

Brazil's foreign policy and health (1995-2010): A policy analysis of the Brazilian health diplomacy – from AIDS to ‘Zero Hunger’

Política externa e saúde no Brasil (1995-2010): uma análise da diplomacia de saúde brasileira – da Aids ao ‘Fome Zero’

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ABSTRACT This article analyses, from a policy analysis approach, how health entered Brazilian foreign policy between 1995 and 2010 and supported the country's international position, which is rarely explored in the literature on Brazilian health diplomacy. By drawing on literature review, document analysis and key-actor interviews, we examined policies triggered by far-reaching and complex historical change processes in Brazil. We find significant interrelationships between foreign policy and social policy, including health. The internationalization of Brazilian domestic policies, and South-South cooperation, played a central role during Lula governments (2003-2010). Health found its way into the foreign policy agenda to support Brazil's growing international presence. These developments were made possible by the activism and engagement of several of State and non-State actors working on two levels: national and transnational advocacy, and coordinated activities of government representatives, including Brazilian diplomats, and civil society activists. The main argument of this study is that national and international policies are intertwined in this process and that domestic dynamics and societal engagement are essential but more is needed: governmental choices are also determinant. Institutional arrangements and policies shift in different conjunctures and are constantly prone to conflicts and change.

KEYWORDS Health diplomacy. International cooperation. Brazil.

RESUMO Este artigo analisa como a saúde entrou na política externa brasileira entre 1995 e 2010 e apoiou a posição internacional do País, utilizando o enfoque de análise de políticas. Essa questão raramente é examinada na literatura brasileira sobre diplomacia da saúde. A partir de revisão de literatura, análise documental e entrevistas com atores-chave, examinamos as políticas impulsionadas por complexos processos históricos de mudança no Brasil. Há importantes inter-relações entre política externa e política social, incluindo saúde. Durante os governos Lula (2003-2010), a internacionalização das políticas domésticas brasileiras, vinculadas à cooperação Sul-Sul, teve papel central. A saúde na agenda da política externa foi um importante suporte à crescente presença internacional do Brasil. Esses desenvolvimentos foram possibilitados pelo ativismo e comprometimento de diversos atores estatais e não estatais, que atuaram em dois níveis: advocacia nacional e transnacional e atividades coordenadas entre representantes do governo, incluindo diplomatas, e atores da sociedade civil. O principal argumento deste estudo é que as políticas nacionais e internacionais são interrelacionadas nesse processo, e a dinâmica doméstica e o engajamento societal são essenciais, mas não suficientes: escolhas governamentais são também determinantes. Os arranjos institucionais e políticos mudaram em diferentes conjunturas e são constantemente propensos a conflitos e mudanças.

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PALAVRAS-CHAVE Diplomacia da saúde. Cooperação internacional. Brasil.



Introduction

In the first decade of the 21st century, Brazil had earned a place as an emerging world power and one of the world's largest and most promising economies. The country has also been very active in 'health diplomacy' and played an increasingly leading role in international health arenas.

The extensive literature on Brazilian health diplomacy rarely analyses the relationship between foreign policy and health or health and international relations. Although they relate dynamics at the national level to those at the international or global level, which undeniably helps to establish the topic and encourages more in-depth analysis, they are usually concerned with decision-making in international arenas or with actions of social movements on specific issues (e.g., HIV/AIDS) and their relationships with the state (especially the Executive branch) and international organizations.

From a policy analysis perspective, Brazil's links between health and international relations are relatively new^{1,2}. Such an analysis considers the political system's historical, contextual, and dynamic elements, and the different governmental conjunctures².

Foreign policy is a public policy at the intersection of domestic and international policy³⁻⁵. It is conditioned by the asymmetric order – the system of states and global capitalism – in which it is embedded^{6,7}. It is produced within the state and its

formulation and implementation fall within the dynamics of governmental decisions, which resulting negotiations within coalitions, bargaining, disputes, and agreements between representatives of different interests⁸⁽²⁷⁸⁾.

Accordingly, like any public policy, it is not only a terrain for conflict, but can also change with each government.

Most authors (and actors) understand health diplomacy (or 'global health diplomacy') as advocacy for specific issues, policies, or actions related to several dimensions of

health on the international stage, pursued by any actor, government or otherwise, without necessarily equating it with the foreign policy of nation-states or the diplomacy of a country as such. The conceptual term vagueness favors its use for different purposes, and its meaning depends on the chosen theoretical perspective and the study object.

We consider that national policies aimed at 'global health' (another imprecise term) are the result of negotiations involving a variety of actors from the health, economy, social development and health sectors^{9,10}; and health diplomacy is a policy-shaping process in which governmental, nongovernmental, and other actors negotiate responses to health challenges or use health concepts or mechanisms in policymaking and negotiation strategies to achieve other political, economic, or social goals¹¹⁻¹⁶.

This study examines how health issues entered Brazilian foreign policy and the factors that allowed them to support the country's international presence, especially between 1995 and 2010. We aim identify the specificities of Brazilian health diplomacy and its role at home and abroad by analytically reviewing the data, events, and policies triggered at different moments by political change in Brazil. It does not ignore the differences between foreign policy and sectoral policies (in this case, social policy, including health policy). It does, however, point to significant interrelationships between them to understand what has been called 'Brazilian health diplomacy'.

This research is a case study and relies on qualitative data: literature review, documental analysis (reports and websites from governmental and nongovernmental organizations), and interviews with key-actors – Brazilian policymakers, public health and foreign policy officials, and civil society representatives. Most interviews were conducted in 2017 and 2018, with a few more in subsequent years (2019 and 2020). The project was approved by the Brazilian Research Ethics Committee [Opinion N° 1.717.292, September 10, 2016].

The study covers a rare period of stable democracy in Brazil, encompassing the governments of 1995-2002 under Fernando Henrique Cardoso (FHC) of the Social Democratic Party (Partido da Social-Democracia Brasileira, PSDB) and of 2003-2010 under Luiz Inácio Lula da Silva (Lula) of the Workers' Party (Partido dos Trabalhadores, PT). Both leaders, each in their own way, sought more significant international influence and relied on different political coalitions. They initiated changes in Brazil's international relations by reviewing certain historical parameters of Brazilian foreign policy and working to help the country achieve a prominent position and visibility in the international system.

