THE INVERSE CAPACITY BUILDING LAW: FROM TECHICAL ASSISTANCE TO TECHNICAL COOPERATION TOWARDS GLOBAL HEALTH

Ricardo Kuchenbecker, MD, MSc[1]

Globalization has been imposing some new challenges to low and middle income countries. In an increasing manner, global economic policies that are sometimes excessively market-oriented and an unprecedented crisis of alternatives for sustainable development represent some of the enormous difficulties faced by the developing world. Frequently, some of the "economic growth" and "development" recipes that were not tested before are supported by international bilateral or multilateral organisms that sometimes impose their own agenda despite cultural, economic and political singularities in the developing countries. This wide range of overcoming challenges go far beyond economic and political issues and impact significantly on development issues, and therefore, on health.

The so-called "global health" agenda faces an enormous paradox represented by technological advances that coexist with infectious diseases that still affects the majority of the developing world population. Since the Second World War, international aid has been regarded as an essential mechanism to address the wide gap between the developed and developing world, especially in health issues. Different ways to promote international aid include multilateral and bilateral agencies and donors, support to specific projects and fund-oriented initiatives, amongst others. Most international aid initiatives are derived from humanitarian and relief issues, but their ultimate motives usually include dependency reduction and promoting sustainable ways of development.

In such a context, more comprehensive ways of providing development assistance to developing countries in order to strengthen national ownership has been proposed(1). Capacity improvement, and therefore, capacity building (CB) represents a core element in the process of healthcare development in the developing countries, not only because it plays a critical role in the sustainability in a broad sense, but also because of its related potential in reducing reliance on external assistance(2). Unfortunately, CB remains a poorly defined concept and a sometimes neglected issue by international aid. The objective of this paper is to revise some of the related aspects of capacity building as an essential element of sustainable international aid initiatives that aim to promote global health. CB is regarded as an essential mechanism to assure that technical assistance provided by international agencies is able to achieve its goals. A more comprehensive approach for capacity building as a core element of technical cooperation between the developed and developing countries is also proposed.

[1] Ministry of Health of Brazil, National Department of Surveillance, Sexually Transmitted Diseases and AIDS Program. Email: rsk@via-rs.net

CAPACITY BUILDING: A STILL NEGLECTED ISSUE IN GLOBAL HEALTH

There is a quite variable definition of CB. According to LaFond and colleagues, capacity building is a

> "Process that improves the ability of a person, group, organization or system to meet its objectives or to perform better. Capacity building interventions therefore work to improve the inputs and processes within the health system as a whole (seeking to improve the way it functions); organizations within the health system (to improve the way they function); health personnel (to improve their ability to perform work functions); and clients of the system and their communities (to improve their ability to engage productively with the health system through accessing services and influencing resource management, and improving their own health)"(2).

Surprisingly, CB is still a poorly defined issue in the international aid initiatives. According to Maconick, CB has "no agreed definition among the entities of the United Nations system", and that concept evolved from a previous concept of "institution building". Further, a more "precise or rather more operational" CB definition is necessary(3). Frequently, CB and training are considered as synonyms(4), and thus oversimplifying the importance of the former, with conceptual and practical consequences(5). It is difficult to believe that without a clear definition of CB, the issue may be thoroughly addressed by international bilateral and multilateral agencies.

Commonly, lack of CB is identified as the most important obstacle for the implementation of healthcare reforms or bilateral or multilateral aid initiatives. According to Potter and colleagues,

> "so widely is the need for capacity building recognized that it has become a cliché, part of the jargon of health sector development to talk about a "lack of capacity" or the need to develop "more capacity" (…)"(5).

Lack of CB has been largely recognized as an important barrier for scaling up national responses to address the infectious diseases at the developing countries. More than 50% of the submitted projects to the Global Fund do Fight AIDS, Tuberculosis and Malaria (GFATM) have not been approved due to technical imperfections. At least part of the funds disbursement delays are attributed to the lack of absorptive capacity from the recipient countries(6). Indeed the proliferation of project-based aid may also undermine the institutional capacity of recipient countries, the ultimate goal of external aid. Different mechanisms to provide development assistance have been proposed by multilateral and bilateral agencies, yet some of them do not emphasize capacity building as an essential mechanism for desired outcomes achievement.

