Introduction

Globalization has brought dramatic changes to the way the world views health. Increased interdependency and interaction between nations has exemplified how quickly emerging diseases can spread across the globe, affecting world trade and diplomacy as much as the health of vulnerable populations. “Global health” as a term has only recently evolved to encompass more than just the linear relationships of international health issues, moving beyond social and development agendas and into the realms of foreign policy and security (1). As globalization has essentially dissolved many distinctions between domestic and foreign health issues, the study and response to health crises has transformed to extend beyond national boundaries and past an exclusive focus on traditional methodologies and perspectives (2).

What has developed in response to this newly globalized world of health issues is a fragmented network of institutions, initiatives, funds, and organizations to tackle diseases on an international scale. Generally, these have taken on the name of “Global Health Initiatives” (GHIs), most of which have been established after the year 2000 and will be defined more clearly later on. Since the creation of many of these GHIs and the shift international donors and governments have taken towards assisting public health in developing countries, there has been much debate over the effectiveness of these funding methods (3). Most international funding for health aid is for service delivery for specific diseases, and usually diseases that pose a great short-term threat to countries, such as HIV/AIDs (4).

There is a host of positive outcomes from these types of funding initiatives, sometimes referred to as “mass campaigns”, as they can bring attention, funding, and services to disease prevention very quickly (5). However, there has been argument for quite some time that international funding for health is not focusing enough on strengthening health systems overall, but rather targeting single-purpose issues (6). In addition, there is also a large body of evidence supporting the argument that GHI style funding has created a wide array of negative outcomes for the populations they are trying to serve (7).

In most cases, it is clear that the underlying cultural and social determinants of health in developing countries are neglected by GHIs and governments, leading to little investment in long-term changes (8). There are several theories, explanations, and accounts of convincing evidence as to why this
JUROS Volume 7

is and has been the case for over fifty years. Especially in the last few decades, the international political system and the global economy undoubtedly play a major role in deciding where and to which health issues donor funds are invested (9).

Unsurprisingly, the true needs of the populations receiving this “care” are often overlooked. There is little agreement on what meets needs, and some donor nations are still left in crippling conditions without a stronger healthcare system (10). For example, rates of malnourishment among children and women in India remain at extremely high rates, despite their booming economic growth. There are a multitude of contributing factors at play in this particular case, but the research available generally seems to point toward a two-fold dilemma: the asymmetrical approach the international community has taken toward global health funding coupled with infectious interactions between gender discrimination and poorly targeted spending programs, resulting in the stagnating rates of child and maternal malnourishment in India.

This paper aims to shed light on how and why international health funding trends can create debilitating outcomes for developing nations. It also explores the reasons why this trend exists in the context of international relations. First, the history surrounding the evolution of GHIs will be examined, along with a discussion of the external variables that are involved in global health research. Additionally, the financing trends will be assessed, along with an overview of the positive and negative effects of these trends. And lastly, the explanations and theories surrounding the trends and effects of GHI funding will be discussed and examined further in the case for malnourishment in India.

The Rise of GHIs

The era of neoliberal globalization in the late 1980s, gaining speed in the 1990s, gave rise to the weakening position of the state in international affairs and the growing position of other international actors (11). The state’s position shifted in the political hierarchy vis-a-vis other actors for various reasons, such as more establishments of decentralized partnerships with non-governmental organizations (NGOs), increased power of finance and trade agencies, and the elevated authority of international organizations. International authority disaggregated, resulting in powerful businesses, institutions, NGOs, and multinational companies involved and very influential in international debates and decisions (12). This change in agency had heavy implications for debates and decisions on issues of international health. Globalization essentially gave way for “the new global health architecture” where new voices, other than states, were at the table (13).

The World Health Organization (WHO), established in 1948 as a specialized agency of the United Nations, retained the clear authority up until the late 1980s—early 1990s on directing and coordinating issues of international public health (14). However, the new architecture shifted this authority, or divided it, among public-private partnerships, private foundations, and NGOs involved in healthcare (15). These partnerships, foundations, and organizations have now come to be known under the term “Global Health Initiatives” (GHIs) because they are characterized by the WHO as having a general set of common features including, “a focus on specific diseases or selected interventions, commodities, or services; relevance to several countries; ability to generate substantial fundraising; Emergency Plan for performance; and their direct investment in countries, including partnerships with NGOs and civil society” (16). A few of the major GHIs are The Global Fund to Fight HIV/AIDS, Malaria, and Tuberculosis (Global Fund), The US President’s Emergency Plan for AIDS Relief (PEPFAR), the Global Alliance for Vaccines and Immunizations (GAVI), the World Bank Multi-Country AIDS Program (MAP), and the Bill & Melinda Gates Foundation (BMGF). The US Agency for International Development (USAID) and the UNAIDS USP signed a bilateral agreement in 1998 where the US donated $387 million to the WHO and $1,050 million to the Global Fund (22). The Global Fund and other major GHIs have kept the primary focus of their efforts on diseases and health issues of most interest to the international community, and largely the wealthy international community. International donors have been giving money to health issues gaining the most press and attention and usually opt for very direct, or “vertical”, service delivery (23). These methods of funding have shown a dramatic impact on health issues such as HIV/AIDS, Tuberculosis, and Malaria to a lesser extent (24). There are social, cultural, economic, geographic, political, etc. determinants of health that vary depending on state to state. There are social, cultural, economic, geographical, political, etc. determinants of health that vary depending on state to state. There are social, cultural, economic, geographic, political, etc. determinants of health that vary depending on state to state. There are social, cultural, economic, geographic, political, etc. determinants of health that vary depending on state to state. There are social, cultural, economic, geographic, political, etc. determinants of health that vary depending on state to state.

