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# Health as niche diplomacy: assessing design and practices of Brazilian health diplomacy at the beginning of the 21<sup>st</sup> century

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## Abstract

The paper explores Brazilian health diplomacy since 2000 by identifying aspects of design and practice employed by the actors involved. The Brazilian engagement is analyzed through the concept of niche diplomacy, with a focus on the use of technical capacities and on the venues through which the country aimed at exerting influence in global health by resorting to its internal expertise.

**Keywords:** niche diplomacy; Brazil; global health; South-South cooperation.

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## Introduction

**D**uring the 2000s and mid-2010s, Brazil directed much energy toward organizing and furthering its actions and activities for development promotion internationally (Instituto de Pesquisa Econômica Aplicada 2013; 2010) and promoted a greater orientation toward South-South cooperation (Lima 2005; Vigevani and Cepaluni 2007). Amid this broader endeavor, a specific policy for international health promotion could be discerned. Brazilian foreign policy for health counted on the coordinated activism of national health institutions and strong involvement of the Pan-American Health Organization (PAHO).

Since 2005, an international health policy was built upon the coordinated engagement of main actors of the national public health field: the Ministry of Health (MoH) and the Oswaldo Cruz Foundation (Fiocruz). From 2005 to 2015, these institutions gradually developed a common framework for the

manifold international health activities undertaken by them. Until that point, international activities were carried out autonomously, without a guiding reference established at the national or ministerial level. The common framework was not established in a top-down, hierarchical fashion: Fiocruz had a central role in devising conceptions that would guide this international activity, framed by a ‘structuring’ approach. Also, besides national institutions, PAHO had a leading role, through the establishment of two cooperation programs specifically aiming at strengthening the Brazilian capacities for an international engagement with health. This broad institutional coordination defined the main frames of the country’s health diplomacy at the turn of the century.

It is important to note that, even though this framework was formally established in 2005, Brazil already had some relevant international projects for health cooperation, which received international recognition since the early 2000s. Two noteworthy examples were the cooperation provided on treatment for HIV/AIDS, managed by MoH, and the international network for Human Milk Banks, spearheaded by Fiocruz. Both projects were advanced as part of a broader engagement of the national government with a platform for international health activities and represented the employment of national capacities to promote international technical cooperation.

This paper aims at presenting the main activities of the Brazilian health diplomacy at the beginning of the 21<sup>st</sup> century, and to analyze the country’s engagement with global health, with a focus on the resources employed in this endeavor. It explores Brazilian engagement through the lenses of ‘niche diplomacy,’ pointing to a strategy of action based on Brazilian internal capacities, and framed by a narrative that distinguished Brazilian health diplomacy from more traditional actions in the field. The period under analysis ranges from 2000 to 2015 and encompasses part of Fernando Henrique Cardoso second term (1999-2002), Luiz Inácio Lula da Silva’s two terms (2003-2010) and Dilma Rousseff’s first government (2011-2014). A stronger focus is placed on the actions undertaken since 2005 when a nationally coordinated policy for health began. The periodization has followed documents produced by the main actors involved: Fiocruz, MoH and PAHO.

The discussion is presented as follows: the next section engages with the concepts of niche diplomacy and global health diplomacy, which provide useful tools for analyzing both the relevance accorded to health internationally and the efforts of middle powers in deploying diplomacy in the context of the post-Cold War period. Next, the article explores how Brazilian health diplomacy has been designed, with attention to the orchestration of coordinated engagements between the main actors analyzed. The following section retraces the main activities deployed by Brazil in that regard, identifying main assets employed and central axes of action. Finally, the paper discusses Brazilian health diplomacy within the selected theoretical framework, presents some limits and dynamics of this engagement, and states its concluding remarks.

## Conceptual approaches: global health diplomacy and niche diplomacy

Global Health Diplomacy has emerged as an established concept among scholars interested in analyzing health dynamics in the 2000s and 2010s<sup>1</sup>. It conveys the idea that health has become a central issue of global politics that cannot be confined within national borders and which must be dealt with cooperatively under a global stance. This new perspective requires changing patterns of health diplomacy, which often are associated with a rise in multilateralism and a centrality of *soft* and *smart* powers for building alliances (Kickbush and Berger 2010).

In the 2000s, the concept of global health substituted the former concept of ‘international health.’ While this older term was associated with a North-South perspective of international cooperation policies carried out through state relations, ‘global health’ claims to be engaged with a more globalized perspective of health as a public good, in need of collaborative approaches to guarantee international safety and the provision of access to medical care as part of the human rights agenda; encompassing also a broad array of public and private actors in its provision. Global health has also been increasingly tied to security, development, and human rights concerns. As such, global health is associated with a perspective of global governance, in which states are no longer the main actors shaping international policy, and multiple centers of authority emerge (Rosenau 1992).

Global health literature has presented main power asymmetries in the field and a multiplicity of perspectives and interests held by different actors. As such, it would be difficult to treat health as a ‘niche’ for diplomatic action, as the field is thoroughly disputed. Nonetheless, the concept of niche diplomacy provides relevant tools to analyze the Brazilian engagement in this field. It centers on strategies developed by middle powers for achieving recognition in international politics, even though initial power resources are not much altered.