Sometimes, the urgency of the aid is alleged as justification for a more prescriptive and vertical technical assistance. For example, President Bush's Emergency Plan for AIDS relief (PEPFAR) was announced in 2003 to fifteen developing countries and included a $15 billion pledge for five years. Unquestionably, a considerable and important sum to face this crippling epidemic. Yet how this money is being channeled to the recipient countries is the vital point at issue. Some of PEPFAR recipient countries, like Mozambique and Zambia

were not even consulted before being designated as beneficiaries of the program(7). According to the Zambian Health Minister, Brian Chituwo, "all (PEPFAR) plans (for Zambia) come from Washington"(7). Some of the prescriptive characteristics and imposed procedures of PEPFAR technical assistance were perceived as "neocolonial" by the Mozambican Health Minister, Francisco Songane(7). The Zambian and Mozambican experiences of scaling up access to AIDS treatment may provide some insightful messages regarding the process of CB as the ultimate result of a technical assistance initiative.

Indeed, these new tendencies in international aid may strongly influence CB issues in the developing world. For example, there is a recent growing movement of donor agencies that are currently shifting towards partnerships with local-based organizations rather than implementing projects directly. Unfortunately, frequently those local-based organizations are not equivalent to national organizations. For example, PEPFAR and USAID sponsored initiatives also give their money to American contractors that operate in the recipient countries, even though that usually represents a substantive extra charge. There may be a vicious circle represented by a vertically imposed bilateral agenda that drives capacity building at country level, which in turn is developed by international NGOs that demand a substantive amount of the financial support offered. The result may be a self-perpetuated process that only fuels international multilateral and bilateral agencies geopolitics and disregards local communities, and therefore, the sustainability of the initiatives themselves(8).

INTERNATIONAL AID: MORE MONEY AND MORE COORDINATION ARE NOT ENOUGH

In recent years, a wide range of new initiatives may represent a changing paradigm in international aid, including GFATM, the "3-by-5", the "3-ones" and the Drugs for Neglected Diseases initiative, amongst others. These "breakthrough" initiatives are certainly less prescriptive and more horizontal, and thus may provide essential subsidy for a new way of international aid promotion. Unfortunately, recipient countries are facing some consequences derived by the conflict between "new" (e.g. multilateral, less prescriptive) and "old" (e.g. bilateral, vertical aid) ways to promote technical assistance. This is exactly the case of the Country Coordination Mechanism (CCM). Under GFATM's framework the CCMs are the local structure conceived by the fund to monitor projects at a country level(9). Despite the fact that CCMs are evolving structures, they may represent a promising new perspective in coordinating multilateral aid initiatives at a local level approach. Brugha and colleagues analyzed the most important aspects related to the purpose, structure, composition and functioning of CCMs(9). The authors provide an interesting country perspective of GFATM's existing mechanisms in four countries (Mozambique, Tanzania, Uganda and Zambia) upon the findings of 137 national-level interviewed stakeholders. These four countries were selected because they are currently implementing SWAP-oriented approaches(9).

From a political perspective, the CCMs are the place where donors' and recipient countries' conflicting interests emerge. Someone may argue that the emergence of conflicting interests at local-level would be natural, and even expected, as a result of the local policymaking implementation process. Unfortunately, this is not the situation in most

cases. Multilateral and bilateral donors and international NGOs frequently impose vertically-driven agendas to developing countries, disrespecting local values and demands, with sometimes serious consequences to their health systems(8). This situation not only determines the occurrence of conflicts at the CCMs, but also shapes the procedures of bilateral-donor representatives at a local level. As pointed out by Brugha and colleagues, governments and non-government organizations interviewed by the study were "most positive" in their expectations of the GFATM compared with those of bilateral-donors. According to the study, some of the donor and recipient countries' conflicts experienced at the CCMs resulted from a difference in the "supportive" approach between bilateral donors' headquarters and their local offices. Country representatives of bilateral donors were often "skeptical" of the success of the GFATM(9) while their headquarters were seen as more supportive of it.

Far from being the result of local policymaking implementations, the emerging conflicts at the CCMs frequently result from the geopolitics of international aid experienced from the local level perspective. CCMs are facing conflicts whose roots go beyond local level interests from international and national stakeholders, thus weakening its capacity to monitor the implementation process of channeled funds. Further, many developing countries face overlapping attributions from several different structures that are quite similar to CCMs, and that process overloads busy and understaffed local decision-making structures. The U.S. international AIDS plan was strongly criticized by NGO Activists attending the 15th International AIDS Conference last July in Bangkok, who demanded more attention to the GFATM instead of the pursuance of US's own agenda by "favoring bilateral deals on AIDS with other countries"(10). All those issues are not merely a matter of conflict of interests at local level, sometimes experienced at the CCMs. This situation is the objective result of the geopolitics of international aid that has been frequently emerging at the CCMs as a local level public sphere.