Before beginning further discussion on the effects of GHIs, it is necessary to acknowledge the countless variables involved. Health systems are very complex and there are endless factors that contribute to and affect health systems differently from community to community, state to state. There are social, cultural, economic, geographic, political, et cetera determinants of health that vary depending on every disease, issue, or aspect of healthcare delivery in every area of the world. It is very difficult to generalize findings for global health studies for this reason. For example, there are certain approaches to funding and care that work well for a disease in one country, but not for the same disease in another country (25). Thus, arguments for ruling out a method of care or funding completely are rather difficult to substantiate. It is also important to remember that the largest GHIs have only been around for a little over ten years, making it difficult to show considerable effects just yet. In addition, most of these GHIs did not establish arrangements for prospective assessment of their effects on countries, and the scientific community has been slow to formulate research methods for these complex interactions (26).

Compounding these problems is the fact that even the most comprehensive and thorough research studies on healthcare and health systems admit to weak and inconclusive findings in the data or trends. This is due to several reasons, a few being the lack of a commonly agreed upon analytical framework, absence of any empirical evidence, and the ambiguity associated with what exactly defines a positive or negative outcome of a health intervention or funding mechanism (27). For example, it is often difficult to link a single health intervention to the increasing rate of homelessness in a population of people with a particular disease. There could be a handful of other contributing factors at play that are underlying reasons for why an intervention is “working”, such as improved economic status, housing, nutrition, or the healthcare environment, etc. Almost every source examined for this paper mentioned these barriers and variables, and called for more robust studies to be done. There is unquestionably a shortage of epidemiologists and researchers, both native and foreign, working in developing countries (28).

Thus, it is important to acknowledge that the nature of the data on health in the developing world may not always be entirely accurate.

The same can be said for GHIs and governments of the developed world, who have not always

Arts & Humanities
GHIs and international funding
research studies on the nature of
and research I have done. It is
compelling based on the evidence
confidently point to the explana-
tions about the findings; the hard data
make sweeping generalizations
wide variety of reputable sources
research I covered. However, I did not
every variable present itself in the
research I covered. However, I did
cover a substantial amount and
of very reputable sources
that I feel confident in drawing certain
certainties from. I cannot safely
make sweeping generalizations
about the findings; the hard data
just does not exist yet. But I can
confidently point to the explana-
tions and trends I believe are most
compelling based on the evidence
and research I have done.

Financing

In order to evaluate trends of
funding, I have read through
research studies on the nature of
GHIs and international funding
for health, along with numerous
reports and data provided by the
WHO, the Global Fund, Partners
in Health, and the BMGF. Many
of the research studies and reports
I examined were by collaborative
groups of epidemiologists, econ-
omists, health professionals, paid
researchers, and a variety of
academics. These groups took the
paining process of gathering, analyzing, and compiling
valueable health and finance data avail-
able. By examining numerous of
these reports and studies, I was able
to get a good sense of some overall
findings in international financing
trends toward global health issues.

Of the reports I examined, the
most comprehensive one that
serves as a foundation for this
specific research focus is the WHO
Maximizing Positive Synergies
Collaborative Group’s initial study
on GHF effects in 2009 titled, “An
assessment of the interactions be-
tween global health initiatives and
country health systems,” which looks at the
overall relationship between GHIs and country
health systems by examining five key
points of interaction that contribute to the
success or failure of the de-
ivery of health services. These five
key points are governance, finance,
health workforce, health informa-
tion systems, and supply manage-
ment systems (33). The WHO ac-
knowledges that a country’s health
system is not just an assessment of its
health service delivery, but “all
organizations, people, and actions
who have a primary intent to
improve, enhance, or maintain health”
(34). However, because GHIs are
primarily concerned with the effort
to “finance the delivery of specific
types of services for priority health
problems that arise in many low-in-
come countries,” it is best to look for
how those efforts interact with
the WHO defined key functions
of a health system for the ultimate
purpose of health service delivery.
This approach serves as a solid
framework for which to compare
and analyze other findings.
Overall, this report along
with several others by the WHO
generally conclude that GHIs need
to turn issues, thus are facing
strengthening health systems
rather than single-purpose
interventions (35). It has been unani-
mously agreed upon that although
funding for many single-purpose
interventions has brought signific-
tive outcomes for global health
systems, yet this is not without
their negative ramifications due to
a lack of supplemental funding to
strengthen the health systems.

