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On the health of International Relations and the international relations of health

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Disease is a transnational phenomenon which pays no heed to territorial state boundaries; yet it rarely features in the discussion of International Relations. It is important that the discipline should address the issue of disease and more broadly, health, not simply to facilitate containment of disease transmission across international borders but also because central notions of justice, equity, efficiency and order are involved. The subject has been overlooked because it does not fit neatly into the dominant state-centric approach of the discipline, and discussion of health might be seen to contravene the aged principle of non-intervention in the internal affairs of other sovereign states. Also the discipline, rooted as it is in developed, and more particularly Western, states' experience and perceptions, has concerned itself with the more threatening scenarios of military security, the social dimensions being settled by way of the welfare state and falling within the realms of low politics.

A discussion of health draws on interdisciplinary debates about human rights, development, self-determination, the role of state and non-state actors in international affairs and many other issues. It challenges the conventional wisdom of the subject of International Relations, and forces us to look beyond the state-centric paradigm to understand social, economic and political linkages between local, national and international levels of activity. The question of health challenges us to accept a more holistic view of international relations, to broaden the scope of our enquiry on the basis that only a wider interpretation of what is our concern can aspire to understand the transformations overtaking international politics and indeed undermining the validity of the idea of a system of sovereign states. Developments in areas traditionally categorized as low politics are affecting profoundly the conventional analysis of international relations.

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The international health regime

In the global context good health remains the expectation of the few.[1] The structure of the international health regime reflects the structure of the international economy, with the result that resources and expertise are concentrated in the developed states. The majority of the world's people have inadequate access to information, advice and treatment, while the élites in the developing states have such access and poor sectors in developed states lack it. Poor health goes hand in hand with underdevelopment. Yet remarkable achievements have been made in certain very poor countries, such as Burkina Faso.[2]

Therefore, improving the health of the world's five hundred million children still living in poverty does not necessarily depend on economic growth; progress can be made in adverse economic circumstances if the political commitment exists at both national and international levels. The political will to recognize health and health education as a basic human right and need, as a priority in any developmental strategy, and as a prerequisite for self-determination at any level must be the first step. In the absence of this belief and the will to act on it, no amount of economic growth will be adequate to secure basic needs, including health, for the majority of the world's most vulnerable groups.

An alternative path to development: health as a motor

Here our focus is on the position of children, as the most vulnerable social group. Any discussion of the health of children must focus on the developing countries, since they house three-quarters of the global population and over 85 per cent of the world's children under five. Every week more than a quarter of a million children die in the developing world from infection and undernutrition.[3] Discussion of possible improvements must consider and evaluate the role of state and non-state international organizations and external powers which have the expertise and/or the resources to facilitate changes in the social welfare of the majority of the world's people; yet of more crucial importance is an approach to development that sees people as the subjects and not the objects, one that is based on mobilization from within and not intervention from without.[4] Sustainable development, in health care in particular and in basic needs in general, is not the gift of the North to give or to withhold from the South, but rather is the right of humanity and is within the reach of the majority of the world's poor if they are empowered to take it.

Rajni Kothari argues for an approach to the idea of development that is divested of Western values of capital accumulation and rigid specification based on horizontal and vertical differentiation. He calls instead for a 'bottom-up' approach which would involve communities from the local level upwards in identifying their needs and meeting them within their specific cultural context.[5] Thus the momentum generated through social mobilization towards a single given end, such as child vaccination, can be expected to have important repercussions in other areas and generally to increase popular participation in decision-making. It can help people to take control of their lives and those of their children. In the face of global economic difficulties the importance of meeting basic human needs, which gained popularity in the early 1970s, has receded in the 1980s. Current health campaigns represent an attempt to give basic needs strategies centre-stage once more. They represent *social movements* involving whole communities, and such social mobilization can be expected to have political repercussions.

Health: cause or consequence of economic growth?

