

Essay

Profile of the Brazilian projects for technical cooperation on Aids in the world: a look into potential study hypotheses*

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Abstract

A few decades ago Brazil became involved in technical discussions about the global response to the Aids epidemics, and assumed an important role for its cooperation and as global public opinion maker on the subject. Despite this characteristic, the predominant profile of these projects remains unknown and unexplored, making it difficult to analyze this potential correlation. This gap will be bridged by means of a study on Brazil's international technical cooperation projects on Aids between 2002 and 2009, using the database of the International Cooperation Advisory of the Department of STD, Aids and Viral Hepatitis of the Brazilian Ministry of Health. The technique used to analyze these data was content analysis, in order to identify the predominant profile of the cooperation, and to propose hypotheses that will provide guidelines for future research. The study presented the distribution of Brazil's cooperation projects on Aids in the world, and the content analysis made it possible to devise two hypotheses: within the given period, Brazil's cooperation attempted to strengthen the responses of other countries to the HIV/Aids epidemic, and to project Brazilian policies for fighting the disease at a global level. These observations, on the other hand, point toward the need for and pertinence of new studies supported by the hypothesis of a strong alignment between the technical characteristic of these projects and the national external policy, the diplomacy of the Brazilian health, and the strengthening of global governance on Aids.

Keywords

international cooperation; South-South cooperation; health sector; HIV/Aids; Brazil

Since the middle of the 2000's the international technical cooperation Brazil offers to the Southern countries started to be seen as a part of the strategic agenda of the country at a global level. In 2006 Celso Amorim, former Minister of Foreign Affairs stated – for the first time in Brazilian history - that *cooperation is a fundamental tool for Brazil's external policy [...] and extremely relevant for Brazil's relationship*

with other countries, especially those in the developing world (AMORIM, 2006, p.16).

The Aids issue is given a key role in Brazil's international technical cooperation. In a recent publication, the Ministry of Foreign Affairs (Ministério das Relações Exteriores-MRE; BRASIL, MRE, 2007) focused on the technical cooperation developed by the partnership between the MRE and the

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Ministry of Health, highlighting the contribution of policies for the strengthening of the Unified Health System (Sistema Único de Saúde-SUS) and the National STD/Aids Program in the role played by Brazil at an international level. Indeed, HIV/Aids is not only one amongst the nine aspects of collaboration Brazil focuses mostly on in the health area, it is also intrinsically related to other three (the Unified Health System – SUS, Epidemiological Surveillance and Pharmaceuticals, and Immunobiologicals).¹

Such importance is due to a series of conjunctural factors, both domestic and international, which contributed to an increasing number of requests for Brazil's participation in international technical discussions about the global response to the Aids epidemic, and to its assuming a key position not only for its important collaborations, but also as a global opinion maker. Therefore, since the end of the 1990's Brazil has been treading an important path as a country that has strong influence on the international system concerning this subject, and also as a country that cooperates for the strengthening of the response to the world HIV/Aids epidemic, especially in the cooperation with countries in the South, and attempting to meet growing international demands by means of its international technical cooperation.

However, if on the one hand one can see a significant increase in the number of international initiatives in terms of technical cooperation on Aids between Brazil and the Southern countries, on the other hand the predominant profile of such initiatives remain unexplored. In other words, how to define Brazil's international technical cooperation on Aids at a global level? How many and what types of projects have been accomplished, and with what approach or purpose? To which extent does Brazil's international technical cooperation abroad reflect, on the one hand, its international health policy, more specifically its Aids policy and, on the other hand, its role as a global player in this subject within the international system?

This essay intends to contribute to the analysis of these aspects, and to the consolidation of hypotheses that may provide guidelines for future research based on the study of project collaborations and regional initiatives between Brazil and developing countries in the response to the HIV/Aids epidemic in the 2002 - 2009 period. The survey was done with the International Cooperation Advisory of the Department of STD, AIDS and Viral Hepatitis of the Ministry of Health (which incorporated the former National Program for Sexually Transmissible Diseases and aids – PN DST/Aids) between July – October, 2009. Year 2002 was chosen as it

was the year when the International Cooperation Program for the Control and Prevention of HIV in Developing Countries (PCI) started. Year 2009, when the survey was carried out, was considered the closing year for the study, even though several of the projects analyzed are still being executed.

The essay is based on the principle that Brazil's international technical cooperation in the Aids area in the world reflects technical and political guidelines. Technical guidelines can be defined as those that have been globally disseminated by the UNAIDS (United National Aids Program)², such as Universal Access and the "Three Ones" initiative.

- a) Universal Access: response strategy to the epidemic that started being disseminated in mid 2005 by the UNAIDS, when the ARV treatment coverage in countries such as Argentina, Brazil, Chile and Cuba surpassed 80%. The scenario at that moment was that in countries with low and medium application rates, over one million individuals were living longer and with better quality as a result of the treatment. UNAIDS, therefore, started to disseminate the information that universal access to treatment was avoiding a global average of 250000 medical leaves of professionals with HIV from their jobs.
- b) Three Ones: policy based on the idea that the countries should maintain domestic responses based on (1) A standardized initiative against HIV/Aids that will serve as the base for the coordination of the work of all associates; (2) A unified national authority for the coordination of HIV/Aids, with a broad multisectoral mandate; (3) An agreed-upon system for the Monitoring and Assessment of HIV/Aids at a national level.

