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The dialog between health and foreign policy in Brazilian cooperation in human milk banks

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Abstract *Mother's milk is the primary source of nourishment in early infancy. When this source is unavailable, secondary sources may be used, such as human milk banks. The first milk bank in Brazil was created in 1943, and they have been used ever since. A national model was developed through a number of phases, culminating in the Brazilian Network of Human Milk Banks. This gave rise to a number of international cooperation projects, with the Brazilian model particularly relevant for developing nations. The main objective of this analysis is to understand what drives Brazil to promote milk banks internationally. To do this we tried to understand the relationship between health and foreign policy, expressed here as soft power, as here the two areas dialog with one another. The results include gains in both areas and the affirmation of health as a central goal of the national interest cluster of the case.*

Key words *Human milk banks, Health Diplomacy, South-South cooperation, Brazilian foreign policy, Global health*

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Introduction

Breast feeding is a socially conditioned practice that benefits the health of the nursing baby. It is an important tool to reduce infant mortality[1]. Initiatives such as milk banks emerge to provide breast milk where the mother is not a viable source. With this in mind, Brazil created one of the most complex and efficient milk bank networks in the world. It is a national tool to address the challenges of infant health. Given the success and the nature of the Brazilian model, it has been exported to numerous other nations, especially those in development. Brazilian activities in health diplomacy over this period correspond to moments of intersectorality, especially between the Ministry of Health and the Ministry of Foreign Affairs.

International activities started during the government of Fernando Henrique Cardoso (1995-2002), and continued in the two subsequent governments of Luiz Inácio Lula da Silva (2003-2010) and Dilma Rousseff (2011-2016). Given the data and literature available, this article covers the period from when Cardoso took office in 1995, to the end of Rousseff's first government in 2014. The main objective of this analysis is to understand what drives Brazil to promote milk banks on an international basis. Our hypothesis is that this is linked to objectives in both health and foreign policy, expressed as soft power, as both areas are involved in the activity.

This contribution on international cooperation in health is part of the strategy and experience for regulating healthcare. Specifically, it addresses emerging international standards and institutions in the area of human milk banks. In this area, Brazil has been essential to configure models in developing nations. This a joint search for development by ensuring infant health in global Southern States low levels of inequality in this area. This article is split into three sections. The first is an introduction to the theoretical framework consisting of Nye soft power[2,3] as a foreign policy tool and its possible relationship with global health. The next section describes the context of the Brazilian milk bank model. The third section interprets Brazil's strategy and results in light of what was presented in the first two sections.

Health and Soft Power: a two-way dialog

Nowadays soft power is an important power resource. As such, it can be used to achieve numerous ends, including in health sector. Thus, an expose of the debate between health and foreign policy is a marker the nature of Brazilian cooperation projects in the area of human milk banks/

Nye[2] coined the term soft power in the post-cold war scenario. He found that the set of factors that shape international power had changed, changing the nature of the relationship between nations. The definition of power had shifted from stressing military actions and territorial conquest - traditional elements of the cold war -, making the use of force less cost effective. On the other hand, areas such as healthcare, technology and education were becoming increasingly important. Issues such as globalization and more intense human interactions led to increased interconnection in space, time and cognitive. This also impacted and reconfigured the nature of power. Thus, there are new problems that require collective solutions, broadening the topics related to foreign policy[2-4]. The rise in number of agents that bring to the international scene objectives other than those of the state also contribute to this scenario. Consequently, other tools such as organization, communication and institutional skills have become important, as has manipulating interdependence (understood as a way to obtain benefits based on the new processes connecting the players). Consequently, power has become diffuse[2]. Thus, core nations, while still controlling hard power resources (traditional military and economic power resources), are now less able to control certain sectors in the international scenario[3].

Thus, soft power has become more important in current times. This process is the result of influence and legitimation of cultural values and ideologies regarding international rules and institutions, and not by coercion, which would be the case of hard power. Although both are important, and together make up what is known as smart-power[3], the power of making your ideas legitimately accepted internationally and then using them to reinforce your position and influence the international scenario is increasingly important. In this way, other nations will be more likely to work with this new, already legitimized practice. Thus, a player may export its values and make its desires more accepted internationally, mitigating or minimizing objections[2].

