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From Humanitarian Action to International Health

Summary

Currently, three main perspectives are considered in international relations in the field of health: humanitarian action in cases of emergency, development cooperation, and "international health". Usually, these situations are described as separate fields, managed by different types of organizations, with specific aims and problems. The main questions raised by these perspectives are first discussed, then elements of convergence between them are described, and finally, some practical ways to reach the objectives of a global model in which humanitarian action and development cooperation are both situated within the broader methodological context of international health are explored.

Humanitarian action

From everyday humanitarian action to public health during wartime

The violation of rights and human dignity begins just meters away from our homes, within families, companies, police stations and prisons. No country, neither in the Northern Hemisphere nor in the Southern Hemisphere is spared of these forms of insidious violence. Although they are difficult to quantify, we may suspect that this represents their most common form, yet the least attainable. It is a matter where international human rights have no jurisdiction against either national or constitutional principles aiming to protect our private lives. Actions taken in this sphere fall into the scope of local social services and organizations such as *Amnesty International* or the *European Committee for the Prevention of Torture and Inhuman and Degrading Treatments* (CPT), which often act at this level. The possible courses of action are:

- the heightening of public awareness and the training of the principal actors concerned by this sort of rights violations: policemen, prison guards, customs officers, soldiers... those who may be compelled to lock up, hold, or use physical force;
- insure close supervision of all therapeutic mechanisms in which restraint could be used, such as: psychiatric hospitals, drug rehabilitation centers, geriatric homes...
- prepare health personnel to play an active role in the prevention and detection of violence, e.g. pediatricians and school nurses in the case of battered children, prison doctors for police violence and emergency room doctors for domestic violence, etc.
- regular visits to detention centers and confidential interviews with the detainees.
- collaborate with social services which take care of high-risk groups such as: asylum seekers, children in threatened families, migrant workers, the homeless, etc.
- reception and treatment of victims of rights violations i.e. those tortured or sexually abused and battered children.

Public health during wartime: protection of health through action and humanitarian negotiations

Although natural catastrophes inflict a heavy tool on health they are unforeseeable, while industrial accidents are largely preventable using existing rigorous security measures.

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On the other hand, the destructive forces of war must be considered a permanent major problem for public health in the world. Humanitarian organizations which act within the context of an armed conflict must, in order to deal with these problems, adopt methods used by public health, such as those used to fight malaria, tuberculosis or nicotine addiction. In other words, the activities must take place on several levels ranging from emergency curative measures to preventive action. This implies a thorough analysis of the mechanisms present in each situation.

Let us go back to the origins and illustrate the negotiation/action process using recent examples. The statement made by Henry Dunant in 1859, on the abandon of 30 000 wounded soldiers in the battle of Solferino aroused a sudden awareness amongst the leaders of that time of the need to limit certain dramatic consequences of war. Catastrophes such as Solferino, due to the disproportionate number of wounded in relation to the medical resources, could be diminished by creating voluntary organizations which would serve as auxiliaries to the medical corps.

Henry Dunant's idea would go well beyond its original practical solution. He would manage to make governments acknowledge the "neutrality" of the wounded, the medical corps, their convoys and the premises where care was administered. This idea, which was revolutionary at its time, became the base on which the Geneva Conventions were built and the ICRC is its promoter and keeper. The Conventions have grown from the protection granted the wounded and those who treat them, to other categories of victims of war such as shipwrecked people, prisoners and civilian victims of war.

So there exists today an international legal purview for protecting war victims which 175 nations have vowed to respect and uphold. If these rules were in fact respected by the belligerent, the health consequences of war would be reduced considerably (morbidity, mortality...) as those not participating directly would be spared.

Negotiation

Negotiation is necessary to obtain access to the most vulnerable victims. Those who have lost all natural forms of protection (government, army, village heads, family) and may even find themselves threatened by the same institutions which are supposed to protect them (i.e. battered children and their parents). If what should be done to protect the health and well-being of these victims is now known and if the necessary means are often available, there still remains the central problem of giving a "new form of protection" to those whose physical and psychological integrity are at risk.

It is here that an organization such as the ICRC, acting as an independent neutral intermediary, has a specific role to play by negotiating the protection of the victims of abusive power or those abandoned by the authorities in power. Its role goes well beyond material aid: its principal role is to insure the protection of these victims, their lives, their health and human dignity.