Political guidelines, on the other hand, are considered as a series of strategic instructions either explicit or implicit in the national DST/Aids policy, in the national foreign policy, in health diplomacy, and in global health governance. The national foreign policy can be understood as

(...) the entirety of actions and decisions by a certain actor, usually, albeit not necessarily the State, with regards to other States or foreign actors - such as international organizations, multinational corporations or transnational actors - formulated as a result of opportunities and demands domestic and/or international in nature. In this sense, it is the combination of interests and ideas of the representatives of a State about its insertion in

the international system as it is, or towards its restructuring, outlined by its power resources (PINHEIRO, 2004, p. 7).

Health diplomacy can be understood as the entirety of strategic guidelines of Brazil's global cooperation in the health sector, defined as a result of the interaction and interrelation between health management technicians and Brazilian diplomats. According to Novotny and Adams, health diplomacy is

(...) a political change activity, with the dual purpose of improving global health while it maintains and strengthens international relations abroad, especially in areas of conflict and in locations with scarce resources (NOVOTNY & ADAMS, 2007, p. 1).

Lastly, global health governance can be defined as

(...) the entirety of collective agreements to deal with international and transnational dependence aspects (MAYNTZ, 2005; BARTSCH & KOHLMORGEN, 2005). This encompasses political efforts by all types of collective actors that attempt to solve specific problems in order to shape a specific sector of global policy, taking into consideration the power relations within the sphere of global political systems (HEIN, 2008, p. 5).

This essay, therefore, is an opportunity to make progress in the discussion about the Brazilian international technical cooperation for the Aids issue in terms of its foreign policy, its health diplomacy, and its global health governance. It should also be understood that the role played by Brazil as an international actor in the response against the epidemic is being gradually solidified, as a consequence of the combination between elements of the domestic policy of the Ministry of Health, and the MRE foreign policy, associated by means of an international technical cooperation strategy of the national STD/Aids program of the Ministry of Health.

The essay is divided into four segments. The first section introduces the construction of the Brazilian national policy for Aids and the emergence of the country as a global player to fight against Aids at the beginning of the 21st century. The second section presents the methodology used in the study. The third section presents results from the data collected from the Ministry of Health on the Brazilian international technical cooperation to fight against Aids between 2002 and 2009. Lastly, the fourth section presents the conclusions

of the essay.

The construction of the national Aids policy and the emergence of Brazil as a global player to fight against Aids at the beginning of the 21st century

The first records of Aids cases in Brazil occurred between 1982 and 1983, and the number kept growing as the country strived to return to democracy, as it was experiencing the fifth government under the Military Dictatorship and the society showed clear signs that it was restructuring itself politically³ (PARKER, 1994, p. 38; LIMA, 2002, p. 7). The sanitary movement was gaining momentum at that time as, in addition to professionals from the health area, it also gathered representatives from various organizations from the civil society, political parties opposed to the regime, and social movements that spoke on behalf of groups considered to be "oppressed" in the Brazilian society, all of which were united in the search for a new perspective for the Brazilian health system. Chequer (2007) and several other authors (SCOREL, 1998; PÊGO & ALMEIDA, 2002; ALMEIDA, 2005) considered that, in addition to defending overlapping interests, these groups had in common the fight for democracy and for a perspective of "broadened citizenship", which included the right to health as a fundamental human right.

In 1986 a National Aids Program was established by the new National Division for the Control of Sexually Transmissible Diseases (STD) and Aids⁴ in the Ministry of Health. In the following year a Ministerial Ordinance provided for mandatory notification of Aids cases, which enabled the national epidemic to be monitored (BRAZIL, 1987, p. 3, PARKER, 1994, p. 41, LIMA, 2002, p.7).

Still in 1986, in the transition to democracy, the 8th National Conference on Health ratified the ideas and the motto of the movement for sanitary reform – health is a citizens' right, and an obligation of the state - which became part of the new Brazilian Constitution, enacted in 1988, which established the SUS, simultaneously with Brazil's full return to democracy. According to Almeida (2001), the Brazilian Constitution approved a *welfare state similar to that of Europe*, where social benefits would extend to all Brazilian citizens, regardless of their contribution. According to the new Constitution, each citizen was entitled to universal access to any health serviced financed by public resources. To this end, the sources of federal resources allocated to health, welfare

and social assistance were unified and broadened.

The process of decentralizing the SUS was regulated by the Ministry of Health in the 1990's, and supported the incorporation of new actors in the decision-making arena of the health sector. This occurred by means of the Basic Operating Norms (NOB), which, according to Almeida (2001, p. 48) became a supporting pillar for the SUS.

Indeed, the NOB were institutionalized to define the allocation of resources in the process of decentralization, but they were also deeply inducing (...) of the specific institutionalization of the decision-making arena of the sector and of the interrelations among government levels (ALMEIDA, 2001, p. 48).

With regards to decentralization, the Norms brought about changes for the decision making process in the health sector at various government levels. Based on these changes, the national, State and Municipal Health Councils had to include representatives of the civil society, which resulted in a more inclusive decision making process.

