There are different perspectives in the ways to lead the cooperation process or to organize high-level meetings. In addition, challenges such as the cultural and linguistic barriers hinder the boost of cooperation in the fields of science and development in the health sector. Organizational differences between the two governments also pose difficulties to the identification of appropriate dialogue partners and to the concrete formulation of what one partner may expect from the other.

The recent approximation between the Ministry of Health and the NHFPC, through a fluid contact between AISA and the Chinese Department of International Cooperation, as well as the expression of the unequivocal political will by the Chinese government to tighten its relation with Brazil on health issues may contribute to leverage the bilateral approximation. The renewal of the Joint Action Plan in Health, and COSBAN's first High-Level Meeting of the Sub-commission on Health, in 2017, may mark the beginning of a new phase in the bilateral relation in health.

The approach of the health topic in the bilateral relation has been restricted, mainly, to the contacts between the ministries of health of both countries. References to health topics are reduced in the ostentatious official documents produced by Itamaraty about the bilateral relationship or even in the reports of COSBAN meetings. The active engagement of the ministries of foreign affairs and the embassies of both countries in order to promote a bilateral approximation in health, seeking to foster the articulation between the competent agencies from both countries may positively contribute for an important political impulse in the relation on this topic.

Even though there are already several collaborations between Brazil and China in the area of traditional Chinese medicine, such as the training of Brazilian physicians in practices of traditional Chinese medicine – usually funded by the Chinese private sector – the institutionalization of a bilateral partnership is of major importance in order to make this cooperation a horizontal collaboration, with exchange of experiences. The institutionalization seeks to ensure this cooperation model with long-term goals, so that the knowledge transferred may benefit the Brazilian population, mainly the portion that depends exclusively on the SUS, which corresponds to 70% of the population (BRASIL, 2017f).

In addition to the favorable political moment, there should also be an engagement of technicians from the ministries of health, academia, the private sector and civil society from both countries. Brazil must reflect, in all these instances and dimensions, its goals concerning the cooperation with China and what Brazil has to offer based on its public health experience. Some areas have started to be defined in the recent context of bilateral political approximation, such as research and development, traditional medicine, exchange of experiences and knowledge in public health policies, in addition to political coordination in multilateral forums. The role of the Ministry of Health, in general terms, and the role of AISA, in particular, will be to provide coherence, organicity and practical sense to this engagement.

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## Annex: bilateral instruments in the health sector

1. Memorandum of Understanding in research and information between Oswaldo Cruz Foundation (Fiocruz), the Chinese Center for Disease Control and Prevention (CDC China), the “Third People’s Hospital of Shenzhen”, the Beijing Genomic Institute (BGI), ZTEICT and the Chinese Academy of Sciences Key Laboratory of Pathogenic Microbiology and Immunology Institute of Microbiology (2018).
2. Term of Reference of the COSBAN Subcommittee on Health (2017).
3. Action Plan between the Ministry of Health of Brazil and the National Health and Family Planning Commission of the People’s Republic of China in the area of health for the period from 2018-2020 (2017).
4. Brazil-China Joint Action Plan (2010-2014) (2011). Signature of the Brazil-China Joint Action Plan in Health (2011-2014), on October 20, 2011.
5. Memorandum of Understanding between the Chinese State Food and Drug Administration (SFDA) and the Brazilian National Health Surveillance Agency (ANVISA), signed on March 18, 2011.
6. Bilateral Memorandum of Understanding between the Chinese State Food and Drug Administration (SFDA) and the Brazilian National Health Surveillance Agency (ANVISA), signed on Friday, June 4, 2010.
7. Memorandum of Understanding about the establishment of the China-Brazil High-Level Coordination and Cooperation Commission (COSBAN), of May 24, 2004.
8. Complementary Agreement on Health and Medical Sciences to the Scientific and Technological Cooperation, of May 24, 2004.
9. Complementary Agreement on Surveillance of Medicines and Health Products to the Agreement on Scientific and Technological Cooperation between the Government of the Federative Republic of Brazil and the Government of the People’s Republic of China, of May 24, 2004.
10. Complementary Agreement to the Agreement on Scientific and Technological Cooperation and to the Agreement on Economic and Technological Cooperation in the area of Exchange of Specialists for Technical Coordination, December 13, 1995.
11. Complementary Agreement to the Agreement on Scientific and Technological Cooperation in the sector of Traditional Chinese Medicine and Phytopharmaceuticals, of April 4, 1994.
12. Complementary Agreement to the Agreement on Scientific and Technological Cooperation (Including the Health Area), of May 29, 1984.
13. Agreement on Scientific and Technological Cooperation of March 25, 1982, under which the health actions have been developed.

# Regional Integration to strengthen health systems: the case of Mercosur

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## Abstract

Going beyond customs-related purposes of the first years of Mercosur, in 1996, the Sub Working Group no. 11 and the Meeting of Health Ministers of Mercosur were established, encompassing the so-called “Mercosur Health”. This study situates the health sector of Mercosur within the scope of the trade bloc dedicated to social development, and shares the activities developed by the International Health Affairs Office (AISA) of the Brazilian Ministry of Health for regional integration. In addition, the study presents the current organizational model within Mercosur Health, its logic and interaction flows, covering regional cooperation promotion tools, and describing examples of current initiatives and practices aimed at strengthening the health systems of the bloc’s States Parties. Finally, this shared scenario guides the presentation of the main potentialities and challenges for “Mercosur Health”.

**Keywords:** Mercosur. Health. International Cooperation. Regional Integration.

## 1 Introduction

The purpose of the creation of the Southern Common Market (Mercosur) in 1991 was the regional integration within the economic and commercial scope of States Parties, Argentina, Brazil, Paraguay and Uruguay. Nine years later, along with the Associated States – Chile and Bolivia – they signed the Charter of Buenos Aires on Social Commitment<sup>3</sup>. At the time, the countries emphasized the purpose of establishing political coordination that would surpass the primarily economic bias, in order to focus on the social dimension (MERCOSUL, 2000). In this effort, social themes such

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<sup>3</sup> In 2012, Venezuela joined as a State Party of Mercosur and was suspended in the end of 2016. Currently, Bolivia is a State Party in the process of membership to the Mercosur. Chile, Colombia, Ecuador, Guiana, Peru and Suriname are Associated States in the bloc. Mexico and New Zealand are observer countries.

as food, health, employment, housing, and education became priority areas. Aiming at ensuring the dignity of their people, the Charter on Social Commitment established, for Mercosur, guidelines towards an integral view for the regional bloc.

Besides the purposes related to the establishment of Mercosur, the Charter of Buenos Aires was fundamental to enable integration processes based on public policies concerning equity and social justice within the framework of the new Latin America regionalism (LAISNER, 2015; SANAHUJA, 2009).

Within the scope of health, the purposes of Mercosur go beyond customs-related objectives and establish a position of relevance for this sector in the South-American regional integration. The first actions of Mercosur Health were the establishment of the Meeting of Health Ministers and the Sub Working Group No. 11; however, it was only in the 2000s that the sector gained effective importance in the agenda of the regional bloc. The organization was strengthened with this new emphasis, providing technological support through specific advising instances, responsible for proposing the first versions of official documents for the health sector.

This article examines Mercosur Health through its bloc's social commitment, more specifically, its purpose of social development promotion. The effort also aims at demonstrating the work of the International Health Affairs Office of the Brazil's Ministry of Health (AISA) in strengthening regional integration. With the purpose of understanding the modes enabling public health activities in regional integration, this article presents, firstly, a comprehensive scope of the bloc. Then, we establish the health sector scope and configure the organizational model in effect within Mercosur Health, its processes and interaction flows, as well as the types of instruments promoting integration. After that, we analyze examples of current actions and practices regarding the processes of strengthening the health systems in areas such as food and nutrition, access to high cost medicines, donation and transplant of organs and tissues, international health regulations, and HIV/AIDS. Finally, we analyze all the aspects discussed to share the main potentialities and challenges for Mercosur Health.

## **2 Integration beyond the Common Market**

In 1991, taking into account the highly competitive scenario of economic globalization, the Treaty of Asunción established, for Argentina, Brazil, Paraguay, and Uruguay, the purposes of regional integration for the coordination of commercial policies and action in international economic forums, as a means to strengthen the economic development of the States Parties and allow the circulation of goods, services and productive factors among the countries (MERCOSUL, 1991).

After the Treaty of Asunción, the Protocol of Ouro Preto (MERCOSUL, 1994) established the basis for Mercosur's institutional structure. The organic structure of the

bloc includes a Common Market Council (CMC), higher body responsible for political coordination. Subordinated to the CMC are the Mercosur Trade Commission (CCM), the Mercosur Parliament (Parlasur), the Advisory Forum on Economic and Social Matters (FCES), the Administrative Secretariat (SAM), and the Common Market Group (GMC); the latter is the executive level of Mercosur. GMC, CCM and CMC have an intergovernmental nature, with decision-making capability (MERCOSUL, 1994).

The FCES, an advisory organization, was the first instance to analyze social issues in the process of regional integration. This forum articulates with representatives from economic and social sectors, and provides recommendations to the GMC (DI PIETRO PAOLO, 2006). However, given the less institutionalized nature of the Forum (SATO, 2014), the social dimension of integration, based on human development and on democratic construction, was only consolidated with the expansion of the GMC and CMC structures, in the 2000s.

This densification is materialized on the pluralization of sectoral instances. Periodical Ministers meetings<sup>4</sup>, linked to the CMC, are no longer restricted to the sectors of economy and foreign affairs, and reach twenty-one areas. The GMC – established by the Treaty of Asunción, with ten Sub Working Groups focused on the economic aspects of the integration – currently has eighteen Sub Working Groups<sup>5</sup>, which include social policies. In the case of health, for instance, since 1996 health topics have been treated by a specific Sub Working group (SGT 11). Until then, health-related matters in the sector were part of a broader Sub Working group (SGT 3), which focused on the production of technical regulations.

This plurality of institutional instances represents a political commitment with thematic issues that go beyond the scope of customs, bringing to the Mercosur's organizational chart the advocacy of social justice as proposed in its foundation. The public policies agenda of the integration expands not only the purposes, but also the South-South cooperation mechanisms (SANAHUJA, 2009), associating themes of equity promotion and the guarantee of rights for the development project of the bloc.

<sup>4</sup> Among the structures linked to the CMC are the Coordination Committee of Ministers of Social Topics (CCMAS) and the Meetings of Ministers and High Authorities of Mercosur in the following areas: Agriculture (RMA), Science, Technology and Innovation (RMACTIM), Culture (RMC), Social Development (RMADS), Human Rights (RAADH), Economy and Presidents of Central Banks (RMEPBC), Education (RME), Sports (RMDE), Industry (RMIND), Interior (RMI), Justice (RMJ), Environment (RMMA), Mines and Energy (RMME), Women (RMAAM), Indigenous People (RAPIM), Privacy and Information Security and Technological Infrastructure (RAPRISIT), Health (RMS), Labor (RMT), Tourism (RMTUR), Afro-descendants (RAFRO), Disaster Risk Management (RMAGIR) (BRASIL, MRE, 2017).

<sup>5</sup> Currently, the GMC is composed by *Ad Hoc* groups, Specialized Meetings, and by the following Sub Working Groups: SGT 1: Communications; SGT 2: Institutional Aspects; SGT 3: Technical Regulations and Conformity Assessment; SGT 4: Financial Topics; SGT 5: Transportation; SGT 6: Environment; SGT 7: Industry; SGT 8: Agriculture; SGT 9: Energy; SGT 10: Topics on Labor, Employment, and Social Security; SGT 11: Health; SGT 12: Investments; SGT 13: Electronic Trade; SGT 14: Productive Integration; SGT 15: Mining and Geology; SGT 16: Public Hiring; SGT 17: Services; SGT 18: Border Integration (BRASIL, MRE, 2017).

One of the milestones in the declaration of purposes of this renovation in Mercosur is the Charter of Buenos Aires on Social Commitment (MERCOSUL, 2000), signed by the Presidents of States Parties and by the presidents of Bolivia and Chile, Associated States. The document presents the commitment with the development of public policies concerning the articulation with civil society, fight against poverty, and the improvement of the quality of life, reinforcing priority attention to vulnerable populations in relation to health, nutrition, employment, housing, and education. Also, the heads of States have acknowledged the need to establish a Plan for the coordination of public social policies in the region and, since 2011, the Strategic Plan for Social Action (PEAS) has been part of the Mercosur agenda (MERCOSUL, ISM, 2012). With the creation of PEAS, we understand that

*the relevance and the understanding of the social dimension in the process of regional integration presuppose viewing social policies not as compensatory or subsidiary of economic growth, but rather, acknowledge that all public policies form a human development strategy (MERCOSUL, RMADS, 2012).*

Mercosur Health is linked to this broad concept of South American integration process, having simultaneously an economic and a social character. Below, we define the structures and the modes of development of this sectoral regional cooperation, including a presentation of the institutions, actors, roles, and process flows to strengthen the region's health systems.

### **3 Mercosur health**

Mercosur Health corresponds to one of the pillars of the Mercosur organizational structure dedicated to the health dimension in the CMC and in the GMC and is formed by the Meeting of Health Ministers of Mercosur (RMS) and the Sub Working Group No. 11 – Health (SGT 11), respectively. The establishment of these institutions, aimed at developing joint health policies and regulations concerning, for example, the circulation of products and people, promotion of health, communicable and non-communicable diseases, health professional practice, and the coordination and harmonization of health policies, corresponds to the consolidation of the States Parties' commitment with the right to health.

RMS is a political thematic forum that advises the CMC. It is responsible for discussing and proposing negotiated solutions on topics of interest to public health. Its responsibilities include: defining principles and policies to protect public health as a basic regulatory framework to harmonize the legislations in the area; creating and supporting the implementation of joint programs and actions for health protection

and care; and preventing environmental risks as well as those concerning the use of products and services (SECRETARIA ADMINISTRATIVA DEL MERCOSUR, 2001). Every semester, RMS meetings are held, considering the exercise of the pro tempore presidency of the countries, which is alternated in alphabetical order. As explained by Frederico (2018) in the first chapter of this book, the pro tempore presidency of Brazil in the scope of health is organized by the International Health Affairs Office (AISA), in coordination with the Ministry of Foreign Affairs (MRE). Table 1 presents the set of conforming instances of the RMS.

**Table 1** – Instances of the Meeting of Ministers of Health

<b>Board of the Common Market (CMC)</b>	<b>Meeting of Ministers of Health (RMS)</b>	<b>Coordinating Committee of the RMS</b>	Intergovernmental Commission For Medicines Policies (CIPM)
			Intergovernmental Commission to Implement International Health Regulations (IHR) (CIRSI).
			Intergovernmental Commission on HIV/AIDS (CIHIV)
			Intergovernmental Commission on Tobacco Control (CICT)
			Intergovernmental Commission on Sexual and Reproductive Health (CISSR)
			Intergovernmental Commission on Environmental and Worker Health (CISAT)
			Intergovernmental Commission on Donation and Transplantation (CIDT)
			Intergovernmental Commission for Food and Nutrition Security (CISAN)
			Intergovernmental Commission on Non-Communicable Diseases (CIENT)
			Intergovernmental Commission on Blood and Blood Products (CISH)
			Ad Hoc Commission for the Negotiation of Medicines of High Cost in the States Parties and Associated States of the Mercosur (CAHPM)

Sources: SECRETARIA ADMINISTRATIVA DEL MERCOSUR, 2001, 2012; Mercosul, RMS 2015, 2017, 2018.

SGT No.11 is the technical forum responsible for health themes. Its task is to harmonize technical regulations, coordinate actions among States Parties related to surveillance, care services, health technology assessment, health professional practices, and health products and inputs, and to promote and protect people's lives, thus contributing to the process of regional integration (MERCOSUL, GMC, 2014). Table 2 presents the conforming instances of SGT 11.

**Table 2** – Instances of the Sub Working Group no. 11

Common Market Group (GMC)	SGT 11 – Health	National coordinators of SGT 11	Commission of Health Products (COPROSAL)	Subcommission of Medical Products Subcommission of Cosmetics Subcommission of Sanitizing Subcommission of Psychotropic and narcotics Subcommission of Pharmacopoeia
			Health Surveillance Commission (COVIGSAL)	Subcommission for Health Control of Ports, Airports, Terminals, and Ground Border Points.
			Commission for Health Care Services (COSERATS)	Subcommission for Professional Development and Exercise

Sources: Based on Mercosur, GMC, 2014; records of the SGT 11 of 2015.

The instances that support RMS and SGT 11 represent an important part of the institutional development process of Mercosur. They act through in-person and virtual work meetings. In the meetings, the production of documents and specific guidelines, as well as projects of regulations and strategies, take into account expert knowledge from the public bureaucracy of the members of the bloc. The representation in these instances is carried out by leaders, experts, and technicians working in the Ministries of Health of States Parties, who debate the topics taking into consideration their national policies (QUEIROZ, GIOVANELLA, 2011) and the possibility of improvement and integration.

To articulate the work between the thematic Commissions and the higher sectoral instances of Mercosur, SGT 11 has national coordinators, and the RMS has a Coordinating Committee. These coordinators are part of the international areas of the Ministries of Health. In the case of Brazil, national coordination is exercised by AISA representatives.

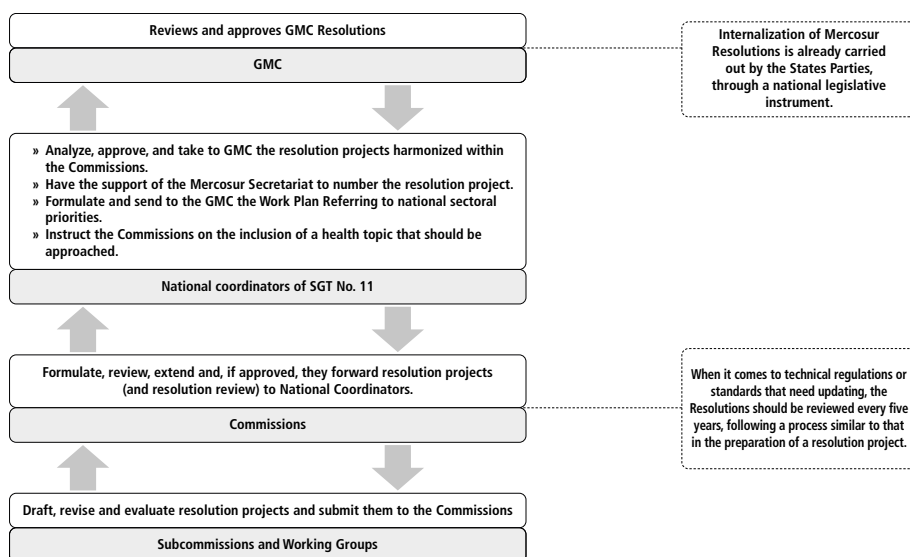
The Coordinating Committee is responsible for proposing recommendations, agreements, and statements to the RMS (SECRETARIA ADMINISTRATIVA DEL MERCOSUR, 2001). In SGT 11, coordinators organize and disseminate activities, define priorities, implement work methodologies, and approve regulations – in the form of projects and resolutions – developed by Commissions and Subcommissions for later submission to the Common Market Group (GMC). They are in charge of observing the health policies and the guidelines defined by RMS to develop regional integration, taking into account both the other areas of Mercosur and opportunities for international cooperation (MERCOSUL, GMC, 2014).

### 3.1 Flows and instruments for regional integration in Mercosur Health

The agreements within Mercosur Health are formalized by means of instruments<sup>6</sup> that establish guidelines, modes of interaction, action plans, functions, or norms for the States Parties to make regional integration feasible within the sector (MERCOSUL, 2018). RMS's recommendations, statements and agreements are conventional formal instruments of Mercosur Health, in addition to projects and resolutions proposed by SGT 11 to the GMC.

Resolutions can be technical regulations for Mercosur, documents establishing the characteristics of a product, their methods or processes, and may include standardization prescriptions. They need to be agreed upon by the States Parties, covering recommendations for their normative national devices (MERCOSUL, GMC, 2017). The development of resolutions, one of the main technical instruments of regional integration in health, is detailed in Figure 1 below.

**Figure 1** – Flow of the development of resolutions in Mercosur Health



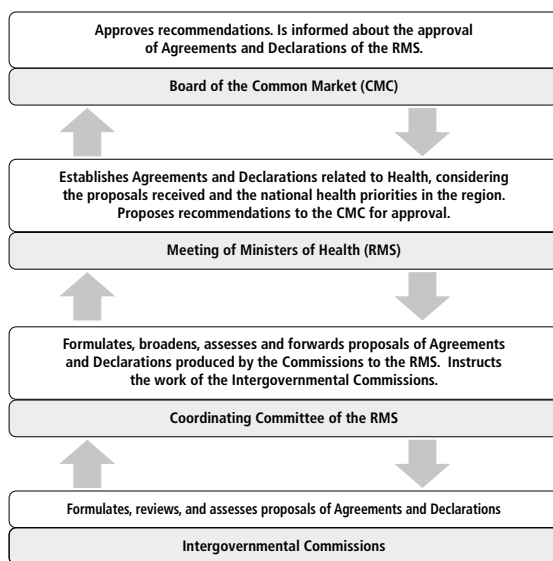
Source: Adapted from Mercosur, GMC, 2017.

<sup>6</sup> We consider the instruments of public action as techno-political devices capable of articulating interactions guided by the purposes of the actors who have participated in their formulation. They can be configured as regulatory means, formal tools to compel action, and compliance standards, including the governing rules of behaviors and results (CRUZ, 2017). For Mercosur Health, we speak about regional integration instruments.

It is important to mention, however, that not all resolutions need to be reviewed. Resolution review is adopted in case of technical regulations or standards that require updating.

The development of recommendations, agreements, and declarations through the Meeting of Health Ministers is one of the most relevant modes of establishing political commitments<sup>7</sup> for regional integration in health. These instruments refer to the Ministers of Health analyses of projects submitted by the bloc's Intergovernmental Commissions and National Coordinations. The interaction flow that produces agreements, recommendations, and statements is detailed in Figure 2.

**Figure 2** – Flow of the development of recommendations, agreements, and declarations in Mercosur Health.



Source: Adapted from Mercosur Administrative Secretariat (2001), and minutes from Intergovernmental Commissions and from the national coordination committee.

The declarations may originate from national priorities perceived by the ministers, by the intergovernmental commissions or by the national coordinators. Some examples of declarations are the ones signed at the RMS in Foz do Iguaçu-PR, in 2017, such as the declaration referring to the inherent risks of harmful alcohol consumption,

<sup>7</sup> Some instruments of the regional integration in health may refer to instructions for the national regulations and norms, as a means to propose the harmonization of practices concerning sectoral policies in the bloc; other instruments may represent the Mercosur platforms for transnational articulation. This is the case of processes concerning access to medicines, materialized in the Declaration of 2017 and discussed in this article under session “Technical Cooperation Practices in Regional Integration” below.

fostering a more rigorous regulation in publicity, verification and labeling of alcoholic beverages. The other concerns agrochemical products management, which highlights the technical competence of health institutions to monitor and provide surveillance over the use of pesticides, also taking into account the health risks of intoxication and the intersectoral nature of health and environment.

The processes for establishing and enabling the Mercosur Health regional integration instruments strengthen the ties between countries, as well as set up platforms for new technical cooperation practices that foster the improvement of health policies and the reduction of asymmetries among the States Parties.

## **4 Technical cooperation practices for regional integration**

AISA cooperates with technical areas of the Ministry of Health and with other States Parties of the bloc to enable the routines and practices of Mercosur Health, taking into account their commissions and other instances in the development of regulations and other instruments for regional integration and for the strengthening of health systems in the region. It includes areas such as International Health Regulations (IHR), food and nutrition, access to medicines, donation and transplant of organs and tissues, and HIV combination prevention within Mercosur.

Although there are several ongoing initiatives within the scope of Mercosur Health, we highlight the above-mentioned ones to represent the possibilities of technical, political and administrative learning, as well as the improvement of public policy management to strengthen health systems, as a result of the regional integration process.

### **4.1 Technical cooperation to strengthen the fulfillment of the IHR<sup>8</sup>**

The IHR, agreed upon by the Member States of the World Health Organization (WHO) in 2005, is a legal and binding international instrument, which aims at preventing the international spread of diseases, protecting the population, controlling public health risks relative to the traffic of people and products, taking into account national and international surveillance processes. Bearing in mind the global commitment, Mercosur Health shares and analyzes surveillance capabilities and responses from countries, evaluating collaboration strategies of IHR monitoring, and sharing experiences from events in the region, as a means to leverage States Parties and Associated States capacities.

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<sup>8</sup> The article by Barbara Pagotto, in this book, provides a more thorough description of the IHR implementation in Mercosur.

Since 2006, has had an Intergovernmental Commission for the implementation of the IHR (CIRSI). Among the several activities enabled by CIRSI/RMS is the agreement signed in 2017 to enable the Technical Cooperation Workshop for collaboration among the bloc's States, aiming at the reduction of asymmetries, and the evaluation and strengthening of Regulation compliance (MERCOSUL, RMS, CIRSI 2017). The agreement was signed in Brasilia, during the Meeting of SGT n° 11, in October 2017.

## **4.2 Food and nutrition security**

Taking into account the UN Decade of Action on Nutrition (2016-2025), the Working Group for Food and Nutrition Security (GTSAN) was converted into the Intergovernmental Commission for Food and Nutrition Security (CISAN) during the pro tempore presidency of Brazil, in the second semester of 2017, giving higher visibility to the issue within Mercosur. This structure adds to the purposes of Mercosur Health as it contributes to the right to food, strengthens food quality surveillance systems, and promotes prevention and control of malnutrition (whether by deficit or excess) and of non-communicable diseases.

Among CISAN's initiatives, there are recommendations and agreements proposals for cross-sectional cooperation in the regional bloc, such as regulatory policies and measures to reduce sodium consumption and eliminate the use of industrial trans fat in food. In the latter case, the Commission proposed, by agreement, the encouragement of monitoring and surveillance strategies, reviewing the importance of mandatory nutrition labels, recommending a shift in the use of trans fats for higher nutritional quality lipid substitutes, and also developing research for technological solutions with a view to replacing trans fats (MERCOSUR, RMS, 2017a).

Also, the RMS counted on the then GTSAN to establish an agreement, in 2015, on regulatory measures to reduce sodium consumption. The instrument considers the Pan American Health Organization (PAHO) goals to reduce sodium intake in processed and ultra-processed foods, and agrees on maximum limits for the use of sodium in foods such as bread, pasta, cookies, processed and breaded meats, industrialized soup cheese, noodles, spices and snacks (MERCOSUR, RMS, 2015). One of CISAN's challenges for the next years will be to prove countries' engagement in sodium reduction based on strategies to monitor their use and their consumption.

## **4.3 Access to medicines**

Countries in the region are concerned with high cost medicines access and, in a coordinated way, are seeking alternatives to this issue. In order to face challenges concerning access to medicines, Mercosur Health established, in 2015, the Ad Hoc

Committee for Procurement Negotiation of High Cost Medicines, to facilitate the procurement of medicines and strategic inputs, supporting the countries in improving access to essential drugs (MERCOSUL, RMS, 2015).

The RMS 2015 Agreement of Montevideo established the Committee and brought directions for the Mercosur Strategy for Prices Joint Negotiation – an important way of public health promotion and protection. In joint negotiations, countries have a higher capacity of reducing prices to purchase high cost medicines. The Joint Round of 2015, the only one carried out so far, negotiated the purchase of darunavir for HIV/AIDS, and sofosbuvir, daclatasvir, and si-meprevir for hepatitis C.

In June 2017, the RMS declaration of Buenos Aires regarding medicines access and intellectual property, presented the importance of prioritizing the public health agenda in free trade negotiations, adopting criteria to protect public health in regards to patents and strengthening access to generic and bio-therapeutic drugs, reaffirming the 2015 Strategy. The RMS statement standardized Mercosur Health position and permitted the group to present, to negotiators of free trade agreements, the relevance of public health, warning about the possible risks of including clauses that could increase the cost of medicines for health systems, such as clauses extending terms of pharmaceutical products patent protection.

In the context of negotiations<sup>9</sup> that Mercosur is conducting with other countries and blocs, such as the European Union, the European Free Trade Association (EFTA) and Canada, the declaration of Buenos Aires presents the positions of the bloc's Ministries of Health regarding key-topics concerning economy, development and the right to health.

#### **4.4 Donation and transplant of organs and tissues**

The Intergovernmental Commission on Donation and Transplantation (CIDT), established in 2006, encourages cooperation in capacity building, analysis development on transplant costs, and the establishment of quality and safety indicators in the processing, preservation, distribution, transport and implantation of organs, tissues and cells (ARGENTINA, MS, INCUCAI, 2018).

An important initiative in this area is the Mercosur Registry on Organ Donation and Transplantation (DONASUL) presented by CIDT for RMS in 2011. This Registry refers to the information technology used for official data collection from and dissemination to the regional bloc, considering member and associate states regarding registration, monitoring and evaluation of organ and tissue donation and transplantation activities, making information available to the international community, contributing to the

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<sup>9</sup> The article by Roberta Vargas in this book brings a more thorough discussion on access to medicines.

strengthening of local registries, and enabling the establishment of regional emergency waiting lists (MERCOSUR, RMS, CIDT, 2017).

Within CIDT, the Project on Training in Donation and Transplantation, developed in 2016, established five workshops: strengthening and expansion of the *Donasul* registry, taught by professionals from Argentina; treatment of intestinal failure and pediatric liver transplantation, also provided by Argentine professionals; training in management and optimization of the detection of potential donors due to brain death, taught by professionals from Uruguay; course for lung transplantation, taught by professionals from Brazil; and training course in tissue donation, also taught by Brazilians. It is an ongoing project and it aims to strengthen the donor and transplant systems of the Mercosur countries, reducing asymmetries and improving the training of professionals involved in the donation and transplantation processes in the bloc (MERCOSUR, RMS, CIDT, 2016).

#### 4.5 HIV Combination Prevention in Mercosur

Established in 2002, the Intergovernmental Commission on HIV/AIDS (CIHIV) focuses on strengthening and implementing health committees in border areas; on the promotion of an integrated HIV/AIDS policy in the region; on the exchange of knowledge, information and technologies; on the promotion of common management instruments and the strengthening of national programs; and on the promotion of access to HIV treatment and opportunistic diseases medicines and diagnostic inputs (BUENO, 2012).

Within CIHIV, Mercosur Health developed an HIV Combination Prevention Workshop in 2017. The Workshop was attended by representatives from municipalities, states, as well as border provinces, in addition to students from the Federal University for Latin American Integration (UNILA), representatives from PAHO and from the Ministries of Health of Mercosur countries. At the time, a general overview of combination prevention was outlined, considering the specificities of each country and presenting the joint experiences and their interaction dynamics. The relevant goal of the workshop was the inter-municipal articulation in border areas, with emphasis on joint initiatives and awareness-raising activities for public officers to assist and consider the flow of people from the bloc. The workshop outcomes include the exchange of information and networking among the participants with a potential to plan integrated actions (BRASIL, MINISTÉRIO DA SAÚDE, 2017).

Also, other themes of regional technical cooperation have been developed: professional practice development; training of professionals to inspect health-related substances and products; assessment and use of technologies; vector-borne disease control; and environmental and worker's health control. In addition, topics such as health

control of ports, airports, terminals, and ground border points, tobacco control, blood and sub products, non-communicable diseases, and sexual and reproductive health have been addressed. The Mercosur meetings guide regulations, identify priorities, offer educational trainings, develop good practices, foster technical knowledge exchange, and establish, among managers and ministerial staff, an integrated sense for promotion and strengthening of public health among the Mercosur countries.

## **5 Final remarks: challenges and potentialities of Mercosur Health**

Mercosur Health has been institutionally established, broadening its technical and regional cooperation capacities, and it is in a thriving moment of impact on people's lives. Closer cooperation among technicians and managers in the region, prioritization of border themes, regulation initiatives, as well as educational and health promotion activities, have accomplished, in practice, the Mercosur Health purposes expressed in its instruments and organizational guidelines, which have, as their goal, the strengthening of States Parties health systems.

Even though this movement is ongoing, there is a potential for cooperation not yet explored in several areas of Mercosur Health. Through the presentation of initiatives, we intend to foster the recognition of successful strategies, aiming at the pluralization of processes and at the enhancement of regional integration in health.

In order to provide other good practices, it is fundamental to think of ways to fund health initiatives in the regional bloc. Countries need to bring the theme of regional integration to their health sector budgets. Even if international institutions, such as PAHO, can finance projects, national resources provide more thematic and project execution autonomy for countries.

Still concerning prioritization of integration in this sector, which is key for the social development of the region, it is worth noting that some of the projects executed are specific and individualized. Although short-term initiatives are important, they may be due to the high turnover of public officials responsible for Mercosur Health. This problem may generate, in addition to the ephemerality of certain initiatives, poor institutional memory and challenges in establishing a long-term commitment.

Besides the improved proximity between technicians and managers of the Ministries of Health, it is also important to enable platforms of dialogue with representatives from universities and civil society. In the case of the business sector, it is possible to notice the presence of some representatives in instances such as COPROSAL. Members of Academic institutions and workers' entities have also been present in meetings, such as the ones held by the Subcommission for Professional Development and Exercise of COSERATS and Mercosur's Permanent Forum for Work on Health. The Social Summit of Mercosur and the Unit to Support Social Participation in the

bloc have made relevant efforts for the proximity between States and people; however, the possibility of direct interaction with sectoral instances could generate a stronger incidence of social demands on specific themes. It would be important to promote qualified and frequent participatory processes in order to legitimize and guarantee, in a more intense way, regional integration in health.

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# The International Health Regulations (IHR 2005) on Mercosur health cooperation agenda and the zika virus emergency

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## Abstract

The International Health Regulations (IHR 2005) are an agreement signed within the framework of the World Health Organization (WHO) to establish procedures to prevent the international spread of diseases, which have innovated the fields of public health regulation and governance. Since its review process, IHR 2005 have fostered regional health cooperation in Mercosur. Besides coordinating their positions on this matter in international forums, Mercosur State Parties have set up a specific commission to deal with IHR related issues. This article analyzes the main procedures established by the IHR against the international spread of diseases and their application during the zika virus emergency. It also describes the initiatives developed within Mercosur to implement the IHR, emphasizing the importance of the bloc as a space for political and technical articulation in this field.

**Keywords:** Mercosur. Regional Integration. International Health Regulations. Zika. International Cooperation.

## 1 Introduction

The International Health Regulations (IHR) are the main international mechanism, binding on all member states of the World Health Organization (WHO), established to “prevent, protect, control and provide a public health response against the international spread of diseases in ways that are commensurate with and restricted to the risks to public health and that avoid unnecessary interference with international traffic and trade” (IHR, 2005 article 2).

When compared to earlier versions of health regulations adopted by the WHO, the IHR (2005) brought important changes in the procedures used to tackle epidemics, introducing new concepts and prerogatives, such as the declaration of “public health emergency of international concern” (IHR, Article 12). Adopting a regulation of this nature and binding on the 196 states was not a simple and quick process, as it included several stages of negotiation and deadlocks (PAGOTTO, 2016, p.25).

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The long and complex negotiation process lasted ten years and involved concerns and interests that went beyond public health, such as human rights, trade and international security (*ibid.*, p. 7). In view of the complexity of the issue, South American countries began a regional dialogue, notably within Mercosur<sup>2</sup>, holding meetings and seminars with the aim of building joint positions to be taken to the World Health Assembly (WHA), responsible for the negotiation and approval of Regulations.

The IHR have thus become a priority on the agendas of specific health-related forums in Mercosur: Sub-Working Group 11 “Health”<sup>3</sup> (SWG 11), established in 1996, and the Meeting of Ministers of Health<sup>4</sup>, established in 1995, to which thematic Intergovernmental Commissions are linked. These two forums constitute what is known as “Mercosur Health”<sup>5</sup>. The political articulation efforts carried out throughout the IHR negotiation process resulted in concrete cooperative actions, leading to the creation of a specific Mercosur commission to deal with IHR related issues.

This article aims to analyze the main changes brought about by the Regulations to prevent the international spread of diseases, with a brief case analysis on the public health emergency caused by the Zika virus epidemic in 2016, emphasizing the role of the International Health Affairs Office (AISA) of the Ministry of Health.

The article will describe how the IHR have stimulated regional health cooperation, especially within Mercosur. The participation of Mercosur State Parties in the IHR negotiation process and the initiatives developed to facilitate the IHR implementation will be discussed as well. As it is impossible to address all actions that have been taken to implement the Regulations, emphasis will be placed on the creation of the Mercosur Intergovernmental Commission for the Implementation of the IHR (CIRSI) and the main activities and projects developed within CIRSI.

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<sup>2</sup> A bloc formed in 1991 by Argentina, Brazil, Paraguay and Uruguay by the Treaty of Asunción. Currently, Bolivia is a State Party in the process of adhesion to the Mercosur. Chile, Colombia, Ecuador, Guyana, Peru and Suriname are States associated with the bloc. Mexico and New Zealand are observer countries. In 2012, Venezuela joined as a Member State of Mercosur and was suspended at the end of 2016.

<sup>3</sup> Subgroup established by Resolution of Common Market Group 151/1996.

<sup>4</sup> Forum created by the decision of the Mercosur Common Market Council 03/1995.

<sup>5</sup> See, in this regard, the article, “Regional Integration for Strengthening Health Systems: The Mercosur Case”, wrote by Wesley Lopes Kuhn and Sonia Maria Pereira Damasceno

## 2 The International Health Regulations (IHR 2005)

From the first International Sanitary Conference, in 1851, until the creation of the WHO in 1948<sup>6</sup>, international cooperation for the control of infectious diseases was marked by the signature of international conventions focused on specific diseases, binding on a limited number of countries, a context that has been defined by Fidler (2005, p. 38) as a true “patchwork of treaties on infectious diseases”.

Since its conception, the WHO has adopted international health regulations, which later became the main instrument to control the global spread of diseases. The first Regulations were adopted in 1951, replaced in 1969, and then amended in 1981 with the eradication of smallpox. The 1969 Regulations remained in force until the beginning of its revision process in 1995. As one of its features, the first Regulations had a restrictive scope of application, limited to a specific list of diseases<sup>7</sup> that gave less flexibility and efficiency to the international regime for disease control.

At the end of 1980s, concerns about emerging and reemerging infectious diseases<sup>8</sup> led the WHO to recognize the precariousness of its surveillance and disease control system, while considering the deficiencies of the 1969 IHR, and to seek the redefinition of its global health surveillance network. The best example of the imperative of a global response to health emergencies was the acceptance by the international community of the need to revise the IHR, in 1995<sup>9</sup> (DAVIDS, KWHATRÖT, RUSHTON, 2015, p.2).

After ten years of negotiation, the adoption by the WHO<sup>10</sup> of the IHR, in 2005, evidenced a drastic change in the methods and procedures applied to global disease control and international health cooperation, introducing a new rationale that combines public health goals with global health security strategies (FILDER, 2005, 328).

While the first two Regulations applied to a specific and restrictive list of diseases, relying entirely on State Parties’ notification and focusing on the use of border measures to prevent the international spread of diseases, the current IHR introduce new concepts and categories that reshape global disease control, with an approach that covers all possible risks, regardless of source or origin: an “all-risks approach” (FIDLER, GOSTIN, 2006, p.3).

<sup>6</sup> The Constitution of the WHO entered into force on April 7, 1948. For information on the history of the Organization, please visit: <<http://www.who.int/about/history/en/>>.

<sup>7</sup> The IHR of 1951 was applicable only to six diseases (cholera, black fever, smallpox, yellow fever, typhus and recurrent fever). The 1969 IHR had an even more limited application scope, as it only applied to cholera, the plague, yellow fever and smallpox. With the eradication of smallpox in 1981, the IHR of 1969 became applicable only to the three remaining diseases.

<sup>8</sup> Of particular note are the emergence of diseases such as the West Nile Fever, the Lassa Fever, the Marburg Fever and the HIV/AIDS epidemic and re-emergence of diseases such as tuberculosis, malaria and meningitis.

<sup>9</sup> The IHR review process began with World Health Assembly resolution WHA 48.7 of 1995.

<sup>10</sup> The IHR were approved through World Health Assembly resolution WHA 58.3 in May 2005. Resolution available at: <[http://www.who.int/ipcs/publications/wha/ihr\\_resolution.pdf](http://www.who.int/ipcs/publications/wha/ihr_resolution.pdf)>.

