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HEALTH AND INTERNATIONAL RELATIONS: LINKAGES WITH NATIONAL HEALTH DEVELOPMENT

Introduction

1. The growing and fast-paced process of globalization has had repercussions on multiple dimensions of social life. Technological, economic, and political changes worldwide influence the established relationships between states. In recent years, a political system has been emerging worldwide, altering relations among states and redefining other aspects of human development. That world system has directly influenced the complex relationship between health and international relations, and the field of international cooperation in health. New international actors have appeared with different roles and responsibilities, new partnerships and associations have been formed, and more stringent criteria for transparency and accountability in international relations have emerged, owing to the expanded role of civil society based on transparency and accountability.

2. The need to analyze the consequences of these global changes on health and human development, as well as the demands that the situation creates for international cooperation in health, has been a topic of debate for some time now. More recently, this need has been voiced in the discussions of the *Working Group on PAHO in the 21st Century* and the Governing Bodies of the Pan American Health Organization (PAHO) and by some Member States.

3. In 2003, PAHO submitted *Globalization and Health* (CE132/15) to its Governing Bodies. This document examines the impact of globalization and its consequent opportunities and challenges for improving the health of the population of the Region, increasing the effectiveness and equity of national health systems, and reducing disparities in access to health care. In 2005 PAHO submitted the document *Country-*

focused Cooperation and National Health Development (CD46/19), which cites international cooperation as a contributing factor to national health development.

4. Foreign policy refers to a country's political relationships with other nations. Traditionally, this policy has focused on protecting national interests, from a security perspective, economic and territorial development, and ideological interests. This perspective has been changing to include other issues, such as health.

5. In recent years, dialogue between the various health fields and international relations has been growing, with health emerging as a relevant foreign policy issue. Today, there is no doubt that health has greater visibility and priority on the international agenda. This fact has major consequences and poses challenges for countries and international organizations alike.

6. International cooperation in health has also undergone significant changes in recent years. The most important examples in this regard include the greater number of national and transnational actors (state and non-state), the complexity of interactions between these actors, and the emergence of new ad hoc organizational mechanisms to facilitate their interaction. Moreover, the role of private enterprise and civil society organizations has become increasingly apparent in international cooperation in health.

7. This document, presented for consideration by the Governing Bodies, proposes a series of ideas, topics, and discussions on the complex relationship between health and international relations, the changes that have occurred in this relationship and in the field of international cooperation, as well as the consequences of such changes for national health development. The purpose of this document is to initiate a dialogue to develop a frame of reference for the Organization's technical cooperation. This programming framework is needed to orient the work of PAHO/WHO in assisting national governments and their specialized entities with developing solid, sustainable institutional capacity in health and international relations. The Member States require adequate capacity to meet the new challenges in governance, governability, and management of international cooperation in health, especially relevant for countries with a greater need for health development.

The Complex Relationship between Health and International Relations

8. Although the worlds of health and international relations are not completely foreign to one another, historically speaking their relationship has never been very significant (Panenborg, 1979), inasmuch as the ministries of foreign affairs have accorded a low priority to health.[1] Some observers have qualified the relationship

[1] In the field of International relations "hard power" issues are those traditionally associated with matters of war and peace, the economy, and trade, whereas health and the environment are considered "soft issues." Notwithstanding, however, since time immemorial health and disease—as both an effect and a

between health and foreign policy as a "historic divorce," although the history of public health has indicated linkages between the two fields for a very long time, as seen in agreements, treaties, and binational exchanges on health in border regions.

9. From the health policy standpoint, it has long been recognized that, trade, international finance, population mobility, climate change, and international conflicts and disasters, as well as international security and other issues, have a clear and demonstrable impact on health. The strongest ties between health and foreign policy are found in the fields of transportation, trade, tourism, and migration.

10. Early forms of international cooperation in health dating back to the 19th century were in response to the spread of infectious diseases that adversely impacted trade between countries, making health in ports a matter of great relevance. The International Sanitary Regulations of 1832 and Pan American Sanitary Code of 1924 were responses to address the need for regulating this situation. Moreover, the creation of the Pan American Health Organization in 1902 was partly a response to this order of needs, associated with engineering advances in the construction of transoceanic canals. Since 1945, the creation of the United Nations, the postwar reconstruction of national economies, and growing trade liberalization have paved the way for numerous international health agreements and institutional arrangements.