The framework of ‘niche diplomacy,’ as elaborated by Andrew Cooper (1997), directs attention away from purely structural perspectives of international relations, and stresses alternative sources of agency that have been opened to middle powers in the aftermath of the bipolar order of the Cold War<sup>2</sup>. The concept is explained partly by these states’ inability “to marshal the requisite resources to conduct foreign policy within the context of a grand global strategy” (Alden and Vieira 2005, 1078). As such, middle powers’ activism is explained not solely as a means to overcome material power deficiencies *vis-à-vis* other states, but by devising strategies of diplomatic engagement which encompass the identification of niches for action and the employment of ‘soft power’ resources, such as technical competence and effective communication (Cooper 2011). By this

<sup>1</sup> Martins et al. (2017) analyzed 54 scientific publications on global health diplomacy until 2014 and identified that 85% of them were produced from 2007 on.

<sup>2</sup> Cooper’s conception of niche diplomacy does not reject the structural perspective and associated constraints derived from the power imbalances between middle and great powers, which are still considered “the most important source of initiative in the international order” (Cooper 1997, 10). The author argues, nonetheless, that the concept of niche diplomacy stretch attention away from dominant approaches, too centered on traditional accounts of power, i.e., military or economic power.

engagement, middle powers develop capacities in specific niches of diplomacy and have their technical competences recognized by other actors within the international arena.

By exerting niche diplomacy, middle powers direct “their attention towards the domains where they (hold) a high degree of resources and reputational qualifications” (Cooper 1997, 3), thereby enhancing a functionalist take on the conduction of their foreign agendas. Nonetheless, even considering signs of greater activism, there remain reservations about the ability of middle powers to supply an abundant measure of international leadership. In order to examine Brazilian health diplomacy within this framework, the next sections explore the design and actions for the country’s engagement. In order to examine those elements, the analysis follows the distinction between foreign policy ‘as design’ and ‘as practice,’ as proposed by Jones (1970) (Tayfur 1994). In line with this approach, policy as design refers to a plan for action deliberately created to achieve specific objectives, and policy as practice refers to the actions effectively undertaken by states at the international scene.

## Designing Brazilian health diplomacy in the 2000s

Brazil has been involved in international cooperation for health since the beginning of the 20<sup>th</sup> century, first as a receiver of foreign aid, and later, as a ‘laboratory’ for the implementation of policies devised by international organizations in the promotion of public health in Latin American countries (Benchimol and Teixeira 1993; Lima 2002; Paiva et al. 2008). As the country’s development levels rose and internal capacities were created, Brazil also began to engage in international cooperation programs as a provider of knowledge and funds, through South-South Cooperation<sup>3</sup>. Activities related to development promotion in health accompanied this trend, and many projects were gradually implemented and diffused to other countries, especially since the 1980s, based on Brazilian experience, capacities, and knowledge.

From 2000 to 2002, the Brazilian presidency was occupied by Fernando Henrique Cardoso, and health was already a tool in South-South cooperation efforts. At the time, activities were dispersed, and conducted by national institutions as part of efforts for internationalizing successful national initiatives, case by case. Engagements in health diplomacy were furthered mainly through traditional diplomatic efforts within multilateral organizations, wherein Brazil and other developing countries, such as India, aimed at securing that the production of generic drugs was considered legitimate by international norms and rules. The Brazilian national health system and the universal coverage for HIV/AIDS were used as assets in international bargaining, which adopted a narrative of health as a humanitarian issue that should be treated differently from other issues within intellectual property trade agreements (Loyola 2008).

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<sup>3</sup> A landmark of this new orientation was the creation of the Brazilian Agency for Cooperation, in 1987, which became the responsible national agency for coordinating both receiving and donor activities within Brazilian foreign aid.

During Luiz Inácio Lula da Silva's presidency, Brazilian foreign policy took a new turn, which also affected the country's engagement with international/global health. Diplomacy under Lula da Silva has been described as occurring 'through diversification' of partnerships, with greater attention to South-South Cooperation (SSC) and associated with a new style of presidential diplomacy (Vigevani and Cepaluni 2007; Visentini 2010; Burges 2012). Involvement with a 'southern agenda,' while not abandoning its relations with developing countries, encompassed greater proximity with other regional powers, and greater activism towards Africa and Latin America (Almeida 2004; Lima 2005). Technical Cooperation became a central asset in this new turn, as Brazil sought to coordinate the bulk of cooperation activities that were until then conducted by dispersed unities, and to further a national policy for technical cooperation towards developing countries (Instituto de Pesquisa Econômica Aplicada 2013; 2010).

Diplomatic actions related to health have been affected by the above tendencies. The increased involvement with health diplomacy was founded on already existent international recognition of Brazilian capacities in health promotion. Brazil conveyed new actions<sup>4</sup> and a broader coordination of national implementing institutions: the Oswaldo Cruz Foundation (Fiocruz), the Ministry of Health (MoH) and the Pan-American Health Organization (PAHO). This coordination was marked by a greater synergy between Fiocruz's and MoH's strategic planning programs, and two cooperation agreements signed with PAHO: the Terms of Cooperation (TCs) 41 and 58<sup>5</sup>.