The concepts of “disease”<sup>11</sup>, “event”<sup>12</sup>, “public health risk”<sup>13</sup> and “public health emergency of international concern”<sup>14</sup> (PHEIC), brought by the IHR along with the State’s obligation to notify the WHO of “all events which may constitute a public health emergency of international concern within its territory” (IHR, Article 6), consolidate the expansion of the IHR scope of action, making it “dynamic, flexible, and forward-looking” (FIDLER, 2005: 362).

To assist states in reporting events that may constitute a PHEIC, the IHR introduces a new mechanism that is an algorithm composed basically of four questions to be answered by the State during risk assessment: (i) Is the public health impact of the event serious?; (ii) is the event unusual or unexpected?; (iii) is there a significant risk of international spread?; (iv) is there a significant risk of international travel or trade restrictions? (IHR, Annex 2). If the answer to two of these questions is positive, the State must notify the event to the WHO within 24 hours after such assessment.

The creation of the PHEIC concept as an open category, which is not limited to infectious diseases, as it encompasses existing, emerging and potential diseases, and the algorithm to assist states in assessing and reporting events have reshaped international disease control, establishing a global health surveillance (WEIR, 2010), whose focus is no longer the application of border measures, but the containment of public health risks at their source.

The WHO Director-General plays an important role in this global emergency surveillance, as the IHR give the WHO prerogatives that strengthen its authority and autonomy in global disease control. The Director-General has the authority to decide the beginning and the end of a PHEIC (IHR, Article 12) and, for this purpose, information from sources other than the states’ notifications may be used (IHR, Article 9). Thus, the Director General may declare a PHEIC regardless of the notification and consent of the affected State, based on the opinion of an Emergency Committee, whose members are recruited autonomously by the Organization (IHR, Article 48).

To declare a PHEIC, the WHO Director-General should take into account: (i) information provided by the State Party; (ii) the decision instrument contained in Annex 2; (iii) the advice of the Emergency Committee; (iv) scientific principles as well as the available scientific evidence and other relevant information; (v) an assessment

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<sup>11</sup> Disease “means an illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans” (IHR, Article 1).

<sup>12</sup> Event “means a manifestation of disease or an occurrence that creates a potential for disease” (IHR, Article 1).

<sup>13</sup> Public health risk “means a likelihood of an event that may affect adversely the health of human populations, with an emphasis on one which may spread internationally or may present a serious and direct danger” (IHR, Article 1).

<sup>14</sup> PHEIC “means an extraordinary event which is determined, as provided in these Regulations: (i) to constitute a public health risk to other states through the international spread of disease, and to potentially require a coordinated international response;” (IHR, Article 1).

of the risk to human health, the risk of international spread of disease and the risk of interference with international traffic (IHR, Article 12).

When a PHEIC is declared, the Director-General has also the prerogative to issue temporary recommendations, which may include health measures to be implemented by the State experiencing the health emergency or by other states in relation to persons, baggage, cargo, means of transport and goods. These recommendations are intended to prevent or reduce the international spread of diseases and to avoid unnecessary interference with international traffic (IHR, Article 15).

In order to contain, at its source, diseases of potential international impact whose control requires interstate cooperation, the IHR determine the implementation of public health surveillance and response measures. These measures include the development, strengthening and maintenance of basic public health capacities at the local, regional and national levels to detect, assess and report on disease events and respond effectively to public health risks and emergencies (IHR, article 5)<sup>15</sup>.

Since it came into force, on June 15, 2007, four public health emergencies of international concern have been declared, concerning the following diseases:

**Table 1 – The PHEIC**

<b>Disease</b>	<b>Emergency start</b>	<b>Emergency end</b>
H1N1 flu	April 25, 2009	August 10, 2010
Poliomyelitis	May 5, 2014	-
Ebola	August 8, 2014	March 29, 2016
Zika	February 1 <sup>st</sup> , 2016	November 18, 2016

Source: WHO Committees and Expert Roster, 2018<sup>16</sup>.

Prior to declaring a PHEIC, the Director-General shall convene an Emergency Committee, pursuant to Article 48 of the IHR, which issues an opinion on whether the notified event constitutes a PHEIC or not and decides on proposals for temporary recommendations applicable to the case. By July 2018, in addition to the Emergency Committees for the diseases identified as PHEIC, there were other Emergency Committees dealing with the following diseases: Middle East Respiratory Syndrome Coronavirus (MERS-Cov)<sup>17</sup>, from 2013 to 2015; yellow fever in Angola and the

<sup>15</sup> These basic capabilities are detailed in Annex 1 of the IHR.

<sup>16</sup> Information on the emergency committees called on the basis of the IHR available at: <[http://www.who.int/ihr/procedures/ihr\\_committees/en/](http://www.who.int/ihr/procedures/ihr_committees/en/)>.

<sup>17</sup> For more information on the Emergency Committee on MERS-Cov, please visit: <[http://www.who.int/ihr/procedures/statements\\_20130709/en/](http://www.who.int/ihr/procedures/statements_20130709/en/)>.

Democratic Republic of Congo, in 2016<sup>18</sup>; and Ebola in the Democratic Republic of Congo, in May and October of 2018.

The Emergency Committee for the poliovirus<sup>19</sup>, in its most recent meeting on May 10, 2018, maintained the recommendation that the risk of international spread of poliovirus remains a Public Health Emergency of International Concern. This recommendation was accepted by the WHO Director General, who extended the Committee's temporary recommendations for a further three-month period<sup>20</sup>.

### 3 International health emergency: zika virus and microcephaly

The first rumors regarding the spread of zika virus in Brazil occurred in February 2015, after the outbreak of exanthematic diseases<sup>21</sup> in the state of Maranhão (OLIVEIRA, 2017, p.50). Until April 2015, zika-related events were evaluated by the Ministry of Health's assessment as unusual or unexpected events, with no PHEIC potential.

With the diagnosis of cases of microcephaly in Pernambuco, Brazil, a risk assessment based on Article 7 of the IHR<sup>22</sup>, provided new information to the WHO on October 23 2015, classifying cases of microcephaly as an unusual or unexpected event.

Due to changes in the epidemiological pattern of microcephaly cases, when compared to historical data, the Ministry of Health declared the zika virus and its association with microcephaly a Public Health Emergency of National Concern (PHENC)<sup>23</sup>, by Ministerial Directive no. 1813/155 on November 11 2015. With the declaration of PHENC, the Emergency Operations Center for Public Health (COES) was established and extraordinary measures were proposed to address the emergency (Ibid, p.56).

Later that month, Brazil issued a new notification to the WHO with updated risk, classifying the event as a possible PHEIC<sup>24</sup> considering that it met the following criteria: (i) serious impact on public health, since the vector was present throughout the national territory; (ii) a common and unexpected event, since no death or congenital

<sup>18</sup> For more information on the Emergency Committee on Yellow Fever, please visit: <<http://www.who.int/mediacentre/news/statements/2016/ec-yellow-fever/en/>>.

<sup>19</sup> Poliomyelitis was declared a PHEIC in May 2014 in response to the cases caused by wild poliovirus in Afghanistan, Cameroon, Nigeria, Equatorial Guinea, Ethiopia, Israel, Nigeria, Pakistan, Somalia and the Syrian Arab Republic.

<sup>20</sup> Meeting of the Emergency Committee for Poliovirus, held on May 10, 2018: <<http://www.who.int/news-room/detail/10-05-2018-statement-of-the-seventeenth-ihc-emergency-committee-regarding-the-international-spread-of-poliovirus>>.

<sup>21</sup> Exanthematic diseases are those in which the clinical symptoms are accompanied by cutaneous manifestations.

<sup>22</sup> Article 7 of the IHR provides for the sharing of information during unexpected or unusual health events.

<sup>23</sup> Decree no. 7,616 of 2011 provides for the declaration of a Public Health Emergency of National Concern. Decree available at: <[http://www.planalto.gov.br/ccivil\\_03/\\_Ato2011-2014/2011/Decreto/D7616.htm](http://www.planalto.gov.br/ccivil_03/_Ato2011-2014/2011/Decreto/D7616.htm)>.

<sup>24</sup> This update occurred after confirmation of identification of the zika virus in tissue from patients who died – two adults and one newborn with microcephaly. This was the first record of deaths associated with zika virus-related infection in history (OLIVEIRA, 2017, p.57).

infection due to the zika virus was expected; and (iii) significant risk of international spread, because the agent is transmitted by vectors that are present in all countries in the Region (*ibid*, p.57).

Based on the epidemiological situation in Brazil and French Polynesia, which reported to the WHO, in January 2016, cases of Guillain Barré syndrome<sup>25</sup> at a frequency 20 times higher than in previous years, the WHO Director-General, Margaret Chan, declared the zika virus and its association with microcephaly a Public Health Emergency of International Concern on February 1, 2016, following the Emergency Committee's statement<sup>26</sup>.

The first meeting of the WHO Emergency Committee for the zika virus was attended by representatives from Brazil, El Salvador, the United States and France, who provided information on the potential association between microcephaly and other neurological disorders and the zika virus. In addition to advising the Director-General on the declaration of emergency, The Committee issued temporary recommendations to be adopted by other countries regarding virus transmission, long-term measures, measures related to international travel and data sharing<sup>27</sup>.

Following the declaration of PHEIC, the Emergency Committee has met frequently to assess the epidemiological situation of the countries affected by the zika epidemic and to issue, extend or modify the temporary recommendations in view of Article 15 of the IHR. Since the PHEIC determination, the Emergency Committee has met five times until the end of the emergency<sup>28</sup>, in November 2016<sup>29</sup>. At each meeting, the recommendations were updated and announced at WHO website.

Although the WHO declared the end of the international emergency on November 18 2016, zika and its association with microcephaly and other neurological disorders

<sup>25</sup> Guillain-Barré syndrome (GBS) is an uncommon disease of the nervous system in which the immune system itself attacks the person's nerve cells, causing muscle weakness and sometimes paralysis. Countries affected by the zika virus epidemic reported an increase in the number of people with Guillain Barré syndrome. Since the discovery of the zika virus in 1942 until October 2016, there had been no reporting of deaths or severe cases of the disease, Guillain-Barré syndrome being the only severe manifestation, affecting the central nervous system, possibly in association with the infection, described from the outbreak in the French Polynesia (2013), in addition to the description of some cases in Brazil in June 2015 (OLIVEIRA, 2017, p.19).

<sup>26</sup> First meeting of the Emergency Committee on zika virus: <[http://www.who.int/en/news-room/detail/01-02-2016-who-statement-on-the-first-meeting-of-the-international-health-regulations-\(2005\)-\(ihr-2005\)-emergency-committee-on-zika-virus-and-observed-increase-in-neurological-disorders-and-neonatal-malformations](http://www.who.int/en/news-room/detail/01-02-2016-who-statement-on-the-first-meeting-of-the-international-health-regulations-(2005)-(ihr-2005)-emergency-committee-on-zika-virus-and-observed-increase-in-neurological-disorders-and-neonatal-malformations)>.

<sup>27</sup> The recommendations of the Emergency Committee can be accessed at: <[http://www.who.int/en/news-room/detail/01-02-2016-who-statement-on-the-first-meeting-of-the-international-health-regulations-\(2005\)-\(ihr-2005\)-emergency-committee-on-zika-virus-and-observed-increase-in-neurological-disorders-and-neonatal-malformations](http://www.who.int/en/news-room/detail/01-02-2016-who-statement-on-the-first-meeting-of-the-international-health-regulations-(2005)-(ihr-2005)-emergency-committee-on-zika-virus-and-observed-increase-in-neurological-disorders-and-neonatal-malformations)>.

<sup>28</sup> The Emergency Committee held five meetings: on February 1, 2016; March 8, 2016; June 14, 2016; September 2, 2016 and November 18, 2016.

<sup>29</sup> Fifth meeting of the Emergency Committee on zika virus: <[http://www.who.int/en/news-room/detail/18-11-2016-fifth-meeting-of-the-emergency-committee-under-the-international-health-regulations-\(2005\)-regarding-microcephaly-other-neurological-disorders-and-zika-virus](http://www.who.int/en/news-room/detail/18-11-2016-fifth-meeting-of-the-emergency-committee-under-the-international-health-regulations-(2005)-regarding-microcephaly-other-neurological-disorders-and-zika-virus)>.

remained a Public Health Emergency of National Concern until May 11 2017<sup>30</sup>, when the Ministry of Health declared the end of the PHENC determination.

During the zika international emergency, Brazil has followed WHO recommendations and has implemented actions to address the epidemic by strengthening its surveillance and response systems, such as establishing a National Network of Specialists in Zika and Related Diseases (Renezika)<sup>31</sup>. In addition, the country has also engaged in multiple international cooperation activities, exchange of information and research initiatives.

Consequently, there was a substantial increase in the demand for international cooperation and requests for multilateral and bilateral meetings and consultations, especially with the Minister of Health. In this scenario, the work of the International Health Affairs Office (AISA) of the Ministry of Health allowed Brazil to successfully meet the demands for cooperation, monitoring international meetings and activities related to the zika emergency, and providing countries with up-to-date epidemiological information.

The following non-exhaustive table presents some of the actions that had the support and involvement of AISA:

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<sup>30</sup> <<http://portalms.saude.gov.br/noticias/722-svs-noticias/28348-ministerio-da-saude-declara-fim-da-emergencia-nacional-para-zika-e-microcefalia>>.

<sup>31</sup> Renezika was created on May 20 2016 by Ordinance No. 1,046, with the aim of integrating managers, researchers and civil society representatives, facilitating the formulation and implementation of actions and policies to fight Zika virus and related diseases at the local, regional and national levels.

**Table 2 – Actions monitored by AISA**

<b>Visits</b>	<b>Meetings</b>	<b>Cooperation</b>	<b>Multilateral</b>
Visit of the PAHO/WHO delegation to learn about the status of microcephaly (May/2016) <sup>1</sup>	Meeting between the Brazilian Minister of Health and the Minister of State for Health, Labor and Welfare of Japan (Brasília, August/2016) <sup>2</sup>	Brazil-Russia bilateral cooperation to fight Zika <sup>3</sup> .	Regional Workshop on Surveillance, Control and Management of Zika, Dengue and Chikungunya in the Amazon Region of the Amazon Cooperation Treaty Organization (ACTO) (November/2016)
Visit of WHO Director-General, Margaret Chan, to Brazil (February/2016)	PAHO/WHO Expert Meeting: Towards the development of a research agenda for the characterization of the Zika virus outbreak and its implications for public health in the Americas (March/2016)	Brazil-US bilateral cooperation to fight Zika <sup>4</sup>	Project "Strengthening the Regional Capacity of Latin America and the Caribbean for Integrated Control of Vectors Especially Zika Viruses" with the International Atomic Energy Agency (IAEA)
Mission to Galveston, Texas/USA, to sign an agreement between the Ministry of Health and the University of Texas Medical Branch (UTMB) to develop the Zika vaccine (February/2016)	Meeting of scientists from Argentina, Brazil, Colombia, USA and PAHO/WHO on the definition of Congenital Zika Syndrome in Brazil (July/2016)	Brazil-France bilateral cooperation to fight Zika <sup>5</sup> .	Follow-up to the meetings of the IHR Emergency Committee on Zika virus (February, March, June, September and November 2016)
Mission with the Japanese delegation to the states of Pernambuco and Paraíba (March/2016) <sup>6</sup>	Meeting with ambassadors from European Union Member States (February/2016)	International Program "Eliminating Dengue: Our Challenge" <sup>7</sup>	Memoranda of understanding and declarations signed with other countries and organizations, such as the Organization of American States (OAS) and Mercosur <sup>8</sup>

1. In May 2016, PAHO and WHO representatives visited Brazil to learn about the Brazilian response to the Zika epidemic at different levels of government. The representatives visited Brasília/DF, Recife/PE, João Pessoa/PB and Belém/PA for institutional meetings.
2. The State Ministers exchanged views on confronting Zika and dengue and discussed other issues such as Brazilian anti-smoking policy.
3. The areas covered by the cooperation proposal for the Surveillance in the Area of Consumer Rights Protection and Human Well-being of the Russian Federation include epidemiological surveillance, diagnosis, studies on virus-specific genetics and preventive measures.
4. Cooperation carried out based on the Memorandum of Understanding on Health and Medical Sciences signed in 2015 by the Brazilian Ministry of Health and the Department of Health and Human Services of the United States. Part of the Brazil-USA bilateral cooperation involved the definition of an emergency work plan for the development of measures in response to the Zika virus and its association with microcephaly, which included the following fronts: vaccine development and treatment; development of diagnostic tools; strengthening of health monitoring and care; research; vector control; surveillance and epidemiological studies.
5. Brazil and France agreed on a biannual work plan during the Franco-Brazilian Health Committee, held in Brasília on July 23 and 24, 2015, which sets the scope in which cooperation on Zika can unfold, with actions related to infectious diseases, the challenges of epidemiological transmission and the promotion and diffusion of innovation in health, health systems management, and cross-border cooperation actions.
6. The purpose of the mission was to discuss prospective cooperation in response to the Zika epidemic and other possibilities for cooperation.
7. Implemented in Brazil by the Oswaldo Cruz Foundation (Fiocruz) and supported by the Ministry of Health, the project integrates the international and non-profit effort known as "Eliminate Dengue: Our Challenge" Program, which studies an innovative approach to reduce dengue transmission by Aedes Aegypti in a safe, natural and self-sustaining manner. The project is funded by the Bill & Melinda Gates Foundation.
8. "Declaración de las Ministras y Ministros de Salud del MERCOSUR y Estados Asociados Ante la Grave Situación Epidemiológica Determinada por Enfermedades Transmisibles por el Aedes Aegypti: Dengue, Zika e Chikungunya" signed on February 3, 2016. In May 2016, Brazil and the United States negotiated a draft declaration on the control of Zika virus. The draft declaration was approved by the 48<sup>th</sup> General Assembly of the OAS in June 2016. "Declaration on Zika Virus: Inter-American Cooperation to meet a Global Health Threat".

Source: Internal elaboration.

AISA played an important role in updating data and producing reports to requesting countries and Brazilian diplomatic missions abroad about the epidemiological situation, the main actions carried out and the supplementary sources of information about the Zika virus and its complications. AISA has also attended meetings at the Emergency Operations Center (COES) and *Renezika's*, besides the efforts to establish an International Partnerships Working Group, within *Renezika*, to facilitate international cooperation for research development on Zika virus infection.

Within Mercosur, concerns on Zika virus epidemic led to an extraordinary meeting between Ministers of Health, on February 3 2016, to discuss potential measures to counter the epidemic. This meeting resulted in the “Declaration of the Ministers of Health of Mercosur and Associated States in the face of the Severe Epidemiological Situation Determined by Diseases Transmitted by *Aedes Aegypti*: Dengue, Zika and Chikungunya.” This Declaration, among other cooperation actions established to face the epidemic, has set up an ad hoc group to monitor and study the emergency and establish the necessary recommendations to Ministers on this matter (MERCOSUR/RMS/DECLARATION No. 01/15).

#### **4 The participation of Mercosur in the negotiation and implementation of IHR (2005)**

The political and technical articulation over IHR within Mercosur was simultaneous to IHR negotiations at WHO. Establishing such comprehensive and binding Regulations for all WHO Member States involved issues that were beyond public health, notably commercial and security interests. This scenario has encouraged some countries to coordinate regional positions regarding the IHR negotiation process, which was the case of Mercosur countries.

In order to coordinate a joint participation in the revision process and to bring their contributions review at WHO, Mercosur States Parties signed, in 2001, the Agreement No. 03/01<sup>32</sup>, which established an Advisory Technical Group to follow up the IHR revision process within the bloc. The Technical Group was formed by the coordinators of Commissions for Epidemiological Surveillance and Sanitary Control of Ports, Airports, Terminals and Border Crossings of the SWG 11.

In addition to the creation of a Technical Group, seminars<sup>33</sup> were held from 2000 onwards to discuss the IHR draft text that was under negotiation, and to build joint

<sup>32</sup> Mercosur/RMS/AGREEMENT no. 03/01: Agreement on the Participation of Mercosur States Parties, Bolivia and Chile in the Process of Revision of International Health Regulations. Agreement between the Mercosur States Parties and Bolivia and Chile as Associated States.

<sup>33</sup> The first seminar was held on September 20 2000, entitled “First Seminar on the Review Process of the International Health Regulations”. Subsequently, up to the year when the IHR was approved (2005), seminars on International

positions on controversial related issues<sup>34</sup>. Mercosur has also sought to coordinate its positions with other South American countries, getting them involved, whenever possible, in the seminars it promoted.

In the final phase of IHR negotiations, two important “International Health Regulations Review Seminars” were held, which included countries from the Andean Community<sup>35</sup>: one held between January 26 and 28 of 2005, which resulted in the agreement “Consensus of Montevideo” (MONTEVIDEO, 2005), and a second one held between April 25 and 27 of 2005, which led to the signature of the “Ata de Buenos Aires” (BUENOS AIRES, 2005). These documents underpinned the joint positioning of South American countries in the final phase of negotiations<sup>36</sup>, influencing IHR negotiations at the multilateral level, as it expressed in a transparent and constructive way the consensus positions of ten South American countries (MENUCCI, 2006, p.79). This has facilitated progress in numerous areas, such as the complete exclusion of the draft article linking the IHR to situations involving the deliberate or accidental use of chemical, biological or radiological and nuclear agents from the Regulations text (PAGOTTO, 2016, p.65).

The political articulation of Mercosur countries over the IHR was not restricted to its revision period and it reverberated across the bloc’s institutional structure. Adhesion to IHR (2005) has generated new cooperation initiatives within the bloc, including the creation of a permanent and specific forum to discuss IHR related issues, an unprecedented initiative in the regional context.

In addition to the meetings of the Technical Advisory Group, later renamed as “Advisory Technical Group for the Analysis, Evaluation and Implementation of the International Health Regulations,” Mercosur countries have sought to ensure the joint participation of other South American countries in IHR implementation activities, while maintaining the results achieved during the review process (MERCOSUR/RMS/AGREEMENT no. 07/05)<sup>37</sup>.

The central objective of the Technical Group was to develop activities to facilitate the implementation IHR, since the main difficulties of Mercosur countries would

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Health Regulations were held in 2001, 2003, and two in 2005, according to official Mercosur minutes.

<sup>34</sup> Among the most controversial issues in IHR review is the attempt to make the IHR applicable to disease events related to the accidental or deliberate use of biological, chemical or radio and nuclear agents. This prerogative was laid out in Article 45 of the draft IHR, released in September 2004, and was advocated by some countries throughout the review process (WHO, 2004).

<sup>35</sup> Participants in these seminars included: Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay and Venezuela.

<sup>36</sup> This final phase corresponds to the negotiating rounds of the Intergovernmental Working Group, created by the WHO in May 2003, to conduct final IHR negotiations (PAGOTTO, 2016).

<sup>37</sup> MERCOSUR/XVIIIIRMS/AGREEMENT No 07/05: “Participation of Member States of Mercosur and Associated States in the Implementation Process of the International Health Regulations (2005)”. Signed on June 30, 2005, at the XVIII Meeting of Ministers of Health of Mercosur.

be the implementation, strengthening and maintenance of basic surveillance and response capacities required in the Regulations' Annex I<sup>38</sup>. Thus, the new Technical Advisory Group had the following priorities: to define an instrument for assessing the core capacities established by the IHR; to establish criteria for identifying the ports, airports and borders that are the object IHR application, and to provide an instrument to evaluate the core capacities related to sanitary control at these points of entry.

In view of the need for greater internal articulation to monitor IHR implementation, the Technical Advisory Group was replaced by the Mercosur Intergovernmental Commission for the "Implementation of the International Health Regulations" (CIRSI), whose first ordinary meeting took place in October of 2006, in Brasilia (MERCOSUR/RMS/CIRSI/MINUTES n. 01/06).

Initially, the Commission continued the efforts made by the Technical Advisory Group, with a particular interest in the establishment of tools to assess the core capacities required by the IHR to detect, notify and respond to public health events at the local, regional and national levels, including the points of entry.

Between 2006 and 2008, the work carried out during CIRSI's regular meetings was devoted to the development of such mechanisms. The first tool proposed for assessing core capacities<sup>39</sup> was finalized in December 2006, and a tool to assess the capacity of ports, airports and border crossings was finalized in 2008<sup>40</sup>, incorporating risk assessment procedures for both routine and emergency situations<sup>41</sup>.

Thus, even before the IHR come into force<sup>42</sup> and the establishment of the IHR monitoring framework<sup>43</sup> by the WHO, Mercosur countries were already seeking to define a common tool to identify the core surveillance and response capacities that already existed within the bloc and those that still needed greater investments in accordance with IHR rules.

The Mercosur-specific instruments comprehensively covered all aspects of IHR's Annexes 1A and 1B as well as the information contained in the indicators proposed by WHO. In addition, they were used to assess basic capacities and to analyze the status of these capacities inside and outside Mercosur countries (MERCOSUR/CIRSI/MINUTES no. 01/10).

<sup>38</sup> These core capacities to be developed are laid down in Annex I of IHR (2005).

<sup>39</sup> This instrument is included as Annex III of Minutes 02/06 of CIRSI Extraordinary Meeting.

<sup>40</sup> Extraordinary meeting of CIRSI in Foz do Iguaçu, July 24, 2008 (Mercosur/CIRSI/MINUTES no. 02/08).

<sup>41</sup> Pilot tests of the basic capabilities assessment tools completed by the end of 2007, with the conclusion that they are useful for measuring basic surveillance and response capabilities, estimating gaps and identifying weaknesses of the system (MERCOSUR/CIRSI/MINUTES no. 02/07).

<sup>42</sup> The IHR came into effect on June 15 2007. At that time, all Mercosur countries had already ratified the Regulations.

<sup>43</sup> In order to monitor IHR implementation and the development of basic capabilities, the World Health Assembly, based on Article 54 of the IHR, established, through Resolution 61.2 of May 2008 that Signatory States to the Regulations should answer a questionnaire to report to WHO, on an annual basis, on the implementation of the core capacities foreseen in IHR.

Based on the application of Mercosur evaluation tool, it was possible to identify common problems faced by countries in the implementation of IHR, especially problems related to intersectoriality, information systems, infrastructure, equipment, financial resources, funding sources and professional qualification (MERCOSUR/CIRSI/MINUTES no. 02/10).

The influenza outbreak (H1N1) in 2009 has highlighted a significant lack of resources in Mercosur countries to achieve the implementation of IHR core capacities and a lack of knowledge about the Regulations, including their purpose, their use and scope, as well as the importance of an effective sanitary control at land border crossings. The H1N1 epidemic exposed the shortcomings and weaknesses of IHR at a global level, since, for the first time, a Public Health Emergency of International Concern was declared by the WHO, according to Article 12.

By identifying the areas where IHR implementation was deficient and required greater efforts and resources, Mercosur Member States began to discuss other initiatives, especially joint training. In 2008, for example, countries began to articulate the implementation of a Mercosur training program for port, airport and border health inspectors (PAF), with remote and in-person activities (MERCOSUR/CIRSI/MINUTES no. 01/08).

In 2009, the Agreement no. 13/09 was signed by the Ministers of Health with the purpose of emphasizing the importance of training human resources involved in the surveillance process and sanitary control at all points mentioned in Annexes 1A and 1B of IHR, to strengthen and promote joint actions in order to guarantee technical, logistical and financial resources, as well as provide training to human resources involved in surveillance and sanitary control (MERCOSUR/RSM/MINUTES no. 02/09).

In August 2011<sup>44</sup>, a joint training effort at points of entry was agreed upon to be held in the first half of 2012 with the goal of developing and updating core skills for the control and monitoring of Public Health Events of International Concern at these locations.

The commission's regular meetings are also an opportunity for countries to articulate positions on IHR issues that are being discussed in other forums, such as the WHA, in order to state their positions, concerns and possible proposals. In 2012, for example, Mercosur national coordinators requested the WHO to review the IHR core capacities monitoring framework, considering intermediate stages of implementation, a proposal that had been developed within CIRSI (MERCOSUR/CIRSI/MINUTES n 02/12).

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<sup>44</sup> CIRSI extraordinary meeting in Montevideo in August 2011.

At most recent CIRSI meetings, country representatives have begun discussing proposals for a post-2016 agenda, which is the deadline for countries to implement IHR's core capacities, according to Article 5 (IHR 2005). The delegations proposed drafting a note to the WHO Secretariat in which they stated Mercosur countries' high interest in learning about and taking a position on documents A69/20<sup>45</sup> and A69/21 in the agenda of the 69<sup>th</sup> WHA's agenda (2016), which provided a new IHR monitoring framework (MERCOSUR/RMS/CIRSI/MINUTES n. 01/2016).

These documents substantially changed the monitoring framework and mechanisms for IHR implementation at a global level. Following the health crisis triggered by the Ebola virus outbreak in 2014, a new IHR monitoring and evaluation framework was submitted to the WHA, comprising three new mechanisms, apart from the mandatory annual self-assessment report: (i) joint external evaluation; (ii) after-action review; (iii) emergency simulation exercises in public health (WHO, 2016, Annex I).

The adoption of a joint position by Mercosur States Parties in regards to the new IHR monitoring and evaluation framework is decisive, considering not only the relevance of the theme, but also its potential for an interference in internal affairs. These new mechanisms are still being discussed at WHO, which has produced two related documents: the Five Year Global Strategic Plan and the IHR Global Implementation Plan<sup>46</sup>, submitted at the 70<sup>th</sup> WHA (2017).

At the CIRSI meeting held in October 2017, in Brasilia, delegations declared their support to the four items of the new IHR monitoring framework, noting that the particularities of American countries should be taken into account, and defended the position that the two aforementioned plans should be presented for approval as separate documents at the 71<sup>th</sup> WHA, in 2018.

At that same meeting, the<sup>47</sup> Workshop on Monitoring IHR Core Capacities was held with the participation of delegations from Argentina, Brazil, Chile, Paraguay, Peru and Uruguay. The workshop aimed at analyzing monitoring and response capacities and evaluating collaborative strategies for IHR monitoring after 2016. The workshop discussed issues such as the need to define intermediate and advanced capacities within

<sup>45</sup> A69/20: Implementation of the International Health Regulations (2005). Annual report on the implementation of the International Health Regulations. May 2016; A69/21: Implementation of the International Health Regulations. Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response. May 13, 2016.

<sup>46</sup> On May 18 2017, the World Health Assembly, through document A70/16, presented the IHR Global Implementation Plan, which comprises 6 action areas, the first of which, *"Accelerating State Parties Implementation of the International Health Regulations (2005), includes the drafting of a "five-year global strategic plan to improve public health preparedness and response", to be submitted to the World Health Assembly in May 2018 (A70/16).*

<sup>47</sup> The promotion of workshops is a recurring activity articulated in CIRSI meetings. Workshops on the implementation of the IHR were carried out in 2007 in Punta del Este and in 2008 in Foz do Iguaçu (MERCOSUR/CIRSI/MINUTES no. 01/08)

the IHR at both the national and regional levels; the development of an action plan to define those capacities; and the possibility of creating a network of Mercosur specialists to assist in conducting joint external evaluation exercises. Delegations also discussed health surveillance at borders, actions by the health sector in public events and health emergency simulations.

CIRSI meetings, therefore, have been an opportunity for countries to share information on IHR implementation, including the experiences and difficulties encountered in the process. CIRSI has become a space for political and technical articulation, focused on a specific topic of extreme relevance for all Mercosur State Parties and Associates, enabling the creation of joint mechanisms and procedures and fostering the effective implementation of IHR in the region.

CIRSI's work has proven to be extremely productive and successful in its purposes, which is possibly due to the countries' deep engagement in CIRSI's activities. The International Health Affairs Offices of the States Parties' Ministries of Health support and encourage the continuity of activities promoted by CIRSI, such as workshops and seminars, and its regular meetings.

Besides articulating with the technical areas of the Ministry of Health in order to guarantee Brazilian representation in different health forums within Mercosur, AISA actively monitors health-related projects developed within the bloc and contributes technically and financially to the participation of delegations in related meetings and activities.

## **5 Conclusions and perspectives**

As the main legal instrument established by WHO to prevent the international spread of diseases, the IHR have generated new mechanisms and instruments to health regulation and governance, whose cornerstone is the category of Public Health Emergency of International Concern. The Zika virus emergency is one example of IHR applicability, the steps involved in declaring a PHEIC, and the international actions that can be taken to address an emergency.

The current IHR have encouraged regional health cooperation among South American countries since its negotiation process. The need to implement the IHR has encouraged both the coordination of positions in international forums and the development of regional initiatives and mechanisms for political conciliation and cooperation, particularly in the areas of public health surveillance and response. Within Mercosur, the creation of a specific forum to deal with IHR-related issues was a unique initiative in the region, which has led to concrete actions to facilitate the implementation of the IHR in Mercosur States Parties, with potential positive impacts on other countries in South America.

The dynamism and productivity of CIRSI stem from the engagement of the Ministries of Health of Mercosur State Parties, responsible for mobilizing the necessary resources and human capital for the Commission's regular meetings. In Brazil, AISA's performance has been remarkable. Since the creation of Mercosur, AISA has monitored the activities carried out in specific health forums, supporting the participation and involvement of technical areas responsible for the health concerns addressed by the bloc.

The latest WHO data for 2016 show that all Mercosur State Parties and Associates, except Guyana, Suriname and Peru, have an average rate of IHR implementation between 75 and 100%, taking into account all core capacities required by the IHR<sup>48</sup>. This is the result of the commitment of South American countries to the effective implementation of IHR, which tends to reinforce the use of institutional mechanisms for regional cooperation in health, aiming to develop strategies and actions with a focus on sensitive and urgent issues, such as IHR monitoring and evaluation.

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<sup>48</sup> Data on the IHR implementation level in each country is obtained from a questionnaire provided by WHO and filled out by the national focal points about the main required capacities provided for in Annex I of the IHR. Thirteen core capacities are evaluated on the basis of twenty indicators defined by the WHO. This data are available at the *Global Health Observatory* (GHO) at: <<http://www.who.int/gho/ihr/en/>>.

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# The More Doctors Program and the Brazil-PAHO-Cuba cooperation for the strengthening of primary care at SUS

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## Abstract

This article analyzes the More Doctors (*Mais Médicos* in Portuguese) Program as an instrument of both the national universal health coverage policy and Brazilian foreign affairs policy. Conceived by means of a trilateral partnership between the governments of Brazil and Cuba and the Pan American Health Organization (PAHO/WHO), More Doctors is the largest international cooperation project ever undertaken by Brazil, the largest in the history of PAHO/WHO and one of the most outstanding health-related cooperation initiatives in the world.

This article discusses the creation, development and early results of the Program for the expansion of health care in Brazil. Also, the authors analyze the model of international cooperation adopted and the role of the Ministry of Health's International Health Affairs Office (AISA) in the design, implementation and improvement stages of the Program. AISA, in addition to its attributions of support and intermediation between multiple actors of the Brazilian and Cuban government and PAHO/WHO, has contributed not only to ensure the success of the project in the domestic sphere, but also to strengthen its link with Brazil's foreign affairs policy.

**Keywords:** More Doctors Program. SUS Human resources in health. Basic health care. International Cooperation.

## 1 Context of the Emergence of the More Doctors Program

The More Doctors Program, officially launched in 2013<sup>3</sup>, was created by the federal government with the political and operational support of the states, the Federal District and Brazilian municipalities to tackle the historical difficulty of providing and assigning doctors in the Unified Health System (SUS), especially in small municipalities and remote areas of the national territory. The program initiative was influenced by the

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<sup>3</sup> The More Doctors Program was established by Provisional Measure 621 of July 8, 2013.

“Cadê o médico?” (Where’s the Doctor) Movement, which in January 2013 brought together municipalities that were unable to expand their health care structure.

The creation of More Doctors was part of the governmental strategy to strengthen primary health care, a priority entry point in the Unified Health System (SUS) care. Primary health care, primarily carried out at the Basic Health Units (BHU), is the first level of health care, whose actions are focused on the continuity of care, integral care, humanization, fairness and social participation.

In 1978, during the International Conference on Primary Health Care, the Alma Ata Declaration was signed – a landmark that identified primary health care as critical to reducing health inequalities between countries. The Declaration states that primary health care corresponds to essential health care, based on accessible technology, which bring health services as close as possible to people’s living and working places, thus constituting the first level of contact with the national health system and the first element of a continuous process of care that is capable of resolving up to 80% of the population’s health problems<sup>4</sup>.

Under the Alma-Ata Declaration,

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. (WHO, 1978).

The lack of health professionals affects countries across different continents and stages of development, and the availability of better wages and working conditions are factors that influence inequalities in the distribution of physicians. The World Health Organization (WHO) estimates that 50% of the world’s population lives in remote rural areas, but these areas are served by less than 25% of the medical workforce (ARAÚJO; MAEDA, 2013).

WHO data show the disparity in the proportion of physicians per thousand inhabitants in countries with public and universal health systems, such as Brazil (1.8

<sup>4</sup> Pan American Health Organization. Declaration of Alma-Ata. In: Conferência Internacional Sobre Cuidados Primários de Saúde, 6-12 set. 1978, Alma-Ata. Available at: <<http://www.opas.org.br/promocao/uploadArq/Alma-Ata.pdf>>. [Acessado em 13 fev. 2018]

doctors per thousand inhabitants), Canada (2.5 doctors per thousand inhabitants), United Kingdom (2.8 doctors per thousand inhabitants), Spain (3.8 doctors per thousand inhabitants), Portugal (4.4 doctors per thousand inhabitants) and Cuba (7.5 doctors per thousand inhabitants) (WHO, 2018). In addition to being one of the few countries that have a public-funded and managed health system for over 70% of its population, Brazil is the only country with more than 100 million inhabitants to have a universal, public and free health system. This continental proportion of the country contributes to the concentration of physicians in large urban and technological centers: about half of the world's population lives in rural areas and is cared for by less than a quarter of the total number of doctors (WHO, 2009). In the context of basic health care actions, the shortage of physicians is especially detrimental, since this model of care aims at being the main gateway to health systems and is the most effective strategy to promote equity in accessing health services and actions (STARFIELD, 2002).

Many countries have sought solutions to expand coverage of primary health care in vulnerable areas, attracting health professionals to these regions (CHOPRA et al., 2008). A recent study by the Organization for Economic Cooperation and Development (OECD) has shown that, even with the increase in the total number of doctors, the distribution of physicians maintains a high concentration pattern in capitals and scarcity in rural areas (OECD, 2013).

Strategies to tackle this problem include at least four dimensions: (i) educational policies, such as changes in medical curricula and admission of students from rural areas; (ii) regulation policies, such as civil service and incentive to enter specialized training for those who work in remote areas; (iii) monetary incentives, such as scholarships and higher wages; and (iv) non-monetary incentives, such as extension of stay visas for foreigners and supervision with peer support (VISCOMI, LARKINS and GUPTA, 2013).

There is no simple answer to the problem of shortage of professionals, and international experience has shown that a variety of strategies are needed to deal with this problem, not only through technology transfer and provision of human resources but also and mainly through the development of capacities to increase the protagonism and autonomy of the health systems of the countries and to strengthen them. This includes the perspective of transforming medical education to strengthen national health systems. In a report published by the expert commission in *The Lancet* in 2010, cooperation between countries is recommended as a strategy to promote such a strengthening (FRENK et al., 2010).

Faced with demands from mayors throughout the country, through the “*Cadê o Médico*” movement in January 2013, as mentioned above, and the popular outcry for more doctors and more health care, on July 9, 2013, through Provisional Measure n. 621, the then President Dilma Rousseff launched the More Doctors Program. The

Program establishes a series of changes aimed at improving health care to SUS users. The measure later voted into Law n. 12,871, of October 22, 2013, was ambitious and established articulation between the three levels of the federation and other partnerships with health-related human resource initiatives for SUS (BRASIL, 2013). The More Doctors Program was thus created with the following goals:

- i. reduce the shortage of doctors in SUS priority areas, in order to reduce health care-related regional inequalities;
- ii. strengthen the provision of basic health care services in the country;
- iii. improve medical training in the country and provide more experience in the field of medical practice during the training process;
- iv. expand the insertion of undergraduate doctors in SUS care units, widening their knowledge about the health reality of the Brazilian population;
- v. strengthen the policy of permanent education with the integration of teaching and care, through higher education institutions in the academic supervision of the activities performed by doctors;
- vi. promote the exchange of knowledge and experiences among Brazilian health professionals and doctors trained in foreign institutions;
- vii. specialize physicians to work in the public health policies of the country and in the organization and operation of SUS; and
- viii. stimulate research applied to SUS (BRASIL, 2013).

