Ilona Kickbusch · Graham Lister
Michaela Told · Nick Drager *Editors*

Global Health Diplomacy

Concepts, Issues, Actors, Instruments, Fora and Cases

Springer

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Preface

In this textbook we focus on global health diplomacy as a means whereby issues affecting health that cannot be resolved by one country or agency working alone are addressed together. It demands the creative engagement of many different bodies including governments, international agencies, civil society and the private sector. It needs to be concerned with the biological, economic, environmental and social determinants of health that affect us all as global citizens, whether in high- or low-income countries. Global health diplomacy that addresses transborder issues has been practiced for some 160 years, but as globalisation has gathered pace in the last decades, the practice of diplomacy in this sphere has gained new relevance. There is now increasing interest in health as a component of the foreign policies of nations and it has become a key topic at UN and meetings of other organizations.

Global health diplomacy has also become a more complex undertaking as many different agencies are now realising their contribution to and responsibility for health. This complexity demands new skills from diplomats and health officials. This textbook is a response to these new needs; it attempts to share the knowledge and experience of practicing officials and academics working in this evolving field to develop the art and science of global health diplomacy.

Context

This textbook is one component among others developed by the Global Health Programme at the Graduate Institute of International Health and Development Studies, Geneva devoted to capacity building in this domain. It complements the other components: a training manual, online course and training of trainer's workshops and serves as a guidebook for in-depth learning on key issues in this field. In addition the Global Health Programme has been publishing a range of case studies on the practice of health diplomacy in different venues and settings. The Global Health Programme has been pioneering executive education in global health diplomacy since its first international course in Geneva in 2007. Since then it has held the

Geneva flagship course on an annual basis and has conducted training in partnership with a range of countries and institutions in the Brazil, Canada, China, Indonesia, Kenya, and USA as well as in conjunction with WHO HQ and regional offices. The Global Health Programme is also part of the global health diplomacy network (GHD.net), which collaborates and disseminates knowledge in this new field.

Global health diplomacy brings together the disciplines of public health, international affairs, management, law and economics and focuses on negotiations that shape and manage the global policy environment for health in health and non-health venues. It relates in particular to health issues that cross national boundaries, are global in nature and require global agreements to address them.

The aim of this textbook is to support capacity building in this new field. It is directed in particular at representatives of ministries of health, foreign affairs, staff of international organisations and non-state actors who engage in trans-border health negotiations. It aims to increase their understanding of the dynamics of global health diplomacy and improve their negotiation skills. It provides the broad group of "new health diplomats" with insight into the institutions and instruments, the mechanisms of policy coherence and the negotiation processes. It attempts to balance conceptual and practical approaches and build a bridge between public health experts and diplomats as well as the many other actors in global health diplomacy. It is also directed at schools of public health and international relations which are beginning to give more attention to this developing area.

Geneva, Switzerland — Ilona Kickbusch
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Authors' Biography

Santiago Alcázar is the first and current Brazilian Ambassador to Burkina Faso. He joined the Brazilian Ministry of External Relations in 1982. He has had a distinguished career, with previous postings to Belgrade, Washington and Asunción. In Washington he was posted to the Brazilian Mission to the OAS. From 1989 till 1994, Santiago Alcázar was the Deputy at the Division of American States, Ministry of External Relations and in the period 2001–2002 he held the position as Head of Division of Social Themes, also at the Ministry of External Relations. In 2003 he became the special adviser to the Minister of Health in Brazil. He left this position when he became the first Brazilian Ambassador to Burkina Faso in 2008.

Sima Barmania is a medical doctor with an intercalated degree in community health science and a masters in public health from The London School of Hygiene and Tropical Medicine and has previously consulted for UNFPA in Papua New Guinea. She is currently a Ph.D. candidate focussing on the public health effects of religion on HIV, in both Christian and Muslim populations and she writes for the Independent on global health and peace issues. http://blogs.independent.co.uk/author/dr-sima-barmania/.

Nick Banatvala is currently senior adviser to the Assistant Director General, Non-Communicable Diseases and Mental Health at the World Health Organization in Geneva. Prior to this, Nick Banatvala was head of Global Affairs at the Department of Health in England and before this he headed up the UK Department for International Development's work on global health partnerships and initiatives and scaling up health services. Prior to this, he worked for DFID on a range of health programmes in Pakistan, Afghanistan and the Middle East. He also has sat on a range of government, non-government and academic boards, as well as national and international committees and boards. Nick has a chair in Global Health at Manchester University and a Senior Lectureship at Imperial College, London.

Chantal Blouin is currently working at the Institut national de santé publique du Québec, Canada. Prior to this, she had been associate director of the Centre for

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Sara Gibbs is a consultant in Public Health at NHS Devon, Exeter, UK. Prior to this Sara worked in the international division of the UK Department of Health. Before qualifying in public health Sara was a researcher at the International NGO Training and Research Centre (INTRAC) where she monitored and wrote on changes in NGO policy and practice. She has worked with a range of other NGOs and multilat-

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David Gleicher worked for Global Health Europe, a virtual policy think tank and platform from 2008 to 2011. While at Global Health Europe, he contributed to the formation of the EU's official strategy on global health and foreign policy through multi-stakeholder forums. David is co-author of two applied policy studies: the EU commissioned study "Dancing the Tango: The Experience and Roles of the European Union in Relation to the Framework Convention on Tobacco Control" and the WHO Regional Office for Europe's study "Governance for Health in the twenty-first Century". Currently, David is a project manager and researcher at the World Economic Forum where he works on critical and emerging global risks. David's current research supports content development for the World Economic Forum annual flagship report *Global Risks*.

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Yan Guo is professor at the School of Public Health, Peking University Health Science Center, and she is deputy director of the Institute of Global Health, Peking University. Furthermore, she is deputy director of the China Academy of Health Policy and vice chairperson of the Chinese Health Education Association. Professor Guo is active advocate in promoting health policy, primary health care, rural health services management in China. Over the years, she has led a number of large-scale research projects of both national and international significance, including research projects on health education, health service research, maternal and child health care, health policy and health systems, as well as health inequity in China. She is also a commissioner of the WHO Commission on Social Determinants of Health. Professor Guo got her M.D. from Beijing Medical University in 1982 and MPH from Tulane University in 2001.

John Hancock works at the World Trade Organization in Geneva, Switzerland, where he has served as senior policy advisor to the Director General, representative to the IMF and World Bank and head of investment issues. He also coordinated the WTO's Aid-for-Trade initiative and was secretary of the 2006 Task Force on the subject. Prior to the WTO, Mr. Hancock was senior advisor to Canada's trade minister. He has also been a guest lecturer at Cambridge University, IMD, and the University of St Gallen. He holds a Ph.D. in economic history from Cambridge and has written and spoken frequently on international issues.

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Julia Heydemann is currently pursuing her Ph.D. in political science at the Graduate Institute of International and Development Studies in Geneva, focusing on conceptualising the EU's role and involvement in global negotiations on the issue of "access to medicines." Her interest in the interplay of regional and international membership obligations, and their implications for modern-day diplomacy, follows from her previous employment with EU and UN Member State Germany. She worked for the Representation of the German Parliament to the EU in Brussels and was then appointed by the German Mission to the UN in Geneva, where she represented Germany in EU coordination meetings and at the WHO during the (H1N1) pandemic. She was subsequently engaged by the WHO to advise the Office of the Assistant Director General of the Health, Security and Environment Cluster on donor relations. Julia has a master's degree from the College of Europe in Bruges.

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Kelley Lee is associate dean, research, director of Global Health and professor in the Faculty of Health Sciences, Simon Fraser University, and professor of Global Health Policy, London School of Hygiene and Tropical Medicine. Her research and teaching focuses on the impacts of globalisation on communicable and non-communicable diseases and the implications for emerging forms of global governance. She has authored over 70 scholarly papers, 40 book chapters and 8 books including G*lobalization and Health, An introduction* (Palgrave Macmillan, 2003), *The World Health Organization* (Routledge, 2008) and *Global Health and International Relations* (Polity, 2012 with Colin McInnes).

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Chapter 1
Global Health Diplomacy: An Introduction

Editorial Team

Readers' Guide

This introductory chapter provides an overview of the evolution and practice of **global health diplomacy** as basis for describing the competence set required by global health diplomats. This provides an outline of the subsequent chapters of this book.

Learning Points

- The origin and application of diplomacy
- The emergence of health as an issue for diplomacy
- **Global governance** in the UN system
- The ethical basis for health diplomacy and human rights to health
- The evolution of **governance for global health** in a multi-polar world
- The fora and processes of global health diplomacy
- The competencies required for global health diplomacy

Global Health Diplomacy

The term "diplomacy" was coined in 1796 by Edmund Burke to refer to the conduct of negotiations between officials of different countries to achieve their foreign policy objectives without recourse to war. As he said:

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> All government, indeed every human benefit and enjoyment, every virtue, and every prudent act, is founded on compromise and barter.

Insights into the practice of negotiation can be found in "The Art of War" attributed to Sun Tzu in the sixth century BC, Nicolò Machaivelli's "The Prince" written in about 1510 and the pamphlets of John Milton published in the 1650s as Secretary of Foreign Tongues to Oliver Cromwell.

Historically negotiations between states have focussed on issues of security and the resolution of potential conflicts over issues such as trade. As described in Chap. 2, these issues dominated early attempts to develop international agreements on health. In recent years, however, dialogue has broadened to include human rights, environment and health, and issues arising from conflict and fragile states as introduced in Chap. 3. At the same time global legal instruments have been developed and applied, see Chap. 4. Global diplomacy in health and other spheres has been transformed from the power block confrontation of the cold war period to the multipolar era of globalisation in which power and influence are exerted in many different ways by new actors including emerging countries and non-government organisations in many new fora (see Chap. 5). This is reflected in the processes of negotiations between states and with other actors described in Chap. 6.

Global governance describes the organisations and processes through which global society defines and interprets shared ethical values that define human rights and responds to the challenges and responsibilities these bring. From 1946 to 1990 was characterised in relatively simple terms as the mechanisms and agencies of the UN that support international cooperation between states. On health issues the leading UN agency is of course the World Health Organization (WHO).

The ethical basis for negotiations concerning health as a human right is examined in more detail in Chap. 7. One key point of reference is set out in the constitution of the WHO written in 1946. As Jacobsen (2008) points out, this provides a powerful declaration by member state, that "in conformity with the Charter of the United Nations, the following principles are basic to the happiness, harmonious relations and security of all peoples:

- Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
- The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and states.
- The achievement of any state in the promotion and protection of health is of value to all.
- Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.
- Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

- The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.
- Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.
- Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures".

While this declaration seems clear and unequivocal, its application has been variously interpreted by the 192 member states of the WHO and the non-governmental groups who bring their own values and interests to bear. Thus, for example, different countries have applied their own interpretation of the rights of women and of gay people, the Holy See (which had observer status at the WHO since 1964 and became a full but non-voting member in 2004) has maintained a vigorous political representation for the Catholic Church's position on issues of sexuality and reproduction.

It is also clear that the economic and commercial interests of member states play a role in their interpretation of human rights and **global public goods** as described in Chap. 8, for example, in the past the USA has been reluctant to participate in measures to improve access to affordable medicines, which can be seen as a global public good that could lead to challenges to intellectual property rights held by US companies as private goods.

The common recognition of the value of human health provides a basis for shared understanding and can be seen as a "bridge to peace" as illustrated by Arya and Barbara (2008). At the same time health threats have become to be seen as human security issues as demonstrated by the discussion of HIV/AIDS at the UN Security Council in 2000. A broad examination of **global health** as a human security issues is provided in Chap. 9.

However, in today's multi-polar world, power and influence are exercised by many different groups of state and non-state actors through many different channels and institutions, including but not restricted to the UN system, as described in Buse, Hein and Drager (2009). Health is an issue that crosses many boundaries both because diseases know no borders and because the determinants of health such as environmental threats (see Chap. 10) and trade, which can both improve health by offering opportunities for economic development to escape poverty and threaten health as a vector of lifestyle conditions such as obesity (see Chap. 11).

Issues affecting health and its determinants are therefore negotiated not only at the WHO (see Chaps. 12 and 13) but also at the UN (Chaps. 14 and 15) at meetings of the EU and other economic groups (Chap. 16) and summit meetings between heads of state, officials and representatives of civil society including G8 and G20 meetings (Chap. 17) and at World Trade Organization negotiating rounds (Chap. 11). This broader engagement to include academics, business interests, civil society organisations and the public as well as states and interstate organisations can be referred to as **governance for global health**.

High level international diplomacy is underpinned by the engagement of civil society through public diplomacy (Chap. 18) and the national coordination of

strategies and actions for global health as described in Chaps. 19 and 20. These developments not only change the nature of global health diplomacy but they also redefine power relationships between states leading to new models of development as described in Chap. 21. New modes of **governance for global health** are also made possible as described in Chap. 3. This can be seen as a Copernican revolution in health and foreign policy as described in Chap. 22.

Competence Required for Global Health Diplomacy

As Berridge (2005) points out, diplomacy also involves the development of relationships and mutual understanding that provide a context to negotiations. And diplomacy and negotiation do not stop with the conclusion and ratification of an agreement, the continuing monitoring, negotiation and application of international laws and agreements is the foundation for **global governance** and is central to the role of agencies such as the WHO and the WTO. At every stage in negotiation diplomats require to match a clear understanding of their own state or organisation's position with the ability to listen to and understand the language, culture and perspectives of the other protagonists, whether this is a foreign language, the language of public health or trade or foreign policy. As Sun Tzu wrote:

> You must know yourself and know your enemy.

The actors engaged in such diplomacy and negotiations are no longer limited to heads of state and officials of Ministries of Foreign Affairs. Politicians and officials from many different Ministries and Government bodies, international agencies, civil society organisations and businesses interests may all be engaged in international diplomacy and negotiation. As a result the role of diplomatic representatives has broadened to include support for a wide range of direct contacts and discussions between countries, while officials from other ministries as well as representatives of civil society have needed to develop skills in diplomacy. In an age of mass media, communications skills to engage with the public and civil society organisations in both home and foreign countries are essential skills for modern diplomacy, though it is salutary to note that John Milton's pamphlets attacking the royalists and defending free speech demonstrated the art of public diplomacy in the seventeenth century.

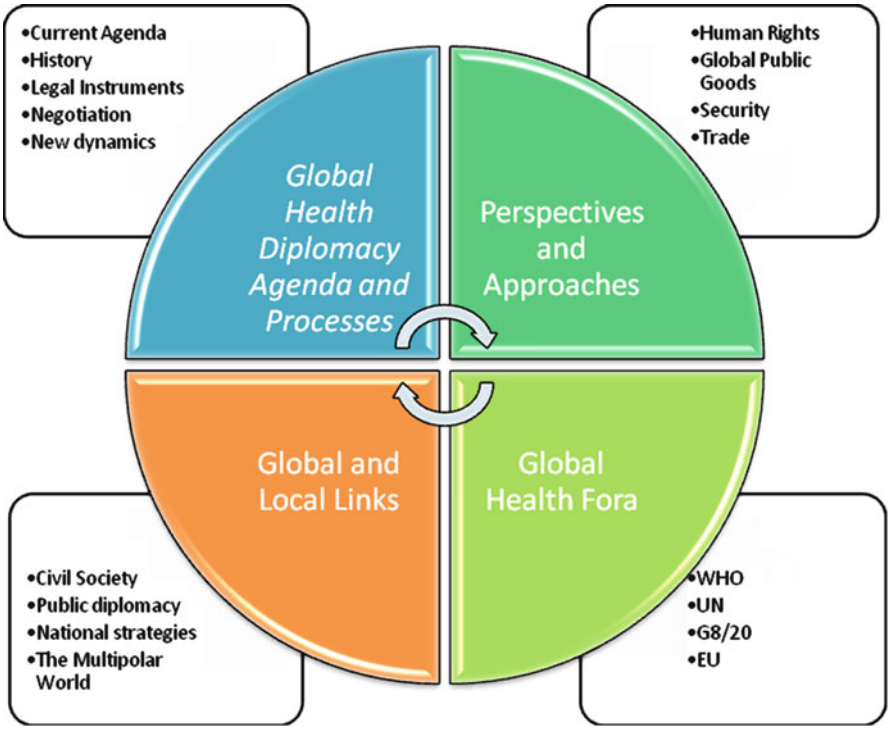
Global health diplomacy has therefore been defined by Kickbusch, Silberschmidt, and Buss (2007) as the multi-level negotiation processes that shape and manage the global policy environment for health. Ideally these result in both better health security and population health outcomes for each of the countries involved (thus serving the national interest) as well as improving the relations between states and strengthening the commitment of a wide range of actors to work towards a common endeavour to ensure health as a human right and a public good.

The discussion of global health diplomacy outlined here and explored in more detail in subsequent chapters provides a basis for building the knowledge understanding and skills required for the exercise of global health diplomacy, as demonstrated in the cases described in this book and in Rosskam and Kickbusch (2011). These include:

- Knowledge of diplomatic relations and multidisciplinary understanding of how issues such as security, trade and development relate to global health.
- Knowledge of the evolution of global health diplomacy, its key concepts and mechanisms including **governance for global health** and **global public goods**.
- Knowledge of the determinants of global health and an understanding of their consequences and links to other aspects of foreign policy.
- Understanding of the moral and ethical value basis of global health in human rights and how such values are interpreted from different cultural perspectives.
- Understanding of the multinational and multilateral nature of global health diplomacy, including:
  - The roles of key fora and agencies and an understanding of their perspectives and how to engage with them.
  - The instruments: international law, treaties, agreements, conventions, protocols, declarations and codes.
  - The mechanisms of global health diplomacy: advocacy, consultation, conciliation, arbitration and recourse to the International Court of Justice.
- Understanding of negotiation processes and skills in the practice of negotiation, these may include:
  - Language skill, listening skills and empathy.
  - Skills in managing meetings including interpersonal skills and logistics.
  - Skills in rational thinking and the conduct of negotiations.

Such a competence set may be found in people with a background in health or development who may need to enhance their diplomacy skills and/or people with experience of diplomacy who may need to deepen their understanding of global health. This book is intended to help readers with some understanding of global health issues to develop key elements of this competence set by examining the application of global health diplomacy skills in many different contexts. Chapter 6 provides an outline of the higher level competence and aptitudes required to lead global health negotiations.

Outline for the Book



This book is set out in four main sections as shown in the diagram below followed by a reflection on the lessons learnt and the future of global health diplomacy.

A Framework for Discussion of Global Health Diplomacy

Global health diplomacy, its current agenda and instruments are introduced in Chaps. 2–6.

- Chapter 2: The Origins of Global Health Diplomacy, Ilona Kickbusch provides an overview of the lessons we can take from history of global health diplomacy.
- Chapter 3: Current and Future Issues in Global Health Diplomacy, Graham Lister and Michaela Told examine current issues, its relevance to unstable states and governance for global health as illustrated in the following chapters.

- Chapter 4: Global Health Law, Allyn Taylor discusses the legal basis of global health agreements and negotiations.
- Chapter 5: The New Dynamics of Global Health Governance, Wolfgang Hein examines the emergence of new actors and mechanisms.
- Chapter 6: The Process and Practice of Negotiation, Graham Lister and Kelly Lee provide a framework for examining the negotiation of global health issues.

Chapters 7–11 examine different policy perspectives which frame global health issues. In

- Chapter 7: Human Rights and Equity: The Value Base of Global Health Diplomacy, Ron Labonté introduces the policy frames in which global health issues arise and considers in more detail the human rights perspective.
- Chapter 8: Negotiating Global Public Goods, David Gleicher and Inge Kaulge consider the emerging awareness of the concept of **global public goods** as a basis for global health diplomacy.
- Chapter 9: Global Health and Human Security, David Heyman and Sudeep Chand discuss global health from a human security perspective.
- Chapter 10: Global Health and Environmental Diplomacy, John Kirton and Jenilee Guebert compare global diplomacy in health and environmental issues.
- Chapter 11: Trade and Health Diplomacy, John Hancock provides a perspective on trade and health diplomacy at WTO.

Chapters 12–17 consider global health diplomacy in relation to the main fora and actors engaged in global diplomacy.

- Chapter 12: Global Health Diplomacy at the WHO, Elil Renganathan examines global health diplomacy as exercised at and by the World Health Organisation.
- Chapter 13: Instruments of Global Health Governance at the World Health Organization, Steven Solomon examines WHO instruments.
- Chapter 14: Instruments for Global Health Diplomacy at the UN, Chantal Blouin and Valerie Percival review approaches to global health governance at the UN.
- Chapter 15: Global Health and Foreign Policy at the UN, Luvuyu Ndimeni discusses global health and foreign policy at the UN General Assembly.
- Chapter 16: The European Union as an Actor in Global Health Diplomacy, Thea Emmerling and Julia Heydemann examine the capacity for joint action, at the EU.
- Chapter 17: The G8/G20 and Global Health Governance, Andrew Cooper reviews global health diplomacy at G8/G20.

Chapters 18–22 consider the links between global and national coherence, public engagement in global health and future directions.

- Chapter 18: Civil Society and Public Diplomacy for Global Health, Sima Barmania and Graham Lister examine the role of civil society organisations in addressing global health issues through direct action and public diplomacy.

- Chapter 19: Health Is Global, Nick Banatvala, Sara Gibbs and Sudeep Chand consider global health policy coherence in the UK.
- Chapter 20: National Strategies for Global Health, Priyanka Kanth and David Gleicher discuss strategies for health and foreign policy in Switzerland and the USA and Guo Yan describes China's emerging approach to this topic.
- Chapter 21: Power Shifts in Global Health Diplomacy and New Models of Development, Paulo Marchiori Buss and Miriam Faid examine shifts in global health diplomacy and new models of development through south–south cooperation.
- Chapter 22: Reflection: The Copernican Revolution in Global Health Diplomacy, Santiago Alcázar identifies some basic lessons from the changing relationship between foreign policy and health.

To support these discussions this text book is accompanied by a glossary of terms and each chapter includes illustrative examples of global health governance issues, questions for readers to promote further thought and discussion and recommended readings.

Questions

1. What is global health diplomacy and how is it changing?
2. How are human rights to health defined?
3. Does everyone interpret these in the same way?
4. What is global health governance and how is it evolving?
5. Prepare a list of global public goods for health—how are they funded?
6. List your current competencies in global health diplomacy and those you hope to develop.

References

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Kickbusch, I., Silberschmidt, G., & Buss, P. (2007). Global health diplomacy: The need for new perspectives, strategic approaches, and skills in global health. *Bulletin of the World Health Organization, 85*(3), 243–244. An important article providing an overview of the issues and making the case for building skills and capacity in global health diplomacy.

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Further Reading

Berridge, G. R. (2005). *Diplomacy: Theory and practice*. 4th edition Palgrave-Macmillan: Basingstoke and New York.

For news and analysis of global health diplomacy issues readers should look at. http://www.ghd-net.org/.

For up to date news, information and debate on global health and governance issues, plus a glossary and details of European global health actors readers should consult the Global Health Europe web site www.globalhealtheurope.org.

Readers may also wish to consult the open access online journal Globalisation and Health published by BioMed Central and available at http://www.globalizationandhealth.com/.

Chapter 2
The History and Evolution of Global Health Diplomacy

Ilona Kickbusch and Margarita Ivanova

Reader's Guide

International health cooperation has been integral to the development of diplomacy in the last century. Building on 160 years of collective attempts to combat diseases that cross national borders, it has developed into what is now called global health diplomacy. The purpose of this chapter is to analyse major milestones in this historical process and help global health diplomats acquire a better understanding of the context in which those changes occurred. Providing information on the driving forces, actors, venues and main achievements, it is structured around five chronological periods. They highlight the interface between the development of diplomacy and health diplomacy, and how they have influenced each other. The concluding section identifies some of the major challenges and opportunities ahead for global health diplomacy.

Learning Points

- Health was one of the first trans-boundary issues to employ multilateral diplomatic mechanisms during the nineteenth century.
- The first half of the twentieth century saw the emergence of the first international institutions working on health, including voluntary organizations.

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- In the Constitution of WHO, member states have given it the mandate to be "the directing and coordinating authority on international health work".
- The increasing complexity of multi-level multi-actor negotiation processes is a defining characteristic of diplomacy in the beginning of the twenty-first century.
- In the past 20 years new actors and innovative mechanisms have entered the global health landscape reflecting a shift towards a multi-polar world.
- Along with advantages of increased attention and much needed resources, this transition has raised concerns as to legitimacy and accountability.
- Such developments serve to reinforce the fundamental importance of global health diplomacy and the central role of the multilateral venues of the UN, and in particular it is specialized agency for health, the WHO.

Introduction: The Realpolitik of the Nineteenth Century: The First International Sanitary Conferences and Conventions

The nineteenth century was an era of preparation for international organization (Kennedy 1987, p. 844). In an age of strong nation states, developments in transport provided the basis for an unprecedented growth of international exchange and commerce. With it came a new age of progress and optimism with great trust in the possibilities of science and technology—disease, poverty and destitution were to be things of the past. Progress was a stimulus for trade but this also made possible the more rapid and extensive spread of diseases (Howard-Jones 1975) which national policies and instruments (such as quarantine) failed to contain. For example, two cholera pandemics hit Europe between 1821 and 1851, which led to great loss of life, in particular among the poorest, including in the capitals of London, Paris and St. Petersburg. Merchants bore the brunt of quarantine measures, exacerbated by unreliable disease reporting and faced great financial loss without compensation. Just like today in the face of tough competition between states in the new global market place there was a political concern that quarantine measures were applied by some countries in order to achieve unfair trade advantages. International cooperation was necessary to create a level playing field.

Health was one of the first trans-boundary challenges which employed a new diplomatic mechanism that had been invented in the early years of the century—the multilateral conference (Fidler 2001). Its construct was simple but revolutionary: countries would meet ad hoc to reach agreement "on a common policy with regard to a common problem", they would then meet again to see if they had been implemented and if necessary adjust them. Over time this led to a more or less regular system of follow-up conferences. International health cooperation was a symptom

of the broader transformation that shaped the nineteenth century. It had become apparent that "technical problems which required simultaneous and expert consideration by many nations" could not be handled expeditiously by traditional bilateral diplomacy. In response, in the second half of the nineteenth century, international conferences were convened "with the object of enabling nations to reach agreements on many non-political subjects" (WHO 1958, p. 5). The emergence of a new multilateral system of diplomacy allowed for simultaneous negotiation between states, an approach that was considered useful for many areas of common concern in an age of geo-political expansion and economic growth. Over time, deliberations during international meetings continued to serve as an important legitimizing and organizing feature of the respective fields (Birn 2009, p. 53; Birn et al. 2009).

The first International Sanitary Conference took place in 1951 in Paris (WHO 1958, pp. 3–6), rendering "important services to the trade and shipping", its 48 plenary sessions took place in a period of 6 months. Each of the participating 12 governments was represented by a diplomat and a physician, each with an individual voting right which enabled them to vote in contradiction to each other (WHO 1958, p. 7). In consequence the second ISC held 8 years later lasted for 5 months and was conducted without medical delegates.

Over the next 50 years ten **international sanitary conferences** were convened (Fidler 2001). For many decades they were dominated by cholera and became a platform for heated debates between different scientific schools of thought on causation. The Fifth Sanitary Conference in 1881 is particularly interesting as it was the first to take place in the USA and included not only the usual European actors but also seven Latin American countries plus China, Japan and Liberia (Birn 2009, p. 53; Birn et al. 2009). In general, however, the conferences kept their strong European focus (Lee 2009, p. 4). By the 1890s the medical establishment was ready to accept the fact that micro-organisms caused cholera—Filippo Pacini in 1854 and Robert Koch in 1883 had long since discovered the cholera bacteria. Thus after 41 years of international efforts to regulate health issues the first international convention was agreed in 1892—focused on cholera control along the Suez Canal, which had been opened in 1869. It was followed by **conventions** on the sanitary control for the Mecca pilgrimage (1894), and on responses to plague (1897). In this context it is worth noting that already in 1839 the Ottoman Empire together with the maritime powers had established the Supreme Health Council of Constantinople in order to regulate the sanitary control of foreign shipping in Ottoman ports.

The idea of creating a permanent international agency to deal with health was raised at the 1874 Sanitary Conference in Vienna. It would take 33 years to establish the first such agency. But the new diplomatic mechanism to defend national interests, less obstructive to trade, and more effective in the control of diseases and health protection, through multilateral ad hoc conferences was a significant shift in the way foreign policy was conducted and a solid foundation for further developments in the twentieth century. But a new need was emerging: "The official collaboration required is now not only the prevention of particular exotic diseases but something very much wider" (Buchanan 1934, p. 882).

The Institutionalization Phase in the First Half of the Twentieth Century: The Establishment of First International Organisations Working on Health

The first half of the twentieth century added a completely novel form to the system of diplomacy: the universal membership organization, open to all states and committed to "open diplomacy". The **League of Nations** created in 1919 marked the beginning of a new phase of diplomatic endeavour to settle international disputes, ensure peace and solve problems common to all based on an "institutionalized" approach to international affairs (Kennedy 1987). The shared assumption was—after the dramatic experience of the First World War—that diplomacy conducted jointly "in the public domain" would preserve peace more effectively than that conducted in secret. A key feature was deliberation in plenary assemblies that bring all delegations together (see France Diplomatie 2011). These assemblies were no longer prepared by the diplomatic corps of a country but by a secretariat and a new corps of international civil servants, in principle beholden to their organization and not to their nation of origin (Nicolson 1969).

As one of the problems "common to all" health was included in the Covenant of the **League of Nations**. Article XXIII (f) provides that members would "endeavour to take steps in matters of international concern for the prevention and control of diseases". This became part of the remit of the first universalistic, multilateral and multi-purpose organization leading to the creation of the **League of Nations** Health Office (LNHO) (WHO 1958, p. 22; Birn 2009).

But LNHO was not the only international actor on health. In 1907, the **International Office of Public Hygiene** (OIHP) was created in Paris. With 12 countries (Belgium, Brazil, Egypt, France, Italy, the Netherlands, Portugal, Russia, Spain, Switzerland, the UK, and the USA) the first meeting of the Permanent Committee of the OIHP opened in 1908 at the French Ministry of Foreign Affairs. By then the regional Pan American Sanitary Bureau had already been working since 1902 (Cueto 2007). As the first regional health agency, PASB provided a platform for dialogue, and led to the creation of the 1924 Pan American Sanitary Code, signed by all 21 Pan-American countries.

While state and interstate organizations were the norm in the still predominantly **Westphalian system** (the recognition of the rights of sovereign states established by the Treaty of Westphalia of 1648) non-state actors began to emerge. The **Rockefeller Foundation** created in 1913, came to be the exemplar of foundation activity on an international scale (Farley 2004). Indeed it was so active throughout the world and in working with the health office of the **League of Nations**, that in 1928 it created its own international health division at its HQ in New York. It was a powerful actor operating health projects, research and educational efforts in more than 90 countries (Fosdick 1952; Cueto 1994; LNHO 1927, p. 743). Key steps towards the formation of other civil society international humanitarian organizations were also made with the creation of the League of the Red Cross Societies in

1919 after the Committee of the Red Cross was created in 1863, which pioneered a new ethics of impartiality and neutrality.

Thus between the two great wars the world had two international health offices—OIHP and the LNHO (Howard-Jones 1975)—both of them weak and not well enough resourced and for political reasons not well coordinated—as well as some important regional bodies such as the PASB. Action at the LNHO was hampered from the start by the fact that the USA had not joined the **League of Nations** and continued to work through the OIHP in Paris on quarantine issues. The **League of Nations** therefore concentrated on a permanent epidemiological intelligence service to collect and disseminate data worldwide on the status of epidemic diseases of international significance (through the Weekly Epidemiological Record) as well as creating technical commissions on matters such as malaria, cancer, typhus, leprosy and biological standardization (WHO 1958, 1968). The OIHP, following on from the **International Sanitary Conferences**, continued to focus on international responses to communicable diseases; most importantly it adopted the International Sanitary Convention in 1926, covering an increasing number of diseases of special significance for trans-boundary health. It also adopted measures requiring governments to notify the OIHP immediately of any outbreak of plague, cholera, or yellow fever or of the appearance of smallpox or typhus in epidemic form. Because of the close links to sovereignty, notification has remained a key issue for health security, almost 80 years later, it would still be a key component of the revised International Health Regulations in 2005.

These first steps in multilateral institution building brought a profound change in the way diplomacy was conducted. In permanent fora of different international bodies countries could search for solutions to their national concerns. In a time of still very formal, state-based interactions the position of health on the international stage was firmly set.

The Creation of WHO and Its Role in Global Health Diplomacy

The second half of the twentieth century saw an unprecedented increase in the importance of multilateralism as countries came together to rebuild the world in the wake of the second world war. During the 1945 San Francisco Conference that established the UN, the 46 delegations that attended the meeting agreed to create a specialized health organization. The joint declaration submitted by Brazil and China calling for the early convocation of a general conference for the purpose of establishing it was approved unanimously by the conference (Birn et al. 2009). The follow-up came just half a year after the first meeting of the UN General Assembly.

For the first time in history, the leading role for health diplomacy was in the hands of a single international institution, with broad mandate for strategic leadership at an international level. It would carry the functions of both the OIHP and the LNHO. A new permanent venue for health diplomacy was established in Geneva (Howard-Jones 1975). The intention was that it would prove to be more effective if it were not

subsumed into the political UN as an office, but would work as a specialized technical agency of the UN with its own governing bodies. This period in the evolution of health diplomacy came "at a time when the governments and peoples of the world were not only animated by the will to rebuild the world (but also confident that science will help them to do so)…medicine is one of the pillars for peace" (WHO 1958, p. 38).

As the first international conference held under the auspices of the UN, the International Health Conference convened at New York on 19 June 1946. Delegations were present from all the 51 members of the UN as well as 13 non-member states as observers. Specialized agencies linked to different aspects of health were also invited including the **Rockefeller Foundation** and the League of the Red Cross Societies (Howard-Jones 1975; WHO 1958, 1968). The secretariat comprised UN officials and civil servants of different governments and also members of the former LNHO and OIHP. In only a month and a half, under its President, Surgeon General Thomas Parran, the Conference succeeded in producing the Constitution of the WHO, 61 states gave their agreement and two of them, the United Kingdom and China achieve became the first full members of the WHO by signing the document without reservations.

The Constitution of WHO came into force in 1948. The organization had the mandate to "act as the directing and co-ordinating authority on international health work". A new permanent venue for health diplomacy was established in Geneva. It brought together all nations states as members with equal representation—one country—one vote, giving it a high level of formal legal legitimacy. This made it different from all other health organizations and constitutes its convening power. For a long period—over 50 years—it has remained at the centre of all international health work.

The first assembly was convened in the Palais des Nations in Geneva on 24 June 1948 (WHO 1958). The Palais hosted the WHO until 1960s when a resolution was passed in favour of constructing a new headquarters building. But since the beginning, Geneva secured its place as the world's health capital. It became the venue for the annual WHA meetings which brought together delegates from the member states chosen "among the persons most qualified by their technical competence in the field of health, preferably representing national health administrations" as well as many observers, such as representatives of non-member states, other specialized agencies and different international bodies (WHO 2008).

The representation of countries in this new organization progressed from diplomats to representatives from Ministries of Social Affairs and then became the responsibility of the Ministries of Health which were increasingly created within the governments of member states. The trans-boundary vision that had driven the International Health Conferences emerged in the successful drive to eradicate small pox, but it became increasingly difficult to overcome national interest to reach joint global goals, despite important political commitments such as the Health For All Strategy adopted in 1977 (WHO 2008).

Working in a divided world, the WHO had to deal with the challenging task of reaching across regions and power groups. In many aspects, it was successful. Its growing importance was reflected in the increasing membership, the growing budget and professional staff, able to provide guidance in more areas than ever before.

Box 1 WHO: "The Directing and Coordinating Authority on International Health Work"

- First decade: major diseases
- Second decade: liberation of former colonies—health manpower development
- Third decade: eradication of small pox, new issues such as family planning
- Fourth decade: Primary health care WHO–UNICEF—Health for All—Equity cooperation
- Fifth decade: investment in health, poverty eradication
- Sixth decade: common health security and health as a global public good

With a USD 3.8 million initial budget, the organization grew quickly and reached a budget of USD 187.2 million in 1978. Two examples of its work are particularly important: the First International Sanitary Regulation in 1951 and the Alma Alta Declaration in 1978, with the latter gathering the support of 175 countries to reaffirm health as a right (Box 1).

Reflecting the change in diplomacy and shaping the way it was conducted, the World Health Organization embodied several novel concepts along with the valuable experience of its predecessors. First, as an organization from the very start it was a hybrid—both a technical and political organization. Second, it was a venue for international health negotiations based on the UN principle of one country one vote. Each member state, no matter how small or big, enjoyed direct representation and equal rights. At the same time, regional offices were introduced.

Beyond Traditional Health Fora: The Emergence of Market Multilateralism

The major geopolitical shift brought by the end of the Cold War and the beginning of the HIV/AIDS epidemics in the 1980s created a "cosmopolitan momentum" for health diplomacy. The sociologist Beck (2007, 2009) describes it as a prism that brings into focus the need to address a problem through collective action motivated by two imperatives. It unites a normative dimension of global responsibility, with elements of **realpolitik**, defending national interests but realizing that global challenges can only be resolved jointly. Cosmopolitan moments often open up new political spaces and allow—and sometimes oblige—new actors to join the global governance effort (Kickbusch 2009). The HIV/AIDS epidemics marked such a moment for diplomacy and brought health forward on the political agenda. In this

early period of transition from international to global health (Brown et al. 2006) health moved to become a prime concern of international development.

But at the same time, the profound changes on the international stage opened the door for new challenges to the WHO. After several decades as undisputed "world leader in formulating professional consensus, setting international technical norms and defining health care standards" (Peabody 1995), the last two decades of the twentieth century saw the rise of serious challenges to this monopoly for several reasons.

First, it was contentious time for multilateral institutions in general. In the context of rising expectations and insufficient commitment from major member states, many UN agencies were struggling to satisfy donor expectations. The same was true for the WHO. It seemed that the institutionalized system of health diplomacy introduced in the mid-twentieth century was in crisis—the technical and the political worlds of health were out of touch. From the early 1980s, the WHO's regular budget was frozen in real terms, a policy imposed on other UN organizations, and then in 1993 in nominal terms (Lee 2009, p. 101). A series of reforms were undertaken to alleviate donors concerns, but the big questions of finding the role of the WHO and ensuring financial sustainability were still unanswered. It became even more challenging as health diplomacy moved beyond the traditional health venues and actors.

Second, the shifting geopolitical context, which saw the entry of new actors and values in the international health field, marked a new stage in the way diplomacy was conducted. The beginning of the 1980s brought an important transition beyond the nation state with the emergence of international and national NGOs. Their growing role was clearly demonstrated in the development of the "International Code of Marketing on Breast-Milk Substitutes" (ICMBFS) at the WHA where a network of public interest groups united in the International Baby Food Action Network, played a key role. They took action on different levels and engaged in lobbying with their governments, monitoring the industry by exposing abuses, sought the attention of international media and managed to gain public support. They proved successful in steering international action, despite the financial power of the industries involved.

The new health diplomats included the AIDS activists and the representatives of the development agencies, for them the institutionalized form of the WHO did not deliver what was necessary—neither the capacity to implement programmes nor the political clout to affect change. Major powers were no longer committed to universal membership organizations or to multilateralism and, without support from member states, the world's expert body for health, the WHO, was challenged. It was deeply symbolic for this crisis that WHO's programme on HIV/AIDS was shut down and a new agency—the UNAIDS—was established in 1996 (Birn et al. 2009).

The late 1980s also saw the growing involvement of the financial and private sectors. The World Bank, regional development banks, and other financial institutions included health in their portfolios and became increasingly important in both mobilizing international health finances and influencing decision making (Finnemore 1997; Brown et al. 2006; Birn 2009). Health was increasingly seen as an investment. It was time to test the ability to achieve results, or to "deliver". The key topics on the stage were development and poverty eradication.

The World Bank's (1987) review "Financing Health Services in Developing Countries" and its seminal 1993 report "Investing in Health" (World Bank 1993), two of the key documents of this time, are clear illustrations of their business-oriented logic (Birn 2009; Birn et al. 2009). They brought a shift towards management-style performance and concrete and measurable goals. Bringing a market-oriented approach into international health, they identified misallocation and lack of efficiency as the main problems. The role of the private sectors was thus promoted as an example of efficient and effective decision making. The focus of international efforts was directed towards health reforms and heath financing.

While the beginning of the twentieth century saw the advent of multilateral universal organizations, its last decades marked a shift towards what was termed market multilateralism (Bull and McNeill 2007). This new form, clearly illustrated in the field of health, brought different principles to the conduct of diplomacy for health. It mixed the norms of multilateralism with the interest of market actors. In the late 1980s and 1990s health diplomacy moved beyond the traditional venue and the state centric approach of the international organizations to mechanisms that could act more rapidly, generate more resources, and allowed for the inclusion of other actors. States lost their monopoly on the international stage and other players emerged to complement their responsibility to deliver health joins in a rapidly changing world (see Chap. 18).

The Global Period from 2000: Toward a Multi-polar World

In the early twenty-first century diplomacy is again in a process of change and adaptation. Global challenges such as the environment and health have transformed the very essence of the task of diplomacy. "In the past, it was enough for a nation to look after itself. Today, it is no longer sufficient" (Cooper 2004). Managing interdependence, securing national interests and promoting development are the action spheres for the new (health) diplomats. Their role now includes a double responsibility: to represent the interests of a country as well as the interests of the global community (Muldoon et al. 2005). This "double responsibility" is best illustrated by the recognition that global public goods (Kaul et al. 1999; Kaul and Goulven 2003) need to be negotiated and ensured and regimes in the area of trade and economic development need to be complemented by binding agreements in areas such as environment and health.

In an interconnected world where diseases can spread faster than ever before but also where there is a growing understanding of the responsibilities of a global community, countries become increasingly aware of the need to cooperate on global health. They do so however in changing constellations where they aim to find their place and spheres of influence in what is often referred to as a "geopolitical marketplace" (Khanna 2008). Hillary Clinton remarked in 2009 that: "In short, we will lead by inducing greater cooperation among a greater number of actors and

reducing competition, tilting the balance away from a multi-polar world and toward a multi-partner world."

A new geography of power is emerging which challenges former divides and groupings between nation states and provides new relevance for multilateral institutions (see Chap. 17). Low- and middle-income countries are increasingly discovering and using the opportunities provided by regional and international platforms. And global health is one of the areas where this is most palpable. "There is an ever growing presence in the global health policy arena of low- and middle-income countries such as Kenya, Mexico, Brazil, China, India, Thailand and South Africa" (Szlezák et al. 2010). With growing discursive and resource-based power, emerging economies use new approaches to diplomacy and include health in their strategic arsenal. Brazil, for example, is "successfully leveraging its model fight against HIV/AIDS into expanded South-South assistance and leadership", in service of Brazil's foreign policy objectives for reform of the UN Security Council and louder voice in the international monetary system (Gomez 2009).

Regional actors such as the European Union, African Union, Common Market of the Southern Cone, Shanghai Cooperation Organisation, ASEAN, APEC, Asia-African Summit/FOCAC, the Union of the South American Nations (UNASUL) are intensifying their work and including health issues more frequently on their agendas (United Nations 2009a). But the consequences of this intensifying dialogue and increasing cooperation go much further than health, they create a habit of communication, and, where possible, cooperation among the countries and thus a basis for building international relationships.

Commentators note that "Understanding 'domestic' issues in a regional or global context must become part of doing a good job. Increasingly, the optimal solution to these issues will depend on what is happening abroad, and the solutions to foreign issues, in a corresponding measure, by what is happening at home" (Slaughter 2004). National (health) systems are now seen as core components of the global (health) system (Frenk 2010). Thus global health begins and ends "at home". In a response to the increasing need to address the intersection between national and global health policy, countries are exploring new mechanisms for policy coherence. Consistency is sought in two directions. The first is across government sectors and the work of different ministries. The second is between national interests and global responsibilities. Switzerland (see Box 2 and Chap. 20), the UK (see Box 3 and Chap. 19), the USA, Norway, Japan, Sweden have already chosen the policy approaches that are most appropriate for their national contexts and elaborated on strategic documents and mechanisms. Beyond national borders, another very important example in the efforts to increase coherence for global health is worth special mentioning: in 2007 the EU health strategy "Together for health" has been published and in 2010 the EU set out the EU's role in global health (see Chap. 16).

A growing and increasingly diverse group beyond the nation states has secured its place and changed the global health landscape profoundly (Szlezák et al. 2010, p. 1). Along with the unprecedented increase in their number, their role has grown and is evident at all stages of the policy process. The diversification of players on the

Box 2 Swiss Health Foreign Policy

In 2006 Switzerland has been the first country to take up improving coherence and coordination for global health on the national level through such a strategic policy document signed by both the ministers responsible for health and for foreign affairs, including development cooperation. Defining 18 medium-term goals structured around five categories, the Swiss Health Foreign Policy makes a step further and elaborates on key measures to follow up on the agreement. They include:

- Establishment of a coordinating office for health foreign policy
- Creation of an information platform for health foreign policy
- Preparation of policy papers on subjects arising in health foreign policy and strengthening of academic competence
- Harmonization with general foreign policy and other sectoral policies
- Creation of an Interdepartmental Conference on Health Foreign Policy
- Staff exchange and foreign missions

Box 3 UK "Health Is Global"

- After a broad consultation, the UK has published "Health is global: a UK Government strategy 2008–2013". Identifying ten guiding principles it highlights that "a healthy population is fundamental to prosperity, security and stability". It includes also the reasons why the UK needs such a strategy and covered five key areas of action.
- In 2011, in order to respond to the complex challenges for global health, and to reflect the feedback from the first annual independent review, "Health is Global: an outcomes framework for global health 2011–2015" has been published. Reaffirming the key principles it covers 12 high-level outcomes to be achieved by 2015 as well as monitoring progress through Departments' own annual delivery plans.
- The "World Health Organization: UK institutional strategy 2008–2013" is a joint strategy that has been led by the Department of Health in England, the Department for International Development and the Foreign and Commonwealth Office. It sets out critical health challenges and explicitly states that "WHO is at the heart of the global response to all of these challenges. As the directing and coordinating authority for health within the United Nations (UN) system, WHO is responsible for providing leadership on global health matters.

global level is also accompanied by changing relationships between them. Innovative forms of governance are emerging to accommodate the increasingly complex interplay between representatives of the three sectors: public, private and civil society. "Nation states have become enmeshed in and functionally part of a larger pattern of global transformations and global flows" (Held et al. 1999)

The rapid changes in the global health landscape have been accompanied by an increasing role of health in international politics. United Nations (2008), United Nations (2009b) and United Nations (2010) on health and foreign policy have ushered a new period for global health diplomacy. Global health diplomacy and civil society advocacy has been extraordinarily successful in positioning health in a multitude of ways in the many negotiations under way in the general system of diplomacy. Health is a subject of the "great power conferences", it has become integral to the G7/8/20/77 meetings (see Box 4 and Chap. 17). The UN SG has appointed a UN System Influenza Coordinator, the UN GA has earlier devoted special sessions to HIV/AIDs and a special session on non-communicable diseases in 2011. Health is also at the heart of the Millennium Development Goals, the leading framework for UN system efforts to advance human development. It is the specific subject of three goals and "a critical precondition for progress on most of them" United Nations (2009c). In addition, the Secretary General has identified the challenge of making people's lives healthier as a touchstone of the effectiveness of UN reforms United Nations (2009a). Today major health negotiations are again conducted within the World Health Organization, which in a very short period was able to approve two major treaties: the Framework Convention on Tobacco Control (2003) and the revised International Health Regulations (2005). And health is back on the agenda of the United Nations. A group of seven Ministers of Foreign Affairs has expressed this development as follows:

> In today's era of globalization and interdependence there is an urgent need to broaden the scope of foreign policy…We believe that health is one of the most important, yet still broadly neglected, long-term foreign policy issues of our time… We believe that health as a foreign policy issue needs a stronger strategic focus on the international agenda. We have therefore agreed to make impact on health a point of departure and a defining lens that each of our countries will use to examine key elements of foreign policy and development strategies, and to engage in a dialogue on how to deal with policy options from this perspective (Oslo Ministerial Declaration 2007).

The more actors, levels and venues for international dialogue and cooperation there are, the more important consultation, negotiation and coalition building become (Moon et al. 2010). As more and more countries learn to take advantage of the decision making and legislative power of international platforms, multilateral organizations acquire new strength. Together with the increasing importance of rising economic powers, a bridge-building role becomes increasingly important in multilateral venues. The new multilateralism promises success to those who are most able to show commitment, gather broader support and form coalitions. In this context, health can be viewed as an instrument for deepening the relationships between different nations and a stable basis for building alliances (Feldbaum and Michaud 2010).

Box 4 G8 Involvement in Health

The role that the G8 has played for global health is twofold. First, it has contributed to raising the profile of health at the global agenda already overcrowded with pressing challenges. The fact that heads of states have devoted their attention to health matters has marked an important transition.

Second, G8 countries have made a number of significant commitments to health, focussing on the fighting infectious diseases, improving access to basic health care and strengthening health systems. The creation of innovative partnerships and initiatives has been another feature of the G8 involvement in health.

In the context of the G8 initiatives for global health, it has been discussed to what extent the G20 could play a role as well. The advantages of the G20 involvement include among others the contribution towards bridging the north–south divide, but it remains open how it could include health issues and how they would relate to the efforts already taken at the G8 summits (Kirton 2010; Chand et al. 2010; G20 Research Group 2008, pp. 45–46; Evans 2004). Examples for the G8 contribution to global health include:

- The G8 Kyushu Okinawa Summit deliberations on infectious diseases in 2000, together with a subsequent endorsement by the UN have led to the establishment of the Global Fund to Fight Aids, Tuberculosis and Malaria.
- The 2001 Genoa Summit included in its Africa Plan the importance of investment in health as part of the initiatives for human development.
- The 2002 Kananaskis Summit devoted a whole subsection on "improving health" as parts of its efforts to support development in Africa.
- The 2003 Evian Summit featured "Health—a G8 Action Plan" covering six topics, including health system strengthening.
- In 2005, the G8 confirmed the importance of investing in improved health systems and gave particular attention to three infectious diseases HIV/AIDS, malaria, tuberculosis. It supported also the Polio Eradication Initiative through "continuing or increasing own contributions toward the $829 million target and mobilizing the support of others."
- In 2007 the G8 made a commitment to provide US$60 billion over several years for fighting infectious diseases and health system strengthening. Only in 2007–2008, G8 provided $22 billion as aid to health. It was reaffirmed in 2009.
- In 2008, it emphasized the need for comprehensive approaches and also stated that the "G8 members will work towards increasing health workforce coverage towards the WHO threshold of 2.3 health workers per 1,000 people."
- In 2010 the leaders of the G8 "working with other Governments, several Foundations and other entities engaged in promoting maternal and child health internationally" have launched the Muskoka Initiative, which pledged to bring together more than $10 billion for women and children health for the period 2010–2015.

Conclusion: Diplomacy Persistent in Change

Diplomacy today is even more crucial for the well-being of states than when Keens-Soper and Schweizer (1983). But the rules, norms and expectations have changed profoundly. Many new challenges, diverse types of actors, new venues and different levels of interactions have changed the global (health) landscape. It includes and makes use of all the forms of bilateral and multilateral diplomacy that have developed over the last two centuries. The **unstructured pluralism** this reflects has two effects: on the one hand it allows flexibility to place crucial issues on the diplomatic agenda in a variety of ways, including testing them out in various fora, on the other hand it promotes multilateralism.

The current phase of diplomacy and specifically global health diplomacy could be considered one of transition, still seeking the right balance between legitimacy and accountability. The central issue is clear: an institutional form needs to be found for the **polylateral diplomacy** of the twenty-first century that can seize the window of opportunity for health and deliver results to an informed and increasingly demanding public. To some extent health diplomacy has gone full circle: in 160 years it has moved from a political to a technical discussion and is now back as a political negotiation. It is no longer seen purely as an operational issue to be managed by second tier technical institutions but as a *political priority* to be addressed by open public diplomacy at the highest level of the United Nations.

Questions

1. Describe the major milestones in the development of global health diplomacy?
2. How has diplomacy changed and how has this influenced the handling of global health issues?
3. How has our understanding of global health changed and what influence has this had on the conduct of diplomacy?
4. What are key actors for global health diplomacy today?
5. What are the current challenges faced by global health diplomacy, can you suggest some potential solutions to such issues?

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Further Reading

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Chapter 3
Current and Future Issues in Global Health Diplomacy

Graham Lister and Michaela Told

Reader's Guide

This chapter provides an overview of the issues that are addressed by global health diplomacy and are discussed in more detailed case studies in the remaining chapters of this book. These are health issues that transcend national boundaries to affect the health of people in rich and poor countries and require concerted international effort to address them. Many such issues arise from the impact of **globalization** on health, which serves to accelerate not only the transmission of communicable disease but also the spread of unhealthy products and lifestyles. Health in **fragile states** poses complex challenges for global health diplomacy, requiring even greater engagement with all parties. This need for wider engagement to create a global movement for health and to establish pathways through which multiple actors can work together is the common theme that emerges at many different levels. It heralds a new era of global health governance recognizing the voice and contribution of all parties.

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Learning Points

- Global health issues affected by **globalization** include: the spread of communicable and non-communicable diseases, access to medicines, resource sharing and investment in research and development, the misuse of medicines, particularly antibiotics, the response to climate change and human health security.
- Global diplomacy in **fragile states** demands even greater attention to the engagement of all parties to establish shared goals and actions for health despite other differences.
- The development of wider engagement through the processes of global health diplomacy offers the prospect of a new form of governance for global health.

Introduction: Global Health Issues

Global health refers to those factors that transcend national boundaries to determine the health and human security of people across rich and poor countries. It is important to stress that global health is not simply concerned with the health of poor people in distant countries, as Skolnik (2008) recognizes, global health affects everyone. **Determinants of global health** include a complex mix of biological, social, economic, political, environmental and security issues many of which, as Lee (2003), describes are driven by aspects of **globalization**.

The increased movement of people, animals and food has added to the threat of communicable diseases new and re-emergent diseases such as HIV/AIDS, Tuberculosis and Ebola pose transborder health threats, as do new strains of the influenza virus and other diseases such as SARS that can be borne by animals. Such diseases now spread more rapidly as a result of **globalization**, tourism and cross border and internal migration driven by conflict. And while communicable diseases are more significant burden of disease for poor countries they also pose major threats to health in rich countries. Efforts to control the spread of these diseases led to the development of global health diplomacy as described in Chap. 3.

Globalization also brings more rapid spread of ideas, lifestyles and consumption patterns such as smoking and poor diet, promoted by global advertising, resulting in a rise in non-communicable diseases including lung cancer, heart disease, bowel cancer and diabetes. For people in rich and poor countries the stress of modern life to our society and culture has brought a global increase in mental illness. These are increasingly important determinants of health not only in high-income countries but also in middle- and low-income countries where the burden of disease may reflect the double burden of both diseases associated with the poverty and malnutrition of a large proportion of citizens and an increase in diseases associated with the consumption and lifestyles of an

emerging middle-income group. Perhaps the best known example of global health diplomacy in this regard can be seen in the Framework Convention on Tobacco Control discussed in Chap. 4.

Private sector investment in poor countries can spread economic development to bring better health but failure to protect the health of workers, the rights of women and the local environment due to the competition for investment can result in a "race to the bottom" with catastrophic effects on local community health—as, for example, in the Bhopal disaster. In this field health diplomacy has led to action in national and international courts to enforce the responsibilities of multinational companies. Chapter 4 provides a discussion of the role of the International Court of Justice.

Pricing and patent restrictions imposed by pharmaceutical companies, which limit access to affordable medicines and failure to support research into diseases affecting poor people are examples of the trade and economic **determinants of global health**. These are addressed by global health diplomacy as part of the Doha round of trade talks on Trade Related Intellectual Property Rights and on innovative ways to finance research into diseases that would otherwise be neglected by pharmaceutical companies. The importance of global health diplomacy in this sphere is demonstrated by negotiation of agreements on access to medicine as part of the Doha Trade Round as described in Chap. 6.

The attraction of health professionals from poorer countries to higher income countries is an example of an economic determinant of health acting upon individual decisions but affecting global health by encouraging movement from areas where health professionals can have greatest impact to countries where their contribution will be less significant. This is an example of a topic raised in negotiations at the World Health Assembly and at the UN General Assembly as described in Chap. 4.

The misuse of antibiotics in both rich and poor countries that lead to drug resistance and makes treatment ineffective everywhere and the supply of counterfeit and fake medicines are examples of failures of national control procedures. But measures to address such problems must also take into account the global impact on health and international action to meet the needs of those unable to afford any form of medicine. Subsidies to farmers in rich countries for producing crops such as sugar beet, cotton and even tobacco can trap poor country producers in poverty, and consequently poor health. These are economic and political **determinants of global health** addressed by the EU strategy for global health (see Chap. 16).

Global warming and the pollution of oceans are examples of environmental factors that not only have a global impact on current health but may also affect the health of future generations. Climate change threatens health in many ways not only increased extreme weather events with flooding and severe heat waves, but also further spread of Malaria and other diseases associated with hot conditions. Climate change and the pollution of oceans threatens the long-term survival of all mankind and provides a clear case for international action but even in this field it seems very difficult to achieve this as described in Chap. 10.

Human health and security is also threatened by international crime that is beyond the reach of national law enforcement. Crimes that pose such threats include

corruption and the action of gangs that smuggle drugs and people across borders. Biological terrorism and other threats to human security are also global health issues that have resulted in death and economic disruption in rich and poor countries. Conditions and diseases of global health have a major impact on health and the burden of disease in both rich and poor countries as Markle et al. (2007) elaborate. Moreover the impact of poor health can restrict economic and social development and in some cases may undermine peace and stability—as illustrated by the riots in Haiti in response to the 2010 Cholera epidemic. These are aspects of human security discussed in Chap. 9 and also in the following section of this chapter.

Health and development needs arising from poverty were identified as global concerns and responsibilities in the Millennium Development Goals (MDGs), which set out commitments to action on eight major targets to be achieved by 2015. These include: reducing under five mortality rate by two thirds from 1990 levels, reducing maternal mortality by three quarters and achieving universal access to reproductive health services, halting the spread of HIV/AIDS and providing universal access to treatment, halting the increase in malaria and other major diseases including tuberculosis and halving the proportion of the population without access to safe water and sanitation. MDG 8, calling for a new global partnership is relevant to the **determinants of global health**, it sets targets for establishing fair trading and financial systems, meeting the UN target for aid first agreed in 1970, working with pharmaceutical companies to ensure access to affordable essential medicines and with private sector partners to make the benefits of new technologies including information and communications available to all. These aspects are discussed in Chap. 7.

Many of the **determinants of global health** may be seen as beyond the normal purview of ministries of health or international health agencies, they may arise in many different fora as security, development, economic or trade issues requiring cross sector concerted international action beyond the reach of national governments acting alone. This might appear straightforward when the objectives of cooperation are so clearly beneficial to all, but, as noted, the interests of states and other actors vary. Even in relation to global public goods for health, from which all benefit and none can be excluded as described in Chap. 8, there is disagreement as to how responsibilities for action and funding are shared. States and other parties such as multinational companies may be happy to benefit from global public goods but unwilling to pay for them. Voluntary cooperation may be insufficient to address such factors, a system of global agreement between all the parties is required, preferably supported by some form of international law. Thus, for example, surveillance of threats to global health is clearly a global public good for health and after some years of negotiation the responsibilities of states were set out in law as International Health Regulations. However, this has not been the end of negotiations as, for example, in the case of influenza virus sharing by Indonesia (see Chap. 6).