In the case of health and healthcare, the nature soft power is perceptible from touch-points which what was observed by Nye[2,3]. As shown in the literature, global health includes a wide range of influential players (state and non-state

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actors and different types of international organizations), and procedures that restructured the mechanisms of interaction, making current relationships more complex[4-7]. Furthermore, a range of new states are gaining prominence, in particular among developing nations such as Brazil, China, India and Mexico, among others. Rapid economic growth change international positioning, making these countries more active in global matters[5].

The literature on global health includes a debate on the relationship between health and healthcare, and player search for soft power. While one perspective asserts that health is being used as a means to achieve greater foreign policy goals unrelated to health, another seeks to evaluate the attainment of health objectives through foreign policy. There is also a third current that tries to go beyond this normative debate on the relationship between soft power and health and states that regardless of the relationship, the health area should attempt to maximize the benefits of this relationship[4].

Fidler[6] is a reference representative of the first position. The author claims that health has long been used to achieve advantages in other areas of foreign policy, even though it is only recently that it has become the object of studies. The main mechanism for this would be bilateral cooperation. Aid would be provided with a double purpose - to address the health or sanitation issue that is of mutual concern, and develop closer ties for a relative increase in power. Fidler[6] is skeptical, concluding that this practice would not result in any significant gains in the political area, and it is unclear if even the gains in health and healthcare would be an meaningful. Therefore, using health diplomacy as soft power following WWII would not provide significant gains in terms of global health[6].

The authors that defend the second outlook, represented here by Kickbusch & Berger[7] and Kickbusch & Buss[5], find that matters of health have gained importance in the agenda, given things such as globalization. Because of this, health and healthcare require intersectoral and collective effort. This creates tension and weakens the traditional interests of nations (specifically trade and security), since the complex nature of 21st Century diplomacy brought in new players, questions, functions and values, transforming health into a diplomatic goal and creating more solidarity. Furthermore, unlike the previous vision, these authors found an increase in multipolarity[7]. The dynamic of this process enables increased integration of health into the foreign policy agenda.

The third and last approach analyzes how health-related negotiations and agreements can benefit from the skills and experience of diplomats. This would be useful since the health sector is viewed as unprepared to deal with other areas. There is an understanding that foreign policy can benefit from health and vice versa, depending on the extent to which the two areas seek out understanding and cooperation[4].

In short, when we compare the first two outlooks we see different assessments as to when (past or current) and how (bilateral or multilateral) the relationship between power and health takes place, in addition to numerous diagnostics that range from the skeptical to the enthusiastic. The third view, although complementing the previous two, adds an important dimension that goes beyond the discussion of foreign-policy and health, enabling the two sectors to meet. While accepting the dialog between the two areas, it focuses less on discussing what the goals might be, and how there might be mutual benefit. It agrees with Nye's[3] understanding that the outcome is more important than the resources. In other words, strategies (understood in the soft and hard power resources) and contexts would be the means, and should be borne in mind by those making the decisions, but in actual fact the end result is more important. We must understand the strategies deployed for this, but also know how to distinguish them from the outcomes. That being the case, a soft power strategy (mean) could deliver positive results in the health dimension (end) and others sectors as well.

Added to this is the fact that players do not necessarily have a single interest or a single strategy for each action. There are national interest clusters[8] that define the decisions made. Each cluster may have its own priority goals (trade, security, education, health, etc.), and others that are tools for achieving the former[8]. Thus, the goals are not static, but vary depending on the case.

Having said this, one thing the literature agrees on is that developing nations such as Brazil are emerging as important plyers in matters related to health. Brazil has taken on a greater importance in the post-Cold War international arena, especially since the government of Fernando Henrique Cardoso, a trend confirmed in subsequent governments.

Cardoso tried to change the foreign policy agenda, replacing it with a new rationale where a proactive international agenda predominat-

ed, shaped by the new world trends, the goal of which was to expand the power and control over its destiny[9]. This would allow Brazil to insert itself in the international arena without submitting; retain its friendly posture *vis-à-vis* developed countries, but meet its own needs and specificities; and influence the global agenda based on its own perspective. It was felt that Brazil's interests were linked to international interests, and taking an international posture would be a way to legitimize and achieve specific Brazilian interests. As a result, global trends would converge and adhere to the regimes, without any subordinate position[9]. In short, Cardoso acted within the existing system to maintain the country's achievements, aware of its power limitations.