In general terms, the Program aims at promoting improvements in the infrastructure of BHUs, changes in the training of medical students, expansion of medical residency openings and emergency provision of physicians to work in all regions of the country, especially in those where there is greater vulnerability, difficulty of assigning these professionals and issues related to primary health care access to the population.

## **2 Emergency provision and international human resource cooperation**

The More Doctors Program established three simultaneous and complementary actions to achieve the above-mentioned goals: the expansion of medical university programs and vacancies for medical residency, the establishment of new parameters for medical training in the country and the promotion of “specialization of physicians in the area of basic health care through teaching-service integration, including by means of international exchange” (BRASIL, 2013), which in practice meant the emergency provision of doctors for primary health care in SUS. Despite having three well-defined levels with medium and long-term structuring measures, one of them called the Brazilian medical community’s attention. The emergency medical provision, entitled in the Program Law as “More Doctors for Brazil Project (MDBP)”, was conceived as a

strategy to provide temporary and emergency supply as a way to cater to the shortage of professionals in areas of greatest vulnerability, until medium and long term measures generated concrete results for the expansion of the number of medical professionals available for health care in the country.

Even though the Federal Constitution does not mention the competence of the Ministry to hire medical professionals, assigning it the function of “ordering the training of human resources in the health area” (BRASIL, 2013), the Ministry of Health has already taken over this role in other situations. The experience, prior to More Doctors, in which the federal government took over the hiring of medical professionals was with the Program of Valorization of the Basic Health Care Professional (Provab) in 2011, created through Interministerial Ordinance n. 2,087, of September 1, 2011, for the assignment of doctors, nurses and dentists to municipalities in small towns and in the outskirts of major cities. During its term, Provab was able to provide more than four thousand doctors in the included areas. The main advantage offered for these professionals was the granting of bonuses in the admission tests to medical residency. After a year of activity and the participant being certified for having performed all their duties, after completing the specialization offered and fulfilling the workload, they would be entitled to a 10% bonus on the admission tests to medical residency in Brazil.

Given the good results obtained, Provab was a model of inspiration for More Doctors. However, the recruitment of Brazilians was not enough to solve the problem of the lack of doctors in the country. It was for this reason that the federal government launched the More Doctors Program, under which the More Doctors Project would be responsible for providing emergency assignment of doctors, initially for three years, renewable for three more.

To design the Project, the federal government studied the model of cooperation and exchange of professionals based on other countries’ experiences. The United Kingdom, for example, has had a significant presence of foreign doctors since the 1960s. Currently, 37% of the health professionals working in the country are foreigners<sup>5</sup>. In the US, 25% of working physicians graduated abroad (PINTO, 2014).

Inspired by international models, mainly those of Portugal and Spain, the Brazilian government also decided to adopt the exchange of doctors as a practice for the Program. These countries were identified as potential sources of labor for the Program because they had a significant rate of physicians per thousand inhabitants – almost twice as Brazil – because they focused on family health training, due to the similarity of the language and the economic crisis they faced at the time, which could facilitate the attraction of workers. Cuba has also been identified as a potential exporter

<sup>5</sup> General Medical Council.; Available at: <[https://www.gmc-k.org/20131004\\_Chapter\\_1\\_SoMEPpdf\\_53706030.pdf](https://www.gmc-k.org/20131004_Chapter_1_SoMEPpdf_53706030.pdf)>. Accessed on 8 fev. 2018.

of doctors. The Caribbean island has one of the highest rates in the world – 7.5 doctors per thousand inhabitants (WHO, 2018) – and the Cuban government has a traditional experience of international cooperation sending Cuban doctors abroad since the first half of 1960s (CHAPLE, 2006).

### 3 Emergency Doctor Assignment – Selection Criteria

Despite knowing the difficulty of assigning doctors to remote areas, the Brazilian government tried issuing notices that could attract Brazilian doctors to these vacancies. The More Doctors Act establishes priority criteria for filling vacancies of the program (BRASIL, 2013). The first priority group consisted of physicians with registration in Brazil. This group included professionals of any nationality trained in Brazil or doctors trained abroad who had a diploma revalidated in the country and were registered with the Regional Board of Medicine (CRM).

If openings remained after the selection of these professionals, the second group was called in the order of priority, which was comprised of Brazilian doctors trained abroad who did not have a revalidated diploma and, consequently, without registration with CRM. If there were still vacancies available, foreign physicians with qualification to practice Medicine abroad whose diploma had not been revalidated in Brazil and who did not register with the CRM are finally called.

Foreign doctors who have graduated or work in countries with a physician per thousand inhabitants rate lower than Brazil's – that is, less than 1.8 doctors per thousand inhabitants – are not allowed to enroll in the Program<sup>6</sup>. This is due to the fact that in compliance with the guidelines of the WHO Global Code of Conduct on the International Recruitment of Health Professionals<sup>7</sup>, the Brazilian government does not accept the registration of doctors from countries that have a physician per thousand inhabitants ratio lower than the one found in Brazil. Thus, Brazil practices an international rule of equity and solidarity through which it seeks to attract foreign physicians only from countries that have a greater rate of professionals than the national, so as not to aggravate the lack of doctors in those countries with a lower average. This is

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<sup>6</sup> This provision was established by Interministerial Ordinance n. 1,369, of July 8, 2013, which provides for the implementation of the More Doctors Project for Brazil. The ordinance establishes as one of the requirements for admission within the Project scope “to be qualified for the practice of Medicine in a country that has a medical/resident statistical ratio equal to or greater than 1.8/1000 (one and eight tenths per one thousand) World Health Statistics of the World Health Organization” (Article 19, subsection II, c).

<sup>7</sup> The WHO Global Code of Conduct on the International Recruitment of Health Professionals aims at establishing and promoting voluntary principles and practices regarding the international ethical recruitment of health professionals in a way that strengthens health systems, including establishing effective planning of health work and introducing strategies for training, qualification and maintenance of health professionals.

why the Program does not allow foreign doctors<sup>8</sup> who have been trained or who work in countries such as Bolivia, Ecuador, Paraguay and other South American and Central American countries in general. This restriction, however, does not prevent or inhibit spontaneous immigration on its own and outside the More Doctors Project scope, of any professional who wishes to apply to work as a doctor in Brazil. Therefore, there are rules of validation of certificates and authorization of professional practice for different health-related professions. In the case of medicine, the professional trained abroad must submit to the National Revalidation Exam of Medical Diplomas issued by Foreign Higher Education Institutions (Revalida).

Following the order of priority, if there were still vacancies after the three individual calls mentioned above, the Ministry of Health was authorized to make a cooperation agreement with international organizations with the purpose of selecting physicians for specific action in the Project. To this end, Brazil has established a cooperation with the Pan American Health Organization (PAHO), the regional arm of the World Health Organization (WHO) and a traditional Brazilian partner in issues such as the development of primary health care and the qualification of work management and health education. PAHO/WHO, in turn, established a cooperation with the Cuban government, which provided doctors with experience and training to work in primary health care, staff of the Ministry of Public Health of Cuba and those who had already worked on international missions. In this way, a triangular cooperation was established between Brazil, PAHO-WHO and Cuba for the implementation of the More Doctors Project in the country. The doctors who participate in the Project for international cooperation with the Cuban government are called “cooperative doctors”. These doctors do not join the Project individually; they do so exclusively through the cooperation with PAHO/WHO.

For Doctors who do not have a registry in Brazil, the More Doctors Act authorized the Ministry of Health to issue a single registration, which allows the physician to practice medicine exclusively within the scope of the Project activities and in the specific locality defined by it. This registration exempts the need to revalidate the diploma during the period of participation in the Project. Pursuant to said law, this period may be up to three years, renewable for three more years.

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<sup>8</sup> Interministerial Ordinance No. 1,708, dated September 23, 2016, suspended the application of the requirement set forth in item “c” of section II of the head provision of the aforementioned Interministerial Ordinance No. 1,369 to Brazilian physicians trained in foreign higher education institutions and with qualification to practice medicine abroad. Thus, any Brazilian physician trained in a foreign institution and qualified to practice medicine abroad, regardless of the place graduation, are now allowed to participate in the Project. The restriction remains valid for foreign professionals trained and/or qualified in countries with less than 1.8 physician per thousand inhabitants ratio.

#### 4 PAHO/WHO's performance in triangular cooperation, within the framework of More Doctors

According to the definition presented in the Report on South-South Cooperation in Ibero-America 2013-2014<sup>9</sup>, South-South triangular cooperation

is a form of SSC which involves a set of actors, all of which provide various types of contributions (technical, financial or other) distributed in three roles: the first provider and recipient (developing countries) and the second provider (developed or developing country, regional or multilateral agency, or an association between them). The distinguishing feature is determined by the role of the first provider, which acts as the main party responsible for capacity building (SEGIB, 2014).

PAHO/WHO, as the body responsible for promoting and coordinating the efforts of the American countries in health care, promotes South-South cooperation as a triangular partner, providing economic and technical resources through different modalities. The More Doctors Project, through the partnership between Brazil, Cuba and PAHO/WHO, is not only an example of triangular cooperation, but also the largest cooperation program ever developed in the Organization's history. According to the representative of PAHO/WHO in Brazil, Dr. Joaquín Molina:

This is the largest technical cooperation undertaken by the Organization and represents a milestone in South-South cooperation by allowing the exchange and registration of experience on universal systems and the strengthening of primary health care. The results of such cooperation will benefit both countries involved, in the first instance, and the Region of the Americas as a whole<sup>10</sup>.

The Cooperation Project to More Doctors (CPMD) is an innovative cooperation initiative for PAHO/WHO, as it involves the international mobilization of professionals for a large public health system. In the first three years of the Program, more than eleven thousand Cuban doctors were hired under the CPMD. The development of this cooperation process required political and technical management between PAHO/WHO and the governments of Brazil and Cuba, carried out through its Ministries of

<sup>9</sup> Secretaría General Iberoamericana. Informe de la Cooperación Sur-Sur en Iberoamérica 2013-2014. Madrid: SEGIB; 2014. Available at: <<http://segib.org/wp-content/uploads/Informe%20de%20la%20Cooperacion%20Sur-Sur%20en%20Iberoamerica%202013-2014.pdf>>. Acessado em 8 fev. 2018.

<sup>10</sup> "OPAS/OMS assina acordo de cooperação com o Brasil para apoiar Programa Mais Médicos" – [Acessado em 19 jun. 2018] Available at: <[https://www.paho.org/bra/index.php?option=com\\_content&view=article&id=3272:opas-oms-assina-acordo-de-cooperacao-com-o-brasil-para-apoiar-programa-mais-medicos&Itemid=834](https://www.paho.org/bra/index.php?option=com_content&view=article&id=3272:opas-oms-assina-acordo-de-cooperacao-com-o-brasil-para-apoiar-programa-mais-medicos&Itemid=834)>.

Health and with the participation of other governmental entities such as the Ministries of Foreign Affairs and Education and state and municipal authorities.

The CPMD is based on other cooperation projects that involved the mobilization of Cuban health professionals in cooperation with PAHO/WHO, but with smaller reach and numbers of foreign doctors recruited. The support given to African countries in coping with the ebola epidemic<sup>11</sup>, the collaboration with Angola for the eradication of polio (MARIMON TORRES and MARTINEZ CRUZ, 2009) and the mobilization of human resources in cases of disaster emergencies, such as the earthquake in Haiti in 2010<sup>12</sup> are some of the highlights.

The Project is a great experience within the Organization, because it manages the financial resources of a member state, Brazil, to mobilize health professionals from another State, Cuba, who are fully integrated into the public health system of the first – SUS. The expressive mobilization of Cuban doctors and the complexity of the recruitment process, preparation and operational coordination between the two countries and the Organization characterizes this project as a unique international cooperation. It is worth noting the complexity of this cooperation due to the large number of doctors that would need to be integrated into SUS in such a short time, as well as the specializing, training, adaptation, logistics and financial issues that involved the arrival of Cuban doctors in Brazil.

The CPMD was supported by the “Technical Cooperation Agreement to expand access of the Brazilian population to basic health care”, signed in August 2013, as a result of the PAHO/WHO partnership with the Brazilian Ministry of Health, to support the implementation of the “More Doctors Program”. This agreement directly addresses the issue of expanding access to health services at the primary health care level in priority municipalities in the country, contributing to the reduction of inequality in these areas, and follows the provisions of the More Doctors Program Act. The main goal of the CPMD is to strengthen the Family Health Strategy<sup>13</sup> and SUS, assuring the presence of physicians in primary health care teams through the mobilization of Cuban doctors to Brazil and, simultaneously, committing themselves to the good performance of these professionals in health services, thus generating an indissoluble articulation between the Program and the Cooperation Project<sup>14</sup>.

<sup>11</sup> Organización Mundial de la Salud (OMS). La OMS agradece apoyo de médicos cubanos en la respuesta al Ebola en África Occidental. [Internet] Centro de prensa de la OMS. Declaración de la OMS. Ginebra, 2014. [Acessado em 18 fev. 2018]. Available at: <<http://www.who.int/mediacentre/news/statements/2014/cuban-ebola-doctors/es/>>.

<sup>12</sup> Pan-American Health Organization (PAHO). Emergency Medical Teams. [Internet] Emergency Preparedness and Disaster Relief. [Acessado em 18 fev. 2018]. Available at: <<http://www.paho.org/>>.

<sup>13</sup> The Family Health Strategy includes a set of measures aimed at strengthening basic care in Brazil. For more information on the Strategy, please visit: <[http://dab.saude.gov.br/portaldab/ape\\_esf.php](http://dab.saude.gov.br/portaldab/ape_esf.php)>.

<sup>14</sup> Organização Pan-Americana da Saúde (OPAS), Organização Mundial da Saúde (OMS). Marco para o monitoramento e avaliação do Projeto de Cooperação Mais Médicos da OPAS/OMS. Brasília: OPAS; 2015.

The PAHO/WHO tool used for the monitoring and evaluation of the CPMD serves as an instrument to monitor project management and to account for the performance of the Organization. Also, it is a mechanism that generates knowledge that can contribute to the improvement of SUS and its services to the population, especially at the primary health care level, as well as for the management of public policies in favor of health development in the country.

In the perspective of PAHO/WHO, triangular cooperation with Brazil and Cuba for the CPMD will leave an innovative legacy of experiences on international recruiting of health professionals, a complex issue in the field of international health. Traditional migration flows of medical professionals usually occur from less developed countries to those with greater economic development. The CPMD showed a different direction by proposing temporary migration – for three years, extendable for the same period – of professionals from countries in which the ratio of physicians per thousand inhabitants is higher than the one in Brazil, regardless of their relative level of development.

In addition to working in SUS's basic health care services, all medical professionals participating in the Program – both Brazilian and foreign – are provided with specialized academic training in general family and community medicine, with extension projects and other modalities of improvement that seek to develop fundamental skills for professional practice and promote the implementation of improvements in the health service.

PAHO/WHO cooperation through the CPMD is not limited to temporarily providing Cuban doctors to Brazil. Other forms of cooperation under way include direct technical assistance to the different bodies of SUS, management of data and knowledge concomitantly with a monitoring and evaluation process, educational activities for physicians and media activities of the Program and the Cooperation Project, such as the launch of the More Doctors Integrated Information System (SIMM)<sup>15</sup>. This tool was created by PAHO to bring together the main databases of the More Doctors Project and can be used by any citizen. SIMM provides an overview of the doctors and municipalities that are part of the technical cooperation between Brazil, Cuba and PAHO, including a time line since 2013, as well as information on the training cycles for the improvement of professionals within More Doctors, under a permanent education perspective.

For the effective achievement of PAHO/WHO objectives, as an international body that includes promoting health cooperation among its purposes, the lessons learned and experience of the Brazil-Cuba-PAHO tripartite cooperation may be useful to other countries in the Americas, especially developing countries facing challenges

<sup>15</sup> Integrated Medical Information System (SIMM). For more information, please visit: <<https://simm.campus-virtualsp.org/pt-br>>.

similar to those in Brazil for the expansion and strengthening of primary health care and compliance with the global commitment to universal health care coverage.

## 5 Cuba: health and medical diplomacy

Cuba was the first country in the world to turn public health organization into a ministry in 1909, making Cuban public health unified and independent of other ministries (GARCIA, 2009).

With the Cuban Revolution of 1959, the country's public health was driven by the political, economic and social transformations carried out by the Cuban government. The main actions aimed at improving the health of the population were established by the Programa del Mocada<sup>16</sup>, including, for example, the reduction of medication prices, the creation of the rural social medical service, epidemiological campaigns, changes in medical and technical training and the reformulation of the Colegio Medico Nacional, the country's medical professional association.

The guiding principles of the Cuban National Health System are:

Health is a right of the population,  
People's health is the responsibility of the State,  
Health service is the same for the entire population,  
Health practices will have a sound scientific basis,  
Social participation is inherent in the management and development of health services,  
Humanitarian aid will be provided by health services (CUBA, 2018).<sup>17</sup>

The Cuban thought of international solidarity of medicine began even before the Cuban revolution, when some doctors voluntarily left Cuba to help different countries or even enlisted in the army during the colonial period. After the Cuban Revolution of 1959, with the principle of "health internationalism" reinforced by Fidel Castro, on May 23, 1963, the Cuban international medical collaboration began, with the dispatch of a permanent brigade of 53 professionals to Algeria. By this initiative, we may see the principle of health internationalism advocated by the former Cuban leader, in addition to the international solidarity of the Cuban public health system and its ethical and humanist foundation. It is not, therefore, only a kind of medical diplomacy, a way of disseminating a political doctrine or an incentive for commercial relations or the sale of medical services.

<sup>16</sup> Cuba Coopera – Website about the Cooperation of the Cuban Government. [Acessado em 19 fev. 2018]. Available at: <[http:// www.cubacoop.com/CubaCoop/Inicio.html](http://www.cubacoop.com/CubaCoop/Inicio.html)>.

<sup>17</sup> Idem.

In order to understand the emergence of international solidarity developed by Cuban medical collaboration, one should look at a brief history of the main actions in the years preceding the Brazil-PAHO-Cuba tripartite cooperation under the More Doctors Program.

Starting in the 1960s, Cuban medical cooperation began in the form of an internationalist mission, based on the principle of free solidarity, which was reinforced by the different liberation movements in Africa and Central America, Algeria, Angola, Ethiopia and Nicaragua.

The 1990s were marked by external events that affected the Cuban economy, including the dissolution of the Union of Soviet Socialist Republics (USSR), the main Cuban market, and the hardening of the economic blockade of the United States of America to Cuba. In this context, a new form of cooperation emerged in the scope of Cuban medical cooperation: compensated technical assistance or direct contract, the essence of which would be the establishment of an agreement whereby the Cuban physician contracted would receive a compensation for the services rendered, allowing the national health system to maintain the medical collaboration, because the country could not do it free of charge, as it had done in previous years.

At the end of the 1990s, natural events took place in the Central American and Caribbean area, with Hurricanes George and Mitch, which modified the structure of this model, reducing the modality of the internationalist mission and promoting the gradual reduction of compensated technical assistance. In November 1998, the Comprehensive Health Program (Programa Integral de Salud, PIS) emerged in Central America and the Caribbean, then expanded to Africa and the Pacific. In 1999, the Latin American School of Medicine was created as a key element for the continuity and sustainability of PIS. The essence of PIS was the sending of Medical Brigades to remote and difficult places where there was no presence of national doctors, thus providing a small grant paid to medical professionals only to meet basic needs.

In the 2000s, the expansion of Cuban cooperation in the field of health abroad, including its offer to the Caribbean and Latin American countries, and the creation of the “Henry Reeve” international medical brigade, specialized in catastrophes and severe epidemics, in 2005. This specialized contingent was organized as a follow-up to Hurricane Katrina, which affected the Louisiana, Mississippi and Alabama territories in the United States, thus providing a new approach to disaster situations. Despite this, since the 1960s, the Cuban government has already offered such relief in natural disasters by means of emerging brigades, such as in Bolivia, China, Guatemala, Indonesia, Mexico, Pakistan and Peru<sup>18</sup>.

<sup>18</sup> Cuba Coopera – Website about the Cooperation of the Cuban Government. [Acessado em 19 fev. 2018]. Available at: <[http:// www.cubacoop.com/CubaCoop/Inicio.html](http://www.cubacoop.com/CubaCoop/Inicio.html)>. Archives 1993-2009: Unidade Central de Colaboração Médico.

All these experiences accumulated during the period of more than half a century have made as one of the fundamental pillars of Cuban medical collaboration the formation of human resources, that is, the creation of national capacities so that countries receiving international cooperation could count on professionals and provide better health care to their populations.

Regardless of whether the doctors are working in Cuba or in the international medical brigades, the assistance work is focused on the Comprehensive Health Program, according to the principles of the Cuban health system. The guidelines for this system are based on primary care, developing specific control programs that contribute to improving the health of communities, such as programs to reduce maternal and infant mortality, fight HIV/AIDS, the application of natural and traditional medicine and the development of joint medical and scientific research between Cuba and the country with which collaboration is developed.

One of the goals of this principle of “health internationalism” advocated by the Cuban government is to stimulate South-South cooperation through political commitment from the Cuban government to provide the necessary human resources for health care. On the other hand, receiving countries can help with the financing of sending these professionals. Thus, the scarcity of local human resources is reduced, and, consequently therefore, the maintenance of the Cuban medical cooperation for subsequent years is guaranteed. The Cuban government thus encourages cooperation projects between countries, including cooperation modalities through international organizations.

For Cuba, the projection of medical cooperation as a basic and indissoluble principle of the essence of the Cuban National Health System is an aspect that contributed immensely to its development. Thus, it is extremely important to promote medical cooperation with the objective of developing and strengthening national capacities, provided that its purposes and principles cater to the needs of each country, guaranteeing the sustainability of the actions of Cuban medical professionals in those places. This brings as main results: the adaptation of methodologies or techniques already developed in their places of origin; the systematization of experiences; the transfer of technology and the publication of scientific results that strengthen the ties between cooperating countries, as well as achieving the best development of their institutional capacities (MARIMON TORRES and MARTINEZ CRUZ, 2010).

Joint cooperation with PAHO/WHO, especially international medical collaboration, broadens the scope and opportunities for Cuba and for the Organization itself, with a common goal: the benefit and improvement of health indicators and social development in countries that are part of the Organization. Also, the results of this aid are strengthened and provide an effective tool for advancing regional integration processes on the continent.

Finally, Cuban medical cooperation, with its principle of solidarity and disinterested assistance to other peoples, contributes to the improvement of the country's National Health System, through the awareness and commitment of its health professionals to the population assisted, based on the ideals of the Cuban revolutionary process and its leader, Fidel Castro Ruz.

## 6 The More Doctors for Brazil Project – First results

By the end of 2017, the More Doctors for Brazil Project (MDBP) had 17,071 physicians, of which 5,247 were Brazilians trained in Brazil and abroad, 3,271 foreigners from other countries – according to data from the Ministry of Health, foreign doctors of 43 nationalities work in the Project (BRASIL, 2017) – and 8,553 Cuban cooperative doctors participating through cooperation with PAHO/WHO. The program has a fixed amount of 18,240 vacancies, distributed in 4,058 municipalities and 31 indigenous districts. In 2,340 Brazilian municipalities, there is an exclusive presence of doctors of the cooperation with Cuba, and 90% of the doctors who work in indigenous health are Cuban cooperatives. More than 70% of the Brazilian municipalities are served by the Project, benefiting 63 million Brazilians (BRASIL, 2017). When professionals decide to leave the project, the remaining vacancies are offered for reinstatement through periodic public notices, and in the case of Cuban doctors, vacancies are provided directly by PAHO/WHO, to ensure that there is no lack of assistance to the municipalities.

With the Project's doctors, it was possible to expand primary health care, with regular care in basic health units, in the composition of new family health teams or in teams that did not have professionals at the time of joining. In five years of the Program, these changes can already be observed. According to a survey by the Ministry of Health, in 2013, the physician/inhabitant ratio in Brazil was 1.8 physician/one thousand inhabitants. The most up-to-date study available is from the Federal Medical Council (CFM), which shows that there has been an increase in physicians to a rate of 2.1 doctors/one thousand inhabitants in Brazil (SCHEFFER et al., 2015).

In order to assess the reception of the program with the population, the Ministry of Health commissioned a survey by the Public Opinion Group of the Federal University of Minas Gerais (UFMG) and the Institute for Social, Political and Economic Research (Ipespe)<sup>19</sup>, which interviewed more than 14,000 people in 700 Brazilian municipalities between November and December 2014. The survey revealed that users of More Doctors gave the Program an average score of nine, on a scale of zero to ten. Among the users heard by the survey, more than half (55%) gave the program a ten, with 89%

<sup>19</sup> Portal Mais Médicos. Brasília, 2015. Available at <<http://maismedicos.gov.br/resultados-para-o-pais>>. Access on: 8 fev. 2018.

of the respondents grading it from seven to ten, 5% evaluating the program with grades four to six, and 1% from zero to three. Another 5% did not know how to answer.

One of the factors that explain the good results of the Program is the profile of physicians with work experience. According to the UFMG research, by the end of 2014, most of the More Doctors' professionals were foreigners (74%), older than 30 (78%), with more than ten years of experience (63%) and with high degree of qualification (98% have a specialization degree).

The publication "Good Practices in South-South and Triangular Cooperation for Sustainable Development"<sup>20</sup>, developed by the United Nations Office for South-South Cooperation and the United Nations Development Program (UNDP), presented More Doctors as one of the good practices relevant to the implementation of the Sustainable Development Goals (SDG), noting that the program "is replicable and potentially beneficial in any country that decides to adopt it."

According to PAHO/WHO research, containing the impact analysis on the average number of medical consultations in the 2012-2016 time period, the MDBP showed ability to improve the standard of medical consultations in the teams in which its professionals were located, reaching and even surpassing the standard of the best teams without MDBP professionals in Brazil. This research confirms evidence that MDBP increases the effectiveness of SUS and primary health care, guaranteeing priority access to significant portions of the population (Campos et al., 2016, SANTOS, 2017 and MOLINA et al., 2017).

According to the results of these surveys, during the period from 2012 to 2017, the Family Health Strategy (FHS) teams reached a standard of prenatal, general, diabetes and hypertension consultations considered satisfactory, as indicated by the results obtained with data from the Basic Care Information System (SIAB) and e-SUS. Confirming the evidence of several authors (BRASIL, 2015; GIOVANELLA et al., 2016; GIRARDI, 2016; KEMPER et al., 2016; MOLINA et al., 2017; SANTOS et al., 2017), research indicate a systemic effect of MDBP in the improvement of the indicators studied, which is particularly important because professionals work in teams located mainly in poorer, more remote areas and with more vulnerable populations. The supply of primary health care consultations has increased since the implementation of the Program, from 33.1% in 2012 to 36.2% in 2016. Thus As a consequence, it is estimated that more than 36 million people have regular access to medical consultations in teams served by professionals of the Program.

<sup>20</sup> Good Practices in South-South and Triangular Cooperation for Sustainable Development, 2016. "More Doctors (Mais Médicos) Project", p. 39. Available at <<https://www.unsouthsouth.org/2016/05/30/good-practices-in-south-south-and-triangular-cooperation-for-sustainable-development-2016/>>. Acesso em: 8 fev. 2018.

Although small and with a short period of time for evaluation, the favorable differences to MDBP were regular, so that Project professionals have guaranteed the extension of access and coverage of health actions in an equitable way. The presence of exclusive dedication physicians in 36.2% of the teams studied was able to guarantee access and longitudinality<sup>21</sup> (STARFIELD, 2004) to people who were previously inadequately assisted, helping to reduce inequities in care and access to health care. Thus, national commitment to the promotion of universal health coverage is strengthened, a goal of both Brazilian domestic policies and of its international action in the field of health.

Since the implementation of the More Doctors Program, Brazil has strengthened its international performance in multilateral forums dealing with health and in bilateral cooperation initiatives in matters related to the provision and training of health-related human resources. Also, the defense of universal access to health as a right, consolidated from the creation of SUS, with the Constitution of 1988, is also critic to the Brazilian international action in the field of health.

Over the last five years, the International Health Affairs Office (AISA) has thus contributed to the formulation of the Program, with its dissemination to governments and medical professionals abroad, and the connection with the Ministry of Foreign Affairs to provide consular legalization of documents. In addition to that, AISA has collaborated with the implementation of the Program, since it is the responsibility of the international advisory office to carry out the analysis and approval of the documents submitted by doctors trained abroad who request participation in More Doctors, as well as to request the Ministry of Foreign Affairs to issue of appropriate visas<sup>22</sup> to the foreign professionals who join the Project and their families. In the framework of the Brazil-PAHO-Cuba tripartite meetings, held periodically and accompanied by AISA, discussions and adjustments to the implementation of the Project are discussed.

By identifying the successes of domestic health policies in broadening the Brazilian population's access to quality public health services, such as the More Doctors Program, AISA has reinforced Brazil's traditional international action in the defense of international health coverage. The Brazilian multilateral discourse, based on solid domestic experiences, is thus legitimized and strengthened.

From the point of view of Brazilian foreign policy, in addition to promoting the country's multilateral engagement in discussions related to human resources in health, especially under PAHO and WHO, the work of the Ministry of Health and AISA in particular also contributed to the deepening of the bilateral relationship with other countries. Representatives from several South American countries have sought

<sup>21</sup> Longitudinality deals with the follow-up of the patient over time by basic health care professionals.

<sup>22</sup> The More Doctors Law (Law n. 12.871, dated October 22, 2013) established the granting of temporary medical improvement visa (VICAM) to foreign exchange doctors and their legal dependents (BRAZIL, 2013, Art. 18).

the Ministry of Health to get to know the Program and evaluate the possibility of implementing similar mechanisms to expand primary health care.

Also, from the point of view of the bilateral political relationship with Cuba, More Doctors has provided an opportunity for high-level and technical contact between the two governments over the last few years, despite the reluctance currently existing in other fields of bilateral relations. In Geneva in May 2017, the ministers of Health of the two countries met, with the participation of PAHO/WHO Director Carissa Etienne, to discuss issues related to the participation of Cuban doctors in the Project. It was the first meeting of high-level authorities of the two countries in a year. In January 2018, then Brazilian Health Minister Ricardo Barros made an official visit to Havana on the first official visit of a high-ranking Brazilian government representative to the country since 2016. On that occasion, issues were discussed concerning the More Doctors Program, trilateral cooperation with Haiti in the field of health and the perspectives of bilateral cooperation in the area of sanitation and water treatment. Following this visit, in May 2018, the mission of prospecting bilateral cooperation to Cuba, coordinated by AISA, the Brazilian Cooperation Agency and the National Health Foundation (FUNASA) was held.

In this way, the experience of cooperation under the More Doctors Project, through the Brazil-PAHO-Cuba trilateral partnership, has also helped to promote new means of contact and overcome any divergences in the bilateral political relationship with the Cuban government. As a unit responsible for coordinating the international action of the Ministry of Health, AISA has thus contributed to reinforce Brazil's international engagement, with practical and positive effects for the country's external relations.

## 7 Final Considerations

The MDBP is the largest initiative of the Brazilian State aimed at the recruiting of medical professionals for basic health care (MOLINA, 2017; FACCHINI et al., 2016). In the first years of its implementation, the Program achieved, in the staffing scope, results such as: meeting the municipal demand for doctors, with the expansion of the family health teams; the improvement in the distribution of professionals, with the allocation of doctors in the areas of greatest need; the expansion of coverage of primary health care, as well as the increase in the number of consultations and the reduction of hospitalizations sensitive to primary care; increasing the credibility of the program, with positive evaluation of more than 90% of users, doctors and managers.

The Brazil-PAHO-Cuba triangular cooperation has been instrumental in achieving these results. The MDBP innovated in the context of international cooperation by counteracting the traditional migration flows of skilled labor, which usually occur

from less developed countries to those with greater economic development. In this case, the Project showed a different path by encouraging the migration of professionals from countries in which the ratio of doctors per inhabitant is higher than that of Brazil, in many cases from developed countries.

The choice of Cuba for such cooperation is also of outstanding importance. In addition to the large number of doctors available for cooperation, since the country has an average of 7.5 doctors per thousand inhabitants (WHO, 2018), the international solidarity of Cuban medicine and its focus on primary health care were critical for the achievement of the goals sought by the Brazilian government.

Despite the significant results in the recruitment of professionals, some challenges remain. There is no denying the increase of Brazilians interested in the Project, but this profile still generally opts to work in places close to major cities in the country, in a number of municipalities much smaller than the places where Brazilians trained abroad and, in particular, foreigners work within the scope of the Project. In addition to that, the time spent by Brazilians in the Project has been shorter than that of foreigners. These two factors point to the need to continue counting on international exchange doctors and cooperation with PAHO for some time (PINTO, 2018).

It is noteworthy the work of AISA since the beginning of the negotiations and consultations with several countries, such as Australia, Cuba and the United Kingdom, on the process of international recruitment of health professionals, taking into account the WHO Global Code of Conduct on the subject. This Code is an important milestone to address the challenges associated with labor mobility and international migration of health professionals, with the aim of strengthening health systems, especially those in developing countries. Their guidelines served as a reference for the rules for enrolling foreign doctors in the Project.

The importance of the preparation, implementation and follow-up of MDBP in the country is noticeable since the objectives proposed by the policy are being gradually achieved, such as strengthening primary health care, expanding and more equal and equitable distribution of medical professionals in previously unattended communities. The formulation of policies and programs can contribute to generate changes in the current health scenario for Brazilians, as well as stimulating a different view of public managers who administer resources for maintenance, construction and expansion of basic health units.

More Doctors is not and does not intend to be the solution for all the health needs of the country. The Program, however, contributes to the resolution of several of these needs. The number of medical professionals in the country is still far from ideal, especially in riparian communities and remote areas. Medical education in the country can also move towards a focus on comprehensive, humanized care. It is also identified the need to carry out new research in relation to the More Doctors Program for a more

precise assessment of its real impact on public health in the country. In any case, by means of the aforementioned evaluations, the importance of the Program is evidenced not only as domestic public policy in the health area, but also as a fundamental instrument of Brazilian foreign policy. Whether by one dimension or the other, More Doctors has contributed in a positive way to advancing what is considered the true national interest.

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# Health in the Brazil-Uruguay border and the Brazil-Germany-Uruguay cooperation project

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## Abstract

Borders are privileged spaces for the integration between countries, as well as for the development of cooperation and commercial and cultural exchanges. In Brazilian cross-border region, public health tends to be emphasized among cross-border problems, given its universal access in Brazilian territory and the capacity limitations of services and financing available on both sides of the border.

The Brazilian-Uruguayan border is the one that presents the greatest legal background, as well as a close and historic relationship between the two governments. This framework has enabled the development of joint actions aimed at improving the quality of life of the citizens of these regions.

The Brazil-Germany-Uruguay trilateral cooperation project was conceived aiming at supporting health through the construction, rehabilitation and equipping of health facilities in Uruguayan municipalities with less than 5,000 inhabitants and is considered as a successful experience of trilateral international cooperation.

**Keywords:** International technical cooperation. Trilateral cooperation. Brazil-Uruguay. Health systems. Health at the border.

## 1 Introduction: Health at the border

The Brazilian border is 15,719 km long, and the border area, a region of up to 150 km wide along its international boundary, covers 27% of the Brazilian territory and it gathers a population of approximately ten million people. In this region, there are 588 municipalities and eleven states: Acre, Amapá, Amazonas, Mato Grosso, Mato Grosso do Sul, Pará, Paraná, Rio Grande do Sul, Rondônia, Roraima, and Santa Catarina (BRASIL, 2017). Brazil is bordered by ten South American countries – Argentina, Bolivia, Colombia, Guyana, Paraguay, Peru, Suriname, Uruguay and Venezuela, as well as the French Guiana – representing a daily communal space with the majority of the countries of the continent. This region presents a series of peculiarities, as well as institutional and structural limitations to the provision of quality public policies – the issue of public health is highlighted among these problems, given its universal access

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in the Brazilian territory and the limited availability of services and funding, especially in more remote areas.

Borders are privileged spaces for the integration between countries, as well as for the development of cooperation actions and commercial and cultural exchanges. The daily practice and the interaction of populations in the border sometimes surpass and anticipate international laws and agreements, and borders are regions of daily coexistence in different political, monetary, security and social protection systems (GIOVANELLA et al., 2007a). Access to health at the border has been a major topic in recent years, especially due to dynamics such as new migratory flows, cross-border interactions and the deepening of integration processes, which generate new challenges for health systems and demand specific policies that ensure the right to public health in these regions.

The Unified Health System (SUS), which is notorious for its conception of health as a right, with integral and universal access, is a recurring object of healthcare demands in these regions, and the movement of foreign citizens who cross the border in search of care in Brazilian lands. According to Nogueira and Fagundes (2014), the most relevant demands of the foreign users of SUS in border regions are the gratuity and the quality of health services provided in Brazil. The difference of the health systems model and policies with the countries with which Brazil shares borders – in physical, financial and human aspects, in the organization of the system and in the profiles of border cities – makes the difficulties of national health systems even more complex and they influence regional integration processes (GIOVANELLA et al., 2007b)

The asymmetries between Brazil and some of its neighbors often lead to intense demand for health care on the Brazilian side, due to the differences between the systems and the distinct free guarantees to the population that the neighbors offer, as well as the Brazilian services available in border towns, which are generally deficient for such demand.

The Ministry of Health, with the support and articulation of the International Health Affairs Office (AISA), has sought to expand health actions at the borders, through the promotion of integrated policies, technical cooperation projects and participation in border committees. Its working premises include: partnership for the definition of priorities and common agendas; respect for differences; integration of actions and close articulation with the local reality; sustainability of actions; mutual development and strengthening of health systems.

In the context of decentralized cooperation, the Ministry of Health provides technical support to Brazilian states and municipalities and it accompanies the undertaking of meetings between the so-called “twin cities”. According to Ministerial Ordinance n. 213 of 2016 of the Ministry of National Integration (BRASIL, 2016), twin cities are

municipalities cut by the border line, be it land or fluvial, articulated or not by infrastructure works, that present great potential for economic and cultural integration, being able or not to present a conurbation or semi-conurbation with a locality of the neighboring country, as well as “condensed manifestations: problems that are specific to border locations, which acquire greater density there, with direct effects on regional development and citizenship [...] twin cities are not those that individually have a population of less than 2,000 (two thousand) inhabitants.

Currently, there are 32 Brazilian municipalities considered as “twin cities”, eleven in the state of Rio Grande do Sul, six of them at the border with Uruguay.

International cooperation has proved to be a practice capable of promoting mutual development and an innovative way of working on health at borders. This article presents the case of a trilateral cooperation project developed at the border between Brazil and Uruguay, to expand access to health in this region, as a successful strategy of mutual collaboration in favor of improved conditions of access to health in the border region.

## **2 The Brazilian-Uruguayan border**

Uruguay is, historically, one of the main strategic partners of Brazil in South America. Their relations date back to 1851, when a peace treaty was signed between the two countries. There are intense historical, political and human ties between the two countries and the border regions (BRASIL, [2017]).

The border between these countries extends throughout the southern region of the state of Rio Grande do Sul, from the triple Brazil-Argentina-Uruguay border to the Chui River in the Atlantic Ocean, measuring 1,069 kilometers. The border area has six twin cities, with a population of approximately 180,712 inhabitants<sup>2</sup>, with great flow of people and animals. Brazilians and Uruguayans from this border share the gaucho culture and they have many similarities. The border between Brazil and Uruguay is the most institutionalized internationally. The “Agreement for the Improvement of Sanitary Conditions in the Region of the Brazilian-Uruguayan Border”, for example, dates from 1969 (BRASIL, URUGUAY, 1969).

Politically, in addition to the diplomatic relations between Brazil and Uruguay, the state of Rio Grande do Sul and its municipalities also maintain relations with neighboring entities, which allows the articulation of activities and projects in several areas. Government visits are quite frequent, as it is the exchange and the dialogue between public managers, providing a propitious environment for cooperation.

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<sup>2</sup> According to IBGE, DOU 2017 estimate.

Northern Uruguay and southern Rio Grande do Sul present some health care deficits regarding the availability of health services: the lack of beds, equipment and human resources is commonly reported. Municipalities face, in addition to that, shortage of medical professionals. The “*Programa Mais Médicos*” (More Doctors Program) was able to alleviate the problem with the allocation of doctors in the primary care of the Brazilian side, in units that lacked these professionals, but the shortage of specialist physicians persists, as is commonly reported by local managers.