GFATM has been self-proclaimed as an exclusive financial mechanism to support worldwide initiatives to AIDS, TB and Malaria(11). Therefore, technical assistance for the recipient countries had not been included in the GFATM portfolio until very recently, when its board authorized the inclusion of technical assistance to support projects at a country level. That is an important initiative, but certainly not enough. Lack of capacity building has been largely recognized as an important barrier for scaling up AIDS national responses in developing countries. More than 50% of the submitted projects to the GFATM are not approved due to technical imperfections. At least part of the funds disbursement delays have been attributed to the lack of absorptive capacity from the recipient countries(6). That seems to be a contradiction: on the one hand, the GFATM remains as an unprecedented mechanism to support developing countries to enhance their national responses to the three diseases. On the other hand, the lack of capacity building still remains a significant bottleneck to channeled funds. These issues were even regarded as a justification for enhancing bilateral initiatives such as Bush's AIDS program, which provides technical help to countries in running their AIDS programs, an "advantage over the Global Fund, which simply makes grants"(12).

Donor initiatives represent important pressure for high level coordination of public health initiatives in the developing countries(13). Walt and coworkers extensively revised

different existing mechanisms of aid coordination on health policy agendas(14). According to the authors, coordination mechanisms have changed their focus towards a more supportive approach to "domestic" (national) processes. In such a context, Sector-wide Approaches for health development (SWAp) represent a "new type of partnership, led by government, and involving a number of donor agencies and other groups of civil society". The authors state that

> "the approach [provided by SWAp] has changed the tools used to promote sector reforms and manage development assistance". And that "central to the notion of a SWAp is the intention to reinforce national leadership, transparent decision-making and to build institutional capacity, thus shifting attention from mechanisms of coordination to a broader view of the policy environment (…)"(14).

The Swedish International Development Cooperation Agency recently sponsored a study that addressed the experiences of SWAp approaches in health adopted by Ghana, Tanzania, Mozambique, Senegal, Bangladesh, Zambia, Mali, Uganda, Burkina-Faso, Cambodia and Malawi(15). Five core elements of a SWAp-approach were analyzed, and three of them were considered not fully implemented: government leadership in a sustained partnership, shared processes and approaches for implementing and managing the sector strategy and work; and commitment to move to greater reliance on Government financial management and accountability systems(15). Not surprisingly, these three components are intrinsically related to CB of the studied countries. The two other aspects that were considered as more comprehensively addressed by studied countries are related to donor-oriented policies: the existence of a common funding agency support, sector wide policy and strategy, and medium term expenditure related framework or budget(15). That seems to demonstrate that even more coordinated efforts performed by countries that are effectively engaged in a SWAp-oriented approach may not be able to address CB towards a comprehensive and effective manner.

Through the aforementioned examples, we intended to demonstrate that more coordination and more money to support international aid in health are certainly important issues, but not enough. It seems that CB related issues may be essential elements towards more effective ways for promoting technical assistance for the developing world.

CAPACITY BUILDING IS A CONTEXT-DEPENDENT ISSUE

As demonstrated above, it seems that some of the international aid initiatives are failing to address CB towards a more comprehensive approach. Indeed, some of the multilateral and bilateral agencies do not address CB as a context-dependent issue. Pfeiffer demonstrated that some of the deleterious effects of a specific way to provide international aid to Mozambique went far beyond the fragmentation of local and national healthcare initiatives. Its consequences included reinforcing mechanisms of social inequalities at local level(8). This is a quite complex issue that encompasses a wide range of determinants. First, CB is frequently understood as a synonym of absorptive capacity. That represents a misleading interpretation that has practical and sometimes negative consequences for recipient countries. Secondly, foreign-led initiatives frequently do not regard local related factors and are very prescriptive it themselves, thus reinforcing dependency instead of

autonomy. Thirdly, sometimes international aid follows a donor geopolitics-oriented policy instead of local assessment-approach needs, therefore enhancing the disparities and inequalities that include undermining local healthcare systems, promotes healthcare workers migration and weaknesses in the decision-making process at local level. All those consequences are not only determined by a prescriptive way of international aid. It also has to do with a concept of technical assistance and its related aspects. For example, some international development agencies orient their policies under a framework that supports a quite inflexible approach that relies on some concepts that usually cannot be applied in all developing countries-contexts. For instance, according to a USAID concept paper:

> "Civil society organizes political participation just as markets organize economic participation in the society (…) Sustainable development is likely to occur where both civil society and markets are free and open"(16).