It is important to note that global health diplomacy does not simply refer to the initial negotiation of international treaties and laws, arguably more issues arise from the subsequent implementation of such agreements. It might be considered that any such agreement had to be ratified by the countries concerned before they can be

considered relevant. Kates and Katz (2010) examine 50 significant international health agreements, classified as legally binding treaties and executive agreements and protocols, non-binding agreements and commitments to UN organisations, agencies and programmes plus declarations, principles, other international agreements and partnerships. Of these only 36 had been joined by the USA and only 8 of the 21 legal binding treaties had been ratified by the US Senate. Examples of such agreements include: the Millennium Development Goals, the Framework Convention on Tobacco control, the Doha declaration on Trade Related aspects of Intellectual Property (TRIPS) agreement and Public Health and the Global Health Security Initiative. However, even when agreements are not legally binding or ratified they may still have moral force and the weight of international public opinion, as noted in Chaps. 7 and 5. This can be an important component of public diplomacy as noted in Chaps. 18 and 20.

Fragile States and Global Health Diplomacy

Chapter 9 provides a broad overview of global health risks that have an impact on human security but as the 2010 Geneva Graduate Institute's symposium on health in **fragile states** illustrated, there are also some very specific challenges to health diplomacy in **fragile states**.

States can be deemed to be in a fragile situation either because they have a very low level of institutional development (i.e., a lack of governance) or because they are in a state of current or recent conflict, requiring the presence of international peace keeping or peace building forces. All too often both conditions apply, leading to what can be described as failed states. World Bank Harmonized List of Fragile Situations (2011) covered 33 states and territories.

Health issues are exacerbated by fragile situations because lack of governance often results in a failure to address the causes of poor health such as conflict itself, poverty, unsafe water supply, malnutrition and lack of education and failing health systems. International civil society organizations and local and international faith-based organizations are usually the main providers of health services in such situations but coordination of services becomes extremely difficult in the absence of even vestigial national governance.

Conflict or post-conflict conditions make it very difficult to deliver health and care services. Whereas in the past health workers and facilities were often regarded as impartial non-combatants, it appears that in recent conflicts ambulances, hospitals and health workers have been targeted by terrorists. In some situations the provision of health services may be seen as an aspect of "winning hearts and minds" or what Nye (2004) has called the projection of smart power, described as combining both the implied or actual threat of force and **soft power** to influence the way people think and to build shared values is emerging as a key strategy for the conduct of international relations. But this insight is not limited to one side in any conflict, in recent years extremist groups have also been seen to provide health, education and

aid as a means of recruiting support for violent causes and it cannot be assumed that health or health workers will be seen as neutral in any conflict.

One might conclude that health provision in **fragile states** was likely to be far less successful than in non-fragile states particularly when funded by international aid; however, a study by Nantulya (2005) for the Global Fund suggests that this may not be the case as early results showed that 19 grants to **fragile states** were no less successful than 55 grants made to non-fragile states. Perhaps one reason for this is

Box 1 Negotiating Health in a Fragile State TB in Somalia

Three different political zones each with disputed sovereignty in Somalia, a multitude of actors and various interests created a complex and volatile environment for negotiating health policy. International actors coordinated their efforts through the Somalia AID Coordinating Body (SACB), which was designed to provide a platform for the coordination of international aid to Somalia.

The success of the TB program can be attributed to a number of factors including the TB Coordination Team (TB CT) administered by World Vision International (WVI), the emphasis on national leadership, multi-stakeholder participation within the structure of the Global Fund TB grant and the participatory design of the SACB-HSC. The negotiations took place in three stages from April 2004 to December 2005. The common goal of the actors, to ensure the availability of funding and improve TB care, unified the efforts of the various actors.

Two overarching Memoranda of Understanding (MOUs) were negotiated and agreed upon, one by WVI and the Somaliland Ministry of Health which set out the responsibilities of various partners according to the principles of the Global Fund and the other, drawn up by UNICEF and WVI regarding the responsibilities of the tuberculosis implementing partners. The MOUs were essential to the successful implementation of the TB program and the constructive collaboration between the actors involved.

The outcome showed that strong multilateral negotiations led by a respected civil society organization can achieve consensus among parties where a central government is weak or non-existent. The success of this grant was heavily dependent upon WVI's ability to engage with three separate health authorities across the country. WVI endeavoured to air issues, strengthen relations, and build confidence, while simultaneously representing a multi-stakeholder group of civil society and technical agencies.

Throughout the negotiations, WVI's strategy was to build a consensus around shared aspirations for increased health funding and improved access to public health for all Somalis, and reach agreements on the legitimate roles

(continued)

Box 1 (continued)

and responsibilities of all the actors and players in the operation of the tuberculosis programme. As an inclusive stakeholder coordinating body with transparent and democratic processes it built collective ownership for a health programme and added legitimacy to the negotiations needed to successfully negotiate the terms of the Global Fund grant with the government.

The Global Fund's policy support for a strong civil society role in grant negotiations made it possible to negotiate the health financing in Somalia despite the absence of a central government. The Global Fund's unique approach to health financing represented a major shift towards a broader concept of national ownership that promoted the collaboration of multiple stakeholders. These principles of partnership aligned well with the Somali context and established the enabling environment in which the negotiations relating to the details of grant implementation could succeed.

Taken from: Negotiating Health in a Fragile State by Claxton et al. (2010)

that health diplomacy is recognized by the Global Fund to be particularly important in fragile situations. Negotiations must recognize the differing cultural expectations and fears of participants in conflict situations to ensure safe access to services by local populations and safe passage for health workers whether from local communities or from external sources. Often such negotiations are even more complex because the participants may include parties in dispute and may involve local and international civil society organizations delivering health services alongside peacekeeping forces (whose role may not be acceptable to all participants).

The Somalia case study of the negotiation of Global Fund TB funding and provision in a **fragile state** by Claxton et al. (2010) illustrates a shift in international health assistance policy from negotiations with state actors, to a more inclusive framework of national ownership, which includes a broad spectrum of public, private and civil society parties. In such circumstances, non-state actors—including civil society as well as technical agencies—play a significant role in negotiating foreign assistance and can be effective in building a collective consensus around the right to public health that rises above political interests.

Conclusions: Health Diplomacy and Global Health Governance

The focus of much debate and action in recent years is on the creation of effective mechanisms to enable international institutions, civil society and other non-governmental organizations (NGOs), businesses and governments to work together

to achieve global health goals. These aspects of global health diplomacy herald a major reform of global health governance. This is not an attempt to impose a single authority or structure in what is clearly a fragmented multipolar field but to provide multiple pathways through which the many different actors can exercise legitimate influence to achieve agreement on action for the common good. The mechanisms through which global health governance is developing can be seen at national, international and global levels.

Chapter 5 describes wider engagement beyond states and inter-state actors, through the creation of Global Health Partnerships and by working with civil society organizations. It notes the development of self-organizing trans-national networks focused on global health issues. Wider engagement is also formally recognized in the Paris–Accra Process.

Civil society organizations as described in Chap. 18 are the foundation for a wider social movement for global health, with the opportunity to engage individuals and communities across continents in a myriad of different ways. Public diplomacy as described in Chaps. 18 and 20 is the process of engaging hearts and minds, to gain influence and to create shared values for health. However, to articulate their many different views and engage in governance for global health, they need opportunities to work together on common themes and issues.

Chapters 19 and 20 describe how cross sector strategies or approaches to global health are being introduced by national governments. These start by addressing the interpretation of global health issues by different departments but often lead to a true cross sector approach with the engagement of business and civil society organizations. A similar broad cross sector approach to the **determinants of global health** can be seen in the EU's evolving approach to global health described in Chap. 16.

Chapter 17 suggests that the involvement of G8 and G20 in global health diplomacy is providing scope for the emergence of new coalitions of interest. The changing character of international negotiations on global health issues can also be seen in examples of south–south collaboration described in Chap. 21. This suggests a shift in the power balance of global governance from north–south, donor–beneficiary relationship to a south–south model of mutual support.

At global level health diplomacy has underlined and built on the role of the UN General Assembly and committees in setting and coordinating the agenda for global governance issues as described in Chaps. 14 and 15. The World Health Organization and World Health Assembly as described in Chaps. 12 and 13 provide technical support and normative leadership for global health diplomacy. The WHO is clearly convinced of the importance of global health diplomacy to address the broader determinants of health Chan (2008). It also recognizes the importance of wider engagement with all sectors of society. The longstanding proposal for the creation of a forum for civil society organizations and other non-state actors alongside the World Health Assembly are discussed in Chap. 18. While the proposal for a World Health Forum was abandoned by the WHO in November 2011 on the grounds of

Questions

1. Prepare a list of global health threats—how do they impact on poor countries and how do they threaten health in rich countries?
2. List some of the determinants of global health and their impact on rich and poor.
3. Give an example of a global health issues arising in other policy contexts—trade, security or development.
4. Examine the list of global health agreements provided by Kates and Katz, why do you think that in so many cases they are not yet ratified by the USA?
5. Why is global health diplomacy so important in fragile states?
6. What is **soft power** and provide some examples of its relevance to health?
7. How is global health diplomacy changing the nature of global governance?

lack of support and finance, the need for such a wider forum remains valid and vital to the emergence of a new phase of governance for global health. This would provide the necessary response to the Copernican shift in our understanding of global health and its governance as set out in Chap. 23.

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Further Reading

Health and Fragile States Network http://www.healthandfragilestates.org/
Project of World Bank on Fragile States (more general, not only focus on health): http://web.worldbank.org/WBSITE/EXTERNAL/PROJECTS/STRATEGIES/EXTLICUS/0,contentMDK:22978911~menuPK:4168000~pagePK:64171540~piPK:64171528~theSitePK:511778,00.html

Chapter 4
Global Health Law

Allyn L. Taylor

Readers' Guide

This chapter provides an overview of the emerging field of global health law. It examines the historical origins of the field and the factors contributing to its development. In addition, the chapter considers the nature and sources of **international law**. It then describes the process of international lawmaking as well as the contribution of international organizations to the development of global health law. The chapter closes with a discussion of role of **binding and non-binding instruments** in global health policy, the advantages and disadvantages of different legal forms, and lessons for future global health law negotiations.

Learning Points

- Public health has evolved, from a realm seen as almost exclusively an issue for national jurisdiction to encompass a range of issues addressed by **international law**.
- Article 38.1 is generally regarded as the authoritative list of the sources of **international law**. In global health, most international law can be found in treaties and other binding agreements between states.
- Although not technically binding as a matter of international law, **non-binding instruments** formally adopted under the auspices of an international

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organization may, at times, have significant legal and political impact and can make an important contribution to global health diplomacy.
- Most international lawmaking today, including in the growing field of global health, is conducted under the auspices of international organizations.
- Public international organizations, such as the World Health Organization (WHO), are international institutions created by sovereign states to accomplish mutual goals.
- Although there is expanding interest in international law as a tool of global health diplomacy, international law is an inherently limited mechanism of cooperation and future international legislative projects should be selected carefully.

Introduction: The Domain of Global Health Law

The growth and elaboration of the field of global health law in the last 15 years has been one of the most significant developments in global health diplomacy. Traditionally, public health was viewed as a realm of almost exclusive national jurisdiction, and multilateral cooperation in this realm was narrowly restricted to discrete areas. Public health law today remains predominantly domestic (municipal and national), but with the rise of global health diplomacy and evolving global interest in formal frameworks for global health cooperation, the field of global health law is now extant and growing.

International law can be understood as a policy tool that can be used to encourage states and other actors to change their behavior. This chapter and the chapters that follow in this section will examine the role of international law as a tool of global health policy and the role of international organizations in the elaboration and implementation of international legal instruments.

The domain of global health law now encompasses increasingly diverse concerns, including aspects of international health worker migration, biomedical science and human reproduction/cloning, infectious and non-communicable diseases, the control of the safety of health services, and the control of addictive and harmful substances such as tobacco. Global health law is also increasingly linked to other traditional areas of international legal concern. Environmental law and the control of toxic pollutants, international trade law and issues related to food and pharmaceuticals in international commerce, arms control and the banning of weapons of mass destruction, human rights law, international narcotics control law and access to pain medication, nuclear safety and radiation protection, and occupational health and safety are increasingly recognized as connected to public health.

The Evolution of Global Health Law

Public health was one of the earliest fields of international cooperation and the first domain in which an intergovernmental organization was created. But, until quite recently, the scope of international legal cooperation in public health was highly limited.

The functions of early international health organizations centred on combating infectious and communicable diseases and preventing their spread across international boundaries (Pannenborg 1979). By the early seventeenth century, the city-states of northern Italy established the first nascent national and international public health systems in an effort to control infectious diseases and to promote international coordination to minimize disruption of international trade (Cipolla 1981). Constantinople's *Conseil superieur de sante* (Superior Council of Health), composed of delegates from the Ottoman Empire and the chief maritime states, was established in 1838 to supervise sanitary regulation of the Turkish port to prevent the spread of cholera (Jacobson 1984). Disease has been the unwelcome traveling companion of international trade throughout history and international public health cooperation has historically been motivated as much by the desire to facilitate trade as by the desire to protect public health..

International communicable disease control remained the predominant area of international legal cooperation in health throughout the mid-nineteenth century and most of the twentieth century. The international legal activities of the first permanent international health organization, *L'Office International d'Hygiene Publique*, were restricted to the administration of international sanitary conventions, including the international exchange of epidemiological information. Its activities were gradually taken over by the League of Nations Health Organization, which served as the "organic" father of the WHO (Sharp 1947; Pannenborg 1979).

Established in 1946 as the United Nations (UN) specialized agency in the field of health, WHO assumed management of the international legal regime for control of the transnational spread of disease. That regime had been developed in a rather piecemeal fashion over the preceding decades, as it was based upon a series of international agreements. In 1948, WHO began revising and consolidating these international sanitary conventions and agreements dating from 1892, and the fourth World Health Assembly adopted the International Sanitary Regulations in 1951. These regulations were renamed the International Health Regulations (IHR) in 1969 and have been revised a number of times. WHO Member States most recently revised the IHR in 2005 to reflect advancements in scientific knowledge and the capacity to control global epidemic diseases (Fidler and Gostin 2006) (Box 3).

Throughout most of the twentieth century, global health remained a relatively neglected field of foreign policy and, concomitantly, of little international legal concern outside the limited area of international communicable disease control. The development of global health law was further impeded because, unlike other specialized agencies of the UN, WHO traditionally neglected promoting international legislative approaches to advance its global public strategies (Taylor 1992). WHO Member States also paid little attention to the potential contribution of international law to advancing

global health during most of the last century. Although public health remained a narrow realm of multilateral cooperation for over 150 years, the long-standing historical connection between international law and communicable disease control pointed to the larger role that international law could serve in future global health diplomacy.

In the last decade and a half the field of global health law has expanded significantly as a result of the exponential increase in the pace of globalization and the rise of global health as a dominant diplomacy issue as described throughout this volume. Although increasing global integration is not an entirely new phenomenon, contemporary globalization has had an unprecedented impact on global public health and is creating new and increasingly difficult governance needs and health policy-making challenges.

The processes of global change brought about by increasing global integration are restructuring human societies, shepherding in new patterns of health and disease, and reshaping the broad determinants of health, including socioeconomic, cultural, and environmental conditions (Lee 2004). Overall, the increasing integration and internationalization of the determinants of health has contributed to the rapid decline in the practical capacity of sovereign states to address public health challenges through unilateral national action alone. In particular, the globalization of trade, travel, communication, information and lifestyles has obscured the traditional distinction between national and global health (Deaton 2004).

Globalization is increasing the need for new, formalized frameworks for international cooperation, including international law, to address emerging threats and opportunities in global health. Despite historical neglect, international law and, in particular, treaty law, has received new prominence as states increasingly recognize the need for international cooperation to attain national public health objectives for which domestic law and other policy responses are increasingly inadequate. For example, the dynamics of globalization have created fertile conditions for the cross-border spread of emerging threats to health and encouraged international legal cooperation in such areas as weapons of mass destruction (e.g., bioterrorism) and non-communicable diseases (e.g., tobacco use and alcohol misuse). Furthermore, rapid worldwide dissemination of recent advances in scientific knowledge and technology has encouraged international cooperation in a wide range of treaties, including those concerning the safety of chemicals, pesticides and food and the disposal of hazardous wastes.

An Introduction to Public International Law

The Nature and Sources of International Law

Understanding the implications of recent developments in global health law requires some appreciation of the nature of international law and the international political system. Since the end of the Thirty Years War in 1648, the global political system

has principally involved the interactions of independent sovereign states. The elaboration of international law has, consequently, focused on the establishment of mutually agreed upon rules respecting the nature of states and their fundamental rights and obligations as well as commitments. **International law**, therefore, is primarily, though not exclusively, focused on the interactions of sovereign states and can broadly be defined as the rules that govern the conduct and relations of states.

International law is traditionally divided into two core realms: public international law and private international law. While public international law is primarily concerned with the relations of states, private international law focuses on the law of private transactions of individuals and corporations. The traditional distinction between public and private international law persists despite the fact that it is not fully accurate. For example, much of private international law concerns the transactions of public entities. In addition, while states are the primary subjects of public international law, they are not its only subjects. International organizations and, through the development of international human rights law, individuals are now also considered subjects of public international law.

In international law, the sources of legal rules are very different than in most domestic legal systems because the international political system of sovereign nation-states differs fundamentally from domestic political systems. Domestic law generally comes from national constitutions, domestic statutes, executive regulations and decisions of domestic courts. In contrast, there is generally no supranational authority within the international system to develop and enforce international law against sovereign states, although there are some important exceptions to this general principle, particularly within the European system. In the absence of a supranational authority, states establish the rules of international law. Article 38(1) of the Statute of the International Court of Justice is generally regarded as an authoritative list of the sources of international law (Box 1).

Box 1 Art. 38.1, Statute of the Court of International Justice

The Court, whose function is to decide in accordance with **international law** such disputes as are submitted to it, shall apply:

a. International conventions, whether general or particular, establishing rules expressly recognized by the contesting states;
b. International custom, as evidence of a general practice accepted as law;
c. The general principles of law recognized by civilized nations;
d. Subject to the provisions of Article 59, judicial decisions and the teachings of the most highly qualified publicists of the various nations, as subsidiary means for the determination of rules of law.

Although there is a wide and complex array of international legal sources, most international law today can be found in binding international legal instruments, particularly treaties. The word "treaty" is a generic term that encompasses all written instruments concluded between states by which states establish obligations by and among themselves. Treaties function essentially as contracts between states whereby states explicitly make binding rules to govern their own conduct and the conduct of their individual and corporate nationals. Generally, treaties are only binding upon states that give their express written consent.

Treaties are also subject to a significant corpus of international law—the 1969 Vienna Convention on the Law of Treaties (the Vienna Convention). The Vienna Convention, the so-called "treaty on treaties," provides general rules of treaty conclusion, interpretation, application and termination. The Vienna Convention confirms the generic use of the term "treaty" by defining a treaty as "an international agreement concluded between States in written form and governed by international law, whether embodied in a single instrument or in two or more related instruments and whatever its particular designation." The terms treaty, convention, protocol and pact are largely used interchangeably in international legal parlance. Article 19 of the Vienna Convention sets forth the basic legal principle concerning the observance of treaties, *pacta sunt servanda*: "Every treaty in force is binding upon the parties to it and must be performed in good faith" United Nations (1968).

A second important source of binding international law is customary international law. Analogous to domestic legal concepts such as "usage of the trade" and "course of dealing," the concept behind customary international law is that widespread international practice undertaken out of a sense of legal duty creates reasonable expectations of future observance and constitutes implicit consent to the creation of legal rules. The determination of whether or not a particular practice constitutes customary international law is a complex analysis. Generally, the determination requires near uniform state practice undertaken because of a sense of legal obligation. Once a rule is recognized as part of customary international law, it is binding upon all states. For example, the Vienna Convention on the Law of Treaties is accepted as declaratory of customary international law and binding on all states, including those that have that have not formally ratified it. Like treaty law, customary international law is said to emanate from the consent of states. States party to a treaty explicitly consent to be bound by codified rules, whereas with customary international law states implicitly agree to be bound to particular rules through consistent state practice.

In addition to binding international law, states produce a wide variety of nonbinding international legal instruments. Nonbinding international instruments is, of course, a generic term that covers a wide variety of agreements, including agreements adopted on a bilateral or multilateral basis. However, for the purposes of this chapter we are primarily concerned with nonbinding instruments formally adopted under the auspices of international organizations. Such instruments include resolutions, declarations, codes of conduct, guidelines, or standards that are typically adopted in the form of resolutions by the member state governing bodies of international organizations and make recommendations to governments. However named, general

declaratory resolutions are, for the most part, intended to be nonbinding instruments expressing the common interest of many states in specific areas of international cooperation. As discussed *infra*, although nonbinding, such instruments are not without legal and political significance. Like treaties, these nonbinding instruments can, at times, advance international consensus on rules and promote consistent state action.

The International Lawmaking Process and the Role of International Organizations

The process of international lawmaking, like the identification of international legal rules, is very different than in most domestic legal systems. The unique character of the international lawmaking process is a consequence of an international political system and the core principle of state sovereignty. Most international lawmaking today is conducted under the auspices of international organizations. The vast majority of international legislative projects tend to be undertaken at public international organizations because such institutions function as formal mechanisms for multilateral negotiation and cooperation for their member states. International organizations can anchor and facilitate treaty-making efforts because their organizational structures and administrative arrangements enable them to serve as stable and ongoing negotiating forums.

International law allows considerable flexibility in the process by which multilateral agreements are developed. The primary source of international law governing the codification of treaties, the Vienna Convention, provides a limited number of ground rules for the conclusion of treaties, concerning the capacity of states to enter into agreements, adoption and authentication of a treaty by a valid representative and expressions of consent to be bound by a treaty. Beyond these few basic requirements, the Vienna Convention does not mandate any particular methods of negotiation or ratification. In the absence of binding international rules, international organizations have adopted a wide variety of strategies to initiate, negotiate, and conclude international agreements, although international negotiations tend to follow a common pattern (Szasz 1997).

The initiation of lawmaking at the global level is a highly decentralized affair. The process of international lawmaking is initiated in an international organization when a relevant proposal to study a particular problem or launch negotiations is adopted by a competent organ of the organization. Although such a proposal is normally introduced by a Member State, the idea for a new international legislative endeavor can come from a variety of sources. Often the idea for a new treaty is initiated by a Member State as was the case with Mexico's efforts in support of the Convention on the Rights of Persons with Disabilities. The idea for a new treaty can also be initiated by an international organization or a nongovernmental organization, such as in the case of the International Campaign to Ban Landmines effort to launch the Landmines Convention. In addition, the idea for a new treaty can

come from individual scholars, such as the Framework Convention on Tobacco Control (FCTC) which was originated by Taylor and Roemer in the early 1990s (Roemer et al. 2005). In practice all recent global health negotiations have been open to participation by all states or all states members of the international organization sponsoring the negotiations.

In recent years there has been considerable development in the field of international organization with a significant increase in the number of international organizations active in the domain of health. Within the UN system, for example, organizations with significant involvement in the health sector include WHO, UNICEF, UNODC, UNESCO, FAO, UNEP, UNDP, UNFPA, and The World Bank. Overall, an increasing number of international organizations have served as platforms for the codification of global health law while others have had a significant influence on the development of international law in this field.

Not all international organizations have lawmaking authority or the legal mandate to serve as a platform for lawmaking in health. In the international legal system, lawmaking authority is always express and never implied. The existence and scope of lawmaking authority can generally be identified by carefully examining an organization's constituent instrument, typically its constitution. The World Bank, for example, is an organization that is highly influential in the field of global health but has no legal authority to serve as an organizational platform for treaty negotiations. As a further example, the World Trade Organization (WTO) is an institution that has lawmaking authority, but does not have a direct legal mandate in international health. Article III of the Marrakesh Agreement that established the WTO specifies that the Organization shall "provide a forum for negotiations among its Members concerning their multilateral trade relations…. (Marrakesh Agreement establishing the World Trade Organization 1994)." The WTO's impact on health law and policy is collateral to its role in establishing a legal framework for international trade relations. Since the principle aim of the WTO is the reduction of barriers to trade and not the protection of public health, the pervasive and growing influence of WTO agreements on national and international health policy has been a subject of increasing concern in global health policy (Taylor 2008; see Chap. 17).

The WHO, the largest international health agency, has wide-ranging responsibilities to address global public health concerns. The structure of the relationship between WHO and the UN, a separate international organization, is grounded in the UN Charter, particularly those sections that describe the objectives of the UN. Article 55 of the Charter describes the goals that the UN has pledged to promote among its members, including solutions to international economic, social, health and related problems (United Nations 1946). As the specialized agency with the constitutional directive to act as "directing and co-ordinating authority" on international health work, WHO has the cardinal responsibility to fulfill the aims of the Charter with respect to health.

WHO's broad legal authority to serve as a platform for global health standard-setting is expressly established by the terms of its Constitution. Article 1 of the

Constitution defines the objective of WHO to be "attainment by all peoples of the highest possible level of health" (Constitution of the World Health Organization 1946). Article 19 specifies that the World Health Assembly, WHO's legislative body composed of all of its Member States, "shall have the authority to adopt conventions or agreements with respect to *any matter within the competence of the Organization*" (Constitution of the World Health Organization 1946) (emphasis added). These constitutional provisions vest WHO with the legal authority to serve as a platform for conventions and agreements that address all aspects of national and global public health, as long as advancing human health is the primary objective of such instruments. In addition to lawmaking authority under Article 19 of the Constitution, the Health Assembly has authority to adopt recommendations "with respect to *any matter within the competence of the Organization*" pursuant to Article 23 (Constitution of the World Health Organization 1946) (emphasis added). The Health Assembly also has the authority to adopt Regulations in specified and traditional areas of public health regulation pursuant to Article 21 under the WHO Constitution a fairly unique lawmaking device in the international system (Box 2).

Box 2 The International Health Regulations

The 2005 IHR are an important example of the linkage of traditionally distinct legal subject matters for the protection of global public health. The new Regulations incorporate intertwined concerns of public health, security, international trade, and human rights. The complex Regulations include 66 articles divided into ten parts and nine annexes. The new IHR expand the scope of disease coverage, incorporate human rights principles, and institute demanding obligations for state surveillance and response, and include significant new authority for WHO.

The IHR were adopted pursuant to Article 21 of the WHO Constitution. Article 22 provides that legally binding regulations may be adopted pursuant to a unique "contracting-out" procedure designed to simplify and thereby encourage the lawmaking process. Regulations enter into force automatically for all Member States except those that notify the WHO's Director General of any rejection or reservations. The drafters of the Constitution severely circumscribed this simplified lawmaking process, however, by limiting the scope of regulatory authority under Article 21 to traditional public health concerns that have been the subject of international regulation since the latter half of the nineteenth century, including "sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease."

Despite WHO's wide mandate in the field of international health standard-setting, it has, as described above, traditional neglected **conventional international law** as a tool of health policy, and has only recently begun to widely use its broad constitutional authority to develop international legal instruments, including, most

significantly, its first convention adopted under Article 19, the 2003 WHO FCTC (Roemer et al. 2005; Fifty-Sixth World Health Assembly 2003; see Chaps. 17 and 22 of Taylor and Dhillon 2011) (Box 3).

Box 3 The WHO Framework Convention on Tobacco Control

Initiated in the early 1990s, the FCTC, the first **treaty** developed under the auspices of WHO, was designed as a mechanism to promote national public health action and multilateral cooperation on aspects of tobacco control that transcend national boundaries. Formally negotiated between 1999 and 2003 in six negotiation rounds open to all WHO Member States, the **treaty** was adopted by the World Health Assembly in May 2003 and entered into force in February 2005. The final text of the Convention addresses a wide range of tobacco control topics, including advertising, production, smuggling and counterfeit cigarettes, warning labels, clean indoor air policies and health education. As of September 2012, 176 states were parties to the FCTC (Roemer et al. 2005).

In another binding standard-setting initiative, the World Health Assembly adopted the new IHR in 2005 (Fifty-Eighth World Health Assembly 2005; see Chaps. 17 and 22) (Box 2). In addition in May 2010, the World Health Assembly adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel (Sixty-Third World Health Assembly 2010) (Box 4), the first non-binding code of practice to be adopted by the Health Assembly in 30 years since the 1980 International Code of Marketing Breast Milk Substitutes (see Chaps. 17 and 22 of Taylor and Dhillon 2011).

Box 4 The 2010 WHO Global Code of Practice on the International Recruitment of Health Personnel

On May 21, 2010, the 193 Member States adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel, the first code to be adopted under WHO auspices in 30 years. The new Code aims to establish an architecture for global cooperation on issues surrounding global health worker recruitment and migration Taylor and Gostin (2010).

Today there is considerable jurisdictional overlap in the field of global health lawmaking. Unlike most domestic systems where lawmaking efforts are largely coordinated into an integrated legal system, in the international legal system lawmaking efforts among different international organizations are notoriously

uncoordinated. In the absence of an umbrella organization to manage lawmaking efforts at the global level, the proliferation of international organizations with overlapping legal authority and ambitions is creating the risk of institutional overload and inconsistent standard-setting (Taylor 2004). In addition, although the purview of global public health law has expanded, the international mechanisms and institutions in existence are widely recognized as incapable of meeting the new needs for international legal cooperation that have been created by globalization. In short, the current system is strained past capacity a globalized world of deepening inequalities and expanding global health crises.

The Strengths and Limitations of International Legal Instruments in Global Health Diplomacy

Today there is a wide and expanding array of international legal instruments in global health, including binding and nonbinding agreements. Recent developments in global health law and diplomacy have also led to increasing calls for international standard-setting. Consistent with other international realms the pattern that is beginning to emerge is a marked preference for binding global health law instruments. This preference for expanding treaty law appears among state actors, civil society and academia and is reflected in the proliferation of proposals for new global health treaties over the last decade.

As health has risen on the global political agenda, some old concerns, such as the traditional neglect of law in health policy, have begun to dissipate. However, a new and more complex set of issues about the role of law in global health governance has begun to emerge. Among the issues being generated are the trade-offs involved in choosing between binding and nonbinding legal forms.

Addressing these various issues involved in choosing between binding and nonbinding legal forms requires unpacking complex and, at times, conflicting perspectives on the role of international legal instruments in global governance. It is important to recognize that international law, is not an effective policy tool for all global health concerns. The remaining part of this section provides a brief introduction of some of the strengths and limitations of binding and nonbinding instruments that should be taken into consideration in future global health lawmaking proposals.

Binding Instruments

Binding international law has important and widely recognized strengths as a framework for multilateral cooperation in global health. There is clearly no substitute for binding international law when states want to indicate their seriousness of their commitment to international cooperation. The formalized process of legalization has important benefits as well as costs described below. In addition to requiring

commitment to a set of international norms, legalization requires state actors to engage in established legal processes and discourse. The fact that international legal commitments must go through a process of national ratification further bolsters the credibility of binding international law. In addition, important domestic and international legal and reputational consequences can attach when states fail to live up to their international legal commitments.

However, international law is an inherently imperfect mechanism for international cooperation. The innate weakness of international law stems in large part from the core principle of state sovereignty. The law that is made and the law that is implemented depends upon the will of states. In the treaty-making process, states explicitly agree to make rules to govern and, thereby, limit their own conduct and that of their nationals. The concept of sovereignty looms large in the international system and states are generally loath to sacrifice their freedom of action through the development of binding international commitments. A related weakness stemming from the principle of sovereignty is the general lack of compliance mechanisms in most contemporary agreements. In contrast to the binding dispute resolution mechanism established under the WTO, for example, most instruments related to global health do not include machinery designed to compel parties to comply with their international legal commitments.

Notably, the international legislative process itself is characterized by numerous challenges and limitations, although considerable advances have been made in the last few decades. Treaties can be remarkably slow to negotiate, conclude, and bring into force. The slowness of the international legislative process can make the use of international legal instruments challenging in global health, as the legislative process cannot generally respond quickly to changes in science. In addition, the drive for universality or widespread agreement among sovereign states often results in the negotiation of shallow international standards, the so-called "lowest-common denominator" of agreement among states.

An emerging challenge in global health lawmaking is the limited scope of entities that are subject to international law and thereby entitled to participate and be bound by international agreements and hold rights and duties there under. As described above, states have traditionally been the primary subjects of international law and the sole participants in the lawmaking enterprise. However, the nature of global health and the major actors in health policy are changing in such a way that challenges this restricted approach to international legal cooperation. In an era of globalization the exclusive focus on territorial statehood is often irrelevant to global health policy. Non-states ranging from Taiwan to Palestine are excluded from a range of international agreements because of lack of statehood. In addition, the major actors in global health policy today, including foundations (e.g., the Bill and Melinda Gates Foundation), and a wide range significant public–private partnerships (e.g., the Global Fund for AIDS, Tuberculosis, and Malaria) are also excluded from the formal international lawmaking process.

Finally, the international legislative process often suffers from severe problems of compliance. Apart from issues of political will, there is increasing awareness that many states, particularly developing countries, face acute problems of limitations of resources and capacity in implementing contemporary treaties. Despite recent

advances to address the lack of domestic regulatory capacity, compliance remains a predominant issue and in other realms of international legal concern much of the community's attention has shifted from formulating new treaties to securing compliance with existing ones.

Despite the conspicuous limitations of the international lawmaking process and the inherent challenges of using treaties to promote collective action, treaties can be useful for raising global awareness, and stimulating international commitment and national action. The fact that many treaties tend to be well respected in practice reflects the fact that they are generally seen as mutually beneficial for states parties (Henkin 1979). As an increasing number of health threats are global in scope or have the potential to become so, binding international legal agreements is likely to increase in importance as an essential component of global health governance.

Nonbinding Instruments

International agreements not concluded as binding legal instruments serve an important role in international relations. Undoubtedly, there is no alternative to treaties when states want to make concrete and credible commitments. However, treaties are not the sole source of norms in the international legal system. It is increasingly recognized that the challenges of global governance demands faster and more flexible approaches to international cooperation than can be provided by traditional and heavily legalized strategies. Consequently, in many realms of international concern, ranging from the environment to human rights to arms control, the world community is increasingly turning to the creation of nonbinding international norms.

Like binding international instruments, nonbinding instruments have a recognized strengths and limitations as international legal tools. Chief among the recognized limitations of nonbinding instruments is that such voluntary agreements are not subject to international law, and particularly not to its fundamental principle *pacta sunt servanda*. There are no rules of international law that regulate or supplement nonbinding instruments like the Vienna Convention on the Law of Treaties. In addition, many nonbinding instruments may be purposefully designed as way stations and even detours from "hard" binding commitments. Consequently, many if not most nonbinding instruments are purely rhetorical and have a limited impact on state practice.

However, nonbinding instruments have some important advantages as a mechanism for international cooperation relative to binding instruments and can, at times, make an important contribution to shaping state practice. A key advantage of nonbinding instruments is their flexibility. Flexibility is an essential component of international negotiations. Nonbinding instruments can facility compromise and cooperation among states with different goals because states do not run the risks to reputation or countermeasures that may be involved in the breach of hard treaty obligations. In addition, nonbinding agreements may be easier to achieve, especially when states jealously guard their sovereignty since nonbinding standards do not involve formal legal commitments. Notably, the FCTC was negotiated in six separate rounds of

2-week negotiation sessions over 5 years. In contrast, the nonbinding WHO Global Code of Practice was formally negotiated in a period of 2 years and in only one global session that lasted for 3 days.

The nonbinding approach is also frequently dynamic and can be more responsive to the needs of an ever-changing world relative to heavily legalized treaty approaches. Nonbinding approaches can initiate a process and a discourse that allows learning and other changes that may lead to a deepening of obligations over time. In addition, the negotiation and implementation of nonbinding instruments can directly involve non-state actors. Consequently, nonbinding approaches can be an effective mechanism to address some of the recognized limitations of formal international legal processes involving binding instruments.

Depending upon political will, nonbinding instruments can also include a wide variety of implementation mechanisms and other features, some of which mirror incentives found in binding instruments. For example, institutionalized periodic reporting is a core feature of many binding and nonbinding instrument ranging from human rights to the environment to health, including nonbinding instruments such as the WHO Global Code of Practice on the International Recruitment of Health Personnel and the FAO Guidelines on the Right to Food (127th Session of the Food and Agriculture Organization Council 2004). As a further example, widely recognized mechanisms for technical advice and assistance are essential components of contemporary regulatory treaties to assist developing countries and other states in meeting their international commitments. Notably, there are strong examples of technical assistance programs in both binding and nonbinding instruments, such as the FAO Fischcode Programme that targets technical assistance to countries to implement the FAO Code of Conduct on Responsible Fisheries (Food and Agricultural Organization of the United Nations 1995).

Although many nonbinding standards are purely rhetorical, they can create norms that effectively guide the behavior of states. Such intergovernmental resolutions have been highly persuasive and states have, at times, followed the principles embodied in these resolutions. The effectiveness of some nonbinding intergovernmental resolutions in promoting international cooperation has led some commentators to refer to them as "soft law," although the term is highly controversial (Box 5).

Box 5 Soft Law

Although the term "soft law" has entered the lexicon of international law, the term and the concept remain highly controversial among international lawyers. This chapter and this volume avoid the use of the term because the concept of soft-law is inherently incoherent.

The concept of soft-law is designed to reflect something in between hard treaty law and no law, but as a theoretical and a practical matter, there is no

(continued)

Box 5 (continued)

middle ground between binding international law and nonbinding instruments (Raustiala 2004). At first instance, the concept does not accord with state practice: in international negotiations states do not behave as if there is no distinction between nonbinding and binding legal forms. In addition, the concept of soft-law has been used to conceptually describe different types of agreements and has the potential to generate confusion among international legal scholars and practitioners. Some scholars, for example, use the term "soft law" to describe all nonbinding instruments while others nonbinding instruments that have a significant impact on state practice. However, others use the term to describe binding agreements with limited content in terms of substantive obligations or implementation mechanisms.

Such instruments are often carefully negotiated and drafted with the intention to influence state practice and can generate an ongoing diplomatic forum. Though not all resolutions lead to the development of formalized obligations or are a significant factor in state practice, some intergovernmental resolutions, particularly resolutions which are supported by influential states often, have a political significance that can stimulate national behavior and lead to the eventual development of binding international law. For example, the Rotterdam Convention on Prior Informed Consent on Certain Hazardous Chemicals and Pesticides in International Trade followed the FAO and UNEP codes of conduct on pesticides and chemicals (Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade 1998).

Lessons for Future Global Health Negotiations

The brief review of the strengths and limitations of binding and nonbinding instruments above evidences that the form of an international instrument does not necessarily dictate the depth of the substantive obligations or the scope of the procedural mechanisms that may be incorporated to promote compliance. International legal scholars widely recognize that the use of "hard" treaty law does not guarantee that states will make "hard" meaningful commitments. States may severely weaken substantive commitments and procedural mechanisms codified in binding international agreements to neutralize any risk of their own noncompliance. At times, nonbinding instruments can be more effective instruments of international cooperation. By removing concerns about legal noncompliance, nonbinding instruments may, at times, promote deeper commitments with stricter compliance mechanisms than comparable binding

instruments. Notably, the 2010 nonbinding WHO Global Code of Practice incorporates procedural mechanisms to advance implementation that are more potent than those incorporated in the 2003 WHO FCTC (Taylor and Dhillon 2011).

Recent research suggests that there are important and not fully understood trade-offs involved in the design of international legal instruments and that more research is needed in this realm (Bodansky 2010; Raustiala 2004; Barrett 2003). Expanding the research agenda and promoting greater understanding of the relationship between the type of a legal instrument and its substantive commitments and procedural mechanisms could make an important contribution to guiding future global health law negotiations.

Conclusions

This chapter has provided a broad overview of the rapidly expanding field of global health law. This is an era of significant change in health policy. Over the two decades public health has emerged as an issue central to virtually all areas of multilateralism, ranging from arms control to security to human rights to trade. At the same time, the global dimensions of public health are transforming traditional approaches to public health. Globalization has limited the capacity of governments to protect health within their sovereign borders through unilateral action alone, and national and international health are increasingly recognized as intertwined and inseparable. In addition, the idea that governments have human rights responsibilities to protect and promote public health and can and should be held accountable domestically and internationally for their actions is gaining widespread acceptance. In this new era of global health governance, international law has an important role to play in promoting and coordinating international cooperation and national action.

International agreements, binding and nonbinding, are now at the core of contemporary cooperation in global health. The effective design and management of global health law is one of the major challenges for global health governance in this century. Recent developments in global health law and diplomacy have led to increasing calls for international lawmaking and, in particular, the codification of treaties to serve as a framework for global governance. However, it is important to recognize that international law is not an appropriate policy instrument for all global health problems. Given the substantial limitations of international law and the international legislative process, careful consideration should be given to the selection of global health concerns and the construction of legal regimes in the future. Policymakers must give high priority to identifying if and how legal strategies can contribute to the agenda in international health cooperation, including, most importantly, the major challenges that plague many developing nations. At the same time increased attention should be paid to the impact, both positive and negative, of existing **international law** on population health.

Questions

1. What types of events motivated early international efforts to protect public health?
2. What factors have encouraged an increase in international legal cooperation in global health?
3. What are the most common sources of global health law?
4. How does **international law** differ from most domestic law?
5. Where does WHO derive its legal power in global health, and what is the scope of this legal power?
6. What are some of the advantages and disadvantages of binding instruments? Of nonbinding instruments?
7. What difference does the form of an international instrument make to its effectiveness?
8. What is meant by soft law? Is soft law a coherent legal concept?
9. How can policymakers advance an optimal policy mix of instrument form and substantive and procedural content in future global health law negotiations?

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Chapter 5
The New Dynamics of Global Health Governance

Wolfgang Hein

Reader's Guide

This chapter considers the impact of globalization on international health policies and the emergence of new approaches to **Global Health Governance** (GHG). The first part of the chapter describes the changes in institutional structures since the 1990s that have had a fundamental impact on GHG. These structural changes have occurred as the discourse on trans-boundary health has broadened and engaged more public, private and voluntary sector actors in the debate. This has brought greater recognition of the need to mobilize a range of financial and other resources and to adopt a more flexible approach to problem solving. But the proliferation of public and private actors has also brought greater complexity that could inhibit the effective application of these resources and solutions.

The second part of the chapter discusses ways of improving the coordination, **accountability** and legitimacy of GHG while preserving the engagement of non-state actors and the ability to respond flexibly to global health challenges. In particular it explores the concept of nodal governance and its implications for the role of the World Health Organization (WHO) in the new dynamics of GHG.

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Learning Points

- The definition of GHG.
- The impact of globalization on health.
- The triangle of GHG.
- The rise of new actors in global health and its governance.
- The importance of open transnational networks and nodal leadership for the engagement of all actors in new forms of global governance for health.

Introduction: Global Transformation and Health

The term **global health governance (GHG)** did not appear in global health discourse before 2002 (Dodgson et al. 2002), but since then it has become a sort of buzzword. Whatever its precise definition (see Box 1), it obviously reflected a change in international health politics which demanded a new term. Since the mid-1990s the number of public–private partnerships (**Global Health Partnerships**) established to deal with specific international health problems has grown rapidly. New actors became increasingly important in financing global health activities including organizations such as the Global Fund. These new actors often developed structures and processes which were significantly different from classical intergovernmental organizations (IGOs) due to their highly focussed **results oriented** approach to single issues. In addition, one of the fiercest conflicts in global health, concerning the TRIPS agreement and access to medicines, unfolded with WHO playing only a marginal role. The leading role of WHO had been challenged.

All three definitions in Box 1, whether explicitly or implicitly, refer to a plurality of actors, processes and regulations which operate in a contested arena and produce health policy outcomes as a result of activities which are not coordinated by conventional institutions. Within a few years, the post-war architecture of international health seemed to have been overturned.

What has led to this change and what does it mean for the future of global health? The rise of GHG is closely linked to the process of globalization (Lee et al. 2002),

Box 1 Defining Global Health Governance

"Global governance for health describes the structures and processes through which the global health issues are addressed" (European Perspectives on Global Health. A Policy Glossary, Brüssel 2006, p. 35).

GHG is the "totality of collective regulations to deal with international and transnational interdependence in the context of health issues" (Hein/Kohlmorgen 2008, p. 84).

(continued)

Box 1 (continued)

"For us GHG is viewed as a contested space which is much broader and deeper than current scholarship acknowledges. Instead of existing in a separate sphere to globalisation, we view GHG as immanent in the critical processes of globalisation and marked by sharp divisions in policy and competing worldviews of global health which have not yet settled or reached an identifiable conclusion" (Kay and Williams 2009, p. 3).

understood as an intensification of cross-border flows of goods, services, finance, people, and ideas. **Globalization** has been facilitated by new technologies and by changes in the institutional and policy regimes at the international and national levels, for example by the promotion of trade liberalization (Held et al. 1999). It extends far beyond the economic realm to political, cultural, environmental, and security issues and implies an increasing transnational interconnectivity of people and communities, leading to a growing density of transnational social relations and the creation of common identities based on characteristics other than nationality—for example among people in civil society networks fighting for justice in global health. Globalization has increased the need for inter- and transnational cooperation to "govern" the many global forces that can effect human health. Yet, in the absence of a central political authority beyond the nation state, there are multiple sets of often conflicting rules and norms. How can the interaction of these rules and norms be resolved? How can relations of legitimacy and **accountability** be established when the *demos* is spilling over beyond the territorial foundations of democratic rule?

Globalization has had important consequences for the dynamics of global problems such as health as well as on the architecture of international relations, as summarized in Box 2:

Box 2 Globalization and Health

- *Health threats* such as HIV/AIDS, influenza, SARS or avian flu threaten every country and the global community as a whole due to the rapid spread based on global travel and mobility; their impact is frequently very serious in economic terms.
- The *globalization of lifestyles* has led to common chronic disease challenges such as diabetes and is linked to the impact of global industries such as tobacco and alcohol as well as the food industry.
- The health sector is a *critical sector for stability* in many countries, healthcare financing is a key political issue in all countries; the mobility of patients and health-care professionals is a global issue

(continued)

Box 2 (continued)

- Health is *one of the largest industries worldwide*, critical issues—for example around intellectual property and trade in goods and services—have major economic consequences for companies and countries, and major consequences in terms of access for poor people and countries. The access issue has gained large attention in particular concerning access to anti-retrovirals (ARVs) and the conflicts related to the TRIPS Agreement and the production and marketing of generic versions of medicines.
- *Inequality of access to health* around the world is gaining more attention and has become a major subject of discourses on human rights and social justice, more investment in health is critical for all nations, especially the poor. Inequality (and the immense resources needed for global redistribution) can be roughly characterized by the gap between annual health expenditures per person of $7,285 in the USA and less than $10 in Myanmar, Eritrea and Ethiopia (World Bank data, http://data.worldbank.org/indicator/SH.XPD.PUBL).

The dynamics of global governance can be understood as a reconfiguration of political actors in dealing with new forms of global problems, which have turned out to be difficult to handle by any one of the three main types of actors in global politics (see Fig. 5.1) for a variety of reasons:

(a) The increasing urgent need to deal with global problems which are *beyond the control of national governments*.
(b) The limited capacity of most **IGOs** to intervene effectively in *trans*national affairs, due to a lack of resources and a limited flexibility for cooperation with non-state actors, but:

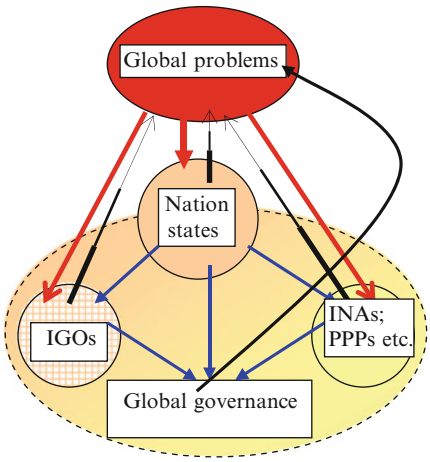

Fig. 5.1 The triangle of global governance. *Source*: W. Hein

(c) While strong efforts by nation states and IGOs frequently led to little or no effect on problem-solving, it has been increasingly easy for **international non-state actors (INAs)** to operate in the transnational space and—due to (a) and (b)—their contributions have generally been welcome within the relevant policy field. Global governance has developed as a field of cooperation and compromise between an increasing number of actors concerned, whereby in many cases—though certainly not always—conflicts which, seemed to be paralyzed, could be resolved.

Global Health Governance: New Challenges and New Constellations of Actors

Three examples are helpful to understand the flexibility allowed by the new openness of global governance structures:

1. The trends towards globalization and economic privatization supported, for example, by the creation of the World Trade Organization (WTO), have reduced the independent capacity of states and IGOs to fight global diseases. As an alternative, **GHPs** have been proposed and founded to integrate a number of different actors in different combinations as required by the specific tasks and the social and political environments. Flexible forms of cooperation became possible which combine the specific needs identified by governments, IGOs or **Civil Society Organizations** (CSOs) with the scientific and technological capacities and economic interests of private corporations and the financial resources of donor countries, public funds or private foundations. During recent years, GHPs made important contributions to research on neglected diseases, to finance health activities in fields like HIV/AIDS and immunization and to improve access to medicines in poor regions (see "Global Health Governance: New Challenges and New Constellations of Actors" section on GHG actors).
2. The zero-growth strategy imposed on the budget of many UN organizations by the USA (but also supported by other high-income countries)—basically an expression of hegemonic conflicts—significantly reduced the governance capacities of WHO: The so-called United Nations Reform Act (Helms-Biden Act, a 1999 US law) set a number of conditions for the reform of the UN system before the USA would even release its total amount of arrears in payment to the UN. The principle of zero nominal growth forced WHO to raise extra-budgetary resources which are mostly ear-marked for specific projects and reduce the budgetary autonomy of the organization.

   Nevertheless, since the end of the 1990s US contributions to global health experienced unprecedented growth. The US strongly supported the G8 initiative to create a fund to finance the global fight against HIV/AIDS, tuberculosis and malaria—provided the fund would not be managed by a UN organization. Thus, an independent fund was established, based on the PPP model (state governments,

representatives of private enterprise and civil society organizations as decision makers; IGOs like WHO and the World Bank included only as non-voting members of the Executive Council). Furthermore, the US government created bilateral channels to make important contributions to global health, in 2003 *PEPFAR, the President's Emergency Plan For AIDS Relief* committed $15 billion for 5 years to the fight against HIV/AIDS; and $63 billion over 6 years to the 2010 Global Health Initiative "to improve health outcomes". In addition, contributions to global health by US private foundations (in particular, the Bill & Melinda Gates Foundation) increased rapidly and since 2006 more or less equal the level of the WHO regular budget.

3. The high prices of anti-retroviral medicines, made possible by the internationalization of intellectual property rights in the TRIPS agreement, turned out to be a major barrier to realizing the human right of universal access to essential medicines. The UN Committee on Economic, Social and Cultural Rights (CESCR), emphasized in its General Comment No. 14 (2000) that the right to "the highest attainable standard of physical and mental health" formulated in the **International Covenant on Economic, Social and Cultural Rights** (article 12.1) obliges member states to make available those drugs that are indispensable (as stipulated in the WHO list of essential drugs).

   In addressing this challenge, it was not only the pressure of civil society organizations for access to medicines but also the response of transnational pharmaceutical companies in selling medicines to poorer countries at reduced prices or to allow generic companies to supply markets where they held patents that were vital. There were also a large number of financing initiatives (such as the GFATM, internationally operating foundations, and various NGO and church initiatives), as even with reduced prices, many poor countries need additional funding to finance AIDS treatment (Hein and Moon 2013). These concrete processes made it possible to significantly expand access to ARV therapy for people living with HIV/AIDS and to expand the "access norm" to include medicines beyond ARV drugs (e.g., for heart disease & cancer).

The rise of new actors has not only contributed to a higher degree of flexibility in dealing with global health problems but also added expertise and financial resources (Fig. 5.2). While the contributions of traditional state actors (bilateral and multilateral agencies) grew from $5.1 billion in 1990 to about $18.1 billion in 2007, i.e. by a factor of 3.5, during the same period the contributions of non-state and hybrid institutions grew nearly 15-fold (from about $0.6 billion to about $8.8 billion).

Most of the changes in international health politics discussed so far were focussed on mobilizing support for developing countries in global health. However, the WHO was not created to be a development organization, but to "act as the directing and co-ordinating authority on international health work" (Constitution of the WHO, Art. 2a). This implies the provision of global public goods, e.g. securing access to vaccines, eradicating a virus or enforcing rules to prevent the spread of infectious diseases or of unhealthy consumption habits. For decades, WHO had been very reluctant to launch initiatives concerning international treaties in the field of health (in contrast to the very different attitude of ILO in this respect). The negotiation of

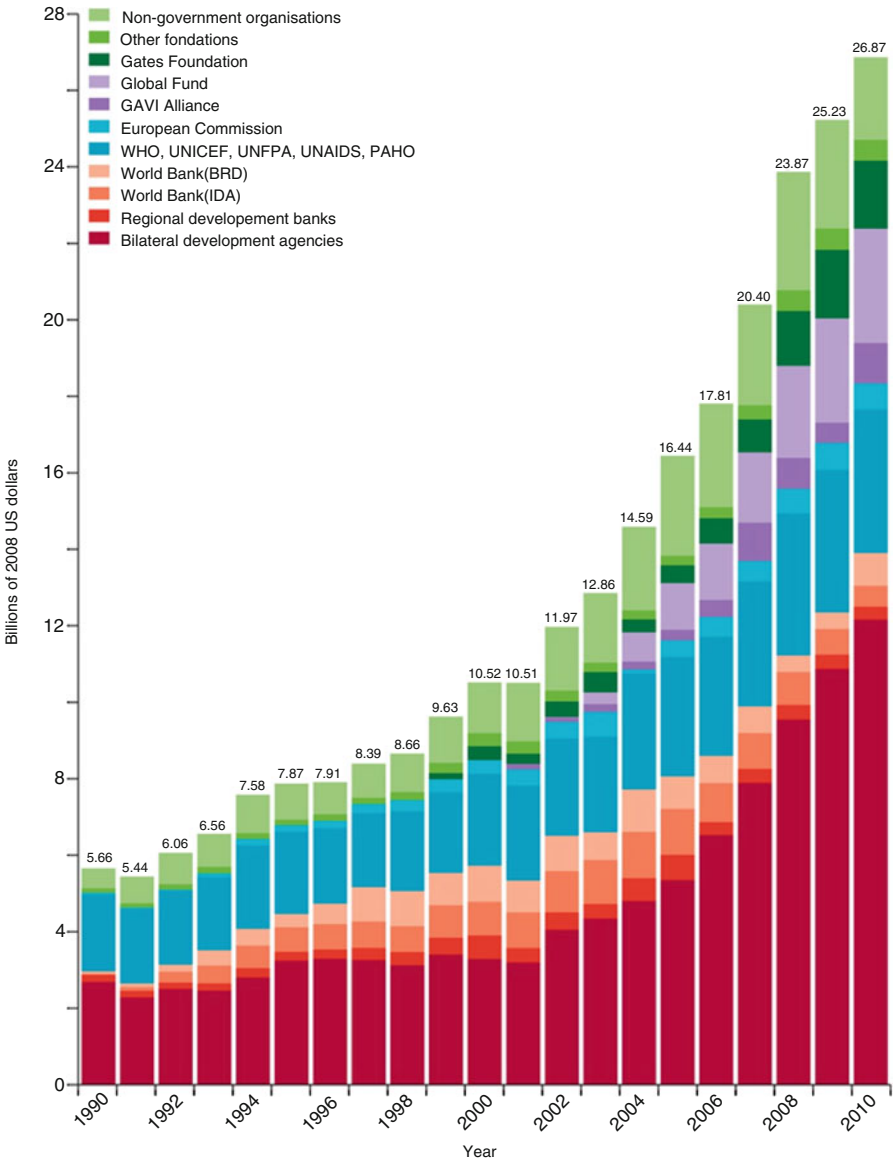

Fig. 5.2 Development assistance for health from 1990 to 2010 by channel of assistance. *Note*: The *bar chart* represents the contributions of specific (groups of) donors in the same sequence as in the legend (*BMGF* Bill and Melinda Gates Foundation, *GAVI* Global Alliance on Vaccines and Immunization). *Source*: Murray et al. (2011, pp. 8–10)

the *New International Health Regulations* (IHR 2005) and the *Framework Convention on Tobacco Control* (FCTC) can be seen as an indication that WHO has also felt the need to respond to the changing global environment, in particular to the increasing needs for the regulation of global public goods for health.

The negotiation of these agreements points to the need to involve Nation states in the politics of global governance: Only states can make internationally binding rules. While in many other fields of global politics, the principle of subsidiarity might apply, strengthening the role of private actors and "reducing" states to just one type of actor among others, there is no way of creating legitimate, universally binding rules other than through agreement between states. Nonetheless, the growing involvement of a globalizing civil society might make it easier for state governments to overcome power-based interests in favour of issue-focussed solutions, in the negotiation and implementation of agreements. Non-governmental organizations played an important role in the intergovernmental negotiating body for the FCTC and the Tobacco Free Initiative (with a strong participation of CSOs) supporting the implementation of the Convention.

It is also notable that in the event of a "Public Health Emergency of International Concern" the new *International Health Regulations* grant the WHO far-reaching powers and non-governmental organizations are assigned key roles (Fidler 2005). The WHO has the right to require member states to develop appropriate capacities for monitoring possible international health risks. It can, however, also use non-governmental information sources and, if necessary, issue recommendations for the restriction of travel and trade without the consent of the state concerned. The WHO led Global Outbreak Alert & Response Network includes the contributions of UNICEF, UNHCR, the Red Cross, non-governmental groups like Doctors without Borders and scientific institutions within member states.

Self-organization Through an "Open-Source Anarchy" or Need for More Coordination and Guidance?

The discourse on GHG points to the importance of new types of actors and the growing importance of non-state actors in global health affairs. But what is actually new? The history of international health is full of non-state actors. In colonial territories, hospitals built by Faith-Based Organizations (FBOs) introduced modern health care in areas beyond the capital or port cities. The International Committee of the Red Cross was founded in 1863 very consciously in the form of an international institution to coordinate decentralized, non-state relief societies to stress the neutrality of medical services in armed conflict (Bugnion 2009). It is also relevant to note that the Rockefeller Foundation financed up to 50 % of the budget of the League of Nations Health Organization.

Nevertheless, most observers of GHG agree on a number of characteristics that are specific to the last 10–15 years of institutional developments in international health:

1. A great proliferation in the number and variety of health actors.
2. Increasing interdependencies between health and other areas of global governance (trade and intellectual property rights; environment; agriculture).

3. A growing impact of CSOs.
4. A growing importance of private funders (e.g., foundations).
5. New types of hybrid actors and global initiatives (e.g., foundations, Public–Private Partnerships, the Global Fund to Fight AIDS, Tuberculosis and Malaria, GFATM) interact with national governments and international governmental organizations.
6. GHG implies a substantive concern with issues that affect populations worldwide directly (for example the global spread of disease, such as HIV/AIDS and the much-feared new pandemic influenza) or indirectly (extreme inequalities in medical care, unhealthy consumption patterns). The Millennium Development Goals (MDGs) (proclaimed in 2000, including goals of fighting infectious diseases and improving maternal health, child mortality and access to medicines) and the Commission in Macroeconomics and Health (WHO 2001) are expressions of this concern.
7. To a greater extent, poor health is not only seen as a consequence of poverty but also as a cause of lack of development; investments in health are seen to offer value for money through their positive impact on development.
8. Cooperation in international health is no longer solely "governed" by state actors or inter-governmental agencies such as the WHO.