Since the early 1990s, funds
for health and development assis-
tance have dramatically increased,
settling unprecedented records.
GHIs have quadrupled globally from
$5.6 billion to $21.8 billion (36).
Partic-
ularly following 2001, the US Gov-
ernment became the largest donor
of public health assistance (37).

Reports that track the financing
of GHIs and health related govern-
ment spending from major devel-
oped countries reveal that a vast
majority of funds go to single-pur-
pose “mass campaigns” for service
delivery (38). Single-purpose
interventions, or “mass campaigns”,
are generally large-scale operations
which attempt to roll out a service
that prevents or treats a specific
ic disease (39). This can manifest in
a variety of ways. For example,
funding can go solely to providing a
vaccine or immunization, mosquito-
to bed nets for protection against
Malaria, or antiretroviral drugs
(ARVs) for HIV/AIDS (40).

Two assessments of financial
tracking in particular, one created
by Oxford University and granted
by the BMGF, the other by Har-
vard University and University of
Washington, reveal the most useful
data and analysis. These reports
both found that a very small por-
tion of funding from large donors,
particularly through the Global
Fund, and the US Govern-
ment-PEPFAR, go towards invest-
ing in general health-sector support
and strengthening for developing
countries (41). As of 2008, these
two donors together issued more
than 98 percent of their funds to
service delivery, yet this is not
without the need for further
analysis, such as vaccines, mosquito nets,
ARVs, etc. (42). This is not to say
that these donors and GHIs are not
discussing the importance of and
investing large sums of money in
health systems, but compared to the
amounts dedicated to service deliv-
er, it is very minimal (43). These
reports indicate that each donor and
GH is unique in its areas of
focus, and some place higher prior-
ity than others on funding health-
care infrastructure development as
well as health issues that stem
from poor healthcare infrastruc-
ture, such as malnourishment,
migrant health, primary care, etc.
(44). However, between all donat-
ed health aid collectively there is
unequal funding for direct health
service delivery over health systems
strengthening (45).

The services required for
treatment and prevention of HIV/
AIDS, malaria, and tuberculosis ac-
count for most of the international
development assistance, HIV/AIDS
in particular (46). Although these
diseases are given the most funding,
it is important to note that
funding for other health issues has
also generally increased since the
1990s-early 2000s, and resources
established for those issues have not
been reallocated for HIV/AIDS,
malaria, and tuberculosis (47).
However, the proportional differ-
ences in funding for these three
diseases over health concerns such
as communicable and noncommunicable
and parasitic infections, maternal
health care, and child nutrition
suggest that there is a consider-
sable amount of neglect (48).
This notion is also reinforced by
the fact that there has been call for
more investment in primary care
and diseases that are pervasive
in developing countries for over fifty
years, yet circumstances have
not significantly changed (49).

To further explain the argument
for more investment in these
“neglected diseases” and overall
health systems, it is necessary to
analyze, and compile the cred-
al findings that a country’s health
systems” (33). The WHO ac-
knowledge the need for most donated funds
are allocated for HIV/
AIDS, yet circumstances have not
considered the changes in international health
financing from a little over a decade
ago, but also why these changes are
problematic. The majority of the
studies are primary source research
accounts, case reports, and both
cross-sectional and longitudinal
studies that help to extrapolate
broader findings. The overhwhel-
mimg majority suggests a general
agreement that there are both posi-
tive and negative outcomes from
international health aid.

How funding is provided,
the amount of funding donated, the
interactions with domestic budget
allocations, the aid effectiveness,
and out-of-pocket payments from
the population or service users are
just a handful of the major factors
that affect performance of health
aid and health systems (50).
There is evidence of an initial concern
that many of the large GHIs and interna-
tional donors do not align
their efforts with countries’ nation-
al interests (51). It appears
that many developed countries have
allocated their own health aid priorities without
explicitly incorporating domestic
needs and demands by govern-
ments and citizens of benefi-
ting countries (52). There is little
account of country “ownership”,
where a country will exercise their
own health aid priorities, for
achieve aid delivery strategies (53).
Although some GHIs have stated
mechanisms to help incorporate
domestic ownership throughout the
process of their donations or grants,
it is very unclear how much priority
these mechanisms take and little
is known about their follow-through
(54).

Developing countries often stress
the need for most donated funds
to go toward a particular area of
focus in their national strategic
development plans, and in prac-
tice, majority of the funds go
alternatively to service delivery for
a specific disease (55). For exam-
ple, Cambodia’s national health
priorities in 2003-2005 stressed a
need for resources to go to primary
health care, but over 60% of
donor funding was allocated for
HIV/AIDS and other infectious diseases
(56). This is reported to happen frequently; one reason being that donor funding tends to have restrictions what the funds can go towards. In addition, governments and health ministries receiving donor funds often have limited awareness of these restrictions and what certain funds are allowed for, creating confusion between local and national healthcare providers and institutions.

