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Original article

Brazil's conception of South-South "structural cooperation" in health*

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Abstract

At the dawn of the new millennium, not only have poor countries' health needs not diminished, but they seem to have worsened due to a complex interplay among many factors that result in huge inequities within and between countries. This critical situation calls international development cooperation into question once again and prompts new thinking. In this process, South-South cooperation has steadily gained importance. At the start of the 21st century, international – particularly South-South – cooperation has come to occupy a strategic place in Brazilian foreign policy, and health is a priority item on this agenda. This paper examines the Brazilian conception of horizontal "structural cooperation in health". It presents a brief historical review of international development cooperation and health cooperation, explores the concept of "structural cooperation in health", and discusses the Brazilian proposal formulated over the past decade and its implementation to date. This Brazilian approach centers on the concept of "capacity building for development", but innovates in two respects: by integrating human resource development with organisational and institutional development and by breaking with the traditional passive transfer of knowledge and technology. It is still early to evaluate its impact, but this cooperation has been implemented on the basis of five interrelated strategic, political and technical considerations: (a) priority for horizontal cooperation; (b) focus on developing health capabilities; (c) coordinated initiatives in the regional context; (d) strong involvement of health ministers in building strategic and political consensus; and (e) encouraging partnership between ministries of health and foreign relations.

Keywords

international development cooperation; South-South international cooperation; international cooperation in health; structural cooperation in health; Brazil, CPLP, UNASUL saúde

At the dawn of the new millennium, poor countries' health needs had not diminished, but may have changed for the worse. This shocking lack of progress was due to a complex interplay among many factors, internal and external to the health sector, that result in huge inequities within and between countries. This situation is aggravated in an increasingly interdependent and unequal world, where the effects of poverty and ill-health are not confined within country borders.

That critical situation once again called international development cooperation into question. Since it was

institutionalised in the 1950s, industrialised countries have sought to address and solve global issues of poverty and social exclusion. Despite the numerous bilateral, regional and multilateral international agencies and organisations devoted to this cause, the record shows few initiatives having contributed effectively to achieving that goal.

More recently, South-South cooperation (or Technical Cooperation Among Developing Countries), a foreign policy and international development promotion tool introduced in the late 1970s by the "non-aligned countries", has steadily gained importance. The political and economic situation of

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the 1990s, represented an important turning point for Brazil's foreign policy and its South-South cooperation.

Brazil has endeavoured to consolidate its re-entry into the international system, seeking to take advantage of both post-Cold War global geopolitics and its own political and economic process (democratic and economic stability, civil society participation and more inclusive social policies)¹. The foreign policy of both Lula administrations since 2003 has differed markedly from that of previous governments by seeking more decisively what the authors term "diversified autonomy" (VIGEVANI & CEPALUNI, 2007).

In the 21st century, technical cooperation has gained a strategic place in Brazilian foreign policy (ABC, 2006), at the same time as health is recognised as a predominant theme on the national agenda for South-South cooperation, revealing an unprecedented approximation between the Ministry of Foreign Affairs and the Ministry of Health (ABC, 2007).

Globally, Brazil is also leading the way in forging closer relations between health and foreign policy. In 2007, the initiative on Global Health and Foreign Policy, to which Brazil is a signatory, emphasized that *"health is one of the most important long-term foreign policy issues of our time"*, and declared the urgent need to broaden foreign policy and to create new paradigms of cooperation, outlining the linkages between foreign policy and health (OSLO MINISTERIAL DECLARATION, 2007).

The Oswaldo Cruz Foundation (Fiocruz)² was then invited to act as the privileged focal point for such cooperation, confirming the national and international role it has played historically.

A Fiocruz regional office was inaugurated in Africa in October 2008, in Maputo, Mozambique, with President Lula and both countries' health ministers present, reiterating the institution's international mission and the government's commitment.

Closely attuned with Brazilian foreign policy, Fiocruz is reaffirming its international calling by leading initiatives in South-South cooperation in health in South America and Africa. And other initiatives also deserve attention: the setting up of two new federal universities and, in 2008, a new institute for the joint training of Brazilian and foreign students³; and the creation of regional research network⁴.

This paper discusses the Brazilian conception of "structural cooperation in health", in the realm of South-South cooperation. After a brief theoretical review, it presents the Brazilian proposal formulated over the past decade and how it has developed to date.