GHG can be understood as a mechanism for collective problem-solving, i.e. health improvements through the interplay of different institutional forms and actors at different levels. All of this points to a form of GHG, characterized by a polycentric, distributed structure and a substantive focus on issues that affect populations worldwide, directly (for example the global spread of disease) or indirectly (through extreme inequalities). It now requires management not merely of specific transborder epidemics but of the host of issues that arise in health at the intersections of a globalized economy and individual lives in particular localities (Hein et al. 2009).

Depending on the vantage point, one can see GHG as an anarchy of actors which constitutes a "creative plurality" in managing global health (at every moment raising new health issues and proposing new ways of solving them), or as waste of material and political resources through the uncoordinated fragmentation of actors and activities. Figure 5.3 illustrates the range of actors in global health according to the public–private dimension.

During recent years the numbers of hybrid organizations (GHPs and GHIs) and private actors have considerably increased. The **interconnectedness** of different organizations is by far too great to be displayed here in a meaningful way. Though there can be hardly any doubt that the number and intensity of links has grown considerably since earlier decades, a large number of inter-organizational relationships already existed in the 1950s and 1960s. What can be assumed as a qualitatively new phenomenon—in correspondence with much of the globalization literature and many accounts from GHG processes—is the high volatility of organizational patterns and institutional change and the flexible reaction of Global Health actors to new challenges. Regrettably there are few systematic analyses of the dynamics of these networks in GHG.

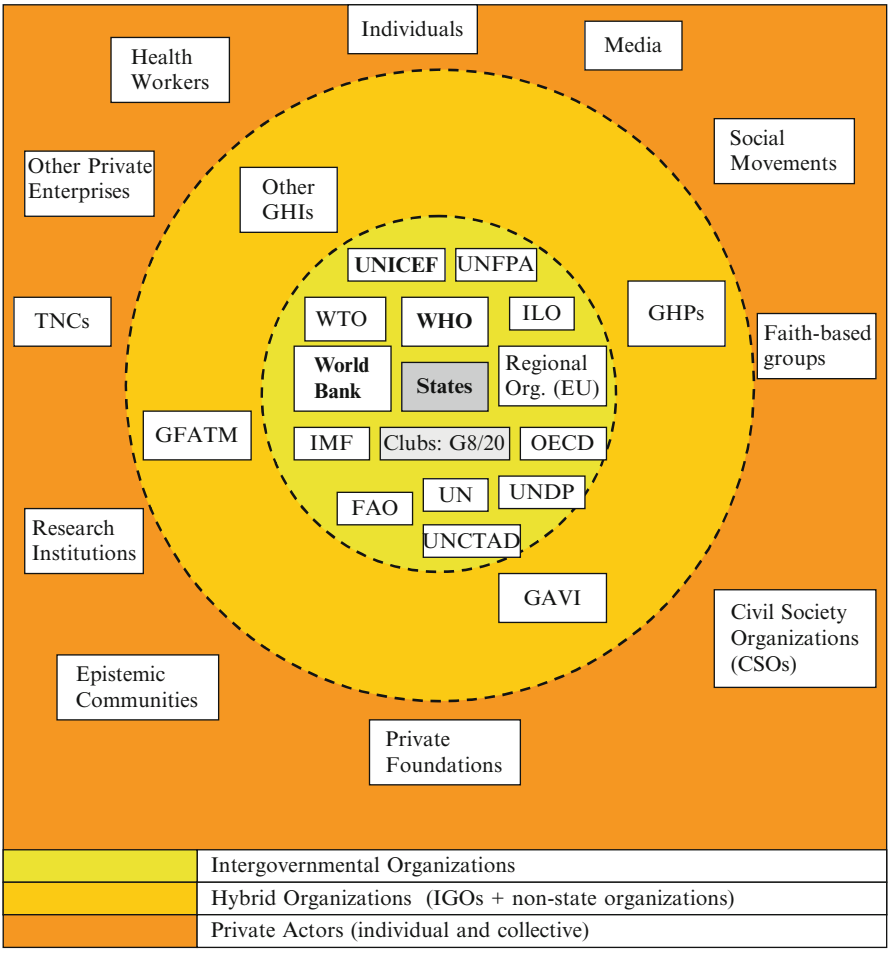

Fig. 5.3 Actors in global health. Abbreviations (besides well-known UN organizations): *GHIs* Global Health Initiatives, *TNCs* Transnational Corporations, *GAVI* Global Alliance for Vaccines and Immunization, *UNFPA* United Nations Population Fund. *Source*: W. Hein

David Fidler characterized the GHG system as a form of "**open-source anarchy**", which is broadening and deepening the normative basis for global health action (2007: 9f.). "Anybody can access, use, modify and improve" (2007: 9f.) similar to open-source software. This means that the interactive space of relations between national societies is no longer dominated by inter-state relations. Transnational relations are not squeezed into diplomatic rules and traditional means of exerting pressure on other states by the application of power politics or through the complicated mechanisms of international organizations. Actors can use their specific strengths to reach their goals (financial and expert resources, discourses and using them to mobilize support, including influence on the process of international law-making). **Transnational networks** between health-oriented actors have been

formed that focus on specific issues (like access to medicines, neglected diseases, and tobacco control) constituting a complex web of global social relations related to the issue of global health.

Jean-Michel Severino and Olivier Ray (2010) discuss similar changes in the field of development aid (which is in part linked to GHG): the surge of an "institutional jungle" and a tendency towards the privatization of international cooperation. They propose the term "hypercollective action" to characterize this "new mode of production of global policies" (Severino and Ray 2010:11). They acknowledge not only the mobilizing and creative dimension of this mode but also the "considerable costs in terms of efficiency, time, coherence and … credibility" (Severino and Ray 2010:12). This leads straight to the points made by the critics of the advocates for effective self-organization through an "open-source anarchy":

1. International cooperation is becoming more complex. Poor countries are receiving aid from a growing number of different organizations. This has made it difficult for national governments to stay in control of their own health systems or to effectively allocate aid.
2. Most of the new non-state actors in GHG can be accused of a lack of **legitimacy** and **accountability**. Large CSOs, GHPs and financially strong foundations (like the BMGF) are having a great impact on global health without being accountable to people affected by their activities. While IGOs might also have legitimacy problems, they are clearly accountable to governing bodies in which sovereign states are represented.
3. GHPs are not necessarily identified with vertical strategies focussed on specific diseases, but their targets are mostly linked to a chain of activities focusing on controlling and treating specific diseases including the identification of pathogens, research and development of medicines and means of treatment, distribution of medicines, securing access (finance, technical infrastructure) and the medical infrastructure for treatment. Horizontal activities like improving national health systems and developing systems of primary health care have been relatively neglected.

Whether the characteristics of GHG are seen from a more optimistic or a more critical perspective, "coordination" has become a major focus of discussions of the future of global health. The need for better coordination is certainly recognized in, first, the processes of assessing health needs and strategies to deal with them; second, the search for more systematic institutional mechanisms for improving coordination and third, the attempts to strengthen legitimacy and **accountability** by engaging multiple forms of networking in the agreed processes for taking important decisions.

Discursive Processes in GHG

It is generally recognized that the broadening and deepening of discursive processes in GHG has contributed significantly to the growth of public attention and strengthening of support for global health action, as well as to the constructive processes of conflict resolution. The open-source character of GHG has facilitated the articulation

of the concerns of very different constituencies (human rights movement, different "publics", expert networks, etc.). Examples of open discursive processes have included the International AIDS Conferences, the Global Forum on Health Research and **Global Expert Commissions** on urgent topics. The power of broader discourses can be contrasted with political power processes: while political processes can release the public sector resources required to address problems in a conventional way, discursive power can find new solutions and call on a wider range of public and private resources. Discursive power (particularly if magnified by mass media) can also put pressure on actors with political and economic power and resources.

World commissions have been established on a number of important issues in global affairs. They *consist of members representing stakeholders of diverse political and cultural backgrounds and charged with producing a substantial report on a topic of far-reaching importance,* supported by a budget which allows them to fund the production of expert papers to shed light on the respective topic from various perspectives. Famous examples are the so-called Brandt Commission on International Development, the Brundtland Commission on the environment and development and the Commission on Global Governance which examined the social determinants of health.

Three such commissions were initiated and managed by WHO. These have been important mechanisms for policy-making, serving as fora for communication between stakeholders with conflicting interests. They played an important role in coordinating the contributions of the multiplicity of GHG actors and to focus the international discourse on specific issues.

Box 3 Expert Commissions on Global Health Issues

The *Commission on Macroeconomics and Health* (*CMH*), launched by WHO Director-General Gro Harlem Brundtland in January 2000 and headed by Harvard professor Jeffrey Sachs: In the resulting *Report on Macroeconomics and Health,* "health" is seen not just as a component of development, but as a basic pre-condition for economic growth itself. The report, presented in December 2001 (WHO 2001), played an important role in raising public consciousness about the need for a massive scaling-up of global health financing.

The *Commission on Intellectual Property Rights, Innovation and Public Health* (*CIPIH*),set up in 2004: It responded to years of conflicts on intellectual property rights and access to drugs. Following the final report of CIPIH (WHO 2006) there was a general recognition of the need for changes in the global system of innovation in drug development and access to strengthen research on neglected diseases and to improve global access to essential medicines. It was recognized that support for innovative capacity in developing countries was an important way to reach these goals.

The *Commission on the Social Determinants of Health*, established in 2005: Its task was to analyse the causes and consequences of health inequality and the social conditions that cause illness as well as the need to make health systems more responsive to the needs of socially disadvantaged people. The Commission's final report was published in May 2008 (WHO 2008).

The CIPIH demonstrated the capacity of such commissions to produce a meaningful focus for strategic debates and to channel their results into international negotiations. The World Health Assembly (WHA) discussed in 2006 a "Global Framework on Essential Health Research and Development". In a resolution passed in May 2008, a *Global Strategy,* and parts of the corresponding *Plan of Action* were adopted (WHA 61.21). The WHA 2010 discussed ideas for financing this strategy; the *Taskforce on Innovative International Financing for Health Systems* estimated that by 2015, US$7.4 billion annually will be needed to fund health research and development.

Today, transnational discourses on health are highly important in raising issues, setting agendas and defining the terms in which problems debated in IGOs and in other international fora are understood by the public and by important political actors. They are also crucial in providing a structure and processes to shape the dynamics of transnational communication. They transform the formerly rather thin and simply structured flows of international communication between governments and a few other actors into a dense web of exchange.

The Paris Declaration: Coordinating Policies?

Following the adoption of the MDGs in 2000, OECD and the World Bank organized a global discourse on the effectiveness of development cooperation, leading to the *Paris Declaration on **Aid effectiveness*** (2005). The Declaration specified five target areas for improving aid effectiveness: ownership, harmonization, alignment, results, and mutual **accountability**. Donor countries agreed to coordinate and harmonize their aid in order to support their recipient country partners' national development strategies. These development strategies will reflect national needs and priorities while recognizing internationally agreed concepts of good governance. In preparation for the *Accra High Level Forum on Aid Effectiveness* (a 2008 follow-up meeting to the Paris conference in Accra, Ghana), the WHO, the World Bank and OECD proposed to use the health sector to track progress on the Paris Declaration: "Aid effectiveness is particularly challenging in health. As with other sectors, difficulties are the result of inefficiencies in the global aid architecture and of poor country policies; however, problems in health are exacerbated by the inherent complexities of the sector itself" (http://www.oecd.org/dataoecd/14/37/42254322.pdf). Global Health is affected by the Paris–Accra-Agenda whenever country level coordination is at issue.

UNAIDS promoted the "Three Ones" (2004), aimed at establishing: one agreed HIV/AIDS Action Framework for coordinating the work of all partners; one National AIDS Coordinating Authority and one agreed country-level Monitoring and Evaluation System (World Bank and WHO 2006, p. 15). The *High Level Forum (HLF) on the Health MDGs* (World Bank and WHO 2006) held three meetings in 2004 and 2005. "Scaling up aid for health" was the HLF's main target, which called for a better coordination between GHPs, the improvement of health funding and

concrete strategies to support the development of health systems in poor countries. The lack alignment of HIV/AIDS funding with government priorities, the lack of long-term support and the volatility of funding was criticized.

The *Scaling Up for Better Health (IHP+) Initiative* established a network of cooperation between the most important health funders. The IHP+ process is led by the so-called Scaling-up Reference Group (SuRG), which brings together the eight most important agencies/initiatives in global health, WHO, World Bank, GAVI, UNICEF, UNFPA, UNAIDS, the GFATM, and the Gates Foundation, which under the name "Health 8", has gained importance beyond IHP+. The focus of all IHP+ initiatives is on achieving health-related MDG outcomes through efforts to increase aid effectiveness, improve policy, strategy and health systems performance, and also a broad mobilization of non-State actors.

Thus, the **Paris–Accra Process** has led to a number of interactive processes for GHG by strengthening the links between the activities of different actors and national decision-making institutions, and improving aspects of accountability and legitimacy. However, this only marginally affects processes of agenda-setting and health policy making at the global level. There is a lack of institutional structures and processes to support continuous interaction between the myriad processes of local, national and international decision making on global health issues and the processes for formulating binding norms and rules for GHG.

Making WHO Fit for Nodal Governance: A Challenge for Global Health Diplomacy

The Role of Nodal Governance

The *interactive processes for GHG* have created new mechanisms for coordination in this field. Multiple forms of transnational links enable state and non-state actors to *coordinate* all kinds of activities: research, production, marketing campaigns, political strategies, CSO campaigns, and whatever might be of interest for a transnational group of actors. In very open forms of organization, networking is the logical compliment to a system which "anybody can access, use, modify and improve" (Fidler 2007, p. 9). In these networking processes important actors, institutions, media or venues emerge as nodes for information exchange and coordination in relation to specific goals like improving access to medicines, improving support systems for Primary Health Care, etc., to link various types of actors and different fields of activity. This creates forms of coordination, cooperation and networked power which have been characterized by the concept of *nodal governance* (Hein et al. 2009). Informal and formal networking in Geneva and at other regular global health events plays an important role in creating flexible links between global health actors. The concept of **interfaces** between different networks can be used to analyze the "power map" of a governance system and the key characteristics of effective

governance nodes. *The interactions taking place may reshape the goals, perceptions, interests, and relationships of the various actors* (Long 1989, pp. 1–2).

Nodal governance operates in a landscape of mixed social interactions and of conflicting or merging cultural and political habits and behaviours. Nodal governance characterizes many issue-oriented programmes like the *Campaign for Access to Essential Medicines,* where MSF/Geneva acts as the central node linking the activities of many NGOs, the *Peoples' Health Movement* as a large network of grassroots organizations or *Knowledge Ecology International* (*kei online*) as a communication platform in the Internet, providing an information exchange on the impact of intellectual property rights on medical research and access to medicines.

The period of the WHA every May in Geneva has become one of the central nodes for GHG, quite independent from what is being discussed in the formal agenda of the assembly. ***Polylateral diplomacy*** (Wiseman 1999, note 10) is conducted: formal and informal meetings take place, agreements are reached, deals are struck, NGOs exert influence, the private sector lobbies, receptions are organized—in short key global health players participate in the Assembly in this period, even if they are not members of the WHA. On the other hand, the WHA, itself provides a decision-making process at the level of a legitimate international body, allowing nations, which are not powerfully represented in nodal governance processes, to express themselves and participate in legitimate decision making. Linking these levels of nodal governance—providing both the political space for informal negotiation and formal-legal decision-making and managing their interface—is a central task for achieving successful overall coordination in GHG (Kickbusch et al. 2010).

Adapting WHO to GHG Through Institutional Reforms

The WHO was created in 1948 to "act as the directing and co-ordinating authority on international health work" (Constitution of the WHO, Art. 2a). WHO was entrusted with the task of "establishing and maintaining effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate" (Constitution of the WHO, Art. 2b) (see Chap. 9 for more details). However, as an **IGOs**, WHO decision-making (aside from technical matters) has mostly been subject to coalition and bloc building processes among nations as well as to periodic attempts to curtail the autonomy of the organization by powerful states—at times coming close to paralysis (Kickbusch et al. 2010).

Gostin (2007) has proposed that the WHO take full advantage of its treaty-making capabilities and establish a *Framework Convention on Global Health* that ties all major stakeholders (states as well as non-state actors) to the aims of building capacity, setting priorities, coordinating activities, and monitoring progress (see also: Global Health Governance 2010). A second proposal, which has recently gained considerable political attention, builds on the importance of the WHA and recommends that a *Committee C of the World Health Assembly* be established that—in addition to member state representatives—would include

the active participation of international agencies, philanthropic organizations, multinational health initiatives, and representatives from major civil society groups, particularly those who legitimately represent the most vulnerable populations (Kickbusch et al. 2010).

The proposed Committee C would debate major health initiatives and provide an opportunity for the primary players involved in health to present their plans and achievements and offer discussion of collective concerns with World Health Assembly's member state representatives. The Committee would then pass resolutions and would be held to rules of procedure and implementation that respects the mutual sovereignty of all parties. As the only legitimate supranational authority on health issues, the WHO is the appropriate vessel for such a central coordination mechanism that would bring all prominent global health actors to the table for harmonized agenda-setting and decision making. Thus, the Committee C proposal can be seen as creating a link or interface between the nodal governance processes in each sphere of action and the legitimate constitutional position of WHO within a system of sovereign nations. This would greatly improve the chances of achieving productive coordination and the harmonization of conflicting strategies by avoiding or mitigating the clash between power blocs and national coalitions with fixed positions.

Conclusion: Global Governance and Nodal Governance

Globalization has increased the need for international and transnational coordination to "govern" the many global forces that can impact on human health. As in all fields of governance, cooperation and coordination are subjects to shifting political power. New actors that can mobilize discursive political power and bring in new financial and human resources offer the prospect of wider public engagement with and concern for global health, more flexible solutions and faster resolution of issues. This may be seen as a challenge to the power of established actors, but it also offers them the chance to enhance GHG if they can take advantage of these new opportunities (Kickbusch 2009, pp. 320–321).

Many new actors have entered the policy field of global health, bringing additional resources and facilitating the resolution of conflicts by encouraging more flexible approaches and wider public engagement. Yet, in the absence of a central political authority, there are multiple sets of often conflicting rules and norms. Their collective impact on health is a central issue in the discourse on GHG. Forms of **nodal governance** have great potential to transform the institutional architecture. The WHO, vested with the authority to create binding regulations and treaties among member states, could strengthen its role in GHG by linking formal decision-making procedures with processes of **nodal governance**, drawing the many networks of non-governmental organizations that form around specific issues to engage them in global health diplomacy with all relevant actors and publics to develop a wider **governance for global health**.

Questions

1. Which aspects of globalization lead to a transformation of international health challenges?
2. Which are the new types of actors in GHG?
3. Which are the advantages of a proliferation of actors and initiatives in GHG and how are they related to failures of IGOs to deal with new challenges?
4. What is the meaning of "open-source anarchy" and what are the costs of an unfettered proliferation of actors?
5. What is the role of discursive processes for coordination in GHG?
6. How does the Paris Declaration support coordination in GHG?
7. Why does nodal governance imply a reconfiguration of power in GHG?
8. Do you think the Committee C proposal is a way to solve the coordination problem?

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Chapter 6
The Process and Practice of Negotiation

Graham Lister and Kelley Lee

Reader's Guide

Global health diplomacy has been defined as the art and practice of negotiation in relation to global health issues. This chapter draws on generic concepts of **negotiation** as a process of diagnosis, formula development, exchange and implementation, reflecting the shared and sometimes contested values, power relationships and interests of the many different actors involved. It sets out a framework for understanding the main phases of **global health negotiation** process as they arise in many different contexts. The negotiation of global health issues is shown to be a driver of the regimes of global health governance institutions that are shaped by the new trends in global governance described in the previous chapter. The leadership and development of diplomatic **negotiation**s at every level with an increasing range of actors is therefore key to global governance for health.

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Learning Points

- Understanding the negotiating process from diagnosis of issues and interests, the establishment of a formula to provide a framework for resolution of conflicting interests to the detailed process of negotiating exchanges to resolve the issues.
- The need to define and frame the issue in a way that can be accepted and addressed by all parties to negotiations.
- The importance of engaging relevant stakeholders and aligning their interests.
- The key role of information and knowledge in preparing a negotiating position.
- The design of the process and formula for the process of detailed negotiation.
- Insights for the conduct of detailed negotiation and exchange and in particular the importance of timing.
- The importance of continuing negotiation in the implementation of international treaties or agreements.
- The exercise of **meta leadership** in **global health negotiations**.

Introduction: The Negotiation Process

Negotiation can be defined as a process of exchange between two or more interested parties for the purpose of reaching agreement on issues of mutual concern. Zartman and Berman (1982) distinguish three main phases leading to agreement: the diagnostic phase, during which the issues are identified, stakeholders engaged and information is prepared, the formula phase, establishing a shared framework for agreement including the process of exchange and the detailed phase of negotiation and exchange. Negotiation is also crucial to the effective implementation of any international agreement, requiring ongoing monitoring and possibly arbitration of disputes by an international body.

Negotiation can be characterized in terms of the expression of values and power. **Global health negotiations** often invoke shared values and goals, though interpretation and interests may differ. As Fisher et al. (1997) note, negotiations based on common principles are fundamentally different to negotiations based on positional power. Where values are shared, stakeholders are more likely to seek, as a minimum, to accommodate the specific interpretations and interests of each party. More constructively they may collaborate to find new solutions to mutually recognized problems. Where values are not shared, stakeholders are more likely, either to avoid the issues or to seek to develop a position of advantage to advance one interest over another. While in the former case there are great advantages in sharing information and working for a "win-win" integrative solution, in the latter case the sides may

wish to apply game-theory based strategies that emphasize their position or the extent of the power of one side in relation to the other, it is assumed that one side wins at the expense of the other.

The ethical values of health as human rights are generally recognized by all the parties as defined in the constitution of the WHO and this can provide a basis for the negotiation of outcomes that can be considered "fair" in these terms. But even values such as fairness and rights to health may be interpreted in different ways. Moreover, it is also clear that the other interests of the parties, as examples: their trade, economic, and security concerns shape their interpretation of health values. Thus while **global health negotiations** tend to be couched in terms of the expression of shared values and concerns for health, it is also possible to discern the interplay between the specific interests and powers of the parties.

Global health negotiations can arise in many different ways in relation to threats posed by different diseases and determinants of health or as a consequence of other foreign policy issues such as security and trade. They often involve multiple stakeholders and interests, both because they deal with trans-border issues and because health and its determinants, including globalization, have impacts across all social and economic spheres. The health issues negotiated are often uncertain in their long-term impact and capable of different interpretation, thus an agreed evidence base and effective presentation of information are essential during the negotiation of international agreements and in their implementation.

For these reasons the negotiation of global health issues can be protracted and though agreements to joint action on health emergencies are often reached within days, this may reflect years of preparation and exchange. Where issues arise within other policy spheres the process can sometimes be very protracted but can be hastened by international events as shown by the negotiation of Trade Related Aspects of Intellectual Property (TRIPS) and access to medicines.

Box 1 The Negotiation of TRIPS and Access to Medicines

World Trade Organisation negotiations on TRIPS were first concluded as part of the Uruguay Round of the General Agreement on Tariffs and Trade (GATT) in 1994. This reinforced the protection of intellectual property rights including those applying to pharmaceuticals, for all countries joining the WTO. The agreement was negotiated purely as a trade concern without regard to public health consequences. As HIV/AIDS and other global health issues gained increasing prominence many resource poor countries and international civil society groups found that TRIPS presented a further obstacle to access to affordable medicines.

This issue came to the fore when the Government of South Africa passed the Medicines Act in 1997. This was intended to enable the SA government to license the production of drugs to treat some of the complications of HIV/

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Box 1 (continued)

AIDS, thus avoiding patent restrictions. An international group of 39 pharmaceutical companies challenged the legality of the act in the Pretoria High Court. This challenge might have succeeded, but for the intervention of a local civil society group called the Treatment Action Campaign (TAC) who alerted the international network of civil society groups in this field and won the right to present their case in court. Protests grew around the world and in the face of this the pharmaceutical firms withdrew their challenge. As a result the legislation was applied more widely than had originally been intended, particularly in relation to HIV/AIDS medicines and other countries followed South Africa's lead in passing similar measures.

The public awareness raised by this case was one of the factors that led to the partial resolution of this issue in the WTO resolutions of 2001 and 2003 (see Box 3).

Diagnosis

Identifying and Framing the Issue

In **global health negotiations** the first step is the identification of issues that are ready or "ripe" for resolution and to frame them in a way that all parties can recognize. This must invoke a common recognition of a problem and the moral and practical case for action. The time when an issue is "ripe" for resolution may depend on

Box 2 Negotiation of the International Health Regulations and Severe Acute Respiratory Syndrome

An illustration of how events can raise awareness of issues and thus facilitate negotiations is provided by Lee (forthcoming 2013) who describes negotiations to revise the International Health Regulations, initiated by a resolution of the World Health Assembly (WHA) in 1995 amid concerns about emerging and re-emerging diseases. While a revision process commenced, progress proved glacial due to the lack of interest and support by key member states. It was not until the outbreak of severe acute respiratory syndrome (SARS) in 2003–2004 that sufficient political priority was forthcoming. This led to concerted efforts, under the auspices of an Intergovernmental Working Group on the Revision of the International Health Regulations, which reached agreement on the revised IHR (2005) which countries have adopted.

factors such as the emergence of research evidence, the response to a crisis or simply as a result of ongoing international discussions.

Issues for global health negotiations are identified in many different ways: as a result of the policy leadership role of WHO, as an outcome of a specific review, or a concern of national governments or groups such as G8 or the EU. Issues may also be raised by civil society groups or as a result of negotiations in spheres not previously associated with health such as the World Trade Organisation. But it is not a simple matter to introduce a new issue to the crowded agenda of global health diplomacy. Moreover the way in which an issue is framed, how it is identified and the policy context in which it is viewed is crucial to subsequent global health negotiations. As Labonté and Gagnon (2010) note, global health issues arise in many different **policy frames**: security, development, global public goods, human rights, trade and ethical/moral reasoning.

Box 3 Framing HIV/AIDS Issues

Issues raised by the spread of HIV/AIDS have been raised in many international fora and policy contexts, framed in different ways, as examples:

- UN Security Council Declaration 1308 of 2000 addressed HIV/AIDS as a security issue and specifically a threat to UN peacekeeping operations.
- The United Nations Millennium Declaration which led to the agreement of 189 countries to the MDGs framed HIV/AIDS as a development challenge.
- The Declaration of the UN General Assembly Special Session of 2001 can be seen as framing the HIV/AIDS crisis in terms of global public goods and the need for joint action and funding.
- In 2006 Member States of the UN adopted a Political Declaration on moves towards ensuring universal access to HIV/AIDS prevention and treatment that frames this issue in terms of human rights.
- The WTO Ministerial Conference in 2001 proposed the Doha Declaration on the TRIPS and Public Health, which balanced trade considerations with ethical/moral reasoning with respect to HIV/AIDS and other global health issues.
- This question has still not been fully resolved as the declaration was only implemented in 2003 by the WTO General Council as a temporary waiver of TRIPS rules. As a consequence negotiations on the application of paragraphs 4–6 of the Doha Declaration that permit the compulsory licensing of drugs (circumventing patent rights) in response to threats to public health considered to be a national emergency or other circumstance of extreme urgency must be negotiated on a case-by-case basis in the light of local conditions (see Box 5).

However the issues are identified, it is important to raise the policy questions in a way that will be recognized by all relevant stakeholders. This does not mean pandering to the lowest common denominator but it does require the legitimate interests of all parties necessary for eventual agreement to be acknowledged. The policy lens or frame applied to the issue may also determine the fora at which the issue will be raised and the way it will be resolved.

One difficulty faced by many of the government and interstate institutions traditionally engaged in global health diplomacy is that their commitment to existing **policy frame**s and ongoing international regimes may make it difficult for them to identify and raise new issues. For this reason civil society organizations including **advocacy** groups and foundations that are less bound by formal roles and positions can sometimes play an important role as in stimulating new thinking to identify and frame issues.

Engaging Stakeholders and Aligning Interests

A second step during diagnosis can be described as engagement of stakeholders or the **alignment of interests**. This involves exploring the perspectives and points of agreement and disagreement between all relevant parties. The parties establish their respective negotiating stances build relationships and common understanding between aligned groups and, if they are wise, explore the positions of other parties.

In the context of **global health negotiations** the **alignment of interests** may include developing a shared position amongst regional or other international groups of states such as the EU, G8/G20 and South–South cooperation. It may also include the alignment of actors at national level to develop national global health strategies. But it is not just states that come together in this way, civil society groups and other actors may also seek to establish shared positions to strengthen their **advocacy** for action on global health issues.

Box 4 Negotiation of the Framework Convention on Tobacco Control

Proposals for an international convention on tobacco control were first raised at the Ninth World Congress on Tobacco or Health in 1994, which resulted in a proposal to the WHA meeting of 1995. Following this the WHO considered various formulae for such a convention, and it was decided to try to produce a Framework Convention to promote international and national action. This was accepted at the WHA meeting of 2000. An International Negotiating Board (INB) was formed which negotiated the wording of the convention over two years. In 2003 the Framework Convention on Tobacco Control (FCTC) was adopted by the WHA, the convention came into effect in 2005 after 40-member states had signed, often following internal dialogue. By 2010, 168 countries had signed, 15 of these including the USA have yet to bring the FCTC into national laws by formal ratification.

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Box 4 (continued)

While this may seem a long drawn-out process, agreement on the FCTC was relatively swift compared to other international agreements and laws. And while the issues were intensively negotiated from 2000 to 2003 the preparation of the grounds for such an agreement by building national awareness and action was a much longer process. Brazil was the second country to introduce graphic warnings on cigarette packs, it has a history of awareness raising and controls on tobacco stretching back to 1990. Its programme of public engagement and working with civil society organizations to reduce smoking rates is regarded as exemplary and perhaps for this reason and because of the growing importance of emerging countries such as Brazil, Russia, India, China and South Africa in international fora—and as target markets for tobacco companies, Brazil was invited to chair the INB. This is described by Lee et al. (2010) as an example of the way Brazil has deployed "soft power" in global health.

It is a tribute to the diplomatic skills of those who negotiated the FCTC that so many countries and organizations from the European Union to national patient groups feel that they have played an important role in its formulation. Consultations within and between countries ensured a coalition of interests was created capable of withstanding the tobacco companies, who were clearly intent on defending their position. Instead of ignoring them WHO initiated public hearings both at international and regional levels to make the consultation process open to them but also transparent to public opinion.

The interests of stakeholders and consortia defined at this stage should clarify the shared goals that provide the basis for aligning interests. Depending upon circumstances it may be that the negotiating strength of a group or consortium is best served by acting together as a negotiating bloc or acting as separate agents with common interests. For example, in certain fora the interests of civil society groups may be most effectively expressed as a single voice, but in other circumstances they may be more effective when supporting a common view from different perspectives.

Stakeholders may also indicate certain sticking points, for example it may be that some governments would be unable to countenance certain forms of prohibition of tobacco use, or would not accept the political and economic impact of limiting alcohol marketing. This will indicate the points at which these parties would walk away from negotiations, it is therefore important either to find a way round such sticking points or to develop new creative solutions to overcome such barriers. It is important to understand the walk away points for all parties to a negotiation as these define the **negotiating space**.

Gathering and Using Information

Effective information gathering and use is essential for **global health negotiations**. Information will be of greatest value once the concerns of all relevant stakeholders are identified as it is then possible to gather information and moral and policy arguments to address the issues of greatest contention in subsequent exchanges.

The way in which information is used and publicized is also vitally important **to global health negotiations**, which are usually conducted in public, or at least in an open transparent process. Scientific papers may be appropriate sources for data but will seldom present information in a way that is most amenable to policy makers or public discussion. Civil society organizations often have more freedom to advocate for a policy case than other parties and can be important in raising public awareness and support for policy change. They may appeal to the public through traditional and new media and, for example, by utilizing celebrity power.

In the period leading up to formal exchange the parties to a negotiation often produce initial position papers setting out their aims and objectives and the relevant evidence on which they draw. They may seek to form a wider coalition for their position by conducting consultations with other parties and groups. This brings a danger that they may trap themselves into commitments that provide no room for negotiation. Thus it is important for global health diplomacy to ensure that the interests of all parties are recognized and that positions statements focus on values and goals rather than specific solutions to the exclusion of other options.

The exchange of views during the diagnosis phase helps to ensure there is a shared understanding of the issue to resolve differences of interpretation and to focus negotiations on points of contention. It should also help each of the parties to understand the perspectives of the others which may be constrained by national economic, cultural, and political circumstances.

Technical knowledge may also be required as global health issues often require some understanding of public health impacts or options for cost-effective intervention. Where a health issue involves other policy sectors, such as trade, agriculture or the environment, cross-sector knowledge is essential.

Box 5 Technical Knowledge in Interpreting the Doha Declaration

The 2007 dispute between the Ministry of Health in Thailand and the pharmaceutical company Abbott Laboratories over the compulsory licensing of the HIV/AIDS drug Kaletra (a combination of Ritonavir and Lopinavir) described by Lee (in press) illustrates the need to bring together different types of technical knowledge. Negotiations between the ministry and private company required specialist knowledge of the drugs themselves and their effectiveness, knowledge of public health conditions and specifically the prevalence of HIV/AIDS and access to relevant medicines in Thailand as well

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Box 5 (continued)

as detailed understanding of the legal flexibilities available under the TRIPS agreement, and its interpretation in the subsequent decisions on the implementation of paragraphs 4–6 of the Doha Declaration on the TRIPS Agreement and Public Health.

Negotiating the Formula

Designing the Process

Once the issues have been clarified and information and interests shared, it may be realized that the parties can proceed directly to agreement. However, as many global health issues are complex and multi-faceted it may be necessary to design a specific **formula for agreement** for the resolution of outstanding issues. The formula defines the **negotiating space** (the limits within which agreement can be reached) and the terms in which agreement will be reached. It is important for the formula to be kept relatively simple but with sufficient scope to allow all parties to benefit from the eventual agreement. The formula identifies the points of disagreement and the terms in which these will be negotiated. Thus for example in relation to tobacco control a study was carried out to determine the form of agreement that would be most appropriate and most likely to gain support from member states of the WHO.

The design of the detailed negotiating process requires agreement upon:

- The objectives of discussion, the issues to be resolved and the broad principles on which agreement might be based.
- The participants including representatives of groups of states and possibly civil society organizations that might be invited as participants or observers.
- The forum for discussion, which might be an existing international agency such as the WHA or United Nations General Assembly or a special meeting or discussion process at some neutral location.
- The chair and secretariat to mediate the meeting, agreeable to all parties.
- The process of the meeting including the timescale, stages of negotiation, arrangements for media coverage and the issue of communiqués.
- Details of meeting arrangements such as the layout, provision for break out discussions and other factors that affect the atmosphere of the exchange.
- The method of agreement whether by consensus, voting or informal agreement subject to later **ratification**.
- The language(s) of the agreement can be important since languages impart cultural assumptions and some allow greater ambiguity of expression than others.

Participants in such exchanges will also need to establish their own rules of engagement, for example who will lead the delegation, what are their negotiating

objectives and walk away points and what freedom do they have to negotiate compromises, to what extent can they represent other members of a group and how will they report back to the governments or groups that they represent.

The processes of framing the issue, the **alignment of interests**, gathering and using information and design of the **formula for agreement** can be seen as steps in preparation for detailed negotiations, which as Drager et al. (2000) note is of fundamental importance to the success of health negotiations.

Detailed Negotiation and Exchange

In conventional negotiation theory bargaining is often characterized by strategic offers and counter offers, with trades proceeding from larger scale claims and concessions to smaller adjustments as differences between parties are resolved. There may be elements of game theory applied with opening moves design to probe the position of others rather as in a chess game. While elements of this sort of bargaining can be seen in **global health negotiation** it is more likely that issues will be resolved through a managed process of exchange in accordance with a process designed as described in the previous section.

Before commencing the detailed exchange process the secretariat may produce an outline draft as a basis for negotiation. This may establish principles for the resolution of issues with areas of disagreement couched in broad terms acceptable to most participants for more detailed discussion. The initial draft may be itself a product of prior discussion and negotiation since, as in any negotiation, an opening proposition can anchor expectations as to the outcome and may define what would be considered success or failure in the talks. Setting expectations too high can be a mistake as it can lead to a perception of failure if they are not met, expectations set too low may result in outcomes that do not challenge participants to seek creative solutions.

Typically the parties reviewing the draft will identify areas which they would wish to see amended and various changes in wording will be proposed to the secretariat and discussed in detailed sessions before agreeing upon a communiqué signifying general agreement.

Headline discussions may be accompanied by other forms of diplomacy and exchange to resolve misunderstanding and barriers to agreement. For example, where a policy may have a financial impact on one or more countries, there may be side room discussions of mechanisms to offset or reduce the economic impact by aid or trade mechanisms. Civil society organizations may exert moral pressure on negotiators from the perspectives they bring of people affected by the policy and by astute use of the media.

The search for agreement can be described as a process in which a range of reciprocal exchanges builds mutual obligation and understanding on which broader agreements can be based. The participants in most global health negotiations seek an outcome from which all parties can claim success. This is essential since although agreements may be ratified and set in international law, compliance depends largely upon the willing acceptance of the agreement by the signatories.

Confirmation and Implementation

Theoretical models of negotiation stress the importance of confirming the agreement, it is often said that nothing is agreed until everything is agreed. The point at which a negotiation culminates in an agreement is therefore of great importance. This can also be true of agreements on global health, many of which are negotiated "down to the wire".

While agreement to a communiqués may be seen as a successful outcome to detailed negotiation, in many cases there will be a further stage in which the agreement is formally agreed by a UN body with the legal status required to establish international law. This will require careful wording of agreements to be signed, together with clear proposals for monitoring its observance. Terms included in the document and the legal obligations assumed by signatories to the agreement should be as clear as possible, though some parties may intentionally leave "wiggle room" for subsequent interpretation.

In many cases states sign an agreement but reserve the right to confirm their legal assent to the law in national legislation. This may be because internal political mechanisms require the agreement of legislative bodies, particularly in federal states such as the USA. Thus in the case of the FCTC outlined in Box 3, while President Bush signed the convention he did not submit it for Senate approval.

It may seem that there should be no further negotiation of the terms of an international treaty between the acceptance of a communiqué and **ratification**. But in practice there are often further negotiations at the time of **ratification** and subsequent adoption and implementation by states. Discussions at this stage will focus on the definition of terms and their specific application, how agreements are monitored and on the conjuncture of different international obligations. These are often the most difficult and crucial issues.

Moreover as Spector and Zartman (2003) note, effective implementation of any international agreement requires ongoing monitoring over many years. Whether issues can be resolved by conciliation between the states, by arbitration by an international agency or by reference to the International Court of Justice will often depend upon circumstances. The WHO may be required to examine the performance of states and raise questions about the extent of their observance of global treaties. International agreements thus help to define the roles and regimes of agencies like WHO in global governance. And as the role and functions of international agencies evolves this will in turn influence the way international agreements are applied. Thus **global health negotiation** can be seen as a mechanism that drives the ongoing evolution of global governance for health as an open system responding to its geopolitical context.

Box 6 Virus Sharing Indonesia and the International Health Regulations

In 2007, Indonesia halted the sharing samples of strains of the Avian Flu virus H5N1 as required by the International Health Regulations. Indonesia was at

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the epicenter of this outbreak with more confirmed human cases and deaths from the disease than any other country. Stopping virus sharing was therefore seen as a serious threat to measures to counter a potential global pandemic. The Indonesian government claimed that samples were being used by pharmaceutical companies to produce patented vaccines for high-income countries which would be unaffordable to Indonesia. Moreover they pointed out that the Convention on Biological Diversity of 1992 requires that countries from which genetic material is drawn should share the benefits of its use.

What followed from this dispute was a protracted negotiation of the interpretation of the International Health Regulation and other international agreements which affect the conditions applied to the sharing of virus samples. These negotiations described by Irwin (2010) are still ongoing, they invoke wider issues concerning capacity for vaccine production, the rights of states to share the benefits of virus sharing, the role of WHO and funding of global public goods for health.

Since global health treaties and agreements often also imply a moral obligation, there is a further "court" at which disputes can be raised, which is the court of public opinion. Civil society organizations often play a valuable role in holding governments or international companies to account in this way, pointing out infringements of human rights or failures to meet their obligation under international agreements and laws.

Leading Global Health Negotiation

Chapter 12 discusses the leadership role of WHO in **global health negotiations**. But organizational leadership is also essential for the negotiation of global health issues at regional, national and local levels. This is not achieved by command and control, planning and budgeting or by evidence and analysis alone, but by working with others to share ownership of and responsibility for global health and build mutual respect and trust.

Discussion of the negotiation process would be incomplete without recognition of the importance of the skills required to lead such negotiations. The examples given in later chapters provide many instances of the ways in which personal leadership has brought people from different countries and organizations together to achieve common goals. The qualities required are described by Marcus et al. (2011), as "meta leadership", which requires:

- An encompassing vision of the values of global health, the political context and the situation as seen from all perspectives, in order to frame the issue in a way that can be accepted by all participants.

- The emotional intelligence required to understand and empathize with different perspectives and influence thinking and action across national, cultural and institutional boundaries by engendering shared understanding and common purpose.
- The ability to encourage and draw on shared leadership from other individuals, institutions and organizations with different skills and perspectives to empower them to act together to achieve common goals.
- The personal integrity, self-awareness and self-control required to lead negotiations unbiased by any prejudgement, to "speak truth to power" where necessary and thereby earn the trust of people from different countries and organizations.

Meta leadership is demonstrated by many of the practical examples as shown in all chapters of this book, it is best learnt by reflecting on experience of leading global health negotiations, perhaps first across local organizations and then with increasingly challenging international contexts. Complex international interdisciplinary negotiation often requires distributed leadership at many different levels as shown in the South African Access to Medicines case introduced in Box 1.

Box 7 Leadership in the South African Access to Medicine Case

The South African Medicines Act of 1997 was signed into law by President Nelson Mandela, but by 2001, when the issue came to the Pretoria High Court, the new president Thabo Mbeki was denying the existence of HIV/AIDS and his health ministers were falling into line. Despite the strong institutional and personal support for South Africa's position by Dr Gro Harlem Brundtland of the WHO, it was felt that the pharmaceutical companies would win their appeal against the Act and fearing this implementation of the act was suspended. The Pharmaceutical Manufacturers Association seemed certain to win, they even appeared to have the backing of Kofi Annan, the EU and the USA.

One man called Zackie Achtmat, a gay HIV-positive South African of mixed race, made a difference. Leading the TAC he vowed not to take antiretroviral treatment until it was available to all South Africans. TAC won the right to present their case in court. And they made their voices heard beyond South Africa. Working with international gay and lesbian groups and the support of NGOs led by Ellen't Hoen of Médecins sans Frontières they built a worldwide campaign for access to medicines that ensured that Clinton and Annan shifted their rhetoric and European Countries began to back down. Facing mounting public disapproval the pharmaceutical companies withdrew their case in a meeting with Nelson Mandela.

Zackie continued to campaign against Thabo Mbeki's refusal to fully fund HIV/AIDS treatment and eventually became seriously ill until persuaded by a personal appeal from Nelson Mandela to abandon his pledge to refuse treatment.

Conclusions

Experience of **global health negotiations** shows the importance of sound diagnosis including the way issues are framed, the **alignment of interests** and the development and presentation of information. This can help to prepare for the time when the issue is ripe for resolution, perhaps as a result of unfolding events or as a shared understanding of common interests and concerns for global public goods emerges. The formula for the resolution of issues including consideration of the form and nature of any international agreement and the terms in which it can be resolved is crucial to successful negotiation of an agreement. But even when formal agreement is reached diplomatic negotiations centred on the international agency responsible for monitoring the agreement are likely to continue. Such negotiations shape the roles and regimes of the international agencies and are the essential basis for global governance for health. While this calls for shared organization leadership at every level it also depends upon on the personal leadership qualities of key individuals.

Questions

1. Does everyone interpret human rights to health in the same way? If not why not?
2. Describe a negotiation process for a health issue with which you are familiar, can you discern key phases and stages within the process?
3. Give examples of global health issues arising in other policy contexts—security, trade or development?
4. What are the advantages and disadvantages of forming a group of nations or a coalition of civil society organizations to press for global health policy change?
5. If you are to take part in a consultation on a global health issue what information would you seek?
6. What do you think are the most important points to consider in setting up a global health negotiating process?
7. What can ensure that an international agreement on a global health issue is implemented effectively, what can go wrong?
8. What competence do you feel you have to **lead global health negotiations**, how can you build your capability in this field?
9. Who showed leadership in the South Africa Access to Medicines Case and who did not?

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Chapter 7
Human Rights and Equity: The Value Base of Global Health Diplomacy

Ronald Labonté

Reader's Guide

This chapter reviews the values base and ethical arguments for global health diplomacy (GHD) and how these are codified within human rights treaty obligations that are binding on nations that ratified them. It begins by questioning if nations only engage in global health for their own security or economic interests. It then discusses the concept of values and the bipolar model of political values (freedom and equality). With reference to the Millennium Declaration's consensus on global values, the chapter next identifies and explains GHD's core value as promoting greater global health equity. This is supported by statements in several recent policies and commentaries on global health as a foreign policy concern. Global health equity requires reasonable access for all to resources for health, which leads into a review of key social justice theories and ethical arguments for systems of global redistribution. These arguments, and the values that underpin them, are implicit in international human rights, notably the right to health. Two main covenants, or treaties, define the major human rights that are legally binding on ratifying nations, many of which are important to health by way of improving social determinants of health. The chapter identifies a short-list of key human rights provisions that could, and should, guide global health diplomacy; and provides a checklist of questions useful for this purpose.

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Learning Points

- In an age of interdependence global health cooperation must be based on values beyond those of simple self interest.
- Global health values can be founded on the moral concept of human dignity.
- This concept is elaborated in social justice and relational justice theory.
- Human rights can be seen as an expression of this moral philosophy.
- Codification of human rights provides a framework for global agreement.
- Human rights to health constitute the basis for collective action on global health issues.

Introduction: Beyond Self Interest

> In our time, the pursuit of pure self-interest of nations might undermine the solutions that respond to the challenges of growing interdependence. We must encourage new ideas, seek and develop new mechanisms for partnerships, and develop new paradigms of cooperation. This new reality creates a need to find shared values that are embodied in the relations between countries. [Foreign Ministers (OSLO) 2007]

If one accepts the realist school of international relations, the primary value driving all foreign policy is political and economic self-interest. This would apply to global health as to any other policy issue. This seems obvious enough when talking about global health from the vantage of national security, where protection of citizens from global infectious disease at home or abroad fits with the traditional "high politics" of foreign affairs. By definition, it also characterizes international trade, where mercantilism still dominates treaty negotiation and health protection has struggled to gain legitimacy as an exception to treaty obligations. But this conclusion has been argued as extending even to health development assistance and international health treaties primarily "driven by state interests" which only incidentally could "either facilitate or undermine global health objectives" (Feldbaum and Michaud 2010). Any normative commitments to global health are viewed as incidental externalities to political and economic interests, especially those of more powerful countries.

The authors' review of recent policy statements and commentaries on health and foreign policy supports this conclusion—mostly (Labonté and Gagnon 2010). But national or mercantile self-interest does not appear to account entirely for foreign policy practices; and others have posited the potential of health to alter the fundamental assumptions of foreign policy citing international activism over tobacco control (the Framework Convention on Tobacco Control) and access to essential medicines (ongoing negotiations to reduce the reach of intellectual property rights over new drug discoveries) as indicative moments (Alcázar 2008). The push for increased maternal/child health aid, as another example, reflects national and economic state interests of wealthier nations only weakly.

Does this mean that there is an evident if not universally accepted value base driving the new practice of global health diplomacy (GHD)? No. Different actors (within or outside of governments) give priority to different outcomes in any set of international or global negotiations. These ends are as likely to be in conflict as in coherence (Labonté et al. 2007). As the Swiss *Health Foreign Policy* cautions about its government's own forays into GHD:

> It is not possible to avoid conflicts of interest. Therefore, one of the main tasks is to carefully weigh up the different interests in specific cases, and to reconcile national priorities with international developments, in order, as far as possible, to avoid an inefficient or incoherent approach]Swiss Federal Office of Public Health and Department of Foreign Affairs (FDHA) 2006].

The Swiss experience further suggests that "health ministries must…be able to accept compromise with other ministries, even in health negotiations" [World Health Organization (WHO) forthcoming].

But how much compromise should be accepted? What rationale(s) should or could guide negotiations in a way that strengthens health as a foreign policy outcome? This chapter argues two candidates, the first based in moral philosophy (values) and the second in human rights.

On Values

Consider, first, the concept of "value," influentially defined by Rokeach, a social psychologist, as an "enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state" (Rokeach 1973, p. 5). There is widespread acceptance amongst values theorists and researchers that individuals have a limited repertoire of values organized into systems. These systems are influenced by early life experiences and culture and bifurcate along two pronounced axes or "general values": freedom (individualism) and equality (communalism). Originally developed during the Cold War period, this two-value model of political ideology has guided much study since. The model has proved durable, with the bipolar values being reframed somewhat as "national strength and order" and "international harmony and equality" (Braithwaite 1994). Individuals are capable of holding both security conscious and self-protective values (freedom, individualism, strength/order) alongside those that are more sharing and humanitarian (equality, communalism, harmony), albeit in moments of choice or conflict they veer to the side has held most influence over their life-course. Political institutions, consistent with political realism, are seen as driven almost exclusively by "national strength and order." This abstract representation of political institutions, however, ignores the fact that such institutions are comprised of individuals who can be held accountable for the moral basis of their actions and who collectively bring to any set of political decisions a melange of values straddling the freedom/equality divide.

GHD's Core Value

Accepting the idea of a two-value system, GHD clearly tilts towards the pole of "international harmony and equality" or, more precisely, to a concern with health equity. Health equity is generally defined as an absence of systematic and remediable differences between population groups (Starfield 2001) that are not freely chosen and which may be considered unfair or unjust (Whitehead 1992). Health equity does not necessarily mean reductions in health inequalities; rather, it implies reductions in inequalities in the resources people need to make choices concerning their health. Health equity is a concept with widespread traction in national public health policy, practice, research and scholarship and has also been elevated to a global level in part through the millennium development goals (MDGs). The MDGs form the backdrop to most state initiatives in global health policy and have been argued as "being partly responsible for revitalising interest in global health" (OSLO 2007).

The MDGs comprise Article 19 of the UN Millennium Declaration, which announces its core value as a "collective responsibility to uphold the principles of human dignity, equality and equity at the global level," requiring of political leaders "a duty…to all the world's people, especially the most vulnerable" (Article 2, General Assembly Resolution 2000) (see Box 1). Nations in their foreign policy practices may not always abide by these declared values, and it is easy to dismiss them as gloss to a more nationalist business-as-usual. But lack of compliance with declared intent does not render nations (or their leaders) unaccountable for their actions. In keeping with values theorists' precept that core values should assist in decision-making where there are competing choices, the Declaration's values can be viewed as one of several screening devices in all foreign policy decision-making. They could, at minimum, be invoked as a guide to global health diplomats in defining the limits of "compromise" when foreign policy goals conflict.

Box 1 The Values Base of the MDGs

Article 6 of the UN Millennium Declaration identifies a number of "fundamental values" agreed upon by the world's nations' leaders in September 2000 as "essential to international relations in the twenty-first century":

Freedom. Men and women have the right to live their lives and raise their children in dignity, free from hunger and from the fear of violence, oppression or injustice. Democratic and participatory governance based on the will of the people best assures these rights.

Equality. No individual and no nation must be denied the opportunity to benefit from development. The equal rights and opportunities of women and men must be assured.

(continued)

Box 1 (continued)

Solidarity. Global challenges must be managed in a way that distributes the costs and burdens fairly in accordance with basic principles of equity and social justice. Those who suffer or who benefit least deserve help from those who benefit most.

Tolerance. Human beings must respect one other, in all their diversity of belief, culture and language. Differences within and between societies should be neither feared nor repressed, but cherished as a precious asset of humanity. A culture of peace and dialogue among all civilizations should be actively promoted.

Respect for nature. Prudence must be shown in the management of all living species and natural resources, in accordance with the precepts of sustainable development. Only in this way can the immeasurable riches provided to us by nature be preserved and passed on to our descendants. The current unsustainable patterns of production and consumption must be changed in the interest of our future welfare and that of our descendants.

Shared responsibility. Responsibility for managing worldwide economic and social development, as well as threats to international peace and security, must be shared among the nations of the world and should be exercised multilaterally. As the most universal and most representative organization in the world, the United Nations must play the central role.

Rokeach's two axes head this list, although "freedom" takes on a nuanced meaning with implied obligations on UN member states to ensure certain conditions beyond just individual rights, notably an absence of hunger, which requires equitable systems of food distribution/redistribution.

Human Dignity and the Special Importance of Health

Although arguments from values or ethics are rare in policy discourse [International forum for social development (IFSD) 2006] the values explicit in the Declaration can be found in at least some recent policy statements bearing on GHD. Sweden's 2003 policy on *Shared Responsibility,* a legislative document requiring the government to report annually on how all of its foreign policies work coherently towards the goal of global development, describes "the firm conviction that everybody has a right to a life in dignity" as "the basis of the solidarity with poor, oppressed and vulnerable people" [Swedish government bill (SW) 2003, p. 19]. The 2007 intergovernmental *Oslo Declaration* on health as a foreign policy concern urges "development cooperation models that match domestic commitment and reflect the requirements of those in need and not one that is characterised by charity and

donors' national interests" (OSLO 2007); as close to an endorsement of solidarity with the global poor as one might get.

The concept of human dignity is considered axiomatic in all Western (and some have posited universal) systems of moral philosophy. Sweden's 2003 policy describes "the firm conviction that everybody has a right to a life in dignity" as "the basis of the solidarity with poor, oppressed and vulnerable people that has been an important element of Sweden's domestic and foreign policies for many years (SW 2003, p. 19)." Human rights scholars argue that a concern for the "equal dignity of the human person" forms the base of all human rights, and represents a core moral value (Yamin 2008). This moral axiom demands respect for the autonomy of individual (freedom) and extends to the provision of core resources for the capabilities people require to live valued lives (communalism) (Sen 1999). Feminist philosophers have displaced somewhat the notion of the individual human person with the concept of, at minimum, dyadic (mother/child) or larger familial and social relations. Dignity and the security of the person cannot be removed from the web of relationships in which persons exist and obtain both meaning and capabilities.

Health, in turn, is argued as having special importance to an individual's experience of security or dignity (Sen 2004), partly manifest in the state of their "well-being and agency" (Ruger 2009, p. 266). The reasoning for health's special importance in life's public and private spheres lies, first, in health being basic to peoples' enjoyment of other rights or capabilities (for example, education, meaningful work); and second, in resources for health being prone to market failures that require collective forms of intervention. This immediately surfaces questions of social justice in how fairly resources are allocated amongst peoples and, from a global health equity perspective, between countries.

Social Justice Theory

Social justice theory is associated with Western societies, and particularly with struggles surrounding the industrial revolution and the emergence of redistributive welfare states (IFSD 2006, p. 6). Because social justice theory is concerned with fairness, it is argued to be a universal (and not just Western) concern, since all social arrangements to be legitimate and to function must attend to issues of equality (Sen 1992). There are two equality approaches in justice theory: equality of opportunity, achieved through procedural justice that treats equals the same; and equality of outcome, achieved through substantive justice that treats unequals differently according to their initial endowments or privileges.

Moral arguments for procedural justice (equality of opportunity) have strong roots in liberal individualism, but do not entirely discount the importance of substantive justice. Smith, in his *Wealth of Nations*, famously argued for some form of state intervention to moderate the inequalities of the market's "invisible hand," extending "not only [to] the commodities which are indispensably necessary for the support of life, but whatever the custom of the country renders it indecent for

creditable people, even of the lowest order, to be without (Prowse 2007).” For Smith’s time and place, this meant a linen shirt for even the poorest worker; and setting the ethical minimum for decency at a global scale remains one of the core debating points amongst those concerned with poverty, its measurement and its amelioration. More recently, Singer, in a utilitarian argument consistent with the traditions of public health, posited that it is both just and of collective benefit to act to relieve poverty and deprivation if, in doing so, we do not sacrifice something of comparable moral significance (Singer 1972). It is difficult to argue something of higher or equivalent moral significance to reducing the indignities arising from poverty. Rawls in his influential *Theory of Justice* argued that people, standing behind a “veil of ignorance” as to their social standing at birth, would agree with Smith’s moral sentiments and choose a justice that guaranteed a minimum of primary goods basic to their needs, which necessarily obliges state interventions to regulate distribution and undertake some means of redistribution (Schaefer 2007).

Rawls’ justice theory is located within the social contract school, which views states as the primary actors in international relations, consistent with dominant international relations theories and the classic hierarchy of foreign policy goals. He held that poverty in low-income countries was primarily an effect of domestic policies and practices with little international or global causality. Pogge (2002), drawing on cosmopolitan arguments, challenges Rawls on this conclusion, as well as on evidence that poverty cannot be de-linked from global economic institutions and actors. In doing so, he extends Rawls’ basic justice theory to a global level, contending that there are not simply “positive duties” to assist those in need (setting aside debates as to the level to which such assistance should rise), but moral obligations (negative duties) to prevent harm (Pogge 2004). The moral implication is not only one of “rectification” through strengthened human rights and more progressive systems of global resource redistribution; but also an obligation to change the way by which the rules of economic governance are established in order to overcome the historic and radical inequalities in initial conditions. This is reflected in the theory of relational justice (see Box 2).

Box 2 The Theory of Relational Justice

The theory of relational justice offers one of the more compelling ethical arguments for GHD. It is based on three lines of argument:

1. The radical inequalities observed between peoples and nations today are partly an effect of a violent history in which some gained at the expense of others. While we individually cannot be held responsible for the actions of our forebears in this “conquest,” as moral persons we can be held accountable for rectifying the vast disparities in initial conditions that this history has created.
2. Not only does procedural justice by itself fail to account for these vast disparities in initial conditions; it is impossible to conceive of these

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Box 2 (continued)

disparities existing on the scale that they do without what Pogge calls "an organized state of civilization" to uphold them.

3. There is evidence that economic institutions operating on an international scale (the "organized state of civilization") have been complicit in upholding these injustices. Persons involved in upholding these institutions are thus implicated in creating subsequent ill health, even though they may be half-way around the world.

International Human Rights: The Normative Expression of Moral Argument

It is generally accepted that states hold a monopoly on the legal exercise of coercion. This is morally troubling to some philosophers attempting to create a foundation for a global health ethic, such as Ruger, who argues for a voluntary internalization ("shared moral convictions") of a global health norm of "human flourishing" and its requisite capabilities (Ruger 2009). Yet state policy is intrinsically coercive by constraining (some) personal choices in order to accommodate others; and we are back at this chapter's opening dilemma of interceding in policy choices where there are conflicts in outcome. Specific efforts (diplomacy) are required to tip the two-value system in the communal direction, in which certain individual choices (freedom) are sacrificed when those directly or indirectly and negatively affect the capabilities of others. Without such efforts the Framework Convention on Tobacco Control would have been much weaker, and prices on anti-retroviral drugs would still be out of reach for AIDS-infected persons living in poor countries.

