

Structural Cooperation, the Fiocruz experience

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Abstract *This article examines the structural approach to health cooperation, focusing on its meaning as a method for promoting institutional policies to improve management models. We draw attention to the differences between this approach and the traditional disease-based approach, showing that the structural approach is centered on health systems, reinforces global governance, and embodies the Sustainable Development Goals (SDG), thus taking on a multi-sectoral dimension. This approach leverages the maximum potential of international cooperation by establishing structuring networks and promoting relations between partner countries through their national health institutions, schools of public health, and technical staff. By way of example, we show that this approach is applied in the Union of South American Nations (UNASUL, acronym in Portuguese) and Community of Portuguese-speaking Countries (CPLP, acronym in Portuguese), especially in Africa. Finally, we underline the importance of this approach for South-South relations, where it addresses the real necessities of partner countries, unlike North-South cooperation that is characterized by power asymmetries, especially within the economic and technical-scientific dimensions.*

Key words *Structural cooperation, Health system, Global governance, Sustainable development objectives, Structuring networks, Unasul and CPLP*

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Introduction and concept

Words are alive: they are born, mature and die. With regard to word usage, it is the relationship between signification, meaning and significant meaning that permits a word's maturation and longevity. The rapid dissemination of a particular terminology before its real meaning has been understood may generalize its application, with the risk of losing its original meaning and weakening it as a signifier. This article aims to clarify the trajectory of the term "structural" when associated with cooperation in order to restore its strategic significant meaning in the field of international cooperation and describe not only its operational basis, but also its reach and development in structuring networks.

The term *structural cooperation* first began to be used in the health sector in 2009 to refer to international cooperation aimed at strengthening the health systems of partner countries. Such actions sought to combine *concrete interventions (for) building local capacities and generating knowledge, promoting dialogue between actors to enable them to assume a leading role in health sector processes and promote the autonomous formulation of development agendas*¹.

It therefore consists of supporting the development of health systems and encompasses prevention and health promotion, regionalization, care, providing inputs, etc. To achieve this, it is necessary to strengthen key organizations that play an essential role in creating, sustaining and improving health policies and in the governance and operation of health systems. These so-called "structuring institutions", which have the capacity to transform health systems, include ministries of health, national health institutes, and training institutions, particularly those dedicated to providing advanced training and essential inputs, as well as model facilities, such as referral hospitals and exemplary primary care centers.

Structural cooperation may be applied across different contexts and arenas, such as science and technology (including basic laboratory research, clinical research, translational research, technological development, quality control, etc.), education (level of education, regionalization, educational technology, production of educational materials, etc.) and, equally, various other settings, such as the transport, utilities and information sectors.

Structural cooperation therefore seeks to work with the organizations that strengthen the building blocks of health systems, sustain their

implementation and adequate management, and generate the evidence necessary to inform policy development and management models².

Operational overview

The main focus of structural cooperation for health is training and capacity building for health systems strengthening. For many years, international cooperation for health was conducted in a vertical manner, based on disease-specific programs, generating segmented and independent divisions within ministries of health, both in terms of human and financial resources. This is reflected today in bilateral cooperation projects focused on sharing techniques and good practices applied to disease-specific programs (HIV-AIDS, malaria, tuberculosis, diabetes, etc.). In this approach, most cooperation activities aimed at strengthening human resources for health end up being restricted to training, without taking into account its real role in generating new knowledge needed to improve individual health systems as a whole and inform health policy reform.

One should not overlook the weight bodies responsible for developing and promoting programs carry within ministries of health, agencies and related organizations that make up public health systems. However, these bodies, whose ultimate goal is to ensure the smooth running of the system, are susceptible to changes in the political and administrative sphere. Within this context, it is the technical-scientific bodies of the health sector, with their permanent civil service employees and less prone to political changes, that provide for greater sustainability of the system as a whole, since they not only provide a constant flow of staff for ministry programs, but also generate new evidence to inform necessary changes to programs.

It is therefore acknowledge that health system strengthening may occur through both technical-scientific bodies and bodies responsible for developing and promoting programs, which in practice comprise complementary elements. One aspect of the realm of vertical, disease-specific programs that should be valued is civil society participation. However, only cooperation between structuring bodies is capable of promoting more comprehensive changes in policies and, consequently, in health systems, as well as joint generation of science-based knowledge. This is what we call the structural approach to health system strengthening.

This perspective introduces innovations in two dimensions: a) it integrates strengthening human

resources with organizational and institutional development; b) it builds on endogenous resources and capacities to enable local actors to take the leading role in the formulation and sustainable implementation of county health agendas.