That statement assumes that all developing countries have a civil society network that is able to actively participate in policy formulation and to monitor its achievements. It also assumes that most recipient countries have a sufficiently developed market that can contribute to regulate policies towards development. These two conditions are commonly not existent in most of the developing countries that currently receive international aid initiatives. On the contrary, many recipient countries usually have a weak civil society that is also subordinated to the State, and it is not possible to expect that the NGO sector can solely be sufficient to regulate the necessary initiatives. That situation resembles that aforementioned example of CCMs. Again, it is hard to believe that all those complex geopolitics of donors' interests can be effectively managed at local levels solely by the NGOs or by the CCMs. It seems to have less to do with a matter of donor-country conflicts and more with the geopolitics of international aid provided by bilateral and multilateral organisms themselves.

A quite similar situation occurs with research performed in the developing countries. Some authors have been arguing that it is time to abandon some "semi-colonial" foreign-led research practices adopted in developing countries by international funding agencies that still support independent research units or expatriate academics(17). A new model of "research partnership" has been proposed based on mutual trust and shared decision making; national ownership; emphasis on getting research findings into policy and practice; and development of national research capacity(17;18). Once more, those issues bring us to the problems of technology transfer and CB in developing countries.

The health systems' constraints that impede the implementation of Millennium Development Goals were recently addressed in *The Lancet*(19). Briefly, the authors pointed out four main questions that public health research must be able to address: A) How best to address shortages of human resources for health and poor health-workers performance? B) How best to increase the use of effective forms of health care and decrease the use of ineffective forms of care? C) How to control the use of pharmaceuticals to ensure that limited resources are well spent? D) How best to integrate programmes targeted at priority problems such as HIV/AIDS into existing health-care systems?(19). All those issues are intrinsically related to CB. This study is part of a series of papers addressing global health

recently published in *The Lancet*. None of them has devoted specific attention on a deeper extension to the issues related to CB.

Despite the multilateral efforts, there is a strong absence of multi-sectoral policy mandates on infectious diseases in donor organisms' mode of operation(20). Donors and international agencies' relationships with the recipient countries remain a politically, economically and socially driven issue(21) and these new initiatives like GFATM, "3-by-5", "3-ones" may be helping to revisit it in a quite distinguishing manner, but yet incomplete. In such scenario, it seems that international bilateral and multilateral agencies may have an important role in supporting sustainable developmental alternatives. These development issues are strongly linked to the CB of the developing countries in order to adopt sustainable ways to promote growth and to reduce the social inequities.

Currently, there still remain several crucial gaps in scientific literature regarding policymaking that challenges institutional efforts towards efficient national responses to infectious diseases and also non-communicable diseases. Briefly, some of the issues may be related to the following questions: a) what are the main components of a comprehensive healthcare network? B) What evidence support them? C) What are the evidence about the effectiveness of policymaking implementation at a country level? D) How should such components interact in order to effectively address patients' demands? E) Assuming that a comprehensive healthcare delivery to infectious diseases care is possible, how may such experience be implemented in low resource settings? F) What kinds of CB strategies are necessary to promote the transfer of technology to low resource settings in order to promote healthcare evidence-based policymaking?

THE INVERSE CAPACITY BUILDING LAW

Global health relies on applied scientific progress achieved at a local level. More participatory, equitable and sustained ways of technology transfer have been considered as an essential condition for genuine partnership between countries(18). Unfortunately, it has been estimated that less than 1% of global research and development is spent on technological innovations devoted to poor countries. King analyzed "the scientific impact of nations" upon a comparison between published research papers, their citations and the nationality of the fist author. According to the report, 31 countries, including the G8 and the 15 countries of the European Union before the 2004 accession accounted for more than 98% of the world's highly cited papers from 1993 to 2001. The remaining 162 countries contributed less than 2% in total published papers in the same period(22). The author states that

> "the cycles of poverty and dependence will only be broken by capacity-building between nations of high and low science intensity, often characterized as the North and the South"(22).