A brief history of international development cooperation: changing approaches

Bilateral or multilateral allocation of international development cooperation funding to countries and regions anywhere in the world occurs on the basis of complex political processes permeated by national and international strategic, economic and political considerations. Conditionalities and priorities have changed over the decades.

In the 1950s and 60s, influenced by the modernisation paradigm (TODARO, 1997), international technical cooperation was regarded as a way to provide human and technological inputs in order to fill development gaps (STOKKE, 1996). From the mid-1960s onwards, de-colonisation movements, dependency theorists, and the movement of "non-aligned southern countries" articulated strong international criticisms against the modernisation paradigm, which stimulated further rethinking of development cooperation (JOLLY, 1989).

The seventies saw the first significant reorientation of technical cooperation, with the Basic Human Needs (BHN) approach embodying greater concern for the human and social aspects of development. A number of initiatives paved the way to pursue opportunities for alliance-building among countries of the South.

Technical Cooperation among Developing Countries (TCDC) – also called "horizontal cooperation" – became an important instrument for the strategy of South-South cooperation and has evolved to gain new political, economic and strategic contours. The "horizontality" principle represented an alternative to the "verticality" – unilateral transfers of ready-made packages – of what was then known as North-South international aid⁵.

In the 1980s, following the second (1979) oil shock and subsequent economic crisis, the neo-liberal principles imposed by loans conditional on Structural Adjustment Programmes (SAPS) held centre-stage in the economic and political spheres and also in development cooperation. In this context, TCDC suffered setbacks, and developing countries' political and administrative deficiencies were addressed through programmes to strengthen government institutions ("institutional development") by training national personnel to perform "essential roles".

At the beginning of the 1990s, widespread agreement on SAP failures led to the understanding that a new development paradigm was needed. During that decade, a series of United Nations conferences⁶ emphasizing human,

social and environmental concerns stressed the need to review the way development-related projects and activities had been implemented.

At the end of the decade, TCDC was also reviewed⁷, and the “capacity-building” approach to development has redirected many such endeavours (UNDP, 1997). This reorientation has brought significant changes to the role of international agents and foreign consultants in all fields of development cooperation (MORGAN, 1994).

By the early 2000s, some forward-thinking developing nations themselves were incorporating this principle into their foreign policies, and TCDC took up the new challenge of constituting an alternative means of neutralising, or at least reducing, the adverse forces resulting from economic globalisation processes (AMADOR, 2001).

The first decade of the 21st century poses new challenges. On the one hand, the international donor community is coordinating more intensely and broadly to improve the effectiveness of international cooperation (PARIS DECLARATION, 2005; ACCRA AGENDA FOR ACTION, 2009), and capacity building continues to be an international priority. On the other hand, the September 2001 terrorist attacks on the USA brought the term “securitisation” to international cooperation, underlining its potential role in global threat containment⁸.

International cooperation in health

International cooperation in health emerged relatively early, largely as a result of 19th century advances in knowledge of infectious diseases and in transport technologies⁹. From 1851 onwards, international conferences were held, treaties were signed and international organisations set up to broaden and strengthen international cooperation in health. This process culminated in a historical milestone: the World Health Organization (WHO) was set up in 1948, along with the International Sanitary Regulations, an extraordinary set of rules for the control of infectious diseases. Together, these initiatives produced the first “processes, rules and institutions for global health governance” (FIDLER, 2001: 843).

Since the 1950s, approaches to international cooperation in health have varied, accompanying trends in development thinking. In the 1960s and 70s, influenced by non-aligned and alternative development movements, international health cooperation focused on building up health systems based on strong primary health care (PHC) services⁹.

From the mid-1970s onwards, fiscal crisis turned attentions to the high costs of medical care. In the 1980s, economic crisis, debt repayment, implementation of SAPs

and deep political shifts¹¹ exacerbated poverty and inequality in the South. The worldwide HIV/Aids epidemic, together with other fatal diseases, disproportionately burdened the health systems in low- and middle-income countries. All this, together with unequal globalisation, increased emigration (mainly to the North) by health workers from the countries (mainly in the South) that had invested in their training.

