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THE WORLD HEALTH ORGANIZATION AND POLICY TRANSFER: THE TRANSFER OF TOBACCO CONTROL POLICY TO BRAZIL

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"*...Even when everything seems to fall apart, it's up to me to decide between laughing or crying, going or staying, giving up or fighting, because I discovered, in the uncertain path of life that the most important thing is to decide.* " (Cora Coralina)

ABSTRACT

The thesis's main goal is to understand how the World Health Organization (WHO) transfer public policies to their members and how this can occur. The studies about diffusion and transfer of policies from IOs are still scarce. The WHO can be a prolific case study because the multilateralism enables a wide range of actors in the WHO decision-making. This research's specific goals can be translated by: investigating the phenomenon of bringing the third party to the WHO; the analysis of diffusion and transfer mechanisms applied by the WHO to translate its regulations into concrete country actions. Moreover, we aim to evaluate whether the non-state actors can hamper or strengthen the policy transfer. The analysis focuses on transferring tobacco control regulation to Brazil and the ultra-processed foods legislation on consumption. The tobacco case is emblematic in the literature, given its considerable success in diffusion and transfer worldwide. Otherwise, there are still some gaps to consolidate an effective global policy to create standards capable of bylaw the agenda of unhealthy foods. The cases are agendas of the non-communicable disease clusters and have in common the feature of treat with a vast complexity of interests among actors involved. We applied three methods to undertake this research: the interviews, the documental analysis, and the network analysis. We conducted two rounds of semi-structured interviews. The first, applied to WHO experts in Geneva, health researchers/or Human Rights researchers, sought to understand the decision-making environment and non-state actors' role through the WHO. The second, to Brazilians engaged in global health, to understand Brazil's performance in the adoption of WHO international guidelines. We sought to identify evidence of non-state actors' role in a more systematic way within the institution through the documental analysis. The third method applied was network analysis. Through this method, we aimed to systematize the triangulation of qualitative data. We identified a normative network that highlights the role of individuals as policy entrepreneurs in the process of transferring. Hence, the relational analysis evidenced key actors in "importing" an international policy from the WHO headquarters to Brazil. Conclusion: The thesis identifies relevant issues that can concomitantly bring contributions to the literature of International Organizations (IOs) and policy diffusion and transfer literature meanwhile. Firstly, the WHO can employ different instruments to transfer their policies. Second, the effective global policy transfer depends on plenty of variables as the degree of complexity of the policy and how the IO can manage divergent interests. Third, the tobacco control is a successful case for its instruments applied for dealing with the diversity of interests. Four, the mechanisms identified in the transferring of tobacco rules to Brazil could be replicated in the case of ultra-processed foods.

Keywords: WHO, Non-state actors, Brazil, Policy Transfer, Tobacco control.

RESUMO

O objetivo principal desta tese é compreender como a Organização Mundial da Saúde (OMS) transfere políticas públicas para seus membros e como isso pode ocorrer. De maneira mais esquemática, definimos como objetivos específicos desta pesquisa: investigar o fenômeno de trazer uma terceira parte para participar nas instâncias decisórias da OMS; a análise dos mecanismos de difusão e transferência aplicados pela OMS para traduzir seus regulamentos em ações nacionais concretas. Além disso, a avaliação de se os atores não estatais podem dificultar ou fortalecer a transferência de políticas. A análise tem como foco principal a transferência das regulamentações de controle do tabaco para o Brasil e a regulamentação do consumo de alimentos ultraprocessados. O caso do tabaco é considerado emblemático na literatura, dado seu sucesso na difusão e transferência em todo o mundo. De modo distinto, ao se observar a pauta de alimentos industrializados nota-se lacunas para a consolidação de uma política global eficaz, capaz de criar padrões direcionados à regulamentar esta agenda. Os casos são pautas do cluster de doenças não transmissíveis e têm em comum a característica de tratar com a grande complexidade de interesses entre os atores envolvidos. Triangulamos as informações a partir de três métodos: entrevistas, análise documental e a análise de rede. Realizamos duas rodadas de entrevistas semiestruturadas. A primeira com especialistas da OMS em Genebra, pesquisadores em saúde / ou pesquisadores em direitos humanos, a qual buscou entender o ambiente de tomada de decisões e o papel dos atores não-estatais na OMS. A segunda foi aplicada aos experts que atuam na saúde global no Brasil e buscou entender o desempenho do Brasil no que se refere à adoção das diretrizes internacionais da OMS. A análise documental buscou entender o papel dos atores não estatais de forma mais sistemática dentro da instituição. A análise de redes buscou sistematizar a triangulação das informações qualitativas. Identificamos uma rede normativa que destacou o papel dos indivíduos como empreendedores de políticas no processo de transferência. Conclusão: a tese identifica questões relevantes que podem, concomitantemente, trazer contribuições para a literatura de Organizações Internacionais (OIs) e, para a literatura de difusão e transferência de políticas públicas. Primeiro, a OMS pode empregar diferentes instrumentos para transferir suas políticas. Segundo a transferência efetiva de políticas globais depende de variáveis como o grau de complexidade da política e a capacidade da OI de gerenciar os interesses divergentes existentes. Terceiro, o controle do tabagismo é um caso de sucesso por seus instrumentos aplicados para lidar com a diversidade de interesses. Por último, os mecanismos aplicados na transferência do controle do tabaco para o Brasil podem inspirar a regulamentação dos alimentos ultraprocessados.

Palavras-chave: OMS, Atores não estatais, Brasil, Transferência de políticas, Controle do tabaco.

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ABBREVIATIONS

ACT	Tobacco Control Association
ACTO	Amazon Cooperation Treaty Organization
AESA	Special Health Affairs Advisory
AFUBRA	Association of Tobacco Growers of Brazil
AISA	Advisory on International Health Affairs
Anvisa	National Health Surveillance Agency
ARV	Anti-retroviral
ASEAN	Association of South East Asian Nations
BAT	British American Tobacco
BFP	Brazilian Foreign Policy
BMGF	Bill & Melinda Gates Foundation
BRICS	Brazil, Russia, India, China, South Africa
CAESA	General Coordination of Special Health Affairs
CAI	International Affairs Comission
CAIS	Coordination of International Health Affairs
CAISAN	Interministerial Chamber for Food and Nutritional Security
CCM	Country Coordinating mechanism
CDS	Communicable Diseases
CETAB	Center for Studies on Tobacco and Health
CNCT	National Commission for Tobacco Control
CNPQ	National Council for Scientific and Technological Development
CNSAN	National Conference on Food and Nutritional Security
CNT	China National Tobacco

CONICQ	National Commission for the Implementation of the Framework Convention on Tobacco Control
CONSEA	National Food Security Council
COP	Conference of the Parties
CPLP	Community of Portuguese Speaking Countries
CRIS	Fiocruz Global Health Center
CSI	Civil Society Initiative
CSO	Civil Society Organization
DAH	Development Assistance for Health
DG	Director General
DHAA	Human Right to Adequate Food
ECOSOC	Economic and Social Council
EMRO	Eastern Mediterranean Regional Office
FAO	Food and Agriculture Organization
FAO	Food and Agriculture Organization
FCA	Framework Convention Alliance
FCTC	Framework Convention for Tobacco Control
FCTC	Framework Convention on Tobacco Control
FENSA	Framework of Engagement with non States Actors
Fiocruz	Oswaldo Cruz Foundation
FNS	Food and Nutrition Security
Funasa	National Health Foundation
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund)
GHG	Global Health Governance
GSM	Global Social Movements

HOLN	Health Organization of the League of Nations
ICA	International Cooperation Advisory
ICPDC	International Cooperation Program for Developing Countries
IFFIM	International Finance Faciliy for Immunization
IGO	International Intergovernmental Organization
IHC	*International Health Commission*
IHD	*International Health Division of Rockfeller Foundation*
IHD	International Health Division
ILO	International Labor Organization
INB	Intergovernmental Negotiating Body
INCA	National Cancer Institute José de Alencar Gomes da Silva
INCA	National Cancer Institute
IO	International Organization
ISAG	Institute of Government in Health
ISC	International Sanitary Conference
ISR	International Sanitary Regulations
JTI	Japan Tobacco International
LNHO	League of Nations Health Organization
LOSAN	Organic Law on National Food Security
LRCS	League of the Cross Societies
MDG	Millennium Development Goals
MEI	Multilateral Economic Institutions
MFA	Ministry of Foreign Affairs
MFA	Ministry of Foreign Affairs
MH	Ministry of Health
MPOWER	Monitor, prevent, offer, warn, enforce, raise -tobacco taxes

MSF	Multiple Streams Framework
NDCs	Non-communicable diseases
NGOs	Non Governmental Organizations
NIEO	New International Economic Order
OIHP	Office International d'Hygiène Publique
OIRH	Offices of International Relations and Cooperation in Health
OIT	Orchestration, Intermediary, Target
OXFAM	Oxford Committee for Famine Relief
PA	Principal- Agent Theory
PAHO	Pan American Health Organization
PASB	Pan American Sanitary Bureau
PATH	Program for Appropriate Technology in Health
PEPFAR	President's Emergency Preparedness for AIDS Relief
PMI	Philipp Morris International
PNAN	National Policy on Food and Nutrition
PNCT	National Tobacco Control Policy
PNSA	National Food Security Plan
PPPs	Public Private Partnerships
RBM	Roll Back Malaria
SAPs	Structural Adjustment Programmes
SARS	Severe Acute Respiratory Syndrome
SDGs	Sustainable Development Goals
SIPT	Integrated Tobacco Production System
SISAN	National System of Food and Nutritional Security
SUS	United Heatlh System
TFI	Tobacco Free Initiative

TNA	Transnational Actors
TRIPS	Trade Related Aspects of Intellectual Property Rights
UFMG	Federal University of Minas Gerais
UN	United Nations Organization
UNAIDS	Joint United Nations Programme on HIV/ AIDS
UNASUR	Union of South American Nations
UNCED	United Nations Conference on Environment and Development
UNCED	United Nations Conference on Environment and Development
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population
UNICEF	United Nations Chlidren's Fund
UNOPS	United Nations Office for Project Services
USA	United States of America
USAID	United States Agency for International Development
WFP	World Food Program
WHA	World Health Assembly
WHO	World Health Organization
WTO	World Trade Organization

CONTENTS

1 INTRODUCTION

The cooperation of Intergovernmental organizations is usually taking place through agreements among states. In the traditional theory of international relations, states delegate to agencies (like international organizations (IOs[1])) the right to make decisions concerning international politics. Researchers hardly applied to international relations this theory named Principal-Agency (PA) theory, in which the Principals are the member states and the Agencies are the International Organizations. Nevertheless, we have seen the growing engagement of non-State actors in international institutions, in particular at the World Health Organization (WHO). At the WHO, besides the member states, we highlight the action of nongovernmental organizations, the private sector, and philanthropic institutions: all could contribute to the decision-making process. This process of engagement call attention at the literature and make us reflect about several preliminary questions: why has the WHO been encouraging the action of non-State actors and how can this process contribute to spreading policies across countries? Would this process suggest that the Principal-Agent theory does not suffice to explain the multilateral cooperation at IOs which allow the action of non-State actors? Otherwise, is the action of systematizing the joining of non-State actors a way to prevent against threats and in this way, reinforce the actions of member states and, in this sense, contribute to the premises proposed by the Principal-Agent theory?

This work is about the engagement of non-State actors and the World Health Organization strategies to transfer policies to the national levels. To operationalize this research, we have two main goals: firstly, to understand the reasons that encouraged the World Health Organization to allow non-State actors' action through formal ways all along the institutional process. Secondly, to know how the non-State actors could supply the transfer of WHO best practices. In this way, we will work with the questions that are:

1. What strategies and conditions allow a successful transfer from the WHO to the domestic level?

2. How can the non-State actors play in the process of policy transfer and diffusion?

3. What reasons encouraged the WHO to include non-state actors into its organizational design on a systematic basis?

In order to answer these questions, we developed a case study of two policies in Brazil, which are: the policies of tobacco control, and the policies to control the consumption of ultra-processed food. In a general manner, these cases have in common the fact to be addressed to noncommunicable diseases and fight against commercial interests. The criteria adopted to select these policies will be presented at methodological section. Moreover, embased on

[1] International Organizations, IOs, and International Intergovernmental Organizations, IGOs will be used in this document as synonyms.

Shipan;Volden (2008) we will consider a **successful transfer** that in which resources are efficiently allocated and can be upheld over the years (SHIPAN; VOLDEN, 2008) , as will be discussed in the section Literature Review. Before discussing the methodological tools chosen to operationalize this work, we will present some characteristics of the WHO.

1.1 WHY THE WHO?

Different reasons could justify the selection of the World Health Organization as a case study for this work. Among others, three aspects are relevant to this research. The first concerns the origins and structure of WHO. The second concerns the action of non-state actors within the institution. The third is related to the fact that the so-called policies are best practices that the states can choose to implement or not. In other words, hardly ever has mechanisms to encourage or enforce actors to transfer the norms to the country level.

1.1.1 A brief description of the origins and structure of the World Health Organization

The cooperation in health issues is historically composed of different actors like epistemic communities, doctors, and hygienists, who since the 15th century begun to discuss manners to avoid epidemics in Europe. At the outset, the Black Death was an expressive reason to encourage meetings from representatives of different countries around Europe. The Black Death is known in the literature for being one of the most devastating illnesses in history. Due to the uneasiness generated by several deaths and the low-quality population health, the national governments were uptight with the economy and the repercussions of reducing consumption. (YOUDE, 2012).

Beyond the fifteenth century's initiatives, the first efforts to institutionalize the cooperation were perceived at the beginning of the 20th century. In 1902 was consolidated the first project that could be associated with an international health organization. The institution created in 1902 was called the International Sanitary Bureau (ISB), and it was created to prevent and control such illnesses as cholera. (YOUDE, 2012). Nevertheless, the limited scope of the institution was not enough to assist the different diseases internationally. It is noteworthy that other institutions specialized in health problems were created between 1900 and 1915. However, only after the United Nations' creation arose an international organization with global purposes called the World Health Organization, hereafter WHO. According to Murphy (2014) the World Health Organization was different from the previous initiatives due to the socio-centric perspective incorporated in the institution instead of the state-centric perspective embodied by initial organizations for health. This feature allowed the WHO to bring a diversity of discussions, issues, and actors to the international organization.

The World Health Organization, in the beginning, was not on the original agenda of the United Nations in 1945. In 1946, the first health conference was convened at the UN, called

the International Health Conference (LEE, 2009), to discuss an international bureaucracy's formalization to global health end. Thenceforth the WHO was consolidated as IO, the concept of health was defined as a state of physical and mental welfare, and not only the absence of diseases (WHO, 1946).

The main idea of a global institution targeted at world health issues was orderly in 1948. The World Health Organization arose within the United Nations system to fulfill the previous initiatives' gap. Among this institution's goals, we can list the search for treatment and prevention of diseases and epidemics worldwide. Furthermore, the WHO guide and develop researches in global health domains (BUSS, 2013).

In the architecture of the WHO, there are regional committees and a decision-making body. The regional committees work as regional organizations that are intertwined with the World Health Organization. The regional committees are not only local representations; they can adopt specific policies that could differ from the headquarters' policies. In this sense, we can say that the WHO has a decentralized government, each regional committee having a Regional Director who would guide the regional "organization." The headquarters' purpose of working through the regional committees is to develop specific health policies. Since the creation of the regional committee, each member state began to be directed to the regional office geographically. The Secretariat of each regional committee more or less corresponds to the structure of the headquarters. The most significant difference, in this case, is the addition of specific problems tackled in each region (LEE, 2008).

Regarding the institution's framework, three central decision-making bodies govern the World Health Organization: the World Health Assembly (WHA), the Executive Board, and the Secretary. The WHA is the place where health diplomacy occurs, and each state can manifest its preferences. At the WHA, there are 194 member states represented by delegations of each national state. This decision-making body's function is to oversee voting to adopt policies and programs for being implemented by the WHO. Some decisions can be approved with 2/3 of the majority, while a simple majority can take others. Policies usually supported by a simple majority are often not very meaningful for member states. Thus, voting patterns could vary accord the program to be agreed upon by the members of the institution. As Youde (2012) studied, some decisions are generally taken by consensus through the members. Therefore, they are not put into vote; they are usually carried to the World Health Assembly as recommendations or resolutions.

The second decision-making body is the Executive Board, composed of 34 members elected by the World Health Assembly. The essential criteria to fulfill a set at the Executive Board is technical knowledge. The members elected should represent the 194 members of the WHA to balance the regional representation. The members of this body could increase proportionally to the enlargement of WHO members. The third decision-making body is the Secretariat, composed of the Director-General (DG) and the staff selected. The DG holds the leading administrative position at WHO.

1.2 WHY BRAZIL AS A CASE STUDY AT THE WORLD HEALTH ORGANIZATION AND AT THE GLOBAL HEALTH GOVERNANCE?

Brazil may be considered a compelling case at the World Health Organization's study, for at least three main aspects: 1-the defense of universal and free access to medicines and health services- in domestic politics and international politics; 2- the prominent position within the WHO, at the Executive Board; 3-The Brazil's actions with non-state actors and national actors within global health governance.

Brazil has been outstanding international efforts in defense of universal access to medicines and health services[2]. According to the Brazilian Constitution of 1988, health became an attribute of the Federal State [3]. Following the provisions of art. 6 of the 1988 Constitution: "social rights are education, health, food, work" (Constitutional Amendment gave redaction No. 64, of 2010) (1988 Constitution). Concerning the inclusion of health as a citizen's right: "the new Constitution contradicted the neoliberal precepts that were prevailing at the time, mainly expressed by the World Bank(MOREIRA, 2012, p.209).

The global Public health policies were not, traditionally, included at Brazil's priority issues in international affairs, such as security policies in Brazilian foreign policy until the 1980s. The social rights advocated by the 1988 Constitution were treated as secondary issues in international negotiation by the states, also called low politics. According to Carrillo et al. (2015), the inaugural effort in the 1990s became more concrete in the 2000s, owing to the closer partnership between the Ministry of Foreign Affairs (MFA) and the Ministry of Health (MH). There was considerable effort to insert Brazil into international regimes. Among them, the health policies began to show a new focus of interest in the Brazilian global agenda, especially in South-South cooperation.

The second aspect to accentuate is Brazilian's performance within the specialized agency for global health. Currently, Brazil coordinates the WHO Executive Council, in the mandate that covers the period from 2017 to 2020 (MH, 2019)[4]. As previously shown, the Executive Council seeks to represent the regions and singularities of the 194 members of the institution in a balanced way. Voters generally elect members to serve their respective geographical areas. In this manner, Brazil's role as a coordinator of this body can ensure a closer defense of America's regional interests. Furthermore, it may suggest a tuning concerning the Millennium Development Agenda's proposals for 2030 and its effective transfer to other WHO members. According to the Brazilian Ministry of Health, since 1961, Brazil did not occupy this WHO position (MH, 2019).

The third aspect of being highlighted about Brazilian's actions at the World Health

[2] We would like to highlight that we refer above all to the Constitution paragraphs and health diplomacy during the first decade of the years 2000.

[3] We also highlight that according to the Brazilian Constitution of 1988, the right of health is extensive to migrants who live in Brazil.

[4] MH- this abbreviation will be currently used in this research and make reference to the Brazilian Ministry of Health, in Portuguese, *Ministério da Saúde*.

Organization and the Global Health governance relates to the partnerships with non-state actors and national actors. In the domestic sphere, the governmental actor, Oswaldo Cruz Foundation, Fiocruz, has been outstanding in the orientation and coordination of research, focused on tuberculosis, malaria, HIV treatment, among others. Fiocruz has been a valuable player in Brazil and outside of the country, developing relevant initiatives to transfer HIV technologies to African countries, such as Mozambique.

At the international level, Brazil has partnerships with non-state actors as the Bill & Melinda Gates Foundation. According to the Brazilian Ministry of Health, in 2011, Brazil signed a partnership with the Gates Foundation through an initiative called Grand Challenges, which aims to search for solutions to global health problems by encouraging scientific research. In numerical terms, since the signing of the agreement, R$ 25 million were invested from different sources, such as about R$ 16.7 million from the Gates Foundation; R$ 10 million from the Brazilian Government, with funds from the Ministry of Health and the National Council for Scientific and Technological Development (CNPQ). Among other achievements, cooperation has enabled public vaccine producers in Brazil to expand the supply of vaccines by the World Health Organization (WHO), which supported the international distribution of vaccines (MH, 2019).

1.3 INTERNATIONAL ORGANIZATIONS, MULTILATERALISM AND THE TYPE OF PUBLIC POLICIES TO BE TRANSFERRED

According to Jakobi (2009), we can say that IOs can employ different strategies transfer policies to its members. Firstly, is relevant to highlight some peculiarities to differentiate policy transfer and policy diffusion. We work with the premisse that IOs can diffund policies over its members. This way, policy diffusion is a broad phenomenon related to the IO's capacity to convince its members to adopt one policy. Differently, policy transfer refers to a minor phenomenon through which we will analyze one IO policy becoming a national policy in one member state. Otherwise stated, some theoretical explanations usually associate policy diffusion with structural conditions that could privilege disseminating policies. Distinctly, in policy transfer, the analysis is typically centered on the role of agency and agents to guide transfer for limited units (COÊLHO, 2016) [5]. Thus, developing a policy transfer research, our hypothesis will be less generalized than policy diffusion researches.

Considering this differences pointed, we understood that there is at least three possible manners to spread policies from the WHO to country levels, there are: 1- discursive dissemination; 2- coordinative function; 3- technical assistance. The discursive dissemination occurs when IOs create norms or best practices to guide States' policies. Concerning the idea of coordinative functions Jakobi (2009) arguments that some IGOs can create standards to be followed by other countries. Moreover, other IGOs can provide technical assistance to

[5] Marsh; Sharman (2010) criticize the segregation of structure and agency. To them the dimensions are connected and agents can change the structure for creating opportunities to act.

other countries such as loans, for example, to help them implement health policies (Fernandes; Carvalho, 2018). In summary, we can qualify the kind of policy to be implemented from an IO as the outcome of a rational design, as in Table 1.1:

Table 1.1 – Rational design and IO policy.

Field of policies	Type of policy
Social Policies and Human Rights	Normative Policies
Economical institutions and environmental institutions	Coordinative and Technical policies
Trade; environment, security (IAEA, OPCW)	Technical Policies

Source: Self elaboration.

As presented above the realm of policies can be related to different patterns of policy-making and policy implementation. Our premise here is that normative policies are made by international organizations that were rationally designed as more pluralistic. In other words, the most "inclusive" organizations usually produce more soft laws and recommendations than the least inclusive ones.

1.3.1 The multilateralism at the WHO and the action of non-state actors

The way the World Health Organization has been addressing the action of non-state actors[6] within the WHO policies is another crucial factor for this research. In 2016 the WHO has consolidated the Framework of Engagement of non-State Actors, henceforth FENSA, which has essential features: 1- to clarify the benefits and to prevent the risks of engagement; 2- to define what kind of actor would be accepted as a non-state actor at World Health Organization; 3- to formalize the nature of engagement.

Regarding the risks and benefits, the benefits can be additional resources coming from non-state actors and consolidating WHO policies, as well as broadening the dissemination of its norms and standards. Nevertheless, the engagement can engender conflicts of interest between non-state actors and the WHO and foster a competitive advantage for non-state actors. Consequently, every type of engagement should be carefully analyzed.

Concerning the kind of actor included, the WHO framework establishes what non-State actors would be: firstly, nongovernmental organizations, i.e., organizations that operate independently of governments and are committed to the public interest. Second, the private sector, like commercial enterprises and any institution governed or controlled by private entities, like international business associations or corporations. Third, philanthropic foundations are non-profit organizations sponsored by donors that have social purposes, such as the Bill; Melinda Gates Foundation. Fourth, academic institutions and experts, whose primary goal is to disseminate knowledge and develop research, education, and training.

[6] The literature uses different names to address the non-state actors; one of them is Transnational Actors, TNAs, as studied by (TALLBERG et al., 2013). Nevertheless, we opted in this research to use the terms commonly employed at WHO documents.

Regarding the nature of their engagement, the non-state actors may have different attendance types: firstly, the meeting at decision-making bodies like the World Health Assembly and Executive Boards; secondly, consultations that can happen physically or virtually and can be at governing body sections or ad hoc. Thirdly, hearings in which the non-State actors can present shreds of evidence and positions about one specific issue, what can happen informally; lastly, there are other types of meetings that include briefings, scientific conferences, and other platforms (World Health Organization, 2016).

For the reasons presented above, the World Health Organization will be considered as our case study for this research. The purpose of this research is to raise explanations about the strategies that the World Health Organization have been adopting in order to transfer policies for other countries. We aim to identify actors and strategies commonly involved all along with policy and the process of transfer. Usually, International Organizations are studied in the international relations field. Nonetheless, how their policies are transferred or what conditions or mechanisms allow the transfer of policies to other countries were not exhaustively studied so far. Starting from studying different kinds of literature in international politics and public policies, we intend to construct our arguments and hypotheses. As said later, IOs vary vastly in their bureaucratic framework, mandate, and sectors of activity.

Moreover, the differences within IOs structures can change the manner a policy will be implemented or transferred to other countries. The World Health organization has specific features: first, non-state actors' action within the organization is encouraged; second, this organization does not usually use coercive mechanisms to convince member states to implement their policies. Hence, the WHO is recognized by the literature as one of the most inclusive, rationally designed organization.

In summary, we might consider that IOs can or cannot use coercive strategies to implement and transfer policies to their member states. By "coercive" strategies, we mean constraints that IOs can apply to compel their member states to follow their directives and internationally established rules. We consider that, somewhat, IOs can employ different mechanisms to convince states to follow the rules, which is what we called coercive strategies. Nevertheless, states are sovereign and can choose whether transfer policies to their territories despite the international pressure or coercive strategies applied by IOs. In this logic, the implementation of the Washington Consensus in Latin American by the International Monetary Fund (IMF) is an excellent example of such initiatives. To encourage countries to adopt the package of the Washington Consensus, the IMF used arguments, like the suspension of loans for developing countries, that seemed a kind of strategy to constrain IMF members to implement international policies in their respective countries (FERNANDES; CARVALHO, 2018).

Conversely, many organizations of the United Nations System create discourses and best practices since they cannot use tools to compel their members to implement their decisions. As an example, we may refer to the policies for Tobacco Control created by the World Health

Organization and its implementation in the United Kingdom. According to Cairney (2012), despite not being obligatory for countries, tobacco control policy was successfully implemented in the United Kingdom. The principal factor of consolidation of this transfer at the domestic level can be explained by domestic interests, with government incentives and civil society advocacy (CAIRNEY, 2011).

We recognize that perhaps IOs that create best practices and discourses may face difficulties implementing or transferring policies towards the country level. In this sense, our focus here is to understand how policies can reach other countries in organizations in which coercive instruments are not often used to compel actors to follow international rules.

Some factors may explain the policy diffusion[7] from IOs, which works in a discursive way. They create norms and best practices to share. One of the crucial factors that we hypothesized here is the engagement of non-state actors along with IOs as intermediaries. Non-state actors can create new agendas in international forums and contribute to the implementation process at national levels. In this sense, the opening up of IOs to non-state actors may be a strategy to increase the pace and scope of policy diffusion.

We already identified that the World Health Organization (WHO) is a relevant case study within international organizations for several reasons. Firstly, this specialized agency of the United Nations Systems does not work with coercive instruments. In other words, the member states can choose whether they will implement the health policies at the national level. Secondly, non-state actors' action has increased in the last fifteen years, which may be understood as a process to open the bureaucracy for different voices and agendas worldwide. Additionally, an important point is the WHO creation of the framework to lead and manage non-state actors' activities within the organization to strengthen the engagement of non-state actors within the organization; while controlling inevitable conflicts of interest and potential risks of disruption for the international institution.

1.4 CATEGORIES OF ANALYSIS

To inquire the research questions proposed: as 1) What reasons encouraged the WHO to include non-State actors into its organizational design, on a systematic basis? If 2) Can non-state actors' engagement at the WHO be associated with effective implementation of at least one best practice? Furthermore, how the non-State actors can enhance the process of policy transfer? We mobilized at least five categories of analysis.

Firstly, International Organizations, thenceforth, IOs; or non-governmental organizations, hereafter, NGOs. IOs arise from formal agreements to represent the interests of their member states. NGOs arise from civil society (IRIYE, 2002). Both organizations will be relevant in this research, although NGOs are only one kind of non-state actor representing interests that arise from civil society demands. Generally speaking, this study aims to

[7] At this beginning, we are using implementation, transfer, and diffusion as synonyms, although we are conscious of the methodological differences among each concept.

understand how non-state actors can uphold global policy transfer. To this end, our analysis will address intergovernmental organizations IOs and their partnerships. IOs develop an essential role in the international arena as teachers of norms, rules, and best practices. Besides their capacity to strike agreements, they can be agenda setters that create new demands to be discussed internationally. Nonetheless, despite being recognized for their capacities to create discourses, norms, and rules, IOs usually face transfer or implementation policies.

The policy transfer is here our second category of analysis. It refers to the capacity that IOs could have to concretize policies agreed among IOs members. Authors as Faria (2018a), Marshan;Dolowitz (1996), refer to this process as an instance of policy transfer or policy diffusion. Policy transfer can be understood as a process to import knowledge about programs and politics from foreign countries. In contrast, policy diffusion relates to how programs and policies will be spread from a governmental entity to another (FARIA, 2018a). For this research, the most important is to highlight how one agreement created among states within a bureaucratic IO can eventually reach member-states; in other words, how international agreements can become domestic policies. In this way, both the idea of implementation and diffusion policies seem relevant for this research project.

Implementation is the third stage of the public policy cycle within IOs, while agenda-setting is the first and decision-making the second. Moreover, implementation is the step in which agreements are translated into concrete actions. Implementation is a crucial point of analysis in this research because it can mobilize plenty of actors. According to Joachim, Reinalda, Verbeek (2008) "implementation may be used by individual actors who had been dissatisfied with the internationally adopted policy to alter its content and therefore pose a challenge for actors to ensure that the agreed-upon policies are carried out as agreed" (JOACHIM; REINALDA; VERBEEK, 2007, p.30). In this sense, the implementation phase can include new actors into international organizations' policy cycle, such as civil society members, and non-governmental organizations.

Likewise, the study of policy implementation and diffusion can help understand the tools and strategies employed by IOs to spread policies. The literature about policy diffusion is an effort to explain the internationalization of public policies from different institutions. Authors as Dolowitz; Marsh (1996); Sharman (2009); Weyland (2005) have studied the concepts and definitions of policy diffusion, using different cases, as such, pension policy in Latin America. The concept of policy diffusion will be slightly used. Marshal; Sharman have shown that the literature on policy diffusion usually uses quantitative techniques to analyze comparatively large-Ns. Despite its outcomes and the possibility of generalization, this methodology is not enough to identify distinctive characteristics, such as specific differences among cases like political patterns in one society that may influence the implementation process at domestic levels. This argument is relevant to our research since its ambition is to develop a small-N study using predominantly qualitative techniques to explain non-state actors' action in the

implementation process. Furthermore, as discussed above, the implementation phase is a dynamic process that supposes the mobilization of many resources and actors that could contribute to developing a more nuanced analysis about non-state actors' actions in parallel to IOs activities.

The non-state actors are the third relevant category of study in this research. As highlighted by Joachim, Reinalda, Verbeek (2008), implementation is a new phase in the policy cycle that provides opportunities for old and new actors to influence the consequences of such international agreements on the ground (JOACHIM; REINALDA; VERBEEK, 2007, p.210). Non-state actors have been studied in the literature in different ways. Tallberg (2013) has inquired about the engagement of transnational actors (TNAs) in IOs. According to him, TNAs can be social movements, philanthropic organizations, international organizations, and transnational corporations. In the same way, the studies of Koremenos (2016); Abbott et alli (2015), Keck; Sikkink (1998) investigate the action of non-state actors in transnational networks. In both types of research, the non-state actors work as intermediaries between IOs and States to reach institutional targets. The categories of non-state actors become relevant to this study because researchers like Tallberg (2013), Koremenos (2016), and Dai (2015) have shown that there is a considerable involvement of TNAs in IOs. The TNAs could suggest new demands in international forums, they could claim to represent social interests. Furthermore, as studied by Huybrechts; Haugh, 2017 non-states actors such as "social movements and professional associations are known to play an important role in institutionalizing new organizational forms because of their greater access to resources, discursive skills and field-level connections (Hargrave; Van De Ven, 2006; Rao, Morrill; Zald, 2000; Schneiberg, 2013 (HUYBRECHTS; HAUGH, 2018). According to Schemeil (2011), IOs improve their management style as a source to survive international pressures, such as transnational elites. When IOs allowed the participation of non-state actors, they can create a deliberative process in which many formal and informal channels of decision-making are created, "which facilitates the adjustments or the juxtaposition at every level of bureaucratic and political leaders, to tie transnational elites and national representatives of their home state"(SCHEMEIL, 2013, p.11).

These new actors can create networks. This will be here our fourth category of analysis. Many authors, such as Keck, have studied networks; Sikkink (1998), Schemeil (2013), Huybrechts, Haugh (2017), among others. The most prominent argument identified among the authors is the potential to create networks to join different actors and connect international and domestic fields. To Keck; Sikkink (1998), networks enable creating links among actors and diversifying the strategies and tools to access the international system. Furthermore, besides the capacity to create channels, networks can optimize cooperation among international and national society through collaboration. As Schemeil (2013) studied, networks of collaborations are built spontaneously, from the relation of non-state actors with IOs. These collaborative networks can institutionalize new roles for IOs in at least two ways:

informal phases of network building or formalized states. The informal phases can work as a forum to integrate discourses, and collective voice (HUYBRECHTS; HAUGH, 2018); on the other hand, formalized networks can have a more practical impact on IOs since they can "coordinate the conciliation between members" and they can amalgamate the connections with plural field-level actors (SCHEMEIL, 2009, p.3). In other words, as proposed by the authors, the capacity to amalgamate refers to the idea that non-state actors can contribute to legitimizing discourses and practices among different stakeholders operating at different levels of action. In that way, they can contribute to create connections and establish networks.

Hence, networks mobilize many resources in different ways. Firstly, they increase collective knowledge and reflexivity (David et al., 2013; Owen-Smith; Powell, 2004; (HUYBRECHTS; HAUGH, 2018, p.5); secondly, networks enable information about members' practices and rules to be exchanged and collectively theorized (Greenwood et al., 2002; (HUYBRECHTS; HAUGH, 2018, p.5). Thirdly, through pooling discursive skills and building alliances across the field, networks 'may exert major pressures on the normative order' (Suchman, 1995, p. 592;(HUYBRECHTS; HAUGH, 2018, p.5). In this perspective, when an IO embodies non-state actors and starts to act through a network, the probability of ratifying their policies can increase, and non-state actors can act as an instrument to translate diplomatic agreements into domestic policies. Because of the factors highlighted above, our purpose is to investigate the channels and strategies that IGOs have been using to implement policies agreed upon at the international level to be effective at the national levels.

1.5 HYPOTHESES

Some possible answers can be hypothesized to explain the recent actions adopted by the World Health Organization to include the non-state actors as part of the framework. The first is related to actors and strategies that could act in a more inclusive environment, while the second refers to the transfer of policies. In a summary way, the first hypothesis is 1) The WHO will increase the action of non-state actors into the institution when the risks and benefits of cooperation and collaboration among IO and non-state actors were strategic and decisive. Also, the WHO can have more success in implementing their policies if non-state actors found enough place to collaborate within national governments.

1.5.1 Hypothesis 1

To ensure benefits, the World Health Organization cooperate rationally and strategically with non-state actors.

(HY1) The World Health Organization and non-state actors cooperate in a strategic way to create new channels of communication and cooperation among other members in which

many components of society can interact. In other words, through this cooperation, actors from different levels and sectors can interact.

The existence of tensions in IOs can encourage innovation and institutional reforms and encourage the creation of networks of collaborations. Schemeil (2013) highlights that IOs seeking to confront institutional stagnation can create alternatives strategies, to strengthen collaboration with external actors and enhance institutional performance. Regarding collaboration, there is a process by which IOs create networks with non-state actors. These new actors achieve prominence in this network of collaboration, in Schemeil (2013) terms: "how much IOs collaborate, more they create networks of interdependency which are not controlled by states neither by political movements"(SCHEMEIL, 2013, p.7), this becomes apparently a decentralized arrangement of power.

The non-state actors can act as transnational actors, bringing new demands to the international arena while spreading new strategies to transfer policies to domestic levels. These actors' action at global health governance seems to be a strategic way to surpass governance problems and resource deficits that non-state actors could attenuate, as Tallberg (2013) studied.

Furthermore, the increasing number of non-state actors in the environment of IOs can be an institutional strategy to respond to the existing tensions with authorities and legitimacy of IOs (TALLBERG et al., 2013). By incorporating non-state actors and including new actors on the agenda, the process can become more horizontal, and tensions between authority and legitimacy can be summarized. By including new actors in the process, it is possible to create new coalitions and new communication channels. These features can encourage the executions of programs and implement policies (MEYER et al. 1997; (JAKOBI, 2009).

(HY1.1) The "security belt": the cooperation with non-state actors will occur if the WHO will be able to manage the conflict of interests.

A second benefit that may explain the opening to non-state actors' action is the logic of costs and benefits and the possibility of managing conflicts of interests that would arise among them. The engagement of non-state actors can bring functional benefits as advantages in policy expertise, more efficiency to shape and solve governance problems. Nevertheless, IOs are frequently confronted with the divergence of interests among states and non-state actors.

This way, the establishment of the Framework of Engagement of non-State actors, FENSA, can also be a strategy to become the cooperation manageable and to avoid potential conflicts of interests. As a metaphor, FENSA seems to be the security belt to lead with non-state actors and avoid conflicts within the WHO. Even with the opening up, the WHO aims to preserve the states' interests and the largest donors' resources, reinforcing the Principal-Agent dynamic. The action of non-state actors seems to result from a balance between the risks and benefits of engagement. We can say that non-State actors' cooperation would be possible when the non-State actors do not hamper the Principal-Agent dynamic.

1.5.2 Hypothesis 2

Effective implementation and non-State allies

To successfully implement their policies, IOs need to enlarge their bureaucracy and ensure more extensive participation of non-state actors.

(HY2) Non-state actors can contribute to transfer policies from IOs if they find enough space for action towards national governments.

(HY2.1) The implementation/transfer is possible when national states allow the action of many intermediaries (stakeholders).

Rival hypothesis

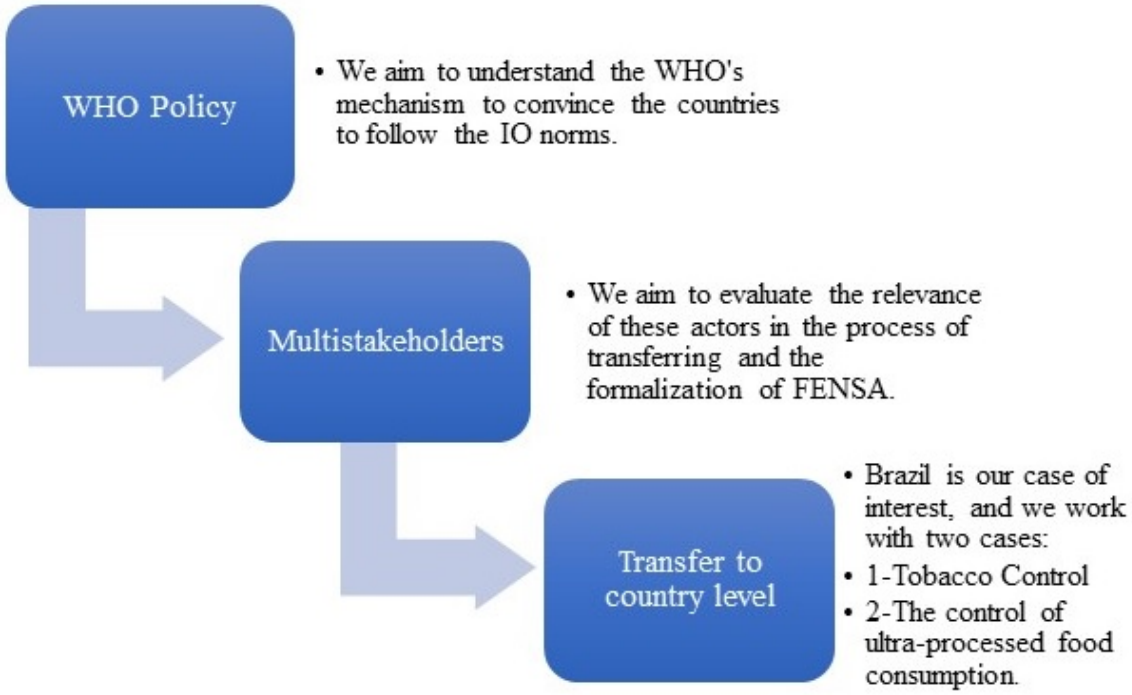
(HY2.2) The practical implementation at domestic levels is possible even if the state does not work through democratic institutions.

One of the conditions for successful policy implementation is the domestic action of non-state actors. We do not neglect the fact that NGOs and other non-state actors as philanthropic foundations can be financed by private enterprises and can act to frustrate political interests and change the dynamic of IOs. We also have been watching that NGOs can reshape the interface among government, business and society as studied by (PEARCE et al., 2003). This thesis considers that non-state actors can work as intermediaries and support IOs to reach their targets. This manner, our second hypothesis highlights that the pluralization of agendas and actors at the international level does not suffice to ensure a well-successful transfer of international agreements to the country level. Governments can contribute or obstruct the implementation of policies, and non-state actors can be a third party to bring new demands to the international arena. However, it can pressure the national government to pluralize politics. Thereby, IOs are supposed to have allies at the national level to implement their policies. In other words, democratized societies, possibly, can ensure more access to non-state actors as intermediaries, although in democracies, policy implementation can be more or less successful. As studied by Joachim, Reinalda, Verbeek, 2008, the degree of democratization in a state can affect global public policies' transfer at the country level. In other words, democracies tend to be more open to receiving IOs policies. Moreover, mature democracies tend to be more effective in the implementation of international agreements than emerging democracies. Nevertheless, even in mature democracies, there may be difficulties in the implementation process since the type of policy and the states' interests could encourage or impede international agreements' transfer. (JOACHIM; REINALDA; VERBEEK, 2007).

1.6 THE MAIN AMBITIONS OF THIS THESIS

This thesis's main objective is to understand how an IO that produces normative and non-binding policies like WHO transfers policies to the domestic level. Moreover, we seek to understand the mechanisms used to transfer policies and how non-state actors contribute to this process.

Figure 1.1 – Thesis main goal



Source: Self elaboration

Recognizing that WHO historically works with non-state actors, we seek to understand why the WHO formalized these actors' engagement and how these actors can contribute to achieving the organization's goals. The systematization of non-state actors' participation seemed strategic to us. It motivated us to raise evidence to understand the importance of multi-stakeholders in transferring global policies to the national level. In the following order, we schematically represent the main objective of this thesis:

As shown above, we are interested in understanding the WHO's strategies and mechanisms to supply the "export" of regulations and transfer global policies to national levels. For this, we initially performed the literature review in international organizations and public policies. Concerning public policies, we seek to establish a more extensive dialogue with public diffusion and policy transfer literature. Lastly, we seek to refine our hypotheses and consolidate our theoretical model of analysis for the thesis.

We defined as a second specific objective the realization of two rounds of interviews and analysis of documents. As will be discussed in the methodological chapter, the interviews were applied to WHO experts and actors involved in global health governance. The interviews' main objective was: 1- to understand how WHO works, 2-to select the cases and understand the transfer process.

Another essential source of evidence to fulfill our primary goal is developing an analysis of the WHO documents. The documents selected help to identify the reasons for the creation of the FENSA Framework. The documental analysis will be relevant to develop the case studies and identify specific features and actors involved in them. To identify the actors that might

contribute to the transfer of policy from the WHO to Brazil, we will use the network analysis to triangulate and systematize the information collected. Thus, we can mapping people and institutions involved in this process.

From the interviews, we operationalized our third specific objective, defined by selecting case studies within the WHO. These repeatedly emerged in the interviews and documents. The cases were selected based on criteria: 1a- to be a policy over which was possible to evaluate the success in "implementation" of norms on the domestic level. 1b- a policy that was not successful in implementing regulations at the domestic level. 2- Involve non-state actors as relevant stakeholders in the process. 3- Show similarities in terms of the scope of action.

For the reasons highlighted above, the cases of the Tobacco Control Policy and control of ultra-processed foods rose as relevant cases in this research. The cases are similar because they deal with chronic non-communicable diseases and deal directly with commercial and marketing interests. We have also identified the role of non-state actors such as private companies, philanthropic foundations, non-governmental organizations, and other international organizations in both cases. Nonetheless, in the tobacco control case, considered emblematic by the literature, we note the success in the transfer of standards. Conversely, in the ultra-processed policy control, success has not yet been achieved in the Brazilian case.

Finally, we evaluated the case studies chosen to understand what factors could enhance the success or failure in the implementation process of one WHO policy to Brazil and what mechanisms did WHO applied to achieve this outcome.

1.7 THE THESIS STRUCTURE

As mentioned before, this work is guided by main questions: What strategies and conditions allow a successful transfer from the WHO to the domestic level? How can the non-State actors play in the process of policy transfer and diffusion? What reasons encouraged the WHO to include non-state actors into its organizational design on a systematic basis? To answer these questions, we will build a thesis as follow.

As studied in the WHO's documents, non-State actors' action at the institution is not something new in the dynamic of the IO. However, it seems to be relatively new to the literature of International Politics. To inquire about this phenomenon in the literature, we aim to build a literature review to understand the IOs necessity to work through non-state actors' and their relevance as transnational stakeholders. Schematically, after this introduction, the second chapter will present a review of the literature to discuss the debates about the joining of non-state actors and transnational actors to international organizations. In this chapter, we will reflect on traditional views that have been applied to explain the cooperation among states within institutions as IOs, comparing with recent changes at multilateral institutions and the opening up to non-state actors based on the logic to maximize the benefits with low

costs. The second part of the theoretical chapter aims to discuss the diffusion and transfer of policies; furthermore, we seek to grasp changes encompassed by the bureaucratic structure to enhance the transfer of ideas and recommendations by the headquarters to the country level.

The third chapter will present the methodological choices to develop this work. The first is to conduct predominantly qualitative research in which we will employ qualitative techniques and relational analysis. One method to be used is the documental analysis to identify historical landmarks that may explain the FENSA creation. We used the software Atlas. ti to categorize words and speeches around crucial concepts studied in the theoretical chapter to analyze the documents. Besides these tools, we use qualitative interviews as a method to collect data from the WHO. For mapping the institutions involved in transferring ideas, we used relational analysis. The network analysis was relevant to recognizing what kind of actors and institutions can frame ideas in one country and convince them to implement policies.

The fourth chapter will discuss the World Health Organization, from the beginning until the year 2019, looking to recognize the historical landmarks that may uphold the organization's changes. This chapter will be more descriptive and will use empirical literature review about the WHO and the documents available at the IRIS repository, as discussed in the methodological section. This chapter's primary ambition is to show when the non-state actors began to gather this international institution, how they have been acting throughout the years, and how they can strengthen the diffusion and transfer of policies.

The fifth chapter wishes to reflect Brazil as a case study. We seek to distinguish Brazilian representatives' in charge of import ideas from the WHO to the ministry of Brazilian health. As from Brazil's analysis as a case study, we attempt to identify stakeholders that may play a relevant role nationally and internationally. Our primary interest is to recognize institutions and actors around the Brazilian ministry of health that plays an international role in health. Brazilian papers have been noticed the action of Oswaldo Cruz Foundation, FIOCRUZ, as an essential player in the international arena. Regarding the relevance of FIOCRUZ in the domain of global health governance, we intend to inquiry about this institution as an essential stakeholder in the process of transferring.

The sixth chapter will be destined for an analysis of the case studies selected. As will be justified by our methodological chapter, we chose a primary case, the tobacco control policy, and a couner case, the control of ultra-processed food. Along with the sixth chapter, we aim to persecute the reasons the tobacco control policy achieved success in diffusion worldwide, and the main reason the transfer was fulfilled to Brazil. Moreover, we present a counter case, the obesity so-called as a silent epidemic by the WHO. It has as the main reason a high level in consumption of ultra-processed foods that deserve being controlled. As demonstrated, our counter case was not successfully spread towards WHO members. Furthermore, Brazil also needs to reinforce the policies in this domain. Hence, the tobacco control policy figure is an emblematic case, and the learning could be applied to our counter case.

The seventh chapter intends to conclude the thesis while discussing and comparing the

main differences noted from the case studies to understand what conditions favored or impeded the transfer of one policy to Brazil. Additionally, considering our theoretical approach, we aim to understand if the engagement is a WHO strategy to maximize benefits as resources and capacity to spread policies throughout the countries. Last but not least, to conclude, the analysis intends to recognize WHO mechanisms and strategies to transfer policies worldwide and how the multi-stakeholders have been working to enhance or impede this process.

1.8 CONCLUSIONS

This thesis aims to reflect the process of policy transfer and non-state actors' action at the World Health Organization. We believe these two modest ambitions could provide valuable explanations for the literature. Above all, it can subsidy the studies of policy diffusion and policy transfer from IOs.

This research's motivations are justified mainly by the process of globalization and the reterritorialization of public policies as we will discuss sequentially. Domestic actors and institutions have often been affected by international factors. From this perspective, we may say that states import policies created by other states or international institutions. Alternatively, domestic policies can, to some extent, be a reflection of international guidelines.

As we will demonstrate, International organizations can create public policies, and they are capable of disseminating and transferring policies to many of their members. Nonetheless, they are not the only institutions capable of doing so. Thus, the analysis focuses on the World Health Organization (WHO) study because it allows an interdisciplinary dialogue between International Relations and Public Policies in health. Simultaneously, we emphasize the importance of non-state actors as stakeholders in intermediating political actions and reaching targets.

We chose to develop a case study considered emblematic by the literature and observe what lessons can be learned from it to be reproduced to cases with similar features. Regarding tobacco control, we find numerous studies published by leading researchers on the subject. For this thesis, we are interested in understanding the mechanisms used by WHO and Brazil and the stakeholders involved in this transfer. In this manner, we understand that controlling the consumption of ultra-processed foods can benefit from this main case's lessons.

We recognize that we could not generalize our explanations made by a single case study. Nevertheless, other hypotheses could arise as from the current inquiry proposing further explanations focused on how IOs orchestrate non-state actors to reach their goals and what kind of stakeholder and implementation factor can reinforce the process of policy transfer.

2 LITERATURE REVIEW

The following chapter aims to reflect the theoretical approaches that can be used to explain the phenomenon of the policy transfer from an international organization to one of its members. We start discussing the principal-agent model that justifies delegating state responsibilities to international organizations. According to this model, IOs are in charge of defending specific interests and coordinating actors' efforts in thematic areas, thus forming a regime encapsulated by a bureaucracy.

Secondly, we will discuss the pathologies of International Organizations. The literature has shown that IOs may have their actions or power of agency limited due to the pathologies they may present. As will be presented throughout the chapter, researchers as KOREMENOS; LIPSON; SNIDAL, 2001 understands that the limited action of IOs in the international scenario can affect the consolidation of institutional programs. Researchers from international organizations such as (ABBOTT; GENSCHEL; SNIDAL, 2014) suggest that IOs can evolve in the multilateral dynamics when trying to overcome the pathologies, in a general manner, through the operation of intermediaries[8], IOs can orchestrate[9] several actors and thus achieve their goals.

Another important argument to be discussed in this chapter concerns the opening up of IOs, such as the WHO. We consider that the pathologies can, to some extent, encourage the opening up of IOs to non-state actors. This openness to civil society, private companies, philanthropic foundations, among others, seems an alternative to improve institutional performance and encourage policy consolidation, as will be demonstrated from the orchestration theory and the arguments that seek to justify the incorporation of non-state actors in the international dynamics.

Sequentially, we discuss the theoretical argument related to non-state actors'. We aim to test the hypothesis that non-state actors' action at IO levels could enhance the transfer of policies in the domestic sphere in at least one of its members. In our case, we are focusing on policy transfer to Brazil.

For this reason, we will dedicate some pages of this section to studying public policies, the public policies cycle, and what literature has come to mean as policy transfer and diffusion.

At the end of this chapter, we present an outcome of our effort to build a theoretical model capable of explaining the WHO's changes, the mechanisms, and strategies applied to transfer a policy at the national level to Brazil.

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[8] In this case intermediaries can be associated with non-State actors. The intermediaries, according to (ABBOTT; GENSCHEL; SNIDAL, 2014)are relevant actors to reach goals and targets in the Orchestration model.

[9] The idea and concept of orchestration will be present along with the chapter.

2.1 THE PRINCIPAL AGENT-MODEL

The international organizations (IOs) arise in the international arena from the interests of states. Many IOs, but not all of them, were consolidated as bureaucracies[10] after the end of the Second World War (1945), as from formal agreements that create an international institution composed by plenty of member states. Currently, several IOs play significant roles in diverse areas, like the economy, security, human rights, environment, and social purposes. Despite the differences in the field of action, the IOs have similar goals. They usually work to develop policies that may represent the diversity of interest of their membership. They coordinate efforts to decrease the asymmetry of information, and they usually develop possibilities to cooperate with different actors while looking for reducing costs to establish this action. In other words, the IO mediates states' interests to expand the chances of becoming cooperation able in a complex environment composed of a diversity of interests and resources among member-states.

In this sense, IOs supposed to represent the preferences of their members. The literature calls this perspective of view as Principal-Agent model (PA), in which the principals are the states, and agents are IOs, i.e., bureaucracies formally created by the states to represent their interests and act transnationally. In this analysis model, the state, called of Principal, delegates to IOs, called of Agent, the authority to act in the state's name (HAWKINS et al., 2006). The delegation is a way to transfer authority from the state to IO. The states that are international organizations delegate authority to specialized agencies to develop policies and lead to global demands. Is important to highlight that the authority achieved is limited by time, space, or geographical area[11].

The principal-agent model is used to explain the strategical relation established between states and IOs within international bureaucracies. The delegation can occur when the costs of interaction with agents (IOs) reveals more benefits than unilateral cooperation.

2.1.1 Some reasons to delegate tasks to IOs

According to Barnett; Finnemore (2004), IOs can make decisions with considerable authority to reach several countries in the international arena and affect different domains; thus, they would comply and implement agreements drawn up by the States. We may consider organizations as bureaucracies with considerable authority and autonomy to affect and change the world with their decisions (BARNETT; FINNEMORE et al., 2004). In other words, according to Hawkins et al. (2006), IOs are essential in reducing transaction costs and increase credibility. They act to reduce the financial, temporal, and costs resulting from single or bilateral negotiations and represent a more secure way to establish international

[10] According to Barnett; Finnemore (2004), IOs can be studied as bureaucracies, which creates and disseminate rules globally.

[11] Despite the authority achieved some factors could restrict the action of IOs, as the influence of the significant donors within the bureaucracy; the type of government in each member state, among other features.

transactions because they have greater credibility among states. Also, agents can interpret and reinterpret rules, and principals generally delegate tasks limited to agents for a restricted time. Agents seeking additional delegation tend to interpret or reinterpret rules in order to extend this delegation.

2.1.2 The Orchestration model

The principal-agent (PA) model, while very useful for understanding cooperation in international organizations, does not incorporate the participation of non-state actors in multilateral dynamics, which in many scenarios may facilitate cooperation and policy consolidation, such as in the World Health Organization. As Sassen (2010) studied, the globalized context impacts the global dynamics, bringing new actors to play in international relations beyond the State. Given this new context, the networks that interconnecting different cities and surpassing the borders of the states have gained prominence (SASSEN, 2010). From the perspective of the interconnectivity between different people and territories and the possibility of expanding infectious diseases, the health issue has become increasingly prominent in international debates, especially concerning health surveillance as a security issue in international relations.

Faced with the growing participation of transnational actors in international organizations, we may say that there has been a change in the model of analysis. If before, researchers constructed their analyzes based on the relationship established between IOs and States; currently, the analysis incorporates intermediate actors, who assist in the diffusion of the policies established by the IOs. Analyzes that previously used the Principal-Agent (PA) model might be analyzed these days, as from the perspective of the Orchestration model. According to this theory, IOs can be orchestrators of intermediate actors, such as non-State actors, and these dynamics would bring more useful contributions to achieve organizational goals.

The orchestration model considers that IOs become orchestrators when they bring the third part to the governance arrangements, acting as an intermediary actor. The IOs insert themselves in a broader dynamic that, besides states and IOs, involves multi-stakeholders- as the non-State actors- to reach IOs targets. The literature characterizes it as the O-I-T model, which means Orchestration-Intermediary-Target.

The orchestrators act through intermediary actors, and there are no enforcement or coercive mechanisms for the intermediaries to fulfill their purpose. The approach is voluntary, and the intermediate actors collaborate with IOs to reach political targets.

Orchestrators act through intermediary actors as an indirect mode of governance. In other words, orchestrators do not have direct control over intermediaries' activities but can mobilize and facilitate cooperation in this mode of indirect governance. In this mode of governance, there is no hierarchy or enforcement for intermediaries to fulfill the purpose.

Authors such as Abbott;Genschel; Snidal;Zangl have shown that some areas tend to

present the most remarkable openness to acting through intermediaries. IOs tend to adapt strategically and rationally to alternatives and resources that are made available by non-State actors. In human rights, states are considerably less interested in monitoring and complying with rules compared to areas of the economy, trade (ABBOTT; GENSCHEL; SNIDAL, 2014). Given this issue, we reflect on what strategies or mechanisms did IOs addressed for social and human rights purposes have been using to convince their members to adopt their policies and regulations?

The principal-agent and orchestration models reflect two indirect modes of governance. While the principal-agent (PA) model considers that states delegate tasks to international organizations for acting as agents in international relations, in the other hand, the orchestration model proposes to bring the third part to political arrangements, defined by Abott et alli as intermediaries. From this perspective, orchestration embodies a logic that goes beyond delegation.

Both models suggest types of indirect governance. In the PA model, we identify restricted power transferred to international organizations; in this case, they are the agents of policies. Applied to the World Health Organization case, member states meet through the World Health Assemblies and define the policies to be implemented by the WHO. It is a transfer of power conditioned to the interests of states. If an IO contradicts its rulers' interests, they could use mechanisms of control[12], such as budget suspension, for example. In this sense, we may say that the motivations of the member states are driven by extrinsic compensation[13].

Whether in the Principal-Agent (PA) model the agents are the international organizations (IOs), in the orchestration model (O-I-T) the third part, -intermediaries- can develop actions, and they can figure as agents. The main difference between both models seems to be the level of autonomy of agents. While in the PA model, IOs receive limited authority from states, in the orchestration model, intermediaries seem to have broad chances to achieve the goals without IOs restriction. It is noteworthy that intermediaries, as non-State actors, do not have the same status in IOs as member states. They are associated members, and they usually join the institution by voluntary means seeking to fulfill specific branches. In contrast to the PA model, at the O-I-T model, the intermediaries join the institution motivated by issues; in other words, we could say that they have intrinsic motivation to follow the enlistment (ABBOTT et al., 2016).

Schematically we show in Table 2.1 the main distinctions between the theories.

In orchestration logic, international organizations allow the voluntary association with non-state actors, such as NGOs, philanthropic foundations, private companies, among other actors. These can indirectly contribute to the implementation of goals set by IOs. The approach is voluntary, and there are no mechanisms of coercion to force actors to comply

[12] We consider that some measures applied by member states could be understood as mechanisms of control. This is the case of budget suspension, or coordination of votes against one policy.

[13] The concept of extrinsic compensation is developed by (ABBOTT et al., 2016) to explain the mechanisms of control often used by states.

Table 2.1 – Principal-Agent vs Orchestrator- Intermediary

	Principal- Agent	Orchestrator- Intermediary
Mode of indirect governance	Delegation: Conditional grant of authority	Orchestration Voluntary-Enlistment
Governor	Principal- Hard control	Orchestrator - Soft Inducements
Third Party	Agent- Extrinsic compensation	Intermediary - Intrinsic motivation
Primary imitation	Agency slack: Agent capable but unwilling	Intermediary incapacity: Intermediary willing but incapable

Source: (ABBOTT et al., 2016, p.6)

with rules. Applied to the World Health Organization, in the case study of this research, we can highlight that non-state actors (intermediaries) join the WHO from specific and thematic guidelines such as NGOs and foundations aimed at combating the spread of HIV, for example. Non-state actors can formalize their interest in contributing to the WHO by voluntary means, and they will not be punished if they fail to achieve the goals.

We can emphasize that intermediaries' action through IOs can bring several benefits, such as expertise and more effective governance. Through a third party's action, IOs allow the insertion of new themes in political debates, favoring the agenda-setting. Among the benefits of the inclusion of intermediaries, Abbott et al. 2015 highlight that third parties can widen policies' acceptability. In other words, by bringing the third part to international forums, we could say that they increase global policies' legitimacy. International organizations often tend to incorporate intermediaries in their bureaucracies when they cannot perform the required tasks. In this sense, IOs as orchestrators, "will try to improve performance through appropriate forms of support to intermediaries, but these measures can fail" (ABBOTT et al., 2016, p.6).

Some governors or IOs will prefer delegation, while others will choose orchestration. Nonetheless, this choice depends first and foremost on the availability of third parties and the limitations of IOs to perform their actions. Some areas, as social policies, usually have more availability of third parties to act. Concerning the health domain, there are plenty the non-States actors like NGOs, philanthropic corporations, private enterprises, among others (ABBOTT et al., 2015).

Furthermore, some IOs usually face problems translating their rules and best practices into political programs; in this case, orchestration can be an alternative to improving IOs' performance. The literature has been calling attention to the fact that IOs can have pathologies, and they could boundary the translation of best practices into concrete actions. This issue will be the theme of our next section. Our main argument here is that some behaviors and pathologies could favor orchestration.

2.2 INTERGOVERNMENTAL ORGANIZATIONS: BEHAVIOR AND PATHOLOGIES

IOs cannot always consolidate their policies internationally, or in some cases, they do not act as their members expect. As questioned by Barnett; Finnemore (1999), "do IOs usually do what their members intend them to do? (BARNETT; FINNEMORE, 1999, p.2). The answer seems to be negative. However, it remains to explain why they do not act as expected and what strategies they are using to develop effective policies transnationally. One of the answers to these questions is that international organizations can achieve enough autonomy in the international arena and act against their most prominent sponsors. For example, a significant percentage of the United Nations for Education, Science and Culture Organization (UNESCO) budget comes from United States private donors. The UNESCO has the autonomy to follow or not US governmental preferences, even if they create pathologies such as budget reduction and restrictions to develop policies in the international arena (FERNANDES, 2015).

The autonomy of international organizations arena can be a reason to engender dysfunctional behaviors. Barnett; Finnemore (1999) have studied some reasons that can explain such pathologies, e.g., bureaucratic universalism, organizational insulation, and cultural contestation. Bureaucratic universalism stems from the fact that IOs "orchestrates numerous locals and contexts at once" (BARNETT; FINNEMORE, 1999, p.721). It means that many bureaucracies assume that rules and norms, and technologies can impact different societies and circumstances in the same way. For example, the World Health Organization, WHO, is an IO leader to care about global diseases. Nevertheless, there are endemic maladies to each region of the world. To "orchestrate" as expressed by Barnett; Finnemore, this diversity of contexts, the WHO works through regional offices to manage the effect of diseases and epidemics transnationally, since the universal policies for health cannot be as effective in tropical countries as they are in non-tropical countries, for example.

The second reason that may create dysfunctional behavior is organization insulation, which refers to the capacity that IOs have to concentrate on professionals working in the same field of expertise. In this way, they can create a skewed view of the institution. The insulation can stem from the absence of diversity of expertise and professional training. The global social movements, GSMs, have been putting pressure on multilateral economic institutions, MEI, which embodies plenty of professionals for the same expertise. This pressure has been amplifying the pluralization of agendas allowing the creation of diversified policies at international institutions' like the World Bank, the IMF, among others (O'BRIEN et al., 2000).

Additionally, the third cause of pathology, according to Barnett; Finnemore, is cultural contestation. It refers to the fact that IOs embody different views and senses of the world since the organization is shaped by "different mixes of professions or shaped by different historical experiences" (BARNETT; FINNEMORE, 1999, p.724). The diversity of members

and cultures and the divergence of preferences and interests among IOs members can be a reason to generate dysfunctional behavior.

The existence of pathologies, as highlighted by Barnett; Finnemore, is one noteworthy argument for our research. They can help explain why and when an international organization can effectively transfer or spread norms and policies. Furthermore, the limitations that IOs may have, and their dysfunctional behavior may encourage changes in international institutions' design. It could eventually suggest incorporating strategies to surpass pathologies in IOs, like the opening of IOs to non-state actors. As Koremenos, Lipson, Snidal (2004) investigated, some IOs can be flexible enough to adjust to the changes in circumstances since flexibility "is one of the most important international institutions' features. It provides a primary way to deal with the pervasive uncertainty in international politics, as well as to address distributional issues" (KOREMENOS; LIPSON; SNIDAL, 2001, p.294). International organizations that are flexible enough to adjust to changes in their rational designs can better overcome the pathologies they face.

Nevertheless, what changes have been incorporated into the rational design of IOs? What tools can be relevant to connect the international level and the domestic politics when it comes to practice? Some authors have proposed similar inquiries and provided good explanations to advance in literature. Reviewing these arguments proposed by researchers seemed an excellent avenue to construct our argument and our hypothesis. Answers have been raised in the literature to show how international organizations have overcome their inefficiency in diffusing norms and policies. One of the answers to remove the obstacles that IOs usually face in policy-making and policy decisions seems to be a controlled opening to non-state actors.

2.2.1 Why studying the action of non-State actors within IOs?

Thus, for our study, we recognize here that non-state actors' action through international organizations can be understood as a means 1) to surpass the pathologies of behavior; 2) to diversify the political processes within IOs; 3) to allow a more effective intergovernmental policy implementation. As previously mentioned before, IOs are confronted with dysfunctional behavior[14], even though, in some cases, the design of the institution can restrict the action of them and the process of policy-making. One of the hypotheses to surpass the pathologies is to embody different actors and cooperate strategically with non-state actors, like civil society, non-governmental organizations (NGOs), and transnational organizations.

Furthermore, through the action of non-state actors, the political process can become more diversified. Tallberg (2013) has inquired about the engagement of transnational actors, TNAs, in IOs. According to Talberg (2013), TNAs can be social movements, philanthropic organizations, international organizations, and transnational corporations. In the same way,

[14] Koremenos; Lipson; Snidal (2004)

the studies of Koremenos (2016); Abbott et alli (2014), Keck; Sikkink (1998) investigate the action of non-state actors in transnational networks. The TNAs could suggest new demands in international forums, defend social interests, and highlight inequalities resulting from the globalization process.

Some researchers, as Tallberg et al. (2013), Koremenos (2016), Abott et al. (2014), have studied the opening up of IOs to non-states actors. They have found that the field of human rights is more opened to non-state actors' action than other fields like the environment, energy, and security. According to them, the hypothesis that could explain the greater access of non-state actors in human rights in IOs is the notable divergence of interest among their members and the difficulties to ratify agreements in politics. In this way, non-state actors can act as specialized actors bringing new issues and more technical knowledge to resolve divergences among IOs members. As hypothesized by Schemeil (2009), one of the "conditions for successful cooperation between IO and NGO is the sufficient NGO specialization on the issues addressed by the targeted IO" (SCHEMEIL, 2009, p.5).

As already said, our main proposal in this research is to connect the literature of international politics and public policies. Some authors have studied the links between international relations and domestic public policies in different ways. This literature review intends to map some of the contributions that these authors have made to this field. Many studies about international organizations have been seeking a better understanding of how they implement policies and what factors can contribute or hamper the implementation of policies. Many hypotheses and different concepts have been raised in this field of literature to explain international organizations' opening up to non-state actors to enlarge the political decision-making process and the policy implementation process. Researchers as O'Brien (2000), Koremenos (2016), Tallberg (2013), Abott; Snidal (2014), Reinalda; Verbeek (2008), Keck; Sikkink (1998), among others, produced relevant contributions in this field.

O'Brien (2000) have studied the multilateral cooperation between international organizations and civil society. According to him, this kind of cooperation is amalgamated cooperation, including social movements, NGOs, and transnational corporations. These actors could contribute to enlarge agendas and make political decision-making more inclusive and participative. This kind of interaction established among international organizations and civil society was called by O'Brien (2000) "complex multilateralism." It means that cooperation is complex when besides the member states of an IO, plenty of non-state actors can intervene in decision-making bodies. O'Brien (2000) made a relevant contribution to the literature when he suggested that a more inclusive and pluralized environment rises within international organizations since the opening of IOs to non-state actors [15].

[15] The concept of complex multilateralism is a broad concept applied to actors who act through multilateral economic organizations, MEI. In other words, this concept will not be the best concept to use in this research despite the reference it makes to non-state actors and their activities through IOs. Our focus here is not to study multilateral economic organizations, as proposed by O'Brien (2000). In this manner, the use of complex multilateralism as a concept could restrict our studies' domain.

Nevertheless, the argument of inclusiveness and broad participation will be relevant for our research. O'Brien (2000) and other researchers, like Abott; Snidal (2016), seem to understand that non-state actors jointly IOs can be a tool to booster international policy diffusion worldwide. Likewise, O'Brien (2000), Abott, Snidal (2016) work with the argument that non-state actors could bring new demands to the political agenda and change the nature of international governance. In other words, Abott; Snidal (2016) argue that the model of governance seems to shift from a hierarchical way to a nonhierarchical way[16]. It means that international organizations are allowing non-state actors' engagement in the decision-making process as agenda setters or consider them as relevant actors in policy implementation. In this perspective, they have been reshaping the governance, changing from states to civil society, and from civil society to states, which the authors recognize as a soft and indirect mode of governance.

According to this perspective, governance can be considered a soft and indirect mode of governance. This mode of cooperation combines various stakeholders. Abott; Snidal (2016) called this multistakeholder interaction "orchestration." The concept proposed by the authors refers to a new mode of governance, indirect, nonhierarchical, in which non-state actors are recognized as intermediaries, which contribute to the implementation of IOs policies.

The argument proposed by Abott; Snidal (2016) explains how IOs can allow non-state actors' joining through IOs bureaucracies and why some sectors of activity can better accept civil society instead of others. Although the model could help explain the changes within IOs bureaucracies, they did not explain how the norms and agreements can become domestic policies. In this sense, the orchestration model will be an intriguing approach to sustain our hypothesis concerning the opening of IOs to non-state actors. Otherwise, the model did not offer enough hypotheses to explain the strategies and tools that IOs have been using to reach domestic levels. At this point, we emphasize a gap in this model of analysis. The authors were very bright in explaining why the IOs brought the third parties to their bureaucracies to reach IO targets; nonetheless, there are no in-depth discussions to explain how the intermediaries can strengthen the transferring and diffusion of policies to country levels.

Considering the gap identified in the orchestration model, we reflect on the intermediary characteristics and how they could act in the international scenario. We consider that intermediaries or stakeholders are non-state actors with different features, such as NGOs, civil society, philanthropic foundations, private companies, and researchers. We cannot say that there is a unanimous characteristic in the way intermediaries operate since their purpose distinguishes among themselves. In this sense, we can say that NGOs and civil society act creating advocacy coalitions to make both the national and international population aware of the relevance of an agenda. An example is the Association for Tobacco Control (ACT), which has played a vital role in defending the tobacco control agenda.

[16] Abott; Snidal (2015) refers to the change of the PA model, - in their perspective-, more hierarchical, to orchestration model, according to their approach, nonhierarchical.

Differently, philanthropic foundations tend to finance international actions and projects, such as Bill and Melinda Gates, the leading sponsor of immunization projects, or the Bloomberg Foundation, which finances projects related to tobacco control and ultra-processed foods.

Private companies defend commercial interests and are usually brought into the international organization to galvanize the debate and reduce conflicts of interest. In other words, at the WHO, the dialogue between private companies and the institution can be seen as a strategy to build bridges between commercial interests and global public health. Hence, by enabling the joining of actors such as the pharmaceutical industries and transnational corporations, the WHO foresee conflicts of interest and can have more responses to manage the existing imbalance between commercial and public health interests.

Researchers can also be seen as important actors in this process. They produce knowledge and innovation and contribute to disseminating information and convincing member states based on the outcomes encountered. Furthermore, new agendas for debate can be brought to the WHO and its members from innovative research.

Schematically, we tend to say that non-state actors can contribute to the process of disseminating and transferring public policies as follows:

1. NGOs and civil society act building the so-called transnational advocacy networks as studied by Keck; Sikkinck (1998). These actors can still be seen as policy entrepreneurs since they highlight the problem for decision-makers and tend to indicate alternatives to solve it.

2. Philanthropic foundations and non-profit organizations financing projects;

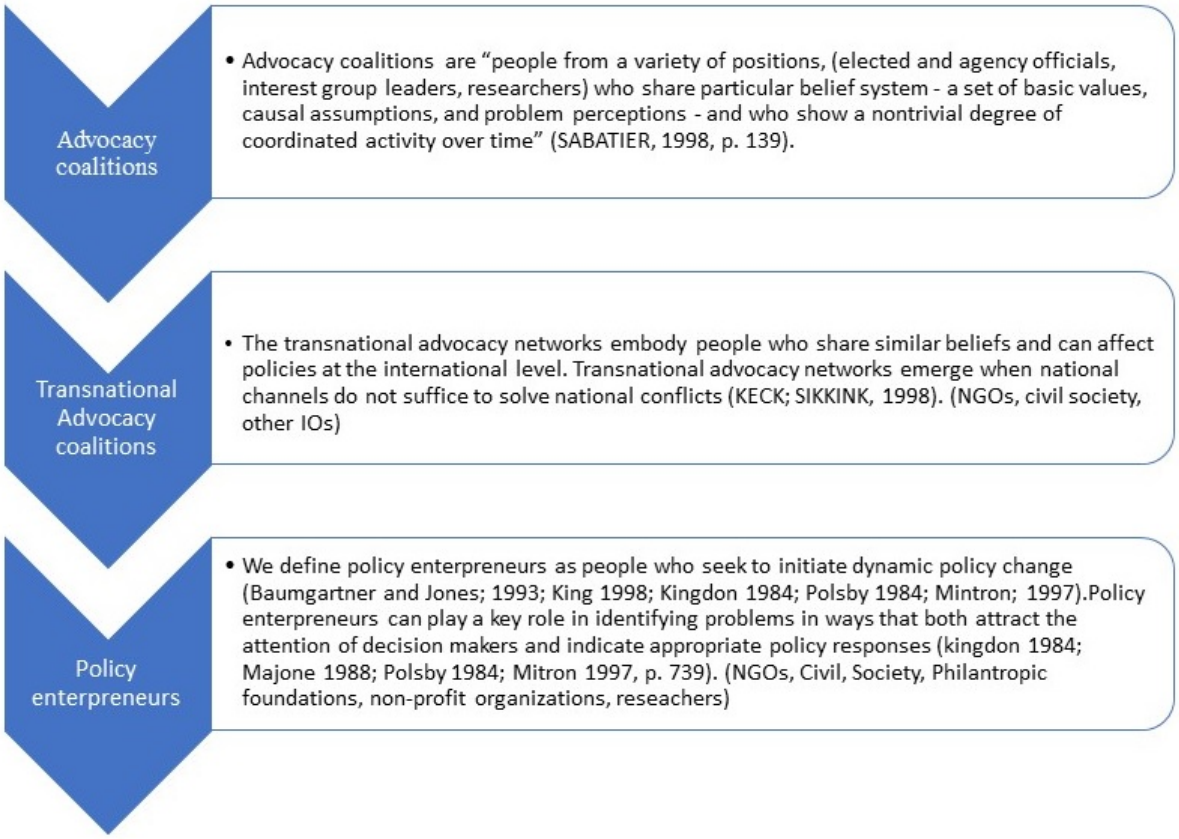
3. Private companies perform seeking for consensus between commercial interest and public health interest;

4. Researchers act in creating expertise and technical knowledge. They can recognize new thematic agendas of global concern.

To summarize, we show in the figure Strategies applied by non-state actors to assist the policy transfer.