The “Complementary Agreement to the Agreement for the Permission of Residence, Study and Work for Brazilian and Uruguayan Border Nationals for Provision of Health Services”<sup>3</sup>, signed in Rio de Janeiro on November 28, 2008, had as one of its objectives to solve the problems of providing services in the Brazilian-Uruguayan border, the transit of Brazilian and Uruguayan professionals. This agreement, which has been in force since 2009, is the most advanced legal framework from the standpoint of integration between the two countries, but the instrument still lacks effective implementation.

The Binational Health Advisory Commission was created by the Complementary Agreement and has as attribution to supervise its implementation, been comprised by representatives of the central, state and municipal levels of the two countries. For this reason, it is often a privileged forum for articulation between governments at different levels, and it contributes to the discussion of issues of interest and of challenges for the area.

The advanced institutionality of the border with Uruguay allowed the development of reflections and proposals to attenuate issues of mutual interest, such as increasing the availability of medical professionals in the border region. For example, studies are under way to enable Brazilian municipalities to recruit Uruguayan physicians in Uruguayan territory, in order to work with the Brazilian population. Another issue at stake is the possibility of creating an International Health Region<sup>4</sup>, so that both countries can share their health and collaborate to improve the service to the population.

Border areas are privileged areas for integration between countries. The border with Uruguay, in particular, due to its cultural similarity and its relative institutional progress, is a case that brings learning to international cooperation, to regional and border integration and to the public policies of both countries, the reason why it was chosen for the case analysis presented in the next section. Firstly, the performed

<sup>3</sup> Promulgated by Decree No. 7,239, of July 26, 2010.

<sup>4</sup> The Health Region is a continuous geographic area made up of groups of neighboring municipalities, delimited by cultural, economic and social identities and of communication networks, and shared transport infrastructure, in order to integrate the organization with the planning and execution of actions and services. Article 4, paragraph 2 of Decree No. 7,508 / 2011 provides for the establishment of Health Regions located in areas bordering other countries.

activities will be presented, and then benefits and challenges will be analyzed under the consulted literature.

### **3 The Brazil-Germany-Uruguay Trilateral Cooperation Project**

In 2008, the governments of Brazil and Germany signed a financial cooperation agreement that provided for the health sector the availability of a donation of five million Euro by the German Development Bank (KfW) to implement the investment project in infrastructure and for purchasing of equipment and materials to support the South-South health cooperation in South America. Under the agreement, funds should be fully allocated to a beneficiary country to be appointed by Brazil, with the Brazilian Ministry of Health being responsible for coordinating the project and indicating the financial manager of such funds, as well as promoting the exchange of experiences and the development of capacity-building. As will be discussed below, the Ministry of Health and the Oswaldo Cruz Foundation (Fiocruz) were responsible for the cost of technical hours, daily allowances, and travel expenses for the implementation of the technical activities of the project.

Considering that a triangular cooperation project was already underway between Brazil, Uruguay and the German International Cooperation Agency (GIZ), whose objective was to strengthen the Uruguayan health system and structuring of healthcare integrated networks in that country, based on the experience of SUS, the Ministry of Health, in agreement with the beneficiary country, suggested the allocation of funds made available by the KfW to a new partnership with Uruguay.

Thus, negotiations for the cooperation and definition of partners for its implementation began. It was also analyzed the most feasible way to execute the German funds in Uruguayan territory, managed by Brazil. Due to the multiplicity of players and changes of government that took place both in Brazil and Uruguay, these negotiations lasted for many years. In this period, due to the crisis and the devaluation of the euro, previously agreed investments had to be reduced. The Uruguayan government requested the rehabilitation of a Tuberculosis Center and two polyclinics (health units), and the construction of seven other polyclinics in four Uruguayan departments bordering Brazil, all of which were duly equipped to assist the population. The proposal was to improve the health infrastructure in that region by strengthening healthcare in towns with less than 5,000 inhabitants. It was also agreed the need for technical exchange and training, to provide sustainability to the infrastructure construction activities.

In January 2015, it was signed the Separate Agreement, an instrument that set the involved players, their roles, and activities in the cooperation. The Foundation for the Scientific and Technological Development in Health (Fiotec), linked to the Oswaldo Cruz Foundation (Fiocruz) was chosen for finance management. It is an institution

with experience in similar initiatives in Latin American and Caribbean countries and in the African continent, including support in initiatives such as the construction of the antiretroviral drug factory in Mozambique. The United Nations Office for Project Services (UNOPS) was chosen for its implementation and to carry out construction and renovation bidding processes directly in Uruguay – by this arrangement, the finance manager would only be in charge of funds transfer. To follow up the project, KfW hired a German consulting firm, which managed the transfer of funds and monitored the outcomes.

The National School of Public Health (ENSP) and the Universidad de la República (Udelar) of Uruguay were selected for the capacity-building training program in for human resources in health education program to offer a blended-learning training course for trainers.

A Monitoring Committee was established, comprised by all involved stakeholders, which met twice a year to discuss the Uruguayan demands and solutions presented by the project and to monitor their execution. On the Brazilian side, the Committee was comprised by the Ministry of Health (MoH) and Fiotec; on the Uruguayan side, by the Ministry of Public Health (MoPH) and the State Health Services Administration (ASSE); on the German side, KfW; in addition to UNOPS, as the agency that supported project implementation.

Implementation of the project began in 2016, when UNOPS started the bidding process. With the difficulties encountered at the time of execution, it was decided that the transfer of funds would be done by KfW directly to UNOPS, under the supervision of Fiotec.

From August 2016 and December 2017, the constructions and the rehabilitations were undertaken, finalized and inaugurated. The following facilities were built and equipped in the provinces indicated below:

- Southern Extension Polyclinic (Bella Unión-Artigas);
- Cuareim Polyclinic (Bella Unión-Artigas);
- Moirones Polyclinic (Rivera);
- Canas Polyclinic (Cerro Largo);
- Laguna Merín Polyclinic (Cerro Largo);
- 18 de Julio Polyclinic (Rocha);
- Lascano Auxiliary Center (Rocha).

The following were rehabilitated:

- MSP Training and Surveillance Center and the Tuberculosis Control Building (Rivera);
- Paso Ataques Polyclinic (Rivera);
- Plácido Rosas Polyclinic (Cerro Largo).

The Training Program was directed to primary care managers at the central level and to municipalities located in border areas between Brazil and Uruguay. The topics of the Program included primary healthcare, health surveillance and healthcare networks, within the framework of a cooperation agreement between MoH and MoPH, implemented by ENSP and by Udelar. Traveling costs and daily allowances for the Brazilian teachers and the daily allowances for the Uruguayan teachers were borne by the MoH. As a counterpart, Uruguay funded internal transportation for all students and teachers.

The course started in March 2017 and it was finished in December of the same year. Classroom lectures of the ten modules were initially planned to take place in twin cities, which would allow the participation of Brazilian managers in the activities. Thus, ten vacancies were reserved for Brazilian students, with one manager from each of the six twin cities, three regional border health managers and one member of the Rio Grande do Sul Council of Municipal Health Secretaries.

Due to the lack of infrastructure in the border cities to carry out the courses, Uruguay decided that some modules would be in departmental capitals. This change increased travel costs and only four Brazilians were able to do the training, two from Aceguá/RS and two from Santana do Livramento/RS. From Uruguay, 26 managers from the four Uruguayan departments participated.

#### **4 Case Discussion**

Triangular international cooperation, often carried out in the North-South-South configuration, as in this case, was introduced as a complement to bilateral and multilateral forms of cooperation. The cooperative work of players from different natures – including players from the North and South, working in arrangements closer to the characteristics of South-South cooperation – can promote a new arrangement in global development governance. This type of cooperation is based on initiatives undertaken between two or more developing countries, which are expanding through cooperation, usually through provision of funds by a developed country or an international organization, “moving toward the triangular cooperation category” (WHO, 2014).

The main intention of triangular cooperation is to bring together the respective forces of each party, including financial resources, services and technical expertise more appropriate or closer to the reality of the country in question. For Kumar (2008), the basic point is that successful experiences in countries of the South can be replicated with the addition of knowledge and organizational know-how in other beneficiary Southern countries. Thus, instead of adopting ideas proposed by the industrialized countries, it is advantageous for developing countries to learn from each other, since the

challenges they face are similar, as well as are “geographies, cultural and linguistic links” (MCEWAN; MAWDSLEY, 2012). Among the main benefits of triangular cooperation are:

- Negotiation process: each stage of the process is discussed and agreed upon by all partners;
- Technology: beneficiary countries play an active role and have authority over projects and programs, leading them in each phase;
- Learning and capacity building: exchange of knowledge, information and skills are explicit objectives of collaboration (WHO, 2014);
- Local development: local and regional knowledge and experience, including external resources to complement them;
- Specific responsibilities: partners take responsibility for their own area of expertise, “to make the best use of their comparative advantages” (FORDELONE, 2009).

In addition to the benefits presented, some problems and uncertainties have also been identified. Hosono (2011), McEwan and Mawdsley (2012) and WHO (2014) mention as examples the lack of clarity and clear political guidances, administrative complexity due to the number of involved players – generally not restricted to only three collaborating institutions – delays, high transaction costs, fragility of measurement of results and differences of understanding about what development is and how to achieve it.

In the case presented herein, some of the benefits of tri-lateral cooperation are highlighted, as well as some of its challenges. Firstly, each stage of the process was discussed and agreed upon by the partners, and once set up, the Monitoring Committee fostered cooperation, making it faster and more effective. As a beneficiary country, Uruguay played an active role in this process and determined not only the important localities, but also what would be built or rehabilitated in response to their needs – which is in line with the basic principles of South-South cooperation of horizontality and demand-driven cooperation.

Throughout the cooperation, there was intense communication among players, generating a broad exchange of knowledge and information, and technicians from the involved institutions got closer, generating synergies to deal with other issues. Not only did Brazil contribute to the strengthening of Uruguayan health policy, but it also strengthened its national policy with the exchanges promoted among the border area managers. Qualifying trainers brought health professionals closer to the border, sharing their experiences and analyzing possible solutions to common problems. On the German side, the provision of funds was essential to increase the availability of health services at the border, and the office that monitored the project played an

important role on the entire process auditing and establishing deadlines for deliveries, ensuring its undertaking within the schedule set by the Separate Agreement.

Likewise, some of the challenges and learnings were presented throughout the process. Due to the multiplicity of players, the negotiation took a few years and, due to the exchange rate differences during the period, led to the reduction of the scope initially foreseen. The delays in negotiation were also marked by political changes in the two countries, which led to the exchange of institutional teams, requiring new agreements and definitions. The transfer design had to be changed during the course of the cooperation, in order to reduce transaction costs, which modified the process initially foreseen for cooperation, since funds were directly sent by KfW to Uruguay. The Uruguayan difficulties in hosting the training in the border region cities also reduced the number of Brazilian managers who could attend the technical exchange.

From the point of view of the health relationship between Brazil and Uruguay, the exchange was intensified due to the activities of the Trilateral Cooperation Project, which proved to be a notable example of international cooperation. This initiative encompassed both a South-South relationship and the complexity of a trilateral arrangement, with an external financing partner, and it was successful in its actions both in infrastructure and in training.

The project resulted in an important legacy of higher proximity between border managers, including interactions resulting from the participation of binational teams in the Training Program, thus providing opportunities for future joint work and boosting greater border integration. The objective of collaborating to improve the health conditions of the resident population in this region could be achieved thus in several fronts, strengthening the bilateral relationship between the two countries and establishing an example of border cooperation that could be adapted to other Brazilian border regions.

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# Humanitarian cooperation in health

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## Abstract

The main purpose of this article is to offer information and data on humanitarian cooperation work, focused on the donation of medicines, vaccines and health supplies, developed by the International Health Affairs Office (AISA). Based on the research methodology used in technical documents of the Ministry of Health, the Ministry of Foreign Affairs (MRE) and specialized literature, in addition to the analysis of data available at AISA, the article documents the work done within the scope of the theme, highlighting the progression of the concepts of aid, assistance and international humanitarian cooperation, as well as its guidelines, action formats and results for the 2010-2018 period.

**Keywords:** International Cooperation. Humanitarian Cooperation. Health. Brazilian foreign policy.

## 1 Introduction

Humanitarian activity provides support to individuals, helping to improve basic wellbeing conditions for those in need, caused by armed conflicts, environmental disasters, shortage of medical supplies, health and/or food inputs or other extreme conditions, with the purpose of mitigating the suffering and adversity caused by these events, helping to protect life, health and fundamental human rights in their entirety.

Throughout the twentieth century, humanitarian action underwent important changes that allowed the adaptation of the assistance provided according to the needs and the demands of the place. In the first half of the last century, the greatest demands for humanitarian action were related to situations of armed conflict, such as the two world wars, which killed 80 million people, and to pandemics such as the Spanish flu in 1918, which killed 50 to 100 million people worldwide. In recent decades, in addition to these traditional causes, the growing number of people affected by natural disasters, significant growth in the transnational flows of people, animals and products,

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the effects of climate change, of diseases such as HIV/AIDS and the lack of essential medicines, among other such events, also contribute to this situation. The growing global interconnection has also driven and been driven by global awareness of solidarity and responsibility to help to overcome the challenges to development and recognition of health as the right of individuals and the duty of the state. It also began to demand more assertive attitudes from governments to meet the needs, especially in emergency situations.

Parallel to the evolution of demands and support needs, the evolution of the concept currently defined as “humanitarian cooperation” has been noticed over the last decades. Based on the principles of human dignity and international cooperation for the progress of humanity, humanitarian cooperation validates solidarity, the defense of human rights and non-indifference as some of the strands of Brazilian foreign policy. Over the last decades, the effective incorporation of these principles into Brazilian practice, particularly in the post-re-democratization context, resonated with the 1988 Constitution and was reflected in the recovery of universalism and cooperation for development as vectors of the country’s international position.

The intention of this article is not to exhaust discussions regarding the history and evolution of humanitarian aid/assistance/cooperation, but to outline, in general terms, the activities that guide humanitarian cooperation on the agenda of the International Health Affairs Office (AISA).

## **2 Conceptual evolution: “aid”, “assistance” and “humanitarian cooperation”**

The literature on the history of humanitarianism presents the First Geneva Convention, signed in 1864, as the founding document of contemporary international humanitarian law and as a framework for the recognition of humanitarian aid as a legitimate practice for the protection of human life. This convention, entitled “Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in the Armed Forces in the Field”, laid the foundations for the recognition of the human rights of victims of armed conflict.

Throughout four Conferences, in 1864, 1907, 1929 and 1949, versions were drafted that formed the legal bases of international humanitarian law. The four Geneva Conventions signed in 1949 updated the texts discussed in earlier meetings, granting protection not only to wounded, sick and prisoners of war, but also to civilians<sup>3</sup>. The

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<sup>3</sup> The four Geneva Conventions of 1949 are international treaties that have been ratified by all present Member States of the United Nations. The Conventions protect the sick and wounded from the armed forces in the field (First Geneva Convention); the sick, wounded and shipwrecked members of the armed forces at sea (Second Geneva Convention); prisoners of war (Third Geneva Convention); and civilians held by a foreign power in the event

original concept of humanitarian assistance was thus broadened, promoting a new scope of protection for individuals. Until then, the actions developed were directed primarily to the military. With the end of World War II, given the magnitude of the conflict and its consequences, the need to extend the protection mechanisms for civilians became clear<sup>4</sup>.

In 1991, the United Nations General Assembly (UNGA) recognized, through resolution A/RES/46/182<sup>5</sup>, that humanitarian assistance is of critical importance to the victims of disasters and other emergencies and has established the following guiding principles: humanity, neutrality and impartiality. International cooperation is recognized as being of great importance to support states' capacity to respond in emergencies, but sovereignty, territorial integrity and national unity of States must be respected, and humanitarian assistance must be provided only with the consent of the state receiving the aid. The resolution also addressed the importance of international community support to developing countries in strengthening their capacities and strategies to prevent, prepare for and mitigate disasters.

Progressively, with normative and legal developments related to the recognition of human rights, the characteristics of what was formerly referred to as "humanitarian aid" or "humanitarian assistance" have also changed, widening its scope to include not only immediate action in emergency situations but also actions in the structuring of preparation, resilience and responsiveness. For this reason, some authors started to use a broader term – "humanitarian cooperation".

The terms humanitarian "aid" and "assistance" are commonly treated as synonyms, as has been observed in technical papers and works produced by scholars and specialized authors. Both terms refer to the notion of welfare, implying a sense of dependency. At the same time, the terminology "technical assistance", established by the UNGA in 1948<sup>6</sup> as the non-commercial transfer of skills and knowledge between countries with different levels of development, was reviewed by the UNGA in 1959<sup>7</sup>, and the term "technical cooperation", which is more descriptive in defining a relationship of mutual exchanges and interests between the parties involved started to be used.

In Brazil, since the early 2000s, the terms "aid" or "humanitarian assistance" have gradually been replaced by the term "humanitarian cooperation", implying a sense of

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of an international conflict (Fourth Geneva Convention). In 1977, two Additional Protocols to the four Geneva Conventions expanded protection for victims of international (Protocol I) and non-international (Protocol II) armed conflicts. Available at <<https://www.icrc.org/pt/publication/convencoes-de-genebra-de-12-de-agosto-de-1949>>. Accessed on: 20 de março de 2018.

<sup>4</sup> The International Committee of the Red Cross (ICRC) provides on its website <<https://www.icrc.org/en/war-rights>> texts that serve as a research material for the subject, including the legal basis of the right humanitarian assistance in situations of war. Accessed on: Tuesday, February 20, 2018;

<sup>5</sup> Resolution A/RES/46/182, 1991.

<sup>6</sup> Resolution A/RES/200 (III), 1948.

<sup>7</sup> Resolution A/RES/1429 (XIV), 1959.

cooperative work in order to achieve a common goal. It has been verified, however, that the terms “aid” and “assistance” continue to be employed by some actors involved with the topic.

The Organization for Economic Cooperation and Development (OECD) uses the term “official development assistance” to include donations and financial loans to promote development and “humanitarian aid”. This is a position more closely related to unilateral donation than to the development of capacities. In line with this view, Stoddard et al (2013) define a humanitarian system as “the network of interconnected institutional and operational entities through which humanitarian assistance is provided when local and national resources are insufficient to meet the needs of a population in crisis” (p. 4, free translation).

In evaluating the three concepts used to designate the humanitarian actions provided above, it can be verified that they have in common the purpose of providing assistance to those in need of support to overcome the hardships to which they are momentarily submitted. It should be emphasized, however, that the term “cooperation” includes a more complete and well structured range of actions: it aims not only at providing “help” in the strict sense of the word, but also working together for the development and/or the recovery of the requesting country, integrating efforts and solutions both to promote its immediate rehabilitation and strengthening its capacity to respond to future emergency situations. On the other hand, the state that is willing to cooperate with the country in vulnerable situation occupies not only the traditional role of donor, but also benefits from the exchange of practices, experiences and policies that strengthen its national capacities to respond to emergencies.

### **3 Humanitarian cooperation in Brazil**

In Brazil, the transition from “assistance” to “humanitarian cooperation” occurred at the beginning of the 21st century, when Brazilian foreign policy prioritized South-South cooperation based on horizontality, which allows the exchange of experiences and practices between cooperating countries. The institutionalization of the Coordination General of Humanitarian Cooperation and Actions Against Hunger (CGFOME) by the Ministry of Foreign Affairs (MRE) on January 1, 2004, was a milestone for humanitarian work in the country. This Coordination was responsible for the political and operational articulation of all the humanitarian actions developed by the Federal Government, acting as an intermediary with other Brazilian governmental bodies, foreign governments and international organizations involved in these actions.

According to the MRE, Brazilian international humanitarian cooperation consists of contributing to the prevention, response,

mitigation and socio-economic and environmental recovery of vulnerable and emergency communities, in accordance with the principles of humanity, impartiality, neutrality and independence, as per Resolutions 46/182 and 58/114 of the General Assembly of the United Nations and Article 4 of the Federal Constitution, which provides that the Federal Republic of Brazil [is guided] in international relations by the principles of the prevalence of human rights and cooperation between peoples for the advancement of humanity, among others (BRASIL [2006]).

Two years after the institutionalization of CGFOME, Decree n. 10,864, dated June 21, 2006, was published, creating the Interministerial Working Group on International Humanitarian Assistance (GTI-AHI), bringing together representatives of fifteen ministries and federal government agencies with the purpose of

I – coordinating Brazilian efforts of international humanitarian assistance;

II – drafting proposals for bills that seek *broad* consent for international humanitarian actions undertaken by Brazil. (BRASIL, 2016, Art. 1)

### The creation of the GTI-AHI took into consideration

the need to establish, in current legislation, authorization for the Executive Power to be able to permanently undertake humanitarian actions with the purpose of protecting, avoiding, reducing or assisting other countries or regions that are momentarily or not in a state of public calamity or emergency situations, in imminent risk or serious threat to life, health, protection of the human or humanitarian rights of its population, respecting the local culture and customs of the beneficiaries (BRASIL, 2016, head provision).

As a result of the activities of the GTI-AHI, a bill was drafted<sup>8</sup> that sought to fill this local gap in order to incorporate the necessary legal formalities to permit “the donation of food, medicines and other goods from Brazilian public stocks to third countries” (BRASIL, 2007). The Group’s activities were interrupted in May 2016 and resumed only in March 2018.

CGFOME was extinct by Decree 8.817 of July 21, 2016. Its attributions were incorporated into the Brazilian Cooperation Agency (ABC), also linked to the

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<sup>8</sup> Bill (PL) 737/2007, which provides “for international humanitarian actions undertaken by the Executive Branch to prevent, protect, prepare, reduce, mitigate suffering and assist other countries or regions that are, momentarily or not in emergency situations, public calamity, imminent risk or serious threat to life, health, the guarantee of the human or humanitarian rights of its population.” The PL is awaiting a decision on an appeal at the Chamber of Deputies since May 2010 and has not had administrative proceedings since that date.

MRE, designed to negotiate, coordinate, implement and monitor Brazilian technical cooperation programs and projects<sup>9</sup>. The resumption of activities by GTI-AHI in March 2018 was promoted by ABC, in order to follow up on the initiative to define a legal framework for the humanitarian cooperation actions developed by the Brazilian government.

## 4 International health-related humanitarian cooperation

AISA is responsible for coordinating all international cooperation actions developed within the Ministry of Health – both technical cooperation and humanitarian cooperation. Its expertise in Brazilian humanitarian cooperation unfolds into two main areas of work: the emergency and the responsive<sup>10</sup>. Cooperation in the emergency model seeks to support populations affected by natural and/or humanitarian disasters, with the donation of medicines and health supplies. On the other hand, responsive actions provide momentary support to national health systems by supplying demands arising from epidemics and/or depletion of stocks.

The South-South Ties Network project<sup>11</sup>, established in 2005, provided, in addition to the combined development of strategies for development, the donation of first-line antiretroviral medicines manufactured in Brazil to fight HIV/AIDS in the countries participating in the initiative<sup>12</sup>. The Brazil-Cuba-Haiti triangular cooperation also sought to reconcile emergency response actions to the January 2010 earthquake catastrophe in Haiti, including the donation of 400 tons of medicines, with actions to strengthen the Haitian public health system, design to build capacity and resilience in the medium and long term<sup>13</sup>.

In the perspective of the actions developed by the Ministry of Health, humanitarian cooperation covers all actions aimed at preventing, protecting, reducing suffering and assisting in the repair and development of countries that are in temporary or long-term emergency situations, public calamity, imminent risk or serious threat to life, health, the guarantee of human or humanitarian rights of its population. In implementing humanitarian cooperation, the humanitarian principles of humanity, neutrality, impartiality and independence must be complied with, in accordance

<sup>9</sup> For more information on the attributions and activities developed by ABC, please visit <<http://www.abc.gov.br/SobreABC/Introducao>>.

<sup>10</sup> Concepts developed by the authors, based on daily practice in humanitarian cooperation work.

<sup>11</sup> The South-South Ties Network initiative was the outcome of a Ministry of Health action that consisted in the donation of antiretroviral medicines produced by Brazil to developing countries.

<sup>12</sup> On this topic, please refer to article “International technical and humanitarian cooperation and the Brazilian protagonist role in regional and global response to HIV”, by Mauro Teixeira de Figueiredo.

<sup>13</sup> On this topic, please refer to article “Health cooperation with Haiti”, by Douglas Valletta Luz.

with the principles established by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA)<sup>14</sup>.

At the Ministry of Health, one of the first regulations for the recognition of the work developed in the scope of humanitarian health cooperation was Ordinance n. 1,650, of August 13, 2008, which created a technical group (TG) to coordinate and monitor humanitarian “assistance” in the Ministry of Health, under the coordination of AISA. The TG was created with the objective of monitoring the growing participation of the Brazilian government in international humanitarian action, specifically in the health area. The TG has had its activities suspended in recent years. A proposal for the reactivation of the group is under way, aiming at improving the work of humanitarian cooperation within the scope of the Ministry of Health, with the updating and establishment of institutional flows that allow the internal procedures to be adapted to the new realities of the humanitarian cooperation demands received and carried out by Brazil.

Currently, AISA aims at maintaining official records and carrying out actions for organizing the necessary procedures for the implementation of international humanitarian cooperation actions. This involves not only multiple stakeholders, both inside and outside the Ministry of Health, but also a wide range of procedures, documents and institutional flows that AISA has sought to optimize and rationalize. It also seeks to develop continuous internal awareness actions on the procedures for the accomplishment and receipt of international donations by the Ministry of Health and on the importance of involving AISA in expediting and making these processes more efficient. These contacts have been established and strengthened at the focal points for humanitarian issues in different technical areas of the Ministry of Health, such as those responsible for HIV/AIDS, tuberculosis and malaria, among others, and with external partners such as the Brazilian Cooperation Agency (ABC), the Pan American Health Organization (PAHO), the Ministry of Defense and others.

Until 2017, AISA records only included donations made by the Ministry of Health, suppressing information on donations received from abroad. This was mainly due to the fragmented communication between AISA and the technical areas and the lack of implementation and dissemination of clear institutional flows to carry out these

<sup>14</sup> According to OCHA's assumptions, the principles of humanitarian action are:

I – Humanity – Human suffering must be remedied wherever it may be found. The aim of humanitarian action is to protect life and health and to ensure respect for human beings.

II – Neutrality – Humanitarian actors should not take sides in hostilities and controversies of political, racial, religious or ideological nature.

III – Impartiality – Humanitarian action must be carried out according to need, giving priority to the most urgent cases and without distinction based on nationality, race, sex, religious beliefs, class or political opinion.

IV – Operational independence – Humanitarian action must be autonomous from the political, economic, military or other objectives that any humanitarian agent may have regarding the areas where humanitarian measures are being carried out. (UN, 2012, Free Translation)

processes. Until then, it was common for some units of the Ministry of Health to seek PAHO directly or its counterparts in partner countries for the solution to problems of impending shortages in the country. AISA was often sought only when there was a problem in the processing of these requests, which could have been avoided if there had been monitoring from the initial stages.

In order to prevent this type of problem from happening again, and also to give more organicity and publicity to the humanitarian actions carried out by the Ministry of Health, the need to seek information on the donations received became prominent. In 2017, the Import Division of the Ministry of Health began documenting these donations, in close contact with AISA. The donations received by the Ministry of Health in recent years are comprised of medicines for the treatment of neglected diseases<sup>15</sup>, such as malaria and leprosy, those in shortage of supply due to temporary unavailability of suppliers or unforeseen delays in the bidding, procurement and/or delivery of these goods. Also, cheap pharmaceuticals whose patents have expired arouse little interest from the pharmaceutical industry, which can also lead to shortages and require the adoption of emergency measures of production in government laboratories. Generally, PAHO plays the role of intermediary or donor for these national demands, identifying countries in the region that may have these medicines in their donation stocks or by donating medicines that may be available from the United Nations Humanitarian Response Depot in Panama.

## **5 History of the donations made by the Ministry of Health with the intermediation of AISA from 2010 to 2017**

The registration of donations of medicines, vaccines and supplies carried out by the Ministry of Health started in 2010. At the time, however, there was no standardization in the compilation of data, so information on donations made in the period from 2010 to 2015 is underestimated. From 2016 onwards, AISA's humanitarian cooperation team began the process of adjusting the records and internal procedures for meeting the demands, based on current international rules, domestic legislation and regulations and guidelines of the Legal Counsel of the Ministry of Health (Conjur).

The humanitarian cooperation coordinated by AISA has been carried out in tandem with the Department of Health Surveillance (SVS) and the Department of Science, Technology and Strategic Health Supplies (SCTIE)<sup>16</sup>, which belong to the institutional structure of the Ministry of Health, with the donation of medicines, vaccines and other inputs in crisis situations, emergencies, shortages of stocks, natural

<sup>15</sup> Neglected diseases are those caused by infectious agents or parasites and are considered endemic in low-income populations.

<sup>16</sup> For more information on SCTIE activities, see RIBEIRO et al., 2018.

and humanitarian disasters or, in the context of international cooperation projects that require such products. Since the Unified Health System is managed in a tripartite manner, by the federal government, states and municipalities, there are products that are not acquired by the Ministry of Health. In these cases, there is a legal and institutional gap in the country that allows the realization and the request of international donations involving federated entities. The humanitarian cooperation developed by the Ministry of Health is restricted to medicines, vaccines and health supplies purchased by the federal government.

The intermediaries for the making and receiving donations by the Ministry of Health are always central governments of other countries, through diplomatic contacts, or international organizations, especially PAHO and WHO. In the context of international humanitarian cooperation actions, the Ministry of Health therefore does not give donations to individuals, private companies or civil society organizations, given the lack of legal mechanisms to provide for this. South American countries are Brazil's main partners for humanitarian health cooperation. This is due to factors such as the similarities of shortcomings, prevention and treatment protocols, geographical proximity, fluidity of contacts through technical cooperation agendas, and joint participation in regional and subregional health forums. PAHO plays a key role in identifying potential donors and recipients in the Americas. In recent years, the Ministry of Health has donated medicines to the countries in the region for the treatment of tuberculosis, HIV/AIDS, viral hepatitis, malaria, leishmaniasis, as well as vaccines and antivenom sera, to meet emergency situations, shortages of stocks and actions planned in cooperation projects with requesting countries.

On the African continent, most of the donations made by the Ministry of Health are composed of antiretroviral medicines and inputs used to prevent and control sexually transmitted infections, especially HIV/AIDS and viral hepatitis. Recent destinations for these donations were Angola, Benin, Cape Verde, Guinea Bissau and Sao Tome and Principe. Donations of yellow fever vaccines to Cape Verde and Sudan, anti-tuberculosis medicines for São Tome and Principe and Cape Verde and antimalarials for Côte d'Ivoire were also made. In 2014, Brazil contributed with the donation of more than six tons of basic medicines and health supplies to help fight the Ebola epidemic in West Africa.

Recent donations to countries in Central America and the Caribbean include support for victims of climate disasters such as the January 2010 earthquake in Haiti that killed more than 230,000 people, Tropical Storm Erika, which hit the Caribbean island of Dominica in 2015, and Hurricane Matthew in Haiti in 2016. In the latter case, the Brazilian government, in an integrated initiative of the Ministries of Health, Defense and Foreign Affairs, sent more than 18,000 units of medicines, rapid HIV test kits, hospital supplies and almost four thousand doses of cholera vaccines to Haiti. In

the context of the development of a technical cooperation project between Brazil and Haiti in the area of HIV/AIDS diagnosis and treatment, the Ministry of Health donated 1,000 rapid oral HIV tests in 2016 to the Haitian government.

Asian countries have also benefited from recent donations made by the Ministry of Health. Syria, Lebanon and Palestine received items to care for people affected by armed conflict in 2013, 2014, 2015 and 2017. In 2015, 10 medicine and health supply kits were sent to Nepal, affected by an earthquake that killed almost 9,000 people and left three and a half million homeless. Each of these kits, whose composition is defined by Ministry of Health Ordinance No. 2,365, of October 18, 2012, is capable of providing care to up to 500 homeless persons, for a period of three months<sup>17</sup>. Although these kits have been constituted in relation to Brazilian reality of natural disasters associated with rains, winds and hail, they can also be adapted to meet international demands, whenever necessary, according to national availability.

## **6 Procedures for international donations under the Ministry of Health**

The process for carrying out humanitarian actions within the scope of the Ministry of Health follows guidelines defined by Conjur, based on constitutional provisions and the analysis of other available legal procedures, since there is no legislation regarding international humanitarian actions in Brazil, and Bill n. 737/2007<sup>18</sup>, which seeks to authorize the executive branch to carry out these actions, has not yet been approved and continues without processing in the National Congress since 2010<sup>19</sup>.

In order for the Ministry of Health to be able to make donations to other countries in need, the request must be made through the MRE, which forwards the request from the requesting country or the international organization, such as PAHO or WHO. Therefore, the Ministry of Health does not receive direct formal requests from foreign governments, since its official process must be through diplomatic channels, in accordance with the legally defined responsibilities for the MRE, through ABC, in this matter. This flow not only gives greater coherence and institutionality to the administrative action of donation, but also allow its monitoring and political evaluation, under the guidelines of Brazilian foreign policy, by the body that is competent to do so.

Upon receiving a request from the MRE, AISA is responsible for identifying and forwarding the request to the Secretariat of the Ministry of Health, which is responsible for acquiring and/or distributing the medicine, vaccine or input requested for its

<sup>17</sup> Ordinance 2.365 of October 18, 2012. Accessible in the Official Gazette published on October 22, 2012 ISSN 1677-7042 n. 204. Text available at: <[http://bvsms.saude.gov.br/bvs/saudelegis/gm/2012/prt2365\\_18\\_10\\_2012.html](http://bvsms.saude.gov.br/bvs/saudelegis/gm/2012/prt2365_18_10_2012.html)>.

<sup>18</sup> Bill 737/2007, which regulates the humanitarian cooperation actions practiced by the Executive Branch (BRASIL, 2007).

<sup>19</sup> <<http://www.camara.gov.br/proposicoesWeb/fichadetramitacao?idProposicao=348306>>.

formal manifestation. When evaluating the availability of the product for donation, the competent secretariat should ensure that any response to the request does not prejudice the achievement of public health policies or compromise strategic stocks or the internal distribution of these items in Brazil.

After the demonstration of the technical area on the availability of donation, AISA, in partnership with the MRE, performs the logistical procedures for the implementation of the action. These procedures range from the release of the necessary documents for the donation and contracting of the freight to the packaging, release of the product in the stocks of the Ministry of Health, customs procedures to leave the country, transit and arrival in the country of destination and all stages of cargo transportation, which require constant monitoring – and often require the solution of operational contingencies as a matter of urgency. When the Ministry of Health does not have the means to pay for the transportation of cargo, cost alternatives are sought in international organizations, particularly PAHO and WHO. The operationalization of the donation ends when the AISA receives the official confirmation of receipt of the cargo by the requesting country. It is common that there are several procedures for making and receiving donations occurring simultaneously, which makes it necessary to have a team exclusively dedicated to humanitarian cooperation in the AISA structure.

The MRE, through Brazilian offices abroad, also monitors the process of reception and symbolic delivery of the cargo in the country of destination, a fact that represents a special political moment to strengthen Brazil's engagement with local society and government. International humanitarian cooperation thus is an important dimension of Brazilian foreign policy, and international health-related donations strengthen the solidary and cooperative aspects of international action in Brazil even more. With some regularity, the Ministry of Health receives letters of appreciation from foreign ministers of Health for the lives saved with the humanitarian gesture of donation.

In order to receive international donations, the units responsible for the missing product in the Ministry of Health contact AISA, which consults PAHO on the possible availability of the donation, and, if necessary, requests ABC to consult Brazilian offices abroad, particularly in Latin America, about the availability of the medicine, vaccine, or input in their inventories.

The Ministry of Health does not carry out sale, purchase or “loan” of products in actions regarding international humanitarian cooperation. These donations are always based on solidarity and on the perspective that health is a universal human right.

In addition to the guidelines of the Legal Counsel of the Ministry of Health, AISA also applies procedures, principles and guidelines adopted by the World Health

Organization<sup>20</sup> and by the Pan American Health Organization<sup>21</sup>, for the implementation of international humanitarian cooperation, such as:

- Donate only what is requested or agreed between countries, in order to avoid waste of products and labor to organize and distribute the inputs received. Sending unsolicited donations to a country affected by an emergency often poses a problem for the coordination of humanitarian staff, who often lack the human and financial resources to receive and manage the cargo or have no place to store them, electricity for the maintenance of refrigerated products, among others. An example of these difficulties was that experienced by El Salvador after the earthquake that hit the country in 2001. According to PAHO data (PAHO, 2008), approximately 37% of the medicines received as donations at that time were inadequate, despite the publication of a previous list of needed supplies established by the Salvadoran government.
- Plan donations and communicate with agents in the affected country to obtain information on logistics and cargo reception conditions. It is important to contact diplomatic and consular offices, which are generally the first to establish communication with emergency authorities, to learn about humanitarian priorities.
- Respect the bureaucratic procedures of the affected country, which sometimes require a range of documents to proceed with the release of medicines into their territory.
- Send medicines with a minimum validity period of six months.
- Send products with certified quality so as not to cause doubts as to their origin.

The Ministry of Health faces occasional criticisms regarding international donations made by Brazil based on humanitarian principles and solidarity. On the AISA website<sup>22</sup>, it is explained

that humanitarian actions do not deprive Brazilians of the right to access medicines, which are donated only if they are not needed by national patients. Besides the moral duty to assist countries and people in situations of basic health needs, humanitarian cooperation actions also reinforce Brazil's institutional commitment to international cooperation, a principle enshrined in the Brazilian Constitution. As a consequence, Brazil's international projection is strengthened.

<sup>20</sup> See, for example, "Guidelines for medicine donations," whose third edition was published by WHO in 2011. Available at: <[http://www.who.int/medicines/publications/med\\_donationsguide2011/en/](http://www.who.int/medicines/publications/med_donationsguide2011/en/)>. Accessed on: 2 jun. 2018.

<sup>21</sup> See, for example, "Humanitarian assistance in disaster situations: a guideline for effective aid", published by PAHO in 1999. Available at: <<https://www.paho.org/disasters/dmdocuments/PED/Publications/books/pedhuman.pdf?ua=1>>. Accessed on: 2 jun. 2018.

<sup>22</sup> Available at: <<http://portalms.saude.gov.br/assessoria-internacional/cooperacao>>. Accessed on: 2 jun. 2018.

Given the interconnected nature of the flow of people and products in the world today, it is important to consider that eventual health problems in other countries may also pose a potential risk to the populations of those countries, something that is amplified in a country as large as Brazil, with over 16,000 kilometers of borders with ten countries. Also, Brazil receives international health donations that contribute to strengthen its service to the population under the SUS health system. International humanitarian cooperation therefore reinforces the recognition of health as an individual right, as enshrined in the Brazilian Constitution, and as a human right, in accordance with Brazil's international commitments in this area.

## **7 Challenges and critical bottlenecks**

The projection of humanitarian cooperation in Brazil and around the world is related to different phenomena, such as climate change, major environmental catastrophes, armed conflicts and forced displacement of people. These factors contribute to the mobilization of the world community on behalf of those most in need.

Over the last two decades, Brazil has been a country engaged in international humanitarian cooperation. It is a permanent challenge. Developing countries are usually the ones with the least capacity for resilience and response to emergency situations. International donations are important in these episodes, but humanitarian cooperation must go a step further towards effective capacity building to prevent and prepare for unforeseen fatalities with initiatives aimed at sustainable development. For Sardenberg (2005), despite significant advances, achievements in the humanitarian area did not produce changes at the desired speed. According to the author, the fulfillment of economic and social rights remains unattainable for many hundreds of millions of people living in extreme poverty.

AISA plays a key role with the Ministry of Health in coordinating, in terms of humanitarian cooperation, to ensure that Brazil maintains its position as a collaborator with other countries and organizations, reinforcing the principles of development and horizontality. Within the scope of AISA's actions, humanitarian cooperation must fulfill a complementary and fully integrated role in the actions developed regarding international technical cooperation.

In the context of international cooperation projects promoted and accompanied by AISA, the donation of medicines, vaccines, health supplies and equipment and the provision of technical assistance and training are recurrent. In addition to meeting emergency demands for international donations, the role played by AISA in international cooperation also includes elements of fundamental importance for the implementation of national foreign policy.

Eventual criticism by sectors of society referring to international humanitarian cooperation activities, given the shortcomings and difficulties of the national health system, reveal a lack of knowledge of the premises of humanitarian cooperation and the principles of morality, altruism, promotion of development and access to health as a human right. Also, it is undeniable that international cooperation actions directly and indirectly benefit the Brazilian population, both through the reception of international donations in temporary and unforeseen situations of scarcity and by the containment of diseases in neighboring countries that could also affect the Brazilian population, for example.