The embodiment of state coercion resides in its legislative authority supported by its policing and military powers. Although few would question the existence of legal authority within national boundaries, there is a surprising lack of attention in foreign policy paid to the International Human Rights Framework (hereafter IHRF) as a legal embodiment of international obligations and responsibilities bearing on states and their global behaviors (Bustreo and Doebbler 2010) (see learning Box 3). Although "nonbinding" lacking in direct enforcement and penalty measures, the IHRF codify many of the value suppositions found in modern moral philosophy and ethics.

Box 3 The IHRF and the Right to Health

The IHRF is comprised of two major covenants and numerous treaties. The two covenants reflect the bipolar system of values and the Cold War era in

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Box 3 (continued)

which they were finally adopted. The ICCPR concerns the freedom rights of individuals; while the ICESCR emphasizes the communal obligations states have towards their citizens. A key text for GHD is Article 12 of the ICESCR, "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." This Article, and its definitive 2000 General Comment 14, specifically obligates states parties to ensure provision of a number of health care and public health services, as well as equitable and affordable access to such key underlying health determinants as "safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and health-related education and information, including on sexual and reproductive health" (General Comment 14 ¶11). Countries' performances in doing so are reviewed periodically by the UN Human Rights Committee that oversees this Covenant.

The importance of human rights is referenced in numerous recent policies and commentaries on health and foreign policy, including reference to health as "a fundamental right of every human being" and, in line with legal scholarship, that "life is the most fundamental of human rights, and that life and health are the most precious assets" (OSLO 2007). France cites its support of EU policies on "health as a fundament human right" and gives as an example its efforts with UNAIDS to eliminate travel or entry restrictions on persons who are HIV-positive (WHO forthcoming). The UK policy commits to including health as a section in its government's annual human rights report [UK Department of Health Annex(UKHG Annex) 2008b, p. 2], claims to champion the rights of women with particular reference to HIV treatment and services access (UKHG Annex, p. 28) and sexual/reproductive rights [UK Department of Health (UKHG) 2008a, p. 42], and even cautions that unfair or unethical trade can deprive workers of their "rights to security of employment and compensation" (UKHG 2008a, p. 60). Thailand claims that the right to health was the driving force behind its GHD efforts while Brazil finds that having the right to health in its federal constitution provides a strong base for arguing health in foreign policy agendas (WHO forthcoming). The Swiss *Health Foreign Policy* states that "one of its main objectives is to strengthen the global partnership for development, security and human rights that has been agreed upon and implemented in the context of the UN" (FDHA 2006, p. 12). Sweden's 2003 legislated *Policy for Global Development* references specific rights issues throughout (SW 2003), while Norway's 2008 Commission report on policy coherence devotes considerable attention to a human rights framing of its country's foreign policies [Policy Coherence Commission (PCC) 2008].

The Right to Health and the Right to Development: From Individual to Collective Rights

Despite this frequent invocation little specific reference is made to the actual IFHR, its many covenants and state-parties' obligations, and its reporting requirements. Central to global health in the IFHR is the right to health, technically known as the Right to the Highest Attainable Standard of Physical and Mental Health. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) obligates states to ensure equitable access to a minimum set of health services, while General Comment 14 [United Nations Committee on Economic, Social and Cultural Rights (UNESCR) 2000] on this Article identifies a broader range of actions required for the progressive realization of this right (UNCESCR 2000). GC 14 further states that "collective rights are critical in the field of health" (UNCESCR 2000) implying a need to counterbalance individual entitlements with their broader social impacts; although there is as yet no clear guidance on when an individual health right claim might compromise a collective health right claim.

The right to development further implies that rights are collective rather than simply individual in entitlement. Adopted by the UN in 1986, the Declaration on the Right to Development contains several articles that place stringent obligations on states parties to ensure greater equality of opportunity and equity in outcome [UN General Assembly Resolution 41(UN 41) 2000]. Some legal scholars believe that this right may actually entitle poorer countries (through their state) to make claims for assistance from higher-income nations (Kirchmeir 2006). As a declaration rather than a treaty, the right is nonbinding on states, although it has become "a focal point of United Nations human rights activity concerning development and has been reaffirmed as a universal human right by the international community (Aguirre 2008a, b)." Hunt, a former UN Special Rapporteur on the right to health, similarly argues that Article 2(1) of the ICESCR obligates "developed States…to provide international assistance and cooperation to ensure the realization of economic, social and cultural rights in low-income countries," a normative affirmation of which exists in the MDGs [United Nations Economic and Social Council Commission on Human Rights (UNCESCR) 2004].

Rights-based arguments are not simply about health or health care; they extend to well-being and to individual capabilities that form a base for individual and group enjoyment of health that, in turn, forms a base for the fuller enjoyment of all human rights. Chapman (2009), an ethicist and human rights scholar, draws on the work of Nussbaum to argue the priority of some rights over others. Nussbaum, with Sen, developed a moral philosophy based on the concept of human capabilities. While Sen argues effectively for the obligations states have to provide a minimum basket of resources allowing people to develop their capabilities (and hence their health), Nussbaum attempts to identify the contents of that basket. Her list is extensive and imprecise (Nussbaum 2000). But, drawing from the International Covenant on Civil

and Political Rights (ICCPR), as well as the ICESCR, Chapman maps these capabilities against what could be considered basic human rights for human capabilities:

1. The inherent right to life (ICCPR, art. 6.1).
2. Components of the right to the highest attainable standard of physical and mental health (ICESCR, art. 12).
3. Parts of the right to adequate education (ICESCR, art. 13).
4. The right to freedom of thought, conscience, and religion (ICCPR, art. 18).
5. The rights to peaceful assembly (ICCPR, art. 21), freedom of association with others (ICCPR, art. 22), and the right to take part in the conduct of public affairs and to vote (ICCPR, art. 25).
6. Equality before the law and the prohibition of discrimination (ICCPR, art. 26).

As with the list of core Millennium Declaration values, one could consider this a short list against which any foreign policy decision should be interrogated before being agreed upon. It should certainly inform GHD efforts that incorporate both health and its key social determinants.

For a more extensive checklist, see Box 4 taken from Annex 1 of P Hunt and G MacNaughton, *Impact Assessments, Poverty and Human Rights: A Case Study Using The Right to the Highest Attainable Standard of Health*, Report to UNESCO, 31 May 2006.

Box 4 A Human Rights Impact Assessment Checklist

AAAQ	Health goods, facilities and services	Underlying determinants
Availability	Is the proposed policy likely to enhance or jeopardize the *availability* of health goods, facilities and services in the State?	Is the proposed policy likely to enhance or jeopardize the *availability* of clean water, adequate sanitation, safe housing, food and nutrition, education, fair employment conditions and/or a healthy environment?
Accessibility	Is the proposed policy likely to enhance or jeopardize the physical and economic *accessibility* of health goods, facilities and services?	Is the proposed policy likely to enhance or jeopardize the *accessibility* of clean water, adequate sanitation, safe housing, food and nutrition, education, fair employment conditions and/or a healthy environment?
Acceptability	Is the proposed policy likely to enhance or jeopardize the ethical and/or cultural *acceptability* of health goods, facilities and services?	Is the proposed policy likely to enhance or jeopardize the *acceptability* of clean water, adequate sanitation, safe housing, food and nutrition, education, fair employment conditions and/or a healthy environment?

(continued)

Box 4 (continued)

Quality	Is the proposed policy likely to enhance or jeopardize the *quality* of health goods, facilities and services?	Is the proposed policy likely to enhance or jeopardize the *quality* of water, sanitation, housing, food and nutrition, education, employment conditions, and/or the environment?
Six concepts		
Progressive realization	Is the proposed policy likely to enhance or jeopardize the *progressive realization* of the right to health goods, facilities, and services?	Is the proposed policy likely to enhance or jeopardize the *progressive realization* of the rights to clean water, adequate sanitation, safe housing, food and nutrition, education, fair employment conditions, and/or a healthy environment?
Core obligation	Is the proposed policy likely to enhance or jeopardize the *core obligation* for the right to health care, including a national health strategy and plan of action and essential primary health care and medicines?	Is the proposed policy likely to enhance or jeopardize the *core obligation* for the underlying determinants of health, including a national health strategy and plan of action and minimum levels of water, food, housing, and sanitation?
Equality and non-discrimination	Is the proposed policy likely to enhance or jeopardize *equality and non-discrimination* in provision of health goods, facilities and services?	Is the proposed policy likely to enhance or jeopardize *equality and non-discrimination* in provision of the underlying determinants of health, including clean water, adequate sanitation, safe housing, food, education, fair employment conditions and/or a healthy environment?
Participation	Is the proposed policy likely to enhance or jeopardize *participation* of the population in all decision-making related to health goods, facilities, and services that affects them?	Is the proposed policy likely to enhance or jeopardize *participation* of the population in all decision-making related to the underlying determinants of health that affects them?
Information	Is the proposed policy likely to enhance or jeopardize government dissemination of *information* related to health goods, facilities, and services and the rights to seek and impart such information?	Is the proposed policy likely to enhance or jeopardize government dissemination of *information* related to the underlying determinants of health and the rights to seek and impart such information?
Accountability	Is the proposed policy likely to enhance or jeopardize *accountability* for the right to health goods, facilities, and services?	Is the proposed policy likely to enhance or jeopardize *accountability* for rights to the underlying determinants of health?

Can Human Rights Prevail?

States are generally seen as duty-bearers in human rights treaties; and the state-centric nature of these treaties in a world in which non-state actors exert enormous policy influence has come under criticism. However, human rights treaties attach three other duties to states parties: to respect, protect, and fulfill the rights. *Respect* requires that states do not actively deprive people of a guaranteed right partly achieved by ensuring that other international agreements they negotiate "do not adversely impact upon the right (UNCESCR 2000)." This appears to mandate a human rights impact assessment before all other foreign policy treaties or agreements, extending to the right to health. *Protect* requires that states ensure that others within their jurisdiction (individuals, corporations) do not deprive people of their rights. While still state-centric, this extends obligations on non-state actors. *Fulfill* requires the state to actively implement legislation, policy and programs, and create appropriate institutions that meet the core obligations of specific rights and allow for their progressive realization.

One of the greatest challenges in strengthening global health as a foreign policy concern exists in the opposition between several provisions of trade treaties and core obligations under human rights covenants. While there has been no shortage of efforts to position both health and human rights more strongly in trade debates, health actually "has a much stronger profile in international trade law than the protection of human rights, which is not an objective trade treaties recognize as a legitimate reason for restricting trade" (Blouin et al. in press). This lack of attention in trade treaties to issues of human rights has been commented upon at the highest UN levels. Several UN Special Rapporteurs have detailed how trade liberalization, as generally negotiated, can undermine states' capacities for the progressive realization of a number of human rights.

Although the relationship of human rights covenants to other treaties, such as trade agreements, is still a central debate in international law, the primacy of human rights is supported by scholarly texts. Section 103 of the *Charter of the United Nations* states that in conflicts between Charter obligations and those under other international treaties, Charter obligations will prevail; while the *Vienna Declaration and Program of Action* (1993) is widely regarded as a state consensus on the moral primacy of human rights over other interests. One hundred and seventy one states proclaimed the protection and promotion of human rights and fundamental freedoms as the first responsibility of governments (World Conference on Human Rights 1993). It has also been argued that "there is a minimum substantive normativity inherent in the international legal order, a kind of foundation or floor, grounding the aspirations and efforts of the international legal system," and that the preservation of human life and health can be understand to comprise that floor (Howse and Teitel 2007, p. 10).

Conclusions: Arguing Process to Influence Outcome

Despite evidence of human rights having legal weight within countries (providing values-based arguments with justiciable leverage), and the exercise of such rights associated with better population health outcomes across a range of countries (Dasgupta 1995), there is no formal mechanism for their enforcement outside of national jurisprudence. Globally, human rights remain "nonbinding," but nonetheless represent "the most globalized political value of our times" (Austin 2001). Their specific obligations on states can and should be used to advance global health equity arguments within foreign policy deliberations. Human rights codify into binding obligations what moral or ethical reasoning has posited as essential responsibilities people have to one another, mediated through state systems.

Boggio (2009) in an argument for why international organizations and those within them have an ethical obligation to act to redress systematic health inequalities, addresses *how* such policy decisions can be made in a just manner. He identifies three basic principles for an "ethically-informed deliberative process": publicity (transparency in process, a comprehensible rationale, and public argument and evidence); relevance (trust in actors/institutions by recipients, opportunity for wide participation, and interventions based on recipients' needs, values and aspirations); and revisability (policies and programs can be challenged over time and improved, and individuals and institutions can be held accountable to purpose). These procedural elements of ethical decision-making, developed to apply to international institutions, could apply equally to negotiations encountered in GHD.

At present, foreign policy issues in which health presently figures in some fashion revolve primarily around security, trade, development assistance, and (to lesser extent) the need for collaboration in the provision of global public goods. The least prominent or developed arguments for health in foreign policy lie in human rights and ethics. The future prominence accorded health in foreign policy may rest upon global health diplomats improving their capacities in both.

Questions

1. How well does the bipolar model describe your understanding of how values might affect diplomatic negotiations? As a global health diplomat, how might having an understanding of which side of the values spectrum other people favor (in conflict-choice moments) help in creating greater attention to health as foreign policy goal?
2. How would the values explicit in the Millennium Declaration shape arguments favoring greater access to medicines around the world in a context where government policy continues to emphasize strengthened intellectual property rights?

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3. The theory of relational justice identifies a moral obligation for global wealth redistribution in order to reduce poverty and improve health equity. What examples for such redistribution exist at the present time that could be "scaled up"?
4. Individuals in some countries have used the right to health to claim government funding for expensive patented drugs of questionable value. The public costs of such drugs could be at the expense of financing other public goods that promote "greater health for the greatest number." How might an argument based on collective rights or the right to development counterbalance the *individual* right to health? How might an emphasis on individual rights over collective rights be a concern in GHD?

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Chapter 8
New Diplomacy for Health: A Global Public Goods Perspective

David Gleicher and Inge Kaul

Readers' Guide

Many global health challenges can be seen in terms of threats to or opportunities for the development of **global public goods** (GPGs) that provide common benefits to or protection for the health all regardless of national boundaries. Such issues require a renewal of institutions and mechanisms to address global concerns and interests through international diplomacy and collective action. "Introduction: Enlightened Self Interest" section of this chapter introduces the concepts of public goods. "The Provision Challenges of Public Goods and Global Public Goods" section identifies some of the problems that provision or protection of these goods pose. Against this background, "Drawing the Lessons for a New Diplomacy for Health" section discusses the implications for **financing for international cooperation** in support of **GPGs** for health.

Learning Points

- **GPGs** are an increasingly important challenge for global governance.
- They are goods that are Non-excludable and non-rival in consumption.

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- They may be categorized according to their: scale of impact, consumption properties, provision status, provision aspects and political reception.
- The way in which GPGs are provided is changing to include not only by state and interstate organizations but also collaborations with the private sector and civil society.
- Provision may be supported not only by state funding or by coercive regulation but also by incentives and encouragement, including consumer preferences.
- A new diplomacy is developing to support international and multi-sectorial support for GPGs and to overcome problems such as free riding.

This chapter is adapted from Kaul and Gleicher (2011).

Introduction: Enlightened Self Interest

A feature of many of today's major policy challenges is that they are global, affecting all humanity, whether rich or poor, from industrial or developing countries. Such global challenges occur more frequently and in a widening range of areas, including health.

In 2003 it took 6 weeks for a deadly variant of pneumonia, SARS, to spread from Asia to Australia, Europe, Africa, and North and South America, infecting thousands, grounding flights, closing schools and stalling economies. Global climate change, counterfeit medicines and the global promotion of smoking and junk foods are further examples of challenges with far-reaching consequences for human health.

These global challenges illustrate the concept of public goods, like peace and security, law and order, street signs and traffic rules—things that are in the public domain. If they are adequately provided, we all benefit from these goods; if they are underprovided, for example, if public health systems fail to control disease threats, we all suffer.

Within the national context the provision or protection of public goods pose very special problems for governance, so-called collective action problems, that if some can avoid paying for such goods but nevertheless benefit from them, they will "free ride". The main points set out in this chapter are: that many global health challenges have the properties of **GPGs**; which pose even more difficult governance problems than national public goods; and that, because the institutions of the state (that help us to overcome national collective-action problems) have no fully developed equivalents at the international level. GPGs are at a particular risk of free-riding; and that they, therefore, require carefully designed diplomatic strategies as well as incentive policies and instruments in order to ensure adequate provision.

Three main strands of international cooperation can be distinguished. Foreign affair strategies tend to focus on the geopolitics of inter-nation relations. Foreign aid tends to be motivated by moral and ethical concerns about global equity or to

function as a "helping hand" of a "donor" country's foreign-affairs interests. But the third and main reason for seeking international cooperation is in support of **GPGs** to address global challenges that affect us all. These challenges demand not only international cooperation between states but also the engagement of academic, business and civil society partners. This requires the recognition of policy interdependence, or enlightened self-interest—put differently, the realization that no country alone can resolve these challenges alone.

Getting to Know Global Public Goods

At the outset it should be stressed that the word "good" or "goods" in this context refers to a commodity, thing, state or circumstance being produced through action (or inaction). It holds no connotation of moral judgement or value, as in the sense of "good" or "bad". Accordingly, an infectious disease can be conceptualized as a good (*a thing*) within the public domain. Just as one might conceptualize a coherent network for pandemic preparedness and response as a good in the public domain.

The Defining Properties

Economists distinguish between two main categories of goods: private goods and public goods. The former are goods that can be made excludable—e.g., land that can be fenced in; a house that can be locked; or a loaf of bread that the person who bought it could claim as hers/his. Many private goods are also rival in consumption, meaning that one person's consumption reduces, perhaps even depletes the good's availability, and hence, benefit for others—once I have eaten my loaf of bread others cannot.

By contrast, the main characteristics of public goods are non-excludability and non-rival in consumption. Goods with both these properties are *pure public goods*. A concrete example of a pure public good at the national level is a street sign. It is there for all to see. A street sign is, as economists say, non-excludable. Moreover, no matter how many people look at the sign, it still remains there for all to see. It does not get progressively used up. It is non-rival in terms of consumption. Other examples are conditions like peace and security or law and order and eradication of communicable diseases, like small pox.

Goods with only one of these properties are impure public goods. Knowledge, for example, is non-rival but it can be made excludable—treated as a secret; or temporarily taken out of the public domain through the protection of intellectual property rights. On the other hand, the atmosphere is difficult to make excludable but rival—too much pollution changes its gas composition and leads to global warming.

Depending on the geographic span of their benefits (in case of adequate provision) or their costs (in case of inadequate provision), public goods can be local,

national, regional or global. Some may also be of inter-temporal reach, that is, affect many generations as would, for example, nuclear contamination of the soil.

The Growing Importance of Global Public Goods

As long as national borders were relatively closed, most public goods were of a national or local nature. They reflected national policy priorities, were the product of national or local policy action, and were usually provided in a country-specific way. The diversity of national health systems (and welfare state-type policies in general) provides a good example of how public goods can evolve distinctively behind closed borders.

With greater openness of national borders and increasing cross-border activity, national policy domains became interlocked. Now the availability of public goods often depends on "spill-ins" from abroad. Just think of the global financial crisis of 2008 and how the contagious effect of the crisis spread from the USA throughout the world

To health professionals this aspect of the financial crisis will sound familiar, and indeed the expression "financial contagion" is borrowed from the health field. Health contagion effects such as those of SARS, the "bird flu" H5N1, and the "swine flu" H1N1, also constitute shared vulnerabilities of states in an interconnected world.

The integration of markets and the increasing permeability of national borders mean that new types of challenges like trans-border spillovers (sometimes referred to as **externalities**) may undermine the effective provision of public goods at the national level. It also means that there needs to be more international cooperation to provide or protect particular public goods. This policy interdependence that results from greater openness of national borders has contributed to the growing importance of GPGs.

There is another category of GPGs. The loss of biodiversity, for example, could affect several generations. While, biodiversity may be regarded as a national or private good, since loss of biodiversity has significant spillover effects or **externalities**, it would be desirable for the international community to create, through international-level cooperation, a common gene bank to generate the GPG "biodiversity preservation" Another example of a GPG is the maintenance of antibiotic efficacy, or the fight against antibiotic or antimicrobial resistance, which is examined in detail in learning Box 1 and Box 2.

All people and all countries may be affected by internationally accepted values and standards like human rights, multilateral trade rules, or international health regulations. These are also often intended to be there for all—complied with by all.

These examples also show that being public or private is, in many cases, not an innate property of a good but the result of policy choice. Global can be seen as a special type of public domain, determined by the openness of national borders and may reflect a policy choice on the part of governments to remove border barriers and allow a globalization of some public goods. Similarly, GPGs like a gene bank or the

International Health Regulations do not happen accidently or on their own; they are based on an acceptance of policy interdependence and often long and carefully negotiated international agreements.

Box 1 Typologies of Global Public Goods

Depending on the scale of their impact, public goods can be of local, national, regional or global reach. Moreover, they come in many different forms. Below is an outline of five ways to categorize public goods, with a special emphasis on **GPGs**:

1. **Scale of impact**

Local public goods benefit mainly the people living in a particular community such as street signs, Public parks and local police services.

National public goods may serve pure national purposes or form the building blocks of GPGs such as national political systems and national health services.

Regional public goods benefit some or all countries within a geographical region such as: early-warning systems for tsunamis, regional disease surveillance systems.

2. **Consumption properties**

Pure GPGs are non-excludable and non-rival such as sunlight, the oceans, financial and economic stability, global markets and communicable disease control

Impure GPGs comprise non-excludable or difficult to exclude, e.g. atmospheric and seawater pollution, and non-rival, but excludable, e.g.: intellectual property made public.

De facto GPGs non-rival goods provided on a global scale: the UN System, Codex Alimentarius. Rival goods that are kept public e.g. human genome sequence. Goods that become public by accident or neglect: flawed medical, financial and other practices.

GPGs with restricted access: Include: patented knowledge (royalties to be paid), the World Wide Web (access depends on private goods like computers and networks).

3. **Provision status**

Underprovided GPGs: Such as peace and security, health care, financial stability, environmental sustainability, health and safety standards for traded goods

Overused GPGs: Include fish stocks, antibiotics effectiveness, the ozone layer.

Absent GPGs: Include an international migration regime

(continued)

Box 1 (continued)

Well-provided GPGs: include communication infrastructure, the World Wide Web.

4. **Production aspects**

The goods' origin: Natural GPGs such as sunlight, the atmosphere and oceans Humanmade GPGs, e.g. Global standards, codes, rules and policy regimes, e.g. FCTC

Production path Best-shot: Inventions and discoveries, Summation: Mitigation of climate change, Weak-link summation: Polio or malaria eradication,

Position in the production stage Final GPGs: Health, Peace, Financial stability

Intermediate GPGs: pharmaceutical knowledge international banking regulation

5. **Political reception**

Typically consensual GPGs: scientific knowledge, rights to basic education and health.

Frequently contested GPGs: include: gender equity, fair trade, aid targets.

Adapted from Kaul (2010)

Box 2 Antimicrobial Resistance as a Global Public Good

Antibiotics have made a major contribution to today's enhanced levels of health. However, if some doctors prescribe this medicine too frequently, in inappropriate cases and in poorly controlled dosages or if patients ignore advice on "how to take this medicine", antimicrobial resistant strains of disease can develop amongst patients which can then be communicated worldwide.

AMR thus exhibits the two defining properties of a public good: non-rivalry in consumption and non-excludability (see also, Coast and Smith 2003). And AMR can and does spread on a national and global scale.

As many **GPGs** do, AMR creates policy interdependence among countries. It cannot be adequately provided through the efforts of one nation acting alone, at national level. It requires international cooperation.

This has, for example, also been the experience of the European Union, where there has been a common policy on AMR since 1999. Despite a series of common cross-border initiative to address AMR 2009 data shows that the EU is experiencing a spread in the worst kind of AMR—resistance to a class of antibiotics called carbapenems (our last line of defence antibiotics)—which can be directly linked to a failure to enforce the agreed common policy in just one country (Wernli et al. 2011).

(continued)

Box 2 (continued)

This tells us that the provision of the GPGs "AMR prevention" follows a "weakest link" summation process: All countries must contribute, but the country contributing the least determines the overall availability of the good (see also WHO 2002). In such cases, it is therefore in the enlightened self-interest of all to nudge the "weakest-link" country into strengthened provision, through positive incentives like financial assistance or negative incentives like exposing its lacking contribution in monitoring reports.

As is the case with many GPGs, the provision path of AMR prevention includes national as well as international building blocks. National governments must ensure that regulations on the use of antibiotics are enforced within their jurisdiction. Health diplomacy is needed to work internationally to ensure that the same level of enforcement is achieved in neighbouring countries, the greater region, and ultimately on a global scale. And national public information campaigns are needed to explain to people at large the risks involved in an overuse or misuse of antibiotics.

The Provision Challenges of Public Goods and Global Public Goods

The Provision Path

Since the 1980s we have seen worldwide a rebalancing of the role of markets and states. Rather than seeing all public goods as provided or preserved by public agencies we see more and more public–private partnering in the provision of public goods. Today, most public goods—whether national or transnational (regional or global)—emerge from a multi-actor process; and in the case of transnational public goods, interventions may happen at multiple levels, national, regional and at the global level.

Moreover, as the foregoing examples have demonstrated, most GPGs pertain to several sectors. Take the case of HIV/AIDS control: in order to produce this GPG, health interventions must be matched by developments in our understanding of human rights, knowledge management, trade, health education, and workplace regulations.

Each GPG may follow a different provision path, involving different actors with different incentives. Figures 8.1 and 8.2 (Kaul and Conceição 2006) depict the provision paths for national public goods and **GPGs**. At the national level, and even more so at the international level, GPG provision is a highly complex process—multi-actor, multi-level, and also multi-sector.

Take, for example, the case of the influenza H1N1. Although it turned out not to be as severe a pandemic as anticipated, many states had to act; many agencies within each country had to get involved. Many parts of WHO played important roles. The pharmaceutical industry had to initiate vaccine production. And last but not least,

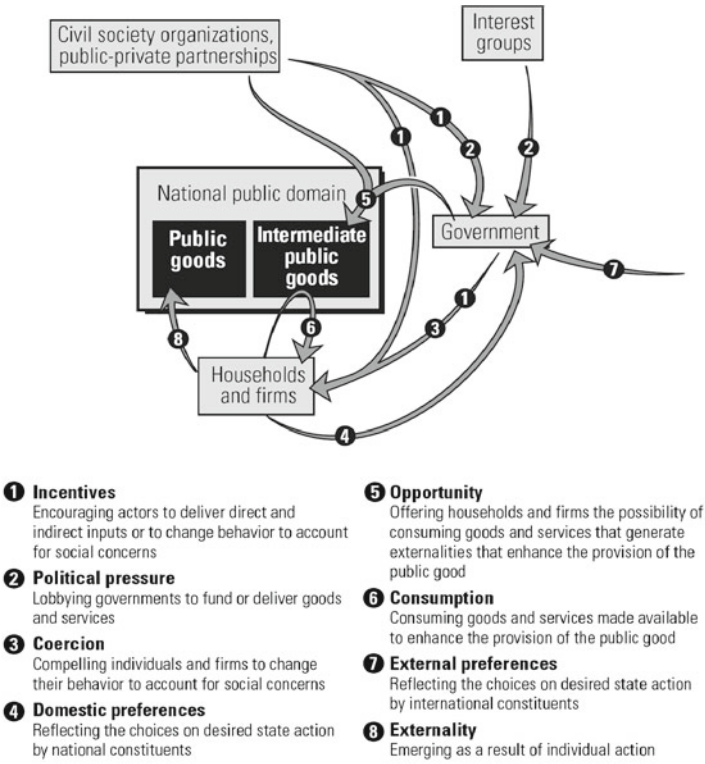
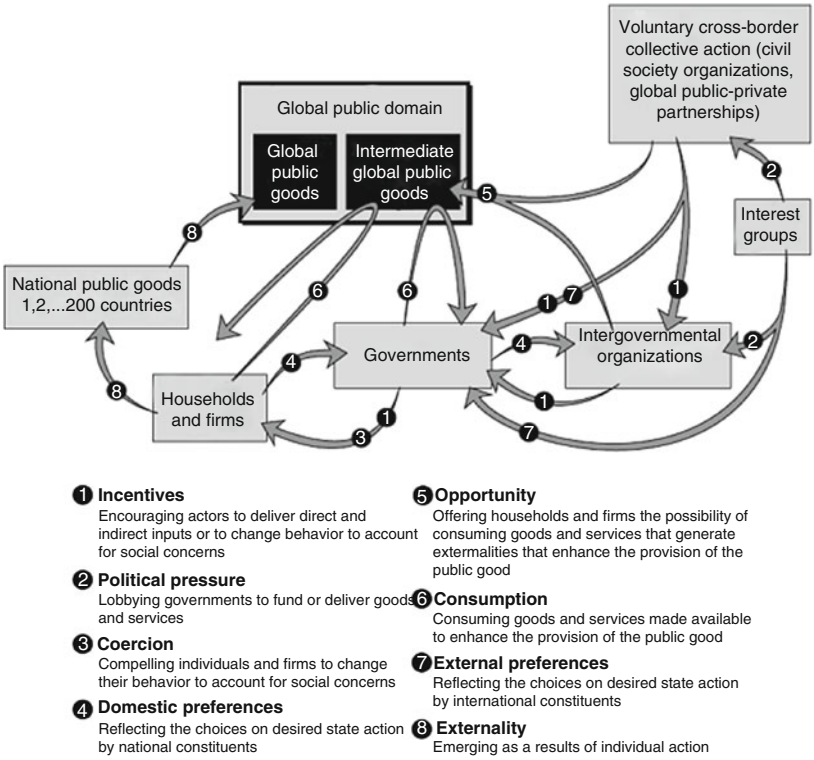


Fig. 8.1 The provision path of national public goods: multi-actor and multi-sector. *Source*: Kaul and Conceição (2006, p. 12)

many individuals worldwide took precautionary measures or sought treatment, because the media and others (e.g. schools and employers) participated in information campaigns.

The Importance of National Building Blocks

As Figs. 8.1 and 8.2 illustrate, national building blocks—national public goods provided in a concerted manner, or the management of (positive or negative) public effects that could spill across borders—in many cases constitute the main building blocks of a GPG. International level action is often a minor element, albeit of critical importance, because it may—as, for example, international agreements do—provide the policy framework that guides national-level policy harmonization or coordination.



Note: The figure is based on the assumption that the good follows a"summation"aggregation technology. Intermediate public goods (like norms and standards) serve as inputs to final public good

Fig. 8.2 The provision path of global public goods: multi-actor, multi-sector, and multi-level. *Source*: Kaul and Conceição (2006, p. 14)

Most GPGs follow a summation process, meaning that several or all countries need to take national-level measures in order to correct the under-provision of a GPG. It might be argued that, if appropriate action were taken at the national level, GPGs would exist without (further) need to cooperate internationally. However, without such cooperation action may be disjointed, inefficient and perhaps impossible with both duplication and gaps in provision.

Consumption and Provision Interdependence

Consumption interdependence—people worldwide being affected by a common good—is one reason for the growing importance of GPGs, particularly in health where there is growing awareness of the common threats posed by both infectious and non-communicable diseases and issues such as the future availability of antibi-

otics. Another is provision interdependence: If a country wishes to enhance the availability of GPG such as monitoring of health and disease threats, it often cannot realize this goal unilaterally, through national policy action alone. Most GPGs require international cooperation—with complementary action by other countries, for example, health/disease monitoring by all, and/or collective action with other countries, for example, the WHO as a common venue for negotiations and international operational follow-up to joint decisions on International Health Regulations.

Public Goods, Including GPGs, Tempt Actors into Free Riding

The temptation to rely on GPGs provided by others, while not contributing to them, is quite understandable, although this is often not in a country's longer-term self-interest. If a national goal is to develop a GPG like food safety standards, it would in the short run look quite tempting not to reveal a preference for this, lest other states ask them to help pay for it. Since public goods are non-excludable, the good, once provided, would also be there for non-contributors to benefit from too—free of charge for free riding. However, if all thought like this, the good would be underprovided. And indeed, many GPGs are underfunded and underprovided.

It often appears as if the world were caught in an ever-denser web of global crises including: global warming, the global financial crash, the spread of infectious and non-communicable diseases, conflicts arising from lack of human rights and rising international criminality and corruption, many of which could be prevented or mitigated through a more complete provision of GPGs. The crisis-prone nature of today's world arises, in large measure, from the fact that when appearing internationally, states mainly pursue their national, and hence, particularistic interests. Moreover, the institution of the state has no full equivalent at the international level. International organizations with coercive powers are more the exception than the rule. Thus, GPGs are subject to two types of failure: global **market failure** and **state failure**.

This has serious implications. Since many public goods need all or at least many countries to act individually and collectively, many international resolutions suffer from lack of compliance and effective follow-up. The consequences of free-riding are especially serious in the case of GPGs which require a certain threshold of provision through a summation process. In such cases, for example, regional or global networks for disease Surveillance, the system can only be as strong as its weakest link.

Preferences for GPGs Vary

Failure to reach an international agreement or non-compliance with agreements is, in many cases, not only the result of free-riding. It is the combined result of variations in states' preferences and priorities for GPGs and international decision-making processes that are often seen as limited and unfair. Just as individual preferences for private goods vary, so do preferences for public goods, depending on national factors such as levels of economic and social development, the nature of the health or

other threats faced, climatic and other local conditions and the culture and history that shape people's expectations.

While other chapters have noted the changing dynamics of global governance, as yet, the world is still divided into "policy-setting" and "policy-taking" nations so that the latter often find it difficult to insert their priorities into international agendas, or even, to vote against the priorities of the major powers. Consequently, reneging occurs to the disadvantage of all. Because, given the policy interdependence that GPGs require, problems of under-provision need to be resolved—or no one will be able to enjoy the desired good, for example a polio-free world.

Drawing the Lessons for a New Diplomacy for Health

Looking at today's global challenges through the lens of GPGs generates important new insights into the nature of these challenges and into the policy options available to us to address them. The following list of practical–political policy recommendations highlights a few of these.

Provision of GPGs Should Be Recognized as a New Strand of International Cooperation Alongside Foreign Affairs and Foreign Aid Negotiation

Policy interdependence means that nation states meet on a more equal basis to discuss GPG issues, which are in every states' enlightened self-interest. Negotiated agreements must be seen to recognize the interests of all parties in a fair and equal manner. This is reinforced by the emergence of new global economic and political powers like Brazil, China, India. Not surprisingly, new diplomatic strategies have been proposed that have even been taken on board in the strategy of the USA, still arguably the most powerful country. The new strategy is that of "smart power".[1] It accepts that all countries expect to derive a clear net-benefit from international cooperation but power politics still matter in determining the actual distribution of net gains across the parties involved. Table 8.1 presents a comparison between the two main strands of international relations.

Table 8.1 Differences between aid and the financing of global public goods

	Aid	Global public goods
Rationale	Equity	Efficiency
Branch of public finance	Distribution	Allocation
Policy tool	Transfer of resources	Panoply of instruments
Policy focus	Country	Issue (public good)
Main net beneficiary	Developing countries	Potentially all countries and generations

[1] See on the concept of smart power, Nye (2010) and U.S. Department of State (2010).

International Cooperation in Support of GPGs Starts at Home

Increasingly states take the outside world—global opportunities and exigencies—into account when formulating national policy. They act as "intermediary states"—as brokers between national and international concerns. This is an important—and encouraging—trend, given that national level policy, notably an adequate provision of national public goods, is the main requirement for the adequate provision of GPGs. However, in order to promote "letting international cooperation start at home"—in order to avoid over-centralization and follow the principle of subsidiarity—national governance arrangements would also need reform. For example, where it has not yet happened, it would be desirable to introduce changes along the following lines:

- The creation of global affairs units in foreign ministries and sector ministries.
- Clarification of which ministry has primary responsibility for each global issue (the foreign ministry or the sector ministry concerned).
- Assessment of the desirability of appointing issue ambassadors (e.g., ambassadors for global health) and review of the staffing of embassies and of the organization and mandates of the committees of the national legislative bodies.
- Review of budgetary rules from the viewpoint of whether they permit the sector ministries concerned (e.g., the health and environment ministry) to disburse money abroad, if this could be a more efficient way to address global challenges.
- Linked to the foregoing, a study of how national ministries could, incentivise other levels of government and civil society and private actors, to contribute to international commitments.

Regional Public Goods Can be a Stepping Stones Towards GPGs

Although the path of social and economic development has been unsatisfactory, progress has been achieved in many formerly underdeveloped countries. As a result national policymaking and the capacity to work together at regional levels has been strengthened. Thus, tasks that might formerly have required an intervention at the global, multilateral level can now be handled through regional cooperation. Regional public goods are, therefore, also becoming increasingly important building blocks of GPGs. Again, in order to avoid over-centralization and over-standardization of international cooperation, it would be desirable to explore a further strengthening of regionalism in this regard.

International-Level Negotiations on GPGs Need to Be Issue-Specific and Take Account of the Economics of Meeting Global Challenges

The conventional system of multilateral aid and cooperation has been designed mainly along sector lines such as: agriculture, health, or industry. However, the

focus under conditions of greater economic openness is to tackle particular issues that pose problems—to avoid future crises. Moreover, GPG-oriented international cooperation is primarily aimed at achieving certain policy corrections. Once these are achieved, the focus of concern may move on to tackle other potential problems. Thus, while foreign affairs and foreign aid strategies require the development of long-term relations, GPG-focused interventions tend to be more targeted and result-oriented in the short or medium term..

This is evident from the fact that since the 1990s, when the end of the cold war gave a fresh boost to globalization, we have seen a rapid proliferation of focused, single-issue international cooperation mechanisms (see Fig. 8.3). Just as most governments have always undertaken some form of cost/benefit analyses to determine which national public good to invest in order to make the best use of scarce public resources, we now increasingly see cost/benefit analyses of GPGs emerge that try to determine the global costs and benefits of inaction as well as corrective action, including the likely distribution of costs and benefits across regions and countries (see Conceição 2006 and Stern). In addition, private actors, who have increasingly become involved in the delivery of international-cooperation outcomes, are, naturally, concerned about the economics of these initiatives, because in many instances their participation is not only a matter of "doing good" but also one of "doing well", as one of their business activities that ought to meet a double bottom line—be profitable and help achieve social benefits.

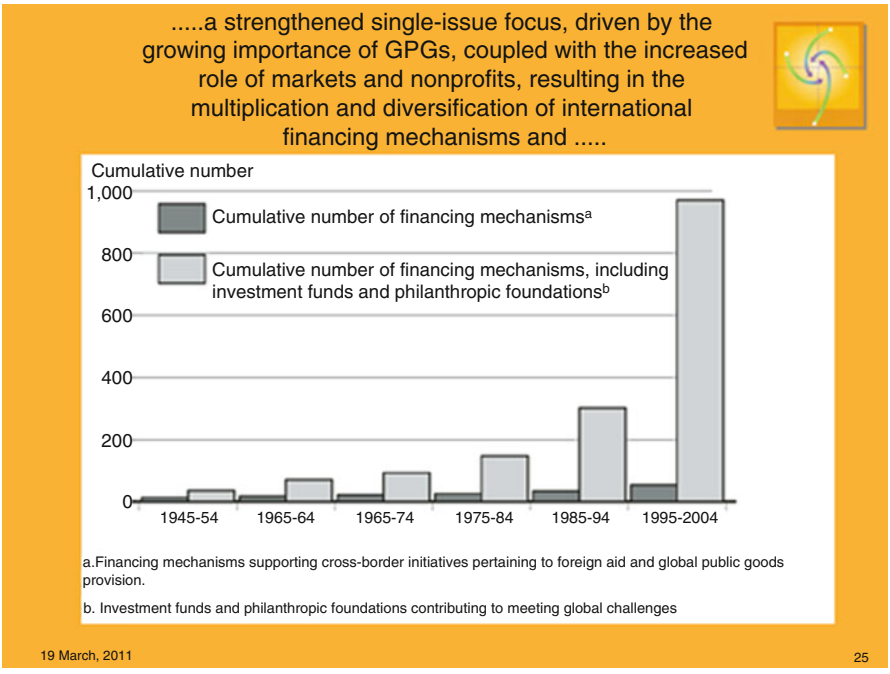


Fig. 8.3 The role of private investment and civil society in provision of GPGs is not matched by voice in international affairs

The Economics of Meeting Global Challenges Must Include a Cost/Benefit Calculation of Fairness

Foreign aid is a voluntary measure, although, over time, firmer international expectations have been formulated concerning what constitutes a desirable level of aid, as demonstrated by the repeated reconfirmations of the 0.7 % of GDP goal for Official Development Aid. However, international cooperation in support of GPGs has more the character of a bargain, a trade. Either cooperation happens because all concerned parties commit to undertake a particular activity; or it happens, because one set of actors offers a certain amount of compensation or incentive payments to another set of actors for undertaking—in the global interest—certain policy measures that exceed what they would do if motivated only by their national interests. In order for the proposed deal to materialize, it matters that the parties on the supply side of the deal consider the offered "price" as adequate and fair. Therefore, fairness has to be figured into the cost/benefit calculations that countries undertake in order to determine whether their participation in a particular international cooperation effort is a good investment from their national perspective. Likely "winners" need to consider the possibility of negotiation-facilitating transfers; and likely "losers" need to determine at what level of compensation they could agree to help the international community to achieve a global goal, although that goal may not yet be one of their top priorities. For example, poor countries might prefer to focus their attention in reducing communicable diseases while other, more advanced countries would like to place a stronger emphasis on the fight against non-communicable diseases

New Policy Tools Are Needed: And Are Feasible

As even a brief look at recent international cooperation realities shows, international delivery mechanisms (e.g., bodies like the Global Fund to Fight AIDS, Tuberculosis and Malaria, GFATM, or the Global Alliance for Vaccines and Immunization, GAVI) have been multiplying. The same is true for international cooperation tools or instruments. In the health field, there have been innovations like: differential patenting such as the Lanjouw proposal; patent extension on existing pharmaceuticals; advance purchase commitments; bond issues to facilitate front-loading of investments in health as practised by the International Finance Facility for immunization and public–private partnerships to provide direct financial support for R&D initiatives. These innovations have been driven by the new challenges of global health, recognizing that anyone could be affected by global health threats, but no one state or non-state actor will be—politically, technically, or financially—capable of addressing them alone. The development of public private partnerships has led to a strengthened role for private business actors like pharmaceutical companies and for non-profit actors like foundations and civil society organizations.

Global/National Policy Links Should Be Strengthened

While international cooperation has to start at home, as point 2 above underlines, it is, often, desirable—more effective and efficient—to take certain aspects of GPG provision to the international level. Yet, once an international agreement has been reached on how to tackle a global challenge like the H1N1 flu, this agreement needs to be taken back to the national level for follow-up action. Although the upward part of this global policy link is often still quite weak, it functions better than the downward one. The reason is that most international agreements are non-binding; and the decisions to act are often taken without detailing who is to pay which costs. A possible remedy could be to undertake more issue-specific negotiations that would identify more precisely what needs to be done, by whom, and what the likely resource implications might be and to consider a further strengthening of regionalism as discussed in point 3 above.

It Is Time to Update the Architecture of Global Health Governance

As we have shown the world has changed in the past two decades with profound implications for global health governance. While there have been many innovations, these changes have happened ad hoc and incrementally. For this reason it is now time to take stock of the changes that have occurred; assess their strengths and weaknesses to explore how they fit together and what additional elements could usefully complete the institutional landscape. The aim would be to develop a more coherent framework for the governance of global health at national and international level to strengthen multi-actor consultations and participation at the political as well as the operational level of global health governance. Perhaps to establish special global leadership body (as in the G8 or G20) in order to assist the health sector and the world at large to establish more fully and systematically the new policy approaches needed to deal effectively, efficiently and equitably with the growing importance of global challenges.

Conclusions: Sovereignty and Openness

This chapter has drawn attention to the growing importance of addressing GPG. It has shown that policymakers—including the health community—have come a long way in finding new and innovative ways of dealing with these issues. Yet further reforms are needed to provide a more effective and prompt policy response to global challenges. International cooperation today is often the best way for countries to meet their national interests, including their interest in enjoying good health. Engaging in international cooperation that is fair and perceived by all as enhancing

their well-being will allow states to retain—or even, regain—some of the policymaking sovereignty they may now feel they have lost due to globalization. Sovereignty and openness can go together. But we need a new architecture of global governance and a new diplomacy for that.

Questions

1. How can countries foster issue-specific global health management at national level?
2. How could national cost/benefit analyses be prepared to establish priority GPGs?
3. Is a new diplomacy for GPGs emerging? What signs of this do you see?
4. What division of responsibility between governance levels (global, regional, national, local) exists and should exist?
5. How are horizontal linkages being fostered at international level, for example, inter-sectoral links between climate change and health?
6. Are new concepts of sovereignty and the global responsibility of states emerging what signs do you see of this?
7. Given that GPGs suffer from **market failure** as well as **state failure**, who corrects **state failure** at the regional and worldwide levels what is the role of civil society in this?
8. What criteria and theories help identify areas where states are likely to enter into competition rather than international, regional and worldwide collective action, coordination, or cooperation?
9. How have the differences and synergy between foreign aid and GPG provision been translated into new institutional arrangements, including new and additional financing arrangements?

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Further Reading

Overview

A comprehensive overview of literature on GPGs can be found at http://www.undp.org/globalpublicgoods/.

For the standard theory of public goods and related concepts, see:

Cornes, R., & Sandler, T. (1996). *The theory of externalities, public goods, and club goods*. Cambridge: Cambridge University Press.

Pickhardt, M. (2006). Fifty years after Samuelson's 'the pure theory of public expenditure': What are we left with? *Journal of the History of Economic Thought, 28*(4), 439–460.

Samuelson, P. A. (1954). The pure theory of public expenditure. *The Review of Economics and Statistics, 36*(4), 387–389.

A suggestion on how to expand the standard concept of public goods to better capture current realities can be found in the following publications:

Kaul, I., & Conceição, P. (2006). The new public finance: Responding to global challenges. New York: Oxford University Press.

Kaul, I., & Mendoza, R. U. (2003). Advancing the concept of public goods. In I. Kaul, P. Conceicao, K. Le Goulvan, & R. U. Mendoza (Eds.), *Providing global public goods: Managing globalization* (pp. 78–111). Oxford: Oxford University Press.

The publications below present extensive discussions on various GPGs, ranging from norms like equity and human rights to the environment and health, the internet, trade and finance, and peace and security, including studies on the provision and financing challenges that these goods present:

Dyna, A.-T., & Conceição, P. with a contribution from Kremer, M. (2003). Beyond communicable disease control: Health in the age of globalization. In I. Kaul, P. Conceição, K. Le Goulven, R. U. Mendoza (Eds.), *Providing global public goods: Managing globalization* (pp. 484–515). Oxford: Oxford University Press.

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Health Related GPG Publications

For a comprehensive free online course on global public goods for health, see the WHO's reading companion to global public goods for health available online at: http://www.who.int/trade/distance_learning/gpgh/en/index.html. It includes modules on: Key concepts and issues, TB control, antimicrobial resistance, Genomic knowledge, public health infrastructure and knowledge, international law, polio eradication, and international regulations for disease control.
European Commission. (2010). *European research and knowledge for global health*. Commission staff working document accompanying the communication on the EU role in global health (an example of applying GPG theory in policy making).
Höjgård, S., & Vågsholm, I. (2010). *Antimicrobial sensitivity as a natural resource and global public good—resistance as an externality* (Working paper). AgriFood Economics Centre, Uppsala University. http://www.agrifood.se/Files/AgriFood_WP20104.pdf.
Gupta, M., & Gostin, L. (2009). Donors' roles in building of global public goods in health. *The Lancet, 373*(9672), 1395–1397.
Kickbusch, I. (2005). Tackling the political determinants of global health is essential if we want to abolish poverty. *British Medical Journal, 331*, 246–247.
Smith, R., Beaglehole, R., Woodward, D., & Drager, N. (2003). *Global public goods for health: Health economic and public health perspectives*. Oxford: Oxford University Press (Includes case studies on polio eradication, TB control, antimicrobial resistance, and the global environment; as well as a thorough discussion on knowledge production, and a critical discussion on the GPG concept).
Smith, R., Woodward, D., Acharya, A., Beaglehole, R., & Drager, N. (2004). Communicable disease control: A 'global public good' perspective. *Health Policy and Planning, 19*(5), 271–278.
Smith, R., & MacKellar, L. (2007). Global public goods and the global health agenda: Problems, priorities and potential. *Globalization and Health, 3*, 9.
Global health governance of particular relevance to GPGs:
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Chapter 9
Diplomacy and Global Health Security

David L. Heymann and Sudeep Chand

Reader's Guide

This chapter discusses the concept of global health security, the key challenges it raises and the role of diplomacy in addressing them. It begins by outlining an expanded understanding of security, describing the concept of health security, including the dual aspects of societal **health security** and individual, or personal, health security. The political context is also described. Key issues in societal **health security** are then outlined, including significant threats and current responses. Threats covered include the emergence of infectious diseases that cross the species barrier from animals to humans, climate change, the deliberate use of disease-causing agents and the growing burden of non-communicable diseases. Current approaches to addressing threats to societal **health security** are discussed, along with the role to be played by international affairs. The chapter then describes key issues in individual health security, including reliable access to medicines and other health-related products and services; and the politically and economically sensitive determinants of access. The chapter then discusses how to ensure stronger global **health security** in the future.

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Learning Points

- Health security—protection from threats to health—is an important human security issue.
- A series of emerging infectious diseases have challenged global **health security** and economic stability.
- Stronger **health security** requires an understanding of the determinants of infectious and non-communicable diseases and how and where intervention can decrease risks.
- Access to health care depends on a variety of factors ranging from effectiveness of health systems and the cost of medicines to the role of governments providing health care.
- The **Oslo Ministerial Declaration** stresses the convergence between foreign policy concerns for security and economic stability and global health issues.

Introduction: What Is Global Health Security and the Role of Diplomacy?

Security can no longer be narrowly defined as the absence of military threat from another state, as it was in the days when Adam Smith wrote his treatise on the duties of a government (Smith 1776). **Health security**—protection from threats to health—is now recognized as an important non-traditional security issue. The global impacts of **pandemic**s, the rise in counterfeit medicines, the role of health provision in post-conflict environments and the centrality of improving universal access to effective health care to economic development are all examples of the growing intersection between global health issues and other dimensions of **human security**.

Health security as broadly defined has both a societal and an individual aspect. At the societal level, global **health security** means reducing collective vulnerability to global public health threats, both immediate and gradual. These threats often go beyond or transcend borders and may be caused by infectious agents that emerge naturally at the human/animal interface, but they may also be caused by chemicals, toxins and radiation, or be deliberately caused by acts of terrorism. The steady and increasing rise in non-communicable diseases also constitutes a threat to societal **health security**. Moreover, reducing vulnerability means, not only combating the disease threats themselves but also addressing their determinants, some of which may also transcend borders, such as international trade and other economic policies that influence the emergence and spread of disease.

At the individual level, **health security** must include protection and provision measures such as access to safe and effective medicines, vaccines and medical care. Increasing personal **health security** thus means providing individuals with more sustained—and therefore secure—access to quality medical goods and services.

Policies and strategies that are developed to address **health security** issues arise within a broad political context. Governance and policies in sectors outside health, such as agriculture, trade, finance, national security or defence, can have significant effects on health outcomes. Likewise, action aimed at improving **health security** can affect other sectors. For these reasons, when **health security** issues involve trans-border events and become international, they can encounter serious difficulties in bilateral relations, at international organizations and in diplomatic negotiations because of a divergence of political, economic or social interests among states, and between states and non-state actors. As examples: efforts to combat counterfeit, falsified and substandard medicines—which pose a significant danger to health—have been hampered by the lack of a consensus definition of counterfeit as it pertains to medicines. This in turn risks becoming embroiled in controversy over which institutions should have how much authority over the problem because issues other than health protection, such as trade, intellectual property and the fight against organized crime, are also at stake. To enable medicines and vaccines to reach those who need them, it is often necessary to address barriers such as trade, regulations and intellectual property rights. Responses to the threat or consequences of chemical and biological terrorism must involve not only public health but also national and international security and crime prevention agencies.

Health security is an important foreign policy and diplomatic concern that is both influenced by and affects decisions on national security, economic well-being, international development strategies and the protection of human dignity. Finding sustainable solutions to global needs in **health security** thus requires better understanding and collaboration between the international affairs and global health communities to achieve effective policies.

Societal Health Security: Threats and Responses

Over the last 15 years, there has been a series of emerging infectious disease threats that demonstrate the collective challenges for global **health security** (Table 9.1).

The majority of emerging infections such as these occur at the animal/human interface, when an infectious agent in animals breaches the species barrier to infect humans (Table 9.2). Their potential for international spread is great in today's world that is increasingly interconnected by extensive and rapid transportation links.

The economic fallout from events such as the Severe Acute Respiratory Syndrome (**SARS**) and H1N1 (swine flu) clearly illustrate the dimensions of **health security** beyond the health sector, involving trade, tourism, and agriculture where costs from trade embargoes or culling of livestock can be significant (Fig. 9.1).

Table 9.1 Infectious disease threats that demonstrate global health security challenges

Year	Disease	Background	Challenge	Reference
1997	H5N1	Has remained a **pandemic** threat since it was first identified in humans in 1997	Continued, longer-term threat to collective security over decades	Van Kerkhove et al. (2011)
2000	Leptospirosis	International sporting event through the Malaysian jungle which resulted in thirty-three cases across seven countries	Trans-border spread of infection across countries	Sejvar et al. (2000)
2000–2001	Meningococcal disease	Mass gathering at annual Hajj in Mecca	Trans-border spread of infection across countries	Memish and Ahmed (2002)
2003	**SARS**	First global epidemic of twenty-first century that originated in SE Asia but spread rapidly, emphasizing global inter-connectedness	Rapid, global spread of an infectious agent that crossed the interface between humans and animals	Donnelly et al. (2004) and Woolhouse et al. (2005)
2009	H1N1	Influenza virus originating from swine in Mexico	Global need for vaccines and anti-viral medicines to insure against collective risk	Fraser et al. (2009), Wallinga et al. (2010)

Table 9.2 Selected infectious agents in animals that have breached the species barrier to infect humans (adapted from Woolhouse et al. 2005)

Infection	Animal linked to transmission	Year infection first reported
Ebola virus	Bats	1977
HIV-1	Primates	1983
E. coli O157:H7	Cattle	1982
Borrelia burgdorferi	Deer	1982
HIV-2	Primates	1986
Hendra virus	Bats	1994
BSE/vCJD	Cattle	1996
Australian lyssavirus	Bats	1996
H5N1 influenza A	Chickens	1997
Nipah virus	Bats	1999
SARS coronavirus	Palm civets	2003
H1N1 Influenza A	Swine	2009

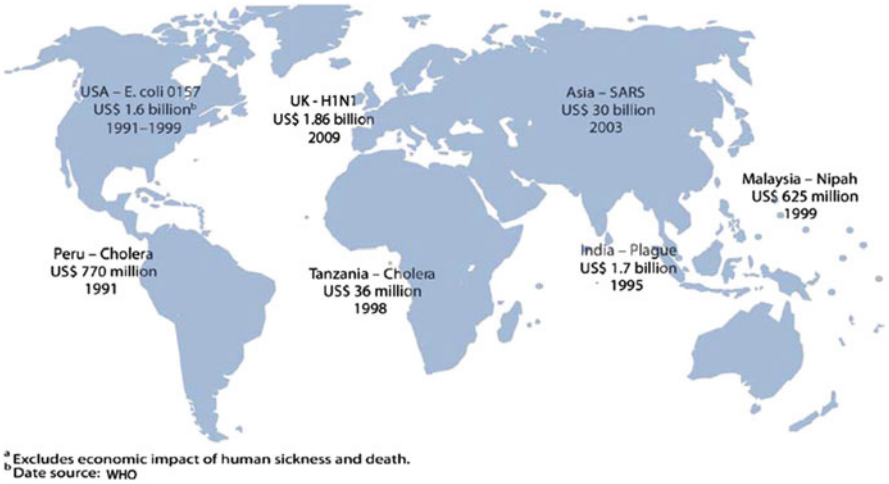

Fig. 9.1 Estimated cost of recent emerging infections

The causes of the emergence of infectious diseases are found in a complex web of determinants that facilitate the passage of infections through and across species. Health security responses must go beyond surveillance and early warning systems to address the ecosystem and the interaction between humans and animals. The proximity of domestic animals to and their interactions with both wild animals and humans are good examples of issues that need further examination. The free range of animals in human communities have been linked with transmission of H5N1 influenza from infected chickens to humans (Van Kerkhove et al. 2011), and human

infections with *Escherichia coli* 0157 have been associated with contamination of meat (Hussein 2007). Infections in workers at slaughterhouses have been shown to occur when domestic animals—infected with microbes from wild animal reservoirs—infect humans involved in their processing. For example, processing of domesticated pigs thought to have been infected with the Ebola Reston virus from its bat reservoir, resulted in infection of slaughterhouse workers and some of the farmers raising these pigs (http://www.who.int/csr/don/2009_02_03/en/). The mixing/intermingling of wild and domestic animals at common water sources and other points of contact have also been implicated in the transfer of infectious agents from wild to domestic animals (Thrusfield 2005).

Severe weather events associated with climate change can have a major impact on the occurrence and distribution of infectious disease. Most of the semi-arid and arid lands of Kenya and other parts of eastern Africa, for example, receive less than 700 mm of rainfall per year. However, periodic, widespread and heavy rainfall that caused extensive and widespread flooding in Kenya, Somalia and Ethiopia in 1998 has been linked to El Niño Southern Oscillation (ENSO) phenomenon, the dominant mechanism driving climatic variability (Nicholson and Kim 1997). These shifts in rainfall patterns caused high levels of rainfall in semi-arid areas where widespread flooding led to the emergence of a larger than usual number of mosquitoes that transmit various types of infection including Rift Valley Fever—a viral disease carried by cattle and other ruminant animals that infects humans, often with a fatal outcome (Anyamba et al. 2001, 2009). Inadequacy of routine veterinary vaccination in the 1990s against Rift Valley Fever had left large numbers of cattle unvaccinated, and when animals and humans were forced to live closer together on remaining non-flooded plains, humans became infected with the virus that was then easily passed from cattle to humans by the higher number of mosquitoes.

Prevailing approaches to the containment of outbreaks caused by emerging infections are often reactive—identifying the infection in humans, then determining the animal source and making efforts to contain infection at both the animal source and in humans. Methods used to contain infectious disease outbreaks such as these include quarantine, a well-known and historic response of isolating those infected, or potentially infected, to prevent onward transmission of an infectious agent; and culling of infected and/or potentially infected animals associated with the outbreak. The phytosanitary conferences of the nineteenth century, where risks to health from infectious disease were addressed alongside risks to trade, were initial multilateral attempts to prevent international spread of infections by increasing measures at borders to prevent the importation and/or breeding of infected animal and insect vectors (Aginam 2002). Newer regimes such as the International Health Regulations (WHO 2005) (IHR) have been developed to serve as a safety net when national detection and containment activities have not stopped disease where and when it occurs. The IHR also require countries to strengthen their national detection and response capacities so that risks of international spread are maintained at a low level.

