

Essay

## Critical essay on international cooperation in health

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### Paulo Marchiori Buss

Professor and researcher of the National School of Public Health, Oswaldo Cruz Foundation (Fiocruz), Rio de Janeiro, Brazil; Director of the Fiocruz Center for Global Health; former president of Fiocruz; Full Member of the Brazilian National Academy of Medicine. buss@fiocruz.br

### José Roberto Ferreira

Doutor *Honoris Causa* by the National School of Public Health, Oswaldo Cruz Foundations (Fiocruz), Rio de Janeiro, Brazil; Head of the Division of International Cooperation, Fiocruz Center for Global Health; Former director of the Division of Human Resources, Pan-American Health Organization (PAHO), Washington DC. ferreirj@fiocruz.br

### Abstract

This essay discusses the need for international cooperation in health, the current dominant model of cooperation in the area, as well as a few alternatives to this model - such as South-South cooperation - and prognoses for the international cooperation sphere, considered a part of health diplomacy.

### Keywords

international cooperation in health; health diplomacy; South-South cooperation; Unasul health; UNASUR Salud; PECS/CPLP

### International cooperation demands in the field of health

The 'short twentieth century', as defined by Eric Hobsbawm (1995), was marked by important economic, social and technical-scientific advances that improved the quality of life and health conditions for millions of people around the world. However, as an 'age of extremes' - also coined by Hobsbawm -, that process of globalization has also produced not only large international disparities, but also huge social and health problems, especially in the countries most excluded from central axes of the global economy (ILO, 2004; BUSS, 2007). In the beginning of the 21st century, declining health conditions for large portions of the population in many countries (WHO/AFRO, 2006; WHO, 2009), food unsafety (FAO, 2009) and, most clearly, the consequences of climate change (IPCC, 2007), have been the greatest causes of concern for the so-called international community.

The above-mentioned countries and regions, bear a 'double burden of disease', that is, they associate epidemic, emerging, reemerging and neglected communicable diseases - such as the 'three big' (HIV/Aids, malaria, and tuberculosis) with chronic non-transmissible diseases, among which are cardiovascular diseases, diabetes, obesity, neoplasias and

mental diseases. Moreover, poverty, hunger, malnutrition and unsatisfactory healthcare provided to mothers, children and the elderly are responsible for the high rates of general mortality and the mortality of mothers and under-fives, as well as for low life expectancies at birth (WHO, 2009). Inequities in health conditions and in the access to healthcare are found both between countries and within countries (WHO, 2009). Furthermore, there is growing consensus that, without healthy populations, there won't be any development.

The so-called low- and middle-income countries - some of the poorest countries in the world and where health conditions are as we described above - are seriously limited in terms of 'governance' and are only marginally able to formulate and implement social and health policies that effectively meet their populations' needs. Their health systems are usually fragile, fragmented, under-financed and lack basic technological resources to offer healthcare and carry out public health measures that are adequate to the needs of the population (WHO, 2008a).

Generally speaking, health professionals are scarce, poorly trained and underpaid (WHO, 2006), which is worsened by the migration of these professionals, especially from developing countries to developed countries. The reasons for

this 'brain draining' are many, but among them are the lack of opportunities and the low wages received in their home countries, but also training schemes abroad without assuring their return - which we consider one of the negative effects of international 'aid'.

The issue of human resources in health is so important that it has been brought to the attention of the World Health Assembly in the last few years, which caused the WHO to make it the theme of its 2006 World Report (WHO, 2006). The World Health Assembly produced a global pact on the development of human resources in health (WHO, 2006a), as well as regulated the migration of professionals (WHO, 2009) - the latter destined to block or compensate the 'brain draining' from developing countries to developed countries.

In short, the health systems of most poor countries are unable to address the needs of the populations, the prevalent diseases, its main risk factors and bad life conditions, which make them very dependent on international aid, which, in turn, is crucial for development as a whole and the life and health conditions of their populations.

The causes of the developing countries' poor life and health conditions and their inability to respond did not evolve by chance. Many international reports and authors point out the social and economic determinants of health (WHO, 2008) and the unfair globalization - over the backdrop of poverty and inequity between and within nations - (ILO, 2004; BUSS, 2007) as the roots of the problem.