TC 41 was signed in 2005 between PAHO, MoH and Fiocruz and lasted until 2015. The agreement was titled 'International Health Program,' and aimed at "promoting, expanding and strengthening a Brazilian international cooperation policy for health," with three main objectives: the strengthening of national capacities for South-South Cooperation (SSC) in health; the mobilization of collaborative networks for SSC in health; and the promotion of SSC by international consortia for the development of human resources in health. More than 680 activities (short duration) and 51 projects (long duration) of international health promoted by Brazil were organized within the TC41 framework (Pan-American Health Organization 2015).

TC 58 was signed in 2009 between PAHO and MoH, and extended until 2019, and named 'Institutional Strengthening of the Ministry of Health's Advisory of International Affairs – AISA/MoH.' Its main aim was to strengthen MoH's Advisory of International Affairs (AISA/MoH)<sup>6</sup> in order to meet the demands for international action, according to national strategies defined within the MoH. AISA's strengthening encompassed the organ's international activities in the coordination of a Brazilian position within the main multilateral organizations; in devising cooperative activities

<sup>4</sup> Many works have presented descriptions and analyses of main cooperation projects or on the Brazilian health diplomacy at large. Recent works produced by lead figures and institutions of the field are Buss and Tobar (2018) and Ministério da Saúde (2018)

<sup>5</sup> Terms of Cooperation (TCs) have been the format of cooperation adopted by PAHO in its partnerships with Brazil since 1973. A main feature of TCs is that, once signed, they allow for a direct relationship between PAHO and the signing organ, with no necessary intermediation by the Ministry of Foreign Affairs. Many TCs have been financed by Brazilian resources, transferred to PAHO for the execution of the agreed activities. The duration of TCs are set for a maximum of five years, with a possible extension for the same period.

<sup>6</sup> AISA was created in 1998, as MoH's organ responsible for the coordination and monitoring of any health issue of international scope. Previously to its creation, other experiences for coordinating international issues inside MoH had existed since the 1970s.

at the national boundaries; and in facilitating and stimulating technical cooperation for health. Despite the different contents, TC58 brought many similarities with TC 41, and can be seen as a continuity of the former agreement, as many projects that were initiated under TC41 were continued within TC58 (Pan-American Health Organization 2014).

Other important events that marked the strengthening of the Brazilian engagement in health diplomacy were the creation of a Fiocruz Regional Representation Office for Africa, in Maputo, in 2008 and the Centre for International Relations of Fiocruz (CRIS/Fiocruz), established in 2009, as an Advisory Body for international activities for Fiocruz's Presidency. As such, the broad coordination between Fiocruz, MoH and PAHO became the groundwork for enhancing Brazilian health diplomacy since 2005.

A narrative of Brazilian health diplomacy was devised along with the setting in place of international cooperation projects. In 2010, an academic paper written by five functionaries of Fiocruz described the Brazilian approach for technical cooperation in health as a 'structuring' approach, which consisted of an 'innovative paradigm,' based on the construction of capacities for development. It was said to be distinct from previous paradigms in that it: i) aimed at integrating the training of human resources, the organizational strengthening, and institutional development; and ii) provided a rupture with a traditional passive transfer of technologies and knowledge. The new approach would explore the capacities and endogenous resources pre-existent in partner countries, and center on the institutional strengthening of their health systems, by constructing local capacities and knowledge generation. Cooperation should be driven within a dialogical approach, giving partner countries the opportunity to autonomously lead the promotion of their agenda for health development (Almeida et al. 2010). Within this framework, Fiocruz functioned as the 'executive arm' and MoH became the central political actor to lead international negotiations - a position that traditionally had been occupied by the Ministry of Foreign Affairs - and participate in summit conferences on health.

## Brazilian practices towards an increased activism

Brazilian engagement with health diplomacy initially gained salience in the 2000s, under Fernando Henrique Cardoso presidency. The development of a national HIV/AIDS of universal coverage and treatment, based on the local production of Anti-Retroviral Drugs (ARVs) dates back to this period, and was marked by a coordination of national policies and international diplomacy, in the context of negotiations for the Trade-Related Aspects of Intellectual Property Rights (TRIPS). With an effort to secure the continuity of public universal coverage for HIV/AIDS treatment with local production of generic versions of ARVs by Fiocruz – which were less expensive than buying from international laboratories – Brazil engaged in an international campaign for the recognition of the access to such medicines as a humanitarian issue, and the legitimization of



compulsory licenses to ARVs drugs<sup>7</sup>. In 2001, the Brazilian HIV/AIDS policy was considered a role model for coping with the disease by the WHO and the United Nations Program on HIV/AIDS (UNAIDS) (Loyola 2008).

This recognition paved the way for a greater engagement with international policies for HIV/AIDS, whereby Brazilian experiences and capacities – in the production of generic ARVs, along its coordination of a national policy for accompanying and delivering medicine to infected people, and involving campaigns for furthering information and prevention on Sexual Transmissible Diseases (STDs) – were employed to further projects in other developing countries (Ministério da Saúde 2002).