Because GHIs and international donors primarily set their own priorities of spending, regulation, and implementation, they often create uncoordinated parallel funding structures (58). The Global Fund, GAVI, and the World Bank MAP depend on different mechanisms for health system engagement with other countries, and because coordination is rare between these GHIs, there ends up being multiple funding streams and applications for the same services (59). The poor alignment of these engagement mechanisms creates a weakened supply management system for services in many developing countries (60). For example, there are several studies following the distribution of medications in a few African countries that show the downfall of a lack of coordination among multiple GHIs. The effects include commodities being under-stocked or over-stocked in regions, poor storage management due to lack of space/infrastructure, waste of products through expiry, and a shortage of human resources to manage and deliver the drugs and commodities (61). The supply management systems often undermine the already existing supply and delivery systems the country has in place. Instead of strengthening the existing systems, the GHIs weaken them with too many of their own systems and their own labor force. If no supplemental investment exists in the health system, the delivery and distribution of donated resources to local communities will undoubtedly suffer (62).

An example of this can be seen in Angola between 2002 and 2007, where there was expressed concern with the ability to cater to the complexity of the countless funding structures. The Ministry of Health reported that, “MAP (World Bank) channeled funds through the Ministry of Planning rather than the Ministry of Health, the usual channel, and the Global Fund donated through the United Nations Development Programme, UNDP. PEPFAR, on the other hand, chose to channel its funds outside the public sector, mainly through international (often US-based) NGOs.” (63).

The WHO Commission on Social Determinants of Health in 2008 defined the problem well by saying, “there is... a danger that large new funding lines, running parallel to national budgeting, continue to distort national priorities for allocation of expenditure and action... While Global Health Initiatives have brought enormous new levels of funding to health-care systems within low and middle-income countries, there is a concern that their vertically managed programs have the potential to undermine the population health orientation of health-care systems and as a result exacerbate health inequality” (64). The commission also raised concerns about the growing dependence that some developing countries were showing toward external funding (65). There is reason to suggest some countries, mainly in Sub-Saharan Africa, have lowered their domestic health funding due to the increase in external resources for health (66). In addition, health ministries in Kenya, Tanzania, and Uganda to name a few, have reported that around 40-60% of their budgets come from external donors (67).

The increased role of civil society, is another notable change, particularly GHIs. NGOs in developing countries as new actors of health care delivery. GHIs have been quick to fund the emergence of new NGOs for health and humanitarian aid (68). Although there are propitious outcomes from the rise of some strong, influential NGOs, there are also negative outcomes for domestic capacity building, or the overall strengthening of human and societal resources. For example, NGOs are now added to the mix of agencies, GHIs, and recipient governments who are competing for donor funds (69). It is arguable that the new competitive nature of healthcare financing draws attention away from health systems strengthening. NGOs and GHIs also tend to miss the mark when it comes to providing free commodities and services by using their own workforce. Instead of helping the domestic economy and workforce, NGOs and GHIs often provide services that run domestic business out and neglect the capable native workforce (70).

Now even though GHIs can have damaging effects, they have still made substantial positive strides forward. GHIs and the NGOs they fund have proven to increase involvement of civil society in partnership with government programs, advocate for better governance, bring much needed vaccines and immunizations to marginalized groups, lower the cost of ARVs for HIV/AIDS, and bring attention to global diseases and health that has never been seen before (71). GHIs have contributed to the tackling of diseases previously thought to be “unteachable”, prompted more scholarly work and research on global and local inclusion and advancement in academic medicine, science, and innovative technologies (72). It is clear that when epideemics hit countries, there is a need for immediate mobilization of resources to address the disease. This is when GHIs are most efficient, using vertical delivery strategies to get needed services to the suffering populations fast. GHIs have, in a large part, been responsible for major reductions in the spread of epidemic diseases, especially HIV/AIDS, SARS, and Ebola (73).

The points and examples discussed above are some of the major outcomes of GHI funding. There are undoubtedly more examples of beneficial and detrimental outcomes and factors to consider. However, the overall point is that GHI funding is only addressing half of the problem. The international community largely discounts the underlying determinants of health disparities. Without attention, the diseases GHIs are targeting have the potential to resurface, and the diseases they are neglecting will continue to eat away at the fabric of developing nations (74). Education, health information systems, community health worker training and retention, cultural stigma, maternal and primary health care, sanitation, regulatory frameworks, and gender equality are just some examples of the neglected areas of focus from the international community (75). Investing in these equates to investing in the long-term sustainability of a health system that can hopefully one day handle domestic health problems on its own. The goal is never to endlessly fund developing countries, something many NGOs and donor agencies seem to forget when their livelihoods depend, in part, on people remaining sick and oppressed (76). In order to see funds for health aid decrease and positive results increase, a more sustainable financing trend is needed.