The United Nations, the cooperation agencies of the most developed countries in the world and the international philanthropy - often serving opposing interests - have not only been trying to respond to those concerns, but also placing health as one of the priorities in the international cooperation agenda and in the plans of development aid programs.

### The dominant model of international cooperation in health

The health sector has been an important subject for international cooperation and foreign aid schemes, which has been provided following the most varied interests, motivations and strategies, and by many multilateral organizations (the United Nations itself, by means of the Millennium Development Goals and its sectoral agencies, such as the WHO, UNICEF, UNDP and others), by the governments of developed countries (USA, Canada, European Union, European countries, Nordic countries and Japan, among others) or by emerging countries (such as Brazil), as well as by NGO and other institutions and initiatives that gather various of the previously-mentioned actors that work in the

international sphere (such as GAVI, for instance).

Despite having the best intentions to help poor populations in the poorest countries in the world, very often those actors impose their own world views, agendas and predefined objectives. 'Recipient' countries are frequently unable to organize their demands given the lack of coordination between its Ministries of Health, External Relations and other key public and private partners. The consequences are fragmentation and low effectiveness of the already limited locally available resources (BUSS, 2007; 2008).

In this context, a slight differentiation can be made between 'technical assistance' and 'technical cooperation'. The first is based on preconceived initiatives developed unilaterally by donors, with little or no participation of beneficiaries; while the second represents a joint effort integrating the partners in a process in which know-how and strategic orientations are shared, thus aiming at the joint planning and execution of programs or projects, with the autonomy of the partners and the sustainability of the process as a whole.

The financial resources available will probably never be enough to cover all of the health needs in the developing world. However, to make matters worse, most of the times, resources are not coordinated, donors support overlapping projects (either with the same purpose or in the same geographical area), and several important areas are left unsupported.

A former Minister of Health of Mozambique, while examining the cooperation processes in his country, once said: *When I was appointed minister, I thought I was the Minister of Health and, therefore, responsible for the health of the country. Instead, I found I was the minister for health projects run by foreigners.*

A recent evaluation on the effects of global partnerships in the health field in 20 developing countries (MCKINSEY & COMPANY, 2005) concluded the following:

*unfortunately, the gains Global Health Partnerships (GHPs) have made have come at a cost. Introducing vertically oriented resources into horizontally organized health systems in a resource-constrained environment creates two likely expected consequences for countries: 1) countries struggle to absorb GHP resources because GHPs do not provide adequate support, technical and other support to implement programs; and 2) countries are burdened with parallel and duplicative processes from multiple GHPs, because they often bypass the processes that countries already have in place. In addition, GHPs have not adequately or effectively communicated*

*with countries and partners. Communication between GHPs and countries is often 'one-way' and the feedback loop from countries is weak. Poor communication complicates the issues described above.*

It is also important to discuss the financing of international cooperation, which was hard hit by the economic-financial crisis of 2008-2009. The richest countries in the world have committed to invest around 0.7% of their GDP in foreign aid until 2015 in order for the Millennium Development Goals to be met. However, the percentage given to poor countries by the rich countries has dropped by half over the last 40 years. It went from 0.48 percent in 1960-65 to 0.24% today (OXFAM, 2004). That percentage represents around US\$ 80 per person per year for rich countries in international aid programs, which is equivalent to about one fifth of the rich countries' defense budgets or half of what they spend in agricultural subsidies (BUSS, 2007).<sup>1</sup>

The comparison between military expenditure and official aid for development (OAD) is shocking, as shown by NGO Economists for Peace and Security (2009): military expenditures throughout the world in 2003 were of US\$ 956 billion, US\$ 417 billion of which were spent by the United States alone. In order for all MDGs to be fully met, it is estimated that no more than US\$ 760 billion will be necessary in the course of the next 10 years, which is, therefore, less than the world spends on arms in only one year. *Per capita* military expenditures was US\$ 1,217.00, while foreign aid received US\$ 46, only 23 percent of which went to those who need the most. This means that for each US\$ 25 spent with the American armed forces, only one dollar goes to foreign aid, and only 23 cents to those who need most. Moreover, most of the United States' OAD goes to strategic military countries (currently, Afghanistan, Iraq, Israel, and Pakistan) (GOSTIN, 2009). In the European Union, *per capita* military expenditures were of US\$ 358, while foreign aid received US\$ 61. Stiglitz and Bilmes, economists and professors at Columbia and Harvard, respectively, estimate that American expenditures with the Iraq War might reach over US\$ 2 trillion (Folha on line, March 2008).