Nonetheless, during the 1980s, restrictive health sector reform agendas prospered and were disseminated worldwide, backed by hegemonic neoliberal ideology and criticism of the Welfare State. Health spending was bundled with macroeconomic demands, incorporating the same principles of “less State”, privatisation, flexibility and deregulation (ALMEIDA, 1995; 2002). Access to health services ceased to be regarded as a public good, and privatisation worsened this situation, demanding greater private spending, even among the neediest populations. This was accompanied by disregard for epidemiological concerns and for public health activities prevention and control of endemic, epidemic and transmissible diseases (ALMEIDA, 2006).

These reforms of health systems did not help overcome existing inequalities in either North or South; rather, particularly in the South, they further impaired health systems’ already precarious problem-solving capacity, thus worsening the inequities. Meanwhile, development cooperation shifted towards technological interventions to improve product research (new drugs and vaccines), while support to systems for delivering interventions weakened considerably. By the late 1990s the results of these decades of (at best) under-investment were apparent.

By 2000, the scenario was more complex, and a number of recent international initiatives signal a new global attitude to tackling the critical state of global health: the Millennium Development Goals (MDGs, 2000), with 3 of 8 objectives addressing health problems (MILLENNIUM DEVELOPMENT GOALS REPORT, 2009); the Global Health Initiatives (GHIs) (since the early 2000s)¹²; the Commission on Macroeconomics and Health (2001)¹³; the Commission on Social Determinants of Health (2005-2008)¹⁴; the Oslo Ministerial Declaration (2007); and the worldwide celebration of 30 years after Alma Ata Conference (2008).

Unfortunately, the proliferation of players, resources and political support for global health has yet to deliver tangible change in health outcomes for all populations. In many parts of the world, even in countries credited as economic success stories, health remains a conspicuous challenge.

That realisation led to major global debate on the effectiveness of international – and particularly North-South

– health cooperation, traditionally structured in the form of vertical programmes connected with specific diseases, which apparently were having little effect on health systems and public health outcomes. Despite evidence mitigating these criticisms (WORLD HEALTH ORGANIZATION GROUP, 2009), that debate resulted in a crucial shift towards the idea of “horizontality” in international health cooperation, which interrelates South-South cooperation with partnering directed to exchanging experience, learning jointly and sharing results and responsibilities.

The conception of ‘structural cooperation in health’: the Brazilian approach

The conception of “structural cooperation in health” rests fundamentally on the approach of “capacity-building for development”¹⁵. This new paradigm innovates in two respects in comparison with previous ones, by integrating human resource development with organisational and institutional development. It also tries to break with the traditional model of passive, unidirectional transfer of knowledge and technology, proposing rather to exploit each country’s existing endogenous capacities and resources.

The purpose is to go beyond traditional forms of international aid and to redefine Brazilian cooperation in health as “structural”, i.e., centred on strengthening recipient-country health systems institutionally, combining concrete interventions with local capacity building and knowledge generation, and promoting dialogue among actors, so that they can take the lead in health sector processes and promote formulation of a future health development agenda of their own (Figure). In such a context the role of the international agent changes substantially.

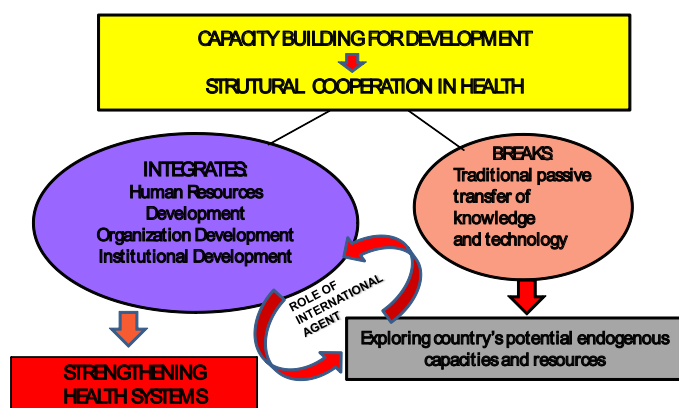


Figure - The Conception of “Structural Cooperation in Health”: conceptual and operation innovations

The main Brazilian cooperation projects in Africa and South America are thus directed to human resource training/capacity-building in either research, teaching or services, and to strengthening or setting up health system “structuring institutions”, such as ministries of health, schools of public health, national health institutes, faculties for higher professional training (medicine, dentistry, nursing etc.), polytechnic health colleges, technological development and production institutes and factories. The proposal is for these institutions to work together in national and regional networks and support efforts to structure and strengthen their respective health systems¹⁶.