One example:

At Jaffna in Sri Lanka, a 1100 bed hospital was not operational as it was situated in a conflict zone, between governmental troops and Tamoul rebels. As neither the patients nor the medical staff were able to reach it, they held up in a small hospital with insufficient infrastructure and were unable to meet the needs of the wounded coming from the Jaffna region.

The ICRC, by negotiating with the interested parties, managed to remedy the situation and gain the right to free access to the hospital along with the protection of its patients and medical staff. In the beginning, 4 delegates (doctors and nurses), by their mere physical presence, managed to give confidence back to the hospital staff and even transported them form their homes to the hospital in Red Cross vehicles. They protected convoys of medical materials and medicine coming from the Health Ministry in Colombo.

After a few days, this hospital was able to function once again thanks to 4 expatriates, and may now, with local resources, resolve the problems for which the humanitarian organizations would not have had the means to assume over the long term.

Health care actions

In the case of armed conflict, whole populations can have their health and welfare seriously affected. Massive aid from humanitarian organizations is often indispensable. Rarely can this aid alone meet the immensity of the needs and be able to save populations threatened not only by the enemy but also by the authorities in power.

Direct medical action must thus be complemented with health "protection" for the populations. This protection can be obtained by playing the role of "catalyzer". By negotiating with the authorities for access to victims and the application of the Geneva Conventions, i.e. neutral status for the wounded, medical staff and premises, and the respect of civilians. Experience in the field shows the sad truth. The respect of the Geneva Conventions, even by those who have signed them, is far from sufficient. We must find a way, not to create new conventions, but to obtain respect of existing ones.

The governments having signed the Geneva Conventions have a great responsibility and should endeavor to insure the respect of these rights and consequentially, limit the suffering of innocent war victims. Along these same lines, one must remember the importance of the International Confe-

rence on the Protection of War Victims, organized by the Swiss government in Geneva (August 1993), which outlined solutions to these problems.

In the field, time, resources and possible courses of action are limited. Choices between different interventions must be made hastily. These choices must be based on pertinent and accurate information on the efficiency and the respective costs of different possible actions.

Within this context, humanitarian aid increasingly recognizes the need to evaluate the impact of their interventions on health. An evaluation which should enable them to improve the appropriateness and efficiency of operations, while taking costs into account. An evaluation which also promotes communication between agencies and the public, the press or the financial backers, and helps in justifying choices.

Nevertheless, the limits of an individual approach to humanitarian action are soon experienced. War is a situation of collective violence. It affects the community, creating shared health problems. An appropriate response must take into account the collective dimension, without which the action will be inadequate, useless, and can become the source of new injustices and social discriminations. Thus, humanitarian aid interventions during armed conflicts are torn between the pressing call of the suffering and the long-term requirements of the population.

That same type of contradiction also exists in the choice between curative and preventive actions. On an individual scale, confronted with someone suffering, the appropriate human action is to care for and relieve the suffering. On a community scale the perspectives are often different and cannot be treated as a sum of the individual problems but must also be approached from a community point of view, while allowing latitude for preventive measures. However, even in situations where preventive measures are more efficient, care and individual measures are often preferred by the populations, organizations and backers, because these measures meet more immediately perceivable needs and offer quicker tangible and visible results.

Finally, from a public health point of view, war leads to the concentration, in one place and at one time, of numerous factors which can affect in many ways health in all its dimensions: physical, mental and social. War creates conditions which are favorable to simultaneous multiple epidemics and provides an important increase in disturbances of all sorts specific or non-specific. Within these particular epidemiologic conditions the evaluation of health needs and the impact of emergency actions present extremely complex methodological problems.

When faced with these constraints and such complexity, classical approaches need to be redefined. Health needs assessment and impact assessments employ complex methods, such as difficult-to-use indirect indicators or, need to develop new, better-adapted epidemiological tools.

The "right to intervene"

The notion of the "right to intervene", which has grown over these last years, does not help eliminate the ambiguity of present international relations. At a first look, it seems attractive as long as it represents the image of "universal democracy". A notion which is not a right, seeing as how no political or judicial system can guarantee its legitimacy or efficiency, but instead represents above all the physical strength of countries which are capable of imposing their world vision upon the entire globe under pretext of protecting the right to human dignity even though, in most cases, the non-humanitarian interests are more than obvious.

Of course there are flagrant cases of systematic violations of the most elementary rules of human societies, where the sensitivity of Westerners leads them to wish for an immediate humanitarian intervention, such as the recent case of Rwanda or, earlier in Equatorial Guinea.