The main argument of the article is that national and international policies are intertwined in this process, and that domestic dynamics and societal engagement are of great importance but not sufficient. Government decisions based on values and principles and supported by political coalitions that change at moments shape the perception of the country's 'place' in the global system dynamics and determine its activities in international arenas. Accordingly, the foreign policy's non-material (symbolic and interpretive) components and their inclusion in decision-making are essential variables. These factors enable the construction of different international scenarios, depending on how decision-makers perceive them and how a particular national 'heritage' is emphasized in international negotiations under national practices or ideological perspectives, as in Brazil establishing the Unified National Health (System Sistema Único de Saúde, SUS) and the country's role in intellectual property rights and access to medicines against HIV/AIDS.

The first part of the paper provides a historical overview of Brazilian foreign policy and international relations from the late 1980s to the FHC and Lula administrations. It then examines the linkages between social policies (including health policies) at home and the foreign policies of these governments. The

concluding remarks provide a brief analytical summary of the findings and suggestions for future research.

Brazil's Foreign Policy and international stance

The Brazilian Foreign Policy (BFP) has traditionally focused on international 'prestige' rather than 'contestation'⁶, enjoying the country's elites' support-neither unconditional nor lasting. According to Lima⁶, prestige diplomacy includes showing or claiming power and performance, to impress other nations and seeking a strong multilateral presence as an instrument of soft power instead of hard power, which they do not exercise. Under the authoritarian regime of military rule (1964 to 1985), Brazilian international posture tended to be defensive and discreet, particularly regarding human rights and other sensitive issues. Political change in the mid-1980s and global changes after the end of the Cold War gradually transformed the Brazilian economic development model, the dynamics of society, and the formulation and implementation of national policy, including foreign policy, which had traditionally been 'insulated' within the diplomatic corps¹⁷.

Historically, the BFP was central to the economic development models that governments have adopted at different times, notably in critical junctures as in the mid-1960s, the 1990s, and again since 2016. Then, "prevailing patterns of national development and international presence are becoming exhausted, and a new sociopolitical coalition emerges"¹⁸⁽⁴⁶⁾, transforming both domestic and foreign policy. However, the persistence of a single and consensual development model does not translate into consensus on the political dimension of foreign policy, i.e., sometimes "foreign policy can be a target for far-reaching review without any change in political regime"⁷⁽⁴²⁴⁻⁴²⁶⁾.

The re-democratization of Brazil in the 1980s required, among other things, that

Brazilian diplomacy become more ‘active’ in developing and implementing an agenda that would provide domestic legitimacy to Brazil’s international positions and intentions, while also allowing it to build national coalitions that would favour a change in the *status quo*^{6,17-19}. This dynamic meant that the former ‘decision-making autonomy’ of the Ministry of Foreign Affairs decreased. At the same time, ‘presidential diplomacy’ increased: Presidents actively participated in the decision-making processes of the BFP. At the same time, political coalitions became increasingly important in Brazil, forming a system known as ‘coalitional presidentialism’^{20,21}. The partisan political system institutionalized in the 1988 Constitution, combined with presidentialism, gave the President the power to set the agenda and the negotiations, while imposing on him the difficult task of creating governability among legislature and ruling elites to implement his governmental program, within big political coalitions. Given the characteristics of the Brazilian political system – a multiplicity of parties, low loyalty and high fragmentation, and rather unorthodox practices among deputies – the President’s ability to coordinate relations between the executive and legislative branches became fundamental.

As a result of the increasing ‘politicization’, BFP became an important issue, reflecting the increasingly strong interrelations between the national and the international spheres in the context of a globalized world⁶. This process also revealed different groups within the diplomatic corps (or Itamaraty, that refers to The Ministry of Foreign Affairs, MoFA, a highly specialised professional organisation), previously considered “monolithic” and for several years “had a virtual monopoly” on expertise in international affairs¹⁷⁽³¹⁶⁾.

Another salient feature of the BFP (throughout the twentieth century and in the first decades of the twenty-first) was the recognition of multilateral spaces (institutions and arenas) as the preferred venue for Brazil’s diplomatic activities^{22,23}, and its role

as a North and South mediator, always respecting the principle of non-interference, which implies certain concessions and the use of soft power^{6,24}. This meant that the BFP could increase its political power through policies of principles, values, culture, and achievements, as well as through collaboration with a wide range of actors.

The BFP has always sought the international recognition of Brazil, considering the country ‘naturally’ qualified for a prominent place in the international system^{18,25}. However, over the years, the strategies to achieve this goal varied with the changes in government. There were times when this ambition cooled or was even abandoned^{6,18,25-28}.

Some authors are critics of the claim that Brazil’s autonomy in the global arena has always been a feature of the BFP^{6,25,29}. They argue that, though it has existed, it was of limited autonomy in “exceptional moments and breaks in the dependent development of foreign policy”; moments that “could be interrupted by conservative forces”⁶⁽⁴²⁻⁴³⁾.

On the other hand, ‘social issues’ were widely discussed on the international stage in the 1990s, especially at the UN conferences (1990 to 1996), in order to ‘rethink development’, whether because of the alarming levels of poverty and inequality in the world, resulting from the economic adjustments of the 1980s, or because of the need to seek alternatives to Welfare State policies that were not tailored to the neoliberal economic realities. The UN conferences involved a wide range of state and non-state actors. Brazil extensively participated in such events^{30,31}.

These international dynamics mirror and project domestic movements: the campaign for Brazilian health sector reform – driven by preventive medicine and public health professionals along with health professional unions and opposition political parties – dates back to the 1970s^{32,33}, while the movement to combat the HIV/AIDS epidemic, focused on human rights and solidarity and networked with other social movements (feminists, sexual and

reproductive rights advocates) that espoused the same principles, had been ongoing since the 1980s^{23,34-38}.

Finally, governments' choices, social and political forces and systemic factors – geopolitical shifts (end of the bipolar era) and geo-economic changes (hegemony of the United States in crisis and rise of China) – have given more space to countries on the periphery of the international arena, possibly by relieving them of 'structural conditioning factors'^{6,29}.

In the same dynamic, the internationalization of economies (globalization and economic liberalization/opening) and democratization of societies (escalated debate among social actors on ideas and ways of institutionalizing demands) – which coincided in Brazil – were among the factors that contributed to the 'politicisation' of public policies, including foreign policy⁷. The increased complexity of policymaking that resulted from these arrangements also encouraged other government agencies and civil society institutions to become more involved in shaping and implementing domestic and foreign policy.

