Global Health Diplomacy: Union Bridge Between Health Policy and International Relations in the Twenty-First Century Cuba As A Case Study

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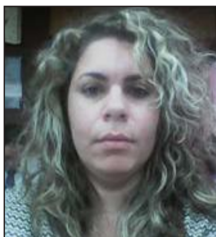

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Introduction

The globalization process, characterized by the steady growth with significant impact on the global population, has been modified continuously by technological, political and economic changes, which govern "global village" in which we are living, affecting manifestly relationships established by the states. The settings in the last two decades of a political system, which modified global trade among states and determined other aspects of human development, influenced directly complex relationship between global health and international relations, especially the field of international cooperation in health (Kickbusch *et al.*, 2007). This scenario has created new global international actors with different roles and responsibilities as well as new alliances and partnerships; assuming a leading role in human community.

Generally, the policy in the external field has been focused on the protection of national interests from the point of view of security, economic and territorial development, and ideological interests. This vision has evolved for seeking to include in discussion circles and meetings of high political level, the high degree of importance to human health.[1]

In the recent years, health policies have had a greater presence and priority on the international agenda.[2] This raises challenges for countries and international organizations to impose an exponentially greater dialogue among the fields of health and international relations.

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Through this we will show and characterize briefly an interesting work tool implemented by governments and other actors of the international politics during the last ten years to achieve increasing attention on global health from a perspective supported by collaboration, solidarity and comprehensive development among countries and international institutions.

Background

Historically, the fields of health and international relations, although not complete strangers, have not had a relationship to consider health as a prominent topic by foreign ministries; instead they considered this a matter of low priority. In this sense, the trend generally, has always been considered of "high politics" to matters of war and peace, economics and trade. However, it should be noted that ancient health and disease (as a result and as a weapon) was a matter of high importance in the wars, particularly in the great wars of the nineteenth and twentieth century.[3]

Source: International Conference at Alma-Ata (USSR) in September 1978. A view from the stage at Alma-Ata. Source: http://www.paho.org/english/dd/pin/alma_photos.htm

From the perspective of policy on health, several observers indicated that international trade and finance, population mobility, environmental change, international conflicts and disasters as well as issues of international security, among others factors, impacted health. Stronger links have been between health and foreign policy in the fields of transportation, commerce, tourism and emigration,[4]

For example, in the nineteenth century various forms of international cooperation were generated in health due to the spread of infectious diseases, which impacted negatively on trade among countries; this gave greater importance to the health of the ports. From there it became necessary to regulate this situation, and in 1832, International Health Regulations were created .

Since 1945, after the establishment of the United Nations, reconstruction of post-war economies and increasing liberalization of trade led to the creation of numerous international agreements and institutional arrangements relating to health.[5] Among them, in 1978 mention may be made, of the Alma Ata's Declaration on Primary Health Care, the significant attention given to the issue of HIV/AIDS in global or regional Heads of States such as the Declaration of Nassau, where Caribbean Community (CARICOM)'s heads of states recognized health of the population as part of the wealth of this geographic region, and also during 2007 Trinidad and Tobago's Summit, when the situation of chronic not communicable diseases was widely discussed. An example of convergence of trade and health interests in 2002 and 2003 with the outbreak of Severe Respiratory Distress Syndrome (SARS) affecting the Asian region was also observed.

However, it should be noted that after the aforementioned Declaration of Alma Ata, the global health agenda was driven mainly by the appearance of diseases with the emergence of the term of health security. Even though the nations agreed to the provision of basic health needs with a model called "Primary Health Care", the language used in the Declaration consisted of an ambiguous interpretation; facilitating many governments for assuming no real commitment. Besides there were health programmes, which they did not consider key elements, such as community involvement and recognition of health promoter.

Global Health Diplomacy, Branch of Science Diplomacy: Highlights

Since 2005, WHO has been at the centre of the new relationship between health and foreign policy, as a result of the negotiations for the formulation and enactment of the Framework Convention for the Control of Snuff, the new International Health Regulations and related to the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property held in 2008.[6]

Another point to note in this transformation was the launch of the Initiative on Global Health and Foreign Policy (GHFP), signed in March 2007, as Oslo Declaration in the Norway's capital by the Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand to move towards a foreign policy taking into account considerations beyond global crises and health emergencies. This initiative sought promotion of use of health lens in the formulation of foreign policy to work together towards common goals. The Oslo Declaration and 2007 Agenda for Action noted the urgency of extending the field of foreign policy to encompass priority health issues in the era of globalization and interdependence, and referred that this new vision was based for protecting life of world citizens

This positive change in the nature and perspective of the relationship between health policy and foreign policy is a challenge as wellas an opportunity for countries and organizations in terms of international cooperation. In this globalized world, every country and sub-region has significant number of problems, challenges, opportunities and commitments, which match conditions of the interdependence between health and foreign affairs policies, and displayed more clearly need to capitalize on global health opportunities for the benefit of their people, to realize the rights and aspirations of their citizens and to assumed commitments presently around the world. That's why it's essential to attract national and institutional capacities to ensure effective management of these opportunities and to address associated risks and threats to health.