The general effects of recession in the international economy, coupled with the particular problems of debt and falling commodity prices, have had devastating effects on the welfare of children. To these economic problems must be added the political and social problems inherent in any new state and society in transition, and accentuated now by economic crisis. However, as James Grant, Director of UNICEF, has argued in the 1988 *State of the World's Children*, these most inauspicious circumstances can be exploited to best advantage for child welfare since they provide the context in which low cost, low technology and highly efficacious measures can be popularized. The need for such measures is clear: four million children still die each year of diseases that are vaccine-preventable, while the same number are permanently disabled. Moreover, several million die of diarrhoeal related problems, and this number could be cut dramatically by the adoption of low cost oral rehydration techniques. Economic crisis, therefore, far from discouraging hope of improvement, should rather be seen as an opportunity for massive popular mobilization for health which will carry through into other areas of social, political and economic activity.

Ten years have passed since the necessity of primary health care was stressed internationally at the Alma Ata Conference.[6] Since then, economic conditions have deteriorated further in many developing states, with the African countries being particularly hard hit. The global goal of clean water for all people by the year 1990 has been pushed back to the year 2000,[7] which is also the target date for the fulfilment of the 'Health for All' strategy promoted by the World Health Organization since 1981.[8] Yet severe questionmarks hang over whether any of these goals will be achieved. Obstacles seem structural in terms of the workings of the world economy and the insular political system with its hierarchy of states and no real sense of community. Yet particular local circumstances can alleviate or exacerbate the structural difficulties, and in certain circumstances circumvent or overcome them.

Whether health is seen as a right *today* or perceived as being *contingent upon* economic growth rests largely on the attitudes of those in power nationally and in international institutions, and the demands made by local populations. Responsibility for poor health cannot be thrust totally on to the workings of the impersonal market; this is simply an abnegation of responsibility by individuals, governments and international organizations. Governments make choices and trade-offs in how to divide the national cake, in terms of weapons or welfare, and even within health budgets, they make choices as to whether urban hospitals or rural clinics take priority, and whether to train doctors or paramedics and so forth. In times of economic crisis most governments cut back on welfare provisions. Indeed, the IMF often requires them to do so as part of an austerity package upon which hinges the receipt of much-needed funding to help overcome balance of payments difficulties. Few poor states have actually increased welfare provision when it is most needed (though the positive efforts of South Korea and Cuba are noteworthy here).

The drive to capture markets impels the governments as well as the companies of the developed states, and some of the developing states such as North and South Korea and Brazil, to pursue arms sales to the poorer states. The emphasis of the competitive state system is on military security as a separate phenomenon from socio-economic security, and not as something intimately related.

Efforts of interstate organizations like Unicef and WHO, and non-state organizations like the Dag Hammarskjöld Foundation or Rotary International, have been directed towards addressing the health needs of the majority rather than the needs of

the élites with their requirements for expensive interventionist treatment. Yet basic needs takes a low priority in many other powerful international fora, such as the IMF, and even in those where it has achieved prominence, such as the UN General Assembly, the rhetoric has often not been matched by action by the governments of member states be they from the North or the South. Certain extraordinary achievements, however, have resulted from mediation efforts of international actors: for example, the civil war in El Salvador has been halted for three days in each of the past three years for an immunization campaign to take place, and in war-torn Beirut in September 1987 all parties agreed to a temporary cease-fire so that children could be vaccinated.[9]

Individuals also make choices. Recent floods in Bangladesh have momentarily focused world news on the massive problem of health and disease in the Third World states; a few weeks previously the spotlight was on drought followed by floods in the Sudan. Massive campaigns have been launched by national and international charities, and these are aimed at the individual conscience. It is to be hoped that governments may be prompted to be more generous in their response to disaster appeals; the willingness of individual citizens to contribute indicates the direction of public opinion; yet at the same time the generosity of individuals can make it easier for governments to hold back.

In many states, especially those of Africa, there are no adequate statistics to measure the effects of economic stagnation on the most vulnerable sectors of the population. Moreover, many of the effects will take time to filter through and a lag between cause and effect can be expected. This lack of information contrasts greatly with the proliferation of predictions and analyses concerning the international economy, and is a stark reminder of the general lack of interest both nationally and internationally in the poor majority of the world's people.

Humanitarian and pragmatic reasons for concern

The health of the most vulnerable group of our global population is a question which concerns not only the governments of those countries most deeply affected but also the other actors in the international system for both pragmatic and humanitarian reasons. In so far as an international society can be thought to exist in our international political system, then the humanitarian impulse is important. The existence of a community of like minds throughout the world on such issues has been evidenced by, for example, the internationally acclaimed Sportsaid runs in which citizens of different countries throughout the world take part in simultaneous fund-raising events.