The lack of a legal framework that supports and regulates the humanitarian cooperation actions developed by Brazil requires special attention. This topic has been treated as a priority by the GTI-AHI. This may also contribute to the fact that the logistic aspects can be more easily solved, considering that the requesting country often faces difficulties in hiring international transport to take the cargo donated by Brazil to its destination, thus restricting the actions by the Ministry of Health.

The strengthening of emergency cooperation actions linked to structuring policies and projects is necessary and critical to qualify the country's international participation, promoting the development not only of the health systems of the countries in the worst situation, but also, and consequently, of their societies.

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# **THE MULTILATERAL DIMENSION OF BRAZILIAN HEALTH ACTIONS**



# The International Health Affairs Office of the Ministry of Health (AISA): the history towards multilateral activity

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## Abstract

This purpose of this article is to present, through a descriptive method, the perceptions surrounding the creation and operation of the International Health Affairs Office (AISA) as part of the coordination structure of the Ministry of Health in support of multilateral health forums, with special attentions to Brazil's coordination and participation in governing bodies of the Pan American Health Organization (PAHO) and the World Health Organization (WHO).

**Keywords:** Health. Multilateralism. Global Health Diplomacy. Foreign Affairs.

## 1 Multilateralism in the area of health

Since the beginning of the 1990s, with the end of the Cold War, the emergence of new independent states and new relevant actors in the health sector, and changes in the global epidemiological profile, there was a shift in how to conduct some issues on the global health agenda. In addition to this, 1993 brought a very important element to the international health scene: the publication by the World Bank of the World Development Report entitled “Investing in Health”, in which, for the first time, a detailed analysis of the relationship between health, health policies and economic development is drafted, with an emphasis on the connection between poverty and health. The association between poverty and health has introduced a new perspective to the debate on health policies in developing countries. Poverty eradication became widely discussed at the international level, more closely related to an integrative approach to health. The importance of strategic actions directed towards the social components of health, such as employment, education, among others, also began to be recognized.

The emergence of new issues on the international agenda, such as the environment, human rights and terrorism, has been followed by the proliferation of actors involved in international affairs. The increasing intersectorality and transversality of health issues has led governments to recognize their inability to tackle common problems individually, leading to the search for collective solutions.

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In the wake of multiple actors and the new dynamics of power that was unfolding, Brazilian foreign policy experienced a phenomenon called by Jeffrey Cason and Timothy J. Powers (2006) as “presidential diplomacy”<sup>2</sup>.

In Keohane’s perspective (apud MELLO, 2011, p.15), multilateralism is defined as the “institutionalized collective action undertaken by a set of independent States established in an inclusive manner.” Ruggie (apud IZUEL, 2010, p.34, free translation), in turn, defines multilateralism as

[an] institutional form which coordinates relations between three or more States on the basis of general principles of conduct, i.e. principles which specify the appropriate conduct for each type of action, without regard to the particular interests of the parties or the strategic requirements that may be relevant in each specific case.

By engaging in multilateralism, States coordinate themselves and chose a model of shared values, creating a “coexistence structure, based on the mutual recognition of independent States and associated with equal rights” (HURRELL 1999: 58).

The 1990s were also an important moment for international relations and States’ communication with international organizations, especially the World Health Organization (WHO)<sup>3</sup>. The attempt to impose health policies, and priorities, to different countries allowed dialogue and interdependence among the actors, given the new global epidemiological profile. Old-time diseases were still a concern in some countries, such as malaria, tuberculosis, yellow fever and cholera. Other health problems emerged more intensely and became epidemic, including AIDS, violence, obesity, alcohol, and cardiovascular diseases. In this context, new health issues have been included in the global agenda more intensely.

Topics such as bioterrorism, influenza pandemics, virus sharing and biological diversity, for example, reflect the growing concern of States with the vulnerability of their borders and the speed with which global contamination can occur. At the same time, there is a mobilization of States and other international actors to establish a connection between critical health situations and international security. For these reasons, a new international arrangement has been noticed in order to strengthen epidemiological surveillance. Exchange of information, development of studies, creation of surveillance networks, creation of even more rigid mechanisms of control and security, and the emergence of new governmental and non-governmental international forums to discuss this new reality are just a few examples of responses given to the so-called

<sup>2</sup> According to the authors, it is the perception that presidents should have a more active role in foreign relations.

<sup>3</sup> The WHO is a specialized agency of the United Nations created in 1948 to promote the acquisition by all peoples of the highest possible level of health. In accordance with the WHO Constitution, the Organization acts as the directing and coordinating authority for international health work (WHO, 1948).

“globalization of diseases”. Due to these transformations, new global health priorities have been established not only by States, but also by international agencies and other stakeholders.

This whole scenario led to debates around the term “global health”. Based on the assumption that the term global health will strongly influence the international agenda and may change power relations between nations, Theodore Brown, Marcos Cueto and Elizabeth Fee (2006) discuss the terms “international health” and “global health” from the following perspective:

“International” health is a term used with considerable frequency in the late nineteenth and early twentieth centuries, and it referred especially to a focus on controlling epidemics by crossing borders between nations, that is, “internationally.” [...] “Global” health in general indicates consideration of the health needs of the entire planet’s population, above the interests of specific nations. The term “global” is also associated with the growing relevance of actors other than government and intergovernmental agencies and organizations [...].

Considering the fact that domestic and international changes affect health in a transverse manner, health is no longer seen as the mere absence of disease, but as a set of social factors related to a person’s physical, mental and social well-being. The significant difference between countries’ patterns of development, the proliferation of actors and the low institutionalization of responses to health challenges, the increase in the incidence of diseases due to climatic and environmental changes and the large population movement in a globalized world are some of the issues that have raised concern about disease proliferation and the fear of a possible pandemics. This scenario has led countries to seek alternatives, especially with respect to tax collection and resource allocation, for the implementation of articulated social policies, a challenge that is even greater in developing countries. In this sense, the private sector, through the work of foundations and the organized society and through non-governmental organizations (NGOs), have been contributing significantly to international funding and the consolidation of specific multilateral health mechanisms. A shortcoming identified in this approach concerns the lack of coordination of initiatives, the short-term focus on capacity building or institutional structuring at those countries, which affects the influence of national health authorities.

## **2 The international participation of the Ministry of Health**

By analyzing the relationships among the multiple actors involved, it is possible to understand the international performance of an agency or institution, how they

organize themselves and, above all, acknowledge that the roles played over time are changeable, depending on the context in which they are inserted.

The Ministry of Health, as currently known, was formally created on July 25, 1953, by Law no. 1.920 that divided the Ministry of Education and Health into two independent institutions: the Ministry of Health and the Ministry of Education and Culture (BRASIL, 1953). Although the Ministry of Health was created only in the 1950s, health in Brazil was already treated in a particular manner, through initiatives such as the collaboration between the Brazilian government and the Rockefeller Foundation, focused on the control of yellow fever.

The collaboration with the Rockefeller Foundation was a long-lasting partnership, between 1923 and 1939, when the Foundation transfer the yellow fever control services to the national government. The publication of Decree no. 1.975, of January 23, 1940, was a milestone in this transition, since it changed the name “Yellow Fever Service”, previously under the responsibility of the Rockefeller Foundation, to “National Yellow Fever Service” (NYFS), then dependent on the Ministry of Education and Health (BRASIL, 1940).

In 1977, the basic structure of the Ministry of Health was changed through Decree no. 81.141 (BRASIL, 1977). The decree created the International Health Affairs Coordination Office (IHACO), responsible for dealing with international technical cooperation. IHACO was responsible for promoting, coordinating, monitoring and evaluating technical health cooperation with international organizations, governments or foreign institutions. According to its Internal Regulations, the IHACO had the following structure: Administration Section; Cooperation with International Organizations; Bilateral Cooperation Service; and Institutional Cooperation Service. This structure reflected the clear concern only with technical and financial health cooperation. At that time, the competencies of the Ministry of Health did not include the issues related to multilateral activities and international negotiations, which were then a responsibility of the Ministry of Foreign Affairs.

Since the 1980s, the international scenario went through a significant transformation: the World Bank’s involvement in health issues, something new until then, weakened the WHO’s performance. While, on the one hand, the WHO was experiencing structural and financial difficulties, due to its bureaucracy, excessive specialization and lack of evaluation and monitoring mechanisms the World Bank, on the other, gained headway, since it had large amounts of financial resources for investment in health projects, especially in developing countries.

During the economic crisis of the early 1990s, under Fernando Collor de Mello’s term (1990-1992), a series of administrative reforms were conducted in the federal government, in which all ministerial units responsible for international issues were extinguished, including IHACO, in the Ministry of Health. Despite this institutional

reorganization, ongoing and imminent projects, as well as international requests for the Ministry of Health's attention and administrative procedures regarding international affairs would still create work demands in this area, and informal arrangements have been established to account for the workflow. For this purpose, an adviser to the Minister of Health was appointed to deal with international affairs and to continue the work that was previously done by IHACO, but without a unit formally responsible for this matters within the Ministry's institutional structure. This was the case until the creation of the General Coordination of Special Health Affairs (GCSHA), by means of the Directive GM/MS no. 382, of May 3, 1991.

GCSHA was part of the Minister's of Health Cabinet until 1993, when, once again, its functions were altered by Directive GM/MS no. 778, of July 15, 1993, and its designation changed to Special Health Affairs Office (SHAP). In one year, between September 1993 and September 1994, the SHAP was linked to the Executive Secretariat of the Ministry of Health and not to Minister's Cabinet<sup>4</sup>.

In 1998, the Ministry of Health went through another institutional restructuring, which resulted in the creation of the International Health Affairs Office (AISA) of the Ministry of Health, a designation that remains until the present day<sup>5</sup>. During the Office's twenty years of existence, several changes in the internal regiment of the Ministry of Health were conducted. However, AISA's multilateral performance was not adequately acknowledged in its organizational structure.

In the early 2000s, the discussion of health issues in multilateral forums got intensified Due to the approval of the Millennium Development Goals (MDGs) in 2000<sup>6</sup>, which encouraged dialogue between governments and various actors seeking partnerships and new forms of collaboration that would support the pursuit of these globalized goals.

Although the international environment requires increasingly robust responses to global challenges, the AISA did not have, in its official structure, a specialized unit on multilateral issues. In order to adapt its existing structure to this new reality, a Multilateral Division was informally created<sup>7</sup>.

<sup>4</sup> It was not feasible to describe CAESA and EFSA's functions, as the authorities responsible have already been revoked, and contents are no longer available.

<sup>5</sup> AISA was created through Decree no. 2,477, dated January 28, 1998, and has since been linked to the Office of the Minister of Health. It was not possible to describe its primary functions, established at its creation, since the ordinance that established the internal regulations of the Ministry of Health has been revoked, and its contents are no longer available.

<sup>6</sup> The MDGs were adopted during the Millennium Summit in New York in 2000. Leaders from 191 nations have signed an international pact to make the world more supportive and fair by 2015. Eight objectives were outlined, to be achieved through actions to fight poverty and hunger, the promotion of education, gender equality, health, sanitation, housing and environmental policies. Of the eight agreed objectives, three were health-related.

<sup>7</sup> The bureaucratic complexity involved in the formal restructuring that led to the creation of units or subunits, especially with regards to job creation, were the main barriers to the DTM, leading to its informality.

Even as an unofficial division, the Multilateral Division was conceived as a political unit, with the fundamental purpose of performing international negotiations surrounding health-related issues. In addition, there was a need to respond to the new demands of multilateral action, especially in preparation of Brazil's participation in the WHO's World Health Assembly (WHA), the most important international health forum.

Among the structural changes carried out over the last two decades in AISA's capabilities, the most important shift occurred in 2010, with the publication of Directive MS no. 3.965, dated 12/14/2010 (BRASIL, 2010). Until then, Article 13 of AISA's<sup>8</sup> internal rules defined its attributions as: (i) to promote, articulate and guide negotiations related to technical, scientific, technological and financial cooperation with other countries, international organizations, regional and subregional integration mechanisms within the Ministry's scope of action; (ii) articulate the collaboration of experts and multilateral and bilateral international missions, taking into account the guidelines of the National Health Policy; and (iii) to advise the Minister of State, in Brazil and abroad, on international affairs related to the Ministry's attributions (BRASIL, 2004).

With the 2010 directive, the scope of action of AISA was expanded, as provided in its article 12:

- i. To advise the Minister of State and other authorities of the Ministry of Health, both in the country and abroad, on international affairs related to the Ministry of Health;
- ii. To promote, articulate, guide and coordinate international actions related to the Ministry of Health, including negotiations with other countries, international organizations, regional and subregional integration mechanisms and international conventions;
- iii. To promote, articulate and coordinate international actions related to the Ministry of Health regarding technical, educational, scientific and technological cooperation in the Ministry's areas of competence.;
- iv. To act as an intermediary of the Ministry of Health in all foreign relations activities, meeting demands and presenting proposals of interest;
- v. To advise the Minister of State on administrative matters regarding international missions, arising from commitments made by the Ministry of Health (BRASIL, 2010).

Despite this restructuring, the Multilateral Division was not formalized. Multilateral activities were timidly included as one of the Technical Analysis Division's responsibilities, one of AISA's units, according to paragraph 15 (I) of the 2010 Directive:

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<sup>8</sup> The abovementioned attributions were established by Ordinance MS no. 2,123, dated October 7, 2004.

“To promote, guide and monitor, in articulation with the Ministry of Foreign Affairs, negotiations within the United Nations System and other forums, including those not exclusively related to health” (BRASIL, 2010).

As well as the Multilateral Division, the National Coordination of Health in Mercosur (Sub-Working Group No. 11 – “Health”), another important multilateral health forum, has not been formally established within the organizational structure of AISA. In 2007 alone, through Directive no. 2.943, dated 11/16/2007, the National Coordination of Health in Mercosur became part of AISA structure, being technically and administratively subordinate to the AISA Office.

Since the mid-1990s, the international advisory services of the Ministry of Health have been traditionally headed by career diplomats, strongly tied to the Ministry of Foreign Affairs<sup>10</sup>. This association, not exclusive to the Ministry of Health, is part of a strategy to build a common discourse between the Ministry of Foreign Affairs, other ministries and Brazilian international diplomatic missions in their interactions with other countries and international organizations.

Despite the significance of the Ministry of Foreign Affairs role in global health discussions, the existence of multiple actors, who became active in the international scene at various levels, and especially when it comes to health, has led to the “decentralization” of foreign policy, making it more democratic and dynamic. Kickbusch et al. (Kickbusch, BERGER, 2010, 22) corroborate this idea by stating that:

The Health Minister today has a double responsibility: to promote health in his/her country and to foster the health interests of the global community. In addition, diplomats no longer negotiate with other diplomats alone. They also need to interact with non-governmental organizations, the private sector, scientists, lawyers and the media, since all of these participants are now heavily involved and engaged in the negotiation process.

The evolution of the multilateral approach to health issues over the last two decades has been accompanied, at the domestic level, by a growing demand for action and monitoring of multiple forums, technical groups and international health initiatives in Brazil. The coordination of various governmental actors involved in health-related issues is, therefore, vital to adequately monitor the agenda and synchronize Brazil's positions in these areas.

<sup>9</sup> SGT 11 “Health” was established through GMC Resolution n. 151/96 (Southern Common Market, 1996), with the general task of harmonizing Member States legislation regarding health-related goods, services, raw materials and products and the criteria for epidemiological surveillance and sanitary control in order to promote and protect people's health and lives and eliminate obstacles to regional trade, contributing to the integration process.

<sup>10</sup> The first time a diplomat was appointed to lead the international advisory services of the Ministry of Health was in 1995. Since then, the unit responsible for international issues within the Ministry of Health has been headed by diplomats, except from 2012 to 2016.

### 3 AISA's multilateral action

By its constitutive nature, the AISA is not an “end unit”. It is an “intermediary unit”, which performs support activities that contribute to move work processes forward and manage the Ministry of Health’s routine. In the sense, the multilateral action carried out by AISA is two-folded, with an internal and an external role. Its internal role is to coordinate different units and institutions involved in international issues. The external role means representing Brazil and the Ministry of Health in multilateral health forums. As examples, AISA’s performance in the context of the Ministry of Health’s participation in WHO and PAHO (Pan American Health Organization)’s governing bodies, this last one a regional arm of the WHO, will be analyzed.

The coordination role deserves special attention. Each multilateral governing body has its agenda defined beforehand, and its work agenda indicates issues to be addressed. Although they are delimited by the criteria set forth by the Organization, the international context and power relations among actors in the global health field are determinant for the definition of the multilateral health agenda.

According to the agenda of the specific forum in which the Ministry of Health will participate – such as the WHO Executive Board, the World Health Assembly or the PAHO Directing Council – AISA begins the process of analyzing the working documents produced by the respective organization or Member States, evaluating aspects such as: language, consistency with national policies and programs, relevance, relation with existing international instruments, political pertinence and related interests. Based on this analysis, and taking into account the principle of intersectoriality, AISA identifies the area(s) within the Ministry of Health that should be consulted. It then initiates a direct dialogue to collect specialized information to subsidize the Brazilian position, including data, national context, and feasibility of the proposal, among others. It is up to AISA to evaluate the information received and to unify the perspectives presented in a single document reflecting Brazil’s position regarding the matter.

Simultaneously to the analysis of the documents that will be discussed in multilateral health forums, AISA also prepares speeches and plan interventions to be delivered by the Health Minister or by the Ministry of Health representatives. In the events where representatives of the Ministry of Foreign Affairs participate, AISA also contributes with the production of contents to support the drafting of speeches and interventions.

The lack of coordination with the AISA for the international action of the Ministry of Health’s agencies in its initial years of operation, led to the need to direct internal information and work flows. Circular Letter no. 025/GM, of October 10, 2003, issued by the then Health Minister, Humberto Costa, stresses the importance of AISA in disciplining international affairs:

Considering the need to discipline the international relations of the Ministry of Health, I hereby determine that any and all matters of an international, regional or subregional nature, involving [...] the mediation of the Ministry of Foreign Affairs, Embassies, Consulates, representative offices of countries or international, regional or subregional bodies, be handled through the International Health Affairs Office (AISA). I request the strict compliance with the foregoing assertion, as well as the disclosure of the matter within the scope of this body's action (BRASIL, 2003).

Awareness about the need for coordinated action between the AISA and the work of the Ministry of Health is still a challenge. The constructive approach to technical areas in international affairs has been the strategy adopted by the Ministry of Health so it could act with transparency and objectivity, ensuring the effectiveness of its performance.

In the context of PAHO and WHO, which represent the main forums for multilateral discussion in health-related issues, AISA plays a representative role in defending the Brazil's interests as well as the Ministry of Health's. These forums also provide opportunities for bilateral contact with a diversity actors: countries, foundations, and representatives of international organizations and civil society. As an advisory body to the Minister, the role of the AISA is to identify possible interlocutors with whom he would exchange impressions and experiences, articulate the approval of documents, propose agreements, projects and partnerships of mutual interest, seek support for the defense of national interests or discuss topics related to bilateral health cooperation. Membership at PAHO and WHO's governing bodies is also shared with the Ministry of Foreign Affairs, with the support of the Brazilian representation in Washington and Geneva and in coordination with the Ministry of Foreign Affairs' Division on Social Issues.

As the coordinator of international health efforts, AISA has the responsibility of accompanying the Health Minister in international appointments as well as representing the Ministry of Health in international meetings and forums of political relevance, in addition to supporting the participation of representatives of the Ministry of Health in technical international forums, whose deliberations may have a potential impact on Brazil's position on matters of extreme relevance to the country's national and foreign health-related policies.

The increasing complexity of international issues, the need for an increasing level of specialization of international action and the need to adopt multi-sectoral approaches have enticed debates around the so-called Global Health Diplomacy (GHD), now recognized as an important tool to strengthen the foreign policy of a country. According to Martins et al. (2017, p. 235),

The GHD, which has been adopted as a tool to strengthen the foreign policy of nations, assumes that people's health influences countries' economies, and that global health is an important part of its well-being and development, particularly in the least developed countries. In addition, it collaborates with these countries' leadership role in international organizations, generating trade opportunities and building trust between nations.

Consequently, the effective participation of Brazil in the main venues for discussion of global health issues and the monitoring of multilateral guidelines at the regional and global levels should be seen as an effective strategy for the country's insertion in the international scenario and the projection of national health interests at a global level.

## 4 Final Considerations

More than different names, the institutional changes that the AISA and its predecessors went through are also related to the country's political situation at each period. From the timid early cooperation activity, with little to propose, it became one of the most powerful international advisories of Ministries.

Remarkable initiatives, such as the creation of the Unified Health System in 1988 and universal access to antiretroviral treatment in the mid-1990s have placed Brazil in a prominent position. Today, Brazil is no longer a simple receiver of cooperation or international aid. Consequently, there was a significant change in its status in the international health agenda.

Now, health is a much broader issue than it was when AISA was founded, two decades ago. Globalization, multilateralism in social issues and the growing participation of new actors were followed by the expansion of a global health agenda, now evident in discussions regarding topics as diverse as trade, environment, labor, education, agriculture, national security, and others.

AISA, as a direct advisory body to the Health Minister, has attributions that relate not only to the technical monitoring of multilateral issues, in coordination with other areas within the Ministry of Health, but also to the political dimension: the strengthening of the Brazilian foreign policy on health. Accordingly, it is important to continue the promotion of proper institutional coordination in order to improve the Ministry of Health's performance in international affairs scenario. Thus, Brazil's ability to act and intervene on matters of interest in multilateral health forums is reinforced, as well as the role that health can play in the formulation of the country's national foreign policy.

Considering the premise that the health sector tends to be increasingly more prominent in international discussions, and the issues addressed by the AISA are

not only technical but political, a coherent organizational planning and long-term initiatives that can consolidate its actions and functions over time must be prioritized.

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# The international action of the Ministry of Health in the issue of access to medicines

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## Abstract

Access to medicines is a fundamental pillar of the right to health enshrined in the Brazilian Federal Constitution. However, there are numerous challenges Brazil faces to ensure access to medicines for the population, both because of their high prices and due to the lack of interest in research and development of medicines for certain neglected diseases. In order to address these challenges, the Ministry of Health, through its International Health Affairs Office, has been active in the international scenario.

This article aims at highlighting some initiatives in the scope of access to medicines that had the participation of Brazil. At the multilateral level, the country has succeeded in promoting initiatives to discuss this issue, always reaffirming its position in defense of the primacy of the right to health over commercial interests. Among the developed actions, the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (GSPA) and the Consultative Expert Working Group on Research and Development (CEWG) can be highlighted. At regional level, it is worth noting the joint price negotiation of high-cost medicines in the Mercosur member states and associates.

**Keywords:** Public Health. Access to medicines. Intellectual property. Research and Development. WHO. WTO. Mercosur.

## 1 The fundamental right of access to medicines and its challenges

### 1.1 Access to medicines: essential pillar of the right to health

Access to effective, safe and quality medicines and vaccines is an essential pillar of the so-called “right to health”, enshrined in various international instruments such as the Constitution of the World Health Organization (1946), the Universal Declaration of Human Rights (1948) and the International Covenant on Economic, Social and Cultural Rights (1966). More recently, one of the goals included in the United Nations (UN) Sustainable Development Goals (SDGs) is:

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3.8 Achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all (UN, 2015).

In Brazil, since the 1988 Federal Constitution promulgation, health is recognized as a right of all citizens and a duty of the State, in the following terms:

Art. 196. Health is a right of all and a duty of the State and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the universal and equal access to actions and services for its promotion, protection and recovery (BRASIL, 1988a).

Hence, in 1990, the Unified Health System (SUS – Brazilian acronym) was implemented, governed by laws n. 8.080/90 (BRASIL, 1990a) and n. 8.142/90 (BRASIL, 1990b), with a public health system aligned with the principles of universality, integrity and equity, whose scope of action is comprehensive therapeutic care, including pharmaceutical assistance.

According to the constitutional guidelines, in 1998 the National Drug Policy (BRASIL, 1998) was approved to guide actions related to pharmaceutical assistance, with the purpose of “ensuring the necessary safety, efficacy and quality of medicines, rational use and access of the population to those considered essential”. Also, in 2004, the National Health Council approved the National Policy for Pharmaceutical Assistance (BRASIL, 2004), which has as one of its main mottos the guarantee of access to essential medicines.

In SUS scope, in order to define the concept of essential medicines for the population, whose access is a constitutional right, as well as to guide the offer, prescription and dispensing of medicines, the National List of Essential Medicines (Rename – Brazilian acronym) (BRASIL, 2017) was created. In this regard, the existence of a clear concept of “essential medicines”, based on technical-scientific criteria on safety, efficacy as well as on the epidemiological profile of the population, “promotes equity and helps to set priorities for care” (OLIVEIRA, 2007, p.64).

However, one of the challenges to maintaining the national policy for pharmaceutical assistance in access to essential medicines is the lack of access to such drugs, especially due to their high prices, and the lack of drug research and development for certain diseases.

## 1.2 Challenges: Access and research gap

More than a national problem, the lack of access to medicines represents a global health challenge. In this regard, it is estimated that two billion people around the world do not have access to the medicines they need (ACCESS TO MEDICINE FOUNDATION, 2018). In this sense, the issue of lack of access can be analyzed under two perspectives: access gap and research gap.

### 1.2.1 Access Gap

The access gap refers to the problem of medicines that are available on the market, but are inaccessible to a portion of the population, mainly due to the high prices of these products, especially those obtained through innovative practices.

Once restricted to developing and least developed countries, this situation, has also concerned developed countries, mainly due to the high costs of maintaining their health systems as a result of the high prices of medicines and other medical products. For example, the European Union Member States have expressed concern about the lack of access to essential medicines due to “very high and unsustainable prices” (EUROPEAN UNION, 2016).

This challenge has increased even more since the advent of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) (WTO, 1994) as part of the Agreement Establishing the World Trade Organization, signed in 1994.

In this regard, it is relevant to briefly explain the interface of intellectual property and public health. Following the TRIPS Agreement, World Trade Organization (WTO) members have committed themselves to adjusting their national legislation to new minimum international standards for the protection of intellectual property rights, for instance, by granting patent protection to pharmaceutical products for a minimum twenty-year period. On the other hand, according to Article 7 of the TRIPS Agreement, such protection should contribute to the promotion of technological innovation and to the transfer and dissemination of technology, in the following terms:

The protection and enforcement of intellectual property rights should contribute to the promotion of technological innovation and to the transfer and dissemination of technology, to the mutual advantage of producers and users of technological knowledge and in a manner conducive to social and economic welfare, and to a balance of rights and obligations. (WTO, 1994).

TRIPS established transitional periods for the implementation of the provisions contained in the agreement at domestic level, by which it granted different time frames to WTO members according to their development level. Specifically, developing countries in whose legislation there were technological areas without patent protection, a deadline was granted until 2005.

As observed in several other developing countries, the Brazilian legislation concerning intellectual property in force at the time, Law n. 5,772/71 (BRASIL, 1971) did not provide for the granting of patents for pharmaceutical products and processes. Therefore, Brazil could benefit from the transitional period established by the TRIPS Agreement. The use of this transitional period would allow the country to strengthen national laboratories to make the local industry competitive to face competition with transnational pharmaceutical companies (CHAVES, 2008).

However, unlike other developing countries, Brazil did not use the transitional period granted in the agreement, and as early as 1996, Brazil approved a new Industrial Property Law – Law 9.279/96 (BRASIL, 1996), in which it recognized patent protection for pharmaceutical products and processes.

The decision not to use the transitional period is strongly criticized by several authors, who point to external pressures, in particular from the United States of America (US), in the mid-1980s, as the main reason for that choice. At that time, Brazil was threatened by the US with trade sanctions, alleging the country was not only a major intellectual property rights violator, but also one of the only major markets not to grant patents to medicines. By means of these trade sanctions, effectively imposed in 1988, the United States aimed at the reformulation of Brazilian intellectual property legislation, so that preventing the advance of the formulation of foment public policies to strategic sectors to curb the drug price control exercised by Inter-Ministerial Price Council (RANZANI, 2006).

Also, the political scenario after the 1989 presidential elections pointed to a change in Brazilian foreign policy, which aimed to bring closer the United States. Thus, the reformulation of the Brazilian Industrial Property Law sought by the US began to be developed in National Congress scope, through Bill n. 824/91. Negotiations on the TRIPS Agreement were concluded in 1994 amidst the voting of the bill.

At that time, the US pressures on Brazil continued, and, in line with the ideals of the federal government, as early as December 1994, Brazil incorporated the TRIPS Agreement into Brazilian legislation. Since then, there have been discussions and divergences of understanding, including in judicial terms, on whether Brazil would have waived the transitional period TRIPS granted to developing countries. Even the Brazilian government had a reticent response to this issue. Through a diplomatic note to the WTO, it reported that the country had not renounced its status of developing country and that, for intellectual property purposes, WTO agreements would only

enter into force at the same time as in other developing countries in 2000 (CAPUCIO, 2015).

In spite of discussions on the transitional period granted for the adaptation of national legislation to the new standards of protection brought by the TRIPS Agreement, on May 14<sup>th</sup>, 1996, the President of the Republic sanctioned Law n. 9.279/96 (BRASIL, 1996), regulating industrial property rights and obligations, providing for even greater levels of protection than those that had been negotiated in the context of the TRIPS Agreement.

Thus, if the constitutional commitment to guarantee universal access to medicines already posed an enormous challenge to Brazil, with the early incorporation of the new patent protection regime, without the necessary investment in training and increasing the competitiveness of the national pharmaceutical industry, the scenario became even more complex.

In practical terms, a patent holder is granted a commercial monopoly, so that, for a certain time, the inventor obtains a financial return on the investment in product research and development. Therefore, the patent excludes potential competitors from the market during its term and leaves its holders free to practice prices at their discretion. In Brazil's case, which has a public health system of universal access, patent protection has led to increased costs due to the dependence on supply purchase from transnational patent-holding laboratories.

Finally, it should be noted the issue of high selling prices for medicines is not limited to only hampering access in itself but it has also implications for access to effective and quality medicines. According to a recent WHO report (WHO, 2017a), the gap in access to medicines due to high prices creates an empty space often filled by the marketing of substandard and falsified products, posing enormous health risks.

### 1.2.2 Research Gap

The research gap refers to the lack of investment in research and development of drugs for the treatment of certain diseases in which the pharmaceutical industry does not see a market potential, either because they affect a small group of people or because they are diseases that reach populations with lower purchasing power, especially those living in developing countries and least developed countries.

In public health jargon, these diseases are known as “neglected diseases” and “most neglected diseases,” a relatively recent conceptual division the non-governmental organization *Médecins Sans Frontières* (MSF, 2001) coined. Neglected diseases are those that mainly affect populations living in developing countries and least developed countries, such as malaria and tuberculosis. The most neglected diseases exclusively affect populations living in developing and least developed countries, such as sleeping

sickness (African trypanosomiasis), leishmaniasis, schistosomiasis, and Chagas' disease. A similar concept was created within the WHO, under the category of Type II and Type III diseases (WHO, 2012b), corresponding to neglected and most neglected diseases, respectively.

In 1999, in the context of the Global Forum for Health Research, the expression "10/90 gap" appeared (Global Forum for Health Research, 2000), meaning less than 10% of global investment in health research is dedicated to diseases that account for 90% of global diseases.

Considering this research gap existence, questions about the patent system effectiveness in the successful promotion of innovation mentioned by the TRIPS Agreement are frequent.

## **2 Addressing the challenges of access to medicines in multilateral level**

In this scenario, it remains evident that addressing the challenges of access to medicines demands efforts that often transcend the health area and require strong action by the state in discussions in different international forums.

In national level, "the Ministry of Health is the Federal Executive branch responsible for the organization and elaboration of plans and public policies aimed at the health care, promotion and prevention to Brazilians" (BRASIL, 2018a). Therefore, since much of the challenge of guaranteeing the constitutional right to health for all – including access to medicines – lies with them, it is their duty to engage in discussions in international level, issuing their position to ensure country's interests in public health agenda are preserved.

In this context, in the institutional framework of the Ministry of Health, the International Health Affairs Office (AISA) is the area responsible for "preparing the guidelines, coordinating and implementing the Ministry of Health's international policy, as well as preparing the Brazilian position on health issues debate in international level" (BRASIL, 2018b). Therefore, as a rule, the Ministry of Health's participation in the different multilateral forums involves AISA's coordination and monitoring.

### **2.1 World Health Organization**

At the WHO, for example, AISA sends its representatives to several WHO meetings, including to the WHO Executive Board (EB) and to the World Health Assembly (WHA), always provided with documents from the Ministry of Health technical areas and in coordination with the Permanent Mission of Brazil to the United Nations Office and other international organizations in Geneva.

In the last decades, WHA and EB meetings have been taken up by discussions on the issue of access to medicines, which have led to some initiatives. Among these, in the present article, we chose to discuss the Brazilian actions in the discussions regarding the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property and its participation in the Consultative Expert Working Group on Research and Development (CEWG).

### **2.1.1 Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property**

The Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (GSPA) (WHO, 2011) was an instrument adopted by resolution WHA61.21 (WHO, 2008), during the 61<sup>st</sup> World Health Assembly, and supplemented in the following year by Resolution WHA62.16 (WHO, 2009).

The initiative, resulting from the strong engagement of developing countries, including Brazil, emerged in the context of a highly polarized debate that had been established within the WHO between developed countries – advocating the primacy of intellectual property –, and developing countries – advocating access to medicines.

Regarding Brazil, we briefly recall the Brazilian role in the proposal of initiatives that preceded the approval of the GSPA. In January 2003, Brazil submitted to the WHO Executive Board a resolution proposal seeking greater involvement of the Organization, traditionally focused strictly on health issues, in the discussions concerning the impact of intellectual property rights on public health. This proposal eventually culminated in the adoption of resolution WHA56.27 (WHO, 2003), at the 56<sup>th</sup> World Health Assembly on May, 2003, which was the first resolution specifically focused on “Intellectual Property Rights, Innovation and Public Health”. From that point on, the Organization has officially become another venue for discussion and analysis of the issue of the impact of intellectual property on public health, from a perspective different from that practiced in the WTO until then.

From WHA 56.27, the “Commission on Intellectual Property Rights, Innovation and Public Health” was created and presented in 2006 a report (WHO, 2006), concluding the exclusivity conferred by intellectual property rights constitutes an incentive to innovation but it is ineffective in promoting access to affordable medicines as well as in promoting research and development (R&D) for drugs whose target audience is limited. The Commission also presented recommendations for improving this scenario. With the results presented in this report, on May, 2006, during the 59<sup>th</sup> World Health Assembly, Brazil and Kenya presented a proposal that resulted in the adoption of resolution WHA59.24 (WHO, 2006) on “Public health, innovation, essential health research and intellectual property rights: towards a global strategy and plan of action,”

requesting, among other measures, the establishment of an Intergovernmental Working Group on this matter, which would be responsible for drafting a document that later became the GSPA.

The GSPA is the result of an approach on access to medicines that, from years prior to its conception, as well as throughout its negotiation process, until its approval, had Brazil's active participation. It is an instrument that has emerged as a response to the impacts arising from the growing interface between the protection of intellectual property rights – especially patents – and public health, proposing that the WHO, within the limits of its attributions as the global coordinating authority for health, plays a central and strategic role in the relationship between public health, innovation and intellectual property.

The primary objective of the GSPA is to promote innovation in health and access to medicines in developing countries by establishing a detailed plan of action to address the challenges posed by the prevalence of diseases that affect these countries disproportionately. In order to do so, the Strategy was divided into eight elements: (I) prioritizing research and development needs; (II) promoting research and development; (III) building and improving innovative capacity; (IV) transfer of technology; (V) application and management of intellectual property to contribute to innovation and promote public health; (VI) improving delivery and access; (VII) promoting sustainable financing mechanisms; (VIII) establishing monitoring and reporting systems.

In the Plan of Action, the stakeholders responsible for carrying out each of the specific actions were identified and assigned in detail. These include the WHO, other international organizations (e.g. International Labor Organization, World Intellectual Property Organization and WTO), governments and non-governmental organizations.

Initially, a deadline for the instrument implementation was established up to 2015. However, in 2015, the 68<sup>th</sup> World Health Assembly adopted Resolution WHA68.18 (WHO, 2015th), which decided to: (1) extend the deadline for the implementation of the GSPA from 2015 to 2022; (2) extend the deadline for submission of the general review of the GSPA to 2018, on the occasion of the 71<sup>st</sup> World Health Assembly; (3) perform a Comprehensive Evaluation and, separately, an Overall Programme Review of the GSPA, as outlined in Document A68/35 (WHO, 2015b).

Regarding the adoption of this resolution, WHO member states and civil society organizations have delivered different interventions (CASSEDY, 2015) (ICTSD, 2015) (SPS, 2015). Brazil, for example, reiterated the importance of the GSPA, which it referred to as a policy of “unlimited validity” but stressed the need to establish a deadline for its implementation and stated the extension until 2022 would be important. Some African countries mentioned the current limited use of TRIPS Agreement flexibilities and suggested the intensification technical cooperation. Non-governmental organizations such as Medicus Mundi and Third World Network praised GSPA's pioneering spirit

but criticized the slow pace of its implementation. *Médecins Sans Frontières* expressed its support to the 2022 deadline extension and highlighted the important role that the GSPA can play in guaranteeing access to health innovation, as long as it is implemented in full and in a proper manner.

With the beginning the review process, the Comprehensive Evaluation (WHO, 2017b) was carried out by an independent evaluator external to WHO (Canadian company Capra International) and was accompanied by an *ad hoc* group selected to assist the process, composed of six experts independent and external to WHO and two experts from the United Nations Evaluation Group.

On January, 2016, the 138<sup>th</sup> WHO Executive Board discussed the document (WHO, 2016), in which the WHO Secretariat compiled the first considerations made by those responsible for the assessment of the GSPA, containing methodological issues to be adopted in the context of the evaluation of the implementation of the GSPA, including the availability of an online survey and the carrying out of case studies in different countries. In 2016, this survey was made available online to the stakeholders mentioned in the GSPA, such as WHO member states, civil society, charitable foundations, national and international research institutions, academia, among others.

AISA sent its replies to the survey and received a consultant appointed by the WHO on a mission to carry out a case study in Brazil, as in 14 other countries. To carry out the case study, documents were made available and meetings were held with GSPA stakeholders, according to the strategy's criteria. Ministry of Health representatives, the Brazilian Health Regulatory Agency (Anvisa), Oswaldo Cruz Foundation (Fiocruz), Pharmaceutical Research Industry Association (Interfarma), Drugs for Neglected Diseases Initiative (DNDi), Brazilian Interdisciplinary AIDS Association and the organization *Médecins Sans Frontières*.

Once the evaluation was completed, it was presented in 2017 to the 140<sup>th</sup> WHO Executive Board. Brazil praised several aspects of the document, in particular for reporting the lack of a sustainable mechanism for coordinating the research and development of medicines for diseases primarily affecting developing countries.

On May, 2017, the Comprehensive Evaluation was presented to the 70<sup>th</sup> World Health Assembly. At that time, Brazil expressed criticism as to the generality of the information and the lack of qualitative data and expressed the external consulting report presented conclusions that could be interpreted as if the usefulness of the GSPA had been exhausted contradicting Brazilian interests in this matter. Finally, Brazil pointed out this report had disregarded important documents, such as the report of the "UN Secretary-General's High-Level Panel on Access to Medicines" (UN, 2016).

Non-governmental organizations such as Knowledge Ecology International (KEI) and *Médecins Sans Frontières* (MSF), both internationally praised in the context of the access to medicines movement, also criticized the evaluation results (SAEZ, 2017). KEI

noted the report did not mention the concept of delinkage between the cost of R&D and the price of medicines. MSF criticized points in the report that could be considered “vague at best and deliberately obscure in the worst possible scenario.” The Peoples’ Health Movement highlighted the failure to mention the threat of bilateral/regional agreements to the use of the TRIPS flexibilities, and stated the assessment results did not present any new or useful insights, bringing up only issues that have already been repeatedly reaffirmed as obstacles to the implementation of the GSPA, such as the lack of promotion of the instrument by the WHO Secretariat and the underfunding of activities related to its implementation (GENEVA GLOBAL HEALTH HUB, 2017).

The Overall Programme Review was not primarily intended to be an evaluation exercise, but a general policy review, in which a panel of 18 experts would be able to – after considering the results of the Comprehensive Evaluation, together with other relevant technical/managerial aspects – point out what needed to be improved and modified in the next stages of the GSPA.