When Lula took office in 2003, the emphasis of certain areas of Brazil's foreign policy started to shift, with changes and adjustments compared to the previous period. Starting then, Brazil started to use a rationale that focused on partnership with nations of the south, and agreements with non-traditional partners to reduce the asymmetry to developed nations and increase its bargaining power. Some of these actions take place as a group, such as joint initiatives between Brazil and neighboring nations or developing nations in general, in a more horizontal position with its partners[10].

During the Rousseff government, even though goals such as autonomy and development remained, the country's posture was less propositive, and its foreign policy more contained and discreet. It is understood that there are factors of continuity such as the non-existence of new bureaucratic demands and the lack of domestic restructuring, whereas changes are basically related to the different presidential profiles and external disruptions (such as the Arab Spring)[11].

In general, it is clear that during the Cardoso and Lula governments there were attempts to actively insert the country in the global order, albeit using different methods and approaches. During the Rousseff government, foreign policy took a more back-burner position, although it continued to follow the paradigms set in the previous government. Furthermore, it is worth pointing out that in geographic terms, Fernando Henrique focused on Europe, while in subsequent periods greater emphasis was placed on the African continent. All three presidents converged when it came to South America however, as it was a priority for all three[12].

Regarding Brazilian diplomacy and health, the Federal Constitution of 1988 is at the core. A decentralized view of public health was created based on this constitution, ensuring full, universal and equal access to healthcare for all Brazilian citizens. Using these credentials the country may take new positions in the international level[13]. One strong feature of the Brazilian position is the involvement of several government agencies cooperating with the Ministry of Foreign Affairs (MFA), reinforcing the horizontalization of foreign policy[14].

This gives rise to the concept of structuring South-South cooperation in health. Especially starting in 2000, Brazil's international project in the area of health is marked by the South-South characteristic. In other words, the interactions happened with more symmetry across agents, with no conditions or any passive technology transfer, which are some of the traditional pillars of North-South cooperation[15]. The goal is to create the ability to move forward with healthcare systems with autonomy, with the necessary leadership and knowledge generation. Brazil is trying to act as an enabler of these capabilities by helping develop processes in this area, both in terms of physical structure as well as in the field of human development.

A known example of Brazil's international activity is the case of anti-retroviral drugs to treat HIV/AIDS. In this case, domestic and international policies were consistent, searching for universal access to the drugs. From the start, Brazil has had to face the task of achieving international recognition. When dealing with this problem and to address the issue domestically, the government sought the support from nations in a similar situation such as India, Thailand and South Africa and NGOs. It also focused on making civil society aware of the issue[16-18]. Not only did Brazil succeed in this regard (resulting in both soft and hard power, the latter in the economic field[16]), this contributed to strengthening the country's position in international discussions involving trade, intellectual property, healthcare and human rights, in a spillover effect.

This example is important as it illustrates a possible relationship between soft power and health, and the importance of the latter in Brazil's foreign policy agenda. Based on the above it is clear that one of the reasons explaining the progress this country made on this is the credibility it acquired through soft power[17]. This conclusion is manifest as it was possible to mobilize even civil society in countries contrary to Brazil's position. In this case, it is fair to say that health was of the elements that was part of the national interest

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cluster. At the same time, the nation gained respect and recognition as growing global leader[18]. Thus, progress was made in terms of power and the health agenda. Foreign policy and health mutually benefitted from the relationship.

It is clear that there are different ways to assess the dialog between foreign policy and health. Among the possibilities, an important analysis tool is the study of how this relationship takes place, and how each sector can benefit in specific cases. The next section describes the context of milk banks in Brazil, and the model that is the basis for cooperation projects.

Breastfeeding and milk banks: the Brazilian model

Human milk is known for its important in infant development, and is the main method of breastfeeding. If the mother is not available as a source, other sources must be found, such as milk banks, first created in Vienna in 1900[1]. The influence of breast milk on survival, growth and development is well known. The most conventional indications for prescribing milk banks are nutritional (premature babies, among others), therapeutic (such as in the case of infectious diseases), and preventive (allergies to the proteins in cow's milk for example)[19].