Brazilian health cooperation with **Africa** prioritises the Community of Portuguese-Speaking Countries (*Comunidade*

Box 1 - Comunidade de Países de Língua Portuguesa (CPLP)

The community of countries where Portuguese is the official language was set up in 1996 in Lisbon, Portugal, by the heads of state of Angola, Brazil, Cape Verde, Guinea-Bissau, Mozambique, Portugal and São Tomé and Príncipe. With its independence in 2002, East Timor became the community’s eighth member. The groundwork began to be laid in the late 1980s, when the first meetings of heads of state and government of Portuguese-speaking countries were held in Brazil (1989 and 1994).

The CPLP was set up in order to consolidate cultural conditions that endow Portuguese-speaking countries with their particular identity, promote political and diplomatic coordination and to stimulate cooperation, so as to foster concerted initiatives to promote the economic and social development of the community’s peoples. Priority areas are the Portuguese language, education and health.

It is composed of the Conference of Heads of State and Government, the Council of Ministers, the Permanent Steering Committee, the Executive Secretariat (in Lisbon), the Meeting of Sectoral Ministers (such as the Health Ministers), the Meeting of Cooperation Focal Points and the International Portuguese Language Institute. In 2007, the Parliamentary Assembly was established. The CPLP has 44 consultative observers, that is, member-country scientific, cultural and economic institutions that contribute to achieving the community’s objectives. Equatorial Guinea, Mauritius Islands and Senegal are also observers.

In the health field, the CPLP has passed several agreements on HIV/AIDS, malaria, illegal drug use, temporary medical visas, and others. The latest agreement established the Strategic Health Cooperation Plan for 2009-2013. In the international sphere, CPLP has also signed agreements with various United Nations units (such as UNAIDS) and is currently negotiating health agreements with WHO. A specific agreement on health documentation in Portuguese, the e-Portuguese, was reached with the WHO, where the platform is housed.

There are major differences among the CPLP countries, not only in population and income, but also culturally and in health indicators and needs. CPLP country populations range from 189 million in Brazil to 155,000 in the islands of San Tome and Principe, and income from US\$21,500 per capita in Portugal to only US\$729 in Timor East, US\$830 in Guinea Bissau and US\$1,200 in Mozambique. There are also great disparities in health indicators and life expectancy. Under-5 mortality ranges from 5 in Portugal to 260 per thousand in Angola; and life expectancy, from around 70 in Portugal and Brazil to less than 50 in Angola and Mozambique.

Chart – Health Cooperation Projects with Africa conducted by Fiocruz, 2009

COUNTRIES	COOPERATION PROJECTS		
	ONGOING	UNDER NEGOTIATION	AT THE EXPLORATORY STAGE
Mozambique (CPLP)	<ol style="list-style-type: none"> 1) Establishment of the public pharmaceutical company in Mozambique, to produce anti-retroviral and other drugs. 2) Strengthening the National Institute of Health. 3) Masters programme in Health Sciences. 4) Setting up the Polytechnic School of Health. 5) Technical capacity-building in equipment maintenance. 6) Setting up the National Institute for Women and Children. 7) Service capacity-building in maternal and child health. 8) Elaboration and implementation of the Strategic Health Cooperation Plan (PECS). 	<ol style="list-style-type: none"> 1) Support for restructuring the FARMAC enterprise and introducing the "Popular Pharmacy" programme. 2) Support for distance learning. 3) Capacity-building in programme and service monitoring and evaluation (part of the Brazil/USA/Mozambique Trilateral Agreement on AIDS). 4) Capacity-building in logistics (part of the Brazil/USA/Mozambique Trilateral Agreement on AIDS). 	
Angola (CPLP)	<ol style="list-style-type: none"> 1) Masters programme in Public Health. 2) Elaboration and implementation of the Strategic Health Cooperation Plan (PECS). 	<ol style="list-style-type: none"> 1) Support for setting up the National School of Public Health. 	
Cape Verde (CPLP)	<ol style="list-style-type: none"> 1) Setting up the Technical School of Health. 2) Supporting to strengthen the recently created University to form health professionals. 3) Elaboration and implementation of the Strategic Health Cooperation Plan (PECS). 	<ol style="list-style-type: none"> 1) Support for setting up the National Institute of Health. 2) Doctoral programme in Public Health. 	
Guinea Bissau (CPLP)	<ol style="list-style-type: none"> 1) Setting up the Technical School of Health. 2) Elaboration and implementation of the Strategic Health Cooperation Plan (PECS). 	<ol style="list-style-type: none"> 1) Support for setting up the National Institute of Health. 2) Support for strengthening the health system. 	
East Timor (CPLP)	<ol style="list-style-type: none"> 1) Elaboration and implementation of the Strategic Health Cooperation Plan (PECS). 		<ol style="list-style-type: none"> 1) Support for restructuring and strengthening the health system
St. Thomas and (CPLP) Prince	<ol style="list-style-type: none"> 1) Elaboration and implementation of the Strategic Health Cooperation Plan (PECS). 		<ol style="list-style-type: none"> 1) Advising and technical support for health system development (services, organizations and health programs)
Nigeria			<ol style="list-style-type: none"> 1) Support for strengthening the essential drug production.
Burkina Faso			<ol style="list-style-type: none"> 1) Advising and technical support for health system development (services, organizations and health programs).
Mali			<ol style="list-style-type: none"> 1) Advising and technical support for health system development (services, organizations and health programs).
Tanzania			<ol style="list-style-type: none"> 1) Advising and technical support for strengthening the essential drug production.