The inclusion of Non-Governmental Organizations (NGO) in the fight against the Aids epidemic in Brazil represents an important stage of the Brazilian response (GALVÃO, 1997a; 2000; 2002; PARKER, 2003), as the release of diagnostic tests and the emergence of the idea of the 'HIV-positive' individual brought to surface the sheer burden of discrimination against those infected with the disease, which in turn would raise the voice of the discriminated groups and encourage them to fight for greater social visibility and demand a response from sanitary authorities. After the 1990's this dynamics would coalesce those social groups organized in civil society and give them national and international recognition.

It was the beginning of an initiative that would make a difference in terms of the national response to the Aids epidemic, as the Brazilian State started to formally acknowledge the voice of those actors of the civil society, in a moment when classic management problems and the limitations of the public resources of the countries, especially the poorest or developing countries, hindered initiatives for the creation and operation of government programs against the epidemic. While many governments simply postponed the recognition of Aids as a serious public health problem, the first speech of the then President of the Republic of Brazil on December 1, 1991 – the world Aids day – was proof of the importance that the Brazilian

government started to place on the epidemic as of the beginning of the 1990's (MANN et al., 1993, p.6; LIMA, 2002, p.7, CHEQUER, 2007, p.3).

Therefore, as Almeida summarizes (2005, p. 5-6), *the 'Brazilian response' to the HIV/Aids epidemic (the 'Brazilian model') was built on fundamental principles, created whether as a result of the mobilization of civil society, or of the implementation of governmental programs (...) revolving basically around the interrelation between human rights and citizenship, in a solidary perspective. (...) Solidarity was the fundamental concept used to transform the predominant discourse of stigma, prejudice and exclusion of individuals with HIV/Aids into a radically different discourse, based on inclusion, which enabled the interaction between prevention, assistance and guarantee of citizenship rights (GALVÃO, 1997; 1997A; TEIXEIRA, 1997; DANIEL & PARKER, 1991, 1993; PARKER, 2003; PAIVA, 2003, apud ALMEIDA, 2005).*

At the beginning of the 21st century, Brazil showed some signs of being a pioneer⁵ in terms of its choice of a domestic response to Aids, in a moment when, at the international level, moving beyond traditional public health methods was being considered in order to contain the epidemic. This was happening not only due to its involving and challenging social and health systems of the countries, but also because the world would later define the global epidemic as a threat to peace and international stability (MANN et al. 1993, p.1; VIEIRA, 2007, p.137). According to Vieira, there was a gradual trend by the international community to move the HIV/Aids subject from the traditional sphere of common public health issues towards other approaches that involved international security. To him, this shift was

(...) part of a progressive historical transition that began before HIV/Aids was first said to be connected to security, in the middle of the 1990's. This historical movement towards the securitization of HIV/Aids can be generically identified by some milestones in the history of global response (VIEIRA, 2007, p. 153).

As examples of this process the author also mentions the creation of the World Health Organization (WHO) *Global Program on HIV/Aids*, in the middle of the 1980's, when the epidemic grew in some African countries, followed by the creation of the UNAIDS, which somewhat evidenced the failure of the biomedical approach employed during

the first years of the epidemic, and finally, the formalization of the 'HIV/Aids-international security' interrelation during the meeting of the UN Security Council, in 2000, which ended up in the UNGASS Commitment Declaration (Special Session of the United Nations General Meeting)⁶, a year later.

On the other hand, in November 1995 the GCTH (Group for Horizontal Technical Cooperation) was created. Its representatives are the National Coordinators of STD/Aids of 21 countries in the Latin America and Caribbean region. Upon its creation, the GCTH signed a document that, among other things, detected the need to establish relationships of direct cooperation on the HIV/Aids subject between the countries. With that initiative, the Brazilian Aids Program created its Foreign Cooperation Unit or Advisory, which was then named Coopex.

It was in that scenario that the first Brazilian initiatives for international technical cooperation emerged, as a response to the Aids epidemic. Later, with the creation and formalization of the PCI (International Cooperation Program for the Control and Prevention of HIV in Developing Countries) in 2002, Coopex took the responsibility for the execution of those cooperation projects.

When the PCI was created, the Brazilian policy for the fight against STD/Aids had made significant progress, and the shape and structure of the Brazilian National Program started to revolve around the premise that preventing Aids and providing assistance to HIV/Aids patients could not be dissociated. Moreover, synergistically and making use of the capacity and legislation of the SUS, the Ministry of Health also started to invest in a universal treatment policy, with free provision of antiretroviral drugs – ARV – to the entire population⁷.

PCI, therefore, has disseminated this type of response to the epidemic, initiating an international selection process capable of assisting ten countries. The first countries benefitting from ARV treatment were: El Salvador, Bolivia, Paraguay, Dominican Republic and Colombia, in Latin America; and Burkina Faso, Mozambique, St. Thomas and Prince, and Cape Verde, in Africa⁸.

For the execution of the program, it was necessary for the Brazilian government to establish important partnerships, both domestically and internationally, such as the work developed along with the UNICEF (United Nations Children's Funds). The creation of the International Center for Technical Cooperation against HIV/Aids (CICT) has also

contributed to the determinant success of the program, by means of technical, financial, and administrative support.