**Explanations and Theories**

So why do GHIs and the international community fund healthcare this way? Why is attention given to short-term service delivery for threatening epidemic diseases and not for long-term health systems investment? There are a few possible explanations and theories to help answer this question. However, what is interesting to note first is that the plea for more funding to health systems strengthening, or more “horizontal” approaches, is not a new plea, but one that has existed for over fifty years. Yet, there seems to be little incentive for the international community to balance out their funding methods.

For at least the lifetime of the WHO, since 1948, there has been debate over “vertical” and “horizontal” programs for healthcare. The Director General of the WHO stated in the Annual Report for 1951 that, "more authorities are becoming aware that many campaigns for the eradication of diseases will have only temporary effects if they are not followed by the establishment of permanent health services in those areas, to deal with day-to-day work on the control and prevention of disease and the promotion of health” (77). In 1965, C.L. Gonzalez provided one of the first comprehensive studies on this debate that was published as a Public Health Paper by the WHO. He argued that horizontal approaches and top-down working the control and vertical approaches to tackling a disease, should not be mutually exclusive, but be implemented simultaneously (78). His findings and suggestions have been replicated time and again over the next fifty years yet little has been done for long-term health systems strengthening, or the “horizontal” approaches to help maintain the achievements of the vertical approaches (79).

There have been a couple clear changes in the nature of the debate over the past fifty years. One of them surfaced in the 1980s when trends in services for general health turned to focus on, “a limited set or package of cost-effective interventions” (80). Macroeconomics became a more central focus of health intervention programs, with more stress put on the economic benefits of disease control. Thus, vertical approaches of disease eradication were prioritized for their cost-effectiveness, as this was also more attractive to donors (81). Short-term vertical programs promise more economic benefits of disease eradication with a time-limited commitment (82). Horizontal approaches, or the intervention in general health services, require considerable financial, logistical, and organizational support because of the complex nature of the system. Investing in the count less areas that contribute to an
improved health sector appears less attractive and risky to donors, and is also difficult to implement in an already weak health system (83).

However, this view is also a result of programs that are designed with poor and inadequate descriptions of cost implications. Many vertical programs chosen 20 years ago had little evidence of relative costs for different strategies of health interventions; the epidemiological data was not strong enough. Looking in retrospect, many horizontal programs that could have been integrated were not actually that much more expensive than their vertical counterparts (84).

Global markets and macroeconomics undeniably play a role in healthcare funding decisions from international donors. This explanation takes a more Marxist approach, where dependency theory and the world economy are argued to be the ultimate reasons for why there is health disparity. Dependency theory, in short, is the idea that resources flow from a"periphery" of poor, underdeveloped states to a"core" of wealthy, developed states. The poor, underdeveloped states remain weak and at a disadvantage as they continue to modernize, with developed states unfairly integrating them into the global economy. It is argued that dependency theorists point to the major critiques surrounding the way global markets view demand for health services and commodities (85). Paul Farmer, physician and American anthropologist, expresses long-standing qualms with the current development and the relationship with markets. He frequently states that, "above all, we fail to bring new deliverables to people who need them most because demand is constructed largely around the notion of markets. There are too few equity plans to link demand to burden of disease. When treatments are easily administered, convenient, and likely to result in cure or excellent clinical response, there will be great demand for them," (86).

The problem for Farmer is that there has not been enough investment in "robust delivery platforms" for developing countries to meet the demand of new therapeutic agents (87). Without these delivery mechanisms, international donors do not legitimize the demand. For dependency theorists, the problem of needing better delivery systems stems from the way the developed world has constructed the global economy. With resources from their spheres of influence, the developed world was able to build strong health systems and eradicate the diseases within their borders that are sadly still afflicting the developing world. The vast health disparities we see today originate from the global north's exploitation of resources in developing countries, crippling those economies and consequently their health systems and abilities to fight off diseases. Therefore, dependency theorists will argue to invest in the development of economic and better health outcomes for developing countries will be seen as a result. Although this claim holds considerable merit, there are convincing counterarguments to this theory. Along similar lines as Farmer and calling for a change in current investments, development and aid is Jeffrey Sachs, an American economist and world expert on economic development. He makes compelling arguments for an increased focus on economic growth for poverty reduction in his report for the WHO titled Macroeconomics and Health: Investing in Health for Economic Development. Sachs discusses the powerful linkages to improved health and longevity that result from allowing developing countries a stronger foothold into global markets, investment in poverty reduction, and long-term economic development (88). In many cases, international donors, who align more with dependency theory perhaps, allocate funds under the assumption that health problems will take care of themselves if economic growth improves. Sachs believes this to be false, saying that, "the disease burden itself will slow the economic growth that is presumed to solve the health problems; second, economic growth is indeed important, but is very far from enough. Health indicators vary widely for the same income level," (89). He also makes the case against donors who refuse to invest in strengthening health systems where government corruption exists. Although corruption is indeed a reason why some interventions do not meet the world's poor, the more basic problem is that, "the poor lack the financial resources to obtain coverage of these essential health services and thus, to place pressure on their governments," (90). Along with Farmer, he stresses the need for modifying health service delivery and the access the world's poorest areas have to helpful interventions. Fluctuating donor priorities and donor funds is another reason why health systems and NGOs to pin down long-term health systems funding. Fluctuations are driven by a number of factors, some having to do with global economic markets, but most related to geo-politics and national strategic considerations (91). For example, a more open political environment has often led to increases in civil-society investment from foreign donors and governments. After the fall of the Marcos regime in the Philippines in 1986, the country saw a dramatic rise of foreign investment in NGOs as democratic world leaders sought to embrace the shift in Pilipino governance (92). These considerations bring us to another clear change in the nature of vertical versus horizontal health program debates; the shifts in foreign policy and securitization.