Following these premises, a technical and academic programme was configured, known by some specialists as Global Health Diplomacy or GHD (Kickbusch *et al.*, 2007. In that way, several academic institutions and think-tanks have begun, as an outcome of the Oslo Declaration, to play a critical role aiming to raise profile of health as a topic of concern for foreign policy, carrying the banner of need for providing policy analysis and research, while improving training opportunities for both diplomats and specialists in public health at the interface between health and foreign policy.

Academic programmes following this line have been implemented primarily at the Center for Strategic and International Studies, based in Washington, through the Global Health Policy Center, Institute for Global Health of Beijing; Center for Global Health Security Chatham House in London; Fiocruz Institute of Brazil through the Institute for Global Health, and the Graduate Institute of International Studies in Geneva, Switzerland.

Several studies conducted in most of these institutions were published regarding relationship between Health's Governance and Health System's Development Process[7] in the nations, which required to analyze changes that occurred in the architecture of international health cooperation in the recent years, which undoubtedly represented a different and innovative behaviour according to what had happened in the field of international health after World War II.

Some of the notable changes included are as follows:

- The proliferation of new transnational actors and private actors in the corporate business sector, including commercial profit companies, the philanthropic sector and business associations and non-governmental development organizations in developed countries;
- The growing role of international financial institutions in the financing and governance of the health sector in countries of low and middle income;

- A progressive interference in the private sector in the development of public policies, particularly developed countries private agents influencing public policy in developing countries.

Dr Ilona Kirksbush, General Director of the GHD Programme, at the Institute of Graduate International Studies in Geneva, Switzerland, stated that GHD tried to relate the negotiation process in which multiple actors were involved to varying degrees of political and economic relevance, and shaping and coordinating global policy environment for health (Kickbusch *et al.,* 2010). Ideally the results of global health diplomacy are reflected in three main following effects:

- To ensure better health security and health outcomes of the population for each of the countries involved (serving national and global interests)
- To improve relations between States and strengthen commitment of a wide range of actors working to improve health; and
- To provide an understanding of health as a common effort for security as a human right and a global public good with the objectives of achieving results that are considered fair for a majority of the population (e.g., reducing poverty, increasing, equity, etc.)

For the academic point of view, it can be seen that these GHD programmes encompass public health disciplines, international relations, management, law and economics disciplines and focus on the negotiations leading global policy environment for health. The main content of these disciplines is aimed for preparing specialists in negotiation of agreements related to public health across national borders and in other fora, global health governance, foreign policy and health and development of national strategies for global health.

Global Health Initiatives

Since the last decade, this academic movement has served according to its promoters for supporting a wide variety of coalitions, networks and alliances, as specialists appointed by the Global Health Initiatives (GHI), which proliferated in the field of international cooperation for the development, especially of new health policies. Those have been created by the GHI as a necessary step to address complex challenges of the global health agenda and to channel additional resources for health organizational model. Some of the most known are the Global Initiatives for the Eradication of Polio, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Global Alliance for Vaccines and Immunization (GAVI), Alliances Stop TB, Roll Back Malaria, Global Alliance for Improved Nutrition (GAIN), Multi-Country HIV / AIDS Programme (MAP) of the World Bank, among others.

Regardless, the reality is there are a few financially and politically important initiatives that are playing a key role in global health governance. One of the most powerful and known is the Bill and Melinda Gates Foundation, a philanthropic institution, which has come to be recognized as an important source of funding and influencing global health activities.

However, growing importance of these GHI raises profound and new challenges, and presses on the sovereignty of states and existing institutional arrangements for international cooperation, taking into account financial resources that enhance decision-making power and intervention at high political and even legal levels.

It is important to note that, despite increased financial resources from the private sector, the public sector continues to provide most of the funds. Private contributions to global health funding are a minor fraction of the total aid. However, private actors have increased disproportionately to the amount of funds which generate greater visibility and control of political power in the framework of global governance.