BFP under Presidents FHC and Lula

There is an intense debate in the Brazilian literature about whether the foreign policies of FHC and Lula represent continuity or innovation. There is some consensus on continuities and change within the debate.

Some authors generally see foreign policy processes as continuing unbroken between the two administrations, with only adjustments in goals and programs^{19,39}, including the priority given to health⁴⁰. Others have noted that Lula extended the changes that had taken place in BFP during FHC governments and also benefited from a more favorable national and international economic situation^{6,7,18}. The main argument in the literature is for continuity in the historical paradigms of BFP, albeit under different traditions in Brazilian diplomacy⁴¹

that shaped FHC and Lula's respective foreign policies. Meanwhile, both governments accommodated social currents, and both are often perceived as having sought greater autonomy for Brazil in their international activities³⁹. However, some analysts believe that foreign policy only exhibited autonomist traits under Lula^{6,25}.

The critical global conjuncture of the 1990s and the spread of macroeconomic structural adjustment processes worldwide (and, in Brazil, by a new constitutional political order and a state in financial crisis) led the Brazilian economic elite to embrace at home the 'orthodox neoliberalism' adopted by the FHC government. Two agendas – currency stabilization (Real Plan) and reform of the 1988 Constitution – were significant in the first FHC government. Thus, the BFP was consistent with those agendas (*table 1*).

The formulation of this strategy dates from the 1990s, during Itamar Franco's government, when Cardoso was Foreign Minister (October 1992 to May 1993) and then Finance Minister (May 1993 to March 1994).

The government considered that, given the 'international political and economic context', it was 'unrealistic' to address or raise discussions on structural determinants of social inequalities; it would be more productive to mobilize developed countries to support the Brazilian agenda, i.e., to contribute (financially) to solving the country's problems, in return for Brazil's support of their policies³⁰.

President FHC enjoyed tremendous support and prestige among the Brazilian elite, and exercised active 'presidential diplomacy', an increasing presence of the President in diplomatic activities. However, his economic and political strategies did not produce the desired results. The 'Real Plan' (introduced in 1994) had stabilized the currency, but by the early 2000s, the country's economic situation (fiscal adjustment without economic growth; growing unemployment, poverty and inequality; and exchange rate and currency crises in 2002), and political setting (deteriorated living and working conditions) had

worsened, led Brazil to fall into considerable disrepute internationally, and to the election of Lula, the candidate of PT, in 2002^{6,25,39}.

Lula governments expanded macroeconomic adjustment policies by introducing a new (third) fiscal and monetary stabilization stage based on the neoliberal paradigm⁴². However, he adopted a ‘neo-developmental’ approach^{6,43}, especially from 2006 onwards, by strengthening the internal market and seeking complementarity between economic and social policies toward an ‘economy managed by social spending’^{42,44}. This was expressed in the adoption of mechanisms that complemented the universal approach and introduced conditionalities in the design of specific policies⁴⁵ (*table 1*).

The prevailing diagnosis was that the world order was in transition and tending toward multipolarity⁶, thus in need of a diversity of alliances both in the South American region and with other emerging or developing countries and ‘political autonomy’, meant that:

[...] claim to international leadership, but with the intention of challenging existing global rules; an orientation of rule-making rather than rule-taking; a more long-term perspective on North-South geopolitical divides; and a posture of active solidarity with similar countries in the South and integration with neighbours in the region⁶⁽⁴²⁾.

Emphasis was placed on “strategic partnering” or building “variable geometry” coalitions, that is, on closer relations with emerging countries to make Brazil more representative and strengthen the less powerful countries, for which Brazil would become a “mouthpiece”⁴⁶⁽¹⁷⁸⁾. To that end, BFP encouraged activities in more restricted forums by proposing and supporting to setting up of new institutions (IBAS in 2003, BRICS in 2006 and UNASUL in 2008) and bolstering existing ones (MERCOSUL).

Presidential diplomacy intensified and closer ties were forged between the President and the Chancellor (Celso Amorim, a recognized and respected diplomat), in both administrations. Together, they made numerous international

visits and regional trips (e.g., to South America and Africa), taking experts from other branches of government and representatives of the business community, new embassies were established (especially in countries and regions not previously favored), and the President took a much more prominent role in several global forums. Similarly, the number of training positions for diplomats was significantly increased at the Rio Branco Institute (institution of the Itamaraty responsible for the training of diplomats at the postgraduate level), where new specialties were introduced to address social issues in general and health care in particular (Itamaraty key-actor interview). The trade interests of leading national corporations and conglomerates were projected outwards^{47,48}.

Brazil’s participation in negotiations and decisions that were considered ‘highly political’ (e.g., on international security issues, such as UN peacekeeping missions that led to MINUSTAH, Mission des Nations Unies pour la Stabilisation en Haïti, in French) drew much criticism, especially from those who favored a more conservative foreign policy. Brazil’s bid for a permanent seat on the UN Security Council was also upheld. The same happened with the internationalization of large Brazilian companies. These potentially contradictory goals were received critically and defensively – or at best suspiciously – in some countries in the region and outside (e.g., in Africa)⁴⁷.

In the second Lula administration, the Brazilian Cooperation Agency (ABC) budget increased. Brazil refused to be considered as a ‘donor’ country, according to OECD parameters, and understood South-South cooperation as solidarity and a commitment to mutual aid among countries of the Global South (particularly South America and the Caribbean, and Africa)⁴⁸.

The foreign policy debate was significantly renewed in Brazil, and other actors in the federal structure and organized civil society gained prominence in national and international issues⁴⁹. Brazil’s international stance changed significantly^{6,25}.