Globalization has not only altered the landscape of international health actors, but it has also contributed to the shift in roles foreign policy and securitization play in regards to global health aid and funding decisions. The rise of liberal institutionalism as a theory for international relations, and an alternative to realism, offers an interesting contrast to this altered landscape. Liberal institutionalism is founded upon the idea that international institutions and organizations can aid in cooperation between states and directly impact and influence world politics. Opposed to this is the "statist" view that international politics is a continuous struggle for power and security issues are always a top priority. Liberal institutionalism can offer explanations for the positive outcomes of the expansion of international health actors and donors, as well as the threats that these actors have had on fighting global diseases. For example, the Global Fund was born from the idea that states do not have to be the only arbiters of global health issues, and international organizations may be able to facilitate aid better (93). They have shown to be a rival of the WHO, representing the shift in approaches from sovereignty and rights-based solutions to ownership and merit-based solutions (94). Although liberal institutionalism can offer an explanation for the positive coordination strategies by the international donors, it fails to offer a strong explanation for the failure of security and foreign policy on global health outcomes that I will continue to discuss next. Since the late 1980s, it has become clearer that international factors have just as much influence on delivery of health care as local and national factors (95). When there are very different trends of the same disease in countries with similar health care structures, it begs questioning how international relations might be responsible for these effects. To explore this situation further, it is important to first discuss the evolution of health as a security issue.

Securitization of health is rooted as far back as 430 BC, as plagues and epidemics have aided in the collapse of great empires and societies (96). Thucydides' account of the fall of Athens from plague in 430 BC may be a similar health gained new speed. In the era of globalization, the new global network expedites the spread of the causative agent to country, instilling fear in the developed world of the difficulties in preventing a disease invasion. Endemic diseases of a state along with epidemics have the ability to keep states in the troughs of poverty, unravel the fabrics of a secure society, and make states vulnerable to foreign invasion (98). HIV/AIDS sparked heightened fears of this vulnerability becoming a reality in the US, but the ultimate turning point came from the terrorist attacks of September 11th, 2001 (99). These two events in particular led the developed world to make global health issues a higher priority in discussions of national security. Funding trends and intervention programs from the international community, especially the US, have since followed priorities of foreign policy over the provision of health care as a human right (100). The more "globalist" view, or view that health is a human right and should be prioritized that way, is concerned with the seemingly more prominent "statist" view where health and security are the first and foremost considerations at any level (101). Globalists will argue that, "emphasizing securitization as a solution to health crises can potentially divert attention away from the most deadly diseases and their causes by drawing attention to only those problems that are seen as "headline-grabbing" quality" (102). It is fair to say that increased focused has been placed on selected infections that have potential to move from the developing to the
strengthening, the fear of security threats manifesting in these areas will lessen. Development aid, and health aid especially, has become more politicized by developed countries as being central to state strengthening. There is a growing body of evidence that suggests recent health initiatives in certain countries are also initiatives for building state stability (104). For example, USAID’s closer connection to the State Department and increased incorporation of short-term state security objectives in development plans have raised suspicions of becoming more of a quasi-security agency in some places (109). In Kenya specifically, USAID has offered training programs to bolster the police force and counter-terrorism units in the name of country development (110). In a 2005 report on African missions, USAID commented that “the overarching goal of US policy in Africa seek to enhance African capacity to fight terrorism and create favorable conditions for US and African trade and business opportunities, while developing the foundation for sustainable growth…” (111). USAID has been referenced to have similar objectives in other countries of strategic importance, raising concerns that the agency is blurring the boundaries between security and development. The outcomes of these initiatives have put them and the US Government under more suspicion and scrutiny when it comes to long-term development goals, which are arguably being sacrificed for short-term state security objectives (112).

There are other similar examples of the US Government, other developed nations, bilateral and multilateral donors, and private foundations switching funding and initiative priorities between countries for reasons suggesting strategic importance. In Asia, many donors following 2001 increased funding to Muslim countries, such as Indonesia, which led to declines in funding for other countries, such as India (113). Other compelling examples include international sanctions for failing to provide medical aid as well as evidence suggesting financial aid being used to keep certain corrupt leaders in power for the sake of security (114). Overall, it is clear that when it comes to international relations and questions of security, health and human rights of less developed countries remain a lower priority.