The transnational advocacy networks embody people who share similar beliefs and can affect policies at the international level. As they have shown, transnational advocacy networks emerge when national channels do not suffice to solve national conflicts. In this sense, activists can act as "political entrepreneurs" and create new arenas and environments for debate through networks. The networks can create strong connections within the actors who are part of them. Likewise, Schemeil (2016), Keck, Sikkink (1998) sustain the argument that as stronger and dense a network is, the action between the non-state actors to reaching their targets would be more powerful. It is essential to highlight that either Schemeil (2016) or Keck; Sikkink (1998) have identified that transnational actors can cooperate strategically with international institutions.

Figure 2.1 – Strategies applied by non-state actors to assist the policy transfer.



Source: Self Elaboration

We highlight the importance of the transnational advocacy networks for our research for two reasons: firstly, they can join in international forums of discussion and offer opportunities to act strategically; secondly, non-state actors can become policy entrepreneurs at the national level.[17]

The studies about how the norms and agreements travel from IOs to national levels are still a challenge to international politics literature. Joachim et al. (2008) offered an interesting perspective on how domestic institutions could facilitate or impede the implementation process from IOs policies to the national level. In the author's words, for effective implementation, IOs may need allies at national levels. Moreover, the authors emphasize the degree of democracy as a benefactor to implementing global policies at the domestic level. In this manner, recognizing the implementation as one step of the public policy cycle, the degree of democracy can enable a stronger connection between the international and national levels. Thus, in more democratic states global policies can be transferred suitably comparing to less democratic states.

Hence, this argument could be useful for this research once our primary goal is to deepen the knowledge about stakeholders' actions in transferring IOs policies. Joachin et al. (2008) amplify the vision of essential stakeholders in transferring. These researchers highlight

[17] We will consider WHO policies as subsystem once different actors and issues compose each policy. he concept of policy subsystem, we refer to a "set of actors who are involved in dealing with a policy problem" (SABATIER, 1998, p.138)for example, specific policies within an international organization.

the domestic allies as valuable and required tools to enhance the transfer or diffusion from the global to the country level. In this sense, we work with the hypothesis that IOs need domestic allies to have an effective implementation process. Thus, we aim to investigate the implementation process and the multi-stakeholders (non-state actors and domestic allies) gathered towards transferring. Regarding the relevance of the public policy approach for this research, the next sections will discuss the public policy cycle and the transfer of policies.

2.3 PUBLIC POLICIES AND INTERGOVERNMENTAL ORGANIZATIONS

As discussed above, we intend to develop a dialogue between International Relations and Public Policies literature. Some arguments and concepts from public policy studies will be particularly relevant for this discussion to create this primary goal. A starting point to connect both kinds of literature seems to be the public policy cycle, made of policy incomes and policy outcomes. As will be discussed sequentially, several issues could influence policy-making and the implementation of policies. Second, regarding the discussion on international organizations, we intend to focus on the implementation stage and the actors involved in this stage to create advocacy coalitions to support their interests. Third, we will review some concepts from policy transfer and policy diffusion that might be relevant for our research.

2.3.1 Public policy and public policy cycle

As we will demonstrate below, Public policy, as other concepts in political science like democracy and power, can have different definitions. Souza (2007) argues that Public Policies propose a scenario in which the state holds responses to encourage changes or adopt a new course of action. Otherwise stated, through public policies, the rulers "translate their intentions into programs and actions "(SOUZA, 2006, p.7). Similarly, Marques (2013) defines the term as the "study of the 'State in action,'" which refers to the idea of seeking an understanding for whenever actions and choices could have precedence over others, and which contexts and institutions may provide the options taken. Furthermore, according to Jobert & Muller 1987; Marques 2013, p. 2, "to study public policies is to analyze why and how the state acts, considering the conditions that surround it" (MARQUES, 2013, p.2).

Public policy "is a more specific term applied to a formal decision or a plan of action that has been taken by, or has involved, a state organization" (RICHARDS; SMITH, 2002, p.1;(CAIRNEY, 2011, p.25). Whether the study of public policies refers to the state's actions, the reviews on the state in the globalization era may propose a new dynamic for public policy studies. With technological advances and the globalization of capital, there is a context in which markets, goods, and services become international. We have seen the reduction of borders and boundaries between distinct states. Globalization is a process rather than a cause in itself. This phenomenon proposes something flowing that changes every moment to reduce barriers in the international arena (DRYZEK; DUNLEAVY, 2009).

Regarding global changes, we assert that international organizations are sources of public policies. Whenever considering the Principal-Agent model, we understand that IOs make decisions to satisfy their member states, and this occurs through a highly complex bureaucracy shaped by plenty of policymakers. Moreover, similarly to (national) states, IOs are environments surrounded by the divergences of interests, the concentration of power, and financial problems.

Public policy is composed of several processes in different branches of government. We consider here that IOs can create public policies. The concept of the public policy applied to IOs, we propose in this research, is a set of decisions and action plans made by an international organization's governing body to reach political targets on behalf of its member states. Regarding the term "government" of international organizations, we intend to refer to an institutional body that can draft an agenda of its priorities or neglect an issue. In other words, a public policy created by the World Health Organization, for example, is made at the Executive Council and put to the vote at the World Health Assembly. These institutional bodies usually earn the highest decisions within this organization. However, the policies are developed by representatives of regions and not precisely by each member state. This study of IO and public policy is relevant to Brazilian literature. Researchers have been highlighting the hiatus in Brazilian Political Science studies to explain the diffusion or transfer of public policies as from international organizations (FARIA, 2018; FARIA, 2012; OLIVEIRA, 2016).

2.3.2 The global Agenda-Setting

As discussed earlier, changes in the state can significantly impact public policies and their consolidation process. Based on this principle, we sought to reflect on how domestic demands can become global agendas or how health problems could be perceived as a global problem. To develop this argument, we will revisit in this section, albeit briefly, Kingdon's model of agenda-setting (1995) much studied in the literature. Despite its limitations[18], - as pointed out by Capella (2007) - it is interesting to understand the formation of the agenda in public policies and the importance of ideas in the political agenda. From Kingdon's perspective, the government agenda refers to a "set of issues on which the government and its people focus their attention at a given time "(CAPELLA, 2007, p.26)

Thus, Kingdon's argument can also be applied to the globalized context to explain how a national problem can become a globalized issue. Through the Multiple Streams Framework, MSF, the author proposes that new demands can set political agendas, causing direct impacts on forming the public policy agenda in an international environment. The MSF has five structural elements, which are: the problem stream, policy stream, political stream, agenda (policy window), policy entrepreneur.

[18] According to Capella (2007), Kingdon used a methodology that focused his analysis on two case studies in which he "sought to collect data primarily through interviews with the government elite, and also through four-year case studies." (CAPELLA, 2007, p. 45). The criticism concerns the fact that the case study, although allowing an in-depth analysis of such phenomenon, may bring limitations to explain other events.

In summary way, we define the main characteristics of each element. The MSF works with the idea that problems need solutions. The **problem stream** are conditions and situations that deviate from policymakers or citizens ideal states and that are seen as a problem in the sense that government action is needed to resolve them" (BÉLAND; HOWLETT, 2016; HERWEG; ZAHARIADIS; ZOHLNHÖFER, 2018, p.22). Usually, three aspects can highlight that a problem must need policymakers' attention: the indicators, the focusing events, and the feedback. The *indicators* can have different natures,as such unemployment figures budget balances, crime statistics (HERWEG; ZAHARIADIS; ZOHLNHÖFER, 2018, p.21). We also consider the level of deaths caused by a specific disease as a heavy indicator.

The *focusing events* can occur suddenly and can be relatively rare. According to researchers of this field, the focusing events can increase the probability of becoming an agenda or change agenda items. Therefore the focusing events can assume different forms as natural disasters, earthquakes, hurricanes, technical accidents as airplane crashes, nuclear accidents, violent crimes, terrorist attacks, school shootings (HERWEG; ZAHARIADIS; ZOHLNHÖFER, 2018, p.22). We also consider that global health epidemics are focusing events and can increase the problem's chances become an agenda. The third aspect of being considered in the problem stream concerns the *feedback*. The feedback is recognized when the policymakers identify that a program did not achieve its goals or created undesired effects (ibidem).

The second element of the MSF is the **policy stream**, often developed by policy communities, as civil servants, interests groups, academic researchers, and consultants. As studied, the majority of policy community are experts that discuss policy ideas. "During the process know as softening up members of the policy community discuss, modify and recombine these ideas" (HERWEG; ZAHARIADIS; ZOHLNHÖFER, 2018, p.23). This process creates the primeval soup [19], when the policymakers began to discuss the solutions for one problem. As analyzed by the authors in the study, the degree of integration in a policy community can influence the proposed solutions. In other words, the more a community is integrated and connected among itself, the best could be the solutions proposed. The proposals made by policymakers can become a viable alternative to solve the problems.

Nonetheless, the feasibility of a proposal can be impacted by the criteria for survival. According to MSF, the criteria for survival are technical feasibility, value acceptability, public acquiescence, and financial viability. It means the criteria for the survival of one proposal relate to the conditions that can constrain a proposal's development. As Herweg et al. (2018) have studied, the proposals cannot survive when the policy experts doubt the implementation of ideas. Moreover, when the proposals are not common values shared by the members of the policy community. Another criteria that can affect whether a proposal will survive relates to the costs of the proposal. When the costs of the proposals are high, it is unlikely that the idea can find a majority in the political stream "or when costs are high, it is unlikely that the idea

[19] According to Kingdon 2011, the primeval soup refers to the diversity of ideas and possible solutions that arise from discussions in policy communities.

will survive softening-up process "(HERWEG; ZAHARIADIS; ZOHLNHÖFER, 2018, p. 23).

The third structural element concerns in the **political stream**.It is noteworthy that the interaction model is the core difference between the policy stream and the political stream. In the political stream, the mode of interaction is bargaining, while the mode of interaction is the policy stream, it is persuasion. According to Kingdon (2006), "consensus is formed in the dynamics of politics through negotiation rather than persuasion"(KINGDON, 2006, p.229).

It means that the policy stream is the stage where actors desire to achieve acceptability. Conversely, the political stream is the bargaining momentum, when the actors mobilize interest groups, arrange lobby and create alliances to support the policy solutions (ZAHARIADIS et al., 2007). The political stream is within a political system where three elements can be emphasized: the national mood, the interest group, the government.

The *national mood* considers that national mood swings from time to time due to the changes of individuals and policy makers in the government in a given country. The *interest groups* can be actors or the most powerful interest groups can oppose to the establishment of an agenda. Interest groups can also propose ideas, once they can be members of a policy community. The last element of the political stream, but not least, are the *governments and legislatures*, in which we can consider that "ideology and opinion of politicians can influence the political process" (HERWEG; ZAHARIADIS; ZOHLNHÖFER, 2018, p.24). Otherwise stated, the opinion of legislature and government can favor or impede a problem become agenda (ZAHARIADIS et al., 2007). Regarding the political flow, Kingdon (2006) argues that the political arena is relevant to agenda-setting. Said differently, the dynamics that conform to the political sphere would have a considerable impact on agenda-setting beyond the problems and solutions. In this sense, the author attempts to explain which reasons lead to becoming an issue on a political agenda rather than others.

Furthermore, Kingdom indicates that new themes can become part of the political agenda, given opportunities that develop in specific contexts. Thus, "Kingdon has introduced the notion of *policy windows* to refer to opportunities that arise and enable the insertion of a specific policy on the agenda"(KINGDON, 1995)(JANN; WEGRICH, 2007, p.47).

The fourth structural element in the MSF is the agenda or the policy window, also called the opportunity window. According to Kingdon (2011) the policy window is when advocates of proposals have the opportunity to push their solutions or to push attention to their striking problems (KINGDON, 2006, p.165). Many situations can affect the agenda. The change of partisan or the change of government composition can open the agenda for new policy proposals. Similarly, an expressive variation in the national mood can create a window of opportunity (ibidem).[20]

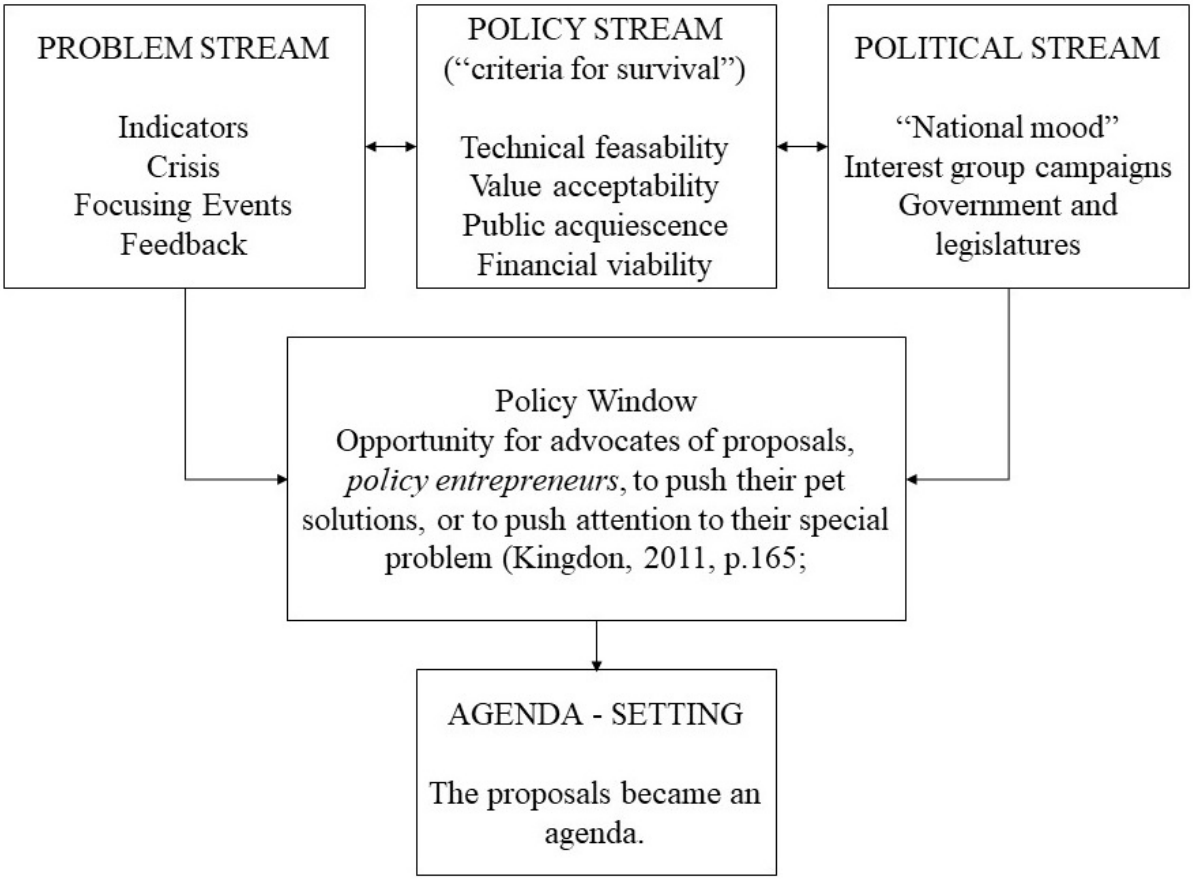
The fifth structural element is the **policy entrepreneur**. According to the MSF, a

[20] In contrast, an agenda window opens in the problem stream when indicators deteriorate dramatically-for example, unemployment or the budget deficit skyrockets in a very brief period (ZAHARIADIS et al., 2007; HERWEG; ZAHARIADIS; ZOHLNHÖFER, 2018, p.26).

policy entrepreneur is who "advocates for a problem, who are willing to invest their different resources like time, energy, reputation, money to promote a position in return for anticipated future benefits in the form of material, purposive or solidary benefits" (KINGDON, 2011, p.179). The policy entrepreneurs are key actors in the MSF, given that they can recognize the opportunity to propose solutions or start the actions. The more resources (time, money, energy) policy entrepreneurs have, the greater the chances of success to push their proposals (ZAHARIADIS, 2003; ZAHARIADIS, 2015, p.14). Additionally, when entrepreneurs have greater access to policymakers, increasing the chances of proposals becomes an agenda item (ibidem).

This manner the MSF perspective considers that agenda setting would involve three distinct flows, defined by problems, policy, and alternative solutions. We summarize the Multiple Streams Model in the figure Figure 2.2.

Figure 2.2 – Kingdon model of streams.



Source: Self elaboration from(CAPELLA, 2007; HERWEG; ZAHARIADIS; ZOHLNHÖFER, 2018).

Kingdon refers to problems as social constructs that can undermine essential values. Therefore, issues would depend on interpretative elements: the perception that a situation can generate a problem. As far as such understanding is concerned, Kingdon refers to *policy entrepreneurs*, which would be relevant to convincing authorities about their perceptions of the existence of a problem (KINGDON, 2006). As demonstrated above, the IOs need policy

entrepreneurs to convince the global public opinion towards a worldwide problem. As emphasized, some IOs have been enabling multi-stakeholders' action to enhance IO's political agenda's pluralization. After interpreting a situation as a possible problem, solutions could be created. According to the author, "People do not necessarily solve problems. [...] Instead, they often develop *solutions* and then look for problems to which they can present their solutions "(CAPELLA, 2007). The proposed solutions depend on aspects such as the technical feasibility to implement it and community acceptance, as shown in the model above. Regarding Kingdon's answers, he points out that ideas can have a relevant aspect in this *flow*, considering that they can have a meaningful impact on creating alternative explanations for this process.

Oliveira (2017);(2020) argue that policy diffusion can occur with policy ambassadors' action. The author uses this term to explain individuals' playing alongside the diffusion of the Brazilian Participatory Budget. In this manner, the also called Ambassadors of Participation are described as " individuals constantly engaged in promoting policies at the local, national and transnational levels" (OLIVEIRA, 2020; OLIVEIRA, 2017, p.55) the concept could also be valuable for our discussion. Nevertheless, we opt not to restrict our focus on the role of individuals, and we also take into account the role of institutions. Regardless the importance of key individuals in the political bargain, as underlined by Oliveira (2017;2020), we consider that plenty of actors can play meaningfully -as such NGO's, civil societies, philanthropic foundations- undertaking the function of motivating the diffusion of a policy even in the international arena. For this reason, the concept of policy entrepreneurs seems to be better applied.

When we look at the case of global health cooperation, we evidence that the formulation of policies reflected the aspirations of the wealthiest countries to prevent diseases and epidemics that could undermine political and economic interests (LEE, 2008). That is, given the great epidemics that struck Europe in the early nineteenth century, governmental authorities seemed to recognize that health problems could not be treated solely as domestic but would depend on external solutions. As discussed, state boundaries have become unclear. In the face of globalization, the flow of people, communication, goods, and services have become more intense, thereby raising concerns about the possibility of local diseases reaching global scales. According to (BERLINGUER, 1999), health became more debatable and negotiated in international agendas from the twentieth century. This period is remembered not merely for being the scene of political conflicts and technological innovations, but also for being a time when "human society dared to think of health as a reasonable practical goal"(BERLINGUER, 1999, p.26).

In our understanding, global health can be analyzed as from the flows, as appointed by Kingdon. With the increasing circulation of people around the world, policy entrepreneurs came to recognize health and health issues as a problem for which solutions would be necessary. The alternative solutions presented, the need to create an institution to coordinate and regulate

health at the international level. That is, the geographically boundary-bound state would no longer be the only actor dealing with health issues. The agreements would come from discussions between different actors, including countries, institutions, and experts. Given the recognition of this problem, we may say that an epistemic community made up of doctors and sanitarists began to work through meetings and conferences, whose main objective was searching for solutions focused on health in the global field.

The globalized context brought a plurality of topics for being placed on the agenda. In other words, to deal with the new issues on the international agenda, international organizations (IOs) have begun to be considered as global policy creators. An important aspect highlighted by Kingdon (2006) is the relevance of ideas in choosing policy alternatives. Actors such as "Think Tanks and International Organizations (IOs) can work as catalysts to foster the exchange and transfer of political ideas, solutions and perceptions of problems among governments and beyond" (STONE, 2004) (JANN; WEGRICH, 2007, p.51). In agreement with (JANN; WEGRICH, 2007), we also argue that ideas and interests interact within an institutional environment seeking to translate them into projects. Moreover we agreed with Abott et al. (2015) with his ochestrator entrepreneurship hypothesis. According to this researchers governance actors are more likely to engage in orchestration when their organizational structure and culture encourage policy entrepreneurship (ABBOTT et al., 2015, p.25). We believe that WHO is an orchestrator capable of fostering different policy entrepreneurs to act in global health governance. This manner the "orchestration will be facilitated where an IGO enjoys sufficient independence from member states to make policy entrepreneurship possible - and has an administrative apparatus capable of carrying out the necessary activities (ABBOTT; SNIDAL, 1998; ABBOTT et al., 2015, p.26). The literature considers that few empirical works focus on the entrepreneurship hypothesis, and we believe that WHO can fulfill this gap.

Referring to the political stream, as addressed by Kingdon and recognizing health as a problem that could affect citizens, there was an underlying political-economic interest. In the nineteenth and early twentieth centuries, Europe's epidemics decimated the population, substantially reducing the consumer market. There was an initial interest that diseases and pandemics could be controlled for supporting the consumer market. Although the WHO has managed most outbreaks, there are still latent economic interests related to the pharmaceutical industry, such as the drug and vaccine, the food industry, and trade. What we could emphasize in this sense is that health issues may have gained space on the agenda due to the political dynamics that were conforming and given the economic concerns that affected the authorities' policies.

Globalization brings greater complexity to the analyses. We consider that the WHO can orchestrate entrepreneurs as the intermediaries and push an item for the global agenda. To analyze the transfer from the international level to the national level, we recognize that entrepreneurs must carry the global problem to the WHO. Nonetheless, we also need

entrepreneurs at the national level to support the policy and strengthen the transfer. Finally, as discussed earlier, the Kingdon model may be useful to explain the creation of new agendas in international health politics.

2.3.3 The International Organizations as agents and orchestrators in transferring global public policies

This section is based in an article written by FERNANDES; CARVALHO (2018). The literature about the transfer and diffusion of public policies from international organizations is a relatively new phenomenon. Since the 1980s, IOs began to be studied as catalyzers in the process of policy diffusion and policy transfer. The terminology "diffusion" and "transfer" are the main concepts used to refer to the same process: the logic of applying elements and instruments created or recommended in a specific time or space to other time/space.

The concepts of "diffusion" and transfer" differ methodologically. While diffusion uses quantitative methods to understand how one policy can spread over the system, the second is focused on understanding the details of transferring to a few actors and commonly apply qualitative methods. Hence, in research that aims to focus on policy transfer, the research tools could predominantly be qualitative. (MARSH; SHARMAN, 2009). According to (FARIA, 2018):

> "(...) While the literature on diffusion is focused on the structure, the transfer focus on the agency. Thus, it is clear that the literature needs to develop more robust explanations from the recognition of the dialectical relationship between agency and structure; (c) if diffusion studies seek to uncover patterns, the transfer usually analyzes process-tracing. However, it seems evident that a complete understanding of these phenomena requires the knowledge of both. Both kinds of literature, for various reasons, have paid little attention to the so-called developing countries. Moreover, both types of literature should be more interested in the fact that diffusion and transfer lead to adopting policies that are not always successful later on.(FARIA, 2018, p.37) (our translation[21])."

Schematically, we may compare policy transfer and policy diffusion as presented in the table below Table 2.2:

The literature around these processes proposes several approaches of analysis, ranging from rationalist proposals to constructivism. It presents, therefore, several alternatives to explain why states resort to global policies. One of them would be because reusing an already used - and successful - policy would save time and resources (DOLOWITZ; MARSH, 2000).

[21] From original: "(...) if the literature on diffusion privileges the structure, that one dedicated to the transfer focuses on the agency. Thus, it is clear that more robust explanations could be developed from the recognition of the dialectical relationship between agency and structure; (c) if diffusion studies seek to uncover patterns, the transfer usually analyzes process-tracing. However, it seems evident that a complete understanding of these phenomena requires the knowledge of both. Both kinds of literature, for various reasons, have paid little attention to the so-called developing countries. Moreover, both literature should be more interested in the fact that diffusion and transfer lead to the adoption of policies which later on are not always successful (FARIA, 2018, p.37)

Table 2.2 – Policy Transfer and Policy Diffusion

	Policy transfer	Policy Diffusion
Definition	Transfer of public policies, emulation and lessons learned (lesson drawing) refer to the process by which knowledge about policies administrative arrangements, institutions and ideas in a political environment (past or present) is used in the development of administrative arrangements policies , institutions and ideas in another environment "(MARSH; SHARMAN, 2009, p.5).	"The process by which the innovation began to communicate through certain channels towards the social system. It is a special type of communication in which messages relates themselves with new ideas "(ROGERS, 2004, p.5)(ROGERS, 1995, p.5).
Cases	Few cases	Many cases
Methodology	Qualitative	Quantitative
Capacity of generalization	Low level	High level
Capacity of prediction	Low	High

Source: Adapted from (FARIA, 2018, p.35)

Another would relate to the fact that guidelines disseminated by other actors could have more legitimacy, mostly if these actors were references in certain areas (DOBBIN; SIMMONS; GARRETT, 2007). Socialization among actors could be a crucial factor, allowing them to share ideas and interest in replicating policies used by others (MCCANN; WARD, 2013). Even geographical proximity can be seen as a driving factor for these processes (BERRY; BERRY, 2018).

The diffusion or transfer of public policy does not necessarily need to be in its entirety. Only parts of the approaches, such as objectives, ideas, administrative techniques, negative lessons, and programs could be involved in the process. There are different degrees to which these processes can occur. These levels range from inspiration, in which actors rely only on policy ideas implemented in another time/space, to emulation, where a policy is "reused" in its entirety (DOLOWITZ; MARSH, 2000).

Moreover, we can highlight two broad approaches for studying policy diffusion: as a result and a process. In studies that analyze the results, the researchers are interested in evaluating the success and the failure of the policy. Differently, while seeking to understand the process, the researchers aim to grasp how the different actors can influence this process (OLIVEIRA, 2016). For this thesis, despite using the term success referring to tobacco control policy to Brazil, we are more curious in raise explanations about how the process occurs. In somewhat the results of tobacco control policy to Brazil are considered.Nonetheless, our main ambition is to identify the role of actors throughout this process.

The literature points out four different mechanisms through which the study can occur, and these mechanisms can interact with one another (MARSH; SHARMAN, 2009). The first one is learning, which presupposes that, through the available information, an actor chooses, in a rational way, to implement a policy recommended or already used in another time/space. The second is imitation (mimicry), in which, through socialization, different units of the system decide to reproduce specific policies. The mimicry would occur, for example, in the search for legitimacy in their implementation, or in the perception that, depending on the cultural similarities among actors, the implementation of a given policy could be feasible (DOLOWITZ; MARSH, 2000);(SHIPAN; VOLDEN, 2008).

Competition is a mechanism in which actors desired to be attracted by others to broaden benefits. States compete for different reasons, as more significant investment from sponsors or better positions in international rankings. In this sense, they end up reproducing successful policies to do better in these classifications. Furthermore, we have the coercion, perceived when there is some sanction whenever the actor does not implement measures or policies (DOLOWITZ; MARSH, 2000);(SHIPAN; VOLDEN, 2008).

Different actors can take part in the process of diffusion or transfer of public policies. As Dolowitz and Marsh (2000) studied, international organizations can figure as agents in the global environment in the process of diffusion or transfer, encompassing plenty of stakeholders. As we are going to show at the table below Table 2.3:

International organizations can be key actors in the process of disseminating public policies, proposing programs, or facilitating policies that are outlined in another time/space to reach a particular actor. As inquired by Tallberg at all (2019) at IOs, two types of authority could exist. The first would be "political," assuming that there should be some actor with the ability to make decisions for the common good, improving the provision of public goods, or at least avoiding chaos.The second type is the epistemic authority based on developing a kind of knowledge or expertise by an IO (TALLBERG; ZÜRN, 2019). For our study, we will consider the WHO as an epistemic authority once the IO focused on developing expertise and knowledge to lead with global health problems.

In the same way that public policies are built at the national level by states and their governments, public policies are formulated within international organizations. They follow the policy cycle steps, such as agenda-setting, policy decision-making, and implementation of public policies. We will consider that the process of diffusion and transfer of policies can be closer to the third stage of the public policy cycle, it means closer to implementation. When choosing to solve a particular "problem," an actor can choose to develop something new or "reuse" a policy. In the context of international organizations, the implementation process refers to the challenge of making agreements established in international bureaucracies, such as international organizations, reach their political targets domestically.

Some scholars like Joachim et al. (2008) have investigated how the IOs can produce results or achieve success alongside implementing their public policies in the States. It is

Table 2.3 – Model of Dolowitz and Marsh for policy transfer and diffusion.

Who Is involved in Transfer?	Elected Officials; Political Parties; Bureaucrats/Civil Servants; Pressure Groups; Policy Entrepreneurs/Experts; Consultants; Think Tanks; Transnational Corporations; Supranational Institutions
What Is Transferred?	Policies (Goals) (content) (instruments); Programs; Institutions; Ideologies; Attitudes/Cultural Values; Negative Lessons
Degrees of Transfer	Internal; Global
Constraints on Transfer	International organizations; Regional; State; Local; Governments; Past Relations
How to Demonstrate Policy Transfer	Copying; Emulation; Mixtures; Inspiration; Policy Complexity (Newspaper) (Magazine) (TV) (Radio); Media Reports; (Commissioned) (uncommissioned); Conferences; Meetings/Visits; Statements (written) (verbal)
How Transfer leads to Policy Failure	Past Policies; Structural; Institutional; Feasibility; (Ideology) (cultural proximity) (technology) (economic) (bureaucratic); Language; Uniformed Transfer; Incomplete Transfer; Inappropriate Transfer

Source: Adapted from (DOLOWITZ; MARSH, 2000, p.9)

worth remembering that international organizations face the challenge of entering national levels endowed with singularities, political, cultural, and economic factors, which can hinder the diffusion/transfer of policies. From this perspective, the transfer of public policy depends not merely on international organizations' agency capacity but also on its recipients' political and cultural characteristics. In this sense, the process of implementing and disseminating public policy by an IO tends to mobilize many actors to incorporate new participants in the public policy cycle of international organizations, such as civil society actors, non-governmental organizations, among others(JOACHIM; REINALDA; VERBEEK, 2007).

It is worth mentioning that the diffusion of public policies from international organizations does not follow a standard. After analysis, we consider that two features can influence the diffusion and transfer from each IO: the field of action and the bureaucratic structure. International organizations that work with human rights and social policies tend to incorporate a greater diversity of actors in the formulation and diffusion of public policies. They present a more inclusive and flexible institutional design, which tends to accommodate changes and demands over time (ABBOTT et al., 2015).

Some IOs, such as those focused on social approaches such as UNESCO, WHO, ILO, UN High Commissioner for Human Rights, tend to be more flexible in incorporating actors in the political process, more diversified and broader access to actors in the policy transfer process. International organizations addressed to low politics, incorporate changes in their institutional designs to overcome challenges either in the formulation or transfer of policies. Conversely, international organizations focused on economic and security issues tend to be less inclusive in the process of formulating and disseminating public policies (KOREMENOS; LIPSON; SNIDAL, 2001).

Koremenos et al.(2004) have inquired about international organizations' institutional design and identified distinct patterns such as flexibility and the number of members within an international bureaucracy. Similarly, Belém Lopes (2016) investigated the degree of democratization in various international organizations.

As investigated by the authors, international organizations focused on social and human rights issues tend to be more inclusive to non-state actors. Differently, economic and security organizations tend to be less inclusive of non-state actors. The literature highlights the importance of non-state actors' to enhance policy diffusion and policy transfer in IOs that do not use coercive instruments to translate their policies to a country level. For this reason, we emphasize the role of this kind of actor as a stakeholder. The discussion about the institutional design of the decision-making process in international organizations is relevant. It helps us to reflect on the features of the process of policy transfer across different IOs. There would not be only one pattern of action to spread global policies from IOs. On the contrary, these actions vary according to the institutional design in each international organization.

International organizations can apply some mechanisms to promote global public policies from the international level to the national level.

They have been using a worthy strategy defined by the creation of spaces for dialogue within IOs bureaucracies. Fink (2013) emphasizes that opening up to non-State actors can facilitate cooperation and encourage actors to solve similar problems and seek alternatives for their disorders, either through learning or imitation (FINK, 2013). In this way, IOs acts in the diffusion of public policies, either by voluntary means (learning), or formulation of standards internalized by its members (imitation) or through the use of sanctions whether soft law was not followed (coercion).

Furthermore, some IOs have been allowing the join of non-state actors, such as civil society actors, non-governmental organizations (NGOs), transnational corporations, and policy-making and policy implementation what we have been observing in the WHO case. The openness to these actors can create spaces for discussion that are more horizontal to facilitate communication between different actors. Jakobi (2009) studied five ways in which these organizations could interfere in policy transfer processes.

For this thesis, we agree with Jakobi (2009) and Carvalho et al. (2021) that there

are strategies and instruments or mechanisms used by International Organizations to make the process of diffusion and transfer to the country level more effective. According to the researchers, six types of mechanisms could favor the diffusion or transferring, namely: the discursive dissemination, the standard setting, the coordinative functions, the financial means, and technical assistance, and the opening of spaces for dialogue.

The **discursive dissemination** is transferring ideas and discourses to convince the States' policy-makers to adopt particular political strategies rather than others. In this sense, an example would be the WHO's campaigns on preventing breast and prostate cancer that commonly occur globally in October and November. WHO's strategy is to broadcast discourses and alerts for making the world population conscious of the benefits of an early diagnosis capable of saving lives. As Jakobi (2009) explored, discursive dissemination is a soft strategy and seeks to share a global discourse to raise awareness among individuals and influence their strategic reasoning. According to the author, IOs have the power to establish ideas and agendas. Implicitly, they also put forward rules, standards, and best practices. In the author words: "It is important to think that ideas can pave the way for public policy initiatives, and they can also be the first element of political change"(JAKOBI, 2009, p.34). Thus, through the propagation of new understandings, people can encompass best practices, either rationally (as from the learning) or as from imitation, as part of creating awareness among actors.

The widespread of discourses can become a social yardstick, changing the individual's political behave. Towards this end, another tool by which IOs can act is the **standard setting** . This mechanism is remarked when the IOs establish conventions, create rules, or develop recommendations. From this instrument, we can also recognize the IOs' capacity to produce regulations to be transferred from the global level to the national level, expecting that IO members will incorporate international standards within their states. As an example, we note the creation of the Framework Convention on Tobacco Control (FCTC) within WHO's scope. The Convention institutionalized a series of speeches to regulate tobacco production and consumption among the World Health Organization countries, reducing smokers' number and the proportion of tobacco-related diseases. We can also consider an example of standard setting, the best practices to prevent COVID-19. Although it has not been institutionalized in the form of a convention, it is observed that masks, alcohol gel, and other recommendations are accepted globally as a standard to be followed. Some countries have adopted sanctions and punishments for individuals who fail to comply with regulations. Nonetheless, there is no international sanction imposed by the WHO for non-compliance with these regulations.

The IOs can offer a prescription of behaviors once they create agreements, laws, and guidelines that can or cannot be adopted by its member states. They can commonly use the mechanism of **coordinative functions** for monitoring its member states in the adoption of models of behavior (JAKOBI, 2009). The IOs can use coordinative functions to propose sanctions, monitor and supervise the application of standards towards IOs members, as Jakobi (2009) stated. In the case of the WHO, States parties to the Framework Convention

on Tobacco Control accept and undertake the following Convention patterns. To become signatories, they bound themselves to the regulations and accept being monitored and supervised by national and international bodies. Researchers such as Bauhr and Nasiritousi (2012) highlight that coordinative functions can create rankings to compare how actors implement IOs regulations. Moreover, they can employ dispute resolution and use military means to supervise how patterns are translated to country levels (Graham, Shipam; Voldem, 2013; Carvalho et al. (2021).

IOs can also provide **financial means** for implementing policies. Financial means can come from the regular or extra-regular budgets of IOs; or even through donations or loans. Additionally, IOs can provide technical assistance through training, staff qualification, and developing actors' expertise to enhance the policy implementation process (Jakobi, 2009; Carvalho et al., 2021). As an example, we show that WHO has invested in emergency funds to deal with outbreaks in Africa. For example, the WHO provides financial resources and qualified human staff for dealing with the Ebola crisis in 2014 in Africa. Although the use of financial means is not the most common tool to be used by the WHO to consolidate diffusion and transfer, given the budgetary constraints, we note that the region of Africa is the largest recipient of WHO financial resources. This large amount of financial means enables the continent to face and overcome severe health and sanitary crises.

Finally, we add the instrument so-called **opening spaces for dialogues**. As discussed by Carvalho; Fernandes; Faria (2021); Stone et al. (2019), and Pouliot and Thérien (2018), we should not neglect informal practices' roles. The meetings on various topics can foster the dissemination of speeches and acceptable practices, reinforcing new patterns and political experiences. In this sense, we highlight that some IOs prioritize using a strategy to allow different actors, such as states and non-state actors, in formal and informal spaces. As a practical example, the WHO has made possible the dialogue with actors such as civil society, NGOs, private companies, and philanthropic foundations. As investigated by the literature, the strategy of becoming the policymakers and entrepreneurs to occupying common spaces enlarged the dialogue, sharing practices, and, consequently, the diffusion of policies among members. Through this opening, the action of non-state actors has been giving voice to new demands and showing new agendas for been debated. Concerning health issues, the spaces for dialogue can be the place for sharing formal and informal practices adopted to prevent and treat disease. Our society is governed not only by traditional rules signed within bureaucracies; there are a diversity of informal rules that emerges from the interaction of citizens (HEIN; MOON, 2016). These spaces for dialogue can be valuable in four aspects: "firstly, to increase the awareness of the dramatic disparities in health status between richer and poorer populations, and to create the normative groundwork for acts of solidarity such as resource transfers to improve health" (HEIN; MOON, 2016, p.20). Second, the networks established in the spaces for dialogue could alert and give hints towards how to face threats such as the pandemic of Sars-Cov2, the pandemic of influenza, and the harmful effects of

tobacco use (HEIN; MOON, 2016). Third, "significant science advances, and innovation of drugs and vaccines can travels quickly and can create higher expectations and new political demands for access to healthcare" (HEIN; MOON, 2016, p.21). And last but not least, these spaces can create "health advocates" in charge of share information and mobilize strategies for pressuring powerful actors as multinational firms and governments to be responsive with health concerns" (HEIN; MOON, 2016).

Finally, we emphasize that IOs can use one or more instruments for diffusion and transfer their policies to the country level. However, whenever considering the IO scope of action, we recognize that perhaps IOs of the same field of expertise could employ analogous diffusion and transfer mechanisms. More objectively, we systematize our reasoning in the tables below.

Synthesis of the mechanisms of diffusion and transfer used by IOs:

Table 2.4 – Mechanisms of diffusion and transfer used by IOs.

Mechanism	Activities developed by IOs	Examples
Discursive dissemination	Dissemination of ideas and standards capable of influencing policy makers	UN Sustainable Development Agenda 2030. The 2011 WHO Global Strategy on Diet, Physical Activity, and Health to lead with obesity
standard setting	Creation of global norms and recommendations, creation of conventions and treaties	The Washington consensus proposed by the World Bank and IMF in the 1980s. The creation of global standards to prevent COVID-19, as such, mask use and regular use of alcohol gel.
Coordinative functions	Monitoring, supervision, and application of sanctions on the employment of international regulations.	IAEA inspections of nuclear installations. Creation of the FCTC that institutionalized standards and monitors the prerogatives agreed by the Convention.
Financial Resources	Donations or loans (with or without conditionalities)	IMF loans. The sending of WHO financial resources for emerging issues in Africa.
Technical Assistance	Training of personnel, development of expertise	Qualification of human resources to deal with the issue of Ebola in Africa and with the MERS-COV in the Middle East.
The opening of spaces for dialogues	Creation of bridges between policy-makers, experts, civil society, and other non-state actors.	The creation of networks at UNASUR catalyzed a process of learning replicated to South American health systems. The civil society action at the World Health Assembly proposing new agendas and sharing experiences.

Source: Adapted from (CARVALHO; FERNANDES; FARIA, 2021, p.7)

As noted by the board, the WHO can use the various instruments to disseminate and transfer policies to the country level. Several factors can interfere with the use of the

instrument employed. At the International Organization level, we can highlight that characteristics such as the scope of action and bureaucratic structure can interfere with the type of instrument used. When focusing on the policy level, plenty of variables must be considered. We can highlight issues such as how often the policy could generate conflicts and the costs and benefits of the diffusion and transfer process. Thus, policies with higher degrees of conflict can hamper the transfer and diffusion processes. For example, the awareness campaign for breast cancer prevention is not seen by the WHO members as a policy that can generate expressive conflicts or resistance among political agents.

Therefore, global awareness of breast cancer prevention can have low costs and many benefits; in that sense, discursive dissemination becomes a useful tool to spread this policy. Otherwise, the regulation of tobacco and consumption of ultra-processed foods has a higher degree of complexity, given the number of actors and sectors involved in the transfer arrangement and the different kinds of conflicts of interests that may arise. It has a high cost due to establishing a balance between commercial and public health interests. Notwithstanding, it has many long-term public health benefits. Regardless of the greater complexity of the policy and potential conflicts, the WHO employed diverse transfer and diffusion instruments, such as the standard setting, the coordinative functions, and financial means.

IOs may employ one or more instruments. Factors such as organizational variables and the type of policy to be transferred or disseminated influence the diffusion and transfer's greater or lesser success. Thereby, we present sequentially the hypothetical deductive classification developed by Carvalho; Fernandes; Faria (2021), which relates the IO and the type of mechanism predominant in the diffusion and transfer process. In an orderly fashion, we seek to contextualize the WHO and the employment of these mechanisms.

Table 2.5 – The IOs field of expertise and the mechanism usually employed.

IOs field of expertise	Security	Trade & Economy	Finances	Human Rights, Social Purposes, Environment
Mechanism				
Discursive dissemination	Low	Neutral	Neutral	High
Standard setting	High	High	High	Low
Coordinative functions	High	High	High	Low
Financial Resources	Neutral	Neutral	High	Low
Technical Assistance	High	High	Neutral	High
The opening of spaces for dialogues	Low	Neutral	Low	High

Source: Adapted from Carvalho; Fernandes; Faria (2021), p. 20.

Considering the field of expertise, we understand that the WHO is an IO of human rights, social purposes, and the environment. As hypothetically observed, WHO's policies

tend to use mechanisms such as discursive dissemination, opening spaces for dialogue, and technical assistance. However, when evaluating the wide variety of policies developed by this IO, we recognize that the use of instruments and mechanisms varies according to the degree of complexity and conflicts that the policy's diffusion or transfer can create. Otherwise stated, policies that deal with commercial interests perhaps require more mechanisms for their effective transfer and diffusion. Furthermore, in cases of health problems that can be aggravated by the use of cigarettes, alcoholic beverages, and ultra-processed foods, there is a need to convince the population, and consequently, negotiations with the sectors involved. Conversely, health crises resulting from communicable disease epidemics tend to convince WHO members of the need for policy enforcement more easily. Hence, the effective transfer can occur with few transfer and diffusion instruments.

The WHO is an extensive institution and works on a wide range of health issues. To be more enlightening, the WHO works through broad clusters of policies, which are: the Communicable Diseases (CDS), Non-Communicable diseases (NDS), Health Systems, WHO Health Emergencies [22]. Each cluster of policy can employ different instruments of transfer and diffusion. Regarding this hypothesis, we show schematically how often the WHO can employ these instruments in each cluster.

Table 2.6 – WHO policy clusters and the use of transfer and diffusion mechanisms.

WHO Policies	Communicable diseases (CDS)	Non-Communicable diseases (NDS)	Health System	WHO Health Emergencies
Mechanism				
Discursive dissemination	High	High	High	High
Standard setting	High	High	High	High
Coordinative functions	Neutral	High	Neutral	Neutral
Financial Resources	High	Neutral	Low	Neutral
Technical Assistance	High	High	Neutral	High
The opening of spaces for dialogues	High	High	High	Neutral

Source: Self elaboration.

More objectively, we consider these four clusters of policies and the greater or lesser need for instruments to spread policies worldwide. In the cluster of **communicable diseases** (CDS) we include epidemics and outbreaks with a high potential for transmission between individuals. In this way, we understand that this large group receives more investments, and possibly a more significant number of mechanisms are applied to diffusion and transfer policies, especially in the African continent. As examples, we can mention the Ebola crisis in Africa

[22] We defined these clusters as from the budget allocation analysis, and we did not include the Programme, Corporate services/enabling functions.

or the global HIV epidemic. Furthermore, when observing the immunization sector, leading against potential epidemics, we understand that this large group of policies tends to develop international standards that may be supervised and monitored internationally. The WHO also includes the **neglected diseases** (NTD), in the CDS cluster. Few actors manifest interest in dealing with the NTD. This group includes endemic diseases in some regions of the world and tropical diseases such as malaria, tuberculosis, Chagas diseases, and dengue [23]. The absence of conflicts of interest in this agenda is seen as problematic. In other words, we can say that there are no expressive efforts to disseminate and transfer the policies related to this agenda [24].

According to the WHO, the cluster of **non-communicable diseases** (NCD) encompasses heart disease, stroke, cancer, diabetes, and chronic lung diseases. As noted from the WHO budget, the agenda for non-communicable diseases does not receive the most considerable amount of resources. However, the high rates of chronic non-communicable diseases can overwhelm national health systems with costly treatments, causing devastating consequences for individuals, families, communities. The tobacco case is emblematic for this thesis, given the employment of many diffusion and transfer instruments. By controlling tobacco-use internationally, the rates of cigarette consumption have decreased and consequently minimize tobacco-related diseases. Nevertheless, there are still significant obstacles to the effective dissemination of WHO policies in this large group. We note significant efforts related to the control of alcohol consumption and ultra-processed foods to reduce the spread of epidemics of non-communicable diseases.

In the cluster of **Health Systems** we can include every WHO initiative for "Strengthening national policy dialogue to build more robust health policies, strategies and plans" (WHO, 2011). According to the WHO there are three main categories of stakeholders acting in the governance of health systems, which are:" the State; the health service providers (different public and private for and not for profit), the citizen (population representatives, patients' associations, CSOs and NGOs, citizens associations protecting the poor, etc.) who become service users when they interact with health service providers" [25]. At a first glance we consider that the mechanisms of discursive dissemination and standard setting tend to be usually applied. Moreover, considering the action of multi-stakeholders, this cluster perhaps employ the mechanism of open spaces for dialogue.

As an example, we also included in this large group of WHO policies the area of water, sanitation, and hygiene (WASH). This large group deals with themes related to the environment and is an issue of health systems. According to the WHO, "safe WASH is not only a prerequisite to health but contributions to livelihoods, school attendance and dignity

[23] To Know more about Neglected diseases see also:https://www.who.int/teams/control-of-neglected-tropical-diseases Last access: Jan/ 2021

[24] WHO has included neglected diseases (NTD) in the same group as communicable diseases (CDS). Due to the absence of conflicts of interests the NTD and CDS could also be consider in different clusters, although we kept the WHO budget allocation

[25] <https://www.who.int/health-topics/health-systems-governance#tab=tab_1>

and helps to create resilient communities living in healthy environments" (WHO, 2021)[26] . The WASH deals with environmental problems as chemical contamination, quality of water to be consumed, and diseases that can proliferate due to the lack of sanitation, such as vectors of neglected diseases, cholera, schistosomiasis, and diarrhea, for example. This agenda can be associated with poor and developing countries due to the lack of adequate sanitary conditions for the population. As reported by WHO, in response to the 2019 WHA resolution on WASH, we identified that 86% of countries "have updated and are implementing standards and 60% are working to incrementally improve infrastructure and operation and maintenance of WASH services" (WHO, 2021)[27]. Thus, this cluster also employs a variety of diffusion and transfer mechanisms to translate the WHO regulations for country levels.

The cluster of **WHO Health Emergencies** is an initiative that seeks to anticipate risk situations and crises related to global health. The program develops a structure that assist countries to prevent, detect, predict and respond promptly to emergencies, "in a more predictable, dependable and accountable way (WHO, 2016; JAKAB; ORGANIZATION et al., 2018). The program deals with different emergencies, such as disease outbreaks, conflicts, and natural disasters that could generate harmful effects for people, economies, and society. As examples, we could mention the Syrian humanitarian crisis, the outbreaks of Ebola in Africa, the Zika virus disease in the Americas, the Middle East respiratory syndrome at the Arabian peninsula, and the Covid-19 pandemic, which achieved global proportions. The mechanism developed by the WHO to deal with emergencies is the International Health Regulations (IHR), which is in charge of guiding countries for achieving common approaches and potential patterns. The regional offices are important actors in this program and can investigate and mapping hazards and vulnerabilities across each WHO Region (ibidem). Regarding the features of this program, we considered that the mechanism regularly employed to this cluster are the discursive dissemination, the standard setting, the technical assistance. In some extent, the cluster use the mechanism of coordinative functions, considering the fact that IHR can foster initiatives to create develop capacity standards and monitor the countries. Similarly, the financial resources can perhaps be applied when the emergency is detected to manage the outbreak or the emergency. Lastly, perhaps the spaces for dialogue become less employed in this cluster, considering that an emergency can occur suddenly, not allowing multi-stakeholders to articulate reasonably.

Based on our categorization concerning the type of WHO policy and diffusion and transfer mechanisms, we aim to highlight that WHO deals with a multiplicity of themes. Therefore, the instruments may vary depending on the cluster, the complexity, and interests involved. With these questions, we emphasize that in this research, we will use the non-communicable diseases sector due to the fact it deals with overly complex policies, a wide variety of conflicts of interest, and has used many instruments of diffusion and transfer.

[26] Source: https://www.who.int/health-topics/water-sanitation-and-hygiene-wash Last Access: Jan/2021
[27] Source: https://www.who.int/publications/i/item/9789240017542 Jan/2021

2.3.3.1 IOs, policy transfer and diffusion: lenses of analysis

We consider that international organizations can assume different ways to transfer or diffuse their policies. The internal structure that makes up the decision-making process can influence the dynamics of this process. In this research, we adopt the World Health Organization as a case of interest and assume that it is a global policy authority since the policies transferred are an outcome of political negotiations among member states. As a consequence, the features identified by the WHO transfer can not be replicated to all IOs. This analysis can contribute to enlightening the process of transfer and diffusion of global health policies, or perhaps could assist in understanding the process of transfer and diffusion in IOs with similar structures and decision-making processes.

Global public policy is broadly used; however, the term does not have a unique definition among researchers. It refers to transnational spaces and new forms of authority able to produce new policies [28]. As studied by Stone (2008), public policy has been a prisoner of the word state"(STONE, 2008, p.1). It means that globalization changes the process and nature of developing policies. While states were accustomed to dealing with what was purely domestic, through globalization, the nation-state needs to deal with global issues (STONE, 2008).

As will be discussed throughout this thesis, health problems transcend state boundaries. Health, while a global policy highlights the impact of international flows of citizens, the globalization of diseases and brings a new awareness towards health and invisible menaces. Concerning the theoretical and methodological implications of using the concept, we consider that health as a global policy brings plenty of actors to play in the international arena. In this manner, it overcomes the methodological nationalism usually employed in public policy research and studies of international relations that uses realism as a theoretical approach (FRANCO-GIRALDO; ÁLVAREZ-DARDET, 2009; STONE, 2008).

Regarding the theoretical approach, different lenses of analysis could explain the diffusion or transfer in the World Health Organization: the *rationalist*, the *constructivist*, and the *sociological institutionalist* approach. From the rationalistic lens, we consider that incorporating new actors, as non-state actors, in the decision-making process's arrangement can be seen as a rational calculation strategy. The cost-benefit of these actors brings more significant gains when compared to their absence.

However, in observing the creation of spaces for dialogue and the approximation with civil society, we recognize the importance of language and the social construction of new signs and symbols through interaction with new actors, as proposed by the constructivist side.

Concerned to the sociological institutionalist perspective, we understand that:

> "The idea of global policy development and the constitution of an international policy field is based on sociological institutionalism and its idea of a world society. As sociological institutionalists have emphasized, the development of political and social ideas is not necessarily bound to

[28] See also.[25]stone2008global

> national paths; rather, they are shared worldwide (for example Meyer et al. 1997a, b; (JAKOBI, 2009, p.8)."

Despite the sociological institutional view that considers the sharing of values from a global perspective, there is a certain skepticism in diffusion studies in accepting diffusion as the simplistic adoption of global ideas and norms. Differently, scholars like Strang; Meyer 1994, p. 103; Jakobi, 2009, p. 9, consider that diffusion can be understood as a process of build identity and representation. In this sense, we believe that choosing a theoretical approach throughout the work would simplify the theoretical lens since, under each context, the pertinence of the theoretical approach's use can variate.

2.4 CONCLUSIONS

This theoretical chapter is a first effort to explain how an international organization such as WHO can transfer or disseminate policies to its members, such as Brazil. In this chapter, we restrict the theoretical chapter to the study of international organizations and public policies. There are still gaps in both kinds of literature regarding how the IOs disseminate their programs to their members. While international policy literature has focused its research on IO decision making, public policy literature focuses on formulating and implementing policy at the national level.

Some scholars, like Marsh; Sharman; Faria, have been working to understand this process of importing ideas and programs from one place to another. It is noteworthy that a large part of the researchers' analysis referred to the shift of policy from one state to another and, therefore, the diffusion to several others. Studies in which international organizations are the places of diffusion or transfer are still scarce.

In summary, we seek to emphasize the relationship of IOs with States throughout the Principal-Agent model and the strategy of IOs to increase their effectiveness on the international stage through the multi-stakeholder orchestration, as studied in the O-I-T model. We understand that WHO orchestrates many actors to expand its scope of global action. Orchestration is understood as a form of indirect governance in which multiple actors and non-state actors bring demands and solutions to deal with global health agendas' diversity.

Indirect governance can favor the transfer and diffusion of WHO policies. As presented in the chapter, IOs can use strategies and mechanisms to export its policies to the country level. From the literature review built, we agree with Jakobi (2009) and Carvalho; Fernandes; Faria (2021) that there are at least six instruments of diffusion and transfer, namely: discursive dissemination, standard setting, coordinative functions, financial means, technical assistance and opening spaces for dialogues. International organizations can use one or more mechanisms to export their best practices. Additionally, variables such as the

area of expertise and bureaucratic structure of an IO can influence the type of mechanism used.

When analyzing the WHO, we identified at least four policy clusters, so-called communicable diseases, non-communicable diseases, neglected diseases, water, sanitation, and hygiene issues. We seek to hypothetically outline which mechanisms would be used by each cluster based on the degree of complexity and divergence of interests existing towards policy clusters. In the end, we justified our choice to investigate a case by the cluster of non-communicable diseases, which deals with interests from different origins, such as public health, trade, marketing. As we have identified, the case of tobacco is an agenda of the non-communicable diseases cluster. It is an emblematic case given its diffusion to a wide range of WHO members. For this reason, we use this case as a model to apply the hypothetical-deductive mechanisms identified in this literature review.

3 WHEN AND WHY POLICIES TRAVEL FROM THE GLOBAL TO THE DOMESTIC LEVEL: STRATEGIES FOR ANALYSIS

As investigated, many studies related to global health and health in international relations apply qualitative methods to develop the research. The main reason to use qualitative strategies in global health studies is associated with the multi-dimensions that could be analysed in international health studies, as such, politic issues, economic, social, culture besides sanitarian issues. Hence, qualitative studies seems to be the best method to understand and capt plenty variables involved in this phenomena. Nevertheless, we considered the fact to use relational analysis as from the study of network analysis to explain, how a good network can enhance global heath transfer for one country.

Considering this fact our research will be predominantly qualitative but we also use the relational analysis to understand the policy transfer. Thus, this research will be composed of different methods. First, the review of the literature to construct a model of analysis that can be able to explain how the IOs works and what factors encourages the transfer of policies from the World Health Organization to Brazil. Our review of literature put in together two different approaches: the International Organizations theory, and the Policy Transfer/ policy diffusion theory.

In summary words, in this section, we will justify our choice to apply the case study method; our research design and the framework of variables we are considering in this work. Sequentially, we wish to justify the importance of interviews, the kind of actors reached, and the challenges this work faced. Also, we will discuss the main purpose of using the documental analysis and a briefly discussion towards the network analysis for this thesis.

3.1 THE IMPORTANCE OF THE CASE STUDY METHOD

This thesis's case study has characteristics such as a small N case study in which we predominantly use the qualitative methodology. We sought to apply a holistic and comprehensive look at the transfer of public policies from WHO to Brazil. We use multiple sources of evidence and triangulate the information collected through information, documents, and an empirical review of what has been generated about the study phenomenon.

Each case can provide single or multiple observations, and once multidimensions could be inquired. The researcher can make different observations to each dimension, measured from the study's analysis (GERRING, 2007). To evaluate our case, we use three dimensions: first, the contextual dimension, which refers to the global political context; second, the organizational dimension is related to WHO. Third, the domestic dimension, which is related to the national level.

In this thesis, our *phenomenon of analysis* is the transfer of global policies from WHO to Brazil. The WHO was chosen as a case study due to the strategies established to expand

its performance globally. As previously investigated, whenever creating spaces for non-state actors, the WHO seems to enhance the effective transfer/diffusion of policies.

In respect to the adoption of Brasil as a case within WHO members, we justify our choice by the country's outstanding performance throughout the history of WHO, and its prominent role on global health governance, as studied in Chapter 5. To understand the dynamics of the transfer and capture the variables involved in this process, we work with two within-cases: the Tobacco Control Policy; and the Control Policy for ultra-processed foods.

Concerning the selection of the WHO policy, we interviewed WHO actors or those involved in global health governance and asked the interviewee if there were any WHO policies that he/she considered successful in transferring to members of the organization. The Tobacco Control policy appeared in several interviews carried out as an emblematic case within the WHO. Otherwise, the case of ultra-processed foods, sugar control, alcohol control, obesity appeared in the interviews as a counter case. As analyzed in the interviews, the lessons learned from the transfer of tobacco can be valuable and contribute to creating a policy capable of regulating the consumption of ultra-processed foods and alcohol internationally.

As investigated by Gerring (2007), a single case study can combine two elements such as a more intense and profound case study and a case study that can be undertaken from a more superficial and less systematic analysis. Given this issue, we treat the within-case of controlling the consumption of ultra-processed foods as a shadow case. The case of ultra-processed foods was treated peripherally and less systematically because we did not reach the saturation point on the subject from the sample of respondents. In other words, we are aware that there is much information about this policy that was not captured in our research. For this reason, we treat this second within-case as a shadow case. Despite the limited collection of information on this second case, we understand that we were able to raise valuable information and contribute to the study of the transfer of public policies from WHO to Brazil.

Regarding the time horizon, we consider that our main case and the shadow case are treated in a *diachronic manner*. According to Gerring (2007) there are two possibilities for conducting a case study: the diachronic whenever the case or units vary over time. The synchronic in which it observes the variations in a specific interval. Our observations happen over time. As we have investigated, the case of tobacco is dated to the 1960s. On the other hand, only from the 2000s, we identified discussions about the consumption of ultra-processed foods and the association of consumption of these foods with obesity and chronic non-communicable diseases.

As studied by Gerring (2007), the case study is applied when we have a phenomenon in which the main objective is to generate hypotheses instead of testing them. We started with two guiding hypotheses and a rival hypothesis that were tested for our research, and we seek to raise new hypotheses about the study phenomenon. At the end of the work, we attempt to afford hypotheses based on the scrutiny of *causal mechanisms*. As investigated by Gerring (2007) a mechanism is what explains the relationships established between X and Y.

In Gerring's (2007) words, the causal mechanism is the causal pathway, or connecting thread, between X and Y (GERRING, 2007, p. 73).

3.2 RESEARCH DESIGN

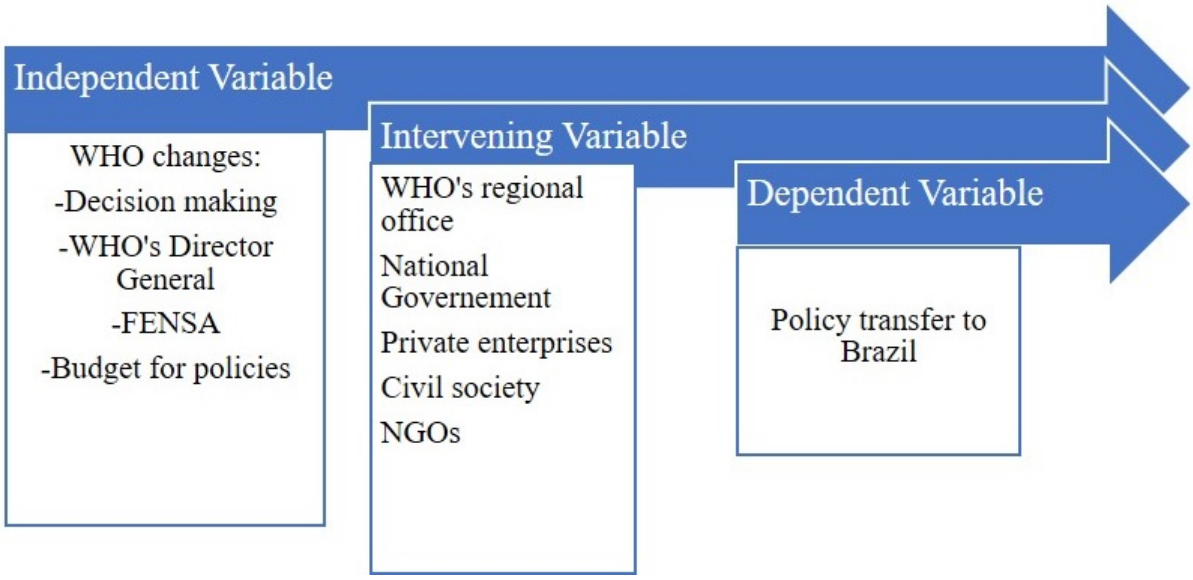
We developed an in-depth review of the literature about the changes in multilateral cooperation at the World Health Organization, the action of non-state actors internationally, and the contributions of non-state actors at the process of policy transfer. To build our model we dialogue with different fields of studies in political science, such as, 1-the international relations, 2-the public policies, more specifically, the transfer of policies; and 3-the action of non-state actors as intermediaries to represent interests, either at the international or domestic level.

The discussion about international relations or international politics is relevant because they provide theoretical arguments to explain *why* and *how* states act through international organizations, and how international organizations create policies. This literature is relevant to reflect on the process of policy-making within IGOs. The literature on public policies could be as relevant as the literature of international politics once it could help us explain the stages of policy-making and could contribute to sustaining our argument of policy transfer or implementation of policies from intergovernmental organizations. In this sense, the literature on public policies can provide important arguments to build our analysis and to identify the characteristics that intermediaries, as such NGOs, civil society, private enterprises- for example, could assume in the process of policy transfer. Moreover, we intend to reflect about the action of non-state actors within intergovernmental organizations, which embodies the discussion of the opening up from international bureaucracies to different actors, as civil society, private enterprises, nonprofit corporations, among others. As follows from the discussion above, our research aims to explain the main features of the World Health Organization policies that are successfully transferred. Can non-state actors contribute to transfer policies from the World Health Organization to the domestic level?

In order to reach answers, we consider Figure 3.1 as research design:

As we have shown in the figure above Figure 3.1, we will work in this research, with three variables, which are the independent variable, the intervening variable, and the dependent variable. The variables in this research are an operational concept. Concerning the definition and identification of them, we consider that the independent is one that influences, determines or affects a result, and we can characterize it as the determining factor, capable of generating some effect on the phenomenon under study (MARCONI; LAKATOS, 2004, p.137). For this research, the determinant factors that may influence the entry of non-state actors at the WHO, and may affect the process of public policies transfer are: institutional changes in different decision-making bodies, policies adopted by the Director General (DG) during his term of office, the political challenges faced by the DG throughout his political leadership. We also

Figure 3.1 – Research design.



Source: Self elaboration.

consider that the budget could affect the phenomenon of inquiring.

We consider the factors listed above as determining factors in the change of institutional dynamics. For this research design, we believe that the greater or lesser participation of non-state actors and the transfer of public policies to Brazil are consequences of institutional changes and budgetary constraints, and for this reason, will be the dependent variables for this research. As studied by Lakatos; Marconi; 2003, "The dependent variable (Y) consists of factors that are influenced, determined or affected by the independent variable (MARCONI; LAKATOS, 2004, p.137)."

Besides the institutional changes and availability of resources in the budget, we consider that other factors could affect the performance of non-state actors and the transfer of policies to Brazil. These factors between the independent variable (X) and the dependent variable (Y), are characterized as intervening variables. For this research, the intervening variables will be: the regional dynamics of WHO, based on the Pan American Health Organization (PAHO); the performance of the national government, an institution that has sovereignty to decide on the transfer of policies; agreements with national private companies; the support of non-governmental organizations in the transmission of a program to domestic levels. Is important to highlight that NGOs and non-state actors will not necessarily be the same ones at the local Brazilian level and the decision-making process in WHO.

3.3 THE IMPORTANCE AND THE CHALLENGE OF INTERVIEWING EXPERTS AT THE WHO

Interviews are a valuable tool for the execution of this study. However, they are, at the same time, a challenging strategy to be employed in several situations. As an example, could be hard to interview staff without previous information of their area of expertise. Thus,

to conduct interviews in a place not familiar to the researcher, with restricted access could be very challenging.

The interviews allow us to build a social relationship that involves the researcher in immediate and interpersonal contact with an individual who will be the interviewee (Devin, 2017) . For this research, respondents are mostly experts who provide services to the World Health Organization or are involved in the arrangement of global health governance. In other words, some actors who will be potential respondents for this research may be members of other specialized agencies of the UN system, may work in non-governmental organizations, NGOs, or may be members of foundations or companies that have a close relationship with the WHO. The link that we consider in this context is the joining in forums, and discussions related to global health policies.

Experts, are mostly the focus of the individual for being interviewed, we believe they have a relevant role in international bureaucracies. "International bureaucracies themselves incorporate experts, they shape information, data, and science that suppose their programs, and engage with the knowledge that is circulated by other competing actors. Experts diffuse knowledge underpinning policy action Demortain,2017; (LITTOZ-MONNET, 2017, p.95)". Besides experts, we also receive worthwhile contribution from researchers and diplomats that acts in global health governance.

The research environment can be a differential in the conduct of the interview, and we can consider that each set is endowed with unique properties. Interviews at specialized agencies of the UN system, such as the World Health Organization, maybe a space marked by discretion, or secrecy, where access to confidential information in the decision-making process can become a challenge to the inquiring conducting the research. Although in large part of the interviews attended the respondents were willing to give information, in some cases the use of the post-interview speech was questioned. Some respondents did not answer some questions by the fact of entering to the confidential matters of the institution. Concerning confidentiality within an international organization we will treat "secrecy" as a type of information since some data couldn't be available to be collected.

Beyond the secret, power asymmetry is another in international fieldwork conducted at an international organization. The place of interview, WHO, and the type of respondent, a highly trained expert within an international organization, reveals a dual externality of power between researcher and interviewee. The "externality of power" is reinforced when it is desired to conduct interviews within the institution. Acquiring permission to enter to the WHO to conduct an interview, requires a request for access permission, a characteristic that reinforces the insertion of the researcher in a "foreign" and restricted space and can signal difficulties in access information (DEVIN, 2016).

Restricted access to international organizations, combined with the full agenda of experts, suggests that the interviews be made more flexible and the latter guided by a semi-directive method. In many cases, due to the interviewee's agenda, the discussion

becomes possible during the time of a meal, a coffee, or on the way back to work or home. In this type of context, the semi-directive method, which consists of a more flexible adaptation of the questionnaire, may be recommended, with some key questions to be asked to reach the information more directly and objectively from the discussion with the interviewee. In addition to the semi-directive method of conducting the interviews, the question of respondents' anonymity raised in several cases. For this research, we chose to preserve the identity of the respondents although this was not a requirement made by them (ALLES et al., 2016;(DEVIN, 2016).

3.3.1 The first round of interviews

As mentioned before the main purpose of the first round of interviews, with experts from WHO or actors engaged in global health governance, were to be closer with the object of study and understand how the bureaucracy works in practical terms. As we've shown at the section above, we conducted a semi-directive interview, in which we focused attention in key questions, as we show below:

Table 3.1 – Categories and questions to select a policy within the World Health Organization

Category	Question
1-Issue (prevent or treat)	What is the main goal of this policy?
2-Network (actors involved) Formal Network or informal network	What kind of actors are involved?
	How they interact?
	How the decisions are made? Among those actors of the network or they are directed to the Executive Board to be voted?
	Can non-state actors vote at the Executive Board? How they can affect this policy?
	What are the major actors of this network?
3-Budget	Is the policy financed by the regular budget of WHO?
	Is there any sponsor that assign funds to this policy?
4-Implementation	What difficulties this sector usually faces to implement policies?
	Who is usually included and excluded?
	What factors can contribute to a successful implementation policy?

Source: Self elaboration.

As from the general issues proposed other questions arose from the interviews to conduct the debate and to deepening the study about the World Health Organization. One interesting point to highlight regards in the amount of networks within the WHO and the existence of non-State actors interacting among themselves.

As mentioned, the interviews were important to be closer to the object of study and to refine our hypotheses about the opening up of the WHO and the transfer of, at least, one

global public policy. The interviews were also important to evaluate the action of non-State actors at the process of transfer from the WHO headquarters to Brazil, and to map strategical relations among actors in the process of transferring.

We tried contact with many staff of the WHO and organizations that played in international health arena. Although, we didn't reached all the interviewees intended. We did two rounds of interviews, the first about the WHO; the second about the policy transfer two Brazil. Put in together the both rounds, we interviewed 20 people. The interviews were transcribed *ispis litteris* to be analysed. Some interviewees allowed the record, some not, and we only took notes of the most important parts. During the interviews I explained the main goal of the research and how the data will be used. Many of the interviews were semi-structured, however some respondents preferred to relate their own experience throughout the organization, what was equally valuable for this work. We triangulate the information collected by interviews, with information collected by documental analysis and empirical review.

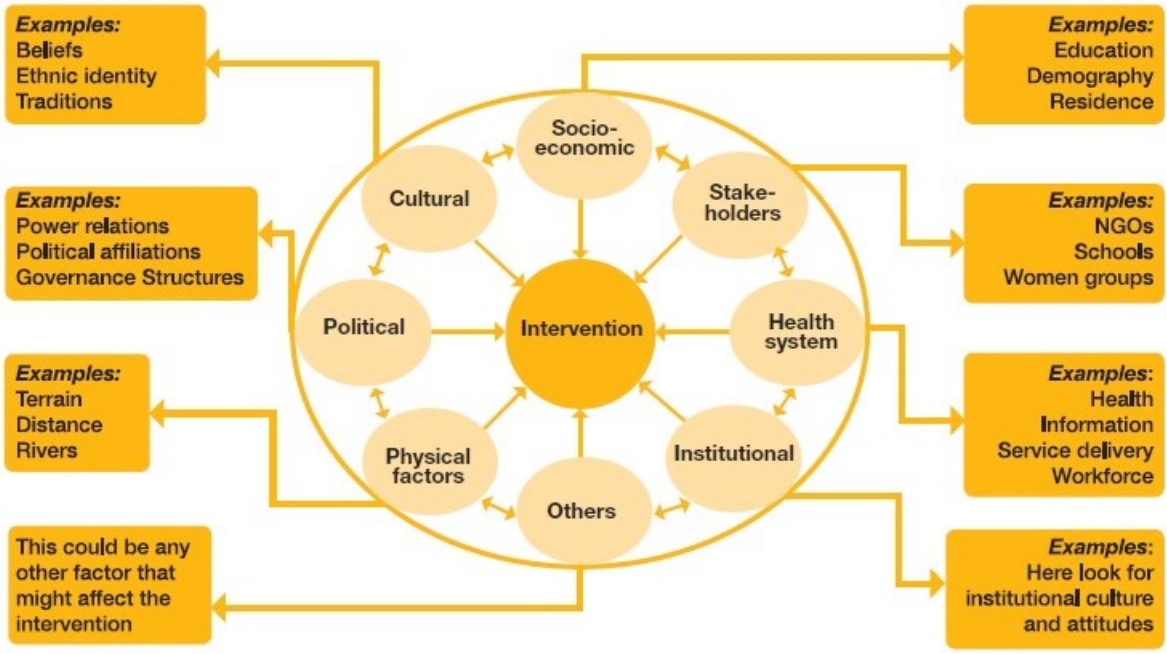
Additionaly, the speech collected by the interview were used as supplementary tool to understand what the documents and the literature were discussing. This effort were an essential stage to build the chapter about the World Health Organization and to identify the action of non-States actors throughout the time.

3.3.2 The second round of interviews

The second round of interviews will be focused on the case selected and the actors involved in them. To develop the second round of interviews I focused on four categories of questions. In other words, the primary goal was to understand what the actors of the network do, how they interact and what factors can contribute to a successful implementation or an unsuccessful implementation. Our case study will be Brazil, and along this second round we intend to interview people intertwined with the transfer of policies from the WHO to Brazil. The first effort was mapping institutions and epistemic communities involved in the transferring of policies and ideas to Brazil. I used the image below, published by the TDR Research and Training for tropical diseases at the WHO, to reflect about traditional factors involved in the process of policy transfer/implementation in one country. Considering this fact, this research develops a single case study, through which we investigate two within cases.

The factors highlighted above are relevant for different reasons. As studied by the World Health Organization (2014) "the factors above are key aspects at the inquire of the research context. Together they contribute and can affect planning, implementation, monitoring and outcomes of any intervention" (ORGANIZATION; UNICEF et al., 2014, p.17). All the factors mentioned must vary from country to country, or from location to location. Despite being a large country with many differences across the geographical territory, for this analysis about policy transfer to Brazil, we aim to understand what changes could be observed in a well succeed policy transfer and factors could be missing in non succeed policy transfer.

Figure 3.2 – Contextual factors for implementation/transfer in one country.



Source: (Toolkit, World Health Organization 2014, p. 16).

Our choice to study the role of stakeholders in transferring is justified with two main arguments: firstly the "opening up" of WHO ton non-States actors- stakeholders, as explained before when Framework of Engagement of non-States actors were discussed. Secondly, the transnational action of stakeholders both at the headquarters, in Geneva, and domestic levels, in our case, in Brazil. One case of brazilian stakeholder with transnational action is Oswaldo Cruz Foundation, FIOCRUZ, that since 2014 have increased its activities internationally. Besides these arguments proposed, our intention to examine stakeholders is reinforced by currently studies published by the WHO. According to the World Health Organization (2014) "the stakeholder analysis is one of the most important activities undertaken by researchers in terms of understanding the context of the intervention, and should be done in a systematic and comprehensive way" (ORGANIZATION; UNICEF et al., 2014, p.20).

3.4 THE IMPORTANCE OF THE DOCUMENTAL ANALYSIS FOR THIS WORK

The documental analysis techniques were relevant for this work to identify when and why the World Health Organization began to incorporate changes within the bureaucratic structure to allow non-state actors' action. According to experts from WHO, the collaboration with non-state actors through *formal* agreements is a relatively new process and could be dated from years 2000s. Nevertheless, few academic papers systematize what conditions favored the opening up of WHO to non-state actors and the main reasons that could explain the creation of the Framework of Engagement of non-State actors (FENSA) in 2016.

Our documental analysis applied most and foremost to understand the historical and

political changes that could explain the FENSA creation, as discussed in chapter 4. In this sense, the process tracing method was a valuable tool to investigate the FENSA creation and the policy transfer to Brazil. To understand "Process tracing we can define it as a method that uses particular observations from within specific cases. It is, fundamentally, a case-based methodology that can be applied successfully only with good knowledge of individual cases (Mahoney, 2010, p.12)".In general, process tracing is a method related to the construction, identification, and contextualization of causal mechanisms, which seeks to connect actions in order to establish cause and result in relationships and can be valuable in the comprehension of explanatory factors of a phenomenon (Bezes, Palier, and Surel 2018, p. 3). Through the process tracing method, we intend to reconstitute actions that occurred at different times, and that may help in the explanation of a phenomenon.