This is one of the reasons that compel us to consider that results obtained so far are not entirely positive. Most of the funding from the GHI and programmes promoted by the GHD are for disease's vertical control programmes with very little support to strengthen basic health infrastructure and health systems.

In this sense, many of these interventions have recharged the work of national health authorities, undermining national health development. Therefore, if in the past, the main issue was the lack of resources, at present is the problem of how to manage and control this complex network of stakeholders without falling into political and economic interference.

Cuba and its View of the Application of the Global Health Diplomacy

An example of real implementation of diplomacy, based on the international collaboration in health, has been developed by Cuba since the last 40 years.

The Caribbean island, which in 1960 had only three thousand doctors to serve about 6 million inhabitants and an incipient scientific and technological development, has managed to become a model of hope for the international cooperation, taking as its premise the priority that government gives to health and better living conditions for its population.

Issues of the Educational and Healthcare Systems In Cuba

Educational System

Education has always been a major priority of the Cuban Revolution; dedicating significant moments since the 1960s being a National Literacy Campaign.

Since then, the National Education System of the Republic of Cuba is conceived as a set of subsystems organically articulated at all levels and types of education. This system began to develop during the 1960s and 1970s of the last century when they were implemented challenging programmes of training of human resources that allowed thousands of young people prepared in different fields of health and science both in Cuba and in different countries of the world. At the same time the government invested millions of dollars in the creation of universities across the country; creating a network of broad participation and desire to study among youth.

Some of the main features and updated statistical data of the Cuban educational system to understand the results achieved are briefly as follows.

Cuba currently has:[8]

- More than 1100 care centres with capacity for 149 100 children
- More than 9400 Elementary Schools
- More than 1900 Media Education Centers (includes junior high school, high school, technical and vocational education and training of teaching staff)
- More than 195,000 workers linked to teaching.
- 17.6 Teachers per thousand, recognized as the highest number of teachers per capita globally.
- 43 inhabitants per teacher
- 11.5 Pupils per teacher (Middle) Pupil Teacher (High)
- 100 percent Primary school enrollment rate
- Nearly 100 percent Secondary enrollment rate

Moreover, in Cuba there are 62 university-level establishments, of which 17 belong to Ministry of Higher Education, 16 to the Ministry of Education, 14 to the Ministry of Public Health and 15 to other agencies. Those Institutions of higher education include 20 753 full-time professors and 1934 part time associate professors. It should be noted that since 1959 to-date more than one million students have graduated in different university courses and about 40 percent of university graduates were engaged annually in postgraduate courses.

Therefore, we are talking about an established educational system that continuously carried out changes in the direction of improving cognitive abilities of the population.

Health Care System

Meanwhile, since the last 60 years, Cuban government have been operated a national health system and assumes fiscal and administrative responsibility for the health care of all its citizens. There are no private hospitals or clinics as all health services are government-run.

On the basis of the educational system described above and the large investment made by the government a health system across the country has been created including free attention at hospital facilities for all population.

The maternal and child care programme, among other goals, has reduced infant and maternal mortality, leading the concept of preventive immunization of all children who are vaccinated against 13 diseases. Cuba was the first Latin American country to meet the goals of primary health care as the international strategy of Alma Ata, adopted in 1978.

Despite the ongoing United States embargo against Cuba during the 1990s, which caused problems due to restrictions on the exportation of medicines from the US to Cuba, the investment in human resources and facilities have enabled lately a strength that certainly explains the current results of health services in Cuba. Here are some statistical data:[9]

Hospitals : 286 (General Medicine 83, Clinical – Surgical 34, Pediatric 26, Gynecoobstetric 18, Maternal – infant 18, Rural 64, Specialized 43, Nursing Homes 197, Homes Grandparents (daytime only) 67, Homes for the handicapped 38, Maternity homes: 289, Blood banks: 27, Cardiocenters 6, Coordination Medical Emergency Centers 10, Pharmacies : 1,961, Research Specialized Institutes : 13, Science and technology units, 37.

Health Indicators

- Life expectancy at birth: 78.19 years
- Infant mortality rate: 4.1/1000 births
- Mortality of children under 5 yrs: 7.0/1000 live.
- Maternal mortality rate: 3.51/1000 live births.
- Total Health workers: 447.023 Represent 13.2 percentof total workers in the country
- One nurse every 126 inhabitants.
- One Doctor every 159 inhabitants.
- One dentist for every 1066 inhabitants

Given the country's population, and the multiple economic difficulties existing, it can be said that there have been significant achievements as well as a successes in implementation so to invest in new conditions of life through scientific and technical development in health.