Other markers that favor the promotion of human milk banks may be seen in the Millennium Development Goals (MDG). Eight MDGs were defined in 2000 with a target horizon of 2015. One of them explicitly aimed to reduce infant mortality, focusing on reducing death among children under five by two thirds. Milk banks may be an effective measure in this regard, and Brazil has achieved this target[20]. The World Bank's agrees by estimating that investing in infant health initiatives has returns of around seven times the amount invested by reducing the costs of social security and increased economic productivity[21].

There is margin to attempt solutions for structural problems linked to infant health by implementing milk banks. It is often the case that among the lower income populations, especially those in developing nations in Africa, Asia and in some cases Latin America, the decision is made not to breastfeed newborns, but rather use processed alternatives. This decision is not only harmful because of the favorable effects of breastfeeding, but also the infants become more vulnerable having not received the benefits of mother's milk, adding to the already precarious situation in these countries. Malnutrition and infection are related, and breastfeeding is even more necessary among this population to revert infant morbidity and mortality[21.]

In recent years, different models for milk banks have been created, the main ones are the Brazilian and the Anglo-Saxon models[22]. The Brazilian model goes from the national to the local, including staff training, certificate registration and state and national centers of reference, all features of decentralization. One of the main goals is to develop technology, cheap methods and equipment for donors to produce breast milk that is safe and high quality[21]. In 2001, the Brazilian initiative received the Sasakawa Health award as the best public health project. Unlike the Anglo-Saxon model, the Brazilian model is simple, efficient and economically feasible in developing nations[21,22]. It is the ideal model for the low-income nations mentioned above.

Regarding Brazil's history of breastfeeding and milk banks, we find differences in their social importance, depending on the moment in time. The trajectory of milk banks in the country can be split into three paradigmatic periods, the last of which is particularly important for this effort.

The first period is what we call consolidation, starting in 1943, when the first milk bank was created in Brazil. At the time, questionable strategies were used to increase the volume of milk collected, including a commercial buy and sell relationship. Furthermore, milk banks at the time were viewed as an option for situations where processed milk was not possible. This phase lasted until 1985, when the second expanded mode of action first started. New activities were added, such as promotion, support and protection for breastfeeding, breaching with the previous standards. Among other reasons, this was enabled by specific federal legislation, social mobilization and efforts in search of better milk banks, made possible by the recently created PNIAM, the national program to encourage breast feeding[23,24]. Evidence that 85% of the deaths due to malnutrition in weaned infants were linked to the use of processed milk also encouraged this new phase[21].

The last step is marked by the model of a national network, growing in a decentralized way and focused on developing technical knowledge at the city and state level. During this period, the Brazilian Network of Human Milk Banks (Rede-BLH) was created, under the aegis of the Oswaldo Cruz Foundation (Fiocruz) and the Ministry of Health. The main goals are to reduce infant mortality and improve the indicators of breast-

feeding in the country, using the dissemination of knowledge and information as tools. Furthermore, this new model enabled the expansion of RedeBLH beyond the nation's borders. Thus, Brazil has consolidated its position as a reference on the theme, especially due to its promotion of technological research and development[24,25]. By 2014 there were 214 milk banks in operation, plus 125 collection centers[21]. Its importance to international cooperation was a determining factor to increase the space and respect of this project within the government, increasing funding and attention[21]. In all periods the Fernandes Figueira Institute (FFI), part of Fiocruz[24], played a leadership role.

Currently, milk banks are seen as an important tool for infant feeding where the mother is not a potential source. Here Brazil has become a reference, especially for developing nations. In the following sections we draw a critical balance of Brazil's international activities, based on what we have said in this document so far.

Brazilian cooperation in human milk banks

Looking at soft power as a foreign policy tool, and the context in which milk bank cooperation projects take place, we will now start our analysis of Brazil's activities. In this section, we try to understand how it happens and how it relates to previous sections.