Table 1. FHC and Lula government's foreign policies

Key Features	FHC government's (1995-2002)	Lula government's (2002-2010)
Goal / Basic premises	The government embraced 'orthodox neoliberalism' and BFP was an instrument of macroeconomic stabilisation policy. Intended to abandon of the 'Third World thesis' and previous correlated alliances, to restore Brazil's international credibility ^{8,39,42} . Accepted the 'rules of the game' and strived to develop 'ways to legitimise its own positions' on economic development within those rules ⁴³⁽¹⁴⁻¹⁵⁾ .	Expanded macroeconomic adjustment policies, but, adopted a 'neo-developmental' approach. Emphasized the inherent contradictions of globalisation and to exploit any room for manoeuvre left by the dispersion of international power as U.S. hegemony began to erode. Pursuit of 'political autonomy'. Opened new opportunities for action abroad to advance Brazil's interests, whether through development or advancement within the world system. Established a social agenda on the international stage, in which the issue of health played a prominent role.
Strategies	Less normative weight to motivations of solidarity and identification with countries of the South. Active 'presidential diplomacy'. <i>Domestically</i> : policies of trade liberalisation and privatisation. <i>Externally</i> : a rapprochement with Western powers, including the United States, and with international regimes. <i>International cooperation</i> wasn't a priority, except in HIV/AIDS.	Establishment of 'strategic partnerships' or building coalitions with 'variable geometry'. Very active 'presidential diplomacy'. <i>Domestically</i> : broadening the social base by expanding political citizenship and including the most vulnerable groups through consumption. And projected outward trade interests of large national corporations and conglomerates. <i>Internationally</i> : broadening participation in a variety of global forums and negotiating arenas in multiple areas, supporting proposals to review and reform multilateral institutions (e.g., the UN Security Council). Advocated multidimensional diplomacy, involving simultaneous actions in different areas at the global, regional, and bilateral levels. <i>International cooperation (South-South and triangular)</i> – technical, political, and economic – expanded significantly and gained strategic importance, as a tool to strengthen alliances and coalitions between countries with perceived similar levels of development and aspirations, driven both by Brazil's improving economic conditions and by the internationalisation of national policies.
Regional policy	Moving away from Mercosul regional interests, BFP advocated greater flexibility in the form of free trade agreements with countries outside the region (e.g., in the European Union).	To link Brazil's prosperity with that of its neighbour's countries in order to mitigate the structural asymmetry between them. To promote activities in narrower forums, proposing and supporting the creation of new regional institutions (IBAS in 2003, BRICS in 2006, and Unasul in 2008) and strengthening existing institutions (ex., Mercosul).

Source: prepared by the authors.

The external projection of national social inclusion policies deserves attention here.

Social concerns and foreign policy in the FHC and Lula governments

There is relative agreement in the literature that the social policy innovations in the FHC

governments have been maintained by Lula governments, albeit with different shades and emphases. It is also affirmed that the governments of this period maintained the same universal principles and institutional framework of the Brazilian social protection system.

Social policy guidelines of FHC combined the restructuring of universal social services and the alleviation of poverty and inequality with specific redistributive measures, primarily targeted equalization programs

– the Community in Solidarity (Comunidade Solidária, 1995)^{50,51}. The ‘targeting within universalism’ approach inspired this decision^{50,52}. In the health field, implementation of the SUS continued with the expansion on basic services and the search for new sources of financing, after changes in the Social Security Budget, deprived of its main source of funding, employee and employer contributions⁵¹. The provisional tax on financial transactions (Contribuição Provisória sobre Movimentação Financeira, CPMF), proposed by then Minister of Health, Adib Jatene, was established in 1996 (table 2).

These measures were only partially compensatory, subordinated to budgetary adjustment needs. Some innovations fragmented poverty reduction efforts at federal and local levels leading to ‘indirect privatizations’⁵³ that became a fixture in subsequent decades, including public-private partnerships for the delivery of health services (in the SUS). The new programs, however, were unable to offset for the losses.

Relationships with social movements at the national level – particularly those related to AIDS – became visible abroad and fostered transnational activism, bringing about significant changes in global policy toward controlling the AIDS epidemic^{23,34,35,37}. In multilateral forums (WHO, UNDP and UNAIDS), a great ‘militancy’ was observed by representatives of the federal bureaucracy together with other non-state actors, both aimed at supporting the demand for HAART (highly active triple antiretroviral therapy), at national and international levels, which effectiveness, confirmed by scientific studies, was first announced at the 11th International AIDS Conference, in Vancouver, Canada, in 1996.

Brazilian diplomacy had won significant victories in this process, but they were unlinked to health. Since 1986, it has played a leading role in drafting and approving the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in 1994, advocating for developing countries, building supportive coalitions, and resisting unilateral

U.S. ambitions. This agreement concluded the Uruguay Round of the General Agreement on Tariffs and Trade (GATT) and established the WTO that same year⁵⁴.

Meanwhile, in 1996, FHC enacted two conflicting laws: the Universal Access to HAART Act (SUS) and the new Patent Act^{23,55}. The former law institutionalized early treatment for AIDS and HIV-positive individuals and prioritized the problem of effective nationwide coverage and associated financing, responding to the demands of community activists and the technocracy. The latter, in turn, favored the countries and companies that held the relevant patents, thus hindering domestic production of generic drugs, although it provided for the possibility of compulsory licensing. This domestic duality and ambivalence were consistent with the FHC government’s international approach.

This interpretation is supported by the victories of Brazilian diplomacy over the United States in the WTO in the dispute over patents (2001) and agricultural subsidies (2003)^{54,55}. Cooperation between actors from the Itamaraty and other ministries was fundamental in both processes, and the support from national and transnational civil society⁵⁶. However, there were doubts about the effectiveness of the TRIPS agreement. “*When the TRIPS was signed [in 1994], many of us thought it was a defeat, but [at least] we had managed to maintain certain ambiguities*” (Itamaraty key-actor interview).

Brazilian diplomats did not focus on the health sector when drafting and signing the TRIPS. Only later the importance of compulsory licensing for the production of generic drugs was recognized, when conditions changed, mainly because of the issue of access to medicines against AIDS:

Health issues were a technical matter [...] They were considered when there was some interface with diplomacy, but only marginally [...] They were not of central importance from the point of view of official foreign policy. (Itamaraty key-actor interview).

This view changed during discussions leading up to the Fourth Ministerial Conference (Qatar, 2001), which adopted the Doha Declaration allowing compulsory medicines licensing in public health emergencies.

When the Doha Round was launched [in 2001], the world had changed, primarily through AIDS [...]. All this coincided with and inspired the tactics of the Doha Round [...] the ambiguities became flexibilities. (Itamaraty key-actor interview).

Several international initiatives in different forums and organizations supported the proposal for early treatment of AIDS^{23,37}. International organizations and developing countries increasingly adhered to the policy of universal treatment while transnational advocacy efforts increased. Even ARV major pharmaceutical manufacturers appear to have bowed to demands and pressures for lower prices and voluntary licencing of certain products in certain countries²³, especially under the “*threat of compulsory licensing and production of generics skillfully used by Brazilian diplomacy in negotiations at the WTO*” (Itamaraty key-actor interview).