Our primary purpose was to inquire about conditions that allowed creating the framework of engagement. In this manner, chapter 4 shows the results of our efforts to apply documental analysis. Nonetheless, we highlight that we used documents as a source of evidence to build other chapters of this thesis, although not as the essential method.

Our documental analysis sought to identify and contextualize causal mechanisms in WHO history. At first glance, our phenomenon of interest was to understand why the non-state actors began to act through the framework of engagement of non-state actors, FENSA. Historically, the non-state actors always had a significant role within the WHO; however, only in 2016, FENSA was consolidated. As the literature highlights, the process-tracing method could uphold to identify historical factors and landmarks that led to the institutionalization of such engagement.

The documental analysis were conducted as following: 1- we accessed the WHO documents available at Institutional Repository for Information Sharing, IRIS, from the world library of World Health Organization. To find the documents we accessed: www.who.int/iris and select the browse Communities; Collections. All the searches were made in English, the official language to publish WHO documents.

After selecting the entry "Communities; Collections" we selected the icon Headquarters. At this option were possible to find documents published by the most important decision-making bodies, which are, the World Health Assembly and the Executive Body. The World Health Assembly, WHA is the decision-making body composed by representatives of all the member states, 194. According to Kickbush, (2015, p. 175) the WHA is the most powerful decision-making body at the WHO. At the WHA they can vote to consolidate policies and programmes. The documents published by the WHA are usually nominated as WHA, or A.

The second decision-making body that makes relevant documents is the Executive Board. The Executive Board is compounded by 34 members elected by the plenary of the World Health Assembly. The leading criteria to fulfill a chair is technical skills in the health domains. Either the WHA or its Executive Board produce relevant documents that describe what the member states agreed upon at the meetings. Plenty of documents can be found in the

IRIS database. To refine the search we focused our attention on reports made by the Director General (DGs) at the World Health Assembly and at the Executive Board, that are related to the engagement of non-state actors. It is noteworthy that the General Director is elected by the World Health Assembly and is appointed to oversee the World Health Organization by Executive Council. In other words, the Director General is the highest administrative functionary within the WHO. To analyze the reports made by the Director General at different institutional decision-making bodies could provide a rich source of information.

To access the documents related to the engagement of non-State actors we made a search with the keyword "non-State actors". In association with this keyword we identified plenty of documents associated with the WHO Reform. With this search we identified three hundred sixty-six (366) documents that could be associated with engagement of non-state actors at the World Health Organization. Among them different types of documents were found, nonetheless we restricted our analysis to: 1- documents and reports published by the WHA ou EB that explicitly refers to WHO reforms and non-state actors 2- the documents related to the framework of engagement of non-state actors (FENSA), in which we explicitly found in the title the keywords "engagement of non-state actors". Furthermore, the interviews and empirical literature help as to refine our documental selection.

The documents correlated to WHO reform were a crucial source of evidence to explain the opening up of the WHO to non-state actors, and for this reason they were considered during this documental analysis. The documents were organized as follows:

3.4.1 Categories of analysis

To develop our documental analysis we used the software Atlas.ti and we create some code of analysis. Due to the frequency in which they appeared in the documents, we consider the codes below as our analysis's main categories.

- *WHO Reform*- This code refers to the mechanisms developed at the WHO to strengthening transparency, accountability, increase the financing sources, and increase stakeholders' participation.

- *New Governance*- This code was used to identify excerpts through which we could evidence that WHO could develop a leading role in health, enabling different actors' effective engagement.

- *Improve Financing*- This code reflects the WHO intention to overcome financial constraints and the strategies employed to become more robust and more effective. Moreover, it refers to creating new financing channels, especially for non-communicable diseases, maternal and child health, and health systems.

Table 3.2 – Documents selected to this documental analysis.

Decision-making body	Kind of the Document	Name of the Document	Title of Document	Date
World Health Assembly (WHA)	Report by the Secretariat	A63/25	Strengthening the capacity of governments to constructively engage the private sector in providing essential health care services	2010
	Report by the Secretariat	A67/6	Framework of engagement with non-State actors	2014
	Report by the Director General	A68/5	Framework of engagement with non-State actors	2015
	Report by the Director General	A69/5	Framework of engagement with non-State actors	2016
	Report by the Director General	A70/52	Engagement with non-State actors	2017
	Report by the Secretariat	A70/53	Engagement with non-State actors criteria and principles for secondments from nongovernmental organizations, philanthropic organizations and academic institutions	2017

Source: Self elaboration.

- *Engagement of actors* - This category relates to discussions in which the main focus was to expand stakeholder participation in WHO. This code attempted to capture in which contexts and under what reasons the engagement of actors was discussed.

Subsequently, we show a graphic with all the categories employed to develop our analysis. As demonstrated by the figure Magnitude of codes in the document, the main features associated with creating FENSA reflect the needs of WHO Reforms, the calling for a New Governance, and the necessity to Improve financing in the institution.

As observed through the figure Magnitude of codes in the documents, the Diffusion of policies to regional levels appears as a meaningful code. This code leads us to consider an outstanding one associated with the WHO's policy transfer and policy diffusion. We hypothesize from the documents analyzed that besides improving financing, governance, and human resources, as WHO staff, the IO sought to enhance the transfer/Diffusion of norms and policies towards its members when allowing the engagement of plenty of actors in WHO

Table 3.3 – Documents selected to this documental analysis.

Decision-making body	Kind of the Document	Name of the Document	Title of Document	Date
Executive Board	Report by the Director General	EB132/5 Add.2	Key issues for the development of a policy on engagement with nongovernmental organizations	2013
	Report by the Secretariat	EB134/8	Framework of engagement with non-State actors	2014
	Report by the Director General	EB136/5	Framework of engagement with non-State actors	2014
	Report by the Director General	EB138	Framework of engagement with non-State actors	2016
	Report by the Director General	EB140/41	Engagement with non-State actors	2016
	Report by the Secretariat	EB140/47	Human resources: update Criteria and principles for secondments from nongovernmental organizations, philanthropic foundations and academic institutions	2016
	Report by the Secretariat	EB142/28	Engagement with non-State actors	2017
	Report by the Secretariat	EB142/29	Engagement with non-State actors Non-State actors in official relationships within the WHO	2017

Source: Self elaboration.

policies [29].

3.4.1.1 The use of Biographies as a source of evidence

Another crucial source of evidence were the biography of Directors General. To access the biographies of Directors General at WHO we accessed the IO BIO: Biographical Dictionary SGs IOs a project conducted by professor Bob Reinalda (www.ru.nl/fm/iobio). The main reasons to use the biographies were: 1- the contents could furnish explanations about the decisions express at the reports analyzed; 2- the contents could provide source of

[29] At the figure Magnitude of codes in the documents we did not use the categories Participation of Women and Specific Provisions. They were recognized as codes at the end of the analysis

Table 3.4 – Documents intertwined to WHO reforms.

Decision-making body	Kind of the Document	Name of the Document	Title of Document	Date
Executive Board	Report by the Director General	EBSS2/2	WHO reforms for a healthy future	2011
	Report by the Director General	EBSS2/2 INFO.DOC./4	WHO reform	2011
	Report by the Secretariat	EB133/16	WHO governance reform	2013
	Report by the Secretariat	EB134/5	WHO reform: reform implementation plan and report	2014
	Report by the Secretariat	EB136/7	WHO reform: overview of reform implementation	2014
	Report by the Secretariat	EB138/6	Member states consultative process on governance reform	2015
World Health Assembly	Report by the Director General	EBSS2/2	WHO reforms for a healthy future	2013
	Financing of WHO	A66/48	WHO reform	2014
	Report by the Director General	A67/4	WHO reform Progress report on reform implementation	2015
	Report by the Director General	A68/4	WHO reform: overview of reform implementation	2017
	Report of the committee of the Executive Board	A70/64	Overview of WHO reform implementation	2014

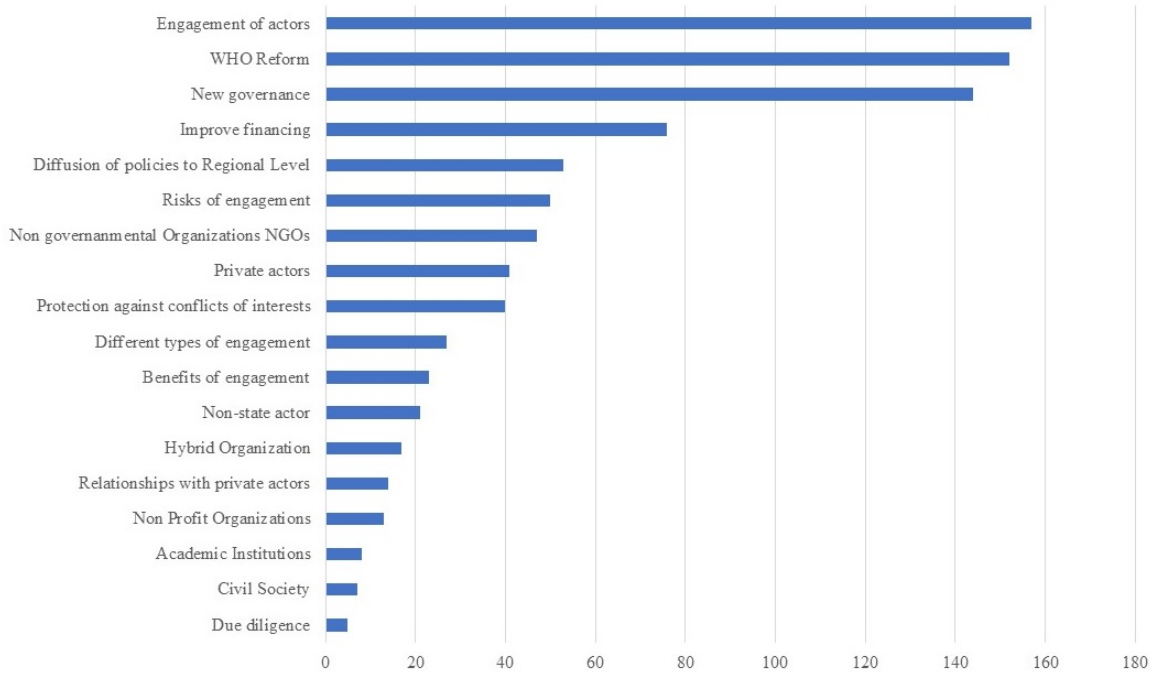
Source: Self elaboration.

information about the opening up of the institution to non-State actors and explained the institutionalization of the engagement as a framework.

3.5 THE NETWORK ANALYSIS

The network analysis is a valuable method for this research and were used for identifying and mapping actors and institutions involved in the process of policy transfer of global public health policy. It is noteworthy that when referring to the networks, we consider a variety of actors such as NGOs, Think Tanks, epistemic communities, among others, that share common interests and articulate in an interdependent way in the international arena. From this perspective, the actors who make up the networks act in a transnational way, since the common objectives shared by them go beyond the borders of the states. According to Borzel, 1997, p.1; FARIA, p.281 networks can be defined as "a relatively stable set of non-hierarchical and interdependent relationships that articulate a variety of actors who have

Figure 3.3 – Magnitude of codes in the documents



Source: Self elaborated as from data generated by Atlas.ti

common interests about a public policy and who share resources, seeking to achieve these common goals, recognizing that cooperation is the best way to achieve collective goals"BORZEL, 1997;(FARIA, 2018, p.81).

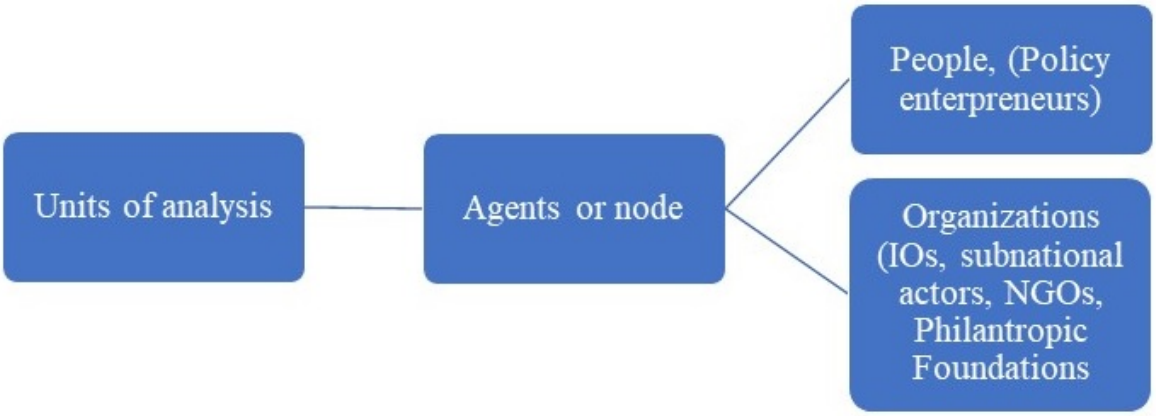
We define the network analysis in this research as the interaction among social actors; therefore, relational analysis often analyzes how actors, organizations, states or international alliances interacts with themselves. The social network analysis tries to understand how the established social bonds between the actors can be relevant to explain the decision making of an actor or an institution. Analysts of the social network often enough seek to explain the types of interaction patterns among actors.

The literature considers the network analysis an intuitive approach (FREEMAN, 2004). For building this study, we shall use comprehensive data, which is defined as the researcher's understanding of the relationship patterns established between the actors. This type of data is characterized by scholars such as Marsden, 2005; Marques, 2010, as *cognitive data*. We recognize, nevertheless, that this type of data may present bias in the analysis, proposing different ways of understanding in the interaction and at the structure of relationships between the actors of the same network. Although, it is essential to highlight that the network research demonstrates that relationships are relevant and have the potential to induce decision making or generate effects among different actors (MARQUES, 2010).

In a summary way, the main features of the social network analysis, according to Freeman, 2004, are:

> "1. Social network analysis is motivated by a structural intuition based on ties linking social actors, 2. It is grounded in systematic empirical data,

Figure 3.4 – Unit of relational analysis



Source: Self elaboration

> 3. It draws heavily on graphic imagery, and 4. It relies on the use of mathematical and/or computational models" (FREEMAN, 2004, p.16).

For this study, we triangulate the data collected from interviews, document and empirical literature to build up an understanding of patterns relations. In this study, the actors can, therefore, be individuals linked to the World Health Organization or the global health network. From this perspective we worked with networks of thematic communities, that is, communities created around specific issues or themes, characterized by involving individuals in a given context or process. In this discussion, the epistemic communities as studied by Hass, 1992, can introduce new themes and discussions. Epistemic communities knows a lot about a specific area and can propose suitable alternatives in certain fields of knowledge (HAAS, 1992).

Hass's (1992) argument is relevant to understand the dynamics that conform in international politics, due to the interaction of different actors and the plurality of themes at the global level. The argument of epistemic communities will also be valuable in understanding the performance of non-state actors within global health networks.

To operationalize the network analysis, we worked with Gephi software. Gephi was used to develop the computational analyzes and the network's graphic systematization. After collecting data and creating the topology, we identified a relatively small network that pointed to individual actors and specific organizations active in global health governance, as shown in the Figure Unit of analysis of the Relational Structure of the Case Study. As we highlighted earlier, we work with networks of thematic communities. We established a thematic network for tobacco and a network for the case of ultra-processed foods. However, it is only in the case of smoking control that we could highlight the importance of influential actors acting in transferring.

Hence, we emphasize that our study adopted agents or nodes as the unit of analysis, underlining the role of people who distinguished as policy entrepreneurs along the process of policy transfer. Likewise, we note the importance of national and international organizations

working in health to transfer tobacco control policy to Brazil.

In the study of networks, we could employ several measures to explain or understand the phenomenon. Given our objective to recognize stakeholders involved in the policy transfer and the ambition of understanding the network performance, we work with centrality. The measure of centrality or prestige seeks to build a ranking of the actors' importance into the network and identify leading actors able to enhance strategic relationships within the network structure (HIGGINGS, RIBEIRO, 2018). As previously indicated, we structured our network based on the triangulation of information collected through interviews, documents, and empirical review. Each source upholds us to recognize the power and influence of agents towards the network structure. The centrality measure has nuances such as the centrality of degree, proximity (closeness), intermediation (betweenness), degree of prestige.

For our analysis, the centrality of the degree and the degree of prestige are relevant. These centrality measures allow us to create the ranking among agents to understand which actors are more active. Otherwise, if the "formation of networks depends on a few actors active and prestigious or there is a balanced distribution of the number of relationships between the nodes" (HIGGINGS, RIBEIRO, 2018, p. 114).

Concerning the network features, we describe our structure as a two-mode, oriented, and multiplexed network. Two-mode networks commonly present two types of identities, in which the nature of the nodes is different. It means that two-mode networks analyze relationships between people, organizations, or aggregated collectives such as communities, municipalities, States, etc. Connections can occur voluntarily, to either transfer material resources or non-material resources ((HIGGINGS, RIBEIRO, 2018). We recognize that WHO is a normative organization, and relationships aim to transfer norms and ideas to the member countries. The network is oriented once there is no reciprocity between the actors', establishing a hierarchical relationship. Finally, our network is multiplexed, given the fact it involves personal and organizational characteristics.

We justify using network analysis to study the transfer/diffusion or even implementation of global health policies in Brazil for all the reasons mentioned above. We have worked to identify bridge-type relations between non-state actors and the WHO, which are capable of connecting actors and ideas from the international policy to Brazilian policies.

3.6 CONCLUSIONS

The chapter above sought to outline the strategies adopted for the investigation of this thesis. The main objective is to understand which mechanisms and strategies can favor the transfer of at least one WHO policy to Brazil. Considering this issue, we highlight the importance of the case study for this work and analyze it in multiple dimensions. As discussed, issues related to global health can scarcely be captured from a quantitative perspective.

Generally, but not only, a holistic and comprehensive view, capable of capturing the

variants of the political process, can better justify the performance of the actors involved and the performance of the international organization under study. Due to this fact, we have chosen to use a small n case study, whose research strategies were mostly qualitative. We adopted a case study considered emblematic in the literature and used a sub-case with similar features whose transfer was not considered successful.

To make the operational analysis, we seek to list independent variables of the transferring, or factors capable of explaining our dependent variable: the transfer or diffusion of global policy to the country level, in our case, to Brazil. We have mobilized the concepts of transfer/diffusion of policies applied to the international organizations, especially, to the WHO. Nevertheless, during the interviews with experts and diplomats from the WHO, they demonstrate skepticism toward the use of those terms. According to them the WHO do not transfer policies throughout other countries. Every state is sovereign and can decide whether a plan will be imported to the country. Although, we believe that some factors can affect decisions, as we have discussed in the section of network analysis. Some patterns and relations can create strong ties, encouraging the actors to adopt global health policies. Despite being criticized by the respondents, we believe that International Organizations can create mechanisms to reach country levels, and for this reason, we are using the term transfer and diffusion of policies, as it has been studied in the literature.

Although it uses the term transfer/diffusion of global policies, the International Organization's work seems to act as a catalyst for the process. If IOs do not transfer policies as respondents have told us, they catalyze a process, globalize political discussions, and ways in which each member has been solving their domestic problems. In this sense, good examples or best practices become policies that can be emulated by other members.

We use interviews, documents, and empirical reviews as sources to collect qualitative data and build evidence. We refined the information through the documentary analysis by creating codes that helped us in the analysis. We triangulate the information delivered by human resources through interviews, with documents and literature produced on the subject. We use network analysis to systematize the information produced and demonstrate the importance of a reliable network and connected actors concerning the process of transferring.

Table 3.5 – Codes documental analysis, part I.

Code	Description
Academic Institutions	This code includes discussions that sought to regulate the participation of academic institutions.
Benefits of engagement	This code embody a variety of discussions in which we could see how the IO could benefit itself from the engagement of external stakeholders.
Civil Society	This code sought to investigate the reasons that motivate to strengthen formal partnerships with civil society in order to generate mutual benefits.
The different types of engagement	This code sought to identify that every engagement reflect an underline interest. Whether the interest of the non-State actor vary the type of engagement will assume a different form.
Diffusion of policies Regional Level	This code reflects discussion in which become evident the importance of non-State actors collaboration with WHO to expand networks and best practices to regional level and country level.
Due diligence	This code was identified in the document as an essential step before the engagement. The main function is to clarify the nature and the purpose of engagement, and the real interests underlining the joining of the actors.
Engagement of actors	This code attempted to capture in which contexts and under what reasons the engagement of actors was discussed.
Improving financing	This code reflects the WHO intention to overcome financial constrains and the strategies employed to become stronger and more effective. Moreover, refers to creating new financing channels, especially for areas dealing with non-communicable diseases, maternal and child health, and health systems.
New governance	This code was used to identify excerpts through which we could evidence that WHO could develop a leading role in health, enabling different actors' effective engagement.
Non Governmental Organizations NGO's	The code sought to identify NGOs' importance in bringing emergency health demands to WHO and enhancing public health responses at the country level.
Non Profit Organizations	This code sought to highlight that actors can be guided by public health or commercial interests. Non Profit organizations are mainly motivated by public health interests and have been strengthening healthcare provision worldwide.
Non-state actor	This code refers to multiple players addressing different health problems and creating health governance. "Non-State actors are entities that do not belong organically to any State institution, that participate or act in international and national relations, and that have the power to influence and cause change" (EB133/16, 2016, p.2).

Source: Self elaboration.

Table 3.6 – Codes documental analysis, part II.

Code	Description
Hybrid Organizations	The code sought to identify discussions of endorsements of public and private partnerships'. Hybrid organizations, such as GAVI, are bodies in which state and non-state actors play the same role in health governance.
Participation of Women	This code was identified as an essential agenda for improving WHO management performance. In the 1990s, a committee sought to discuss strategies to strengthen women's participation at the various levels and positions of the institution. Although it is not the main focus of the research, we highlight it because of its association with the discussion on WHO reform.
Private actors	This code emphasizing the importance in establishing cooperation with private actors and private suppliers of health care services.
Protection against conflicts of interests	This code reflects the WHO intention to protect both the IO and the health policy development against vested interests as from the interaction with external stakeholders. The interest can be perceived or potential.
Relationships with private commercial	This code refers to private providers and alerts on the caution required to accept a financial contribution from the private sector that could have commercial interests.
Risks of engagement	This code refers to the risk assessment or risk management of engagement when the engagement with the private actors or any other non-State actor does not act in line with the WHO policies and could prejudice the institution (WHA69.10, p. 13).
Specific Provisions	The code refers to the WHO forbiddance in cooperating or establish any partnership with the tobacco industry and the arms industry or non-state actors that defend these industries' interests.
WHO Reform	This code refers to the mechanisms developed at the WHO to strengthening transparency, accountability, increase the financing sources, and increase stakeholders' participation.

Source: Self elaboration.

4 THE WORLD HEALTH ORGANIZATION AND GLOBAL HEALTH GOVERNANCE

4.1 INTRODUCTION

The chapter that begins has the main objective of discussing the World Health Organization, WHO, and the complex multilateral dynamics to which it is inserted. The participation of different actors such as States, other international organizations, and different non-state actors as private actors, civil society, and non-governmental organizations, characterizes the complexity of global health regime.

As presented at the beginning of the thesis, after having identified a complex health regime, one of the thesis proposals is to seek an explanation for WHO's creation of the Framework of Engagement of non-States actors. As translated by the question proposed: What reasons encouraged the WHO to include non-State actors into its organizational design, on a systematic basis? Thus, the chapter sought historical and contemporary evidence that may have led to the consolidation of the so-called FENSA. WHO is part of a dynamic composed of several actors and multi-stakeholders, recognized by the literature as Global Health Governance, GHG. Despite not having a consensus in the literature, this chapter initially discusses a possible GHG definition to be used in this thesis.

In sequence, we seek to highlight why health can be considered a matter of national policy and how it has gained space in international discussions, starting from the European epidemics that affected Europe and preceded the creation of international health organizations. After this discussion, built mainly from field literature and documents, historical analysis is made to understand the institutional arrangements that preceded the WHO and the main actors involved in this process. The formalization of WHO as an international bureaucracy evidenced that, similarly to other IOs, the institution faces challenges such as the maneuver of large donors, such as the States or non-state actors.

After discussing the structure and budget of WHO and the actors who gain prominence in Global Health Governance, conclusions are drawn about the creation of FENSA and the complex dynamics of action of actors in global health.

4.2 THE CONCEPTS AND DEFINITIONS OF GLOBAL HEALTH GOVERNANCE

Studying the World Health Organization, WHO, its mechanisms, and its dynamics for transferring and/or disseminating global health policies throughout other countries, also implies discussing the concept of governance and, more specifically, global health governance, GHG. As will be demonstrated throughout the chapter, even though the WHO was created to coordinate collective actions around global health, there is a great diversity of actors working in the international environment, such as other international organizations, philanthropic foundations, private actors, among others. Broadly speaking, this multilateral

dynamic that involves cooperation between an international organization and other actors could be characterized as global governance. However, it would be challenging to define a concept as Global Health Governance, GHG.

After conducting a brief review of the literature, it appears that the term global health governance does not have a consensual definition in the literature and admits ontological variations. For many scholars, the term is presented in the discipline of international relations in the 1990s. However, as will be presented in Table 4.1 through Table 4.6, it is noted that this phenomenon of several actors working in health under a global perspective can be noticed before the WHO creation. Thus, it is considered that besides the absence of ontological consensus, the historical moment considered as a landmark for the study of Global Health Governance is not precise among authors of this field.

In historical terms, it seems more pertinent to consider for this thesis that the efforts that preceded the creation of WHO could be seen as a way to build GHG. However, defining this phenomenon could still be seen as an arduous task to be done. The investigation of Lee; Kamradt-Scott, 2014, carries out to seek greater precision about the term global health governance. The authors identifies, therefore, three different streams that propose to explain what GHG consists, namely: the globalization and health governance, global governance and health, and governance for global health. The main difference among the streams seems to be the institutions that play alongside the WHO, and the normative character of GHG definition, as will be shown following.

In the same vein, Kickbush (2014) proposes definitions for this phenomenon, considering the level of analysis and the actors that play in the health arena. According to Kickbush (2014), the three possible explanations could be global health governance, global governance for health, and governance for global health. To be more precise, we summarized in the table "Global Health Governance: what we are talking about?" the concepts often used in the literature refer to this complex multilateral dynamic in global health.

After analyzing the definition of the concepts proposed by the literature, we adopted for this work the Kickbush (2014) definition of Global Health Governance and Lee's (2014) definition of Globalization and health governance. At the beginning of this inquiry, we focused primarily on the World Health Organization as the center of global health decisions, considering its constitutional basis to deliberate towards global health problems. Recognizing that the WHO is not the unique center of power in this complex dynamic and assuming that exists polycentric cooperation in health, both concepts must be considered in this chapter as the most proper to describe the phenomenon in the study at this thesis.

From this perspective, global health governance is a phenomenon composed of actions and mechanisms to protect and promote the health of the citizens through which different actors can interact at the global level in order to articulate best practices and establish obligations and laws among them.

Thus, the chapter aims to investigate global health governance and the joining of

Table 4.1 – Global Heath Governance: What are we talking about? First concept: Global Governance.

Definition	Author
"(. . .) is essentially characterized by new multi-actor approaches that aim to deal with global interdependence as well as new power relationships; for example, the global forces and global flows that determine health can no longer be resolved by one nation or sector but can be significantly shaped by one industry as is the case of tobacco."	(KICKBUSCH; SZABO, 2014, p.3)
". . . implies a system of rules, processes and institutions which functions and operates at the global level and provides the frame within which actors interact and take decisions on priorities and direction."	(KICKBUSCH; SZABO, 2014, p.3)

Source: Self elaboration.

Table 4.2 – Global Heath Governance: What are we talking about? Second concept: Global Health Governance.

Definition	Author
Global health governance refers mainly to those institutions and processes of governance that have an explicit health mandate, such as the WHO, hybrid organizations such as the GAVI Alliance (GAVI) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), as well as health focused networks and initiatives and non-governmental organizations.	(KICKBUSCH; SZABO, 2014, p.3)
"(. . .) the use of formal and informal institutions, rules, and processes by states, intergovernmental organizations, and non-state actors to deal with challenges to health that require cross border collective action to address effectively'"	(FIDLER, 2010) (KICKBUSCH; SZABO, 2014, p.3)

Source: Self elaboration.

Table 4.3 – Global Heath Governance: What are we talking about? Third concept: Global Governance for Health.

Definition	Author
"refers mainly to those institutions and processes of global governance that do not necessarily have explicit health mandates, but that have a direct and indirect health impact, such as the World Trade Organization and the post-2015 MDG/Sustainable Development Goal (SDG) process"	(KICKBUSCH; SZABO, 2014, p.6)

Source: Self elaboration.

Table 4.4 – Global Heath Governance: What are we talking about? Fourth concept: Globalization and Health Governance

Definition	Author
The underlying idea in this stream is that "GHG is primarily concerned with the health-related institutions that provide collective government responses to such issues"	(LEE; KAMRADT-SCOTT, 2014, p.5)

Source: Self elaboration.

Table 4.5 – Global Heath Governance: What are we talking about? Fifth concept: Global Governance and Health

Definition	Author
", in this second stream, institutions outside the health field are considered and can affect or influence social determinants of health. According to Lee (2014), this literature also deals with multilateral institutions such as the World Bank and the International Monetary fund. They seem to emphasize the global economic relations related to health. In Lee's words, this stream of the literature considers "the health impacts in low-and middle-income countries of the Structural Adjustment Programmes (SAPs) of the World Bank, for instance, arouse much interest "	(LEE; KAMRADT-SCOTT, 2014, p.6)
"refers to the institutions and mechanisms established at national and regional levels that contribute to global health governance and/or to governance for global health".	(KICKBUSCH; SZABO, 2014, p.7)

Source: Self elaboration.

Table 4.6 – Global Heath Governance: What are we talking about? Sixth concept: Governance for Global Health

Definition	Author
This literature uses GHG seeking to achieve goals as such to amplify the access of medicines, health equity, and human rights. This third definition seems to be more normative and make efforts to build arrangements in this global health governance to answer health impacts and seeking to achieve particular goals, as health equity, for example. Thus, concerning the definition of Global Health Governance for being applied in this thesis, the approach seems to be closer to the first stream. The WHO, despite being the holding authority to lead with global health, usually face resource constraints and other limitations that seem to encourage the institution to seek new forms of governance.	(LEE; KAMRADT-SCOTT, 2014)

Source: Self elaboration.

non-state actors at the WHO. Global health governance refers to something broader than multilateral cooperation, as such "the use of formal and informal institutions, rules, intergovernmental organizations, and non-state actors to deal with challenges to health that require cross-border collective action" (FIDLER, 2010)(LEE; KAMRADT-SCOTT, 2014, p.6).

The global health governance is highlighted in this research by the fact that the participation of non-state actors increased in the organization lately. This enlargement brought the expansion of themes and issues in the decision-making process in a way that seems to incorporate more diversity of demands and issues at the WHO agenda. These features suggest innovations in the dynamics of multilateral cooperation in international organizations, as will be demonstrated throughout the chapter.

4.3 WHY DOES HEALTH MATTER IN GLOBAL AND POLITICAL ISSUES?

The first section aims to demonstrate how public health has become a global concern. The section reflects the emergence of spaces in which actors as doctors and members of Europeans governments, brought up issues and problems related to public health. Discussions about health problems in XVth centuries, as epidemies for example, encourage the raise of informal spaces to discuss the importance of health in political and economic terms. Besides war and wealth, health started being considered a relevant phenomenon in International Political Relations and diplomacy among states. But why the health achieved this importance in international scenery?

Some important reasons could be highlighted when we evaluate different theoretical backgrounds. In summary words, whenever we look to the mainstream realist and liberal, some issues can be thought-provoking, as the importance of security, power (wealth), and survival. Security and power could also be discussed, however, the diseases, and illness threatened the survival of people within states. This biological menace caused in some causes by sanitarian problems or negligence with health care have gained attention since the XVth centuries whenever many people were severally affected by epidemies.

In intention to make a hindsight of the history, is possible to identify that the first efforts related to international health were observed in Europe around the 1400s.What was observed was a context in which a considerable percentage of the population was affected by the Black Death. The numerous deaths in that period materialized the governments concerns with illness, public health and economy. Health and economy was attached once the deaths caused by diseases implied in the reduction of consumer market. In this context, doctors and sanitarians began the first meetings to recognized the Sanitary issues and International Health as political issues (CUETO, 2015).

Regarding the importance of survival mentioned above, one of the theories of international health highlights that germs disrespect borders (-the discussion about

international health theories will be presented in the next section-). This theory considers the ability of germs and diseases to cross borders. In (PANISSET, 2000, p.30)[30] "infectious diseases, environmental pollutants and other health hazards" can surpass national boundaries. In this perspective, the absence of policies addressed to public health and sanitarian issues can create menaces to the health and existence of one population.

In other words, more and more states started considering International Health a relevant phenomenon to influence International Political Relations and the diplomacy among states. At the beginning, the discussion has involved at least to sides that dialogue with them, the government and economic sectors. The second one manifests its worries to consumer market and the upside-down of selling along XVth centuries and later. Besides these actors mentioned above, we may say that this first efforts to discuss health in international arena create informal spaces for discussions composed by a diversity of actors, among them, doctors, sanitarists, philanthropic foundations, etc. The informal spaces composed by distinct actors, -as mentioned before-, seemed to give birth to the global health regime. As studied in theoretical section, regimes can be understood in a summary way "as norms, rules and decision-making procedures around which the interests of actors converge in a particular area, (KRASNER, 1982)". The efforts and discussion towards health issues precedes the establishment of many international health institutions including the World Health Organization consolidated in 1948.

The European epidemics sparked discussions of an epistemic community[31](HAAS, 1992, p.5), destined to seek alternatives to the health problems towards this contexts.The actions initiated by representatives of European states extended until the XIXth and XXth centuries in the form of meetings and conferences. The results of this discussion, were usually presented as regulatory documents, publication of articles or conventions whose main theme was the European epidemics[32]. None of the initiatives were deeply institutionalized, and it seems to be restricted to specific diseases which were currently affecting the partners of the conferences. Nevertheless, the first initiatives achieved an important role in international health history once this primary effort shifted the focus from national health public policies to international health public policies. According to Brown et al (2006), since the early twentieth century, the term international health was often used to characterize actions aimed at controlling epidemics among nations, as the authors themselves underlined were actions that focused 'internationally'(BROWN; CUETO; FEE, 2006, p.3).

[30] This theory is criticized in the literature, and also by Panisset (2000) for not evaluating domestic factors in different countries, as political systems, cultural conditions among others. Although, our purpose here is not to develop an exhaustive section about the Theories of International Health and express our impression about each of them. Otherwise, our purpose is to discuss the raise of the discussion of international health and some important theories that main explain and justify the health as an international issue in politics.

[31] We understand that "Epistemic communities are one possible provider of this sort of information and advice. As demands for such information arise, networks or communities of specialists capable of producing and providing the information emerge and proliferate. The members of a prevailing community become strong actors at the national and transnational level as decision makers solicit their information and delegate responsibility to them. A community's advice, though, is informed by its own broader worldview."

[32] To know more see also: MARKEL, Howard. Quarantine!: East European Jewish Immigrants and the New York City Epidemics of 1892. JHU Press, 1999.

This shifting from national health to international health encourage the creation of international institutions for health at the end of XIXth century and beginning of XXth century. At the end of 1800 century an important landmark is the first international sanitary convention, addressed to Cholera. The International Sanitary Conference (ISC), based in Venice in 1892, "focused efforts on protecting states against the spread of infectious diseases while minimizing interference with international trade and travel"(YOUDE, 2012, p.17).

The major gain achieved by this international conference was to create common measures for being followed by member parts in order to prevent and care the spread of cholera epidemics. In other words, the International Sanitary Conference create conventions establishing rules and procedures for dealing with the spread of this plague. After the Conference in Venice, further sanitary meetings placed in Drusden, 1893, and Paris (1894) and another in Venice dated of 1897, created three additional conventions to cholera (WHO, 2019)[33]. Differently from the other efforts, the ISC, encouraged a more institutionalized way to lead with health problems. Among the measures to reach goals while ensuring trade interests, were to "maintain adequate public health capabilities at ports of entry and exit, such seaports and airports"(WHO, 2020f);(YOUDE, 2012, p.17).

The fourth conventions established along the years 1890's was consolidated into a document recognized as an International Sanitary Convention, dated from 1903. The first institutionalized measured to regulate the practices related to health and to foment international health cooperation (WHO, 2020f). The International Sanitary Convention preceded the first institution addressed for health, dated from the beginning of 1900's as we will show in the next section.

4.3.1 The primary efforts to create an International Health Organization

It's noteworthy that until the early twentieth century the actions addressed for international health were outlined among government of states. There were no formalized institutions to coordinate the actions, among states, as a formalized International Institution. The literature usually mentioned two initiatives as the leading in the history of international health institutions. As demonstrated in the section before, the International Sanitary Conferences seems to become more institutionalize. Although, along the process of institutionalization of the ISCs[34], new demands arose internationally encouraging the creation of regional institutions for health.

An initiative named International Sanitary Bureau (ISC). The mainly goal of the institution was to coordinate the cooperation in health field among States, seeking to oversee and implement regulations throughout the mishmash of quarantine regulations in trade and movements of goods. Although, the United States, considering its business

[33] WHO, 2019 <https://www.who.int/global_health_histories/background/en/>

[34] We refer to the ongoing process of institutionalizing the International Sanitary Conferences as an International Sanitary Bureau.

interests and restrictions with its expansion of economy and trade called a new convention to harmonize the regulation in Americans.

According to (YOUDE, 2012):

> " to resolve these difficulties, the delegates to the Second International Conference of the American States in 1901 charged the Governing Board of the International Union of American Republics to call a convention to establish sanitary regulations that would harmonize and minimize quarantine restrictions throughout the region" (YOUDE, 2012, p.18).

The creation of an International Sanitary Bureau addressed to regulate and coordinate policies throughout Americas is a milestone in the history of international health, for some reasons. Firstly, for its regulatory capability, secondly by the ability to foster new agreements and bring innovations to sanitary health field. This institution was firstly named International Sanitary Bureau, and regarding the regional scope it was later called Pan American Sanitary Bureau (PASB).

Herewith, the Pan American Sanitary Bureau, later called Pan American Health Organization, (PAHO) is historically considered the first international health institution. This institution was created in 1902, at the headquarters in Washington DC, in response to yellow fever crisis at the United States and addressed to ensure the safety flow of goods across American countries, as mentioned above. The first name it received was International Sanitary Bureau, and then Pan American Sanitary Bureau (PASB). Only after the II Word War it was renamed as Pan American Health Organization. Concerning to the goals the Bureau was in charge to coordinate regulations focused in controlling foremost communicable diseases at the ports, as yellow fever, malaria, smallpox, tuberculosis (Meier e Ayala 2014). In other words, "the ISB, later called Pan American Health Organization was established to implement the International Sanitary Convention in the Americas" (YOUDE, 2012, p.18).

The regional factor is an important criterion for the study of international public health, as will be demonstrated in the next section. The climate and temperature, and regional particularities may influence the flare-up of certain diseases, such as tropical diseases, and endemics in Central and South America, for example. The establishment of an institution for the Americas could reinforce the efficacy in actions to prevent diseases, even considering the continental differences between Americas regions.

Founded in December 1902 and headquartered in Washington, D.C., the Bureau long sought to coordinate national regulations as a basis to control infectious diseases and thereby assure the free flow of goods across the Americas. Beginning out of a concern for communicable disease control at the Hemisphere's ports (focused on the control of yellow fever, malaria, yaws, tuberculosis, and smallpox), the development of the 1924 Pan American Sanitary Code became the basis for uniform regulations and international actions to protect public health.

Considering the regional criteria, the second institution was addressed to European countries as will show below. Hence, "the International Office of Publique Hygiene (Office International d'Hygiène Publique, OIHP) sought to oversee quarantine regulations and focused its attention on protecting European countries" (YOUDE, 2012, p.19). Likewise, the Pan American Sanitary Bureau, the creation of an International Office of Public Hygiene was agreed at the beginning of XXth century, and the main purpose was to coordinate policies against epidemic diseases. The attempt to regulate sanitary legislation faced problems and fears within member states. Likewise, the United States, the Britain manifested its hesitance with foreign competition to different industrial hygiene companies. The country, in the context of the International Sanitary Conferences, declared its apprehension with international intervention at national laws. According to British delegates the restrictions imposed could augment the cost of production while destroying some business (LANCET, 1909).

In December of 1903, countries[35] decided to consolidate a project to create an institution for health. On the occasion of the International Sanitary Convention, held in Paris, countries recognized the necessity to create an international bureau for public hygiene. The conferences realized at that period produced international normatives recognized as International Sanitary Regulations (ISR). The ISR beyond the capacity to regulate and coordinate actions started offering the possibility to develop research on epidemiological diseases as cholera, tuberculosis, among others. However, only in 1907, through the Treaty of Rome, the Office International d'Hygiène Publique, OIHP come into being (YOUDE, 2012).

This institution emerged with a broader scope. In other words, this would also focus on epidemiological research and data collection on a wider range of infectious diseases. Beyond the widened scope, the International Office adopted in its statute the principle that "it must not interfere, in any matters at internal administration in any country (LANCET, 1926). While ensuring the regulation without international intervention through national legislation, countries seems being motivated to sign the new international health agreement. The French diplomat, Mr. Cazotte, with no medical knowledge but very wise in international health agreements and regulation of sanitary ports developed an important role in this context. According to Cazzote, the important changes embodied at International Office of Public Hygiene statute boost the adherence of new countries to the new agreement. Another innovation brought by this international office, in 1907, was to joint technical delegates into a committee as part of the newly institution (LANCET, 1926).

The fear to hamper business interests, trade agreements, and the surveillance of the population was a common feature among the European countries member of this institution.

[35] The following 20 Powers were authorised to sign the convention. The order in which they are placed corresponds with the French alpha- betical arrangement : Germany, Austro-Hungary, Belgium, Brazil, Spain, United States of America, France, Great Britain, Greece, Italy, Luxembourg, Montenegro, Holland, Persia, Portugal, Roumania, Russia, Servia, Switzerland, and Egypt ("THE INTERNATIONAL SANITARY CONFERENCE AND THE PROPOSED PERMANENT INTERNATIONAL SANITARY BUREAU." 1903, 1).

"Fundamentally, the OIHP, was a club of senior public health administrators, mostly European, whose main preoccupation was to protect their countries from the exotic disease without imposing too drastic restrictions on international commerce" (HOWARD-JONES; WHO et al., 1978, p.17). The underlying fear towards international health agreements, at the beginning of XXth century, the slow action of states to ratify regulations in its states, represented a restriction in the advanced of health agreements. Furthermore, the limited scope of OIHP, directed, most and foremost, to epidemic diseases seemed to be insufficient for leading with international health demands. Given this context, and in face of institutional weakness the OIHP was replaced by initiatives that emerged along and after the World War I.

4.3.2 The innovations in Global Health and the First World War

Since the beginning of XXth century, countries started being motivated to consolidate international health institutions which attempting to coordinate epidemic diseases. The institutions discussed before, despite the adherence of a diversity of members destined its efforts to act mostly regionally, as we can see in the case of PASB and OIHP. Although, the context of the First World War seemed to change this reality, bringing contributions and innovations in health cooperation agreements and in the framework of the newest institutions.

As mentioned above, the OIHP embodied a small staff, predominantly composed by French politicians and destined in its majority to care with European health issues. Even though conventions which follows the signature of 1907 treaty of Rome, seemed to reformulate the OIHP in order to enhance an amplified scope of action, in as much of health measures, as diversity of countries.

In 1912, a new convention was realized in France which seems to be a benchmark in the reorganization of the OIHP. In this occasion governments recognized that epidemic diseases as cholera and yellow fever must be prevented. The discussion through preventive medicine that began to raise in 1912 were relevant to encourage diplomatic arrangements and impel states going to a consensus for protecting themselves against external biological threats and enhance social health conditions (WEINDLING, 1995). Among the discussions of the new conventions related to OIHP, they start to consider advancing "knowledge in biochemistry, immunology, and pharmacology " (DUBIN, 1995, p.57). Notwithstanding, the convention solely come into force in 1920's.

Herewith, one of the crucial changes thereafter 1900's was the conscience that the creation of an organization to treat only, epidemic diseases could be insufficiently to avoid health problems. This way seemed to urge the raise of new strategies to foster the exchange of information while preventing future diseases. The important points that raised as from this discussions and conventions was to grow into measures for: preventive medicine; and social medicine or public health. Considering that human mobility would affect not only political, economic, cultural and informational flows, states seems to recognize more consistently the

fear of spread diseases around the world.

Within the context of the end of World War I, an epistemic community eager to consolidate health cooperation in international basis became more evident in international scenery. As mentioned by Lee (2009) "as well as intergovernmental cooperation, numerous nongovernmental organizations were founded during this period concerned with health activities" (LEE, 2008, p.24). Nongovernmental actors as such the Red Cross Society and Rockefeller foundation begun to act internationally. This actors provided advances in international health cooperation, above all in "wartime medical relief, public sanitation and scientific medicine" (WEINDLING, 1995, p.57), -as will be discussed in the next section.

The World War First, notably brought greater contributions in the health and immunization systems. The 1918-19 years' war severally affected by a pandemic of influenza " which killed around 25 million people worldwide"(LEE, 2008, p.23). In face of this dramatic health crises states were motivated to wondering about greater collective strategies of action. Towards this scenery, one of the improvements accomplished was the importance destinated to social medicine and public health (LEE, 2008).

It's worth noting that the XXth century introduce a new form of cooperation. At the first-time states could become members of an organization addressed to universal purposes: The League of Nations. The raise of this multilateral institution in 1919, -despite not being well succeeded-, create an era of open diplomacy[36] "which endeavor to settle international disputes, ensure peace and solve problems common to all based on an "institutionalized "approach to international affairs"(Kennedy, 1987; (KICKBUSCH et al., 2012, p.14)).

Therefore, was consolidated one of the most representative institutions in the history of international health, wich were called the League of Nations Health Organization (LNHO)[37] in the year 1920[38]. The founders desired an institution with a broader role, playing vigorously in controlling and preventing diseases. This new institution, with amplified purposes established in its Article XXIII that members of this international agreement "would endeavor to take steps in matters of international concern for the prevention and control of disease" (KICKBUSCH et al., 2012); (LEE, 2008).

Important for mentioning that the United States refuse to make part of the League of Nations Health Organization. The US had some critics to the League of Nations systems, and regardless its contribution to create the health organization institution the country vetoed the project. The LNHO become weak and vulnerable considering the absence of US action, the

[36] We understand as open diplomacy a context in which states beginning to consider that diplomacy could also be efficient whenever agreed "jointly in public domain" (KICKBUSCH et al., 2012, p.14), and not in secret, as states usually did.

[37] Some authors as (YOUDE, 2012) refers to this institutions as Health Organization of the League of Nations (HOLN), although we opted to use the League of Nations Health Organization, commonly used by authors as (Kickbusch et al. 2013; Manderson, 1995; Dubin, 1995; Weindling,1995) among others.

[38] Thus between the two great wars the world had two international health offices—OIHP and the LNHO (HOWARD-JONES; WHO et al., 1978) —both of them weak and not well enough resourced and for political reasons not well coordinated—as well as some important regional bodies such as the PASB (KICKBUSCH et al., 2012, p.15)

insufficiency of resource and the management compromised. In other words "the LNHO was hampered from the start by the fact that the USA had not joined the League of Nations and continued to work through the OIHP in Paris on quarantine issues (KICKBUSCH et al., 2012, p.15)".

Despite its fragility's, the League of Nations Health Organization brought main contributions and innovations in health cooperation and development of public health. In summary words the institution for the first time heighten the knowledge of preventive medicine. It also brought contributions in epidemiological research through the creation of "Service of Epidemiological Intelligence and Public Health based in Geneva" (DUBIN, 1995, p.57). This innovation inaugurated policies based on research, collecting data and developing statistics on health cases. Another important contribution concerns in advance of social medicine, and developing of studies about nutrition and hygiene. Furthermore, the technical assistance starts to be thought as a possible way to avoid health crisis. Through training and qualifying personnel the institution could furnish assistance (WEINDLING, 1995).

The aforementioned suggested that despite of weakness and coordination problems highlighted above the institution shared an innovative framework which foster changes and advances in health cooperation. Some contributions become part of the World Health Organization, WHO, in 1948, as the initiatives of collecting data towards epidemiological diseases which were inherited by the WHO. We also may to consider the action of nongovernmental actors in this period as important players in health cooperation through the interwar as will be shown in the next section.

4.3.3 Non-state actors and the global health cooperation

As discussed in the section before, the beginning of 1900's was a landmark in the history of global health cooperation. Within this period the international health regime moves forward to a more institutionalized one. Whilst in the XIXth century the states were still the only sovereign actors in international scenary recognized by the Treaty of Westphalia 1648, at the end of XIXth century and beginning of XXth century, non-state actors began to upsurge and play an important role internationally. As will shown at the next sections, non-state actors can be categorized differently, as nongovernmental organizations (NGOs) private institutions, business companies, civil society, faith-based organizations among others. Nevertheless, when we look to international health cooperation the evidences suggest that nongovernmental actors, as Red Cross and Rockfeller Foundation were the firstly to emerge in this agenda.

4.3.4 The Rockefeller Foundation

In June 27, 1913 was created a nongovernmental institution by the Standard Oil American magnate, John D. Rockeffller[39]: the International Health Commission (IHC) of the

[39] John D. Rockefeller Sr.'s Standard Oil Company, founded in 1870, had risen to dominate the world oil markets with its control of wells, refining and oil trans- In 1891, he appointed as his principal aide in philanthropy

Rockefeller Foundation at the United States. This institution emerged internationally to succeed the Rockefeller Sanitary Comission, which works were focused in developing activities in the southern of United States. The main difference between the both institutions was the scope of action. The IHC emerged with the purpose to promote public sanitation and foster the development of scientific medicine. "Throughout its history the institution the organization underwent a variety of mandates and name changes, as International Health Board in 1916, and International Health Division (IHD) in 1927"("International Health Division - The Rockefeller Foundation: A Digital History" [s.d.]).

Hence, this nongovernmental institution is usually referred in the literature as International Health Division of Rockefeller Foundation and raised to forward the public health and well being, not only in United States, but also throughout the world. Nonetheless, the charitable goal to promote the health well-being throughout different countries should not be evaluated lonely. Underlying the benevolence of the US aspirations, we should also consider that this institution makes part of an "American movement of scientific philanthropy" launched by Scottish-born steel mogul Andrew Carnegie in his 1889 essay "The Gospel of Wealth" (BIRN; FEE, 2013, p.1). This project aimed to keep US interests whenever providing welfare over other countries. As studied by Birn; Fee (2013) the philanthropic aid was a cynical strategy that prejudiced the social welfare, while ensuring profits to American business interests. In other words, "these philanthropic efforts helped stave off the welfare state in the USA and gave private interests considerable purview over social welfare (BIRN; FEE, 2013, p.1)".

Despite our accordance with Birn, Fee (2013) regarding the political interest underlying the philanthropic actions of Rockefeller Foundation, we also consider that this institution highly contributed with the advances of international health cooperation. It becomes a powerfully actor that starts to operate in health projects, scientific research, public sanitation. Indeed, it becomes so active and starts to work with the League of Nations through an office in 1927 when it becomes the International Health Division and works until 1951, when it closed down. Henceforth, the Health Organization of the League of Nations and the Rockefeller Foundation started identifying central issues in the promotion of health-related policies, especially in social medicine.

Through this partnership the Rockefeller Foundation started acting over 80 countries[40] seeking for controlling and eradicating diseases as malaria, yellow fever, tuberculosis the hookworm as the main focus of this institutions policies (FARLEY, 2004). Nevertheless, at the end of the World War II the Health Division of Rockefeller Foundation became less effective, what evidenced in somewhat inabilities for changing and adapt at a new world era. The changes imposed by the end of the second World War fostered the

38-year old Frederick Gates, who had played a major role in Rockefeller's endowment of the University of Chicago (FARLEY, 2004, p.3)

[40] The United States and Canada, 25 nations in Europe, 15 in the Caribbean, every country in South and Central America, 19 in the Far East, and several in Africa and the Middle East (FARLEY, 2004, p.2).

reorganization of the Rockefeller Foundation in a creative way and the ending of the Health Division. Despite not survive, it merited considerable attention once "its ideas lived on and found expression during the early years of the WHO" (FARLEY, 2004, p.4), tending to contribute straightforward to the construction of the global health cooperation.

4.3.5 The Red Cross

The Red Cross or the International Health Committee of the Red Cross emerged internationally, in 1863, seeking for protecting and ensuring assistance for people affected during armed conflict, above all the soldiers bruised at battle of Solferino in 1859[41]. Whilst the states were seeking for strategic forms of cooperation in a state-centered format, the Red Cross, emerged as an nongovernmental organization seemed to inaugurate a new form of cooperation, based on the civil society interests. This pioneer actor, at the beginning, seemed to be less partial and more neutral in the employment of the action and defense of humanitarian action, and represent a key step in the arrangement of cooperation with civil society (WEINDLING, 1995), nevertheless, the voluntary assistance started to suffer influence of business companies, and states in somewhat, interested in overcoming interest throughout different international actors.

The Red Cross is a notable NGO by the fact of being supported by international agreements. Concerning its establishment, it can be comparable with International Organizations. The Red cross is available in different countries, as United States, with American Red Cross, in France, French Red Cross, in Italy as Italian Red Cross and Britain as British Red Cross, Japan, as Japanese Red Cross, most of them recognized as the biggest Red Cross. These organizations played an essential role since 1918's to establish the League of the Red Cross Societies. On 5 May, 1919 it was formally agreed, with the purpose to reduce and alleviate the problems and calamity launched by diseases (WEINDLING, 1995).

As discussed above, even being a voluntary institution we may thought that external interests could act upon the institution. Likewise the power exerted as from the Rockefeller Foundation, at the Red Cross, the United States developed an outstanding role which can be seen as from the impact on mold and funding the "two largest international health organizations in the world until that moment, which were the League of the Cross Societies (LRCS) and the League of Nations Health Organizations" (LNHO) (Towers, p.36; (WEINDLING, 1995). Within this context, the American Red Cross played a major role under, Henry Davison, the main figure behind the foundation of the League of the Red Cross Societies[42] ("International Red Cross and Red Crescent Movement History: Sub Title" [s.d.]). Beyond American state intervention, the American Red Cross and Rockefeller Foundation imported some practices as

[41] The initiative was encouraged by Henry Dunant a man which helped bruised soldiers in the occasion of Battle of Solferino in 1859, International Committee of the Red Cross <https://www.icrc.org/en/who-we-are/history/founding#gs.kcn9on>

[42] Henry Davison- <http://www.redcross.int/en/history/not_Davison.asp> Accessed in: Dec 12, 2019.

from the business style, trying to influence and persuade health cooperation to adopt practices as efficiency, strategic planning, among others (WEINDLING, 1995).

As a result of the establishment the League of the Red Cross Societies (LRCS) and as from the influence of American Red Cross, the LRCS acts more actively in public health education and publicity, the american areas of expertise. Moreover, as from the LCRS we evidenced the beginning of diffusion of policies and health practices. In other words, as from this institution many of the Red Cross societies achieved know-how in preventive care, public health and infant welfare programmed among other areas (Towers, 1995; (WEINDLING, 1995). Despite American influence or business influence, we tend to claim that this pioneer institution also brought innovation and cooperation in health agreements and diffusion of norms and practices through countries involved in.

In summing up, we could saw in a summary, the emergence of non-states actors into internationally. As from the history of the Rockefeller Foundation and the Red Cross presented above we evidenced the changes towards the international health cooperation and the dynamic of cooperation among the actors and states of the agreement. We also affirm as from the literature read that the previous collective bargaining around health agenda gave substance to the health framework built after the Second World War, formalized as the World Health Organization in 1948, as will seen in the next section.

4.4 THE WORLD HEALTH ORGANIZATION ORIGIN AND STRUCTURE

As mentioned, between 1900 and 1915 international offices for health emerged, however, only in the late 1940s the World Health Organization come into force. The establishment of the World Health Organization as a bureaucratic institution is directly intertwined with the previous efforts. As we have shown before, the sanitary conferences and meetings related to health problems encouraged the strengthening of the global heath cooperation. In other words: "the creation of the WHO stemmed from the International Sanitary Conferences which met between 1851 and 1938, and the adoption of the first International Sanitary Convention in 1903" (BEIGBEDER, 2017, p.22), which had the main goal to establish common sanitary practices to avoid epidemic diseases and the minimum of coordination at the exchange trade.

However, the reality of the second half of twentieth century seemed to be changed. Besides the unprecedented efforts, the governments started to advance and became stronger in multilateral cooperation in the context of the League of Nations and thereupon. Indeed, the advances of scientific research, medicine and social science galvanized the development of new health techniques at international institutions. In other words, the advances in scientific research in health field and this relation to "government and policymaking is a twentieth-century phenomenon" (BULMER, 1995, p.321).

As aforementioned, the creation of the League of Nations Health Organization

(LNHO) were not able to gather strong cooperation among member states. The League of Nations Health Organization, was criticized since its establishment for being costly to the LN. The International Health Division of the Rockefeller Foundation (IHD) agreed to provide funds to LNHO in order to finance qualified staff as epidemiologists. The symbiotic relationship created between IHD and LNHO subsidized the projects of public health along the LNHO until 1937. As mentioned by Dubin (1995);Youde, (2012), the grants provided by the RF "supported international exchanges for public health officials through 1929 and the epidemiological intelligence until 1937"(DUBIN, 1995);(WEINDLING, 1995); (YOUDE, 2012, p.23).

Nevertheless, with the beginning of the World War II the international arrangement of health cooperation has changed. The Rockefeller Foundation carried on with funds, although they decreased. Furthermore, the epidemiological staff, -which played core functions- was limited to travel and developed its works. Without an adequate support and budget, the LNHO could not hold its actions. Likewise, the LN, the LNHO "fell victim to the same maladies that undermine the rest of the League of Nations. LNHO delegates assembled last time in 1939 (...) after that time, the organization effectively ceased to function" (YOUDE, 2012, p.24).

The end of the second World War brought innovations into the discipline of international organizations. We may say that the year 1945 can be a milestone in the study of international organizations which is justified by the coming into force of the United Nations Organizations. However, an institution for health was not initially part of the United Nations project. As reported by Lancet (1945);(HARRINGTON; STUTTAFORD, 2010) until the moment of United Nations Charter was drafted we do not evidenced any mention of health or either human right. Even tough, within 1945 and 1946, we identify discussions moving towards a health institution which would be able to establish collective action in this domain.

In 1945, along the San Francisco Conference, Brazilian and Chinese representatives had made considerable efforts in intention to establish an international health organization, more solid, to lead with global diseases in order to inserting this issue at the United Nations Carter(YOUDE, 2018; LEE, 2008; HARRINGTON; STUTTAFORD, 2010). Throughout the year 1946 a Technical Preparatory Committee foregather in Paris drew up a drafted of the main activities to be accomplished by this new health organization. The Committee was in charge to present at the International Health Conference, in New York of 1946, the basis of the Constitution of the emerging health organization. In this same year 51 members of the United Nations have signed a letter that origin the World Health Organization (WHO, 2020f).

Nonetheless, it was only in 1948 when the World Health Organization, WHO, come into existence. The context of the Cold War, and the rising tensions among United States and Soviet Union affected the establishment of the WHO. In summary words, the philosophy of social medicine was perceived by the United States government as a threat, that could

favor Soviet Union geopolitical interests. The absence of consensus among these great powers seems to justify the delay in the establishment of the global institution. It is also noteworthy, that the US supported the autonomy of Pan-American Health Organization. Despite the creation of the WHO, the PAHO does not become subordinated to WHO (LEE, 2008). This fact, reinforce that US were preoccupied that Soviet Union ideologies hampered its political interest, hence opting to keep the regional health organization in Americans (PAHO) closer to its influence zone.

Thus, the WHO raised as an autonomous agency to lead with health issues. Despite the autonomy, the WHO belongs to the large system of the United Nations, UN, being connected to one of the six main organs of the United Nations, namely the Economic and Social Council, hereafter, ECOSOC . The same way as other specialized agencies, the WHO is an autonomous institution of its own structure, staff and budget. In other words, it means that, the WHO is a specialized agency along UN system. We may say that the WHO emerged to fill the gap not occupied by the previous initiatives. As suggested by its name, the World Health Organization, emerged with broader goals and global ambitions, whilst the previous were addressed to regional or international focus. Additionally, the WHO presented new demanding as treatment; prevention of diseases, and the intention to promote and foster research towards epidemic diseases among others. The consolidation of an organization devoted to a social theme suggests a possibility of shifting the focus of concern from the state to society.

As aforesaid, the shifting from the state to society could also be seen clearly in the first paragraphs of the 1948, Constitution. As defined, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946, p.1). The health, within the WHO, achieved the status of a fundamental right, through which every human being should have access, and governments became responsible for ensuring it. In other words, health appeared as a human right and become a cornerstone in the international health cooperation. "As a normative framework for international public health, the right to health is seen as foundational to the contemporary policies and programs of the World Health Organization (WHO)(MEIER, 2010, p.174).

As demonstrated beforehand, the previous institutions gave rise to the discussions of social medicine, health for all and prevention of diseases. This manner the previous initiatives can be recognized as basis that lay the foundation of a stronger and amplified health institution with social purposes. Despite not being the focus of this research, we could not ignore the fact that since the establishment of the WHO we could see advances in human rights whenever discussions within the WHO aimed to develop public health policies for all members involved in the agreement, as we can see "WHO's early years are marked by its active role in developing human rights treaty language, working with States and UN agencies to expand human rights principles for public health" (MEIER, 2010, p.168).

The coming into force of the WHO suggested to us, at least, three conclusions as will demonstrate below. Firstly, the WHO was shaped plenty of years before its establishment.

We evidenced as from the discussions forehead, that first, raise an international health regime in Europe at the end of the XIXth century, as from the influence of the epidemics. This international regime became strong and resilient in the face of the opposing influences. Thus, the international health regime since its beginning passed to work with a broad range of actors, among them non-state actors, as we could see as from the action of the Red Cross Societies and Rockefeller Foundation.

The second conclusion we may evidence is the influence of the contexts of the great World Wars along the process of the WHO conception. The establishment of the international organization in 1948, should not be analyzed lonely. We might consider the previous efforts and the self-interest of great powers that have been shaping this dynamic. The divergence of interest and the absence of consensus among the United States and European countries underlined the discussions interconnected to the purposes of the new organization. Regarding the purposes and scope, as an effect of these enduring negotiations from the end of the XIX century until 1948, we could better understand how the institution come into force, and what justifies the adoption of specific values. Even though the conflicts of interests did not end, as will be shown in the next sections, we can perceive different kinds of conflicts among member states and non-states members.

The third conclusion, as a reflection of the abovesaid, concerns in the adoption of social values as one of the purposes of the World Health Organization. As demonstrated before, we could evidence debates towards social medicine and public health from the end of the First World War, which extends until the end of the Second World War. The Great Wars had an unfortunate effect on people's health and justified many deaths in Europe. Nevertheless, as from this scenario, the debates about humanitarian action, social medicine, public health, and human rights rather than the self-interest of the states achieved high priority, along with the WHO discussions towards its conception. Consequently, this fostered a legacy based on equality of health and the recognition of health as a human right as a significant purpose, as expressed through the Constitution of 1948.

The universal and equitable purposes put forward as a value were also reflected in the structure of the institution, as will be demonstrated in the following sections.

4.4.1 Structure and core actions

The WHO is composed nowadays by 194 members, they meet every May at the World Health Assembly, WHA, one of the central decision-making bodies. Thus, the governance of the institution is made at three different instances, which are: The World Health Assembly, WHA, usually called the Health Assembly, the Executive Board, and the Secretariat.

The WHA, gather the 194 members annually at United Nations Palais de Nations, which is represented by delegations from the states usually composed by at least three delegates. The sections take place in Geneva and have the main goal to discuss the policies and approve the biannual budget and activities of the Executive Board. In summary words,

the core functions of the World Health Assembly could be described as follows: "1)to name the members entitled to designate a person to serve on the board; 2) to appoint the Director General; 3) to invite non-state actors to participate in the section, without right to vote", among other functions (WORLD HEALTH ORGANIZATION and others, 2014, p.6). In this perspective, the WHA has the role of aggregate members to discuss alternative policies and strategies to be more effective in implementation policies. Thus, we can consider the World Health Assembly the body where global health diplomacy occurs. The WHA is the place and occasion for becoming possible the meeting of different actors, which plays essential roles in global health governance, as experts, civil society, private enterprises, among others. In other words,

> "the World Health Assembly has become the incomparable meeting point for global health diplomacy. . . . Health experts, advocates from civil society, business representatives and representatives of a multitude of other global health organizations interact with officials from health and foreign ministries and representatives from the donor community, development agencies and the large donations, as well as with other UN bodies"(KICKBUSCH et al., 2012; BEIGBEDER, 2017, p.18).

The WHA is the organ through which the documents as convention and regulations can be established as an agreement among states. The policies usually need two-third votes to be approved at the Health Assembly; however, in practice, many decisions are taken by consensus among members (verbal Information). As will show in the next sections, the character of the policies could be different, which means that conventions and frameworks are agreed and accepted differently among states. Despite being an international organization addressed to soft laws without generating strong binding among actors, we may say that conventions could probably be more readily accepted and implemented by members when compared with regulations, campaigns, and others.Concerning recommendations, are usually adopted by a simple majority and approved by resolutions [43]. They are understood as soft instruments, once does not exists mechanisms to obligate members to follow and adopt this international law. Frequently, WHO recommendations can refer to code, strategic plans, or plans of actions, such as Global Strategy to Reduce the Harmful Use of Alcohol (WHA 63.13) (SOLOMON, 2013). The World Health Assembly also has the authority to create international agreements and conventions, as the Framework Convention on Tobacco Control, which can bind the WHO members acting as an instrument of hard law. Members state when express accordance with the agreement or convention approved by a qualified majority of the WHA-(two-third majority)- assent to ratify the programs and (SOLOMON, 2013).

The second main WHO organ presented here is the Executive Board, usually called Board by its members. The Board is composed of thirty-four members who are designated by members. Along the Health Assembly, the members appointed by states are selected to fulfill

[43] "WHO resolutions are political instruments and represent decisions taken within an established intergovernmental UN framework"(SOLOMON, 2013, p.189)

the places at the Board. The main criteria established by the World Health Assembly to take place at the Board is balanced geographic representation. The Executive Board seeks to ensure the balance of regional representation, searching for representing all of the 194 members of WHA.

No more than three representatives of each region can be represented at this organ. The WHO is divided by regions, through which the members are allocated, as will be demonstrated following.

The main criterion for holding a seat on the Board is technical qualification.The Executive board seeks to ensure the balance of regional representation, in this sense, the purpose of the elected members is to represent the 194 members of WHA. The number of members of this body grows proportionally with the growing of WHA. As an example, in 1948, it was composed by 18 members. In 2007, with the entry of new members in WHO this number raised to 34 (LEE, 2008).

Concerning the main actions, this is an essential organ. Whilst the WHA establish and recommend the policies, the Board is the Executive organ of the WHA. Another important characteristic for holding a seat on the Board is technical qualification in health domain, once they will need to seek for strategies addressed for effective implementation and possibly emergencies, the members of the Executive Board acts as experts in health rather than representatives of its own country. The technicals of the board acts for three-year terms, and every year one third of the Executive Board changes (LEE, 2008; WORLD HEALTH ORGANIZATION and others, 2014).

Among the functions of the Board, the decision-making body is in charge to prepare the agenda of the Health Assembly. Thus, the Board meets twice a year. The first usually happens before the Health Assembly to establish the priorities to be discussed, while the second meeting usually occurs after the Health Assembly. In a compact way to describe the foremost functions of this organ, we could mention: "1) to give effect to the decisions and policies of the Health Assembly; 2) to nominate the Director General appointed by the Health Assembly ; 3) to take emergency measures within the functions and financial resources of the Organization to deal with events requiring immediate actions";(WORLD HEALTH ORGANIZATION and others, 2014, p.9). The Board, consequently, acts in name of the whole Health Assembly.

The third organ of the WHO is called Secretariat, and comprises the Director- General, DG- the head of the institution-, and technical and administrative staff which supports the Director. The Director General is the WHO's chief administrative officer. Concerning its responsibilities, the DG is in charge for connecting member states and keep relations with them. It usually prepares the reports, financial statements and estimate budget. As a Director General he or she can take actions and follow resolutions decided by the World Health Assembly and the Executive Board (BEIGBEDER, 2017). Since the WHO came into existence, there have been nine Directors-General, all of them with advanced expertise in medical issues. Despite being medically qualified and need to follow the protocols of the Constitution, the WHO can

change every DG mandate. Hence, one of them invites different staff and experts to compose the Secretariat. It is also important to highlight that each context could influence the way each DG will manage the policies of the WHO. Issues as a financial statement, international politics, external pressures, or health crisis may affect the action of DGs.

As will going to show in the table below, the DGs elected to take this position usually have an active carrier developed in health policies and could apply considerable impact at WHO programs and policies. The previous experience and expertise is not an explicit profile rule to select DGs; however, it seems as a tacit agreement recognized among WHO members and staff at Health Assembly selection. Another characteristic we may highlight is the intention to balance geographical representation among DGs as we can observe in the following table:

Table 4.7 – Table Director's General of the WHO (1948-2020)

Director General	Period	Origin
Dr. Tedros Adhanom Ghebreyesus	2017-(current)	Eritrea
Dr. Margareth Chan	2006-2011 (first term) 2012-2017 (second term)	Republic of China
Dr. Anders Nordstrom	23-May-2006 to 3-January-2007	Sweden
Dr. Lee Jong Wook	2003-2006 2006-Death of Dr. Lee	Republic of Korea
Dr. Gro Harlem Bruntland	1998-2003	Norway
Dr. Hiroshi Nakajima	1988-1993 (first term) 1993-1998 (second term)	Japan
Dr. Halfdan Mahler	1973-1978 (first term) 1978-1983 (second term) 1983-1988 (third term)	Denmark
Dr. Marcolino Gomes Candau	1953-1958 (first term) 1958-1963 (second term) 1963-1968 (third term) 1968-1973 (fourth term)	Brazil
Dr. George Brock Chisholm	1948-1953	Canada

Source: Self elaboration.

Since WHO come into existence, the international organization was managed by DGs with different nationalities, and they brought diversified contributions based on its previous areas of expertise. The DGs at WHO take over the position for a five years term. Nationality, the field of knowledge, and context of the health crisis, for example, can influence the way the organization will be managed during the term.

In intention to summarize the main policies and facts of each Director General we may demonstrate briefly some of each one biography. Starting from the first DG, George Chisholm, we evidenced some important features. Instead of international organization, Chisholm suggested the name World Health Organization in intention to emphasize that this new organization raised for attendig global purposes being addressed to work for all nations. With this vision and argument Chisholm achieved enough acknowledgment among health

technicals for being elected as the first Director-General of WHO. Among the main actions, Chisholm "dealt successfully with a cholera epidemic in Egypt, malaria outbreaks in Greece and Sardinia, and introduced a global shortwave epidemic-warning system for ships at sea" (WHO, 2020e).

Despite its talented management and possibility to take over position for a second h refused reelection and was succeeded by Marcolino Candau in 1953. Candau was a Brazilian Director General that served as chief administrative of WHO for four years term. Curiously, he was a physician but also developed its studies in medical qualification at School of Medicine of State of Rio de Janeiro. In its twenty years of mandate he aggregate plenty of contributions of the international organization. Among the diversity of initiatives he oversaw the enlargement of members at the WHO from 54 to 138, from 1953 to 1973. The increase of members was mainly justified by the fact that plenty of African and Asian coutries achieved independence from their colonizers along this epoch. The expansion of member states brought significative contributions to the institution being reflected in the rise of staff and budget (WHO, 2020e). Among the policies during Candau's mandate, we could see a strong effort to eradicate smallpox, malaria and onchocerciasis. It is also noteworthy, that Candau's diplomatic ability to not alienate with great powers in the context of Cold War as well as its managerial accuracy to lead the WHO explained its re-election for three successive terms (CUETO; REINALDA, 2015). Candau's was succeeded by a Dane Dr. Halfdan Mahler an expert in tuberculosis whom were described by Candau as "young and charismatic" and could implement the changes needed by WHO at that moment (CHOREV, 2012; CUETO; REINALDA, 2015, p.57).

Halfdan Mahler had a considerable expertise in tuberculosis. Concerning to his previous experience Mahler was notably recognized by his action through the Red Cross in Equator at the years, 1950-1951 fighting against tuberculosis. At the year 1951 he joined the WHO headquarters whenever begin to develop his WHO career. Besides his expertise in tuberculosis, along his term many managerial changes were implemented, being recognized as the period most idealistic of organization's history (HANRIEDER, 2017). As investigated by Hanrieder (2017) Mahler was an "outspoken supporter of the New International Economic Order (NIEO) [44] and was the spearhead of the so-called Primary Health Care movement, which sought

[44] What is the New International Economic Order? As studied by Cox: "At a first level, the NIEO is a series of specific demands and considerations embodied in an impressive range and number of official documents adopted by international conferences." (...) "At a second level, the NIEO is a negotiation process, broadly speaking, between countries of North and South but taking place through a variety of institutions and forums in which are represented wider or narrower ranges of functional and geographical interests. This negotiation process is concerned with the possibilities of agreement concerning both revised international policies and reformed or new institutions (including the power relationships governing these institutions)." (...) "At a third level, the NIEO has precipitated a debate about the real and desirable basic structure of world economic relations. Though, the term "international" (consciously chosen in preference to "world" or "global" by the authors of the demand) connotes a limitation of the issue to relations among countries, the debate cannot be so artificially constrained and has ranged inevitably into domestic and transnational structural issues". (COX, 1979, p.258-259). To know more about the New Economic Order see also: COX, Robert W. Ideologies and the new international economic order: reflections on some recent literature. International Organization, v. 33, n. 2,

to reorient international health toward basic health needs"(HANRIEDER, 2017, p.2).In the 1970s, Mahler tried to establish a connection between primary health care, development, and cooperation within the Conference of Alma-Ata. The Alma-Ata conference was a milestone that encourages primary health care and public health throughout WHO members[45].

Another important change that must be considered was the implementation of the HIV program. Along his term Mahler established the "Special Programme on AIDS and made combat of HIV a WHO priority" (HANRIEDER, 2017). He also adopted a Model List of Essential Drugs seeking for protecting developing countries from the hostile marketing of pharmaceutical industries. Is also noteworthy that along Mahler's mandate, during the 1980's decade, the WHO face a neoliberal dilemma [46] and the United States threatened to freeze the contributions. Mahler finish his mandate on 1988 and was succeeded by Nakajima.

The Doctor Hiroshi Nakjima was a Japanese Director General which managed the WHO from 1988 to 1988. As others DGs, Nakajima achieved recognition from his colleagues as from his previous experience within the WHO. Concerning its main activities Nakajima begin its career at the institution as scientist working form policies to controlling Drugs. He also played a notable role as a regional policy maker, when he was elected as a Regional Director to guide the regional policies of WHO Western Pacific Region. His outstanding actions on drugs control and public health made Nakajima been reward with the highest prize on public health on 1980's decade and been elected as a Director General at the WHO at 1988. Regarding his management as a WHO DG, in Nakajima's first term 1988 to 1993, the Japanese endeavoured initiatives to eradicate Polio, and fomented expressive campaigns to combat malaria, dengue and the spread of infectious diseases in African countries, as Guine, for example. It's also noteworthy, that he worked over the establishment of bridges between health and culture, above all in the issue of female mutilation. In this case, Nakajima's efforts were addressed to build lobbies well- suited to support the end of this aggressive policy against woman. In his second term, the most remarkable policies were the strategies implemented for caring and controlling Tuberculosis which started in 1995. Furthermore, he has meaningful recognition towards the initiatives to combat children illness, and policies to enlarge the Programmed for Childhood and Immunization (WHO, 2020e). After his ten years in charge of WHO management, he did not seek for reelection and was followed by the doctor Bruntland.