CICT is a joint initiative of the Brazilian government and UNAIDS for the strengthening of national responses by means of international technical cooperation initiatives against HIV/Aids. The CICT was established in 2005, and its mission is to facilitate and promote South-South horizontal technical cooperation programs and activities, with the purpose of locally strengthening and enhancing sustainable responses against HIV/Aids. To this end, the Center set forth five strategic goals: a) to identify and elaborate projects and/or programs for horizontal technical cooperation against HIV/Aids in order to meet the needs and priorities of developing countries; b) to develop, monitor, build capacities and promote partnerships within a network of governmental and non-governmental organizations, so that they can develop a high-quality work in projects of technical cooperation against HIV/Aids; c) to implement technical cooperation projects that allow for the construction of sustainable and lasting capabilities, to provide more effective responses to the epidemic in developing countries; d) to disseminate experiences, lessons and achievements, with the purpose of sharing good practices, identifying lessons learned and promoting more specialized activities in terms of technical cooperation among developing countries; and e) to identify and raise financial, technical and human resources so as to strengthen the capacity of the Center to manage technical cooperation projects (CICT, 2008, p.6). As a result of the creation and solidification of the CICT, all activities of cooperation against HIV/Aids performed by Brazil started to be coordinated by that Center, whose headquarters are located in the National Department of STD, AIDS and Viral Hepatitis.

Therefore, it is clear that the PCI, Brazil's first initiative in technical cooperation against Aids, was implemented in a moment when the paradigm of securitization of the epidemic was strong, and at that same moment the international ARV market, with the substantially lower prices offered by generic drugs, shed light on the discussion on public health and aspects that involve the right to treatment of diseased individuals in developing countries.

It can be inferred that the growing demand for cooperation coordinated by the CICT with countries is different areas of response to the epidemic, at the beginning of the 21st century, has been gradually consolidating a path under construction since the end of the 1990's or, in other words,

the international recognition of the Brazilian Aids program. According to Chequer (2007, p. 6) the most prominent feature for the international community was the capacity of Brazil's national program to integrate prevention and assistance⁹, and to incorporate the perspective of civil rights to the prevention, in addition to universality, an indissociable aspect of the SUS. Thus, if on the one hand the success of the national response was a consequence of the legal principles of SUS itself, on the other it also represented the dynamic evolution of a society's response to the challenges posed by the epidemic, giving rise to Brazil's potential capacity to share its experience, especially with developing countries within the sphere of south-south relations.

In the face of what has been exposed, and also due to its strong leadership in the GCTH, Brazil was at the center of a process of intense exchange among the countries of the region, since its initiatives promoted and enhanced bilateral and multilateral cooperation initiatives (BRAZIL, 2008). This allowed Brazil to enter the international

scenario with significant strength, making it an important global player in several circumstances of the international discussion on the epidemics, and attempting to guarantee the adoption of some decisions on behalf of global public health. The publication below presents some of these major international decisions with the participation of Brazil (Box).

The Box shows that the background of Brazil's strives in the different multilateral forums on Aids is the Universal Access of the society to prevention, assistance and treatment, a human right, a strategy being disseminated by the UNAIDS since 2005:

The goal needs to be to ensure that all countries do their very best to guarantee universal access to prevention, treatment, care, and the decrease of the impact (...) [goals that] have to be pursued simultaneously, not consecutively, or separately from one another. Countries must focus on the execution of programs, including the strengthening of human

Box - International decisions on the Aids subject with the participation of Brazil

1. Approval of Resolution 33/2001 in the 57th Session of the United Nations Commission on Human Rights, which established that access to antiretroviral drugs is a basic human right.
2. Approval of Brazil's proposal, presented during the World Health Assembly in May, 2001, which highlights the importance of the growing availability of drugs accessible to those affected by the disease.
3. Approval of the Declaration of Commitment on HIV/AIDS in the United Nations General Assembly on HIV/AIDS, which acknowledged the need to adopt a comprehensive approach between prevention, treatment and protection of the human rights as the only way to effectively contain the dissemination of the epidemic.
4. Brazil's direct involvement in the Global Fund for the Fight Against Aids, TB and Malaria, fighting for an egalitarian participation between the wealthy and developing countries in its main decision-making agency, the Directive Board. The Fund also publically acknowledged that it will allocate financial resources to support projects involving the distribution of antiretrovirals, which will represent yet another important achievement for developing countries. The Global Fund recently approved its first round of 58 proposals, of which 5 came from countries from Latin America and the Caribbean, which jointly represent US\$ 616 million.
5. Approval of a Brazilian proposal in the World Trade Organization that defines that nothing in the TRIPS Agreement (Agreement on Trade-Related Aspects of Intellectual Property Rights) can stop countries from adopting measures to protect public health.
6. Intense mobilization of Brazil's technical structure to give support to several delegations / missions that look for assistance in terms of treatment and care.

Source: Brazil (2002, p.8).

resources and the application of strategies that allow for the highest possible level of service integration (UNAIDS, 2005, p. 5),

Hence the need to better understand the aspects of the relationship between Brazil and the UNAIDS, and to which extent an actor supports and legitimizes the other in the South-South technical cooperation to come to a response to the Aids epidemic. According to Vieira (2007), Unaid is one of the normative leaders in HIV/Aids, employing mechanisms and an institutional apparatus for the dissemination of norms. As an example, it suffices to remember the prologue written by then Executive Director Peter Piot for the UNAIDS Report on the Global Aids Epidemic in 2004¹⁰, where he positively states that, as the 2004 report indicates, UNAIDS knows what works as in terms of a response to the Aids epidemic.