The criticism to the United Nations does not fall behind. Pointed out as inefficient, the UN system, which the World Health Organization is a part of, has a stagnating regular budget, which requires a mandatory contribution from all States, while only financial resources destined to specific purposes and granted by donors grow. In the case of the WHO, currently, around 60% of the budget stems from voluntary contributions (from countries, philanthropic foundations

and private companies), which leaves the WHO's Executive Council and Secretariat with little leeway. Fearing that these contributions might dwarf even further, the Secretariat goes to great lengths to avoid conflicts with powerful donors or the countering of their interests. The growth of voluntary contributions - in detriment to mandatory contributions (which would strengthen the regular budget and, therefore, multilateral cooperation institutional programs) possibly signals distrust from member-countries towards the WHO's ability to implement cooperation projects. Even if the reason is not as serious, it at least means a deformation of the process of multilateral cooperation, which should necessarily be revised over the following years, as the currently underway UN and WHO reform projects recognize (see below).

Finally, as summarized by Birn et al. (2009, p.62-3), *most initiatives in international health are not shared between 'equivalent' nations; they reflect the international political and economic order, in which international 'assistance' is 'provided' by rich and industrialized nations and 'received' by poor and underdeveloped countries. [...] The international assistance reflects geopolitical relations and replicates inequalities in power and resources.* This means that, as an integral and essential part of international relations, international cooperation also reproduces the power relations of a globalized world and can only be effectively changed if the rules and structures in global governance in health are altered.

In view of the current situation in the area of international cooperation in health - very briefly described above -, and dissatisfied with the results obtained in development and health, several actors engaged in global health began seeking alternatives to the dominant model, a few of which are discussed below.

### Alternatives to the dominant model

The criticism to the global governance in health is valid. Throughout the whole spectrum of international relations in the health field - including technical cooperation, the perspectives, policies and practices of the governments, non-governmental organizations, philanthropic organizations and corporate institutions of the most economically powerful nations - which also take most of the positions in multilateral organizations and global partners with greater political and/or economic power or press them to fulfill their political orientations.

Since the issue is not central in the article - and, therefore, will not be fully developed here (except when related to international cooperation) - we will refer the reader to many actors and organizations who criticize current global health

governance schemes (GARRET, 2007; BLOOM, 2007; BIRN et al., 2009; GOSTIN & MOK, 2009).

In order for more adequate cooperation schemes to be carried out between developing countries, various alternatives - which, one way or another, question the traditional and prevalent practices in cooperation - should be considered. This process should:

- change the cooperation strategy (currently based on programs that provide a single global guideline for donors) to more shared cooperation schemes, whose strategic planning is guided by the reality of partner countries; move from “vertical” aid programs (with interventions based on specific diseases, situations or problems) to a “horizontal” approach, that focuses on a comprehensive development of the health system. Vertical programs do not contribute to the strengthening of the system as a whole; on the contrary, they lead to fragmentation and weakness of the system by recruiting the best staff available in the country and as they concentrate themselves in certain areas, they abandon other important areas;
- emphasize the long-term instead of focusing exclusively on short-term needs. This means strengthening key institutions to acquire true leadership in national processes; in the development of a future-oriented agenda; and in balancing specific actions destined to solve immediate problems with the generation of knowledge and the development of sustainable national institutional capacities;
- to broadly incorporate the social determinants of health and intersectoral actions in health cooperation programs;
- to prioritize public health programs (focused on the population) over activities strictly focused on individuals.

In order to promote a global health perspective, it is also important to combine excellence in Health and soundness in the International Relations sector, specially referring to South-South cooperation. Health diplomacy (KICKBUSCH et al., 2007; BUSS, 2008) as a concept emerged to deal with health factors that transcend national borders and expose nations to global influence. This notion also supported an improved, consistent coordination between the Health and the International Relations public sectors, fostering the acceptance of the Millennium Development Goals’ health topics, as well as their incorporation into health and development policies.