dos Países de Língua Portuguesa, CPLP) (Box 1 and Chart), although cooperation projects and negotiations are ongoing with other African countries.

The model of health cooperation adopted by CPLP countries is based on a prior, joint strategic health cooperation plan (*Plano Estratégico de Cooperação em Saúde*, PECS) constructed with intensive participation by senior authorities from the eight countries' Ministries of Health and resting on local "focal points" tasked with identifying interests and needs by mobilising ministry authorities and other actors. Funding is from government and other national and international sources.

The CPLP structure for cooperation in health consists of the Council of Health Ministers, which decides the "focal points" in each country and is coordinated by the CPLP Executive Secretariat, with formal technical support from Fiocruz (Brazil) and the Institute of Hygiene and Tropical Medicine (Portugal). This model was discussed and approved at successive meetings of the member countries' health ministers¹⁷.

The CPLP PECS has the distinguishing feature of clearly taking into account MDG advances in each country, as well as the social determinants of health (MDG AFRICA STEERING COMMITTEE, 2008). To begin with, the PECS spans seven priority areas and includes a number of specific diseases and thematic areas, but that array can be revised periodically, according to each country's needs¹⁸.

This form of health cooperation does not exclude any of the other bilateral or multilateral projects in place in each country, including those involving the CPLP countries. However, the model does also seek articulation and coordination among them, with a view to reducing fragmentation and leveraging results.

The countries have welcomed the PECS warmly, leading the CPLP to apply a similar model to other areas of social cooperation, such as education, the environment and others.

Brazilian health cooperation with South America has been driven by its foreign policy focus on the recently created

Box 2 - Union of South-American Nations

The Union of South-American Nations (USAN) is an intergovernmental union integrating two existing customs unions: Mercosur and the Andean Community. It is part of an ongoing process of South American integration. Its Constitutive Treaty was signed on May 23rd, 2008, in Brasilia, Brazil, by twelve heads of state. It is modeled on the European Union.

Under the Treaty, the Union's headquarters will be in Quito, Ecuador. The South American Parliament will sit in Cochabamba, Bolivia, while the Bank of the South will be housed in Caracas, Venezuela.

The UNASUL's provisional structure is as follows:

1. The Council of Heads of State and Government will be the lead political actor;

2. The Council of Ministers of Foreign Affairs will formulate concrete proposals and make executive decisions;

3. The Council of Delegates, composed of high-level government officials, will organize the work of the two Councils and implement their decisions;

4. A Secretary-General will be elected to set up a permanent secretariat in Quito, Ecuador;

Presidents will call sectoral Ministerial Meetings, which will follow Mercosul and Andean Community procedures. The Pro Tempore Presidency will be held for a year and will rotate among member States.

These twelve South American countries share thousands of miles of inland borders. Covering 10.99 million square miles of land, they are home to some 385 million people (2008) and extend to both the Atlantic and the Pacific Oceans. They span the South American continent from the Equator to Antarctica and contain the Amazon Forest – the largest on the planet.

In December 2008, the Presidents convened in Bahia, Brazil, to set up the South American Health Council, comprising the 12 Ministers of Health.