The doctor Gro Harlem Bruntland was an outside among the Director General of the WHO for, at least two reasons. Differently of the previous DG's studied she did not have a WHO career before her DG candidacy. Furthermore, she was the first woman to fulfill this post. Bruntland achieved an international recognition by United Nations members for her distinctive work as a Norwegian Prime Minister in 1981 (WHO, 2020e). With her revealing

p. 257-302, 1979.

[45] Conference of Alma Ata – To know more about the Alma-Ata Conference and the creation of programs for public health systems see also (PIRES-FERNANDO; CUETO, 2017)

[46] In the 1980s, within the neoliberal wave, the IGOs became a place of economic opportunities for policymakers within the neoliberal period. The WHO was also recognized as a place wherever positive financial outcomes could be achieved. To know more see also: (KRIPPNER, 2007)

work in 1983 she was invited by the United Nations to arrange the World Commission on Environment and Development and become step by step internationally appreciated. It is also noteworthy, that Bruntland has in her biography several influence from social democrats' aspirations and developed works as political activist in areas as sustainable environment. This previous experience, even outside of the WHO ensured her prominence in international scene and endeavor her election as a DG by the Health Assembly at 1998. As a Director General she faced some difficulties explained by the fact that the budget was severally limited in the previous years, aggregate by the fact that Nakajima's management was criticized for over-centralization (GUILBAULD, 2014)

Towards this context, Bruntland take over DG position, with challenges to maintain policies and create new ones. Besides the policies some expectations over WHO changes in management were created through her. Concerning her main policies and strategies adopted she made relevant changes in WHO structure. As from the evidences, we may say that Bruntland spearhead what some years later would be recognized as the Framework of Engagement of non-state Actors, (FENSA). Bruntland worked to build up fruitful relations with private sector and industry. Thus, she was an "advocate of the public-private partnerships to tackle health issues" (GUILBAULD, 2014, p.4) . Regarding to the policies she played a crucial role fighting against Malaria and worked on enlarge immunization access, above all, for developing countries. Beyond the efforts destined against Malaria proliferation, Bruntland's term was remarkably by the creation of the Framework Convention for Tobacco Control (FCTC). Bruntland, sought to reduce the consequences of the massive use of tobacco and faced some adverse circumstances with industry to establish the framework. Despite the difficulties, the FCTC come into force in 2003 and is perceived as one of the outstanding achievements of Bruntland's mandate. After her five years term she did not seek for reelection, probably because her health problems that limited her actions .

With the end of Bruntland's term, the korean Dr. Lee Jong Wook took over the position of DG. Doctor Lee was a physician and also achieve his medical degree at Seoul National University's College of Medicine. Doctor Lee took over his position as a DG in 2003 for his term and become the first South Korean chief administrative at the WHO. Similarly, as much of DG's elected at the World Health Assembly, Lee had previous expertise working through the institution. "In 1983 Lee began his long association with the World Health Organization (WHO) by accepting a position as a leprosy consultant at the agency's regional office in Fiji (WHO, 2020d)". Hence, he become the leader of policies addressed for controlling leprosy at the region of South Pacific. Despite of not willing to hold for a long time at the WHO, Dr. Lee passed plentiful years of his career at this international organization.

Among the policies delineated by Dr. Lee we identified considerable efforts in eradication of Polio in Western Pacific, Tuberculosis, Immunization and notable initiatives to build upon bridges with private sector. As well as Brundtland, Lee seemed to encourage the partnerships with non-state actors, above all, with private sector. He was internationally

recognized for his noticeable action to construct strong health relations related against tuberculosis, and to build upon the Global Partnership to Stop Tuberculosis. One of the most influential partnership, that needs to be highlighted is the Boston Globe and is considerable for "having brought the leadership and political skills needed to build consensus and 'spur former antagonists to work together'" (WHO, 2020e). In a summary way, Doctor's Lee managed the institution in a clever and active way, supporting the WHO Reform Process. His management was distinguished for the several coalitions he has made with international partners. In other words: "Dr Lee led the growth of a remarkable and complex coalition of more than 250 international partners that includes WHO Members States, donors, NGOs, industry and foundations". Doctor Lee did not finish his term. He was suddenly accompted by an infirmity which led him to death on May 22 in 2006.

Towards the death of Dr. Lee, his assistant Director-General, Dr. Anders Nordström took over position in May 2006 until January 2007. Dr. Anders besides being an Assistant Director during Lee's term, was appointed by the Executive Board to fulfill the position of DG. It is noteworthy that, since 2003, Dr. Anders took office at the WHO for supporting the policies and programs drawed by Dr. Lee. In this sense, Dr. Anders closely shared with Dr. Lee's vision, also working for a more 'effective and efficient organization that is equipped to "do the right things, in the right place"'(WHO, 2020a). Regarding the policies Dr.Anders worked to strengthening the initiatives of WHO Reform, seeking to amplify the budget, the human resources while improving the transparency and accountability within the institution. Furthermore, he focused to the enlargement of the health partnerships with the WHO and different non-states actors as private sector, among others.

Concerning his main policies, Dr. Anders has considerable expertise in the fight against AIDS, and before his career at the WHO he worked in programs destined for reducing the poverty and increase the development of African and Latin American Countries. His action was connected to the Swedish Red Cross and International Development Cooperation Agency (WHO, 2020e). Upon his short term as DG he followed up Lee's initiaves two increase the efficiency of the institution and strengthening policies to fight against AIDS. In 2007, he left the DG position and was succeeded by Doctor Margareth Chan.

Doctor Margareth Chan was a doctor from Republic of China and obtained her medical degree at University of Western Ontario, at Canada. Before entering at the WHO career, she dedicated many efforts to public health, especially when she was at Hong Kong Health Department. During her work as a health chief in Hong Kong she developed actions to control communicable diseases and increase surveillance. She managed in a convincing way the outbreak of avian flu- influenza, and severe acute respiratory syndrome (SARS), towards the year of 1994 (WHO, 2020b). Even with her noticeable health experience, Dr. Chan started her WHO career only in 2003 at the Department for protection of Human Environment. Owing to her respectable experience to lead with communicable diseases and influenza, she was designated as a Director to the department in charge to care of Communicable diseases

and managed the Influenza Pandemic at that period. In the same year, 2005, she was also nominated as Assistant-Director for Communicable diseases. With this professional trajectory she started to be perceived as a potential Director General for being elected at the World Health Assembly in 2006 for her first term and was reelected in 2011 for her second term that begun in 2012 and have finished in 2017.

In 2006, she was one of the five potential candidates to fulfill the DG position. After the Health Assembly Dr. Chan was elected as a new Director General of the WHO. Among her main issues, in her speech of acceptance she highlighted that she shared similar visions as her predecessors and was interested in focus his term to improve WHO technical, administrative and political skills in order to reach powerful health results. Dr. Chan was also interested in developing and strengthening policies for women and developing countries as African countries, as she has mentioned in her speech of acceptance: "what matters most to me is people. And two specific groups of people in particular: I want us to be judged by the impact we have on the health of the people of Africa, and the health of women" (WHO, 2006). Dr. Chan was determined to implement operational changes within the WHO. Besides the improvements and policies to lead with the outbreaks of influenza and SARS, she additionally employed many efforts in strengthening relations with non-state actors and create a wide-range alignment with civil society, private-sector, among other actors. The evidences suggested that Dr. Chan followed up Bruntland's and Lee's initiatives of opening up the WHO to non-state actors as a means to enhance the institution's performance and effectiveness (WHO, 2006). Thus, one of the cornerstones of Dr. Chan terms was the consolidation of the ongoing process for accepting non-state actors into systematic basis, knowledge as the Framework of Engagement of non-state actors, FENSA, in 2016, as will be better discussed in other section. Furthermore, Dr. Chan was a powerful DG to fight against SARS and worked for strengthening policies to lead with communicable diseases. Dr. Chan managed the WHO as a chief administrative until 2017 at the end of her second term she was followed by Dr. Tedros from African Region.

Since June 2017, Tedros Adhanon Ghebreyesus of Ethiopia, take over position as head of the institution. He is the first African administrative chief to fulfill this position at the WHO. Ghebreyesus was elected in a process considered single for being more transparent than the others who elected Directors-General at WHO. The process that elected the General Director of Ethiopian origin was voted by the 194 members of the World Health Assembly, as opposed to previous processes whose voting was carried out by the 34 members of the Executive Committee. In other words he was directly elected by the World Health Assembly rather than of experts from Executive Board (WHO, 2020c).

Regarding his previous experience, "Dr. Tedros was an Ethiopia's Minister of Foreign Affairs from 2012-2016 and led considerable efforts to negotiate Addis Ababa Action Agenda and achieve financing for Sustainable Development Goals" (WHO, 2020c). During 2005 to 2017 he was Minister of Health in Ethiopia and his efforts have increased the health care access to Ethiopian population. He has also a prominent passage as a chair of "the Board of

the Global Fund to Fight AIDS, Tuberculosis and Malaria; as a chair of the Roll Back Malaria (RBM) Partnership Board" among others (WHO, 2020c).

Similar to state elections, which seek to elect representatives by voting, there was a campaign of candidates David Nabarro from the United Kingdom, Sani Nishitar from Pakistan and Tedros Adhanon Ghebreyesus from Ethiopia seeking support and voting from the others members. Tedros Adhanon has received support from different countries and institutions, as such the African Union, countries such as Brazil, US philanthropists such as Bill & Melinda Gates, civil society, among others. At the occasion of the seventieth World Health Assembly he was elected as a Director General. As soon as he took office on July 2017, he outlined the priorities for his term. In summary way, he highlighted five priorities, which are: "universal health coverage; health emergencies; women's, children's and adolescents' health; health impacts of climate and environmental change; and a transformed WHO (WHO, 2020c).

Its is still kindly early to evaluate Dr. Tedros management. Although, we can see some directions appointed by Dr. Tedros as administrative Chief of the WHO. Among the features of his term, the evidences suggests that he has been attempting to strengthen partnerships and have been seeking to reform internal governance, however, he seems to adopt strategies different from her predecessor, Dr. Chan. Dr. Tedros is focusing on WHO capacity to lead with emergencies, public health, human rights, and solve internal problems as accountability and transparency (WHO, 2020c).Moreover, Tedros is facing a great challenge in the management of Sars-Cov-2 (COVID-19) pandemics crisis. Therefore, the management of Tedros seems being more challenging than it could appears. According to data collected, we may say that he has been facing conflict of interest with major donors, of the WHO, as such the United States, -for example (verbal information), which not totally support the projects of public health. The conflict of interests between Gebreyeusus policies can impede the development of new policies and the strengthening of currently programs.

As we could see above, many factors could influence the management of the institution. The DG needs following the WHO Constitution; nevertheless, the nationality, the DG background, the context, and the conflicts of interests the DG's face could influence the policies and programs developed along with his or her term. Besides the DG's position, the policies could change from headquarters to regions. As we shown each country is allocated towards a regional committee, and each of them has its staff and regional director. In summary way, the bureaucratic structure of the regional committees corresponds to the same structure of the headquarters, as will going to demonstrate below.

4.4.2 The Regional Committees of the WHO

The World Health Organization is managed regionally by WHO's regional organizations. Differently from many of the international organizations from United Nations system, the regional bureaucratic structure is more than merely a regional representation, it really works

as regional organizations. This difference implies that each Regional Committee can apply for specific policies and programs which could be more feasible, being in somehow different with WHO official headquarters. This difference can be explained by the authority and autonomy of regional organizations to employ and conduct their regional actions. Despite the structure, similar to the headquarters, the director has enough authority to guide and employ actions in a different way of the headquarters. For the WHO six regions are considered, which are: Africa, Americas, Eastern Mediterranean, Europe, South-East Asia, and the Western Pacific.

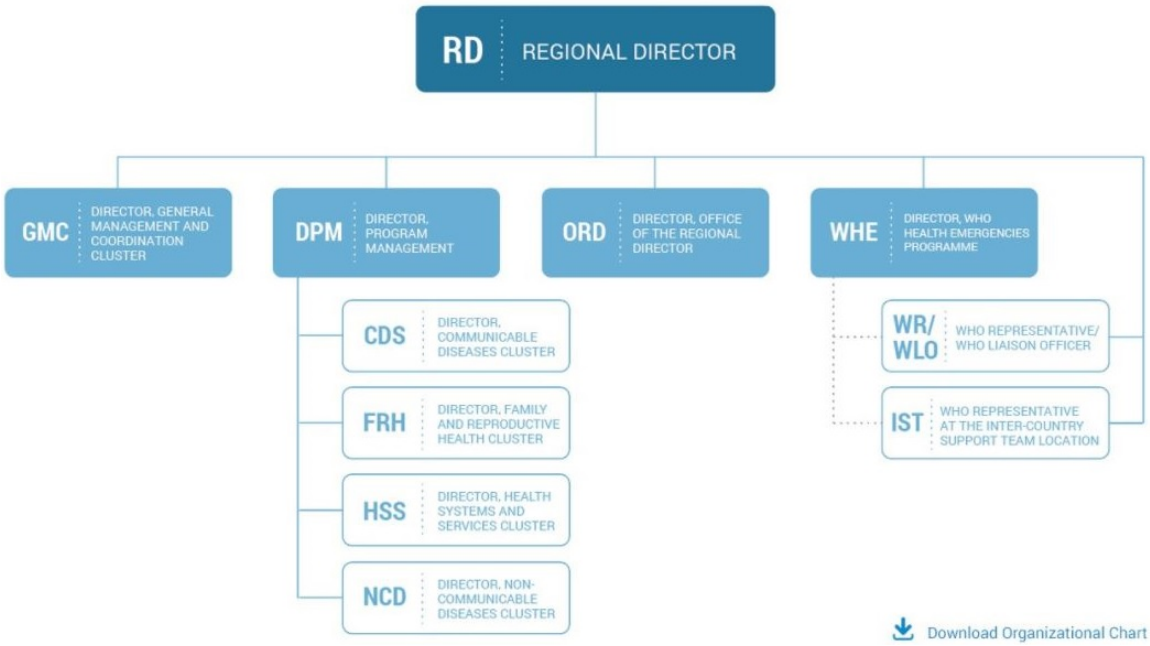
Regional organizations are a powerful WHO arm in the combat against regional diseases. As demonstrated before, the creation of the first intergovernmental regional organization, called Pan American Sanitary Bureau in 1902, recognized nowadays by Pan American Health Organization, fostered the creation of Regional Committees into WHO basis (BEIGBEDER, 2017). The existence of endemic diseases in different regions of the world made the creation of global health policies unfeasible. With this argument, in 1948 the WHO called for the incorporation of regional health organizations and the creation of new regional bodies to create a greater geographical balance within the institution (LEE, 2008). Since the creation of the Regional Committees, each Member State has been allocated to a regional office related to its geographical region and coordinated by Regional Directors. The secretariat of each regional office roughly corresponds to the structure of the WHO headquarters in Geneva. Although, the major distinction in this case is related to the addition of specific programs for the region.

The considerable autonomy of the regional directors can be viewed as from two perspectives: in one hand it can decentralize actions from the headquarters and may contribute to be more efficient in the fight against regional crisis. Nevertheless, in the other hand, the decentralization can create a lack of authority between regional committees and the policies established by the Director General in Geneva creating political tension. In other terms, "'this degree of decentralization fragments the organization, jeopardizes programmed coherence, and weakens accountability'" (LEGGE, 2012; BEIGBEDER, 2017, p.7).It is noteworthy that the autonomy of the regional committees is one of the American requirements. As mentioned before, the United States only allowed the "integration of the Pan American Sanitary Bureau into WHO in 1948" (ibidem) for its autonomy achieved. In a summary way, the structure of the regional committees can be presented as follows:

The figure presented above represents the organizational chart of the regional office in Africa [47] . This image could be illustrative to show the main structure of the regional committees and the autonomy of each regional director to lead with specific diseases and emergencies. Besides its regional director, which acts as an administrative chief of the regional organization, each regional organization has its provisional agendas and the budget to create programs and policies addressed for regional emergencies. While the African organization is focused on epidemics as Ebola virus, Malaria, and HIV/ AIDS, for example, the Southeast Asia

[47] To know more information access: <https://www.afro.who.int/about-us/organizational-structure>

Figure 4.1 – WHO structure of Regional organizations



Source: (WHO, 2020g)

organization leads with emergencies as the Pandemic of Influenza and natural catastrophes, as tsunamis at regional countries as it happened in 2018 in Indonesia.

The decentralization of tasks from the WHO headquarters can contribute to being more useful to give answers to the outbreaks of each region. Nevertheless, as appointed below, the autonomy of the regional directors and possible political conflicts between regional directors and WHO headquarters could impede to solve problems more accurately. According to verbal information collected, we identified that could exist divergence of interests from regional staff and WHO headquarters, and this could affect the composition of the budget and the voluntary contributions the regional committee can receive. The budget is an essential part of the WHO dynamic and regional committees, as will going to show the following.

4.5 THE BUDGET ISSUE: AN INSTITUTIONAL DILEMMA

Likewise, most of the international organizations, the WHO's budget is composed of accessed contributions and voluntary contributions. The accessed contributions, also called core contributions, are sending by states as from the state capacity, based on gross national product and the state population. In other words, the donations sent by the States are directly proportional to the GDP of each country. Thus, the more the developed members are the largest the donations sent to the WHO tends to be. The main contributors can donate until 25 percent of the institution's budget.

The United States is one of the main contributors, sending towards 22 percent of the resources of the regular WHO budget. It is essential to mention that US aid is forwarded through different channels and not only by assessed contributions. The US is also an impactful

donor of different health institutions. The resources directed to health institutions are usually called Development Assistance for Health, -from now on-, DAH. From 2010 to 2018, the US was the major contributor providing 13.2 billion dollars to more than 100 countries in 2018. As an example, the US provide funds for bilateral agencies as United States Agency for International Development (USAID), Global Fund ($733.5 million), Global Alliance Vaccines (GAVI) ($233.8 million) and NGOs which received towards 34,1 percent of the United States Development Assistance for Health (DAH) (MICAH; DIELEMAN; CASE, 2019, p.53).

The budget can represent the level of engagement of one country in the institution, which means that the country which pays more tends to be more engaged in the institution's process of decision-making. It is noteworthy that the WHO works with the system of proportional justice [48], and the most prominent donors do not have any privileges for its payments. This fact can discourage some states from keeping on following the contributions. In other words, the WHO has "little leeway to force states to pay even their membership dues; loss of voting rights is the most extreme step it can take, but this approach is rarely taken unless a state is in significant arrears" (CLINTON; SRIDHAR, 2017, p.2).

Otherwise, the voluntary contributions are donations usually destined to specific programs, which is usually called earmarked donations. In this case, there is not a criterion to select the donors, and this can be sent by states, nongovernmental organizations, companies, among others, and destined to specific programs. As we have inquired, the voluntary contributions are more flexible and can be addressed to particular policies and being suspended whenever the donor judges it is appropriately. "Currently approximately 80 per cent of WHO's budget is in the hands of philanthropic foundations such as the Bill & Melinda Gates Foundation, (verbal information) a small number of industrialized countries that provide voluntary earmarked funds and 'Big Pharma'"(BEIGBEDER, 2017, p.10). As inquired, "the move towards the partnership model in global health and voluntary contributions to WHO and the World Bank allows donors to finance and deliver assistance in ways that they can more closely control and monitor at every stage" (CLINTON; SRIDHAR, 2017, p.5). This way, voluntary contributions, and earmarked contributions can be viewed as a leeway of influential donors to achieve their goals.

The United States is one of the countries that usually send earmarked contributions to the WHO through different channels of Development Assistance for Health DAH, which is sending especially for emergency programs. According to data collected, the United States send around 480 million dollars for emergency programs (verbal information). The institutional budget reveals the vulnerability of the institution from its members. The budgetary dilemma is a trade-off generated between the contributions submitted and the absence of political privileges and incentives for contributors. Whereas the WHO adopts a global policy of equality among its members, the balance of institutional rights and duties seem to leave the institution

[48] We use the concept of proportional justice applied to International Intergovernmental Organizations to refer to possible privileges that richer countries can achieve at the decision-making process, as such voting rights, for example.

vulnerable to the political maneuvering of its contributors.

The biggest donors can obstruct the advancement of institutional programs and projects suspending their resources. This way, in accordance with Beidberger (2017) "the main and most critical issue for WHO has been its progressive and vertiginous loss of control of the regular, public and compulsory budget" (BEIGBEDER, 2017, p.10). In the 1980s and mid-1990s, the WHO was considerably affected by the neoliberal wave. Throughout the period based on market logic, many WHO states undergoing the privatization of their health care systems, this way, the institutional budget has been frozen, creating a scenario of containment in many of the institution's programs.

The neoliberal dilemma of the 1980 decade, above mentioned, encouraged the US suspending donations doomed for the WHO. The budget obstruction frustrated the carry out of institutional projects and programs in the long term. Given the imbalances between regular budget and extra-budget resources, raised concerns about the organization's ability to consolidate its strategic planning, and the broad nature of programs designed by the organization.

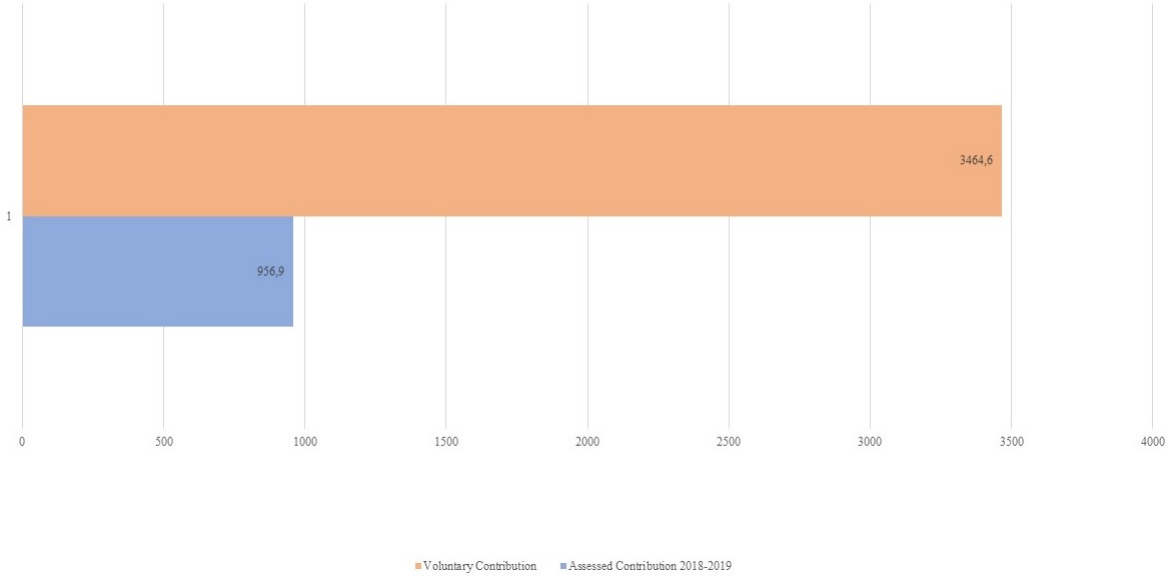
Currently, some strategies have been considered to implement programs and projects. One of the changes strategically adopted at Tedros management is the WHO "new financing model," defined as a more "realistic and driven by priorities" (WORLD HEALTH ORGANIZATION and others, 2017, p.11). Nevertheless, what we could evidence is that the WHO has been financed most and foremost by voluntary contributions, and as mentioned before, this could influence the loss of budget control of the organization. The high amount of sources from voluntary donations, against the decreasing of assessed contributions, seems to be a problem that creates an institutional weakness in the institution and encourages it to search for new strategies to develop programs and policies.

As approved by the Seventieth World Health Assembly, WHA, on 26, may of 2017, the amount of resources for the financial period 2018–2019 was 4421.5 million dollars. This value combines assessed and voluntary contributions. Regarding the origin of the sources, the WHA resolved that 956.9 million corresponds to the assessments from the Member States, while 3464.6 million dollars would be provided by voluntary donations (WORLD HEALTH ORGANIZATION and others, 2017, p.148).

Concerning the distribution, the programs, and policies related to communicable diseases receive the most of WHO resources. In other words, the programs for fighting against outbreaks and emergencies could take the major part of institutions budget, as the case of Ebola in Africa or Influenza in Asia, for example. At the figure of budget distribution, we aim to present some areas of priorities according to the budget planning of WHO 2018-2019. It is noteworthy that the amount of resources from policy to policy could variate every program budget, and this variation can be explained predominantly by the budget available at the institution and the areas of priorities of each term of a Director-General.

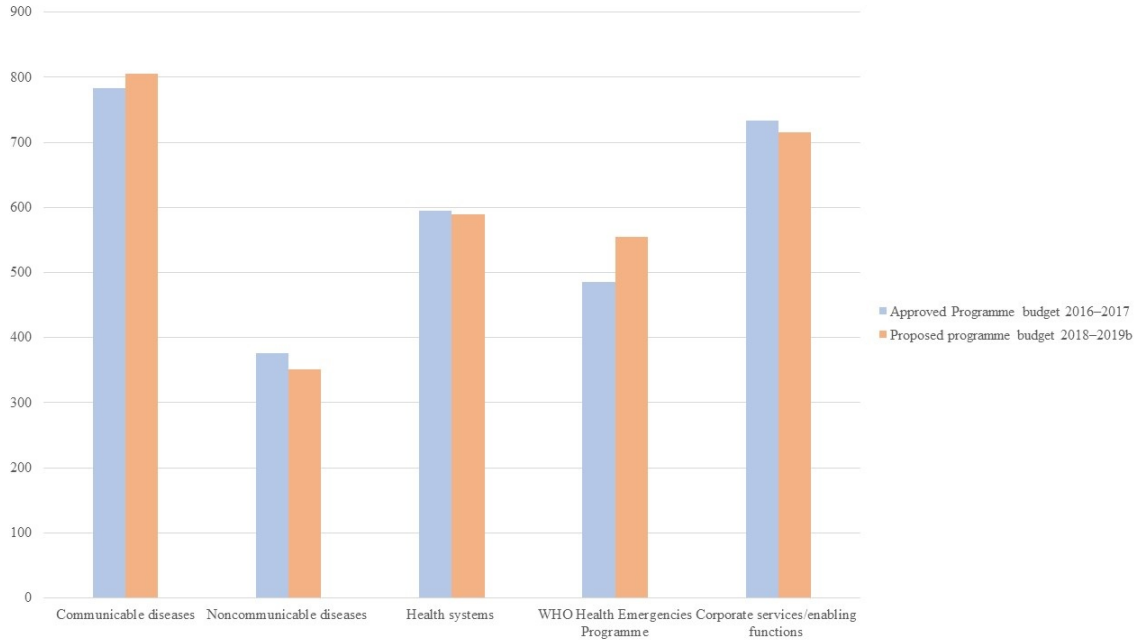
[49] Licence allowed by creative commons-(CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/

Figure 4.2 – Assessed contribution vs Voluntary Contribution 2018-2019



Source: Self elaboration as from (WORLD HEALTH ORGANIZATION and others, 2017, p.9)

Figure 4.3 – Budget distribution (2016-2019)



Source: Self elaboration as from (WORLD HEALTH ORGANIZATION and others, 2017, p.9)[49]

Traditionally the area of communicable diseases have been receiving the most part of the resources. In accordance with the WHO purposes expressed towards the Constitution to fight against health emergencies is listed as an institutional priority. Comparatively from 2016-2017 programme budget, we could evidenced some punctual changes towards specific programs, as such the decreasing in allocation of resources through non-communicable polices and corporate

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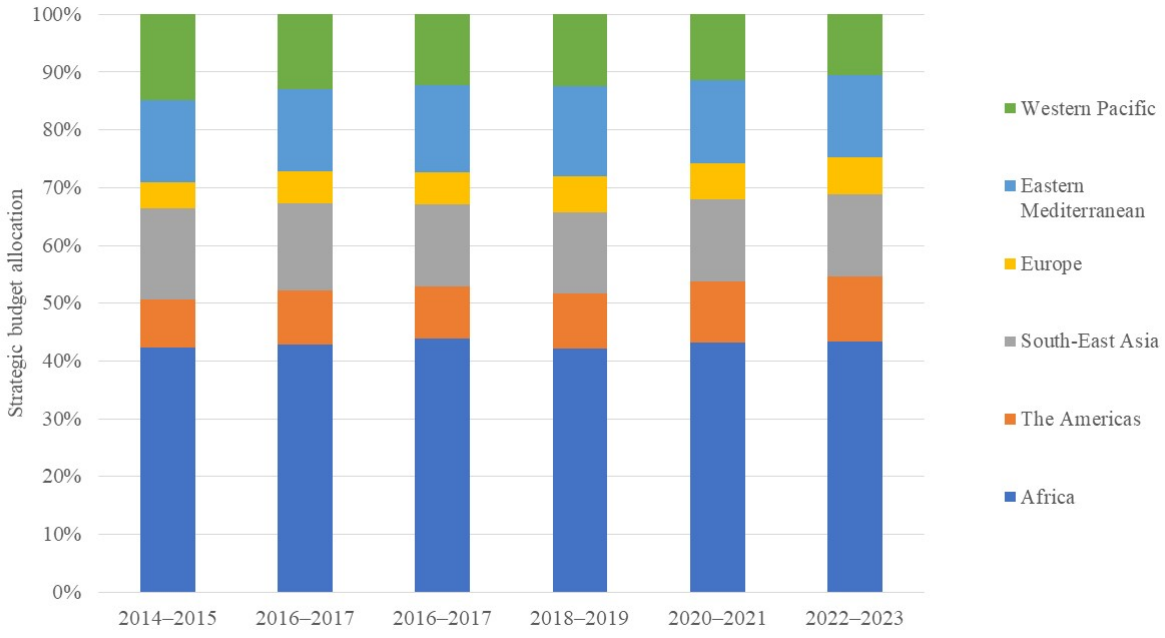
services. As we have inquired, the allocation of WHO budgets usually follow at least two pillars, a normative pillar and an operational pillar. The normative is related to the creation of norms and programs for a long term, which involves researchers, experts, consultants and plenty of meetings. The operational pillar is related to the staff and resources which is usually addressed to emergencies and solutions of crises (Verbal information). Additionally, we could also consider that these pillars are related to financing of programs, -normative-, and financing of staff, operational.

The budget of the headquarters is commonly redistributed towards the regional organizations of the WHO. The budget sent for each regional organization is proportional to the demands faced by each one. The distribution of the budget through the regions is based on health emergencies and outbreaks faced. Regarding the functions of regional organizations, they need to "provide technical support to implement actions plans, to develop regional networks, to disseminate recommended policies and programms to prevent, care and treat epidemics, among others" (Programme Budget, 2019, p.21). As represented in the figure, the African-Region have been receiving the largest part of the budget, what could be justified by the necessity of African leaders to provide intense support to give answers for the epidemics and diseases in that region.

Figure 4.4 – WHO Budget Regional allocation



Source: Self elaboration as from (WORLD HEALTH ORGANIZATION and others, 2017)[50]

An expressive amount of sources is allocated to Africa and Eastern Mediterranean. The Eastern Mediterranean comprises countries as Afghanistan, Egypt, Iran, Somalia, United

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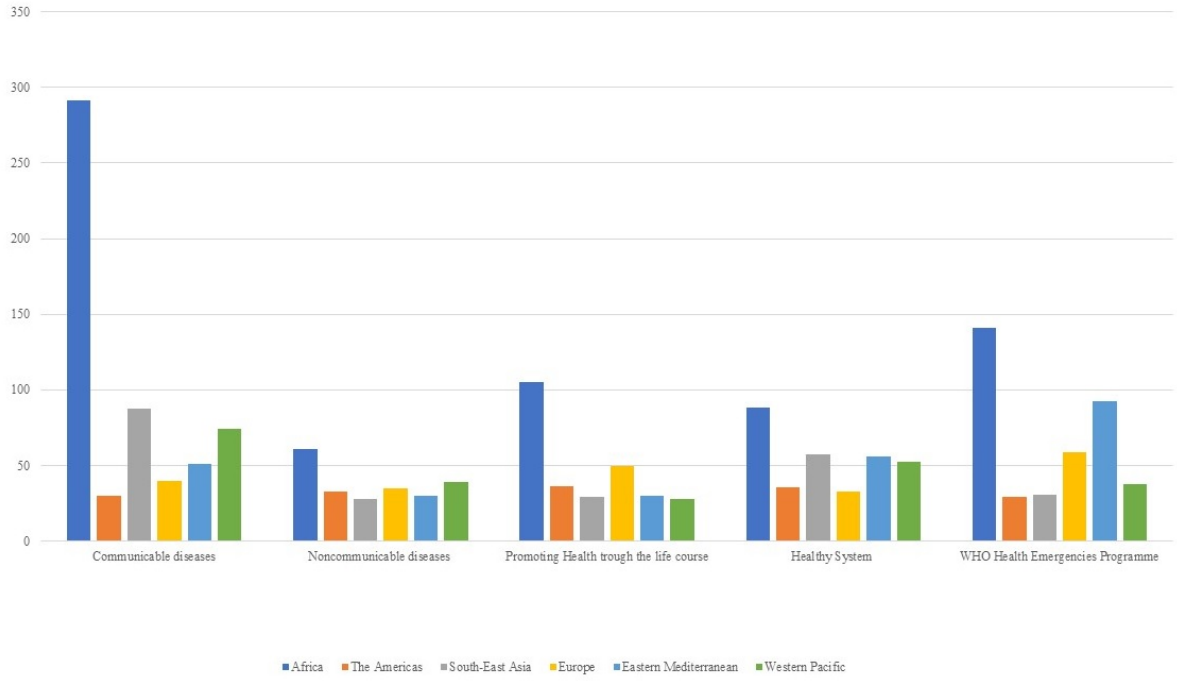
Arab Emirates, among others [51] . As we can demonstrate through Figure 4.5, the African countries receive the biggest amount of sources to lead against communicable diseases, as HIV, hepatitis among others. The Eastern Mediterranean Regional Office (EMRO), receives considerable resources to strengthen the regional capacity to lead with health emergencies towards its different countries. Among the diseases we can mentioned the fight against cholera, and poliomyelitis.

Figure 4.5 – WHO Regional distribution of the Budget



Source: Self elaboration as from (WORLD HEALTH ORGANIZATION and others, 2017)[52]

Budgetary constraints and difficulties in implementing programs have enabled other actors to act on the health agenda on a global scale. Among these actors include international organizations such as the World Bank, for example, private foundations such as Bill & Melinda Gates, civil society organizations such as NGOs, programs for specific health actions such as UNAIDS, United Nations AIDS Program, among others. The various actors that have been acting on the world health agenda have structured what the literature has characterized as global health governance as we could see in the next section.

[51] Countries in the WHO Eastern Mediterranean: Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen. Source: https://www.who.int/about/regions/emro/en/

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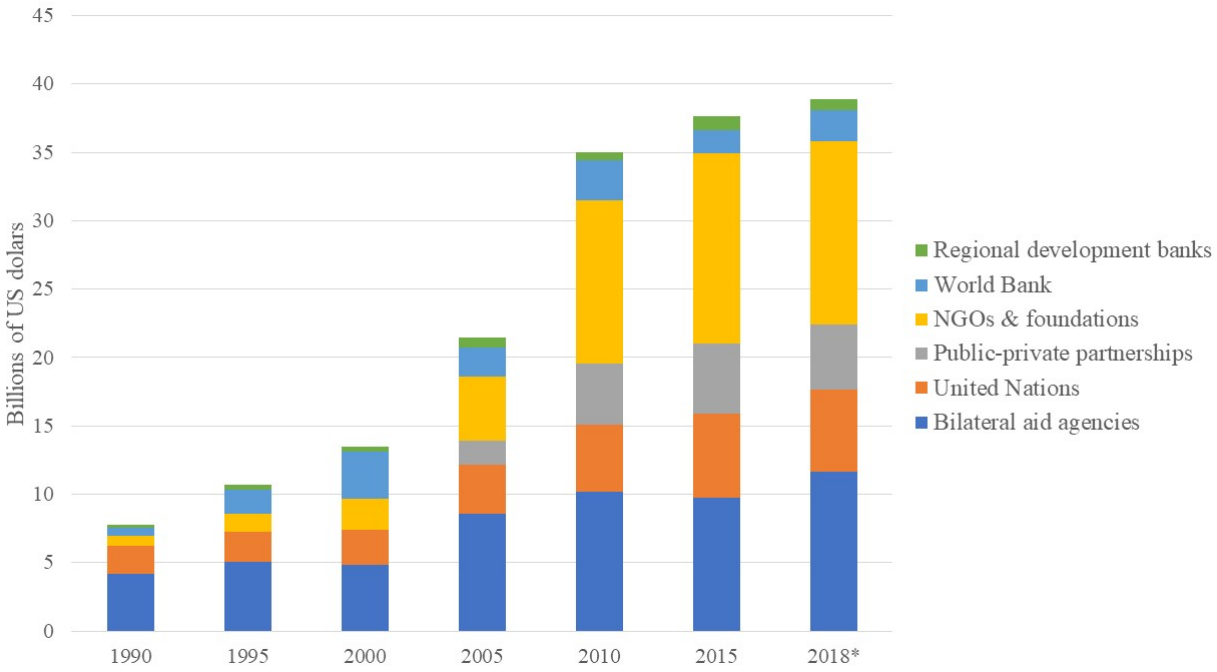
4.6 WHO FINANCE THE GLOBAL HEALTH GOVERNANCE?

As from the analysis of the budget, we could evidence many actors interacting at the global level and consolidating what we analyze as global health governance. The WHO needs more and more financial contributions from different actors to support the budget and keep delivering international organizational projects. As demonstrated through the graphic Assessed and Voluntary contributions (2018-2019), the budget is in its majority composed of voluntary contributions nowadays.

As shown above, the organization created for health is susceptible to assessed and voluntary contributions, which undermines the power of institutional agency. Institutional gaps appear to be filled by different non-state actors. We may say that the WHO's volatile budget is a consequence of the donor's mistrust in this agency (CLINTON; SRIDHAR, 2017). The lack of accountability and transparency for organizational members and the absence of voting rights for non-state actors are widely criticized. The United Nations agencies usually admit non-state actors as observers; nevertheless, most UN agencies do not ensure voting rights to them. At the WHO, however, the difference comes from the fact that non-state actors send a sizeable part of the WHO financing. In other words, "despite a proliferation of plenty initiatives, much of the financing for global health cooperation comes from few powerful donors" (CLINTON; SRIDHAR, 2017, p.1), as we can see in the figure entitled Channel of Assistance.

Figure 4.6 – Development assistance for health by Channel of Assistance 1990-2018



Source: Self elaboration from data available by the Institute of Health Metrics and Evaluation (IHME) Financing Global Health (2018)

According to data analyzed from the Institute of Health Metrics and Evaluation, there

is a plurality of institutions involved in global health governance, which can be multilateral aid understood as donations made by institutions that comprise two or more governments as such the World Bank. Bilateral assistance, characterized as foreign aid made by governments like the United States, United Kingdon, destined for specific purposes as such the US donations to African emergencies, as mentioned above. There also exist programs as UNAIDS, Global Fund, Global Alliance for Vaccines and Immunizations, GAVI, that provide direct support to agendas and concurrently can act as mechanisms of financing within the WHO. In other words, these programs can also create conditions to develop some policies against others. To be more precise, it is possible to say that there are different kinds of actors interacting in Global Health Governance. As we can see through the table "Global Health Governance players," we may associate those actors with different categories:

Table 4.8 – Global Health Governance Players

Player category	Examples	
States	Great powers	United States, China
	Emerging powers	India, Brazil
	Developed states	Britain, Canada, Germany, Japan, Norway
	Developing countries	Bangladesh, Indonesia, Kenya, Venezuela
	Failing or failed states	Congo, Haiti, Zimbabwe, Somalia
IGCs	Multilateral	ILO, UN, UNAIDS, UNICEF, World Bank, WHO, WTO
	Regional	African Union, ASEAN, European Union
PPPs	Mechanisms to increase access to health technologies	AMCV; GAVI Alliance; Global Fund; IFFlm
	Drug and vaccine development partnerships	Drugs for Neglected Diseases Initiative, International AIDS Vaccine Initiative, Medicines for Malaria Venture, Malaria Vaccine Initiative, TB Alliance
Nonstate actors	Philanthropic foundations	Bloomberg Initiative, Carter Center, Clinton Foundation, Gates Foundation, Rockefeller Foundation
	NGOs and civil society groups	Amnesty International, Doctors Without Borders, Human Rights Watch, Oxfam
	Multinational corporations	Food and beverage, pharmaceutical, and tobacco companies

Source: (FIDLER, 2010, p.12)

4.6.1 The action of great powers and bilateral aid

States have different understandings about the importance of health and politics. Among the largest donors, there are significant contributions from the United States and the United Kingdom. It is worth noting that the USA traditionally acts through multilateral aid (assessed contributions) and bilateral channels, with donations for specific programs, such as

emergency issues, as such, the President's Emergency Preparedness for AIDS Relief (PEPFAR), and other programs as such the Global Fund. The creation of this mechanism to address funds directly to specific programs is a strategic way of controlling the WHO and the main actors of the GHG. States as the US and emerging powers as Brazil, for example, recognized in health a valuable component of smart power, and a way to use health as a soft power in international politics. Not only emerging powers but also major countries have also been using global health to express their interests, such as the United States, the United Kingdom, among others (FIDLER, 2010).

4.6.2 The International Organizations

As presented by the figure "Global Health players," the collective action in global health counts on the participation of several International Organizations (IOs). IOs that work in the complex health regime can contribute to filling the gap not filled by the WHO through the financing and execution of institutional projects, in Fidler's (2010) words: " IOs have become more prominent as venues for analyzing problems, designing solutions, and facilitating negotiations"(FIDLER, 2010, p.12). Nevertheless, they can generate competition and hinder the coordination of collective action. In this way, GHG constitutes a decentralized and polycentric regime, in which the WHO is unable to coordinate the efforts of the actors involved in international cooperation. The WHO was created to coordinate health-related actions; however, the diversity of IOs acting at global health policies generate a conflict of authority with the WHO.

4.6.3 The World Bank

Among the actors of global health governance, the World Bank is a prominent player. Since the late 1960s, the World Bank has been adopting a pro-development discourse and has been able to work in health fields little explored by WHO, such as family planning. According to Youde (2012), the World Bank has a significant role in health governance for three reasons. Firstly, the World Bank has a more technocratic and non-political image, an important feature compared to the WHO, which acquired a political vision in the 1970s because it was viewed as sympathetic to socialism for supporting health equality for all.

Secondly, due to the budget dilemma and the WHO vulnerability, the international organization cannot take on new projects or follow up on ongoing projects. Thirdly, the World Bank institutional responses to further health challenges. The WHO is comparatively slow to give answers for specif issues. The World Bank, in a different way, adopts a more robust structure and can respond more accurately to the demands. The financial bank resources allow it to fill the gap left by the budget weaknesses that the WHO faces(YOUDE, 2012).

The World Bank is an old actor in GHG. As studied by researchers such as William; Rushton (2011), global health governance has been experiencing an ongoing process through

which actors are more frequently involved in this arena. The transformation of this arena reveals old and new actors, changing the architecture of this multilateral cooperation and the distribution of power. Nonetheless, we have been watching a new generation of actors involving in this arena, as from the emergence of global health partnerships, private foundations, and business actors as legitimate players in global health governance (RUSHTON; WILLIAMS, 2011). Once the World Bank was the dominant player in GHG decades ago, as from the involvement of new actors, around the years 2000's, we can identify new channels of influence and power in global health architecture.

As Stein; Sridhar (2017) studied, since 2014, the World Bank has been working on a financial mechanism to support global pandemics due to the Ebola outbreak in Africa. Through this mechanism, the Bank proposes to create an insurance arrangement capable of attracting private investors, what the Bank has been calling Pandemic Emergency Financing Facility (PEF) (STEIN; SRIDHAR, 2017).

As mentioned above, the WHO faces budget problems and challenges to provide answers for outbreaks and health emergencies. The Ebola outbreak in 2014 foregrounded the WHO's boundaries of leading with the crisis. Within this context and the imperative of upgrade financial resources for health, the World Bank advocate for PEF creation. According to the World bank view, the PEF arise to be a global public good [53] and mobilize private financial to establish "insurance markets" for health (ibidem).

The Bank's idea is to raise private grants to avoid catastrophic consequences of pandemics, especially in economic sectors. In other terms, global health is understood as an "economic wellbeing," and this upholds World Bank efforts in providing the greatest contributions to fight against outbreaks like Ebola and to mobilize efforts to avoid severe impact in economies due to health emergencies once the "epidemics can devastate economies and threaten major investments by multinationals and small businesses alike". (STEIN; SRIDHAR, 2017, p. 2).

We could say that World Bank has become a central actor in carrying out the financial provisions and play in global health. Nonetheless, the strategies applied by the World Bank are market base and unclear. Thus, even consider the financial role of the World Bank in global health, the absence of clarity to declare the interest in making profit or provide healthcare to poor countries remains controversial.

4.6.4 UNAIDS

Another expressive player in global health governance is the joint United Nations AIDS program known as UNAIDS. The program works in a focused way, seeking to connect leaders from different parts of the world and reach effective responses related to AIDS. The joint AIDS

[53] The term public good refers to the framework used by Stein; Srhidar (2017) in which we can identify four types of goods in health: the private goods as pills and syringes; the club goods as patent and knowledge protect; common goods universal as universal health care; and public goods as information and the pandemic preparedness.

program, UNAIDS, has its bureaucracy and is maintained by 11 UN[54] system agencies that finance the proposals and policies. Thus, UNAIDS can be seen as an international bureaucracy with an independent WHO budget (verbal information).

The UNAIDS works to provide more assistance in HIV/ AIDS policies on the international stage, even though the creation of UNAIDS reveals WHO vulnerability and the existence of clusters in the global health regime. That is, it can reflect how powerful actors like the USA can create other initiatives and mechanisms to act on specific global health agendas, instead of strengthening WHO strategies and actions (FIDLER, 2010). Resources that could be allocated directly to the WHO by other IOs or States have been allocated to UNAIDS, a characteristic that may demonstrate the loss of WHO authority to deal with specific issues within global health.

4.6.5 UNICEF

Another essential agenda concerning the performance of international organizations in the field of health is related to humanitarian assistance for mothers and children. The United Children's Fund is part of the health regime with a focus on providing humanitarian aid, especially for mothers and children to issues of nutrition, immunization, health issues, and also works together with UNAIDS on policies related to HIV / AIDS. According to data provided by the report entitled Financing Global Health, "UNICEF disbursed 1.9 billion in DAH in 2018, up 16.4 percent from 2017 (MICAH; DIELEMAN; CASE, 2019, p.64)".

The external health assistance highlighted above will not necessarily be directed to a WHO policy or project. The health policy or action can be developed by another international actor, such as UNICEF, in this case, with resources or with funding received from other international actors. UNICEF has been receiving funds from philanthropic foundations, corporations, and states like the USA to implement its projects in humanitarian health assistance for mothers and children. As highlighted by the Financing Global Health report, "Private philanthropies provided UNICEF with $ 424.2 million or 22.3 percent of its funding in 2018, and the US contributed $ 209.0 million or 11.0 percent (MICAH; DIELEMAN; CASE, 2019, p.64). In this sense, global health governance has the characteristic of including several agendas in its actions and tends to ensure the right to health from a global perspective. However, the allocation of global resources focused on different international organizations, or specific global health guidelines seems to make WHO's action diffuse and, this way, spread resources that could be relevant within the institution.

[54] To know more about the cosponsors: <https://www.unaids.org/en/aboutunaids/unaidscosponsors>

4.6.6 UNFPA

Similarly to UNICEF, the United Nations Fund for Population, the UNFPA[55], is also an actor in global health governance that works mainly on issues related to sexual and reproductive health. The fund directs its policies and programs to access, family and maternal planning and newborn health. Among the central policies, there are actions such as interventions at strategic times to prevent deaths and diseases in the maternal-neonatal context. According to the consulted data related to 2018: "In 2018, the US withheld funding from UNFPA for the second year in a row. The funding from the US to UNFPA expected was $ 32.5 million for the 2018 fiscal year" (MICAH; DIELEMAN; CASE, 2019, p.64).

This subsection, destined to scrutinize the IGOs working in global health governance, do not intend to exhaust the theme of the plenty IGOs working in this complex health regime. The goal, instead, is to briefly present global intergovernmental actors who have guided actions and policies and who have been the "recipient" to receive funding from powerful actors who participate in GHG. Greater emphasis was placed on the IGOs shown in the figure Channel of assistance, but not all have been explored here. As noted, IGOs play a significant role in democratizing the global health agenda by including new agendas and proposing to implement them more effectively. However, they have impacted the dynamics of cooperation within the WHO, making multilateralism complex, and health actions increasingly diffuse.

4.6.7 The Public Private Partnerships (PPPs)

Private actors play a crucial role in Global Health governance. The private actors at global health governance constitute what the literature defines as Public-Private-Partnerships, PPPs. Many actors tried to describe the interaction between private actors and international organizations; nevertheless, there is no consensual definition of this kind of partnership. As an example, "author as such Sonja Bartsch[56] defines PPPs as output-oriented cooperation of local, national, transnational, and international actors from the public, the private, and the NGO sector" (CLINTON; SRIDHAR, 2017, p.12). Still considering the effort to define the term Public-Private-Partnerships better, Wolfgang Reinicke and researchers of these themes usually refers to this partnership as Global Public Policy Networks. According to them, PPPs could be understood as bridges established throughout different sectors of society as such, the public sector, business, and civil society, for example(CLINTON; SRIDHAR; SRIDHAR, 2017).

Regarding the fact of absence of a definition, we adopt an interpretation that seems reasonable in this context, which consists of the fact that "partnerships involve financial and/or in-kind commitments from nonstate actors such as corporations or foundations to enhance public projects. Ideally, the partners share common goals and a shared approach to achieve those goals" (CLINTON; SRIDHAR; SRIDHAR, 2017). And complementary these partnerships can create networks to enhance the projects, as discussed by Wolfgang and

[55] To know more about the United Nations Population fund UNFPA access: <https://www.unfpa.org/>
[56] Studied by (CLINTON; SRIDHAR, 2017, p.12)

colleagues. Nonetheless, for this thesis, the creation of Global Public Policy Networks seems to be a consequence and way through which the PPPs can act within international organizations and beyond. Though, the partnerships, PPPs, appears to be a financial process. In summary words, this thesis considers that PPPs are a partnership made by nonstate actors and international organizations, in which nonstate actors firstly agreed to finance IOs programs or policies and then can create networks for strengthening the diffusion of IOs policies.

Consequently, the rise of new actors at Global Health Governance suggests overcoming WHO inefficiencies. Thus considering the WHO constraints to direct its policies, the institution seems not to have a different alternative unless to engage in partnerships with nonstate actors, above all, with private actors, as demonstrated above. Before present, the main actors that play in global health governance, some aspects concerning these new partnerships need to be presented. The partnerships foment reflection towards what motivates nonstate actors to finance the global health governance, and how the WHO has been reacting. Concerning the encouragement of nonstate actors to finance global health actions, we agree with (CLINTON; SRIDHAR, 2017) that through this kind of finance, nonstate actors can impact in normative concerns and efficiency concerns.

Regarding normative concerns, the nonstate actors can create mechanisms inside the WHO and make their main ambitions easier. The nonstate actors can pose and impose different agendas within the WHO. Thus the finance can eventually democratize agendas in one hand and be a leeway to conduct the international organization to the priorities of influential donors on the other side. Second, the nonstates actors through financing can input the increasing of efficiency towards the institution. In other words, they can amplify the health fundings encouraging the WHO acting in specific agendas, even when the agenda was not considered a WHO priority (CLINTON; SRIDHAR, 2017)[57].

4.6.8 The Global Alliance for Vaccines

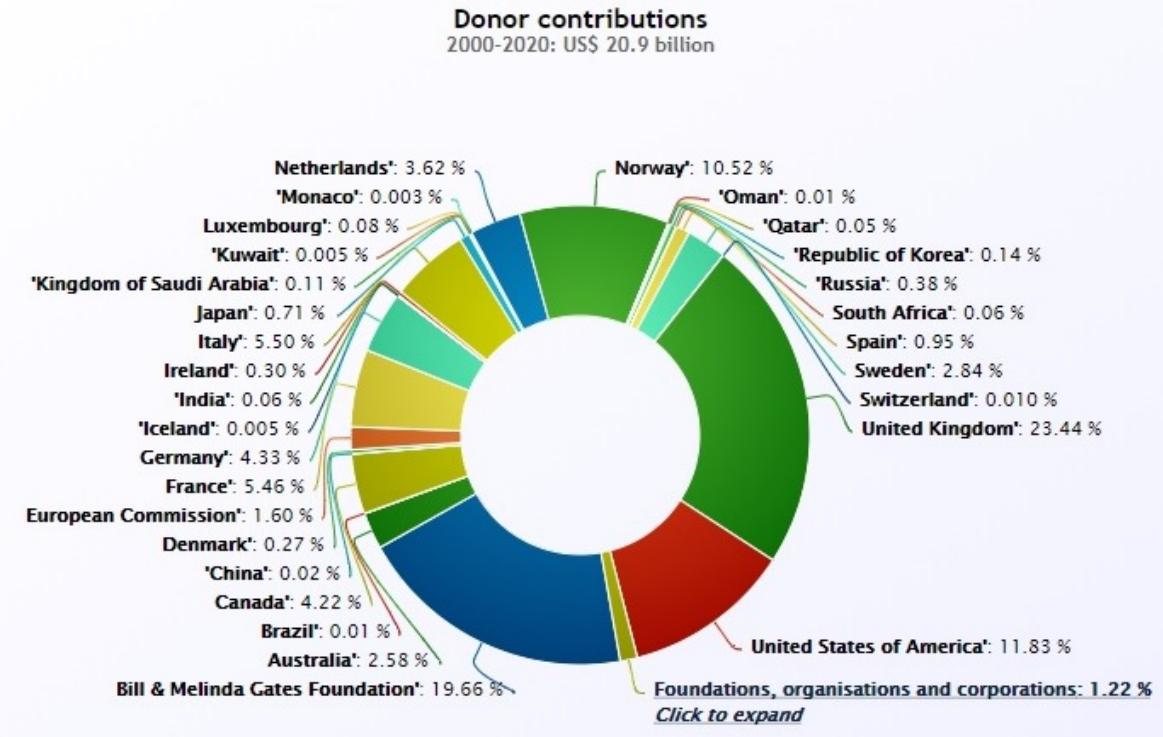
In 1999, the Global Alliance for Vaccines, GAVI, was created. The GAVI was born as a strategical partnership and a new form of governance in the global public health sector. This partnership appears with the purpose of acting more specifically in the immunization sector, especially in more impoverished and developing countries. Therefore, the main objective and mission of this new international cooperation in health were to protect mainly children and expand the conditions of access to vaccines and immunization to the emerging countries.

GAVI is considered a public-private partnership and was designed by prominent players in global health governance. Among the actors that are part of this PPP, there are: "the Bill and

[57] The authors highlighted three aspects of the action of nonstate actors in global health governance. The first is the normative concern, the second is efficiency, and the third are the shifts in global health financing and governance. The third aspect will not be explored at this moment for considering that the process tracing method can provide us other conclusions and understandings. However the reader interested in know more about this concern can access (CLINTON; SRIDHAR, 2017, p.6)

Melinda Gates Children Vaccine's program; the Program for Appropriate Technology in Health (PATH); the International Federation of Pharmaceutical Manufacturers Association; the World Bank; the Gates Foundation; US Agency for International Development in Washington, DC; the WHO, the UNICEF, and the Rockefeller Foundation "(MURASKIN, 2004, p.1922).The figure donors' contributions of GAVI alliance aims to summarize the biggest sponsors of this PPP.

Figure 4.7 – Donor contributions of GAVI Alliance



Source: GAVI,2020. [58]

It is worth noting that this new form of governance in global health has gained space under Bruntland's management and has translated into a way of raising extra-budgetary resources and voluntary contributions to the institution. The PPPs that emerged from 1998 aimed to bring together different donors and external financial grants to allocate funds for specific policies and actions, such as the immunization actions that emerged with GAVI (BROWN; CUETO; FEE, 2006).

As mentioned earlier, the Vaccine Alliance has the primary purpose of creating equality of access to vaccines for countries throughout the world. According to the data from the report of global health governance, "in 2018, GAVI disbursed 1.5 billion to vaccines and immunization"(MICAH; DIELEMAN; CASE, 2019, p.63). This public-private partnership joins different actors as such the UK, which "provides 296.3 million to GAVI in 2018, the Gates Foundation provides 310. 4 million, the US provided 238.8 million, and Norway provided 158.7 million" (MICAH; DIELEMAN; CASE, 2019, p.63). In a summary way, the GAVI is an actor of GHG which receives funds from private companies, states, and

[58] <https://www.gavi.org/investing-gavi/funding/overview-2000-2037>

philanthropic foundations, as such Bill and Melinda Gates to defend the right of immunization access for WHO countries, especially for the poorest. For this reason, we consider that since GAVI and PPPs were established, they brought a new dynamic to global health governance arrangement [59].

4.6.9 The Global Fund

The Global Fund is a response initiative to coordinate actions to combat and control three diseases: AIDS, Tuberculosis, and Malaria. The Global Fund joins private-sector, states, and other global health governance actors to foster funds to these specific diseases. The Fund was established in January 2002 to boost resources and manage efforts to control these three diseases mentioned above. The major part of funds usually flows to emerging countries as sub-Saharan Africa, for example, which suffer from devastating effects of these three maladies (BRUGHA et al., 2004). Despite being a fund, the Global Fund for HIV, Tuberculosis, and Malaria has an independent bureaucracy of the WHO. The Fund is governed "by a board of 18 votings and five non-voting members and supported by a secretariat of about 70 staffs in Geneva"(BRUGHA et al., 2004, p.95).

For having access to the grants, countries should apply and submit proposals searching to justify the real needs for receiving the Global Fund resources. Usually, the projects are evaluated by the Global Fund's technical and experts before being approved or rejected. When countries are eligible to receive grants, they need to have what researchers call a state coordinating mechanism (CCM) [60] to implement the measures for combat fruitfully and control AIDS, Tuberculosis, and Malaria. In other words, the CCM seems to connect the domestic level with international purposes and seek to support the implementation of Global Fund programs effectively. "The Fund requires CCMs to include a broad representation from governments, non-government organizations, civil society, multilateral and bilateral agencies, and the private sector. A principal recipient is a country organization that receives funds, implements, and Monitors programs"(BRUGHA et al., 2004, p.95) [61].

According to recent data, from 2018 and 2019, the Global Fund provides "17.5 million antiretroviral medicaments for HIV aids in 2018, 5 million people were tested and treated for Tuberculosis, and 197 million mosquito nets were distributed as a result of the Global Fund's programs"(MICAH; DIELEMAN; CASE, 2019, p.63). In the same way as the Global Alliance for Vaccines and Immunization, GAVI, the Global Fund, receives grants from different sponsors. Some of the financers are the US, the United Kingdom, Japan, and the Gates Foundation. In 2018, the United States provided 23 percent of the Global Fund's core budget, the United

[59] To know more about GAVI and advances of global health governance see also:(BRUGHA; STARLING; WALT, 2002)

[60] To know more about the action of CCMs see also: (BRUGHA et al., 2004)

[61] Concerning the local fund, it usually be a professional organization hired by the Global Fund, which oversight the use of receiving funds within the country selected (BRUGHA et al., 2004)

Kingdon 19.7 percent, Japan contributes with 11.6 percent, and Gates Foundation delivers 8.4 percent of the budget (MICAH; DIELEMAN; CASE, 2019).

4.6.10 Philanthropic Foundations

At least two foundations should be highlighted at Global Health Governance: The Bill and Melinda Gates and the Rockefeller Foundation. We will give more attention to the Bill & Melinda Gates Foundation - (henceforth referred to as Gates Foundation, BMGF)- for the significant amount of resources provided, comparatively more extensive than the Rockefeller Foundation grants to GHG.

The Gates Foundation is the largest private philanthropic foundation in the world. It develops a leading role in global health issues and is entirely financed by its founder, the businessman, Bill Gates. The resources are very expressive in GHG and make other IOs be fear about the real interests of this private actor in global health politics. Concerning to the grants destined to health "in 2007 the resources spent by the Gates Foundation on Global health was almost as much as WHO's annual budget and was substantially more than the total grant spending of the Rockefeller Foundation across all programmatic areas in the same year (0·17 billion dollars)" (MCCOY et al., 2009, p.2).

Besides being the wealthiest non-profit organization playing at global health governance, the Gates foundation is relevant for offering innovative techniques and support different niches of health programs internationally (YOUDE, 2013). The foundation makes generous contributions to global immunization. It plays an essential role in central areas as such secondary education, supporting US programs, and sponsoring the global development initiatives to combat hunger and poverty (MCCOY et al., 2009).

The focus of the foundation is access to immunization and the reduction of poverty and inequalities. This actor is a private non-profit actor who acts "without"[62]. financial interests within the WHO. Even so, the absence of financial interests does not mean the absence of interests, as identified by collected data. The Bill and Melinda Gates have enough power to act through the WHO decision-making channels and express their political interests through these channels (Verbal information) as related in some interviews applied at the WHO the Gates foundation can contribute or impede politics. Some programs can be approved at the WHO and receive the support of these actors. Otherwise, some policies or programs can face difficulties in being implemented.

The action of the Gates foundation at the GHG seems to make researchers of this field of study question themselves about the real interests of this private foundation in global health policies. The role played by Gates foundation can, on one side, fill the resource gap in specific

[62] We defend here that the foundation seems not being transparent in its interests. The interest's upholder by Gates Foundation seems not to be financial; it seems to look for influence and power. We agree with Youde (2013) that "Critics lambaste the philanthropy for running roughshod over international health structures, playing too dominant a role, ignoring the concerns of other actors, supporting inappropriate technologies and diverting attention from its founder's ethical lapses and economic Inequalities" (YOUDE, 2013, p.2)

areas as vaccines access, neglected diseases, as malaria, and foster the grants mobilization. We recognize that the action is not merely financial support of global health policies, it can promote the creation and establishment of networks contributing this way to increase the allocation of grants (MORAN, 2011, p.131).

Nonetheless, the action of Gates foundation in internationally is criticized by its non-transparency in the advocation of interests. While bringing more resources, this private actor seems to create what the literature has been entitling as market mulitateralism[63] . Through the market multilateralism, we refer to the idea that private foundations can bring actors to GHG to actively play the policies as transnational corporations business associations, among others. The creation of this lobbying with private companies allows private actors to become more and more embedded in global health governance (MORAN, 2011, p.131).

Private actors as foundations can shape global health governance through different ways, and one of them is towards resource mobilization, as above mentioned, and through the investment in public-private-partnerships, PPPs, to fulfill the gap in areas as immunization and vaccines. As studied by Clinton; Sridhar, 2017 The Gates Foundation has invested significantly in PPPs, including its founding 750 million dollars to Gavi to help close the so-called vaccine gap (CLINTON; SRIDHAR, 2017, p.16). Thus, the creation of PPPs seems to be a strategical way that non-state actors have been employing to rise voices, energy and grants to the WHO and the GHG.

4.6.11 NGOs and Civil Society Organizations

Civil society organizations (hereafter CSOs) can be understood in the context of global health policies as a social arena able to create bridges between states and individuals. When we discuss CSOs, we aim to refer to non-profit organizations that have considerable capacity to mobilize financial and social resources; in other words, we highlighted that CSOs could influence people in issue areas. Non-governmental Organizations (NGOs) are one actor of civil society, but for us and according to WHO documents, NGOs are not the only actor of civil society. Thus, the term Civil society Organization is a broader term that brings a wide range of actors to the international arena, including the NGOs [64].

Among a variety of civil society organizations, there are religious organizations, non-governmental organizations, NGOs, organizations that arise from patients with the same disease, and a network of health professionals organized around a specific cause. It can be said that they occupy the third place between government and market, bringing responses and interventions to local needs. According to Lee (2009), the full range of civil society organizations expresses interests and values based on the ethics, culture, politics, and science of a particular group (LEE, 2008).

[63] To know more about market multilateralism, see also:(MORAN, 2011)

[64] The Conference of Alma Ata in 1978 is a landmark in the history of CSOs in health systems. Through this document social participation were recognized and achieved a crucial role in health programs as such Primary Health Care (WHO and others, 2001, p.5)

The CSOs are essential to creating bridges between state and society. Concerning the international role, they can act as a vehicle bringing new voices and demands and creating new agendas in international forums as the WHO. Furthermore, they act in the response of lobbies and market interests in many cases (CSI, 2001). Towards the areas CSOs have engaged, there are a wide range of CSOs playing in areas "as trade agreements and health, prices of and access to drugs, international conventions and treaties on health-related subjects such as landmines, environment, breast milk substitutes and tobacco and in debates around policies and public health standards" (WHO and others, 2001, p.8).

Table 4.9 – Health Systems and Civil Society

Health system function	Examples of roles of CSOs
Health services	Service provision; Facilitating community interactions with services; Distributing health resources such as condoms, bed nets, or cement for toilets; and Building health worker moral and support.
Health promotion and information exchange	Obtaining and disseminating health information; Building informed public choice on health; Implementing and using health research; Helping to shift social attitudes; and Mobilising and organizing for health
Policy setting	Representing public and community interests in policy; Promoting equity and pro-poor policies; Negotiating public health standards and approaches; Building policy consensus, disseminating policy positions; and Enhancing public support for policies
Resource mobilisation and allocation	Financing health services; Raising community preferences in resource allocation; Mobilising and organising community co-financing of services; Promoting pro-poor and equity concerns in resource allocations; and Building public accountability and transparency in raising, allocating and managing resources.
Monitoring quality of care and responsiveness	Monitoring responsiveness and quality of health services; Giving voice to marginalised groups, promoting equity; Representing patient rights in quality of care issues; and Channelling and negotiating patient complaints and claims.

Source: (WHO and others, 2001, p.6)

To capture the CSO's, which plays in GHG, is a challenging task. Many organizations disseminate informal norms[65] and generate a considerable impact on global health

[65] We refer to the fact that same norms arise socially as a tacit agreement and are not formally legitimized by decision making bodies. According to Hein (2013), Informal norms can be considered Informal norms also play a role at all levels of social organization (from routines in everyday life to diplomatic conventions), but they are based on shared norms and beliefs and not on formal institutional decisions. There is no formal (legal) obligation to comply with these norms, but social sanctions against non-compliance can be rather severe (e.g. exclusion from a relevant social group, loss of public support) (HEIN; MOON, 2016, p.3)

governance as studied by Hein (2013) and colleagues. The norms socially created and disseminated by CSOs could impact nationally and internationally. Some of the impacts usually observed are the strengthening of transnational networks and the capacity to access medicines, share health practices and information for different people (HEIN, 2013). Additionally, CSOs could mobilize resources in a very talented way and create strategies for pressuring government against influential actors as large corporations, multinationals, and majors' sponsors of GHG that could affect health as a human right. Despite not being the only actors of civil society, NGOs are a representative sponsor that finance plenty of health areas. According to Global Health Report (2018), "NGOs channeled 2.5 billion dollars or 23.2 percent of funds to HIV/AIDS, and 4.0 billion dollars or 37.1 percent to reproductive, maternal, newborn, and child health"(MICAH; DIELEMAN; CASE, 2019, p.64).[66]

4.6.12 Multinationals and corporations

Global health governance is a cross-cutting arena. It dialogues with industries and commercial sectors in different areas. The pharmaceutical industries are the most apparent business corporations playing in global public health. Investments in medicines and vaccines are directly connected to public health. Nevertheless, the sector of ultra-processed food, soft drinks, alcohol, and tobacco, for example, must be recognized in the universe of health issues. Regarding the several impacts that the excessive use of sugar, alcohol, and smoking could generate in people's health, these industries are usually afraid of global health policy regulations, and conflicts of interest arise within negotiations.

Regarding business actors, we refer to multi and transnational corporations that directly interest people's health. Examples of business actors are the giant pharmaceutical Pfizer, the Coca Cola manufacturer, which works with non-alcoholic beverages, the food industry, Nestlé that works with ultra-processed food, baby milk (infant formula)[67]; Heineken which works in the field of alcoholic beverages. Business actors of global health governance can also be the global cartels, defined as a group of large enterprises that gather efforts against other competitors(BUSE; LEE, 2005). As an example, we may cite "the existence of a global price-fixing cartel for the sale of vitamins between 1989 and 1999 resulted in convictions in the EU and the US of Hoffman-La Roche, BASF, Merck and ten other pharmaceutical firms"(BUSE; LEE, 2005, p.8).

Multinational corporations and the private sector also play in Global Health Governance. However, the divergence of interests between state-centric organizations and business organizations seems to be one of the significant problems in this kind of relations. For example, the food industry usually resists WHO calls for reducing the level of salt, sugar, and fat on ultra-processed foods as a measure to avoid chronic diseases like diabetes, obesity,

[66] This amount refers to the Development Health Aid (DAH) provided to Global Health Governance programs and initiatives, not only to World Health Organization programs.

[67] See also: (SMITH, 2012)

heart problems, cancer, and others (GOSTIN, 2009). Nevertheless, the food industry argues that the amount of salt, sugar, and fat level makes ultra-processed food more attractive to clients. The reduction of these components could represent the loss of the consumer market. Once the consumer market reduces, one enterprise's capacity to keep and pay their employees reduces and could create a social problem (Verbal Information).

The commercial sector and health issues pose a challenging trade-off. The sector is so expressive and influential once it can provide resources to GHG. Transnational corporations can propel the creation of robust networks, foster technological innovation contributing in this manner to economic development and health advances (BUSE, LEE, 2005). Thus, to resist the industry, the pressure seems to be harder than it could appear. Once, on the one hand, large corporations can sell attractive food and drink, it can create many jobs. On the other hand, the excessive use of the products sold can develop several problems in people's health as chronic diseases, as abovementioned. In hindsight from the beginning of the years 2000 until 2019, we have observed that global health governance is working to create suitable solutions to gather private stakeholders and enhance the health governance dynamic.

The industry is an essential actor in global health governance and "represents around 1/8 of global economic flows"(KICKBUSCH; SZABO, 2014, p.3). The establishment of a proper understanding among WHO regulations and global health industries could minimize the conflicts of interests. In GHG, we find what the researchers call the golden era of global health, around 2013, a phenomenon to describe "an explosion of players in the global health arena and, particularly the growth in influence of non-state actors"(KICKBUSCH; SZABO, 2014, p.3). Within this context, Dr. Chan, the WHO Director-General, relates at the occasion of the 66th World Health Assembly (WHA66) that the WHO was suffering intense pressure from private companies must and foremost in the cases referred to non-communicable diseases (NCD) (KICKBUSCH; SZABO, 2014). The action of multinational corporations into GHG dynamics is a relevant phenomenon, and it is not new. As inquired, the activity of business actors within health governance could be observed throughout the years. However, only in 2016, the WHO decided to control the involvement of these actors into systematic basis, with the creation of the Framework of Engagement of Non-States Actors, FENSA. More information about FENSA,and more detailed information are available on the appendix of this thesis.

4.7 THE TURNING POINT TO CREATE THE FRAMEWORK OF ENGAGEMENT WITH NON-STATE ACTORS

As demonstrated above, the health environment has many global health players. The multi-stakeholders give sense to global health governance, a process in which many actors interact with themselves and create regime clusters. As observed from the documental analysis, the diversity of health players is an ongoing process; however, only in the latest decades, the action of actors seems to become more institutionalized. Seeking for reasons that may explain

why the WHO decides to lead with the non-state actors through a systematic basis, some answers seem to arise.

For this thesis, we have considered that the initial efforts to systematize and strengthen relations with non-State actors began towards the 1980s during Mahler's term with discussions about collaboration with Non-Governmental Organizations to implement the Global program Health for All[68] . The efforts emphasized the need to build strong partnerships between the WHO and NGOs and among NGOs themselves to promote effective implementation at national levels. In this sense, the WHO developed a catalytic role that could use the NGO's potential as an ally to implement health strategies at the national level. During the 1980s, the engagement of Non-Governmental Organizations could contribute to the mobilization of international support to lead with issues as leprosy, tuberculosis, primary health care, infant and young child feeding, family planning, prevention of blindness, alcohol, and drug use, among others (A/38 Technical Discussions/4). NGOs were an essential stakeholder in the mobilization of expertise and resources and health care promotion, despite the efforts to mobilize NGOs for collaborating with the WHO, the term "non-State actor" concerned with Non-Governmental Organizations (NGOs).

As inquired from the documents, the term non-State actor is applied for several actors currently. Notwithstanding, the evidence suggests that throughout the years, the collaboration with non-state actors within the WHO change its meaning and jointly more actors to play in global health governance systematically. The word non-state actors at the WHO documents were related to WHO Reform in many entries. The 1990's decade shows some meaningful changes in WHO governance. In 1992 under the United Nations Conference on Environment and Development, UNCED was identified initiatives related to interagency collaboration. The WHO start to collaborate with other United Nations organizations and UN Programs, such as the Food and Agriculture Organization, FAO, and International Labor Organization, ILO. The primary purpose was to build linkages of health and the environment. Therefore, regarding the WHO comparative advantage in health issues, the multilateral institution acquired the task to be the Manager on Promotion and Protection of Human Health. Thus, the WHO played a leading role in establishing networks connecting health, environment, and economic development, bringing the expertise of partners inside and outside the UN system (Changes and Reform at the WHO, 1997, p. 13).

Another landmark in the WHO history of reforms was dated from 1997[69] under Nakajima's direction. According to documents, Nakajima's term was criticized by his form to guide the organization and the budget problems that arose. In a report entitled "Changes and Reform at the WHO," the pieces of evidence may suggest increasing efforts to strengthen relations with private and public actors. In the 1990s, one of the WHO priorities for the twenty-first century was to build strong partnerships for health. This period reveals

[68] Document: A 38 Technical Discussions/ May 1985 WHA 38.

[69] Document: Changes and reforms at the WHO 1997. World health Organization

WHO efforts to bring the private sector as a stakeholder to build bridges and achieve the health goals rationally and economically from the creation of partnerships and establishment of innovative networks (Changes at the World Health Organization, 1997). The financial problems the WHO have faced fostered the institution to seek initiatives to lead with a shortage of funds. Towards 1998's under Bruntland's term, we have observed more intense efforts to build partnerships with private actors and business actors to supply WHO's financial lacks[70].

The Framework encompasses three pillars: management, finance, and governance—the managerial changes, concerns on strategies to enhance internal governance through decision-making bodies. The reforms seek to improve organizational transparency, effectiveness, human and financial resources, accountability, and strategic communication (EBSS/2/2, 2011, p. 2). The focus on financing issues is an essay for better alignment between resources and objectives to surpass the continuing financial crisis faced by the institution. The governance pillar refers to increase stakeholders, to bring multiple voices and new actors for GHG as a strategical way to spread the WHO policies throughout the WHO members. Hence, the engagement of actors was a kind of mechanism to enhance WHO capacity to mobilize funds, expertise, technology, and to supplement WHO external governance [71].

Besides the pillars identified as reasons to foster changes at the WHO and the reinforcement to bring non-State actors to play at the health governance, some contextual aspects encouraged the reform process under which FENSA was established. A crucial contextual aspect was the Agenda for Sustainable Development. The United Nations General Assembly resolution 70/1 proposed a document entitled "Transforming our world: the 2030 Agenda for Sustainable Development" focused in "revitalize global partnerships, strengthen global solidarity to reach the needs of the poorest and most vulnerable people of all countries"(WHA 69 R.10, 2016, p.2). This contextual aspect proposed to build a closer link between health and sustainable development and to build advocacy for controlling and prevent Non-Communicable diseases [72].

The second contextual aspect that seems relevant for this analysis reflects the importance of the Busan Partnership for Effective Development Co-operation held in the Republic of Korean in November of 2011. The Busan partnerships emphasize the necessity to ratify the more inclusive and broader partnerships for cooperation, especially South-South cooperation (EB132/5, 2013, p. 4). The context "post-Busan Partnership brought the importance to revitalize the International Health Partnership and similar initiatives that bring together different funding streams in support of national health priorities." (EB132/5, 2013,

[70] An interesting study about business actors at the WHO was realized by GUIBAULD (2012)

[71] The WHO relates "resource mobilization mechanism is linked to 'validation mechanism' that assesses the distribution of funds between the major offices, including headquarters. For regions, allocation is based on a set of criteria that are now regarded as not sufficiently fair, rational or transparent" (EBSS2/2, 2011, p. 33)

[72] This discussions was also part of the Addis Ababa Action agenda of the Third International Conference on Financing for Development (Addis Ababa, 13–16 July 2015), which is an integral part of the 2030 Agenda for Sustainable Development;" (WHA 69 R 10,2016, P.1)

p.4).