The severe criticism made on the currently existing modes of foreign aid for development provided by developed

countries and multilateral organizations led them to carry out the High-Level Forum on Aid Effectiveness in 2005, in Paris, in order to improve foreign aid for development and, thus, make it more effective – as would be proposed in the quinquennial review of the Millennium Declaration and the MDGs to take place later that year. This event produced the “Paris Declaration on Aid Effectiveness” (OECD, 2005), which was signed by 125 countries and dozens of global institutions, including civil society organizations. It stresses the need not only to increase aid for development, but also to improve its efficacy. To attain such, the following strategies were established:

- *Ownership* - Beneficiary partner countries exercise effective leadership over their development policies and strategies and coordinate the related actions;
- *Alignment* - Donors base their support on partner countries’ national development strategies, institutions and procedures;
- *Harmonization* - Donors’ actions are harmonized, that is, coordinated amongst each other, non-competitive and complementary, as well as more transparent and collectively effective;
- *Managing for results* - The decision-making process is centered in obtaining results and resources are employed coherently with the process;
- *Mutual accountability* - Both donors and partners are accountable for development results.

For each of the above-mentioned strategies, goals for 2010 and a monitoring process were established.

The central ideas and guidelines of the Paris Declaration are:

- strengthening partner countries’ national development strategies and their corresponding operational processes (planning, budget and performance assessment, for instance);
- aligning aid with partner countries’ priorities, systems and procedures, as well as supporting the strengthening of their capacities;
- enhancing donors’ and partner countries’ mutual accountabilities to their respective citizens and parliaments regarding development policies and strategies and results obtained;
- eliminating duplication of efforts and rationalizing donor activities to render them as cost-effective as possible;
- reforming and simplifying donor policies and procedures as to facilitate collaborations and progressively align them with the priorities, systems and procedures of their partner countries;

- defining measures and standards of performance and accountability of partner country systems in the domains of public finances, procurement, fiduciary assurances and environmental evaluation, in conformity with broadly accepted good practices and applying them quickly and generally.

Finding the capable mechanisms to implement the principles in the Paris Declaration is also a growing concern. This way, the so-called 'sector-wide approach' (SWAPs) (CASSELS, 1997; BROWN et al., 2001; HUTTON & TANNER, 2004) has been used in many different situations, such as in the health field in Africa (WALDORF, 2007), in order to bring into operation the ideas of ownership, alignment and harmonization, in particular. SWAPs seek to facilitate and reduce the weight of coordination, the fulfillment of requirements concerning follow-up reports and accountability actions that fall over the government of countries due to the proliferation of donors with different demands and management practices. The many partner agencies are changed into a sort of "consortium of partners for health", which have agreed to use equal procedures concerning planning, implementation, monitoring and reporting; they would also commit to coordinate the initiatives of various different actors involved in one specific issue or in a particular part of the country (BIRN et al., 2009).

Another initiative, the International Health Partnership (2010), was launched in 2007 and advocates for the harmonization of international donors and partners around national health strategies led by partner countries, using the principles of the Paris Declaration and the Accra Agenda. This initiative is under development in 15 African countries and 2 countries in Asia.

One could only assume that the important Paris Declaration and the adhesions of numerous countries and organizations to its proposals would result in more foreign aid for development and in more adequate practices, thus producing positive consequences over the 'jewel of the crown' of international cooperation, that is, the great global development project of the United Nations for the 21st century: the Millennium Development Goals (MDG), established at the Millennium Summit, carried out in the year 2000, in New York (UN, 2000).

However, the conclusions of the last two Reports on the MDG – including Objective #8 – were a great cause of concern. The 2007 Report (UN, 2007) states that aid for development has been dropping in spite of donor countries having reaffirmed their commitments (which appears to have been only rhetorical); that donors have committed to double

their aid to Africa, although very little has been accomplished by now; and that the preferential access to markets in developed countries has been reduced for most developing countries. Additionally, the 2008 Report (UN, 2008a) added that aid for development dropped for the second consecutive year, thus affecting commitments for 2010; that agricultural subsidies in rich countries largely surpassed the money provided for aid for development; and that the low availability and high prices constitute barriers for the access to essential drugs in developing countries. In 2008, the United Nations carried out, in New York, a High-Level Event on MDG, in which concerns about the slow progress towards attaining the goals in many countries - especially in the poor countries and, despite constant reiteration, due to failures in the financing by developed countries - were expressed.