It is evident also in the commitments of non-governmental international organizations such as the Rotary club which has launched a massive campaign to pay for the vaccine required by any developing country wishing to carry out a polio campaign over the period 1985–90. At the inter-governmental level, the Charter on the Rights of the Child, under discussion for several years at the UN, seems likely to materialize soon and thus indicates at least at the level of rhetoric the progress of the human rights debate concerning children in international fora. At the level of the individual government, state interest should dictate positive action. This interest should flow not simply from medical reasons, such as the risk of the importation of disease from other poorer states, but also from economic reasons: the cost of coping with the importation of diseases, and the necessary screening and surveillance systems that must be set up. Moreover, today's children will form the bulk of the labour in the international economy in the future, and they will also form the bulk of

the world market at least in terms of sheer numerical volume. Today's children form a huge source of potential for tomorrow's world, and as such even those state leaders for whom humanitarian concerns hold no sway might see the necessity of establishing and sustaining the health of the young.

What can be done?

Millions of children die each year from vaccine-preventable diseases such as measles, and millions more die from diarrhoeal-related causes. Breakthroughs have been made in supply and demand which mean that several low-cost measures are available to prevent many of these deaths. On the supply side, for example, the technology exists to keep certain vaccines—such as the latest freeze-dried measles vaccine—potent even in tropical conditions for several weeks, and knowledge is being taken out of the preserve of the medical profession and placed in the hands of community volunteers trained for example in basic techniques of vaccination with disposable syringes. On the demand side, many states are mobilizing to immunize on a massive scale, and are using the outreach potential of religious institutions, the media and teachers to inform people of what is available for themselves and their children and how to gain access to it.

Where there's a will there's a way: lessons from the smallpox eradication campaign

In 1967, smallpox killed two million people. Twenty years earlier, it killed many more. The disease had plagued humanity for more than three thousand years when in 1977, the last case of smallpox worldwide was recorded in Somalia.

The campaign to eradicate smallpox was pushed by a Soviet delegate to the World Health Assembly, Professor Viktor Zhdanov. At first there was little enthusiasm even within WHO, which had spent much of its resources, energy and reputation on the unsuccessful campaign to eradicate malaria. However, unlike malaria, carried by the mosquito, smallpox does not have an animal vector; therefore the task would be more straightforward. If the human reservoir of the virus could be eliminated, there would be no remaining reservoir to harbour the disease. Even so eradication proved very difficult.

All states supported the idea of an eradication campaign co-ordinated by WHO, yet the problem of sustaining national and international commitment to the programme was difficult, and resources were always in short supply. Indeed, the project was run on a shoe-string budget. Fenner *et al.*, in their monumental work on the history of the eradication of smallpox, comment that: 'The execution of this global programme, like that of any other, was inevitably complicated by a host of natural and political problems ranging from floods, drought, famine and war to such human failings as incompetence, dishonesty and personal antagonisms.' (p. 515) They stress the vital role played by the WHO in co-ordinating the project. Setting aside their personal loyalties as employees of the Organization at various times, their judgement is surely correct in so far as operations of this nature are facilitated by central co-ordination at the international level of national programmes. Transmission of disease is an international hazard, and while local conditions require a flexibility in approach, the central store of information on vaccines and the disease itself is vital for cost-effectiveness. WHO played an interesting role in that it provided *principles, information* and *methodologies* rather than *directives*. WHO had no power over national programmes but it had the reputation of holding a central pool of

information and experts, which could be tapped as and when required at the national level. Responsibility for programmes was located nationally and regionally, *not* internationally in WHO.

The success in eradicating smallpox has provided an impetus for the development of other campaigns, and in these lie hope for present generations worldwide. While new diseases, such as AIDS, have begun what some would regard as an unstoppable spread in parts of the world, we have still to eradicate the older diseases: yet this is now within our capability. Moreover, the full potential of control or eradication campaigns is now seen in far wider terms than simply the freedom from disease: education, social mobilization and political participation are as vital for development as the health goal—indeed, all are inter-related.