Regarding the Panel of Experts, WHA68.18 (WHO, 2015a) requested its establishment to conduct the general review of the mechanism, inviting member states to appoint experts. Brazil appointed – who was later effectively chosen by the WHO – Claudia Inês Chamas, a researcher at Fiocruz and actively involved in issues of intellectual property and access to medicines, both nationally and internationally.

During 2017, the Panel of Experts held several meetings and briefings in Geneva. Likewise, on June 2017, it provided an online survey, so that interested parties could offer contributions to the review, which was answered by the Ministry of Health, in a coordination between AISA and relevant technical areas.

In 2018, the Overall Programme Review report (WHO, 2018a) was presented to WHO’s 142<sup>nd</sup> Executive Board, recommending the strategy be maintained with a leaner plan of action, owing to one of the major criticisms of the GSPA was in relation to the original plan large scope and “ambition”. There has been intense discussion on the implementation of the recommendations that the Panel of Experts has identified as priorities. Equally, the polarization between developing and developed countries was once again evident. Especially the recommendations on transparency in the pricing of pharmaceuticals, as well as on the delinkage between R&D costs and drug sales prices, encountered particular resistance from the USA, UK and Switzerland.

At the end, the Executive Board adopted a decision to distinguish, among the 33 experts’ recommendations, those that would be addressed to the WHO Secretariat and those that would depend on the action of the member states. As for the first category, it was decided Director-General of the WHO should implement them consistently with the GSPA and, in relation to the second category, Member States should implement them according to their national contexts. Restrictions were made to three recommendations on which there would be a need for further discussions: on transparency; on the

allocation of 0.01% of the GDP for R&D in health issues of interest of developing countries; and on shortage of medicines and vaccines. According to the Secretariat's opinion, the latter recommendations innovate in relation to the GSPA approved by the Member States in 2008 and should therefore be treated differently from those other 30.

In 2018, the decision of the EB was presented (WHO, 2018b) to the 71<sup>st</sup> World Health Assembly, together with the consolidated report of the GSPA review, and ratified (WHO, 2018c) by WHO member states, in line with the decision of the WHO Executive Board. Also, a deadline has been set for the Director-General of WHO to submit to the 73<sup>rd</sup> World Health Assembly in 2020 a progress report on the implementation of the adopted decision.

### **2.1.2 Consultative Expert Working Group on Research and Development (CEWG)**

Considering the actions proposed in the context of the GSPA approved in 2008, in particular to item VII – “Promoting sustainable financing mechanisms” – it was created a Working Group on Research and Development: Coordination and Financing (EWG). The expert group has emerged as a response to concerns about insufficient resources being globally allocated for R&D of drugs to treat neglected diseases. Its purpose consisted in examining R&D investments as well as analyzing proposals for new and innovative funding to stimulate R&D related to Type II and Type III diseases as well as the specific R&D needs for Type I<sup>2</sup> diseases affecting developing countries (WHO, 2012b). In 2010, the EWG presented the final report to the 63<sup>rd</sup> World Health Assembly, which was considered by WHO member states an insufficient document in several respects.

In this context, Resolution WHA63.28 (WHO, 2010) was adopted, establishing the CEWG – whose purpose would be to continue and deepen the analysis EWG carried out – aiming at promoting new thinking about innovation and access to medicines, unlike the traditional R&D logic, based on purely commercial interests, giving relevance to the problem of the research gap of medicines for neglected diseases. From the outset, the group launched a call for proposals for R&D aligned with the goals of the CEWG. Regarding the components of the CEWG expert group, on April, 2011, the Norwegian John-Arne Rottingen was elected president, and the Brazilian Claudia Inês Chamas, from Fiocruz, vice-president.

During the 65<sup>th</sup> AMS on May, 2012, the final CEWG report was presented (WHO, 2012a), adopted after intense discussion. The document offered the group's analysis

<sup>2</sup> Type I: incidence in rich and poor countries, with large numbers of vulnerable populations in both.  
Type II: incidence in rich and poor countries but with a significant share of cases in poor countries.  
Type III: massive or exclusive incidence in developing countries.

of proposals for new, innovative and sustainable R&D funding mechanisms for the specific health needs of developing countries. Also, the group's recommendations were listed, among which the following stand out: open knowledge innovation (research and innovation mechanisms that generate free use knowledge); patentpools; alternative financing mechanisms; delinkage between R&D costs and final product prices; pooled funding; and open licensing.

Since then, discussions have followed, based on the recommendations made by the CEWG and on other proposals for R&D coordination and sustainable financing to meet the health needs of developing countries. Several regional and multilateral meetings were held aiming at promoting a dialogue on the proposals the experts suggested.

On May, 2013, as part of the 66<sup>th</sup> World Health Assembly, a new resolution (WHO, 2013) was approved endorsing the implementation of R&D health projects aligned with GSPA and the recommendations made by CEWG.

Following the process of implementing the recommendations, discussions started to take place within the WHO, and concrete actions started, including periodic calls for selection and financing of demonstration projects based on the principles of funding sustainability and delinkage, as the group recommended.

On November 2014, the Brazilian demonstration project of schistosomiasis vaccination – a parasitic disease directly related to precarious sanitation that infects around 200 million people in the world and which, in Brazil, is present in 19 states, especially in the Northeast Region, in Minas Gerais and in Espírito Santo (FIOCRUZ, 2016), entitled “Development of a Vaccine against Schistosomiasis based on the recombinant Sml4, a member of the fatty acid binding protein: controlling transmission of a disease of poverty”, elaborated by Fiocruz, was selected and validated by a group of experts. The project reached a maximum score, receiving one of the highest evaluation rates by the WHO.

On January, 2015, during the 136<sup>th</sup> WHO Executive Board, the Brazilian project was presented as reviewed and considered for follow-up. At the same time, besides the Swiss and Norwegian delegations, the Brazilian Ministry of Health announced the contribution of US\$ 1 million to the joint implementation fund for the demonstration projects, to be managed by the Special Programme for Research and Training in Tropical Diseases (TDR). The TDR is an independent global scientific collaboration program established in 1975 and co-sponsored by the United Nations Children's Fund (UNICEF), the United Nations Development Program (UNDP), the World Bank and the World Health Organization (WHO). The TDR aims at helping coordinate, support and influence global efforts to address a range of serious diseases affecting poor and disadvantaged populations.

In 2016, CEWG released US\$ 400,000 to produce the vaccine, which made it possible to carry out phase II clinical trials (in humans) in an endemic zone in Senegal. Now, Fiocruz is waiting for new funding for a new phase of clinical trials in school children in Senegal and in an endemic area in Sergipe.

However, the CEWG suffers from chronic underfunding, which represents an obstacle to the project continuity. In 2018, the WHO reported, while recognizing the project relevance – which will remain in the CEWG's demonstration list – it can no longer provide resources to support the project.

## 2.2 World Trade Organization

In the context of the WTO, since the issue of access to medicines has also been raised in the discussion venues of the trade agenda, Brazil's participation has been active, both defensive and offensive.

On January, 2001, Brazil was urged to position itself, after the US requested the establishment of a panel with the WTO Dispute Settlement Body (WTO, 2001), alleging article 68 of the Brazilian Industrial Property Law, dealing with the compulsory licensing of patents, would contradict the TRIPS Agreement. At the time, the Minister of Health of Brazil responded:

Continuing the panel would be detrimental to both countries. To Brazil, because it would threaten its policy for producing generic AIDS drugs and other products. And to the USA because, of course, the global public opinion is on our side (BRASIL, 2001a).

Also, in his speech (BRASIL, 2001b) given at 54<sup>th</sup> World Health Assembly on May, 2001, the Minister of Health of Brazil advocated the respect by the Brazilian laws and public policy to the internationally agreed standards. He emphasized the successful Brazilian AIDS program was only possible as a result of policies implemented with “due respect to the international commitments Brazil assumed in the World Trade Organization.” He also defended the policy of national production of generic medicines as an effective measure for the reduction of drug prices and reiterated the Brazilian positioning on the primacy of the right to health over commercial interests, in the following terms:

[...] Brazil cannot place the health of its population at risk by waiving the safeguards determined in national and international legislation, for these safeguards are the last barriers to transformation of intellectual property into an absolute and unconditional right, subject to monopolistic abuse. (BRASIL, 2001b)

He took the opportunity to meet the US Secretary of Health and discuss the differences between the two countries within the WTO. During the meeting, the Brazilian Minister of Health mentioned aspects of Brazil's fight against the pharmaceutical industry's pricing policy and took the opportunity to suggest the withdrawal of the panel the US opened against Brazil with the WTO. After a few months of negotiations between Brazil and the United States, the US government decided in June 2001 to withdraw the complaint filed against Brazil with the WTO.

In addition to the need to adopt a defensive stance, Brazil has started to plead, in constant coordination with other developing countries, offensive interests with the WTO, in particular to reaffirm the importance of full use of the flexibilities contained in the TRIPS Agreement, as well as the need for a balance between intellectual property rights and public health interests, such as ensuring access to medicines.

That same year, at the 4<sup>th</sup> WTO Ministerial Meeting in Doha, the African countries group, with the support of countries as Brazil, presented a proposal for a declaration on the TRIPS Agreement and Public Health. This proposal was approved and became known as the Doha Ministerial Declaration on TRIPS and Public Health (WTO, 2001b), adopted on November 14<sup>th</sup> 2001. The Doha Declaration reaffirmed the commitment made through the TRIPS Agreement but recognized concerns on the effects of intellectual property protection on prices of medicines and reiterated the right to use the flexibilities contained in the TRIPS Agreement with the aim of protecting public health, in the following terms:

We agree that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm 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. In this connection, we reaffirm the right of WTO members to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose. (WTO, 2001b).

These flexibilities include: compulsory licensing (TRIPS Article 31), parallel import (TRIPS Article 6), experimental use (TRIPS Article 30), "Bolar" exception for scientific research purposes (TRIPS Article 30) and action of the health sector in pharmaceutical patent application processes (TRIPS Article 8). In this regard, in 2007, when Brazil was unable to afford the high cost of purchasing efavirenz for antiretroviral HIV treatment, Brazil declared compulsory licensing of the drug.

### 3 Initiatives to address the challenges of access to medicines in regional level

Besides addressing the challenges of access to medicines in multilateral level, there are other strategies that can be adopted to ensure countries can provide their citizens with access to medicines.

Such strategies can be adopted at the regional level – such as the initiative for joint negotiation of high-cost medicines among Mercosur member states and associates. It is a practice endorsed and encouraged by the Pan American Health Organization (PAHO), particularly from Resolution CD55.R12 (PAHO, 2016), adopted at the 55th Directing Council of PAHO. The initiative consists in the negotiation of a higher volume of purchased medicines, adding up the demands of several countries in the area to get a price reduction. It should be noted, in national level, the Brazilian Ministry of Health makes use of the government purchasing power to obtain centralized procurement of certain medicines in major quantities to get lower prices and thus guarantee the supply of the national demand by the states and municipalities under SUS.

The idea of a joint regional negotiation came in 2015 when representatives from the Ministries of Health in South America found a large disparity in the prices of medicines offered by the pharmaceutical industries to each country in the area. In this scenario, it was verified that countries that purchased smaller volumes of medicines had less affordable prices than those that purchased larger volumes.

Thus, in an effort to align the positioning of South American countries to consider access to medicines and public health concerns as a priority – which was officially declared at the 37<sup>th</sup> Meeting of Ministers of Health of Mercosur and Associated States, on June 11<sup>th</sup>, 2015 – the Ministry of Health of Brazil, by means of an articulation between AISA and the relevant technical areas, coordinated the “joint negotiation” initiative within the *Ad Hoc* Committee for the Negotiation of Prices of High-Cost Medicines in Mercosur States and Associates, in partnership with the PAHO Strategic Fund, to the purchase of medicines of interest to the countries of the region at more affordable prices. It was agreed to call it a “joint negotiation” instead of “joint purchasing” because only the price would be agreed upon jointly, while the acquisition of the medicines would be made subsequently by the country with PAHO.

On November 2015, a negotiation round concerning the HIV/AIDS medicine darunavir and concerning the medicines sofosbuvir, daclatasvir and simiprevir for the treatment of hepatitis C.

At the end of the round, for darunavir, an Indian pharmaceutical company offered to sell it for US\$ 1.18 per pill. It is worth mentioning that, for Brazil, which already had one of the lowest prices of the bloc, in the amount of US\$ 2.98 per unit, the reduction achieved savings of approximately 50%, or US\$ 14.2 million. As a comparison, it should

be noted that, at the time, Uruguay paid US\$ 6.85 per pill, and Chile paid US\$ 7.36 per pill. Also, there was a spillover effect as a result of this negotiation, given that the price obtained became the lowest in the world and became a reference for acquisitions made by the Global Fund to Fight AIDS, Malaria and Tuberculosis. However, in relation to darunavir, it must be recognized, despite the relevant achievement of price reduction, Brazil had to make an emergency purchase from its previous supplier, at higher prices, due to procedural delays in the purchase conclusion.

Concerning sofosbuvir, the joint negotiation resulted in a commitment by the drug manufacturer to guarantee the price sold to Brazil to the other MERCOSUR countries, in the amount of US\$ 93.90 per pill. To Chile, for example, the negotiation result represented enormous savings, considering the treatment price was reduced from US\$ 20,000 to US\$ 7,000.

Regarding daclastavir and simeprevir, the price obtained in the negotiation was above the price sold to Brazil, and, therefore, the negotiation was suspended. In any case, even so, the obtained price with these drugs was still lower than the one nationally offered to some countries in the region, such as Uruguay, and consequently would represent savings for them.

Despite the undeniable positive results, it should be noted the use of this mechanism may be relatively complex and requires technical knowledge and planning. Besides the pressure made by the pharmaceutical industry against the mechanism, some logistical, legal and regulatory barriers inherent to the process make difficult to carry out joint negotiation. Moreover, to the negotiation be beneficial to all participating countries, the list of medicines of interest to the negotiation should be strategically assessed.

In this context, some lessons learned from the first round of joint negotiation remain. As an example, it should be mentioned that, due to delays in delivery of medicines purchased in the last round, there was a risk of national supply shortages, which generated additional expenses for the Ministry of Health due to the need for emergency purchase. Therefore, it is very important to pay attention to the alignment of the deadlines for negotiations with national demands.

Finally, it can be observed the countries of the region evaluated the experience as successful, and there is great expectation for new rounds of joint negotiation of high-cost drugs within the South American bloc. The possibility of resumption of the strategy has been a recurring theme in the meetings of Mercosur Ministers of Health, and the possibility has been suggested that future rounds aim to the joint negotiation of cancer drugs.

## 4 Final Considerations

Brazil's international action on the issue of access to medicines has been remarkable over the last years. Aligned with other developing countries, the country has played a leading role and, foremost, consistently in expressing its position on the issue of access to medicines in different international forums it participates.

The strong Brazilian position in the defense of access to medicines should not be a surprise. In fact, it is in full compliance with the provisions of its Constitution, which recognizes health as a right of all and a duty of the State, including, in this context, guaranteeing access to medicines.

In this regard, it should be noted that, despite the possible failures and difficulties faced by Brazil in maintaining the Unified Health System (SUS), the reality is that about 70% of the Brazilian population – approximately 150 million people – rely exclusively on SUS for access to health services, and consequently to the medicines necessary to treat their illnesses. Therefore, aiming at the sustainable maintenance of the public health system, it is incumbent upon the Brazilian State, in addition to implementing the relevant public policies in national level, to be able to act on the international scenario in favor of national public health interests. Precisely in this sense, Brazil has stepped up in facing the challenges to provide access to medicines.

In this context, as this article – which, it should be emphasized, was not intended to exhaust the theme, but only to present some examples of Brazil's international action on the subject of access to medicines – sought to demonstrate, the International Health Affairs Office of the Ministry of Health has been a key participant in recent years in the construction and defense of the Brazilian position regarding the issue. This action has taken place in several ways, by sending representatives to the relevant meetings, drafting documents to propose multilateral initiatives, and coordinating with Ministries of Health in other countries to carry out joint projects and adoption of common positions in multilateral venues.

The Ministry of Health has played an active role in the discussions that have been held in recent years in the various multilateral forums – such as the WHO and the WTO – in particular regarding the potential impacts of the protection of intellectual property on public health. At the WTO, the Ministry of Health has been both defensive and offensively defending the use of the TRIPS flexibilities. In relation to the WHO, the country's role in the design and implementation of initiatives as relevant as the GSPA and the CEWG remains evident.

However, to rely only on the tradition or the Brazil's historical role of in the defense of access to medicines is not enough. It is necessary to constantly work to reaffirm, before the international community, the principles that have guided the Brazilian positioning for the primacy of the right to health over commercial interests

as a State policy. More than ever, it is imperative that the Ministry of Health has the necessary pulse and empowerment to maintain this position, especially when facing the unrelenting pressure exerted both in multilateral forums and bilaterally by developed countries, whose interests are often distinct from ours.

At regional level, the initiative for joint negotiation of high-cost medicines in Mercosur member states and associates is a good example of a mechanism to address the challenges of access to medicines due to high prices. The price reduction obtained from the negotiation carried out in 2015 demonstrates the great potential of this type of strategy.

Undoubtedly in South America, Brazil's active participation in the process is critical, not only because of its technical expertise in negotiating with the pharmaceutical industry but also because the volume of acquisitions in Brazil, which when jointly negotiated, generates significant price reductions for the other countries in the region.

Regarding specifically the joint negotiation round that took place in 2015, the only one so far, the outcome has undoubtedly been positive – given the undeniable benefit of price reductions, which has even transcended the borders of South America, as observed with the spillover effect on the Global Fund – as well as nurtured the countries' expectations in the region regarding the carrying out of other rounds. However, the implementation of this mechanism may be relatively complex and therefore requires careful evaluation of logistical aspects and possible legal and regulatory barriers that cannot be ignored.

In addition to working at multilateral forums and implementing strategies in regional integration contexts, Brazil's role in addressing the issue of access to medicines has a clear potential for expansion among developing countries with similar interests, realities, and challenges. Within BRICS group (composed by Brazil, Russia, India, China and South Africa), favorable conditions and still unexplored cooperation perspectives in R&D and other initiatives can be envisaged in the area of access to medicines, especially for the establishment of technological partnerships for research, development and joint production of medicines for communicable, non-communicable, and neglected diseases affecting particularly the BRICS and other developing countries. AISA might continue to contribute to identifying possibilities and opportunities leading to concrete initiatives that may mutually strengthen the access to medicines as a public health policy within the scope of SUS and as an instrument of Brazilian foreign affairs policy.

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# Antimicrobial Resistance: Multilateral approach and the Brazilian response

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## Abstract

The text presents an overview of how a multilateral approach tackles antimicrobial resistance also the main Brazilian strategies in the area. Regarded as a global issue for health systems, antimicrobial resistance mobilizes several international organizations, industries, academia, and governments. In addition to presenting the ramifications of the subject on the international agenda and the role of the International Affairs Health Office in the discussion process and regulatory formulation of this matter, the paper addresses the main challenges related to drug resistance in Brazil.

**Keywords:** Human Health. Antimicrobials. Antimicrobial Resistance (AMR). Multilateralism.

## 1 Introduction

Antimicrobial resistance (AMR) is considered a challenge to contemporary health systems<sup>2</sup>. Seven hundred thousand deaths are estimated antimicrobial resistance caused on an annual basis<sup>3</sup>. According to these analyses, without changing the approach to contain the problem, until 2050 AMR may cause more deaths than cancer<sup>4</sup>.

The class of antimicrobials includes natural (antibiotic) or synthetic (chemotherapeutic) substances that act on microorganisms to inhibit their growth or eliminate them. (SÁEZ-LLORENS, 2000). Antimicrobials are one of the most prescribed and dispensed drug classes for therapeutic and prophylactic use.

The World Health Organization (WHO) defines AMR<sup>5</sup> as the “ability of a microorganism to prevent the action of an antimicrobial agent”. As a result, treatments

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<sup>1</sup> Graduated in Social Work and a master's degree in Social Policy, both from the *Universidade de Brasília*. She also holds a specialization degree in Management of Tuberculosis Programs from National School of Public Health ENSP / Fiocruz,

<sup>2</sup> O'Neil J., *The Review on Antimicrobial Resistance*. “Tackling a crisis for the health and wealth of nations”. London, UK, 2014.

<sup>3</sup> The term “antibiotic” refers to substances produced by fungi and bacteria that are capable of fighting infectious microorganisms in the body. Penicillin, for example, is an antibiotic synthesized by fungi of the genus *Penicillium* synthesized, having a bactericidal role. Currently, the substances that inhibit microorganisms produced by the pharmaceutical industry are mostly artificially manufactured chemotherapeutic agents. The term “antimicrobial” encompasses both antibiotics and chemotherapeutic agents.

<sup>4</sup> O'Neil J., *The Review on Antimicrobial Resistance*. Tackling Drug-Resistant Infections Globally: Final Report and Recommendations” UK, 2016.

<sup>5</sup> World Health Organization. “Antimicrobial resistance: global report on surveillance” 2014.

become ineffective and infections, persistent and even incurable. Some resistance characteristics also apply to drugs used for treating viral, parasitic or fungal infections <sup>6</sup>.

One of the existing barriers to fighting AMR is the lack of innovation: the development of new health technologies has not kept pace with the adaptation of microorganisms. Furthermore, the number of laboratories and companies in the pharmaceutical industry that invest in research on new antimicrobials has been declining over the years due to low profitability. The recent shortage of penicillin that has affected several countries, including Brazil, can be mentioned as an example. Since this is a drug with low financial return, few companies are interested in its production. The result has been the resurgence of diseases such as syphilis, which was under control as a public health problem a few years ago, and a significant increase in cases of the disease has been observed in Brazil over the last years. The cases of syphilis in adults increased by 27.9% from 2015 to 2016 in Brazil. Among pregnant women, the increase in cases was 14.7%. Congenital syphilis infections, transmitted from the mother to the baby, increased by 4.7% <sup>7</sup>. A large part of the drugs currently used for the treatment of endemic diseases in developing countries, such as Chagas' disease, schistosomiasis, leprosy, leishmaniasis and tuberculosis, have a low production and marketing cost, and for this reason they have attracted increasingly less interest from the pharmaceutical industry.

Antimicrobial resistance also relates to economic loss due to decreased productivity. According to the British economist Jim O'Neill<sup>8</sup>, until 2050, ten million annual deaths will be attributed to antimicrobial resistance. In accordance with the same study, the impact on global economy will be approximately one hundred trillion dollars. The economic and financial estimates, however, take only one side of the problem into account.

For health services, the main consequences from antimicrobial resistance are an increase in the morbidity and mortality<sup>9</sup> of diseases that were previously treatable with antibiotics or antimicrobial chemotherapeutic agents. In addition, the possible return of infectious diseases such as yellow fever, dengue, Chagas' disease, schistosomiasis, leprosy, leishmaniasis, malaria and tuberculosis also stands out. Mutations in microorganisms have led to greater resistance of parasites and agents causing these and other diseases that pose serious public health problems, especially in more vulnerable

<sup>6</sup> The WHO Global Action Plan on AMR broadly covers antibiotic resistance and refers, where appropriate, to action plans for viral, parasitic and bacterial diseases, including HIV/AIDS, malaria and tuberculosis.

<sup>7</sup> Brazil. Ministry of Health – Secretariat of Health Surveillance – Department of Surveillance, Prevention and Control of Sexually Transmitted Disease, HIV/AIDS and Viral Hepatitis. Epidemiological Bulletin – AIDS and STD 2017.

<sup>8</sup> O'Neill J., 2016, op. cit.

<sup>9</sup> Morbidity refers to population's acquisition of diseases. Mortality refers only to cases in which the disease leads to death.

populations, increasingly thwarting their control. Furthermore, the extension of hospital stay, the low effectiveness of prophylactic therapies and the increased costs of treatment create a substantial financial impact on health systems and individuals (CASTRO, 2002). Thus, the fight against AMR has a direction connection with social, economic and geographical inequalities in the access to healthcare.

In 2014, AMR was recognized as a threat to international sustainability and development efforts by the United Nations General Assembly. The problem also threatens the reach of the Sustainable Development Goals (SDG), especially the one that intends to “ensure healthy lives and promote well-being for all at all ages” (SDG). Target 3.3 of the SDG shall, “by 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases”<sup>10</sup>, many of which AMR affected.

Recognizing these different facets of the problem AMR caused, international organizations, countries, academia and the productive and technological sectors have mobilized to combat it at different levels of activity. In 2015, the WHO Member States endorsed the “Global Action Plan on Antimicrobial Resistance”, organized in collaboration with the United Nations Food and Agriculture Organization (FAO) and the World Organization for Animal Health (OIE). According to the text of the Global Action Plan, its goal

is to ensure, for as long as possible, the continuity of the successful treatment and prevention of infectious diseases responsibly using effective, safe, quality-assured drugs that are accessible to all of those who need them. Countries are expected to develop their own national action plans on antimicrobial resistance in line with the global plan.

To achieve this goal, the global action plan sets five strategic objectives: (1) to improve the awareness and understanding of antimicrobial resistance; (2) to strengthen knowledge through surveillance and research; (3) to reduce the incidence of infection; (4) to optimize the use of antimicrobial medicines; and (5) to develop the economic case for sustainable investment. These objectives can be met by implementing actions that are clearly identified by the Member States, the Secretariat and national and international partners in different sectors. The actions to optimize the use of antimicrobial medicines and renew investment in the research and development of new products must be accompanied with actions ensuring equal access and fair prices for those who need them.

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<sup>10</sup> Available at: <<http://www.un.org/sustainabledevelopment/sustainable-development-goals/>>.

With this approach, the main goal of ensuring the treatment and prevention of infectious diseases with safe, effective, quality drugs is attainable.<sup>11</sup>

Antimicrobial resistant bacteria can circulate between humans and animals through food, water and the environment. Their transmission can be influenced by trade, travel and human or animal migration. A multisectoral approach to the combat against resistance could be more effective than actions focusing only on human health, for example. The One Health Approach, which has been reflected in the design of the Global Action Plan, establishes the need for this multi-sectorial engagement in order to ensure that the issue be addressed from the combined perspectives of human, animal and environmental health.

The recent global call for the combat against AMR, expressed in multilateral forums and some countries embraced as part of their active foreign affairs agenda in the areas of human and animal health, has led a few governments, especially in developed countries, to formulate strategies for the development of new antimicrobial agents. In general, this strategy tends to mostly benefit pharmaceutical companies in these countries, often concealing protectionist commercial interests under the guise of health defense. Consequently, a mismatch is seen today between the encouragement to develop new molecules, on the one hand, and the promotion of access to new and existing antimicrobial drugs on the other hand. In addition, while attention is drawn to the development of new diagnostic methods and medicines, it is imperative to discuss issues such as the cost of these new technologies and their impact on health systems.

The global combat against AMR goes on, posing challenges to the sustainability of global public health. Countries which, like Brazil, have the right to health enshrined in its Constitution are responsible for assuring that commercial interests will not supersede public health concerns. Internationally, Brazil has played an outstanding role in recognizing AMR as a public health issue and in defending multisectoral strategies to combat it, considering access to healthcare, particularly in developing countries, as a main course of action. The role played by the International Health Affairs Office (AISA), along with the pertinent technical areas in the Ministry of Health, in shaping the Brazilian position on AMR in the international forums in which the country participates is, therefore, closely connected to the defense of access to health as a right.

In face of this situation, this chapter intends to broadly present the development of the discussion on antimicrobial resistance from a multilateral perspective since 2011 and highlight Brazilian efforts in tackling this problem. To this end, the main frameworks in the international context and the actions the Brazilian government carried out in formulating the National Plan for Prevention and Control of Antimicrobial Resistance

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<sup>11</sup> Available at: <[http://www.wpro.who.int/entity/drug\\_resistance/resources/global\\_action\\_plan\\_eng.pdf](http://www.wpro.who.int/entity/drug_resistance/resources/global_action_plan_eng.pdf)>.

(PAN-BR) will be addressed, and the role of the AISA in these processes will be brought up.

## 2 Multilateral approach

According to WHO<sup>12</sup>, AMR develops with the growth and adaptation of bacteria in the presence of antimicrobial agents. Although this has been a natural phenomenon inherent in antimicrobials since their discovery by Alexander Fleming in 1928,<sup>13</sup> it may be potentialized by the inadequate use of these agents, by the low quality of medications, by an inefficient laboratory network, or even by poorly efficient infection prevention and control strategies<sup>14</sup>.

In 2011, during the “World Health Day”, WHO presented a package of policy strategies to combat AMR. The initiative, whose message was “*Combat drug resistance: No action today, no cure tomorrow*”<sup>15</sup>, was considered the blueprint for the Global Plan on AMR approved in 2015 and intended to engage civil society with the issue. Due to the fragility of both the information systems in the countries and the data on drug resistance conveyed to WHO, it was necessary to know the real magnitude of the problem among the Member States in order to formulate an effective strategy to fight it.

With this purpose, WHO started in 2013 a situational analysis including 133 countries to understand the profile and initiatives to tackle antimicrobial resistance. In the same year, the Organization set up a Strategic and Technical Advisory Group on antimicrobial resistance (STAG-AMR) comprising technical teams from each region, public health experts, observers, and representatives from international partner organizations. The group helped WHO’s director-general develop the strategic plan and priority activities to combat AMR, survey resistant pathogens and define the role of participating organizations. According to the report from the first STAG-AMR meeting<sup>16</sup>, the main guidelines for developing an “Action Plan on AMR” were listed. This was the blueprint for the Global Action Plan.

The publication of the document “Antimicrobial resistance: global report on surveillance”<sup>17</sup> in 2014 was the first attempt to present the extension of antimicrobial resistance worldwide. The WHO, with the collaboration and information from

<sup>12</sup> World Health Organization. Global Action Plan on Antimicrobial Resistance. 2015.

<sup>13</sup> Alexander Fleming; The Discovery of Penicillin. British Medical Bulletin, Volume 2, Issue 1, 1 January 1944, pp. 4-5. Available at: <<https://doi.org/10.1093/oxfordjournals.bmb.a071032>>.

<sup>14</sup> World Health Organization, 2015. Worldwide country situation analysis: response to antimicrobial resistance.

<sup>15</sup> World Health Day 2011: Policy briefs. Available at: <<http://www.who.int/world-health-day/2011/policybriefs/en/>>.

<sup>16</sup> Document available at: <[http://www.who.int/antimicrobial-resistance/publications/amr\\_stag\\_meeting-report0913.pdf?ua=1](http://www.who.int/antimicrobial-resistance/publications/amr_stag_meeting-report0913.pdf?ua=1)>.

<sup>17</sup> World Health Organization, 2014, Antimicrobial resistance: global report on surveillance 2014.

Member States, prepared the report focused on antibacterial resistance and indicated the existence of high resistance rates in all regions, claiming that we are living in a “post-antibiotic era”<sup>18</sup>.

The document showed the fragility of surveillance systems for antibacterial resistance and the existence of disjointed responses from the countries and the sectors involved, as well as gaps in the information on resistant pathogens that are significantly important to public health, such as *Escherichia coli*, *Klebsiella pneumoniae* and *Staphylococcus aureus*, which cause urinary tract infections, blood infections, and pneumonia.

During the 67th World Health Assembly (WHA) in 2014, the WHA Resolution 67.25, relative to antimicrobial resistance<sup>19</sup>, and the data presented by the recently published report pointed out the need for developing a global plan to curb the problem. A commitment was made to submit a global plan proposal to the 68<sup>th</sup> WHA, which, among other things, should present a multisectoral approach based on the One Health perspective.

The One Health approach is a world strategy the World Organization for Animal Health (OIE) adopted in the early 2000’s, for interdisciplinary and global collaboration among organizations concerned with human and animal health. The importance of this concept lies in the fact that the vast majority of emerging infectious diseases are zoonoses<sup>20</sup> (Conrad et al, 2013).

The One Health Concept relies on applying practices related to the prevention, surveillance and detection of zoonoses, as well as notifying these situations and establishing effective, timely responses. The concept also encompasses applications related to food innocuity and food security. Although this approach for animal health, it has a direct impact on human health and the environment.

Also in 2014, the United Kingdom created the Review on Antimicrobial Resistance, an initiative of the UK government in collaboration with Wellcome Trust – an English foundation that supports and invests in research and innovation in the areas of human and animal health. Since then, under the coordination of the review committee, ten independent studies have been published with a multisectoral focus, in which the economic and social impacts of AMR have been presented. In the reports, topics relative to access to new medicines, use of infection diagnosis, surveillance and control, alternative treatments and administration of antibiotics in agriculture are addressed, and the restriction on the use of growth promoters in agriculture and livestock farming is especially highlighted.

<sup>18</sup> Alanis AJ. Resistance to antibiotics: are we in the post-antibiotic era?, Arch Med Res, 2005, vol. 36, pp. 697-705.

<sup>19</sup> World Health Organization, 2014, Antimicrobial resistance: global report on surveillance 2014.

<sup>20</sup> World Health Organization, 2014. World Health Assembly Resolution WHA67.25

The use of antibiotics to accelerate the growth of animals intended for human consumption and its possible consequences for AMR and health is a matter of great importance for the agricultural sector in view of its potential economic impact. For this reason, from the perspective of some countries, any restrictions on the imports of meat from animals medicated with antimicrobials may constitute trade protection measures under the guise of sanitary concerns, if not based on scientific evidence. Therefore, it is necessary to find evidence to allow decisions to be made on this matter considering all its aspects, from sanitary to commercial. Hence the role played by the pertinent international organizations in this area is essential.

In 2015, on the eve of the 68th WHA, the WHO published the result of the situational analysis of the countries. The survey found that few countries had national multisectoral AMR plans and the nearly non-existent monitoring was pulverized and unsystematic. Other highlights: poor quality of storage, counterfeit medications, absence of minimum pharmacovigilance standards, and lack of action by regulatory authorities. Some countries also reported easy access of the population to antimicrobials, lack of restriction measures and prescription control, and nonexistent hospital infection prevention and control programs, which are important measures for AMR prevention.

In the face of this situation, during the 68th WHA, in 2015, the WHO Member States endorsed, by means of Resolution WHA 68.20, the “Global Action Plan to Tackle Antimicrobial Resistance”, WHO in partnership with FAO and OIE devised. The document sought to encourage Member States to formulate their respective national action plans until May 2017. The main objective was to ensure the continuity of the response in the treatment and prevention of infectious diseases using effective, safe medicines in an accessible, responsible way, prioritizing the One Health approach.

The strategical objectives of the Global Action Plan aimed at increasing awareness, promoting full knowledge of AMR, strengthening epidemiological surveillance, reducing the incidence of infections, optimizing the use of antimicrobial medicines in human and animal health, and ensuring sustainable investment for its implementation. To this end, to promote the engagement of civil society and a focus on prevention strategies and access to medicines. At the time, Brazil supported the adoption of gradual goals for the implementation of national plans and the prioritization of actions for access to medicines as a key strategy to ensure a full, effective approach to the problem.

Several initiatives are intended for tackling AMR on a multilateral basis. One of such initiatives which Brazil joined is the “Alliance of Champions against AMR”<sup>21</sup>. Set up in 2015, concomitantly with WHA, by proposal of the Swedish government, this coalition intended to engage governments and enhance the political treatment given to the issue. The group proposed holding a high-level meeting outside the United

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<sup>21</sup> Zoonoses are infectious diseases of animals transmitted to humans.

Nations General Assembly (UNGA), which eventually took place in 2016. Despite the heterogeneity of the countries in the group, which gathers nations at different levels of development and with different approaches to public health and AMR, Brazil supported the initiative, recognizing the need for promoting greater political commitment to the issue globally.

In 2016, the final report on AMR the British economist Jim O'Neill produced was published. The document drew attention to the global problem of AMR, proposed specific actions to deal with it and raised questions about public awareness at a global level, the pursuit of joint efforts, and international funding in the area. The report also addressed more sensitive topics, especially for developing countries, such as the supply of new medications to replace drugs to which there is resistance, a reduction in the extensive use of antimicrobials in agriculture, and the creation of a global innovation fund for investments. These are issues with potentially large impacts on developing countries because, when it comes to the development and supply of new medicines, there is a natural concern with their price. Dissociating R&D costs from prices and sales volume is hence crucial to facilitating fair access at reasonable prices to new medicines, vaccines and diagnostics. This point of view, however, does not find consensus, especially among developed countries with a large pharmaceutical industry.

As far as the development of new medications is concerned, Brazil has pointed out, in its official statements, the importance of associating innovation, investment and access, as advocated by the Unified Health System (SUS). In addition, the use of innovative funding and investment mechanisms should be oriented not only to the production of new antimicrobials, since the development of new vaccines, technologies, diagnostic methods and other elements aimed at reducing or rationalizing the demand for antimicrobials is also of paramount importance. In this regard, it is necessary to consider the SUS access to medicines policy and the national positions on this issue<sup>22</sup>. Furthermore, the importance of the populations, especially the most vulnerable ones, having access to these elements in order to tackle AMR must be considered. From the Brazilian perspective, the discussion on access should contemplate not only the financial difficulties in procuring antimicrobials, but also other types of restrictions, such as shortage and all sorts of inequalities in the access to healthcare: social, economic, ethnic/racial, gender, geographic, among others.

The document from the UK different international organizations and governments were welcome and became a reference for the adoption of different initiatives related to this issue, especially in European countries. However, the scientific evaluation of the potential impacts of the proposed measures still stirs controversy in different

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<sup>22</sup> The group includes South Africa, Germany, Australia, Canada, China, South Korea, United States, Finland, Japan, Mexico, Norway, Netherlands, Pakistan, United Kingdom, Sweden, Thailand, and Zambia.

countries. For the Brazilian farming sector, for example, the express recommendation for discontinuing the use of all antimicrobials in the sector encounters resistance, as it contrasts with the strategy the OIE adopted on this matter, which provides for the responsible and prudent use of these inputs, without vetoing its indiscriminate use.

There is evidence in the specialized literature generally recognizing that the use of antimicrobials is one of the key factors in generating and enhancing AMR in humans and in animal production. Brazil has argued that scientific evidence-based risk analyses should be used to establish what antimicrobials have the greatest potential for generating AMR, the specific mechanisms whereby the AMR development process takes place and the impact of those measures on human and animal health. The Brazilian government has gradually eliminated the use of some antimicrobials based on the list of medicines renowned international organizations, such as WHO, FAO, OIE and Codex Alimentarius created that assess the harmful effects arising from the use of these substances as growth promoters in animals.

Since 2016, the European Union has banned the use of antimicrobials as growth promoters in agriculture. The European Union is the leading food importer in the world, although a significant part of the food imported by its members comes from other European countries. For this reason, any European restriction on imports from external markets that keep using additives of this type may be regarded as favoring European producers. The boundaries between alleged health reasons and the protection of commercial interests are therefore blurred. Their precise outline still needs robust scientific evidence.

In the context of the new approach of the European countries, several R&D projects for the implementation of new drugs were designed with the European pharmaceutical industry. The bloc, which has relied on antimicrobial resistance actions since 2011, is in the second stage of its plan to tackle AMR, covering the period from 2017 to 2022. The European strategy involves issues such as environment, agriculture, R&D, and global cooperation, including a specific agenda for developing countries, especially in Latin America.

In order to reaffirm the political significance of AMR and as a result of the mobilization of the “Alliance of Champions against AMR” member countries, the United Nations High-Level Meeting on Antimicrobial Resistance was held concomitantly with the 71st UNGA. The event, the United Kingdom organized and South Africa, Argentina, Australia and Kenya co-sponsored, intended to engage governments, industry, academia and civil society in the combat against AMR, reinforcing the importance of the One Health approach and pointing out the need for ensuring access and development of new antimicrobials. At the time, the directors-general of WHO and FAO expressed their stance against the use of growth promoters by the agricultural sector. Despite the emphasis in a large part of the speeches delivered at the event, no

direct references to a reduction in the use of additives of this kind were included in the political declaration adopted on the occasion<sup>23</sup>.