Framing health as a security issue has been a major concern in the field of global health because of its potential for negative outcomes in struggling developing countries. It is worth considering how US policy in Africa seek to enhance African capacity to fight terrorism and create favorable conditions for US and African trade and business opportunities, while developing the foundation for sustainable growth... (111). USAID has been referenced to have similar objectives in other countries of strategic importance, raising concerns that the agency is blurring the boundaries between security and development. The outcomes of these initiatives have put them and the US Government under more suspicion and scrutiny when it comes to long-term development goals, which are arguably being sacrificed for short-term state security objectives (112).

India has often been referred to as an enigma when it comes to child and maternal nutrition. With all the economic growth the country has experienced in two decades, India still has one of, if not the, worst rates of child and maternal malnourishment in the world (116). In the past two decades, India has experienced a growth rate of approximately 7%, and is now classified as a newly industrialized country in the G-20 with a continually developing economy. India’s rapidly growing economy and integration into global markets has made it the “bright spot” in the global landscape, as it has surpassed growth predictions and still maintains positive future outlooks. However, despite the fact that the country has a thriving economy and the quality of living for the middle class has risen, 42% of children under the age of five are underweight (117). Good nutrition is an extremely important foundation for overall development and health, allowing for better health outcomes and immune system resilience. Without good nutrition and essential micronutrients from infancy, children are at high risk for contracting diseases and infections even into adulthood, and cannot thrive and perform at their highest potentials (118). Micronutrient deficiencies and malnourishment take shape in many forms and can exist in countries, such as several in South Asia, where the food supply is adequate when it comes to meeting daily energy needs but severely lacking in enough or maintaining essential nutrients (119). There is no doubt that good nutrition and strong child development is essential to cultivating a healthy population, workforce, and society.

Health researchers and medical professionals who have studied child and maternal nutrition in India over the past two decades state that conditions generally have not changed for the country’s poor and malnourished children and mothers, and they do not look to be changing anytime soon (120). The New York Times has been covering healthcare and nutrition in India for several decades, and one particular article reveals that although India has moved to a “lower midd-dle income” country from a “low income” one, activists point out that “it continues to be a country of rampant poverty and vast inequi-rities (121). Despite two decades of growth, over 400 million people in India live on less than $1.25 a day, and the country’s malnutrition figures are among the worst in the world. India has had its welfare programs, but it spends only 0.9 percent of gross domestic product on health care, among the lowest in the world, and 3 percent below the world average.” (122)

South Asia and Sub-Saharan Africa account for the highest rates of child stunting, wasting, and malnourishment. South Asia also has the highest records of maternal undernutrition, which recent evidence strongly suggests has implications for child mortality (123). Statistically speaking, South Asia and particularly children of South Asia should be better off than Sub Saharan Africa according to Millennium Development Goal indicators, the International Food Policy Research Institute, and other global research reports (124). Despite being ahead of Sub Saharan Africa in other determinants of nutritional status, such as national income, democracy, food supplies, health services, and education, South Asia still remains the leader in maternal and child malnutrition (125). India in particular has the worst rates, where nearly a third of its people suffer from hunger and malnutrition (126). Amartya Sen, a prominent Indian economist, has made countless contributions to maternal and child nutrition research, as well as studies on welfare economics of India at large, for which he won a Nobel Memorial Prize. In various studies and articles, Sen draws a link between gender inequality in India and childhood malnourishment.
Gender inequality and maternal health has been a concern in India for a very long time, where the country is responsible for nearly a quarter of global maternal deaths (139). Women in India make up “the most deprived and long-neglected segment of the society, despite the fact that they constitute a significant percentage of that particular segment” (130). Women are victims of socio-economic, political, and cultural discrimination as a result of colonial domination and societal conditions (131). Women are often underpaid and in order to manage public facilities and stay afloat financially, tend to introduce a commercial rationale to service delivery that will hopefully maximize income (137). Public-private partnerships for healthcare may have good intentions for contracting out better care, but they have had a limited impact on maternal health outcomes in India. There is a trend of well-funded, private hospitals popping up in more urban settings in India that are too expensive for most children building one hundred new ships for its navy over the next decade, it is difficult to rationalize giving the country health aid donations (154). This relates to the domestic issues of spending and funding that, similar to international donors, have neglected health systems development and investment in child and maternal care.

India has the largest child-feeding program in the world, with a budget of $1.3 billion a year (155). However, the problem does not exist with funds and assistance, but it is also interesting to compare the child malnutrition rates of both countries. China, as opposed to India, was able to greatly reduce its child malnutrition rates when it became an economic powerhouse. Between 1990 and 2002, China was able to cut the rates by two-thirds, where now only 7 percent of Chinese children under five are underweight (163). There is often comparison to China in regards to development, but it is also interesting to compare the child malnutrition rates of both countries. China, as opposed to India, was able to greatly reduce its child malnutrition rates when it became an economic powerhouse. Between 1990 and 2002, China was able to cut the rates by two-thirds, where now only 7 percent of Chinese children under five are underweight (163). There is often question as to why India has not been able to do the same, given similar trends in economic growth.
The most common answer seems to suggest a difference in governance, and the recognition that the problem is, in fact, multi-faceted (164). Unsurprisingly, when an issue is considered an emergency to a state, there tends to be more attention, resources, and dedication given to resolve it. This dedication was witnessed not only in China with child malnourishment, but also in Brazil and Thailand in the 1980s (165). While the governments of these countries were/are less democratic than India, and there was a certain level of heavy-handedness from these governments, the fact remains that they confronted child malnourishment with great urgency (166). This, however, is an important factor to consider when questioning why India still remains so far behind in tackling this issue that in many respects should be deemed an emergency.