The creation and operation of Human Milk Banks, a project developed nationally by Fiocruz since the 1940s, was also acknowledged by the WHO as a successful policy toward the reduction of child mortality in this period. Since 2003, Fiocruz has coordinated an international network of Human Milk Banks, fostering Brazilian experience and expertise to the consolidation of national networks within partner countries, in the Americas and, since 2008, also in countries of the Community of Portuguese-speaking Countries (CPSP).

Since 2003, first year of the Lula da Silva presidency, a stronger orientation towards Portuguese-speaking countries in Africa could be felt with the implementation of a project that became a symbol of presidential diplomacy and of Fiocruz's protagonism in advancing an 'innovative' technical cooperation. It is the case of the agreement for the implementation of a public-owned factory in Mozambique, to produce generic ARVs. The initiative was stated by the President in its visit to the African country during his first year of government. It would be the first ARV factory on the African continent.

The cooperation project was formalized in 2003 and idealized as a broad technology transfer initiative, involving, beyond the plant infrastructure, the training of local people by Fiocruz. All necessary knowledge and most of the structure for the functioning of the factory would be provided by Brazil. After some years of negotiation, the project began to be implemented in 2005, and the factory initiated operations in 2013 (Siqueira 2014). The factory became an emblem of Brazilian engagement in South-South technical cooperation, as it was deemed free of conditionalities and oriented towards the effective creation of capacities for overcoming the dependency on the international market for the provision of medicines. Another cooperation project with Mozambique, signed in 2003, was the PCI-Ntwanano, aiming at developing capacities for the treatment of HIV/AIDS. The agreement encompassed the training of technicians and the delivery of generic antiretroviral drugs and computer equipment to Maputo General Hospital. Both initiatives were based on Brazilian capacities and knowledge, that the country was willing to share and provide with resort to its public personnel and institutions.

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<sup>7</sup> Diplomacy concerning the break of patents for drugs in the context of the implementation of TRIPS engaged many actors at the international field: pharmaceutical companies, developing and developed countries and international organizations, such as UNAIDS and WHO, and lasted many years. An agreement concerning the legitimacy for compulsory licenses in case of public health interests was reached in 2001, with the Doha Declaration of the WHO and its acceptance by the World Trade Organization.

Since 2005, the involvement of Fiocruz and MoH under a shared framework of cooperation marked the beginning of a nationally framed policy, which continued those successful initiatives that became landmarks of Brazilian capabilities in health provision. TC41 and TC58 provided a legal structure for orienting the actions undertaken. Within these compromises, we discern five main axes of Brazilian health diplomacy: i) South-South technical cooperation projects; ii) advancing international networks for health; iii) providing health supplies under demand from countries or international organizations to the global market; iv) improving regional integration; and v) participating as a meaningful player in multilateral forums within health debates. Below we discuss each of these axes, with a focus on the assets employed. The axes were identified based on Fiocruz's management reports from 2000 to 2015; MoH official documents related to international activities in the same period; and on management reports from TCs 41 and 58.

### Technical Cooperation between Developing Countries (TCDC)

The bulk of TCDC projects was provided by Fiocruz and, generally, followed the terms that came to be described as the 'structuring approach.' Projects were driven towards the institutional strengthening of public health institutions, encompassing the creation and strengthening of institutions for human resources training in areas of services provision (such as nurse and medical schools) and management (such as public health schools and post-graduation courses). Projects also encompassed the creation of institutions for knowledge provision, and research and development aimed at informing the public health sector. Within this strategy, two main paths were followed: the strengthening of National Health Institutions (NHI) – for which, generally, Fiocruz served as a model; and the training of human resources for health provision and administration.

NHIs were considered central elements for the strengthening and functioning of national health systems. In this regard, Fiocruz has participated in the elaboration of a Strategic Plan for organizing the NHI in Mozambique and supported the creation of the Women and children NHI in this same country. It also advised on the creation of a NHI in Guinea-Bissau. Fiocruz also organized assessment missions for NHI of the Community of Portuguese-speaking Countries (CPSC)<sup>8</sup> and together with Portugal elaborated the 'Strategic Plan for Health Systems in CPSC.' In Latin America, Fiocruz has promoted many cooperation projects with the National Administration of Laboratories and Health Institute Dr. Carlos Malbrán (ANLIS), from Argentina. Both Fiocruz and ANLIS worked on the institutional strengthening of organizations for Health and Science and Technology for Health. Fiocruz also advised in the creation of the National Institute for Science and Technology in Health, in El Salvador.

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<sup>8</sup> CPSC is the intergovernmental organization of Portuguese Speaking Countries, with nine members: Angola, Brazil, Cape Verde, East Timor, Equatorial Guinea, Guinea-Bissau, Mozambique, Portugal and São Tome and Príncipe.



Those projects reveal a strong commitment of Fiocruz in devising National Health Systems in African and American countries, following Fiocruz's knowledge and experience. As such, these activities proved to be a strategic link for the deployment of Fiocruz's health diplomacy, as it created international linkages between NHIs, wherein Fiocruz's role encompassed advice and expertise provision.