The third contextual fact that has impacted on WHO Reforms was the outbreak of the Ebola virus in the West of Africa in 2014. The outbreak "has revealed areas in which further reforms may be required to ensure the Organization could respond rapidly and effectively in emergencies" (EB136/7, 2014, p.1). Along with the West African outbreak, the WHO faces challenges in mobilizing human and financial resources, which bounded organizational efficiency to provide adequate answers for African countries. The Ebola outbreak reveals a crucial weakness that the WHO Reforms must consider. In WHO words, "the unprecedented complexity and scale of the outbreak have placed enormous strain on WHO's managerial structures and systems" (EB136/7, 2014, p.1).

Therefore, the evidence may suggest that the contextual factors mentioned above have impacted into the establishment of the Framework of Engagement with Non-State Actors (FENSA). The international scenario and the WHO constrain to lead with new demands related to sustainable health development, and to provide adequate answers for emergencies seems to be the turning point for WHO reforms. Furthermore, creating bridges and partnerships with different actors seems to arise as a necessity throughout the years.

Henceforth, the ongoing process to bring non-State Actors to play jointly with the WHO was concluded on the 69th World Health Assembly, in May of 2016, as an outcome of successive sessions of negotiations. Through the adoption of the Framework of Engagement with Non-State Actors (FENSA), the WHO formalize the different types of actors and variations of engagement systematically accepted in WHO meetings. Thus, FENSA "shall replace the previous initiative that established rules between the WHO and non-governmental organizations and Guidelines on interaction with commercial enterprises to achieve health outcomes (WHA 69. 10, 2016, p. 2). Beyond the non-governmental organizations and commercial enterprises, the document also formalized the joint action of private sector entities [73], philanthropic foundations, and academic institutions.

The formalization of engagement of non-state actors was a smart strategy to bring new actors for Global Health Governance, mobilize financial and human resources, and strengthen networks of collaboration in the transfer of policies. Additionally, through the consolidation of the framework, the WHO could evaluate the potential risks and benefits of the partnerships methodically. As discussed above, the most evident benefits seem to be the creation of new sources of grants, expertise, among others. Nevertheless, the engagement can generate risks as "conflicts of interests [74] , negative impact on WHO's integrity, credibility and reputation

[73] Private sector entities can also be International business associations as corporations and big companies.

[74] Conflicts of interests: "A conflict of interest arises in circumstances where there is potential for a secondary interest (a vested interest in the outcome of WHO's work in a given area) to unduly influence, or where it may be reasonably perceived to unduly influence, either the independence or objectivity of professional judgment or actions regarding a primary interest (WHO's work) The existence of a conflict of interest in all its forms does not qualify that a improper action has occurred, but rather the risk of such improper action occurring. Conflicts of interest are not only financial but can take other forms as well" (WHA 69.10, 2016, p.10).

and public health mandate" (WHA 69.10, 2016, p.6) [75] . Thus, seeking to avoid conflicts of interests and reduce the possibility of vested and improper interests to influence the WHO mandate and member states' interests within the institution.

4.8 CONCLUSIONS

The chapter sought to investigate the motivations that led the WHO to consolidate the Framework of Engagement with Non-State Actors, FENSA, in 2016. As presented in this chapter, the international health regime emerged from numerous international health meetings and conferences composed of different health actors.

After investigating documents, reviewing the empirical production of the field, and analyzing interviews, relevant theoretical, empirical conclusions are reached. Regarding the theoretical conclusions, the existence of a complex multilateralism is evident, as discussed in the theoretical chapter. For this thesis, such multilateralism has, at least, three aspects. First is related to the idea of being multifaceted. Although being international health cooperation, there is a multiplicity of themes and actors acting, for example, on issues such as environment, sustainability, human rights and health, disease prevention, outbreaks, among others. The second aspect is related to the diversity of actors, such as states, corporations, philanthropic foundations, and private actors, among others, that act in a way to propose themes and strategies for issues related to global health. The last aspect is related to the fact that it is a decentralized multilateralism, and the central authority is not always the WHO.

As highlighted in the theoretical chapter, IOs can be seen as orchestrators of different actors.The joining of non-state actors can supplement institutional skills for reaching political targets more effectively. The number of actors has been increasing and broadening the focus of policies. Nevertheless, the expansion of non-state actors can bound the WHO autonomy to deal with actions.

After analyzing the documents, were noticed that the term new governance gained space among the General Directors' speeches. Moreover, the term non-state actors have become more frequently used in meetings of the World Health Assembly and the Executive Council.

The use of these terms and expressions should not be seen merely as a matter of language. The interviews and data related to financing indicate that these expressions figure as strategies to retake the WHO role as an orchestrator among the multi-stakeholders.

Regardless of the FENSA consolidation, the document is a strategy of regulating the action of non-state actors within the WHO while contributing to public policy dissemination on global health by the creation of networks of collaborations. The creation of systematic

[75] The risks of engagement are evaluated by what the WHO call as Due Diligence. Due diligence refers to the steps taken by WHO to find and verify relevant information on a non-State actor and to reach a clear understanding of its profile. While due diligence refers to the nature of the non-State actor concerned, risk assessment refers to the assessment of a specific proposed engagement with that non-State actor (WHA 69.10, 2016, p. 11).

basis to lead with non-state actors reinforces that WHO is becoming a hybrid organization once many public and private partnerships have been enhanced to ensure that institutional policies could be reached.

As proposed by the hypothesis, it is understood that FENSA acts as a security tool to ensure the performance of this third party (non-State actor) within IO. Nevertheless, it seeks at the same time to guarantee that the interests of member states and the WHO itself can be maintained against the preferences and interests of non-state actors while increasing the volume of human and financial resources.

5 FROM THE GLOBAL TO THE REGIONAL: BRAZIL AND ITS LEADERSHIP IN HEALTH COOPERATION

5.1 INTRODUCTION

This chapter has the main objective to highlight the reasons that justify Brazil's choice as a case study among the 194 members of WHO. We use two strategies to develop it: first, we seek to identify emblematic moments and actions in Brazil in regional and international forums and in global health policies. Moreover, we investigate domestic factors that contribute to the Brazilian role in building a foreign health policy.

In addition to the literature review, we used interviews with WHO/PAHO experts and health experts in Brazil to understand more about this actor's role at the international level. Additionally, we used the speeches of the Ministers of Health at WHO, which proved to be a valuable source of data to understand which themes were defended by Brazil over the years in the supreme instance in global health, namely the World Health Assembly.

Our main objective was defined by Brazil's global health role, especially in its relationship with the World Health Organization. However, we identified that the country had acquired considerable prominence at the regional and horizontal cooperation, which the literature has also characterized as South-South cooperation. Through this type of cooperation, the country has acted in strengthening national systems' capacities and transferring human and technological resources, acquiring the characteristic of structuring cooperation in health. Such actions were possible due to the growing performance of national actors, above all, from the Oswaldo Cruz Foundation's performance, FIOCRUZ, a relevant actor when discussing Brazilian protagonism, either regionally or globally.

Finally, we discuss foreign health policy, through which we consider that internal changes to the Itamaraty can be reasons to explain a more dynamic performance of Brazil in global health.

5.2 THE BRAZILIAN LEADERSHIP IN GLOBAL AND REGIONAL HEALTH POLICIES

Throughout the chapter, we sought to raise reasons that justified Brazil's choice as a case study within the WHO. Brazil is a fruitful case to be examined in WHO member states, mainly to defend a universal and accessible health system. During the 38th World Health Assembly, the ambassador Paulo Nogueira in his speech, announced that a new era was beginning in Brazil. In his words, "for us, a new era dawned, which we have affectionately termed the New Republic, a symbol of the transition to full democracy in the form of the national constituent assembly which will be elected in 1986" (WHO, 38, 1985, p.1). The beginning of the New Republic in Brazil brought beneficial changes to the Brazilian health system.

At the 38th WHA, the ambassador presented to WHO members the health commitments that Brazil was willing to offer for the coming years. Among the commitment was the ongoing project of national health systems through which could be ensured the free access to all types of health care, the extension of the coverage of primary health care services, the improvement in the quality and quantity of health services provided (38th WHA, 1985). As we can see, on this occasion, Brazil shared with the WHO members the intention to create a health system based on universal and equitable access for citizens.

Since the promulgation of the 1988 Federal Constitution, Brazil has implemented the so-called Unified Health System, hereafter (SUS), considered by scholars the world's most extensive public health system. According to the Constitution of 1988, health has become a state attribute to be assured to Brazilian citizens. Following the provisions of art. 6 of the 1988 Constitution: "social rights are education, health, food, work" (...) (Wording given by Constitutional Amendment No. 64 of 2010) (BRASIL, 1988).

According to Pinheiro; Milani (2011), regarding the inclusion of health as a citizen's right: "the new constitution contradicted prevailing neoliberal precepts expressed above all by the World Bank while providing institutional and legal support for AIDS treatment policy (PINHEIRO; MILANI, 2011, p.209)[76] .

It is worth mentioning that, according to WHO, a health system is defined as "the sum of all organizations, institutions, and resources whose primary purpose is to promote, maintain or restore the health of a population (WHO, 2007). In this way, we define what we call health service systems [77]" (GIOVANELLA, 2017, p.226). Therefore, there are two ways of providing or financing health systems, namely public and private financing. As mentioned above, Brazil stands out to provide public and equitable health services. The public funds came from the government through the Ministry of Health and subnational spheres.

In contrast, in private health systems, services are provided through the purchase and sale system. Generally, this system favors higher-income social groups once access to health services tends to be purchased more easily by this social stratum. In this sense, the relationship between health and poverty seems to be established. This connection between health and poverty is particularly observed in populations with lower incomes, which faces more challenges to purchase health services.

It is above all, due to the health system issue, that Brazil becomes a useful case study within the WHO. Recently, Brazil has been a relevant player in strengthening its neighbors' health systems in Latin America and the Caribbean. The countries of Latin America and the Caribbean face challenges such as segmented service coverage and privatization of these

[76] Brazil is distinguished from other democratic states, such as the United States, where the state does not fully guarantee health policies, and there is a complex and controversial relationship between private and public health care. As investigated in the USA, it does not provide efficient systems to the citizens to serve the neediest population.

[77] Free translation from the Portuguese: ... "the sum of all organizations, institutions, and resources whose primary purpose is to promote, maintain or restore the health of a population (WHO, 2007). In this way, we define what we call health service systems" ... (GIOVANELLA, 2017, p.226)

services' financing, making the provision of services precarious. There is, therefore, a deficit in terms of efficiency in the provision of services. As mentioned, beyond Brazil, countries like Costa Rica and Cuba are important exceptions in this region. Costa Rica, through the so-called Caja Costarricense [78] , universally provides health services to the population. Similarly, Cuba's national health system underwent changes in 1959, which began to guarantee universal and free access to the population (GIOVANELLA, 2017).

Brazil played an important role in universal access to antiretroviral treatment (ART) in the mid-1990s. The breaking of patents to produce and offer the ART drug to combat the human immunodeficiency virus, HIV. The argument put forward by the Brazilian government was based on the prevalence of public good concerning the profit of pharmaceutical companies (VIGEVANI; OLIVEIRA; CINTRA, 2003). With actions to ensure broad access to a drug considered high-cost internationally, Brazil has undergone significant changes becoming a protagonist in health cooperation and technology transfer, leaving the role of being merely a receptor of international health aid policies (RUSSO; CABRAL; FERRINHO, 2013). With the speech to ensure broader access to high-cost medicine, "the country has legitimized its demand and gained sympathy from most other UN countries, WHO and non-governmental organizations (NGOs) involved in public health and humanitarian law issues" (VIGEVANI; OLIVEIRA; CINTRA, 2003, p.20).

Beyond the change of Brazilian position in health cooperation, the 1990s brought a significant milestone to Brazil and international health issues. In 1993, with the publication of the World Bank report under the title "Investing in Health," the relationship between health policies and economic development began to be established, suggesting the existence of a relationship between the degree of poverty and the deficit of health services provision (BUSS; GALVÃO; BUSS, 2017). The 2030 Agenda for sustainable development brought health as a fundamental axis to achieve the Sustainable Development Goals (SDGs). They were allowing health to acquire a transversal character, creating an increasingly closer interface with different themes, such as environment, economy, development, among others. Throughout this context, and with Brazilian presidents' incentive to strengthen health cooperation, the international health agenda becomes a fundamental element for Brazil's international scenario projection.

It can also be said that Brazil has a history within the WHO. As studied in chapter 4, Brazil played an essential role in the history of the WHO creation, defense of social medicine construction, and the provision of health as a human right. In the history of management, WHO had a significant contribution from Marcolino Candau, General Director of Brazilian origin, who stayed for the longest time in the highest administrative position at WHO. It is up to us to briefly resume that a Director-General's choice considers criteria such as universality and geographic distribution. In this sense, we consider that the election of Candau and the reelection for three consecutive terms are synonymous with the approval of the policies drawn

[78] In 1961, the social security Caja Costarricense was implemented in Costa Rica under the Universal Health Insurance Law. Since then, the country has provided health services for the entire population in a free and comprehensive manner(GIOVANELLA, 2017).

up by this director within the institution. We may say that due to these facts, Brazil has been building a reputation in this specialized agency to deal with health worldwide.

According to the information collected, Brazil becomes internationally prominent due to its active participation within WHO in guidelines such as universal access to medicines and health services. During the period 2018-2019, Brazil was the Executive Council member, a seat that the country had not held since 1961. Brazil's presidency in the Executive Council suggests that Brazil has a strong presence within the institution and ensures legitimacy to deal with health-related issues. For example, "to coordinate the multilateral discussion of health-related topics in line with the objectives of the 2030 Sustainable Development Agenda" (MH, 2018)[79] .

Brazil takes on a significant role in the fight against tropical and infectious diseases such as Malaria, tuberculosis, AIDS. To keep this prominent role, Brazil has the support of a national foundation, highly respected in terms of scientific production and international cooperation capacity, the so-called Oswaldo Cruz Foundation, Fiocruz, - which we will discuss in another section. In summary, the foundation is a relevant stakeholder inside and outside the country for its capacity to build research, development, and cooperation networks. Fiocruz has a significant national capacity to deal with issues as the development of vaccines such as yellow fever and has acted in the transfer of technologies to countries in the global south.

5.2.1 Brazil and the 2030 Sustainable Development Agenda

We also highlight Brazilian efforts to implement the Sustainable Development Goals (SDGs) and the 2030 Agenda for sustainable development. The 2030 Agenda for sustainable development is an initiative of the United Nations, which among other purposes, health is a contributing factor to generate sustainable development. In summary, through these objectives, a global agenda was built among UN members' heads. WHO has led attempts within this broad global project to defend universal and equitable coverage in health (BUSS; GALVÃO; BUSS, 2017; BUSS; TOBAR, 2017).

Health has, therefore, become a topic related to sustainable development. The evidence has made it clear that economic development has significant impacts on the health of populations. There is considerable consensus among scholars regarding the universal and equitable provision of health as a path to the country's economic development (ibidem).

The figure Sustainable Development Goals (SDGs) presented the seventeen objectives outlined by the United Nations to achieve sustainable development. The health and wellbeing agenda appears as the third objective within the framework of the SDGs.

Among other issues, we highlight the remarkable alignment between the health actions promoted globally and the objectives related to health, either in the Milennium Development Goals [80], MDGs, or in the 2030 Agenda. Within the health concerns raised by the heads of state

[79] <https://www.saude.gov.br/noticias/noticias-aisa/43418-brasil-e-eleito-presidente-do-conselho-executivo-da-oms>

[80] Buss;Galvão, Buss(2017) highlights that health MDGs did not achieve satisfactory performance globally. In

Figure 5.1 – Sustainable Development Goals (SDGs)

Source:UN (2019)[81].

were issues such as: " HIV, malaria, tuberculosis, neglected tropical diseases, communicable diseases the threat of non-communicable diseases such as cancer, chronic cardiovascular and respiratory diseases, diabetes, and mental health "(BUSS; GALVÃO; BUSS, 2017, p.355). Moreover, guidelines to reduce maternal and child mortality gained considerable prominence among these objectives.

Given this context, we consider Brazil a prominent actor in the employment of the MDGs' and the 2030 Agenda. As we will demonstrate in the following, Brazil has played a significant role in many of the guidelines of the United Nations' objectives, acquiring international prominence in issues such as HIV, malaria, tropical diseases, and reduced tobacco consumption, among others.

According to Buss (2017), four strategies were adopted to implement the objectives: 1) the adoption of the WHO Framework Agreement for Tobacco Control in all countries. As will be discussed below, Brazil gained considerable prominence in implementing this agenda, gaining prominence internationally .

A second means of implementing the SDGs was to support research and development of vaccines and medicines to facilitate and expand access to essential medicines, especially in developing countries (BUSS, 2017). In this second aspect, Brazil can also be considered outstanding, given the actions related to HIV, the breaking of patents for the antiretroviral medication (ART). Along with these actions, we have identified Fiocruz's prominent role in developing research and transfer of technical capabilities to developing countries, building the so-called horizontal cooperation, which we will discuss throughout the chapter .

several countries (UN, 2014), health has become part of an unfinished agenda of millennium commitments (BUSS; GALVÃO; BUSS, 2017, p.354)

[81] Source: <https://www.un.org/sustainabledevelopment/wp-content/uploads/2019/01/SDG_Guidelines_AUG_2019_Final.pdf>

The third aspect of implementing the SDGs is financing health to development. As we will discuss in the next sections, especially around the 2000s, Brazil's success internationally proved to be the result of the expansion of Itamaraty resources for social agendas. Due to the more attention given to the health agenda and the intersectoral dialogue established among the Ministry of Foreign Affairs, the Ministry of Health, and subnational actors more resources became available in this political agenda .

Finally, the last strategy to implement sustainable development goals was to strengthen countries' capacity and manage national and global health risks (BUSS; GALVÃO; BUSS, 2017; BUSS; TOBAR, 2017). We also consider that Brazil has acquired an essential role in this regard because they were notable Brazilian actions to strengthen health systems' capacities in developing countries.

For the issues highlighted above, we consider that Brazil's success since the 2000s can be related both to the Brazilian effort to implement the United Nations SDGs and the country's proactivity in international health forums, as will be demonstrated in the next sections.

5.3 BRAZIL AND ITS ROLE IN HEALTH AT THE REGIONAL LEVEL

As investigated, Brazil's global health policies go through the Pan American Health Organization, PAHO, the WHO regional arm in the Americas. As studied in chapter 4, the WHO headquarters is based in Geneva, where global policies are negotiated among its 194 members. As previously studied, the geographic regions encompass different demands concerning diseases. Regarding this fact, the WHO acts in a decentralized way through regionally arms to provide answers to each location's emergencies.

Brazil also works at PAHO, a regional health organization composed of 35 countries where health issues endemic to the Americas are discussed, and policies are deliberated. To put it briefly in context, PAHO emerged in 1902 in the face of the yellow fever epidemic threat and it's is headquartered in Washington D.C. In this context, the American countries developed to mobilize to contain the spread of the disease on the continent and called a so-called International Health Convention of the Republics of the Americas. As studied by Meier; Ayala (2018), at the beginning, the focus of the institution was to control the communicable diseases at the Hemisphere's ports "(focused on the control of yellow fever, malaria, yaws, tuberculosis, and smallpox)"(MEIER; AYALA, 2014, p.3).

One of the first achievements was the development of the Pan American Sanitary Code in 1924, a normative basis to regulate international actions seeking to protect and ensure the population's quality of health. In the early years, the Sanitary Convention encompassed more modest functions and responsibilities, only "in 1924 the Office expanded its functions with the consolidation of a Pan American Sanitary Code, signed by 18 countries in Havana, Cuba, during the 7th Sanitary Conference [82]". The ratification of the Pan

[82] Free translation from the portuguese: "(...) em 1924 a Oficina teve suas funções ampliadas com a consolidação

American Sanitary Code symbolizes a milestone in coordinating health-related efforts on the American continent. In a relatively short period, the code has been ratified by all states in the Americas region, assuring PAHO the role of managing and coordinating health-related problems (MEIER; AYALA, 2014)).

In 1958 was created the Pan American Sanitary Office, which some years later came to be known as the Pan American Health Organization, PAHO, as is recognized nowadays. PAHO emerged before the WHO as a regional health organization, and not merely a representation in the Americas.

Although it is related to WHO, PAHO has a dual identity. That is, it addresses the issues of the United Nations System, through WHO; and meets the demands of the Inter-American System, through the Organization of American States, OAS. In 1948, with the WHO consolidation, PAHO became the WHO regional office for dealing with health issues in the Americas. Similarly, in 1950, after signing an agreement with the Organization of American States, OAS, PAHO became the specialized health agency within the inter-American system. For this reason, we said that PAHO has a dual identity. In some subjects, such as HIV, PAHO is more advanced than WHO. It can be said that there is a certain degree of independence between PAHO and WHO. Concerning the financing structure, countries, in general, send duplicate contributions that serve to provide the United Nations system and the inter-American system. However, PAHO does not always receive a double contribution (PAHO, 1954).

Concerning the structure and composition, PAHO is composed of 35 states full members and two states that are associate members - that is, observers. Further than Brazil, the other states of the American continent comprise the group of full members. The observer members are States external to the continent; they are Portugal and Spain, which became members associated with the regional organization due to the construction of international relations with PAHO. Concerning financing, "PAHO is financed by its Member States through regular annual contributions stipulated from the OAS contribution grid" [83]. Likewise the WHO, PAHO, also receives voluntary donations, the so-called extra-budgetary resources, usually destined for specific policies and actions.

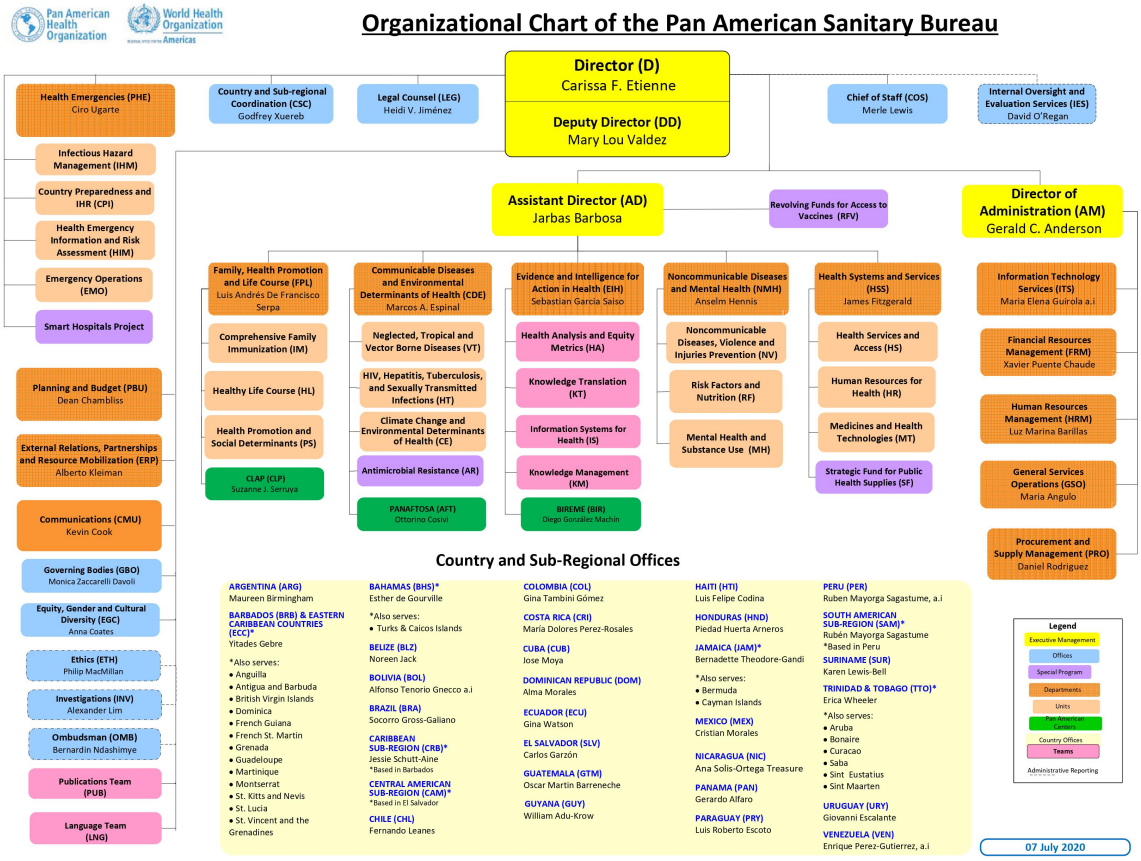
As mentioned above, PAHO is a regional organization specialized in American health issues. Therefore, it operates as a bureaucracy, with four decision-making bodies that develop specific actions: The Pan American Sanitary Conference, the Directing Council, the Executive Committee of the Directing Council, and the Pan American Sanitary Workshop. In the figure below entitled Organizational Chart of the Pan American Sanitary Bureau, we show the general structure of this regional organization.

The Pan American Sanitary Conference is the PAHO organ that assumes similar

de um Código Sanitário Pan-Americano, assinado por 18 países em Havana, Cuba, durante a 7ª Conferência Sanitária"(MEIER; AYALA, 2014; BUSS; TOBAR, 2017, p.403)

[83] Free translation from portuguese: a PAHO é financiada pelos seus Estados-Membros por meio de contribuições regulares anuais estipuladas a partir da grade de contribuições da OEA ((BUSS; TOBAR, 2017, p.413)

Figure 5.2 – Organizational Chart of the Pan American Sanitary Bureau



Source:PAHO (2020)[84]

functions to the World Health Assembly, WHA, considered the regional health organization's supreme organ. This body oversees of establishing the general rules of the institution and the financial guidelines. The Conference meets every five years. The 35 members of the institution participate with voice and vote, and the Director-General of PAHO, also called the regional director, could attend the meetings without voting rights (PAHO, 1954).

The Governing Board is charged with carrying out the functions defined by the conference. Generally, meetings are held once a year in the years in which the conference meets. Among the functions, it is understood that the Directing Council meetings are equivalent to the meetings of the WHO Regional Committee for the Americas.

Another substantial body is the Executive Committee of the Board of Directors, responsible for authorizing the office director to call the conference and board meetings. Therefore, the executive committee assumes a central administrative function once most of the actions carried out by the conference and the council require authorization from this body for execution. The committee is composed of nine government representatives, elected by the Conference or Council. The other member states, not represented on the committee, are invited to participate in meetings without voting rights. The committee meets twice a

[84] Available at: <https://www.paho.org/en/documents/organizational-chart-pan-american-sanitary-bureau>. Last access: 11/09/2020.

year, usually before and after the conference or the council. About the voting criteria, "although the Constitution of PAHO advocates that decisions should be made by voting, these are usually defined by the total consensus of the committee members " [85] (BUSS; TOBAR, 2017, p.407).

Finally, PAHO also has a Sanitary Office, which corresponds, roughly, to the WHO Secretariat. The office, also called the office, comprises the General Director (Regional) and specialized personnel appointed by him, who occupy this space for five years. Most of the functions that must be performed by the office are established by the Pan American Sanitary Code, although the Conference or Council may eventually designate specific functions. It is the body that establishes the bridge between the regional and the international and reports the actions and policies of the Pan American level to WHO (ibidem).

In the history of PAHO, we identified a Brazilian as the General Director, the physician Carlyle Guerra Macedo, from Piaui [86] , who was in control of the institution for two consecutive terms, between the years 1983 to 1995. During his management, he acted primarily "for improving people's health, providing basic health care, strengthening health service infrastructures on the national and local levels, and drawing a closer relationship between health and social, political, and economic development [87]"(PAHO, 2020). Although representatives of the office cannot represent a government or member state, Carlyle's performance, and re-election to a second term indicate the construction of a good reputation in Brazil in WHO. Currently, the Brazilian Dr. Jarbas Barbosa da Silva [88] is an assistant director at PAHO.

It is noteworthy that PAHO governance seeks to ensure health as a human right in the Americas. Thus, the right to have good physical and mental health becomes a normative pillar in the institution to be exported to PAHO members. Despite the diversity of cultures, PAHO has prioritized health as a human right among its members. This principle comes from the intention to employ social medicine purposes in Latin America dated from the beginning of the 20th Century. Social medicine considers to "study the social determinants of health/disease and health services" (MEIER; AYALA, 2014, p.5) and was primarily employed by countries as Chile, Argentina, Ecuador, and Uruguay. As a result of these American countries' efforts, we could note social medicine's expansion supporting health as right within PAHO (MEIER; AYALA, 2014).

Brazil's performance through PAHO suggests the creation of a relationship network

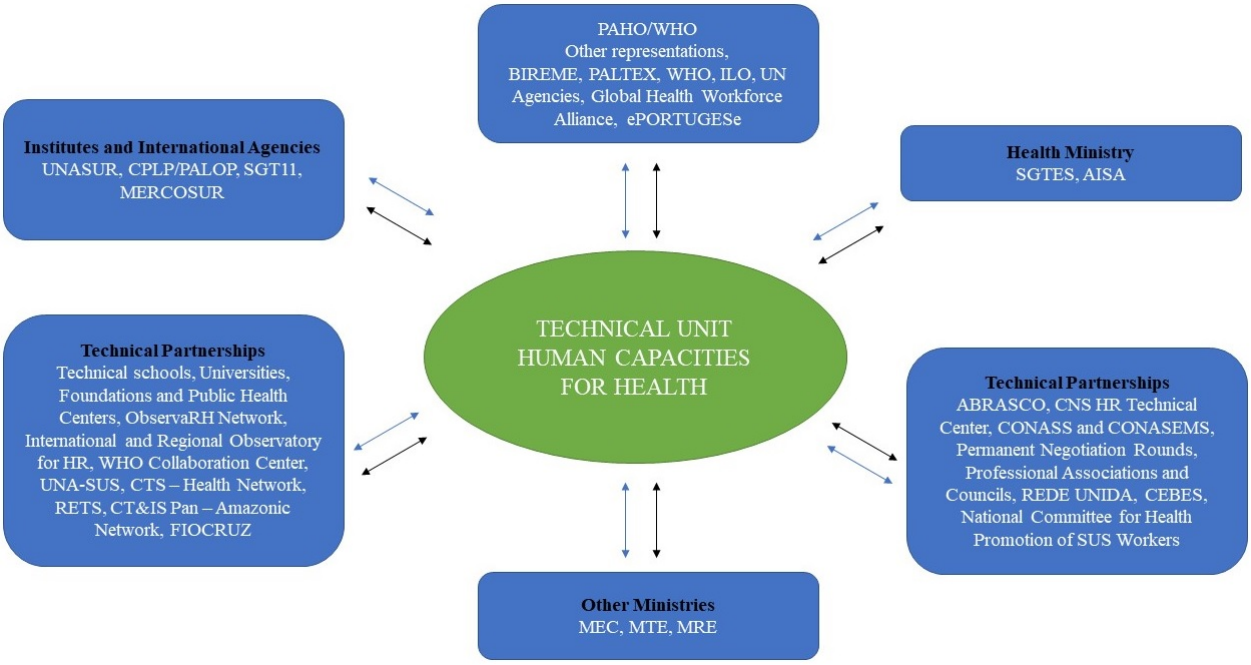
[85] Free translation from portuguese: (...) "apesar de a Constituição da Opas defender que as decisões sejam tomadas mediante votação, normalmente estas são definidas por consenso total dos membros do comitê" Buss e Tobar (2017)[p.407]

[86] Brazilian state

[87] Source:<https://www.paho.org/en/who-we-are/pahos-former-directors>

[88] Dr. Barbosa received his medical degree from the Federal University of Pernambuco (Recife, Brazil). He specialized in public health and epidemiology at the National School of Public Health, Oswaldo Cruz Foundation-FIOCRUZ (Rio de Janeiro, Brazil). He holds a master's degree in Medical Sciences and a Ph.D. in public health from the University of Campinas (São Paulo, Brazil).

Figure 5.3 – PAHO Collaboration Network in Brazil.



Source: Adapted from (ORGANIAÇÃO PAN-AMERICANCA DE SAÚDE, 2018)[89].

with other specialized health agencies and national units. As demonstrated by the figure: PAHO Collaboration Network in Brazil, health policies at the regional level receive contributions from various stakeholders to be implemented locally. At the global level, health policies are influenced by international bodies within the UN system, such as the WHO, ILO. At the regional level, efforts are being coordinated through UNASUR, Portuguese Speaking Countries, the PALOP, and Mercosur. At the local level, there is the coordination of actions established through the International Advisory on Health Matters, AISA, linked to the Ministry of Health, and several technical partners that mobilize human, technical capacity to transfer and implement international health policies in Brazil.

After considering the importance of this network, we highlight some health policies conducted by Brazil, especially at the regional level. As mentioned above, Brazil has gained considerable prominence in the theme of HIV, becoming a reference in the fight against HIV, and becoming an influential player in the definition of strategies and practices related to fighting and controlling the epidemic both regionally and globally.

5.3.1 The efforts to control HIV and the universal access of medicines

The year 2001 is a milestone in the history of access to antiretrovirals, ARV, the medicament to treat HIV. This year Brazil defended the thesis that the international trade agreements and intellectual property could not hamper the implementation of public health

[89] Original figure published in Portuguese. Available at: <https://iris.paho.org/bitstream/handle/10665.2/34872/OPASBRA18007-por.pdf?sequence=5&isAllowed=y>

policies (VENTURA, 2013; FIGUEIREDO, 2018)[90]. This context has become decisive for broader access to antiretroviral drugs. We may highlight that this thesis was sustained in the World Trade Organization, WTC, during the TRIPS [91] deal rounds through the International Health Advisory, AISA, and the Brazilian Ministry of Foreign Affairs .

In the same year, Brazil carried the pilot project, entitled International Cooperation Program for Developing Countries, ICPDC [92] , in which it achieved prominence internationally. Through this program, the Brazilian government offered to donate ARV drugs to treat patients infected with the human immunodeficiency virus to developing countries (FIGUEIREDO, 2018).

In 2004, this same project advanced to a second stage named "Laços-Sul-Sul [93] " based on a partnership with the United Nations Children's Fund (UNICEF), whose main goal was to amplify the access for the medicament to treat the epidemic. "Through this project, countries such as Bolivia, Cape Verde, Guinea-Bissau, Paraguay, São Tome, Príncipe, and Timor-Leste were included" [94] (FIGUEIREDO, 2018, p. 81). With these actions, Brazil gained international prominence in combating and treating HIV, and in policies for universal access to medicines.

5.3.2 The creation of Human Milk Banks

Brazil is still considered a case of success in the transfer of technologies to create human milk banks. The project started in Brazil and aimed to encourage breastfeeding and combat malnutrition. From the 2000s onwards, Brazil was engaged in the systematic international effort to create a human milk bank network. According to this project, breast milk figure as an effective strategy to reduce infant mortality and early childhood problems. The PAHO offered support for the project to reach most American continent countries (REZENDE, 2018).

In 2001, the successful project to create human milk bank networks in the American continent was recognized by WHO as an innovative project capable of promoting healthy development [95] . The project was mobilized by the Brazilian researcher at FIOCRUZ, João Aprígio Guerra de Almeida, who argued that creating a network of human milk banks could be useful for breastfeeding newborn babies who could not be nourished by their mothers.

On the occasion of the 54th World Health Assembly, WHA, in 2001, the Minister of Health, José Serra, talked about breastfeeding successes and reinforced the objective to

[90] In the 1990s, the Uruguay Round dealt with the complex relationship of pharmaceutical products and the relaxation of patent rights and their impact on public health .It gained international repercussion from the deliberative instances of the World Trade Organization and later expanded to other international organizations (ALVES; PAIVA; SANTANA, 2010)

[91] TRIPS- Trade Related Aspects of Intellectual Property Rights

[92] In Portuguese: Programa de Cooperação Internacional para outros países em desenvolvimento. (PCI).

[93] We are using the name of the project as it was used in Portuguese.

[94] Free translation from the Portuguese: Por meio deste projeto, países como Bolívia, Cabo Verde, Guiné-Bissau, Paraguai, São Tomé e Príncipe e Timor-Leste foram incluídos no projeto

[95] The Human Milk Bank Network received the Sasakawa Health Prize, which rewards innovative work in health: <https://agencia.fiocruz.br/ganhador-do-premio-dr-lee-jong-wook-de-saude-publica-2020-joao-aprigio-defende-mobilizacao-social>

expand the project to other countries. On this occasion, the minister proposed to the WHO to reconsider recommendations related to breastfeeding. Under the minister's terms, "we proposed that the WHO definitively adopt the recommendation of exclusive breastfeeding in the first six months of life" (54th WHA, 2001). The proposed recommendation is based on extensive research conducted in Brazil, which demonstrated that breast milk should be the only source of nutrition in the first months of life. It should be noted that Brazil's performance in international forums such as the WHA achieved great relevance for Brazil's projection internationally.

A year later, the 55th WHA endorsed the Brazilian recommendation on the Global Strategy for Feeding Infants and young children. Since then, the WHO began to recommend exclusive breastfeeding for the first six months of life globally. In this context, Brazil played a successful case that became an instrument of foreign policy and international cooperation in health (REZENDE, 2018). Among the national stakeholders who contributed to this action, we may highlight the coordination by the Brazilian Cooperation Agency, ABC[96] , with the Ministry of Health and Fiocruz. They offered technical support "for creating human milk banks in 19 other countries in the Americas, three African countries and one European country[97] " (ALMEIDA, 2013; REZENDE, 2018).

5.3.3 Tobacco

Brazil distinguishes itself in actions related to the fight against smoking. The program of actions implemented in Brazil was considered a model by the WHO (REZENDE, 2018). In Brazil, actions related to tobacco control started around the 1960s, with policies at the state level aimed at restricting cigarette use. In 1986, anti-smoking policies advanced to the national level through the National Program to Combat Tobacco, a program coordinated by the Ministry of Health. In 1989, the National Cancer Institute (INCA [98]), -an agency linked to the Ministry of Health-, developed the National Tobacco Control Program. Only in 1995, the theme acquired international scope. From this context, discussions concerning adopting a normative instrument for tobacco began to be considered in international forums.

As analyzed in the Minister of Health's speeches, at WHA, Brazil outlined significant measures to combat smoking, such as "legislative actions and educational campaigns, mainly targeting youth. Furthermore, the Brazilian Government has trained professionals in 3000 municipalities to implement actions in schools, health units, and workplaces" (52nd WHA, 1999). It is noteworthy that Brazil initiated policies to combat and control tobacco consumption before becoming an international standard. In 2000, WHO was already starting to mobilize efforts to consolidate an international tobacco control policy. As noted in the speech by the health minister, "concerning tobacco Brazil will play a vanguard role in the

[96] ABC is an acronym of the portuguese: Agência Brasileira de Cooperação

[97] Free translation from the portuguese: "(...) para implantação de bancos de leite humano em outros 19 países das Américas, três países africanos e um país europeu."(REZENDE, 2018, p.64)

[98] Acronym from the Portuguese: Instituto Nacional do Câncer

process of elaborating the future framework convention on tobacco control and its protocols" (53rd WHA, 2000).

Brazil has committed itself internationally to comply with international regulations related to the issue of tobacco. In 2003, the Framework Convention on Tobacco Control, FCTC, was officially created by the WHO. The FCTC is the first international public health treaty in WHO's history, evaluated by many scholars as a case of success concerning Brazil's implementation (REZENDE, 2018, p.61). Considering the relevance of this case, we will allocate the next chapter to study Brazil's tobacco control implementation policies.

5.4 THE BRAZILIAN MINISTRY OF HEALTH AS AN INTERNATIONAL PLAYER

As discussed in the previous chapter, global health governance has brought new domestic actors to negotiate international political issues. The Ministry of Foreign Affair,MFA, was, for many years, the only actor destined to build bridges globally. We should emphasize that the MFA intermediated a large part of Brazil's international health actions through the Brazilian Cooperation Agency, ABC [99] . The agency was responsible for establishing the bridges between the Ministry of Foreign Affairs and the different ministries to coordinate international technical cooperation actions. Nonetheless, recently there has been an international role for actors such as the Ministry of Health and institutions linked to it.

The negotiation of health at the international level configured a new way of doing diplomacy, which authors in the field have been defining as global health diplomacy. In this sense, diplomacy is understood as an action developed not only by the foreign service of the countries but also by the ministries of health, which have to undertake negotiations at different levels and with plenty of actors within the global health governance (THAKUR; WEISS, 2006; BUSS; TOBAR, 2017).

The International Sanitary Conferences of the 19th century are landmarks of the history of international health relations [100] . However, we saw Brazil's greater involvement in health cooperation along with the creation of the Pan American Sanitary Bureau, currently known as Pan American Health Organization, PAHO, and the creation of the World Health Organization in 1948. Although it was only in the 1950s that Brazil created an International Health Commission to deal with health internationally.

In 1950, this Ministry of Health also combined Education issues. It was only in 1953 [101] this government agency undergone structural changes becoming the Ministry of Health as we know it today. The International Health Commission preceded the Advisory on International Health Affairs, AISA, responsible for establishing the bonds of cooperation and partnerships in health in a bilateral, trilateral, or multilateral way. Until formally consolidated as AISA, a

[99] From the Portuguese: Agência Brasileira de Cooperação. The Brazilian Cooperation Agency, ABC, was created in 1987, linked to the Alexandre de Gusmão Foundation of the Ministry of Foreign Affairs (MFA).

[100] See also chapter 4

[101] Through Law nº1920 from July 25 of 1953, the Ministry of Education and Health were separated in two ministries creating the Ministry of Health and the Ministry of Education and Culture.

bureaucratic body responsible for international health relations, the Ministry of Health created initiatives capable of contributing to international cooperation in this area (Ministry of Health, 2018).

Countries' governments generally invest in the creation of international bodies with the Ministry of Health to facilitate international cooperation in health. As Buss (2017) studied, the national departments of health have been mobilizing efforts to give birth to the so-called Offices of International Relations and Cooperation in Health, generically called OIRH [102] , an acronym for Office on International Relations in Health (TOBAR et al., 2017). The main functions are to establish bridges with international countries and foster the exchange of knowledge and technology. The OIRH plays a strategic role in supporting the ministries of health to act internationally and joining a wide range of actors involved in global health governance.

In Brazil, efforts to create a solid body focused on health diplomacy took about forty-five years to consolidate, as seen in Table 5.1 entitled "Chronology of formalization of the International Health Relations Office in Brazil" (OIRH).

Political changes in the Brazilian presidency and the Ministry of Health can directly impact the conduct of international health policies. The Advisory on International Health Affairs is a structure linked to the office of the minister of health; thus, the cabinet changes suggest direct implications for the management of international advisory and how international health issues will be guided. Thus, we may say that the action of the OIRH in the international environment is an outcome of relations launched with political power. To be more precise, the closeness the OIRH is with health authorities, the higher could be the prioritization of health themes in international issues. In other words, whenever changes reach the Ministry of Health authorities, the changes would be perceived at OIRH (TOBAR et al., 2017; BUSS; TOBAR, 2017).

As demonstrated in Table 5.1 "Chronology of the formalization of the International Health Relations Office in Brazil," in some periods, the OIRH achieved more prominence in international relations against others. A prominent landmark that highlights some weakness in this institutional body was the extinction of the Coordination of International Affairs, CAIS, in 1991, during the Collor de Melo government. Otherwise, in 1998, the Office was formally established jointly to the Ministry of Health.

As demonstrated through the Table 5.1, the Office of International Relations in Health in Brazil, is the so-called International Advisory of Health Affairs, hereafter, AISA. Among its primary functions, AISA act as an interlocutor of the Ministry of Health in all activities related to international health relations. Furthermore, play a crucial role in the recognition of stakeholders, both nationally and internationally. As studied in the previous chapter, Global health governance has been incorporating key players. The joining of the ministries of health by representatives of civil society could represent a valuable tool in countries' health diplomacy (BUSS, 2017).

[102] In Portuguese: ORIS Oficina de Relações Internacionais em Saúde

Table 5.1 – Chronology of the Office on International Health Relations in Brazil

Name of the institutional body	Date	Legal Instrument	Function
International Affairs Commission	1953	Law 1920	
International Affairs Comission (CAI, in Portuguese)	1964	Decree nº 55.041	
Coordination of International Affairs (CAI in Portuguese)	1969	Decree nº 65.253	
Coordination of International Health Affairs (CAIS in Portuguese)	1970	Decree nº 66.623	
Coordination of International Health Affairs (CAIS in Portuguese)	1977	Decree nº 81.141	Foster health cooperation with international organizations, governments, or foreign entities.
CAIS extinction	1990	Provisional Measure nº 150	Collor government period. Extinction of all international areas linked to the government.
General Coordination of Special Health Affairs (CAESA in Portuguese)	1991	Government ordinance[103] GM nº 382	This structure oversaw international activities, although it was not formally created for this function.
General Coordination of Special Health Affairs (CAESA in Portuguese)	1992	Government ordinance nº 1.157	It formally undertakes international health cooperation functions.
Special Health Affairs Advisory (AESA in Portuguese)	1993	Government ordinance GM n 778	
Advisory on International Health Affairs (AISA)	1998	Decree nº 2.477	

Source: Self elaboration as from (MH, 2018)

5.5 THE ROLE OF THE ADVISORY ON INTERNATIONAL HEALTH AFFAIRS

Since its creation, AISA has been acting to foster intersectoral dialogue in the Ministry of Health, being, therefore, a key actor to mobilize actors and agencies inside and outside the Ministry of Health. AISA has become a crucial actor for the Brazilian State. AISA acts to project Brazilian interests at the international level and strengthen principles dear to SUS at the domestic level (BRASIL. Ministério da Saúde, 2018).

Concerning the mobilization of actors within the Ministry of Health, AISA works in close dialogue with the minister of health's bodies. Given the hierarchy and the ability to draw decisions, the bodies closely related to the minister of health can be more sensitive to political changes. The vulnerability to political changes can be attributed to the fact that AISA is associated with the minister's office (BRASIL. Ministério da Saúde, 2018).

The Ministry of Health is also composed of several secretariats highly specialized in health issues that, among other functions, are designed to formulate and implement public policies for a specific purpose. The secretariats generally act to propose policies for the domestic level. Nevertheless, AISA seeks to establish a dialogue with the thematic secretariats, aiming to consolidate technical knowledge on specialized topics that are substantive to define Brazil's international priorities.

Moreover, AISA works closely with ministerial entities, coordinating efforts to either implement foreign policies to Brazil or transfer health policies from Brazil to other countries. There is a dialogue effort aimed at coordinating actions and establishing cooperation with institutions launched with the Ministry of health, such as the National Health Surveillance Agency (Anvisa), the National Cancer Institute (INCA), the National Health Foundation (Funasa), the Oswaldo Cruz Foundation (Fiocruz), among others. AISA's performance goes far beyond the full mastery of all issues related to the health area. AISA also functions in the "ability to dialogue and coordinates plenty of relevant actors, inside and outside the Ministry of Health, to identify and pursue Brazilian international interests in this area" (FREDERICO, 2018, p.28).

AISA proved to be a key player in inter-ministerial[104] coordination within the Ministry of Health's scope and intersectoral[105] coordination, especially between 1998 and 2018. Regarding its inter-ministerial coordination and dialogue with different sectors of the Ministry of Health, AISA achieved the technical capacity to act in different health areas internationally. AISA's performance was equally relevant in intersectoral coordination, above all, in the dialogue with the Ministry of Foreign Affairs, which contributed to promoting national interests and the construction of a foreign health policy (ibidem).

After analyzing the history of the Advisory on International Health Affairs, we may

[104] Inter-ministerial refers to the coordination of actions within the Ministry of Health. It embodies the different organs of the Ministry .

[105] Intersectoral – we use this term to refer to the coordination of action within different Ministries. In this case the intersectoral coordination refers to the Ministry of Health and the Ministry of Foreign Affairs.

say that AISA's performance is directly related to Brazil's consolidation of foreign health policy. Among the actions performed by AISA at the international level, it is noted that the advisory oversees negotiations and associations with public institutions in different countries, usually called interinstitutional agreements. Important to highlight that these agreements are negotiated not by diplomatic officials, but by ministries of health (BUSS; TOBAR, 2017).

Notably, since the 2000s AISA has become a powerful promoter on coordinating integration mechanisms at the regional and global south levels. The actions related to the BRICS, the CPLP countries, and the articulation with Latin American neighbors were notable. Among the organizations and mechanisms aimed at coordinating health at the regional level, we can mention the Brazilian participation in Mercosur, the performance in the Union of South American Nations (UNASUR), the Amazon Cooperation Treaty Organization (ACTO), the Ibero-American Organization Americana (FREDERICO, 2018; BUSS; TOBAR, 2017)

Additionally, to initiatives at the regional level, AISA is Brazil's main interlocutor in multilateral forums in the health and related fields. AISA actively participated in WHO and, in the regional organization, PAHO, considered the arm of WHO in the Americas. The advisory is also Brazil's interlocutor in specialized UN system agencies such as the United Nations Office for Project Services (UNOPS), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the United Nations Food and Agriculture Organization (FAO), the United Nations Development Program (UNDP) and the World Food Program (WFP) (FREDERICO, 2018).

As highlighted in chapter 4, non-governmental organizations are relevant stakeholders in the health arena, to mobilize financial resources and technical capacity to implement actions. The Brazilian health ministry receives support from non-governmental organizations such as Bloomberg Philanthropies and the Bill & Melinda Gates Foundation (ibidem).

As we previously demonstrate, some subnational actors play an essential role in establishing international health agreements for supporting the transfer of technologies from Brazil to its American or Global-South neighbors. A vital stakeholder we will highlight is the Oswaldo Cruz Foundation, FIOCRUZ. The foundation is internationally recognized for its technical capacity and technological development, about which we will discuss the following.

5.6 A GOVERNMENTAL AND AUTONOMOUS ACTOR IN GLOBAL HEALTH: THE OSWALDO CRUZ FOUNDATION (FIOCRUZ)

The role developed by Brazil in global health governance receives many contributions from the Oswaldo Cruz Foundation, hereafter Fiocruz. The institution is a Brazilian international player linked to the Ministry of Health but with considerable technical and administrative autonomy to guide health issues in Brazil and outside with its international partners.

Fiocruz was created in 1900 as Federal Seroterapic Institute towards the contexts of Brazilian epidemic of yellow fever, smallpox and bubonic plague. We may say that the beginning of the institution coincides with the Brazilian public health beginning, once until the years 1900s public health was not a human right constitutionally ensured. The institution was born in a farm so-called Manguinhos, at Rio de Janeiro with the main purpose to develop serum and vaccines to combat and control bubonic plague. Later, the institution developed an essential role in the fight against yellow fever. The bacteriologist Oswaldo Cruz proposed a theory in which it considered the mosquito the main vector of yellow fever and proposed changes in a way to lead with this infirmity. The theory was successful tested in Brazil, since then new strategies was adopted in controlling and combat the disease. Thus, the name Fiocruz is in honor of Oswaldo Cruz[106] the clever bacteriologist and first head of this new institution (FIOCRUZ, 2020; BRITTO, 1995; BUSS; TOBAR, 2017).

We could not neglect the fact that Sanitarian movement had a great contribution in this context to expand the notion and importance to consider health as matter of politic in Brazil. Among the revindications of the Sanitarian movement three aspects should be highlighted. The first was the necessity to consider health as condition for progress; the second consists in the urgency to create a theory to explain that social inequalities were intertwined to sanitarian inequalities[107]. The third concerns in refuse the idea that the absence of adequate conditions of health was an outcome of climatic conditions in the country (BRITTO, 1995).

Despite having autonomy from the Federal government for dealing with health matters, Fiocruz success in international health is an outcome to the Brazilian political regime. Thereby, what we could observe throughout Fiocruz history is that the most democratic the Brazilian federal government is the most successful and innovative Fiocruz can be. As studied by Brito (1995), Fiocruz suffered the loss of autonomy towards the 1930 Revolution . In the context of the Coup of 1964, this actor was massively attacked [108]. During this context, some scientists had their rights suppressed, limiting the advances of research, science, and technology. Throughout Fiocruz's history, policies and grants were intensively restrained by the government during the military period. The period of the shortage was overcome during the 1980s whenever Brazil become a democracy again. Another famous landmark in Fiocruz's

[106] "The doctor and scientist Oswaldo Gonçalves Cruz was born in São Luís do Paraitinga (SP), on August 5, 1872. His father was Bento Gonçalves Cruz and his mother, Amália Bulhões Cruz. His family moved to Rio de Janeiro in 1877 where he studied at Colégio Laure, Colégio São Pedro de Alcântara and Externato Dom Pedro II. He graduated at the Faculty of Medicine of Rio de Janeiro in 1892 and developed his doctoral thesis about microbial transmission through waters". Our translation from:<https://portal.fiocruz.br/trajetoria-do-medico-dedicado-ciencia>

[107] According to Belisário Pena, the head of Sanitarian League, all "cultured countries," e.g., England, Italy, France, Germany, Japan, United States. - owed "their amazing progress" due to the adoption of the hygienic guidelines resulted from Louis Pasteur and the influence of social medicine from the 19th-century (BRITTO, 1995, p.5)

[108] During the military regime occurs the so-called Massacre of Manguinhos.This tragic episode of Fiocruz history represents a backward step in the political rights and development of Research and Science. Over this period, ten reputed scientists had their rights denied. Moreover, the decrees (AI-5 and AI-10) foresaw compulsory retirement and prevented these scientists from working in any institution that received resources from the federal government. Source:(https://portal.fiocruz.br/linha-do-tempo).

history was the direction of the sanitarian Sergio Arouca. He settled a great extent of advances, such as the isolation of HIV in Latin America (FIOCRUZ, 2020).

As mentioned above, Fiocruz is an institution bound to the Ministry of Health; therefore, the resources came from the Brazilian federal government. Nevertheless, the public grants allocated for international health cooperation are limited. As studied by Ferreira et al. 2017; Buss, 2017 "the availability of resources from the National Treasury only covers the expenses of the regular human resources framework offered by Fiocruz as a counterpart in negotiations with international partners. In other words, the staff does not receive specific fees for cooperation activities [109].

Regarding its structure, Fiocruz has among its core functions the task "for training and qualifying personnel in areas related to science and technology in general" (TOBAR; COITIÑO; KLEIMAN, 2017; BUSS; TOBAR, 2017, p.621). The institution receives students from different countries and offers courses in the postgraduation level as masters and PhDs.

Fiocruz plays an essential role nationally and internationally. Through the creation of bridges, it fosters cooperation, establishes partnerships, and attracts technical assistance, in different scopes, such as north-south and south-south cooperation. Historically, Fiocruz has been intensifying efforts to cooperate and expanding technical cooperation with developing countries. Employing this policy, Fiocruz instigates the creation of international health networks to boost collaboration between developing countries. Thus, a specific body was established to lead with international health issues. The first initiative was the International Cooperation Advisory, ICA, launched in 1986. Due to Brazilian efforts to strengthen cooperation in global health with other countries, in 2009 Fiocruz has consolidated, a more standardized body internationally recognized as Fiocruz Global Health Center, henceforth Cris/Fiocruz [110] .

Thus, through the action of Cris/Fiocruz, Brazil begin to play a leading role in global health diplomacy seeking to fortify the national health systems, above all, in countries from the global south. We could also observe the change of paradigm in Brazilian politics. Brazil was traditionally encouraged to establish relations with the north to attract high-level technology. Throughout the creation of the Cris/Fiocruz, we observe the change in health cooperation from the north to the south, and Brazil becomes willing to share technology and best practices [111]

[109] Our translation: "A Fiocruz é uma instituição pública vinculada ao Ministério da Saúde e, portanto, vive primordialmente com recursos públicos. A disponibilidade de recursos do Tesouro Nacional cobre apenas, no âmbito da cooperação internacional os gastos do quadro regular de recursos humanos (salários e subsídios trabalhistas), que é ofertado pela Fiocruz como contrapartida nas negociações com nossos parceiros internacionais. Ou seja, nossos quadros não recebem pro labore específico para atividades de cooperação" (TOBAR; COITIÑO; KLEIMAN, 2017; BUSS; TOBAR, 2017, p.623)

[110] The institution in Brazil is called Centro de Relações Internacionais em Saúde, Cris. Cris is internationally recognized as Fiocruz Global Health Center. The nomenclature adopted along the text will be Cris/Fiocruz.

[111] Scholars from international organizations use the term best practice to refer to the set of standards that become expressive internationally and achieve results. However, there is no consensual and unambiguous definition among scholars. Good or best practices are used in a plural manner in the literature and encompass the set of practices that different international organizations use to disseminate their norms in global governance (KLEIN; LAPORTE; SAIGET, 2015)

to developing countries. Ever since, the Fiocruz role "has been to reverse the dynamics and effects of a time when the negotiation of north-south projects was based on offering financial resources for predefined solutions, not necessarily taking into account the real needs of the institution [112]"(TOBAR; COITIÑO; KLEIMAN, 2017; BUSS; TOBAR, 2017, p.611).

Beyond the crucial role developed by Fiocruz for controlling epidemic diseases in Brazil and leading research to provide solutions for Brazilian health problems, Fiocruz achieved an important place in international and global health relations. We may emphasize that Fiocruz experienced a golden era in terms of research, innovation, and cooperation from 2000 to 2015, as we can see in the table "Fiocruz international health cooperation from 2000 to 2015". We had observed an intensive mobilization of this institution during this period, attending meetings, forums, and actively joining in multilateral organisms.

Over the years of intensive cooperation, we identified a Brazilian health foreign policy that used two strategies. As evidenced by the literature was common to talk about global health diplomacy and soft power in international health relations. The term diplomacy is often used in international relations to describe the interaction among actors and states, and its usually associated with the Ministry of Foreign Affairs.

Nonetheless, towards 2000 to 2015, Brazil watched an era of global health diplomacy, in which the Ministry of Health and Cris/Fiocruz became institutional references internationally. Thus, in summary, ways the concept of Global Health Diplomacy can be defined as "a process through which intergovernmental organizations and other actors deal for answers and strategies in the field of health" (FIDLER, 2007; LEE; CHAGAS; NOVOTNY, 2010; BUSS; GALVÃO; BUSS, 2017). In this sense, we can recognize that Brazil exercised the Global Health Diplomacy during this period above mentioned. The health diplomacy agreed among actors employed some strategies such as the use of soft power or the creation of an international narrative capable of constructing an image to be emulated by other states. This strategy reveals the multidimensional character of power. Hence, soft power refers to non-coercive strategies for setting an agenda and influencing other actors' interests. As studied by Nye (2004), soft power is a smart power whose main ambition is to legitimate leadership in specific policies or agendas, such as global health (JOSEPH, 2004). The employment of soft power to build diplomacy in the health area was especially noted along with the Lula administration (2003-2010), which benefited the Brazilian image in the international environment. Therefore, we observed that Fiocruz and the Brazilian Ministry of Health had adopted many actions to reinforce Brazilian image regionally and internationally during this period.

Concerning regional leadership, Fiocruz attempted to support and finance a South American Institute of Government in Health (Isags)[113] within the already nonexistent Union

[112] Our translation: O papel do Cris/Fiocruz tem sido o de reverter a dinâmica e os efeitos de uma época em que a negociação de projetos norte-sul se baseava na oferta de recursos financeiros para soluções predefinidas, não levando necessariamente em conta as reais necessidades da instituição [2]"(TOBAR; COITIÑO; KLEIMAN, 2017; BUSS; TOBAR, 2017, p.611)

[113] "ISAGS is an advisory body of the UNASUR Health endowed with legal personality and headquartered in

Table 5.2 – Fiocruz International Health Cooperation

Year	**Meeting or multilateral organization**
2002-2010	Member of World Health Assembly
2007	Meeting of national health institutes of the Community of Portuguese Speaking Countries (CPLP)
2008	Provision of technical assistance to the members of the Community of Portuguese Speaking Countries
2008-2009	Meeting to discuss the technical assistance for the elaboration and approval of the CPLP Strategic Health Cooperation Plan (Pecs).
2011	World Conference on Social Determinants of Health, with the World Health Organization (WHO), Rio de Janeiro.
2012	Conferência Rio + 20, de Desenvolvimento Sustentável.
2012 - 2015	Promotion of courses and congresses with renowned Brazilian and foreign managers and researchers. The overall was four classes, 42 lectures sponsored by Cris/Fiocruz Research Group on Bioethics and Diplomacy in Health (Nethis).
2013	3rd Global Forum on Human Resources in Health, in Recife, promoted by Opas and the Ministry of Health of Brazil.
2014	International Seminar on Biotechnology Applied to Health: current situation and perspective for joint action between the countries of the Latin America-East Asia Cooperation Forum (Focalal), April.
2014-2015	Workshops and updates on Ebola within the scope of Rinsp at Unasul and CPLP.
2015	Seminar to improve Fiocruz units in the field of international relations.
	Full member of Pasteur network institute in Biomedical Research.
	Member of the board of the International Association of National Health Institutes.

Source: Self elaboration as from Buss, 2017; p. 625

of South American Nations, hereafter, UNASUR. The main objective was to mobilize and coordinate efforts to improve South America's health quality by training leaders, providing knowledge, and technical support for health systems. According to Agostini's (2016), Unasur became a fruitful case study in the diffusion of public health policies in South America. To a great extent, the efforts directed to health in Unasur is an outcome of Brazilian intention to build its regional leadership. The regional organization became a catalyzer to foster the

Rio de Janeiro. The institute's objectives are to support domestic capacity-building, conduct policy-oriented research, and disseminate scientific information on regional and global health issues supporting inter-state cooperation. The creation of ISAGS was also an outcome of Brazil's regional leadership in the health sector (AGOSTINIS, 2019, p.9)

coordination of actions to improve health quality among their member states. In the author words, "UNASUR Health was one of the first sectoral councils to be created within UNASUR as a result of the interplay of Brazil's leadership capacities in the health sector and member states' shared interest in deepening regional health cooperation"(AGOSTINIS, 2019, p.8). Fiocruz's actions could also explain this project's outstanding success for improving regional health and establishing networks in this field [114].

The soft power and health diplomacy were evidenced as Brazil's strategies to foster health cooperation. Three cooperation models become notable from 2000 to 2015: North-South Cooperation, the triangular cooperation, and the South-South cooperation. In all of them, we evidenced Cris/Fiocruz's actions to enhance the partnership. The North-South Cooperation is the oldest kind of relation in which Brazil sought for technical assistance. The expression assistance has been changing throughout the years for cooperation. Hence, nowadays, North-South relations are called technical cooperation once all countries can achieve mutual interests. In the other vein, triangular cooperation was raised as an innovative model of cooperation. It consisted of a trilateral experience in which Brazil could use strategies to spread health policies. As an example of triangular cooperation, we can highlight Brazil-Cuba-Haiti's cooperation to strengthen the Haitian health system. The initiative responded to the 2010 earthquake, which created a scenery of a sanitarian emergency in Haiti. The primary purpose was to provide health assistance and reinforce the missions of peace guided by the United Nations Organization. Cris/Fiocruz oriented necessary actions for controlling epidemics and fortifying primary health care in this vein. Among other actions employed by Cris/Fiocruz, many Haitian leaders received training to lead with epidemics and endorsed an immunological campaign to provide vaccines accessible to the population (LEE; GOMEZ, 2011).

The third cooperation model emerged as an alternative model of cooperation, which sought to foster horizontal relations as from the so-called South-South cooperation. In 1955 during the Bandung Conference, South-South cooperation was addressed to encourage interhemispheric commercial exchange. Nonetheless, during 2000s, the expression was used on the social agenda to build bridges and foster health cooperation (BUSS; TOBAR, 2017). As practiced among emerging countries, South-South cooperation was defined as actions to build local capacities and engender knowledge to support national health systems (ALMEIDA, 2013; ALMEIDA, 2010; ALMEIDA et al., 2010) [115]. The main goal was to redirect Brazilian cooperation for American and African countries, to develop the capacity building, which consists of an action plan to provide conditions to empower national health systems.

[114] As studied by Buss (2017), some networks linked to Unasur can be highlighted as: Network of national schools of public health; Network for training technical staff.

[115] The South-South Cooperation is the so-called Structuring Cooperation, in Portuguese, Cooperação Estruturante em Saúde. We do not emphasize this concept in this discussion, considering our focus of analysis. To read more about this theme, also read (BUSS; TOBAR, 2017; ALMEIDA et al., 2010; ALMEIDA, 2013)

5.7 BUILDING AN IDENTITY IN FOREIGN HEALTH POLICY

Foreign policy is defined as a public policy, in other words, governmental policies aimed at solving public needs (GELINSKI; SEIBEL, 2008) and overcoming democratic purposes with the potential to impact the real-world. We then question whether there is a foreign health policy in Brazil and the characteristics of this foreign policy. From the issues highlighted above, it is possible to affirm that Brazil has a foreign health policy; nonetheless, it has undergone significant changes. Nevertheless, to Lopes (2013), historically, the "public" character of foreign policy would hardly be combined with the participation of the population in the decision-making process" (LOPES, 2013, p.158).

Lafer (2000); Almeida (2017) pointed out that Brazilian foreign policy would have continuity patterns justified by historical, geopolitical, and socio-cultural factors, contributing to creating an international identity, observed from the Brazilian actions projected abroad. As highlighted above, Brazil has been building a trajectory in global health over the years. Historical landmarks as Brazil's performance in the International Sanitary Conferences and the performance in the context of creation of the WHO reveal Brazil's engagement abroad. Since the beginning of the 19th century, these actions suggest that Brazil has developed policies and actions to participate internationally in issues related to health (ALMEIDA, 2017; LAFER, 2000).

The identity of foreign health policy has been built at the beginning of the 19th century. At the beginning of the 1980s, Brazil began to participate more actively in the areas of health. The first speech identified is dated from 1983, at the 36th WHA, with the participation of Health Minister Waldir Arcoverde. In the 1980s and 1990s, Brazilian speeches highlighted the economic crisis and the new health system's ongoing creation in Brazil, the Unified Health System (SUS). The creation of a new system brought contributions to foreign health policy. According to Rezende (2018), Brazilian foreign policy in health matters benefits from the Ministry of Health, the national system experience, and technical competence in designing and implementing effective, democratic, and participatory public policies (REZENDE, 2018, p.66)[116].

Towards the 2000s, the Ministry of Foreign Affairs becomes more open to subnational entities. By bringing new actors into political negotiation, the public character associated with public policy abroad seems to achieve more significance, since then social issues, such as health, began to be more frequently considered in political discussions. Domestic politics changes were notable during this context, allowing more significant action by subnational entities in the Ministry of Foreign Affairs decisions.

The inaugural effort in the 1990s became more concrete in the 2000s, due to the closer partnership between the Ministry of Foreign Affairs (MFA) and the Ministry of Health

[116] Our translation from Portuguese: a política externa brasileira em matéria de saúde beneficia-se da experiência e da competência técnica do Ministério da Saúde e do SUS – na elaboração e na implantação de políticas públicas eficazes, democráticas e participativas (REZENDE, 2018, p.66)

(MH). The health began to show a new focus of interest in the Brazilian international agenda, especially after the creation of south-south cooperation (ROA; SILVA, 2015).

In the FHC government, we noted the inclusion of new themes on the international agenda. In the meantime, there was the establishment of the Community of Portuguese Speaking Countries CPLP in 1996, and Brazilian efforts aimed at strengthening cooperation with the community's countries. Within CPLP, Fiocruz[117] began to receive considerable prominence as a Brazilian foreign policy actor.

Under the Lula administration, health has also received more attention in Diplomacy. Lula's foreign policy emphasized only one project and a set of actions and trends already coined in the Cardoso administration (ALVES; PAIVA; SANTANA, 2010; VIGEVANI; CEPALUNI, 2007). However, for authors such as Oliveira; Vizentini (2005), under Lula's direction, changes in the course of Brazilian Diplomacy gained greater prominence (ALVES; PAIVA; SANTANA, 2010). Although the authors have divergent positions regarding foreign health policy, actions focused on "health diplomacy" can be more easily found in the Lula governments. In terms of Vaz; Inoue (2007), "added to vocational training and agriculture, health now represents two-thirds of Brazilian cooperation with developing countries" (VAZ; INOUE, 2007; VENTURA, 2013, p.9).

The inclusion of health in the foreign policy agenda, among other purposes, can contribute to broadening strategic partnerships with other states and to pro-developmental actions. In other words, "cooperation in health fits into the set of public actions against poverty" (RUBARTH, 1999, p.159). Within this context, Brazilian agencies began to dialogue with multilateral agencies, seeking to defend distinct purposes to health. In summary, we present below some Brazilian agencies with their respective focuses that gained prominence during the Lula administration. As studied by some authors: the plurality of actors and the politicization of foreign policy allowed Brazil to accomplish more visibility and broader international projection accompanied by the diversification of themes in foreign policy (PINHEIRO; LIMA; HIRST, 2010; MEDEIROS; JÚNIOR; REIS, 2017, p.24).

As Almeida (2017) studied, "the collaboration between the Ministry of Health and the MFA has rarely been so intense and fruitful" during Lula's government (ALMEIDA, 2017, p.500)[118]. As she complement this "partnership" resulted in the development of several projects of horizontal cooperation and closer and lasting dialogue between areas and institutions of the Ministry of Health and sectors of the MFA, (ibidem)[119]. As demonstrated in the table below, we can see some national actors which played a meaningful role in Brazilian foreign policy.

[117] "In the area of medicines, Fiocruz, through the Farmanguinhos Institute of Technology in Pharmaceuticals, is leading an unprecedented international cooperation project for Brazilian technology transfer: the Antiretroviral Factory in Mozambique, which aims to reduce Mozambique's dependence on foreign donors, focused on medicines, especially for the treatment of HIV / AIDS.(ROA; SILVA, 2015, p.165)"

[118] Our translation from Portuguese: Na área da saúde a colaboração entre o Ministério da Saúde e o MRE poucas vezes foi tão profícua (ALMEIDA, 2017, p.500)

[119] Our translation from Portuguese: Essa parceria resultou no desenvolvimento de vários projetos de cooperação sul-sul e em diálogo permanente entre áreas e instituições do próprio Ministério da saúde e AISA (ibidem).

Table 5.3 – Domestic actors and actions at the international level

Actors	**Actions at the international level**
The Advisory on International Health Affairs (AISA)	Actions aimed at strengthening relations between geographic and economic blocks
STD-AIDS Program	Promoting debate and participation in HIV forums
National Cancer Institute INCA	Actions related to smoking reduction and diseases caused by tobacco and its derivatives
National Health Foundation (FUNASA)	Projects focused on sanitation, alcohol control and suicide in indigenous populations
Oswaldo Cruz Foundation (FIOCRUZ)	Conducting scientific research, does not act directly on technical cooperation and implementation of public policies.
National Agency for Supplementary Health	Control and supervision of companies in the health segment; setting standards to ensure the public interest

Source: Self elaboration.

As shown, initiatives focused on international health in recent years have become more frequent on the Brazilian foreign policy agenda. It can be said that the joining of several Brazilian actors contributes to diversify and expand Brazilian partners, which can strengthen Brazil's role as a global player on the international scene, pursuing autonomy through diversification[120] as proposed by Lula (2003-2010). In other words, "the enlargement in international technical cooperation, especially with developing countries, highlighted the international performance of domestic ministries" [121] (ALMEIDA, 2017, p.504).

As mentioned in the previous sections, health has become relevant in international negotiations and, in recent years, has gained relevance in the Brazilian foreign policy agenda. The distinction between high and low politics became obsolete, since issues related to low politics, such as health, were incorporated into foreign policy agendas as a means of expanding diplomatic negotiation capacity to project state power [122]

Since World War II, Brazilian foreign policy has been characterized as bureaucratic insulated by the predominance of Itamaraty's role in international matters and the low permeability to popular participation. However, it is noted that the confluence of factors, such as re-democratization and a new constitutional framework, since 1988, has provided a favorable environment for changing the "status quo" of this public policy. Among other

[120] Changes in the foreign policy of the Lula administration came to be analyzed by experts in the field such as Vigevani, Cepaluni (2007) as an autonomy for diversification. The Brazilian strategy, among other actions, was to strengthen bilateral and multilateral relations and expand exchange in different areas, such as economy, finance, culture and technology (VIGEVANI; CEPALUNI, 2007).

[121] Our translation from the Portuguese: "o aumento importante da cooperação técnica internacional, sobretudo com os países em desenvolvimento, deu destaque à atuação internacional dos ministérios domésticos,"(ALMEIDA, 2017, p.504)

[122] Health policies have provided a favorable environment for international cooperation in this area, especially with African countries, among them the Portuguese-speaking Community (MILANI; PINHEIRO, 2013). Through efforts in this area, Brazil has been able not only to expand its ties of cooperation, but it has also advanced its efforts to project its image more intensely on the international scene.

issues, it favors establishing an ever-closer interface between the Ministry of Foreign Affairs and distinct subnational actors (LIMA, 2000).

While internationally, foreign policy health creates an image to be emulated by other actors, domestically, we evidenced several changes during foreign policy formulation and implementation stages. Faria (2012) refers to this process horizontalization of Brazilian foreign policy which refers to the growing participation of actors in foreign policy's decision-making process, "a process in which a new institutional arrangement between the [Ministry of Foreign Affairs] and the other Executive entities" is established (REZENDE, 2018, p.50). Thus, from a normative perspective, it can be said that foreign policy was in the process through which Itamaraty was losing its monopoly over the formulation of Brazilian foreign policy (FARIA, 2012; LOPES; FARIA; CASARÕES, 2010).

This loss of autonomy of the MFA would reinforce the growing inclusion of subnational actors in different foreign policy cycle stages. Concerning health, became notable the increasing relationship between MFA, Ministry of Health and institutional actors. As an outcome of the pluralization of actors in foreign policy, we could say that a new way of diplomacy was established. Traditional diplomacy refers to foreign policy's centralization in the ministry of foreign affairs hands, made only by diplomatic corps. Otherwise, contemporary diplomacy implies that various actors, official or not, governmental and non-governmental, could make diplomacy (SILVA; SPÉCIE; VITALE, 2010; PINHEIRO; LIMA; HIRST, 2010; ALMEIDA, 2017).

The pluralization of actors in Brazilian foreign policy fosters a debate about intra-governmental and intergovernmental relations. In this research agenda, a relevant gap is defined by Itamaraty's relationship with other governmental and institutional actors, which may not share the same interests and aspirations proposed by the country's diplomacy (FARIA; NOGUEIRA; LOPES, 2012; LOPES; FARIA; CASARÕES, 2010).

Due to these new actors in the MFA decision-making arena, it is essential to underline that coordination encompasses a diversity of actors' playing at the federative level. The diversity of actors works to reinforce the process of implementing public policies, jointly and under the same source of authority (GONTIJO, 2012). Otherwise, it distinguishes from the cooperation, a process in which entities have autonomy and do not share the same authority (SOUZA, 2006).

As shown, although efforts on international health cooperation are not recent, the connection established between health discussion and Brazilian foreign policy has gained prominence in Brazilian politics only in recent years, read (1995-2015). Above all, in the Cardoso administration and the Lula administration, initiatives were more concrete in this international social theme. Nevertheless, the Brazilian performance in this global health regime [123] has been active and has had national actors' participation in its design and

[123] As studied in chapter 4, the global health regime refers to actors that foster health cooperation initiatives, as intergovernmental organizations such as WHO, PAHO, UNAIDS, philanthropic foundations such as Bill &

implementation, especially in the south-south context. Brazil was sufficiently persuasive in the health regime to encourage the Brazilian pharmaceutical industry to provide antiretroviral drugs and create a health cooperation agenda [124].

The inclusion of health in Brazilian diplomacy brought greater alignment with government priorities and social aspirations. Moreover, the inclusion of health as a Brazilian foreign policy theme fortified Brazil's dialogue with different countries of the international scenario, favored acting as a global health player.