There is great heterogeneity among and within South American countries. Populations range from 189 million in Brazil and 40 million in Argentina and Colombia to less than one million in Suriname and Guyana. The per capita income range is from around US\$15,000 in Argentina to around US\$3,000 in Bolivia. Under-five mortality ranges from 9 to 60 per thousand and life expectancy is around 70 in all the countries. Bolivia and Guyana are clearly the poorest countries in the region and have the worst social and health situations.

Union of South-American Nations (*União de Nações Sul-Americanas*, UNASUL)¹⁹ (Box 2).

The South American Health Council (*UNASUL Saúde*), set up in December 2008 at the UNASUL Presidential Summit, comprises the Ministers of Health of the twelve member-States and an executive structure²⁰. The Council's goals are to consolidate South American integration in health through consensual policies, and coordinated activities and cooperation efforts between countries²¹.

The health cooperation model adopted by UNASUL is quite similar to the CPLP model, and the preliminary Work

Box 3 - The South American Health Agenda

The South American Health Agenda includes the following themes:

1) The South American epidemiological shield: coordination among member-States surveillance and response networks according to international health regulations;

- Early detection and response to outbreaks
- Elimination of communicable diseases

2) Universal health systems: development of health systems that assure peoples' universal right to health and are based on the comprehensive primary health care approach

3) Universal access to drugs and medications:

- South American drug policy
- Health production complex

4) Health promotion and social determinants of health

• Setting up the South American Commission on Determinants of Health

• Implementing intersectoral measures to address the social determinants of health

5) Human resource management and development

• Assessment of progress by sub-regional groups in identifying the capacities and knowledge necessary for training human resources

• The UNASUL Health Scholarship Program

• Establishment of the South American Institute of Health Governance (Instituto Sulamericano de Governo em Saúde, ISAGS), whose mission is to develop innovation for health governance and to prepare high-level personnel to lead health systems in the Region.

Plan, also called the South American Health Agenda, was approved in April 2009²² (Box 3). Another important piece of this process involves engaging politicians, leading public health figures and civil society.

The main goals of UNASUL health cooperation are to strengthen health systems and services and their structuring institutions and to further develop human resources for health. Unlike the CPLP proposals, however, they also include establishing the South American epidemiological shield and jointly negotiating with pharmaceutical companies to secure fair prices for drugs, diagnostic kits, vaccines and medical equipment.

Reflections on lessons learned so far

It is still early to evaluate impacts, but Brazil is attempting to apply the structural cooperation approach to South-South health cooperation, based primarily on five interrelated political, strategic and technical aspects: (a) priority for horizontal South-South cooperation, (b) focus on developing capacities in health, (c) coordinated initiatives in the regional context, (d) strong involvement of health ministers in constructing strategic and political consensuses, and (e) nationally, close partnership between its Health and Foreign Ministries.

The horizontality of its South-South cooperation is evident in the continuous emphasis on exchanging experience, learning jointly and sharing results and responsibilities with national and international partners. This is a political and strategic posture framed by the recent democratic experience of grassroots social participation in making social policy – particularly health policy – in Brazil. Cooperation projects do involve a wide range of actors from both sides and, consequently, decisions are taken at several levels and different loci of power, involving different organisational and institutional cultures in different countries.

Meanwhile, the focus on health capacity-building is a major challenge. Despite this important conceptual change, little has been done to explore how to do it with a view to strengthening health systems. In addition, the role of “international agents” becomes less clear and more complex, while partnering is crucial to identifying issues and tackling problems. Also, high expectations for effective results go hand-in-hand with seriously limited administrative mechanisms on both sides. There is a need to define the most appropriate institutional arrangements to respond to foreign policy decisions and to avoid the risk of responsibilities being pulverised (FRANÇA & SANCHEZ, 2009).

The shift to region-wide coordination in Brazil’s cooperation in health, both in Africa and in South America, stems from the understanding that in order to assure a foreign policy of “diversified autonomy”, and also greater effectiveness in its international cooperation in the present, Brazil must find a place in regional arrangements that enable it to build political strength and gain greater strategic room for manoeuvre than afforded by merely bilateral relations.