AISA followed up and took part in the preparation of the instructions that guided the Brazilian position in the negotiation of this declaration in partnership with the competent technical staff in the Ministry of Health and in coordination with the Ministry of Foreign Affairs (MRE), the National Sanitary Surveillance Agency (Anvisa), and the Ministry of Agriculture, Livestock and Supply (MAPA). Bearing in mind the traditional defense of the access to medicines as a State policy embraced within the SUS, the action of the Ministry of Health focused on adopting a position that enshrined the five objectives of the Global Plan as simultaneous lines of action, prioritizing access to health and the special attention given to the needs of developing countries in tackling AMR. Brazil's position in the negotiation was based on the following general principles:

1. strengthening of the multilateral processes in progress, reaffirming the Global Action Plan and its implementation process as institutional guidelines for international action in this area;
2. importance of the articulation between WHO, FAO and OIE to tackle the issue;
3. recognition of the influence of social health determinants, especially those related to challenges to development, on the national capability to respond to AMR;
4. supporting the development of national AMR plans in line with the strategic objectives of the Global Action Plan and the One Health multisectoral approach, focusing on international cooperation;
5. balance between the discussion on the preservation of antimicrobial effectiveness, including control of antimicrobial use, and the guarantee of access to medicines and quality health services<sup>24</sup>;
6. balance in promoting the development of new drugs, vaccines, prevention methods, and diagnostic tools;
7. defense of the dissociation between R&D costs, on the one hand, and final costs of new technologies, on the other;
8. need for initiatives on the control of antimicrobial use in animal health to be based on scientific evidence.

One of the results of the political declaration from the AMR meeting was the creation of the Interagency Coordination Group on Antimicrobial Resistance (IACG), which was organized to enhance the coordination among international organizations

<sup>23</sup> About this topic, refer to the chapter "The international action of the Ministry of Health in the issue of access to medicines" by Roberta Vargas de Moraes.

<sup>24</sup> United Nations, 2016. Political Declaration of the high-level meeting of the General Assembly on antimicrobial resistance. New York, USA.

in the global response to AMR. The president of Anvisa, Jarbas Barbosa, was the only expert from South America who joined the group. The IAGG will prepare a report for the UN secretary-general to be presented to the UNGA in 2018.

The High-Level Meeting also addressed issues related to the Global Action Plan, especially the inadequate use of antimicrobials, the lack of awareness in prescribing antibiotics, and the importance of developing more efficient diagnostic methods and new vaccines for disease prevention. The completion of National AMR Plans was also discussed, and the commitment of the countries to completing their formulation was reinforced.

In view of the shy engagement of the countries in organizing strategies to tackle AMR, by the end of 2016, WHO, FAO and OIE published a manual to support the development of national AMR plans<sup>25</sup>. Created to enable and encourage the participation of different sectors, the manual was based on the One Health approach and, in line with the Global Action Plan, stressed that local specificities should be considered, in addition to highlighting the importance of optimizing resources and pre-existing activities for AMR control.

Until December 2017, 55 of the 194 WHO Member States had completed their national AMR prevention plans<sup>26</sup>. In the region of the Americas, only Argentina, Barbados, Canada, Peru and USA had presented their plans that date. Although the National Antimicrobial Resistance Prevention and Control Plan (PAN-BR) has already been finalized, Brazil still awaits the completion of the administrative proceedings by the ministries involved for its formal submission to WHO. Despite this, a few actions PAN-BR defined are already in progress and will be detailed in the second part of this article.

In addition to providing technical support for the development of National Plans to tackle AMR, WHO also supports different antimicrobial resistance initiatives within the organization. Some initiatives in this area are: the Global Antimicrobial Resistance Surveillance System (GLASS)<sup>27</sup>, the Global Gonococcal Antimicrobial Surveillance Program (GASP)<sup>28</sup>, the Global Antibiotic Research and Development Partnership

<sup>25</sup> In many developing countries, the main challenge is still the lack of access to medicines and quality health services. For this reason, excessively restrictive measures on production, distribution and sales without any guarantee of access may worsen this situation.

<sup>26</sup> WHO, OIE, FAO, 2016. "Antimicrobial resistance: A manual for developing national action plans"

<sup>27</sup> Available at: <<http://www.who.int/drugresistance/action-plans/library/en/>>.

<sup>28</sup> Created to support the Global AMR Plan, the system aims at collecting, analyzing and standardizing AMR data to contribute to decision making. In force between 2015 and 2019, GLASS reinforces the importance of producing robust scientific evidence to drive action at the local, regional and global levels. The tool also collects, organizes, and disseminates clinical, epidemiological and laboratory data on the pathogens that pose the greatest threats to global health. Brazil joined the system in December 2017 and must report the first data from the pilot project, operationalized in Paraná, in November 2018.

(GARDP)<sup>29</sup>, the Latin American Surveillance Network of Antimicrobial Resistance (ReLAVRA)<sup>30</sup>, the Stop TB Partnership<sup>31</sup>, among others.

Antimicrobial resistance has also been incorporated as a topic of discussion into other non-specific multilateral forums in the health sector, such as the G20<sup>32</sup>. Within the G20, in 2017, the German presidency set up a working group to discuss health issues in the group, and the AMR issue was added to the agenda. From the Brazilian perspective, the decisions on health issues of multilateral groups or forums, such as the G20, should be made in support of ongoing multilateral processes and multilaterally established mandates on these issues. The reason is that overlapping competencies between these forums and multilateral organizations, such as WHO, could not only weaken multilateralism as a global decision-making venue, but also lead to the adoption of consensus reached by small groups, in which developing countries have lower leverage and a lower relative political weight, and these consensus could later be multilateralized – which may virtually mean their imposition on other countries that did not participate in the decision, mostly to the detriment of developing countries.

As a result of this stance, AISA, as a representative of the Brazilian government in the G20 Health Working Group, has insisted on the need for the role of WHO and the multilateral processes to be strengthened as a path of action for the G20 work in healthcare. Within the G20, the agreement between the positions of the Ministries of Health in the BRICS has contributed to maintain this stance.

During the negotiating process of the Berlin Declaration, adopted at the First G20 Meeting of Health Ministers in May 2018, Brazil reaffirmed its positions on access to health as a key element to decision-making to this subject. Brazil supported the inclusion of references to the primacy of WHO's work on the global coordination of

<sup>29</sup> The program monitors the trends of drug-resistant gonorrhea. Antimicrobial resistance has made gonorrhea, which is a common sexually transmitted infection, much more difficult and sometimes impossible to treat. The program data showed, from 2009 to 2014, evidence of widespread resistance to almost all drugs in most countries. At the December 2017 meeting, Brazil presented the SenGono Project experiment, which tested the resistance of gonorrhea in Brazil and could also serve as a reference to the other countries of Latin America and the Caribbean.

<sup>30</sup> "Drugs for Neglected Diseases Initiative" (DNDi) incubated and WHO supported to encourage research and development of new antimicrobials through public-private partnerships. It aims to develop, until 2023, new treatments and antimicrobials and to improve the use of existing drugs. Brazil supports the partnership with GARDP and participates in the clinical phase of the global trial of the new drug to fight gonococcus, the bacteria that cause gonorrhea.

<sup>31</sup> Created in 1996 with the support of PAHO, the network seeks to obtain reliable, timely and replicable microbiological data to strengthen AMR surveillance. In its initial phase, ReLAVRA focused on monitoring the resistance of pathogens acquired in the community. Since 2000 it has focused on resistant pathogens. Brazil sends reports annually, using information from the Laboratory Environment Management System (GAL) databank.

<sup>32</sup> NGO founded in 2000, it works to ensure adequate treatment and diagnosis for tuberculosis, focusing on the most vulnerable populations. Present in nearly 100 countries and comprising more than 1.500 institutions, it includes the participation of specialized international organizations, civil society representatives, foundations, and the private sector.

AMR initiatives and the recognition of the Global AMR Plan as a guide for action, a position that was reflected in the final document.

In addition to the Minister of Health, other governmental actors are also involved in the combat against AMR in Brazil and work as protagonists in the area, such as Anvisa, Fundação Oswaldo Cruz (Fiocruz), MAPA and the Ministry of Science, Technology, Innovation and Communications (MCTIC). In the next section, the roles of some of these institutions in the Brazilian response to AMR will be identified.

### 3 Brazilian response to antimicrobial resistance

Brazilian actions related to antimicrobial resistance prevention and control began long before the adoption of the Global Action Plan in 2015. In the context of human health, a milestone for infection control actions in the country was the creation of the “Hospital Infection Control Program”<sup>33</sup> in 1998. The goal of the program was to reduce the incidence and severity of hospital infections by improving hospital care and sanitary surveillance. The ordinance instituting the program mentioned, for the first time, the need for the rational use of antimicrobials, germicides, and medical and hospital supplies, in addition to having stressed the importance of identifying indicators in the use of antimicrobials.

In 2005, the Ministry of Health and Anvisa, in partnership with PAHO, established the “National Network for Monitoring Microbial Resistance in Health Services” to increase the detection, prevention and control of resistance emergence in health services in the country. Another highlight in the fight against antibacterial resistance in Brazil was the regulation of antibiotic sales<sup>34</sup> Anvisa instituted in 2011 to control the distribution of antimicrobials for human use. Prior to this resolution, there was already a requirement for the prescription of antibiotics, a measure WHO considered effective to address the unnecessary use of these drugs.

Concerning animal health, MAPA was recognized as the body responsible for regulating the registration, manufacture, trade and use of antimicrobials in animals in 1969<sup>35</sup>. More recently, MAPA has regulated the use of veterinary antimicrobial products for animal feed through Normative Instruction no. 65/2006. This ministry also plays a leading role in governmental initiatives to control and prevent AMR in the

<sup>33</sup> The Group of 20 (G20) is made up of representatives from the nineteen largest economies in the world plus the European Union. The forum was created in 1999 as a venue for international economic and financial discussions. In the context of the global economic crisis that began in 2008, the G20 achieved the status of principal global forum for the discussion of economic and financial issues. Recently, other areas have been incorporated into the discussions in the G20. In 2017, under the German presidency, the first G20 Meeting of Health Ministers was held.

<sup>34</sup> Ordinance no. 2616/MS/GM, dated May 12, 1998, Ministry of Health

<sup>35</sup> Anvisa, Resolution of the Collegiate Board of Directors – RDC #20, dated May 5, 2011.

area of animal health, such as the National Pathogen Control Program<sup>36</sup>, which aims to monitor and manage the risk and presence of pathogens in animal source foods, such as *Salmonella spp.* in chickens and pigs and *Verotoxigenic Escherichia coli* in beef. In 2014, MAPA also launched the “National AMR Monitoring Program on Fishery Resources”<sup>37</sup>.

Although numerous and successful in different aspects, the strategies of the Brazilian government to control and prevent AMR were not previously based on the One Health approach, as advocated by the Global AMR Action Plan, and were developed in a disjointed fashion without integrated monitoring, even within SUS, which indicates, in its principles, the integrality of health actions.

Global Plan discussions mobilized, and the international commitments made in the corresponding multilateral forums, the Brazilian government proceeded to prepare the National Action Plan for Antimicrobial Resistance Prevention and Control (PAN-BR). The PAN-BR is based on the guiding principles defined by WHO, FAO and OIE, with a special focus on the multisectoral approach, directly involving the Ministry of Health, Anvisa and MAPA, with the support of the Ministry of the Environment, the National Health Foundation, the Ministry of Cities, MCTIC, among others.

According to the Global Plan, the PAN-BR is composed of strategic, operational and monitoring pillars and will cover the 2018-2022 period, structured around five strategic objectives:

1. Improve the awareness and understanding of antimicrobial resistance through effective communication, education and training.
2. Strengthen knowledge and the scientific basis through surveillance and research.
3. Reduce the incidence of infections with effective sanitation, hygiene and infection prevention measures.
4. Optimize the use of antimicrobial drugs in human and animal health.
5. Prepare economic arguments for sustainable investment and increase investments in new medicines, diagnostics and vaccines, and other interventions.

Nationally, these goals break down into 15 main objectives, 39 strategic interventions, and 104 activities.

The Ministry of Health was the department responsible for preparing the PAN-BR and coordinating the proposed actions. In 2016, a committee was set up<sup>38</sup> to formulate and carry out the actions of the national plan (CIPAN). This committee is composed of 26 areas of the federal government that participated in its elaboration and will be

<sup>36</sup> Law no. 467/1969.

<sup>37</sup> MAPA, Ordinance SDA no. 17/2013.

<sup>38</sup> MAPA, Normative Instruction no. 30/2014.

responsible for implementing the PAN-BR. In addition to PAN-BR, some agencies have also developed sectoral strategies to prevent and control AMR.

The Health Surveillance Secretariat (SVS) is responsible for organizing AMR actions under the Ministry of Health. The General Coordination of Public Health Laboratories, a division that is part of the SVS, is specifically responsible for the preparation of the PAN-BR, the organization and the monitoring of related activities.

Among its specific areas of activity, the technical meetings on antimicrobial susceptibility testing at the national level and the qualification of national and regional reference laboratories for the National Network of Public Health Laboratories stand out. In 2017, an ordinance of the Ministry of Health<sup>39</sup> established the Working Group for the Analysis of Methodologies for Sensitivity Testing used in Microbiology Laboratories (GT-TSA) with the objective of preparing technical documents on the methodologies used for antimicrobial susceptibility testing (TSA) in Brazil.

The Secretariat of Science, Technology and Strategic Inputs (SCTIE) of the Ministry of Health also plays a key role in the elaboration of PAN-BR. In order to meet objective 2, which deals with knowledge, scientific bases and research on AMR, the “Workshop on Priorities for Research on Antimicrobial Resistance” was held in July 2017. The aim of the workshop was to define priorities in AMR research to support the formulation of research notices the Ministry of Health is going to release. Because of the workshops, 12 priorities of research on AMR were defined for the Brazilian government. Since December 2017, seven research notices have been launched by the Ministry of Health in partnership with the National Council for Scientific and Technological Development (CNPq) and the Bill & Melinda Gates Foundation, which funds various initiatives related to health research.

AISA is a member of the PAN-BR drafting committee. In addition to participating in regular committee meetings and monitoring the issue together with the Ministry of Health divisions involved, the International Health Affairs Office prepares, with the support of these divisions, data and interventions to support the participation of Brazilian representatives in international events on AMR. In international health forums, especially at WHO, PAHO and the G20, it is incumbent upon AISA to represent the Ministry of Health in coordination with the MRE. In addition, the technical areas of the Ministry of Health request to AISA to follow up cooperation projects involving international actors and the AMR issue.

Anvisa's actions to tackle AMR are very diverse and involve activities of education, regulation, control and monitoring of antimicrobials. To this end, the Agency has elaborated a specific action plan, which includes health surveillance actions to prevent and combat AMR. Covering the period from 2017 to 2021, the Sanitary Surveillance

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<sup>39</sup> Directive No.: 2,775/2016. Ministry of Health.

Action Plan is contained in the PAN-BR and was developed by the Sanitary Vigilance Committee on Antimicrobial Resistance, which gathers twenty different areas of Anvisa. Among the objectives expressed in the Sanitary Surveillance Plan on AMR, the improvement of the sanitary intervention to qualify the prescription of antimicrobials and reduce its use without prescription stands out. Another goal is the qualification of the national laboratory network for surveillance and monitoring of AMR, coordinated with the Ministry of Health, states and municipalities, which will contribute to expand the information on infections by resistant pathogens.

In addition to the animal health actions contemplated in PAN-BR, MAPA also organized a specific plan on AMR in agriculture, whose objectives are to strengthen knowledge and the scientific basis, monitor the use of antimicrobials through integrated AMR surveillance and promote sustainable farming practices. The plan is in its validation phase and aims at integrated, proportional, feasible and sustainable actions. Some of the actions carried out have already suited the One Health context, such as the “National Program for the Prevention of Antimicrobial Resistance in Animals”, a strategic project of the Agricultural and Livestock Defense Plan for the 2016-2017 biennium.

MAPA’s position on AMR issues is cautious about recommendations that are not based on sound scientific evidence, such as the widespread ban on performance-enhancing additives in agricultural production. Indiscriminate banning, according to industry experts, could increase the use of therapeutic antimicrobials in animals and generate food security risks by increasing contamination of carcasses. For the agency, there is also a lack of knowledge about its impact on productivity and public health. In addition, the actions MAPA proposed also aim at a greater focus on critically important antimicrobials for WHO.

Despite contemplating these different perspectives inherent in the One Health approach model, the PAN-BR seeks to balance the positioning of the different sectors involved in formulating a single shared national position in this regard. In order to define Brazil’s positions in international forums dealing with AMR, AISA maintains close contact and coordination with the above-mentioned institutions to defend a governmental position that is consistent with national interests and backed by domestic practices and experiences. This praxis strengthens the position of Brazil as a player engaged in global AMR issues.

Brazil has been actively involved since the beginning of the WHO discussions that led to the approval of the Global Action Plan, it has worked with the G77 countries to ensure the adoption of a high-level declaration that addresses the interests and needs of developing countries at the UN General Assembly in 2016 and continues to coordinate positions on the subject with the other BRICS in the context of the G20. By promoting the One Health approach as a beacon of Brazil’s positioning on this

matter at the international level, AISA bases these actions on principles consistent with Brazil's traditional health work in multilateral forums. Consequently, the country's international projection as an important player to discuss this matter is strengthened. For the benefit of the historical positioning of Brazilian foreign policy, multilateralism is thus recognized as an appropriate space for discussion and adoption of decisions that impact the realities of all countries, paying special attention to the interests and the needs of developing countries for the health of the most vulnerable populations.

The main challenges imposed on PAN-BR lie in the institution of the strategies of AMR prevention and control as a State policy and in the guarantee of funding for its implementation. Decentralized implementation of the plan is also an important challenge, especially for the roles Brazilian states and municipalities played in the task. It is the responsibility of all governmental institutions involved in the issue to promote the awareness of everyone – individuals, health professionals, farmers, entrepreneurs and public managers. Because of the national improvements, the role played by Brazil in this matter at the international level will be strengthened.

## 4 Final Considerations

The introduction of the last class of a new antibiotic was registered almost three decades ago<sup>40</sup>. Despite numerous recent initiatives to tackle AMR, there is still a need to measure the extent and impact of resistant pathogen infections on human and animal health.

As demonstrated by the evolution of agreements and approaches on AMR in international forums, competition and conflict of interests may sometimes represent an obstacle to globally establishing a definitive perspective of this agenda. The proposed approach to fighting AMR, its multisectoral nature marked, adds challenges to the search for consensus.

On the one hand, the pharmaceutical industry justifies the gap in innovation as a result of low incentives for the development of innovative medications and diagnostic methods; on the other hand, the most vulnerable populations with limited access to health systems suffer from the low investment and low commercial interest due to the high price for new drug development; in turn, the governments of developing countries lack the financial and technological mechanisms that shorten the distances between suppliers and demanders of these health inputs.

For Brazil, the balance between the effectiveness of antimicrobials and the expansion of access to medicines, vaccines and diagnostic methods is a fundamental part of promoting universal access to health. For this reason, the country argues that,

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<sup>40</sup> Ordinance No.: 33/2017. Ministry of Health.

in order to ensure availability of access to antimicrobials, there can be no setbacks in intellectual property, a historical achievement of developing countries within the appropriate multilateral forums. Nationally, the use of generic medicines, voluntary licensing and the use of intellectual property flexibilities provided for in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) are factors that contribute to promote access to health and must be preserved in the mechanisms established to deal with AMR. Without denying the proper recognition of intellectual property rights and valuing innovation, research and development in public health, Brazil argues that it is necessary to promote the dissociation between the amounts invested in research and the final prices of a product in order to prevent new inputs and technologies of having exorbitant prices that hinder or prevent access to them by the most vulnerable populations.

Considering the multiple initiatives of countries, forums and organizations in the fight against AMR, the key role of WHO in the discussion is a position Brazil defended, so that there is more balance between the interests and the needs of countries at different levels of development.

The challenges of building and implementing national plans for confronting AMR in a coordinated and objective way are added to this scenario. Countries must promote improved surveillance of antibacterial resistance, collaboration between networks and research centers in this area, and the integration of human and animal health.

In this context, the work of the International Health Affairs Council has been instrumental in the progress made by the country in this regard internationally and in building an internal consensus on the technical and political aspects related to this sensitive issue. At the national level, the participation of AISA in the elaboration of the PAN-BR and in the support of the technical areas affected has allowed a broader view on the discussion of AMR on the global health agenda, allowing the development of a single position for the country with domestic support and in line with positions historically Brazil internationally defended.

In order to allow the continuity of this action, in defense of Brazil's interests in AMR, it is essential that the joint effort to prepare the PAN-BR be also reflected in the multisectoral engagement for its implementation. It is necessary to continue expanding the dialogue between different sectors of government and society on this issue, in addition to monitoring and improving existing actions. The maintenance of political commitment and the allocation of financial resources for its implementation will be essential to ensure the effective fulfillment of Brazil's domestic and international commitments on AMR.

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# Brazil's process of access to OECD and the prospects for a discussion on health

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## Abstract

Brazil has been moving towards the Organization for Economic Co-operation and Development (OECD) since the 1990's. In 2007, the country became one of the key partners of the Organization, increasing its participation in the agencies and activities of the OECD and, in May 2017, it formally requested accession to the organization as a full member. Since then, the Brazilian government has made efforts to adopt OECD legal instruments within the framework of national legislation and practices to demonstrate the country's preparation for the accession process and to reinforce the Brazilian commitment to public policy practices consolidated in the Organization.

Regarding health discussions, Brazil's engaged participation in the OECD, if accession is achieved, will be a challenge, considering factors such as the proliferation of international forums dealing with the standardization of health issues, the institutional capacity to respond to new demands and the difficulties arising from asymmetries of power and interests, especially in relation to the developed countries that are members of the Organization. On the other hand, the possibility of Brazil taking the opportunity to assess practices recommended within the OECD and to contribute to national reality is envisaged, in addition to contributing to diversify the Organization, presenting its experiences and prospects as a developing country with global projection.

**Keywords:** Health. Multilateralism. OECD. Brazil. Brazilian foreign policy.

## 1 Introduction: The OECD

### 1.1 Brief background and objectives

The Organization for Economic Co-operation and Development (OECD) was established in 1961 to promote policies aimed at achieving the highest economic growth, employment rates and living standard for the member countries, for the expansion of global trade, on a multilateral basis, and for the economic expansion of member and non-member countries in the process of economic development (OECD, 1960).

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The OECD was originated from the reformulation of the Organisation for European Economic Cooperation (OEEC), which was established in 1948 to manage the resources from the Marshall Plan to rebuild Europe after World War II. (OCDE, [201-]b)

In July 1947, European countries<sup>2</sup>, led by the United Kingdom and France, met at the Paris Conference to discuss the establishment of a stabilization program with the solutions required<sup>3</sup> to rebuild their economies, which would depend on the cooperation among countries and additional foreign aid. To organize these efforts, the Committee of European Economic Cooperation (CEEC) was created. The CEEC began working on a report that would be presented to the US government in September of the same year, demonstrating the possibilities of the countries and the necessary requirements, in terms of material and financial resources, for European recovery. In the document, the Committee informed about an estimated European deficit, for the period of 1949-1951, of 22 billion dollars. Of the total, approximately 19 billion dollars were requested from the USA and three billion from the International Bank for Reconstruction and Development (IBRD) (USA, 1947; OECD, 1997).

In April 1948, the US Congress passed the European Cooperation Act, a framework on which the European Recovery Program (ERP), known as Marshall Plan, was built. The nickname was created as a reference to the Secretary of State at the time, George C. Marshall, who, during a speech at Harvard University in June 1947, called for the development of a comprehensive European reconstruction program, which encouraged the creation of the CEEC. Although there are divergences about the reasons that boosted the Plan, it can be said that it was a diplomatic and economic initiative that aimed at dealing with the deterioration of economy and the extension of the Soviet influence in a situation in which the population in Western Europe was impoverished, seeking to enhance the coordination and integration among the involved countries (USA, 1947; USA, 1948).

In a meeting held in March 1948, the CEEC countries decided to establish a permanent self-coordination structure to boost cooperation and to allocate resources from the Marshall Plan, creating the Organisation for European Economic Cooperation (OEEC). This effort was translated into the 1st article of the Convention for European

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<sup>2</sup> The countries that signed the CEEC report on September 22, 1947, were: Austria, Belgium, Denmark, France, Greece, Ireland, Iceland, Italy, Luxembourg, Norway, Netherlands, Portugal, United Kingdom, Sweden, Switzerland, and Turkey.

<sup>3</sup> According to the CEEC report, the reconstruction plan should be based on four points: (i) large production effort in each of the participating countries, especially in the areas of agriculture, fuel and energy, transportation and equipment modernization; (ii) the creation and maintenance of internal financial stability as an essential condition for ensuring the full use of production and financial resources; (iii) the development of economic cooperation among the participating countries; (iv) a solution to the deficit of the participating countries with the USA, particularly by means of exports.

Economic Cooperation<sup>4</sup>, in which the interconnection between economies and the importance of coordinated action for reducing trade barriers among the members were already considered. In addition to being the organization that was the precursor to the OECD, the principles for the establishment of the OEEC formed the basis for the signature of the Treaty of Rome in 1957, which would create the European Economic Community (EEC) (OEEC, 1948, OECD, 1997)

By the end of the 1950's, the existence of the OEEC was threatened. The organization started declining after 1952, when the Marshall Plan ended and activities within the North Atlantic Treaty Organization (NATO) started being favored (OECD, n.d.). For Hahn (1962), the disagreement in developing the concept of a free trade area in Europe that was acceptable both for the member states of the European Free Trade Association (EFTA)<sup>5</sup> and for the EEC<sup>6</sup> member countries was one of the reasons that led to the end of the OEEC.

In order to overcome the dissent on the issue of free trade and to continue the successful cooperation between the OEEC member countries, it was decided to reconstitute the OEEC as OECD, with the inclusion of the United States and Canada – which already participated as associate members of the organization since the early 1950's – and with the intentions of assisting developing countries and providing consultations on economic policy and trade beyond the European continent (CLARKE & THOMPSON, 2011).

According to Leimgruber and Schmelzer (2017), OECD was important to build the identity of Western capitalism during the Cold War and to change the global power balance resulting from the decolonization process. The organization represented, at the time, an economic complement to NATO, contributing to the liberalization of trade and investment and to the consolidation of the North Atlantic as the center of the global capitalist economy (CLIFTON; DÍAS-FUENTES, 2014). With respect to this, during the first Ministerial Meeting of the organization, the goal to increase the gross

<sup>4</sup> “The Contracting Parties agree to work in close cooperation in their economic relations with one another. As their immediate task, they will undertake the elaboration and execution of a joint recovery programme. The object of this programme will be to achieve as soon as possible and maintain a satisfactory level of economic activity without extraordinary outside assistance, and to this end the programme will take special account of the need of the Contracting Parties to develop their exports to non-participating countries to the maximum extent possible. Accordingly the Contracting Parties pledge themselves to carry out, by their efforts of selfhelp and in a spirit of mutual aid, following General Obligations, and hereby set up an Organisation for European Economic Co-operation (...)” (OEEC, 1948)

<sup>5</sup> The EFTA is an intergovernmental organization in which Iceland, Liechtenstein, Norway and Switzerland participate. It was set up in 1960 by seven member states (Austria, Denmark, Norway, Portugal, United Kingdom, Sweden, and Switzerland) to promote free trade and economic integration among its members.

<sup>6</sup> The European Economic Community (EEC) was a regional organization that intended to promote economic integration among its member states. It was established by the Treaty of Rome in 1957. With the establishment of the European Union (EU), based on the Maastricht Treaty (1992), the EEC was incorporated and renamed “European Community” as one of the pillars of the EU. In 2009, the institutions of the European Community were absorbed by the EU, ending the pillar structure, and the Community ceased legally to exist.

domestic product (GDP) of the member countries by 50%, by the end of the 1960's, was set and effectively achieved, reinforcing the role of the OECD as the “guardian of liberal capitalism” (LEIMGRUBER, SCHMELZER, 2017).

Since the 1960's, the OECD has aimed to improve the economic performance of its members and it was, until the 1970's, a space for decision-making and coordination among Western countries. Following the emergence of the G77<sup>7</sup> in 1964, the Organization shifted its focus to soft power<sup>8</sup> instruments (BEROUD; HAJDUK, 2015). As envisaged by the first Secretary-General of the OECD, Thorhild Kristensen, the Organization should work as a think tank that would catalyze new ideas proposed by the Secretariat to the countries (LEIMGRUBER; SCHMELZER, 2017).

Despite the assignment of promoting public policies on various issues and of helping countries with their formulation (OECD, [201-] c), it must also be considered the historical, strategic and geopolitical dimensions of the OECD in power relations and negotiations between States.

## 1.2 Expansion: diversification of topics and accession of new members

The composition of OECD member countries has changed at three different moments. When the Organization was constituted, the member countries were the same as those of the OEEC, plus Canada, Spain and USA. The process of accession of new members to the Organization lasted until 1973, when Japan (1964), Finland (1969), Australia (1971) and New Zealand (1973) became members.

The second period of OECD expansion happened only after the disintegration of the USSR in the 1990's. Mexico became a member in 1994, after it adhered to the North American Free Trade Agreement (NAFTA), in 1992. In the following years, the Czech Republic and Poland, in 1995, Hungary and South Korea, in 1996, and Slovakia, in 2000, also joined the Organization. At the time, according to Clifton and Días-Fuentes (2014), the accession of new countries<sup>9</sup> depended on the negotiation between OECD members that supported different regional allies.

Recognizing the importance of expanding the relevance and the reach of the Organization, and considering the political and economic rise of emerging economies

<sup>7</sup> The Group of 77 (G77) was set up in 1964 by seventy-seven developing countries. Currently, it includes 134 countries.

<sup>8</sup> “Soft power”, according to Joseph Nye (1990, 2004), refers to the ability of a State to attract and persuade others, instead of employing means of coercion or payment, relying on resources such as cultural attraction, ideas, policies, values, and institutions. The OECD, unlike institutions such as the International Monetary Fund (IMF), has no binding power over its members.

<sup>9</sup> According to Article 16 of the OECD Constitution, the accession of new members to the Organization is by invitation of the Council. That decision must be unanimous, and the accession takes effect from the deposit of the instrument of accession with the Government of France, designated as the depositary by the OECD Constitution (OECD, 1960).

in the early 21st century, the third period of expansion of the OECD began when the Organization Council decided, in 2007 (OECD, 2007), to strengthen its cooperation with South Africa, Brazil, China, India and Indonesia, which became key partners of the Organization. On the occasion, the aforementioned States did not join the OECD as members, but closer relations were established between the Organization and their governments. At the same time, the Council decided to start negotiations with Chile, Estonia, Israel and Slovenia, which were accepted as members in 2010, and with Russia, whose accession process came to a halt in 2014, as a response to the Russian annexation of Crimea. In 2016, Lithuania deposited its instrument of accession to the OECD Convention, becoming the 36th member of the Organization. In May 2018, Colombia was formally invited to become an OECD member, and the Colombian government signed the accession agreement at the OECD Ministerial Council meeting held in the same month. Its accession will come into effect once the instrument of ratification of the OECD Convention has been deposited by the Colombian government.

### **1.3 The OECD and the development of transnational comparative studies and research**

The OECD provides a forum in which governments can share experiences and seek solutions to common problems. In addition, it produces and uses data to develop indicators and statistics to enable comparisons between countries in the most diverse issues (OCDE, 2011).

According to McBride (2014), there is evidence of a causal connection between the recommendations formulated by the OECD and the policies developed by the Member States. However, the greatest contribution from the Organization to countries is, according to the author, its capacity for mediating and researching, whereby trends, common problems and solutions are identified. There is also the development of concepts and the use of statistical tools that allow the evaluation of the policies of the member states. Ultimately, definitions originating in the OECD are transferred to other documents and resolutions approved in more representative multilateral organizations (MCBRIDE, 2014).

The recommendations adopted by the OECD Ministerial Council, developed through good practices and guidelines, are not binding or mandatory. Without means of coercion and operating by consensus, the Organization often makes use of soft law<sup>10</sup> in subjects as diverse as taxation, public governance, environment, health, or education. Due to organizational flexibility and the wide range of topics it addresses,

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<sup>10</sup> The term “soft law” refers, in the scope of international law, to instruments of a non-binding legal nature, which do not create obligations in the field of positive law.

the Organization can quickly take a position on emerging issues in international discussions and offer soft law tools to deal with them (BEROUD; HAJDUK, 2015).

The OECD recommendations are jointly formulated. The Secretariat collects and analyzes data, policies are discussed in the committees with the participation of national policy makers, and the Council adopts, by consensus, decisions to be implemented by the Member States. The implementation of these decisions is supervised by means of peer review (OCDE, [201-]c).

For Leslie Pal (2009, apud BEROUD; HAJDUK, 2015), OECD exerts influence through instruments based on studies and information, laying down international standards. In the context of global governance, defined best practices, goals and indicators allow systems to become similar over time, and the managers of these systems are allowed to share experiences, use similar language, and, ultimately, begin to coordinate policies, even without the existence of a central coordinating body.

## **2 Brazil and the OECD: background and overview**

### **2.1 “Enhanced engagement” of Brazil: key partnership and request of accession as a full member**

According to Denis Pinto (2000), the bilateral relationship between Brazil and the OECD was strengthened with the visit of the Brazilian mission to the organization in 1991, an occasion on which the country formalized, by letter, its intention to enhance the collaboration between the parties. In 1992, in a document sent to the Organization, Brazil indicated the following areas of interest: a) Economics Department (national accounting and economic provisions); b) Economic and Development Review Committee (EDRC); c) Public Governance Committee; d) Industry Committee; e) Steel Committee; f) Environment Policy Committee. The Brazilian government also expressed its willingness to participate in the Development Centre and in the International Energy Agency (IEA)<sup>11</sup>. Brazil has been participating in the Steel Committee since 1996 and became a full member of the Committee in 1998.

In 2007, Brazil was invited for “enhanced engagement” and became one of the five key partners of the OECD, together with South Africa, China, India, and Indonesia. At the time, the Brazilian government did not express any aspiration to be admitted as a full member of the Organization, aiming at bilateral technical approximation only.

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<sup>11</sup> The OECD Development Centre was set up in 1961 as an initiative to promote talks between the Organization and developing countries. Brazil has been a member since 1994. The International Energy Agency (IEA) was founded in 1974 and it is a platform for dialogue and a source for sharing the latest data in the energy industry. Brazil joined the Agency in October 2017 (BRASIL, 2017d).

In June 2015, the Cooperation Agreement and the Brazil-OECD Programme of Work 2016-2017 were signed in order to deepen the partnership between Brazil and the Organization. In May 2017, the Brazilian government formally requested to begin the process of accession to the OECD (BRASIL, 2017c). In the same month, Brazil requested adherence to the Organization's Code of Liberalisation of Capital Movements and Code of Liberalisation of Current Invisible Operations, legally binding instruments that provide a framework for countries to eliminate barriers to capital movements, on a progressive and non-discriminatory basis, and to financial services and other current invisible transactions. In May 2018, an agreement was signed between the Brazilian government and the OECD, the initial framework for Brazil's formal evaluation process by the Organization. To this end, the country is expected to prepare a report on the existing restrictions in the Brazilian legislation and to propose a list of restrictions on direct investment, before it defends its adherence to the Codes.

The historic evolution of the Brazilian engagement with the OECD over nearly three decades reveals an increasing approximation movement, initially at a technical level and, more recently, resulting in the concern with greater political approximation, which was substantiated in the Brazilian request of accession to the Organization. Brazil has regularly participated in two thirds of the OECD Committees (BRASIL, 2017b), and the Brazilian government, as part of the preparation process for the country's eventual accession, has made efforts to evaluate the conformity of the guidelines issued by the Organization to the national legislation and policies.

## **2.2 Evaluation of the compatibility between national policies and standards and the OECD *acquis***

In April 2017, even before Brazil formally requesting accession to the OECD, the Federal Government started evaluating the compatibility of the Brazilian legislation with the body of legislation and the standards of the Organization (the so-called "*acquis*"), in an initiative coordinated by the Chief of Staff Office of the Presidency of the Republic and the Ministry of Foreign Relations, within the Inter-ministerial Working Group for OECD Affairs. With this initiative, Brazil is expected to request adhesion to the largest possible number of instruments prior to the formal start of the accession process. With respect to this, the Brazilian government announced its adhesion to 31 new instruments considered to be compatible with national practices in the first week of September 2017. Brazil has adopted or is in the process of adopting at least 107 of the 240 normative instruments of the Organization (BRASIL, 2017b).

Taking as an example the "*roadmap*" to the recent accession of Lithuania to the OECD, the country could position itself in the following ways in relation to the legal instruments: a) acceptance; b) acceptance with a specified timeframe for

implementation; c) acceptance subject to reservations or observations; d) rejection (OCDE, 2015).

In the initial assignment of tasks to the departments of the Federal Government, the Ministry of Foreign Affairs took responsibility for receiving data and organizing them on the “acquis” worksheet as follows: a) instruments to which it is easy to adhere and which coincide with policy guidelines and do not conflict with the current Brazilian legislation; b) instruments that do not conflict with the current Brazilian legislation, but do not coincide with current policy guidelines in force in Brazil; c) instruments that deviate from policy guidelines and conflict with the current Brazilian legislation.

After the preliminary analysis, the Chief of Staff Office of the Presidency has organized meetings and requested that the competent governmental departments thoroughly evaluate the instruments, aiming at identifying potential conflicts or incompatibilities with the Brazilian legislation and/or practices and guidelines, or which cause a divergence between the parties responsible for the evaluation.

Until July 2018, the Ministry of Health carried out compatibility analysis of 31 OECD instruments, among recommendations, decisions and declarations, relative to environmental health, worker health, science and technology and data governance issues. The International Health Affairs Office (AISA) is the division, within the institutional structure of the Ministry of Health, responsible for coordinating the activities related to the Brazilian accession to the OECD. In contact with the technical divisions that are responsible for the respective areas, AISA has supported this compatibility verification process. As a result of this effort, in the evaluation of the Ministry of Health, there have been no obstacles to Brazil's accession to most of the instruments in the area, which demonstrates the high level of normative adequacy to OECD recommended standards and practices within the framework of national health policies.

Brazil's access to the OECD is considered a priority for the Brazilian Government. For this reason, efforts have been made within the federal public administration to carry out the aforementioned normative and policy compatibility assessment in order to demonstrate not only the country's effective willingness to become a Member State, but also the alignment of domestic policies with practices adopted within the Organization (BRAZIL, 2017b).

Due to the expectation of greater Brazilian engagement in meetings of the committees and working groups of the organization, and participation in research and comparative analyses, a specific team was assigned to take care of this agenda at the Brazilian embassy in Paris, led by ambassador Carlos Márcio Cozendey (NUNES, 2018). The effective start of any eventual Brazilian accession process to the Organization, however, still depends on its approval by the OECD Council.

### **3 Brazil and the OECD: health discussions**

#### **3.1 The multiplication and overlapping of forums dealing with health**

Over the last decades, global health governance has coexisted with a multiplicity of organizations – both governmental and non-governmental – initiatives, coalitions and diverse interest groups that deal with health issues, often acting on a fragmented and pluralized manner. In addition to the work overload generated for the Ministries of Health caused by this proliferation of forums, there is also, in some cases, conflicts of interest with national health authorities, a particularly serious situation in relatively less developed countries. Furthermore, there are risks that several health initiatives are competing to each other and do not produce the expected results, with inadequate allocation of human and financial resources. Problems such as the lack of transparency, monitoring and of mechanisms that ensure the execution of projects and the achievement of goals are thus recurrent (GOSTIN; MOK, 2009). Similarly, the interrelation between the economic interests of specific sectors and the policies developed by a group of countries at the international level, particularly by developed countries, poses an additional challenge to countries that, like Brazil, advocate the assurance of universal health access as a constitutional right.

Health issues are known to intersect other agendas. There is, within the United Nations, an agency with a specific mandate to deal with the matter, the World Health Organization, regionally represented by the Pan American Health Organization. In this sense, while it is important to bring health to the center of multilateral discussions in a number of areas, due to the impact of health and well-being on societies and the development of countries, it is also clear that the multiplication of political initiatives and techniques, often overlapping each other, can weaken the results achieved and lead to additional work for the States on their public policies. For this reason, Brazil has advocated that the diverse instances debating health issues should contribute to strengthen the multilateral health system, avoiding the possible adverse effects of the multiplication of forums. Care should also be taken to ensure that discussions and meetings promote pragmatic and measurable results, especially in light of the growing importance of the health issue in international discussions.

The current global health governance scene is multifaceted and, therefore, poses risks and opportunities. It is the responsibility of everyone, particularly governmental managers responsible for health policymaking, to ensure that this plurality of global initiatives contribute to add efforts towards population health in the first place.