Box 1 The SARS Epidemic 2002–2003

At the beginning of the twenty-first century, instances of the deliberate spread of anthrax and the **SARS** epidemic placed infectious disease threats squarely within the arena of national security. **SARS** clearly demonstrated the characteristics of infectious diseases that make outbreaks a security threat; a symptomless incubation period which allows the pathogen to spread undetected, the rapid spread made possible by air travel and the public concern heightened by access to immediate information through electronic communication methods (Heymann and Rodier 2004). The rapid global spread of **SARS** also made it clear that public health can no longer be viewed as a domestic concern by any one country but needs to be incorporated into foreign policy (Chan et al. 2010). The epidemic has prompted much discussion on the relationship between infectious diseases and non-traditional security issues and emphasizes the need for a balanced focus on both economic growth and the building of a robust social infrastructure.

Although SARS was not covered under the International Health Regulations (IHR) in force at the time, the rapid spread of **SARS** and the fact that no cure existed caused great public concern and motivated an unprecedented cooperation between countries to quickly identify the causative agent and to contain the disease. The rapid containment of **SARS** can be attributed to global political commitment and evidence-based outbreak control measures such as early detection through surveillance. As a result of the **SARS** epidemic, IHR have now been updated to reflect an interconnected global society (IHR 2005).

Future approaches to societal **health security** must include seeking feasible and cost-effective options that will change the focus of efforts to combat infectious disease threats at the animal/human interface. This entails shifting from emergency response to a more preventative approach focused on addressing the politically and economically sensitive determinants that shape disease emergence and spread as described above.

Stronger **health security** therefore requires an understanding of the determinants at the source of human/animal infections, and how and where intervention can decrease risks. Determinants of emerging infections must be addressed through better regulation of the animal husbandry industry, ranging from water and feed sources to veterinary care, slaughterhouses, marketing and trade. Such measures to increase **health security** require investment and are issues where health and other sectors, including agriculture, trade, and transportation, must work together both nationally through enforceable regulation and internationally through diplomacy that leads to agreed international norms and regulations. Likewise, safeguarding **health security** from the threats posed to it by climate change must involve continued development of the United Nations Framework Convention on Climate Change

(FCCC) and must address the political, economic and other issues linked to climate change and its effect on health security.

Infectious disease threats to societal **health security** can also be the result of the deliberate use of infectious disease-causing agents, or noxious chemical substances. Biological and chemical terrorism present high profile challenges for the public health sector, organizations working on international criminality and international relations. Hoaxes are often perpetrated and can increase the negative psychological and social consequences for health. The social and economic costs of prevention and response can also be considerable. Threats from chemical and biological terrorism and warfare are currently addressed through diplomatic interaction and unified action under the Chemical Weapons Convention (CWC) and the Biological Weapons Convention (BWC), respectively (CWC 1997; BWC 1972).

In addition to infectious diseases, non-communicable diseases, responsible for 60% of deaths globally (Zarcostas 2010), are also an increasingly important threat to health security, with some of the same cross-sectoral determinants and implications as infectious diseases. The underlying cause of the growing epidemic of non-communicable diseases is the rise in lifestyle-related risk factors linked to social and economic changes, which has been given momentum by the globalization of many countries.

Effectively tacking non-communicable diseases and their key risk factors—bad diet, lack of physical activity, use of tobacco and alcohol—requires addressing politically and economically sensitive determinants on a societal level, from national transportation and food labelling policy to international trade agreements and transnational food and beverage marketing. The Framework Convention on Tobacco Control is an example of collective activity to combat advertising and promotion of goods that are harmful to health and linked to non-communicable diseases. Such conventions are negotiated through skillful diplomacy that navigates through concerns of various sectors such as industry and trade, communication and agriculture. Intergovernmental action on other determinants of non-communicable diseases is beginning, with member states of the World Health Organization placing special attention on addressing non-communicable disease determinants such as diet and physical activity; the harmful use of alcohol and the marketing of food and non-alcoholic beverages to children.

Individual Health Security: Threats and Responses

Individual **health security**—including reliable personal access to medicines, vaccines, other health-related products and health care—is not as readily recognized as an issue of **health security** compared to high-profile cross-border infectious disease outbreaks.

However, it clearly provides **health security** to individuals in that their health needs can be met and managed. It has been postulated that providing access to health care, especially in post-conflict situations, also adds to stability and thus national security, but research attributing increases in stability to access to health care is limited (Pavanello and Darcy 2008).

Access to health care and the medicines and vaccines necessary for promoting health depends on a variety of factors ranging from the effectiveness of health systems and the cost of medicines and health products to the engagement of governments in providing resources for health care. For vaccines, development agencies were able to justify childhood vaccines as a cost-effective investment over 30 years ago, and the purchase of vaccines and equipment necessary to store vaccines at cold temperature—along with needles and syringes for their administration—has steadily increased since then with the advent of the WHO Expanded Programme on Immunizations (http://www.who.int/immunization_delivery/en/). Recently, access to newly developed vaccines has also been increased for the poorest countries through the Global Alliance on Vaccines and Immunizations (GAVI), and through targeted disease programmes such as those for polio and measles (http://www.polioeradication.org/ and http://www.measlesinitiative.org/, respectively). But sufficient funds have not been made available to fully introduce and sustain provision of newer vaccines such as meningococcal A conjugate vaccine and the human papiloma virus vaccine that prevents infection and the long-term sequelae of cervical cancer. Recent attempts to increase access to influenza vaccines have had limited success in ensuring provision of **pandemic** influenza vaccines when the next influenza **pandemic** occurs, and diplomatic efforts continue to focus on this issue through an intergovernmental process facilitated by the World Health Organization (Fidler 2010).

During the past 10 years, as a result of arguments made by the Commission on Macroeconomics and Health, and other initiatives, the availability of some existing medicines to developing countries has increased significantly as a result of the proliferation of new funding mechanisms, particularly those targeted at specific diseases (see Box 2). However, the current financing architecture does not systematically provide access to medicines for neglected tropical diseases, but pharmaceutical companies donate medicine for some of them, such as onchocerciasis, leprosy and lymphatic filariasis. Similarly, there is no established equivalent mechanism for providing access to medicines for preventing or managing such non-communicable diseases as chronic pulmonary obstructive disease, heart disease, diabetes and cancer. This, together with the weakness in national health systems in many low- and middle-income countries, presents a significant challenge to individual **health security** in developing countries, where the non-communicable diseases are increasingly becoming a health threat.

Box 2 The Commission on Macroeconomics and Health, the G8 and Access to Medicines

For many decades, development agencies focused their attention on improving access to childhood vaccines. But in 2001, the report of the WHO Commission on Macroeconomics and Health made the case for investments in health as a contributor to economic growth (WHO 2001), using examples such as malaria, which is estimated to kill 1 million children under the age of 5 each year, and to cost sub-Saharan Africa at least $12 billion annually. Together with other studies, and discussions through the G8 and other diplomatic fora, the Commission provided justification for action to improve access to medicines, both in targeted multilateral and bilateral development support, for several high mortality infectious diseases for which no effective vacciness exist. The result has been the creation of the Global Fund to fight AIDS, TB and Malaria (The Global Fund), with increasing multilateral funding, and UNITAID, which provides funding for the purchase of medicines through an innovative tax levy on international air tickets. Bilaterally, funding has increased for the purchase of medicine through such programmes as the President's Emergency Relief Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI), which also provide funds to strengthen health systems (PMI 2005). Funds and initiatives such as these have addressed the **health security** needs for three infectious diseases—AIDS, TB and malaria and through the Global Alliance for Vaccines and Immunization (GAVI), provide newer vaccines for childhood diseases. It remains to be seen whether the Global Fund, GAVI and UNITAID are sustainable and able to meet increasing needs and challenges in the long term, or whether other, more sustainable mechanisms that are less reliant on donor must be developed.

Another challenge to increasing **health security** through provision of medicines and vaccines is weak regulatory agencies and the increasing problem of substandard medicines and vaccines, which can contain insufficient amounts of active ingredients to be effective, or can contain harmful ingredients. Substandard medicines are those that do not meet national regulatory standards of quality, efficacy and safety and can be substandard either unintentionally or deliberately. The latter category includes drugs that have been produced outside the legitimate supply chain—that have not been submitted to regulators, that misrepresent themselves as to use, identity or source, or pass themselves off as brand name medicines (using counterfeit trademarks). Globalization, through a widening of the drug-manufacturing base, has created threats for the legal supply chain, but also facilitates opportunities for the production of illegitimate medicines. The challenge can be illustrated in the finding that in Southeast Asia in 2007, one in two tablets of artenusate, an antimalarial drug, were substandard, some with counterfeit trademarks, others falsified or fake in other aspects (Newton et al. 2008). Responses to substandard medicines include strengthening of national regulatory agencies and enforcement, and a criminal response that crosses international borders, involving law enforcement and multilateral support from agencies such as INTERPOL.

One of the most challenging contexts for increasing access to medicines, vaccines and health services occurs in post-conflict situations and after natural disasters such as earthquakes and widespread flooding. In such contexts, delivery of health services is complicated by the multiplicity of responders and challenges of coordination to ensure local needs are met. In post-conflict situations, the challenge is amplified by controversies regarding the legitimacy of warring forces, NGOs and donors in providing such services, but successes do occur. In Afghanistan in 2007, for example, when there was a noted reduction in access to vaccination programmes, the International Federation of the Red Cross (IFRC) successfully negotiated with the Taliban to gain permission for health workers to enter Taliban-controlled areas to conduct Health campaigns in areas where there had been a marked decrease in access to medicines and vaccines (WHO).

Ensuring Stronger Global Health Security

Over the past decade, recognition of the relationship between global **health security** and international affairs has increased. For instance, the 2007 **Oslo Ministerial Declaration** on Global Health and Foreign Policy, in which ministers of foreign affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand pledged to bring health issues more strongly into foreign policy discussions and decisions, recognized health as one of the most important, yet still broadly neglected, long-term foreign policy issues of our time, tying it to the environment, trade, economic growth, social development, national security, human rights and dignity (Lancet, 2007).

Box 3 The Oslo Ministerial Declaration and Global Health Security

The Oslo Ministerial Declaration, a product of the Global Health and Foreign Policy Initiative launched in September 2006 by the foreign ministers of Norway, Brazil, France, Indonesia, Senegal, South Africa and Thailand, gave impetus to the current thinking on global health security. The ministers pledged to build cooperation for global **health security** by strengthening the case for collaboration and brokering broad agreement, accountability and action. The Declaration defined national **health security** as relating to "defence against internal and external public-health risks and threats", making reference not only to protection against trans-border infectious disease risks, but also to ensuring access to medicines and health services. It regarded global **health security** as an area that encompassed diplomacy, governance, development, poverty, trade, conflict and disaster preparedness and response, and the ministers pledged to integrate health impact assessments into key elements of their foreign policy and development strategies. In this sense, the economic and security focus of foreign policy become concerns for global health, and the focus of global health becomes a concern for the economic and security concerns of foreign policy. In general terms, examination of global health issues from an international affairs perspective permits a focus on their political and economic determinants and implications.

Some interventions to improve global **health security** have the added attraction of supporting broader security efforts. This may include the stabilization of demography through the provision of family planning; the enhancement of economic growth through healthy working environments, and the legitimization of government because it provides health services.

Investments in global **health security** can have outcomes that are both economic and social. As previously noted, there has been much discussion of whether these investments can promote stability, particularly in post-conflict settings. Little research has been done in this area, reflecting the traditional status of sectors such as health and education as low priorities in reconstruction efforts. But experiences in post-conflict countries have underscored the importance of delivering health assistance and rebuilding health sector capabilities as a key part of recovery from conflict. Health sector investments are viewed by some as a bridge to peace; a form of diplomacy aimed to build trust between communities and actors. This is currently played out by a variety of actors, such as the NATO sponsored International Security Assistance Force (ISAF) in Afghanistan, where strengthening national health services is one of its priorities. International affairs reflect an enduring interest in security and prosperity.

Conclusion: Developing a Wider View of Health Security

Health security is much more than the prevention and control of infectious diseases that cross international borders. Infectious disease has been seen as the archetypal **health security** threat and remains the primary concern of national governments, as evidenced by the national security strategies of the G8 countries in initiatives such as The Global Health Security Action Group (GHSAG), and multilateral agreements such as the IHR (2005). NCDs, on the other hand, represent a higher burden of disease at the global level across all ages, but they are often viewed as too indirect, or their emergence too slow, to be viewed within the reactive politics that tend to dominate security discussions. Inequality in access to medicines, vaccines, other health-related products and health services, and the problems associated with substandard medicines are less evident **health security** threats than cross-border infectious disease outbreaks, but threats in this area can be expected to continue to surface in the future.

The financial crisis of 2008 has put pressure on donors to spend health development funds elsewhere, threatening global access mechanisms such as GAVI and the Global Fund. Work must be done to develop sustainable financing mechanisms suitable for high-volume, low-margin markets to improve access in as many developing countries as possible, while ensuring that substandard medicines and vaccines can be detected and kept to a minimum. The High Level Taskforce on Innovative Financing for Health in the United Kingdom came to the conclusion that the bulk of long-term funding of health systems, which are necessary to support efforts to improve health security, had to come from domestic mobilization (Fryatt et al. 2010).

Both technical and political skills will be necessary to accomplish these goals and to strengthen and maintain global health security.

Questions

1. What is security?
2. What is global health security?
3. What kind of cross-sectoral tensions can arise in diplomacy for global health security?
4. How sustainable/effective are current approaches to enhancing global health security?
5. What challenges arise in delivering **health security** in post-conflict and fragile states?
6. How can global health diplomacy ensure better global health security?

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Chapter 10
Global Environmental Diplomacy: Comparing and Sharing

John J. Kirton and Jenilee M. Guebert

Reader's Guide

This chapter offers an overview of global environmental diplomacy (GED) and highlights comparisons and connections that could be utilized in the field of global health diplomacy. It identifies the significant similarities and differences between the two fields and shows why a comparison is useful. It also highlights why health diplomats have to be cautious when making comparisons. It defines and examines the dominant ideas, principles, foreign policy linkage, actors, instruments and processes in GED. It analyses the approaches that have been taken in the field and explores whether or not they can or should be transferred to global health. Lessons that health diplomats might learn from their environmental counterparts are emphasized. The chapter concludes by proposing additional approaches, mechanisms, processes and policies from other fields such as the economy, trade and food and agriculture, which should also be explored for the benefit of global health diplomacy.

Learning Points

- GED offers important lessons for health diplomacy.
- It is important to recognize the similarities and differences between these fields.
- Oceanic and atmospheric concerns including climate change and the ozone layer were the first "**global public goods**" concerns for GED.

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- GED has been grounded in dominant, defining, progressive ideas and principles that have often been clear, comprehensible and compellingly attractive to publics, stakeholders and policymakers.
- Environment has had strong economic and human security linkages—the two main drivers of foreign policy.
- GED has involved a growing and varied number of actors. They come from not only various governmental departments and ministries but also industry, non-governmental organizations, science and academia.
- A wide range of mechanisms have been employed in GED ranging from punitive measures such as trade and economic sanctions to technology and development assistance and other forms of financial support.
- Health and environmental diplomats would benefit from sharing information, tactics and strategies where they have succeeded, as well as where they have failed.

Introduction: Similarities and Differences

It is important for global health diplomats to look outside, as well as within, their field to learn lessons on the types of instruments, institutions, actors and approaches that could and should be applied and which ones should be avoided for successful outcomes. When extracting lessons from other fields, several key questions should be asked, including: Why was the approach used? How did it unfold? What strategies and skills were employed? Was it successful and effective? Are there any critical differences that might lead to an alternative outcome in another field?

Global health diplomats have used this comparative approach in a variety of ways and areas in the past. For example, the framework convention on tobacco control (FCTC)—the first global health treaty to be adopted—was largely influenced by and modelled on environmental law (Taylor and Roemer 1996; Taylor 1996; Roemer et al. 2005; Fidler 2008; Collin and Lee 2009; also see Chap. 4 in this volume). It is clear that certain experiences and approaches from other areas, such as international environmental law, have been useful in influencing and shaping global health diplomacy (Taylor 1996; Aginam 2005). Experiences from trade, food and agriculture and the economy have also been drawn on. However, **GED**—with its established history, varied actors and approaches, and innovative instruments—has been one of the most important.

Physically, both the environment and health are driven by natural and human-affected biological and chemical processes, extending across borders and the natural media of air, water, land and living things. Both are systems where the behaviour of living things matter, and in which unintended or deliberate human intervention plays a critical role. Policy in both domains has been shaped by an evolving, cumulative scientific consensus about the causes and corrective solutions and interventions that should be applied. Both are genuinely global in their reach, even with their varying impacts at local and regional levels.

Politically, both health and the environment are established subjects for national and global governance—governance that embraces formal international organizations, informal intergovernmental institutions and an increasing number of non-governmental actors. They have both increasingly become critical issues at the global level. In both fields there are multilateral and regional institutions dedicated to the issues they raise. Both have had to deal with challenges across the north–south divide. Both have merged into the field of foreign policy in a variety of ways, with actors increasingly recognizing that cooperation among nations is critical for their effective governance and successful outcomes (see Box 2 and also Chap. 8). And both have increasingly attracted the attention of comprehensively concerned, global, summit-level institutions.

The two fields also have important differences that can limit the easy and effective transfer of lessons between the two. Health is focused on direct, often deadly threats to human beings, alone or in large populations. Politically, policy responses rely heavily on **biomedical models**—physical, scientific and/or mechanical approaches. In health scientific consensus drives negotiations, policy and outcomes and is rarely contested. In sharp contrast, the environment embraces integrated ecosystems—a broad array of living things, where humans have no natural primacy, where destruction and death tends to be more diffuse, incremental, and unfolds over a longer period of time—indeed in some cases, such as biodiversity and climate change, it takes centuries or even millennia for the impacts to show. Thus scientific consensus has been much more difficult to transfer to the political-policy realm, particularly on issues such as climate change.

Politically, legal instruments have been utilized more readily in the field of the environment than in health (see Chap. 4). Yet national health ministries were established long before environmental ones. And to this day, there is still no World Environment Organization, whereas in the field of health, the central World Health Organization (WHO) has been around since 1948 (Biermann and Bauer 2005).

Recognizing these important differences, the similarities between each sector make a comparison useful (Aginam 2005). This chapter therefore examines the ideas, instruments, actors, institutions and processes that have been employed by environmental diplomats. It explores why they have been used and identifies which ones have and should be adopted and avoided by global health diplomats.

Box 1 Global Environmental and Health Diplomacy: Similarities and Differences

Similarities

- Require cross-border cooperation
- Growing number of actors, particularly non-state ones, involved
- Increasingly important topic for global governance
- Growing number of institutions dealing with the topic

(continued)

Box 1 (continued)

- Depend on scientific evidence
- Security and economic links
- Growing number of non-health/environmental portfolios dealing with the issue
- South–north divide

Differences

- Degree of scientific consensus
- Utilization of legal instruments, particularly binding ones
- Core international organization
- Individual versus collective rights

Origins

In considering which elements of GED are most relevant to global health diplomacy, it is important to assess the origins, dominant ideas and principles, foreign policy links, actors, instruments and processes of negotiation used. GED was established as a familiar concept and practice at an early stage—earlier than global health diplomacy. It flowed naturally from the classic concern of states and their diplomats with the oceans and concerns of commerce, military navigation and the very territorial extent and jurisdiction of the state itself. For the great powers that drove and defined most diplomatic negotiations, the inherently global law of the sea and international shipping mattered (Tolba and Rummel-Bulska 1998). In the broadest terms, GED began largely because of local concerns with single species protection, point source poisons and pollution, reactively addressed through conservation and "end-of-pipe" solutions to reduce and limit the death and damage that resulted (Susskind 1994; Tolba and Rummel-Bulska 1998). It then moved to focus on preventing irreversible damage and existential death to integrated global ecosystems through a broad array of measures, embracing the entire world and unfolding over a long period of time. Oceanic and atmospheric concerns including climate change and the ozone layer were the first "**global public goods**" concerns for GED (see Chap. 8).

The first generation of visible environmental disasters came from the over-exploitation of maritime species, from trans-boundary waterways such as the Danube river and the Great Lakes and then, in the 1960s from oil tanker spills on the shores of the USA. Somewhat later, legal and security issues relating to the atmosphere and extending into outer space reinforced the classic case that GED was at the core of what real diplomats should deal with. This was certainly the case during the Cold War, when the advent of the long-range bomber and the space race fuelled military demand to know more scientifically, not only just about the weather

but also about the climate system and environment. When the oil shocks hit in 1973 and 1979, global environmental diplomats had to deal with issues of energy conservation and diversification as well.

In 1970, two legendary innovative thinkers and practitioners of foreign policy offered two very different visions of how GED should unfold. The first was Kennan (1970), who sought to prevent "a world wasteland" by having a small group of the most powerful and committed countries create an informal club that could act quickly and effectively through flexible instruments for the greater global environmental good. The second was Maurice Strong, who envisioned a broadly inclusive multilateral body, grounded in the UN (Vaillancourt 1995; Strong 2001).

Strong's vision triumphed with the UN-sponsored Stockholm Conference in 1972, the creation of United Nations Environment Programme (UNEP), the publication of the Brundtland Commission report in 1987, the summit-level United Nation's Conference on Environment and Development in Rio in 1992, and the framework conventions on issues such as climate change and biodiversity that came. This approach was grounded in the principles that the environment was integrally linked to economic development and that developing countries should be free to develop their economies first, while developed countries bore the burden of environmental protection. This approach relied on a heavily legalized, but lightly and diffusely implemented approach (Hunter 1999; Tolba and Rummel-Bulska 1998).

Kennan's vision also had an intellectual and institutional legacy. The plurilateral summit level Group of Seven (G7) major market democracies dealt since its start in 1975 with energy conversation, and a broadening array of environmental issues. It pioneered discussions on climate change in 1979, 1985 and continuously since 1987. More recently, the **Major Economies Forum (MEF)** of the world's 16 leading carbon producing and absorbing countries, formed in 2007, took up the issue as well, suggesting a desire and need for a more flexible approach to accompany the heavily legalized one that dominated the field (Kirton and Guebert 2007).

Dominant Ideas and Principles

GED has been grounded in a succession of dominant, defining, powerful, progressive ideas and principles that have often been clear, comprehensible and compellingly attractive to publics, stakeholders and policymakers. Such principles have been grounded in, but not confined to, science. They have been carried forward to political and policy agendas—with varying degrees of success. On issues, such as climate change, for example, there has been much more difficulty.

At the outset, the "polluter pays" principle dominated most GED. Costs, government regulation and pollution reduction through "end-of-pipe" technologies and interventions were emphasized (Ogilvie 2006). The second principle was pollution prevention. This contrasted with the idea of pollution control, which sought to manage pollutants only after they were formed. Here the focus was on increasing energy efficiency and reducing the amount of pollution generated at source. The third principle

was sustainable development. It presented economic development as an issue that could not be excluded from environmental considerations. The hope was that by addressing them together, both could be realized in a synergistic way. The fourth principle was precaution. It captured the complexity and uncertainty of the integrated global ecosystem as a **complex adaptive system**. This emphasized the unintended or unforeseen consequences that could result from certain policies, which had become a clear cause of concern as issues such as climate change came to the fore.

Box 2 The Environment and Foreign Policy

	Foreign policy neglects or hinders the environment	The environment is an instrument of foreign policy	The environment is an integral part of foreign policy	Foreign policy serves the goals of the environment
Comments	Foreign policy is enacted without considering or despite any environmental impacts	The environment is used a means of reaching a non-environmental outcome	There are environmental impacts, but the main driver is non-environmental	The environment is the key driver and beneficiary of foreign policy
Example	Testing of nuclear weapons	Space race	Fishing subsidies	UNFCCC

Foreign Policy Linkages

As noted previously, from the outset the environment has had strong economic and security linkages—the two main drivers of foreign policy. In both instances, economic and security concerns have historically trumped environmental ones. However, more recently there has been a shift in the "foreign policy-environment spectrum"—which ranges from foreign policy neglecting or hindering the environment—for example, where trade and security priorities take precedence over environmental ones—to the other end where the environment is the main driver of foreign policy, and environmental outcomes take pride of place. This is a fluid situation and negotiations continue to span the range of this foreign policy-environment spectrum. However, environmental concerns have become more prominent, as both means and ends, over time (see Box 2).

Environmental Diplomats

GED has involved a growing and varied number of actors. They come from not only various governmental departments and ministries but also industry, non-governmental organizations, science and academia. Individual citizens, celebrities, philanthropists

and religious organizations have become involved in a variety of causes. The field of diplomacy is no longer confined to traditional state actors (Kelley 2010).

These actors have been critical in influencing all stages of GED—from getting issues onto the agenda and influencing the negotiation process to monitoring compliance, implementation and tracking outcomes. At the individual level, concerned citizens were at the forefront of the movement to refuse to use plastic bags. Philanthropists and celebrities have aligned themselves with non-governmental organizations, freely arranging meetings with governmental officials and making use of easily available media outlets to raise issues and lobby their causes (Cooper 2008). Individuals like Al Gore and Leonardo DiCaprio are now commonly associated with environmental concerns (Leonardo DiCaprio Foundation; All American Speakers). At the 2010 Religious Leaders Summit, participants urged governments to step up and make the environment a priority (2010 Interfaith Partnership 2010). Business and industry officials have lobbied both against and for environmental causes (Usui 2004). Scientists and academics have been critical in defining the challenges and policy options available on environmental issues (Benedick 2007).

NGOs have been amongst the most important actors in **GED**. If NGOs are taken to include voluntary associations such as birdwatchers, they have been extensively engaged in environmental diplomacy for well over a century. Their role has expanded immensely over time. In 1972 at the Stockholm Conference on the Environment, fewer than 300 NGOs attended. By contrast, at the 1992 Rio Earth Summit more than 1,400 NGOs registered to attend and 18,000 NGOs attended a parallel forum (Clark et al. 1998; Finger and Princen 1994). Environmental NGOs have also become increasingly involved in every aspect of GED—lobbying and networking with local, state and national governments; educating civilians and businesses; formulating plans of action; networking with each other; and championing celebrity diplomats. They have learned to work every angle of **public diplomacy** winning hearts and minds of a wide audience. Overall they have been very successful and effective at championing their causes (Kirton and Hajnal 2006).

Local, provincial, national, regional and global governance all have a role in GED. Governments at the local and sub-federal level have taken environmental action aimed at or affecting those outside their country's borders. They have implemented recycling programs, introduced energy efficient standards, required dramatic drops in carbon from transportation fuels and set targets for reducing greenhouse gas emissions.

National governments have increasingly established mechanisms to support and engage in environmental diplomacy abroad. They have done so by creating ministries and agencies dedicated to the environment, and established within them units to deal with international affairs. At the same time, foreign ministries have created units for environmental affairs. Other ministries and departments, such as energy, trade, health and finance have all gotten involved as well.

Environmental challenges have also been governed from the very top. From supranational organizations, such as the European Union and global governors, such as the UN, APEC, MEF, G8 and G20, an increasing number of institutions and

organization have engaged in GED (Kirton et al. 2010). Issues that are truly global in scope, such as climate change, require global diplomacy. This is critical for effective results and outcomes.

However, as the number of actors engaged has increased, coordination among actors has been limited and challenging. Often different actors bring different perspectives and positions to GED, and at times they may be at cross purposes—for example industry and NGOs or trade and environment ministries; but they can also come together and work in a constructive way to produce effective results (Hale and Mauzerall 2004; Benner et al. 2003; Joyner 2005; Streck 2004; Bäckstrand and Lövbrand 2007). This often is the result of necessity. For example, NGOs have had to work closely with governments to support their cause, because there is no other clear means to initiate change.

Instruments

A wide range of mechanisms have also been employed by global environmental diplomats. The instruments range widely from punitive measures such as trade and economic sanctions, fines in domestic courts, to technology assistance and transfer, development assistance and other forms of financial support. They include a wide range of measures from binding to non-binding measures (Taylor 1996; Abbott 2000; Kirton and Trebilcock 2004; Kirton and Guebert 2010b).

One classic diplomatic instrument, used to support environmental policy change, is development assistance, or more broadly, concessional finance. The call for environmental aid started in 1972 when Articles 2 and 12 of the Stockholm Declaration stated that "additional international technical and financial assistance" should be made available for environmental protection in developing countries. The Global Environmental Facility (GEF) was set up in 1990 to provide financing to environmental projects. In the negotiations of the Earth Summit in 1992, developed and developing nations struck a "Grand Bargain," where wealthy countries agreed to underwrite the participation of less developed countries in global environmental accords. The GEF was later restructured to embody these principles. The resulting "climate finance" is the newest form of assistance.

Another important element in GED is the transfer of technology and suspension of intellectual property (IP) rights or rules that determine who controls information and technology. IP is important, particularly in the context of climate change and biodiversity. The main ways IP are relevant to environmental policy are: international trade obligations; the protection of traditional knowledge; promotion of technology transfer; prevention of bio piracy; threats to agricultural biodiversity; and impacts on social equality (Tarasofsky 2005). One of the main concerns of the intersection of IP and the environment is the north–south divide. Many commentators have emphasized that it is critical that the North share information and technology with the South if global challenges are to be solved. It is important to ensure that vulnerable countries and communities have access to technologies that will help them to mitigate and eliminate

carbon emissions and that will help them to adapt to avoid the harmful environmental impacts they face. The importance of information-sharing has been reinforced in many bilateral, multilateral and international forums.

The central thrust of modern GED has been to use international law and legal instruments (Roemer et al. 2005). International laws require high degrees of precision, with a clear delegation of obligations in domestic law and may be embedded in enforceable international treaties. Environmental diplomacy has used a wide array of legal instruments. These range from informal, consensual, voluntary codes to international binding agreements. These instruments have been applied to issues from the oceans, ozone and climate change, to biodiversity, persistent organic pollutants, chemicals and desertification. Legal mechanisms have been pioneered in many new fields, such as the Forestry Stewardship Council, where binding instruments have been difficult to obtain (Bernstein and Cashore 2000, 2004).

The framework-convention-to-protocol approach has been one of the most popular instruments in GED (Taylor 1996; Tolba and Rummel-Bulska 1998). However, the degree to which this instrument has been successful has varied. For example, in the critical case of climate change, greenhouse gases continue to rise despite the establishment of the United Nations Framework Convention on Climate Change (UNFCCC) and the Kyoto protocol, which sets binding targets for 37 industrialized countries and the EU. The most polluting country in the world (the USA) has yet to ratify numerous environmental conventions and protocols. Many other environmentally significant countries, such as China, Brazil and India, have yet to be included in the control provisions of many of these agreements. And even in cases where conventions and protocols are signed and ratified, the degree to which countries actually keep their commitments has also varied. Nevertheless, there is much to learn from theses processes, particularly from the negotiations and the language used in the various agreements (Susskind 1994; Kütting 2000; see Chap. 4 in this volume). Processes such as those used in the Acid Rain and the Ozone Convention and the Convention on Long Range Air Pollution have been much more successful and should continue to be utilized (Taylor 1996; Benedick 2007; Aginam 2005).

A variety of coercive instruments have also been used to advance GED. For example, in the 1990–1991 Gulf War, Saddam Hussein sought to use environmental damage as a weapon of war by releasing Iraqi oil into the waters of the Gulf. Canada and Iceland have used military-like forces in oceans adjacent to their countries to stop overfishing from foreign fleets. The USA has used unilateral trade sanctions to protect fisheries. Countries have also imposed embargoes or quarantines to stop the import of environmentally dangerous goods and endangered species.

The Process

Regardless of which instrument is employed, the process of diplomacy is always complex and challenging. Trying to reach an agreement that satisfies multiple parties requires planning, skill, strategy and patience. Environmental agreements are

among the most difficult to negotiate (Chasek 2001). The numerous actors, with their various interests; the economic implications; the lack of ownership; and persistent scientific scepticism all contribute to the complexity.

Most diplomatic processes occur in three stages: pre-negotiation, negotiation and post-negotiation (see Box 3 and Chap. 5). On the whole, these stages proceed from one to the next—often in a very slow manner; however, there may be some backtracking when new evidence, events and actions arise. In the pre-negotiation stage, issues arise for attention and discussion—spurred by public opinion, lobbying, natural disasters or other events; challenges are defined; non-governmental actors lobby governments to take action; and instruments are chosen. During negotiations, governments take positions and they bargain and compromise to come to an agreement. During this stage, lobbying often continues to take place, costs can come into consideration, and new evidence can arise. This can all have an effect on the negotiations taking place. Discussions are often stalled, postponed or collapse—sometimes many times. In the post-negotiation stage, countries' compliance might be monitored; agreements may be enforced, agreements can be amended; and physical outcomes assessed. Each negotiation—at all of these stages—has an impact on further steps and negotiations. Precedents are set, lessons are learned and outcomes are evaluated.

Box 3 The Process of Global Environmental Diplomacy

Pre negotiation	Negotiation	Post negotiation
– Scientific fact finding	– Taking positions	– Enforcement
– Event (e.g., natural disaster, oil spill, species extinction, etc.)	– Bargaining	– Monitoring Compliance
– Public opinion	– Reaching agreement	– Environmental improvement/ degradation
– Economic considerations	– New evidence	– Amendments
– Defining the challenge	– Lobbying	– Protocols
– Lobbying	– Costs	– Adoption
	– Convention	– Ratification
	– Treaty	

Lessons for Global Health Diplomacy

Environmental diplomats are better at solving problems that have already been recognized and are specific, acute, concentrated and deadly than new and future, diffuse, silent, chronic, cumulative—but even more dangerous—potentially deadly problems. There is no room for triumphalism, and it is important to be cautious in sharing lessons from successes in this field. With that said, both health and environmental diplomats would benefit from sharing information, tactics and strategies where they have had

success, as well as flagging areas where there have been failures (see Box 4). There is scope for much greater collaboration between the two fields to jointly address the future, preventative, global, challenges to humankind that affect both health and the environment (Taylor 1996). This should start with the critical connection between health and climate (Kirton and Guebert 2010a; Costello et al. 2009; Parry et al. 2007).

GED has benefitted from a succession of dominant, defining, powerful, progressive ideas and principles—polluter pays, prevention, sustainable development, and precaution—that are clear to the many stakeholders involved, and that have infused and influenced the entire environmental field. Health diplomats could benefit from adopting a similar approach. But it appears that there has been a static reliance on the 1948 WHO charter, with little added to elaborate and modernize it. While the ideas and principles remain relevant, global health diplomacy could benefit from defining and diffusing new and comprehensible core principles attuned to today's needs. This would help guide and influence the wide array of instruments and institutions relevant to global health.

GED is integrally linked to foreign policy through a number of key security and economic dimensions. While global health diplomats have been successful in framing health as a security concern—from pandemics to HIV/AIDS (see Chap. 9)—and have started to emphasize the socio-economic determinants of health, the economic link has remained much weaker. The lesson for global health diplomacy is to concentrate on the health-economic link as a synergistic, mutually supportive solution. In particular, global heath diplomats should look to how environmental diplomats were able to use the 2007–2010 global financial crisis to promote a green recovery (Kirton and Guebert 2010a).

In relation to actors, citizen-wide engagement, stronger sub-federal alliances and further foreign ministry institutionalism and cooperation could be pursued in the field of health. In particular, the environment has long benefited from NGOs that employ **public diplomacy** to engage local citizens in their causes, from buying energy efficient appliances to refusing to use plastic bags. While global health NGOs have tried to make similar connections through overseas sponsorships and celebrity-driven causes such as the RED campaign, they have not been nearly as far-reaching or successful as those in the environment (Iaffaldano 2006).

With respect to legal instruments, lessons from the environment for health come from the environmental diplomat's use of development assistance and international law, including sanctions and voluntary codes (see Chap. 4). While health has used similar means, it has had much less experience, and therefore could usefully seek to further develop its capacity by examining the wide breadth of instruments that exist in the environment. Environmental cases can be used as models and serve as starting points for future global health negotiations. Different legal instruments should be assessed, as they are better suited to different cases. And each case should be improved upon where possible.

Health diplomats can learn process tactics and skills from their environmental counterparts, where all stages of negotiation are extremely complex and difficult. Utilizing scientific evidence, civil society activists, public opinion and the media can all be critical to reaching an agreement and achieving a successful outcome.

Box 4 Lessons for Global Health Diplomacy from the Environment

1. Modernize and expand on the core principles established in the WHO charter to better reflect the current global health field.
2. Focus on mutually supportive economic-health links, where positive outcomes in both fields can result.
3. Engage individual citizens in global health causes. Provide individuals with outlets where they can contribute to global health in their daily lives.
4. Undertake more concrete assessments of instruments that have been successful.
5. Improve negotiation tactics and strategies, utilizing all possible tools, including scientific evidence, civil society activism, the media and public opinion.

Conclusions: Shared Lessons

There are several instances where global health diplomats can learn lessons from the ideas and principles, foreign policy links, actors, instruments and processes of GED. In each instance, it is important to remember that there are inherent differences between the fields, and therefore the outcomes will inevitably be different. There are no hard and fast rules. In global health diplomacy, as in all areas of diplomacy, a case-by-case assessment is critical. However, valuable lessons and tools can and should be extracted. In many cases, multiple approaches should be applied simultaneously. Global health diplomats should look to other areas for lessons as well; the global economy, security, trade and food and agriculture should all be explored. Looking beyond the global health field can provide diplomats with valuable, cost-effective lessons that could help them to achieve better outcomes in future negotiations.

Questions

1. Why is a comparison between global health and environmental diplomacy useful?
2. What lessons should global health diplomats learn from their environmental counterparts?
3. What have been some of the key challenges in GED? How are they similar to the ones in global health diplomacy? How are they different?
4. What are some of the important lessons that can be employed from other areas, such as the economy, trade and food and agriculture?

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Chapter 11
Global Trade and Health Diplomacy: Maximizing Cooperation and Minimizing Conflict Through Coherent International Rules

John Hancock

Reader's Guide

This chapter looks at the ways that a fast-evolving global trading system influences how countries pursue their national and international health objectives. In particular, it aims to do three things. First, the chapter highlights the policy areas where the trade system is most relevant to global health policy—health standards, intellectual property protection and trade in services. Second, it examines several current (and looming) health challenges that underline how closely trade and health officials must now work together to design and implement effective global policy. Third, it suggests ways in which even greater coherence in trade and health policy-making might be achieved, both at national and international levels.

Learning Points

- The global trading system is complex and extensive—governed by multilateral, regional and bilateral rules, negotiated in a wide variety of fora, including the World Trade Organisation, and often involving the same countries in multiple trade arrangements.
- Global trade rules affects health policy in many ways, but the main interface is health and food safety standards, intellectual property rights (IPRs) and trade in health-related services.

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- In each of these areas, trade agreements attempt to provide a balance between encouraging open trade and promoting health.
- There is a clear trend towards more collaboration, more dialogue, and increasing cross-referencing of international agreements between the trade and health communities.
- The central issue for the trade is not *whether* health objectives are valid, but *how* the actual policies are pursued—in particular whether policies are designed in a way that restricts trade as little as possible and does not discriminate between national and foreign producers.

Introduction: The Global Trade System Is About More Than Just Trade

The global trading system represents one of the most significant advances in international economic co-operation in history. Although its aim is to liberalize world trade and strengthen international economic relations, the system has also come to have a major impact on a range of non-trade issues, including health, as the scope of its rules have expanded, and as the world economy has grown more integrated. Sometimes this impact is direct—as when reduced tariffs improve access to medical equipment, or when trade rules regarding product standards affects national policies on food safety, or when intellectual property commitments affect the price of medicines and vaccines. Other times the impact is indirect. For example, open trade can promote economic growth, which can in turn help to reduce poverty and improve health, but open trade can also make it easier for diseases to spread quickly across borders. More than ever, health diplomats need to be aware of the increasingly complex ways that the trade system now interacts with health issues so policies can be designed in ways that are mutually supportive—in other words, to maximize coherence and to minimize conflicts.

At the centre of the global trading system is the World Trade Organization (WTO). With 155 members and rules covering almost every sector of international trade, the WTO is the key institution dealing with trade relations at the global level. The WTO has at least three core functions. It is a forum for liberalizing trade, advanced through a succession of giant multilateral negotiations, or "rounds", of which the current Doha Round is the latest effort. It is a set of binding international trade rules—some sixteen multilateral and two plurilateral agreements, including the three main agreements covering trade in goods [the General Agreement on Tariffs and Trade (GATT)], trade in services [the General Agreement on Trade in Services (**GATS**)] and intellectual property [the Agreement on Trade-Related Intellectual Property Rights (**TRIPS**)]. And it is judicial body for settling trade disputes—a kind of "world trade court". Besides these core functions, the WTO also does a number of other important things. For example, it is involved in making countries trade policies more transparent, both through its Trade Policy Review

(TPR) Mechanism and the hundreds of "notification requirements" embedded in various WTO agreements. The WTO secretariat has also become much more active in providing trade-related training, technical assistance and even capacity building for poorer developing countries. More generally, the WTO provides an increasingly important context where countries can openly discuss and coordinated their economic policies, not just with each other, but with other international and regional organizations.

Few international systems have expanded as dramatically as the global trading order. Although the WTO was only launched in 1995—making it the first new international organization of the post-Cold War era—it was built on the foundations of the older GATT which, together with the IMF and the World Bank, formed three pillars of the international economic system that emerged at the end of the Second World War. Over 60 years the system has evolved into something very different than its original architects envisaged. Whereas the original GATT had just 23 members in 1948, the WTO is practically global in scope, and includes all the major world trade powers, such as the USA, the European Union (EU), China, India, Brazil and most recently Russia. And while the early GATT was focused mainly on freeing up trade in industrial goods, the WTO now covers almost every sector of world trade—agriculture, raw materials, services and intellectual property, in addition to manufactured goods. Another important difference between the GATT and the WTO concerns the depth and reach of their rules and obligations. Early GATT rounds concentrated almost exclusively on reducing border tariffs to the point where industrial tariffs have fallen from an average of almost 45% in 1945 to less than 4% today. But the system's success in chipping away border barriers has inevitably resulted in "behind the border" or "non-tariff" measures becoming more relevant to trade flows—everything from national standards and regulations to differing legal systems—and the WTO's rules becoming more intrusive, more technical and more binding than anything envisaged in the early GATT. Creating international rules that impact on health policy was not the aim of the WTO, but a by-product—or unintended consequence—of its efforts to manage a world of deep economic integration.

The WTO does not have a monopoly on international trade rules. The trade landscape is also shaped by a fast-expanding web of bilateral and regional trade agreements (RTAs) which numbered over 300 at last count (Crawford and Fiorentino 2005). In addition, there is an even more extensive network of bilateral investment treaties (BITs) and double taxation agreements that have a growing impact, not just on trade flows, but on other policy areas, such as heath. These various agreements differ dramatically in their ambition and breadth: ranging from simple bilateral undertakings to "cooperate" on sectoral trade, to free trade agreements (**FTAs**), to customs unions, to deep continent-wide economic integration, exemplified by the EU.[1]

[1] Roughly 85% of the preferential trade agreements notified to the WTO are FTAs, while <10% are full customs unions. Some 75% of these agreements are bilateral, while the remainder involve three or more parties.

Besides their more limited membership, the main difference between these agreements and the WTO is that the former are preferential and discriminatory—i.e., the benefits and obligations apply only to parties to the agreement—whereas the WTO is non-preferential and non-discriminatory—i.e., all members must be treated equally and countries are not free to discriminate. Another key difference is that many of these agreements involve deeper levels of obligations and rule-making than in the WTO—resulting in a kind of WTO-plus type trade system, where smaller groups of countries can in theory liberalize "further and faster" than the broad membership of the WTO. So, for example, many recent bilateral and regional agreements not only include tariff-free trade but also provisions (either in stand-alone chapters or in relevant provisions in related chapters) on investment, services, government procurement and intellectual property that go well beyond existing WTO obligations, effectively creating a new regulatory regime superimposed upon the wider multilateral system. The geographical scope of RTAs is also changing. Whereas in the past bilateral and regional trade deals were usually struck between the so-called "natural" trading partners—that is, geographically contiguous countries with already well-established trade patterns—the newest generation of RTAs involve partners further afield (sometimes on different continents), and link advanced economies with developing ones (e.g., the European Union-Korea Free Trade Agreement) or developing economies with each other (so-called "South–South" agreements).

Thus the global trading system is as complex as it is extensive—with rules spanning within and across continents, including WTO plus and minus obligations, and involving the same countries in multiple trade arrangements. The growing complexity of the system has led many to worry about fragmentation, duplication and overlap in international trade relations—the so-called "spaghetti bowl" effect. However, it is important to note that despite the proliferation of RTAs, almost all are built upon the basic principles, rules and structures of the WTO system. Instead of viewing the WTO and regional agreements as two different, even opposing approaches to international trade relations it may be more useful and accurate to see these development in terms of the evolution of a multi-layered, multi-speed trade architecture, with the WTO providing a global foundation of rules and procedures (for example, in areas, like subsidies, that can only be negotiated multilaterally), and regional arrangements providing more ambitious or regionally specific "levels" on top of this (for example, in areas, like standards or transport logistics, that can best be managed regionally).

Pressure Points: Standards, Intellectual Property and Services

The evolution of a complex and wide-ranging system of global trade rules has inevitably had a growing—if sometimes unintended—impact on the way countries pursue their national and international health objectives. While it is beyond the scope of this chapter to list all the ways that trade rules influence health policies, there are

three key policy areas of interaction that need to be highlighted: health and food safety standards, IPRs and trade in health-related services.

In the WTO, there are two agreements—one on Technical Barriers to Trade (TBT) and the other on Sanitary and Phytosanitary measures (SPS)—that deal directly with health and food safety. Both are broadly designed to strike a balance between ensuring that countries can establish their own national standards, on the one hand, and ensuring that these standards do not act as unnecessary or hidden barriers to trade, on the other. The TBT agreement has the broadest scope, covering all issues related to product regulations, standards and testing and certification procedures, many of which have human health or safety as the objective. At the heart of the agreement is a recognition that all WTO members have the right to establish their own product standards and requirements for "legitimate objectives", including the protection of human health and safety. At the same time, the TBT agreement aims to ensure that these requirements, and the procedures used to assess compliance with them, do not unnecessarily restrict imports and exports.

Although the TBT agreement is complex, it rests on three basic concepts: first, a country's technical standards must be non-discriminatory—i.e., the same requirements must apply equally to all foreign and domestic products. Second, countries should design their technical requirements in ways that are not more trade restrictive than necessary to fulfil a legitimate objective—i.e., they need to be proportional to the objective they are trying to achieve. And third international standard should be used wherever possible to avoid the proliferation of multiple technical requirement and conformity assessment procedures. Countries can set higher standards but only on the grounds that the application of existing international standards would be ineffective or inappropriate for the fulfilment of certain legitimate objectives. Of all the TBT regulations notified to the WTO since the agreement came into force in 1995, the largest single group had human health or safety as their objective—underlining the obvious relevance of the agreement to health regulators.

The SPS agreement was negotiated during the Uruguay Round (1986–1994) to deal specifically with food safety and animal and plant health regulations. Covering everything from pesticides, to Mad Cow (BSE) disease, to hormone treated beef, the SPS agreement was part of the Round's broader effort to liberalize agricultural trade. Like the TBT agreement, the SPS agreement allows a WTO member to choose the level of regulatory protection it needs to preserve "public health" and to protect the environment from "risks arising from additives, contaminants, toxins or disease-causing organisms in foods, beverages or feedstuffs". However, the agreement sets out a detailed framework within which the decisions about SPS measures need to be made. As with the TBT agreement, the SPS agreement requires measures to be non-discriminatory and to be designed in the least trade-restrictive manner possible. It specifically notes that any measures relating to animal and plant health and safety cannot represent an "unnecessary, arbitrary, scientifically unjustified, or disguised restriction" on agricultural trade. And it too encourages countries to use international standards, guidelines and recommendations wherever possible—in the case of public health, these are established by the joint FAO/WHO **Codex Alimentarius** (the agreement also names the Organization for Animal Health as the relevant

organization for animal health and the International Plant Protection Convention for plant health.)

Where the SPS agreement differs from the TBT agreement, besides the exclusive focus on agriculture trade, is its specific requirement that any SPS measure that results in higher levels of health protection than international standards—or that addresses a health concern for which international standards do not exist—must be scientifically justified. Whereas the TBT agreement covers a vast range of technical requirements and standards, and permits the introduction of technical regulations to meet a variety of legitimate objectives, including national security, the SPS agreement applies to a narrowly defined range of health protection measures, and demands greater scientific rigour when countries depart from international norms. These requirements are primarily to ensure that bona fide health regulations are passed, not "protectionist" devices under the pretext of "public health" .But this increased level of obligations has also opened core aspects of the SPS agreement to differing interpretations by members.

Another key area where trade rules impact on health policy concerns IPRs—and, in particular, the provisions on patent protection embodied in WTO's agreement on **TRIPS**, and in the **TRIPS**-plus clauses found in a growing number of bilateral and regional **FTAs**. The **TRIPS** agreement establishes minimum levels of protection that each government must give to the intellectual property of fellow WTO members—such as patents on drugs or vaccines. Like all WTO agreements, it is based on the principle of non-discrimination: governments have to treat their own nationals and other WTO members equally. The **TRIPS** agreement also requires all WTO members to adhere to existing international intellectual property agreements, such as the Berne Convention on copyright or the Paris Convention on protecting industrial property (patents, trade-marks, industrial design, etc.), while adding a significant number of new and higher standards to these existing undertakings. And it sets out detailed rules for the enforcement of IPRs in domestic courts, while including provision for WTO dispute settlement if a member feels that another WTO member's domestic enforcement has been inadequate.

As noted above, most recent bilateral and regional **FTAs**—particularly those signed with the USA or the EU—also include IPR commitments that usually go beyond what is included or consolidated in the minimum standards of the **TRIPS** agreement. Such "**TRIPS**–plus" provisions typically extend standards of protection (e.g., from 10 to 15 years in the case of trademarks and copyright) include new areas of IPRs (e.g., protection for non-original databases), and weaken developing-country "flexibilities" in the **TRIPS** agreement, and strengthen enforcement. A number of existing BITs also contained high-level investment commitments which have a direct bearing on IPR protection, indeed, intellectual property is often defined as an "investment" for the purposes of these agreements (Mercurio 2006).

The issue of patent protection for pharmaceutical products is obviously highly relevant to health policy, but this is not the only area where the **TRIPS** agreement is significant. Trade in counterfeit drugs or protection for traditional medicines are both key issues for health policy makers, as are broader concerns about the complex linkage between technology flows and advances in economic development, poverty

reduction and improved health. It should also be noted that flexibility or "policy space" for health objectives is built into the **TRIPS** agreement in several ways. The agreement contains specific provisions that enable governments to implement their intellectual property regimes in a manner which takes account of immediate and longer-term health concerns. It also provides some flexibility in the implementation of the agreements by allowing countries, under certain circumstances, to limit patent owners exclusive rights, for instance by granting compulsory licenses and allowing parallel importation of patented products.

The third key area where trade rules and health policy interact concerns trade in services—and in particular the provision of the **GATS** agreement and the "deeper" services commitments in many recent **FTAs**. The rapid move towards an open world market for services—driven in part by technology, and in part by national regulatory changes (especially privatization)—is having a profound effect on national health systems. Because services trade is more complex than trade in goods, the **GATS** agreement starts by defining four ways or "modes" of trading a service: services supplied from one country to another (e.g., on-line "telemedicine" or "outsourcing"); consumers or firms making use of a service in another country (e.g., health tourism); foreign investment to provide a health service in another country (e.g., the opening abroad of clinics or hospitals) and individuals travelling from their own countries to provide services in another country (e.g., the cross-border movement of doctors or nurses). Besides the basic requirement that all WTO members be treated equally and that certain policies and processes be transparent, **GATS** imposes only very limited general obligations on members, who are free to choose which services sectors to open up and which modes of services to liberalize in their WTO schedules. Market access and national treatment in **GATS** represent conditional—and negotiable—obligations which may be subject to qualifications that members also inscribe in their schedules. This possibility, as well as the continued right to regulate for domestic policy purposes, provides substantial scope for national policy.

In this respect, the services provisions in many recent **FTAs** mark a significant departure from the **GATS**. Taking their inspiration from the NAFTA architecture, these agreements typically use a "negative list" approach, as opposed to the **GATS** more cautious "positive list" approach, to scheduling commitments. This means that liberalization obligations apply only those services sectors listed in schedules (and then subject to limitations inscribed), while a negative-list approach essentially means that the liberalization obligations apply fully to all sectors, subject to reservations listed. **FTAs** identify relevant trade in services in different chapters. For example, the NAFTA includes a chapter on cross-border services trade, a chapter on investment, and separate chapters on telecommunications, financial services, and movement of business persons, though most US **FTAs**, including all the most recent, exclude "temporary entry and stay" from the scope of the chapter on cross-border trade in services.

Aside from architecture and liberalization modalities, the biggest difference between **GATS** and recent FTA is the level of actual commitments undertaken by countries in these agreements. While very few countries have been ambitious in the **GATS**, there is clear evidence that countries have gone well beyond their **GATS**

obligations in recent **FTAs**—both in terms of more binding commitments for sectors already agreed under **GATS** and in terms of new commitments in services sectors uncommitted under **GATS**. What this means for policy makers concerned about actually health services liberalization commitments is that current—and future—**FTAs** might be more immediately relevant than the **GATS**. At least they need to be aware that services negotiations now take place along multiple tracks.

The Trade-Health Interface: Real-World Examples

The growing interface between trade and health is not just an abstract issue but one with direct and concrete relevance to the way that policy makers now design and implement global policy. Although convergence is hardly perfect—and significant gaps remains—the overall trend is unambiguously towards more collaboration, more inter-disciplinary dialogue, and increasing cross-referencing of international agreements between the trade and health communities (WHO 2002).

Disease Control

A good example is joint collaboration in the control of the spread of infections diseases. As economies become more interdependent and interlinked through increased trade and financial flows, health and trade officials are becoming more aware of the broader implications of their policies and are working together more closely to rapidly contain disease outbreaks and to mitigate any unintended or adverse economic spill-overs. Whereas in the past disease outbreak control often involved blanket quarantines or trade embargoes, health officials are now more focussed on effective information sharing and early containment strategies, through early warning surveillance systems, rapid verification procedures and international response networks. And when restrictions are used, they tend to be time-limited and aimed at minimizing trade and travel disruption. This is one of the fundamental principles underlying WHO's current revision of its International Health Regulations (IHR) which aims to "ensure the maximum security against the international spread of disease with a minimum interference with world traffic". The revised IHR specifically seeks to make its recommendations for control measures, issued at the time of a public health emergency, consistent with WTO member rights and obligations under the SPS agreement. Likewise trade officials who design and implement WTO rules have become more aware of health risks, as reflected in the architecture of the TBT, SPS and **GATS** agreements, all of which specifically recognize the right of governments to restrict imports for reasons for "human health". Specific measures used to control infectious disease, whether adopted by national governments or recommended by WHO in the performance of its IHR duties, are unlikely to run contrary to WTO rules as long as they are designed to be proportional (i.e., least trade restrictive) and non-discriminatory. The successful international response to the

2003 SARS outbreak—a new disease not identified by the then current IHR—highlighted just how effectively WHO could mobilize a coherent international response within the context of a globally integrated economy underpinned by WTO rules.

Food Safety

Food safety is another area where there is a clear and unavoidable trend towards more dialogue and closer cooperation between trade and health regulators, indeed the SPS agreement explicitly requires this collaboration. As noted above, the agreement gives governments the right to restrict trade in order to achieve health objectives as long as the measures applied are based on scientific evidence. It formally recognizes the food safety standards, guidelines and recommendations established by the FAO/WHO **Codex Alimentarius** Commission. This effectively provides the technical and scientific "backstop" for WTO rules and eliminates the need for each country to do its own risk assessment for any given hazard for which a standard, recommendation or guideline exists, it relies explicitly on "scientific considerations" and advice in SPS-related disputes. At a minimum, the SPS agreement provides a focal point for discussions of food safety and trade, and a framework within which the health and trade communities can interact. Food safety issues that have been addressed in the SPS committee range from discussions on restrictions on imports of hard cheese made from non-pasteurized milk to labelling requirements on shelled eggs, or shelf-life requirements for canned food products. Even when concerns regarding food safety measures and trade are solved bilaterally before they come to the WTO or around the edges of the SPS committee meetings, without actually being raised in the meetings themselves, the SPS agreement has provided an important focal point for inter-disciplinary dialogue and policy making as illustrated in Box 1.

Box 1 Assessing the Health Risks of BSE: Canada Versus Korea

The SPS agreement continues to be a focal point for WTO disputes. Most recently, a panel was established in August 2009 at Canada's request to review measures taken by Korea affecting importations of Canadian meat products (see WTO 2009).

Canada claims that this request came after 6 years of negotiations with Korea to resolve the issue—including 13 technical-level discussions. Canada argues that its beef exports are still banned from Korea despite clear guidelines from the World Organisation for Animal Health allowing safe trade of beef under conditions that Canada claims it has met.

Korea argues that WTO members have the right to sanitary and phytosanitary (SPS) measures for the protection of human, animal health or life. Korea

(continued)

Box 1 (continued)

adds that there is no effective treatment yet of BSE and that 16 BSE outbreaks had been reported in Canada, including two recent reports. Korea concludes that under these circumstances SPS measures were indispensable to prevent the introduction of BSE into Korea where this disease has never occurred.

The SPS agreement also provides an increasingly important legal framework for resolving international conflicts over the safety of traded foods. While the agreement and Codex standards have proven helpful in resolving such issues, there also remain significant challenges. One challenge relates to differing views on the limits of acceptable health risks and by extension, the limits of science in accurately assessing such risks. The Hormone Panel, in particular, showed both sides split (among other things) over the meaning of "scientific justification", what "based on" international standards means when choosing a level of protection, the role of the **Precautionary Principle**, and the precise contours of a "risk assessment" in the context of the SPS Agreement. Similar problems are likely to arise over attempts to resolve differing views on the safety of a range of new biotechnologies. A different and broader challenge is to help developing countries build the capacity to better meet international food and quality standards and to participate effectively in the international standards-setting process.

Access to Medicines

Access to drugs, vaccines, medical supplies and technologies is another complex field demanding ever closer cooperation between trade and health officials. Reducing barriers to trade is clearly one part of the answer to this access problem. As a result of multilateral, regional and bilateral agreements, as well as unilateral liberalization, import duties have decreased for a wide range of medical supplies, to the point where duties are low or moderately low in much of the developing world (with several notable exceptions), thus lowering costs while widening choice. Tariffs on the active ingredients that go into the manufacture of pharmaceuticals are also declining rapidly, helping to lower the price of finished products, and further expanding the scope for local manufacturing.

The **TRIPS** agreement's strong intellectually property protection requirements raises even more complex access issues—and underlines the need to balance adequate market incentives for research and investment, with improved access to affordable drugs and vaccines, especially in poorer countries. The scope in the **TRIPS** agreement for domestic regulation and national health policy in general is an important part of the "balance" in the agreement. This includes flexibility for: compulsory licensing, parallel imports and the use of price or similar controls to help ensure access to affordable medicines, especially in the case of national health

crises or emergencies. Governments need to address a range of problems outside the field of intellectual property to address issues of access to and prices of drugs. The fact that billions of people lack access to essential drugs that are not protected by patents, underscores that there are other problems besides the high price of patented drugs, such as poorly developed supply and distributions systems, lack of financing, lack of generic drug production or import capacity and the affordability of even generic drugs for people in poorer countries. Nevertheless, while the importance of patent protection in providing incentives for R&D is generally accepted (see Box 2), there continues to be a major debate, first, about the extent to which a global requirement to protect pharmaceutical inventions at the level mandated in the **TRIPS** agreement enhances the overall level of incentives for R&D and second, about the extent to which such a requirement affects such incentives in the case of diseases which predominately afflict people in developing countries. Owing to the inconclusive nature of this debate, and because of the impact that more stringent intellectual property requirements could have on access to drugs in poor countries, the WHO continues to monitor and evaluate the effects of **TRIPS** on the price of medicines, technology transfers, levels of R&D for drugs for neglected diseases, and the evolution of generic drug markets. Here, as in many other areas, the scope of policy dialogue between trade and health regulators is expanding.