Despite generating a positive image and increasing participation in global or multilateral health diplomacy, we may affirm that external projection was an outcome of an acute interaction built between domestic actors and Itamaraty. We evidenced that a decision context with a multiplicity of actors coincides with an Itamaraty less insulated. In this regard, national actors began to gain space in the foreign policy decision-making process. This opening of the Ministry of Foreign Affairs to subnational actors strengthened international cooperation in health as we could evidenced through the examples given in the previous sections.

5.7.1 A turn in the Brazilian health foreign policy?

Despite the great image Brazil achieved internationally, the current context suggests a setback for domestic actors' participation in foreign health policy formulation and limited Brazilian participation in multilateral fora. Through 1995-2015 representatives prioritized a more horizontal policy, seeking to foster South-South cooperation and universal access for medicines, as from 2016 the Brazilian foreign health policy points in a direction whose political retraction stands out and the yearnings for cooperation and partnerships were subordinate to the economy.

As discussed above, Brazil was building an international identity in foreign health policy and global health. Nevertheless, the continuity patterns in foreign policy, as proposed by Lafer (2000), seem to decline after 2011.With the election of Dilma Roussef in 2011, in its first term (2011-2014), the Brazilian foreign policy would be gradually changed. As noted by Saraiva (2014) "despite the apparent continuity, "Brazilian behavior showed a visible reduction in proactivity and lost its leading role in global politics, assuming a reactive character"[125] (SARAIVA, 2014, p.25).

Scholars, as Gómez, Perez (2018), Cervo, and Lessa (2014) have studied the BFP to understand the reasons that could explain the decline of this policy. One of the reasons raised by them was Roussef personal lack of interest in international affairs. While Lula foreign

Melinda Gates, civil society movements, and non-governmental organizations, NGOs.

[124] A great example of this is Fiocruz's decisive role in Mozambique during the Lula administration, seeking to develop HIV/AIDS research.

[125] Our translation from the Portuguese: "Apesar da aparente continuidade, "o comportamento brasileiro [apresentou] uma visível redução na proatividade e foi perdendo seu protagonismo na política global, assumindo um caráter reativo" (SARAIVA, 2014, p.25).

policy uses the BFP as a channel to build international opportunities and foster development, Roussef addressed her policies to national economic and social development. In other terms, despite being of the same party, Workers Party (PT)[126], the president did not use the foreign relations to boost domestic development as her predecessor (GÓMEZ; PEREZ, 2016).

Another reason raised by the literature was the challenge faced by Roussef concerning funding and budgetary management. We could evidence the decline in funding and Itamaraty gradual loss of autonomy, which had several implications in ongoing projects during her term. As an example, "the government's contributions to international organizations became the responsibility of the Ministry of Planning, Budget, and Management. This loss of financial autonomy and an overall reduction in budgetary support greatly impacted Itamaraty's daily operations" (GÓMEZ; PEREZ, 2016, p.8).

Seems to be consensual among scholars of this field that during Roussef government we could see efforts to uphold Lula's governments premises of foreign policy. However, even in face of this efforts "Roussef international performance would have weakened the insertion of the emerging power" (CERVO; LESSA, 2014; SARAIVA, 2014; ALMEIDA, 2017, p.501). In the same way, the process of weakening foreign policy observed in Roussef administration appears to have ended with the president's impeachment in 2016. In other terms "the impeachment of the president in 2016 definitively ended PEB's upward trajectory of the previous 14 years". (ibidem)[127]".

Referring to Temer-Serra's foreign policy since the first half of 2016, there have been significant changes in the way it was conducted. Since the Temer period until 2020, we have been noticed a setback in this dynamic. The proposal to freeze public spending and the low incentive to social issues observed at the domestic level could also be viewed in foreign policies. We could notice that domestic actors have received less stimulus to participate in discussions, creating a lacking of Brazilian performance in multilateral forums.

As studied, the foreign health policy is affected by domestic arrangements. The most successful international health policy period showed that it was an outcome of greater alignment among executive and subnational entities. Besides the more inclusive pattern of domestic policy, we noted the focus on international horizontal cooperation. Nevertheless, in the last years, this profile seems to be changed. Domestic politics has suffered a setback, tending to prioritize vertical relations, which implies that few actors could engage, and fewer interests could be represented internationally. Thus, it can be said that domestic politics impacts could result in a low profile in international forums and international health cooperation.

[126] PT is the Brazilian acronym of the Workers Party.

[127] Our translation from the Portuguese: "O impedimento da presidente em 2016 encerrou definitivamente a trajetória ascendente da PEB dos 14 anos anteriores". (ALMEIDA, 2017, p.501)

5.8 CONCLUSION

As highlighted at the beginning of this chapter, we seek to raise reasons to justify Brazil as a prolific case study within WHO. As studied, Brazil has been engaging in the international health agenda since the International Sanitary Conferences. However, it was only with the creation of PAHO and the WHO that more solid efforts in international cooperation became notable.

As analyzed by WHA speeches, Brazil since the New Republic has been striving to build a reputation at WHO based on universal access to health and medicines. Several Brazilian representatives corroborated this speech at the World Health Assemblies between 1985 and 2015. Among the prominent guidelines, Brazil has become a reference in issues such as communicable diseases as HIV, projects such as breastfeeding, tobacco control, and other projects - although not covered in detail here-, ensuring Brazil a leading role in global health diplomacy.

After this analysis, we may recognize the Brazilian foreign health policy's identity that seems to have reached its golden years between 2000 to 2015. Among other factors, we recognized that the Brazilian success in health diplomacy could be attributed to at least two issues: first, a more horizontal and inclusive domestic arrangement enabling fruitful dialogue between subnational units. We perceived the intensive exchange of technical knowledge among different sectors, which strongly favored Brazil's international projection.

Secondly, we highlight the Brazilian government's support for actions related to global health. Health has gained greater prominence in Brazilian foreign policy in the context in which social issues have officially become a foreign policy agenda in the country. Such a Brazilian effort is also a product of the country's desire to dialogue with the international environment. In other words, many of the health actions highlighted, especially in the period from 2000 to 2015, were related to the implementation of the Sustainable Development Goals, such as the transfer of technical capabilities in health systems to countries in the Global South. In this context, there was a clear link between global health policies with the aim of achieving development. It is worth noting that many of the cooperation actions consisted of horizontal cooperation, in which economic gains are not necessarily earned. In this case, the greatest Brazilian gain was a greater international projection, that is, foreign health policy had become a soft power tool in diplomacy.

Finally, although we have raised reasons to justify Brazil's leading role in global health, we note a weakening of Brazil's global health actions after 2015. As demonstrated, domestic arrangement challenges such as the financing in foreign policy on social issues and presidential changes have significantly affected international health cooperation projects.

6 WHEN A GLOBAL POLICY BECOME A NATIONAL POLICY: THE TRANSFER OF TOBACCO CONTROL TO BRAZIL

6.1 INTRODUCTION

The following chapter discusses the Tobacco Control Policy's case study its transfer to Brazil and its success in implementation. The case study was based on interviews with experts from WHO, PAHO, and actors who worked in the Brazilian government in the context of policy transfer. We use the triangulation method, in which we triangulate the information collected by the interviews, the literature already produced on the subject, and documents produced by the WHO.

From the literature produced on the tobacco control case, we identified that many key actors in transferring global policy are also academic publications on this topic. We then use these references that contributed to the construction of this chapter. We seek to highlight the importance of key actors in transferring WHO policy to Brazil and the **mechanisms** of transferring employed in this global policy considered successful by the literature.

Equally important, it is to understand how the case study can be useful for other policies. As identified by the interviews, the case study has become an emblematic case. It can be used as an example to contribute to the transfer of policies that have similar characteristics. In this sense, we used a shadow case, represented by obesity and unhealthy food habits, which the WHO considered a new epidemic. It appears noiseless in the global environment and has caused about 70% of deaths related to non-communicable diseases, NDCs. Unhealthy food habits, represented here by the excessive use of sugar, fats, and processed foods, have been considered one of the leading causes of obesity and the rise in NDCs. The necessity to regulate the industrial food sector as a strategy to intervene in advance of this epidemic can be comparable to tobacco and its regulation and taxation.

What is typical between these policies is the need to consider usual actions between different States to favor global health as a universal common good. The following cases deal with industrial and advertising interests to contain the spread of deaths and diseases related to chronic non-communicable diseases, which could be avoided by implementing comprehensive policies and re-educating habits. The cases differ considerably from many diplomatic negotiations that put trade deals at the center of the discussion. Based on these issues, the tobacco case investigation seeks to understand which strategies contributed to the transfer of this global policy and what strategies could be applied to the shadow case.

6.2 CONTEXTUAL FACTORS THAT LED TO GLOBAL TOBACCO CONTROL POLICIES

As investigated in the previous sections, international organizations appear to be negotiating mediators on the international stage. As discussed by the principal Agent theory,

International Organizations arise to represent their member states' interests. Therefore, IOs are considered agents that aim to achieve a particular objective established by their principals. We seek to investigate conditions that allow us to understand International Organizations beyond meta-institutions through the WHO study. In other words, the objective is to understand IOs farther the normative scope, as a norm creator, but also as agents that, in different ways, orchestrate social changes at the domestic level.

Given this discussion, we have chosen the case of tobacco control from the World Health Organization. "International organizations, such as the World Health Organization, are no longer the extension of national policies - they modify, tie and sometimes offer the foundation for national legislation" (VENTURA et al., 2015, p.5). The case of tobacco control, through the Framework Convention for Tobacco Control (FCTC), emerges in the literature as a classic case that guided WHO member states to create normative structures at the domestic level to control the expansion of smoking in the international context.

6.2.1 The mechanism of discursive dissemination

Tobacco emerged as a global health concern several years before the consolidation of FCTC, as shown in the figure Phases of tobacco promotion and restriction. As stated by the former WHO Director-General, Gro Harlem Brundtland in 2000 "Smoking is a communicable disease. It is a disease transmitted by advertising and marketing that makes smoking look admirable and glamorous" (Brundtland, 53rd WHA, 2000). It should be noted that tobacco comes from an era whose dominant assumption was economic interests. The tobacco industry received government incentives to expand the sale of tobacco and bring benefits to the economy. However, this concern has been replaced over the years by socioeconomic understandings related to smoking and health problems, leading to smoking restriction and policy control (CAIRNEY; STUDLAR; MAMUDU, 2011).

Table 6.1 – Phases of tobacco promotion and restriction

Political Economy	***Tabaco promotion***
Phase 1- 1885-1914	Consolidation of the Cigarrete Industry and early Controversies over Morality and Public health
Phase 2-1914-1950	Tobacco Growing and Manufacturing Promoted by Governments
Phase 3 1950-1964	The Gathering Storm of Health Concerns
Public Health	***Tobacco restriction (The beginning of an international regime)***
Phase 4- 1964-1984	Regulatory Hesitancy; Tobacco control seen as a Developed World Issue
Phase 5-1984-2010	Tobacco as a social and Global Menace
Phase 6	Neo-prohibition vs. Harm Reduction and or/Decommercialization?

Adapted from (STUDLAR et al., 2002) (CAIRNEY; STUDLAR; MAMUDU, 2011, p.62)

The shift from an economic to a social perspective has global implications for the pattern of consumption and tobacco users' profile. In other words, in the tobacco promotion phase as an economic good, it was noted that developed countries received greater prominence

in production and marketing. Notwithstanding, in the restrictive phase, it was noted that developing countries were the most affected by the sale of tobacco. The tobacco legislation was less restrictive in developing countries than in developed, furnishing an attractive territory for tobacco multinationals, which expanded their markets for these regions. Therefore, an alarming effect of the tobacco epidemic was the expansion of consumer market activities to developing countries. In the WHO words, "when smoking was tending to stabilize or even decline in the industrialized countries, the multinational tobacco companies were finding new markets in Africa, Latin America, Asia, and eastern Europe (WHO, 1981, p. 7).

The tobacco control policies result from international efforts mobilized since the 1960s and gained greater intensity in the 1980s. With the scientific findings that proved the harmful effects of nicotine on the human body, greater international acceptance to regulate tobacco use was noted in this period. Given the evidence surrounding adverse health effects, governments began to be more willing to implement regulatory actions (WHO, 1981).

Concomitantly, there has been an increasing action by civil society and anti-tobacco groups, evidenced by " political advocacy by anti-tobacco groups, including both professional and voluntary health organizations" (STUDLAR, 2006, p.6). The mobilization and networks that formed around the anti-smoking initiatives started in developed countries. Nonetheless, developing countries like Brazil, Singapore, Thailand, and Venezuela showed a great innovative capacity to deal with controlling tobacco (CAIRNEY; STUDLAR; MAMUDU, 2011).

6.2.2 The role of the non-state actors and the power of transnational advocacy coalitions

According to information collected, transnational civil society's performance and the diversity of transnational actors -such as philanthropic foundations and NGOs- pushed for constructing a WHO convention to control tobacco consumption (verbal information). Besides, Cairney (2011) confirms that the action of governmental actors such as the European Union and the United States, accompanied by the overall performance of organizations such as the World Bank, the United Nations (UN) and NGOs, fostered the creation of a normative instrument in the frame of the FCTC (CAIRNEY; STUDLAR; MAMUDU, 2011).

It is essential to highlight that the role of transnational civil society and non-state actors highlighted a health threat related to the use of tobacco and nicotine for the human body. The widespread use of tobacco and the impact of advertising as an incentive to smoking become a matter of public health, making it increasingly urgent to create regulations to restrict advertising and tobacco selling. The change in tobacco use pattern is strongly related to the research results that identified the harmful effects of nicotine on health, a context in which countries began to adopt legislation in the domestic sphere to restrict tobacco and ban advertising that would encourage such habit. Actions to increase cigarette taxation and government campaigns to alert and warn about tobacco use harm have become more frequent.

6.2.3 The creation of patterns mechanism

In the 1980s, countries were already developing legislation to deal with the tobacco epidemic in their territories, and the WHO documented the growing number of states developing legislation to control smoking. We can say that such initiatives led to creating an international tobacco control regime that started to develop around the 1960s and decades after it expanded to other countries through the creation of national laws. In 1982 about 57 countries started to adopt domestic laws restricting the use of cigarettes, and in 1995 that number was expanded to 91 countries as reported by the WHO in its document entitled Legislative action to combat the world tobacco epidemic (WHO, 1981; 1993; STUDLAR 2006).

What we have noticed over the years has been the consolidation of an international regime around tobacco issues. States expanded upon and implemented its proper initiatives. As highlighted by Roemer (1993), restrictive legislation was observed in many developed states. However, many of the regulations presented weaknesses or were inadequate to deal with the epidemic. In other words, although the tobacco control convention was created in the 2000s decades, which was already promoting the 1980s more consistent efforts. In the 1990s, therefore, a new phase concerning tobacco control appears to have emerged.

As Studlar (2006) points out, the denormalization of smoking tobacco marks the 1990s. The habit of smoking came to be seen as something of social concern with the potential to generate chronic and non-communicable diseases, such as respiratory diseases, lung problems, and cancer. From the 1980s onwards, the evidence already pointed out that in addition to the harmful consequences concerning tobacco use, passive smokers - nonsmokers - that is, those who were frequently exposed to smoke and nicotine also became more susceptible to cancer, cardiovascular diseases, and respiratory illness (ROEMER; ORGANIZATION et al., 1993).

Despite the identification of non-communicable diseases with smoking, the spreading of diseases is justified by advertisements' strong influence and the market encouraging smoking. Under the WHO terms, "the tobacco industry spends thousands of millions of dollars on advertising which presents a flattering, often dazzling, image of smoking" (ROEMER; ORGANIZATION et al., 1993, p.13).

The Cooperation towards this agenda was urgent, given the paradox it was inserted. Whereas "about five million deaths and diseases were related to smoking, in contrast, there was a strong influence of cigarette manufacturers" (VENTURA et al., 2015, p.4), and a broad consumer market -above one billion consumers according-, to data from the World Bank from 1999 (ibidem). In the early 1990s, the WHO signaled the urgency to create a health program for tobacco control. The core difference of this program is seeking to alert and prevent citizens from using a drug. It distinguishes from previous programs that sought to guarantee citizens' protection against diseases and natural disasters.

To reverse this scenario of avoidable deaths and harmful health consequences caused

by tobacco's continued use, the WHO has invested in orchestrating negotiations with different political actors to consolidate the Tobacco Control Convention. After discussions held at the World Health Assemblies, WHO approved in 2003, during the 56th WHA, the first international public health treaty called the World Health Organization Framework Convention on Tobacco Control (WHO-FCTC) (PEREZ; SILVA; BIALOUS, 2017).

As discussed in chapter 4, the WHO can create normative instruments of different orders, such as conventions, recommendations, regulations, among others. The vast majority of the WHO instruments are no binding. In other words, there are no enforcement mechanisms to enforce the global rules negotiated at the World Health Assembly. Unlike the other initiatives created by the WHO, the FCTC became an instrument capable of impacting each state party's national legislation that ratified it. Thus, there was a legal instrument to regulate tobacco use (ALCAZAR, 2008; VENTURA, 2015; PORTES; MACHADO; TURCI, 2019).

6.2.4 The establishment of a coordinative function mechanism

The tobacco case study, therefore, shows a break with the traditional study of international relations by at least two main characteristics, namely: the change in the paradigm of international relations, taking trade exclusivity from the center of diplomatic negotiations; and the creation of an international health treaty, ensuring greater importance for health in diplomatic negotiations. The new normative instrument emerged with characteristics distinct from the previous regulations and guidelines. As highlighted by Alcazar (2008), the FCTC presented substantial scientific evidence and unquestionable credibility, gaining support among the WHO members.

The FCTC came up with the objective and challenge of implementing measures to protect and alert the population against the consequences of consumption and exposure to tobacco. The Convention placed great emphasis on the role of civil society as a relevant actor to achieve the goal of consolidating normative arrangements at the international level (ALCÁZAR, 2008). The WHO brought this third part to the arrangements in a creative fashion that was particularly new to an international arrangement. As evidenced by the interviews conducted, the tobacco case has a powerful and organized civil society that has led efforts to consolidate the arrangements proposed by the FCTC, which we will discuss the following.

6.3 THE FRAMEWORK CONVENTION ON TOBACCO CONTROL

As we discussed above, the mobilization around the control of tobacco consumption emerged around the 1960s. Nonetheless, only in the 1990s, the requirement to create a normative instrument arose among the World Health Assemblies. The resolution at the 48th WHA endorsed the document's creation in 1995. Subsequently, at 49th WHA, Director General Hiroshi Nakajima received orientations to develop the international instrument for tobacco control, called the Framework Convention on Tobacco Control, hereafter, FCTC (WHO and

others, 2003).

In 1998, the ongoing project for the creation of the FCTC acquired greater centrality. In the course of the Director-General Gro Harlem Bruntland, tobacco control issues gained international attention by creating the Tobacco Free Initiative project, TFI. The project's foremost mission was to prevent future generations from exposure and tobacco use risks. The project is of singular importance in training national governments to effectively implement international and transnational tobacco consumption (WHO, 2020) [128]. Bruntland's management of tobacco control proved to be innovative, either through the creation of the TFI or searching for new international partnerships to convince a wider audience about the need to contain the tobacco epidemic and create the Convention for restricting the use of tobacco. According to the WHO, "Dr. Brundtland worked with the Member States to secure a negotiating mandate for the Framework Convention on Tobacco Control and set about the task of mobilizing public and political opinion in favor of global rules for tobacco control" (WHO and others, 2003, p.3).

As analyzed in the interviews and documents, Brazil has played an active representation in this process since the beginning. We evidenced the Brazilian engagement in this agenda through the notable policy entrepreneurs supporting this global agenda, as the Brazilian ambassador Celso Amorim which was elected as a Chair of the intergovernmental negotiating body[129]. The body had relative autonomy concerning the WHA and acted in an *ad hoc* manner, seeking to advance in negotiations and elaborating the convention . The first meeting session took place in October 2000 in a context in which the working group prepared a draft text with substantive elements for the convention. "Subsequently, Ambassador Amorim prepared a Chair's text of the Framework Convention on Tobacco Control; this first draft was released in January 2001 as a basis for further negotiations at the second session" (WHO and others, 2003, p.41).

Through Celso Amorim's performance, we found the evidence concerning Brazilian engagement in this normative document. As discussed in previous sections, the WHO decision-making bodies' elections adopt universality and geographic representation as a criterion. The representative should act impartially, without bringing direct benefits to the country, even though the Amorim's performance is shown to a case of great use of soft power. We believe that Brazil has acquired visibility within this process to build a reputation on the tobacco control agenda.

It is also important to highlight that the tobacco case brought new actors to the negotiation. Bruntland's mobilization to bring a multi-sectoral vision to the organization and combat smoking has made the negotiating environment more plural and diverse. There was the active involvement of civil society and non-governmental organizations, NGOs, for example,

[128] Source: <https://www.who.int/nmh/about/tfi/en/>

[129] As discussed by FCTC a bureau to negotiate the Convention was established. Amorim was elected as a Chair and the Vice-Chairs was Australia, India, Islamic Republic of Iran, South Africa, Turkey and the United States of America (FCTC, 2005, p.41)

the International Nongovernmental Coalition Against Tobacco's [130], which since 2001, has had official relations with the WHO.

The negotiating body established in the 2000s met approximately five times between 2000 and 2003 in intense negotiations to establish the document that would guide countries in creating legislation to combat tobacco consumption. In February 2003, the negotiating body held the final session in which it made available the text constructed for consideration and adopted at the WHA56. As highlighted by WHO, in 2003, the Framework Convention on Tobacco Control, FCTC was unanimously approved. The document represents a milestone in the history of the WHO and international health relations. As the WHO defines the framework "is a landmark for the future of global public health and has major implications for WHO's health goals" (WHO and others, 2003, p.41).

The FCTC achieved exceptional relevance for being the first international public health treaty, negotiated under the WHO's auspices. It stands out for its characteristic of dealing with the interests of a tobacco-producing industry and acting in the fight against the illegal trade in this product, differing from previous initiatives that aim to control the use of drugs. Therefore, the treaty stands out for combating the denormalization of a habit cultivated by citizens and encouraged by the advertising market for many decades. The document was created by the evidence that smoking and exposure to nicotine could have severe health impacts. Thus, the FCTC is called the scientific evidence-based treaty, whose purpose is defined by the defense of high public health standards for any human being.

6.3.1 The diffusion of tobacco control policies worldwide

The Framework Convention on Tobacco Control was "implemented under the bylaws of the World Health Organization (WHO), the FCTC has been the product of multi-level and multi-actor negotiation processes that define" global health diplomacy" (LEE; CHAGAS; NOVOTNY, 2010, p.2)". As previously discussed, the FCTC is the first international public health treaty consolidated under the WHO framework, following the foundations of the 1948 WHO Constitution. After extensive discussions, the treaty was unanimously adopted during the 56th World Health Assembly on May 21, 2003. Nevertheless, it was only in February 2005 that the treaty comes into force. The Convention currently has 168 signatories and 182 parties. The signatories are states that signed the treaty ratifying the interest and agreement with the rules created by the FCTC between June 30, 2003, and June 29, 2004, during which the treaty was open for signature.

Non-signatory parties have access to the treaty and agree to implement the regulations at the domestic level [131] . Parties to the Convention may or may not be members of WHO. According to information provided by the health agency, "the Convention

[130] <http://www.ingcat.org/>

[131] For additional information concerning the process to become the FCTC party please access: <https://www.who.int/fctc/cop/ratification-checklist-becoming-a-party-en.pdf?ua=1> Acessed: 28/09/2020

Figure 6.1 – States parties of the FCTC

Source: WHO (2020)[134]

was open to signature by all Members of the World Health Organization (WHO), all States that are not Members of WHO but are Members of the United Nations and any regional economic integration organization. All of these may become Parties to the Convention by ratifying it (WHO, 2020)[132].

As shown in the figure entitled States parties of the FCTC, the Convention has an overall coverage. The policies have been disseminated to approximately 90% of the world population, allowing us to affirm that WHO has successfully disseminated this policy.

The success in spreading tobacco policy around the world can be related to different issues. Given that it is an international treaty governed by a convention, it differs from other WHO policies due to the bureaucratic apparatus that supports it. When investigating the different health policies, we noticed that the vast majority are supported by resolutions and technical bodies to deal with the theme. In many cases [133] , a WHO team acts as a working group to offer the necessary support to create and implement programs and initiatives to deal with the theme.

The tobacco case proves to be distinguished because we have identified government agencies' existence to deal with the issue in its various sectors, such as negotiations with

[132] Source: <https://www.who.int/fctc/cop/en/>

[133] The WHO team's existence could be seen in many actions developed by the WHO, but not in all. After a brief analysis, we understand that some policies are in more advanced discussion stages, possibly related to emergency and epidemic demands. This characteristic favors the creation of working groups and the hiring of experts to work on specific topics.

[134] Source: <https://www.who.int/fctc/cop/en/> (<https://www.who.int/about/who-we-are/publishing-policies/copyright>)

the industry to contain the illegal tobacco trade. There is, therefore, a greater degree of institutionalization in the policy to deal with smoking, regulated by the FCTC. The Convention is "administered" by a secretariat whose core function is to implement the Convention's rules. The convention secretariat is an entity headquartered by WHO in Geneva, acting cooperatively with other WHO departments, international and non-governmental organizations.

6.3.2 The technical assistance mechanism

Among other functions, the Convention Secretariat acts substantially in actions to transfer legislation and implement at the domestic level. Significant action concerns the multisectoral promotion and comprehensive tobacco control policies at the local level, in addition to strict coordination with actors at the international level with IOs and NGOs[135] (WHO, 2020). Transnational coordination is fostered through meetings between countries whose primary focus is on implementing the FCTC, actions that take place in partnership with WHO regional offices. Cooperation with several actors reinforces the role of multi-stakeholder working on the agenda. Beyond its own secretariat, the Convention works additionally with its work plan, budget and reports prepared by the Conferences of the Parties, hereafter COP, which assist in implementing the general guidelines of the Convention [136] .

These characteristics reinforce this agenda's relative autonomy within the WHO, favoring the transfer to domestic level and diffusion for many countries. We emphasize that the bureaucratic apparatus comprises the secretariat and the Conference of the Parties (COP) understood as a governing body within the treaty [137] . We underline that COP is a body that corresponds to the World Health Assembly (WHA) to bring all parties together and foster discussions in search of better solutions to deal with WHO demands.

The Convention is composed of 38 articles that seek to ensure strategies for strengthening and empower each party's national system to combat the tobacco epidemic. Generally, the mobilization around the creation of the FCTC underlined the intention to establish intersectoral government policies for public health, inspired by the UK model and academic publications. The goal is to suppress the fragmentation between policies and government departments (LENCUCHA et al., 2017).

As investigated, the success achieved by the spread of tobacco policies can also be explained by the WHO actions. The IO has created an increasingly robust bridge between international standards and each part of the treaty. The Convention has become a guiding instrument to be used by countries to implement regulations. In this vein, the Secretariat plays a vital role in *technical assistance* for implementing the treaty. Equally important, the reports produced served as a basis for countries to guide actions to implement domestic-level

[135] Source: <int/fctc/implementation/en/>.
[136] Source: <https://www.who.int/fctc/implementation/workshops/en/>
[137] Source: <https://www.who.int/fctc/about/WHO_FCTC_summary_January2015.pdf?ua=1&ua=1>

policies from successful cases. In this fashion, the secretariat uses instruments as the *learning* and *emulation* throw the creation of models shared by other countries.

We highlight in the table 6.2 the general division of the articles and the focus given to each one of them:

Table 6.2 – Overview of the FCTC

Part	***Article***	***General goal***
I	1 to 2	Terminoly of the Convention and legal instruments of international law
II	3 to 5	Guiding principles and general obligations
III	6 to 14	Demand-side reduction measures
IV	15 to 17	Supply-side reduction measures
V	18	Protection of the environment
VI	19	Liability
VII	20 to 22	Cooperation and Communication
VIII	23 to 26	Institutional arrangements and financial resources
IX	27	Settlement of disputes
X	28 to 29	Development of the Convention
XI	30-38	Final provisions, means of acceding to the Convention

Source: Self elaboration as from (WHO and others, 2003)

The Convention can be fully accessed easily [138]. Although all objectives are of great relevance for tobacco control, we highlight articles 4 and 5. As defined by Article 4.4 of the FCTC-WHO, governments are encouraged to develop multisectoral arrangements to reduce tobacco consumption. As stated, "each Party shall develop, implement, update and periodically review national tobacco control strategies, plans, and multisectoral programs..." (WHO and others, 2003, p.7). From this article, we distinguish the Convention's stimulus to the parties to develop national actions for implementing the treaty's articles.

Complementarily, Article 5, and Article 5.3 play a prominent role in general obligations. The article encourages the parties to develop an adequate domestic structure to develop multisectoral strategies to implement tobacco control policies. The Convention encourages the parties to establish cooperation networks with other stakeholders, such as with other international organizations, to mobilize resources and technical capacity for implementation at the national level. The main objective is to stimulate public policies to protect the population from the tobacco industry's interests (WHO and others, 2003).

The Convention also brought instructions to the parties for dealing with advertisements and marketing. As described in Article 8, the parties recognized the need to create comprehensive strategies to ban marketing advertisements. The marketing regulation could avoid that a vast audience becomes a tobacco user through the potential of advertising.

[138] To know more information about the Convention please access: <https://apps.who.int/iris/bitstream/handle/10665/42811/9241591013.pdf;jsessionid=EEE7618867FDDF2396C85747DCFAD89D?sequence=1> Last access 29/09/2020

In general, the Convention brought essential normative bases to coordinate previous tobacco efforts, mainly regarding legislation implementation at the domestic level. An essential step in advancing tobacco-related discussions concerns the initiative to monitor implementation via observatory centers -as we will discuss sequentially. Considering the public policy cycle, the monitoring stage of a policy is related to progressive policies. In other words, it refers to policies that have already been implemented. By means of monitoring, is possible to evaluate to what extent the process of implementing or transferring a policy has been positive or negative.

6.3.3 The employment of financial means mechanism and the funding by non-state actors

In 2007, the WHO created the *Mpower* initiative, with Bloomberg philanthropy financial support, to monitor and offer smokers the necessary assistance to give up smoking. As investigated by the WHO documents and as reported by an informant, the initiative aims to: *Monitor* tobacco use and create policies to prevent this epidemic; *Protect* the population against tobacco smoke; *Offer* help for smoking cessation; *Warn* about the dangers of smoking; *Enforce* bans on advertising, promotion and sponsorship; *Raise* tobacco taxes. The initiative can be translated as a package of political strategies to control tobacco consumption. The pillars of Mpower dialogue with the SDGs and aim to strengthen Goal 3 of Health and Well Being. They also act to enhance target 3.4, which foresees 2030 reduction of premature deaths related to NCDs. Additionally, Mpower has worked as a facilitator in implementing the FCTC, serving as a reference for stakeholders from different countries of the Convention concerning surveillance and combating tobacco consumption (WHO, 2019).

6.3.4 The development of a governing body to monitor the tobacco industry

Another essential step in evolution of tobacco control policies raised in October 2015, after the meeting of the BRICS [139] , Ministers of Health in Moscow. As a result of this meeting created a pioneering project to develop observatories for monitoring tobacco industry's performance. We highlight that BRICS is a coalition of developing countries, whose percentage of smokers is still high. According to verbal information collected "*this project was approved at the Brics Health Ministers meeting and came out as a recommendation. The International Union against Tuberculosis and lung diseases is involved and supporting the realization of this project at the country level,*"*(verbal information)* [140]. According to data published by WHO, the ministers recognized the need to create monitoring strategies to deal with the tobacco industry and move forward in actions aimed at reducing the proliferation in the use of tobacco products (WHO, 2016) [141].

[139] Acronym used to refer to Brazil, Russia, India, China, and South Africa.
[140] Interview available at the end of this thesis.
[141] <https://www.who.int/fctc/mediacentre/news/2016/TI-observatories-in-BRICS-countries/en/?ua=1> Last access: 30/09/2020

The BRICS countries have drawn attention to the fight against smoking once they have made considerable progress in implementing the Convention in their countries. However, the emerging economies bloc encompasses over 40% of the world population. In all of them, the tobacco industry's presence is noted, an actor that weakens the actions aimed at the implementation of international standards. Brazil increases the statistics of tobacco users, even though the number of smokers is falling. Despite the importance acquired by the country in tobacco control, the industry has increased its performance and has tried to influence control policies[142] .

In this regard, to create observatory centers to monitor the industry's performance emerges as an innovative initiative. As analyzed, Brazil's performance is considered a pioneer for two reasons. The first, because it is the first observatory created by the countries party to the FCTC. The second is a public observatory, hosted by the Oswaldo Cruz Foundation in Rio de Janeiro, an entity linked to the Ministry of Health. Fiocruz has become a relevant stakeholder in this process and works through a study center. This study center acts as the "comprehensive body of knowledge and comes from academic and non-profit groups which have invested time and effort to conceptualize it" (WHO, 2016) [143].

The study center was created in 2012 within the scope of Fiocruz and is called the Center for Studies on Tobacco and Health, CETAB[144], whose function is to develop teaching, development, and technical cooperation projects. CETAB has been an outstanding center within Fiocruz to generate knowledge and support the monitoring industry strategies. As stated in an interview[145] , *"CETAB/FIOCRUZ main function is to nourish, and stimulate this discussion within the institution, this is starting to consolidate even better with the Observatory" (verbal information)*. The observatory creation through CETAB/Fiocruz makes Fiocruz further expand its tobacco control policies (ibidem).

The Tobacco Tactics observatory, created by the University of Bath in England, is a reference to the development of the Observatory in Brazil and within the BRICS's scope. There are currently three observatories in operation, namely, Brazil, South Africa, and Sri Lanka, which also invested in creating monitoring centers (WHO, 2016). The observatory consists of creating a digital platform to gather information on how the industry has been working and acting worldwide and formulating its supranational policies. The idea is to be an integration platform with information, mostly in English. By grouping information on how the tobacco industry has subsidized supranational policies to increase its revenue, it seeks to understand which strategies have been used by the industry and what measures could combat them. As stated in interview, *the objective is to create a repository of information gathering the*

[142] Interview available at the end of this thesis.
[143] Source WHO (2016) <(https://www.who.int/fctc/mediacentre/news/2016/TI-observatories-in-BRICS-countries/en/?ua=1)>
[144] Acronym from the portuguese: Centro de Estudos sobre Tabaco e Saúde- CETAB
[145] Interview available at the end of this thesis.

strategies that the industry uses to undermine tobacco control policies (*verbal information*)[146]. From this perspective, the observatory develops a comprehensive look for strategies to combat the tobacco industry.

The repository will seek to gather diverse information about the tobacco industry's performance in Brazil in the short term to foster new studies and research on this topic in the medium term. In the long term, the main objective is to enhance the tobacco control policy and equip the National Commission for Implementation of the Framework Convention, CONICQ, for information to deal with this industry's challenges. As stated in an interview, "*we consider that, as of the ratification made by Brazil in 2005 of the FCTC, we have a legal obligation to comply with the articles. Moreover, Article 5.3 makes exactly this mention, which is to protect public policies from tobacco interference*"[147].

Concerning the creation of the observatory, Brazil can be seen as a catalyst, an actor that facilitates actions to happen. The catalyst we are referring to is the promotion of innovative strategies to deal with the challenges that the tobacco industry imposes on society and the creation of bridges between different actors on the international scene. Through these actions, the FCTC Secretariat aims to create a global network of affiliates capable of mapping the various actions used by the transnational tobacco industry to propose better strategies to combat this epidemic.

We present an overview of the global tobacco control policy, which is governed by a legal instrument, the Framework Convention for Tobacco Control, FCTC. As we have seen, FCTC was the first global public health treaty. Therefore, this global public policy shows itself at an advanced stage when analyzing the public policy cycle. Considering that public policies go through stages such as agenda creation, formulation, implementation, monitoring, or evaluation, in our perception, tobacco control policies are forward because they have reached the stage of implementation amid the parts of the treaty. Considering the implementation, we devote the next part of this chapter to analyze the process of implementing FCTC in Brazil.

6.4 THE TRANSFER OF THE FRAMEWORK CONVENTION ON TOBACCO CONTROL TO BRAZIL

From interviews, we identified that the transfer of the FCTC to Brazil was considered a successful case. In the first aspect, we highlight the *mechanism of coordinative functions* of the FCTC, which favors such transfer, not only to Brazil but also to its party countries. The legal aspect, the monitoring, and supervision of patterns are innovative issues in the global health universe.We should not neglect that Brazil has a respectable role in implementing strategies among the parties to the treaty. The country is recognized as an international reference both for its role in the treaty negotiations and for creating an "interministerial management model

[146] Interview available at the end of this thesis.
[147] Interview available at the end of this thesis.

responsible for coordinating the National Tobacco Control Policy – PNCT[148]" (PORTES; MACHADO; TURCI, 2019, p.2).

Additionally, Brazil is one of the world's largest producers and exporters of tobacco. The characteristic of being a leading producer and exporter creates the opportunity to examine the tobacco industry's behavior around producers and the influence of these transnational actors in international negotiations. Even though Brazil stands out for the transfer of the FCTC, the country deals with dilemmas such as the cigarette industry lobby in the Brazilian congress (Verbal information).

6.4.1 The role of Brazilians as policy entrepreneurs

The country's paramount performance is the product of the Brazilian professionals at the forefront of the negotiations, such as Vera Luiza da Costa e Silva[149] , a Brazilian physician who actively participated in the tobacco control negotiations and was the coordinator of the WHO Program between 2014-2020. Moreover, Brazil's remarkable performance was observed in the Intergovernmental Negotiating Body (INB) from the performance of Brazilian diplomats such as Celso Amorim, mainly[150] (LEE; CHAGAS; NOVOTNY, 2010, p.3).

In most of the interviews, José Serra's performance at the head of the Ministry of Health (1998-2002) was emphasized. José Serra performed a notorious job, above all, in the agendas related to the access of generic medicines and the breaking of patents and the issue of Tobacco. In 1999 and 2000, whenever speaking at the 52nd and 53rd WHA, he highlighted the importance and urgency of consolidating policies to combat the tobacco epidemic. At the 52nd WHA in 1999, José Serra highlighted actions such as educational campaigns that the government implemented in Brazil to control tobacco use. At the 53rd WHA, he emphasized the importance of drafting the protocol and stressed that despite Brazil being a major tobacco producer and exporter, it would play a leading role in drafting the future Framework Convention.

Meanwhile, at the international level, leading the Ministry of Health-as highlighted by an informant-, José Serra, and the Brazilian Minister of Foreign Affairs, Minister Celso Amorim (2003-2010) favored tobacco control policies. We highlight that the politicians assumed the position of authority as Minister of Health and Minister of Foreign Affairs and contributed to the defense of the international scenario's agenda and consolidation of the domestic sphere legislation.

The Brazilian government was an essential player in the policy transfer process. As

[148] PNCT Abbreviation of the Portuguese- Política Nacional de Controle do Tabaco

[149] Vera Luiza da Costa e Silva biography: <https://www.who.int/fctc/secretariat/head/dacostaesilvacv/en/> Last access: 05/10/2020.

[150] In 2002 the ambassador Celso Amorim was replaced by Ambassador Seixas Corrêa. Corrêa took over as a Permanent Representative of Brazil in Geneva and was elected as a Chair of the Intergovernmental Negotiating Body on the WHO Framework Convention on Tobacco Control during its fourth Session (Geneva-18-23, March 2002) (WHO and others, 2003, p.35).

studied in Chapter 4, IOs are the norm creators but do not have the autonomy to implement global policies within their members' territorial limits. States are sovereign and can choose to adhere to a policy or not. In this vein, the success of the transfer/ diffusion of policies developed by OIs is conditioned to the national government's opening. Considering this aspect, the set of policies developed for tobacco control is inserted in a context where the Brazilian government destined considerable support to the foreign health policy agenda, in other words, Brazil had many domestic allies to support the transfer of this global policy.

The contextual factor is noteworthy because tobacco control is one of the United Nations Sustainable Development Goals (SDG). As discussed in chapter 5, health is inserted among the SDGs, and Brazil, since 2003, has mobilized efforts to achieve the global goals proposed by these objectives. As we discussed, the 2030 Agenda brought together broad objectives, and health has become a global goal for not "leaving anyone behind," as advocated by the United Nations. As investigated, "the WHO Framework Convention was included as a strategy to achieve global health goals (SDG 3) and a goal to reduce deaths from Non-Communicable Diseases, NCDs" (INCA, 2017, p.11).

The costs spent by the Unified Health System, SUS, to deal with tobacco-related diseases yield to Brazil a political incentive to engage in tobacco control actions. As we discussed in chapter 5, Brazil adopts a health system model that provides access and provision of health services to the population. According to a study conducted in 2011, SUS spending to treat patients with lung cancer, heart disease, and stroke, for example, amounted to around 23.37 billion reais, equivalent to 0.5% of 2011 GDP (INCA, 2017).

Controlling the smoking epidemic and preventing the disease's population could imply a reduction in SUS spending on tobacco-related diseases. In this way, it can represent a public health issue and a national economy. Thus, the Brazilian government's interest in implementing the Framework Convention legislation for the country seemed to be justified at the domestic level. Similarly, at the national level, negotiations for tobacco control proved to be an opportunity to gain international visibility.

According to Celso Amorim, cooperation between the Ministries of Foreign Affairs and Health did not appear new. Nonetheless, it became more systematic during the years of President Lula da Silva's (2003-2010) context in which it coincided with the performance of Professor Paulo Buss in the leadership of Fiocruz. The support given by the Brazilian government's to the health agenda on the international stage highlighted the cooperation between Itamaraty and the Oswaldo Cruz Foundation, which played a prominent role in global health, as highlighted in chapter 5 (BUSS; TOBAR, 2017).

The actions of the actors mentioned above have undeniable relevance in the tobacco agenda. Nevertheless, we emphasize Amorim's performance for at least two reasons: the first for his performance in the International Negotiating Body and the second aspect in his articulation to approve international health resolutions in the national Congress. The FCTC was approved in May 2003 by the 56th WHA and signed by Brazil on June 16, 2003. The

ratification of the international health treaty in the National Congress took place two years later, on November 3, 2005, by Decree No. 5.658/ 2006 3. Whenever ratifying the Treaty, Brazil agreed that international rules would become measures to be complied with by the Brazilian State and that internationally approved legislation would become part of the national legal configuration (PEREZ; SILVA; BIALOUS, 2017).

Therefore, we can say that when ratifying the Framework Convention, Brazil was willing not only to fulfill its obligations but to import and transfer legislation negotiated by the Convention at the international level. As highlighted above by Article 4, the parties to the Treaty are committed to creating the conditions necessary for the transfer to the national level to be possible. The Framework Convention stood out due to the fact it proposed an interministerial management model, anchored on the principle of fostering dialogue between different ministries to minimize difficulties in the implementation process.

In this vein, Brazil once again pioneered the international scene by creating the mechanism responsible for coordinating the transfer of tobacco control policies, the so-called National Commission for the Implementation of the Framework Convention, CONICQ. It is worth noting that the creation of CONICQ preceded the ratification of the Treaty in Brazil. After the negotiations that formalized the FCTC, the Brazilian President Luiz Inácio Lula da Silva established a decree on August 1, 2003, to create the Commission.

The creation of the Commission from a high level of government, that is, by the Presidency of the Republic, guaranteed CONICQ greater legitimacy and authority. Hence the government ministries and departments could not neglect the proposals made by the Commission. CONICQ proved to be innovative due to the proposal for intersectoral work. Through this mechanism, efforts were made to coordinate tobacco control measures by establishing bridges with ministries and other government entities to contribute to this policy. Differently, the absence of intersectoral coordination or weaknesses in this cooperation could boundary the implementation of the FCTC-WHO legislation in other countries (LENCUCHA et al., 2017).

CONICQ is an organ of action and symbolized a space "through which actors interact and deliberate on tobacco control strategies, especially the implementation of measures of the FCTC-WHO"(LENCUCHA et al., 2017, p.4). CONICQ acts to articulate actions to build a harmonious positioning between ministries and different sectors of government. As foreseen by the Convention, the intersectoral mechanism faces different forms of conflicts, whether potential or real, for example, when trying to establish a dialogue with the tobacco industry and farmers who plant and survive on tobacco.

6.4.2 The National Commission for Implementation of the Framework Convention and the evolution of the PNCT

As we highlighted above, President Lula da Silva, through a presidential decree, approved the creation of a body with multisectoral functions whose purpose would be to

facilitate transferring the Framework Convention to Brazil. CONICQ consisted of a framework that proposed to be the bridge between different ministries and different government departments to generate consensus and coordinate the creation of norms and rules of conduct among members. The following is a brief overview of the creation and operation of CONICQ.

The National Commission for Implementation of the Framework Convention, created in 2003, was preceded by the National Commission for Tobacco Control, CNCT, created in 1999. CNCT members participated in the Framework Convention's international negotiation sessions at the Intergovernmental Negotiating Body (INB) between 1999-2003.

The Commission adopted inter-ministerial characteristics and was composed of seven ministries[151]; the Ministry of Health was the core. Regarding the structuring and management, the Ministry of Health was the chair body, while the National Cancer Institute - INCA served as the Commission's executive secretary between 1999-2003 (PORTES; MACHADO; TURCI, 2019).

Concerning the structure and functioning, CONICQ emerged by articulating representatives from 18 different government sectors, as shown in the table 6.3.

The Ministry of Health manages CONICQ, while INCA exercises the function of the Executive Secretariat. The Commission also brings together the Advisory on International Health Affairs, AISA, another meaningful body in articulation with the international scene. As informants stated, the tobacco agenda is highly complex due to the diversity of actors it involves. The creation of CONICQ supports this process of transferring the tobacco control policy. Brazil was a pioneer actor in creating this mechanism and has been seen as a case of success in management due to the unprecedented nature of articulating a diversity of ministries to achieve success in implementation (PORTES; MACHADO; TURCI, 2019).

Many parts of the Framework Convention follow the Brazilian model to transfer the International Treaty rules to their countries. The fact that CONICQ is an innovative mechanism considered successful in transferring the Convention has fostered the *emulation* of the mechanism for other parts of the Convention. As investigated by scholars on the subject, "data from 2014 indicate that around 60% of the States Parties to the FCTC present this management model"(PORTES; MACHADO; TURCI, 2019, p.11), based on ministerial coordination as has been done in Brazil.

The Brazilian case study can also contribute to studies on the diffusion of public policies based on IOs. The Brazilian mechanism has inspired a considerable percentage of the parts of the Framework Convention. It is worth noting that although the Brazilian model is considered successful in management, there is no single model to achieve success in transferring the

[151] Our translation: The Ministry of Health chaired the Commission. It included representatives from seven ministries (Ministry of Foreign Affairs, Finance, Agriculture and Supply, Justice, Education, Labor and Employment and Development, Industry and Trade), plus an eighth, the Ministry of Agrarian Development in 2001. The National Cancer Institute José Alencar Gomes da Silva (INCA) served as executive secretariat of the Commission (LENCUCHA et al., 2017, p.5)

Table 6.3 – CONICQ's Nature and Representativeness

Full name and acronym	***National Commission for Implementation of the Framework Convention on Tobacco Control and its protocols***
Nature	Governmental Commission formed by representations of 18 federal government bodies
Presidency	Ministry of Health
Secretariat	National Cancer Institute José de Alencar Gomes da Silva (INCA)
Representations	I Ministry of Health
	II Ministry of Foreign Affairs
	III Ministry of Finance
	IV Ministry of Planning, Budget, and Management
	V Civil House of the Presidency of the Republic
	VI Ministry of Agriculture, Rural and Supply
	VII Ministry of Justice
	VIII Ministry of Education
	IX Ministry of Labor and Employment
	X Ministry of Development, Industry and Foreign Trade
	XI Ministry of Agrarian Development
	XII Ministry of Communications
	XIII Ministry of the Environment
	XIV Ministry of Science, Technology and Innovation
	XV Secretariat of Policies for Women of the Presidency of the Republic
	XVI National Secretariat for Drug Policy of the Ministry of Justice
	XVIII National Health Surveillance Agency

Source: Adapted from (SILVA, 2014, p.25), self translation.

FCTC. Domestic factors, such as political, social, and cultural issues, interfere in this process. What the WHO has highlighted when considering a Party as a success story is related to the creative solutions that countries have been using to deal with the transfer obstacles (BLANKE; SILVA, 2004).

Since the creation of CONICQ, a National Tobacco Control Policy, PNCT, has been instituted and has become a State Policy responsible for dealing with tobacco control demands. The Commission's articulation efforts have been relevant to prevent the PNCT from interference from the tobacco industry (SILVA, 2014).

According to information provided by INCA, CONICQ acts as a forum, being a liaison body, both in Brazil and abroad. At the domestic level, four annual meetings are held, and when necessary, extraordinary meetings are called. The annual meetings have the pre-defined objective, coordinate intersectoral actions between the different ministries and secretaries, and prepare strategies and action positions that will be discussed at the Conference of the Parties (COP). The Commission is also responsible for defining working groups to analyze demands

on specific topics related to the National Tobacco Control Policy (ibidem). In general, we present CONICQ's General Competencies in the table 6.4.

Table 6.4 – General Competencies of CONICQ

General Competencies of CONICQ	I To assist in the formulation and fulfillment of obligations provided by FCTC
	II To assist in negotiation and elaboration process of complementary protocols.
	III To articulate different sectors through interministerial actions to implement the agenda and obligations ratified in the FCTC .
	IV To develop strategies through plans and programs to meet international obligations with the FCTC
	V Encourage the mobilization of financial resources for the Commission's functioning and the fulfillment of the FCTC obligations.
	VI To promote studies and research on topics of interest of the FCTC.
	VII To establish a dialogue with national and international actors and entities.
	VIII Whenever necessary, request information about governmental or non-governmental bodies, national or international, on matters related to the area of interest.
	IX Consider taking various actions that are necessary to achieve the FCTC objective.
	X Perform other tasks whenever appropriate to fulfill

Source: (SILVA, 2014, p.33) Self translation.

CONICQ plays an articulating role with international and transnational actors. According to INCA data, a regional organization that has been relevant in this cooperation has been the Pan American Health Organization, PAHO. INCA consolidated a cooperation agreement with PAHO to strengthen actions that foster cooperation through intersectoral channels and create innovative strategies capable of contributing to the National Tobacco Control Policy (INCA, 2014).

The National Tobacco Control Policy, PNCT, received outstanding *technical and financial support from a transnational actor- the Bloomberg Foundation-*, identified through documents and interviews. The international financial and technical resources received by the Bloomberg Foundation led to the improvement of international standards and the promotion of laws. Many of them aimed to ensure that indoor environments should not be polluted by tobacco smoke. In 2011, the National Congress approved the 12.546 Law, supporting establishments to impede smoking customers to smoke in closed places. Moreover, become more frequently the production of research and materials to educate and alert the population about tobacco use (INCA, 2017).

A substantial role in controlling the tobacco epidemic is also related to civil society and the third sector action. *The building of partnerships with NGOs and social and professional associations contributed to public awareness of the harmful effects of tobacco.* Civil society's contribution was built through "regular meetings with legislators that focused attention on tobacco control" (BLANKE; SILVA, 2004, p.164).

To deal with industrial giants would be necessary to build a broad coalition at the domestic level, establishing bridges between the government and civil society to combat economic interests and lobby of this industry (LEE; CHAGAS; NOVOTNY, 2010). At the international level, this articulation was being created by mobilizing civil society through the "Framework Convention Alliance (FCA), a worldwide coalition of non-governmental organizations and interested parties. FCA played an important contributory role in FCTC negotiations, ratification, and implementation" (LEE; CHAGAS; NOVOTNY, 2010, p.4).

Nationally, efforts were made to build this broad coalition through inter-ministerial coordination and articulations with international actors, such as PAHO, the Bloomberg Foundation, and the Tobacco Control Alliance, ACT[152] . ACT is a Brazilian NGO that works by mobilizing networks and advocacy coalitions to convince different spheres of power to formulate and approve more democratic and representative government policies. This civil society association played a meaningful role in defending the tobacco policy in Brazil. One of its achievements was the approval of the 2009 Anti-Smoking Law approved in São Paulo state. This law's approval fostered the formulation and approval of smoke-free laws in other Brazilian states and municipalities (ACT, 2020).

Brazil presented the great challenge of being a huge producer and exporter of tobacco and subsidizing multinational tobacco companies in its territory. According to data collected, the core industries that operate in the Brazilian market are Sousa Cruz "and the multinationals Philip Morris International and Japan Tobacco International that operate in Brazil and receive foreign direct investment" (DROPE et al., 2017, p.6). Yonder to these two significant multinationals, data from the NGO ACT reveals that British American Tobacco and China National Tobacco operate in the Brazilian market. Due to these large companies' performance in the Brazilian market, the country is considered the largest tobacco exporter and the second-largest producer of tobacco in the world (ACT, 2020). Compactly we present the tobacco multinationals in the table entitled Tobacco Multinationals in Brazil.

As noted in Table 6.5, there is a strong presence in the tobacco industry in Brazil. The prominence in Brazilian actions against tobacco lies in the fact that Brazil is one of the world's largest tobacco producers and deals with the tobacco industry's interests, which is highly active and powerfully articulated in political terms. Despite this national challenge, Brazil played a critical international role in constructing guidelines and recommendations for negotiations related to FCTC and in strategies aimed at implementation at the domestic level. According to INCA data, the country acted as a key-facilitator in actions related to the search

[152] Tobacco Control Association - <https://actbr.org.br/>

for economically viable actions to protect the environment and public health (INCA, 2014).

Table 6.5 – Tobacco Multinationals in Brazil

Tobacco Multinational	***Features***
British American Tobacco (BAT)	The BAT group also bought a large part of Sousa Cruz's actions and currently holds 79.3% of the Brazilian cigarette market and markets the brands Lucky, Strike, Dunhill.
Philipp Morris International (PMI)	This multinational is the second-largest producer of cigarettes in Brazil, produces the Marlboro cigarette. They plant tobacco in the southern region of Brazil, in the state of Rio Grande do Sul.
Japan Tobacco International (JTI)	Until 2018 he was a buyer of tobacco leaf. In 2018, it inaugurated the first cigarette factory in Latin America, in the Brazilian state of Rio Grande, do Sul.
China National Tobacco (CNT)	CNT is a Chinese state-owned company considered the largest cigarette producer in the world. In Brazil, China-Brazil is a joint venture that has allied with another great industry, the so-called Alliance One International.

Source: Adaptaded from ACT (2020)[153]

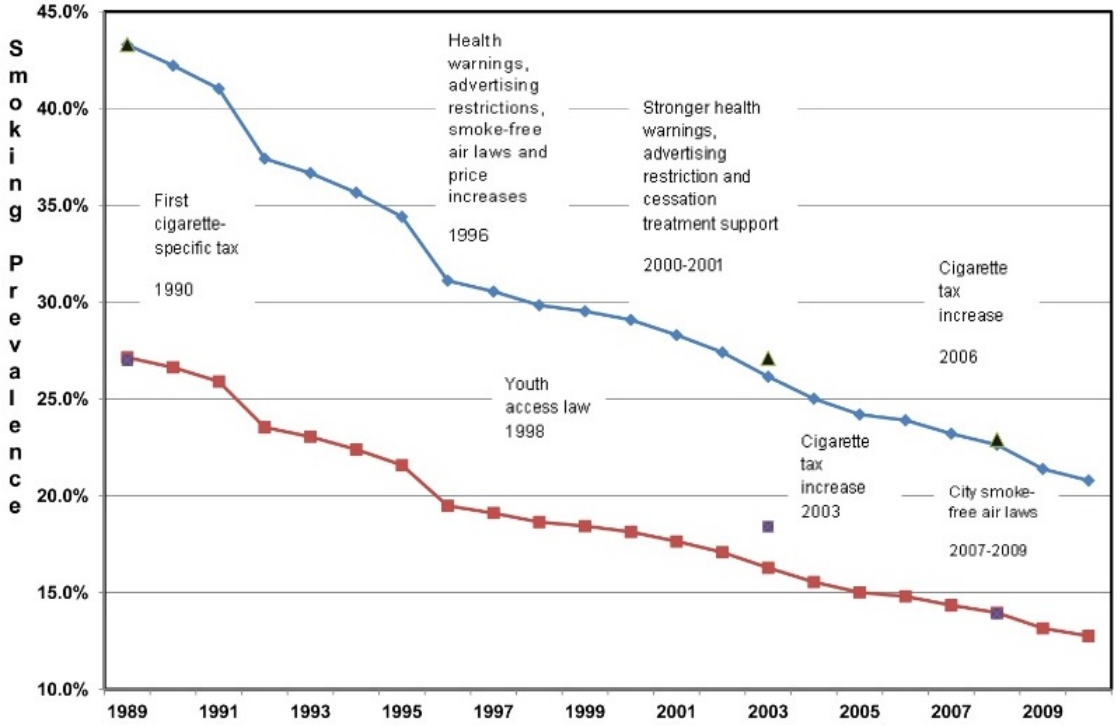
Among the awareness measures, Brazil was the second country, after Canada, to demand graphic alerts on cigarette packages informing about the harmful effects of tobacco use. "The first to create a body to regulate tobacco contents and emissions, and the first to ban the use of "light" and "mild" terms in describing tobacco products" (LEE; CHAGAS; NOVOTNY, 2010, p.3). It adopted comprehensive legislation that included the increase in taxation for tobacco and its derivatives, intensification of health warnings on packaging, control, and prohibition of advertising and smoking in public and closed places (LENCUCHA et al., 2017). As we can see in the figure below, entitled Evolution of the National Tobacco Control Policy in Brazil (1989-2008)[154], with the implementation of restrictive measures on cigarette and tobacco use, there was a considerable reduction in smokers' percentage in Brazil.

Levy et al. (2012) demonstrated that since the 1980s, Brazil has been adopting measures to consolidate a state policy for tobacco control. It is noteworthy that restrictive measures and actions were being implemented. Nonetheless, the ratification of the FCTC and the transfer of the Convention to Brazil accentuated the curve for reducing cigarette consumption. As underlined in the figure, there has been a significant reduction in cigarette consumption and the approval of laws prohibiting smoking in closed environments towards 2003.

[153] Document produced by ACT (2020) Tobacco Control Alliance

[154] The figure was used by Levy et al. 2012 to signal the prevalence of smoking among men and women between 1989-2008. For this thesis, the work developed by Levy et al. (2012) offers possibilities to analyze the evolution of measures and the construction of a State Policy for tobacco control.

Figure 6.2 – Evolution of the National Tobacco Control Policy in Brazil (1989-2008)



Source: (LEVY; ALMEIDA; SZKLO, 2012, p.4).

Brazil's political structuring as a federative republic has meant that tobacco control measures have adopted decentralized and multi-layered action in the country. In other words, legislation and regulation were not restricted to the national level. As foreseen by the Brazilian Constitution of 1988, "the states, the Federal District and municipalities are authorized to legislate on their health matters" (BLANKE; SILVA, 2004, p.4). Regardless of the regional singularities that the tobacco control program assumed in each unit of the federation, we will assign our analysis to an evaluation of the National Tobacco Control Policy (PNCT) - at the federation level -, based on the activities of CONICQ, ministries, and related entities. Thus, we devote the next section to investigate how the actors acted to transfer international FCTC legislation to Brazil and implement it at the national level.

6.4.3 Intersectoral action in the transfer and implementation of FCTC in Brazil

6.4.3.1 INCA's performance

As highlighted in previous sections, the tobacco control program is guided by the National Cancer Institute (INCA), an agency linked to the Ministry of Health that promotes cancer control programs and acts as a WHO collaborating center controlling tobacco issues. INCA is the bridge between international and domestic concerning the PNCT. It operates nationally, developing actions and campaigns such as Brazil's National Day Against Smoking and the World No Tobacco Day to disseminate educational actions in schools and social media Cheers. INCA's action has been extremely relevant in establishing this international-domestic

connection and articulating partnerships with ministries and civil society and non-governmental organizations (NGOs) (BLANKE; SILVA, 2004).

6.4.3.2 The Ministry of Health and the International Advisory of Health Affairs

Given the Convention's general obligations as provided by Article 5, each party must implement the comprehensive and multisectoral tobacco control strategies. The Ministry of Health and AISA played a leading role, becoming international interlocutors, representing Brazil at the Conference of the Parties (COP) and in the working groups built in the drafting of the Convention. The role of MH and AISA at the international level had normative characteristics as the creation of consistent standards capable of dealing with the industry. At the domestic level and the normative function, these two entities played the role of coordinating the implementation of the FCTC through CONICQ, the multisectoral mechanism created by Brazil that works to foster cooperation between ministries and entities to make them robust prevent tobacco reduction and nicotine use policies.

6.4.3.3 The Ministry of Finances

The Ministry of finances acted significantly in measures of tobacco demand. Article 6 of the Convention highlighted the importance of raising prices and creating taxes on tobacco and tobacco products to hinder tobacco demand and consumption. The Federal Revenue Secretariat is responsible for taxing and taxing tobacco-producing and exporting companies in Brazil. Taxation has been effective in controlling demand. With the increase in taxes, the sale value increases and hinders the final consumer's purchasing power. The Internal Revenue Service has been effective and has reduced the number of smokers. According to the Ministry of Health, in 2016, there was a 35% drop in the demand for tobacco. A reduction was observed in the percentage of deaths from lung cancer, one of the major diseases associated with tobacco consumption.

As a result of the increase in prices, the industry has acted through illicit trade, smuggling, and new alternatives to sell cigarettes. This social problem has been raised as a consequence of the success in tobacco reducing consumption. Recent studies indicate that large transnational companies have bet on the use of electronic cigarettes. The consumer inhales nicotine with flavors of their preference to attract the consumer market declining.

Despite the reduction of cigarette demand and the notable reduction in deaths from chronic diseases, the reality is still worrying. Social and political problems aggravate the Brazilian situation. We identified illegal trade, smuggling, and the lobby of Congress industries to weaken the FCTC articles' implementation. Concerning illegal trade, we identified that many smuggled products come from Paraguay, a country that has not yet adopted austere measures to control tobacco (WHO, 2018). Given the ease of access to tobacco in neighboring countries, the PNCT in Brazil becomes vulnerable to illegal trade.

Regarding the lobbying in Congress, it was identified that the tobacco industry adopts fraudulent practices to attract consumers and tobacco producers. The industry also works by financing election campaigns to become a pressure group in decision-making bodies in Brazilian politics. For example, in 2018, Senator José Serra submitted to the Congress a project of law to amplify the measures to combat smoking; however, the project was frozen due to the cigarette industry lobby in the Brazilian Senate (verbal information). Despite the success in implementing FCTC in Brazil and the adoption of strategies to fight the tobacco epidemic, there are still severe political and social challenges to be addressed. Another vital player in this activity has been the Ministry of Justice, which has prohibited additives to cigarettes and has made national law, norms established by the PNCT and FCTC.

6.4.4 The Ministry of Agriculture

A major challenge for Brazil was to deal with the planting of tobacco. As we mentioned earlier, the country is an international highlight in the production and export of commodities. In the fifth Conference of the Parties (COP5) in 2012, a project was presented to reduce the tobacco area planted. This proposal engendered contrariety among the actors of CONICQ, mainly within the Ministry of Agriculture representatives, as pointed out by scholars (PORTES; MACHADO; TURCI, 2019).

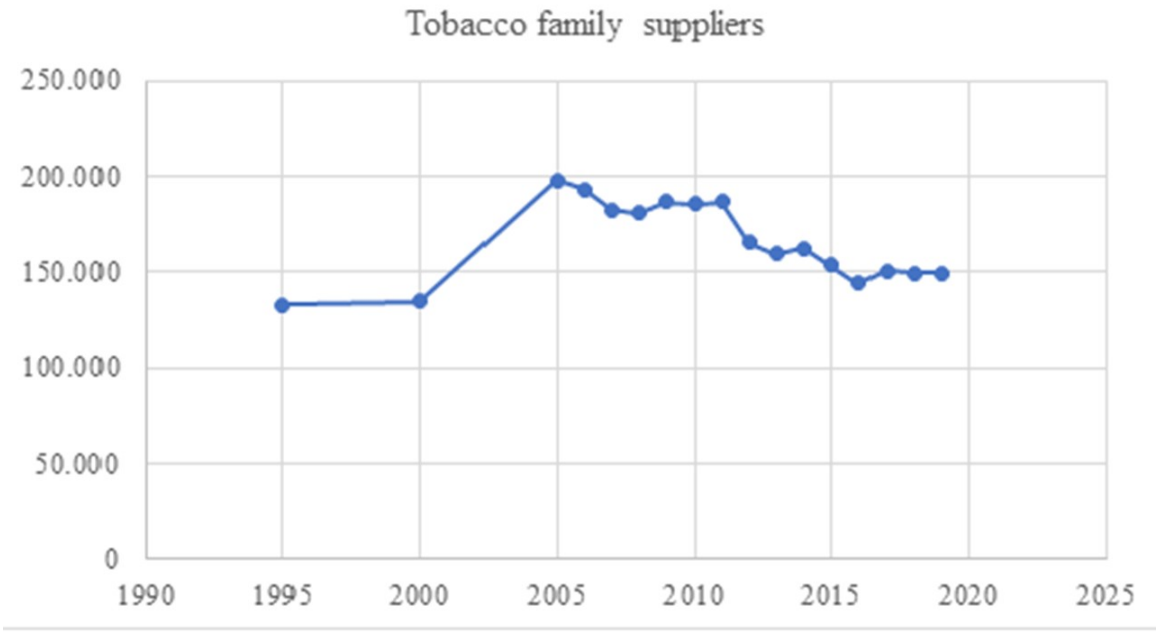
The negotiation with the Ministry of Agriculture presented the challenge of reducing the number of workers and employees in this field by reducing the planting area, which may affect families' survival that depended exclusively on this work. According to data provided by the Association of Tobacco Growers of Brazil, AFUBRA, "the tobacco sector provides an important social contribution involving more than 2.1 million people in the process. This alleviates unemployment, one of the major world concerns" (AFUBRA, 2020)[155] . This social scenery is a worrying situation, given issues such as child labor in cultivation and school dropout.

The report "*Vidas tragadas*"[156] published by ACT in 2020 highlights that approximately 150 thousand families produce tobacco in 619 cities in Brazil's southern region. The most prominent region in the country for the cultivation and production of tobacco. Tobacco growers are part of a production chain and plant according to the tobacco companies' guidelines[157] that supply inputs, pesticides, and necessary machinery. The data survey carried out by ACT signals the existence of an unequal relationship between tobacco growers and tobacco companies, in which the tobacco grower already starts his enterprise with a debt due to the technical assistance received.

Another outstanding aspect resulting from the tobacco production chain is the exploitation of child labor and impacts on the health of tobacco growers and the

[155] AFUBRA (2020) - <https://afubra.com.br/fumicultura-brasil.html>
[156] Downed lives in our translation
[157] These guidelines generally follow what the Integrated Tobacco Production System, SIPT, establishes as standards.

Figure 6.3 – Tobacco Family suppliers



Source: Self elaboration as from data published by AFUBRA (2020)

environment. Based on the NGO ACT's information, 90% of tobacco growers do not even complete elementary school. This reality reveals a social problem in the tobacco production chain, the existence of child labor accompanied by parents' low level of education. In addition to this reality, contact with pesticides and nicotine causes health impacts, such as nausea, vomiting, headaches. Additionally, Brazil is considered one of the countries that massively use pesticides, damaging the environment, such as impacts on native forest (ACT, 2020).

The restriction of tobacco planting has been a significant challenge for the National Tobacco Control Policy. As provided in Article 17 of the Convention, the signatory Party to the treaty should create alternative economic activities for tobacco growers and tobacco professionals. To implement this article, Brazil sought to encourage the substitution of agriculture through the granting of credit for the National Program for Strengthening Family Agriculture and the Implementation of the Diversification Program in Areas Cultivated with Tobacco. Portes et al. (2018) highlight that between 2011 to 2016, approximately R$ 60 million reais[158] were invested in the format of technical assistance and rural extension (PORTES; MACHADO; TURCI, 2019). As can be seen in the figure Tobacco Family suppliers.

As noted in the figure Tobacco family suppliers with the ratification of FCTC by Congress in 2005, we noted a downward trend. The reduction in families cultivating tobacco became clearest after 2010. We understand that the Diversification Program in Areas Cultivated by Tobacco and the government incentive can be seen as the main factor capable

[158] The Real is the Brazilian money. According to data from <Bloomberg.org>, the quotation of Dollar is 1 dollar to 5,42 reais in November 12 of 2020. Source: <https://www.bloomberg.com/quote/USDBRL:CUR>

of justifying this reduction. Nonetheless, as the data suggests, since 2016, the number of families producing tobacco has increased. The expansion evidenced weaknesses in the National program to encourage family farming and reduce government incentives in this policy.

The role of the Ministry of Agriculture in creating alternative economic forms for tobacco-producing families can be seen as essential in this process of intersectoral coordination. As inquired, to strengthen the articulation between sectors such as the Ministry of Agrarian Development, the Ministry of Agriculture, Rural, and Supply should intensify the dialogue with states and municipalities to redirect families for other types of crops without being economically harmed (PORTES; MACHADO; TURCI, 2019).

6.4.5 The Ministry of Communications and Justice

The Ministry of Communications assisted the implementation of Article 13 of the FCTC. According to Article 13, advertisements and any form of marketing that encourages tobacco use should be banned. As highlighted by the Convention, "Each Party shall, by its constitution or constitutional principles, undertake a comprehensive ban of all tobacco advertising, promotion, and sponsorship" (WHO and others, 2003, Article13.2, p.18). Some measures approved was "the enactment of the Law No. 12.546 / 2011 and the Decree 8.262/2014, which become more stringent the advertising, the warnings on product packaging and the restriction of smoking in closed collective environments"[159] (PORTES; MACHADO; TURCI, 2019, p.9).

Furthermore, it has become mandatory to use warning messages in advertisements for tobacco products in the media, whether on TV, radio, or other vehicles. Based on Article 220 of the 1988 Brazilian Constitution, which refers to Social Communication. With the support of this article, it was established that the advertisements of tobacco products and their derivatives would be subject to legal restrictions and should inform about the harmful health consequences resulting from tobacco use (PEREZ; SILVA; BIALOUS, 2017).

Throughout 1999 and 2005, we evidenced the growing of rules and laws to support the tobacco control policy efforts to restrict cigarette advertising at sale points. As an example, we can highlight the Federal Law 10.167, approved on December 27, 2000, which provided restrictions on the use of advertising to encourage the consumption of smoke products. According to this law, marketing and communication companies received restrictions to carry out advertisements. They could not associate cigarettes with sports practices and could not include children's and adolescents' participation. It was also prohibited for manufacturers to finance sporting and cultural events, among other actions (BRASIL, 2000).

[159] Our translation from the portuguese:"a promulgação da Lei nº 12.546/2011 e do Decreto 8.262/2014, que conferiram maior rigor à restrição da propaganda, ao destaque das advertências nas embalagens dos produtos e à restrição do fumo em ambientes coletivos fechados" (PORTES; MACHADO; TURCI, 2019, p.9)

As noted, the success achieved by implementing FCTC in Brazil is the result of strong intersectoral coordination and a close commitment to international standards. The success deals with a considerable reduction in percentage terms, the number of smokers, and the number of deaths and related chronic tobacco diseases. Although Brazil has achieved notable success in implementing the Convention's articles, there are still challenges such as illegal trade and strategies to intensify the reduction of tobacco use among men and women.

6.4.6 Why do we consider the Transfer of Tobacco Control Policy to Brazil a successful case study?

Concerning the issues presented above, we create an index to evaluate the tobacco control policy transfer's success. As studied in the figure, the Index of success in the Transfer of Tobacco Control Policy, this case study has many features that supplied the transfer. It is noteworthy that the word success means using a set of regulations implemented in Brazil from the FCTC and the consequent reduction in the percentage of smokers, tobacco-related diseases, and social problems, as the exploitation of child labor in families that survive on tobacco cultivation. The term success should not be understood as the total resolution of tobacco problems since there is still much to be progressed. Given these issues, we consider as indicators of success for the transfer to Brazil:

Table 6.6 – Index of success in the transfer of Tobacco Control Policy

Indicator	***Definition***
1- Existence of a Clear global policy to guide states.	The FCTC addresses the measures that should be implemented among its signatories.
2- Existence of a responsible sector in the Ministry of Health to deal with policy.	In Brazil, INCA has acted as the responsible sector of MH.
3- Existence of an intersectoral mechanism.	CONICQ is the sectoral mechanism in charge of coordination.
4- Existence of international guidelines and national protocols	The existence of guidelines and protocols from the FCTC and PNCT is identified.
5- Product Taxation	The government's work with the Ministry of Finance and the Federal Revenue in tobacco and its derivatives' taxation.
6- Government incentive to consolidate policy.	We noticed Brazil's engagement at the domestic and international levels to consolidate the policy.
7- Existence of a robust and articulated network between national, international, and transnational actors.	A broad and articulated network was identified, allowing the transfer of the policy as described in the interviews.

Source: Self elaboration

Given the indicators above described, we consider this case a successful transfer to Brazil. We highlight that those indicators were built from the triangulation of information shared on interviews, documents, and WHO websites. Considering these issues, we evaluate

a shadow case - approached in a more general and panoramic way - of a policy that has not yet achieved the expected success in implementing or transferring in the country.

6.4.6.1 The network analysis

As mentioned before, we apply the network analysis to formalize the triangulation of information found, and our information source guided us to actors shared in this network. We evidenced that both the documents, the empirical review, and the respondents guided us, predominantly, to individuals, supported by the literature we refer to them as policy entrepreneurs. Hence, we inferred that these could be those actors with expressive playing towards the policy transfer.We employed the statistics of centrality and in degree to understand what actors could be more active in this process.

We do not neglect the fact that interviews can reduce the universe of relationships established between individuals. Nonetheless, when using other sources of evidence, we consider that the network built can considerably express the reality of the relationships established in the context that enabled the transfer of tobacco control policies to Brazil.

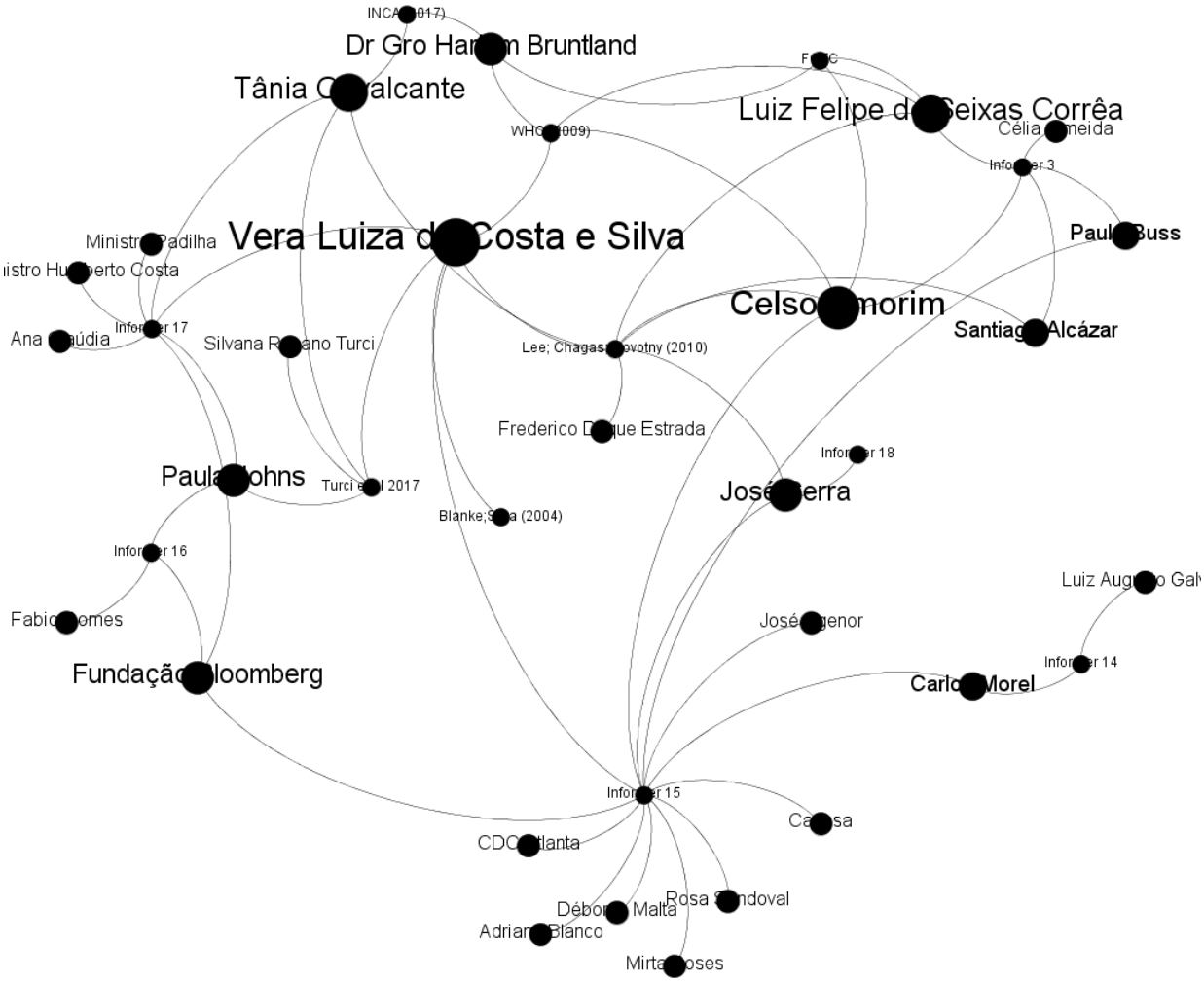
From the observation of the network, we remark that there are groups of actors. We believe that these groups are related to the institutions enrolled in the policy transfer process. As mentioned in the text, one condition of the policy's successful transfer is the connection with domestic allies, such as the Ministry of Foreign Affairs, the INCA Ministry of Health. At the regional level, Brazil received strong coordination from PAHO, a regional organization linked to the WHO. Notwithstanding, it has considerable autonomy and expertise in some areas of WHO restricted knowledge.