A World Bank-IMF report also warns that most countries will fall short on MDG. Though much of the world has been able to reduce extreme poverty, prospects are the gravest for child and maternal mortality goals. The same occurs with the universalization of primary school, as well as with nutrition, and sanitation goals. The report also emphasizes the link between development and the environment and calls for urgent action on climate change. To further build on hard-won gains, developing countries need support to address the connections between growth, development and environmental sustainability.

The Accra High Level Forum on Aid Effectiveness was carried out in Accra, Ghana, on September 2008 and produced the 'Accra Agenda for Action' (UN, 2008a), which reiterates the Paris Declaration and stresses the need to reduce the burdensome fragmentation of aid. Subsequently, in Doha, on December 2008, the Conference on Financing for Development took place and produced the 'Doha Declaration on Financing for Development' (UN, 2008b), which (at least on paper) reaffirmed the willingness of developed countries in committing 0.7% of their respective GDP on foreign aid to developing countries until 2015. Both include specific references and special emphasis on cooperation with Africa, where MDG evolved the worst (MDG Africa Steering Committee, 2008).

The United Nations, which had been criticized due to the lack of coordination of its actions in the health field, launched an initiative (administered by UNDP) to articulate the work of its various agencies within countries.

Regarding the health sector specifically, one of the first initiatives taken between countries was the 'External Policy and Global Health Initiatives', launched by the Ministries of External Relations of South Africa, Brazil, France, Indonesia,

Norway, Senegal, and Thailand (2007), which produced the Oslo Declaration, calling attention of countries to prioritize health in their foreign policies with every country. In response to this international call to action - conducted by important countries in various continents -, the General Assembly of the United Nations, at the 63rd Session (2008), adopted Resolution 63/33 on Global Health and Foreign Policy, recognizing the close relation between both fields and determining that the Economic and Social Council (ECOSOC), in its session in July 2009, addressed the 'achievement of the objectives and commitments agreed upon internationally regarding the global public health', besides requesting greater coordination of the health field within the UN system.

The Ministerial Declaration on Global Public Health, a long document that emerged from the ECOSOC's 2009 High-Level Segment (UN/ECOSOC, 2009), carried out in Geneva, announced a comprehensive agenda for governments, United Nations agencies and the global civil society around the topic of global health, which then went on to be negotiated by member-States of the UN, either at the General Assembly or within the WHO.

On the other hand, a Cooperation Policy Centered on WHO Countries (WHO, 2010) was launched within the WHO and its Regional Offices. The policy gathers the following features:

- to establish clear cooperation strategies between countries in the health field that have been developed after careful consultation of national health authorities;
- to provide WHO Representations in countries with the adequate human resources to fulfill the cooperation strategies agreed upon between parties;
- to provide coherent technical and programmatic support to the countries through Regional Offices (such as PAHO) and the headquarters (in Geneva);
- to assure effective administrative operations in the countries' Representations to facilitate meeting the goals agreed upon with national health authorities;
- to develop information and knowledge management initiatives from within countries and for the countries;
- to collaborate with the United Nations system and associate agencies towards development.

The result of these actions within the United Nations are still to be felt and should be followed closely by actors interested in global health and health diplomacy.

With the growth in importance of the theme in the international agenda, many academic institutions around the

world have been establishing research and training centers dedicated to global health, international relations and health diplomacy. In Brazil, one example of that is Fiocruz's Center for Global Health (CRIS), created in January 2009 (FIOCRUZ, 2010), under the institution's Presidency, in order to endow the institution's international health cooperation sector with greater organicity, closely aligned with Brazilian foreign policy, which is highly focused on cooperation for development in the social sphere, especially health. In the international sphere, academic alliances have been made, such as the Global Health Education Consortium (2010), the Consortium of Universities for Global Health (2010) and the Consortium for Global Health Diplomacy (2010). As international friendship and solidarity surpass pure (and often exploitative) competition between nations, such initiatives tend to grow both in Brazil and the world.

In the field of health research, besides the historic work carried out by TDR (2010) in stimulating research and innovation in infectious diseases, there is also another more recent initiative, the Global Forum for Health Research (2010), an independent international organization, dedicated to 'stimulating research and innovation for health and health equity, aimed at the world's poor and excluded populations'.