11. One impressive example of the convergence of perspectives and efforts between foreign policy and health policy at the international level was the Declaration of Alma-Ata at the 1978 International Conference on Primary Health Care. The Declaration of Alma-Ata was the fruit of a prolonged, intensive diplomatic dialogue that helped mobilize convergent interests in a large number of the countries to adopt the strategic vision of achieving health for all by the year 2000, formulated within the framework of the World Health Organization. On this accomplishment, Fidler notes that never was the gap between foreign policy and health so great and dramatic than during those years, but that despite this fact, health policy was able to forge its most ambitious and optimistic global strategy (Fidler, 2007)**.**

12. The history of Central America and, indeed, of PAHO/WHO includes one highly significant experience for the countries of the subregion, involving a broad vision of the relationship between health and foreign policy. This is *Health as a Bridge for Peace* (HBP), which is a clear example of coordinated diplomatic efforts for peace, the rebuilding of democracy, and the mobilization of resources within a framework of substantial innovations in international cooperation (PAHO and ASDI, 2002).

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weapon—have been highly relevant issues in wartime, especially during the great wars of the 19th and 20th centuries (McNeill, 1984).

13. More recently in 2002, health once again played its diplomatic role amid the border conflict between Ecuador and Peru. Working together, the two countries were able to complete the drainage and clean-up of the Zarumilla Canal, which involved the populations on both sides of the border, the creation of a protected binational park, and strengthening of the public health surveillance system along the common border.

14. In the recent years, this pattern of relations has again been observed in responses to new situations. Examples include the significant attention paid to the HIV/AIDS pandemic in the forums of heads of state and the inclusion of health issues at the meetings of the G8 and World Economic Forum at Davos. Another important example in the Caribbean is the Nassau Declaration on Health (2001) by the heads of government of the Caribbean Community (CARICOM), recognizing the health of their populations as a precious resource of the Region, and their recent Summit in Trinidad and Tobago to consider the situation of chronic noncommunicable diseases. Likewise, another example of the joining of commercial and health interests was observed in 2002 and 2003, with the outbreak of severe acute respiratory syndrome (SARS). In fact, since Alma-Ata the global health agenda has focused on diseases rather than health promotion, with the emergence of the term *health security*.

15. Over the past 10 years, health has become a matter of growing importance on the global political agenda. There is greater awareness in the field of international relations about the broad spectrum of health issues and the consequences of the rapid pace of scientific and technological development; problems that transcend national borders and demand global action. In response to calls for concerted action on a wide range of political, economic, and social issues with consequences for health, a growing number of diplomats are entering the health arena and more public health specialists are entering the diplomatic arena. A technical field is taking shape, which some authors have dubbed "global health diplomacy" (Kickbush et al., 2007).

16. The importance of health in the Goals of the Millennium Declaration (2000) and the Report of the WHO Commission on Macroeconomics and Health (2005) also show that health has come to play a central role in the international debate on social policy and economic development. The United Nations reform, promoted by former Secretary General Koffi Annan, also assigns a very important role to health within the framework of human rights, in order to achieve its greatest objectives[2] (United Nations, 2004).

17. Recently, with the negotiations on the formulation and approval of the Framework Convention on Tobacco Control and the new International Health Regulations (2005), the World Health Organization has found itself at the center of the new relations between health and foreign policy.

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[2] In order to achieve one of the three higher freedoms (freedom from want), the Secretary General believes it is critical to achieve the eight Goals of the Millennium Declaration. Of these, three are specific to health and the remaining four seek to improve the determinants of health.

18. The Oslo Ministerial Declaration On Foreign Policy taking up the challenges of global health: agenda for action, issued by the ministers of foreign affairs of Brazil, France, Indonesia, Norway, Senegal, and Thailand (March 2007), represents another milestone in this transformation. The declaration notes the urgency of broadening the scope of foreign policy to give priority to addressing matters of health in the era of globalization and interdependence and argues that this new vision is based on the principle of protecting the fundamental opportunity for life for the world's citizens. The ministers called for more active collaboration among the ministries of foreign affairs, ministries of health, and other government agencies in matters of global health security (Oslo Ministerial Declaration, 2007).

19. This positive change in the nature and perspective of the relationship between health policy and foreign policy implies a challenge, but also an opportunity for the countries and international cooperation agencies such as PAHO/WHO. In this globalized world, each country, and each subregion of the Americas faces a substantial number of problems, challenges, opportunities, and commitments resulting from this interdependence between health policy and foreign affairs. Accordingly, the need to capitalize on current opportunities for global health for the benefit of the world's populations is increasingly clear; the need to secure the rights and aspirations of its citizens and to assume commitments implied by democracy. To this end, it is critical to build and maintain national institutional capacity to manage these opportunities effectively and to confront the consequent risks and threats to health.