Concerning the training of human resources, projects were developed to create and strengthen teaching institutions for management positions or health service provision in the assisted countries, or involved the training of foreign students in Fiocruz's teaching institutions. In this respect, Fiocruz had much expertise, as it was the main institution in Latin America for the training of human health resources. Under TC 41, projects encompassed evaluating foreign missions; the creation of post-graduation courses in cooperation with African and American Countries; the teaching of foreign students in national institutions. There were also training courses for capacitation on specific diseases, such as Tuberculosis and HIV/AIDS, which relied on the national expertise in the field. The list of attended countries for each objective is presented in Table 1, with all projects having Fiocruz as its main executor.

**Table 1 – TCDC for the training of human resources**

<b>Objective</b>	<b>Partner Countries</b>
Creation or strengthening of post-graduate courses in public health	Guinea-Bissau, Angola, Mozambique, Argentina, Peru, São Tomé and Príncipe
Training of human resources for health services provision (technical teaching)	Guinea-Bissau, Angola, Mozambique, Argentina, Bolivia, Honduras, Paraguay, Uruguay, Cape Verde

## International networks for health promotion

Another main axis of Brazilian cooperation in health was the promotion of international networks. This subsection describes efforts of network creation with a multilateral nature, excluding a few cases of bilateral or trilateral cooperation. International networks encompassed the goals of strengthening National Health Systems, promoting regional integration or the exchange of knowledge between countries. While some networks for health promotion or knowledge exchange existed long before 2005, they were mostly characterized by greater involvement of one of the actors and were not tied to a broad project for international health cooperation. Also, since 2005, new international networks were created, most of them coordinated by Fiocruz, at least in its beginnings. These are displayed in Table 2. Mostly, new networks encompassed health institutions of lusophone or Latin and Central American countries. They were described by CRIS/Fiocruz as collaborative structuring networks in health, and their development was seen

as a tool of Brazilian cooperation, aiming at inter-programmatic approaches and interaction between countries.

**Table 2 - Promotion of International Networks for Health by Fiocruz (2005-2015)**

<b>Network / year of creation</b>	<b>Participants</b>	<b>Network Coordinator (during the analyzed period)<sup>9</sup></b>
Ibero-American Network of Human Milk Banks (2007)	Argentina, Bolivia, Brazil, Colombia, Costa Rica, Panama, Paraguay, Peru, Spain, Uruguay, and Venezuela. Activities were also developed in Angola, Cape Verde, and Mozambique	Fernandes Figueira Institute/Fiocruz
International Network for Health Technicians Education <sup>10</sup> (RETS) (2005)	110 health institutions from 22 countries. Encompasses two other networks for Health Technicians Education: RETS-CPSC and RETS-Unasul	Polytechnic School of Health Jorge Venâncio (EPSJV/Fiocruz)
National Institutes of Health Network (RINS) (2010)	Union of South American Nations (Unasul)	International Relations for Health Centre /Fiocruz
National Public Health Schools Network (RESP) (2011)	Union of South American Nations (Unasul)	National School of Public Health Sérgio Arouca /Fiocruz
Pan-Amazonian Network for Science, Technology and Innovation for Health (2007)	Organization of the Amazon Cooperation Treaty; Association of Amazonian Universities (UNAMAZ); PAHO and Fiocruz	Organization of the Amazon Cooperation Treaty; PAHO; Fiocruz; UNAMAZ; Amazonian Intergovernmental Committee for CTIS
Health Research and Development Network for Malaria (RIDES/Malaria) (2008)	CPSC	Malaria Department of the Oswaldo Cruz Institute/Fiocruz (since 2013).

The table brings together different sorts of networks, and it is important to point to some of their peculiarities. The Ibero-American Network of Human Milk Banks represents an international cooperation founded on a successful Brazilian initiative: the national network for Human Milk Banks. The technology for human milk packing, preservation, treatment, and distribution has been developed nationally, within the Fernandes Figueira Institute, in Fiocruz. The knowledge and practices involved have acquired international attention and the creation of international networks can be seen as a deployment of good practices by their own terms – a result that could have been reached even without a broader orientation for health diplomacy, put in place by Fiocruz functionaries as a continuity of a successful national experience.

Other networks, such as the RETS, RINS, and RESP, were furthered by Fiocruz inside a regional organization – Unasul, created in 2008 and comprising all twelve countries of South

<sup>9</sup> According to the Fiocruz Reports from 2001-2015 and TC 41 Reports from 2009-2015. Coordination may have changed since then.

<sup>10</sup> The Network was created in 1996, under the coordination of the School of Public Health from Costa Rica. It was deactivated in 2001, and reactivated in 2005, under the coordination of the Polytechnic School of Health in Fiocruz.

America<sup>11</sup>. These were specifically developed in association with this regional integration project. As such, they can be understood as networks that bridged Fiocruz's knowledge and institutions with other national health institutions from Unasul, under common projects in their specific themes – Technical Education for Health; NHI; and Health Public Schools. Considering these networks within this diplomatic context, it is possible to assume that they represented the knowledgeable, technical, and material bases for sustaining a project of political integration in which health also played a role. The paths through which health was being imagined and cooperatively structured within them reinforced a peculiar public health structure, similar to that developed in Brazil since the 1990s and in accordance with PAHO's main visions and orientations.