As stated, the second period of Brazilian milk banks in Brazil started in the 1980s, a period that coincides with the nation's return to democracy and tools such as the 1988 constitution, bringing new identity to health and healthcare in Brazil. This is when cooperation in milk banks first started. The creation of RedeBLH in 1998 solidified and encouraged international cooperation. In international activities related to milk bank projects, Fiocruz is normally in charge. It provides support such as technology transfer to create or restructure this area in the receiving nation, with technical instructions related to physical infrastructure and human resource training, as well as the transfer of Brazilian technology for collecting and storing human milk. It is an important link between Brazil and the partner nation. Another player with wide-ranging action is the Brazilian Cooperation Agency (BCA), part of the MFA, which provides financial support[21]. This intersectorality demonstrates the horizontalization of foreign policy which we referred to above[14]. Due to these characteristics, the Brazilian model is the one used in cooperation projects, with the adjustments required by the partner country.

Working under the principles created in 1988, and with the international credibility conferred by other health programs (such as HIV/AIDS), Brazil embarked on a path of cooperation in human milk banks. This took place through bilateral, trilateral (primarily with international organizations such as the Pan American Health Organization) and multilateral projects. Milk banks are quite important to the Ministry of Health, accounting for 37% of the projects in 2010[26]. Brazil started its international cooperation in Latin America, in 1996, with a technical cooperation project between the Ministry of Health and Fiocruz in Brazil, and the government of Venezuela. This project resulted in the foundation of two milk banks in that country using the Brazilian model. Other initiatives were also made, such as the Ibero-American Program of Human Milk Banks (IberBLH). This program, approved in 2007, seeks the exchange of knowledge and technology to reduce infant mortality.

Regarding the Community of Portuguese Speaking Countries (CPLP), these agreements are signed within the Strategic Cooperation in Health Program, whose strategy is to build networks with structuring institutions and train human resources in healthcare, which is unlike the traditional approach of vertical projects and programs. The Program to Implement Human Milk Banks in the CPLP was proposed by Brazil, and should have worked according to this model[27]. However, due to problems resulting from the specificities of each country, the project did not continue within the multilateral plan. Nevertheless, it was approved and started, and continued separately (bi or trilaterally) in each country of the group, adapted to its own needs[28].

It is worth pointing out other events of the multilateral trajectory, which started in 2000, with the 1st International Milk Bank Congress held in Natal. Delegates from several countries participated in what turned out to be an intense exchange of experiences. The Brasilia Letter came out in 2005, issued during the 2nd International Milk Bank Congress, which took place together with the 1st Latin American Forum on Human Milk Banks. Countries within and outside the region participated, as well as a few international organizations. This was the start of the Latin-American Network of Human Milk Banks. In 2010, new events ratified the Brasília Letter[21]. These projects followed the Brazilian model, and the concept of structuring South-South cooperation in health[15]. The search is to transform the

existing structures to deliver long-term benefits and project continuity, even after a possible end of the cooperation term and the exit of the Brazilian government and its institutions. In addition to clear Brazilian leadership, a desire to meet the MDG, especially reducing infant mortality (where Brazil is an example) is normally present as well.

These projects started during the Cardoso government. As mentioned, this is the period in which the county became more proactive, with South America being one of the priority regions. This is when the first milk bank projects were created in the region, as shown in Chart 1. Regional congresses also took place in this period. Chart 1 shows that almost all other initial contacts happened during the Lula government (many in 2007, when IberBLH was created), the last one being an exception. Going back to what we said in the first section, this is evidence of the importance assigned to links with Southern nations. Another important point is the inclusion of African nations, confirming the foreign policy trend for the period. In the following period, the Rousseff government kept the previous agreement and furthered others. Here there is a clear continuity between the Rousseff and previous governments, especially the Lula government, as no relevant changes have been found.

Chart 1. Partner nations and initial contact.

Partner country	Year of the initial official agreement to implement a milk bank
Venezuela	1996
Uruguay	2003
Ecuador	2004
Argentina	2006
Cuba	2006
Belize	2007
Bolivia	2007
Colombia	2007
Costa Rica	2007
Spain	2007
Honduras	2007
Mexico	2007
Nicaragua	2007
Panama	2007
Paraguay	2007
Dominican Republic	2007
Cape Verde	2008
Guatemala	2008
Haiti	2009
Mozambique	2009
Peru	2009
Portugal	2009
El Salvador	2010
Angola	2011

Source: prepared by the authors based on RedeBLH/Fiocruz data[25].