In our methodological chapter, we discussed the employment of two-mode networks. It means that we analyze the relationships between people, organizations, and how they voluntarily connect with material or non-material resources (HIGGINS; RIBEIRO, 2018). Thus we recognized that actors were enrolled with different institutions that led to transferring from the WHO to Brazil. We developed an oriented network, once some actors as Vera Luiza, Celso Amorim, for example, achieved high positions, configuring this manner a hierarchical relationship in this network. Our network's outcome was the creation of bylaws and decrees in Brazil, once the WHO is a normative organization.

6.5 THE SHADOW CASE: THE RISE OF A NOISELESS EPIDEMIC

For this thesis, we used a shadow case that can be comparable to the case of tobacco. When analyzing the theme of Noncommunicable Diseases (NDCs) at the WHO, we identified that approximately 70% of deaths could be related to NDCs, such as heart disease, stroke, cancer, diabetes, and chronic lung disease (WHO, 2020b)[160]. Mortality from NDCs is most evident in developing countries, according to WHO data. The main risk factors associated with the cause of the diseases mentioned above are: the tobacco use, physical inactivity, obesity,

Figure 6.4 – The network of tobacco transfer to Brazil



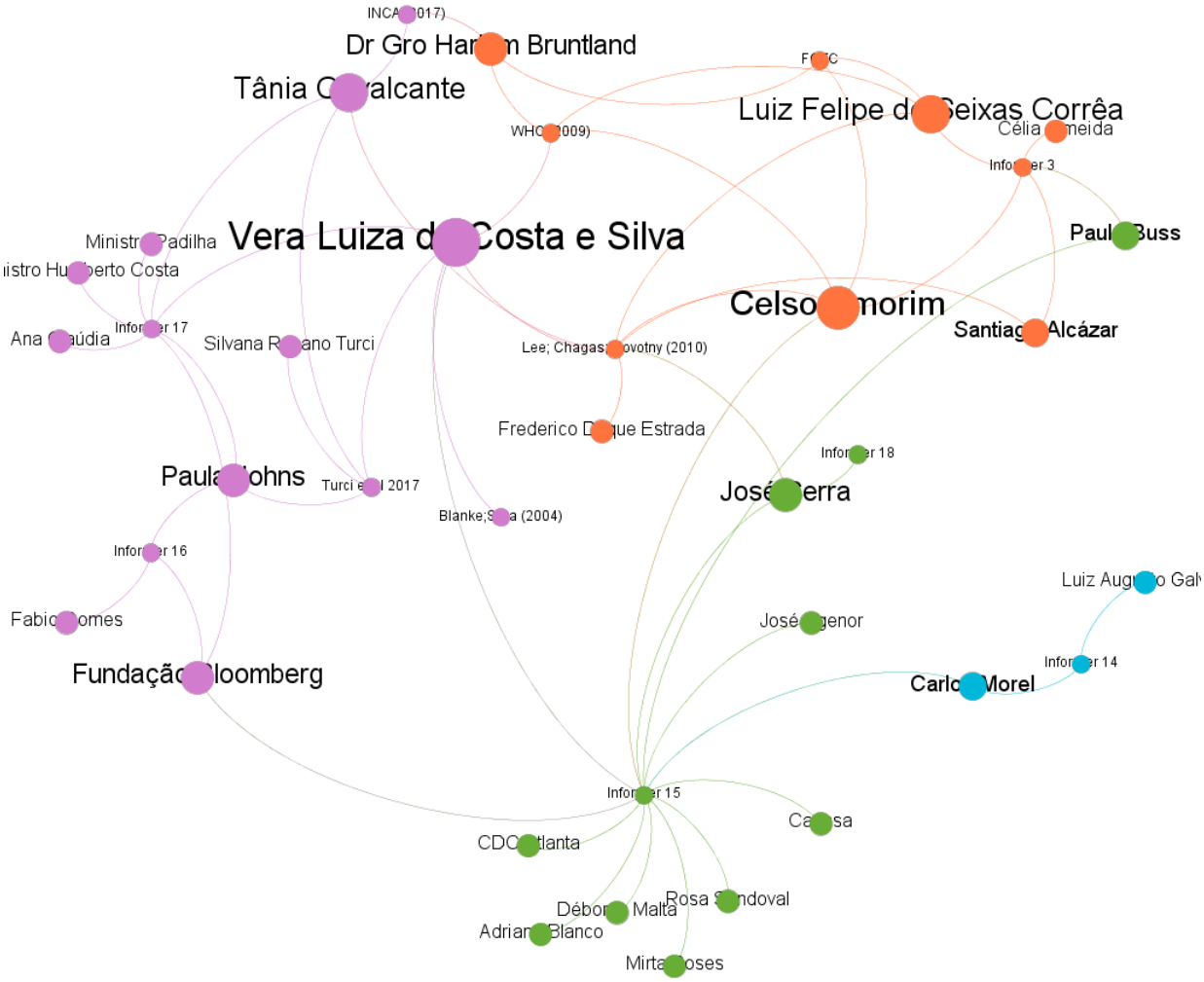
Source: Self elaboration as from our database

alcohol use, precarious diets, excessive use of ultra-processed foods, high caloric content, and low nutritional value. We found that policies to deal with factors associated with NDCs are less advanced and consolidated than those to lead with tobacco control. This feature makes the policy relatively less successful when compared to the Tobacco Control Policy.

Therefore, our shadow case encompasses the ostensible use of sugary drinks and ultra-processed foods that can be seen as a global public health issue. According to the WHO's data, this is a new epidemic, which appears silently in the social environment and can bring irreversible consequences to the population's health. "The socioeconomic costs associated with NCDs make the prevention and control of these diseases a major development imperative for the 21st century" (WHO, 2020b).

[160] Source: <https://www.who.int/health-topics/noncommunicable-diseases#tab=tab_1>

Figure 6.5 – The groups enrolled in tobacco transfer



Source: Self elaboration as from our database

In the same vein of tobacco control policy, the solutions to deal with these NCDs demand a comprehensive view in awareness and alerting the population as done with tobacco control. Moreover, they demand an integrated action at the domestic level led by governments, which among other sectors, may involve an arrangement with the beverage and food industry, which is why they demand enormously economical solutions. As WHO identified, the objective is to provide enough leadership and evidence to act in the prevention and control of NCDs.

We bring an overview of the shadow case consecutively. We aimed to emphasize inadequate nutrition, the use of processed and ultra-processed foods, and chronic non-communicable diseases associated with these habits, especially obesity. "There is an undeniable similarity between the tobacco industry practices and the industry of ultra-processed foods, sugary and alcoholic beverages (TURCI et al., 2017, p.4). The study

of these policies can bring contributions to mitigate the risk of chronic non-communicable diseases (ibidem). The main objective is to understand why the successful transfer and implementation of the tobacco control policy and the limited success of food and nutrition policies. What would be the indicators of success and non-success?

6.5.1 The international context and the recognition of a new global health problem

In 2000, the WHO launched the report entitled Obesity: Preventing and managing the global epidemic. It warned about the obesity dangers and the association with overweight and the growing of chronic non-communicable diseases. Besides the health problems related to inadequate nutrition and physical inactivity, the document brought warnings about the social issue, such as the economic costs of this type of chronic disease.

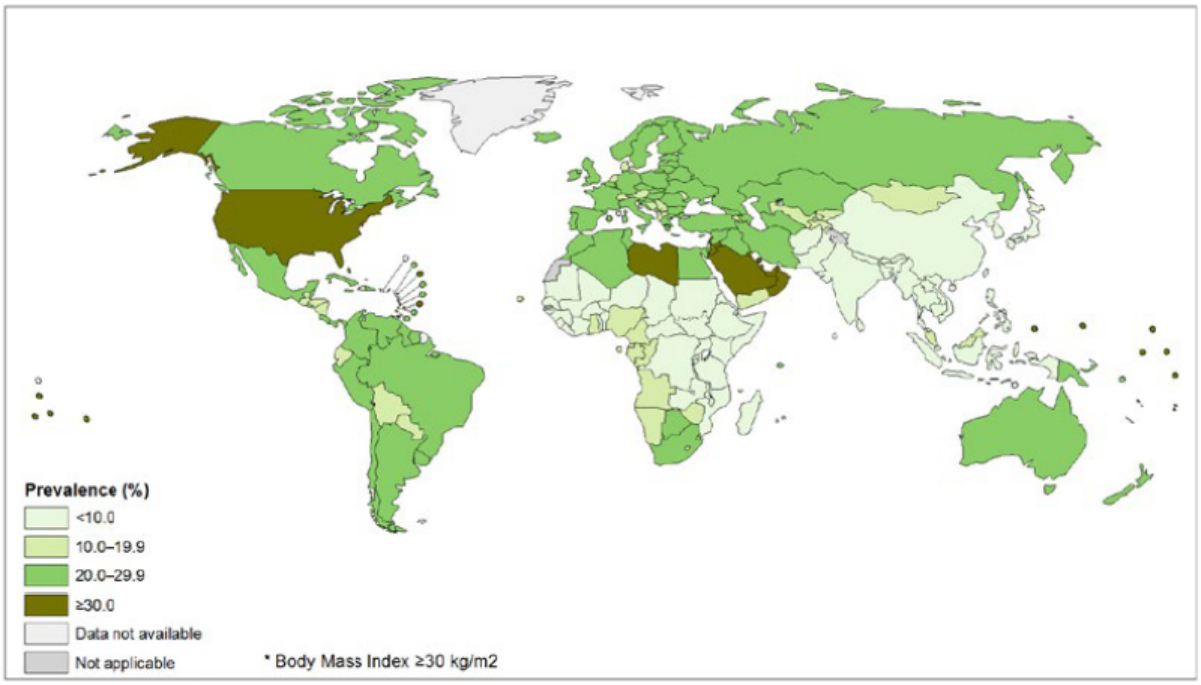
Regarding the economic issue, the document emphasizes that this new epidemic impact countries' economy, especially poor and developing countries. These diseases generate health systems expenses to treat problems such as cardiovascular diseases, high blood pressure, diabetes, and others. As reported by the document, "the real costs of therapy in developing countries exceed those in developed countries because of the extra burden associated with the use of scarce foreign exchange to pay for imports of expensive equipment and drugs, as well as the need for the specialized training of staff" (WHO, 2000, p.91).

The economic costs of obesity and overweight can be direct costs associated with the medical treatment costs to treat these diseases NCDs related. Moreover, indirect costs can arise from the absence of work and the reduced production of patients affected by these chronic diseases. As approached by the World Bank, in the 1990s, 50% of deaths were caused by NCDs. For 2020, the prospect was growing to reach 77% of deaths, a projection that has been confirmed. As we can see in the figure, thec Global elevation in obesity and overweight, the world population has suffered from being overweight in recent years.

As indicated by the figure, the Americas' region has a high prevalence of overweight and obesity, a characteristic that may indicate higher rates of chronic non-communicable diseases. WHO pointed out the leading causes of the increase in weight and obesity, are the impact of social changes. As diagnosed, "the demand for convenience foods and labor-saving devices such as the microwave oven" can be related to the increase in chronic diseases (WHO, 2000, p.135). The increase in consumption of processed foods, characterized as convenience foods, is due to the impact of the lack of energy and motivation to prepare their food at home, justified above all by the progressively intense performance of women and men in the labor market. The lack of energy and skills to prepare the food itself results in the precarious ingredients' quality and nutritional components (WHO, 2000).

If there was a drop in food preparation at home, there was a simultaneous opening of space for food industries' performance. As already pointed out by the WHO, the globalization of world food markets has become remarkably favoring processed foods. As investigated, due

Figure 6.6 – Global elevation in obesity and overweight (Data until 2014)



Source: WHO, 2015 Age-standardized prevalence of obesity in adults aged 18 years and over ($BMI \geq 30kg/m^2$), 2014

to the advances in food technology, as the use of sugar and the conserving, accompanied by the impact of merchandising, the diets become continuously dependent on processed foods"(WHO, 2000, p.143). The growing dependence on industrialized and ultra-processed foods brought the problem related to the globalization of world markets. As reported by the WHO, a small number of multinational companies supply the world food market. This characteristic reduces "their consumer responsiveness and increases their influence on government policy" (WHO, 2000, p.136).

The control of overweight and obesity can benefit the health system and the national economy since the direct and indirect costs related to NDCs can be reduced. Considering these issues, the WHO has invested in actions and action plans to control this epidemic's progress. As investigated, there is still no global policy, such as tobacco control, that binds signatories. There are action plans, recommendations that countries have voluntarily implemented in their territories.

6.5.2 The mechanism of discursive dissemination

In 2013, the NCD Action Plan 2013-2030 was designed to establish the necessary measures and interventions to reduce NCD rates. The action plan is part of the 2030 Sustainable Development Goals, which, among other objectives, aim to reduce premature deaths related to NCDs. Broadly speaking, WHO has reinforced the importance of establishing partnerships with civil society to strengthen nutritional and sports policies. To reduce NCDs' level, we identified that necessary interventions should be implemented in

lifestyle, physical activity, and diet. In other words, "the environmental and societal changes associated with economic development, are necessary" to achieve goals until 2025 (WHO, 2000, p.2).

From the investigation of WHO documents, we identified ten measures considered necessary in this intervention, as shown in the figure Measures to control obesity and overweight:

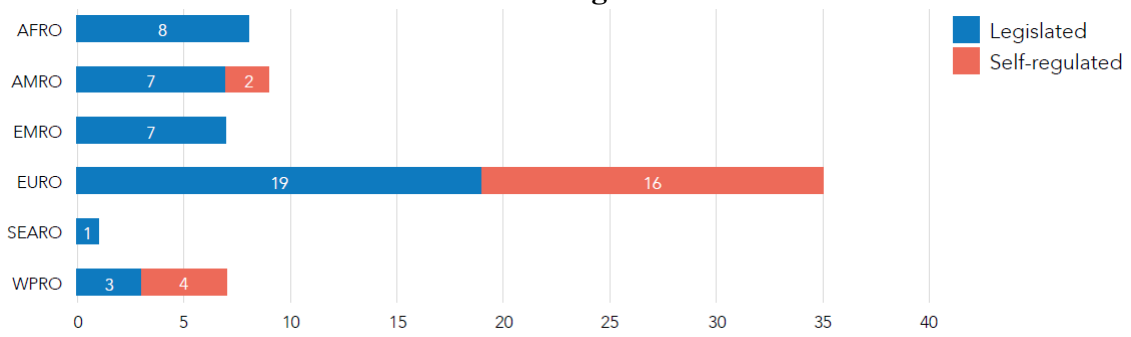
Table 6.7 – Measures to control obesity and overweight

Measures	***Description***
1- Support breastfeeding	The goal is to support a good nutrition in early life to protect against obesity
2-Establish fiscal policies	The goal is to increase the prices of processed foods and sweetened beverages to reduce the consumption
3-Improve the provision of healthy food	The goal is to improve the supplying of healthy food above all in public institutions, such as schools.
4-Social marketings initiatives	The main goal is to implement public campaigns and social marketing initiatives encouraging healthy dietary practices and physical activities.
5- Establish understable nutrition labellings	The main goal is to become easier to read and understand the nutrition labels on food products.
6-Develop guidelines and recommendations	The main objective is to policy measures capable of engaging different actors in the food system.
7-Reduce the content of free sugars and fat in food beverages	The goal is to reduce the consumption of these ingredients even when they eat processed foods.
8-Reduce portion size	The main goal is to encourage people to reduce the portion of meals
9-Increase availability on healthy foods	The main goal is to become healthy foods affordable to increase the consumption of fruits and vegetables.
10- To restrict the marketing of foods	The main ambition is to reduce the levels of sugar, salt, fat, for children.

Source: Self elaboration (WHO, 2015),(WHO, 2018)

As noted, the measures signal relevant points that need intervention to contain the spread of the epidemic. From the information collected, the starting point has been feeding in early childhood. In other words, breastfeeding has been increasingly encouraged, and efforts have been made to monitor maternal malnutrition and overweight. Additionally, the use of complementary feeding in early childhood raises towards early nutrition. According to data and interviews evaluated, complementary feeding (infant formula) can generate conflicts of interest related to health and commercial. As demonstrated by the WHO, "complementary feeding is an opportunity to ensure good nutrition at an early age but can be undermined by inappropriate marketing of commercial products" (WHO, 2018, p. 3). There is a need to regulate and prevent complementary feeding using from vested commercial interests. This policy focuses on preventing childhood obesity as a first step to avoid the advancement of NDCs.

Figure 6.7 – Countries with restriction on Marketing food and beverages to children by WHO Region



Source: (WORLD HEALTH ORGANIZATION, 2018).

Some countries are already implementing WHO recommendations. Kuwait "has adopted many recommendations to restrict the inappropriate marketing of complementary foods for up to 36 months (WHO, 2018, p. 3). There was an increase in exclusive breastfeeding in New Zealand from 8% to 18% due to the policies implemented. In Nepal, the full implementation of the Code of Marketing of Breast-milk Substitutes in 1992[161] (ibidem) was identified. With this policy's implementation, an increase in exclusive breastfeeding was noted up to six months, and many children continued to be breastfed until two years of age.

As studied, several countries have been implementing national policies related to food and beverage marketing, and there is a predominance in the creation of national legislation in European countries. The government's effort to regulate marketing policies, which appear in blue as Legislated, was noted. That is, 45 countries have national laws created by governments. In the same way, the sector's self-regulated[162] voluntary actions were found, which appear in the graph in red, as Self-regulated (WORLD HEALTH ORGANIZATION, 2018).

Concerning taxation, limited progress has been made. A small number of WHO countries created effective policies to tax products. According to the WHO document, the country that has shown prominence in these actions has been Mexico. It was observed that since the beginning of taxation, the amount of sugar in beverages has reduced. "Evaluations show that purchases of sugary drinks have decreased due to the tax, particularly among lower-income groups, while purchases for untaxed beverages increased" (WORLD HEALTH ORGANIZATION, 2018, p.5).

Broadly speaking, the international mobilization towards this agenda is noted. There are guidelines and recommendations which are followed voluntarily by some WHO members. Differently from the tobacco control policy, to lead of NDCs obesity-related, there are global Action Plans and strategies[163] aimed at strengthening states to incorporate recommendations

[161] For more information se also Code of Marketing of Breast Milk-Substitute- LESTER, Gillian et al. The international code of marketing of breast-milk substitutes: survey of national legislation and other measures adopted (1981-1991. World Health Organization, 1992. (WHO and others, 1981)

[162] We do not have much information regarding these voluntary agreements.

[163] Some example of strategies are: The WHO Global Strategy on Diet, Physical Activity and Health; the WHO

and action plans according to national priorities.

6.5.2.1 Domestic policies

PNAN established guidelines to prevent and treat obesity in the Brazilian Unified Health System, SUS. As we highlighted in previous sections, from the year 2000 onwards, the health theme received great incentives from the federal government. In 2003, for example, the Federal Government reinforced its commitment to combating hunger and poverty and the construction of a Food and Nutrition Security (FNS) agenda to make it a state policy (Ministry of Citizenship, 2020)[164]. Given this context, the "concept of adequate and healthy food begun to dialogue with the food and nutritional security policy, which refers to the cultural, social, economic adequacy of food, and not merely nutritional" (DIAS et al., 2017, p.5).

In 2006, there was an advance in politics and the creation of an *intersectoral coordination mechanism*, The National System of Food and Nutritional Security (SISAN), that arises from civil society's demand. As stated by Law 11.346 of 2006 also known as the Organic Law on National Food Security (LOSAN). SISAN was created with the "primary objective of guaranteeing, through intersectoral actions, the Human Right to Adequate Food, DHAA, for all people in Brazil, through the National Food and Nutrition Security Policy" (BRASIL, 2020)[165]. Among the bodies coordinated by this mechanism, we identified five members, as shown in the figure SISAN Structure.

As observed from the information collected, it is noted that there is a special incentive for an organized civil society to act. As set out in Law 11.346 of 2006, the mechanism arises from civil society's demand, which claims food as a human right of society and proposes guidelines for the National Food Security Plan (PNSA). Even though a mechanism that proposes intersectoral coordination is observed, the law's weaknesses can be seen. As shown by the SISAN Structure figure, some competencies are not very clear. The manner as private institutions or non-profit institutions will operate does not have a defined regulation. Despite these weaknesses, Brazilian states have widespread adherence, which has contributed to the implementation of measures at the subnational level.

There are notable efforts at the national level; however, these have not proved to be enough to deal with the epidemic of unhealthy habits and obesity. The challenge lies in proposing measures capable of transforming "obesogenic environments" into healthy environments. The proposed switch is based on the regulation of food marketing and

Global Strategy for Infant and Young Child Feeding ; the WHO set of recommendations on the marketing of food and nonalcoholic beverages to children (PAHO, 2014).

[164] <http://mds.gov.br/assuntos/seguranca-alimentar/direito-a-alimentacao/sistema-nacional-de_-seguranca-alimentar-e-nutricional-sisan>

[165] <http://www4.planalto.gov.br/consea/acesso-a-informacao/institucional/conceitos/sistema-nacional-de-seguranca-alimentar-e-nutricional> Last acces: 16/10/2020

[166] <http://www4.planalto.gov.br/consea/acesso-a-informacao/institucional/conceitos/sistema-nacional-de-seguranca-alimentar-e-nutricional> Last access: 16/10/2020; <http://mds.gov.br/assuntos/seguranca-alimentar/direito-a-alimentacao/sistema-nacional-de-seguranca-alimentar_-e-nutricional-sisan> Last access: 16/10/2020

Table 6.8 – SISAN Structure

Member	***Compositions and Skills***
National Conference on Food and Nutritional Security (CNSAN)	The CNSAN is the supreme instance of deliberation, composed of civil society and government representatives. Responsible for presenting the guidelines of the National Food Security Policy law.
National Food Security Council (CONSEA)	CONSEA is an advisory body of the Republic's Presidency composed of 2/3 of representatives of civil society and 1/3 of government representatives. It acts to propose guidelines and priorities for the PNSA and to mobilize actors to implement public actions for National Food Security.
Interministerial Chamber for Food and Nutritional Security (CAISAN)	It brings together 19 ministries. The main task is to prepare the Food and Nutrition Security Plan.
Organs and entities of food and nutritional security of the Union, the States and the Federal District	25 Brazilian states and the Federal District are SISAN members. Only the states of São Paulo and Mato Grosso did not join SISAN yet.
Could be admitted actors, whether for-profit or not, private institutions that express an interest in joining and respect the criteria, principles, and guidelines of SISAN.	Theme not regulated by CAISAN

Self elaboration as from data collected in <www.planalto.gov.br>[166]

advertising, and by creating taxes, for example, an issue that imposes a broad political challenge to be managed, considering the need for coordination with industry and commerce (DIAS et al., 2017).

6.5.3 The role of non-state actors

Regarding reducing sugar in soft drinks, the NGO ACT collected data and shared data about the sugar syrup manufactured in the Amazon region. According to them, the soft drink industry in Brazil and South American countries are powerful clients that endorse this production. Moreover, the industry receives a government subsidy to produces the syrup. There are fiscal maneuvers that dispense producers from taxation in the Manaus Free Zone region. "The maneuver allows soft drink companies to stop paying R $ 3 billion in taxes every year - an estimate based on data from the Federal Revenue" (ACT, 2020b)[167].

The WHO and civil society have been demanding the taxation of sugary drinks to reduce consumption and the secondary objective of generating revenues that may be used in social projects related to health and awareness of the consumption of ultra-processed foods.

[167] ACT 2020b - <https://actbr.org.br/post/a-destruicao-da-amazonia-e-o-subsidio-aos-refrigerantes/18615/>

Therefore, the objective is to eliminate the tax incentives in the Manaus Free Trade Zone granted to companies operating in this market. Furthermore, an attempt is made to create a specific tax to make drinks and food more expensive and to hinder access, especially by the most impoverished strata (ACT, 2020c)[168].

The importance of taxing sugary drinks and foods emanates from shreds of evidence that excessive use of sugar can cause obesity and other chronic diseases. As the WHO demonstrates and ACT data replied, 74% of deaths in Brazil correspond to NDCs. Among them, there are cardiovascular diseases (31%), neoplasms (17%), and diabetes (6%). These diseases impact individual health and public health due to investments destined for the public health system to deal with diseases (ibidem).

It is noteworthy to highlight that Brazil has been mobilizing efforts on this agenda; nevertheless, negotiations with the industry are a great challenge to be overcome. Among the actions raised, Brazil has been entering into international, voluntary, and *non-binding* agreements to combat the epidemic of obesity and poor eating habits. In 2014, Brazil signed an agreement with PAHO, the so-called Action Plan for the Prevention of Obesity in Children and adolescents. In 2017, Brazil committed to the UN to achieve specific goals within the Decade of Action and Nutrition scope. In the same year, INCA expressed support for the taxation of sugary drinks as an effective measure to reduce the consumption of these drinks and enhance the epidemic's confrontation. Taxation has already been discussed in Brazil and pointed out by the WHO as one of the effective measures to control the epidemic of chronic non-communicable diseases in the country (ACT, 2020c).

As can be seen, there is a strong articulation in Brazil to face this new epidemic that has been rising in the social environment. In general, we can say that tackling tobacco and tackling lousy eating habits could be comparable because it deals with industrial sectors and needs to create specific taxation. Additionally, as demonstrated in tobacco, when dealing with the industry, it raises a social problem-expressed by the reallocation of jobs generated by these industries. Differently from the case of tobacco, the shadow case still needs advances for a successful implementation. As the informants declare, our shadow case is inconclusive, and it is a more recent policy, less discussed and regulated than tobacco. In summary, we present in the figure below the indicators that can limit the policy's success.

As we highlighted above, we have identified some indicators that can limit the success of this policy's transfer and implementation. First, politics at the global level appears to be at a less consolidated stage. There are global recommendations outlined by the WHO warning about the dangers of NCDs; however, the regulations do not yet provide guidelines for overcoming the challenges imposed by the industry. In the second aspect, Brazil has been mobilized to implement actions at the domestic level based on commitments assumed with PAHO and the UN. Despite this, there is no evidence of Brazilian international protagonism on this agenda, as we have found through the tobacco study. The government's incentive for

[168] <https://actbr.org.br/tributacao-de-bebidas-adocadas>

Table 6.9 – Index of possibly limited success

Indicator	***Definition***
1-Existence of a Clear global policy to guide states.	Recommendations and guidelines were identified at the WHO, although they do not have a binding character. Policies are transferred voluntarily and aim to strengthen national capacities.
2-Government incentive to consolidate policy	We identified Brazil's engagement at the domestic level. At the international level, there is an articulation with international actors to consolidate the policy, even though the actions seem to be more limited than the efforts used to tackle tobacco.
3- Existence of a responsible sector in the Ministry of Health to deal with policy.	In Brazil, INCA has acted as the responsible sector of MH.
4- Existence of an intersectoral mechanism.	SISAN is the sectorial mechanism responsible for coordination; although, the performance still seems limited compared to CONICQ.
5- Existence of international guidelines and national protocols	The existence of WHO guidelines and protocols and the National Food Security Policy in Brazil is identified.
6-Product Taxation	Mobilizations related to product taxation have been observed; however, there is still a great challenge to deal with this issue.
7- Existence of a reliable and articulated network between national, international, and transnational actors	From the interviews carried out, it was not possible to map the actors that make up the network and how they are connected. We identified Brazil's work with PAHO, the UN, and civil society organizations, such as the ACT, though a broader network of actors still need to be mapped.

Source: Self elaboration

this agenda seemed more limited. It is relevant to consider that this is a more recent policy and that Brazilian efforts in the international environment may arise in the coming years, depending on the government's interest.

Similarly, INCA has acted as a responsible sector within the Ministry of Health, promoting measures to face this new epidemic. We note an intersectoral mechanism that can favor the coordination of the multiple actors involved in this agenda. Despite SISAN existence, we have found narrow information that allows us to make statements about this mechanism's functioning. Overall, based on the legislation analyzed, the non-regulation of private actors and non-profit institutions' actions can limit networks'. The absence of performance regulation can impact network creation and limited the mobilization of technical, human, and financial resources.

6.6 CONCLUSION:

As a conclusion, we can say that the tobacco case study shows *theoretical* and *empirical* relevance for this work. Regarding theoretical relevance, the case study is prominent to demonstrate changes in international relations, above all, the change in the commercial paradigm and the rise of global health as a relevant field in diplomatic issues. Theoretical relevance also shows the importance of international organizations as actors of social change. Through the tobacco control study, it is possible to observe IOs as actors capable of promoting change at the country level. In this sense, the WHO can be a success story of how IOs orchestrate actions and actors to "transfer" and spread global health policies, even though, issues such as the interest and national sovereignty of each country are safeguarded.

Regarding the theoretical contributions, we could saw broad contributions applied at the *international level* and *country level*. Concerning the *international level,* we evidenced the employment of WHO mechanisms to translate a global policy to a normative country policy. As demonstrated, the diffusion of tobacco control policies worldwide seems to follow a process. Firstly, the WHO recognized a global tobacco epidemic and the fear of overwhelming national health systems and national economies due to tobacco-related diseases. Researchers and WHO staff highlighted how intense was the global problem and the necessity to create solutions.

Additionally, we could saw *the distinguishable role of non-state actors*, as civil society, philanthropic foundations, and other international organizations creating transnational advocacy coalitions to deal against this problem. The formal and informal spaces for dialogue allowed creating a new agenda at the WHO and established the dissemination of the first discourses. Hence, we could evidence civil society's remarkable action and other non-state actors since the beginning of discussions at the tobacco control case. The *first mechanism* identified was the opening of spaces for dialogue.

Following the historical landmarks, we identified the change in world discourse. In other words, the speech aimed at commercial interests and encouraging tobacco consumption was gradually replaced by the speech in defense of public health and well-being, discouraging the use of tobacco and its derivatives. Thus, we highlight the WHO use of the *second mechanism* used by the literature, defined by discursive dissemination. In this second moment, we noticed a diffuse action by WHO. We have evidenced the emergence of a global discourse warning about the dangers of smoking; however, the actions of countries occurred diffusely without a global standard to be followed.

In the 1990s, the WHO warned the urgency to undertake the tobacco epidemic with more austerity. We understand that WHO began to develop measures to standardize and regulate tobacco consumption at this historic moment. In this sense, we understand that the WHO used the mechanism for creating patterns as discussed in the theoretical chapter. Unlike

the discursive dissemination in which we note diffuse actions, *the creation of patterns* can be seen in a more orchestrated fashion, whose foremost authority was the WHO.

The patterns established were institutionalized in the Framework Convention on Tobacco Control, a WHO mechanism to regulate and control the global tobacco epidemic. The Convention raised to monitoring and supervising bylaws' dissemination and has proved to be innovative and effective. The FCTC, through the Secretariat, the bureaucratic apparatus is capable of offering for signatory countries a guide of transferring policies to the country level and provide technical assistance. In this regard, the creation of FCTC directly involves two mechanisms discussed in the literature: *the mechanism of coordinative functions and technical assistance*.

We also identified the use of financial resources to help spread the policy. In tobacco control, *the mechanism of financial means* can be strongly associated with the philanthropic Bloomberg Foundation. This non-state actor financed the transnational tobacco control agenda. Bloomberg's performance highlights the considerable performance of non-state actors, both in creating the agenda and in its international diffusion. In this respect, we get back to the orchestration theory presented in the theoretical chapter. As we have seen, the WHO enables a third party to expand its international scope and favor the achievement of its political target. By strengthening partnerships with non-state actors, we observe WHO's role as an orchestrator in the global tobacco control agenda.

At the country level, Brazil played a catalyst role in the international scene and had strong domestic allies to enhance the transfer. Brazil acted in the decision-making bodies of the FCTC and the international negotiating body, with considerable emphasis on this agenda. It promoted significant changes at the domestic level as the creation of the intersectoral mechanism, a model that has been emulated by other signatory countries to the Convention. In this sense, tobacco control can also be used by international organizations' studies and public policy diffusion. The policy's broad scope among the WHO members and tobacco control worldwide becomes a fruitful case study within the WHO.

Concerning empirical contributions, the case is considered by the literature and informants as an emblematic case. From an empirical point of view, the case of tobacco control in Brazil demonstrates Brazil's strategies to articulate the necessary network for the policy's transfer. Through actors from different segments, it was possible to mobilize enough human resources to deal with interests, from the lobby of tobacco multinationals in Congress until the relocation of families that worked in tobacco growing. From this perspective, the case of tobacco turns out to be a compelling case of investigation that goes through different levels of analysis, going from the global to the local, reaching from cigarette consumers until farmers who survived on this growing.

The empirical contribution is relevant to understand the regulation of ultra-processed foods and alcoholic beverages. Likewise, tobacco represented a global epidemic in the past; currently, the WHO considers obesity the new and silent epidemic. The regulation of ultra-

processed food could be one step in this new battle to fight against chronic non-communicable diseases related to these products' use. As noted, there are striking similarities, above all, concerning commercial interests. However, it must be considered that the policy aimed at controlling food and beverages perhaps could be more complex to be controlled, considering the variety of products for selling and the need to regulate each one. Creating patterns in this agenda seems to be more challenging than tobacco-products; nevertheless, strategies for dealing with this epidemic have already been developed by countries individually.

The beverage and food industry also covers a wide range of workers, and the reduction in consumption of these items can generate social impacts related to employment and income. Despite the undeniable similarities pointed out by most interviewees, some consider that the cases are different and cannot be compared. Nonetheless, the tobacco control policy provides lessons being a fruitful case to support actions to regulate the use of ultra-processed foods and alcoholic beverages as a necessary measure for the intervention and fight against the obesity epidemic and non-communicable diseases worldwide.

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7 CONCLUSIONS

As we reported initially, this thesis aims to inquire IO's strategies to transfer policies to the national level and non-state actors' role within this process. We sought to investigate the role of the WHO beyond a meta-institution, it means above being a norm creator how the WHO orchestrate actors and actions to foster social changes at domestic level.

The *first chapter* describes the general overview of the work, the guiding questions, and the hypotheses initially constructed. As we highlighted in the first chapter, the research questions sought to understand: first, what strategies and conditions allow a successful transfer from the WHO to the domestic level? Second, how can the non-State actors play in the process of policy transfer and diffusion? Furthermore, third, what reasons encouraged the WHO to include non-state actors into its organizational design systematically?

Throughout our analysis, we considered the WHO an epistemic authority. In other words, it has expertise in health issues and acts to spread the knowledge produced by the institution. As we investigated in our theoretical chapter, Tallberg (2019) discusses two types of authority: political authority and epistemic authority. The political authority consists of making decisions capable of impacting public goods, while epistemic authority refers to an institution's ability to create knowledge and expertise. After investigating WHO's work, and the transfer of the Tobacco control policy, we understand that WHO acts in a normative way and can successfully spread standards capable of creating laws for its members' national policies. The success of transferring in tobacco case seemed emblematic and was measured as from the creation of national laws regulating this product's sell and marketing.

As we justified in the first chapter, Brazil stood out as a successful case in the transfer of tobacco control regulations. Brazil managed strategical and brightly fashioned to transform many international regulations into national decrees and laws. Besides, the first chapter highlighted the guiding hypotheses of this research. The hypotheses presented at the beginning of this work aimed to understand non-state actors' role in WHO and their relationship with the transfer process. Secondly, we assess conditions at the country level, such as the existence or not of domestic allies. Thus, we built an analysis model in which the combination of the instruments used by WHO, the performance of stakeholders (non-state actors), and the performance of domestic allies at the country level tend to result in the successful transfer of a global policy.

In *chapter 2*, we present our literature review. The objective of which was to establish a dialogue between the literature of International Organizations and Public Policies. As scholars have declared, there is still a shortage of work in this area. This thesis sought to contribute, albeit minimally, to this literature by proposing the study of WHO policy transfer to Brazil. The literature review offers an analysis of international organizations and their way of functioning. We understand that traditionally, the role of IOs was explained by the Principal-Agent model, through which agents supported their principals' interests.

Nonetheless, the literature has highlighted the role of transnational actors working with international organizations. Some IOs would tend to be more forbearing for non-state actors. The human rights and social purposes IOs tend to give more space to non-state actors. Given this phenomenon, the literature has shown that IOs can be orchestrators, bringing the third part to strengthen their diffusion power globally. In this way, IOs would act from the orchestration model's perspective, which understands that IOs act through intermediaries to achieve their political goals, O-I-T.

We highlight then that the orchestration model can be defined as an indirect governance model through which intermediaries ally voluntarily and use soft inducements to enhance the international organization's performance.

As questioned by Barnett; Finnemore (1999, p.2), IOs cannot always put their global policies or regulations into effect and transfer them to the domestic level. As inquired, the pathologies in International Organizations, such as budget deficits, problems in the bureaucratic nature, and behavioral dysfunctions, could hamper the transfer and diffusion of global policies. From the research carried out, we note that WHO has pathologies such as budgetary insufficiency and the need to mobilize different resources, furthermore the WHO acts to endure its large donors' maneuvers. Otherwise stated, we identified that a form of resistance could be observed in the US's case by channeling resources to specific projects through flexible, voluntary contributions. This characteristic weakens the institutional budget.

To overcome pathologies, as mentioned above, IOs use strategies such as opening up to dialogue with non-state actors, as NGOs, civil society, philanthropic foundations, transnational corporations. The performance of non-state, or transnational actors, as Tallberg (2013) classified it, can be understood as a rational and strategic way to favor the diffusion of policies. There is a diversity of non-state actors on the international scene. Alongside our theoretical review, we sought to relate the type of non-state actor and the possible form of transnational action. As we have highlighted, non-state actors can play differently, such as through transnational advocacy, policy financing, and the creation of agendas. All of these actions can significantly impact the global public policy cycle within an IO.

Through Kingdon's model, we sought to highlight these actors' importance in presenting problems and agendas and proposing streams of solutions. Likewise the national public policies, we believe that public policies are created within international bureaucracies and follow the policy cycle of agenda creation, formulation, implementation, transfer, and diffusion. From the review related to transfer and diffusion, we identified six instruments that, hypothetically, IOs can employ to transfer their global norms: discursive dissemination, the creation of patterns, the coordinative functions, technical assistance, financial means, and the opening of spaces for dialogue.

Concisely, we can say that IOs can use one or all of the mechanisms to consolidate

a policy's transfer. The field expertise of an IO and can influence the mechanisms to be employed. The instruments identified in the literature were used to track the process built to study the case of tobacco. Nonetheless, the use of mechanisms within an IO as the WHO, for example, may variate, affecting the diffusion and transfer of policies. Put differently, policies involving many actors and conflicts of interest may require different consolidation mechanisms. In WHO, there are clusters of policies with different degrees of complexity and divergent interests. The tobacco control and control of ultra-processed foods are part of the cluster of chronic non-communicable diseases. They resemble the degree of complexity and conflicts of interest, the second major WHO areas of interest at the WHO.

In *chapter 3* we present the research design and the tools used to develop the thesis. We highlighted the importance of the case study and proposed building our inferences from the triangulation of three sources of evidence: documental analysis, interviews, and empirical review. Moreover, websites related to WHO and global health have proven valuable sources of information. We built a research design that sought to relate determining factors that can influence the process of transferring WHO policies to Brazil and non-state actors' role in this process.

As we signaled, the Director-General's performance, the policies developed, and each management context's challenges could imply greater or lesser openness to non-state actors. Additionally, problems such as budgetary constraints can serve as a driver for the search for new resources and affect this phenomenon of pluralization of actors in health governance within the WHO's scope. Consequently, they could impact the process of transfer and diffusion of policies.

The dependent variable is the combination of WHO's actions at the global level and the country's actions at the domestic level, which result in a successful policy transfer. As independent variables, we worked with changes within the WHO, the Director-General's role, and policy budget, influencing the transfer process. Moreover, we considered the transfer to the country level dependent on intervening variables such as government, regional and domestic allies, the role of civil society, and other non-state actors.

To investigate the variables of our research design, we employed predominantly qualitative techniques. At documental analysis, we created codes described in chapter 3, and for the process tracing, we use the mechanisms identified by the literature as discussed in the theoretical chapter. We employed the network analysis to systematize the triangulation. Through this method, we could highlight the role of Brazilians (individuals) as policy entrepreneurs. As highlighted by the performance of policy entrepreneurs and allies at the domestic level, such as the national government Ministry of Health, Ministry of Foreign Affairs, INCA, AISA, conditioned the transfer of the policy to Brazil. As informants pointed out, there was a harmonic and well-articulated network that favored intersectoral dialogue and, consequently, brought contributions to the process of "importing" the policy. The network outcome was the transfer of regulations, decrees, and bylaws to Brazil that

effectively impacted tobacco marketing and consumption.

The *Chapter 4* scrutinizes the World Health Organization and the network of actors of Global Health Governance, GHG. As investigated, the term Global Health Governance has multiple meanings. Nevertheless, succinctly, we can consider that GHG refers to the actors actively engaged in health's broad theme. As we have seen, non-state actors' role in GHG precedes the WHO's formalization as an international bureaucracy. Hence, beyond exploring the WHO and the GHG, the chapter sought to raise explanations to understand FENSA creation. The development of a systematic structure to deal with non-state actors figures as a regulatory mechanism's employment. Alternatively, we could also understand that FENSA was created to monitor and supervise non-state actors performing at the WHO. In this manner, in our view, FENSA is a coordinative function instrument.

The documents and interviews pointed to the need to improve administrative issues, strengthen governance, and diversify the sources that support the WHO budget. As documents suggest, the initial efforts to bring non-state actors to the WHO political arrangement were identified from the 1980s, in the management of Halfdan Mahler. In this context, NGOs were seen as essential stakeholders for mobilizing expertise to implement the Health for All program.

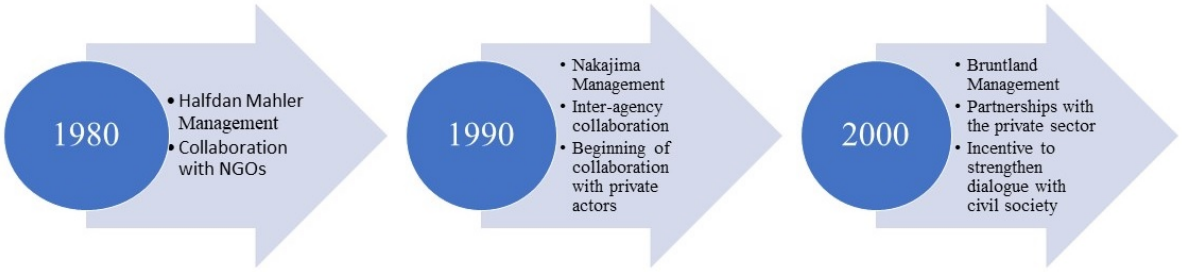
In the 1990s, raised interagency collaboration, which brought other international organizations to collaborate with the WHO. As investigated, the global agenda has the characteristic of being multifaceted and multidimensional. That is, health negotiations increasingly require a dialogue with other specialized agencies, such as, for example, the International Labor Organization, ILO, the Food and Agriculture Organization, FAO, among others, who act as relevant IOs in our case studies selected.

During the 1990s, the shreds of evidence highlighted budget problems and severe criticisms of the Nakajima management, led to discussing new strategies to mobilize resources to the institution. As pointed out by the document "Changes and Reform at the WHO" in the 1990s, efforts were observed to strengthen WHO's work with private actors and foster new collaborative networks capable of contributing rationally and economically to its objectives. During the Brundtland administration, this director invested in building partnerships with the private and business sectors as an alternative to overcome the lack of budget in the institution. As the interviews and documents reinforced, Brundtland also invested in civil society's approximation around 2001. As investigated by the Tobacco Control Policy, the civil society's performance brought substantive contributions to the Framework and its dissemination to the states parties.

The creation of a *mechanism* to deal with non-state actors has evolved. As we discussed in chapter 4, the idea of a non-state actor has undergone substantive changes over time, as shown in the figure lution of non-state actors' participation within the WHO.

The evolution and the changes applied to the term non-state actor throughout the time gave sense to the so-called global governance in health. In other words, the multiplicity of actors involved in plenty of WHO themes shape an arrangement that encompasses several

Figure 7.1 – Figure: Evolution of non-state actors participation within the WHO



Source: Self Elaboration

actors whose central authority is not always WHO. As investigated by the theoretical chapter, non-state actors' performance reinforces two critical issues: International Organizations as Orchestrators and the strategies used by IOs to overcome international organizations' pathologies.

Concerning the Orchestration model, we identified that it increases its role in indirect governance by bringing non-state actors into the political arrangement. As noted, non-state actors voluntarily ally themselves with specific agendas, which may increase the organization's technical capacity and the mobilization of resources for the institution.

As studied upon the cases, a significant role was played by civil society in both cases, especially ACT and Philanthropic Foundations such as Bloomberg Philanthropies mainly. It should be noted that in the context of tobacco trading, the performance of state actors was not formalized at WHO in the FENSA format. However, we note that the negotiations to consolidate the Framework Convention can be considered, to a certain extent, as catalysts of creating the systematic bases that formalized non-state actors' performance.

As noted in the investigated documents, the evidence indicates that in the context of 2001, during the Brundtland administration, there was a significant effort to set up a dialogue with civil society, private actors and to formalize the so-called Public-Private Partnerships. Despite not searching for models that try to establish the causal link between the creation of the Framework Convention and the Convention for non-state actors, when analyzing the director-general's performance in 2001, we recognized the impact of the discussions of this period with the formalization of non-state actors framework. For this reason, we consider the Framework Convention as a possible catalyst in formalizing FENSA.

Thus, when we reflect about whether the openness could impact in the transferring of policies, our answer is affirmative. According to our analysis non-state actor could impacts in the process of transferring. It is noteworthy that the engagement of non-state actors was a process built throughout the years as a strategy to galvanize financial and human resources to amplify the WHO endeavor. This manner, we recognize that since the 1980's, the WHO has been mobilizing efforts to boost its capacity to translate IOs programs into concrete actions and programs for its members.

In the case of tobacco, we recognize the importance of articulated civil society, the

Bloomberg Foundation's substantive role as a philanthropic organization, and the importance of interagency collaboration. The tobacco case was relevant to show the importance of non-state actors, as stakeholders or as policy entrepreneurs at the national level, carrying out advocacy, as in the case of ACT. Even though, we observed these actors' relevance in the theme of tobacco, it is still not possible to say whether, after the formalization of FENSA, WHO has been more effective in transferring its actions. We understand from the documents evaluated that FENSA did not necessarily expand WHO's ability to achieve its political goals. Based on our analysis, we consider that FENSA accomplishes a bureaucratic process, which had been underway for decades within the institution. With the formalization of non-state actors' engagement, WHO started to act as a facilitator in building bridges with multi-stakeholders. This research could not capture the extent of the direct impact of non-state actors' arrangements on WHO policies' transfer and diffusion. We believe that it is a research agenda to be deepened in the future.

The creation of a mechanism as FENSA can be seen in the first aspect to mitigate the pathologies of WHO and expand the possibility of mobilizing human and financial resources. In hypothesis 1, we consider that WHO cooperates with non-state actors rationally and strategically to create cooperation and collaboration networks. When studying the creation of FENSA, we noticed that WHO sought to bring the "third party" rationally and strategically, aiming to amplify its capacity to act in the international scene through overall performance in diverse and multifaceted networks. Simultaneously, according to data collected in interviews, the creation of FENSA suggests a way for WHO to prevent possible vested interests. In this way, as data from the interviews and documents point, the creation of FENSA can be analyzed strategically to ensure that cooperation happens if WHO can manage conflicts of interest that may occur. As we discussed in our hypothesis 1.1, we consider that FENSA acts as a seat belt to deal with this dynamic of bringing non-state actors to the WHO.

The *Chapter 5* seeks to highlight Brazil's role in global health governance and the domestic allies that favored Brazil to achieve a prominent role in global health, especially in the 2000s. The chapter brought a panoramic review of Brazil in global health and investigated the subnational actors involved in arranging a foreign health policy. We highlight one of the conditions for the transfer at the country level, the need for domestic allies with the federal government, which can ensure greater or lesser permeability of global policies in the country.

As we analyzed from the empirical review and speeches of health authorities at WHO World Assemblies, Brazil has built a reputation within this specialized agency and is recognized for its defense of free and equitable access to health services for all citizens, with the national Constitution endorsement. For many years, Brazil has acted against the neoliberal precepts of liberalizing the national health system and services correlated to this sector. In the 2000s, Brazil achieved the golden years of international health cooperation performing global goals aligned with the 2030 agenda of Sustainable Development Goals and global discourses.

Overall, we highlight that Brazil had strong allies such as the national government, the Ministry of Health, an agency specialized in international health relations, AISA, and the renowned institution FIOCRUZ, which has meaningful expertise in developing vaccines and play on the tropical diseases agenda. These domestic allies have allowed Brazil international visibility and action through a soft power in diplomacy.

Among the guidelines that gained prominence in the golden years of health, we highlight the control of HIV and the defense of universal access to high-cost drugs such as ARTs. Brazil led the movement related to the breaking of ARTs within the World Trade Organization. Given the success on this agenda, Brazil distinguished itself in the transfer of policies and technologies related to HIV control, above all, to countries like Africa. Furthermore, we saw that Brazil played a prominent role in human milk banks, a Brazilian innovation whose knowledge and technical capacity were transferred to other countries. Over this context, Brazil obtained the necessary conditions to transfer the Framework Convention on Tobacco Control to Brazil. Thus, we can highlight that one of the factors contributing to the policy transfer to the country level was the executive chief's incentive, accompanied by his domestic allies and well-established intersectoral coordination.

The *Chapter 6* undertaken our case study, defined by tobacco, and offered a counter case, namely, obesity and inadequate consumption of ultra-processed products. In the case study chapter, we applied the mechanisms identified by the literature. We understand that the tobacco control policy was successful in its global dissemination due to the plurality of diffusion and transfer instruments used by WHO. As highlighted throughout the chapter, for the first time, WHO used a mechanism to link actors; that is, it created an international health treaty. As we discussed, WHO generally uses soft mechanisms to disseminate its policies, such as opening spaces for non-state actors, discursive dissemination, creating standards, and in many cases offers technical assistance. Nonetheless, there are usually no instruments to punish actors for not complying with the global norms outlined.

The convention is a WHO legal instrument to assist the diffusion and transfer of regulations and supervise how the treaty parties have been implementing global standards. We note that WHO employed the mechanism of coordinative functions essential in this process of spreading global policy. When relating historical moments to transfer and diffusion instruments, we understand that the instruments have undergone an evolution and institutionalization over the years. In other words, we could associate the instruments of opening spaces for dialogue and discursive dissemination with less institutionalized instruments. Even though coordinative functions, technical assistance, and financial resources could be associated with instruments that require a major degree of institutionalization.

Upon resuming our HY2 translated by Non-state actors, besides their joining at international organizations, they can transfer policies from IOs if they find enough space of action among national governments. Indeed, we found that the federal government is the authority that can ensure greater or lesser permeability of global politics in a country. As

several informants have stated, IOs do not directly transfer or implement policies in one country. Each member of the organization is sovereign to decide and allow policies to enter their territories. When analyzing the case of tobacco and ultra-processed foods, we note that the considerable success obtained by the transfer of tobacco to Brazil can be attributed, mainly, to government incentives. Unlike the case of ultra-processed foods, whose Brazilian performance has not yet gained such prominence.

As we identified, in the first case, Brazil's performance earned notoriety for reasons such as the performance of the Ministries of Foreign Affairs at the INB; the successful intersectoral coordination that created bridges between the Ministry of Health and other different ministries. As we demonstrated in Chapter 6, intersectoral and inter-ministerial cooperation were notable in the case of tobacco. Through this case, the ministries of health, agriculture, farm, among others, established closer relations to contribute to the implementation of comprehensive measures negotiated internationally at the domestic level. Beyond the HY2.1, we have considered that: The implementation/transfer is possible when national states allow the action of many intermediaries (stakeholders). As we evaluate, tobacco success is an outcome of the engagement of strongly organized civil society and the substantive financing of Bloomberg Philanthropies projects to transfer tobacco control policy. In this case, we are talking about transnational actors capable of engaging in international forums and exert considerable pressure on the WHO agenda setting. In other words, we note here the need for public policy entrepreneurs, and individual actors, doing advocacy in defense of specific guidelines. The tobacco case drew our attention for two main aspects: firstly, we observed that the network built pointed us to key actors who acted in the national and international advocacy process to defend the recognition of tobacco consumption as a global health problem.

Second, we observe the performance of specific individuals and institutions in this process of transferring the set of regulations created by the WHO to Brazil, additionally we evidenced a successful intersectoral coordination. In this case, it is interesting to discuss that the tobacco case met the necessary conditions for a successful transfer. From our analysis, the performance of individual entrepreneurs was understood as a necessary condition for the topic of tobacco control to create an agenda both at the WHO and in Brazil. However, we believe that success was achieved in this first case due to the Brazilian government's incentive to ratify the Convention at the international level, it means at the WHO level. Besides the international projection, the government subsidized national level, favoring the creation of regulations, through decrees and creating intersectoral mechanisms capable of dealing with the different sectors involved in the transfer and implementation of policy in Brazil.

In contrast, when looking at the case of ultra-processed foods and the obesity epidemic, we note that the policy is in an earlier stage of discussion. As discussed in the theoretical chapter, we understood that this second case is in the agenda-setting stage, according to the Kingdom model. Considering this model, we realize that the subject of

ultra-processed foods and its relationship with obesity and chronic diseases still seems to be in the process of becoming an agenda to be discussed globally. Nevertheless, we could not neglect the fragmented efforts that already exist to address this problem both within the WHO and individually, by states.

As noted, there are widespread efforts to address this issue, and WHO members have acted in a diffuse manner on the topic of ultra-processed food. From the analysis, we noticed the absence of individual entrepreneurs. Although we have identified actors such as civil society and foundations acting on this agenda, we consider that the actions have still been limited and have not effectively made this problem an issue to be solved globally. Considering the Kingdom model of multiple flows, we understand that there is still no flow of solutions as we identified in the tobacco case. Thus, the "age" of the policy has an impact on the policy cycle. In other words, the fact that it is a more recent debate implies that there is still a process to go through, from setting the agenda until creating solutions. According to our analysis, policies at the beginning stages of discussions tend to employ less institutionalized mechanisms. In this agenda, we identified global discourses being disseminated and establishing a dialogue with civil society, philanthropic foundations, and others.

As a general conclusion to the thesis and in response to the questions raised to guide this research, we consider that two general conditions can ensure the success of the transfer of WHO policies to Brazil: firstly, the recognition of a global health agenda, followed by the development of mechanisms such as openness to dialogue and action by non-state actors, creation of speeches and standards, coordination and monitoring strategies, provision of technical assistance and financial resources. Secondly, the country's performance, the chief executive's engagement, the incentive given to domestic allies to act on the political agenda and develop expertise.

Furthermore, we emphasize that the various non-state actors can play an essential role in the transfer process. At the global level, civil society and NGOs can advocate and pressure WHO to put a new issue on the agenda. At the local level, they pressure Congress to create national policies. Actors such as philanthropic foundations can play an indispensable role in financing political projects and providing technical assistance. Regarding the potential of the thesis, the model we applied to understand tobacco control can subsidize studies and policies that aim to regulate the consumption of ultra-processed foods and alcohol consumption once they are policies of the same WHO cluster. There are undeniable similarities between the cases, and the main difference is perhaps how old is the policy debate. As discussed, WHO used the constitutional authority to create a treaty to deal with the smoking epidemic and reduce tobacco-related diseases. Similarly, in the case of the regulation of ultra-processed foods and alcohol consumption, it is considered necessary for WHO to use the regulatory mechanism to achieve success in the diffusion and transfer of this global policy.

Likewise, tobacco control policies, for dealing with the new and silent epidemic, the scientific community needs to create and spread the shreds of evidence. The policy

entrepreneurs may act to convince other sectors and departments of WHO about the issue's urgency. Similar to the tobacco case, it may be required the strengthening of partnerships and multisectoral action. Unlike the case of tobacco, in the current context, there is already a regulated performance of non-state actors through FENSA. This characteristic can endorse building bridges between WHO and the multi-stakeholders faster than it occurs in the tobacco-case.

We believe that the tobacco case study's lessons can be replicated for other WHO political clusters. As we have seen, the Convention was created to deal with a non-communicable disease epidemic. Furthermore, perhaps regulatory mechanisms within the WHO can be created to deal with global health emergencies and communicable disease pandemics. Regarding this thesis's limits, we consider that the single case study, although offering a high degree of depth, does not allow us to make generalizations. Thus, although it can bring contributions to the study of diffusion and transfer of public policies from International Organizations, it is limited to organizations that operate in the broad scope of social issues.

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A APPENDIX

A.1 FENSA

ANNEX

FRAMEWORK OF ENGAGEMENT WITH NON-STATE ACTORS

(adopted in resolution WHA69.10)

OVERARCHING FRAMEWORK OF ENGAGEMENT WITH NON-STATE ACTORS

INTRODUCTION

1. The overarching framework of engagement with non-State actors and the WHO policy and operational procedures on management of engagement with non-State actors apply to all engagements with non-State actors at all levels of the Organization,[1] whereas the four specific policies and operational procedures on engagement are limited in application to, respectively, nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

ENGAGEMENT: RATIONALE, PRINCIPLES, BENEFITS AND RISKS

Rationale

2. WHO is the directing and coordinating authority in global health in line with its constitutional mandate. The global health landscape has become more complex in many respects; among other things, there has been an increase in the number of players including non-State actors. WHO engages with non-State actors in view of their significant role in global health for the advancement and promotion of public health and to encourage non-State actors to use their own activities to protect and promote public health.

3. The functions of WHO, as set out in Article 2 of its Constitution, include: to act as the directing and coordinating authority on international health work; to establish and maintain effective collaboration with diverse organizations; and to promote cooperation among scientific and professional groups which contribute to the advancement of health. The Constitution further mandates the Health Assembly or the Executive Board, and the Director-General, to enter into specific engagements with other organizations.[2] WHO shall, in relation to non-State actors, act in conformity with its Constitution and resolutions and decisions of the Health Assembly, and bearing in mind those of the United Nations General Assembly or the Economic and Social Council of the United Nations, if applicable.

[1] Headquarters, regional offices and country offices, entities established under WHO, as well as hosted partnerships. For hosted partnerships the Framework of Engagement with Non-State Actors will apply, subject to the policy on WHO's engagement with global health partnerships and hosting arrangements (resolution WHA63.10). Hosted, as well as external partnerships are explained in paragraph 49.

[2] WHO Constitution, Articles 18, 33, 41 and 71.

4. WHO's engagement with non-State actors supports implementation of the Organization's policies and recommendations as decided by the governing bodies, as well as the application of WHO's technical norms and standards. Such an effective engagement with non-State actors at global, regional and country levels, also calls for due diligence and transparency measures applicable to non-State actors under this framework. In order to be able to strengthen its engagement with non-State actors for the benefit and interest of global public health, WHO needs simultaneously to strengthen its management of the associated potential risks. This requires a robust framework that enables engagement and serves also as an instrument to identify the risks, balancing them against the expected benefits, while protecting and preserving WHO's integrity, reputation and public health mandate.

Principles

5. WHO's engagement with non-State actors is guided by the following overarching principles.

Any engagement must:

(a) demonstrate a clear benefit to public health;

(b) conform with WHO's Constitution, mandate and General Programme of Work

(c) respect the intergovernmental nature of WHO and the decision-making authority of Member States as set out in the WHO's Constitution;

(d) support and enhance, without compromising, the scientific and evidence-based approach that underpins WHO's work;

(e) protect WHO from any undue influence, in particular on the processes in setting and applying policies, norms and standards;[1]

(f) not compromise WHO's integrity, independence, credibility and reputation;

(g) be effectively managed, including by, where possible avoiding conflict of interest[2] and other forms of risks to WHO;

(h) be conducted on the basis of transparency, openness, inclusiveness, accountability, integrity and mutual respect.

Benefits of engagement

6. WHO's engagement with non-State actors can bring important benefits to global public health and to the Organization itself in fulfilment of its constitutional principles and objectives, including its directing and coordinating role in global health. Engagements range from major, longer-term collaborations to smaller, briefer interactions. Benefits arising from such engagement can also include:

(a) the contribution of non-State actors to the work of WHO

[1] Policies, norms and standard setting includes information gathering, preparation for, elaboration of and the decision on the normative text.

[2] As set out in paragraphs 22-26.

(b) the influence that WHO can have on non-State actors to enhance their impact on global public health or to influence the social, economic and environmental determinants of health

(c) the influence that WHO can have on non-State actors' compliance with WHO's policies, norms and standards

(d) the additional resources non-State actors can contribute to WHO's work

(e) the wider dissemination of and adherence by non-State actors to WHO's policies, norms and standards

Risks of engagement

7. WHO's engagement with non-State actors can involve risks which need to be effectively managed and, where appropriate, avoided. Risks relate inter alia to the occurrence in particular of the following:

(a) conflicts of interest;

(b) undue or improper influence exercised by a non-State actor on WHO's work, especially in, but not limited to, policies, norms and standard setting;[1]

(c) a negative impact on WHO's integrity, independence, credibility and reputation; and public health mandate;

(d) the engagement being primarily used to serve the interests of the non-State actor concerned with limited or no benefits for WHO and public health;

(e) the engagement conferring an endorsement of the non-State actor's name, brand, product, views or activity;[2]

(f) the whitewashing of a non-State actor's image through an engagement with WHO;

(g) a competitive advantage for a non-State actor.

NON-STATE ACTORS

8. For the purpose of this framework, non-State actors are nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

9. **Nongovernmental organizations** are non-profit entities that operate independently of governments. They are usually membership-based, with non-profit entities or individuals as members exercising voting rights in relation to the policies of the nongovernmental organization, or are otherwise constituted with non-profit, public-interest goals. They are free from concerns which are

[1] Policies, norms and standard setting includes information gathering, preparation for, elaboration of and the decision on the normative text.

[2] Endorsement does not include established processes such as prequalifications or the WHO Pesticide Evaluation Scheme (WHOPES).

primarily of a private, commercial or profit-making nature. They could include, for example, grassroots community organizations, civil society groups and networks, faith-based organizations, professional groups, disease-specific groups, and patient groups.

10. **Private sector** entities are commercial enterprises, that is to say businesses that are intended to make a profit for their owners. The term also refers to entities that represent, or are governed or controlled by, private sector entities. This group includes (but is not limited to) business associations representing commercial enterprises, entities not "at arm's length"[1] from their commercial sponsors, and partially or fully State-owned commercial enterprises acting like private sector entities.

International business associations are private sector entities that do not intend to make a profit for themselves but represent the interests of their members, which are commercial enterprises and/or national or other business associations. For the purposes of this framework, they shall have the authority to speak for their members through their authorized representatives. Their members shall exercise voting rights in relation to the policies of the international business association.

11. **Philanthropic foundations** are non-profit entities whose assets are provided by donors and whose income is spent on socially useful purposes. They shall be clearly independent from any private sector entity in their governance and decision-making.

12. **Academic institutions** are entities engaged in the pursuit and dissemination of knowledge through research, education and training.[2]

13. For each of the four groups of entities above, the overarching framework and the respective specific policy on engagement apply. WHO will determine through its due diligence if a non-State actor is subject to the influence of private sector entities to the extent that the non-State actor has to be considered itself a private sector entity. Such influence can be exerted through financing, participation in decision making or otherwise. Provided that the decision-making processes and bodies of a non-State actor remain independent of undue influence from the private sector, WHO can decide to consider the entity as a nongovernmental organization, a philanthropic foundation or an academic institution, but may apply relevant provisions of the WHO's policy and operational procedures on engagement with private sector entities, such as not accepting financial and in-kind contributions for use in the normative work.

TYPES OF INTERACTION

14. The following are categories of interaction in which WHO engages with non-State actors. Each type of interaction can take different forms, be subject to different levels of risk and can involve different levels and types of engagement by the Organization.

[1] An entity is "at arm's length" from another entity if it is independent from the other entity, does not take instructions and is clearly not influenced or clearly not reasonably perceived to be influenced in its decisions and work by the other entity.

[2] This can include think tanks which are policy-oriented institutions, as long as they primarily perform research; international associations of academic institutions are considered as nongovernmental organizations, subject to paragraph 13.

Participation

15. Non-State actors may attend various types of meetings organized by WHO. The nature of their participation depends on the type of meeting concerned. The format, modalities, and the participation of non-State actors in consultations, hearings, and other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat.

(a) **Meetings of the governing bodies.** This type involves sessions of the World Health Assembly, the Executive Board and the six regional committees. Non-State actors' participation is determined by the governing bodies' respective rules of procedure, policies and practices as well as the section of this framework that deals with official relations.

(b) **Consultations.** This type includes any physical or virtual meeting, other than governing body sessions, organized for the purpose of exchanging information and views. Inputs received from non-State actors shall be made publicly available, wherever possible.

(c) **Hearings.** These are meetings in which the participants can present their evidence, views and positions and be questioned about them but do not enter into a debate. Hearings can be electronic or in person. All interested entities should be invited on the same basis. The participants and positions presented during hearings shall be documented and shall be made publicly available, wherever possible.

(d) **Other meetings.** These are meetings that are not part of the process of setting policies, norms or standards; examples include information meetings, briefings, scientific conferences, and platforms for coordination of actors.

16. WHO's involvement in meetings organized wholly or partly by a non-State actor can – subject to the provisions of this framework, its four specific policies and operational procedures, and other applicable WHO rules, policies and procedures – consist of any one of the following possibilities:

- WHO jointly organizes the meeting with the non-State actor
- WHO cosponsors a meeting[1] organized by the non-State actor
- WHO staff make a presentation or act as panellists at a meeting organized by the non-State actor
- WHO staff attend a meeting organized by a non-State actor.

Resources

17. Resources are financial or in-kind contributions. In-kind contributions include donations of medicines and other goods and free provision of services[2] on a contractual basis.

[1] Cosponsorship of a meeting means: (1) another entity has the primary responsibility for organizing the meeting; and (2) WHO supports and contributes to the meeting and its proceedings; and (3) WHO reserves the right to clear the agenda of the meeting, the list of participants and the outcome documents of the meeting.

[2] With the exception of secondments, which are covered in paragraph 47.

Evidence

18. For the purposes of this framework, evidence refers to inputs based on up-to-date information, knowledge on technical issues, and consideration of scientific facts, independently analysed by WHO. Evidence generation by WHO includes information gathering, analysis, generation of information and the management of knowledge and research. Non-State actors may provide their up-to-date information and knowledge on technical issues, and share their experience with WHO, as appropriate, subject to the provisions of this framework, its four specific policies and operational procedures, and other applicable WHO rules, policies and procedures. Such contribution should be made publicly available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.

Advocacy

19. Advocacy is action to increase awareness of health issues, including issues that receive insufficient attention; to change behaviours in the interest of public health; and to foster collaboration and greater coherence between non-State actors where joint action is required.

Technical collaboration

20. For the purpose of this framework, technical collaboration refers to other collaboration with non-State actors, as appropriate, in activities that fall within the General Programme of Work, including:

- product development
- capacity-building
- operational collaboration in emergencies
- contributing to the implementation of WHO's policies.

MANAGEMENT OF CONFLICT OF INTEREST AND OTHER RISKS OF ENGAGEMENT

21. Managing, including by, where appropriate, avoiding, conflict of interest and other risks of engagement requires a series of steps, as set out below:[1]

- WHO needs to know the non-State actors that it engages with. Therefore each non-State actor is required to provide all relevant[2] information about itself and its activities, following which WHO conducts the necessary due diligence.
- WHO conducts a risk assessment in order to identify the specific risks of engagement associated with each engagement with a non-State actor.

[1] The framework is designed to regulate institutional engagements; its implementation is closely coordinated with the implementation of other organizational policies regulating conflict of interest in respect of individuals (see paragraph 49).

[2] As defined in paragraph 39.

- Risks of engagement need to be managed and communicated coherently in each of the three levels of the Organization and throughout the Organization. To that end, WHO manages engagement through a single, Organization-wide electronic tool.[1]

- Member States exercise oversight over WHO's engagement with non-State actors in accordance with the provisions in paragraphs 67 and 68.

Conflict of interest

22. A conflict of interest arises in circumstances where there is potential for a secondary interest (a vested interest in the outcome of WHO's work in a given area) to unduly influence, or where it may be reasonably perceived to unduly influence, either the independence or objectivity of professional judgement or actions regarding a primary interest (WHO's work) The existence of conflict of interest in all its forms does not as such mean that improper action has occurred, but rather the risk of such improper action occurring. Conflicts of interest are not only financial, but can take other forms as well.

23. Individual conflicts of interests within WHO are those involving experts, regardless of their status, and staff members; these are addressed in accordance with the policies listed under paragraph 49 of the present framework.

24. All institutions have multiple interests, which means that in engaging with non-State actors WHO is often faced with a combination of converging and conflicting interests. An **institutional conflict of interest** is a situation where WHO's primary interest as reflected in its Constitution may be unduly influenced by the conflicting interest of a non-State actor in a way that affects, or may reasonably be perceived to affect, the independence and objectivity of WHO's work.

25. In actively managing institutional conflict of interest and the other risks of engagement mentioned in paragraph 7 above, WHO aims to avoid allowing the conflicting interests of a non-State actor to exert, or be reasonably perceived to exert, undue influence over the Organization's decision-making process or to prevail over its interests.

26. For WHO, the potential risk of institutional conflicts of interest could be the highest in situations where the interest of non-State actors, in particular economic, commercial or financial, are in conflict with WHO's public health policies, constitutional mandate and interests, in particular the Organization's independence and impartiality in setting policies, norms and standards.

Due diligence and risk assessment

27. When the possibility of entering into an engagement is being considered, the relevant technical unit in the Secretariat conducts an initial examination in order to establish whether such an engagement would be in the interest of the Organization and in line with the principles of WHO's engagement with non-State actors in paragraph 5 and the priorities defined in the General Programme of Work and Programme budget. If this seems to be the case, the technical unit consults the WHO Register on non-State actors and as needed asks the non-State actor to provide its basic information.

[1] WHO uses an electronic tool for managing engagement. As described in footnote 1 of paragraph 38, the publicly visible part of the tool is the register of non-State actors; the tool also provides an electronic workflow for the internal management of engagement. A similar electronic tool is used for the management of individual conflicts of interest, in order to harmonize the implementation of the framework with the implementation of the policy on management of individual conflicts of interest for experts.

Using the Organization-wide electronic tool, the unit then complements this information with a description of the proposed engagement and its own assessment of the benefits and risks involved, as needed.

28 The technical unit makes an initial assessment. If the engagement is of low risk, for example because of its repetitive nature[1] or because it does not involve policies, norms and standard setting, a simplified due diligence and risk assessment modulating the procedures in paragraphs 29–36 as well as 39 can be performed by the technical unit and the risk management decision taken, taking such steps as are necessary to ensure full compliance with paragraphs 5–7.[2] For all other engagements full procedures apply.

29. Before engaging with any non-State actor, WHO, in order to preserve its integrity, conducts due diligence and risk assessment. **Due diligence** refers to the steps taken by WHO to find and verify relevant information on a non-State actor and to reach a clear understanding of its profile. While due diligence refers to the nature of the non-State actor concerned, **risk assessment** refers to the assessment of a specific proposed engagement with that non-State actor.

30. **Due diligence** combines a review of the information provided by the non-State actor, a search for information about the entity concerned from other sources, and an analysis of all the information obtained. This includes a screening of different public, legal and commercial sources of information, including: media; the entity's website companies' analyst reports, directories and profiles; and public, legal and governmental sources.

31. The core functions of due diligence are to:

- clarify the nature and purpose of the entity proposed to engage with WHO;
- clarify the interest and objectives of the entity in engaging with WHO and what it expects in return;
- determine the entity's legal status, area of activities, membership, governance, sources of funding, constitution, statutes, and by-laws and affiliation;
- define the main elements of the history and activities of the entity in terms of the following: health, human and labour issues; environmental, ethical and business issues; reputation and image; and financial stability;
- identify if paragraph 44 or 45 should be applied.

32. Due diligence also allows the Secretariat for the purpose of its engagement to categorize each non-State actor in relation to one of the four groups of non-State actors on the basis of its nature, objectives, governance, funding, independence and membership. This categorization is indicated in the register of non-State actors.

[1] Provided that due diligence and risk assessment have already been carried out and the nature of engagement has remained unchanged.

[2] The simplified due diligence and risk assessment, and information to be provided by non-State actors as well as the criteria of low risk engagements are described in the guide for staff.

33. Risks are the expression of the likelihood and potential impact of an event that would affect the Organization's ability to achieve its objectives. A **risk assessment** on a proposed engagement is conducted in addition to due diligence. This involves the assessment of risks associated with an engagement with a non-State actor, in particular the risks described in paragraph 7 and is to be conducted without prejudice to the type of non-State actor.

Risk management

34. **Risk management** concerns the process leading to a management decision whereby the Secretariat decides explicitly and justifiably on entry into engagement,[1] continuation of engagement, engagement with measures to mitigate risks, non-engagement or disengagement from an existing or planned engagement with non-State actors. It is a management decision usually taken by the unit engaging with the non-State actor based on a recommendation of the specialized unit responsible for performing due diligence and risk assessment.

35. A dedicated secretariat mechanism reviews proposals of engagement referred to it and recommends engagement, continuation of engagement, engagement with measures to mitigate risks, non-engagement or disengagement from an existing or planned engagement with non-State actors. The Director-General, working with the Regional Directors, ensures coherence and consistency in implementation and interpretation of this Framework across all levels of the Organization.

36. WHO takes a risk-management approach to engagement, only entering into an engagement with a non-State actor when the benefits in terms of direct or indirect contributions to public health and the fulfilment of the Organization's mandate as mentioned in paragraph 6 outweigh any residual risks of engagement as mentioned in paragraph 7, as well as the time and expense involved in establishing and maintaining the engagement.

Transparency

37. WHO's interaction with non-State actors is managed transparently. WHO provides an annual report to the governing bodies on its engagement with non-State actors, including summary information on due diligence, risk assessment and risk management undertaken by the Secretariat. WHO also makes publicly available appropriate information on its engagement with non-State actors.

38. The **WHO register of non-State actors** is an Internet-based, publicly available electronic tool used by the Secretariat[2] to document and coordinate engagement with non-State actors. It contains the main standard information provided by non-State actors[3] and high-level descriptions of the engagement that WHO has with these actors.[4]

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[1] Other than decisions related to official relations as set out in paragraphs 50 to 57.

[2] The register of non-State actors is the first level of a tool used by the Secretariat containing four levels of information: a publicly available level, a level made available to Member States, a working level for the Secretariat, and a level of confidential and sensitive information accessible to a limited number of individuals within the Secretariat.