Box 2 The Evolving Intellectual Property Debate: Declaration on the TRIPS Agreement and Public Health

The World Health Assembly's annual meeting in May 2001 devoted substantial attention to the lack of access to essential drugs, which had become acute in light of the spread of HIV/AIDS. It adopted a resolution noting that "the impact of international trade agreements on access to, or local manufacturing of, essential drugs and on the development of new drugs needs to be further evaluated". This resolution, plus concerns raised in other international fora, helped pave the way for the WTO's Declaration on the **TRIPS** Agreement and Public Health adopted at the 2001 Doha Ministerial Meeting.

The Declaration responded to concerns about potential negative impacts of the **TRIPS** agreement on access to drugs in several ways. First, it emphasized that the agreement does not and should not prevent members from taking measures to protect public health and reaffirms the right of members to use, to the full, the provision of the **TRIPS** agreement which provide flexibility for this purpose. Second it makes clear that the agreement should be interpreted and implemented in a manner supportive of members' rights to protect public health and, in particular, to promote access to medicines for all (providing important interpretive guidelines, in the event of disputes). Third, it contains a number of important clarifications of some of the flexibilities contained in the **TRIPS** agreement (e.g., with regard to parallel imports). With regard to least-developed country members, it accords them an extension of their transition period until the beginning of 2016 for the protection and enforcement

(continued)

Box 2 (continued)

of patents and rights in undisclosed information with respect to pharmaceutical products. Until then, these countries are exempt from these **TRIPS** obligations.

Delivery of Health Services

Service trade liberalization is another broad subject with a direct bearing on the structure and operation of national health systems. The efficient and equitable delivery of health services depends on many factors, including the appropriate combination of resources available domestically as well as internationally. Besides essential drugs and medical supplies, critical resources include qualified health personnel, well-equipped facilities, and accessible financing, whether through insurance coverage or affordable public sector provision. Access to many of these resources is being opened up, in some cases dramatically, through global services trade. For example, health professionals are increasingly moving to other countries, whether on a temporary or permanent basis, in search of higher wages or better working conditions. Foreign investment by hospital operators and health insurance companies in search of new markets is also increasing. At the same time, a growing number of countries are seeking to attract health consumers from other countries—a phenomenon that has been labelled "health tourism" (see Box 3).

Box 3 Health Tourism

Countries are increasingly competing to be exporters of health services, nowhere is the more evident than in the growing phenomenon of "health tourism". Over 35 countries offer attractive surgery, recuperation and rejuvenation holiday packages—and this number is projected to grow significantly in coming years.

In 2008, more than 400,000 non-residents sought care in the USA and spent almost US$ 5 billion for health services. Developing countries are also flourishing destinations. India attracted some 450,00 health tourists in 2008; Malaysia 300,000, Singapore 410,000, and Thailand 1.2 million (Deloitte 2008).

New communications technologies are making it possible to supply or "outsource" a range of health services at a distance and, by implication, across national borders. Depending on appropriate regulatory conditions, this expansion of health services trade can help countries, both directly and indirectly, to expand the resources available to their citizens. For example, hospitals financed by foreign investment can provide services not previously available. And such new hospitals can offer attractive employment alternatives for health professionals who might otherwise

leave the country. Revenues generated through the treatment of foreign patients may be used to upgrade facilities that also benefit the resident population.

The **GATS** leaves countries huge flexibility to manage the internationalization of health care services in ways that are consistent with their national health policy objectives. Countries can choose whether to make commitments only in some sectors (or no sectors) and have immense scope to set specific limits on these commitments as required to deal with various policy concerns. Although commitments are binding, governments can also modify or withdraw these commitments (subject to compensation) 3 years after their entry into force. Governments also remain entirely free to introduce national regulations in the pursuit of quality, competitions, and other domestic policy objectives. More to the point, countries have shown a marked reluctance in both the Uruguay and Doha trade rounds to undertake health sector-related commitments in the **GATS** (with the exception of insurance) and an even greater reluctance to challenge existing **GATS** commitments in any sector in a WTO dispute (see Box 4). None of this changes the fact that **GATS** commitments voluntarily undertaken by governments (including through accessions) could involve potentially significant changes to national health systems, and this underscores the need for close strategic collaboration between health policy-makers and trade negotiators to ensure that any **GATS** obligations undertaken are fully considered and appropriate.

Box 4 Where Are the GATS Commitments?

Although the potential impact of the **GATS** on health-related policies was initially viewed with some trepidation by many experts, its actual impact has been very modest. At the end of the Uruguay Round in 1994, the vast majority of WTO members elected not to assume any trade obligations, in terms of market access or national treatment, in relevant sectors—and this has remained largely the case since then. Typically, medical and hospital services (health care) are the only major areas that have remained exempt from the **plurilateral** request-and-offer process initiated in the wake of the 2005 Hong Kong Ministerial Conference. And for lack of interest, no group of "proponents" has emerged in the Doha Round. A notable exception is health insurance. Like other financial services, insurance services have been included frequently in schedules of specific commitments, and this was largely a result of the "late harvest" of commitments in 1997, after the formal conclusion of the Uruguay Round.

Issues related to the particular role of health-related services, which might warrant attention in a trade context, have also largely been absent from **GATS** discussions to date. Governments seem generally aware of existing legal or definitional uncertainties and, more importantly, of the political sensitivities involved. Nor, in the absence of egregious violations of current obligations, does any country seem particularly eager to launch a legal challenge, whether in health or any other service sectors for that matter.

See Adlung (2011).

Conclusions: Towards Trade and Health Policy Coherence

Clearly international trade rules affect public health policy across a widening range of issues and vice versa. The right of governments to take measures to restrict or limit trade in order to protect or promote health is not—and has never been—under question. The central issue for the trade is not *whether* health objectives are valid, but *how* the actual policies are pursued. Are measures applied or enforced in a way that is non-discriminatory, or do they unfairly differentiate between trading partners or between foreign and domestic producers? Are the measures proportionate to the health objective being sought, or are they unnecessarily trade restrictive? It is these kinds of practical issues—ensuring that policies are applied in a non-discriminatory, measured way, and ensuring that there is a reasonable scientific justification for measures—that form that basis of the policy dialogue between trade and health officials, and lie at the heart of almost all health-related trade disputes. Real-world examples of how policy-makers are managing the trade-health interface, illustrated in this chapter, help to show, not just where this flexibility is being optimized, but where it is still potentially ambiguous and open to conflicting interpretations and concerns.

The essential challenge is to ensure that trade and health officials work together more often, more effectively and in a wider variety of contexts to develop trade and health policies that are mutually supportive and coherent. But while policy coherence is easy to propose in principle, it is sometimes harder to achieve in practice. One problem is that trade and health policy making often takes place in vertical "silos"—in trade or in health ministries, in the WTO or the WHO—with relatively little cross-fertilization and few mechanisms for promoting horizontal interaction. A deeper problem is that the backgrounds, preoccupations and intellectual frameworks of trade and health officials can be very different—with one community focused on economics, the private sector, making markets freer, and the other focused on social policy, the public sector and designing effective regulations. From a trade ministry perspective, health may be seen in the context of trade agreements that are essentially about liberalizing trade. By contrast, health professionals may perceive that the need to submit health measures to trade scrutiny will subordinate health to trade interests. How to maximize policy coherence when these communities can sometimes seem to inhabit different worlds?

Better collaboration at the international level represents one answer to this challenge. Although the roles, objectives and structures of the WTO and WHO are distinct, there is huge potential for complementary work between the two organizations. While the WTO provides a forum for countries to negotiate and enforce trade rules, it is not a scientific body, nor does it develop standards. Here the WHO can—and does—provide an important role. The WHO's active presence at SPS meetings has allowed WHO staff to provide advice on health matters related to trade. Examples include WHO's input on the risks of Mad Cow disease (BSE) to human health, and on the health effects of genetically modified organisms in food. WHO representatives have also provided expert testimony to WTO dispute settlement panels, for

example, in the EC-Hormones case. Staff from the two organizations participate frequently in regional or country-level meetings for the purposes of technical assistance, for example, to help countries confirm to SPS requirements. In addition to the SPS committee, the WHO's official relationship with the WTO also includes observer status in the TBT and **TRIPS** Councils, and at the WTO Ministerial Meetings Observer status at the in relevant bodies increases WHO's ability to identify mutually supportive health and trade policies, and to help forestall potential conflicts. The WTO, for its part, has observer status at the WHO's annual meetings of the World Health Assembly. WTO staff also participate as observers in meetings of the Codex and in the deliberations on the Framework Convention on Tobacco Control.

But international organizations do not create global policy—national governments do. For coherence in trade and health to have any meaning, it has to begin at the country level, within governments and among ministries. This is particularly important for poorer countries, which often need technical, capacity building and financial help to create appropriate intra-governmental structures and strategies. There are examples of successful country-level mechanism for improving collaboration between health and trade ministries and for developing unified trade-health strategies. Although the models differ and are rightly tailored to specific national circumstances, all share a basic commitment to regular dialogue, information sharing and coordinated action between policy makers and advisors on all sides. Perhaps most importantly, all share a high-level political commitment to achieving a coherent, "whole of government approach" to national trade and health strategies.

The regular participation of health officials in health-related WTO discussions, both at the national level, where policy is formed, and at the global level, where negotiations take place, can be extremely helpful in this regard. It would be useful, for example, for all delegations to include health officials when health issue are the focus of WTO meetings, whether as specific agenda items of regular meeting of the General Council or Ministerial Conferences or in the more focused deliberations of issue-specific bodies, such as the **TRIPS** Council. Aside from the work undertaken in the operational committees already mentioned (SPS, TBT, agriculture, etc.), the WTO TPR Mechanism also provides a valuable forum for exploring trade and health issues in a non-negotiating context. Here too the active participation of health experts needs to be encouraged and even formalized.

Then there are various contexts in which the rules of the WTO system are reviewed, amended or negotiated by government officials, often over several years. The most significant context of course is the current Doha Round of global trade negotiations. Launched at the WTO's ministerial conference in Doha Qatar in November 2001, and covering twelve broad subject areas (many of which, such as **TRIPS** and **GATS**, explicitly involve health issues), the Doha Round it is the eighth such major multilateral negotiation since the multilateral system was created in 1948 and the main global focal point for updating and expanding the trade system's rules. Accessions provide another important context where very significant rule-making often takes place, as candidate countries negotiate and then implement the domestic economic reforms required to adapt to WTO rules and to reflect the

bilateral market access "concessions" extracted by WTO trading partners. Finally, there is the Dispute Settlement process (both panels and appeals) which plays an increasingly important part in interpreting (and adapting WTO rules), which encourages and may even force parties to a dispute to draw on increasingly wide range of policy and legal expertise including on health matters.

In the end it is up to government to decide whether to involve health officials in domestic trade policy preparations or to include them directly in negotiations or the panel process. Nevertheless, the logic of ensuring that health objectives are fully taken into account in any national trade strategy is hard to refute. As was seen during the SARS outbreak or the more recent H1N1 scare, the interface between health and trade becomes more and more critical in a fast-changing, more interconnected world. With the appropriate information and resources, with the requisite spirit of collaboration, and with the right strategic vision, policy synergies can be used to advance the common goal of sustainable human development.

Questions

1. What are the main functions of the WTO?
2. How do the functions and competence of WHO and WHO compare?
3. In what ways does trade impact on health?
4. And how does health affect trade?
5. What are the main trade regulation instruments that impact on health?
6. How have trade agreements recognized health concerns?
7. What do health diplomats have to learn from the experience of trade diplomacy?
8. How can health and trade officials work more closely together in the future?

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Chapter 12
The World Health Organization as a Key Venue for Global Health Diplomacy

Elil Renganathan

Readers' Guide

This chapter explores the role of the World Health Organization (WHO) as a venue for, and actor in, global health diplomacy. It examines the origins and development of WHO, its structure and processes and how its responsibilities have evolved, as a basis for considering its future role in global health negotiations. This is illustrated by examples of WHO's negotiations with Member States, showing how it has moved beyond the traditional areas to provide a forum to discuss issues such as global health and trade, intellectual property and health security. This has required a renewed focus on concerns such as policy coherence at WHO between governments and with other sectors and actors. The WHO has therefore needed to engage with many new actors in public health decision-making. Global health diplomacy has been central to this development, shaping the way WHO works with others to address new global challenges.

Learning Points

- WHO's objective is the attainment by all peoples of the highest possible level of health defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

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- It is directed by the World Health Assembly and the Executive Board and is carried out by the Secretariat staff working in Geneva, six regional offices and country offices.
- It provides leadership at both political and professional levels working closely with Member States, other international intergovernmental organizations, academia, civil society, the private sector and other stakeholders.
- WHO has redefined global health governance as a key aspect of human security, a central issue for development and a way to address shared global challenges.
- Recognizing the need to increase engagement of different actors in global health it has created partnerships bringing together international agencies, bilateral donor agencies, private and civil society groups and partner countries to coordinate action, scale up development efforts, and deliver improved health.
- WHO's role in global health diplomacy includes negotiating global public goods for health, providing a venue and expertise for the negotiation, and supporting countries in the implementation of agreements and standards.

Introduction: The World Health Organization's Role and Functions

WHO is the directing and coordinating authority for health within the United Nations system. Its membership, as set out in Article 3 of the WHO's constitution, is open to all recognized States and is presently made up of 194 Member States and Associate Members. The work of the Organization is facilitated by a Secretariat led by the Director-General.

WHO's core functions are to provide leadership on matters critical to health and to engage in partnerships where joint action is needed; to shape the research agenda and stimulate the generation, translation and dissemination of valuable knowledge; set norms and standards and promote and monitor their implementation; articulate ethical and evidence-based policy options; provide technical support, catalyse change and build sustainable institutional capacity; and monitor the health situation and assess health trends. These functions and how they will be fulfilled are set out in the 11th General Programme of Work (GPW), entitled "Engaging for health", which provides the framework for Organization-wide actions, budgets, resources and results covering the 10-year period from 2006 to 2015.

In fulfilling its role, the Organization works closely with Member States, other international intergovernmental organizations, academia, civil society, the private sector and other stakeholders.

History, Institutional Structure and Governance

At the end of the Second World War when countries met in San Francisco to consider the establishment of the United Nations (UN), they also discussed setting up a global health organization. This was followed by the adoption of a resolution at the UN's Economic and Social Council meeting in 1946, leading to an International Health Conference to consider the scope of, and appropriate machinery for, international action in the field of public health, including the establishment of a single international organization of the United Nations to cover public health.

This International Health Conference adopted the WHO Constitution, which came into force on 7 April 1948—the date on which World Health Day is celebrated every year. The first World Health Assembly, in June 1948, was attended by delegates from 53 of WHO's 55 original Member States. At the first Health Assembly, it was decided that WHO's top priorities should be malaria, women's and children's health, tuberculosis, venereal disease, nutrition and environmental sanitation—many of which we still grapple with today. The Organization has since grown to a membership of 194 Member States and two Associate Members. The scope of its work has also expanded to cover a broader set of public health issues, including some which were unknown when WHO was first established, such as HIV/AIDS and SARS. Moreover, as a specialized agency of the United Nations, WHO is accountable to its Member States and works closely with other entities of the UN system.

WHO's objective, as set out in its Constitution, is the attainment by all peoples of the highest possible level of health. Health is defined by the WHO Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The Constitution clearly outlines, inter alia, WHO's objectives, its functions, its membership, and the role of the World Health Assembly, the Executive Board and the Secretariat.

The work of the Organization is directed by the World Health Assembly and the Executive Board and is carried out by the Secretariat. The World Health Assembly is the supreme decision-making body for WHO. It generally meets in Geneva in May each year, and is attended by delegations from all Member States. Its main function is to determine the policies of the Organization. The Health Assembly appoints the Director-General, supervises the financial policies of the Organization, and reviews and approves the proposed programme budget. It similarly considers reports of the Executive Board, which it instructs with regard to matters upon which further action, study, investigation or report may be required. Apart from the Member States' delegates, the Health Assembly is also attended by representatives of the United Nations and other intergovernmental and nongovernmental organizations in official relations with WHO.

The Health Assembly has the authority to adopt conventions or agreements with respect to any matter within the competence of the Organization. It also has the authority to adopt regulations concerning:

- Sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease.

- Nomenclatures with respect to diseases, causes of death and public health practices.
- Standards with respect to diagnostic procedures for international use.
- Standards with respect to the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce.
- Advertising and labelling of biological, pharmaceutical and similar products moving in international commerce (*Article 21 of the Constitution*).

The regulations adopted by the Health Assembly come into force for all Member States after due notice has been given, except for those Member States notifying rejection or reservation within a stated period. The Health Assembly conducts its business through plenary sessions and committees (in particular committees A and B), and its work is supported by drafting groups and working groups.

The Health Assembly is supported by the Executive Board, which is composed of 34 members technically qualified in the field of health. Members are elected for 3-year terms. The main Board meeting, at which the agenda for the forthcoming Health Assembly is agreed upon and resolutions for forwarding to the Health Assembly are adopted, is held in January, with a second shorter meeting in May, immediately after the Health Assembly, for administrative matters. The main functions of the Board are to give effect to the decisions and policies of the Health Assembly, to advise it and generally to facilitate its work, as its executive organ. Its other functions include performing any functions entrusted to it by the Health Assembly; submitting advice or proposals to the Health Assembly on its own initiative; and taking emergency measures within the functions and financial resources of the Organization to deal with events requiring immediate action (for example, authorizing the Director-General to take necessary steps to combat epidemics or to organize health relief to victims of a calamity). Furthermore, the Director-General, who serves as the chief technical and administrative officer of the WHO Secretariat, is appointed by the Health Assembly on the nomination of the Board.

The Secretariat of WHO has a staff of around 8,000 health and other experts and support staff, working at its headquarters in Geneva, in the six regional offices in Brazzaville, Cairo, Copenhagen, Manila, New Delhi and Washington DC, and in over 147 country offices. The six regional offices, i.e. for the African Region (AFRO), the Region of the Americas (AMRO), the Eastern Mediterranean Region (EMRO), the European Region (EURO), the South-East Asia Region (SEARO) and the Western Pacific Region (WPRO), are directed by regional committees and a Regional Director. Each regional committee is composed of delegates of Member States of the respective region and meets annually. Its overall functions outlined in the Constitution include policy discussions on health matters of regional concern and adaptation of global policies to address regional needs and inputs into the development of the Organization-wide programme budget. The regional committees also elect the Regional Directors who head and are responsible for the work of the regional offices, a unique situation among the UN specialized agencies. Governing Bodies' meetings, both at the global level (Health Assembly and Executive Board) and the regional level (regional committee meetings), are thus relevant venues for negotiation of key

public health issues and hence fora for global health diplomacy. Notable health issues that have been the subject of WHO and World Health Assembly intergovernmental negotiations and treaties include the International Health Regulations (2005), the Framework Convention on Tobacco Control (FCTC), the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property (see Box 1) and the Intergovernmental Meeting on Pandemic Influenza Preparedness.

Box 1 The Intergovernmental Working Group on Public Health, Innovation and Intellectual Property

There has been a growing international debate on the wider aspects of the relationship between intellectual property rights (IPRs), innovation and public health. This has focused on the contribution that innovation in the public health field can make to the improvement of human health in developing countries, especially for the poorer and more vulnerable sectors of the population. Mobilizing research and development that responds to the needs of these populations is crucial, recognizing that the contribution innovation can make will only be meaningful if products are acceptable, affordable and accessible.

In response to this public concern, the World Health Assembly of 2003 decided to establish an independent time-limited body, the Commission on Intellectual Property Rights, Innovation and Public Health (CIPIH), to collect data and proposals from different actors involved and produce an analysis of IPRs, innovation and public health, including the question of appropriate funding and incentive mechanisms for the creation of new medicines and other products against diseases that disproportionately affect developing countries. The Commission submitted its report to Member States in April 2006. It contained 60 recommendations grouped into 5 categories: discovery, development, delivery, fostering innovation in developing countries and the way to support a sustainable global effort (see the CIPIH report of 2006).

The Commission also proposed an important role and responsibility for WHO for preparing a global plan of action to secure enhanced and sustainable funding for developing and making accessible products to address diseases that disproportionately affect developing countries. The World Health Assembly welcomed the report of the CIPIH and, as a follow-up, adopted resolution WHA59.24 on Public health, innovation, essential health research and IPRs: towards a global strategy and plan of action. Among other proposals, the resolution asked the Director-General of WHO to establish an intergovernmental working group open to all interested Member States to draw up a global strategy and plan of action in order to provide a medium-term framework based on the recommendations of the Commission.

The Intergovernmental Working Group on Public Health, Innovation and Intellectual Property (IGWG) was mandated to develop a global strategy and plan of action aimed at, inter alia, securing an enhanced and sustainable basis

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Box 1 (continued)

for needs-driven, essential health research and development relevant to diseases that disproportionately affect developing countries, proposing clear objectives and priorities for research and development, and estimating funding needs in this area. In fulfilling this mandate, the IGWG became the first forum to simultaneously address the issues of innovation and access.

WHO Member States from around 150 countries and other key stakeholders held three meetings of the IGWG (December 2006, November 2007, and April 2008) to discuss ways to foster innovation, build capacity and improve access to health products to achieve better health outcomes in developing countries. They also met in regional and subregional consultations and other multilateral meetings linked to the IGWG. Their work was enhanced by written submissions from Member States on various negotiating texts, as well as inputs from a wide range of stakeholders organized through two web-based public hearings. Additionally, a pool of experts and concerned entities were invited by the Director-General to attend sessions of the Working Group and to provide inputs. Stakeholders also included representatives from other international and nongovernmental organizations (including public health advocacy groups and industry associations).

In May 2008, the World Health Assembly adopted the global strategy and the agreed parts of the plan of action on public health, innovation and intellectual property in resolution WHA61.21. This outcome was the product of extensive consultations with and among Member States, in both sessional and intersessional work. The negotiations were held in a spirit of constructive engagement and much was achieved.

The global strategy proposes that WHO should play a strategic and central role in the relationship between public health and innovation and intellectual property within its mandate. To achieve this principle, Member States endorsed by consensus a strategy to promote new thinking in innovation and access to medicines, which would encourage needs-driven research rather than purely market-driven research to target diseases which disproportionately affect people in developing countries.

The global strategy is comprised of eight elements, the development of which was guided by a set of principles established and agreed upon by Member States. In particular, the elements of the global strategy are designed to promote innovation, build capacity, improve access and mobilize resources. The plan of action, linked to the global strategy, outlines a set of specific actions. Furthermore, it identifies lead stakeholders and timeframes for implementation, thus providing a roadmap for carrying forward this important work in fostering innovation and improving access relevant to diseases that disproportionately affect developing countries.

The IGWG was a unique exercise for WHO and, given its broad interdisciplinary nature, a number of challenges arose, for example ensuring

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Box 1 (continued)

participation of competent delegations from all Member States, especially from developing countries. This was difficult at the outset but improved over time and, in addition, regional and subregional groupings emerged, making it easier for smaller delegations to contribute to the process. Other challenges the IGWG faced included differing views and interests among Member States, in particular as to the role and mandate of WHO. A group of Member States clearly wanted the focus of the IGWG to be on innovation, i.e. on R&D for diseases that disproportionately affect the poor, while others clearly wanted the global strategy and plan of action to also adequately address access/delivery issues which are important to many developing countries. Moreover, a number of Member States wanted WHO to concentrate on its public health mandate and leave trade and intellectual property-related issues to organizations such as the World Trade Organization (WTO) and the World Intellectual Property Organization (WIPO).

The successful outcome of the IGWG has been described as a key event in this new era of global health diplomacy, demonstrating what can be achieved when public health experts and diplomats work together (see Chan et al. 2008). The successful outcome was due to the flexibility that Member States demonstrated in negotiating the global strategy and plan of action, which advocates a more proactive approach in the quest for innovation of, and equitable access to, life-saving and health-promoting interventions.

Box 1 illustrates the WHO's role in Member States' negotiations. But it also shows how WHO is called upon to address non-traditional areas and provides an example of the creation and operation of a new forum for discussing interlinked issues (health-trade-intellectual property) and the concomitant issues such as policy coherence, multiple sector involvement, and the involvement of new players in public health decision-making.

The Evolution of WHO and Its Role in a Changing Global Environment

Recognition of the importance of health to development and security has led to substantial growth in national and international investment in global health. At the same time, there has also been much greater awareness of how the health of populations is shaped by powerful global trends such as ageing, international mobility, urbanization, the globalization of unhealthy lifestyles, and other social determinants of health. These factors have led many more organizations and groups to engage with global health issues.

WHO's most recent GPW, noted in the first section, coincides with the time frame for achieving the Millennium Development Goals (MDGs). The GPW was the product of an extensive review by the WHO Secretariat, its Member States and partners, who examined current global health problems, the challenges they imply and the ways in which the wider international community, not just WHO, must respond to them over the next decade. The GPW recognizes health as a shared resource and shared responsibility and thereby redefines the scope of global health governance.

The GPW defines global health as a key aspect of human security and a central issue for development; it addresses shared global challenges. While there have been major gains in life expectancy, the GPW notes widening gaps in health outcomes. These in turn reflect gaps in social justice; gaps in responsibility; gaps in implementation; and gaps in knowledge.

The analysis of the past and present challenges and gaps leads to the identification of seven priority areas for action and six core functions. The GPW recognizes the need to engage new partnerships for health, noting that while this is a welcome reflection of political and financial commitment, it also leads to a complex **global health governance architecture**, with new challenges and expectations for WHO.

When the current WHO Director-General took office in 2007, she also recognized that the world in which WHO operates is complex and rapidly changing and that the boundaries of public health action have become blurred, extending into other sectors that influence health opportunities and outcomes. In responding to these challenges she provided a clear leadership vision. The Director-General's six point agenda addresses two key health objectives: promoting development and fostering health security; two strategic needs: to strengthen health systems and harness research, information and evidence; and two operational approaches: enhancing partnerships and improving performance. She declared that the effectiveness of WHO would be judged in terms of improvements in the health of the people of Africa and the health of women, and reaffirmed WHO's commitment to primary health care.

Global Health Governance Architecture

One response to increased engagement of different actors in global health has been the creation of multi-participant partnerships bringing together international agencies, bilateral donor agencies, private and civil society groups and partner countries to coordinate action, scale up development efforts, and deliver improved health outcomes. While the initial stimulus for such initiatives has more often arisen from other parties such as G8 meetings or the OECD, the WHO has been a participant in the negotiation of many such partnerships focused on global health.

The International Health Partnership (IHP) was launched on 5 September 2007 to bring agencies and groups together to address the health-related MDGs and universal access commitments. Other multi-partner initiatives in this field include the "Catalytic Initiative", the Deliver Now Initiative, Harmonization for Health in Africa (HHA),

GAVI's Health System Strengthening, the Global Fund to fight AIDS, Tuberculosis and Malaria—National Strategy Applications, the Health Metrics Network, the Global Health Workforce Alliance, the UN Secretary-General's High Level Initiative to support the MDGs in Africa, and the "Providing for Health Initiative", have also been launched to coordinate action, scale up access to interventions and address health systems' bottlenecks that hinder progress in achieving outcomes. The common goal of all these initiatives is to accelerate the achievement of the health-related MDGs in line with the Paris Declaration on Aid Effectiveness of 2005.

Two further examples of interagency collaboration are the "H8" and the "H4". The "H8" health organizations consist of the Bill & Melinda Gates Foundation; the GAVI Alliance; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the Joint United Nations Programme on HIV/AIDS (UNAIDS); the United Nations Population Fund (UNFPA); the United Nations Children's Fund (UNICEF); the World Bank and WHO. These interagency collaborations meet twice a year to strengthen linkages and work jointly to address challenges to scaling up health services and improving health-related MDG outcomes, particularly for low-income countries. The H8 has agreed on a global common results framework for evaluating progress in health.

"H4" is an interagency mechanism aimed at harmonizing and accelerating actions to improve maternal and newborn health and consists of UNICEF, WHO, UNFPA and the World Bank. These institutions have chosen to work together to improve maternal health and reduce newborn deaths due to the complexity of the field, which involves strengthening health systems, scaling up programmes to reach remote rural areas and marginalized populations, and targeting resources to a cross-cutting issue. During the coming years, the four agencies will enhance their support to the countries with the highest maternal mortality, starting with six (Afghanistan, Bangladesh, the Democratic Republic of the Congo, Ethiopia, India and Nigeria), scaling up to 25 more and later covering 60 countries. They will focus on helping countries to strengthen their health systems so that they can reduce the maternal mortality ratio by 75% and achieve universal access to reproductive health, as called for by MDG 5. The joint efforts will also contribute to reducing child mortality, as called for by MDG 4.

New interagency collaborations continue to form in a range of areas relevant to public health. For example, a 2010 symposium held by WHO, the WIPO and the WTO examined issues concerning access to medicines for poor populations. WHO's Director-General welcomed this opportunity to collaborate with WTO and WIPO to jointly consider policies for drug procurement, pricing, and intellectual property from a public health perspective identifying access to medicines as an appropriate, and a challenging, focus for joint efforts.

WHO and International Treaty Negotiations

In addition to interagency collaboration, WHO has managed two treaty negotiations: the 2003 WHO FCTC and the 2005 International Health Regulations (IHR).

The FCTC is the first treaty negotiated under the auspices of the WHO. It was adopted by the World Health Assembly in 2003 and entered into force in 2005. It has since become one of the most widely embraced treaties in UN history and, as of today, has already more than 170 Parties. The FCTC was developed in response to the globalization of the tobacco epidemic and is an evidence-based treaty that reaffirms the right of all people to the highest standard of health. The Convention represents a milestone for the promotion of public health and provides new legal dimensions for international health cooperation (see Chap. 4).

The International Health Regulations (2005) were revised between 2004 and 2005. This legally binding agreement makes a substantial contribution to global public health security by providing a new framework for coordination of the management of events that may constitute a public health emergency of international concern, and will improve the capacity of all countries to detect, assess, notify and respond to public health threats. States Parties to the Regulations have 2 years to assess their capacity and develop national action plans and then 3 years to meet the requirements of the IHR. These requirements relate to their national surveillance and response systems as well as the requirements at designated airports, ports and certain ground crossings (a 2-year extension may be obtained, and, in exceptional circumstances, an additional extension could be granted, not exceeding 2 years).

WHO's Evolving Role in Global Health Diplomacy

WHO's role in global health diplomacy can be illustrated by its dual role in negotiating global public goods for health (see Chap. 8), such as conventions, regulations, codes, standards and guidelines. It provides both a venue and expertise for the negotiation of such goods and may be a key actor in interpreting and supporting countries in the implementation of agreements and standards. This is likely to be crucial in relation to disputes between States or other parties, but WHO may also be the agency responsible for monitoring performance in relation to global public goods. WHO's comparative advantage as a forum for global health diplomacy lies in its neutral status and nearly universal membership, its impartiality, technical capability and strong convening power. WHO has a large repertoire of global normative work. Many countries rely on WHO standards and assurances in medicines and diagnostic equipment. WHO promotes evidence-based debate, and has numerous formal and informal networks around the world. WHO's regionalized structure provides it with multiple opportunities for engaging with countries.

However, while the WHO has taken steps to recognize the new world in which it provides leadership, authoritative advice and support, working with a wide range of other actors, clear/formal mechanisms for engaging stakeholders such as civil society and private sector are still being discussed by its governing bodies. Furthermore, while its experience in global legal negotiations and the implementation of legally framed international agreements is growing, this is a new and difficult arena.

These issues were addressed during negotiations on the future funding of the WHO, which raised questions as to its future role and functions as described in Box 2.

Box 2 The Future Role and Financing of WHO

In January 2010, the Director-General of WHO convened an informal consultation on the future of financing for WHO. The original impetus for this meeting came from budget discussions at the Executive Board and the World Health Assembly in 2009. Two key issues underpinned the debate: firstly how to better align the priorities agreed by WHO's Governing Bodies with the funds available to finance them; and, secondly, how to ensure greater predictability and stability of financing to promote more realistic planning and effective management. While WHO's financing was the starting point for the consultation, it prompted a series of more fundamental questions about what should constitute WHO's *core business*. How, for instance, should the mandate to "act as the directing and coordinating authority on international health work" be understood in the radically changed landscape in which WHO now operates, 60 years after the constitution was drafted?

The consultation brought together ministers and senior officials from ministries of health, development cooperation, finance and foreign affairs. In her introduction, the Director-General stressed that this was not a meeting for making decisions or even, necessarily, for reaching a consensus. Rather, it was to be conducted as a *strategic conversation*: identifying key issues in relation to WHO's work at global and country level; acknowledging differences of opinion where they exist; and charting a way forward to ultimately bring the debate into the more formal ambit of WHO's Governing Bodies.

Over the course of the meeting, participants reviewed the changing landscape for global health, acknowledging the growing number of actors involved, the consequent risks of fragmentation and duplication of effort, and the growing number of competing demands on WHO's resources. In some areas of work—particularly in relation to global norms and standard setting, surveillance and the response to epidemics and other public health emergencies—it was agreed that WHO performed effectively and there was little disagreement that these areas should remain key elements of the Organization's core business. In the field of humanitarian action, WHO's role in coordinating the health cluster was widely accepted. However, while there was debate as to the applicability of the health cluster concept more broadly in the sphere of development, WHO's humanitarian work per se was not discussed in detail.

In several other areas of work, particularly in the field of development, differences of opinion were more evident—both in regard to WHO's current level of performance and capacity and in regard to the role that the Organization should play in the future. Several themes emerged from initial discussions: (a) to what extent, and how, should WHO address the broader social and economic

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Box 2 (continued)

determinants of health? (b) what constitutes good partnership behaviour at global and country level—and what are the implications for WHO? (c) what constitutes effective country support in countries at very different levels of development and capacity and how can it match the support it provides more closely and flexibly to country needs? and (d) how can WHO be more consistent and effective in the field of technical collaboration?

Each of these themes has implications for how WHO is governed and how it should be financed. Two sets of governance challenges emerged for future debate: firstly, how to deal with *system-wide* governance issues—acknowledging that the challenges facing WHO are far from unique—when each of the agencies involved in global health (in the UN and more widely) has its own individual governance structure; secondly, recognizing the growing role of non-state actors, how to achieve more *inclusive* governance of global health. Through better adherence to the principles of the **Paris Declaration** and the Accra Agenda for Action, these issues may be more easily addressed at country level, at least in those countries with many development partners.

The meeting conveyed a sense of urgency and a general acceptance that this was a good start and that wider consultations were now necessary to seek the views of all Member States on the wider issues raised at this meeting. For example, a web-based consultation was launched, to which all countries and other stakeholders have been invited to contribute their views. Discussions are being held during the regional committee meetings in 2010 and a synthesis of these discussions will be prepared in the form of a paper to the WHO Executive Board in January 2011 and thereafter to the World Health Assembly.

Extracted from *The Future of financing for WHO* Report of an informal consultation convened by the Director-General

Conclusion: New Challenges for Global Health Diplomacy at WHO

WHO's GPW, the leadership vision provided by Margaret Chan, its work with inter-agency and cross sector partnerships and in developing the legal framework for global health all show that WHO is very aware of the need to adopt new ways of working in a changing world. These new approaches build on WHO's traditional strengths of universality, impartiality, technical excellence and convening power, but add a further dimension. If WHO is to provide leadership to an ever widening range of actors in many different partnerships and programmes it also needs the capacity, procedures and systems for dialogue with such groups.

This will require WHO to develop further its capability in global health diplomacy and to build the international framework of laws and agreements which

better promote health equity and health-related human rights. In particular it will need to find ways of working better with international civil society groups and the private sector both to draw on their strength and support and where necessary to enforce international laws and agreements.

Questions

1. What are the main functions of the WHO?
2. How was the WHO directed in 1948, has this changed?
3. How have the challenges to global health been changed since 1948?
4. How have the actors engaged in global health changed?
5. What new skills does WHO now require?
6. Give some examples of the application of global health diplomacy at WHO.
7. And provide examples of how WHO staff have had to use such skills.

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Chapter 13
Instruments of Global Health Governance at the World Health Organization

Steven A. Solomon

Readers' Guide

This chapter will examine the types of **normative instruments**, such as recommendations, international agreements (including conventions) and regulations produced by the WHO. It will consider the extent to which such agreements are capable of being implemented through various means including **international law**. However, the degree to which any instrument can be imposed on States or others, as "hard" law as opposed to its application through "soft" policy moral force or public opinion can obscure important political and legal consideration involved with international instruments. Accordingly, this section aims also to provide readers with a sense of how negotiators and policymakers assess the various instruments and select from amongst them.

Learning Points

- The World Health Assembly (WHA) can apply three types of instruments: recommendations, international agreements (including conventions) and regulations.
- Each of these instruments has differing legal and practical consequences and obligations for Member States and the WHO.
- WHA resolutions are not considered binding decisions in a strict international legal sense but they often have considerable force, as well as specific requirements, as an international political matter, especially when constituted as "strategies" or "codes".

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- International agreements, conventions and regulations, on the other hand, create binding obligations under international law.
- However, in practice the distinction between "hard" legal instruments and "soft" **normative instruments** is complex. The effectiveness of agreements will depend upon factors such as the relative burden of implementing the agreement and the strength of the monitoring and review mechanism.
- It is important to consider the advantages and disadvantages of adopting different types of legal or **normative instruments** to address global public health issues.

Introduction: The World Health Organization Constitution

The World Health Organization (WHO) is an international intergovernmental organization composed of 193 sovereign states, as described in Chap. 12. The objective, structure and legal capacities of the organization, including its authorities to adopt and approve **normative instruments**, are established by the treaty upon which it is based, known as the WHO Constitution, and it is the starting point for understanding the role of WHO in global health governance and the nature of the **normative instruments** it produces to establish, monitor and enforce: recommendations, international agreements (including conventions) and regulations.

The intergovernmental negotiating process to establish the WHO was speedy. In the spring of 1946, over the course of just 3 weeks, governmental experts meeting in Paris developed a draft Constitution for a WHO. Then, during the summer of 1946, 51 countries, gathered at an international conference in New York, adopted, based on the expert draft, the Constitution of the WHO. The Constitution entered into force on April 7, 1948, and a new era of international action on public health opened.

The Constitution itself was and remains a remarkable achievement. Its preamble defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"; establishes the principle that the "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being"; and connects the concept of public health to global peace and security, affirming that "the health of all peoples is fundamental to the attainment of peace and security …"

The Constitution's 82 articles describe the objectives of the organization (simply stated in Article 1 as "the attainment by all peoples of the highest possible level of health"), its functions, the rules of membership (open to all "States"), the organization's structure [the World Health Assembly (WHA), the Executive Board and the Secretariat] and, most importantly for this discussion, its normative capacities.

Normative Instruments of the WHO

The normative capacities of the WHO, as provided for by the Constitution, include authorization for the WHA, to take three types of action. The WHA may adopt *recommendations*, *international agreements (including conventions)* and *regulations*. Each of the three forms is separately addressed in the WHO Constitution and each has unique characteristics.

Recommendations

Article 23 of the WHO Constitution gives the Health Assembly (WHA) authority to make recommendations on all matters within the competence of WHO. Such recommendations are normally constituted as, or approved through, resolutions of the WHA. They do not bind Member States as an international legal agreement. They are therefore, in a general sense, "soft" instruments.

The essentially recommendatory nature of WHA resolutions does not, however, mean that they are devoid of effect. WHO resolutions are political instruments and represent decisions taken within an established intergovernmental UN framework. They are linked to the credibility of the WHO and to the confidence of the Member States in the WHO as a means to achieve their common objectives in health-related fields. As such, the political force and effect of WHA resolutions can be, and often is, considerable. This is especially the case when such resolutions garner the unambiguous consensus of Member States.

Recommendations become effective immediately upon adoption by a simple majority of the WHA. Thus, at the current membership level of 194 Member States, only 98 are required to approve a resolution. Resolutions are, however, rarely approved by vote. In almost all cases, resolutions are adopted by consensus after negotiations aimed at overcoming objections. Consensus, as applied to intergovernmental negotiations, means agreement without a formal vote. It does not necessarily mean unanimity though it would be possible for resolutions to be adopted based on a simple majority vote at the WHA.

On occasion the terms "codes", "strategies" or "plans of action" are used to describe a more complex recommendation, or set of recommendations, similarly approved by the WHA through a resolution. Examples of such instruments include the recently concluded WHO Global Code of Practice on the International Recruitment of Health Personnel (WHA 63.16) and the recently endorsed Global Strategy to Reduce the Harmful use of Alcohol (WHA 63.13). Note that WHA resolutions are numbered sequentially, the first two numbers indicate the number of the WHA meeting in which the resolution was passed, the number 63 indicates the meeting held in 2010. Table 13.1 provides a list of relevant WHA recommendations.

Table 13.1 World Health Assembly resolutions

WHA 60.25	Strategy on integrating gender analysis and actions into the work of WHO
WHA 58.15	Global immunization strategy
WHA 57.12	Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets
WHA 57.17	Global strategy on diet, physical activity and health
WHA 56.21	Strategy for child and adolescent health and development
WHA 56.30	Global health-sector strategy for HIV/AIDS
WHA 55.25	Infant and young nutrition
WHA 54.11	WHO medicines strategy
WHA 52.19	Revised drug strategy
WHA 51.28	Strategy on sanitation for high-risk communities
WHA 51.18	Non-communicable disease prevention and control
WHA 51.11	SAFE strategy
WHA 51.10	Revised drug strategy
WHA 49.14	Revised drug strategy
WHA 49.12	WHO global strategy for occupational health for all
WHA 48.11	An international strategy for tobacco control
WHA 46.20	WHO global strategy for health and environment
WHA 45.35/WHA 42.33/WHA 40.26	Global strategy for prevention and control of AIDS
WHA 34.36	Global strategy for health for all by the year 2000
WHA 33.16/WHA 31.45	Malaria control strategy
WHA 24.49	Strategy for health during the second United Nations development decade
WHA 22.39	Re-examination of the global strategy for malaria eradication

Such codes and strategies are “soft” instruments in the sense that they fall within the framework of Article 23 and the Health Assembly’s recommendatory authority. They should not be confused with **regulations** adopted under Article 21 of the WHO Constitution or Conventions adopted under Article 19 of the Constitution, both of which establish legally binding obligations in accordance with their terms. Box 1 provides some insight into the use of the terms “code” and “strategy” at the WHA.

In summary, WHA resolutions which recommend that Member States act or refrain from acting in certain ways are not considered binding decisions in a strict international legal sense. They are soft instruments. However, they often have considerable force, as well as specific implementation requirements, as an international political matter, especially when constituted as “strategies” or “codes”.

Box 1 The Coded Meaning Behind the Terms "Code" and "Strategy"

While the terms "code" and "strategy" in theory, could be used interchangeably, in practice they convey varying degrees of political importance that countries wish to assign to the recommendations contained within them. The term "code", when used to describe a more complex health-related recommendation, has been used only twice in WHO history and thus appears to be reserved for matters of relatively greater political significance. The International Code of Marketing of Breast Milk Substitutes (WHA 34.22), the first such "code", was adopted in May 1981 in the Health Assembly by 118 votes in favour, 1 opposed and 3 abstentions. Its approval followed debate over whether the provisions should have been concluded under the article of the WHO Constitution authorizing the elaboration of legally binding regulations. Proponents and opponents of a legally binding arrangement eventually settled on adoption of a "code" to convey heightened political importance, albeit as a non-binding recommendation of the Health Assembly. The Global Code of Practice on the International Recruitment of Health Personnel, referred to above, adopted 29 years later, constitutes the second WHO "Code". In contrast to "codes", WHA approved strategies on various health matters are quite numerous. Since 1948, the Health Assembly has adopted over 20 "strategies" and thus seems to have established something of a pecking order, with the "strategy" appellation being commonly used and the "code" moniker being used to convey a special political status. Both types of recommendations, however, have similar normative force. Formal WHO codes and strategies are, in almost all cases, developed at the intergovernmental level with WHO Secretariat coordination and promotion, and then "adopted", "endorsed" or otherwise approved by a resolution of the Health Assembly. In these resolutions, the Member States are normally exhorted or urged to act, while the Director-General is requested to support Member States.

International Agreements and Conventions

Article 19 of the WHO Constitution gives the WHA the authority to adopt international agreements and conventions on any matter within the competence of WHO. Unlike resolutions, international agreements and conventions and regulations can be regarded as hard, legally-binding instruments of international law. However, in contrast to both resolutions and regulations conventions or agreements under Article 19 require adoption by a two-thirds majority. Once adopted, such agreements come into force in accordance with their respective final clauses and only for those Member States which accept to be bound by them through their

domestic ratification procedures. The WHO Framework Convention on Tobacco Control (FCTC) is the first international agreement concluded by the Health Assembly under Article 19.

Regulations

Article 21 of the WHO Constitution provides the Health Assembly the authority to adopt regulations in a limited number of areas. These are:

(a) Sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease.
(b) Nomenclatures with respect to diseases, causes of death and public health practices.
(c) Standards with respect to diagnostic procedures for international use.
(d) Standards with respect to the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce.
(e) Advertising and labelling of biological, pharmaceutical and similar.

Unlike "recommendations" adopted under Article 23, such regulations are legally binding for Member States, creating "hard" obligations under international law. Regulations are adopted by a simple majority of the Health Assembly and are designed to come into force for all Member States, after an agreed period, at the same time, applying to all WHO countries. Member States may individually choose to "opt out" of such a global application by rejecting the regulations in advance of their entry into force but practice has shown they do not. The International Health Regulations (2005) [IHR (2005)] are the most recent examples of regulations adopted under Article 21 of the WHO Constitution. In the case of IHR (2005), all 193 Member States of the Organization became bound to it upon its entry into force on June 15, 2007.

Amendments to the IHR (2005) would also be legally binding and would come into force in the same manner as the IHR itself. An example of such an amendment would be the addition of an annex to the Regulations. Proposals for enhancing the IHR in such a manner have been considered within the WHO framework since 2005, but there has been little enthusiasm among Member States for doing so.

In conclusion, the WHA has three normative tools: (1) **recommendations**; (2) **international agreements and conventions** and (3) **regulations**. Recommendations do not bind Member States under international law and are, in this narrow sense, "soft" instruments; international agreements, conventions and regulations, on the other hand, create binding obligations under international law and are therefore, in this same narrow sense, "hard" instruments. As we will see, this distinction can mask certain key aspects of international instruments. There are other constitutional aspects of recommendations, conventions and regulations which are important to Member States in selecting amongst them for the elaboration of health-related standards and norms. Table 13.2 summarizes some of them and provides a more graphic presentation of the information provided above.

Table 13.2 WHA recommendations, agreements conventions and regulations

Article/instrument	What may be addressed?	When do the provisions apply?	What majority is required for WHA approval?	Hard or soft in terms of binding or non-binding character?
Article 23 Recommendations	Any matter within WHO competence	Immediate upon adoption	Simple majority	"Soft"
Article 19 International agreements and conventions	Any matter within WHO competence	After domestic ratification for each, and only each, state concerned (i.e., this is an "opt-in" arrangement)	Two-thirds vote	"Hard"
Article 21 Regulations	Only those matters identified in Article 21	After an agreed period for *all* states at the same time (but States may effectively "opt-out" by submitting reservations)	Simple majority	"Hard"

Aspects of WHO Normative Instruments

The use of the terms "soft" and "hard" law is useful shorthand to quickly characterize instruments along a binary normative spectrum. However, these terms can obscure important aspects of international agreements that are critical in appreciating the trade-offs involved in the international negotiations which produce them. When states promote or resist "hard" or legally binding instruments, they are in fact wrestling over not one but several key dimensions of every agreement, including, in particular: (1) the "lightness" or "heaviness" of the substantive commitments (or, put another way, the degree to which the undertakings impose new burdens or costs on a state—the greater the burden or higher the costs, the "heavier" an agreement is substantively) and (2) the weakness or strength of the review/compliance mechanism; see Raustiala (2005).

Table 13.3 offers an illustration of these considerations. The vertical axis displays the "weight" of the substantive undertakings, from light to heavy. The horizontal axis corresponds to the strength of the review/compliance structure, from weak to strong.

The shading is an attempt to capture a more textured picture of "hardness" vs. "softness", with the greyest cells representing the hardest commitments (all of the last column) and the progressively lighter shades of grey indicating softer commitments, the softest being the cell on the bottom left which includes with the lightest substantive commitments and the weakest review structure applying to various WHA recommendations. Note that whether an instrument is binding or non-binding does not determine where it may reside in the second and third columns. Thus, one finds legally binding instruments as well as non-binding instruments such as the Code of Marketing of Breast Milk Substitutes the List of Essential Medicines, the Code of Practice on International Recruitment of Health Personnel and the Pandemic Influenza Preparedness (PIP framework) agreement (parts of which include contractual oblications that will be legally bioing), in both columns of the matrix, however, the last column contains only binding instruments. This is a function of the "hardest" kind of review structure which involves, in one form or another, acceptance of a third party's determination (such an acceptance "hardest" when the parties intend the arrangement which contains it to bind them legally).

What then is the relationship between "binding-ness" (whether an agreement is legally binding) and substantive weight? Binding-ness and substantive weight are sometimes negatively correlated. That is to say, the heavier the obligations (in terms of new burdens taken on) contained in an instrument, the less likely parties are to choose a legally binding mechanism as its vehicle. In other words, and predictably, if states are asked to depart significantly from the status quo, they want to avoid being *legally* bound to do so. States will often, in such cases, decide to adopt a "recommendation" as opposed to a "regulation".

However, there can be a positive correlation between binding-ness and substantive weight when substantive "lighteners" are used (e.g., caveats on individual provisions

Table 13.3 Heavy/light burden, strength of review and hardness/softness of instruments

Review structure Burden	Weak review structure None or voluntary conciliation/ negotiation	Moderate review structure Review mechanism but no binding determination	Strong review structure Binding adjudication, determination or prescription
Heavy significant departure from status quo/high cost	FCTC Code of Marketing Breast Milk Subs	WHO Constitution	UN charter
Moderate new burden/moderate cost	IHR (2005) List of essential medicines WHO strategies	UN convention on rights of people with disabilities Code of Practice on International Recruitment of Health Personnel	WTO agreements
Light burden limited new burden/low cost	Various WHA recommendations	IHR (1969) PIP framework agreement	Vaccine contribution agreement

such as “as appropriate” or “in accordance with domestic law”), or when domestic influence groups are politically powerful and insist on having a binding agreement. For example, the successful adoption of the FCTC was due, in large part, to strong domestic anti-smoking lobbies in many of the countries promoting the Convention. Indeed, a number of years prior to the WHA’s adoption of the FCTC, a non-binding “recommendation” dealing with tobacco control was adopted by the WHA. This recommendation, which took the form of an international “strategy”, was regarded as too weak to deal with the global problem of tobacco use.

Finally, there is sometimes no correlation between binding-ness and substantive weight. If we look at the health-related instruments that are shown in Table 13.2 both the Code of Marketing of Breast Milk Substitutes and the FCTC involved commitments that required a significant departure from the status quo ante. The former compelled states to regulate their infant formula producers marketing practices; the latter obligated states to establish restrictions on smoking and marketing of tobacco products. Neither, however, created a central body for reviewing compliance. Rather, it was implicitly (in the case of the Code), and explicitly (in the case of the FCTC), clear that questions of implementation would be handled through negotiations between those concerned. Thus, both instruments can be characterized as substantively heavy with weak review structures. Yet, the code is often described as “soft” law and the FCTC as “hard”. The soft/hard description therefore obscures these important characteristics, as does the binding/non-binding description.

The point here is that just because an instrument is binding does not mean it is necessarily “hard” and just because another is non-binding does not mean it is

necessarily "soft". Indeed, the use of these short-hand terms can be misleading. They suggest a limited, binary option for policymakers when in fact binding-ness is just one of several dimensions of concern. These other dimensions, including substantive weight of the commitments as well as the nature of the review structure, are interrelated. They present various advantages and disadvantages depending on one's perspective, and, therefore provide a basis for trade-offs and compromise in the negotiating arena.

Given that questions of substantive weight and strength of review structures may be negotiated independently from the question of instruments binding-ness, what are some of the underlying considerations which go into states selection of binding or non-binding instruments? Table 13.4 sets out some key underlying features which are often considered by States when choosing between binding and non-binding instruments:

Conclusion: A Complex Choice Amongst Normative Instruments

In summary, the normative spectrum is both more complex and more fluid than is conveyed by a binary concept of soft vs. hard law. While the short-hand descriptive of "hard vs. soft" will probably persist in international parlance, it would be unfortunate if it hampered global health governance choice of **normative instruments**.

The nature of the **normative instruments** negotiated with Member States and other parties is an important dimension of global health diplomacy, it is rarely a binary choice between, on the one hand a clear enforceable legal agreement and on the other a moral argument with no procedure for monitoring observance let alone any legal sanction. Instead global health diplomacy is likely to result in a form of agreement attractive to all main parties, with a mix of moral force and mutual obligation. Moreover commitment to such **normative instruments** may grow in strength over time and new agreements can build on the benefits seen to arise from progress in applying prior levels of agreement.

Normative instruments also shape the role and functions of the WHO not only in negotiating such agreements but also in monitoring and implementing such agreements; see Chap. 12.

Many states and other actors in the global health community often overlook the benefits of non-binding arrangements. These include faster applicability and implementation, as well as the potential to carry significant substantive weight. Furthermore, many states often overplay the perceived costs of binding agreements, seeing them as automatically more burdensome substantively and intrusive than non-binding arrangements.

Table 13.4 Non-binding vs. binding considerations

Feature	Non-binding	Binding
Speed of entry into force (EIF)	Fast: EIF upon adoption	Slow: EIF after domestic ratification
Commits all branches of domestic government	Weakly: because not domestic law	Strongly: because becomes domestic law
Flexibility to modify	Easy: no formal amendment process	Hard: formal amendment process required
Interpretive framework	None: up to the participants	Precise: Vienna convention on treaties
Status	Lower: tends to be seen, often inappropriately, as implying both shallow substance and weak review structure	Higher: tends to be seen as raising the moral, political and legal stakes of non-compliance. Often mistakenly assumed to imply deeper substance and strong review structure, possibly because an instrument must be "binding" to be in the third column (third party adjudication). However, an instrument does not have to be "binding" to be in the top row (significant new burden). This can be seen, for example, in the case of the Code of Marketing on Breast Milk Substitutes
Credibility	Depends on the instrument: High: Code of Marketing for Breast Milk Substitutes Low: strategies which have not been well-implemented	Depends on the instrument: High: FCTC Low: original IHR which was limited to specific diseases
Universality (degree to which countries participate)	Higher, in general	Lower, in general
Impact on compliance	Depends on review structure and/or political will	Depends on review structure and/or political will

In fact, a consideration of a variety of both binding and non-binding health-related agreements presents a more nuanced picture. One finds binding agreements that are neither intrusive nor burdensome and non-binding instruments that are substantively significant and contain review mechanisms. A clearer understanding of the dynamics of **normative instruments** in the global public health arena may help stakeholders in shaping them to accommodate their various needs and public health objectives.

Questions

1. What types of **normative instruments** can the WHO deploy?
2. Provide examples of each type of instrument, and discuss why the form of instrument has emerged in each case?
3. What is meant by "hard" and "soft" agreements, what other factors are relevant to the choice of appropriate **normative instruments**?
4. What are the advantages and disadvantages of each type of instrument, from the point of view of States, Civil Society Organisations and the WHO Secretariat?
5. Review the background to the FCTC and describe how, when and why agreements developed towards the current convention?

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Chapter 14
Instruments for Global Health Diplomacy in the UN System Beyond the WHO

Chantal Blouin, Mark Pearcey, and Valerie Percival

Reader's Guide

This chapter explores the practice of health diplomacy in four forums of the United Nations (UN): the General Assembly, the Security Council, the Economic and Social Council, and the **Human Rights Council**. Although health is not central to their mandate, over the past decade, Member States have placed health on these institutions' agendas. The increasing amount of health diplomacy in these UN forums reflects the incorporation of global health objectives into the foreign policy goals of Member States and the recognition that diplomatic action in multiple forums is critical for the achievement of global health goals. Health diplomacy has created new global health norms, established new health institutions (UNAIDS), and obliged states to report on their fulfillment of global health commitments. For each forum, we describe how Member States utilize these institutions to address global health challenges.

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Learning Points

- Diplomatic engagement on global health at the United Nations reflects both the integration of health into foreign policy and the recognition that global health challenges require collective action by a wide range of actors beyond the health arena.
- United Nations General Assembly resolutions are the most common instrument of health diplomacy at the UN. While not legally binding "hard" instruments, they build international consensus on the scope of the global health issue under discussion, identify priority areas for collective action, and often task relevant multilateral organizations with specific elements of the international response.
- With the exception of references to the provision of humanitarian assistance in conflict zones, health issues do not receive much attention from the UN Security Council. However, in July 2000 Security Council adopted Resolution 1308 on HIV/AIDS and peacekeeping operation which stressed that "the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security."
- The UN Economic and Social Council (ECOSOC) is a discussion forum rather than a decision-making body, but it can support other elements of the UN system, for example it supported World Health Assembly resolutions to address the burden of NCDs.
- The Human Rights Council is an important focus for the work of a variety of UN organizations and agencies that encourage states to respect international commitments to human rights. It has the capacity to pass resolutions related to human rights and receives reports through the Universal Periodic Review on the degree to which members have met their human right obligations. This can be an important mechanism for examining the practical observance of health as a human right.

Introduction

Diplomatic engagement on global health at the United Nations reflects both the integration of health into the foreign policy objectives of Member States, as examined further in Chap. 15, and the recognition that global health challenges require collective action outside of international health institutions and by actors other than members of the global health epistemic community. International diplomats, who traditionally undertake negotiations related to peace, security, commerce and trade, now also participate in negotiations on HIV/AIDS, maternal health, pandemic influenza, and

chronic diseases. While more research is needed to determine if diplomatic engagement on global health issues has a greater likelihood of success than other areas of international engagement, health diplomacy at the United Nations has resulted in important global health achievements.

Health diplomacy has developed and furthered international norms related to HIV/AIDS, maternal and child health, sexual and reproductive health and rights, and the right to the highest attainable standard of health; mobilized financial resources to address global health challenges; and engendered commitments from Member States for global health action. The involvement of global civil society, as participants in the dialogues that frequently accompany global health negotiations and as observers who scrutinize their outcomes, has been critical to ensure transparency and accountability for the implementation of global health commitments. High-Level Forums at the United Nations have heightened awareness among Member States of the importance of global health challenges, which may advance the integration of emerging global health norms into the domestic agendas of Member States.

This chapter outlines the practice and achievements of health diplomacy at four fora of the United Nations: the General Assembly (discussed further in Chap.15), the Security Council, **ECOSOC**, and the **Human Rights Council**.

Other United Nations bodies and agencies play an active role in global health diplomacy such as the Children's Fund (UNICEF), the Population Fund (UNFPA), the Development Program (UNDP), the World Food Programme (WFP), and of course the WHO. The number of relevant agencies increases if a broader view is taken of the determinants of global health; taking into consideration the agencies negotiating responses to challenges related to food security, access to water, poverty and economic inequality, climate change or the prevention of conflict all also considered to be relevant to global health and engaged in global health diplomacy. However, for the purpose of this chapter, we focus on forum the four main fora where resolutions have been raised to address global health challenges.