José Serra's tenure in the Ministry of Health (MoH) (1998-2002) had positive aspects besides to the institutional stability: from the 1980s to 1998, there was considerable turnover in the Ministry of Health – Brazil had four ministers of health in the second half of the 1980s; the instability of the department continued in the following period – with four ministers from 1990 to 1994 and three from 1995 to 1998. Serra did not take over the MoH at his request but accepted the post to further his electoral ambitions. His performance as minister was characterised by using the technical possibilities in this area to make his political mark. For example, during questions on the 2000 annual report of WHO, which ranked member states' health systems based on a composite performance index in which Brazil (and other countries) performed quite poorly and whose methodology was strongly

questioned^{57,58}, and also during discussions on the dispute over patents and access to AIDS medicines^{59,60}.

Interviews with key stakeholders confirmed that the minister was fighting ‘personal battles’ to gain visibility and support for his election campaign. Nevertheless, he is credited for his important participation in international forums, where he even advocated positions that differed from those of the government, allied himself with other efforts of Brazilian diplomacy, and helped to strengthen Brazil's presence and prestige in the international arena, primarily through AIDS-related events.

There was an important coincidence: Serra at the MoH and Celso Amorim in Geneva [...] Amorim had previous experience. He had worked in the Ministry of Science and Technology [1977-1989], had witnessed the discussion on patents, had been involved in the resistance to the patent law when the Americans had forced us to make changes, since the time of the Sarney government [the mid-1980s], pressure escalated during the Collor government [1990s] [...], and came back to these issues in 1999-2000, when he returned to Geneva and the issue was ‘revived’. (Itamaraty key-actor interview).

[...] I do not mean to say that Itamaraty was against or did not support the local production of medicines, but at the time it was not pushed forward. (MoH key-actor interview).

International technical cooperation on HIV/AIDS played an important role in Brazilian health diplomacy. It was one of the objectives of the Brazilian National Program and was institutionalized as part of the strategy to give international visibility to the Brazilian experience. This visibility was facilitated by the World Bank loans AIDS I (1994-1998) and AIDS II (1999-2003), and promoted by the creation of the United Nations Joint Programme on HIV/AIDS (UNAIDS), established in 1994⁶¹. This allowed the national program's institutionalization,

and the implementation of triangular agreements for collaboration, that is, cooperation between Brazil and developing countries supported by aid donors, a traditional model for international cooperation in Brazil⁶¹⁻⁶³.

Cooperation on AIDS was first formalized with the creation of the Horizontal Technical Cooperation Group on HIV/AIDS (HTCG) in 1996. The Group brought together several AIDS national coordinators, mainly from South American countries, under the leadership of the Brazilian National Program. It also collaborated with UNAIDS⁶¹. The HTCG established direct links with national program directors without going through official Ministry of Health channels, such as the Advisory Service on International Health Issues (Assessoria de Assuntos Internacionais de Saúde, AISA), formally established in 1998 under the Minister of Health Office. Contacts with the Itamaraty Cooperation Agency (Agência Brasileira de Cooperação, ABC) were purely administrative. Meanwhile, discussions began under these arrangements on the 'horizontal' (South-South) principles and values that would later define Brazilian cooperation.

Brazil's experience was showcased at the 13th International AIDS Conference in Durban (July 9-14, 2000), where positions of international agencies were challenged and a new global consensus was proposed. It was then argued that it was possible to increase production of antiretroviral drugs stimulating competition and drug price reductions⁶⁴⁻⁶⁶, attracting the attention of the Minister of Health (José Serra). At the same event, Brazilian professionals offered to the world the technical cooperation on AIDS as an alternative to traditional technical cooperation of international organizations and agencies⁶¹.

The Brazilian report to the Conference was well received in Brazil and internationally, strengthening the collaboration between the MoH and Itamaraty for the elaboration of the Brazilian position at the 2001 Special Session of the UN General Assembly in New

York (UNGASS-AIDS), with the participation of other Brazilian agencies. This evidence was used to coordinate positions and interventions of the countries of the South at UNGASS, which eventually endorsed universal access to antiretroviral drugs. As a result, Brazilian professionals joined UNAIDS and WHO teams^{23,61}.

In 2002, the MoH and Itamaraty launched the International Cooperation Programme for HIV Control and Prevention Activities in Developing Countries (Programa de Cooperação Internacional para Ações de Controle e Prevenção do HIV para Países em Desenvolvimento, PCI), which consolidated the Brazilian technical cooperation on HIV/AIDS, in conjunction with the national program.

Previous policies were continued during Lula governments, but with fundamental changes. Social policies promoted the improvement of living conditions for the poorest populations and regions, gaining political and electoral support of a population group other than the social movements and unions that usually formed the party's base^{67,68}. However, it initiated the reform of retirement pensions: new criteria and additional pension contributions. The growing trend toward private sector presence in the social field (e.g., in higher education and health care) continued^{67,69}.

In short, the social policies of PT governments were based on conditional cash transfers through the Family Allowance Programme (Bolsa Família, BF), which added value to the existing cash transfer program. Starting in 2003, the BF combined all existing programs to overcome absolute and relative poverty of millions of Brazilians while linking this to health and education (*table 2*).

However, BF did not change the structural conditioning factors and determinants of poverty and inequality. They did not constitute a right and could easily be discontinued or interrupted^{51,67,69}.

The BF was linked to the National Social Assistance Policy to combat poverty and the increase in extreme poverty, which has been

formulated since the 1990s through intense discussions and civil society mobilization (as the 'Citizens Action against Hunger Extreme Poverty and for Life', a program of the NGO Ação da Cidadania, established by Herbert Daniel de Souza, which had enormous effects across Brazil). According to ECLAC⁷⁰ programs such as the BF are part of a 'second generation' social policies in Latin America due to the limited progress in reducing poverty since the 1990s. It served around 28% of the population (in 2016) and was closely targeted, ensuring poverty and extreme poverty reduction⁷¹. A second successful strategy was to raise the minimum wage, and consequently the value of social security benefits: the minimum wage was increased by 54% in real terms between December 2002 and December 2010, making it a powerful redistributive instrument⁵¹.

In a nutshell, Lula's income policies, associated with monetary stability and the resumption of economic growth (in the second government), fostered an increase in formal employment opportunities^{67,69,72}.