Therefore, it can be inferred that the Brazilian cooperation has been working not only as an instrument for the legitimization of policies and opinions supported by the UNAIDS, but also it has been contributing to their elaboration by means of the success of its national response.

The national response to the control of the epidemic in Brazil, in line with the demands of civil society, as well as a national monitoring and assessment plan, have also been fostered by the UNAIDS since the release of the Unaid worldwide campaign for the "Three Ones", where it adds: *the reasons on which the "Three Ones" are based are to ensure a harmonized, coordinated response to the Aids epidemic, and above all one that is directed by and adopted as belonging to the country* (UNAIDS, 2005, p.2)¹¹. In other words, national strategic plans built and executed by a national agency that is a forum for the discussion and resolution among the different sectors of the society (government, civil society, private sector) and with transparent mechanisms for monitoring the response that allow for an assessment of the latter. Everything that Brazil has been proving to be a successful response.

Based on the assessment by Buss et al. (2010, mimeo), one can also perceive that the universal access policy emerged in Brazil before it did within Unaid itself. They go as far as stating that Brazil's perception, which was legitimized in the national constitution of 1988, on health as being a human right and an obligation of the State, and the guarantee of equitable health services care, is what supports the foreign health policy and consequently makes Brazil advance in the field of health diplomacy, where technical

cooperation acts as an instrument.

About the universal access to treatment the actors add that: *For the Ministry of Health, associating access to medication and human rights was a consequence of the discourse that defined health as everyone's right and an obligation of the State* (p. 6). This, added to the

(...) request made to the American Government by an entity representing the Pharmaceutical Industry to include Brazil in the 'watch list' of the American trade law, and later on, rumors that the United States would open a 'panel' against Brazil in the WTO, led the Brazilian Ministry of Health to broaden its international activities concerning the policy of cooperation in the Aids area (BUSS et al., 2010, mimeo, p. 5).

Therefore, it is clear that Brazil's response to Aids can be understood as an important segment of the National health diplomacy, and that the main instrument of this activity is the international technical cooperation for the enhancement of responses to the epidemic in the countries, based on universal coverage and health systems with participation, social control, and intersectoral plans and actions. Hence the pioneer experience in terms of incorporation of the civil society in the elaboration of policies against Aids is at the core of Brazil's international technical cooperation process in the area.

According to Vieira (2007), the transnational activists of HIV/Aids are also important tools for the dissemination of norms. They have been increasing their area of activity especially since the mid 1990's. If they previously were mainly based on symbolic categories, such as: development, humanitarian causes and human right, they gradually started to consolidate their speech around the concept of security as inherent to that of HIV/Aids. Still according to Vieira:

(...) [They are] also important actors in promoting the implementation of norms at the state level. By means of their participation in National HIV/Aids counsels, as well as of their connections with civil society groups organized at the community level, the transnational advocacy networks become involved in practices of discussion with local actors. It is in their participation in these social instances that they ultimately attempt to align national behaviors and policies with the international prescriptions.

Therefore, from the creation and consolidation of the

National STD/Aids program it can be seen that as Brazil improved its capacity to respond at the national level and consolidated its role as a pioneer in the elaboration of policies for intersectoral response with an intense participation of the civil society, it also became stronger in terms of international cooperation, and gradually started to respond to a growing international demand of countries and international agencies that intended to learn about and understand the specificities of its apparent success. Additionally, the country has been performing a strong political and articulating role at the south-south level by means of the GCTH, ACI (International Cooperation Advisory of the STD/Aids and Viral Hepatitis Department) and CICT, and contributing to the worldwide dissemination of Brazil's response to the global governance of the Aids issue.

Methodology

This study is exploratory in nature and has a historic and social approach as described by Polit and Hungler (2000): approaches that take into consideration the *systematic data collection and a critical assessment of past phenomena that have the purpose of answering questions about related causes, effects or tendencies, and that allow for the establishment of behaviors, habits or situations of the present* (p.239-40)¹².

Twenty-nine projects were used as primary sources, as well as three regional initiatives that were distributed in a table depending on the cooperation target-country, year of start and finalization of the proposal and theme areas for its execution. Additionally, some documents related to international agreements and official publications by the Brazilian government on international cooperation in Aids have also been investigated.

Based on these data, it was possible to identify aspects of the Brazilian international cooperation in Aids, and later these aspects were addressed through the Content Analysis Method. Despite having been initially described in the middle of the 20th century, this method was chosen because it is still broadly employed when the researcher has the intention of quantifying the narrative-qualitative material.

According to Berelson (1971, p.18) the Content Analysis is an investigation technique for the objective, systematic and quantitative description of the contents of an official communication, and is quite objective according to rules explicitly stated that work as investigation protocols. In such a way that, even if they are applied by two different

researchers, the same results will be obtained. According to Polit and Hungler (2000) this analysis is systematized by the *inclusion or exclusion of material according to coherently applied selection criteria* (p.204).