RIDES-Malaria is described as a thematic network of investigation, which provides techno-scientific support to the Ministries of Health of CPSC. Another similar network was the 'RIDES-HIV,' aiming at promoting HIV/AIDS research and development in CPSC, with representatives from the MoH, under the National Program for Women's Health. Both cases represent an effort of network structuration for specific themes, in which the involved Brazilian institutions had recognized expertise and knowledge. Nonetheless, in the CPSC case, it is important to recognize the membership of Portugal, a developed country, which also actively engaged in the definition of strategies of cooperative models. In this group, Brazil did not figure as the sole leader in terms of expertise provision, as many projects for health cooperation were led by Brazil and Portugal. Even so, the RIDES networks encompassed the association of national expertise with a broader diplomatic orientation toward South-South Cooperation. Within RIDES, the objective was more thematic-specific and research-oriented, and less driven toward the building of structuring institutions for health training, as was the case of networks within Unasul. It is possible to argue that the distinct conformation and membership of each integration bloc was crucial for explaining the distinct arrangements, but further analysis of the functioning of networks would be required.

Besides networks backed by Fiocruz, other networks were supported by TC 41, and many of them inspired by Brazilian experiences in areas of health information provision, and courses and observatories for human resources in health, among others. For instance, the International Interagency Network for Health Information was a project supported by PAHO in collaboration with the Institute of Communication and Scientific and Technological Information in Health of Fiocruz (ICICT/Fiocruz), that was modeled upon the Brazilian Interagency Network for Health Information (RIPSA), aiming at the provision of relevant health data of the country. Another example is the international network of courses CADRHU/CIRHUS, aimed at strengthening national capacities for leadership and human resources management for health, also modeled on a successful methodology created in Brazil. This international network was backed by PAHO and MoH. It is worth mentioning that the 'Brazilian models' were themselves developed within PAHO's historical cooperative engagement with the country. As such, these cases exemplify the

<sup>11</sup> Unasul is an intergovernmental organization constituted in 2008, conveying all twelve countries of South America. Since 2018, seven countries either suspended their activities within the bloc or withdrew their membership. Since then, the continuity of the organization has been severely strained.

use of Brazil as a ‘laboratory’ for the implementation of health initiatives, expanded through international cooperation with PAHO, that when successful were disseminated to other countries or amplified through an international network.

## Provision of health supplies for global health

Provision of health supplies to other countries, such as vaccines and antiretroviral drugs (ARVs), became a new form of Brazilian engagement in global health. An important distinction is that the *donation* of supplies was managed through AISA/MoH, while Fiocruz could only *sell* vaccines with a price below their market price<sup>12</sup>.

During Fernando Henrique Cardoso government, MoH launched an international call for applications for the donation of ARVs produced in Brazilian public laboratories. This program was later transformed in an international initiative for fighting HIV/AIDS – ‘*Laços Sul-Sul*,’ – which encompassed Brazil, Bolivia, Cape Verde, Guinea-Bissau, Nicaragua, Paraguay, São Tomé and Príncipe and East Timor, in collaboration with UN agencies and the International Center for Technical Cooperation in HIV/AIDS<sup>13</sup>. *Laços Sul-Sul* was established in 2004, aiming at broadening the activities for the disease treatment. The Centre promoted universal access to prevention, treatment, and care in HIV/AIDS and mobilized society towards this end and created a supportive environment to diminish the stigma associated with the disease. The Brazilian government remained committed to the donation of ARVs to member countries, until the end of the initiative.

Fiocruz participated in the export of vaccines on two occasions. In 2007, it attended an international call of the WHO for suppliers of vaccines against meningitis, after private laboratories ended their production. In 2010, Fiocruz exported millions of vaccines for yellow fever to Africa and Latin America under pledges from Unicef (Thorsteinsdóttir and Sáenz 2012). These actions demonstrate the use of Fiocruz’s productive capacity – both in the production of ARVs and vaccines – to increase its participation in the provision of supplies for global health. As such, Brazilian public laboratories appeared as potential providers of health supplies within international aid dynamics, as private laboratories no longer produced the necessary inputs to cover such diseases. This work has been carried out in close association with UN agencies for international cooperation.

## Regional integration projects

This topic encompasses activities related to regionalization processes. As could be seen above, many international networks for health conveyed an integrative perspective related to international arrangements that Brazil furthered in the 2000s and 2010s, especially within Unasul and CPSC.

<sup>12</sup> This distinction encompasses legislation the use of public funds. To provide international donations, it is necessary to have approval from the National Congress. As Fiocruz is a state owned enterprise, it cannot donate medicines or vaccines by itself.

<sup>13</sup> The International Center for Technical Cooperation on HIV / AIDS was created by a partnership between Brazil UNAIDS to combat AIDS through South-South cooperation. The center was in charge of the management of *Laços Sul-Sul* initiative, but was extinguished in 2010.