In health care, implementation of the SUS continued with rhetorical political support from the President, while underfunding worsened with the suspension of the CPMF in 2007. Nevertheless, Brazil's international reputation was fostered and strengthened by the principles of a universal public health system and the compulsory license granted in 2008 for the production of the antiretroviral drug Efavirenz, conducted by the then Minister of Health, José Gomes Temporão, and supported by intense civil society mobilization⁵⁶.

Although Lula's government did not change the concept and strategy of international cooperation at AIDS, its implementation was expanded and diversified with the significant participation of the Itamaraty and its agency⁶¹, as international South-South cooperation was henceforth given great importance in BFP.

The implementation of the third World Bank loan (AIDS III, 2004-2007) facilitate the expansion of the directorate of the national program to include 'consultative functions'

and triangular collaboration with international agencies and new donors⁶¹. A memorandum of understanding between the two ministries – MoH and MoFA – in 2005⁶¹ formalized very effective joint efforts

to support technical cooperation on HIV/AIDS [especially in 2005-2006], which was well coordinated, included dialogue with other government sectors and countries to disseminate this policy worldwide. (MoH key-actor interview).

The National AIDS Program successfully applied to be the UNAIDS Technical Support Facility, enabling the establishment of the International Centre for Technical Cooperation on HIV/AIDS (ICTC) in 2005. The ICTC brought together different Brazilian and international institutions and organizations, operating as a 'collaborative network with shared governance'⁶¹. Implementation of cooperation by the national program with such a broader partnership and funding required a high coordination effort.

The issue was the production and distribution of medicines and a worldwide discussion on patents. Coordination was at its best, because when the national agenda arrived at the international level, it was well structured and aligned with the two sectors [health and diplomacy]. [...] there were regular working meetings with the MoFA on health issues and joint activities towards sound policy decisions that could not be challenged in court [for example, the compulsory licensing of Efavirenz]. (MoH key-actor interview).

The external funding enabled ICTC to pay better external professionals as consultants to meet different countries' cooperation needs, which led to institutional friction within the MoH. On the other hand, international partners' agendas interfered in the Brazilian cooperation decision making process.

In 2009 the MoH was restructured internally: The National Department of Sexual Transmissible Diseases (STDs/AIDS) and

Viral Hepatitis was established together under the National Health Surveillance Secretariat and changes were made to the World Bank-funded activities (AIDS-SUS); these changes were directed to planning horizontality and promote integration among levels of government, gradually altering how AIDS control was conducted institutionally. Conflicts began to arise in the Ministry's techno-bureaucracy (MoH key-actor interview) within that department. The change did not affect how the program was conducted at that moment and the department continued working together with the social movements.

The National AIDS program funded events directed to reduce stigma and discrimination (e.g., gay parades) through the PAG [Programme of Actions and Goals], whose funds were transferred to states and municipalities. (MoH key-actor interview).

Efforts to align cooperation on AIDS with ABC/Itamaraty practices, using the national program's experience and capacity for dialogue mediation and leadership at home and abroad, were not well received by international actors, which would have hampered the country's autonomous decision-making in this area. Thus, in 2010, when the second Memorandum of Understanding with UNAIDS expired, the Brazilian government decided to break with the model. From then on, the ICTC was to be managed by ABC/Itamaraty, while the MoH came to be the main funding source for cooperation. Soon after, ICTC shut down.

South-South cooperation in health was gradually gaining a prominent place in official MoH documents (such as the '2004-2007 National Health Plan: a pact for health in Brazil' and the 'More Health: Everyone's Right 2008-2011' and their successive versions until 2015), in connection with the internationalization of the SUS areas of significant success (HIV/AIDS, cancer, tobacco control etc.), but not always explicitly interlinked with foreign policy.

Beyond the issue of AIDS, Lula's strategy of linking 'poverty (as a cause of hunger)

with development' also had its origins in the demands of civil society. After decades of political and economic discussions Lula's government adopted the 'Zero Hunger' ('Fome Zero') program as its guiding proposal. 'Poverty reduction' had also been the World Bank 'mission' since McNamara (1968-1981), to make the Bank a 'development agency'^{73,74}. In the 1990s, the World Bank became increasingly involved in health issues, exerting more and more influence in this area⁷⁵. The issues of poverty and global health were already on the Bank's agenda.

The issue was revisited at the Joint Press Conference by the UN secretary-general and Presidents of France, Brazil and Chile at Palais des Nations in Geneva (January 30, 2004)⁷⁶; and at the Meeting of Heads of State on 'Combating Hunger and Poverty', held at the United Nations Headquarters in New York (UN) at the initiative of the Brazil, France, Chile and Spain Presidents, in parallel with the UN General Assembly (September 20, 2004). The proposal was to 'unite efforts around a common goal' and seek solutions to achieve it.

To fight hunger and poverty is no utopian ideal; it consists of fighting against exclusion and inequality and in favor of social justice and sustainable growth. [...] The challenge today is to combine economic stability and social inclusion. [...] We have agreed to make a joint appeal for the establishment of a [...] global alliance against hunger and poverty [...] it should make it possible for developing countries to receive continuous support through freer international trade, foreign debt relief, foreign investment, greater international aid, and alternative financing mechanisms. [President Lula's speech at the Joint Press Conference, 2004]⁷⁶.

A technical report prepared by the four countries discussed innovative financing mechanisms. The same rhetoric has been used at other world conferences and summits on development (e.g., the 2005 New York Declaration on Innovative Sources of Financing for Development).

Nevertheless, Brazil was unable to establish Zero Hunger as an international policy:

It proved very difficult to fulfill the President's wishes of combating hunger [...], which led to efforts shifting to the issue of access to medicines. [...] It was a very concrete health opportunity that would involve some countries and impact the fight against hunger and poverty. [...] from then on [2004] we have become more aware that health is highly relevant. [...] these efforts even led to the creation of UNITAID [2006]. (Itamaraty key-actor interview).

UNITAID is an evolution of this process, was launched in September 2006 during the United Nations General Assembly in New York and is supported by Chile, France, Brazil, Norway and the United Kingdom. It works in partnership with several actors – governments, public-private partnerships, and multilateral, nongovernmental, and civil

society organizations (including private foundations such as the Bill and Melinda Gates Foundation), as Jorge Bermudez, a Brazilian and former director of UNITAID, explains:

UNITAID is an innovative financial organization that uses mechanisms based on market dynamics to expand access to treatment and diagnosis for HIV/AIDS, tuberculosis, and malaria, where we seek to balance lowering drug prices while ensuring quality, faster availability, and scale^{77(n/p)}.