[3] Information on financial contributions received from non-State actors is documented in this register and in the Programme Budget web portal.

[4] The register covers all three levels of the Organization – global, regional and country – and includes hosted partnerships and joint programmes.

39 Non-State actors engaging with WHO are required to provide information on their organization. This information includes: name, membership, legal status, objective, governance structure, composition of main decision-making bodies, assets, annual income and funding sources, main relevant affiliations, webpage and one or more focal points for WHO contacts.

40. When the Secretariat decides on an engagement with a non-State actor, a summary of the information submitted by that entity and held in the WHO register of non-State actors is made public. The accuracy of the information provided by the non-State actor and published in the register is the responsibility of the non-State actor concerned and does not constitute any form of endorsement by WHO.

41. Non-State actors described in the register must update the information provided on themselves annually or upon the request of WHO. Information in the WHO register of non-State actors will be dated. Information on entities that are no longer engaged with WHO or that have not updated their information will be marked as "archived". Archived information from the WHO register of non-State actors can be considered in relation to future applications for engagement, where relevant.

42. In addition to the publicly available information, Member States have electronic access to a summary report on due diligence of each non-State actor and their respective risk assessment and risk management on engagement. Member States also have access, on demand, to the associated full report through a remote secure access platform.

43. WHO maintains a handbook to guide non-State actors in their interaction with WHO in line with this framework. A guide for staff is also maintained on the implementation of the Framework of Engagement with Non-State Actors.

SPECIFIC PROVISIONS

44. WHO does not engage with the tobacco industry or non-State actors that work to further the interests of the tobacco industry. WHO also does not engage with the arms industry.

Engagement where particular caution should be exercised

45 WHO will exercise particular caution, especially while conducting due diligence, risk assessment and risk management, when engaging with private sector entities and other non-State actors whose policies or activities are negatively affecting human health and are not in line with WHO's policies, norms and standards, in particular those related to noncommunicable diseases and their determinants.

Association with WHO's name and emblem

46. WHO's **name and emblem** are recognized by the public as symbols of integrity and quality assurance. WHO's name, acronym and emblem shall not, therefore, be used for, or in conjunction with, commercial, promotional marketing and advertisement purposes. Any use of the name or emblem needs an explicit written authorization by the Director-General of WHO.[1]

[1] See http://www.who.int/about/licensing/emblem/en/.

Secondments

47. WHO does not accept secondments from private sector entities.

RELATION OF THE FRAMEWORK TO WHO'S OTHER POLICIES

48. This framework replaces the Principles governing relations between the World Health Organization and nongovernmental organizations[1] and the Guidelines on interaction with commercial enterprises to achieve health outcomes (noted by the Executive Board).[2]

49. The implementation of the policies listed below as they relate to WHO's engagement with non-State actors will be coordinated and aligned with the Framework of Engagement with Non-State Actors. In the event that a conflict is identified, it will be brought to the attention of the Executive Board through its Programme, Budget and Administration Committee.

(a) Policy on WHO's engagement with global health partnerships and hosting arrangements.[3]

(i) Hosted partnerships derive their legal personality from WHO and are subject to the Organization's rules and regulations. Therefore the Framework of Engagement with Non-State Actors applies to their engagement with non-State actors. They have a formal governance structure, separate from that of the WHO governing bodies, in which decisions are taken on direction, workplans and budgets; and their programmatic accountability frameworks are also independent from those of the Organization. In the same way the framework applies to other hosted entities which are subject to the Organizations Rules and Regulations.

(ii) WHO's involvement in external partnerships is regulated by the policy on WHO's engagement with global health partnerships and hosting arrangements. The Framework of Engagement with Non-State Actors also applies to WHO's engagement in these partnerships.[4]

(b) Regulations for Expert Advisory Panels and Committees and the Guidelines for Declaration of Interests (WHO Experts). The management of WHO's relations with individual experts is regulated by the Regulations for Expert Advisory Panels and Committees[5] and the Guidelines for Declaration of Interests (WHO Experts).

(c) Staff Regulations and Staff Rules. All staff are subject to the Organization's Staff Regulations and Staff Rules, noting in particular the provisions of declaration of interest therein:

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[1] Basic documents, 48th ed. Geneva: World Health Organization; 2014: pp.97–102.

[2] See document EB107/2001/REC/2, summary record of the twelfth meeting.

[3] Endorsed by the Health Assembly in resolution WHA63.10 (2010) on partnerships and its Annex 1.

[4] The Codex Alimentarius Commission is an intergovernmental body which is the principal organ of the joint FAO/WHO food standards programme for which the administration is not solely provided by WHO. The Commission is supported by subsidiary bodies including Codex committees, regional coordinating committees and task forces. Meetings of the Commission, Committees, including independent expert committees, and Task Forces are regulated by the Rules of Procedure and other decisions adopted by the Codex Alimentarius Commission.

[5] See Basic documents, 48th ed. Geneva: World Health Organization; 2014: pp.121–130.

according to Article 1.1 of the Staff Regulations of the World Health Organization, all staff members "pledge themselves to discharge their functions and to regulate their conduct with the interests of the World Health Organization only in view."

(d) Regulations for Study and Scientific Groups, Collaborating Institutions and other Mechanisms of Collaboration. Scientific collaborations are regulated by the Regulations for Study and Scientific Groups, Collaborating Institutions and other Mechanisms of Collaboration.[1]

(e) Financial Regulations and Financial Rules.

(i) The procurement of goods and services is regulated by the Financial Regulations and Financial Rules;[2] it is not covered by the Framework of Engagement with Non-State Actors, although pro-bono contributions from non-State actors are covered.

(ii) Like any other financing of WHO, financing from non-State actors is regulated by the Financial Regulations and Financial Rules and the decision on accepting such financial contributions is also regulated by this framework.

OFFICIAL RELATIONS

50. **"Official relations"** is a privilege that the Executive Board may grant to nongovernmental organizations, international business associations and philanthropic foundations that have had and continue to have a sustained and systematic engagement[3] in the interest of the Organization. The aims and activities of all these entities shall be in conformity with the spirit, purposes and principles of WHO's Constitution, and they shall contribute significantly to the advancement of public health. Organizations in official relations can attend governing body meetings of WHO but are otherwise subject to the same rules as other non-State actors when engaging with WHO.

51. Entities in official relations are international in membership and /or scope. All entities in official relations shall have a constitution or similar basic document, an established headquarters, a governing body, an administrative structure, and a regularly updated entry in the WHO register of non-State actors.

52. Official relations shall be based on a plan for collaboration between WHO and the entity with agreed objectives and outlining activities for the coming three-year period structured in accordance with the General Programme of Work and Programme budget and consistent with this framework. This plan shall also be published in the WHO register of non-State actors. These organizations shall provide annually a short report on the progress made in implementing the plan of collaboration and other related activities which will also be published in the WHO register. These plans shall be free from concerns which are primarily of a commercial or profit-making nature.

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[1] Basic documents, 48th ed. Geneva: World Health Organization; 2014: pp.131–138.

[2] Basic documents, 48th ed. Geneva: World Health Organization; 2014: pp.103–113.

[3] At least two years of systematic engagement as documented in the WHO register of non-State actors, assessed by both parties to be mutually beneficial. Participation in each other's meetings alone is not considered to be a systematic engagement.

A.2 INTERVIEWS

TERM OF FREE CONSENT AND ENLIGHTNMENT

TERM OF FREE CONSENT AND ENLIGHTNMENT

Dear,

You are being invited to participate in this research, which aims to understand the functioning of the World Health Organization and the dissemination of health policies to Brazil.The study has been developed, by **Jéssica Silva Fernandes**, **PhD Candidate** at the Post-Graduation Program in Political Science of the Federal University of Minas Gerais, hereafter UFMG. The thesis is **supervised by** professor Dawisson Lopes from UFMG, and **co-supervised by** Prof. Yves Schemeil from Institute d'Études Politiques de Grenoble, Sciences Po, Grenoble. Your perception of the functioning of the World Health Agency and the mechanisms that are used in the transfer or dissemination of global health policies will be an essential source of data for this research. If you want to participate, we can assure that your name will not be revealed under any circumstances; the results or excerpts of your speech will be used in the doctoral thesis as "verbal information."

You will not be identified at any time when your registration material is used, both for scientific or even educational publication purposes.The only risk this research can pose is the creation of expectations among participants. The method used in the research is a semi-structured interview, in other words, you will answer a script of questions among which, we seek to understand your involvement with the theme of global health; the World Health Organization, and your thoughts about the transfer to Brazil of policies such as tobacco control, reduction in consumption of ultra-processed foods and infectious diseases. **If at any time you feel embarrassed about the themes, please, feel free to interrupt.**

If you allow, we will record the interview and make notes. The script, recording and notes will be kept with the researcher for five years, if necessary, after this period will be destroyed.Your participation in this study is more than necessary for this research and voluntary. You are rightfully permitted to refuse to participate or leave this study at any time without penalty or loss of any benefit or care. If you agree to participate in this research, please be aware that the researcher will ensure your privacy and will not disclose its source under any circumstances. You will not spend financial resources on participating in the survey, and you will not receive any payment for it. Whether any doubts raised about the ethics of this research, the researcher and supervisors should be consulted.

DECLARATION OF PERMISSION

I have read (or someone read to me) the information contained in this document before signing this consent form. I declare that I understand everything that has been explained and that I have received answers to all my questions. I confirm that I received a copy of this Term of Informed permission, and the researcher kept another. I know I am free to withdraw from this study at any time.

Date: ...../ ...../ .....

Interviewer name:
Jéssica Silva Fernandes

_____ _____

Participant signature **Jéssica Silva Fernandes**

Informer 01

Aspectos gerais da entrevista

A OMS não tem a função de difundir políticas, ela estabelece diretrizes. Não é função da OMS difundir normas são os próprios países que vão buscar implementar ou não, a OI não tem autonomia para romper a soberania de um país e exigir que uma política seja implementada.

Estabelecer um norte ou guias.

Exemplo:

Lista de modelo de medicamentos essenciais da OMS, lista de como devem ser tratadas as questões e as doenças. O Estado observa a lista modelo e decide se vai implementar em seu território ou não.

Programas que recebem a maior parte de recursos:

1- Doenças transmissíveis recebem grande parte dos recursos

Dentro da instituição existem 2 pilares de atuação, quais sejam:

O primeiro é o pilar normative

O segundo é o pilar operacional;- gente, salário, reunião

1- O pilar normativo está relacionado à consultoria, realizações de reunião, envolve gente, e tem resultados em um longo prazo;

Exemplo do caso normativo;

INPN- International non proprietary nomenclature- Pilar normativo para remédios genéricos e possibilidade de tornar remédios mais acessíveis ao não utilizar a patente de um fármaco específico.

2- Pilar Operacional

Exemplo: O caso do Congo

Existem pessoas que trabalham em situações de emergências

Tipo de orçamento da OMS

Orçamento regular + Orçamento voluntário

2 tipos de contribuição:

1- Acessed contributions
2- Voluntary contributions- Flexíveis – Glosadas – direcionadas a um programa específico.

A OMS é bastante refém dos recursos voluntários.
A instituição tem problemas com o orçamento, a justificativa é o fato de sempre existirem novas demandas e a necessidade de novos programas.
Os EUA pagam mais de 480 milhões para programas emergenciais. Trump envia muito dinheiro para missões emergenciais.
Pilar normativo e Pilar Operacional
Formulação de políticas dos EUA
Nível de influência de um Estado é proporcional ao nível de engajamento.

Mecanismo de influência- **Secondment**
Problemas de restrição orçamentária- Programa de situação orçamentária quem paga a conta escolhe o prato.
Marco para a interação com a sociedade civil **FENSA**
Implementação;-

- *Dificuldades orçamentárias*
- *Secretariado*
- *Responsabilidade dos Estados*

OMS – Relatórios de responsabilidade da OMS e dos EUA
Tabaco- redução geral do uso de Tabaco
Programas emergenciais
Saúde Pública e Propriedade Intelectual
Nível de engajamento político de alto nível
Dinheiro
Engajamento Político

Transcrição da entrevista

Sobre a alocação de recursos

Existe a alocação bianual de orçamentos, esta discussão inclusive está acontecendo agora e é até uma discussão interessante porque está vindo uma nova forma de você discutir o orçamento da OMS. Que é você vincular o orçamento ao planejamento

estratégico de médio prazo dentro da OMS. A OMS acabou de aprovar um programa geral de trabalho, que é uma estratégia geral de médio prazo. Então o orçamento que nós estamos discutindo agora ele será vinculado a esta estratégia de médio prazo. Então eu acho que tem uma importância central, mas assim, as áreas de atuação elas são muitas, não tinha como eu singularizar uma ou outra e fazer esta distinção entre os dois pilares. O *pilar normativo* e o *pilar operacional*.

Quem pode participar do processo de formulação de políticas?
Os Estados Unidos, principalmente, que são os Estados que criam os mandatos e que aprovam por meio dos órgãos de governança, que são dois: O Conselho Executivo e a Assembleia Mundial da Saúde.

Qual órgão tem mais peso?
A Assembleia. A Assembleia é a instância decisória final. O Conselho prepara os temas para o debate na Assembleia e são aprovadas a partir da participação dos Estados, por meio de um Estado, um voto. E via de regra, as decisões são consensuais.

Existe algum ator que exerce algum controle sobre a instituição?
Eu não diria controle porque é uma palavra muito pesada. Mas assim, o nível de influência é diretamente proporcional ao nível de engajamento que você tem com a organização. Tanto engajamento político, o nível de importância que você dá à organização, seu nível de participação, seu nível de debate. Mas também o engajamento se reflete na quantidade de dinheiro que você doa para a organização. Então quanto mais você doa, mais você vai ter *leverage* para ditar como seu dinheiro vai ser utilizado. Existe um outro mecanismo de influência que é um mecanismo que nós chamamos de *secondment.* Mecanismo em que funcionários nacionais são cedidos para atuar na OMS. Então um funcionário que é funcionário da saúde do Ministério Alemão ele é cedido para atuar na OMS. Naturalmente ele está atuando na OMS, mas quem está pagando o salário dele é o governo alemão. Então ele tem aquela coisa, *follow demand*. O *secondment* é uma forma de influenciar o debate e de você colocar pessoas da sua confiança e da sua orientação, uma orientação que você compartilha para ajudar ou influenciar os rumos da organização. O *secondment* você encontra em outros lugares também.

Existem problemas com relação à restrição orçamentária?

Teria problemas, mas a organização está funcionando bem, de certa forma está saudável em termos de orçamento, mas o orçamento reflete uma dinâmica de predominância das contribuições voluntárias que respondem por mais de 90% do orçamento da OMS. E se você está dando o dinheiro voluntariamente, você naturalmente vai eleger as políticas que são favoráveis ao seu interesse de avançar. Então isso é também uma situação de interesse orçamentária e os países em desenvolvimento não tem tanto dinheiro para contribuir, e eles se vem de certa forma desprivilegiados porque eles não estão pagando a conta. Então essa restrição orçamentária é na verdade uma situação que influencia neste sentido que eu te coloquei também que quem paga a conta é que escolhe o prato né, tem o ditado que diz assim.

Existe participação da sociedade civil?

Sim. A sociedade civil participa ativamente da OMS por meio de um *mecanismo.* O Marco para interação com atores não estatais, cuja sigla em inglês é FENSA. Que aí você tem instituições acadêmicas, organizações da sociedade civil, e organizações representativas do setor privado, então a indústria farmacêutica participa da OMS. Então tem sim, e existem regras muito claras acerca da participação e controle, mas eles participam à exceção da indústria de armas e a indústria do tabaco.

ACQCT é uma Convenção separada, é um regime próprio, e dentro da CQCT não pode mesmo qualquer tipo de contato. É até um pouco mais restrito que o FENSA.

Quais dificuldades a OMS enfrenta na implementação de políticas?

É uma dificuldade orçamentária. Por vezes existem atividades ou mandatos que são criados para a OMS que não são cumpridos por conta da ausência de recursos não tem como cumprir. Então por vezes você aprova um conjunto de atividades, mas você não tem contribuição, core, que é o *core budget*. E você não tem nenhum país que pague por essa atividade. Então esta atividade fica meio abandonada, fica órfão. E aí não vai a frente.

Quem participa do processo de implementação?

Uma parte da implementação pode ser feita pelo próprio secretariado da OMS. Então por exemplo, se você cria uma normativa de que a OMS tem que criar uma lista modelo de diagnósticos essenciais. Para criar esta lista você precisa ter gente trabalhando. Então

criou-se este mandato dos diagnósticos. O secretariado contratou gente porque tinha recursos para fazer a lista de diagnósticos e a lista de diagnóstico foi publicada agora em abril foi a primeira lista de diagnóstico de medicamentos essenciais, a exemplo do modelo de medicamentos essenciais. Então foi uma coisa importante que pode ser o secretariado, mas também pode ser de responsabilidade dos Estados, dos países, que tem que pegar estas diretrizes e canalizar nas suas práticas nacionais. A gente tem por exemplo, relatórios. Então assim, às vezes os países aproveitam os relatórios para dizer, por exemplo, em relação à cólera nós estamos fazendo isso e aquilo, e já reduziu em tantos por cento, como oportunidade de intercambiar as informações entre os Estados mínimos e as organizações. Tem uma parte que é responsabilidade da OMS, mas tem uma parte que é responsabilidade do secretariado dos Estados-membros.

Você tem algum exemplo de sucesso na implementação?

Tem muita coisa que dá certo, mas tem muita coisa que não dá tão certo por falta de dinheiro. Mas se eu fosse pensar em termos de sucesso absoluto na implementação eu citaria a *Convenção Quadro de Controle do Tabaco*, que é uma iniciativa de sucesso. Houve uma redução geral, global do consumo do tabaco. O programa de emergências está entrando numa fase de grande reconhecimento de sucesso. Enfrentou duas grandes epidemias de Ebola no Congo este ano e tem conseguido bons resultados, evitando uma reprise da crise do Ebola de 2014 que matou mais de 5000,00 pessoas. Então é assim um caso de sucesso. É uma organização muito grande e muito complexa. Outras pautas de sucesso são a pauta de saúde maternal, o câncer de mama. A pauta do câncer de mama toda foi inspirada na OMS, do outubro rosa, do auto exame. Foi muita coisa legal que acontece aqui e acaba sendo refletida nos países.

Teria algum exemplo de política de menos sucesso?

A parte de saúde pública inovação e propriedade intelectual é uma parte que não teve tanto sucesso. Mas porque faltou dinheiro e uma posição muito forte dos países desenvolvidos para a implementação. Tem a ver com a flexibilidade do acordo de TRIPS, diminuição do preço de medicamentos patenteados isso é uma resistência muito grande dos países desenvolvidos. Ao mesmo tempo, os países que se beneficiariam não têm tanta clareza política sobre a oportunidade de utilizar este mecanismo que tem um certo custo político. E a gente está forçando para que isto mude, mas ainda não é o caso.

Queriam acabar com a estratégia global de saúde pública inovação e propriedade intelectual e nós pedimos para renovar e nós mostramos a necessidade de renovar. Tentamos fazer uma doação, mas ainda não conseguimos por conta da situação política que atualmente está em curso.

Como seria esta doação, de onde para onde? De quem para quem?

No caso nós tentaríamos obter o recurso do Brasil para destinar à OMS e dizer, este recurso é para esta atividade, para trabalhar a saúde pública, inovação e propriedade intelectual. Nós não conseguimos viabilizar isto ainda.

O Ebola de 2014 poderia ser considerado uma política limitada, mas já foi modificado e melhorado.

Qual a principal diferença entre a política bem sucedida e a não implementada?

Não tem muito segredo. A questão aqui é dinheiro. Uma questão importante é que, é dinheiro, mas não é só dinheiro. Devemos também considerar o nível de engajamento político em relação a um determinado tema. Então os dois fatores limitantes seriam dinheiro e o nível de engajamento político.

Qual o papel do nível doméstico nas políticas?

O papel do nível doméstico é total. Os países e seus Ministérios de Saúde têm um papel fundamental na implementação das políticas porque a OMS não tem uma capacidade financeira e pessoal e nem tem mandato para implementar regras normativas no âmbito nacional. O nível nacional pode contribuir implementando, e obstruir, seja aqui, seja no nível internacional que adote certa política nos órgãos de governança. Ou não aceitando no seu nível nacional algum tipo de recomendação da OMS que em alguma medida faz parte do mandato. Então dinheiro contribui, engajamento político contribui, e isso conversa um pouco com os fatores de sucesso e fracasso que uma determinada política possa ter.

Informer 03

Sobre o processo decisório

As polêmicas são destiladas em comissões, lá tem votação, de maioria simples. É como se fosse assim a Comissão de Saúde, a Comissão de Justiça no Congresso. Passa por aquela Comissão destila as coisas essenciais e leva para o plenário. Quando chega no plenário já está bem garantida e consolidada a política. É um processo muito complexo de criação em si. Existe uma capacidade de nós dentro da organização termos uma voz. Pelo protocolo, dentro da organização, você não pode chegar e oferecer alguma coisa. Os departamentos fazem isso através dos países. Para lançar o meu programa, num momento em que eu estava com pouco apoio político, eu conversei muito com a representante da Burkina Faso que era chefe da comissão, cientista brilhante, e deu suporte ao meu programa, tinha interesse e era considerado referência no projeto na África, e dizia: deixa comigo, vai passar (vai ser aprovado). Passou pelo Caucus Africano, convenceu o pessoal. E depois disso veio muita gente apoiando. Entendendo a importância do projeto para os próprios países.

Um caso interessante também a ser mencionado, é o caso das doenças negligenciadas. O informante ressaltou que determinados temas podem ser aprovados por si mesmo na Assembleia. Diferentemente, em temas mais polêmicos/ complexos, é necessária uma articulação maior para aprovação. Importante destacar que só o país pode apresentar uma Resolução. Nós, staff, não podemos apresentar. O país pode apresentar uma resolução exigindo que determinado departamento apresente o tema a ser debatido na Assembleia.

Quem é o representante o oficial do país dentro da Assembleia Mundial de Saúde?

Na Assembleia, se não me engano você tem 194 países. Você tem um Comitê Executivo (CE), o CE tem uma representação por região. São 31 países (eu acho). Esse Comitê Executivo que decide tudo, inclusive a pauta da Assembleia Mundial de Saúde, a eleição do diretor. Ele é o "todo poderoso" o Comitê executivo. Geralmente os países se organizam no Comitê executivo por *Caucus.* Então você vai ter, os africanos se reúnem antes da reunião e fazem votos em conjunto é lógico que o país tem um papel fundamental, mas é feito assim. Nas Américas também os países se reúnem para tentar formular uma posição conjunta. Isso é muito comum de acontecer nas regiões,- entre os países- antes de cada reunião. Isso acontece sempre, é uma forma complexa de trabalho mas é quase uma forma parlamentar mesmo de trabalho. Na AMS cada país tem direito a um voto. No Comitê executivo não é cada país um voto, depende da representatividade daquele país para auferir votos. O voto dos EUA *vale muito mais* do que os outros pela quantidade de recursos financeiros que coloca na instituição. Neste sentido, o voto dos EUA claramente vale mais dos que os outros.

O Trump tem o poder de barrar que a OMS toque no assunto aborto, por exemplo. Os EUA fizeram isso. Nesse sentido que eu falo que nós devemos olhar pra realidade e a capacidade de força que um país tem para obstar ações dentro da instituição.

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Você tem alguns casos que são antigos, muito estudado e tem muita literatura sobre isso, que é o caso da *Convenção Quadro para Controle do Tabaco*. É um caso clássico, porque apesar do momento de grande força das indústrias tabaqueiras os países estavam entrando em uma certa contradição também. Os EUA estavam tendo um gasto absurdo por causa do tabaco. Pegou a parte do Bill Clinton que tinha muito interesse nesta pauta, então a coisa amadureceu e caminhou. Foi uma negociação muito difícil e o Brasil teve um papel fenomenal na aprovação do CQCT dentro da OMS. Inclusive uma parte desse sucesso se deve ao *Celso Amorim*. Dois grandes embaixadores brasileiros que desempenharam esse papel de sucesso, o outro eu não estou me lembrando do nome. O Brasil é o primeiro exportador mundial do tabaco. A China é o maior produtor. O Brasil é o segundo maior produtor, mas é o maior exportador. A China consume muito do que planta. Então você vê, apesar do interesse, prevaleceu a preocupação com a saúde. Tem muita gente envolvida nesta política. O *Paulo Buss, a Célia Almeida*. O Brasil caiu para 32% de consumo.

Assim se você for mencionar ou estudar o caso do tabaco, tem uma pessoa que chama *Allen Taylor*. Ela é uma advogada, e a última vez que eu soube ela estava em Hopkins. É fácil de achar, porque ela é advogada na área de saúde. Ela basicamente investiga algumas OIs da ONU, e mostra o seguinte, que essas OIs trabalham bem com a opinião pública e canalizam apoio pra pressionar a mudança nos países. Então ela mostra assim que estas organizações vão até a sociedade civil e tentam jogar a sociedade civil para uma agenda que elas acham que é melhor.

Esse exemplo da Allen Taylor se assemelha ao que a OMS tem feito em relação à proximidade com a sociedade civil?

A OMS fala que devia, mas a Allen Taylor fala que a OMS não trabalha bem com essas questões. No caso do tabaco essa aproximação aconteceu um pouco. A minha hipótese é que a sociedade tem medo da sociedade civil. Medo demais. A OMS se sente a guardiã, global, universal da parte técnica da saúde, então é essa visão. Quando começa a me pressionar de fora, vai me forçar a cometer alguns erros e sair dos cânones. Só que isso é uma percepção. A OMS até 2006, ela não usava as melhores evidências científicas colhidas globalmente para fazer as recomendações, sabe, este é um outro caso interessante. Um exemplo, os médicos devem seguir protocolos e *clinical guidelines* o que gera um impacto seríssimo na conduta médica. No ano de 2005, a OMS publicou 78 guidelines num ano só. Desses 78 guidelines, só 40% tinham ao menos duas referências. Quem faz os guidelines são os departamentos. É algo meio descentralizados. Quem faz são os departamentos específicos de cada área de atuação. Por exemplo, vai fazer o de epidemiologia, entra o departamento de doenças crônicas.

Quem faz os guidelines da OMS?

Aí é que tá, tem muita gente referência na própria área, com um amplo conhecimento global e tal. Mas essas pessoas dependiam de experts. O expert acabava sendo o *Gobst Good Old Boys Sitting around the table*. Então acontecia o seguinte, eu sou um expert e eu nunca vou chamar um expert que discorda da minha posição, eu vou chamar vocês.

Você me contrata para gente fazer um protocolo. Aí como é que é, põe aquele artigo seu, aquele artigo meu, era uma coisa mais ou menos assim. Então um desses guidelines era o marítimo. Pela lei internacional o navio deveria ter pelo menos 1 manual deste a bordo. Então era assim, um *best seller* da OMS. E nós fomos olhar e revisar e não estava com uma boa qualidade. Tinha coisas que não tinham sido atualizadas desde 1959, se tratando de asma, coisas absurdas.

Então juntou o editor do *The Lancet*, um periódico inglês, muito famoso e muito prestigioso, Richard Gordon, começou a pressionar dizendo que se a OMS não mudasse a forma de fazer guias eles iriam denunciar. Então imagina se eles fazem esse movimento todo.

Aí a Margareth Chan ficou numa situação embaraçosa, já estava com tudo pronto, toda a metodologia desenvolvida, pegamos os melhores metodólogos que fazem revisão sistemática. E Richard Gordon publicou no *The Lancet*.

Não saía por que existia essa política interna "Gobst", como você disse?

Exatamente. O dia que saiu a publicação, a diretora Geral chamou meu diretor e perguntou por que ele não tinha feito a confirmação de mudança para a produção dos guidelines. Meu diretor disse, não eu estava aguardando a assinatura da senhora. A diretora Geral disse, você não devia ter esperado, você deveria ter me feito assinar. Então saiu publicado e virou todo um trabalho dentro da OMS que é o chamado *Guideline Review Committee*. Agora praa você publicar um guia é um processo que leva 1 ano, 1 na e meio. Com vários ciclos de conferência e re-conferência dos protocolos. O departamento encomenda revisões sistemáticas, que pegam todos os estudos, fazem uma meta-análise para saber o que é mais definitivo. Então é essa confusão toda que se criou.

Um outro caso que eu acho que é muito interessante porque este eu convivi com ele desde o início. Eu trabalhava na OPAS mas o meu posto era na OMS. Tem alguns postos que são da OEA, outros são só da OMS, e outros são unidos. Para relembrar a OPAS tem dois chapéus, um é o da OEA e o outro é o da OMS. Então eles usam conforme eles precisam, eles usam ou um ou outro, o que for mais conveniente. Eu trabalhava com promoção de pesquisa. Era o *Advisory Committe for Health Research*- reunia muitos cientistas do mundo inteiro que vinham mostrar tendências. Vinham olhar todo o trabalho científico da OMS, davam palpites, era uma coisa muito legal. Então eu sou chamado para Assistent Record General, agora aumentou muito, mas antes era uns 5, ou 4. Então vamos organizar um *Ministerial Summit on Health Research*. Precisamos trazer o maior número possível de Ministros da Saúde e precisamos discutir o que eles realmente querem com a pesquisa em saúde.

Isso foi no México em novembro de 2004. E o governo mexicano entrou pesado. Aí você começa a ver o seguinte, eu identifiquei uma série de grupos independentes que é uma coisa quase maçônica, que tem um clube fechado entre eles, tem um cumprimento especial entre eles, tem um símbolo. Esses grupos independentes que atuam no cenário

internacional eles individualmente defendem interesses de outros grandes grupos por de trás.

Então tem um grupo que eu identifiquei que era desse diretor *Assistent Director General*. Isso funcionava assim, eles mantinham entre eles esse jogo da cadeira dançante assim, a fundação Rockfeller na parte da saúde, a Harvard, todos eles são egressos da Harvard. São Confrarias, eles são independentes até certo ponto, porque cada um deles está vinculado com alguma instituição ou governo, um com o governo do Canadá, o outro com o governo americano, o outro com a Harvard, o outro com a Fundação Rockfeller.

Agora são gente progressista, no sentido assim, eles não são de esquerda, eles são pessoas que acham que a saúde é tão importante que não pode ser deixada na mão dos políticos, deve estar na mão de gente que conheça e tal. Pra eles, -(indivíduos deste grupo) a OMS era a cereja no topo do bolo. Eu comecei a identificar porque eles começaram a trabalhar com a OPAS na parte de equidade em saúde. A Rockfeller financiou um super livro de equidade em saúde, a OMS entrou com Conselho de Desenvolvimento Humano, não só o Conselho de Desenvolvimento econômico e por aí vai.

Então era um pessoal do bem e eu aproximei muito deles. Um deles era um cara muito neoliberal que chama Júlio Frenck mexicano. Ele não era membro de carteirinha deste grupo. Mas era de uma área próxima. O Júlio Frenck estava fortemente vinculado mesmo ao México com o Carlos Slim (dono da Time, do Wall Street Journal, se não me engano).

O Júlio Frenck foi diretor da FIOCRUZ no México, Instituto Nacional de Saúde Pública, durante uma década. É um cara do partido PRI, *Partido Revolucionário Institucional*. Ele sempre com posições neoliberais. Sempre discutia questões como, a saúde deve ser fundamental para as outras coisas funcionarem. E pesquisador bom, cara renomado nas pesquisas e a esposa dele também. Só que o Júlio Frenck foi se aliando cada vez mais com o Carlos Slim que é dono da Fundação Nacional de Saúde do México, FUNSALUD. O Slim fica disputando com o Bill Gates ali quem é o mais rico, tem hora que é com o cara da Amazon, então eles ficam disputando.

Então para você ter uma ideia, o Júlio Frenck ele e a mulher dele defendem que a saída para uma cobertura universal em saúde (*todos desse grupo defendem a cobertura universal em saúde*).

O que vem a ser a Cobertura Universal de Saúde?

É um Sistema em que todo mundo tem direito à saúde, como o SUS no Brasil. Os EUA não têm uma cobertura Universal em Saúde, é bem restrita. Mesmo com o Obama Care tem aí umas 20 milhões de pessoas fora do que é atenção à saúde e qualquer recurso.

Me pareceu um pouco contraditório eles defenderem um sistema neoliberal e uma cobertura universal em saúde, é isso mesmo?

É contraditório demais. Mas eu diria que são os neoliberais iluminados, mas tem isso. Eu humildemente defendo um sistema de saúde Universal, que seja realmente baseado na equidade e que seja para todos. E que o financiamento tem que ser do Estado. Nossa Constituição fala, é dever do Estado, um direito do cidadão. Tem que financiar, tem que buscar formas de financiar. E o SUS é subfinanciado, é cheio de problemas, não tem uma fonte estratégica de recursos que você saiba que dali vai sair uma quantidade determinada de recursos. Como por exemplo, não se tem uma menção explícita na Constituição de onde vão sair os recursos, como do imposto de renda por exemplo. Nós não temos isso.

Então o Júlio Frenck defende que isto precisa ser atingido a partir do seguro de saúde dos pobres. Você tem que pagar para ter isso. Então você pensa bem a economia de escala disso. Mesmo que seja os pobres pagando pouquinho, como os pobres são muito na América Latina, ia dar um elevado montante. Para você ter uma ideia, o Carlos Slim comprou uma seguradora do México por 30 milhões de dólares hoje ela vale 1 bilhão 1, 4 alguma coisa assim. Isso é um ponto sem nó. Ele cumpre isso, o Júlio Frenck vira ministro da saúde.

Como é que funciona esse pessoal. O Fox assumiu a presidência pelo PAN (Partido da Ação Nacional, do México),-partido que assumiu pela primeira vez a presidência do México. Júlio Frenck era do PRI, ele foi o único ministro do PRI no governo do PAN. Quem colocou ele no governo? Foi o Carlos Slim. Você está percebendo como é que funcionam as coisas? O que ele dá em contra parte? Ele cria um Seguro de Saúde dos Povos do México, que é um fracasso.

O Júlio Frenck lança este seguro dá uma fortuna. Quem é o maior beneficiado? Quem tinha comprado empresas de seguro de saúde. E isto se transforma em uma super empresa. Este é o exemplo que eu estou te dando para ver como este pessoal funciona. O outro era da Rockefeller foundation. Eles começam a fazer uma armação para eleger uma pessoa da OMS que seria o Júlio Frenck, para substituir o Coreano que havia sido eleito como Diretor Geral, Dr. Lee. O Júlio Frenck perde. Nós devemos pensar o seguinte, não é geração espontânea, o país decidiu, não é um esquemão por de trás, é tudo calculado politicamente. Então este cara o Lincoln Chen, chinês de Hong Kong que vive de pesquisa, com muito dinheiro arrecadado de Médicos chineses, de médicos do pessoal de Hong Kong. Tem este outro que é o Tim Evans ele foi da Fundação Rockefeller, depois ele foi para a OMS para esta área de informação, evidência pesquisa. E depois foi ser o diretor de Saúde e Planejamento, Nutrição e Planejamento familiar do Banco Mundial. Foi uma das maiores diretorias do Banco Mundial. O atual chefe do Banco Mundial é também um Coreano, ele foi daqui da OMS. Depois saiu e voltou para os Estados Unidos depois foi para uma Universidade, depois foi ser presidente do Banco Mundial. Então ele colocou o Tim Evans lá.

Jéssica: *Só voltando um pouco você me disse que a OMS tem medo da sociedade civil, mas ao mesmo tempo em 2016 a OMS regulamentou a participação da Sociedade civil por meio do Framework. Isso também pode ser visto como um jogo político?*

É a pressão né. O jogo político ele é múltiplo. Então ele tem por exemplo, alguns Congressistas americanos que pressionam. Porque tem Constituintes deles que

pressionam. Aí você tem a Bruntland, aqui foi um feudo japonês durante muito tempo, no governo Nakajima, ele quase fechou a OMS. Aí veio a Bruntland, que ocupou o lugar dele. Tem um episódio interessante que a Hillary Clinton pegou o avião foi ao Butão e convenceu o chefe de estado de lá a votar na Bruntland. E a Bruntland ganhou por um voto. Ela foi a primeira-ministra da Noruega. Ela tinha uma proximidade muito forte com os chefes de Estados. E isso deu muita força para a OMS. Ela chegou com essa conversa de estabelecer diálogo com a sociedade civil e isso aconteceu a partir de 2001. O processo ia e voltava, foi um processo longo. A ratificação do framework só ocorreu em 2016.

Você falou que estudar a difusão de políticas públicas a partir deste contexto é algo muito difícil, por que é difícil?

Existem várias redes dentro da OMS. Existem pessoas que tem mais o poder estatal mesmo. Sempre conseguem apoio, e são pessoas respeitadas. O Tehdros está lidando com dificuldades e pressões deste tipo, busca por ampliar apoio dentro da instituição.

Então eu te falei sobre a Convenção do Tabaco, o Brasil teve um papel de destaque na negociação e com o Celso Amorim, inclusive, no papel de Ministro o país conseguiu implementar mais coisa ainda.

Você falou da Fundação Gates e da Fundação Rockefeller, elas agem com muita força dentro dessas redes?

Anne-Emanuelle Birn Historiadora da Saúde Global- Teve um período que a Rockefeller era Gates na área da saúde. A Rockefeller influenciou todas as escolas. Era um dos maiores compradores das finanças. Muito tempo depois surgiu a Fundação Gates, a maior fundação privada que além de pesquisa passou a atuar em outros setores. A área principal da Fundação Gates é a parte de Vacina. Eles não fazem nada diretamente ligado ao Sistema de Saúde.

Existem os “cardeais” que vem e desaparecem. Agora com o Tehdros na Diretoria Geral mudaram-se os cardeais. (*O termo cardeais* foi usado no sentido metafórico para fazer referência aos poderosos que circundam o poder).

Aí você tem os outros que são o baixo clero que são trabalhadores que atuam dentro da OI.

Um exemplo, eu e minha equipe trabalhamos pesadamente para aprovar uma resolução e convencer o Conselho Executivo de que determinadas demandas seriam necessárias de ser discutidas. Isso é um trabalho diplomático. Nós recebemos grandes interesses de fora.

Informer 09

Discussion:

Policy implementation-

Two years to have adopted by non-states.

Close meeting made by non-state actors.

Negotiation made by informal consultations (2010-2012) different actors were consulted.

The discussion about the joining of non-states startes around 2010, with the campaign to reform WHO. **Reform WHO (2010)**

Three main points have raised in the discussion of reform:

Firstly, the finance, second the management, and thirdly the governance, how to shape the WHO.

- Finance
- Management
- Governance- FENSA is associated with this third point, how to shape, new strategies in global governance, norms and standards.

Private sector

How best they can contribute and advance the work of the WHO.

The Challenge for General Directors

We need to engage more, we have to make rules.

Five types of Engagement:

- General program of Work

-Set the types of activities 2030

The WHO has na egocentric perspective, in other words, how people or non-states actors can contribute in order to advance the work of WHO.

MSF- Médicin sans frontier – NGO -they are not indoor

Three types of conflicts of interests

1- Staff – declaration of interests
2- Individuals- Experts/ researchers- declaration of interests
3- Institutional- Partnership as time- access institutional private sector- NGO are guided by private sector.

Legal department

1- Headquarters
2- Regional offices
3- Country offices

WHO representatives

Assessment:

Due Diligence

Tobacco- Arms control

Profile and Project – Phillipe Morris

Gates Foundation- Why we need to have relations with the non-state actors working with WHO.

Non-State actors

WHO needs to work.

Every 3 years every plan of collaboration is reviewed. The plan are presented every january. Entities for reviews. Plans of collaboration.

2 examples:

Tobacco- How Brazil did this?

How in principle a policy can be routed?

Follow the recipe

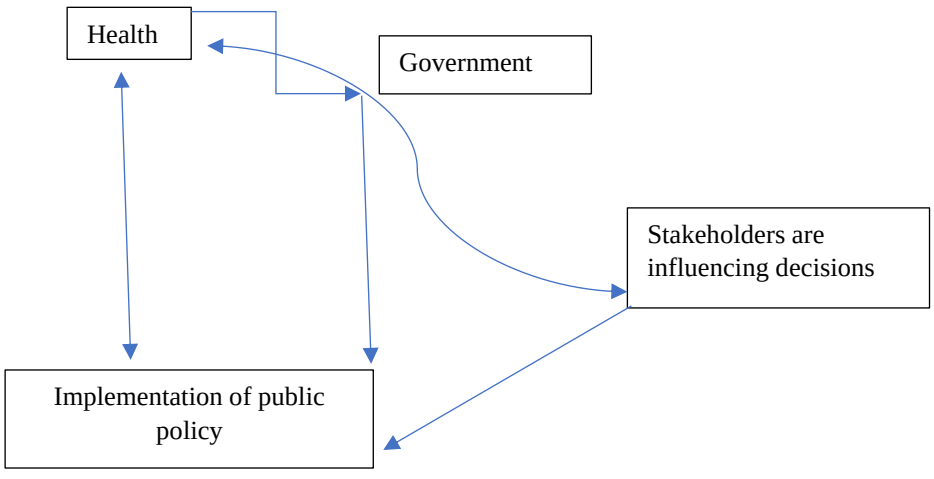
Example of policies:

- Tobacco
- Sugar reduction
- Water sanitation

2 policies different countries:

Brazil and Argentina- for example

We need to think that the process of transfer or difusion involves:



Informer 10

WHO- statekeholders are member states

Member states themselves need to implement the policies agreed on WHO.

Secretariat

Group of the countries

World Health Assembly

Executive Board- bring every country is vary costly

↳ More dynamic, cheaper, can meet every year in (May)

- They speak through resolutions or decisions:

In other words the Executive Board speaks in resolutions, which can be:

- Resolutions of diseases
- Health insurance
- Public Health

The Executive Board can give instructions or recommendations to the Secretariat and made the Executive report.

The **instructions** can be:

Recommendations;

Whenever member states needs to do;

Allocate financial or monitor resources;

They don't recommend

Develop tools

To develop guidelines

Intergovernmental organizations

People are employed by the organization;

Recommendations to government

The **main** implementators are the **member states** (Ok- if the main implementators are the member states, what could encourage or impede states to follow IOs instructions, or in which situations a member state transfer a policy to national levels?)

FENSA

-Non-state actor

-WHO need to define who engage and who doens't.

- Involving with academy- business association

- How WHO engages

-Fantastic terminology

NGOs clear definition

How WHO should engage?

Categories- Profit companies – business association

_ represent the interest of companies

_ they work with the interest of business companies.

Profit organization argument

We don't make any business.

Foundations:

- Example: microsoft
- Gates foundation- Non-profit but acts with the interests of microsoft

Arm langs- distante enough by mother company

WWF – Money from individuals

Arm long- trust of the objective of WWF

Thousands of money

-Foundations are not

-Conflict of interests.

For profit sectors- non-profit

Private – for profit

_for non profit

Make money

Public- for profit

-for non- profit

Non-profit= no body makes money

Private sector- private hospital- for profit / or for non-profit (don't make money)

FENSA usually talk about private sector for profit;

They are not completely free;

Philantropic associations

Who gaves money for american country association?

Sub category
- Philantropic foundations
- Advanced organizations

Comprehensive approach- health insurance for wholes;

Philantropics

Academies- institutes

- -Russia academia big researcher
- -Academy

Secondary aspect- the main aspect is the National level

Suggestion of analysis:

To compare resolutions from 1948 to 1950's to analyse the recommendations to the member states.

Recognition from the institution of the NGO.

Look the resolutions of World Health Assembly. – from the first to 20th.

Necessary actors to implement policies.

Resolutions:

How nay times the word Non-state actors appear in the resolutions?

WHO – Organization of states

Secretariat

Second part of WHO

WHO

Comparing resolutions

WHA 1- 1948

Each resolution has 2 or 3 pages

Reference of non-state actors -
- -non profit
- -philantropic organization
- -academy
- -private sector

Non-state actor

Academy: represented by research institutions, hospitals, researchers. Most of them are state actors

Centre for diseases control

Huge researcher in Atlanta

States actors; everything is a type of actor, research institute, scientific actor.

Different states- Different arrangement- WHO will engage with all of them

Collaborator center

That will be to costly

Specialized

Re-establishing

Will have million employee

This organization benefits

Big Universities

Elaboratory- ministry of healty

Designtation Collaborator Center

Produce advices

Will you plan how to produce advices. Sistematic review

Require how we do some analysis of data.

Hole time of statisticians help us to drawn conclusions.

8 hundred:

They don’t need this anymore?

This is not formal definition- scientific people

Institutions has the agreement with WHO

Establishment agreement with the collaborators center.

WHO Experts- Work assembly

They plan to do same research

Help analysing this plan of groups of actors

Extra information;

There us not

FENSA

- Conflict of interest
- We need to decide what we do.

Same experts are not free from conflict of interest.

Types:

- Real conflict of interest
- Perceived conflict of interest- perception of interest

Some areas are more controversial

Neglected diseases- exist interest of some private enterprises

Sugar- Food industry

- The campaign needs to be carefully when bring experts
- Experts limitations

Sugar guidelines, representing interests:

Bring the science

Guideline for declation of interests.

Problems when publish the name.

The looby with experts

The problem to publicize information and the name of people to be invited.

To publicize the name of experts at web sites could be rather good or bad.

Informer 11

1- Do you work for WHO or UNAIDS?
2- What kind of actors are embodied in this institution? Only states? Or either non-States?
3- How the non State can join the institution?
4- Why UNAIDS was created?
5- How can I considered UNAIDS, an independent institution or a program?
6- Who can take part of decision making body?
7- Is there any actor or factor along the decision making process that could impede the consolidation of politics?
8- About the budget
   8.1 How the budget of UNAIDS is established?
   8.2 What strategies UNAIDS usually search in order to increase the budget?
9- In your opinion what difficulties states usually face to implement na UNAIDS policy?
10- What Kind of actors usually accept to implement the best practices in their countries?
11- What kind of stakeholders can contribute to the implementation of policies in one country?
12- Do you have na example of one country that well succeed in the implementation and another that did not succeed?

Answers:

1-UNAIDS secretariat composed by a secretariat and 11 co-sponsor

Lina works at the Secretariat of UNAIDS

2- In the framework of UNAIDS we find the UN body, five NGOs representing NGOs-

the NGOs are defined by ECOSOC resolutions-, 6 co- sponsors; 5 NGOs delegates and civil society.

3- NGO- selection process and joining

They can participate in Executive Boards, nevertheless they cannot vote. They have the same rights at UNAIDS internal issues and procedures.

4- Administrative systemas by WHO, in other words, is administered by WHO.

5- UNAIDS co-sponsors and delegates as observers. Observer can also speaking but they don't participate in negotiation.

6- The different types and forms of Conflict of interest we may find at UNAIDS sessions:

*Ideological issues among different nations

*Sex workers

*Property rights

*Pharmaceutical industry

7- Budget Secretary

Is mobilized by the Secretary- Book : AIDS between Sciences and polities Peter Piot

Crisis- migration crisis

Core budget and extra- core budget (ear market funds)

8- Leadership

Development guidance

To support countries to collet data AIDS/HIV response

Made from sponsors

Each of co-sponsors act in their field

9- Political resistance

Capacity issues funding issues

International level move fast

Guidelines HIV/ treatments

Countries have to provide treatment for every people;

Chile- they pay high prices for treatment

Conflicts- economics and finance.

HIV people who use drugs

General assembly- HIV monitories and their responsens. (Instruments to collet data.)

10 Envolvement of people in HIV National HIV/ responses- To include civil society

Many countries receive money from Global Funds

Key issues- involvement of actors in different levels most of Africa countries.

Civil Society identity of UNAIDS.

HIV- created 1980's – multilateral response to lead with HIV;

Informer 14

Bloco1

1- Sobre a instituição e o processo decisório
A atuação do Secretário Geral no condução das políticas

- Qual a relação do Diretor Geral da OMS em Genebra com os Diretor Regionais?
Antonio Tehdrus- a OMS é muito direcionada pelo que é aprovada pela Assembleia Mundial de Saúde- o Diretor foi eleito em 2017, pela Assembleia
Global Program of work n 13 de 2019 à 2023 – Estados Membros Taiwan não é reconhecido, Palestina não é reconhecido, Santa Sé
Aprovado pelos países deve ser implementado- a descontinuidade é bem menor
Os diretores acabam sendo reeleitos para o cargo. Via de regra ele pode ser eleito para um segundo mandato. Maioria geral de votos.
Na relação dos Diretores Regionais são eleitos pelos países da região. Muitas vezes é um acordo político entre países da região. As regiões aprovam as suas próprias estratégias mas elas devem seguir. O maior órgão que sobrepõe todas as decisões.
Países têm autonomia

- Essa estrutura descentralizada, pode de algum modo afetar a transferência de políticas para os membros?
Comitê regional ainda não tem uma avaliação crítica de quanto isso impacta a implementação
GPW- busca um alinhamento entre os níveis
Estabelecer normas e standards na saúde
Define nomes para produtos genéricos
Guias terapêuticos
País internaliza ou não
O país internaliza ou não, variabilidade lista de medicamentos essenciais… Países mais ricos a lista de medicamentos essenciais seria um pouco maior… medicamentos essencias = medicamentos não patenteados. Medicamentos de câncer, termos de sobrevida. Medicamentos de altíssimo custo- tempo sem

progressão de doença. Países ricos podem absorver melhor o custo. O que é um preço justo para se pagar.

- As mudanças que são feitas na sede em Genebra, como a criação do Framework para atuação de atores não Estatais são reproduzidas nas estruturas regionais como na Pan American Health Organization (PAHO)?
- Os atores não estatais, podem formalizar a participação do mesmo modo?

***Sobre o Brasil dentro da Instituição

- Em qual período o Brasil foi mais ativo dentro da instituição? E por que você considera que foi uma atuação diferente de outros anos? No sentido de contribuir com o orçamento regular, transferir políticas, propor políticas
- País sempre levantou a voz dentro da OMS, sistema universal de saúde, integralidade, SUS, Brasil sempre teve um protagonismo muito forte, aliado em relação à inequidade, do ponto de vista da Diplomacia.

Bloco 2

2- Sobre a transferência

- What difficulties the members of the WHO usually face to accept the adoption of best practices in their countries? And what difficulties Brazil usually face to accept the adoption of policies?

  Qualquer decisão da OMS *não* é obrigatória. Anvisa Global Bench Mark – Autoridade regulatória nacional

  Consulta pública- implementação- Tanzânia foi reconhecido com nível de maturidade 3

  OMS deu suporte técnico. Kênia também. A OMS colocou os standards e avaliou - processo voluntários e de longo tempo. Se não tiver agências regulatórias funcionando bem. Sistema regulatório.

  Adoção pode ser gradativa,

  *Brasil estava sempre a frente da OMS nas questões da AIDS

  Guias terapêuticas dependem da demanda regional

Brasil protagonismo- nas doenças tropicais, Malária, tuberculose, AIDS – produtos são os controles do vetor-

HIV – O Brasil tem que comprar o que a Ciência diz que é bom-

OMS tem que ir baseada em Hard evidences –

Para entrar no Guideline

- What kind of stakeholders can contribute to the implementation of policies in one country?
- No caso do Brasil, podemos dizer que a FIOCRUZ tem sido um stakeholder relevante na transferência de políticas? Essa atuação seria mais direcionada às doenças tropicais ou seria também estendida às outras áreas da saúde?

Como produtora ela tem uma limitação na exportação, vacinas da febre amarela – limitações com relação à exportação que não são vacinas. Respeitadíssima em termos de capacidade nacional, local, países de língua portuguesa, redes de cooperação internacional. Eles fazem parte da rede nacional de pesquisa e desenvolvimento.

- Do you have an example of one policy that well suceed in the transfer to Brazil? Tabaco no Brasil
- Do you have an example of one policy that failure in the transfer to Brazil?
- Em quais áreas o Brasil se destaca na adoção de boas práticas na OMS?

A importância das redes na formulação e difusão de políticas

Informer 15

Tabacco- gerar resultados (EUA)- Recebeu recursos pesados externos-
Três fontes de recursos que ajudaram muito na implementação **CDC- de Atlanta**- produto de exportação- minimização de danos do destino- Deram muito recursos-
Fundação Bloomberg- Brasil ganhou um prêmio
Países- No Brasil- inquérito- IBGE fez uma pesquisa medindo o uso do tabaco-
Recurso do México-
Recursos casados-
25 engenheiros que foram realocados

Para o Tabacco eles geraram uma estratégia com 5 eixos específicos

Genebra fica com uma grande parte dos recursos- recursos de implementação
Recursos de violência, segurança humana, Saúde do consumidor

A resolução- Condições que existem no país para implementar as políticas-
O Trabalho de Secretaria da organização de alocação de recursos
Recebiam o recurso econômico

Quais dificuldades os membros da OMS geralmente enfrentam para aceitar, ou incorporar a adoção de práticas para os seus países?
A modulação sempre é do país.
A importância do Ministro e do indíviduo na posição de autoridade.
Serra era obcecado com o Tabacco- Mandatos regionais servem para priorizar mandatos- José Serra e Celso Amorim favoreceram muito a questão do tabacco.
O Haiti também é um caso interessante. Sugeriu criar as políticas consciência e educação.
No caso do Haiti o mais importante era a questão da água e o saneamento.
Chile foi um caso difícil, com grande resistência ao caso do Tabaco. República Dominicana.

Estratégia de aprovação dos países é extrema, a questão do imposto é uma variável complexa, espaço fiscal, incentivo ao cultivo do tabacco- BNDES,- Criaram uma iniciativa no formato de um manual.

Vera Lúcia Costa e Silva: Chefe do programa do Tabaco em Genebra

Álcool e Drogas-
Alimentos e atividades físicas

Causam dependência
Alimentos ultraprocessados- açúcar – coca-cola
A pior droga que nós temos no Brasil é o álcool
Todas causam danos à saúde- todas com consequências à saúde

Caso de ultraprocessados- publicidade para crianças
Número de células gordurosas é criado até três anos de idade, fórmulas da Nestlé, número de células que existem- Nestlé é uma violadora do código do leite, combate o aleitamento materno. Parte de propaganda- todo o dinheiro que o governo americano gasta para educar a população em termos alimentícios é pífio.

Criação de estratégias do governo para combater o consumo- Coisa nova- necessidade criar esforços preventivos. É muito estimulado pela organização (OMS).
Dificuldades para lidar com a temática saúde e atividade física.

Doenças crônicas e questão ambiental- tudo isso no final resulta em redução do impacto ao meio ambiente. Contribuem também para a questão ambiental- melhoria para o ambiente. Tinha muito intercâmbio.

*Alimentos ultraprocessados
Chan- a modulação é feita no nível do país
Tem problemas que vão além da questão da saúde, são também sociais, econômicos…
No caso do Tabaco, substituição por alguma outra coisa que também dê lucros.
Melhoria no consumo do tabaco, em várias partes do mundo, como EUA, Europa, e América Latina.
Taxação de alimentos açucarados- os trabalhos ainda são muito inconclusivos.
Contaminação
A indústria vai se adaptar a tudo que gere lucro.

O problema em si não é que a indústria quer matar o consumidor, alguma coisa falhou nesse processo.

No caso do Brasil, podemos dizer que a FIOCRUZ tem sido um stakeholder relevante na transferência de políticas?

A FIOCRUZ está mais associada à iniciativas regionais.
Na parte de produção, produção de vacinas e medicamentos, febre amarela- FIOCRUZ trouxe uma contribuição muito grande como um todo.
90% de Pesquisa da FIOCRUZ está muito mais alinhada com as iniciativas globais, a OPAS até contribui com ideias.
O norte para a FIOCRUZ é HARVARD e outras instituições…
Na área de formação de recursos humanos a FIOCRUZ está muito mais voltada ao SUS- UNASUS. A Opas participa.

Carlos Morel e Paulo Buss- foram representantes do Brasil na OMS
O ministério é o que toma decisões- ideal é que sejam acadêmicos-
Paulo Buss foi um batalhador em prol da propriedade intelectual.
Quando a FIOCRUZ se envolveu com o Bias da Colômbia- José Serra

A representação da OMS- atual é a embaixadora
Centros colaboradores- uma vez por ano eles olham para fazer os relatórios técnicos-
FIOCRUZ- Anísia- visão um pouco diferente do engajamento internacional- criar uma comunidade e uma colaboração no âmbito internacional, grande colaboração na área de mortalidade materna-
Na parte de pesquisa tem uma parceria.

Paulo Buss- aprovaram um simpósio com a OPAS, vacina, mortalidade infantil e mortalidade materna.

Existem centros colaboradores, ou atores regionais que contribuem com esse processo de importação de normas, isto é, difusão de políticas globais?

Centros Colaboradores- foi muito produtivo no começo- posteriormente houve uma inflação dos centros colaboradores – CDC– EPA- Escola de proteção ao meio ambiente- (USP- classificação de doenças)…
Com a inflação dos centros colaboradores, chegavam pessoas com capacidades muito díspares e não conseguiam, de fato colaborar.
Reduziu de 4.000 (aproximadamente) para um número muito menor, com o objetivo de dar uma chance para novas capacidades e subiriam para o processo de cooperação.
Nunca houve um entendimento pleno dos centros colaboradores- a OMS deveria usar aquele centro colaborador e não usar aquele recurso.

Agente não vê um convívio tão intenso com os centros colaboradores- não funcionou muito bem.
É muito bem elaborado- tem toda regra bem estabelecida- se isso funciona ou não funciona é outra história- os mandatos são mandatos muito de governos-
A FIOCRUZ – automaticamente contribui com o SUS, não precisa ser considerada como um centro colaborador.
Para que os Centros funcionassem o ideal seria que existisse uma configuração mais colaborativa

Conselho diretivo da OPAS
De 2003 a 2011- Todos os anos tem um informe do tabaco.
Na OMS- Comitê Executivo- documentos relacionados ao tabaco
Às vezes não vai para o Conselho diretivo, mas para o Conselho Executivo com certeza estará.

Fundação Bloomberg- Projeto de Financiamento para o Tabaco (ganhou prêmio no Brasil)
Tobacco Free Kids

Informer 16

Eixo 1- The WHO/PAHO

About the institution and decision making process:

A como a OPAS é algo mais que uma representação da OMS.

Posição mais adiantada que a OMS, a OMS não está tão definida em algumas coisas.

Movidos mais separados, muitas vezes mais adelantes.

Categoria socioeconômica.

Quando eles atuam também atuam em nome da OMS

1- The structure of PAHO is the same of WHO? With 3 major decision- making bodies?
2- Conselho directivo, reuniões a cada 5 anos. Conferência Sanitaria Pan americana, elege-se o diretor da PAHO.

30 setembro, similar à Assembleia Geral OPAS- corpos diretivos

Diretor Regional- Assistant director, director de administração, departamento técnico, qual departamento está abaixo de quem. Estrutura de oficina.

PWR- Paho WHO Representative- oficina do Brasil é uma das maiores. Todo os países estão submetidos à Diretora Regional

- How is the relation of DG from WHO to DGs at PAHO? Sim, tem algo a ver. Fundo voluntário. Voluntary accessed contributions, contribuições que os países fazem à OMS. Aportam à OMS e à OPAS, alguns países aportam uma dupla contribuição. Porcentagem da contribuição
- Organismos do sistema interamericano
- This relation could affect the diffusion of policies to american member states?

About Brazil within the institution:

- In which period Brazil played a more active role within WHO or PAHO?
- País grande. E muito ativo. O país pode atuar de diferentes formas, grupos de trabalhos, dentro da mesa do Conselho Executivo. Está frequentemente dentro do Conselho Executivo. Eleições, cada país fica 3 anos. Os outros países geram
- Why do you consider the action different from other years, regular budget, policy transfer, policies?

- A contribuição do Brasil não é a maior, (EUA é a maior), mas faz uma contribuição relevante. Caso não paga perde os votos, a participação de alguma maneira. Nunca se atrasam muito

Eixo 2- A Transferência/diffusion

- What difficulties does Brasil usually have to translate norms and recommendations into national practices?
- Desafio maior foi a questão da indústria. Souza Cruz é muita ativa, Fillip Morris, 200.000 famílias de produtores. Indústria usa os produtores. O que o Brasil, produz de tabaco é maior portador de tabaco.
- Existência do Convênio Internacional legalmente vinculante, países foi um dos países impulsores. Possibilidade pressionar um pouco.
- Figuras dentro do governo que apoiaram a importância
- Sociedade Civil muito organizada em termos do tabacco
- Sistema da iniciativa Blumbler- usou fundos dessa instituição
- Why we can consider that Brazil have success in transfering tobacco policies? What factors and stakeholders were involved?
- Regarding the Tobacco policies there was any Person of the government at this time that encourage the movement of difusion or transfer?
- ACT Brasil – Aliança Contra o Tabaco- ONG paráguas- associadas a outras ONGs
- Framework convention Alliance- mobilizaram apoios internacionais
- Iniciativa Bloomberg significativa quantidade de dinheiro- pagaram muito dinheiro- governo queria financiar, e financiamento para sociedade civil
- What strategies and **stakeholders** were employed to achieve success in the policies towards Brazil and Americas and other American States?
- Dentro do governo- separar a existência da CONI- Comissão para implementação do Convênio Marco- grupos com ministérios- conferências das partes. Brasil tem os opositores. Secretaria de questões agrárias, geraram oposição em virtude do cultivo do tabacco. A indústria. Representante das indústrias. Como convertir todas estas famílias. Difícil tomarem conta até o momento.

"O Brasil conta com a Comissão Nacional para Implementação da Convenção-Quadro para o Controle do Tabaco (CONICQ) que é responsável por articular a implementação da agenda governamental para o cumprimento dos artigos do tratado. É presidida pelo Ministro de Estado da Saúde e composta por representantes de 18 Órgãos e Ministérios." <https://www.paho.org/bra/index.php?option=com_content&view=article&id=4779:convencao-quadro-para-o-controle-do-tabaco-da-oms-cqct-faz-10-anos-salvando-vidas&Itemid=839>

- In an opposite side, the policies addressed to ultra-processed food, as sugar reduction, for example- are not well succed in Brazil and other american countries. In your opinion, what could influence this process?

  Grandes desafios são as indústrias, álcool tabacco, indústria com muito poderio econômico. Bebidas alcoolólicas. Com a experiência que tem no tabacco, servirá de experiência para trabalhar nas outras pautas.

  Políticas para o Tabacco- proibiu-se a publicidade-

  Açúcar avisos nos alimentos- não se deveria

  Bebidas- não se deveria permitir a

  Sociedade civil tem trabalhado dentro desta pauta

  CLAS- Alimentação saudável- tem dado muito apoio político em temas de nutrição

  O que falta no caso do Brasil é um ator governamental- **que vá contra a indústria**. Quando muda o governo, os problemas mudam. Não existe uma pessoa de governo que dê a importância devida ao tema. ANVISA tem sofrido muito porque a indústria manda fotocópias.

  Há muitas lições em relação ao tabacco que podem ser aplicadas a outras políticas.

  Política fiscal

- We may say that Brazil has considerable involvement in developping medicaments and vaccines to treat infectious diseases, as HIV and tropical diseases. In this case, the transfer of recommendations to Brasil, could be easier than other policies?

Governing Bodies comprises the following: The Pan American Sanitary Conference, the Directing Council, and the Executive Committee. The auxiliary advisory body to the Executive Committee is the Subcommittee on Program, Budget, and Administration.
Questões importantes levantadas durante esta entrevista.

A informante esclareceu a diferença da PAHO de uma representação regional da OMS. No caso da PAHO existe uma dupla identidade, isto é, ela atende a questões da OMS e do sistema interamericano ligado à Organização dos Estados Americanos, tem desta forma uma dupla função. Em alguns assuntos a PAHO está mais a frente do que a OMS, podendo-se dizer que existe certo grau de independência entre a PAHO e a OMS.
Os países em geral enviam contribuições duplicadas, que servem para prover o grande sistema das Nações Unidas e o sistema interamericano. No entanto, nem sempre a PAHO recebe a dupla contribuição.
No que se relaciona ao tema do Tabacco, a informante compartilhou que este caso pode trazer muitas lições e ser visto como um caso emblemático, entendendo por que deu certo e de que maneira o país atou. Quando se observa o caso dos alimentos ultraprocessados, nota-se que existem stakeholders, como sociedade civil, e existe a batalha contra a indústria, no entanto, existe o desafio para combater a indústria, ou estabelecer um diálogo. Falta no governo uma pessoa ou um organismo voltado à coordenação de esforços nesta área, questão que existiu no caso do tabaco, mas que não se mostra evidente no caso dos alimentos ultraprocessados.

Informer 17

Anotações sobre a entrevista:

Coincidiu no contexto de o tema Doenças Crônicas ser muito forte. OMS- opas

2004 Estratégia

Plano de enfretamento do Tabacco, - tema prioritário- doenças crônicas

4x4 doenças cardiovasculares

Tabaco, álcool, inatividade física

4 fatores de risco

Mortalidade por doenças crônicas.

Plano Brasil se destacou muito- o Brasil teve muita visibilidade- gratuidade para os medicamentos de doenças crônicas.

Coordenou o plano de doenças crônicas no Brasil- implicava ações mais gerais

Prevenção da saúde

Violência

Coordenação de um fórum da ONU

Porta voz do Brasil em fóruns internacionais

Muito destaque em casos como o tabagismo

2015 – Brasil saiu na frente na avaliação

Horizonte temporal-

Tabaco – anterior ao governo Lula

2003- fórum da OMS de doenças crônicas

2004- aderiu ao programa de doenças crônicas

2005- liderança maior

2006- assinatura da Convenção Quadro-

2008-realizou de uma pesquisa relacionando questões da saúde e questões

Fundação Bloomberg – financiamento da pesquisa

2013- primeiro país que realizou uma pesquisa em tempo recorde

Lançamento do Mpower

Legislação para fumar em ambientes abertos- importante declínio da prevalência do tabaco.

2011- aprovada a lei de ambiente livres do tobaco. Comissão interministerial para o tabaco Coniqc, aumento de preços do tabaco, questão do contrabando. Reduzir Diversificação de cultura- criado -no governo Lula- Reforma agrária,.

Tabaco era produzida por pequenos produtores.

Primeiro maior exportador, segundo maior produtor- o ministério da agricultura

Ministro Humberto Costa

Ministro Padilha 2004

Ministro Padilha 2014 (ambientes livres de tabaco)

Regulamentação- trabalho bem articulado

Aumento do imposto- articulação do Ministério da Saúde com o ministério da Fazenda.

VIGITEL

Muitas ações- Brasil completamente alinhado com as normativas internacionais

Bianualmente tinha um encontro

Vera Lúcia Costa e Silva – indicada para o Alto Comissariado da FCTC

Ministério das Relações Exteriores tinha uma sintonia e articulação

A questão da alimentação é bem mais complexa

Em 2006- mostram a associação causal entre tabaco e câncer que causavam doenças cardiovasculares. Começou a ser associado como algo que causa prejuízos à saúde.

Medidas regulatórias- o tabaco deixa de ser desejado.

Cerveja 4%- não é proibida

Alimentos- presença mais forte da indústria-

Ultra-processados – preferir sempre alimentos in natura- ou prepara-se em casa- ou minimamente ultraprocessados. Alimentos naturais

Ultra-processados- várias farinhas q vão gerar alimentos gordurosos. – É diferente do tabaco,

Associação do tabaco e câncer é muito mais longa, é da década de 1950.

Indústria alimentícia é muito mais poderosa que a indústria o tobacco.

Sociedade capitalista, mundo real falta de tempo para preparo dos alimentos. Substitui o preparo pelo alimento congelado.

Aleitamento- pediatras começaram a ser os principais

Medidas regulatórias

Medida do governo Bolsonaro de reduzir os preços de refrigerantes

Proibir

Subsídio para agricultura familiar-

Aleitamento materno

Cantina saudável

Acordo voluntário com ABIA – Associação Brasileira de Indústria Alimentícia

Recomendações –

Tendência de tabaco

Monitoramento do plano de doenças crônicas

Balanço de promoção da saúde

Stakeholders- Patrícia Jaime- profa da USP- coordenação de alimentação e nutrição

Carlos Augusto Moreira-

Quem acompanhou bastante

Juliana Valini- OPAS

Tabaco

Tânia Cavalcante- servidora do INCA

Ana Cláudia- ANVISA-

4 andar 402

Sociedade civil- ACT- **Paula Johns**

Aliança de Controle do Tabaco

Plano consenso- 20 ministérios vários atores

Várias ações não são da área da Saúde. MRE.

Participação da sociedade civil- entidades médicas- sobretudo para construção de evidências

Informer 18

O tabagismo continua sendo um problema mundial de saúde pública 6 milhões de mortes anuais causada pelo tabaco. O Brasil é um país que engrossa essas estatísticas, porque o Brasil ainda tem um elevado número de fumantes, em que pese a proporção de fumantes esteja caindo. O Brasil tem se destacado no mundo pelas suas políticas, mas é preciso notar que a indústria tem aumentado sua atuação e tem tentado influenciar essas políticas. Então você vê que recentemente o Senador José Serra submeteu ao senado brasileiro um projeto de lei que foi devidamente congelado para novas verificações por conta do lobby da indústria dos cigarros no Senado Brasileiro. Com isso o Brasil perde a população e perdemos nossas crianças e adolescentes sendo cooptadas pela indústria a fumar cigarros que têm aditivos cuja proibição é diretamente pendurada no judiciário, que ainda tem nos pacotes de cigarros brasileiros uma propaganda subliminar, aquilo é um outdoor ambulante que o projeto de lei transforma em maços padronizados. Fora isso o projeto coloca a proibição de fumar em carros onde existam crianças e proíbe a apresentação dos maços nos pontos de venda que a indústria tem usado sobejamente como forma de fazer publicidade nos pontos de venda que está proibida. Então a gente vê que a indústria ela é extremamente ativa e utiliza os plantadores de fumo como massa de manobra e é precisa ser segura de alguma maneira.

Nesse sentido eu acho que o Brasil é um país de ponta porque tem uma agência reguladora que pode e tem o mandato de segurar a indústria. E tem iniciativas como essa que tem o suporte do Secretariado internacional do tratado internacional do tabaco que é a iniciativa de se criar um observatório das estratégias da indústria do tabaco que vai servir de subsídio para as políticas públicas do governo brasileiro e também vai servir numa plataforma internacional para subsídio das partes do tratado para se fazer uma política internacional para aumentar a ofensiva contra a indústria do tabaco. Esse observatório é o primeiro de uma linha de observatórios que é modelado pelo Tobacco Tactics que é um observatório da Universidade de Bath na Inglaterra. E, ele faz parte de um projeto nos países BRICS, ou seja, Brasil, Rússia, Índia, China e África do Sul, de estabelecimento desses observatórios para monitorar a indústria. Esse projeto foi aprovado no encontro de Ministros de Saúde do Brics e saiu como uma recomendação e a Union a União Internacional contra a Tuberculose e doenças pulmonares está envolvida e apoiando a realização disso em nível dos países.

A ideia é que se tenha uma plataforma de integração e que todos os observatórios que não sejam formulados em língua inglesa que eles tenham ao menos os grandes títulos e as grandes informações passadas para o inglês para que a gente possa ter um cenário internacional. O mesmo vai acontecer com o da Rússia e com o da China. Uma fonte de informação internacional que é como a indústria trabalha. A indústria junta todas as informações de todas as suas subsidiárias de todos os países do mundo e formula políticas supranacionais para aumentar seu faturamento e seu lucro e evitar regulação dos países.

Informer 19

Eu diria que a gente tem uma missão no curto, médio e no longo prazo. Então no curto prazo a gente está reunindo documentos, fotos, filmes, livros, teses de mestrado e doutorado, teses dissertações, artigos científicos e artigos de jornal também como um grande repositório. Então todas essas informações estão sendo triadas, organizadas e colocadas dentro do observatório para que qualquer pessoa da sociedade civil, para que qualquer pessoa interessada possa ter acesso e conhecer um pouco mais como a indústria do tabaco vem agindo para tentar comprometer a saúde pública e as políticas de controle do tabaco.

No médio prazo, eu acho que a gente pode citar como prioridade que os alunos, principalmente os alunos interessados na área de saúde pública eles possam ter acesso a essas informações e organizar essas informações de modo a fazerem mais estudos mais estudos, discutir como essas estratégias têm atrapalhado especificamente algum tema, como por exemplo, publicidade como ela atrapalha nos pontos de venda, como a indústria atua por exemplo na indústria legislativa, impedindo o andamento de alguns projetos de lei no Senado no Congresso. Outro exemplo interessante é como a indústria vem agindo junto aos agricultores usando esse grupo de trabalhadores como massa de manobra para defender seus próprios interesses.

E no longo prazo, eu acho que o que seria mais interessante seria solidificar nossa política. A gente considera que, a partir da ratificação feita pelo Brasil em 2005 para a Convenção Quadro do Controle do Tabaco, a gente tem uma obrigação legal de cumprir os artigos. E o artigo 5.3 faz exatamente esta menção, que é proteger as políticas públicas da interferência do tabaco. Então eu acho que quando a gente olha num horizonte mais longínquo a gente vai olhar e ver que o Brasil está cumprindo integralmente as propostas do tratado.

Informer 20

A missão do CETAB de certa forma é desde sua criação em 2012 é de se criar desenvolver projetos de ensino desenvolvimento e cooperação técnica visando o controle de fatores de risco de doenças crônicas em especial o tabagismo. No Brasil quem tem a responsabilidade de cumprir a agenda política de controle do tabaco é a Comissão Nacional de Implementação da Convenção Quadro do Controle do Tabaco que tem no assento de vários ministérios. Então a nossa função enquanto CETAB/FIOCRUZ é de estabelecer, gerar informação e conhecimento que possa subsidiar a política. O CETAB, hoje então, ao criar o observatório, ele realmente é uma iniciativa pioneira até mundialmente, porque existe um exemplo atualmente na Inglaterra o qual está sendo a nossa referência que é o *Tobacco Tactics*, mas aqui no Brasil, havia uma necessidade a entendimento da CONIQ de se criar, como diz a Vera, um sentinela dessas estratégias, de modo assim isento de certa forma. Não isento, a gente não pode ser isento, a gente claramente tem que enfrentar, tem que subsidiar a política à enfrentar a indústria do tabaco. Então a ideia é fazer este enfrentamento de forma subsidiada, tendo documentos que nos permitam alimentar a CONIQ daquilo que ela precisa e a política, e o Brasil e os acadêmicos das informações que eles precisam para enfrentamento dessas estratégias que a indústria utiliza para minar as políticas de controle do tabaco. Nós do CETAB fomos criados na FIOCRUZ para exatamente alimentar, estimular ascender essa discussão dentro da instituição como um todo e eu acho que isso está começando a se consolidar ainda melhor com o Observatório, porque o Observatório é uma ferramenta que deve estar dentro de uma instituição de ensino como é feito em outros lugares do mundo exatamente para dar maior credibilidade ao observatório. Então eu vejo o Observatório como uma iniciativa que realmente não só para o CETAB, mas para a FIOCRUZ como um todo coloca a FIOCRUZ como protagonista de uma das questões principais na política de controle do tabaco que é o Artigo 5.3.

A.3 DOCUMENTAL ANALYSIS

Date	Documentary source	Document title
1985	A38/Technical Discussions 4	Collaborating with Non Governmental Organizations in Implementing the Global Strategy for Health for all
1997	WHA 530.1 97 CH C.2	Changes and Reform of the WHO
2001	Discussion Paper Nº 1 CSI/2001/DPI	Strategic Alliances The role of civil society in health
2010	A63/25	Stregthening the capacity of governments to constructively engage the private sector in providing essential health cares
2011	EBSS/2/INF. DOC./4	WHO reform
2011	EBSS/2/2	WHO reforms for a healthy future
2013	EB 132/5 Add 2	Key issues for the development of a policy on engagement with nongovernmental organizations
2013	EB 133/16	WHO Governance Reform
2013	EB 132/5	WHO's role in Global Health Governance
2014	EB 134/5	WHO Reform: reform implementation plan and report
2014	EB 136/7	WHO Reform: overview of reform implementation
2015	A 68/5	Framework of Engagement with non-State actors
2016	A69/6	Framework of Engagement with non-State actors
2016	A69/60	Framework of Engagement with non-State actors
2016	WHA 69.10	Framework of Engagement with non State actors
2017	A70/73	Engagement with non-State actors