The New Global Scenario of International Cooperation in Health

20. Health policy is the responsibility of states. In today's world, local and national health policies and actions to guarantee the health of populations, especially in view of health problems and risks that transcend borders. Against this backdrop, it is ever more apparent that the structure, regulations, and forms of organization employed by each state must improve substantially, reducing the levels of exclusion observed in development processes, if they are to include and benefit all members of society.

21. The health sector is complex and involves multiple actors, needs, and sources of financing. Within the framework of the globalization processes—and with only seven years remaining before the target date for achieving the Goals of the Millennium Declaration—the rapid increase in the flow of official development assistance for health and the numerous providers of financial resources in the sector have created a complex scenario, in terms of efforts to align and harmonize cooperation and to ensure adequate governance at all levels (Garrett, 2007).

22. International development cooperation has been changing at a dizzying pace. The box below summarizes some of the main changes specific to the field of health cooperation in recent years:

Recent Changes in the Field of International Health Cooperation at the Global Level

- Growing importance of health on international political agendas
- Substantive increase in the flow of nonconcessional resources for health originating in the field of international assistance
- Proliferation of new transnational actors on a worldwide scale in the areas of: a) private enterprise, including for-profit corporations, philanthropy, business associations, and b) nongovernmental development organizations in the developed countries[3]
- Growing role of international financial institutions in health sector financing and governance in middle- and low-income countries
- Growing involvement of the private sector in public policy development, especially private agents of the developed countries that influence public policies in developing countries
- Development of new partnership modalities among international entities, in the ways these interact among themselves, including relations with national counterparts to finance and provide international cooperation, that results in new innovative initiatives for health that seek more effective ways to increase and contribute health resources destined to the developing world
- New and growing interest in global public goods and their international regulatory implications

Source: L. Nervi. Study commissioned by PAHO/WHO (2007)

23. There is a relationship between governance in health and the national health development process that requires an analysis of changes in the architecture of international health cooperation in recent years and represents a departure from what took place in the field of international health following World War II.

24. According to their proponents, global health initiatives (GHIs) were created over the past 10 years as a necessary organizational model to deal with the complex challenges of the global health agenda and channel additional resources to health.[4] In the past 10 years more than 120 GHIs have been created, some of which have met with a great deal of success (Gates Foundation, 2005), including the Global Polio Eradication Initiative, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), the Global Alliance for Vaccines and Immunization (GAVI), the Stop TB, Roll Back Malaria partnerships, the Global Alliance for Improved Nutrition (GAIN), and the Multi-Country HIV/AIDS Program (MAP) of the World Bank. New actors, such as private philanthropic foundations, private enterprise, and civil society organizations should also be counted among this group (OECD, 2007). Among philanthropic foundations, the Bill & Melinda

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[3] USAID has referred to this phenomenon has a “private revolution in global development” (USAID, 2006), while Hall and Biersteker have called it the “emergence of private authority in global governance” (Hall and Biersteker, 2004).

[4] For purposes of this document, global health initiatives (GHIs) refer to the ample array of coalitions, networks, and alliances that have proliferated in the field of international development cooperation. The most frequently used term in English literature on the subject is public-private partnership (PPP). However, a careful analysis shows that less than half of such organizations have some type of public-private interaction. Most GHIs are informal associations that rapidly evolve into new types of partnerships or disappear.

Gates Foundation has been a major source of financing and influence on health action worldwide. The growing importance of these GHIs poses profound new challenges and exerts pressure on national sovereignty and current institutional arrangements in the area of international cooperation.

25. Despite the numerous GHIs identified, only a few, like the new funds, are financially and politically significant and play a key role in global health governance. The funds are made up of public and private donors and have become key agents in global development—and not only in the field of health. Nevertheless, it is important to bear in mind that despite the increase of private sector funding, the public sector continues to contribute the most funding. Private contributions to global health financing represent only a fraction of total cooperation assistance. However, private actors have increased their visibility and power in global governance—disproportionately to the magnitude of the funds they contribute (Nervi, 2007).

26. One result of these global changes has been an increase in official development assistance for health. According to reports by the OECD, official development assistance for health increased from US$6 billion in 1999 to US$13.4 billion in 2005. The average annual growth in official development assistance for health has increased 5.4% over the past 15 years. Of this amount, bilateral assistance grew over the period 1996-2004, while multilateral assistance remained constant. Two-thirds of assistance for health is bilateral, while one-third is multilateral. In Latin America, official development assistance for health reached US$402 million (PAHO, 2007), although its weight proportional to Africa and Asia has been diminishing in recent years (17% of all assistance).