Impact of Education and Health Services of Cuba In Global Health Diplomacy

After five decades from1959, when Cuba had only 3000 doctors, there has been an increase of more than 70,000 medical specialists, 90,000 nurses, and about 30,000 health technicians, who provide high quality services to more than 11 million inhabitants. More than 134 000 Cuban health workers, trained in the past 40 years, have provided services to more than 108 nations in Latin America, Africa, Asia and even Europe, under different collaborative programmes, coordinated by the Cuban Ministry of Health with support from other governments, non-governmental organizations and the regional Health Authorities. In addition, the Caribbean island has promoted with its own resources and expertise the creation and support of international medical schools in Cuba and several countries where innovative and proactive Cuban teaching method is being used and thousands of young people have completed medical programmes and other health specialties.

During the present century, several examples have shown the style implemented by the government of Havana to employ health and outcomes in the education system as an efficient and supportive mechanism to improve relations with different countries and agencies worldwide following Science Diplomacy programmes.

Cuban Response to the Tsunami Hit in Asian Countries (2006)

Medical teams from Cuba operated clinics in Indonesia and Sri Lanka following tsunami that rolled across the Indian Ocean on 26 December 2006, taking hundreds of thousands of lives.

Cuban government, with the agreement from the Indonesian authorities, implemented fast way transfer of a medical brigade to assist affected population.

The 25 volunteers in the team to Aceh, Indonesia, treated wounds, infections, respiratory diseases and also psychological shock behaviors.

In Sri Lanka, the Cuban volunteer team had set up a temporary clinic in Galle, 70 miles from Colombo, the capital undertaking a demanding work in coordination with the health authorities of this country and international organizations

Earthquake in Haiti and the Response of the Cuban Health System (2010)

Cuba was the first to arrive in Haiti with emergency medical help after the earthquake of 12 January 2010. Solidarity among many nations, Cuba and its medical teams played a key role in assisting earthquake victims. Public health experts said the Cubans were the first to enable medical facilities among the ruins and strengthen hospitals immediately after the earthquake.

Haiti and Cuba signed a medical cooperation agreement in 1998. Before the earthquake struck, 344 Cuban health professionals were already present in Haiti, providing primary care and obstetrical services as well as restoring the sight of Haitians blinded by eye diseases. Medical staff flew shortly after the earthquake as part of the rapid response.

In almost 15 years of presence of the Cuban medical brigade in Haiti, especially after the earthquake, a total of 20 million 946 thousand 528 patients were treated, of which 6 million 792 thousand 394 were seen in their own homes. There were 373,000,513 surgeries, 140 thousand of which 191 were major surgery, and assistance was given for 150,000,336 births, of which 16,000,481 were caesarean. Also, through Operation Miracle programme, returned or improved vision of 60 thousand 281 Haitians, while 322 thousand 753 were treated in rehabilitation, of which 55,000,707 were fully rehabilitated.[10]

South–South Collaboration in Biotech Field (2007)

A partnership between the Institute of Immunobiological Technology (Bio-Manguinhos/ Fiocruz) of Brazil, and the Finlay Institute in Cuba, allowed an effective response to an emergency appeal of the World Health Organization (WHO) for distribution of vaccines for the Meningitis Belt in Africa; the area, which stretched from Senegal in the west to the east of Ethiopia, between 2006 and 2007, by at least 14 warnings of disease outbreaks.

Finlay Vaccine Institute based in Havana City with a long history of meningitis research and managed to control a meningitis outbreak in Cuba in the mid-1980s, developing a purified meningococci vaccine that was the first of its kind worldwide. Bio-Manguinhos Institute, located in Rio de Janeiro, also has extensive experience in vaccine research and manufacturing, and has developed an efficient scale-up process using lyophilization. By collaborating and relying on their respective strengths, these two organizations were able to supply, in a timely fashion, meningitis A vaccine capable of combating the African meningitis outbreak.

For other part, the WHO also facilitated the collaboration by making it possible for ANVISA, the regulatory agency in Brazil, to collaborate with the Cuban regulatory agency CECMED. The agencies were able to exchange information about their respective regulatory systems, which made it possible for them to align the collaborative process. Neither Bio-Manguinhos nor the Finlay Institute alone would have been able to respond so quickly and efficiently to this request. This example therefore demonstrates how South-South collaboration can be harnessed to address a health threat when spurred by demand and funding from an international organization. It also shows how South-South collaboration can contribute toward improving global health.