What is also interesting to ruminate is the changing relationship between the geography of the global poor and economic growth. Economist Andy Sumner at the Institute of Development Studies published a study in 2010 titled, The New Bottom Billion. This study found that, “two decades ago, 93 percent of the world’s poorest lived in low-income countries. Now, nearly three-quarters of them, or one billion people, live in middle-income economies,” (167). Economic growth does not simply translate into poverty eradication. It is about how the growth is distributed and clearly there is a problem with the distribution of income. When applying theories of international relations to this case, it appears to be a mixed and confusing blend of perhaps several different explanations. Marxist dependency theory does not offer a fully rational explanation on an international scale. The fact that India has grown so drastically in wealth and power over the last couple decades but has yet to distribute that wealth to issues of child malnourishment makes dependency theory less compelling. India is now more on the end of exploiting rather than being exploited by international actors, which is true for several other middle-income countries. Other developing nations that have enjoyed considerable economic growth and elevated status have not necessarily had the same problems aiding domestic nutritional problems. Entry into global markets and increased economic growth for developing countries does not always equate to the betterment of health. The global economy may influence decisions newly industrialized countries make, but it cannot be generalized as the cause for the health problems of the world’s poor. When it comes to using liberal institutionalism as a lens for India’s case of malnourishment, there exists only an explanation for the positive outcomes. The wide array of new international health actors has definitely presented its share of benefits. For example, there have been a few strong NGO movements for women’s rights and advancement in India that have formed partnerships and made impressive strides in a number of areas, including health (168). There are also movements and developments being made for women in parliament, in large part because of India’s democratic republic (169). The democratic nature of India has definitely brought advancements for women and health in many ways, however it is not necessarily the solution to everything, as liberal institutionalism might have one believe. There are a fair amount of corrupt officials in India’s government making budget and financial decisions that would suggest a greater desire to gain power than to alleviate its populations in poverty (170).

Liberal institutions have also shown to be uncoordinated in their efforts and detract from their recipient populations in India in unintended ways, discrediting the argument that they can perform better than the government programs. The motives behind health financing in India or any state for that matter are definitely ambiguous, and do not often suggest a rights-based approach. Because of this, it is easy to turn to realism for an explanation, which has its merits especially on the international scale. Links can be drawn between issues of national security and economic growth to decisions on healthcare funding in India, as well as countless other countries. The links have proven strong enough to incite questions about the true motives behind big GHIs and government funding agencies.

Conclusion

From the examples and studies discussed throughout the paper, as well as the case for child malnourishment in India, it is clear that a large body of evidence exists following the positive and negative outcomes of international health funding. This body of evidence still seems to suggest a broad trend when it comes to GHI funding. It is clear that explaining this trend does not lend itself to easy generalizations about funding approaches or theories of international relations. However, a few suggestions and arguments can be made with the data that is available, acknowledging that these suggestions and arguments are rarely universally true when it comes to healthcare.

The argument I have attempted to make in this paper is certainly not a new one and in some respects can be explained by mere common sense if using a realist context. By showing that India, it is arguable that international funding for health is greatly influenced by issues of global economics and security threats and often neglects health systems strengthening and domestic health priorities. The stagnating rates of child undernutrition and poor maternal health in India, despite its booming economy, suggest deeper structural problems, such as gender discrimination, that are not being addressed by governments or international institutions. Similar issues exist in other developing countries, some of which continually struggle with issues neglected by GHIs and international donors. Although these countries are often flooded with support for high attention diseases such as HIV/AIDS, malaria, and tuberculosis, support for issues such as primary health care, health education, communicable infections, and nutrition is significantly lacking. The situation I have painted for global health is rather grim, especially if viewed through a realist lens. There is reason to believe states will always place security issues of the developed world as the top priority, where anything and everything to retain power will be done, even when it comes to health and humanitarian aid. However, there is also reason to believe global health can escape the negative ramifications that come with an over-securitized view from the international community. With GHIs and international donors becoming increasingly critical and self-reflective, along with substantial critiques from researchers and scholars, there is hope funding can balance out to support health systems as much as service deliveries. It will take time to see the effects of the proposed changes in funding some GHIs have recently made. What to believe is ambiguous and depends on endless variables, yet the handful of examples of significant positive strides and improvements in global health are enough to keep the hopes of a more equitable global health system alive.
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