27. The increase in global financing for health can be attributed in part to the new global actors, such as global health initiatives and private foundations. According to reports by the Organization for Economic Cooperation and Development (OECD), the contributions of private foundations and resources channeled by international programs promoted by these global health initiatives together represent between 20% and 25%.

28. The results obtained thus far are not all positive. Most assistance is channeled to vertical disease control programs, with very little support provided for strengthening basic sanitary infrastructure or health systems. Moreover, many of these interventions overburden the national health authorities and consequently undermine national health development. Whereas before, the problem was considered the lack of resources, today it is primarily governance of this complex network of stakeholders. Many studies point out that this complex situation is a significant hurdle for the developing countries, which must manage and spend these resources effectively while having to cope with the numerous assistance instruments and monitoring and evaluation mechanisms required by the various partnerships and alliances. A classic example is the case of Tanzania reported by Birdsall, who noted that in the period 2001-2002 the country had 1,300 external

assistance projects, 1,000 donor meetings per year, and was required to submit 2,400 annual reports for donors (Birdsall, 2004).

29. For these reasons, in February 2003, the primary multilateral development banks, international and bilateral organizations, and representatives of the beneficiary countries met at the High-Level Forum on Harmonization (of international cooperation) that took place in Rome. Two later years, in March 2005, the Paris Declaration on Aid Effectiveness, signed by the delegates attending the Second High-Level Forum on Harmonization, introduced a change to the aid effectiveness program, with a view to turning the general consensus reached in Rome into more concrete commitments aimed at increasing harmonization,[5] alignment,[6] and management efforts. Furthermore, the High-Level Forum at Paris established mechanisms for monitoring progress. The main objective of aid alignment and harmonization is to strengthen leadership and the internalization of objectives on the part of the receiving countries, thereby avoiding the duplication of actions and structures for aid delivery and monitoring. One such example is found in the endorsement of the "Thee Ones" principles by the Board of UNAIDS: one agreed HIV/AIDS Action Framework; one National AIDS Coordinating Authority; and one agreed country-level Monitoring and Evaluation System.

30. Accordingly, several challenges must be faced with respect to the governance of international cooperation in health: reaching agreements on a common regulatory framework for the operations of the global initiatives promoted in recent years; strengthening leadership or institutional authority to guide global actions; and generating the necessary resources to ensure the effective operation of this international cooperation in health and its adequate distribution in accordance with needs.

Implications for National Health Development

31. Document CD46/19 (2005) called attention to national health development process[7] and its components: the plane of the level, structure, and trend in health status, which reflects the influence of health determinants; the plane of policies, priorities, strategies, and interventions that define the health systems; and the plane of cooperation in health, which includes the resolve, resources, and concrete national and international interventions to support national management. The purpose of country-focused

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[5] Harmonization is understood as donor efforts to coordinate their activities with each other.

[6] Alignment is the coordination of donor and receiving country priorities, according priority to those of the latter.

[7] National health development in each country is the process (economic, social, political, cultural, and health-related) that creates the structural foundation for defining both the living and health conditions of the populations, such as the potential for state and social interventions to modify and improve such conditions. It is against this dynamic and complex backdrop of social and health realities, and institutional and organizational characteristics of each country that cooperation actions are implemented for development.

international cooperation is to accelerate advances in national health development in each country as a member of the international community.

32. Given current conditions, it is critical to take into account that as the interdependence among countries increases, virtually all health policies acquire a significant regional or global dimension; therefore, as the number of international conventions and agreements increase, so does their impact on national decision-making processes. Accordingly, political coherence, strategic management, and a foundation of solid principles and common values are increasingly indispensable (Kickbush et al., 2007). This institutional capacity is essential for nation-states states to operate in the new global health environment.

33. A starting premise is the creation and maintenance of institutional bridges, joint capacities, and a shared culture of joint action and practices among the various government agencies involved in international cooperation, primarily in the areas of health and international relations, but also other sectors, such as foreign trade, finance, labor and employment, education, and culture.

34. Taking into account two main elements of national policy objectives for both health and international relations,[8] and considering elements from the previous analysis, in the following sections we will explore the spheres of action (defined in the logical sequence of "what, why, how, and with what") with an approach involving interventions for institution strengthening. These include, for the purposes of illustration, processes, issues, or current problems in the global, regional, and subregional scenario.