In summary, the BF, the principles of SUS, the relationships between hunger, poverty, and structural considerations produced values and principles that were firmly coordinated and widely disseminated and internationalized in statements by President Lula and the diplomatic corps, and in South-South health cooperation projects.

Table 2. FHC and Lula government's main social policies

Area	FHC government's (1995-2002)	Lula government's (2002-2010)
Overall social policies	<p>Restructuring of universal social services continue.</p> <p>Beginning of processes of privatizations in the economic and social areas (mainly in the first one).</p> <p><i>Basic programmes:</i> to increase redistributive impact and efficacy in combating poverty; and policies to basic education.</p> <p><i>Community in Solidarity Programs^a (Comunidade solidária, 1995):</i> priority actions linked to cash transfer for groups targeted by territorial criteria and income, under conditionalities and partnerships with states, municipalities and civil society^a.</p>	<p>Restructuring of universal social services continue, plus retirement's reform.</p> <p><i>Raising the minimum wage</i> and the social security benefits pegged to it.</p> <p><i>Raising levels of education,</i> policies directed to higher education (e.g., quotas for low-income and black students).</p> <p><i>Privatization of social services</i> continue (in higher education and health).</p> <p><i>Bolsa Família:</i> family allowance cash transfer with two benefits –</p> <ul style="list-style-type: none"> • Basic, for families in extreme poverty, transfer with no conditionalities, similar to basic income programmes in place in other countries. • Variable, for low-income families with children or adolescents, subject to conditionalities relating to health (vaccination) and education (school attendance).

Area	FHC government's (1995-2002)	Lula government's (2002-2010)
Health: Implementation of the SUS	<p><i>Decentralisation and social participation:</i> continued.</p> <p><i>Care network:</i> significant expansion of primary health care.</p> <p><i>Under-funding:</i> not solved, temporarily offset by the CPMF^b.</p> <p><i>National AIDS Programme:</i></p> <ul style="list-style-type: none"> • Horizontal Technical Cooperation Group on HIV/AIDS (HTCG) set up (1996). • National Coordination on Sexually Transmitted Diseases and AIDS (Coordenação Nacional de Doenças Sexualmente Transmissíveis e AIDS, DST/AIDS) set up (1999) under the then Health Policy Secretariat. • Negotiations with the World Bank (ongoing since 1990) finalised for loans specifically for this area: AIDS I (1994-1998) and AIDS II (1999-2003). • Early treatment with antiretrovirals (highly active triple drug antiretroviral therapy, HAART) begun in the SUS (1996). • 13th International AIDS Conference held in Durban (9-14 July, 2000): important participation by Brazil. • Special Session of the UN General Assembly on AIDS (2001): antiretroviral treatment officially recognised. • International Cooperation Programme for Actions to Control and Prevent HIV in developing countries, launched by the MoH and Foreign Ministry (ICP, 2002). 	<p><i>Decentralisation and social participation:</i> continued.</p> <p><i>Care network:</i> no progress in secondary care or coordination among levels; little progress in regionalisation.</p> <p><i>Underfunding:</i> not solved, culminating in suspension of the CPMF in 2007. Minor expansion in <i>public health spending</i>, municipalities' and states' relative shares increased and federal share decreased.</p> <p><i>Private medical insurance coverage increased:</i> from 18.9% in December 2004 to 26% in December 2014^c.</p> <p><i>National AIDS Programme:</i></p> <ul style="list-style-type: none"> • Beginning of the implementation of the ICP (2003). • Approval and implementation of the third World Bank loan (AIDS III, 2004-2007) and approval of the fourth and final loan (2007, AIDS SUS). • Creation of the International Centre for Technical Cooperation on HIV/AIDS (ICTC) (2005), the name given to a new <i>Technical Support Facility</i> involving Unaid and the national programme, establishing Brazilian cooperation on HIV/AIDS and a leading role for Brazil in the international arena. • First use of a compulsory licence to produce generic antiretroviral drugs in Brazil (2008). • Creation of the National Department of STDs/AIDS and Viral Hepatitis, including the coordinating offices of the National DST/AIDS Programme (PN-DST/AIDS) and the National Viral Hepatitis Programme, all under the National Health Surveillance Secretariat (Secretaria Nacional de Vigilância em Saúde, SVS) (2009), similar to the structure of the programmes at the state and municipal levels^d.

Source: prepared by the authors.

^a Comunidade Solidária comprised a series of cash transfer programmes, the most important being: a national minimum income programme, the Bolsa Escola (2001), tied to primary and lower secondary education; a national programme for access to food (2003); a national minimum income programme, the Bolsa Alimentação (2001), tied to health; and a cooking gas allowance programme (2002).

^b The CPMF was drafted on the basis of the Provisional Tax on Financial Transactions (Imposto Provisório sobre Movimentação Financeira, IPMF), which was applied only in 1994. In 1996, major discussions were conducted by the then Minister of Health, Adib Jatene, in an attempt to restore the funding sources of the Social Security Budget and increase funding for health: the CPMF was finally approved and began to be levied in 1997. This tax was charged on all bank transactions – except for trading on the stock exchange, retirement pension withdrawals, unemployment benefit, wages and transfers between current accounts of the same holder – and remained in place in Brazil for 11 years (1997-2007). In late 2000, cross referencing was introduced between banking information and income tax declarations, so as to identify possible discrepancies between amounts declared to the Inland Revenue and movement of money in bank accounts. From then on, the CPMF, because it was a tax that was difficult to evade, began to encounter fierce opposition in parliament. Several studies have shown that both governments used the enormous revenue from the CPMF for other areas, besides healthcare, and perpetuated the underfunding of the SUS, even during the period when the tax was levied. The CPMF was extended several times following hard-fought legislative battles. Despite the considerable volume of funds raised, it was discontinued in 2007.

^c Possible explanations for this increase are the inclusion of medical care in employment contracts (which had been on workers' and trade union agendas since the 1970s) and partly the growth in formal employment and the government's maintaining the heavy subsidy on tax waivers arising out of related payments, i.e., individuals' and businesses' spending on private health care was discounted from their tax base⁶⁷⁽¹³⁹⁾. In Brazil, several other tax waiver factors benefit the private sector.

^d The coordinators of the two programmes, DST/AIDS and Viral Hepatitis, became, respectively, head and deputy head of the new department.