In this specific field, Rottingen et al. (2009) have recently advocated for the rationalization of the global architecture of health research, thus condensing and merging many organizations and initiatives headquartered in Geneva.

### A different alternative: South-South Cooperation

*The responsibility for the development of the South lies in the South, and in the hands of the people of the South*  
(Julius Nyerere, 1990)

The idea and praxis of 'South-South cooperation', also known as 'horizontal cooperation', emerged in both political and economic spheres in the Cold War years. In the political field, after the Bandung Conference (1955), countries of the so-called 'Third World' established the 'Non-Aligned Movement' to oppose bipolarity and remain equidistant from the United States and the Soviet Union blocs, as well as seek a more favorable economic order. At that moment, independent States popped up everywhere in Africa and Asia, after years of colonial exploitation. Most of them suffered from severe social, political and economic disorganization due to years of fight for autonomy and/or local ethnic conflicts. A few Latin-American nations have also developed the willingness to cooperate with Southern countries in search for solutions for similar problems.

In 1964, at the end of the United Nations Conference on Trade and Development (UNCTAD), 77 developing countries signed the declaration that created the Group of 77. Currently composed of 130 countries, the Group convenes annually, acts concertedly in international *fora* and has been an important actor in South-South cooperation, although mainly economic cooperation, as demonstrated by the Declaration of the South Summit and the Havana Action Plan (2000), the Teheran Consensus on South-South Cooperation (2001), the Dubai Declaration for the Promotion of Science and Technology in the South (2002), the Marrakech Declaration and Framework on South-South Cooperation (2003) and, finally, the Development Platform for the South, with its set of principles on South-South cooperation, and the launch of the South Fund for Development and Humanitarian Assistance (2008; G77, 2010).

In the economic realm, South-South cooperation was dedicated to stimulating intra-hemispheric trade, as well as the sharing of production technology. With the end of bipolarity and with the changes occurred in the international development order, the emphasis on human development and poverty eradication allowed South-South cooperation to be strengthened in the social field.

In reality, it was due to a claim by Southern countries - for cooperation to transcend aid attached to political/strategic interests and become a source for exchange and mutual interests, thus enriching all parties involved - that the United Nations revised the notion of *technical assistance* and substituted it with the term *technical cooperation* (Resolution 1383B, the UN General Assembly, 1959).

Over 30 years ago, in 1978, in the midst of the decolonization process - which took place predominantly in Africa, but also in Asia and the Caribbean -, the United Nations Conference on Technical Cooperation among Developing Countries was carried out. The conference's recommendations were approved by the 138 participant countries and compiled as the *Buenos Aires Plan of Action on the Promotion and Implementation of Technical Cooperation among Developing Countries*, a true landmark in the history of international cooperation – the basis for autonomous action in external cooperation among developing countries.

The Special Unit for South-South Cooperation (SU/SSC) was established by the United Nations General Assembly in 1978. Hosted within the United Nations Development Program (UNDP), its mission is to promote, coordinate and support South-South and triangular cooperation on a Global and United Nations system-wide basis. The SU/SSC

receives political guidance and counseling and works as a Secretariat of the High-Level Committee (HLC) for South-South Cooperation of the United Nations Assembly.

In 1983, the General Assembly established the Perez Guerrero Trust Fund, managed by SU/SSC and dedicated to supporting activities regarding technical cooperation among developing countries (TCDC) of the Group of 77. The Fund finances pre-investment and feasibility studies and facilitates the implementation of projects of that nature.

In 1987, the South Commission, composed of 28 leaders from Southern countries, among which included Brazilians Dom Paulo Evaristo Arns and Celso Furtado, was established to expand South-South cooperation schemes. Its report (THE SOUTH COMMISSION, 1990) became a classic and was turned into a global reference on the theme.

In 1993, the United Nations Economic and Social Council, in a resolution ratified by the General Assembly, stressed that all agents connected to the development process should double their efforts in order to make broad use of TCDC as the preferred method for preparing and implementing development-related projects and activities, thus overcoming the mere marginal use that it had previously.