Health at the General Assembly

The UN General Assembly (UNGA) is the central decision-making body of the United Nations, where representatives of its 192 Member States deliberate and make recommendations on all issues within the scope of the UN Charter, with the exception of disputes actively under consideration by the Security Council. The UNGA "encourage[s] the progressive development of international law and its codification [and promotes] international co-operation in the economic, social, cultural, educational, and health fields" (UN Charter, Article 13.1).

The UNGA meets every year, with an agenda that typically includes the maintenance of international peace and security, economic growth and sustainable development, the protection and promotion of human rights, coordination of humanitarian assistance, disarmament, justice, and international law. Member States work within

the Assembly's Committees to achieve consensus prior to deliberation by the Assembly: within these Committees, states present and negotiate draft resolutions, discuss reports from UN implementing organizations, and hear presentations from UN representatives. Global health issues are discussed most frequently at Third Committee, which is responsible for social, humanitarian, and cultural matters, including human rights. While the UNGA's main plenary session runs from September to December, activities of its committees and subsidiary bodies continue throughout the year UN Economic and Social Council (2010c).

Member States also use the UNGA to mobilize international action and resources for global health through high-level forums. These forums take the form of Special Sessions or High-Level Meetings. Special Sessions are relatively rare, standalone Assembly Sessions, which are held at the request of the majority of Member States or the Security Council. One UNGA Special Session focused specifically on a global health issue—the June 2001 Special Session on HIV/AIDS. High-Level Meetings are commonly held on the margins of the annual UNGA and have focused on HIV/AIDS (June 2006); the Millennium Development Goals (MDGs) (September 2010), and **Non-Communicable Diseases (NCDs)** (planned for September 2011). Both of these forums attract participation from the highest levels of government and present an important opportunity to build consensus for international action. In some cases, the participation of political leaders may also heighten the prioritization of these global health issues within the domestic policy, although this is an area that requires further research.

While not as high profile as Special Sessions or High Level Forums, UNGA resolutions are the most common instrument of diplomacy at the UNGA. Member States, alone or in concert, draft these resolutions, and present them either to the relevant committee for discussion and negotiation, or work outside the Committee structure to achieve consensus among Member States prior to introducing them within the UNGA Plenary. Resolutions typically outline why this issue is under consideration by the UNGA and identify existing international norms (preamble paragraphs), and produce nonbinding recommendations for action by Member States and multilateral organizations (operational paragraphs). UNGA Resolutions are considered "soft law" in international relations(see Chap. 13), in contrast to hard instruments (such as Resolutions of the United Nations Security Council), i.e. "legally binding obligations that are precise and that delegate authority for interpreting and implementing the law" (Abbott and Snidal 2000).

Despite the inability to enforce implementation and compliance, UNGA resolutions offer some advantages to policymakers. They build international consensus on the scope of the global health issue under discussion, identify priority areas for collective action, and often task relevant multilateral organizations with specific elements of the international response. These nonbinding resolutions are less threatening to national sovereignty, which facilitates compromise and cooperation on more contentious proposals. Moreover, UNGA often passes successive resolutions on the same topic, which develops norms, promotes policy learning, monitors compliance, and establishes a foundation for future policy implementation (Abbott and Snidal 2000).

Box 1 UNGA Resolutions on Health Issues

The General Assembly has passed a number of health-specific resolutions, with the most important listed below. In addition, many resolutions negotiated at the UNGA have a direct or indirect impact global health such as the protection and promotion of human rights, the right to water, the provision of humanitarian assistance, and sustainable development.

The 2001 Declaration of Commitment on HIV/AIDS (A/S/26/7): this resolution was a milestone in the global fight against HIV/AIDS. The Declaration helped build international consensus on the devastating global impact of HIV; outlined an agenda for international action on prevention and treatment of HIV/AIDS; highlighted the social and economic impact of HIV; outlined the relationship between stigma and human rights abuses and the spread of HIV; and emphasized the important role of civil society.

The 2006 Political Declaration on HIV/AIDS (A/RES/60/262): while reiterating many of the same themes as the 2001 Declaration of Commitment, the 2006 resolution included stronger language on the relationship between gender discrimination and violence and HIV, and committed Member States to scale up towards universal access to antiretroviral treatment. Under the terms of the Declaration of Commitment and the 2006 Political Declaration, countries are required to submit regular progress reports to the United Nation on their achievement of specific targets related to their domestic response to HIV.

The MDGs: the Millennium Declaration adopted at the UNGA in 2000 (Resolution A/RES/55/2) established the MDGs, which include combating HIV/AIDS, malaria and other diseases; improving maternal health; and reducing child mortality. The MDGs outlined a set of specific targets to be achieved by 2015. In 2010, a High-Level Meeting was held to evaluate progress made on the MDGs, which produced the resolution "Keeping the Promise: United to Achieve the MDGs" (UNGA Resolution A/65/L.1). While committing member-states to accelerate progress on the health-related MDGs, this resolution included new commitments related to "Promoting Global Health for All" (Paragraph 73). The international community pledged to strengthen national health systems, prioritize primary health care, and improve the quality, effectiveness, and equity of health services.

Foreign Policy and Health: A resolution recognizing the interdependence between health and foreign policy was passed first in November 2008 (A/RES/63/33) and again in December 2009 (A/RES/64/108) (see Chap. 15).

NCDs. UNGA passed a resolution that recognized the growing global burden of **NCDs**, and called for a High-Level Meeting of the General Assembly, planned for September 2011, on the prevention and control of **NCDs** (A/RES/64/265).

Health at the Security Council

The **UN Security Council** has primary responsibility for the maintenance of international peace and security. The Council is composed of five permanent members (China, France, Russia, United Kingdom, and the USA) and ten non-permanent members, elected by Member States for 2-year terms. The Security Council has a unique status among UN institutions. While other organs of the United Nations make recommendations to Governments, the Council alone has the power to take decisions related to Chap. 7 of the UN Charter which Member States are obligated to carry out.

With the exception of references to the provision of humanitarian assistance in conflict zones, health issues do not receive much attention from this UN body. However, in July 2000 Security Council adopted Resolution 1308 on HIV/AIDS and peacekeeping operation which stressed that "the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security." Focusing on the risks associated with HIV/AIDS for international peacekeeping personnel, the resolution encourages all UN Member States to adopt strong strategies for HIV/AID prevention, treatment, training for all their peacekeeping personnel. Five years later, the Executive Director of UNAIDS, the UN agency created in 1996 to pilot the global response to the HIV/AIDS pandemic, declared that this resolution had a very significant impact. It transformed how world leaders view HIV/AIDS, not only as a public health problem, but also as a security threat. Because of this transformation, "the world's response to AIDS has gathered such strength that for the first time ever we have a real opportunity to halt and begin to reverse this devastating epidemic, as called for in MDG 6" (Piot 2005).

Box 2 Does the HIV/AIDS Epidemic Lead to Failed States and Conflict?

The impact of infectious diseases on global peace and stability, particularly the impact of HIV/AIDS on state fragility and security in Africa, is the subject of scholarly debate. The argument focused on (1) the negative impact of high prevalence of HIV/AIDS in the military, (2) reduced economic growth of already poor economies, and, (3) the capacity of government to deliver public services because of high-level of absenteeism and lower public revenues (Garrett 2005). There was little empirical evidence to support these claims. In 2005, a large research program was launched to investigate the relationship between HIV and conflict and concluded that the linkages are not confirmed by existing data (summarized by De Waal 2010). For instance, "fears of much-elevated HIV rates among soldiers with disastrous impacts on armies as institutions, have been overstated. In mature epidemics, rates of infection among the military resemble those of the peer groups within the general population" (De Waal 2010).

Health and the UN ECOSOC

ECOSOC functions as the primary UN forum to discuss international social, economic, and humanitarian issues. In addition, it coordinates UN agencies and bodies concerned with these issues (Fasulo 2009, p. 76). Through this mandate, **ECOSOC** is charged with four responsibilities UN Economic and Social Council (2010a):

1. Promoting higher standards of living, full employment, and economic and social progress
2. Identifying solutions to international economic, social and health problems
3. Facilitating international cultural and educational cooperation
4. Encouraging universal respect for human rights and fundamental freedoms

Fifty-four Member States are elected by the General Assembly to sit on the Council (Weiss et al. 2010), which holds a 4-week substantive session in July. This includes a high-level segment involving representatives from national governments, international institutions, civil society, and the private sector.

Given its broad socioeconomic mandate and inclusiveness, **ECOSOC** seems well suited to facilitate action on matters of health. In practice however, "**ECOSOC** is a relatively powerless part of the UN structure" (Hanhimäki 2008, p. 75). This is largely due to the fact that **ECOSOC** was established as a deliberative rather than operational body of the UN, intended to help other bodies examine issues and shape programs (Fasulo 2009, p. 75). Jussi Hanhimäki (2008) suggests that true power on economic and social affairs rests with the "three sisters" of the UN family: the World Bank (WB), the International Monetary Fund (IMF), and the World Trade Organization (WTO) (pp. 41 and 42). Problematically however, these bodies pose challenges to the diplomatic capacities of low-income countries. Voting power in both the WB and IMF, for instance, is weighted on individual countries' contributions; this provides wealthy countries significant leverage over low-income countries. Indeed, "countries that have the most at stake – the countries in the developing world that are often in need of World Bank loans or IMF credits – have relatively little power within these institutions" (Hanhimäki 2008, p. 43). Although voting in the WTO is not weighted like the WB and IMF, its wide membership and need for consensus leads to significant "behind the scenes" negotiations, that wealthy states are typically advantaged in, due to economic and/or political leverage (Hanhimäki 2008, p. 43).

The relative weakness of **ECOSOC** has led to calls for reform. In 2005, several countries proposed two new mechanisms to increase **ECOSOC**'s relevance: (1) Annual Ministerial Reviews (AMR) and (2) a Development Cooperation Forum (Fasulo 2009, pp. 76 and 77). As mandated by the World Summit in 2005, **ECOSOC** added the AMR. Held during the high-level segment, the Ministerial review includes a global review of the UN development agenda, a thematic review, and voluntary presentations from national governments—the latter highlight in-country progress towards development targets UN Economic and Social Council (2010b). Following the high-level segment, the Council adopts a Ministerial declaration which offers

policy guidance and recommendations UN Economic and Social Council (2010a). It has been through the AMR that **ECOSOC** has begun to address health in a more substantive way. This has included high-level segments, during the Substantive Sessions, on eradication of poverty and hunger in 2007 and on global public health in 2009 (http://www.un.org/en/ecosoc/about/index.shtml).

Despite its limited powers, **ECOSOC** can help focus attention on global health issues through the AMR, and other deliberative functions (e.g., initiation of studies/reports; preparation/organization of international conferences). For example, **ECOSOC** Resolution 1994/24 created the UN's Joint Programme on HIV/AIDS, also known as UNAIDS. In this respect, Nancy Lins and colleagues (2010) suggest that **ECOSOC** "has brought attention to the fact that there is no mention of NCDs [**non-communicable diseases**] in the MDGs and that technical assistance and expertise are hard to harness if **non-communicable diseases** are not a formal priority for the countries." In doing so, **ECOSOC** has supported World Health Assembly resolution WHA61.14 (2008), which urges Member States to strengthen national efforts to address the burden of NCDs (Lins et al. 2010, p. 28; WHA61.14; WHO (2008)).

Box 3 ECOSOC and NCDs

In July 2009, **ECOSOC** held the high-level segment of its annual substantive session; focusing on global public health, the outcome of this segment was the 2009 Ministerial Declaration, *Implementing the internationally agreed goals and commitments in regard to global public health*. Recognizing the heavy burden of NCDs, the Declaration outlines a number of actionable items Economic and Social Council (2009). At the time of its adoption, observers and public health activists have noted how the Ministerial Declaration has the potential to elevate NCDs on the global health agenda. For instance, the NCD Alliance—an international alliance of four federations, the International Diabetes Federation, the World Heart Federations, the International Union Against Cancer and International Union Against Tuberculosis and Lung Disease—has welcomed **ECOSOC** action. They highlighted the global agenda-setting role played by such Declaration and how other UN bodies pay attention and respond to themes raised in the high-level segment NCD Alliance (2010). And indeed, following this declaration, the UN General Assembly will hold in September 2011 a **NCDs** Summit bringing together, for the first time, head of states to discuss strategies to address the threat of rise of NCD in all region of the globe.

Health at the Human Right Council

The right to health consists in the obligation of national governments to ensure that their citizens achieve the highest attainable standards of health. This obligation emanates from many different bodies of international law, including the

International Covenant on Economic, Social and Cultural Rights (ICESCR). In 2000, the UN Committee on International Economic, Social and Cultural Rights published General Comment 14 to the ICESCR, in an effort to detail the content of the right to health (Kinney 2001, p. 1467). Recognizing the financial and human constraints on governments, particularly those in low-income setting, it allows for the progressive realization of the right to health, i.e. that national governments are accountable to their citizens to adopt policies leading to rapid progress in terms of availability, accessibility and quality of health facilities, goods and services, as well as basic determinants of health such as safe water and adequate sanitation. Yet, as Eleanor Kinney points out, (Kinney 2001).

Speaking to issues of implementation, a recent article by Alexis Palmer and colleagues (2009) asks, "does ratification of human-rights treaties have effects on population health?" Data from this research, suggests that it does not. Indeed, their analysis shows that ratification of primary human-rights treaties does not correlate with a significant, positive change in domestic health status (Palmer 2009, 1989). Why then is international human rights law significant for health? Despite the limited impact of human rights treaties on domestic health, human rights law has been highly influential in legal arguments concerning the right to essential medicines and public health. Furthermore, "important examples of access to health care based on the argument of the right to health, enshrined in several constitutions and in many international treaties, have been effectively used to reduce child labor, increase access to antiretroviral health care, promote care of people who are elderly and mentally ill, and improve the quality of public spaces" (Palmer 2009, 1989–1990).

A variety of UN organizations and agencies have in their mandate to encourage states to respect international commitments to human rights. Of them, the **Human Rights Council** (the Council) is perhaps the most prominent; specifically, for its role in investigating violations, and working toward the progressive realization of human rights—including the right to health. The Council is not without controversy however. In 2006, for instance, the Council was created by the General Assembly as a new forum to replace the Human Rights Commission (the Commission), following years of criticism that the Commission had been too politicized, inconsistent in applying human rights standards, and composed of many Member States which showed clear patterns of human rights violations (Weiss et al. 2010). Amongst the most noticeable changes included a reduction in membership (from 53 in the Commission, to 47 in the Council), intended to reduce the number of human rights violators on the Council. However, while "this apportionment may seem democratic in terms of the distribution of the globe's population, […] it hardly did justice to the fact that it might be difficult – at any given time – to find thirteen countries in Asia or Africa with acceptable (let alone exemplary) human rights records" (Hanhimäki 2008, p. 124).

Under its current structure, the Council's secretariat is the High Commissioner for Human Rights; a position established in 1993 by the General Assembly to oversee the UN's human rights activities, to help develop rights standards, and to promote

international cooperation in terms of rights (Fasulo 2009, p. 148). Significantly, the Office of the High Commission "does not control the **Human Rights Council**, nor does it have much influence over its **special rapporteurs**" (Fasulo 2009, p. 148). This is important considering that one the most important instruments available to the Council in advancing human rights, has been the use of these independent experts, appointed by the **Human Rights Council** to examine and report back on a country situation or a specific human rights theme.

The position of the **Special rapporteur** on the right to health was created in 2002 with the mandate to gather information, report, engage in dialogue and make recommendations on how best to promote and protect the right to health. The Rapporteur does so by publishing an annual report, conducting country visits and missions and receiving several individual complaints. The Rapporteur engages with national governments about these complaints and reports on them annually too Human Rights Council (2010). For example, in 2008, the Rapporteur received complaints about the removal of harm reduction from Canada's national strategy to address controlled substances. The 2009 report notes that "given that decades of research have demonstrated that harm reduction services are important in protecting and promoting the health of drug users, Canada's departure from an evidence-based approach run counter to its obligations to progressively realize the right to health" (2009). The Canadian government responded to the communication from the Rapporteur that, even though harm reduction is not explicitly discussed in the National antidrug strategy, the services available for people with drug dependence has not been reduced Grover (2009).

Alternatively, the **Human Rights Council** has the capacity to pass resolutions related to human rights and receives reports through the Universal Periodic Review on the degree to which members have met their human right obligations. Where the former is concerned, this instrument was used in June 2009 to address maternal mortality in a resolution co-sponsored by Columbia and New Zealand, *Preventable maternal mortality and morbidity and human rights* (http://righttomaternalhealth.org/hrc-resolution) International Initiative on Maternal Mortality (2009). Through the resolution, governments recognize preventable maternal mortality and morbidity as an impediment to the full achievement of women and girls' human rights The Partnership (2009). The resolution provokes a number of practical consequences as it "places specific legal and ethical obligations on states, such as the establishment of effective mechanisms of accountability (i.e., maternal death audits or reviews)" (Lancet 2009, p. 2172). Where the latter is concerned, the Universal Periodic Review serves as a process through which reports are issued on the compliance of UN members states with human rights norms (e.g., compliance with obligations mandated by treaties it has joined) (Fasulo 2009, p. 147). Significantly however, the meaningfulness of these reports rests on the level of rigor and impartiality with which these reports are conducted; as such, the claims made in these reports must be met with a level of analytical scrutiny.

Box 4 Patent Protection and the Right to Health: Involvement of the Special Rapporteur

The impact of global trade rules strengthening patent protection on access to medicine has received much attention since the adoption of the TRIPs agreement at the WTO in 1995. This issue has subsequently been debated in a multitude of national and multilateral forums, as nongovernmental organizations and state actors have aimed to limit the negative impacts of intellectual property rights protection on access to drugs. Within the UN, the **Special Rapporteur** on the Right to Health has served as a diplomatic vehicle in this respect.

In 2003, Paul Hunt—then **Special Rapporteur** on the Right to Health—wrote a report on the impact of international trade agreements on the right to health, including access to essential medicines. In 2004, in a report based on a country visit to Peru, he subsequently expressed concerns about free trade negotiations between Peru and the USA; in particular, the fact that the USA was requesting stronger protection for intellectual property. In addition, he stressed "the human rights responsibility of countries to make use of the safeguards available under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and the Doha Declaration on the TRIPS Agreement and Public Health – such as compulsory licenses – to protect public health and promote access to medicines" (Hunt 2005). For Peru to agree to a trade agreement which would limit access to essential medicines could thus violate its constitutional and international human rights obligations; accordingly, the USA should not pressure Peru to enter into such commitments. Despite Hunt's efforts however, the trade agreement signed between the USA and Peru did include TRIPS-plus provisions. In this case, it would appear that health diplomacy was unsuccessful.

Conclusions: Global Health Is Central Issue in the Wider UN System

The UN provides a forum for global health diplomacy. Four different channels offer ways of engaging a wide range of diplomatic interests. Resolutions at the UN General Assembly can develop consensus on issues of importance for health, economic and social development. Issues raised at the UN Security Council stress the impact of human security. Discussions at ECOSOC can prompt further action by parts of the UN system and the Human Rights Council can help to focus on the specific impacts of international actions and or failure to act on health as a human right. Thus the UN provides a wide canvas which sets the diplomatic background for global health diplomacy at many different levels.

Questions

1. What are the risks in linking global health to the national or global security agenda?
2. What role can human rights play in advancing global health?
3. The USA voted against the **Human Rights Council** in 2006. According to Jussi Hanhimäki (2008), "What has kept the United States out of the new human rights regime is, basically, the same conundrum that has handicapped the UN in so many other fields as well: the contradicting demands of national security on the one hand, and universalism on the other hand" (p. 124). Does this "conundrum" impede forums like the **Human Rights Council** on matters of health? Why or why not?
4. Do deliberative forums (e.g., **ECOSOC**) have sufficient power to promote the global health agenda?

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Chapter 15
Global Health and Foreign Policy at the UN

Luvuyo Ndimeni

Readers' Guide

This chapter will identify the major actors in the nexus between foreign policy and global health at the UN General Assembly. It will examine the roles and the interconnectedness between major actors in this sphere and how they work together at key committee stages to reach agreement. This will be illustrated by the initiative of the "Oslo Group", to raise an agenda item entitled "Global health and foreign policy" in the Assembly and successfully negotiate its adoption. A group of seven countries founded the initiative on foreign policy and global health and adopted the "**Oslo Ministerial Declaration-**global health: a pressing foreign policy issue of our time". This initiative complemented other health initiatives within the UN multilateral system, with a broader focus on issues of trade, environment, infectious diseases, preparedness, disasters, conflict, development, global health security, human resources and HIV/AIDS.

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Learning Points

- Health issues have been the subject of many resolutions at the UN General Assembly.
- A UN diplomat's challenge is to correlate national interests and position with respect to the specific health issue with the wider concerns of foreign policy.
- Health is an issue with wide ramifications for other sectors and interests and thus this is often complex, technically demanding and uncertain, it is therefore a particularly difficult challenge.
- The **foreign policy and global health initiative** of the **Oslo Group** highlighted the need to recognize the nexus between foreign policy and global health.
- This initiative required first that the member states sponsoring the resolution should clarify their proposition and build widespread support, second that they should gain support for its inclusion on the agenda, third that they should demonstrate wide ranging geopolitical support at the United Nations General Assembly (UNGA) and fourth that they should establish a continuing programme of action following the adoption of the resolution.
- Each of these phases in the development, passage and application of the resolution demonstrates the practical application of global health diplomacy.

Introduction: The Health and Foreign Policy Nexus

The **United Nations General Assembly** (UNGA) is the main deliberative forum of the UN system, where representatives of its 192 Member States can debate and resolve issues of common concern. The increasing focus on health issues at UNGA in recent years provides a good demonstration of the growing nexus between health and foreign policy. While the World Health Organization (WHO) is the directing and coordinating authority for health within the United Nations system, as discussed in Chap. 12, global health issues that raise concerns for foreign policy and human security may warrant consideration in the context provided by the UNGA, where Member States can raise, negotiate and adopt reports and resolutions in field of health that have a wider impact on foreign policy.

The Charter of the UN is focussed on its role in promoting peace and avoiding conflict, as discussed in Chap. 14, but it is also mandated to promote social progress, better living standards and human rights, including through its subsidiary bodies and organs such as the WHO, as well as through the UNGA and its Committees. This institutional linkage promotes complementarity in the work and representation of the UNGA based in New York and the WHO in Geneva, while the somewhat different focus of their mandates also delineates their roles. For UN Member States

there is usually a clear designation of representation responsibilities. The UNGA is normally attended by foreign affairs ministers and the WHO by health ministers. However it is also clear that global health issues affect foreign policy concerns for human security and mutual support and that foreign policy issues such as conflict, trade and development are also fundamental determinants of health. Thus the nexus between health and foreign policy arises from the fundamental nature of the issues as well as the institutional links.

This nexus of health and foreign policy issues was the focus of discussions between what came to be called the **Oslo Group**. The name was never formally adopted, however, within UN circles this reference has been increasingly used to refer to the seven founding members: Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand.

Evolution of Health Diplomacy in the UN General Assembly

In Chap. 2 global health diplomacy is described as the processes whereby compromises are found and the agreements are reached in new alliances, bilateral and multilateral agreements to promote and protect global health. These are processes in which the art of diplomacy juggles with the science of public health and concrete national interest balances with the abstract collective concern of the larger international community in the face of intensive lobbying and advocacy. No longer do diplomats just talk to other diplomats—they need to engage with the private sector, non-governmental organizations, scientists, activists and the media, to name but a few, since all these actors must become parties to the negotiating process.

Global health diplomacy has posed a challenge to the diplomats working with the UNGA as Permanent Representatives based at Missions to the UN (a bit like ambassadors and embassies) and their staff. Their training equips them with generalist skills in diplomacy to enable them to be deployed as and when political circumstances determine the need. Their training and deployment results in them as non-technical specialist working in an environment which requires them to adapt to issues many diplomats are not familiar with but for which they have to represent national interests. A diplomat's challenge is to correlate national interests and position with respect to the specific issue and the wider concerns of foreign policy. Health is an issue with wide ramifications for other sectors and interests, and it is often complex, technically demanding and uncertain, it is therefore a particularly difficult challenge.

The UNGA has discussed and adopted many resolutions concerning global health since 1995, when major conference and summits on socio-development issues adopted milestone decisions that were reviewed 5 and 10 years later. The period between 1995 and 2000 also saw a sharper focus on the devastating scourges of Malaria and HIV/AIDS, especially in Africa. The Millennium Summit and its Declaration mobilized political will significantly and ensured that Heads of State and Governments for the first time addressed themselves to the reality that resources had to be distributed in a manner that took into account these challenges.

Table 15.1 Health-related resolutions at the UNGA 1995–2009

Year	Resolutions
1995	Preventive action and intensification of the struggle against Malaria in developing countries, particularly in Africa
1999	Review of the problem of HIV/AIDS in all its aspects
2000	2001–2010: decade to Roll Back Malaria in developing countries, particularly in Africa
2000	Follow-up to the outcome of the Millennium Summit (Para 8)
2000	Review of problem of HIV/AIDS
2000	Millennium Declaration
2002	High-level Plenary Meetings devoted to the follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS
2002	Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS
2002	2001–2010: decade to Roll Back Malaria in developing countries, particularly in Africa
2002	Follow-up to the outcome of the Millennium Summit
2003	Organizational arrangements for the high-level meeting to review the progress achieved in realizing the commitments set out in the Declaration of Commitment on HIV/AIDS
2003	2001–2010: decade to Roll Back Malaria in developing countries, particularly in Africa
2003	Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS
2003	Access to medication in the context of pandemics such as HIV/AIDS, tuberculosis and Malaria
2003	The right of everyone to the enjoyment of the highest attainable standard of physical and mental health
2003	Enhancing capacity-building in global public health
2004	2001–2010: decade to Roll Back Malaria in developing countries, \particularly in Africa
2004	Enhancing capacity-building in global public health
2005	Follow-up to the development outcome of the 2005 World Summit, including the millennium development goals and the other internationally agreed development goals
2005	Political Declaration on HIV/AIDS
2005	Preparedness for and organization of the 2006 follow-up meeting on the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS
2005	2001–2010: decade to Roll Back Malaria in developing countries, particularly in Africa
2005	Enhancing capacity-building in global public health
2005	2005 World Summit Outcome
2006	2001–2010: decade to Roll Back Malaria in developing countries, particularly in Africa
2006	World Diabetes Day
2007	2001–2010: decade to Roll Back Malaria in developing countries, particularly in Africa
2007	Organization of the 2008 comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS
2008	2001–2010: decade to Roll Back Malaria in developing countries, particularly in Africa
2008	Global health and foreign policy
2009	Draft outcome document of the high-level Plenary Meeting of the sixty-fifth session of the general assembly on the Millennium Assembly on the millennium development goals
2009	Prevention and control of non-communicable diseases
2009	2001–2010: decade to Roll Back Malaria in developing countries, particularly in Africa

Major conferences and summits and their reviews continue to play a critical role in mobilizing political will and commitment. In former years, major conferences have generally occurred at intervals of 5 years with the objective of reviewing the progress made in implementing the programmes of action and committing politicians in the spirit and letter of the political declarations adopted. Table 15.1 indicates that

in recent years the UNGA has undertaken reviews of its major conferences annually as well as on a 5-year review cycle. Typical examples of this can be seen in the resolutions on Roll Back Malaria and the HIV/AIDS, both of which were reviewed at regular intervals with important milestones. The decade 2001–2010 was declared for Malaria by the UN General Assembly.

Global health issues raised at major conference and summits have included, what has become a divisive political issue; sexual and reproductive health. Over the years, policies to address HIV/AIDS and birth control have exposed fundamental difference of approach amongst Member States, for cultural and religious reasons or for purely technical health reasons. In spite of this, Member States have successfully reached consensus on these issues.

Setting the UN General Assembly Agenda

The United Nations has traditionally planned its work programme and agenda based on priorities identified by the UN Secretary General, currently Ban Ki Moon, in consultations with Member States prior to the sessions of the General Assembly. The UN Secretary-General's leadership of this process is crucial in setting the agenda of the United Nations and its General Assembly and thereby in shaping global policies.

The critical links in the relationship between Member States and the UN Secretary General, in setting the agenda are the Main Committees of the UNGA these are: First Committee (disarmament issues), Second Committee (economic and development issues), Third Committee (social, cultural, humanitarian and human rights issues), Fourth Committee (decolonization), Fifth Committee (budgetary and financial matters) and Sixth Committee (legal issues). The resolutions and recommendations of these Sub Committees shape the main agenda of the UNGA itself.

The outline of the work of the committees noted above excludes work in the fields of peacekeeping, and the Peacebuilding Commission, peace and security issue are dealt with by the UN Security Council. While the UN Secretary General plays a central role in working with all parts of the UN system, the development and negotiating of resolutions is the sole responsibility of Member States. This may be supported by reports and advice from the Secretariat which provides a general overview on specific matters.

The committees outlined above report to the Plenary Session of the UNGA, presided over by the President of the UN General Assembly nominated by Member States. The President of the UNGA ensures the adoption of all the reports of the plenary items and items directly attributed to the Plenary of the General Assembly. These items are largely cross-cutting and/or political issues that warrant the attention of the permanent representatives. Some of the items may overlap with the work of the committees mentioned above in content; however, the fine dividing line is determined by the General Committee which allocated the work of the General Assembly. The General Committee considers the appropriateness of placement of agenda items in the Main Committees or Plenary and decides accordingly.

It is worth observing that the work of Missions in New York is most often associated with the agenda of the Third Committee, which is social, cultural and humanitarian. There may be some reluctance to engage the issue in other committees, because of the allocations between home country ministries and Missions and to a certain extent work overload for smaller Missions who are unable to follow all issues.

There are also various UN Specialized Agencies, Funds and Programmes, within the total UN system. All of these are linked directly or indirectly to the Plenary of the **UNGA** where their reports, resolutions and the outcomes of their work is adopted by consensus or by vote, depending on the complexity of the issue. Some of these entities of the UN System are based outside New York, several including the WHO are located in Geneva, while other agencies are based in Paris, Rome and Nairobi. In the sphere of economic and social development the UN is advised by its Economic and Social Development Council (ECOSOC) which coordinates the work of 14 specialized UN agencies and 11 UN funds and programmes.

The Foreign Policy and Global Health Initiative

The **foreign policy and global health initiative** of the **Oslo Group** highlighted the need to recognize the nexus between foreign policy and global health. The outcomes of other conferences such as the Millennium Declaration, numerous Declarations and Programme of Action at UNGA and at General Assembly Special Sessions, the Paris Declaration on Aid Harmonization as well as the intergovernmental and WHO negotiations on International Health Regulations (IHRs), the Framework Convention on Tobacco Control, required strategic decisions to ensure that the context for global health diplomacy was not overlooked.

The idea of an initiative focussing on the cross-cutting foreign policy issues that have an impact on global health was first raised at a meeting in New York in 2006 between foreign policy and health representatives from the founder countries. The group then met in a further conference in 2007 which produced the **Oslo Ministerial Declaration**, highlighting the links between health and foreign policy and noting that the implications for security, economic growth and environment degradation all fell within the purview of the General Assembly. With its foreign policy focus, it was the ideal and supreme body of the UN to address these issues across its committees as well as subsidiary bodies such as the ECOSOC. The progress of negotiations to include foreign policy and global health in the agenda of the UNGA is described in Box 1.

Box 1 Negotiating Support for the Global Health and Foreign Policy Resolution

The resolution proposed in 2008 when the issue was first introduced at the UN was procedural. The resolution called on the Secretary-General to submit a report (Document A/64/365) which identified five recommendations for Member States: (1) identify priority global health issues that require foreign policy action; (2) strengthen the political and institutional foundations for foreign policy action on global health; (3) increase the quantity and quality of health information through more transparent and rigorous monitoring and assessment of foreign policy and global health initiatives; (4) heighten the involvement of diplomatic forums in global health and (5) train more diplomats and health officials in global health diplomacy. As an overall reaction of Member States to the first round of negotiations most Member States acknowledged the importance of the initiative as well as the fact that no delegation or political grouping had undertaken to put such a cross-cutting agenda on the Plenary of the UN General Assembly before. Previous initiatives had focussed on specific epidemics and health emergencies such as the bird flu, Malaria and HIV and AIDS. Other Member States reacted to this issue by portraying is as a "Geneva issue", which should not be placed on the General Assembly agenda.

Other views exchanged during these negotiations included objections to the **Oslo Ministerial Declaration** with some Member States expressing the point that the declaration was adopted by only seven countries and could not therefore claim to be universal. The negotiations were also characterized by the attendance of several New York-based UN agencies, driven by their interest and the potential impact the resolution may have on their mandates. These agencies included: the UN Population Fund (UNFPA), UNADIS and the WHO, the International Red Cross also became involved as an international NGO. Another positive development during the negotiations was the invitation to the **Oslo Group** represented by South Africa, as the key negotiator at the time, to present the FPGH Initiative to a special event on "Globalisation and Health" in the Second Committee of the UNGA on 24 October 2008. This event was moderated by Professor Jeffrey Sachs of Columbia University who is also well known for his work on MDGs and Dr Margaret Chan, the DG of the WHO also participated in this event. This event profiled the FPGH Initiative through the interactive discussions.

On December 10, 2009, the **UNGA** approved a second resolution on health and foreign policy (64/108) which has the objective of improving policy coherence, and coordination, on global health and foreign policy. The resolution was introduced by the South African Ambassador, on behalf of the members of the FPGH. Resolution 64/108 identified four thematic areas to utilize foreign policy to advance global health: (1) fully implement the IHRs to enhance surveillance and response capacity at the national, regional and international levels; (2) finalize the Pandemic Influenza Preparedness Framework for sharing of influenza vaccines; (3) finalize the WHO code of practice for the international recruitment of health personnel, and get a commitment from Member States to address the debilitating shortage of health workers in developing countries; and (4) submit a report on health and foreign policy to the next General Assembly.

The Impact of the Adoption of the Global Health and Foreign Policy Resolutions

These resolutions have played an agenda-setting role by signaling directions to governments, international organizations and non-state actors. It is also a means to integrate a new issue in the formal mechanisms of an institution such as the general assembly. David Fidler (2009), Director of the Center on American and Global Security at Indiana University, argued that: "the new resolution is important because it continues attempts to heighten the profile of health in foreign policy and diplomatic practice. This is especially crucial at a time when conditions are increasingly difficult to sustain high-level foreign policy attention on health within foreign ministries, regional organizations, and other international organizations". The placement of the agenda item was agreed and the issue is now permanently on the agenda of the assembly.

It may appear simple and automatic to achieve these two first steps; however, a lot of lobbying for support for the placement of the agenda item and the resolution was necessary prior to its introduction. The **Oslo Group** benefitted from the attendance and participation by the UN Secretary General and the Director-General of the WHO at the launch of the **Foreign Policy and Global Health Initiative** in 2007. This event occurred in the margins of the UN General Assembly meeting during which both the UN Secretary-General and the WHO Director General expressed full support. This may have convinced sceptics in the following year in 2008 when the negotiations on the issue began.

For the first time in 2009, there was an agenda item devoted to "global health and foreign policy", note that the title was changed from "foreign policy and global health" to "global health and foreign policy" in detailed negotiations because this was found to gain more support. The interest in both resolutions in 2008 and 2009 was reflected in the number of countries that increasingly sponsored both resolutions. Sponsoring a resolution indicates commitment and ownership, identifying the sponsor country with the spirit and letter in the contents of the resolution. Member States were specifically interested in establishing the interaction between foreign policy and global health whilst reaffirming the role of the WHO as the principal body responsible for health. It was also important that **Oslo Group** members were drawn from different political and economic groupings of the UN system. The cross-regional composition of the initiative between developed and developing countries added credibility to the process.

The reports and resolutions on Global Health and Foreign Policy have put the issue of global health at the centre of the UN General Assembly. There will now be an annual consideration of foreign policy and global health, as part of the agenda of the General Assembly and the UN Secretary General will produce annual reports on the issue. This complements other specific resolutions that are directed to issues such as HIV/AIDS and Malaria.

The tabling of the resolutions in New York has increased awareness of the linkage between foreign policy and global health in Geneva. Many delegations in Geneva are now calling for a process at the WHO to inform the General Assembly. The potential impact of this will be a coordinated approach between the WHO and the General Assembly, leading to better policy coherence and coordinated. Better coordination will lead to better implementation at the national, regional and international level and is therefore an important contribution to global governance for health.

The future prospects for the governance of global health in the foreign policy domain appear to be headed in the positive direction, especially with the level of interest shown by the UN Secretary General. For the first time, numerous references to health have been included in the 2010 the follow up to the Millennium Summit resolution entitled "Keeping the promise: united to achieve the Millennium Development Goals". The UN Secretary General also included a section on health in his report in preparation for the summit, which indicated that it will be a subject of annual follow-up especially in the context of health-related MDGs.

There is now widespread agreement and understanding that diplomats need to factor health in their consideration of traditional foreign policy issues. In order for this to be possible, familiarity with developments in the health and foreign policy fields has become indispensable in both Geneva and New York. Some of the academic institutions have launched intensive training programme on global health diplomacy and hopefully in the near future, the WHO will provide further support and processes in this field.

Conclusion: Getting on the UNGA Agenda Requires a Multi-Party Process

It will be apparent from this discussion that it is no simple matter to place an issue on the agenda of the UN General Assembly. The relevant committees must be engaged and convinced of the value of addressing the issue, and it will be important to secure the commitment and support of the UN Secretariat and ultimately the Secretary General. This will be informed by the various agencies of the UN concerned with the issue. They in turn will respond to their Member States and the views of experts and opinion leaders in the field. And to convince opinion leaders it will be essential to engage academics, business groups and civil society organizations. In other words, to initiate a mass movement in support of the proposition that will ultimately be expressed as a resolution of the UN General Assembly. While this would be a complex undertaking within one country, it must be achieved on a global scale. But, as the example of the Foreign Policy and Health Initiative shows, it can be achieved.

Questions

1. What is the role and function of the UN General Assembly?
2. How does it address global health issues?
3. How are items included in its agenda, what helps and what can hinder inclusion?
4. Describe some of the ways in which global health and foreign policy issues are linked.
5. What global health policies affect foreign policy and what foreign policy issues affect global health, give some examples of each?
6. What challenges did the FPGH initiative face and how did it overcome them?

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Chapter 16
The EU as an Actor in Global Health Diplomacy

Thea Emmerling and Julia Heydemann

Readers' Guide

This chapter explores the past and present role of the **European Union** (EU) in global health. It begins by tracing the historical evolution of health policy in the EU: the EU evolved around the idea of step-wise economic integration and health was not explicitly on the agenda of the founders. On the basis of different Treaty articles, the EU gradually started to be actively involved in health questions and this involvement has increased ever since. Today, the EU is an important partner in nearly all global health topics: politically, economically and financially—and the implementation of the Lisbon Treaty is expected to strengthen this role. The second section sheds light on the most important EU health actors and their roles. The third section outlines the increasing role of the EU in global health. It explores the EU's contribution and participation in several international health negotiations and processes as well as its role as a donor of development assistance. The fourth section describes the new global health framework which the EU set itself in May 2010 with the Council Conclusions on "The EU's role in global health". For the first time the EU defined its objectives and its role in and for global health, thereby linking internal and external health policies. The chapter concludes with a summary and an outlook for the EU's potential in global health.

The views expressed in this article are the personal views of the authors and do in no way constitute the official views of the institution.

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Learning Points

- Health has long been part of EU development policy, though health did not explicitly feature in the initial treaties.
- It was the Maastricht Treaty that marked a breakthrough for public health within the EU: For the first time a treaty contained a separate article on public health: article 152.
- The Lisbon Treaty of 2009 makes it clear that today the EU shares competence with the Member States on common safety concerns in public health matters, for the aspects defined in the treaty.
- As regards protection and improvement of human health, the EU supports, coordinats or supplements the actions of member states.
- Externally, in its development policy, the EU promotes health systems strengthening, universal coverage of basic quality care and the right of everyone to enjoy the highest attainable standard of physical and mental health.
- In 2010, the EU set out the EU's role in global health, thereby linking the internal and external aspects of its health policies.
- The three main bodies of the EU for law and policy making are: the **European Parliament**, the **Council of the European Union** and the **European Commission**. This institutional triangle develops policies and laws including consideration of their impacts on health which apply throughout the EU and in its external relations.
- In its first health strategy adopted in 2007, the Commission called for a strengthening of the EU's voice in global health, and today, the EU is an important partner in nearly all global health topics, politically, economically and financially.
- The implementation of the Lisbon Treaty and the setting up of the European External Action Service both aim to strengthen this role.

Introduction: The Evolution of Health Policy in the EU

What is today the European Union has gradually evolved around the idea of stepwise economic integration. The process started with the Treaty establishing the European Coal and Steel Community (ECSC) which came into force on 18 April 1951, thus putting the coal and steel sector of the six founding members (France, Germany, Italy, Netherlands, Belgium, Luxemburg) under a common authority and frame. A few years later, on 25 March 1957, the Treaty establishing the European Economic Community (EEC) and the Treaty establishing the European Atomic Energy Community (Euratom) were signed. They came into force on 1 January 1958. These three treaties created the "European Communities", i.e. the system of joint decision-making on coal, steel, nuclear power and other major sectors of the member states' economies (European Commission 2003).

This chapter mainly focuses on the evolution of the legal basis for health in the internal EU policies including their external dimension, where appropriate. In the beginning, health was only dealt with from the angle of occupational health, in art. 55 of the ECSC. The core Treaty, the EEC Treaty, aimed at creating a single market in Western Europe with free movement of goods, people, services and capital, only mentioned public health in connection with the use of prohibitions or restrictions on the movement of goods (art. 36). This article, together with the articles 43, 39 and 100, made it possible to gradually set up a common veterinary policy. Free trade should not include the free spread of infectious agents and toxic substances by animals and food of animal origin which were primarily considered as economic/market "goods" (European Commission 2008). The different treaties and their relevance to health are shown in Box 1. Major EU Charters relevant to health are shown in Box 2.

The Single European Act, which came into force in 1987, was the first major amendment of the Treaty establishing the EEC. But it was the Maastricht Treaty that came into force in November 1993 that marked a breakthrough for public health. For the first time in the history of the Community, a treaty had a separate article on public health: article 152. This article was, however, limited to incentives for actions and recommendations that focussed on disease prevention, rather than following a broad public health concept. It could hardly be used as a basis for secondary, health-related legislation.

Major pieces of health-related legislation were only developed over time on the basis of other Treaty articles, mostly using the agricultural, single market, environmental or health and safety at work provisions of the Treaty. These legislative provisions, although geared towards a high level of health and consumer protection, mainly pursued other objectives. Although they took health concerns into account, they did not follow a consistent concept of public health and thus led to a piecemeal approach in health and health-related legislation at the European level.

Despite the absence of a clear legal basis, growing awareness of drug addiction, cancer and AIDS, coupled with the increasingly free movement of patients and health professionals in the EU pushed public health further onto the agenda (European Parliament Fact Sheet 2000). Worth mentioning in this context are the first Community cancer programme—which eventually led to major tobacco control activities at the European level—and the 1991 Europe against Aids Programme. The disease-specific approach was later followed by a more horizontal, interdisciplinary approach.

During all these years the European Parliament was one of the important actors in strengthening EU health actions. The BSE crisis, the Parliament's investigation committee to uncover possible omissions at EU level in the fight against BSE and its following "conditional motion of censure" on the European Commission led to a major rethinking of health and consumer health questions. Before and after the BSE crisis the Parliament had been a very strong supporter and promoter of health action at the European level—through financial programs, public health, food safety or pharma-related legislation. The European Court of Justice was also an important driver for health, mainly through case law with regard to the freedom of access to health services. It is worth mentioning that throughout all the years health has been an important component of EU development policy.

Ironically, it seems that major health-related crises were necessary to improve the legislative health provisions within the EU. The most important ones were the

BSE crisis (which led to the development of a consistent "farm to fork approach" for food and feed, covering the whole production chain), the scandal that arose when it was discovered that contaminated blood had been supplied to haemophiliacs in France (which led to EU blood safety legislation) and the terrorist attacks of 11 September 2001 in the USA (which led to a strengthening of health security provisions and activities).

The Lisbon Treaty, which came into force on 1 December 2009 and sets the present legal framework for all EU activities, stipulates that a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities (art. 9 TTEU). It also clarified that today the EU shares competence with the Member States on common safety concerns in public health matters (for the aspects defined in the Treaty). The Union also has the competence to carry out actions to support, coordinate or supplement the actions of the Member States as regards the protection and improvement of human health. The specific public health article (art. 168, see Box 3) specifies the health provisions and emphasizes that European Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organization and delivery of health services and medical care. Until recently freedom of access to services in the health sector there has only been established through European Court of Justice case law. A new directive on cross border patient rights was enacted in 2011 (see http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:EN:PDF). The Lisbon Treaty also establishes a High Representative for Foreign Affairs and Security Policy and a new European External Action Service which will also put the external aspects of EU health policy into a new light. In addition, it stipulated that the term European Union replaces and succeeds the term European Community.

The Lisbon Treaty is accompanied by the Charter of Fundamental Rights (European Institutions and Bodies 2007), which came into force on the same day (except for the UK, Poland and the Czech Republic). The Charter gives every citizen the right to social security (art. 34), the right of access to preventive health care and the right to benefit from medical treatment (art. 35). And, even if Member States are reluctant to discuss health care legislation at EU level, a strong consensus and deep commitment exists across all EU Member States and European societies on the right to health care, on the overarching values of universality, access to good quality care, equity and solidarity (Official Journal of the European Union 2006).

Externally, in its development policy, the EU promotes health systems strengthening and steps towards universal coverage and the right to health. It thus "exports" the "European social model". This is of major importance, since the European institutions and EU Member States together stand for more than half of the Official Development Assistance (ODA). It is fair to say that the EU as a whole (for national and for EU competence) is delivering on its objectives and principles: Member States are providing health care and universal coverage to their citizens. Together with the European institutions, they are promoting these values and principles and the internal safety-related health-relevant legislation also externally.

In its development and trade policy, the EU is committed to improving access to medicines for developing countries and ever since the problem was recognized, it

has contributed to broadening access to essential medicines for developing countries and to striking the balance between the intellectual property rights of pharmaceutical companies and the need to ensure that medicines are available for poor countries based on the "Doha Declaration" on the WTO TRIPS agreement (see Europa EU 2010a).

The Treaty developments outlined above are reflected in the institutional structure of the European Commission. From the 1980s until the mid-1990s, it had a Directorate on occupational health in the Social Directorate General (DG); veterinary health was dealt with in the Agricultural DG, and food in the Enterprise DG. Following the BSE crisis and the criticism that health issues should be treated independently from commercial and economic interests, a whole new DG on consumer health policy was set up in 1997. It was gradually strengthened with the relevant food and feed safety legislation, as well as public health legislation under the Prodi Commission 1999 and finally, the pharmaceutical and genetically modified organism legislation under the Barroso II Commission at the end of 2009.

Box 1 European Treaty Development and Health[1]

Treaty	Major health-related treaty articles	Remarks
Treaty of Paris (ECSC), entry into force 23.07.1952, expired 23.07.2002	**Article 55**: high authority to promote research on occupational safety in coal and steel industry	Health not mentioned explicitly, only occupational safety research at the workplace
Treaty of Rome: Entry into force 01.01.1958	**Article 48**: freedom of movement for workers can be limited on public health grounds **Article 56**: freedom of establishment can be limited on public health grounds	Health not mentioned in its own right, public health only mentioned as a possible limitation to the rights and freedoms of workers and the freedom of establishment
• **EEC Treaty**		
• **Euratom Treaty**	**Article 2b**: community shall establish uniform safety standards to protect the health of workers and the general public and ensure that they are applied **Article 30**: community to lay down basic standards for the protection of the health of workers and the general public against the dangers arising from ionizing radiations	Only geared at nuclear energy; contains a whole chapter on health and safety (articles 30–39); establishes uniform safety standards to protect the health of workers and of the general public

(continued)

[1] This table contains "health" in a narrow sense, only where health is explicitly mentioned or referred to as public health or health at the workplace, although the latter is not the focus of this table. Social security development assistance and provisions are left out.

Box 1 (continued)

Merger Treaty, entry into force 01.07.1967		Does not mention "health" at all—pure administrative treaty which merges institutions of the three founding treaties
Single European Act (SEA), entry into force 01.07.1987	**Article 18 supplements art. 100a of the EEC Treaty**: in its proposals, the Commission will take a high level of health , safety, environmental and consumer protection as a basis	Health not mentioned as a distinct policy, but subsumed as an objective of the single market
	Article 21 supplements art. 118a of EEC Treaty: objective is harmonisation of health and safety conditions at work	Introduction of a legal base for the harmonisation of "health and safety" at work
	Article 25: adds article 130r to the EEC Treaty: community actions for environment **shall** contribute to protecting human health	
Maastricht Treaty (EU)[2], entry into force 01.11.1993	**Article 3-o**: community activities shall include contributions to attain a high level of health protection	First public health article in its own right (article 129), but without major legislative competences
	Article 129: public health: the community to contribute to • Cooperation between MS in human health protection • Focus on disease prevention, research promotion, health information and education • Foster cooperation with third countries and competent international organizations • Adopt incentive measures, recommendations	Attainment of a high level of health protection as one objective of Community activities
Amsterdam Treaty, entry into force 01.05.1999	**Article 129 slightly amended**: Human health protection to be ensured in the definition and implementation of all Community policies and activities	Driven by the BSE-crisis, the scope for legislative measures concerning human health protection was enlarged
	Scope for legislative measures enlarged to quality and safety of organs and substances of human origin, blood and blood derivatives, veterinary and phytosanitary measures whose direct objective is protection of public health	Treaty specifies that the Community shall not affect national measures set out for healthcare financing and provision
	Community shall fully respect national health care financing and provision	

(continued)

[2] Opting out of the social policy by the UK, see: *Agreement on social policy concluded between the MS of the EC with the exception of the United Kingdom of Great Britain and Northern Ireland* (the promotion of healthy working conditions).

Box 1 (continued)

Nice Treaty, entry into force 01.02.2003	No change as regards health provisions, article 129 becomes article 152 in consolidated version	
Lisbon Treaty, entry into force 01.12.2009	Article 152 amended, becomes **new art. 168**: Monitoring, early warning, combating serious cross-border threats to health enlarged; tobacco and alcohol specifically mentioned, Union can adopt measures setting high standards of quality and safety of medicinal products and devices for medical use **Article 2C (k)**: Common safety concerns in public health matters are shared competence **Article 2E (a)**: Protecting and, improving human health is coordinating competence	The health security provisions were slightly strengthened: Tobacco and alcohol specifically mentioned Quality and safety for medicinal products and devices for medical use Clearer delineation between shared and coordinating competence in health

Box 2 Charter Development and Health[3]

Charter	Health-related articles	Remarks
European Social Charter (ESC), entry into force 26.02.1965	**Article 3**: the right to safe and healthy working conditions **Article 11**: the right to protection of health **Article 13**: the right to social and medical assistance	First explicit mentioning of the effective exercise of the right to protect health and undertaking measures to promote health and to prevent epidemic, endemic and other diseases
Revised European Social Charter, entry into force the 01.07.1999	See above	Unchanged as regards articles 11 and 13, rights to safe and healthy working conditions amended

(continued)

[3] This table contains "health" in a narrow sense, only where health is explicitly mentioned or referred to as health at the workplace. Social security, development assistance and provisions are left out.

Box 2 (continued)

Charter of Fundamental Rights of the EU[4]**,** drafted the 18.12.2000 and made legally binding following the coming into force of the Lisbon Treaty	**Article 31**: every worker has the right to working conditions which respect his or her health, safety and dignity **Article 35**: everyone has the right to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities	Health in line with Solidarity and universal coverage of health systems

Box 3 Article 168 of the Lisbon Treaty

1. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.
   Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education, and monitoring, early warning of and combating serious cross-border threats to health.
   The Union shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.
2. The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas.
   Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States,

(continued)

[4] *Opting-Out Protocols* by:
UK and *PL* from the Charter, and later by the *CZ:*
http://www.consilium.europa.eu/uedocs/cmsUpload/cg00014.en07.pdf (TL/P/en 17–18) and http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/ec/110889.pdf (Annex I)

Box 3 (continued)

take any useful initiative to promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organization of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation. The European Parliament shall be kept fully informed.

3. The Union and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.
4. By way of derogation from Article 2(5) and Article 6(a) and in accordance with Article 4(2)(k) the European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee (ECOSOC) and the Committee of the Regions, shall contribute to the achievement of the objectives referred to in this Article through adopting in order to meet common safety concerns:
   (a) Measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures.
   (b) Measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health.
   (c) Measures setting high standards of quality and safety for medicinal products and devices for medical use.
5. The European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the ECOSOC and the Committee of the Regions, may also adopt incentive measures designed to protect and improve human health and in particular to combat the major cross-border health scourges, measures concerning monitoring, early warning of and combating serious cross-border threats to health, and measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol, excluding any harmonization of the laws and regulations of the Member States.
6. The Council, on a proposal from the Commission, may also adopt recommendations for the purposes set out in this Article.
7. Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organization and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them. The measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

Hand in hand with these internal-institutional developments came attempts to gradually make a consistent whole out of the different health-related policies and pieces of legislation which had been developed over time. The first step was the White Paper on Food Safety in 1999 (EC 2000) followed by a Health Strategy in 2007 (EC 2007a, b) and an Animal Health Strategy in the same year. In 2010, the EU tried, for the first time, to specify the EU's role in global health, thereby linking the internal and external aspects of its health policies (EC 2010a, b).

EU Health Actors

The EU is not a federation comparable to the USA. Nor is it an organization for purely intergovernmental co-operation. The 27 countries that form the EU remain independent sovereign nations, but on certain policies and sometimes just part of these policies they pool their sovereignty to gain strength and influence none of them could have on their own (EC 2003). These policies are then decided jointly in European institutions by using specific processes. The uniqueness of the EU is that the European institutions have own lawmaking authority, implementation and enforcement powers.

The three main decision-making bodies are: the European Parliament which represents the EU's citizens and is directly elected by them. The Council of the European Union, which is comprised of the representation of the Member States. The European Commission, which is the EU's executive arm and seeks to uphold the interests of the Union as a whole. This institutional triangle develops policies and laws which apply throughout the EU. The European Court of Justice upholds the rule of European law. In addition, specialized agencies have been set up to handle certain technical, scientific or management tasks. Finally, the Court of Auditors checks the use of EU funds (see Europa Web site European Union Institutions and other Bodies).

The **European Parliament** (EP) has at present 736 members, directly elected by the citizens of the European Union to represent their interests. Parliament has three main roles: firstly, it passes European laws, in many areas jointly with the Council. Secondly, it exercises democratic supervision over the other EU institutions, and, in particular, over the European Commission. It has the power to approve or reject the nomination of Commissioners, and it has the right to censure the Commission as a whole. Thirdly, it has the "power of the purse": Parliament shares with the Council authority over the EU budget and can therefore influence EU spending. Elections to the European Parliament are held every 5 years. Parliament thus expresses the democratic will of the Union's citizens (more than 490 million people) and represents their interests in discussions with the other EU institutions. Health questions are mostly dealt with in the Parliament's Committee on the Environment, Public Health and Food Safety, and, of course, in plenary sessions. Health issues are also regularly discussed in an informal "health intergroup" of Members of Parliament with a special interest in health. The Parliament has always been an active promoter of health issues at EU level, due to its legislative and budgetary powers.

The **Council** is the EU's main decision-making body. It represents the Member States and it adopts legislation, in most of the cases together with the European Parliament. It also co-decides with the European Parliament on the EU's budget. Its meetings are attended by one Minister from each of the EU's national governments. Health matters are dealt with by the Council for Employment, Social Policy, Health and Consumer Affairs, the EU's relations with the world by the "General Affairs and External Relations Council". The Council meetings are prepared at a technical level by respective committees and working parties. Each Minister in the Council is empowered to commit his or her government. In other words, the Minister's signature is the signature of the whole government.

Up to four times a year, the Heads of State or Government of the Member States, together with its President and the President of the European Commission, meet as the **European Council**. The High Representative of the Union for Foreign Affairs and Security Policy takes part it its work. These "summit" meetings set overall EU policy and resolve issues that could not be settled at a lower level (i.e., by the Ministers at normal Council meetings). Health issues rarely make it onto the agenda of the summits.

The **European Commission** is independent from national governments. Its job is to represent and uphold the interests of the EU as a whole. It drafts proposals for new European laws, which are then discussed, and either adopted or (in rare cases) rejected by the European Parliament and the Council. The Commission is also the EU's executive arm, in other words, it is responsible for implementing the decisions of Parliament and Council. This basically means managing the day-to-day business of the European Union: implementing its policies, running its programmes and spending its funds. The Commission, as a body, is politically answerable to the European Parliament. The European Commission has four main roles: to propose legislation to the Parliament and the Council; to manage and implement EU policies and the budget; to enforce European law and to represent the Union on the international stage (with the exception of common foreign and security policy and other cases provided for in the Treaties). The European Commission employs about 32,000 staff and is headed by 27 Commissioners (one from each Member State) who take decisions as a College. Within the Commission, not only the Directorate-General for Health is the main health actor, but also the DGs for Development and for Research are active players.

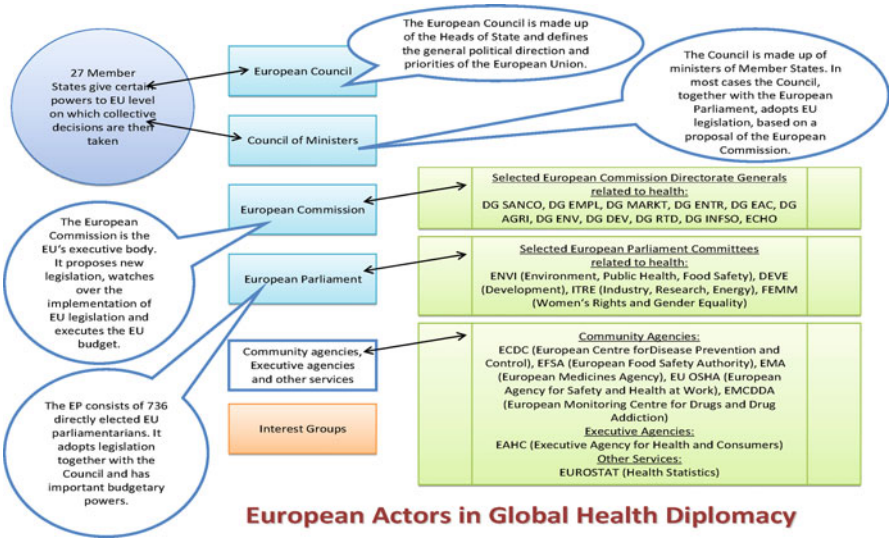
The **European Court of Justice** makes sure that EU legislation is interpreted and applied in the same way in all EU countries, so that the law is equal for all EU citizens alike. It ensures, for example, that national courts do not come to different rulings on the same issue. The Court also makes sure that EU member states and institutions do what the law requires. The Court has the power to settle legal disputes between EU Member States, EU institutions, businesses and individuals. It is composed of one judge per Member State, so that all 27 of the EU's national legal systems are represented. The Court has been a major actor in sharpening internal market rules, including the freedom of access to health services.