In 1971, A classic paper by Hart described the inverse care law that states that the availability of good medical care tends to vary inversely with the need for the population served(23). A very similar situation occurs with CB. Developing countries deal with low resources, understaffed healthcare services and lack of CB in a vicious circle that result in bad performance and continued dependency. Most technical assistance provided by donors

and international aid agencies are vertical and prescriptive, and thus do not address CB in a comprehensive manner. The most affected countries receive humanitarian and relief actions where technical assistance is provided by expatriates and foreign NGOs and that situation may represent an enormous challenge in terms of sustainability. In other words, accordingly to most technical assistance services that are currently provided by donors and bilateral and multilateral agencies, the more CB countries need, the less they get. That situation represents a certain kind of an inverse capacity building law that helps to perpetuate external dependence and lack of autonomy.

TOWARDS A NEW MODEL OF TECHNICAL COOPERATION TO PROMOTE GLOBAL HEALTH

As stated before, CB is a context-dependent issue that must be addressed in a horizontal, multilateral/bilateral process of mutual exchange. Also, CB has to do with sustainable development and should be viewed as a core element of a process of technology transference between developed and developing countries. In such a context, it is necessary to readdress North-to-South current practices of technical assistance and technology transference. Further, a more comprehensive framework to promote CB is necessary. Scientific progress does not guarantee economic growth or social wealth. Brazil provides a particular example in that subject. Brazil ranked the nineteenth place of the 31 countries that concentrate more than 98% of most cited scientific papers worldwide from 1993 to 2001, representing a 45% growth comparing to world performance(22). In the same period, Brazil faced a long period of economic stagnation that represented the persistence of huge social inequities. The scientific development experience in Brazil has not translated into patent registration, in which field the country only grew 1% in the same period(24).

The World Trade Organization's (WTO) trade-related aspects of the intellectual property rights agreement (TRIPS) reinforce international enforcement of property rights and will represent an important obstacle for developing countries to have access to new technologies(25). According to Donald, "WTO agreement enforcing trademarks and patents will increase the price poor countries pay to gain access to new, patented technologies". The author also stated that "active policies" rather than "passive diffusion" are needed to sustain a broader access to new technologies for developing countries(25). The argument that developing countries cannot get new technologies they need due to lack of financial resources is too simplistic an approach. Technology cost is a determinant factor, but does not exclude a broader framework that is necessary to ensure that it would be introduced in a sustainable manner.

Existing Intellectual Property (IP) agreements promote an unbalanced system for developing countries that do not support innovation and R&D. Further, the current IP system scarcely contributes to the social and economic development of the developing countries. Recently, developing countries lobbied the World Intellectual Property Organization (WIPO) to incorporate development goals and consumer rights to counterbalance the interests of powerful nations and corporations. WIPO approved the proposal of resolution elaborated by Brazil and Argentina, with the backing of Bolivia, Cuba, the Dominican Republic, Ecuador, Iran, Kenya, Sierra Leone, South Africa, Tanzania and Venezuela. WIPO's resolution includes a joint international seminar on IP

and development with other multilateral organizations like UN Trade and Development Conference (UNCTAD), WHO and the UN Industrial Development Organization (UNIDO). The resolution approval was also influenced by "the Geneva Declaration on the Future of the World Intellectual Property Organization" signed by more than 500 prominent scientists worldwide. WIPO has a budget of 500 million dollars for the 2004-05 period, 85% devoted to cover revenues from patent registration and copyright systems.

CB resembles a form of technology transfer, and it must be a process of reciprocal exchange(18), otherwise it will fail. Once again, the multilateral aid agencies can play an essential role in helping to change the paradigm of technical assistance towards a new way of international cooperation. How? There is no blueprint to address CB on a scaled up approach. Maybe the first step should be to recognize its crucial importance. A learning-by-doing approach can be very helpful if it is able to include civil society (e.g. NGOs) in its planning, monitoring and evaluation(26;27). Does civil society have a role in CB issues? Brazil has been playing an international leadership role in advocating access to AIDS treatment as a human right all over the world. In such a context, Brazil has been involved in some international initiatives such as: 1) The approval of Resolution 33/2001 at the 57th Session of the United Nations Commission on Human Rights, establishing that access to antiretroviral treatment is a basic human right; 2) the creation, in 2001, of the Global Fund to fight Aids, Tuberculosis and Malaria; 3) The approval, at the World Trade Organization, of the Brazilian proposal establishing that nothing in the TRIPS can prevent countries from adopting measures to protect public health. The involvement of civil society goes far beyond advocacy issues. Civil society plays an essential role in the sustainability of technical assistance. Further, NGOs are essential in assuring that technical competences can be absorbed by national health authorities and translated into effective care. All these issues have profound ethical implications that go far beyond benefit-sharing and equal access to the advances of scientific knowledge. Ethical values must be applied in the process of defining priorities and decision-making at every level of healthcare policy(28). The point here is not only to provide emphasis on CB as an instrument to obtain expected outcomes (e.g. incidence rates reduction), but to really address it as an essential mechanism to improve national sustainable responses to infectious diseases. The second step may be to recognize that geopolitics of donation and multilateral/bilateral agencies may provide some obstacles for CB promotion at the "recipient" countries. That means that it is time to rebuild technical assistance initiatives towards more cooperative and horizontal approaches.