It is interesting to point out that Fiocruz was on the frontline of new network arrangements, creating and establishing technical and material substance for cooperation with Unasul and CPSC countries, and MoH remained in charge of more traditional integration blocs, such as Mercosul, but also participated in networks aiming at furthering a place for health within new integration projects, as is the case of the South-American Network for Technical Cooperation in Health and International Relations Workshop (Redessul-Oris), composed by MoH of each member of Unasul.

Institutional settings for health cooperation were greatly created within Unasul. In 2009, the organization established the South-American Health Council (or *Unasul-Saúde*) as a permanent forum to be attended by Health Ministries of the Member countries. The Council should be a space for health integration activities, the promotion of shared policies, and coordination of activities. In 2011, Unasul created the South-American Institute for Health Government (ISAGS), which implemented technical cooperation through the networks RETS, RINS, RESP and Redessul-Oris presented above, but also by the Network of National Institutions for Cancer and the Network for Disaster Risk Management. MoH has also been an active promoter of such initiatives, especially by furthering the creation of ISAGS. Nonetheless, ISAGS' activities were suspended in 2019, as a result of Unasul's political crisis, marked by the withdrawal of half of its members. Within CSPS, Portugal and Brazil have set a Strategic Plan for Health Cooperation, from 2009-2012, aiming at strengthening the national health system of its member states. Fiocruz was the Brazilian organ involved in the plan developed, but MoH participated in the conduction of health initiatives within the CPSC, with the creation of a Technical Group for Health for CPSC, in 2009, inside the AISA/MoH structure. Concerning Mercosul, the bulk of activities in health have been conducted by the MoH and has its beginnings before the 2000s. Many activities developed in the period were related to legislations and vigilance control.

## Health diplomacy in multilateral forums

The improvement of Brazilian capacity to integrate multilateral forums and negotiations on international governance issues, with greater relevance, was one of the objectives established by TC 58. These activities were mainly attributable to AISA/MoH, but in some cases, conducted or signed by the Ministry of Foreign Affairs.

It becomes interesting to consider that such activities were made possible as health was being treated as a main theme for international politics at the beginning of the 21<sup>st</sup> century, and was incorporated as a central issue for debate inside many multilateral forums created on distinct thematic arrangements. They mostly involved political cooperation based on shared identities of their members – be it their economic power, their level of development, or their status as middle/regional powers. In these forums, Brazil aimed at improving its participation in health debates. In 2007, Brazil signed the Oslo Declaration, along with Norway, France, Indonesia, Senegal, South Africa, and Thailand. These countries reached a compromise in establishing an Agenda for

Action, placing health as a central concern within their foreign policies. Brazil also reinforced its intention to engage with the reform of the World Health Organization.

Within the BRICS, formally created in 2009, health received great attention. Since 2011, health ministries of its member countries have met aiming at developing a common agenda for health. BRICS has also sought to evolve as a forum for the coordination, cooperation, and consultation on issues related to global health. Otherwise, Brazil has integrated the debates on South-South Cooperation for Health of the Organization for Economic Cooperation and Development (OECD), through a process of enhanced engagement, even though Brazil is not a member of this Organization.

## Assets, imbalances, and limits of Brazilian niche diplomacy

Can Brazilian health diplomacy in the period analyzed be approached through the lens of niche diplomacy? If so, what efforts were employed in attempts to create a niche, and how is that niche distinct from overall global health diplomacy as it came to be occupied by Brazil? In order to approach these questions, it is important to identify what assets were engaged in the conduction of actions, and thus, if a functionalist take has driven health diplomacy, by making use of national knowledge, expertise, and capacities.

The main asset employed in Brazilian health diplomacy was expertise in health policy. Fiocruz provided a model of National Institute for Health, which was central to TCDC initiatives; employed its capacities in research and development for health; and made use of its teaching institutions. MoH employed its knowledge in promoting networks and participating within multilateral forums and also sought to further develop its skills in health diplomacy. The National Health System (SUS) constituted an important capacity employed throughout the Brazilian project. Brazilian health diplomacy, as much as Brazilian South-South engagement in its many areas of activities, has been based mostly on such 'expert resources' or internal knowledge that was developed within public institutions; it did not require a large extra-financial budget. An exception was the donation of the antiretroviral medicine factory to Mozambique.

Paramount diplomatic projects that were based on international recognition were the international cooperation for HIV/AIDS treatment and Human Milk Banks implementation, which had their roots prior to the establishment of a coordinated policy for international health. Since 2005, diplomacy was driven through the main axes discussed previously. In all axes, expertise remained a crucial asset for the conduction of actions, and reputational skills proved important for engaging with less developed countries and participating in established multilateral spaces within which Brazil was not a member or main actor.