Let us raise two important points which highlight the arbitrary choices in this matter. Who can legitimately judge which aberrations committed in such disparate cases as Equatorial Guinea, the Iranian Islamic revolution, or the war in Afghanistan are more unacceptable? Who can uphold the legitimacy of the right for one particular country to intervene in Rwanda when it still supports African dictators guilty of grave human rights violations? The American example clearly shows that, in Haiti, as in Panama and the Persian Gulf, intervention is a right which is forcefully appropriated, not negotiated.

Development cooperation

The situation

Development cooperation in the health field is indissociable from socio-economic growth. It involves multisectorial, multidisciplinary, participatory action. Within this realm, the palette of institutions is particularly dense and complex with Development banks (IBRD, ADB...), Non-Governmental Organizations (NGOs) and the United Nations system (WHO, UNICEF...), as well as bilateral organizations. If the situation is relatively clear at the central level, it often remains unclear in the field.

In nearly every case of development cooperation there is a sort of pre-colonial paternalism which prevails and is manifested daily

through the relationships between the technical assistance personnel and their so called "partners". The persistence of this fundamental attitude stems from the fact that the North, by definition strong and developed – paternalistic-, helps the South, less developed, weak or weakened, and poorly prepared for negotiations.

As far as technology transfer (goods and services) is concerned, as with humanitarian aid, they correspond poorly to local needs. The transfers frequently obey traditional logic based on the standards of the donating country. The disastrous effects are shown every day in health care facilities conceived in a western way. These establishments, at least in the sub-Saharan region, are unmanageable both organizationally and medically. Most of the time these conditions are imposed by the donors not only by their own management principles but also by the receiving administrations which are often modeled after the donating countries. It all takes place in negotiations between two administrations at the exclusion of those who are principally concerned, the populations. But, are not these populations often excluded from the political debate within their own countries?

This attitude is neither required nor inevitable and is not more efficient, in the short- and intermediate term, than the alternative of self-participatory development. Moreover, this attitude completely overshadows other possible South to North contributions, for instance the social management of the groups which are universally problematic, e.g. chronic patients, mothers, children and the elderly.

It is difficult to propose concrete alternatives in the health development field because this implies the study of both the origins of the present situation as well as the future management of the activities.

On a theoretical level, the Alma Ata principle formally adopted in 1978 by most nations and UN Agencies, looks to facilitate universal access to essential health care facilities and to promote the full participation of the populations concerned. Although we might have expected the installation of structures to back the communities by helping them develop the services responding best to their needs and hopes, we saw the implementation of (in contradiction to Alma Ata) programs and budget structures fulfilling the purpose of targeted technology, all in the name of "efficiency". The complex dynamics of health services development was reduced to a juxtapositon of campaigns "by illness" or by program. These campaigns were established in international forums, often using a market, and financial logic framework.

On a practical level, it is not easy to modify traditional management schedules where objectives are expressed in terms of health service reinforcement, while supposing that improved health is automatically derived from improved services. This supposition would be true if the services were always correctly oriented in relation to priority problems and to the needs expressed or formally identified by those concerned. This is rarely the case. We know in particular the three main characteristics according to which nearly all services are established in industrialized countries or in the developing world: urban, curative, hospital oriented. This is in opposition to known priority needs which are: rural, preventive and primary care oriented.

An alternative

An alternative model is suggested here, where objectives are mainly expressed in terms of improvement of health or, a decrease in the importance of specific health problems. The objectives, aiming to strengthen services or improve structures, are derived from these primary objectives.

In this systemic model, evaluation is a continuous process fully integrated into the planning process. The first step consists of setting up a system, before the beginning of the program, in order to collect data which will allow a before/after comparison (evaluation planning). Conversely, traditional programs tend to distinguish between the initial evaluation, follow-up (or internal evaluation during the program) and outside administrative evaluation (external audit). As the objectives in terms of improvement of a health problem are generally not defined, the last step of the evaluation, i.e. the impact on health, is in principle, useless...

The introduction of a continuous, integrated process of planning presumes, in its initial steps, close negotiations with those involved. These negotiations must aim to determine the problems, the needs, and amongst them, the priorities. Experience shows us that the sole opinions of those affected is not sufficient for this evaluation. In fact, the perception of health problems is directed towards the present illnesses and the demand is always curative, both in the industrialized and the developing world (An extreme case, the prevention of accidents at home or on the road, a major problem in both hemispheres, is nearly never cited as a priority need). Thus the intervention of experts and administrative heads during the problem-defining stage is essential. Negotiations must then be multilateral. Which development project, which structural adjustment can pride itself on originating in the village and not in some ministry? How can such a program, such arrangements, originating nationally, pride itself on taking into account the cultural diversity or the participatory principles of Alma Ata?