After the initiatives and their corresponding countries have been identified, the Bardin Content Analysis method (1977) was applied for the quantification of qualitative data to explore the profile of the Brazilian international technical cooperation against Aids. A description of the steps used for the management of the data of this study, according to the criteria of this method, has been included below:

- a) reading the goals of regional projects/initiatives and selecting the registration units – To Bardin (1977, p. 199), registration units are text units selected by the researcher based on the goals of the study, where they can be words or sentences that will divide the content into meaningful groups;
- b) categorizing the registration units in Exploratory Categories, according to their similarities – Bardin calls this the codification stage. For this study, the categorization was based on criteria set forth by the UnAids for a country's response to the Aids epidemic;
- c) establishing the Analysis Units (Analysis Categories), based on a new classification of the exploratory categories – It is through these analysis categories that the study proposes hypotheses that may provide guidelines for future research on the subject.

The profile of the Brazilian international technical cooperation on Aids from 2002 to 2009: an initial and preliminary approach of the analyzed data

According to the primary sources of this study there were initially a total of 29 projects, which does not correspond to the total amount of 39 target-countries in the cooperation. This occurs because after the advent of CICT as execution coordinator in 2004, and after several technical and financial support partners joined, several projects started to simultaneously assist more than one country. In the case of the PCI, it should be noted that in 2004 it started to be coordinated by the CICT and to be called the "South-South Link Project", maintaining the donation of medications and taking the cooperation aspects beyond the qualifications in clinical management and involving different areas of response to the epidemic. Some countries received this cooperation only as the South-South Links, whereas others

had both types of initiative, which makes PCI a long-term project, counted only once per country.

In addition to the PCI, other projects were also counted only once, in spite of encompassing more than one country. Here is a list of such projects: "Harmonization of policies for sexual education, HIV/Aids prevention, and drugs in the school environment", with the support of GTZ, UNAIDS, UNESCO, UNFPA, DFID (Argentina, Chile, Paraguay, Peru, and Uruguay); "Strengthening programs for the STD/HIV/Aids prevention, surveillance, full assistance and human rights in cities within the MERCOSUR", supported by GTZ (Venezuela, Colombia, Peru, Bolivia, Argentina, Paraguay, and Uruguay), and "Responding to the vulnerabilities of Street-Dwelling Youth: the South-South cooperation as an axis of integration", supported by the Netherlands Embassy and by UNICEF (Colombia, Peru, and Bolivia).

With regards to the strategy for the donation of medications, in 2009 CICT coordinated the distribution to the following countries within the South-South Links Project: Bolivia, Burkina Faso, Cape Verde, Guinea-Bissau, Nicaragua, Paraguay, St. Thomas and Prince, and East Timor. It should be noted that Colombia, Mozambique and the Dominican Republic, which were part of the PCI, did not remain in the second stage.

It has been seen that, in geopolitical terms, the countries that received international technical cooperation in HIV/Aids (either finished or still in execution) by means of cooperation projects are located in Africa (Botswana, Burkina-Faso, Cape Verde, Ghana, Guinea-Bissau, Mozambique, Kenya, St. Thomas and Prince, Tanzania, and Zambia), Central America (Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama, and Dominican Republic), South America (Argentina, Bolivia, Chile, Colombia, Ecuador, Paraguay, Peru, Suriname, Uruguay, and Venezuela) and in Asia (East Timor).

In addition to these bilateral projects, there are also records of technical cooperation projects of Brazil with Caricom (Caribbean Community) and three other regional initiatives: one based on a decision made within the sphere of UNGASS, focusing on monitoring social and reproductive rights encompassed in the national plans for the fight against Aids in the subscribing¹³ countries, and another one within the sphere of the Latin American Network of Pastorals of Aids¹⁴, and yet another within the sphere of the Committee for the Control and Prevention of HIV/Aids of the Armed and Police Forces of Latin America and the Caribbean (Coproces)¹⁵.

Among African countries, Mozambique was the one that hosted the highest amount of initiatives: a total of five, followed by Burkina Faso with two initiatives, and all other listed countries with one initiative each. In South America, Paraguay and Peru stand out with five initiatives each, followed by Bolivia, and Colombia, with four initiatives each, Uruguay, with three initiatives, Argentina and Ecuador, with two initiatives each, and the remaining countries with one initiative. In Central America, El Salvador and the Dominican Republic stood out with three initiatives each, Guatemala and Nicaragua with two initiatives each, and the other countries with a single initiative.

In order to proceed with Bardin's (1977) content analysis, out of the projects identified 27 subjects related to Brazil's activities of cooperation in Aids were identified. Then, the subjects related to Brazil's activities of cooperation in Aids were considered to be record units, and assorted in an analysis board with capital letters (Table 1).

The next step consisted in sorting the 27 record units into exploratory categories. 11 categories were created (Table 2).

Table 2 above draws attention to the fact that the ARV donation, which was the pioneering strategy for the Brazilian international cooperation in HIV/Aids, corresponds to only 2.3% of the subjects of cooperation between 2002 and 2009. This reminds us of the need to run a deeper investigation on the trajectory and aspects intrinsic to this cooperation, whether they are involved partners and countries, and/or other correlated variables.