The niche explored by Brazil was specific, and associated with the development of national public health systems that counted on National Health institutions for the provision of knowledge for policy-making and for training of specialized human resources for health management and



care in accordance with the needs of that system. Initiatives of technical cooperation and network creation consisted in diffusing this model in its entirety or in parts. The TC 41 Report of activities stated that the Brazilian government's interest was to publicize and disseminate its health system in order to strengthen it. Towards this end, two main strategies were adopted: the exchange of knowledge and technology with other countries, and the quest for its international recognition as a model of health policy. The report continued by stating that 'what is sought is the strengthening of a proposal for health whose doctrinal scope points to the construction of health systems of universal, equitable, and integral coverage' (Pan-American Health Organization 2014, 47–48). This niche was not created by Brazil alone: in fact, the country has occupied and broadened a niche formerly developed by PAHO all along the 20<sup>th</sup> century, namely the strengthening of public health systems in American countries. In this specific realm of activities, Brazil remained a leader. Brazil combined international recognition in the management of important health problems typical of southern contexts, with a narrative of horizontal cooperation with no strings attached. Its reputation was not overtly criticized by other actors in the course of the conduction of this niche diplomacy.

Leadership, nevertheless, encompasses imbalances of power as influence. Such imbalances can be identified in different cases of Brazilian activism and may affect the country's position in relation to its partners. Of central importance are the manifold networks for health promotion, created or expanded, as well as the TCDC developed. Engagements with less developed countries eventually characterized networks and relations in which Brazilian institutions could exert more power than its partners in framing visions and decisions on health, because Fiocruz and MoH stand out as very powerful institutions: Fiocruz is the largest NHI in Latin America, and MoH is characterized by a considerable share of governmental funds and great knowledge on the management of complex public health systems. Also, both institutions have developed specific expertise required for the continuity of cooperation projects and networks. Thus, while networks were a main device in international cooperation, tying together partners in the exchange of knowledge and information, they also turned Brazilian institutions into an unavoidable passage point for all other health institutions, which may create a situation of dependency on Fiocruz's and MoH's work and expertise. As such, imbalances of capacities between partners were not overcome with the creation of networks, even if knowledge was effectively diffused.

Within integration arrangements, such dynamics are entangled with other political issues. In CPSC, for instance, leadership in elaborating a 'Strategic Plan for Health Systems' for the countries of the bloc was shared with Portugal. In Unasul, Fiocruz's association of health with international cooperation may be deemed too bold by countries with different perspectives. Within BRICS, Brazilian capacities as a health leader seemed much less accentuated *vis-à-vis* the other partners involved, as there is no identifiable outcome during the period of analysis in which Brazil employed its reputational skills to drive or suggest specific paths for health. In OECD, Brazil managed to integrate the debates on South-South Cooperation, which can be considered an engagement based on the country's reputation. Imbalances are also perceived in TCDC: even

though the Brazilian narrative points towards a demand-led model, projects were led through a well-established orientation, and could also lead to a continued dependence on Fiocruz's expertise for their continuity.

Brazilian health diplomacy of the period, nonetheless, can be read as confronting usual practices in global health, as it was based on a system of care that required strong monitoring and continued care by trained human resources. Traditional health aid has been characterized, on the other hand, by prioritizing 'vertical approaches' that do not require a great quantity of qualified human resources and are exemplified by vaccination of large populations, mainly with vaccines bought from private corporations (Deaton 2017). Brazilian provision of health supplies can be seen as an attempt to participate in such an endeavor with the use of public resources, while also interfering in this global market and earning revenues. Engagement with this diplomatic niche, nonetheless, has proved its limits. To the extent that regional integration arrangements are dismantled in response to broader political dynamics in International Relations, or as foreign policy changes, niche diplomacy may lose its strength. Unasul, wherein many activities were conducted, is representative of these dynamics. Also, prospects for the continuity of South-South engagement centered on a national public health system are doubtful after a steep change in the political orientation of the national government.

## Conclusion

This paper presented Brazilian practices for health diplomacy at the beginning of the 21<sup>st</sup> century, and analyzed it through the concept of 'niche diplomacy,' while also recognizing developments on global health diplomacy. To achieve this objective, we analyzed Brazilian health diplomacy through the lenses of design and practice, and explored the ensemble of activities undertaken by the country in health cooperation. Cooperation activities were categorized within five main axes, by which main venues of engagement could be discerned. The revision of practices allowed for an appreciation of political actions effectively undertaken. As was highlighted throughout the analysis, Brazilian protagonism was driven by a specific model and understanding of health governance, which took the Brazilian health system organization as a leading model.

Niche diplomacy and global health diplomacy conceptualizations provided guidance for the analysis of Brazilian engagement. As global health emerged as a central thematic of international politics, leadership has been disputed among different actors and institutions. In this context, Brazil has sought to participate by employing its internal capacities, and defining its role as a significant contributor and player of the international agenda for health. The support from WHO and the orientation towards the South set a relevant political space wherein Brazil could perform a leadership role. Engagement with internal capacities was a central tenet of Brazilian activism in the field.

Otherwise, recognizing global health as a novel framework wherein health dynamics are scrutinized within the international arena can shed light on how the issue has been incorporated in multilateral organizations already in place, such as OECD and Mercosul, or in emerging ones, such as BRICS or Unasul. This opens up a space for Brazilian engagement within such debates. Activism within established multilateral organizations did not preclude main power asymmetries, but Brazil used its health diplomacy to gain some space in those arenas. Brazil also employed health diplomacy as a form of engaging meaningfully in emerging regional initiatives in which health was recognized as a central element to be treated. Such engagement, nevertheless, proved its limitations, as broader political dynamics in international or national settings can hinder its development.

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