On an operational level, one must emphasize the nearly universal absence of evaluation based on the health impact of a program. This inadequacy is primarily due to the essential nature of the administration of programs and the absence of objectives stated in terms of health. Further upstream is the lack of initial concern for the planning of evaluation (see above). Such concerns have been frequently seen as academic and, a "loss of time" for operational activities. As we will see later, the destruction of this myth could constitute a concrete solution to the deadlock in which development projects are frequently found.

International health

As an article was written on this specific subject in this issue we will not develop it in detail. However, remember that the field of international health can be seen in a very wide perspective i.e. the field of public health seen on a planetary scale with emphasis on political, socio-economic and cultural diversity. On a more confined scale, international health can be considered to be a comparative approach of problems, services and health care systems, involving particular attention to training and research. In opposition to the situation described for humanitarian action and development cooperation, the international health approach does not imply socio-economic differences between partners. It clearly represents a global methodological framework for every kind of action aiming to improve health of a whole population.

Health and medicine in international exchanges

A group of specific branches is to be considered under the heading of health in international exchanges:

- health and international travel
- health and migration
- health and commercial trade.

We shall not dwell on this last point, although important, connected with commercial trade involving food products and measures taken to guarantee that these products are fit for consumption.
International travel and migration, on the other hand, present problems connected with all aspects of the problematic which has been discussed above i.e. human rights, emergency actions during wartime or after natural or industrial disasters, socioeconomic development, cultural identity and North-South/South-North, East-West/West-East cooperation.
The globalization of economy and trade and the extraordinary development of transport systems and their wider use, as well as the ever-growing access to information, all make our world more finite, compact and accessible. The most isolated regions are opening up, allowing a comparison with the outside world. With more than 475 million arrivals registered per year (1992), tourism has become the third largest world industry, with a $278 billion turnover per annum. This acceleration of exchange has revealed the social and economic disparities which exist in the world between North and South, East and West, and, as a consequence, has increased sharply the number of local, regional and international migratory movements.
In addition, the crises brought on by the destabilization of the end of the Cold War have forced the displacement of refugees and outbreaks of violence, and the resulting victims, which we are witnessing all over the globe today.
As a result, there is a tremendous intermingling of peoples and thus, epidemiological consequences, i.e. travelers from northern industrialized countries are exposed to the endemic diseases of tropical countries (malaria, hepatitis A, bilhariziasis, dengue fever). Even though a large majority of these diseases do not find a favorable environment for their propagation in temperate countries, we are witnessing the transfer of cosmopolitan germs and an acceleration in the spread of different strains, particularly those which resist to antibiotics (gonococci, shigellae, salmonellae, Tb bacilli). Travelers can be exposed to certain diseases and may also facilitate the introduction or spread of some of these in the countries they are visiting (sexually transmitted diseases, AIDS). The forced, or spontaneous, migratory movements in poor countries also contribute to the intermingling of germs and entire populations are being exposed to infectious agents against which they have no immunity.
The increase in migrants coming from the South or the West towards Europe and North America participate in this intermingling though are not creating epidemiological situations in the host countries (due to the high level of, and access to, health care). On the other hand, these migrants constitute an ever-growing number of patients of diverse origins confronted with problems of comprehension and communication which they are neither used to, or prepared for:
patients from diverse cultures and religions, for whom illness and health possess different meanings; patients who expect different things from the health care staff and, populations which are untouched by national preventive programs. This phenomenon, originally considered negligible and temporary, is ongoing and intensifying. The practitioner is forced to deal with this new dimension in the practice of medicine and health care. He/She must internationalize as the medical practices from abroad reach his practice. Because of migrations, we are witnessing an extraordinary reduction of the worlds dimensions, conceptions,

practices, needs and requirements. This may be confronted by refusal, rejection, or, on the contrary, seen as new, diverse and enriching.

Points of convergence: towards a global model for cooperation?

Returning to the three components of the international exchanges in the field of health, there appears to be a number of common concepts or "key words", representing both the integrating principles and the outline of the systemic model we are seeking.