GOBI-FFF: the way forward

In 1982, Unicef and the WHO lent their weight to the GOBI-FFF. This represented the championship of low-cost measures which could result in fewer child deaths and a better quality of life for children without any massive injection of economic resources. In other words, it offered hope for improved welfare even in the face of stagnating economies. Health could be enjoyed *before* economic growth rather than *after* it; it could be seen as a *cause* rather than a *consequence* of economic growth.

GOBI-FFF stands for simple principles: growth monitoring, oral rehydration therapy to combat diarrhoeal related illness, breast feeding to combat malnutrition, and immunization to stave off six major diseases. To these four practices have been added three further aims: better feeding, family spacing, and female education. Together, these have been called the Child Survival and Development Revolution—CSDR. The importance of these aims is highlighted by a few examples.

Prevention of measles requires one single vaccination. If the present global level of immunization against measles remains the same, it is estimated that there will be twenty million deaths by 1996 from the disease, each of which could have been prevented by a single injection.[10] During recent flooding in Khartoum, the main cause of child deaths was measles, which swept through the capital. Vaccine against measles was actually available in the capital, but was in storage awaiting the organization of an immunization programme when the flooding occurred. In the words of Gustav Nossal, 'vaccines are the most cost-effective public health tool in history'.[11] Yet organization is vital if they are to be used effectively.

Acute diarrhoeal dehydration kills over three million children a year. Diarrhoea is the most common illness in the developing world. If treatment is received at all it has conventionally been in the form of anti-diarrhoeal drugs and an intravenous drip. Few people can afford the drugs or the hospitalization and thus few have access to such treatment. A revolution has been effected in recent years with the promotion of oral rehydration therapy (ORT), which is basically a mixture of sugar and salts in water. While Unicef provides sachets of a sophisticated version of the mixture to which water must be added, health workers all over the world have been promoting adequate equivalents on the basis of so many pinches of this and so many of that, with the relevant amount of water measured out in such unlikely receptacles as Coca Cola bottles. Forty-seven developing states are now mass-producing OR salts, and Unicef has estimated that 20 per cent of children with diarrhoea are being treated with some form of ORT.

Regarding female education, it is widely recognized now that the key to improved child welfare is an increase in the knowledge of mothers, for it is they who will decide whether to breast feed and for how long, what to do when a child has diarrhoea, and

whether to take a child to be vaccinated. Given that women also play the major role as farmers, water-carriers, cooks, home-makers and child-minders in much of the developing world, more support has to be forthcoming for them and more recognition given to their role by the rest of their societies if any inroads are to be made on their position, which could then be translated into better provision for children's health.

Looking to the year 2000

There is no doubt that health for all is within our reach, if the social mobilization that will bring it about is allowed to develop and is encouraged. Yet that mobilization itself is perceived as a threat by many entrenched political and social interests. Health for all rests on the belief that there is a universal human right to freedom from disease before economic growth; it rests on the belief that development means the fulfilment of basic human needs by a bottom-up approach which allows people to determine themselves and involves mass mobilization and the spread of knowledge rather than its retention within a circumscribed group; it rests on the belief that economic adjustment must have a 'human face'.[12] All these beliefs go against the tide of convention in international politics and challenge the basic order in the international system. Entrenched interests of institutions like the IMF are ruffled by such ideas; those ideas are rejected by many state actors who have failed to acknowledge the primacy of positive social and economic rights alongside the negative ones of freedom from interference; and the most powerful state actor in the system, the United States, has even rejected the right to development.[13] Despite all the entrenched opposition, the seeds of change have been sown. Changes in attitudes to health at local, national and international levels, albeit on a small scale, suggest the beginning of a revolutionary new path to tackling the problem of health, based on a new recognition of fundamental human rights, a conception of development which challenges the conventional orthodoxy, and a new political commitment to social mobilization, education and popular participation. While in the developed world we have already brought most of the major diseases afflicting the South under control, there is room for us to learn from these new methods in dealing with the widespread health problems in our society—smoking, alcohol and drug abuse, and potentially, AIDS. The consequences of the adoption of social mobilization as a vehicle to the fulfilment of the right to freedom from disease will have far-reaching effects on national politics and international relations if they gather momentum. For the health of our subject, we ignore them at our peril.

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