At the 10th Session of the United Nations High-Level Committee on TCDC, in 1997, it was pointed out that, in order to fully optimize TCDC, it would be necessary to contribute to the development of policies and institutional procedures which ensued recommendations not only for developing countries to incorporate TCDC as a central element of their national development strategies, but also for providing national TCDC-related instances and focal points with the essential human and financial resources for their effective functioning. It was also recommended that financing for TCDC be substantially increased by developing countries themselves and by cooperating countries and multilateral agencies.

The fall of the Berlin Wall and the subsequent collapse of the unipolar world (represented by the United States' imperial power, which was responsible for the most recent crisis in global capitalism - unprecedented since the 1930s), as well as the growth of emerging economies and the resulting increase in their political power, stimulated the emergence of a multipolar world, in which South-South cooperation also flourishes. The United Nations High-Level Conference on South-South Cooperation (carried out in December 2009, in Nairobi, Kenya, with the theme "Promotion of South-South Cooperation for Development", and whose documents, debates and results can be accessed in the conference's website) is a significant sign of this situation, which has been globally shouldered by the international community.

Many analysts say that, due to the proliferation of discriminatory commercial barriers, the decrease in aid for development (caused by the economic/financial crisis), the increase in foreign debt and the decline in prices for raw materials, South-South cooperation has grown in importance. In this context, Southern developing countries, although with inherent difficulties to the process, seek to strengthen unity and solidarity as a necessary condition to develop their negotiating capacity in international multilateral *fora*.

A study published in 2004 (UNDP, 2004) by the Special Unit for South-South Cooperation (UNDP) points out how important it is to strengthen mutual assistance 'in a period of quick globalization'. Driven by the leadership of Brazil, China and Cuba (later joined by India), South-South cooperation schemes have been examples of the principles referred to in the above-mentioned study.

Brazil has been very active in providing aid for development to other countries in the fields of public administration, health<sup>2</sup>, education, agriculture, the environment, energy and small companies, for instance. China and India have important technical training programs for nationals of developing countries, which in turn improves the institutional capacity of these countries.

The G8 is paying attention to the process and responded to the Group of 77 accepting the creation of the G20, which is led by Brazil. This is still in dispute and what will come out of it depends on the capacity of actors to reach a consensus between relevant political actors among the developing countries, such as Brazil, India and China.

Regional organizations between neighbor countries in the hemisphere also play a fundamental part in South-South cooperation. ASEAN (Association of Southeast Asian Nations), in Asia; the African Union and NEPAD (New Partnership for Africa's Development), in Africa; and UNASUR, in South America, are a few examples of South-South cooperation schemes in the economic and social realms that, despite still under development, should be paid attention to due to their potential. South-South solutions are sought even in communities only culturally linked, such as the Community of Portuguese-Speaking African Countries (CPLP). This publication also includes an article on the experiences of CPLP and UNASUR regarding South-South cooperation in health<sup>3</sup>.

### Prognosis for international cooperation in the health field

International efforts have recently expanded into a series of initiatives that are able to stimulate international cooperation in health.

The Millennium Development Goals (UN, 2000), the great global pact towards development signed by all United Nations member-States, is a very positive example of an international response to global health problems (three of the eight goals focus specifically on health problems (child mortality, maternal health and specific communicable diseases, such as HIV/Aids, malaria and tuberculosis) and the social determinants of health (such as poverty, hunger, basic education, and environmental sustainability).

The WHO 2008 Reports mention two other extremely important initiatives that represent an expansion in international cooperation efforts: the strengthening of Primary Healthcare as an idea and a practice 30 years after the Alma-Ata Conference of 1978 (WHO, 2008) and the debate sparked by the Commission on Social Determinants of Health (WHO, 2008a), which brought to the table a vast set of social determinants of health and the necessary political responses in order to adequately address them and improve health conditions both globally and locally. In 2011, Brazil will host the Global Conference on Social Determinants of Health (whose organization had been decided by a WHO Resolution approved by the World Health Assembly in 2009), working towards a comprehensive international political pact and a global strategy dedicated to fighting social inequities in health.

Global international agreements concerning health that have been reached within the WHO still in the first decade of the new millennium - such as the Framework Convention on Tobacco Control (FCTF, 2008) and the International Sanitary Regulations - point out, despite the WHO's credibility crisis, to the vitality and viability of international negotiations on essential health issues.