Negotiation

Used here first in the example of the application of the Geneva Conventions, negotiation represents the main tool of action for a humanitarian aid organization such as the ICRC, thus allowing operational access to victims of conflicts.
In the case of development cooperation, negotiation has traditionally been the instrument of dialogue, principally between administrations of the two partner administrations. It is regrettable that the population towards which the aid is directed is systematically absent. This statement highlights the paternal characteristics of aid given by the North, as well as the failure of the popular participation policy in health care as defined by the Alma Ata Declaration. It has also been stated that the lack of democracy in most of the countries concerned, probably constitutes the basis of this situation.
A systemic model based on the application of the integrated planning process is now proposed. This model will most likely improve the management of humanitarian action and development cooperation, and may also pave the way for the continuity between the two perspectives as well as an evolution towards long-term participatory health care action. What is needed is a formal gathering of the decision makers, experts, and the community involved, for the initial negotiations of all projects and actions in an effort to define the objectives in relation to national, regional, and local priorities in terms of health problems.

Evaluation

The evaluation, as defined above in the context of a integrated planning process, is essential to the development of a new outlook on actions that are undertaken. Actions will be judged by their impact in terms of health improvement and not on their managerial performance or on the proper functioning of operations. The planning tool proposed above, finds its application in emergency situations as well as in development co-operation. Furthermore, the strict application of the evaluation is essential in insuring an uninterrupted passage from one situation to another. We can also, in an emergency, initiate the following stages by: setting early long-term objectives, defining the evaluation criteria, and the timely gathering of the necessary data.
Moreover, this approach can be integrated into the negotiation process discussed above. A process which aims (using a participatory mode), to define, with the people concerned, the strategies and actions to be undertaken in order to: reach the goals set and, analyze and coordinate the resources (especially human) necessary for these actions.
If the evaluation, in terms of impact on health, is an integral part of the general planning process, the necessary data can come through routine procedures. Usually, the data must be gathered in a way so as to fit into the framework of a process that can be used for applied research.
Epidemiology plays a central role in this evaluation. How does one estimate a rate, when the inconstancy of the populations does not allow the definition of a denominator? How can one evalute the health needs of a population when certain groups are inaccessible? How can one measure the health needs when the sanitary information systems have collapsed and data is nonexistent? How can one make an epidemiological study when there is no longer any confidence between the people?
Confronted with these constraints and their complexity, classical epidemiological approaches need to be redefined. The evaluation of health needs and impact must use complex methods, such as indirect indicators (which are sensitive to use), or, develop new epidemiological approaches which are better suited. More generally, the validity of the obtained results necessitates strict methods using epidemiology, economic analysis, health systems research and social, behavioral and communication sciences.

Research

In order to evaluate the decrease in acute malnutrition cases in a refugee camp where a health improvement program is to be implemented, one needs to gather early epidemiological data, essential to before/after, and regional comparisons. In this particular case, the data in itself (weight, height, age...) and its interpretation pose few problems. However, there are often cases where the relationship between the risk factors and/or the interventions and their consequences are not, as yet, explicit, and would need specific investigations.
For instance, the relationship between the incidence rate of HIV infection and those of other sexually transmitted diseases has not yet been explained from all perspectives. We know, for example, the role of genital ulcerations as a cofactor in the transmission of HIV infection, but it is still unknown

if the individual diagnosis of gonorrhea should lead to a systematic diagnosis procedure for HIV infection. In the same way, we still do not know if HIV screening provokes, within the group of those declared negative, a subsequent increase or decrease of behavioural risk.
In another area, it would have taken years of research to reveal the fact that the water alone from the family taps was capable of significantly decreasing the incidence of schistosomiasis in the West Indies.
As stated above, from a public health point of view, war accumulates, in one place and time, numerous factors which can have multiple effects on the physical, mental and social health of the people involved. War also creates favorable conditions for the simultaneous outbreak of multiple epidemics and provokes an important increase in all sorts of afflictions, both specific and non-specific. Within these particular epidemiological conditions the evaluation of health needs and the impact of emergency actions poses a set of very complex methodological problems.
It is obvious that this type of research can only be done in the field, in the heart of the action. The availability of certain team members when an immediate set of problems arises can be troublesome. It is a question of state of mind, first of all, then competence, involving the heightening of awareness and the training of the organizations concerned, with the contribution of universities and polytechnic schools etc.