The previous steps led to the identification, at this point of the research, that one option for sorting exploratory categories could be having two large groups, which Bardin calls analytical categories: (1) strengthening the responses of countries to the HIV/Aids epidemic; and (2) strengthening Brazil's insertion and consolidation into the global health scenario. The first analytical category was given this name because it groups subjects of cooperation with the potential capacity to influence on the systematization or formulation of national HIV/Aids policies in partner countries, directly influencing their health systems. It accounts for 78% of the record units found in Brazil's cooperation projects.

The second analytical category – strengthening Brazil's insertion and consolidation into the global health scenario – presents those exploratory categories that were left out of the first category due to their not having direct incidence in the technical strengthening of the response to the epidemic in the target-country, but due to their regional

Table 1 - Distribution of record units according to subjects related to Brazil's international technical cooperation in HIV/Aids, 2002-2009

Record unit	Subjects of Brazil's Cooperation in the analyzed projects, in alphabetical order	Amount of record units found on the subject in regional projects and initiatives	
		N	%
A	Public Policies	31	7,07
B	Human Rights	27	6,16
C	Promotion	39	10
D	Prevention	39	10
E	Protection	38	8,6
F	ARV Donation	10	2,3
G	Diagnosis	36	8,2
H	Assistance	36	8,2
I	Treatment	36	8,2
J	Epidemiological Surveillance	21	4,8
K	Harmonization and Intersectorality	15	3,42
L	Institutional Development	15	3,42
M	Monitoring and Evaluation	19	4,3
N	Social Mobilization	6	1,3
O	Education	4	1
P	Drugs	4	1
Q	Bordering Cities	7	1,6
R	Mercosur	7	1,6
S	Management	4	1
T	Social Communication	1	0,2
U	The Military	1	0,2
V	UNGASS	1	0,2
X	Logistics	16	3,6
Z	Network Strengthening	13	3
Y	Support to the global fund	9	2,0
A1	Social vulnerability	2	0,5
A2	Pastorals	1	0,2
TOTAL		438	100

Source: Advisory on International Cooperation of the Brazilian STD/Aids Program, Ministry of Health.

Table 2 - Division of the record units of Table 2 into exploratory categories according to Bardin (1977)

EXPLORATORY CATEGORIES	SUBJECTS of Cooperation sorted by Exploratory Category	Record Unit	Amount of Record Units found on Exploratory Categories	
			N	%
Management	Institutional Development Management Logistics	L	35	8
		S		
		X		
Monitoring and Evaluation	Monitoring and Evaluation UNGASS	M V	20	4,5
Epidemiological Surveillance	Epidemiological Surveillance	J	21	4,8
Universal Access	Promotion Prevention Protection Diagnosis Assistance Treatment Social Communication	C	225	51,3
		D		
		E		
		G		
		H		
		I		
Strengthening Civil Society	Social Mobilization	N	6	1,3
Borders Policy	Bordering Cities	Q	7	1,6
Strengthening Health Systems	Public Policies Human Rights Social vulnerability	A	60	13,7
		B		
		A1		
Strengthening Cooperation Networks	Strengthening Networks Mercosur	Z R	20	4,5
Intersectorality	Education Drugs	O P	25	5,8
		K		
ARV Donation – Clinical Management	Harmonization and Intersectorality The Military Pastorals ARV Donation	U	10	2,3
		A2		
		F		
Support to the Global Fund	Support to the Global Fund	Y	9	2,0
TOTAL			438	100

Source: Elaborated by the authors.

Table 3 - Establishing analysis units based on exploratory categories according to Bardin (1977)

Grouping Possibilities of Analytical Categories	Exploratory Categories grouped by Analytical Category	Record Unit	Amount of Record Units four on the Analytical Category	
			N	%
Strengthening the responses of countries to the HIV/Aids epidemic	Universal Access	C,D,E,G,H,I,T	342	78
	Strengthening Civil Society	N		
	Strengthening Health Systems	A,B,A1		
	Management	L,S,X		
	Monitoring and Evaluation	M		
	Epidemiological Surveillance	J		
	ARV Donation - Clinical Management	F		
	Intersectorality	O,P,K,U,A2		
Strengthening Brazil's insertion and consolidation in the global health scenario	Aids Policy for the Borders	Q	96	21,8
	Strengthening Cooperation Networks	Z,R		
	Support to Countries' Application for the Global Fund	Y		
TOTAL			438	100

Source: Elaborated by the authors.

characteristic, they may contribute to Brazil's consolidation in the global scenario (Table 3). It received this name because supposedly it encompassed subjects that, after the HIV/Aids program, directly influence the health systems and services in the countries, and strengthen Brazil's bilateral and multilateral relations in the global scenario.

Table 3 demonstrates that the exploratory categories that comprise the "Strengthening countries' responses to the HIV/Aids epidemic" analytical category are basically the items that the national DST/Aids policy of Brazil recognizes as being ideal for a consistent response to the epidemic. These categories clearly include the universal access as well as UNAIDS' three-ones policy, and intersectorality, which is peculiar to the Brazilian response.

As for "Strengthening the insertion and consolidation of Brazil in the Global Health Scenario" three of Brazil's major

efforts are very clear: strengthening the response to HIV/Aids on the borders, strengthening cooperation networks, and supporting countries applying for the Global Fund. This suggests the need for deeper research on the correlation between these strategies, in the light of the concepts of global health governance or, more specifically, South-South governance in health.