Thus, what you see is a convergence of the foreign policy priorities linked to domestic policies that will result in milk bank initiatives. Through technical cooperation in health the country exports a public policy, in addition to its technology, which delivers internal results and attracts developing countries due to the effectiveness and low cost of its solutions. At the same time that cooperation contributes to health goals, it also brings an increase of power. Regarding the former, this is seen in the consolidation of domestic policies, the exchange of knowledge (even if still asymmetrical), stronger institutions, and expanded intersectoral dialog, among others. Regarding the latter, as the supplier of technology to develop or adapt structures in the receiving nation, it uses an approach that is unlike the traditional North-South approach, capturing soft power and increasing nation's prestige, the credibility and leadership ability. This *modus operandi* demonstrates that the governments in this period understood the situation was favorable for soft power measures. In short, by helping partner countries implement these projects, Brazil exports its model and legitimizes its practices, creating new rules and institutions ruled by these values, and enhances dialog and makes room for intersectoral cooperation.

Its activities in milk banks gave the nation credibility and legitimacy in the theme, consolidating its policies in an external environment bereft of hegemonic models. This is reflected in the attraction of CPLP members and other countries in Latin America. The country operates under the third outlook of dialog between foreign policy and health, which we described in the first section. Intersectorality allows health players to benefit from the skills of the Ministry of Foreign Affairs diplomats. This decentralization can be also reflected in the goals sought by the national interest cluster, given that its priority targets include progress in both of the matters in question. Each player may be involved in projects and negotiations seeking its own goals, in an interaction

that does not overlap one area onto the other. As consequence, there were advances in the constitution and in consolidating and strengthening the milk bank network (RedeBLH), which gained in institutionalization, making progress in the area of proprietary technology and delivering the main gains in the area of health. Regarding soft power, this addition is seen as the export of Brazilian culture and ideology in matters of health, cultivating a good relationship with partners that could result in advantages in other areas, such as the support of Latin American and African nations when making demands to international organizations. Thanks to this prestige, RedeBLH is free of major external pressure to possibly switch to another model (such as the Anglo-Saxon model), which is particularly important in a sector where power is so diffuse, such as the case of global health. In this case, health was one of the purposes linked to the national interest cluster in question, and enabled progress in other areas of foreign policy, creating a possible spillover effect. Confirming our hypothesis, the dialog between the two areas benefited both.

In short, clearly the Brazilian government worked in a manner consistent with the principles of redemocratization and south-south cooperation. This enabled simultaneous gains in health and foreign policy. The domestic context of a successful model and the international context of the diffusion of power in soft areas enabled Brazil to executing these strategies.

Final Considerations

Based on the above, one can understand how Brazilian international projects for milk banks took place. This was done in the context of the global and national environments for milk banks, a dialog between foreign policy and global health, and an analysis of Brazil's situation as a sponsor of such initiatives. We started out by showing the importance of human milk bank policies in global and national terms. The Brazilian model has mechanisms that make it very efficient, with low-cost technology. Consequently, it is the ideal model for developing nations.

We realized that dialog between foreign policy and soft power in health is possible. When it comes to intersectoral activities, both spheres may arrive at satisfactory results. Thus, health goals may be part of a country's national interest cluster in any specific moment in time. Furthermore, this paper makes clear the role of developing nations in global health, an area where power is largely diffuse. Finally, Brazil seems to have realized the diffusion of power in global health, and the post-cold war tendency towards the increased importance of soft power. Consequently, activities in this area are an example of success in obtaining this type of power, while improving and consolidating the nation's domestic positions and policies at the global level. Consolidation is important in an area where power is so diffuse, as there is no hegemony capable of imposing a single model. Thus, considering these policies as significant for achieving global goals such as the MDG, gives the nation autonomy for implementing its own policies (i.e. it is free of external interference), and demonstrates its ability to lead and generate prestige.

The limitation of this study lies in the fact that that is a panoramic and introductory overview of Brazilian cooperation in milk banks. It is a systematic compilation of data and a theoretical analysis of this data. Future studies may contribute with primary data or analyzing the situation of one specific case of cooperation in human milk banks.

Collaborations

TM Pittas and CF Dri were equally involved in all steps of preparing this article.

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