Training

Given this perspective, training represents one of the principles of continuity most likely to implement the systemic model sought after. The role of intervention-type organizations (e.g. the ICRC, and some universities) has been discussed in detail in two other papers in this issue, so that we will not evoke them any further. In other respects, the institutions of tropical medicine and development studies offer programs which are focused more and more on international public health.
The ambiguity which persists at this level is analogous with the situation in the field. The organizations specialized in humanitarian intervention propose (in association with universities) programs which meet their specific needs just as the development cooperation agencies and the international health departments do.
This situation is worsened by an ambiguous definition of objectives, technical levels and targeting of the programs. Is the training intended for future international experts or should it be above all for the national staff? Should this training take place near the theater of operations, "on the job", or on the contrary, in the protected surroundings of a European or North American institution? How can the national delegates/students avoid spending decades in such programs, neglecting their professional activities? How can one meet the challenge of a system with minimal coordination between proposed programs while being confronted with the "high profile" syndrome imposed by the media and the financial backers? And finally, how can one insure that traditional ways of teaching will progressively leave room for training programs where the results are professional competence (research is also a profession...) and not just academic white-wash?
A technical answer was proposed long ago, using a similar approach to the research and operations program planning where the trainee was called upon by his/her teacher to define his/her professional needs which would then define the methods and content of their programs. Very generally, this method equally concerns the retraining of traditional mid-wives as well as the professional and university training of doctors, public health specialists, nursing staff and managers.

Conclusions

Of all the instruments likely to introduce a continuum into different forms of action, and the different situations of international collaboration in the health field, negotiation is the one (although on different political, administrative, and technical levels). The main theme which links this to the principles developed by the large international organizations, particularly the ICRC (based on the Geneva Conventions) and the WHO (based on the Alma Ata Declaration) is the concept of community participation, at all levels, in the decision-making process. Be it for the protection of fundamental rights or the planning of socio-economic and health care program priorities.
A second instrument, the integrated planning process, more particularly aimed at the administration of services, health systems and programs, is the "system framework" where the process looks to meet well-defined objectives. Objectives must be defined in terms of improvement of a problem related to a health risk or the performance of a service or a structural component of the health system.
Given this perspective, contributions from both fundamental and applied research are essential. In fact, the evaluation of results and the processes described above must call upon knowledge and information which needs to be permanently validated using methods like: epidemiology, economic analysis, social, behavioral and communication sciences.
The implementation of planning methods, as well as those for the fundamental fields of public and community health, need specific

training programs, adapted to each situation. In these programs the trainee must plan his own training and not have arbitrary non-pertinent programs imposed by the teacher. The training programs must be negotiated individualy by both the "suppliers" and the "seekers" of educational programs.

The triad *evaluation/research/training* defines the methodological framework of international health, and serves as the guarantor of the quality and continuity of actions undertaken.

In the proposed model, emergency humanitarian aid is conceived in such a way that it merges naturally into a participatory system of development cooperation. A development cooperation system which will henceforth be considered effective, thanks to permanent feedback and an ongoing evaluation of its performance in anticipating, and forecasting certain reoccurrences of violence within the global framework of socioeconomic and long-lasting political development.

Negotiation, in turn, will assure political equality in international exchanges, between North-South, East-West, and populations of all nations.

Zusammenfassung

Von der Entwicklungshilfe zur weltweiten Gesundheitsförderung

In internationalen Beziehungen sind, was die Gesundheit betrifft, drei Situationen möglich: die humanitäre Hilfe in Ausnahmezuständen, die Entwicklungshilfe und die „Internationale Gesundheit". Meistens sind die drei voneinander unabhängig, verfügen aber über eine eigene Organisation, eigene Ziele und eigene Probleme. Hier werden Fragestellungen, die sich auf diese drei Gebiete beziehen, diskutiert. Es wird auf mögliche Vernetzungen hingewiesen. Ein globales Modell, in welchem sich humanitäre Hilfe und Entwicklungshilfe an die methodologischen Ansätze der „Internationalen Gesundheit" anknüpfen, wird vorgestellt.

Résumé

De l'action humanitaire à la santé internationale

On distingue habituellement trois principaux types de situations dans les échanges internationaux dans le domaine de la santé: l'action humanitaire en cas d'urgence, la coopération au développement et la «santé internationale». Souvent ces situations sont décrites comme des champs séparés, gérées par différents types d'organisations, avec leurs propres objectifs et leurs propres problèmes. Cet article passe tout d'abord en revue les principales questions soulevées par ces trois situations. On décrit ensuite les éléments qui les rapprochent. Enfin, certaines voies susceptibles d'aboutir à un modèle global, dans lequel l'action humanitaire et la coopération au développement se situeraient dans le contexte méthodologique plus global de la santé internationale sont passées en revue.

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