Final remarks

'Brazil's health diplomacy' can be better understood by considering Brazilian foreign policy as a public policy and by examining the role of social policy (including health policy) in the formation and implementation of foreign policy in a given period, and the role of politics in this discussion⁷⁸. Priority given to 'social' concerns on Brazil's international agenda, a process that stemmed from the demands of civil society movements, was crucial.

The changes that occurred in Brazil with the end of the military dictatorship and the restoration of democracy were reflected in all public policies, including foreign policy. The government began working with several traditional and nongovernmental actors and agendas in several different areas. Changes at the international level and globalization, interacting with domestic affairs, led to discussions on several issues and a diversification of Brazil's international activities that provided space for broad political mobilization and advocacy, despite structural inequalities and differences among countries in the world system.

The health sector also had its historical background. Brazil had been a leader in initiatives that were later taken up at the global level, since the 1960s. These experiences were brought by Brazilian personnel to PAHO and later to WHO – e.g., several primary health care ideas were considered in Brazil 12 years before Alma-Ata. The same is true for human resources, social determinants of health, and others. It can be said that 'Collective Health' (a concept coined in Brazil in the 1970s)⁷⁹ was born internationalized⁸⁰. All the major health movements in Brazil and in the Latin American region (or at least the most important ones: social medicine, strategic planning of the health sector, and health sector reform) had links with international institutions, actors, ideas, and shared efforts, especially since the 1950s.

In Brazil, the establishment of SUS as a universal public system and to define health services and activities as a public good and

health as a fundamental component of development has been a common concern for decades among a large part of those working in the health sector, and the leading institutions in the field (FIOCRUZ, National Cancer Institute – INCA, Butantan Institute and others). Strengthening the public health systems was a central theme for Brazilian representatives at WHO.

Civil societies Brazilian actors were increasingly present in these discussions, which had developed slowly since the onset of the political transition period (1985-1990) and escalated in the 1990s. This was an important development in the process of restoring democracy in Brazilian society: social movements had grown – from sectoral (health care reform) and thematic (combating the HIV/AIDS epidemic) motivations – and demanded rights (social, human, voice and vote) and universal public policies in solidarity, adding quality to the struggle against dictatorship and political transition. This practice was reinforced by the incorporation of activist professionals into the state apparatus. In other words, one could say that Brazil was already practicing a kind of 'health diplomacy' before the term even existed.

However, the health issue really entered the foreign policy agenda and became an important factor in Brazil's growing international presence and prestige only on the two Lula administrations. Brazilian health diplomacy, strengthened and stimulated during this period, gained a certain 'autonomy' as a field of activity of the health sector, facilitated by the activism and commitment of a variety of state and non-state actors linked to social movements and the state apparatus. In the same period, the 'internationalization of Brazilian domestic policies' drew on these domestic developments and was linked to the country's upward strategies in the international system, also establishing a link with South-South cooperation, which put into a new context the historical discussions that influenced the Brazilian government's activities after the transition to democracy.

South-South cooperation in health, an important foreign policy strategy, which operated on a demand-driven approach (mainly from Africa and Latin America)⁴⁸, especially from 2003 to 2010^{24,48,81,82}, leveraged and sustained Brazilian health diplomacy. It was no coincidence that two councils of ministers were created at UNASUR – one for health and one for defence. Moreover, on May 15, 2009, the Strategic Plan for Cooperation in Health (Plano Estratégico de Cooperação em Saúde – PECS) of the Community of Portuguese-speaking Countries was adopted, with priority given to member countries in Africa⁸¹. The Latin American and Caribbean Alliance to Fight Cancer was also established in 2007, an initiative of the INCA, which assumed the coordination; in 2010 this Alliance was transformed into the Network of National Cancer Institutes, as part of the UNASUR/Health international cooperation (coordinated by INCA)⁸³. In that period, Brazilian foreign policy adopted “a declared ethic of solidarity among developing countries”, with an explicit political dimension,

which provides a platform for co-operation among countries that want to strengthen their bilateral and multilateral coalitions in order to obtain bargaining power on the global agenda⁴⁸⁽⁷⁾.

Brazilian diplomatic activism in the health field – understood both as the actions of specific health policy circles in national and global socio-political environment⁸⁴ and as the activity of diplomats in specific periods and on specific issues – operated on at least two lines: one focused on national and transnational advocacy, the other on the coordinated activities of Brazilian diplomats, representatives of other agencies in international arenas and civil society and state apparatus activists. The intersection of internal and external variables in formulating and implementing of these policies is crucial to this dynamic. A similar internal-external interrelation can be seen

at other times, as in the leading role Brazil had played since the 1980s in preparation of the Framework Convention on Tobacco Control^{14,84,85}, combining the expertise of Brazil’s tobacco use control policy (an initiative of the INCA) with the competent actions of Brazilian diplomacy in international arenas. However, this activism did not involve BFP directly.

Despite the importance of these developments, they do not mean that the several actors have the same weight domestically and internationally, nor do they mean that social activism is directly reflected in the foreign policy of a particular country, although it may have contributed to formulating and implementing a successful, temporary domestic policy and carried its own struggles to the international level. Nor does the internationalization of values and principles express itself *a priori* as an imitation of the politics of others or as a reproduction of processes triggered by a specific national context.

Although social advocacy is extremely important, its effectiveness depends on the government’s choices, the reciprocation of other, equally important actors and on institutionalized, national and international public policies. The latter, in turn, can be de-structured or even destroyed depending on the political coalitions that sustain them, because ‘institutions tend to be process-oriented’, that is, as analysed by Jönsson & Hall, cited by Almeida⁸⁴, they depend on formal and informal rules that prescribe behavior, constraints, and activities and shape expectations. Indeed, institutional arrangements changed and adapted to the relationships between actors through different contexts and conjunctures, in a process that was constantly prone to conflicts, twists and turns.

From this viewpoint, more than constant advocacy is needed to change national and international politics: governmental choices are also determinant. However, it is essential to maintain the struggle for human rights and solidarity between peoples and the vigilance (and

pressure) over the actions of governments. Therefore, we emphasized the importance of more systematic and rigorous studies on the possibilities and limits of the links between health and international relations, as on the so called health diplomacy.

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Collaborators

Almeida C (0000-0002-1758-1142)* performed and coordinated the research, conceived and wrote the paper. Lima TS (0000-0001-8276-4124)* supported the paper's data collection, drafting and reviews. Campos RP (0000-0001-7480-4050)* discussed, drafted and reviewed the paper. ■

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