Level 1: Leadership in Health ("What?")

35. This is the government institutional capacity that ensures institutional conditions, political leadership, the legal regulatory framework, and the technical competencies for the governance and governability of the health sector and its public policies. Generically, it is the management capacity of a state for implementing and successfully meeting its national and international health policy objectives in regard to international relations. It ensures the alignment of national policies in health and foreign policy. It is also underpins the ability to take advantage of opportunities for international cooperation to benefit the population. It implies, for example:

- Exercise of sectoral leadership in health at the national level and orientation and support for the health development process with subnational government agencies (decentralization and/or regionalization);

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[8] Traditionally, there are four essential macro functions in the field of international relations: safeguarding national security; defending national economic interests; promoting development, and fostering human dignity.

- Leadership and direction of the harmonization, alignment, and coordination of international cooperation;

- Negotiation of projects and agreements with international aid organizations, technical cooperation agencies, and other countries, which can involve financial commitments; and

- Shared responsibility with other countries for implementing agreements for the common good, which can imply some surrender of sovereignty in health (as is the case for binding international agreements).

Level 2: Health Diplomacy ("Why?")

36. This refers to the capacity of the national government to conduct international relations on health issues through diplomats and public health experts within an agreed institutional framework at the intersectoral level, for the purpose of defending and benefiting national and sectoral interests. It should ensure action at the different levels of relations between health and foreign affairs and their coordination with other fields. It should be capable of acting effectively, but also have the ability to impact the makeup of the international policy environment in the furtherance of health. It implies action in:

- Diplomatic efforts in international forums and arenas;
- Cooperation among countries on common problems and the sharing of experiences;
- Health policies and the health of population in border areas;
- Collective leadership and concerted action at the international level for actions of mutual benefit;
- International policies and agreements to address matters associated with migration (protection of migrant's health or the emigration of health personnel);
    - International solidarity and humanitarian action;
    - Ethics of international relations and its relationship to health; and
    - Policies for the management of global public goods, the TRIPS Agreement, and the principles of the Doha Declaration.

Level 3: Management of International Cooperation ("How?")

37. This level involves the need to capitalize on the potential and opportunities offered by international cooperation for the national good--that is, for the benefit of the country's entire population. It is closely related with leadership in health and must ensure:

- Proactive, effective action for mobilizing the necessary resources to meet health needs that cannot be met with internal resources. To this end, consideration of the economic, political, and legal conditions of cooperation are very important;

- Evaluation of the cooperation received in terms of the benefits, impact, and sustainability, and ex ante evaluation;

- Ensuring development or strengthening of autonomous and sustainable institutional capacity; and

- Effective and efficient resource management, taking into consideration the national legal and regulatory framework in terms of the international regulations and standards in effect.

Level 4: Development of National Capacity for International Action in Health ("With What?)

38. This is the basic institutional premise to acting effectively at the two previous levels. It implies the education and retention of human resources that are proficient in the aforementioned competencies and well versed in the regulatory and legal foundations to ensure its implementation. It requires political decision-making, sufficient resources, and a clear strategy for the creation of institution networks, active exchange processes, as well as institution-building strategies and interventions.

39. Two types of gaps should be borne in mind when planning for institutional capacity building in this field: on the one hand are the gaps that may exist between public health and international relations in terms of existing capacity (a group of trained professionals and the existing potential), and on the other, gaps attributable to an imbalance between countries in the power to negotiate, influence, pressure, and act, especially between the developed and developing countries (Kickbush, 2007). Some necessary actions are mentioned:

- Mapping of competencies and their alignment with national policies;

- Sustainable programs for strengthening institutional capacity of the pertinent government entities, including education programs; and

- Capacity to exercise public health functions and responsibilities at the international level (for example, implementation of the new International Health Regulations).[9]

[9] This document will be followed with an international technical cooperation policy proposal and cooperation strategy to strengthen the institutional capacity of the Member States in the area of

Action by the Executive Committee

40. The Committee is requested to provide relevant comments and suggestions to refine the document and facilitate discussion on it with the Directing Council. Specific interest exists on the revision of the suggested areas for action to strengthen the institutional capacity of governments in health and international relations. Additionally, ideas on the best approach to foster dialogue among Member States on these subjects in order to identify priority areas for technical cooperation in health and international relations are requested.

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international relations and health, including the different levels suggested, and will be presented for discussion by the Governing Bodies of the PAHO in 2009.

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