The Paris Declaration on Aid Effectiveness (OCDE, 2005), which was prepared after a consultation with traditional donors and partner countries, is crucial to international cooperation and is able to provide guidance - especially by means of its harmonization and alignment strategies - to future cooperation processes, thus rendering them more equitable, less onerous and more adequate to developing countries, especially in the context of the MDG.

Either acting alone or through international partnerships, governments develop programs and make financial resources available for development or health programs. New institutional arrangements, such as the alliances and coalitions with specific goals who gather many partners such as The Global Fund to Fight Aids, Tuberculosis and Malaria (GLOBAL FUND, 2010) and The Global Alliance for Vaccines and Immunization (GAVI, 2010), as well as the

traditional international philanthropic foundations, provide significant financial resources to the cause of global health, but consolidated themselves as large providers of traditional assistance and not as actors in innovative cooperation in health. Southern countries that have been witnessed quick growth and development, such as India, China and Brazil, have become aid providers and international investors. Moreover, the European Union has just launched a Global Health Europe initiative, defined as “a platform for the engagement of Europe in Global Health”. At the same time, the number and the scope of activities of the organized civil society, which offer support and services throughout the world, also grew.

The Global Health Committee of the Institute of Medicine of the United States Academy of Sciences prepared two seminal documents on the “United States Commitment to Global Health”; one with recommendations to the new administration, which was delivered to President Obama right after his election (IOM, 2009) and another, the Final Report (IOM, 2009a), with recommendations on global health and international cooperation in health, which was delivered to the government and the American society as a whole, as well as the private sector. On February 2010, partly influenced by the IOM report, the American government published a consultation document on its Global Health Initiative (U.S. DEPARTMENT OF STATE, 2010), which is clearly based on the Paris Declaration and rectify various deformations of the previous air programs developed by the United States.

Furthermore, a number of new actors have demonstrated the level of commitment of the civil society with international cooperation in health, including the World Federation of Public Health Associations (WFPHA, 2008) - which gathers more than 70 national and regional associations and represents around 250 thousand public health professionals throughout the world (IANPHI, 2008; BUSS et al., 2009) - and the International Association of National Public Health Institutes (IANPHI, 2008; BUSS et al., 2009) - which congregates around 60 existing institutions and provides support for the creation of public health institutes in developing countries -, among many others dedicated to various aspects of public health and healthcare all over the world.

New financing strategies and new cooperation models - as well as profound changes in a few countries that moved to an intermediary category of development (and are now considered “Innovative Developing Countries”) - have been facilitating new partnerships for health (and, consequently, also new partnerships for development and peace). Among

these countries is Brazil, which is increasingly present in the international sphere and in South-South cooperation schemes in the health field (MRE, 2008; ALMEIDA et al., 2009). The country has been developing a participative, democratic, inclusive and comprehensive model of cooperation that is able not only to encompass the health domains, but also its social determinants and intersectoral policies. The country advocates the idea that health is essential for development, which should include a social dimension, citizenry, quality of life and health - and not only “economic growth”.

In conclusion, despite the distance between the boastfulness of intentions and the materialization of gestures, it could be said that the balance for international cooperation in health is positive, regarding either the countries’ global health and health diplomacy policies or the initiatives of multilateral agencies, civil society organization or global partnerships.

However, notwithstanding the positive signs, the authors would like to convey their deep concern with the risk that the recession in the richest countries (which they themselves caused) could threaten the vital international cooperation in health. Nonetheless, if the global community is willing to invest trillions of dollars to save banks from bankruptcy, it should also be able to allocate at least a fraction of that to alleviate poverty, to fight hunger, inequity and social exclusion and to implement suitable projects in the domain of international cooperation in health.

## Notes

1. One useful source for those interested in the evaluation of the foreign aid provided by rich countries to developing countries is the website of the Center for Global Development (<http://www.cgdev.org>) which, by using a composite index (Commitment to Development Index), assesses various dimensions, such as the level of aid, trade, investments, migration, the environment, security and technology.
2. The Brazilian South-South cooperation in the health field is analyzed in a different article in this publication (ALMEIDA et al., 2010).
3. Buss and Ferreira (2010). Another article on cooperation in health within UNASUR is Buss (2009).

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