Conclusion

The study presented in this essay points toward the need to continue the research after the guiding hypothesis that the content of Brazil's international technical cooperation in Aids between the southern countries denotes a technical and political alignment profile reflected in the search for the strengthening the countries' responses to the HIV/Aids

epidemic and in the strengthening of Brazil's insertion and consolidation in the global health scenario.

As the study pointed out, these are only two out of several possibilities to group analytical categories. However, they point toward the need and the importance of continuing with the research to validate or refute these categories, in search of a deeper understanding of the profile of Brazil's international technical cooperation in Aids, and its relationship with foreign policy aspects, Brazilian health diplomacy, and global health governance.

Notes

1. According to the Ministry of Foreign Affairs (2007, p. 04) the main areas where cooperation is offered are: Malaria, HIV/Aids, the Unified Health System, Nutrition, Human Milk Banks, Environmental Surveillance in the Health Sector, Epidemiological Surveillance and Immunobiological Medicines.

2. The UN Joint Program on HIV/Aids – Unaid was created in 1996, as a result of a concern with the advances of the global epidemics, when the health sector was already showing signs that alone it did not have all the means to control the dynamics of the epidemic. The UN System then noticed that it would be necessary to create a theme area on Aids within the UN that could contribute with all the specific works of the agencies in a joint plan, free from effort duplicity and supporting the responses of countries in the social and human rights areas that fell outside the scope of the health sector. Thus, Unaid is co-sponsored by ten agencies of the United Nations System, which are: UNHCR (United Nations High Commissioner for Refugees), Unicef (The United Nations Children's Fund), the WFP (World Food Program), UNDP (United Nations Development Program), UNFPA (United Nations Population Fund), UNODC (United Nations Office for Drugs and Crime), ILO (International Labor Organization), Unesco (United Nations Educational, Scientific and Cultural Organization), WHO (World Health Organization), The World Bank. Data taken from the UNAIDS website, available at <http://www.unaids.org/en/default.asp> (Accessed on 03/19/09).

3. Since the beginning of the 1980's, the military regime gradually reduced its control over political processes, and the civil society organizations slowly started to occupy more positions in the political debate. (PARKER, 1994, p.38)

4. After the Aids epidemic, the STD recovered importance as a public health problem (BRAZIL, 1999, p. 05)

5. In 2002 some indicators showed the comprehensiveness of the success of the national response towards reverting the scenario that had been built over the course of two decades. This was becoming possible "as it gradually became possible to join prevention and assistance to the civil society and the State in a single purpose." (BRAZIL, 2002, p. 6-7).

6. According to Vieira (2007, p. 156) "The UNGASS Declaration of Commitment of June 2001 is also an important guideline for both state-owned and non-state-owned actors. He describes the sheer size of the

epidemics, its effects, and ways to fight against it (...) it establishes the main normative ideas that will justify the action of the state".

7. The Ministry of Health, supported by the approval on that same year of the legislation that granted access to medications, despite the recommendations and warnings of the World Bank, adopted a drug distribution policy through the SUS to all those infected by the disease. According to Chequer, overtime "this strategy proved to be effective not only from the point of view of reducing mortality, but also of saving resources, in that the expenditures related to the treatment of Aids in its initial stages use up less resources than the repeated hospitalizations of patients in serious conditions" (p. 4).

8. Burundi, Namibia and Kenya were also among the proposals, but the negotiations did not progress and the projects were not accomplished.

9. "The Brazilian response established this principle long before its adoption by the UN General Assembly on Aids in 2001. The equitable and free universal access in the Aids context, in all its actions, norms and adequate resource allocation became a technical reference in terms of policy, controlled by the society and fully considered a policy of the Brazilian State" (CHEQUER & SIMÃO, 2007, p.9).

10. Every two years, Unaid publishes an HIV/aids Global Report to update the state of the epidemic worldwide. This study is considered the most reliable HIV/aids statistical reference by almost all institutes, NGO, governments and individuals interested in tracking the progress of the epidemic worldwide (VIEIRA, 2007, p. 172).

11. Additionally, Unaid presents this policy as a vehicle for the United Nations reform, and as a process based on fundamental and more general principles of optimal international practices, such as: a) The Millennium Declaration (2000); b) the declarations of the OECD of Rome (2003) and Paris (2005) on harmonization and efficacy of the assistance; and c) the Monterrey Consensus (2005) on financing for the development.

12. Quoting the original:...*la colecta sistemática y la evaluación crítica acerca de sucesos pasados y que tiene como fin responder preguntas acerca de las causas, efectos, o tendencias relativas al pasado que permitan esclarecer comportamientos, hábitos o situaciones del presente.*

13. South Africa, Belize, Chile, India, Indonesia, Mexico, Nicaragua, Peru, Kenya, Thailand, Ukraine, Uganda, Uruguay and Venezuela.

14. Includes Argentina, Chile, Colombia, Ecuador, Guatemala, El Salvador, Panama, Peru, Mexico, Paraguay, Dominican Republic, and Uruguay.

15. Belize, Chile, Colombia, El Salvador, Ecuador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Peru, Dominican Republic, and Uruguay

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