Since the start of production of vaccines for the region, the joint initiative has already provided more than 20 million doses by various international organizations, such as WHO, Médecins Sans Frontières, the United Nations Fund for Children (UNICEF) and the International Committee Red Cross.

Health Policies+International Relations = GHD.

Those were examples upon which we could comment. However, another approach has been the internationalization of agile, safe and free method of health care as that Miracle Operation which has restored or improved vision for millions of Latin American, African and other regions of the world through intergovernmental cooperation programmes that allow free access of patients to public attention system.

As if this were not enough, Cuba has managed to deploy and maintain, an extraordinary scientific and technological system whose highest point is a biopharmaceutical industry through a closed cycle can develop quickly and efficiently, registration and commercialization of vaccines and biopharmaceutical products characterized by its novelty, its quality and especially the philosophical view that is affordable for countries and companies with fewer resources. In this line of work this system today markets more than 50 products to high impact and added value in more than 60 countries on all continents.

These results have been supported by seasoned diplomats from the Ministry of Foreign Affairs who have collaborated with these and other programmes implemented at national level followed by its application in dozens of countries, being besides common in each of these examples, the interaction between the Ministries of Health, Science and Technology and Foreign Affairs which work together in these developing collaborative projects.

With this strength of Human Resources and principles based on the collaboration and solidarity Cuba has become one of the largest and best examples of the practice of GHD.

Thus, using techniques, resources and plans based on GHD this small country has significantly increased its influence and political and trade relations with a large quantity of countries on the basis of ethical and solidarity principles put forward by the political will, the scientific and technical development and the development of human knowledge, in this case in the field of health.

Conclusions

The world of the XXI century is a complex world, in which the development mankind has achieved in science and technology can't yet deliver real benefits to the entire population of the planet. In our humble opinion, the contrasts and differences between developed and developing countries are increasing every day. In this sense, human health is an essential resource that must be taken utmost care and concern by the governments of nations. If we make a brief consultation to map the planet, we can see that there is a high level of agreement while comparing countries with a fewer resources to those with weak health systems and poor technical scientific development. It is a known fact, but a few people admit it or try to do something about it.

In this sense the GHD is an academic tool which, theoretically, trying to achieve an agreement between the richest countries to raise awareness about the situation and by health policies achieve better results in those countries with lower incomes. That's why, the role of governments is essential, besides NGO, biopharmaceutical industry, regulatory agencies and the educational system of the most industrialized countries. The way that all these actors could be sensitized and act together or not, would depend on the success of this programme, and this can be a first conclusion.

Cuba's example has shown how far a country with few economic resources can carry on actions of solidarity, cooperation and scientific exchange to increase its international relations with countries of the world while helping health thereof. Obviously, there are difficulties, and it's impossible to say that these programmes are perfect, but our intention is to show a different model. Thus, even if it's not a perfect model; through the practice it has achieved incredible success improving lives of many people on this planet through the practice of GHD as a real branch of Science Diplomacy.

Endnotes

1. On the issue expands on the Oslo Declaration signed in 2007 by the Foreign Ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand
2. In addition to the aforementioned Declaration of Oslo can be consulted resolutions taken at regional international organizations such as WHO, as the PAHO, which have been analyzed in Official Events Areas Policy and Economic Integration and the European Union, MERCOSUR, ACP, between other.
3. The American writer William McNeill in his book "Plagues and Peoples", published by the Spanish editorial "Siglo XXI" in 1984 relates several examples that allow to support this. Subsequently, other authors such as Laura Nervi, Laurie Garret and Ilona Kirkbusch have extended the analysis of this issue in articles and studies for international organizations such as WHO.
4. This issue is widely reflected in the final document adopted at the 60th. Session of the Regional Committee of the Pan American Health Organization. Available in http://issuu.com/researchforhealth/docs/cd48-17-english-with-annex
5. In January 2008, the UN General Assembly adopted Resolution 63/33 which was a boost for the actions that were previously executed in various scenarios.
6. In the article published by Dr. Kickbush and Dr. Berger "Global Health Diplomacy" at. R. Elect.de Com. Inf. Innov. Saúde. R. de Janeiro, v.4, No.1, p 18-22, Mar, 2010.
7. For further information are available articles published by Dr Illona Kirksbush, M. Thieren and others.
8. In all cases, data are extracted from the website of the National Bureau of Statistics. Available in www.one.cu
9. Ibid
10. Maceo Leyva L. Fifteen years of white coats. Available in http://www.granma.cu/espanol/nuestra-america/4diciembre-batasblancas.html

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