The inclusion of health issues in forums that did not originally have this mandate also poses challenges to international action in this area. While incorporating health issues into initially economic forums, such as BRICS and G20, for example,

can contribute to broaden the visibility of health on the international agenda and to strengthen political agreements between countries in this area, attention must be paid to the importance of defining mandates, objectives and action patterns for these groups in order to avoid their dissociation from the purpose of health promotion.

Within BRICS, this effort has proved to be successful<sup>12</sup>. Since the group's first Meeting of Health Ministers – held in 2011 in China (BRAZIL, 2011), the governmental authorities of the five countries have discussed common priority topics for their national health policies, such as conducting research and fighting communicable diseases. The tuberculosis agenda, for example, has gained evidence with the approval of the BRICS TB Cooperation Plan in 2016 and the establishment, in 2017, of the TB Research Network under the Plan. BRICS has also made progress in coordinating health policy issues in areas of mutual interest within the World Health Organization and other global agencies dealing with the subject.

In 2017, during the German pro-tempore presidency of the G20, the first Meeting of Health Ministers was held within the group, initially designed to coordinate financial policy measures. The establishment of a forum for discussing health issues in the context of the G20 thus represented an extension of its initial mandate. Although G20's work on health promoted, during the German presidency, an approach to issues that mattered to developed countries – such as antimicrobial resistance and health emergencies – Brazil sought to promote balanced discussions considering the needs and interests of developing countries. As a result, the approved final document was balanced, conciliating the different existing points of view within the group and reaffirming principles dear to Brazil: the importance of health access, strengthening of multilateralism within WHO, special attention to developing countries, among others. In the declaration adopted by the Health Ministers in Berlin, the need to make health systems strong and resilient in order to increase the ability of response to global crises and challenges was highlighted. The importance of health to the construction of a sustainable society was mentioned, taking account of the social determinants of health<sup>13</sup> and the correlation between the subject, economic development and productivity. In the document, the ministers also recognized the leadership of WHO and pledged to work together with the Organization (G20, 2017).

Over the past three decades, with the increasing appreciation of social issues on the international agenda, the inter-relation between economic, social and environmental development has been brought to the center of multilateral discussions. Consecrated

<sup>12</sup> See the article “Political coordination and cooperation in health within the BRICS”, by Eduardo Shigueo Fujikawa.

<sup>13</sup> The social determinants of health, according to the World Health Organization (WHO), are the conditions under which people are born, grow up, live, work and get old. These circumstances are influenced by factors such as income distribution, power and resources at the global, national and local levels. These social determinants of health are largely responsible for health inequalities seen within countries and between them (WHO [201-]).

in the concept of “sustainable development”, this view has translated into the adoption of national and international policies focusing on this issue, currently supported by the 2030 Agenda for sustainable development.

The OECD, although remarkably based on economic goals, has promoted initiatives towards increasing integration with social areas that are directly connected to the promotion of sustainable growth, increased employment, investment and trade, and higher living standards. Thus, the development and support of education, health and social protection policies, considering the negative impact of inequality and lack of inclusion in the global economy, have been important aspects of the Organization’s recent work (OECD, 2011).

### **3.2 Brazil’s accession to the OECD and discussions on health: challenges and opportunities**

Criticisms of Brazil’s potential accession to the OECD include those related to the eventual loss of national sovereignty over public policies, particularly in view of the interests of the Organization’s developed members. The influence of developed countries on the Secretariat could thus bias the development of the good practices that characterize the history of the Organization to the detriment of the autonomy of other members (BEROUD; HAJDUK, 2015).

Regarding the specific topic of this article, one should consider the peculiarities of the Brazilian health system, as well as its effects on national foreign policy and the challenges that the country may face in the context of its accession to the OECD.

The Unified Health System (SUS), the largest universal health system in the world, was set by the 1988 Federal Constitution, which ensures universal and equal access to actions and services to promote, protect and recover health as a duty of the State and a right of all. As part of the efforts to operationalize this social right, Brazil has stood up, in the international sphere, in advocating health as a right, with special attention to the interests and needs of the developing countries and an emphasis on strengthening multilateralism. In this respect, the strengthening of the activities carried out by the Ministry of Health over the last three decades in the following issues should be highlighted: access to medicines, seeking to reconcile intellectual property with public health needs; tobacco control; universal treatment of people with HIV/AIDS; South-South technical cooperation, focusing on the abilities of developing countries and the sustainability of initiatives; humanitarian cooperation, among others. Thus, global health occupies a prominent position as one of the major topics of current Brazilian foreign policy.

The eventual accession of Brazil to the OECD may allow the country to participate in strategic discussions and in the formulation of concepts and practices

that could later be brought to debate in more representative forums. By providing the prospect of a developing country with a global vision engaged in the defense of principles traditionally associated with the defense of the right to health, Brazil could contribute not only to balance the different perspectives in the Organization but also to ensure that the work carried out in it can effectively contribute to ensure health and development as complementary dimensions. Thus, Brazil can use the OECD as a platform, not usually reserved for developing countries, to reiterate the pillars of Brazilian foreign policy in health, such as: the importance of South-South cooperation to strengthen the institutional capacities of countries, with transfer of practices and knowledge; the importance of building resilient and capable health systems, with attention to social determinants; the concept of health as a human right; and the defense of issues dear to the country, namely, access to medicines, development of capacities, and a multidimensional perspective on health (FPGH, 2007; ALMEIDA et al., 2010).

In this regard, criticisms of possible difficulties in reconciling positions with developed countries within the OECD, which “dominate” the Organization’s agenda, require further reflection. The claim that the organization is a “rich men’s club” in which developing countries as Brazil would be isolated, does not reflect, on the one hand, the complex reality of health positions adopted by developed countries, and it is not consistent, on the other hand, with the history of active participation of national diplomacy in defending its interests at the international level.

First, the recent evolution of international health debates in forums such as WHO or G20 and the North-South international cooperation initiatives being undertaken by Brazil in this area have demonstrated that the attempt to categorize developed and developing countries as two homogeneous groups with diametrically opposed interests is far from contemporary reality. Several developed countries, many of them OECD members, share the concerns and central positioning adopted by Brazil in various aspects of health issues. Therefore, Brazil would not be isolated in its positions in the OECD sided with the few other developing members<sup>14</sup> comprising it.

The Ministry of Health is currently engaged in designing and implementing cooperation projects with Australia, Canada, Denmark, France and the United Kingdom, for example, in addition to promoting and strengthening the already traditional relations in terms of research, science, technology, and health innovation with the United States<sup>15</sup>. Although on specific agendas there have been divergences of position between Brazil and some of these countries in health issues, this has not

<sup>14</sup> Chile, Mexico and Turkey. Colombia is a developing country undergoing the accession process.

<sup>15</sup> An example of the recent relationship with the United States on health is the several fronts of action in response to the Zika virus since 2016. See, in this regard, the document “Health Co-operation Plan for Zika Virus – Monitoring and Results”, published by the Ministry of Health of Brazil and by the US Department of Health and Human Services in May 2018 (BRAZIL, 2018d).

prevented a significant expansion of the external relationship of the Ministry of Health with developed countries over the past years, having as key being to strengthen Brazilian public health.

In addition, even in multilateral forums with universal representation, such as the World Health Organization, the position of some developed countries is well-known to be a frequent obstacle in advancing negotiations over several areas. To consider that these countries would defend extreme positions in favor of their own interests in the OECD and then would give up those interests in forums such as WHO is a simplified view that is a far cry from practical reality. Possible difficulties arising from divergences in positions within the OECD may be very similar to those already experienced in multilateral forums with universal scope. In multilateral forums, Brazil is traditionally recognized for its role in consensus building. Without neglecting the traditional principles of international insertion that are dear to the country, Brazil has historically promoted a multilateral activity characterized by the persistent pursuit of national interest. The capacity to negotiate that is essential to dealing with contrasting points of view and finding possible paths to dialogue and understanding is characteristic of Brazilian diplomacy, and the country's participation in the OECD could diversify the points of view addressed in the Organization in defense of interests that traditionally matter to the country .

Although there is a predominance of developed members in the OECD, common problems are noted to affect health systems around the world, such as increased health expenditure and challenges to the sustainable funding of systems; the increase in life expectancy and demographic transition; and the increase in chronic noncommunicable diseases. Finding ways to handle these challenges is a task that can benefit from the experiences and perspectives of countries in different situations, even in terms of development. Over the last thirty years, Brazil has effectively demonstrated that it has an important role to play in this issue.

It is also clear that the OECD, in contrast to other international organizations, does not have the power to impose rules or standards on its members. The decisions and recommendations the Organization are adopted, as a rule, by mutual agreement of all members and do not apply to those who abstain from voting. State sovereignty over public policy making is thus fully respected and there is no risk that a member will eventually be forced to adopt policies with which it disagrees, for example.

As previously discussed, one of the OECD's goals is to build knowledge from the data reported by countries, and one of the initiatives undertaken is the annual publication of *Health at a Glance*. In this publication, specific indicators were developed to assess the overall health performance of countries in certain areas considered to be more relevant to the understanding of the global situation. Though imperfect, this type of aggregating effort, which involves working with a massive amount of data, allows

countries to be compared and the evolution of each to be evaluated, and the trends of global health problems can also be observed. Given that Brazil is a key partner of the OECD, there are already several comparative data, in several categories, on the overall health situation of the country in relation to other enhanced engagement States and Member Countries.

The most recent OECD publication on health is *Health at a Glance 2017*, which aims to present a comparison of the health status of populations and the performance of the health system in the Organization's member and partner countries with an emphasis on public health. The conceptual framework of the document is based on the premise that the ultimate goal of health systems is to improve the health status of the population, and the social determinants of health are considered in the analysis. The indicators were developed in order to evaluate countries' performance in five aspects: (i) population health status; (ii) risk factors for health; (iii) access to care; (iv) quality and outcomes of care; and (v) healthcare (OECD, 2017).

SUS, a decentralized, public and universal health system having the participation of the three levels of government, is relatively recent, and there are still challenges to the operationalization of the constitutional right to health on several fronts. Evidently, the country cannot be expected to present, in all aspects, health indicators similar to those of developed countries or to the average of the OECD. Despite this, the significant advance of all main health indicators in Brazil over the last three decades is remarkable. Therefore, tools such as *Health at a Glance* can be useful not as an initiative for merely ranking the participating countries, but to aid in decision-making and the improvement of public policies. Additionally, it is possible to monitor the evolution of the indicators over the years and correct possible setbacks. The indicators certainly do not cover all possible aspects – not all of them are objectively measurable – of the access to health and enjoyment of the right to health. Nevertheless, they can help build an extensive body of information that can help managers of the three levels of government seek improvements in the public health system.

With respect to the Brazilian mortality table, a life expectancy of 75.8 years was observed for the general population in 2016. In 1940, life expectancy was 45.5 years. For the male population, life expectancy in 2016 was 72.2 years, lower than the average of 77.9 years for OECD countries. For the female population, the average for OECD countries is 83.1 years, while in Brazil it was 79.4 years. The general expectancy for the Brazilian population at age 65 was more 18.5 years, close to the average of 19.5 years for OECD countries.

In 2016, the higher mortality rate in the male population in comparison to the female population was concentrated in young male adults, which can be explained by the higher incidence of deaths due to external or non-natural causes. Although infant mortality is still relatively high and largely affects the most vulnerable groups and

regions, the increase in per capita health expenditure and actions related to vaccine coverage – one of the most extensive in the world – food and strengthening of primary healthcare have helped reduce overall mortality in the Brazilian population.

Compared to data from Chile and Mexico, developing countries in the region that are full members of the OECD, the life expectancy of the Brazilian male population is similar to that of the Mexican population, 73.3 years, which is also lower than the Organization's average. Chile's indicators are close to the OECD average, with the male population having a life expectancy of 76.5 years.

For health expenditure, the OECD average is 9% of the GDP. Brazil is above average. In 2015, the final consumption of health goods and services in Brazil was BRL 546 billion, 9.1% of the GDP, compared to an expenditure of 8% of the GDP in 2010. However, considering Brazil's mixed health system model, it should be noted that only BRL 231 billion (3.9% of the GDP) corresponded to consumption expenditures of the government, while BRL 315 billion (5.2% of the GDP) accounted for expenses of families and institutions at the service of families (IBGE, 2017; OECD, 2017).

Although an increase in public spending on health is positive, governments around the world have been concerned with the sustainability of spending, considering factors such as demographic transition, the increase in noncommunicable diseases and the usual limitations in times of economic crisis, in which the contraction of the GDP and the resulting fiscal constraints affect the amount of resources available for public investments, including those in the social area. The efficiency of spending is, in this sense, fundamental to the quality and resilience of the systems.

The recent expansion of the OECD, according to Clifton and Días-Fuentes (2014), is explained by the emergence of developing countries on the global scenario. According to the authors, the work of building and transferring the policies and good practices of the Organization depends on the ability to cover a significant number of countries, on obtaining quality data and data on global economy trends, on achieving more political experience with developing countries and on the need to adapt OECD policies to the national realities of the countries in the Global South.

The participation of Brazil and other developing countries in the OECD has already contributed to make the Organization more representative, a trend that should widen as a result of Brazilian accession. OECD traditional standardization role in several areas, not only in health, is notorious. A number of deliberations from the Organization end up influencing global discussions conducted both within countries and within other international organizations. This is already a reality. By effectively participating in the OECD as a full member, Brazil can contribute, with its experience and ability of consensus building, to have its interests and views represented there. Obviously, this is not an easy task. The Ministry of Health will have an important role to play in overcoming these challenges.

The participation of the Ministry of Health in OECD activities and meetings has usually been modest. The designation of a specific division of AISA to track OECD-related topics is recent, and the effective engagement of the technical areas of the Ministry of Health in multiple initiatives and technical working groups of the Organization is still a challenge.

The verification of the terminology used in the Organization and its correspondence with terms whose use is nationally established, the requests for data and information scattered across different divisions of the Ministry of Health or whose control is shared with other federal departments, and raising awareness about the practical usefulness of spending human and financial resources for these activities, for example, will require a gradual adaptation of flows and procedures in order to allow the country to regularly and more effectively participate in the health forums of the OECD. It is also necessary to better understand how the indicators used by the Organization are built and applied and how important it is to systematize these data in order to contribute to a more qualified action of the country on health issues in the OECD.

AISA therefore plays a key role not only in mediating contacts between specific forums of the OECD and relevant technical divisions in the Ministry of Health, but also in ensuring the consistency and effectiveness of Brazil's participation in the Organization in health-related discussions. In the current context of compatibility analysis for adherence to OECD instruments, for example, AISA has centered the demands on the Ministry of Health and promoted articulation with the technical areas in charge of document evaluation and with the Chief of Staff Office of the Presidency of the Republic and the Ministry of Foreign Affairs, which are responsible for the process within the Federal Government.

Regardless of Brazil's OECD accession process being accomplished, the exercise of talks between the Federal Government and, particularly, the Ministry of Health on urgent topics on the Organization's health agenda can contribute to the systematization of practices and internal procedures to produce and disclose data, the sharing of best practices related to policies of national interest and the dissemination of successful Brazilian public policies and initiatives to the international community, for example. By enhancing its engagement with the OECD, whatever its membership status with the Organization is, Brazil can contribute to bring new perspectives and interests dear to the country in terms of health. The country's international performance in healthcare will thus be strengthened. Consequently, Brazilian health and society will be benefited.

## **4 Final remarks**

Reflections on the pertinence of the accession of a country as Brazil to the OECD have traditionally led to a number of political, economic and social debates

on the subject, which have gained new momentum in the last year since the accession application was formally submitted. Apart from economic and financial reasons, which are beyond the scope of this article, the Brazilian government also mentions its concern with the defense of Brazil's interests, as it seeks inclusion in strategic decision-making spaces (NUNES, 2018).

In the context of a multipolar and multifaceted international order, in which developing countries have achieved greater importance on the international scenario, Brazil's participation in new spaces can be strategic. In this setting of diffuse power and multiple expressions of global interests, beyond the traditional concepts of military power, there is no incompatibility between the participation of a country like Brazil in a plurality of international forums. On the contrary. If, on the one hand, the multiplicity of forums can pose challenges to the consistency of international actions in progress, on the other, it is an unrelenting reality of the contemporary international order.

A traditionally recognized actor for its capacity of consensus building and foreign policy positions based on guiding principles, such as universalism, pragmatism and the defense of development and human rights, Brazil has promoted, in the several international forums in which it participates, solid positions in defense of the social advances accomplished by Brazilian society since the 1988 Constitution. The pragmatic participation of the country in the OECD can consequently give greater visibility to its policies and strengthen its insertion on the international scene. Similarly, the diversity of experiences can benefit the OECD as well by broadening its horizons and scopes of action, which could make its discussions and policy recommendations more democratic, legitimate and representative.

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# The Decade of Action on Nutrition: Commitments, Challenges, and the Health Strengthening in the Agenda of Food and Nutrition Security

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## Abstract

The article aims to present the recent evolution of food and nutrition security concept in Brazilian and in global contexts. It also briefly describes the development of national food and nutrition security policies and their intersectoral governance system to support the position adopted in multilateral forums and in the initiatives the Ministry of Health has been promoting in the United Nations Decade of Action on Nutrition scope.

**Keywords:** Food and Nutrition Security. Food. Multilateralism. UN. Decade of Action on Nutrition.

## 1 Introduction: The food and Nutrition Security Concept in Brazil and in the World

Having healthy, safe, assorted, suitable, enough food permanently and continuously on our table and being able to consume it with friends, our family or in our social group is currently the image that closest approximates to the food and nutrition security concept advocated in Brazil. **However**, behind this apparent simple meal there are other equally important concepts, such as the guarantee of decent work on the land – for everyone – the reduction of distances between the farm to table, the valorization of local and regional culinary traditions, access to water, adoption of food and nutrition education measures, among others. Besides having significantly evolved over the years, the food and nutrition security concept unfolds on several ramifications. But it has not always been like that.

Globally, the most recent records about food security concept refers to discussions arising from the serious world food crisis in the mid-1970's. That time, the factors considered to have triggered the crisis were highlighted in the World Food Conference, held in 1974, by United Nations' Food and Agriculture Organization (FAO). This analysis led the member states to focus the food security debate on production, trade

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and global food stocks. The idea was in assuring a suitable food supply through the control of production, price stability and establishment of reserves a new crisis would not happen again. Accordingly, that year, the Conference participants agreed the definition of food security would be “availability at all times of adequate world food supplies of basic foodstuffs to sustain a steady expansion of food consumption and to offset fluctuations in production and prices” (FAO, 2003).

However, the initial focus on food supplies, offer, and, to some extent, on the stability of basic foodstuff prices quickly proved to be insufficient to cope with the problem. The most concrete evidence was the success of the so-called “Green Revolution” denominating the set of technological transformations in agriculture in the mid-20<sup>th</sup>. century failed to lead to automatic reductions in the overall levels of malnutrition, hunger and poverty (MALUF *et al.*, 1996). That moment, it was concluded we needed to focus also on the demand side as a focus on attention and priority in coping with food insecurity.

Therefore, over the past decades, food security concept has been expanded and established, incorporating not only concerns on food supply and demand but also issues related to access (physical and economic) to food, food security, nutritional balance, different food crops and – why not? – the health and well-being of individuals and communities.

Thus, the widely-used concept so far was agreed on at FAO’s World Food Summit in 1996 and incorporating multidimensional nature of food security and including four key dimensions: Access, Availability, Use and Stability<sup>2</sup> (FAO, 1996). Since then, at a global level, it was consolidated the simplistic historical correlation between food security, starvation and agricultural production flops was outdated (DEVEREUX; MAXWELL, 2001).

At national level, the discussion on the theme has also progressively changed. It is no exaggeration to say Brazil and Latin America, more broadly, had a pioneering historical role in food issue. It should be remembered in the 1940’s Josué de Castro, one of FAO founders, envisioned hunger as a biological expression of sociological malaises (CASTRO, 1980).

In the early 1990’s, the Movement for Ethics in Politics, the same initiative that boosted the impeachment process of former President Fernando Collor, helped disseminate the information, recently published in the “Hunger Map” of the Institute of Applied Economic Research (IPEA, 1993) there were nearly 32 million extremely poor people in Brazilian countryside and cities. Among children under age five, more than 30% were undernourished.

<sup>2</sup> According to Rome Declaration on World Food Security: “food security (is) a situation that exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life” (FAO, 1996).

The initial mobilization for impeachment ended up incorporating flag causes, such as fighting social inequality and broadening access to basic rights, strengthened by initiatives as the Citizenry Action against Hunger and Poverty and for Life, sociologist Herbert de Souza (Betinho) led and several other civil society entities supported, such as Brazilian Bar Association (OAB), Caritas, representing the National Conference of Brazilian Bishops (CNBB), the Unified Workers' Central (CUT), Brazilian Institute of Social and Economic Analysis (Ibase – Brazilian acronym), Institute of Socioeconomic Studies (INESC – Brazilian acronym) and the National Association of Directors of Higher Education Federal Institutions (Andifes). The situation was conducive to the achievement of the 1<sup>st</sup>. National Conference on Food Security in 1994, in which various segments of society had the opportunity to discuss and put in evidence their common concerns about hunger, poverty and the exclusion of millions of Brazilians. The agenda was extensive, but the claims had an obvious point in common: Broadening the access to fundamental rights for the huge number of people who had been excluded in the country throughout history.

Another key step was the creation that time, 1993, of the National Council for Food Security and Nutrition (Consea), an advisory body for the President. Despite having its activities suspended from 1994 to 2003, Consea was and still is a key-actor in food-and-nutrition security governance in Brazil and contributed to confer some prominence to the hunger issue on political agenda. From then on, the adoption of food security concept was extended in the formulation of public policies in federal, state and municipal levels (MALUF *et al.*, 1996).

This process led to the formulation of Brazilian concept currently employed, which was based on a document approved at the 2<sup>nd</sup>. National Conference on Food Security and Nutrition, in 2004, and was subsequently incorporated into the Organic Law of Food and Nutrition Security (Losan) in 2006 (BRAZIL, 2006). According to Losan, food and nutrition security is defined as “the realization of everyone’s right to regular and continuous access to quality food in a sufficient amount without compromising access to other essential needs, based on health promoting dietary practices that respect cultural diversity and are socially, economically and environmentally sustainable”. Therefore, Brazil already incorporated references to sustainable production practices, multisectoral and human rights perspectives into its legislation in the past ten years.

Losan was sanctioned in the wake of the same movement Brazilian government promoted with the proposal of Zero Hunger program, launched in 2003, integrating a set of policies and actions that aimed at boosting the fight against malnutrition and hunger in the country, raising the issue priority status on national government agenda. In addition to governmental and institutional commitment to the implementation of the new food and nutrition security agenda through Brazilian public policies, the strong

role of civil society in this matter has contributed to Losan effective implementation, keeping the food and nutrition security theme in the agenda of social demands.

## **2 Decade of Action on Nutrition (2016-2025): from the hunger eradication to the fight against all forms of malnutrition**

On April, 2016, the United Nations General Assembly (UNGA) announced, through Resolution 70 / 259 (UN, 2016b), the Decade of Action on Nutrition (2016-2025), recognizing the:

need to eradicate hunger and prevent all forms of malnutrition worldwide, particularly undernourishment, stunting, wasting, underweight and overweight in children under 5 years of age and anemia in women and children, among other micronutrient deficiencies, as well as reverse the rising trends in overweight and obesity and reduce the burden of diet-related non-communicable diseases in all age groups.

The goal of instituting this “Decade of Action” is to coordinate efforts in diverse sectors to effectively fight all forms of malnutrition, starting from a broader perspective recognizing the root causes and factors contributing to different nutritional outcomes are complex and multidimensional (FAO, 2017). Although the world has registered important advances in the area of food and nutrition security, the nutritional challenges faced by many countries keep increasing and changing, requiring continued commitment and strong political leadership. That occasion, UNGA stated it would not be possible to combat malnutrition without solving determinant factors, such as poverty, unemployment, inequality and inequity, lack of basic sanitation, and lack of access to education and healthcare.

The resolution recognized the existence of new challenges that also contribute to the worsening of nutrition: Countries or regions in conflict or post-conflict situations, humanitarian crises, and climate changes. The resolution also established FAO and the World Health Organization (WHO) are going to coordinate the implementation of Decade of Action on Nutrition in close collaboration with the World Food Programme (WFP), the International Fund for Agricultural Development (IFAD) and the United Nations Children’s Fund (Unicef).

## **3 Main frameworks: ICN2 and 2030 Agenda**

To put the Decade of Action on Nutrition into practice, it seeks to catalyze and facilitate continued efforts alignment of all involved sectors, both governmental and

nongovernmental, to promote a global movement consistent with national, regional and global policies developed in this area.

Ultimately, the goal of Decade on Nutrition is to accelerate the implementation of global commitments countries already taken in multilateral forums to end hunger and all forms of malnutrition, and no new goals have been negotiated. The Decade has set a timeframe over which effective global engagement to the matter will be sought, strengthening the coordination and integration of previously agreed initiatives, and encouraging the adoption of new initiatives and related commitments.

In the Decade scope, it is recognized the existence of local, national, regional and global movements that must be strengthened. The documents resulting from the 2<sup>nd</sup>. International Conference on Nutrition (ICN2): the Rome Declaration (FAO, 2014b), and its Framework for Action (FAO, 2014a), the goals of Global Nutrition and Diet-Related Chronic Noncommunicable Diseases until 2025 (WHO, [2018]), and 2030 Agenda for Sustainable Development, all ones are particularly highlighted.

Regarding 2030 Agenda, the major global agenda for sustainable development aiming to end poverty, promote everyone's prosperity and well-being and protect the environment, the topic of nutrition is directly or indirectly related to six of its 17 Sustainable Development Goals (SDGS), the second being exclusively dedicated to the topic: "end hunger, achieve food security and improved nutrition, and promote sustainable agriculture" (UN, 2015). Undoubtedly, the implementation of the agenda for the Decade may also contribute to the achievement of almost all SDGS, since there is no development without access to healthy and adequate food. The transversal and intersectoral nature of health, and of food and nutrition security, is therefore a key component in promoting sustainable development throughout the world.

The Rome Declaration on Nutrition and the recommendations of its Framework for Action, both documents resulting from ICN2 are taken as the basis for the organization of the six pillars that guide actions on nutrition in UN Decade of Action context, namely:

- Sustainable food systems and promoters of healthy eating;
- Aligned health systems providing universal coverage of essential health actions;
- Social protection and nutritional education;
- Trade and investment for better nutrition;
- Enabling food and breastfeeding environments;
- Governance revision, strengthening and promotion in nutrition and accountability.

The six thematic pillars that organize the Decade action groups make it clear that tackling malnutrition is only possible with a set of complementary and intersectoral policies. It is recognized not be feasible to fight hunger thinking only of

increasing food production, nor thinking in undernutrition as the only consequence of malnutrition, especially with the increasing numbers of obesity and overweight presented by populations around the world. Most countries currently experience multiple malnutrition outcomes, i.e., they simultaneously present high rates of child undernourishment, anemia among women, and adult and child obesity. In view thereof, it is crucial to look at all steps that make up the food system, from production in the countryside to consumption on the table, and foster policies in each specific involved sector to allow access, throughout the year, to appropriate food to meet individuals' nutritional requirements and promote healthy, safe diets.

#### **4 Multistakeholder agenda: Intersectoral policies and health sector role**

The evolution of food security policies in Brazil is consonant with the six pillars of the Decade-of-Action work plan and supports the understanding that coping with all malnutrition forms is only possible with a set of complementary and intersectoral policies aiming at a sustainable food system that produce healthy food.

Through the National System for Food and Nutrition Security (SISAN) (BRAZIL, [201-]), Losan also created, organs of government (municipal, state and federal) and civil society organizations work together in the formulation and implementation of policies for food and nutrition security promotion. Besides Consea, which represents an area of social participation and control, Sisan also counts with a governmental coordination body, the Inter-ministerial Chamber for Food and Nutrition Security (Caisan), which comprises twenty ministries and is chaired by the Ministry of Social Development (MDS). Caisan “has the purpose to promote the articulation and integration of organs and entities of federal public administration related to the area of food and nutrition security” (BRAZIL, 2007). Its first responsibility is to “develop, based on the guidelines National Council for Food Security and Nutrition – CONSEA – issued, policy and the national plan for food and nutrition security”. An example of this articulation is the compulsory purchase of at least 30% of small family farming products for school meals.

The right to health is inseparable from the right to adequate nutrition<sup>3</sup>. In addition to the promotion, comprehensive health care also encompasses disease prevention actions and risk factors as well as health systems that fall the burden of food and nutrition insecurity, represented by the various forms of malnutrition. There is vast scientific evidence to prove the growing epidemic of chronic noncommunicable diseases, currently accounting for 70% of deaths worldwide<sup>4</sup>, is directly related to diets and lifestyle changes (WHO, [2014]). Unhealthy diets, along with the consumption of

<sup>3</sup> Brazilian Constitution of 1988 recognizes health as a social right. The right to nutrition was included in 2010 through Constitutional Amendment n°. 64.

<sup>4</sup> These include heart conditions, stroke, some types of cancer, diabetes, and chronic lung disease.

tobacco, harmful use of alcohol and low physical activity levels are the four major risk factors that drive the increase of these diseases.

In the same way a set of intersectoral policies was responsible for the important advances that Brazil has had in tackling malnutrition and hunger<sup>5</sup> in recent decades, it is also necessary to look to the social dimension of chronic diseases and the other consequences of malnutrition. Guarantee of food and nutrition security requires continued improvement of public policies in an integrated, complementary manner, prioritizing, in conjunction with health, aspects such as education, income, sanitation, urbanization, support for family farming, access to adequate, healthy food and the improvement of the entire food system, from production to distribution and consumption.

## **5 The leadership of the Americas on the food and nutrition security agenda**

Brazil submitted to the 60<sup>th</sup>. session of the United Nations' General Assembly a motion for a resolution that led to the adoption of the Decade of Action on Nutrition. In his speech, the permanent representative of Brazil to the United Nations, Ambassador Antonio de Aguiar Patriota, emphasized the understanding historically developed in Brazil on social dimension of hunger and malnutrition, and called upon countries to tackle their root causes, which largely arose out from poverty and inequality (UN, 2016a)<sup>6</sup>.

The Brazilian government, along with other countries in the region, such as Argentina, Chile, Colombia, Ecuador and Mexico, played a leading role in the articulation that resulted in this resolution. That leadership reflects the importance of the region on the issue of nutrition and the defense of the human right to food.

A year before, in 2015, Latin America and the Caribbean were considered a global example, as they were the first region in the world to meet the undernutrition goal of the Millennium Development Goals (MDG), i.e., to reduce hunger by 50%, which dropped from 14.7% in the 1990-1992 biennium to 5.5% in the 2014–2016 period. Besides having achieved substantial advances in the combat against poverty and hunger, the region is also a major food producer.

The strengthening of social policies and changes in food systems have the potential to generate positive effects such as broadening the access to basic rights and the reduce of inequalities. Conversely, they also have caused worrisome changes to the patterns of food consumption and nutritional status of their populations. Studies show a reduction

<sup>5</sup> Brazil came out the so-called "World Hunger Map" in 2014, according to data published in the report "State of Food Insecurity in the World" by the United Nations' Food and Agriculture Organization (FAO, 2014).

<sup>6</sup> Speech delivered on April 1<sup>st</sup>, 2016.

in the consumption of *in-natura* products and an increase in the consumption of ultra-processed foods or with large amount of sugar, salt and fat in Latin America, factors that explain the considerable increase in overweight and obesity in most countries of the region (CASTRO, 2017). At the same time, this reality coexists with the persistent prevalence of hunger and malnutrition in specific populations.

During the 35<sup>th</sup>. FAO Regional Conference for Latin America, held in Montego Bay, Jamaica, on March, 2018, the Organization's Director-General, José Graziano da Silva, stated that "eradicating hunger should not be the only concern in a region where overweight affects 7% of children under five years of age and in that 20% of adults in 24 countries are obese" (UN, 2018).

Particularly on Brazil, governance for food and nutrition security policies is considered an international reference for having achieved sound results and significantly reduced hunger and malnutrition. Among the Brazilian initiatives considered more successful, the *Bolsa Família* Program<sup>7</sup>, the National School Food Program and the National Food and Nutrition Policy stand out.

Regarding fighting obesity, the region has experiencing innovative public policies, such as taxation of soft drinks in Mexico, new food labeling in Chile and Peru, and the publication in Brazil and Uruguay of food guides based on meals that adopt the classification of foods according to their degree of processing. There is certainly a strong expectation the region will work in a coordinated way, so that the Decade can achieve sound results and allow substantial advances on food and nutritional security agenda. For this reason, the Ministry of Health has sought to promote, through an integrated action between the International Health Affairs Office of the Ministry of Health (AISA) and the Coordination of Food and Nutrition (CGAN), initiatives aimed at reinforcing the food and nutrition security agenda in the Americas, engaging the countries of the region in concrete initiatives for strengthening the Decade and effectively meeting its objectives.

## 6 Commitments and Action Networks in Brazil

On May, 2016, the World Health Assembly (WHA), through Resolution WHA 69 / 8, requested the Director-General of WHO work in coordination with the Director-General of FAO "to support Member States, upon request, in developing, strengthening and implementing their policies, programs and plans to address the multiple challenges of malnutrition and convening regular meetings, inclusive to share best practices, including the consideration of commitments that are Specific, Measurable, Achievable,

<sup>7</sup> Bolsa Família is a direct income transfer program aimed at families living in poverty and extreme poverty throughout the country, so that they can overcome the situation of vulnerability. The program seeks to guarantee these families the right to food and access to education and health.

Relevant and Time-bound (SMART) (WHO, [2016]), inside the framework of the United Nations' Decade of Action on Nutrition" (FAO, 2017).

Faced with this request, Who drew up a Work Plan for the Decade of Action on Nutrition. The document provides recommendations and indicates mechanisms by which countries and other interested parties should collaborate to achieve the goals of the Decade. The Plan describes objectives, guiding principles, priority actions, modalities of engagement, and roles of Member States and other interested parties.

In addition to SMART commitments, the establishment of Action Networks is recommended as catalytic mechanisms for their fulfillment. According to the Plan, Action Networks must be formed by groups of countries presenting common interests in specific topics on the food and nutrition security agenda, aiming at: Promoting the creation and strengthening of policies and / or laws on this matter; fostering technical cooperation initiatives; and sharing good practices related to specific themes.

In this work proposal view, AISA coordinating with CGAN, has built an action strategy to highlight the national policies of food and nutrition security and, at the same time, to reassure Brazilian commitment to the success of Decade.

On May, 2017, Brazil was the first country to embrace and formalize to WHO its SMART commitments established in the Decade of Action framework<sup>8</sup>. The Minister of Health, Ricardo Barros, submitted to the 70<sup>th</sup>. World Health Assembly three Brazilian commitments to fight obesity and specific measures to set out to achieve them, including: Measures to increase consumption of fruit and vegetables, reformulation of processed foods to reduce sodium and sugar levels, and the continuous improvement of the breastfeeding promotion policy. The three commitments Brazil presented were to up to 2019 (WHO, 2017):

1. Stop the growth of adult obesity rate (at the time, 20.8%);
2. Reduce by at least 30% the adults' consumption of sugary beverages;
3. Increase by at least 17.8% the proportion of adults who regularly have fruits and vegetables.

Besides the process of formalizing SMART commitments to WHO, AISA has also worked in identifying healthcare reference policies that could become the object of cooperation among countries through Action Networks. In this sense, articulations with American region countries were crucial to establishing strategic partnerships that could support the strengthening of policies and programs of mutual interest. The Brazilian Ministry of Health proposed the coordination of two Action Networks under Decade framework: (i) Network for the dissemination of Food Guides based

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<sup>8</sup> SMART commitments Brazil formalized are related to the II National Plan of Food and Nutrition Security (PLANSAN 2016-2019).

on the level of food processing, and (ii) Network on strategies for reducing sodium consumption and prevention and control of cardiovascular diseases.

Brazil also integrates the network Chile's Ministry of Health coordinated called "American Network of Healthy Food Environments (Realisa – Brazilian acronym)", which covers regulatory actions, such as front-of-package nutrition labelling policy of processed foods – a policy currently under review in Brazil and that is considered an important tool for promoting healthy diets. At the 42<sup>nd</sup>. Meeting of Mercosur Health Ministers held in Asunción on June, 2018, State Members of the bloc adopted an agreement to improve nutrition information for packaged foods by implementing front-of-package nutrition labeling in the context of their public health policies, establishing a set of principles (MERCOSUR, 2018) that must be followed in this task, such as:

- a. Report excessive amounts of critical nutrients (sugars, sodium, total fats, trans and saturated fats) contained in foods associated with a higher risk of non-communicable diseases.
- b. Include information to enable consumers to easily and quickly understand the excessive content of critical nutrients, facilitating informed decision-making.
- c. Determine the limits of critical nutrient excesses based on PAHO/WHO recommendations.
- d. Report only the excessive presence of critical nutrients.
- e. Allow consumers to compare foods in the same and different categories.
- f. Be located on the front of the package, easily visible to quickly attract the consumer's attention.
- g. Do not allow the consumer's misperception food with excessive amounts of some critical nutrient is healthy.
- h. Be based on scientific evidence that has demonstrated its effectiveness.
- i. Be mandatory.

Coordination and participation in Action Networks involves constant dialogue with partner countries, sharing documents, technical notes, in person and virtual meetings, and sharing experiences reporting successes and challenges. The main agents in these exchanges are the professionals from the technical areas of the Ministries of Health, monitored by international advisors.

The potential positive outcomes, both at the national and global levels, from the engagement of the Ministry of Health in these spaces for sharing experiences and holding talks are evident. National strategies, such as *Food Guide for Brazilian Population*, are strengthened when used as reference and inspiration for other countries – as Uruguay, which launched a guide based on Brazilian experience.

Likewise, sharing experiences with other countries in the formulation and implementation of policies to locally develop can broaden the chances of success and minimize challenges.

Measures such as implementing regulatory measures to ensure healthy environments, for example, pose a significant challenge to the Ministries of Health across the region, particularly due to their direct implications for the food and beverage industries. Sharing experience and advancement of international consensuses over these issues allow, at the same time, the formulation of regional strategies to cope with common problems and strengthen national capacities to advance public policies focusing on health.

## 7 Prospects

Having a proper, healthy diet is much more than ingesting micro or macronutrients in suitable amounts: it reflects centuries of practices, traditions, cultures and adaptations to new, different environments. Enjoying the right to proper food implies a socially and environmentally sustainable healthy food system, taking into account the impact of the forms of production, distribution and types of food made available for the population's consumption, as well as social justice, integrity, access to natural resources, and protection of traditional crops.

Brazil defends this perspective in its domestic intersectoral policies on food and nutrition and in its international action, whether through international cooperation projects developed in this area – such as the ongoing technical cooperation project in food and nutrition security area with Mozambique – or in its positions in multilateral forums – as in its choice of nutrition as the theme for Brazilian Presidency of Foreign Policy and Global Health Initiative<sup>9</sup> in 2018. Along with other regional partners, Brazil also defends this understanding of food and nutrition security, in the activities undertaken in the context of the Decade of Action on Nutrition.

AISA is responsible for translating these concepts into positions of the Ministry of Health in forums for concertation and dialogue with other countries. It is in the interest of Brazilian State and its society the Decade of Action enables the implementation of concrete advances on the food and nutrition agenda, both domestically and internationally.

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<sup>9</sup> *Foreign Policy and Global Health* (FPGH), created in 2006, made up of representatives from seven countries, South Africa, Brazil, France, Indonesia, Norway, Senegal and Thailand, and aims to promote discussions and international awareness of the relation between foreign policy and health, despite the multiplicity and diversity of its participants. FPGH Initiative presidency is rotating among its participants and Brazil assumed in 2018.

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The International Health Affairs Office (AISA) celebrated its 20<sup>th</sup> anniversary in 2018, and the publication *Health and Foreign Policy: 20 years of the International Health Affairs Office of the Ministry of Health of Brazil (1998-2018)* intends to present the history of the actions conducted in this period as well as the practical aspects of the work executed by the Office, its main challenges, the multiplicity and extent related themes, and the performance of the technical staff, who has contributed to the establishment of the Ministry of Health's leading role in the international arena.

AISA is an organizational unit institutionally linked to the Office of the Ministry of Health. Its competencies include dealing with international issues concerning the Ministry of Health and advising the Minister of Health on topics regarding international contexts. This book shows how AISA has focused on strategic issues for the Ministry of Health and Brazil, contributing to strengthen Brazilian foreign policies, defend the principles that guide the Unified Health System (SUS), and promote effective improvements in health care, both inside and outside the country.



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