International technical assistance projects sometimes support strategies that remain on poor reliable evidence, such as the so-called ABC approach to AIDS prevention(7). Even considering that phenomenon as a result of the geopolitics of donor policymaking, innovative multilateral initiatives may help to change such scenario in several ways. One feasible suggestion would be the creation of an international registration system for technical collaborative efforts promoted worldwide under the coordination of multilateral agencies such as the WHO, as has been occurring with clinical trials(29). There is a clear analogy with clinical trials register. The public-good of such an "international technical cooperation" registry is that it may provide the necessary transparency, as well as enhance international access and use of health-related knowledge favoring a more evidence-based decision-making. As in the clinical trials register, information about supporting donors would be valuable in understanding the flow of resources, as well as synergy and priority

setting at a local level(29). There is a clear role for the academy in such process, not only because some international aid practices are poorly evidence-based, as stated before, but also because it can remain impartial to the geopolitics and commercial interests that so often come to the detriment of the patients themselves. Independent research evaluating NGOs and multilateral/bilateral aid at local health services and communities is scarce in the literature(8). Other practices, designed and implemented in the developed world, still need to be adapted and, perhaps, validated in the low and middle-income countries. Enhancing academy's participation in multilateral aid initiatives may also be helpful in establishing a feasible framework for scaling up multi-sectoral approaches that are really based on developing countries' demands(30). Again, there are no recipes for that, except the fact that community-based approaches(31) may drive towards an effective multilateral and sustainable effort to address global health. Changing the paradigm of CB reinforces the role of multilateral agencies like WHO and all UN affiliates in supporting initiatives at a country level towards a more comprehensive and horizontal approach(21;32;33).

The current experience in some of the developing countries suggests several issues that can be considered in the process of definition of a new model of cooperation: a) codes of conduct establishing the role of donors, multilateral agencies and national authorities in technical cooperation initiatives; b) longer projects that are able to address CB as a core element, intrinsically related to outcome indicators; c) practical initiatives to assure the transference of skills towards learning-by-doing approaches; d) new model of NGO collaboration(8) and an innovative framework to provide synergy between multilateral/bilateral initiatives in the developing countries.

A G-20 of Leaders could help to drive CB as an essential issue towards global health in several ways. Firstly, making sure that CB can be more comprehensively addressed as a main element of international aid. In fact, CB may be addressed upon cross-section approaches, thus enhancing its relationship with sustainability and local-level development. A global effort promoted by a G-20 of Leaders may enhance synergism between major players in global health like the World Bank and UN affiliates towards less prescriptive North-to-South approaches.

Brazil, Nigeria, China, Thailand, Ukraine and the Russian Federation signed a joint declaration last August aiming to enhance technology transference related to antiretroviral drugs production, condoms, vaccines, microbicides and laboratory supply under more horizontal and reciprocal processes of change. More recently, UNAIDS and Brazil agreed to implement an international cooperative initiative on HIV/AIDS to other developing countries. That initiative includes a technical cooperation program involving Latin American and the Caribbean countries to expand access to AIDS treatment. These are some of horizontal technical cooperation initiatives that a G-20 of Leaders may reinforce.

Certainly, capacity building is not included in the most important discoveries in science. Meanwhile, capacity building is indubitably necessary to provide access for all to the achievements provided by scientific discoveries in a sustainable and feasible manner. There is a strong message stated at the core of the GFATM's recent and evolving experience: an unprecedented international mobilization effort to address three diseases that represent a huge burden worldwide. Such multilateral initiative must be able to reinvent

collaborative efforts and to change the geopolitics of international aid and donors' procedures. There is no doubt that the GF is performing an essential leadership in that, and also in the way we face those diseases. But, as stated by Mr. Kofi Anan, UN General Secretary, at the opening ceremony of the Bangkok AIDS Conference, leadership means showing the way by example. We hope that the multilateral initiatives like the GFATB may continue to behave as leaders in the long way we have ahead of us in assuring that the need of the people living in the developing countries are, in fact, being attended to.

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