Based on this rationale, it is important to note that the process of structural international cooperation involves more than advice from foreign experts or exchange of 'experiences' and 'good practices'. Rather, it seeks to increase the ability of countries to introduce the changes necessary to improve their health systems³. This approach focuses on the development of health systems as a whole, significantly broadening the scope of efforts to include the biological, social and environmental aspects of public health issues and ensure access to comprehensive health care, rather than simply the diagnosis and treatment of disease.

In other words, the focus of structural cooperation is the *social right* to healthcare provided by the state based on *political rights* enjoyed by citizens, rather than *individual rights* in the health sphere⁴. On an even broader scale, this approach can be applied to global health governance, taking on a multi-sectoral dimension and encompassing several of the Sustainable Development Goals (SDGs) in line with the WHO's Health in all Policies strategy to build on health system changes.

Desired outcome

Globalization can be viewed as a multidimensional process that includes economic, political, cultural, social, and technical-scientific aspects and fosters migration flows by which knowledge and technologies permeate national borders, favoring the development of new common goods⁵.

In this globalized world, the structural approach to cooperation represents a significant shift of focus away from the traditional model of technical cooperation promoted by developed countries. In this model, cooperation initiatives are generally guided by previously defined objectives and, more often than not, based on donor concerns about the risk of health problems spreading to their own populations. As mentioned above, this approach targets specific diseases, which, at the present time, does not seem to be sufficient and fails to leverage the full potential of this type of assistance.

This observation echoes some of the reflections from international meetings hosted by the Organization for Economic Co-operation and

Development (OECD) in the first decade of this century aimed at improving the effectiveness of development cooperation, notably that which took place in Paris in 2005. This meeting underlined the need to promote joint planning with partner countries, harmonization of activities, partner country ownership, and mutual accountability⁶.

This approach has also begun to be applied to North-South cooperation, whereby negotiations between donors and partner countries have become less prescriptive. However, the approach is particularly effective when applied to exchanges between developing countries, affording elements that build upon our structural cooperation proposal through relationships that go beyond the aid criterion and can be characterized as actions between partner countries.

Unlike the more traditional disease-specific approach, strengthening and transforming health systems as a whole creates the necessary conditions for more general actions that have the potential to combat a variety of illnesses. In addition, as mentioned above, this approach focuses on health promotion, considering not only the biomedical aspects of disease, but also the social and environmental determinants of health.

Strategies for improving health systems: structuring networks

With a view to enhancing the effectiveness of structural cooperation in situations where actions of the same type (strengthening or supporting national health institutions, schools of public health, and other bodies) are undertaken in different countries, partner countries seek to establish institutional relations to enable sharing of experiences and human resources through structuring networks, thus maximizing outcomes for each country.

In general, structuring institutions carry much political weight within their respective countries, which often seek to pursue common agendas oriented by regional political and cooperation arrangements, such as the Union of South American Nations (UNASUL, acronym in Portuguese) and Community of Portuguese-speaking Countries (CPLP, acronym in Portuguese), which discuss issues related to international cooperation for health between member countries⁷.

Over the last decade, the Oswaldo Cruz Foundation, an agency of the Brazilian Ministry of Health, has played an advisory role in the development of UNASUL's strategic agenda, elab-

orated by the organization's health commission, and a Strategic Plan for Health Cooperation (PECS, acronym in Portuguese) for the CPLP. The Oswaldo Cruz Foundation has a complex structure, which has enabled the organization of the structuring networks mentioned above, thus supporting health system strengthening in the countries in these regions.

Final considerations

The international community has shown strong commitment to overcoming global imbalances, an example of which is Agenda 2030 and its Sustainable Development Goals (SDGs), adopted by heads of state at the General Assembly of the United Nations in 2015. The last goal (number 17) proposes to revitalize partnerships for capacity building to support national plans to implement these goals.

In this respect, emphasizing long-term needs, we sought solutions that leverage the maximum potential of international cooperation for health between developing countries by strengthening key institutions that have the potential to promote true leadership in the sector. The structural cooperation approach fulfills this objective by

promoting actions that address the social determinants of health rather than just individual medical care¹, taking into account the synergies between the SDGs.

It is known that the *power asymmetries between developing and developed countries, especially within the economic and technical-scientific dimensions, interfere in the cooperation process*². As such, structural cooperation for health broadens the scope of international cooperation between developing countries towards research, technological development and innovation in this field of knowledge within the social dimension, paving a path towards equality in these countries.

In the sphere of social rights, structural cooperation provides a framework for applying the WHO's Health in all Policies approach to progressing the SDGs, which emphasizes the importance of intersectoral collaboration for health and highlights its real meaning and effectiveness in strengthening the institutions that inform health system policy development, thus assuring improved health outcomes in partner countries.

As such, this approach shows its sophistication and superiority over other approaches that offer less scope, contributing towards ensuring sustainable intended outcomes within the deadline set by the United Nations.

Collaborators

The authors, JR Ferreira and LE Fonseca, contributed equally to the preparation of this article.

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