The strong involvement of health ministers in building strategic and political consensuses has been secured by frequent meetings among the countries at a variety of locations and levels, in partnership with other international organisations and prominent actors committed to promoting South-South cooperation in health. These meetings have

enabled provisional consensuses to be built, thus permitting these endeavours to advance.

Lastly, the close partnership between Brazil’s Ministry of Health and Foreign Ministry – called “health diplomacy”²³ – signals the national effort to associate expertise in health with the strength of the foreign affairs sector, especially as regards South-South cooperation.

To conclude

In order to formulate a better notion of international health cooperation in developing countries, the following alternatives – which challenge traditional practices in one way or another – must be taken into consideration.

- Supporting comprehensive health system development, surmounting fragmentation and lack of coordination.
- Emphasising long-term needs. By strengthening key institutions to acquire true leadership, promoting a future-oriented agenda and balancing specific actions with knowledge generation.
- Moving from programmes based on a single global orientation to strategic planning centred on “recipient” country realities, broadly incorporating the social determinants of health.
- Prioritising population-based (health needs-oriented) programmes over activities focused strictly on individual care.

In the process of building a conception of structural cooperation in health, Brazil is continuously learning from successes and errors. There are great challenges ahead, but the prospects are also very promising.

Notes

1. Although it is acknowledged that two theoretical approaches – liberal and developmentist – coexist in a tense balance in Brazilian diplomatic thinking, and that present foreign policy priorities and guidelines emerge from the clash between them, there is a consensus among the authors regarding the strategic and political place that Brazil should occupy on the international stage (SARAIVA, 2007; ALMEIDA, 2004).

2. The Oswaldo Cruz Foundation (Fiocruz) is a public foundation connected with the Brazilian Ministry of Health, and “right arm” of the Unified Health System (SUS). Fiocruz has a diversified mission – teaching, research, production and technological development – performed through different Technical and Scientific Units, and also engages in global interchange with scientific and technological centres in developed and developing countries. Its headquarters and 10 specialised Units are in Rio de Janeiro, distributed in two campus

– Manguinhos and Jacarepaguá – but Fiocruz has Units in 7 provinces in Brazil, giving it national scope. The Fiocruz Centre for Global Health was set up in January 2009, (Cris/Fiocruz) in the campus of Manguinhos, in Rio de Janeiro. The centre provides advisory support to the Fiocruz Presidency and coordinates the Fiocruz International Cooperation Technical Group, which comprises representatives of the Institution's 17 Technical and Scientific Units.

3. The International Portuguese-African-Brazilian Integration University (*Universidade Internacional da Integração Luso-Afro-Brasileira*, UNILAB), in Fortaleza, Ceará, Brazil; the International Latin-American Integration University (*Universidade Internacional da Integração Latinoamericana*, UNILA), in Foz de Iguaçu, Brazil, at the triple border between Brazil Argentina and Paraguay; and the South American Institute of Government in Health (Instituto Sul-americano de Governo em Saúde, ISAGS), in Rio de Janeiro, Brazil, set up for the purpose of heading a network of schools of government in the countries of South America. All the initiatives will offer several courses, including Public Health, to Brazilian, Portuguese-speaking and South American students, respectively.

4. The Amazon Agreement on Health Research, which gave rise to the Pan-Amazonian Health Research Network, an articulation among scientific institutions from the Amazon countries (Bolivia, Brazil, Colombia, Ecuador, Guyana, Peru, Suriname and Venezuela) – Fiocruz among them – with the objective of jointly carrying out relevant projects for the specific and defying situation of this vital region for the planet. Currently in the health sector there are research projects in malaria, hemorrhagic fevers (including dengue fever) and health systems.

5. The 1978 Buenos Aires Plan of Action (BAPA) proved a seminal document in establishing and advancing "horizontality" as the fundamental principle of TCDC.

6. For a complete list and brief explanation on each conference held in the 1990's, visit the United Nations website: <http://www.un.org/News/facts/confers.htm> (Accessed on 30 Jul. 2009).

7. As indicated in the United Nations Economic and Social Council resolution (1993), and in the 10th Session of the United Nations High-Level Committee on TCDC (1997).

8. This conception is quite evident in a 2003 World Bank Report (*Breaking the Conflict Trap: Civil War and Development Policy. A World Bank Policy Research Report*) (WORLD BANK, 2003).

9. The 1st International Sanitary Conference, a historic landmark in international health cooperation, was held in Paris In 1851. At that time, European states were discussing for the first time coordinated cooperation initiatives to combat the threats from cholera, plague and yellow fever. That event represented "*one such dramatic transition in how health was conceptualised and approached internationally*" (FIDLER, 2004:1).

10. The trend was strengthened in the late 1970's by PHC programmes and the "Health for All in 2000" strategy proclaimed in the Alma Ata Declaration (1978).

11. Civil and political unrest, the spread of neoliberal hegemony,

processes of political re-democratisation in South America and the building of new nations following post-colonial wars of liberation in Africa.

12. The GHIs comprise increasing involvement by the private sector, philanthropic bodies and civil society in health, as a result of the proliferation of global initiatives in health at the start of the 21st century (WHO MAXIMIZING POSITIVE SYNERGIES COLLABORATIVE GROUP, 2009).

13. The Commission Report (December, 2001) and the Declaration on the Second Consultation on Macroeconomics and Health (Geneva, October, 2003), "*Increasing Investments in Health Outcomes for the Poor*" are available at: <http://www.who.int/macrohealth/en/> (Accessed on 3 Aug., 2009).

14. The final report on the Commission on Social Determinants of Health – *Closing the gap in a generation: Health equity through action on the social determinants of health* (Geneva, 2008) is available at: http://www.who.int/social_determinants/en/ (Accessed on 2 Aug., 2009). The Commission focused on nine broad areas that contain within them major determinants of health. Each of the themes was the area of a "knowledge network" (KN). Each KN was comprised of experts in the field and collectively they studied the pertinent social determinants and health equity issues. The final reports of the KNs, and other supporting background documents, as well as links to the organizations that led the work of the respective KN, can be found at: http://www.who.int/social_determinants/themes/en/index.html (Accessed on 2 Aug., 2009).

15. "Capacity building for development" is defined as *the process by which individuals, organizations, institutions and societies develop abilities (individually and collectively) to perform functions, solve problems and set and achieve objectives* (UNDP, 1997:2).

16. For more information please see the articles published by Buss & Ferreira, in this issue.

17. The meetings were held in Praia, Cape Verde, April 2008, and in Rio de Janeiro, Brazil, September 2008. The PECS for the coming four years (2009-2013) was given final approval in another meeting held in Lisbon, Portugal, in May 2009.

18. Initially, these areas are: health workforce development, epidemiological surveillance, emergency and disaster preparedness, Information and communication, Research & Development for health, technological development and drug and vaccine production, health promotion and protection including inter-sectoral actions (health determinants). The diseases are malaria, tuberculosis and HIV-Aids, and the thematic areas are health and migration, and health diplomacy.

19. Mercosur and the Andean Community (CAN) have been for many years the two main regional blocs of South-American countries. The creation of Union of South American Nations community (*União das Nações Sulamericanas-UNASUL*) crowns a movement to broaden the process and scope of regional integration in South America. This movement was initiated in 1994 when Brazil, Argentina, Paraguay and Uruguay (the original Mercosur member countries) proposed to set up a South American Free Trade Area (ALCSA). Although the move was first tabled in the mid-1990s, it was only in 2004, ten years

later, that the movement regained political momentum. UNASUL was officially established on 23 May, 2008, in Brazil's capital, Brasília.

20. The structure of the Council includes a Coordinating Committee composed of representatives from each country's Ministries of Health; a Technical Secretariat under the responsibility of the country currently occupying the UNASUL *Pro Tempore* Presidency, the last country that held it and the country that will hold it next; workgroups on specific themes; and the health-related focal points (UNASUL Steering Committee on Health).

21. The main objectives of UNASUL Saúde include strengthening Ministries of Health and other "structuring institutions" within health systems; developing policies and inter-sectoral actions to tackle social determinants of health; establishing sectoral institutional networks; providing a coordinated response to emergencies and disasters; promoting scientific research and stimulating innovation in health; and harmonising sanitation standards and health actions in border areas.

22. The "South American Health Agenda" was developed by Technical Groups on specific priority themes, was reviewed by the UNASUL Steering Committee on Health, and approved in April 2009 at the Council meeting in Santiago, Chile.

23. The concept of "health diplomacy" has emerged to contemplate health factors that transcend national boundaries and expose countries to global influences, and to enforce better and more cohesive coordination between governments' health and foreign affairs sectors (KICKBUSCH et al., 2007, 230).

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