The **Court of Auditors** has the power to check and control that EU funds are properly collected and that they are spent legally, economically and for the intended

purpose. Its aim is to ensure that EU taxpayers get maximum value for their money, and it has the right to audit any person or organization handling EU funds. The Court has one member from each EU country.

A number of agencies and services must also be mentioned that work on health issues. They mainly support the European Commission: the European Medicines Agency in London, the Center for Disease Prevention and Control in Stockholm, the European Food Safety Authority in Parma, the European Monitoring Centre for Drugs and Drug Addiction in Lisbon, the European Agency for Safety and Health at Work in Bilbao and the Community Plant Variety Office in Angers. They were set up by an act of secondary legislation (contrary to EU institutions which were created on the basis of European Treaties). They usually accomplish a specific technical, scientific or managerial task in a well-defined area. By contrast, Executive Agencies are established to manage certain EU programs, for example, the Public Health Agency in Luxemburg which manages the Commission's public health programme. Finally, the Commission can draw upon other important services, such as Eurostat which provides relevant statistical data.

It is important to note that in the past these aforementioned actors have not necessarily acted under the guise of "global health diplomacy", although considerable work was done on health issues. This point is a central one to make since the concept of global health diplomacy (GHD) is still relatively new. It does not, however, mean that European actors in health have not been engaged in the issues and approaches referred to by the concept of GHD. As will be demonstrated in the next section, the Commission in particular has been actively engaged in GHD by participating in several international negotiations on health and actively promoting the global health concept.



GHD and the EU

Since the concept of GHD has been elaborated elsewhere in this book in much greater detail, this section will resort to recapitulating the following definition: "As diplomacy is frequently referred to as the art and practice of conducting negotiations, the term 'global health diplomacy' aims to capture the multilevel and multi-actor negotiation processes that shape the global policy environment for health. It bridges the commitment to development and the need to define collective action in an interdependent world" (Novotny et al. 2008). In other words: "Global Health Diplomacy is concerned with the negotiation processes that shape and manage the global policy environment for health and its determinants" (Kickbusch 2009). This environment is not only a dynamic one with a multitude of players: states, international organizations and increasingly also non-state actors, like private foundations, NGOs and individual experts; it is also a field that is constantly shaped and reshaped by the push and pull of varying interests and multi-level power games. This context presents a challenge to any form of governance, particularly to the attempt of global governance in an area of public concern such as health.

In its first health strategy adopted in 2007, the Commission called for a strengthening of the EU's voice in global health. But even in the past, the EU was engaged in a number of diplomatic activities involving global health issues. The key international organization for setting standards in global health still is the World Health Organization (WHO). As early as 1972, the then European Community sought close cooperation with the WHO. This was done by exchanges of letters between the Commission and the WHO (Official Journal 1972–2001), the last and most recent one being between the former Director General of WHO, Gro Harlem Brundtland, and the then Health and Consumer Commissioner David Byrne, dating from 2001. The European Community—which was converted into the European Union by the **Treaty of Lisbon**—has the status of observer, not as a full member in the governing bodies of WHO, as WHO is made up of States. The EU is, however, increasingly invited to participate in intergovernmental processes and in the work of WHO under the title of "regional economic integration organization" (Eggers and Hoffmeister 2006).

This was the case for the first time when the (then) European Community was invited to the negotiations on the WHO Framework Convention on Tobacco Control (FCTC) (see Box 1). The (then) European Community ratified the first public health treaty negotiated by WHO for the parts that were under Community competence and thus became a Party with full rights (except the right to vote) and its own financial contribution to the Convention. As the first international public health treaty, the FCTC binds not only health ministries, but also national governments and regional economic integration organizations as a whole and therefore pushes and promotes the "Health in all policies"-approach.

EU representatives also participated in the negotiations on the International Health Regulations (IHRs) 2004–2006. They were also specifically invited and actively participated in several other recent intergovernmental processes in health: the Global Strategy and Action Plan on Public Health, Innovation and Intellectual

Property and its follow-up, the Pandemic Influenza Preparedness framework, the IHR review process and the open-ended working group on substandard/spurious/falsely labelled/falsified/counterfeit medical products, since all these processes touch upon major areas of EU competence. As a full party in the FCTC the EU also participates fully in the negotiations on a protocol on illicit trade in tobacco products. Today, between 70 % and 90 % of WHO resolutions contain at least a component that touches upon EU law. In addition, EU Member States and the EU increasingly attempt to coordinate their positions and speak with one voice on important parts of the health topics dealt with by WHO.

The EU is also active with other health partners on a global level: the European Commission and several EU Member States are among the founding members of the Global Fund to Fight Aids, Tuberculosis and Malaria and the EU is a major financial contributor and has a seat on the governing bodies. It also provides financial and other support to the Global Alliance for Vaccines and Immunisation (GAVI), the European Observatory on Health Systems and Policies and many other international health partnerships and actors. Together, the EU and its Member States account for about 60 % of global development assistance and thus play an important role in shaping the global health architecture. The Commission has endorsed the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008) (see OECD 2008). Politically, it is highly committed to the achievement of the Millennium Development Goals (MDGs) and has specifically pushed for the implementation of the health-related MDGs. The EU agreed to increase official development assistance to 0.56 % of its gross national income by 2010 on the path to achieving the UN target of 0.7 % by 2015. Of course, the EU has several long-standing collaborations with other international and regional organizations and entities and sometimes health topics are on the agenda. In this context, it is worth mentioning that an important collaboration exists with the African Union which also encompasses health aspects.

Health makes up the biggest component of the EU's Research Framework Program which also addresses issues such as tropical and neglected diseases. Together with eight states (Canada, France, Germany, Italy, Japan, Mexico, the UK and the USA) and the WHO, the Commission is a member of the Global Health Security Initiative which is an informal international partnership of like-minded countries to strengthen health preparedness and response globally to threats of biological, chemical, radio-nuclear terrorism and pandemic influenza. In the World Trade Organization, once the problem was recognized, the EU contributed to getting agreement on better access to medicines for developing countries and then implemented the provisions internally.

As regards food safety and trade, the EU—being the world's biggest importer and exporter of agricultural and food products—is one of the major players in the WTO Committee on Sanitary and Phytosanitary Measures. Here, the EU promotes the application of high health and safety standards for food products worldwide. The Commission also supports specific training programmes on food safety for developing countries. The EU is a member in the WHO/FAO Codex Alimentarius Commission that sets food standards and actively follows the work of the World Organization for Animal Health (OIE). The European Union also participates in the

G8 and the G20 meetings and is involved when the summits deal with health questions.

Today, the EU is therefore an important partner in nearly all global health topics, politically, economically and financially. The implementation of the Lisbon Treaty and the setting up of the European External Action Service both aim to strengthen this role. The value-added of joining forces within the EU to address global health questions is at least threefold: firstly, the push for coordination obliges all EU Member States to make up their minds at an early stage and to pre-discuss a significant amount of the items. Secondly, smaller Member States that would normally hardly be heard on the international arena have a substantial influence when the EU establishes a position and can thus be more influential than without the EU. Thirdly, the EU is generally considered a stable and reliable partner in the world and its collective weight is considerable. It can and has often acted as a mediator on certain international issues. But a joint voice is also essential: in an increasingly multi-polar world, where the European population is shrinking compared to other regions of the world, it risks losing creative power and influence to shape and work on global solutions, which would only be accentuated if the European voice were divided.

The process of "finding" that common voice can be cumbersome, but often the political will to "speak as one" prevails and constant coordination has become day-to-day business. Representatives of EU Member States and of the European Commission/EU Delegations meet regularly, during international negotiations even daily, to discuss the issues to be negotiated and to define and coordinate a joint EU position. Prior to such coordination meetings a draft EU position is prepared and then discussed, modified and finally agreed in the coordination meeting itself. At the time of writing this article, the agreed position is then voiced either by the EU Delegation or the country that holds the Presidency of the council of the EU, depending on the issue covered and the fora in which it is expressed. At times, there is a good chance that other actors in international negotiations unite around the EU position, as it already reflects a compromise between different positions. The Lisbon Treaty—which, among other improvements, aims to strengthen the EU voice and structure in common foreign and security policy with the designation of a High Representative for Foreign Affairs and Security Policy and the setting up of the European External Action Service—is expected to gradually lead to more external representation by the EU Delegation and less by the country that holds the Presidency of the council.

Thus despite the achievements so far, there is still room for improvement. Opportunities for increasing the EU's engagement in GHD in the twenty-first century will be elaborated in more depth in the next section.

GHD for the EU in the Twenty-First Century

The cross boundary and global dimension of health has gradually been recognized in the areas of foreign policy, national health strategies, development partnerships and in the international discussion on global public goods. There is growing interest in global health questions in the World Health Assembly, in the UN General

Assembly and in the UN's ECOSOC. Several countries, such as the UK and Switzerland, have developed their own global health strategies and other countries are starting to work on this. While different in nature, all strategies and policies voice the need to bring more policy coherence to health, especially with regard to other policies (often foreign and/or development policy).

The importance of a European contribution to the debate was recognized in the first European Health Strategy in 2007. Reflecting the shared view among experts that health in the twenty-first century cannot be seen in isolation but needs to be included in all related policies, three Directorates General of the European Commission—the Directorates General for Health, for Development and for Research—collectively consulted with various stakeholders from October to December 2009. In the resulting joint communication and accompanying staff working documents that were adopted by the Commission end of March 2010, an attempt was made to delineate the "EU's role in Global Health."

The document identifies the challenges to act—the challenges of governance, of policy coherence, of universal coverage and of knowledge—and identifies the legal basis, value-added and framework for joint EU action. With the aim of "a stronger EU vision, voice, and action" in mind, the communication then proposes actions for an enhanced EU response to the four challenges outlined above. Trade, migration, security, food security and climate change are identified as policy fields where increased coherence is needed. At international level, the EU should endeavour to defend a single position within the UN and its agencies and supports a stronger leadership by the WHO in its normative and guidance functions. In development policy, it calls for strengthening health systems and aid effectiveness; and in research it seeks to promote research that benefits the health of all people. The Communication also suggests a coordination and monitoring mechanism, as well as capacity building in global health.

On the basis of this communication, the Foreign Affairs Council—the representatives of the EU Member States—adopted Council conclusions on the EU's role in global health on 10 May 2010. These conclusions firstly reaffirm important principles for the EU in health: health as a human right; health as a key element for sustainable growth and development; the importance of economic and social conditions for health; equity and health in all policies; solidarity and universal coverage as basis for EU policies in this area. The conclusions then derive actions from these principles: actions as regards development assistance (e.g., a focus on health systems strengthening), external policy actions (support increased leadership of WHO, shift to core voluntary contributions, speak with a stronger and coherent voice), research policy (financing of research that benefits the health of all, ensure that innovations produce products and services that are accessible and affordable). The text then elaborates on the five priority areas identified by the Commission communication on global health. These Council conclusions now form the basis for all EU actions in global health in the foreseeable future.

This means that the EU has recognized the need for a more coherent internal as well as external position on global health matters. It also demonstrates that the EU has competitive advantages, such as its rights-based approach to health, its commitment

to solidarity towards equitable and universal coverage of quality health services, its own regulatory experience, its preference for working through multilateral institutions. These are consistent with WHO policies. It can therefore add substantial value to the global health governance architecture and the current global health debate.

The EU has given itself a framework for action on global health questions. It will now be measured on how its intentions are translated into the EU's and the Member States' political, financial and legal instruments, as well as in its day-to-day policies. The next financial framework and the renewal of the legal texts for most of the financial instruments that go hand-in-hand with the financial planning will be one indicator of the realization of the political intentions. In addition, certain structural issues will need to be resolved, such as the EU's status within the UN after the ratification of the Lisbon Treaty; serious work also has to be done as regards policy coherence: both at EU and at Member State level. The EU will have to honour its pledges for ODA and its commitments to the MDGs.

It is also important to increase the understanding of policy makers and the public that "while the governance of health systems remains a core area of national policy-making, protecting the health of the population is increasingly situated between domestic and foreign affairs, because most health risks (whether related to communicable or non-communicable diseases) in the twenty-first century are transnational. (…) This interdependence in health blurs the dividing line between domestic and foreign policy" (WHO Europe 2010). This can lead to tensions between national responsibilities and those delegated by countries to the EU level.

Finally, the EU is very well aware that its economic strength implies important responsibilities towards the global community. To promote a country's or a region's health must today be combined with advancing the health interests of the global community. Fair and equitable access to universal coverage and a human-rights and solidarity-based approach are crucial elements for this. The EU statement in the UN General Assembly debate on health and foreign policy expressed this well by underlining "that discussions on health and foreign policy link two areas that form the basis of the entire UN system: the fight against poverty and the pursuit of peace and human security" Europa 2010b.

Conclusion: The EU Can Contribute to a More Equitable World

With the history the EU Member States have in health and social affairs, the EU, although originally constructed around the idea of economic integration, has become an important social and health voice in the international arena. Holding a lead role in trade and development, the EU must now aim at policy coherence and combine this role with its stated commitment to social and environmental progress. This will need the combined will and efforts of the EU institutions and of all the EU Member States to act together for health and to cooperate and collaborate on global health questions. If these challenges are met, the EU can contribute to making this world a bit more equitable.

Questions

1. Why wasn't health on the initial agenda of the European founders?
2. How did health become part of the "acquis communautaire"?
3. What consequences arise from this historical evolution?
4. Explain which competence Member States have given to the European level in health and which they retain in national competence.
5. What consequences could the Lisbon Treaty have for the field of health in the EU?
6. What are the decision-making bodies in the EU in the field of health?
7. In which diplomatic activities that involve global health has the (then) European Community been engaged in and is the EU engaged in today?
8. What is the value added of the Council Conclusions "The EU's role in global health"?
9. What is the EU's added value and role in the future of GHD?

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Chapter 17
The G8/G20 and Global Health Governance: Extended Fragmentation or a New Hub of Coordination

Andrew F. Cooper

Readers' Guide

This chapter provides an overview of the current position and the possible future of Global Health Governance (GHG)—in terms of the connections and disconnections with the overall architecture of international organizations engaged in global governance. The main focus of this discussion is on the relationship between GHG and leadership summits, including both the "G8" and "G20." The discussion first notes that while GHG has become a central focus for international diplomacy it has become ever more fragmented as new actors and venues negotiate aspects of global health without apparent reference to a central agency or process. It then briefly reviews the growing role of foundations before focusing on the role of **G8** summitry in GHG. The final section and conclusion consider how the **G20** could provide a further venue for GHG.

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Learning Points

- GHG has become more prominent in international diplomacy at all levels, but at the same time it has become fragmented between different agencies and fora.
- New actors have taken up GHG issues, these include private foundations and international political leaders meeting at **G8** summits.
- While **G8** meetings have increased focus on GHG issues and raised new forms of funding, it could be argued that rather than confirming the control of the GHG agenda by the existing agencies such as WHO, this has increased fragmentation.
- The **G20** is sometimes talked of as being a new global compact, being more inclusive than the **G8** and introducing North–South dialogue. The opportunity exists for **G20** to take forward GHG issues in a way that would coordinate action and reinforce the overall leadership of this issue by the WHO.

Introduction: The Fragmentation of GHG

What must be acknowledged at the outset is the paradoxical manner by which Global Health Governance (GHG) has risen on the global governance agenda as a central focus of concern but one which is fragmented by the many different agencies and processes designed to address it.

Intellectually, in many policy relevant ways, GHG has become a pivotal issue on the international stage. New centers have gown up around the world, for example, at the Geneva Graduate Institute, at Chatham House UK, at the US Council on Foreign Relations (CFR), and Center for Strategic and International Studies (CSIS). Rather than discounting health as a specialist technical/scientific subject, prominent academics from a range of disciplines have embraced the topic—and become more prominent by doing so. Research networks straddling regional divisions have flourished. Graduate students have grasped the topic with unexpected enthusiasm.

At international diplomatic levels health had traditionally been seen as an issue of concern only to technical officials in relevant departments—but not to senior diplomats; it was an issue, well down the agenda—below traditional areas of focus such as war and peace, commercial activity, and even competing social/environmental issues notably climate change (as subject which it must be remembered, brought the G5 to life at Gleneagles, as a staging post for the **G20**). This status is certainly changing—health is now a focus of negotiation and frontline activity (with a proliferation of health attaches/consular officials, etc.). As just one illustration of this trend of 2000 US embassy/diplomatic officials in Thailand one-half are said to work on health.

The reasons for this growing ascendancy are the trans-nationalization and securitization of health issues. The GHG agenda epitomizes the blurring of the divide

between domestic and international concerns. These trends are illustrated by the intensification of fears about pandemics such as SARS and Avian flu and threats of bio-terrorism in the mail, ports and airports and by the higher profile of issues such as AIDS—with levels of death rivaling those of the 1919 influenza.

GHG permeates a wide set of major debates and issues. It dominates the campaign for the MDGs. It adds to concerns about trade and migration (of doctors and nurses); Trade-Related Aspects of Intellectual Property (TRIPS), health concerns during emergencies—and questions about the availability of health-care facilities to migrants. All of these debates and issues cross or transcend national boundaries. All affect a commercial nexus, with huge economic disruptions/commercial losses—as in the SARS outbreak that cost 40–80 $billion. And all are issues that test social cohesion and solidarity.

Yet, if there is more attention, there is also increased fragmentation in GHG. Rather than coordination we see a great deal of messiness in the organizational/institutional architecture of GHG. Every international organization now undertakes GHG. These range from well-established bodies such as the WHO and UNICEF to civil society groups in the forefront of issues such as health as a human right and the right to affordable medicines, taking on Big Tobacco when national governments would not, and active in health and development diplomacy.

Yet these organizations are not only under-resourced but caught between issue and policy choices. These problems are reflected in, if not caused by, the fact that no International Commission on global health has grabbed international public attention in the same way that the Brandt, Palme, or the Brundtland Commissions grabbed attention in other subject areas and that there has not been one overarching rather than issue-specific UN world conference in the way that the environment/climate change, human rights, racism, and social development has done.

Moreover reforms to the GHG architecture have not been entirely successful. The World Bank has highlighted this, noting that the reforms have resulted in confusion with traditional institutions being increasingly marginalized. The WHO is also limited in the new era by its legal framework—in so far as it has had limited "interactions with the private sector and non-governmental organizations." There have been many calls for reform, but the WHO has not been able to move quickly enough to reverse its marginalization in the new GHG order (Reich and Takemi 2009).

The Rise of New Challengers

Over the past decade new actors have gained prominence in the GHG arena these include private foundations and international political leaders meeting at **G8** and **G20** summits.

The rise of private foundations has generated some criticism and controversy. At the core of this issue is simply the unease about the amount of money and the dominant role played by Bill & Melinda Gates Foundation (Szlezák et al. 2010).

The Gates Foundation is now a larger international health donor than all governments, except for the USA and the UK (McCoy et al. 2009).

The rise of foundations has also had the effect of further fragmenting health governance. The Gates Foundation's decision to start the Global Alliance for Vaccines and Immunization outside of the United Nations is one telling example of this trend, with many resources increasingly being funneled into "smaller, independently governed initiatives that focus on 'quick fix,' high profile health problems" (Yamey 2002). This has raised the attention of traditional institutions like the WHO, where members have expressed concerns about their institution being sidelined with this new growth in private donors (Yamey 2002).

Beyond the institutional consequences, alarms have been raised over the question of what these changes will mean for the communities struggling with health emergencies. Sanders and Chopra raise just this point about GAVI and the Global Fund:

> On the other hand, these initiatives are causing a dangerous degree of fragmentation and overcrowding of the international health field, and at country level they can distort priorities, undermining country-led approaches and increasing opportunity costs for already overstretched ministries of health. Specific initiatives reinforce the notion that diseases are unfortunate, random occurrences, and allow us to turn a blind eye to the global political and economic conditions that underlie the desperate poverty in Africa.
>
> (Sanders and Chopra 2005, p. 757).

However, the positive contributions of both these challengers should not be underestimated. The Gates monetary contribution to vaccine research is impressive. And the Gates Foundation has demonstrated strong staying power. Nor has it been quiescent to western governments. The Gates Foundation has been outspoken on many issues, even chastising leaders—such as Stephen Harper for his abortion-related restriction on maternal health funding (Boseley 2010a).

Both Bill Clinton and Bill Gates have been outspoken in calling for the more efficient use of resources to deliver results in Africa. Unread reports and unneeded trips were cited as ways much present funding is wasted, when the international community's money should be paying for the services and goods that will help the individuals challenged with diseases and the risks of disease (Boseley 2010b).

The Gates Foundation has also moved into parallel issue areas that address some of the determinants of health. A prime example has been the Gates Foundation contribution of US $30 million to a new fund for poor farmers. By comparison the USA, Canada, South Korea, and Spain contributed a total of US $875 million. "Far short of the $22bn agreed to by the international community" at the **G8** summit in L'Aquilla (MacAskill 2010).

The **G8** has put the fight against infectious diseases on the highest political map over a long period. Infectious diseases have been central to most **G8** agendas since Okinawa in 2000, where the **G8** "acknowledged for the first time the link between health and poverty" (Kirton and Mannell 2005, p. 6).

The **G8**'s initial involvement in GHG took the form of raising money for UN and WHO initiatives—and the creation of the Global Fund—proposed by Japan at the 2000 Kyushu–Okinawa—to Fight AIDS, malaria, and tuberculosis in 2001 (Kirton

and Ditto Mannell 2005, p. 1). From this starting point, the **G8** moved to more independent initiatives. In 2001–2002 it created the **G8** Africa Action Plan as well as counter-bioterrorism institutions (Kirton and Mannell 2005, p. 1). Although the 2002 Global Fund requests saw little investment from member nations—USA 13 %, Japan 12 %, Italy 57 %, UK 44 %, Canada 41 % (Kirton and Mannell 2005, p. 9), 2004 saw a reversal—USA 117 %, UK 140 %, Italy 430 %, Canada 51 %, Japan 33 % (Kirton and Mannell 2005, p. 9).

By 2002–2003 three areas of sustained institutional reform could be credited to the **G8**: first, better international cooperation for the containment of disease outbreaks and HIV/AIDS, second, in the establishment of the Global Fund and the "creation of a Global HIV Vaccine Enterprise in 2004," and third the ministerial meetings that were established to deal with issues of biological warfare and security (Kirton and Mannell 2005, p. 10).

Between the 2003 Evian Summit and the 2005 Gleneagles meeting, the **G8** moved to target diseases that the UN and WHO had failed to combat effectively, with HIV/AIDS vaccine programs and Polio elimination (Kirton and Mannell 2005, p. 2). And at the 2008 **G8** summit in Toyako, the leaders reiterated the Heiligendamm Summit commitment to provide US $60 billion over 5 years and 100 million mosquito nets to combat malaria by then end of 2010—with the initiative led by Japan, reflecting a reversal of past hesitation to fully commit resources to such endeavors (Reich and Takemi 2009, p. 508.

The **G8** summit has continued to emphasize global health in its agenda and declarations though as shown in Box 1 this has been variable and may have reduced in recent years.

Box 1 Percentage of Total Paragraphs in G8 Summit Documents Related to Health

2000—17.9 %	2006—38.3 %
2001—20.5 %	2007—12.9 %
2002—13.1 %	2008—9.1 %
2003—34.7 %	2009—6 %
2004—6.5 %	
2005—14.6 %	

(**G8** Information Centre) (2010)

Observers have generally seen the **G8** in a positive light as being able to "think and act outside the existing global health bureaucracies and stakeholders" (Reich and Takemi 2009, p. 512). In terms of the GHG agenda the **G8** has similarly been credited with the broadening of GHG to include "neglected tropical diseases," whereas the old standard had been to focus on just the larger diseases, like HIV/

AIDS (Liese et al. 2010, p. 71). The **G8** Research Group has been even more glowing in its praise: "the **G8** has been a relatively effective centre of GHG, from its pioneering decision-making start in 1980 through to the present. The **G8**'s performance is distinguished by the large number of commitments it has made, above all at the summits in 2006 (with 61) and 2007 (with 43). Moreover, its members have complied with these commitments to a substantial degree, at an average solid B level of 77 %" (Guebert and Kirton 2009, pp. 1–2).

But rather than confirming the centralized control of the GHG agenda by the existing agencies such as WHO, it could be argued that the **G8** has increased fragmentation. The **G8** has built up a constituency around it, a host of NGOs and other civil society groups attend. Some gain considerable access to both the media center and to state officials. Stephen Lewis argued that the **G8** should be a mobilizing agency for the UN—especially the WHO.

While this constituency is not uncritical, some see it as failing short of delivering its commitments. Laurie Garrett argued that more people died of the diseases covered by the Global Fund than ever in history. Others suggest the **G8** has been captured by specific interests. Traditionally, the finger has been pointed at material interests, with GAVI, which is partly funded by **G8** contributions, "over-reliant on private sector funding and hi-tech vaccines" which are unsustainable and non-transparent (Sunder 2003).

More recently the criticism has turned towards more ideological concerns, as showcased by the controversy over maternal health at the 2010 summit. As one critic stated: "Beside endangering the lives of women in the poorest countries, this reluctance to embrace family planning as part of a **G8** initiative is toe-curlingly embarrassing for all those countries, like the UK and now the USA as well, that wholeheartedly support it. Let's hope international development ministers are hitting the phone to Canada even now" (Boseley 2010a).

Moving into the G20 Era

Against this background, there appears to be some logic in the calls for the **G20** to move more decisively into the domain of GHG as the **G8** has done. This logic is not without flaws, like the **G8** the **G20** is an example of exclusive executive multilateralism. This develops a distinctive form of **summit diplomacy** sometimes known as **forum diplomacy**. Top leaders and bureaucrats get to work together and to know and trust one another. When its club dynamics grows and some collective identity emerges behavior changes. Of course this is more difficult at the **G20** which inevitably has more of the atmosphere of a public concert than a private club. But while this may not achieve the same level of discourse as a **G8** meeting, there are offsetting advantages. As opposed to the **G8** the **G20** allows key voices from the global South to be heard in global and regional decision-making, and in so doing it injects both a catalytic element and degree of equality.

Putting GHG on the agenda of the **G20** could also prove valuable for this summit meeting. In terms of its mode of operation, the **G20** process has done remarkably well in mobilizing a collective response to the global financial crisis, largely addressing failures in regulation of the private sector. Among the **G20**'s successes:

- It has cut through the traditional boundaries of North–South and has mobilized both national and international fiscal stimulus packages.
- It has prevented a repeat of 1930s-style protectionism.
- It has served as a platform to build a new regulatory regime through the Financial Stability Board, invoking mechanisms for benchmarking and peer pressure.
- It has negotiated policy trade-offs and facilitated compromises, including IMF quota reform for the emerging economies in exchange for moving the sensitive issue of global imbalances onto the institutional agenda.
- It has allowed—although far from complete—the promise of a coordinated exit strategy from expansionary fiscal activity.

These achievements deserve praise. Yet, if the **G20** is to move to the hub of global economic governance—as advertised at the September 2009 Pittsburgh G20—it must be more than a crisis committee. It must do more than correct private wrongs. It must support global public goods.

As the economic crisis subsides, a much longer list of tasks and responsibilities begins to emerge. While systemically important, remedies undertaken to address private greed in global commerce—through better regulation and institutional reform—do not provide succor for the poor in the countries affected by the reverberating crisis and unrepresented in the **G20**. This is an opportunity that should not be missed for a number of reasons. One is simply the importance of the GHG agenda. To paraphrase the D–G of the WHO Dr Chan: health did not make the crisis—but it bears the brunt of the crisis.

The GGH agenda also deserves to get onto the **G20** leaders agenda on its own merits. More out of convenience rather than commitment, GHG has fewer constraints than other areas for getting onto the agenda of the **G20**—as it did for the **G8.** There aren't the competitiveness problems for **G20** countries embracing the GHG agenda that are associated with climate change, for example. There is a perception that if China, India—or for that matter the USA—do more to cut emissions they will hurt their own industries

Building national and global health infrastructure will help competitiveness—Canada's state health system, for instance, adds to the competitiveness of the Canadian auto sector in comparison with the USA. In the same way the redirection of the Chinese stimulus package to health infrastructure should add to Chinese competitiveness. Improved health in turn leads to increased capabilities—a prerequisite to accelerated economic growth. A third major benefit—although there is sensitiveness—is that health goes beyond some of the sovereignty taboos that we find in other areas. That is to say, it blends the Westphalia understanding of national independence with a modern understanding of interdependence without compromising either.

On traditional security issues—lack of communication remains rife—as witnessed by the remarks of the retiring US admiral of the Pacific fleet that he didn't know how to communicate to his Chinese counterpart. Health operates in a very different more benign context and learning trajectory. China—as other countries—learnt a lot from the SARS episode—that withholding information did it more harm than good in terms of reputation. Information about outbreak will get out—so it might as well be managed effectively.

Although China was criticized by some individuals—during the H1N1—it was not trying to pretend there was not a problem. Increasingly it will not be simply a question of upgrading China's health system at home, but measuring the impact of China's global reach in terms of health diplomacy—Chinese supply of vaccines to Africa, for example. But there is still need to be more done in the immediate future to build trust—a key public good in itself.

The opportunities of the **G20** for GHG were appreciated even before the **G20**—came into being. As early as 2004, at least one WHO official (Evans 2004) made a number of strong points:

- **G20** could serve as forum for raising awareness of health crises in areas or countries not receiving proper attention, such as Eastern Europe.
- **G20** could also work on "unfinished agendas," such as infant mortality rates and maternal health.
- The **G20** leaders have the capacity to "catalyze the action necessary to get these MDGs on track."
- **G20**'s global reach exceeds the **G8**'s and, consequently, it may be able to better assess "global preparedness" in the international health sector to deal with new problems.
- **G20** can name and shame ("label the laggards") on topics like preventable deaths in childbirth.
- **G20** would be better positioned to deal with medical brain-drain of impoverished nations than the **G8**.

There are of course risks in trying to raise health issues at the **G20**. Health issues could create tensions along older North–South fault lines—as witnessed by the case of virus sharing with Indonesia (see Chap. 6, Box 6) or on the level of donations and contributions. Yet the best way to deal with these tensions may be to embed them in the **G20** process, with meetings not just among state officials but engaging non-state actors.

To develop such an expanded mandate for **G20** in global health there it would be desirable for the D–G of WHO to attend at least one summit each year (assuming there are two meetings each year). This could match the attendance of the heads of IMF, WB OECD, and other relevant UN organizations at the **G20**. The **G20** could also provide regular access for regional groups—including ASEAN and the African Union—as this could build international/regional linkages on GHG.

Conclusion: The G20 as an Opportunity for GHG

There is always of course going to be competition for the form and scope of GHG—and the mode of diplomacy that goes with it. In such a competitive and fragmented atmosphere it is easy to opt for the status quo. Yet the **G20** does seem to be a special opportunity that should not be missed, allowing GHG a hub that it needs. Moreover, in practical terms there are signs of moves in this direction. The focus on the notion of a "global safety net" put forward by South Korea as hosts of the November 2010 **G20** is compatible with this development. So is the prominent place accorded to Bill Gates in the context of the Business **G20** to be held in conjunction with the leaders' summit.

The **G20** is sometimes talked of as being a new global compact—albeit an incomplete one—that allows a sense of mutuality to be reinforced. We should grab the opportunity to redefine and elevate the sense of urgency with which we deal with global health, what (Fidler 2004) calls scaling up political commitment.

Questions

1. Why have global health issues become so prominent in diplomacy?
2. Is the agenda and mechanism for GHG coordinated?
3. Why have global foundations entered the global health arena?
4. What advantages and disadvantages do **G8** meetings have in addressing GHG?
5. It appears that **G8** meetings have worked well with civil society organizations and foundations why can't the WHO operate in the same way?
6. What are the advantages and disadvantages of the **G20** in addressing GHG?
7. If the **G20** takes up GHG will this displace the functions of the UN?
8. Will **G8** continue to play a role in GHG or will they be displaced by **G20**?
9. How should the WHO respond to these emerging players in GHG?

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Chapter 18
Civil Society Organisations, Global Health Governance and Public Diplomacy

Sima Barmania and Graham Lister

Readers' Guide

Civil Society Organisations have become influential actors in the global health arena and thus an understanding of who they are, their legitimacy, roles and the tensions they face is crucial to understanding global health governance. This chapter describes the growing role of **Civil Society Organisations** in global health governance. The first sections define the term **Civil Society** and then discuss the different types of organisation which may be regarded as **Civil Society** actors and their strengths and weaknesses. The following sections describe the roles that are played in global health diplomacy by these different actors with case study examples of the way **Civil Society** can shape global health through engagement in international meetings, championing specific causes and holding government and international agencies to account. In many cases **Civil Society** actors provide a vital link between the discourse on global health issues at international and national levels and the concerns and contributions of ordinary citizens. This **Public Diplomacy** function is described as a vital component of global health governance. The chapter concludes with some thoughts on the tensions **Civil Society Organisations** face and how their roles can be enhanced in the future architecture of global health governance.

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Learning Points

- **Civil Society** in health is supported by a wide range of different types of organisation including: **Faith-Based Organisations** (FBOs), **Health NGOs**, **Patient and Community Health Organisations**, **Academic and Professional Networks** and **Foundations**.
- While **Civil Society Organisations** may not be democratically representative they may claim the legitimacy of giving voice to people who share a common belief, knowledge or resource.
- There has been increasing recognition of the importance of **Civil Society Organisations** over the past two decades as a keystone of democratic government, a defence against authoritarianism and the basis for community action.
- The fragmented nature of CSOs has made it difficult for them to participate in global health diplomacy other than as providers of services. But in recent years they have become more vocal helped by the formation of multi-partner alliances focused on key issues.
- CSOs are vital for creating a global mass movement for global health, deploying a full range of **Public Diplomacy** techniques.

Introduction: Civil Society Organisations in Global Health

The term "Civil Society" can have different connotations and meanings for different people, its meaning changes with time and is often poorly understood. Although **Civil Society** may be perceived as a modern concept, the notion can be traced back to the time of Aristotle. Early modern thinkers found very little differentiation between **Civil Society** and the state. However, in the nineteenth century it became widely understood as something specifically, distinct from the state. Kaldor summarises Hegel's definition of civic society as "the intermediate realm between family and the state, where the individual becomes a public person and, through membership in various institutions, is able to reconcile the particular and the universal" (Kaldor 2003a, b).

The twentieth century definition narrows somewhat as being not only simply that space between the state and the family but also occupying the space outside the market, state and family—including the spheres of culture, ideology and political debate. Kaldor's own definition may be particularly relevant to discourses surrounding global health governance: "the process through which individuals negotiate, argue, struggle against or agree with each other and with the centres of political and economic authority. Through which voluntary associations, movements, parties, unions, the individual is able to act publicly".

Civil Society is supported by a wide range of different types of organisation including: **Faith-Based Organisations** (FBOs), **Health NGOs**, **Patient and Community Health Organisations**, **Academic and Professional Networks** and **Foundations**. Their scope can range from local to global. At the local end of the spectrum **Civil Society** groups may be more informal in nature, based in local communities, such as youth groups or women's groups or groups bound by common interests such as child health, cooking or religion. At the other end of the spectrum global **Civil Society Organisations** are not only major funders of health, as for instance the Gates foundation but also often major provider of grass root health services, such as FBOs in rural Africa.

Civil Society Organisations have a different history in each country, developing most rapidly the open societies of western democracies in the nineteenth and twentieth centuries and emerging or re-emerging in Central and Eastern Europe after the fall of Communism. While most CSOs work with and support democratic governance, in some countries of Africa CSOs have grown despite the absence of effective local or national democracy and may in some respects provide opportunities for public engagement where other forms of participation are distrusted.

The emergence of international **Civil Society Organisations** has sometimes occurred as an organisation spread from one country to another—as in the case of Oxfam or as national organisations form an international network such as the International Diabetes Federation. **FBOs** developed as international health organisations as missionaries spread their faith during the nineteenth century. Other long-standing examples of international action by a **Civil Society** on global health are provided by the Red Cross and Red Crescent organisations, founded in 1863, and that not only provides global health services through almost hundred million staff and volunteers worldwide but also leads to the development of global standards and norms of behaviour in health.

The impact of modern international **Civil Society** in raising awareness was seen most clearly in 1985 when a CSO called "Band Aid" was formed by Bob Geldorf and Midge Ure to raise money for the victims of famine in Ethiopia, by staging simultaneous international "Live Aid" concerts. During the 1990s CSO activists joined forces to demand action on issues such as HIV/AIDS, human rights to health and access to medicine. In these cases **Civil Society Organisations** came together not only through international consortia but also as networks linking national or local activists across different countries in a common cause. More recently FBOs have also come together in networks to speak out on health issues such as female genital mutilation. **Health NGOs** have also held governments to account by examining their commitments and actions in respect of health aid and issues such as human rights abuses. These developments have been empowered by the Internet which provides a channel for sharing views and experience.

While some CSOs have a form of internal democratic governance structure, many do not. CSOs are differentiated from local government representative organisations whose legitimacy may be based on public elections. **Civil Society**

Organisations may claim the legitimacy of giving voice to people of a specific faith (**FBOs**) or those subscribing to a particular cause (**Health NGOs**) or people with a specific condition or disease (**Patient and Community Health Organisations**) or with research knowledge and experience to share (**Academic and Professional Networks**) or on the basis of charitable endowment (**Foundations**). The different basis for the legitimacy of **Civil Society Organisations** leads to fundamental differences in their functions and roles in global health governance. Some of the main actors in **Civil Society** are introduced below along with their inherent strengths and weaknesses.

Faith-Based Organisations

FBOs have played a leading role in health provision in low-income countries since the early nineteenth century, when health, education and welfare services formed an important basis for developing community links and a route to conversion. By 1897 the first missionary medical school was opened in India.

Christian Aid, the Catholic Agency for Overseas Development (CAFOD), World Vision and the Aga Khan Development Fund are all examples of such FBOs. Charity is a major tenet of all main world religions including Christianity, Islam, Hinduism and Buddhism. A very high proportion of philanthropic giving from community to community is faith based particularly in the USA. This giving is often channelled directly to specific community partnership projects through church, temple or mosque links. Faith provides a direct link between benefactors and recipients which is stronger than simply contributing to a good cause, it engages people and communities in a shared responsibility for health and well-being. FBOs are also direct providers of a great deal of health services in poor countries. Across most of sub-Saharan Africa, faith-based hospitals are generally estimated to provide 30–40 % of health-care services, particularly in rural areas though some estimates are as high as 50 % (Obaid 2005).

Until recently there has been little acknowledgement of the contribution of faith and FBOs to health; however, in the USA the Bush administration greatly expanded US aid to FBOs particularly in relation to health and perhaps surprisingly this trend has continued under Obama. One aspect of the Bush administration's policy was to withhold aid from organisations providing advice about a woman's choice to terminate a pregnancy, in deference to a particular religious viewpoint in America, this was reversed by Obama but for a while it caused considerable difficulties. Religion was also seen to drive health policy in the case of President's Emergency Plan for AIDs Relief (PEPFAR) and specifically the Abstinence, Be faithful and Use a Condom campaign (ABC). Some FBOs have been extremely helpful in the fight against AIDs as Box 1 illustrates, but others have hindered progress by denying the existence of HIV, moralizing and stigmatising HIV, and negating health promotion campaigns by spreading misleading information about the effectiveness of condoms in preventing transmission.

Box 1 Christian Leaders Alliance on HIV and AIDS Papua New Guinea

An example of the impact of FBOs is shown by the formation of the Christian Leaders Alliance in Papua New Guinea. This formation with the aid of UNAIDS collated a network of faith leaders dedicated to fully engage in the fight against the HIV and AIDS and to:

- Promote a theology of understanding, compassion and love towards those with the disease.
- Take a more active role in exposing the epidemic, particularly from the pulpit.
- Affirm dignity for all persons and their rights to life, health care, acceptance, respect and love.
- Provide pastoral care, counselling and prayer, for those affected at all stages of the infection.
- Work to reduce the stigma and associated discrimination faced by carriers of the disease.
- Relay information relating to prevention, treatment, care and support.
- Promote a relationship with Jesus Christ to bring about changes in sexual behaviour.

Some of the practical concerns regarding FBOs are that they are sometimes seen as lacking in professionalism with little emphasis on evaluation, drawing doubts over their effectiveness (Bradley 2005). There are, however, valuable assets that can be tapped into by FBOs for development and public health (ARHAP 2007). These can either be "tangible" including, facilities, places of worship, churches, community leaders or activities or rituals; or "intangible" assets such as motivation and mobilising capacities that are rooted in various dimensions of religious faith. Religious leaders often have great wealth of local knowledge which can be leveraged to tap into many networks which have substantial implications for access and sustainability.

Health NGOs

Health Non-Government Organisations (NGOs), such as the Red Cross and Red Crescent, Save the Children, CARE International and Oxfam, have grown considerably over the past two-and-a-half decades. They constitute a wide range of actors that not only play an important role in health service delivery but also in advocacy. A particular subset of civic society involvement is that of assistance in humanitarian crises and emergencies, including conflict situations, where organisations such as Medical Emergency Relief International (Merlin) and Médecins Sans Frontières (MSF) are active.

The leading role of some large NGOs, like Oxfam and MSF, has increased their impact on public opinion. Oxfam has led a number of major initiatives such as its "Make Trade Fair" campaign, which also includes a focus on access to medicines. MSF has also provided leadership with the creation of the Drugs for Neglected Diseases initiative (DNDi) as a new form of developing research and development. In recent years **Health NGOs** have often gained more strength by joining forces in international collaborations to support particular causes such as the 2005 "Global Call to Action Against Poverty". They have also learned a great deal about the art of **Public Diplomacy**—which can also be described as global social marketing. Thus working with celebrities, marketing material, well-produced advertisements, web-sites and social networks are part of their armoury as well as community engagement through local groups and charity shops.

Although NGOs vary considerably, they share certain inherent strengths and weakness. One of the consistent values of NGOs is the strength of their grass root links which have been noted by both UNDP and World Bank. Oftentimes NGOs are "closer to the people" with greater local knowledge and understanding of the cultural context. In particular community-based organisations are best suited to understand the health conditions in the community in which they work. This field-based approach means that NGOs offer a very solid development experience and thus have a more practical and less theoretical approach. They are also considered able to be more flexible and adaptable and thus a greater capacity for innovation, akin to **Foundations**. NGOs are often effective both in terms of cost and in offering more sustainability. In addition, NGOs are perceived to be less bureaucratic than governmental organisations, though large NGOs may fall prey to this same bureaucracy.

Unfortunately the NGO sector can also fall victim to a number of weaknesses, namely, insufficient financial and management expertise, lacking in ability to coordinate with other organisations and having limited information at their disposal. NGOs also have the same issues of accountability and lack of transparency as other civic groups. However, given that NGOs often operate in fragile states and areas afflicted with conflict there is often speculation that they can often camouflage corruption in such relief operations. In terms of governance and the negotiation process NGOs can lack the skills required to interact with both other civic society groups and state, thereby lessening their influence.

Some **Health NGOs** have been criticised at times for lacking a wider perspective on human development, focusing on their special interests and concerns, making it difficult to arrive at a clear consensus from **Civil Society** or to work with an increasing number of small-scale NGOs in poor countries which may have limited capacity to coordination their work. This has been countered by the cross sector international campaigns noted above and by better coordination at country level. But in some cases there is no single viewpoint from **Civil Society**, why should there be? (see Box 2).

Box 2 Coordination of Relief Work in Haiti

In January 2010 Haiti, one of the poorest countries of the world, was hit by a massive earthquake resulting in hundreds of thousands of deaths and injuries leaving more than one million people homeless. Relief teams and resources flowed into Haiti totaling some Euro 2 billion, in government aid, support from **Foundations**, NGOs and private donations.

MSF was one of 70 NGOs working in Haiti, it set up 20 medical centres and treated some 16,500 people in the immediate aftermath of the emergency. However, loss of life from the earthquake itself was followed in October by an outbreak of cholera which resulted in 3,000 more deaths. The head of MSFs mission to Haiti criticised the coordination of the response to the emergency noting that there were more aid resources there than anywhere else on the planet but still not enough was done to prevent cholera which could have been readily prevented by simple measures to improve sanitation and protect public health.

Médecins Sans Frontières 2011 Haiti 1 Year After

Patient and Community Health Organisations

Most patient organisations were formed to serve the needs of patients with particular conditions or disease. Many were formed in the twentieth century as a focus for complaints in response to the perceived inadequacy of local or national provision. Generic patient organisations which may be termed Community Health Organisations developed from the 1980s till today. These provide a focus for general complaints about health systems, patient access and patient rights. Other forms of patient organisations developed to support and advocate for medical research and treatment in particular fields. While loose international collaborations and conferences between patient organisations in each area have been common the emergence of stronger international groups has been a relatively recent phenomenon of the 1990s.

Perhaps the best known example of international action by patient organisations is in respect of HIV/AIDS organisations' fight for access to anti-retroviral medicines (see Chap. 6, Box 7). This was not originated by an international patient organisation but grew from a local South African group called the Treatment Action Campaign, which with the support of Médecins sans Frontières contacted national groups throughout the world to build a concerted global coalition.

An example of a highly regarded developing network at the global level is the People's Health Movement (see Box 3).

Box 3 The People's Health Movement

The People's Health Movement is a large global **Civil Society** network of health activists supportive of the WHO's Health for All policy. It is organised to combat the economic and political causes of deepening inequalities in health worldwide, and to revitalise the implementation of the WHO's primary health-care strategy. It was established in 2000 at a People's Health Assembly in Savar, Bangladesh, attended by 1,453 delegates from 75 countries.

The 5 days meet led to sharing of experiences from across the globe. The representatives discussed the adverse impact of the structural adjustment programmes on people's health and the role of the World Bank, IMF and WTO in pushing these policies. The assembly in a single voice condemned these institutions and governments which are willingly pursuing these anti-people policies. The multi-national corporations who use their money-power to push for policies which put profits before people and the proponents of liberalisation who recommend that governments should cut expenditure on social sector like health and education also came in for criticism.

The People's Health Movement now comprises a range of NGOs and community-based organisations. It is playing an increasingly active advocacy and educational role at both national and global level. It has already had some success, in alliance with selected country governments, in clarifying and strengthening the WHO's position and in revitalising its commitment to the principles of primary health care.

The strengths of **Patient and Community Health Organisations** can be seen in their power to bring together people across the world who share an illness or a concern for health rights. Their weakness lies in their highly fragmented nature. Even within one country there are divisions between different patient organisations, so that the idea of a single "patient voice" is illusory. They also suffer from problems of funding, if a patient organisation becomes dependent upon pharmaceutical company financing this may undermine their credibility, but if it is dependent upon donations this can be financially precarious. And in common with all **Civil Society Organisations** their management and financial control is often weak.

Foundations

Foundations have a longstanding record of participation in global health. One of the most distinguished being the Rockefeller Foundation, founded nearly a century ago, in 1913. In more recent times, the Bill & Melinda Gates Foundation has become a central actor in global health. It was estimated that in 2007, this foundation distributed US$ 2.3 billion. To put this into context, the WHO 2008–2009 programme

budget was US$ 4.23 billion. An increasing number of global health programmes—including WHO initiatives—are dependent on support from the Gates Foundation, these initiatives include research into health solutions such as malaria in pregnancy. The Wellcome Trust is the world's largest medical research charity, providing about US$ 1 billion per year for medical research including research and technology transfer projects relevant to global health. Other examples of European **Foundations** working in global health include the Calouste Gulbenkian, the King Baudouin and the Volkswagen **Foundations**.

In addition to their financial resources the strength of **Foundations** lies in their autonomy of research and decision-making, free from commercial and political interests. Thus, they are able to act in a free and flexible way which is more amenable to taking risks with people and new concepts, including community-based partnerships. They often combine funding with "think tank" activities which enables them to have a greater influence on health policy see Box 4.

Box 4 The Nuffield Trust Global Health, a Local Issue

While the official story of the development of the UK Health is Global strategy is given in Chap. 19, the unofficial story reveals the influence of **Civil Society** actors. In 1998 the Secretary of the UK Nuffield Trust Foundation and think tank, John Wynn Owen visited the USA and attended a meeting hosted by Hilary Clinton to discuss the recently published paper "America's Vital Interest in Global Health" by the US Institute of Medicine (1997). He returned to London and set up the Global Health, a Local Issue programme, coordinated by Graham Lister. This brought together a group of academics, health professional leaders, other **Foundations** such as Oxfam, the WHO and business and government representatives to prepare a series of 20 papers presented at a national conference in December 1999. This in turn led to the establishment of the UK Partnership for Global Health, which ran a series of further initiatives examining the impact of global health on corporate social responsibility, women's health and development, responses to globalisation and the first international seminar on global health and foreign policy attended by several Ministers and the DG of WHO, they also supported the development of similar groups in Ireland the Netherlands and Germany and the Medical Students International group (Medsin). A particular focus of the UK Partnership for Global Health was the call for a UK wide strategy for global health arising from the 1999 conference. In 2004 John Wynn Owen managed to persuade the UK Chief Medical Officer Liam Donaldson of the importance of this and the rest as they say is official history.

Foundations are not accountable to electorates or shareholders and are able to support issues which are not necessarily de rigueur due to their innovatory character. In this regard they may be likened to philanthropic venture capitalists. **Foundations** can combine research, practical innovation and advocacy for change

and can facilitate amendments at various levels of policy making. One of the critical strengths is that **Foundations** are removed from politics or the need to make profit and are less likely to be affected by shifts in economy and thus can continue when other groups are not financially able to do so. **Foundations** can give a positive lead to national action, as for example in the 2011 announcement of a $1 billion dollars donation to the GAVI initiative for child immunisation by the Gates Foundation, which was quickly followed by a similar donation from the UK government. However, some **Foundations** significantly lack transparency and accountability and may pursue the private political or other beliefs of donors.

Foundations and other **Civil Society Organisations** which are formed as charities often benefit from favourable tax regimes; however, this varies greatly between countries. Even within Europe some tax systems treat domestic philanthropy more favourably than international philanthropy. And there is still no clear definition of what constitutes a charitable aim, thus, for example the largest "charity" in Europe the INGKA Foundation has been accused of being little more than a tax shelter for the IKEA company and the family that owns it.

Academic and Professional Networks

Academic and Professional Networks are active in all fields of health, supporting the global communication of research and developments in knowledge. They are also involved in developing professional standards for education and practice, for example the International Council of Nurses.

Global health is in itself emerging as a burgeoning academic discipline, aided in part by the focus on this field by established medical journals such as *the Lancet*, whilst new journals have emerged dealing specifically with this topic. Networks, centres and publications have been established even in the relatively new field of global health diplomacy.

The Global Health Council, mainly active in the USA but which also has a global membership, Action for Global Health and Global Health Europe are examples of cross sector networks joining academics practitioners and others with an interest in this field. Most recently the European Academic Institutions for Global Health has been established.

There are also national interdisciplinary groups focusing on global health developing in many countries, for example, the UK Partnership for Global Health which operated from 2000 to 2008 and Irish Forum for Global Health. Many of these networks focus on the provision of health knowledge, for example, the Supercourse Series, while others focus on the exchange of knowledge, for example, the Health Information for All network.

Such network has many strengths in bringing together leading academics and professionals across the world to develop a consensus for action. However there are also weaknesses, for example, critics point out that most such networks on global health issues tend to be dominated by American and European voices with little

input from poorer countries of the South. Networks of health professionals suffer from similar problems as professional organisations are less well funded and supported in poorer countries.

The Role of CSOs in Global Health Governance and Public Diplomacy

Despite the difficulties they face, there has been an increasing recognition of the importance of **Civil Society Organisations** over the past two decades. In 1998, http://www.brainyquote.com/quotes/authors/k/kofi_annan.htmlSecretary-General, Kofi Annan gave a speech on the emerging power of **Civil Society** stating that: "A strong **Civil Society** promotes responsible citizenship and makes democratic forms of government work. A weak **Civil Society** supports authoritarian rule, which keeps society weak" (Annan 1998).

He also acknowledged that the nature of international diplomacy had shifted and could now encompass **Civil Society**. Whereas customarily such diplomacy would involve the state now NGOs are being included in partnership. There is a wide appreciation that: "any national project is influenced by international conditions" and that "a true partnership between NGOs and the United Nations is not an option; it is a necessity" (Annan 1998).

During the 1990s many donor governments and other aid providers saw CSOs as important ways of getting aid more directly to those in greatest need and perhaps avoiding the corruption, inefficiency and diversion that was associated with aid provision through government agencies. This was perhaps best illustrated by the inclusion of **Civil Society** representatives at the G8 meeting of 2005 (see Box 5).

Box 5 CSOs at G8

NGOs have shown a growing capability in **Public Diplomacy** to engage support for action on issues of global significance. Campaigns such as the "Global Call to Action Against Poverty" and the linked "Make Poverty History" have drawn together a wide coalition of global NGOs and other CSOs. These campaigns were targeted at the G8 member states based on an analysis of commitments and the failure to meet them since the Millennium Development Goals. However, the impact of the campaign lay less in its analysis and critique of G8's failures than in its ability to communicate simple messages to the public in many innovative ways. These included international pop concerts, slick advertising, on-line forums sponsored products such as trendy white wrist bands and celebrity leadership from Bono and Bob Geldorf. Much of the campaigning was targeted at G8 leaders, lampooning their failure to live up to successive promises of aid. It was therefore perhaps surprising that at the 2005 G8 meeting at Gleneagles, rather than leaving the CSO representatives

(continued)

Box 5 (continued)

to protest outside the meeting, leaders of the organisations involved in the Make Poverty History Campaign including the celebrities were invited to participate in an extensive programme of dialogue both in the run up to and during the summit meeting (Simonson 2005).

While further G8 meetings have maintained some dialogue with CSOs this seems to have been a high point in their engagement at this level of negotiations. For their part it may also be that CSO leaders found protesting more comfortable than engagement. In more recent years there has been a greater focus on the problems arising from the fragmentation of aid as well as the recognition that it is not just government agencies that can be corrupt and inefficient. Thus the pendulum may be swinging back towards the provision of aid through budget support for governments with accompanying measures to improve accountability and cross sector coordination with CSOs but with less direct involvement at policy level. It is interesting to note that at the 2011 G8 meeting leaders of Google, Amazon and Facebook were invited rather than CSO leaders, while Bill Gates was invited to prepare a report on development finance for the G20 meeting.

The 2005 Paris Declaration on Aid Effectiveness refers to the importance of recipient governments coordinating and working with **Civil Society Organisations**, but this is perhaps a less prominent mention of the role of CSO than might have been expected (Howell et al. 2006). The follow-up to the Paris Declaration was provided by a conference in 2008 which issued the Accra Agenda for Action went some way to reaffirming the importance of CSOs or at least of coordination with them, in response to a report from the Advisory Group on **Civil Society** and Aid Effectiveness (see Tomlinson et al. 2008).

Collaboration with CSOs is a longstanding issue for the WHO, indeed it may be said that interaction with CSOs is encouraged by its Constitution. However it is also apparent that WHO has in the past found it difficult to work with CSOs if this meant bypassing governments, who constitute its board and assembly. More recently Margaret Chan acknowledged that "given the growing complexity of these health and security challenges and the response required, these issues concern not only governments, but also international organisations, **Civil Society** and the business community. Recognizing this, the World Health Organization is making the world more secure by working in close collaboration with all concerned" (Margaret Chan 2007, Director General, WHO).

The appreciation that the contribution of **Civil Society Organisations** in policy, public engagement and provision is far reaching and has led to the formation of a task force "WHO **Civil Society** Initiative and Training and Research Support Centre" (TARSC). It was initiated to review existing research on **Civil Society** engagement in health to "identify the knowledge emerging from current research in these areas and the issues informing future research on **Civil Society** and health" (see Loewenson 2003).

Conclusions: Better Global Governance Architecture for CSO

One of the main strengths of CSOs is their diversity, which enables them to engage with the many different interests and groups in society, but this diversity is also their weakness.

In service provision tensions may arise as different local and international CSOs have different objectives and priorities. They may find it difficult to conform to a programme coordinated by others, yet they may lack the resources to participate in such planning. Often it will be those with the greatest financial resources that will dominate.

In policy negotiations small fragmented local organisations find it difficult to make their voice heard and even large-scale international CSOs can find it difficult to make their case without support from others. This has led to the formation of multi partner alliances focused on key issues which can engage support across many different publics by presenting a simple moral case for action. This is a keystone for creating a global mass movement for global health, deploying a full range of **Public Diplomacy** techniques using all relevant media, celebrities and advertising. While this sounds simple and has been effective at times, the global health market is crowded with initiatives and ideas as CSOs compete to establish the next focus for action.

It is also difficult to improve the transparency and accountability of CSOs without undermining their autonomy, which is another important asset. And it may be difficult if not impossible to balance their specific viewpoint validated by experience and contact with local communities against the views of representatives elected by a more or less democratic process.

The resolution of such tensions requires understanding and compromise by all parties, through the negotiation of common interests and differences. The architecture of global health governance should facilitate this by creating negotiating fora at every level. Thus, for example, in Ethiopia village health issues are discussed in local Woreda health councils with religious and other leaders. At national and regional level coordination between governments and CSOs are called for by the Accra Agenda for Action, though in practice reports of the practical implementation of such coordination meetings often suggest it is difficult due to some mistrust on all sides. At global level the creation of a Global Health Forum to represent CSOs at the World Health Assembly on selected issue (see Chap. 3) would not only allow their collective and individual voices to be heard it would also provide an important venue for negotiations between CSOs. The WHO and World Bank and other UN institutions may benefit from a shared approach to CSOs. This will also require CSOs to develop new skills in this field.

In conclusion it may be said that CSOs are important global health actors both in the provision of services and in building and maintaining public understanding of and engagement with global health issues. If the system of global health governance were to provide greater access and opportunities for CSOs in negotiations at all

Questions

1. Describe **Civil Society** in your country and identify leading CSOs in health.
2. What advantages and disadvantages do different types of CSO face?
3. Give examples of the ways CSOs with which you are familiar have been effective in health.
4. Give examples of some of the ways CSO have been ineffective or damaging to health.
5. How have CSOs affected global health policy and provision?
6. What can pop stars and Internet company founders contribute to global health?
7. How could CSOs become more effective global health actors?
8. What skills do CSOs and Ministries of Health need to develop?

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Chapter 19
Health is Global: A UK Government Strategy 2008/2013

Nick Banatvala, Sara Gibbs, and Sudeep Chand

Reader's Guide

This chapter demonstrates how policy coherence at the national level can impact on bilateral, regional and multilateral diplomacy. The Labour government in the United Kingdom (UK) published a global health strategy (GHS) in 2008. The strategy set out a cross-government approach to protecting the health of the UK population, promoting the UK's economy and security, whilst also promoting improvements in health abroad. It recognized that in an interdependent world where diseases know no borders health must be considered as a global and multidisciplinary issue. This case study outlines the development, aims, challenges and impact of the strategy and raises questions for readers about how national policy serves global health diplomacy.

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Learning Points

- The strategy set out in Health is Global was developed to ensure a consistent and joined-up approach across all UK government departments.
- The strategy's goal was to improve the health of the populations of the UK and of the world recognizing the inextricable links between health at home and health abroad.
- It was developed through a process of engagement and consultation with a wide range of participants, who would be partners in implementing the strategy.
- The strategy identified the UK government's principles in respect of global health and the key areas for action in which progress could be achieved.
- It achieved significant results, its principles, influence, partnerships and actions reflected in concrete outcomes despite unprecedented and unexpected domestic and global challenge.
- After 2 years the strategy was reviewed by a new government. The result was the publication of a new outcomes framework for 2011–2015.

Introduction: The Evolution of "Health Is Global"

When published in September 2008, "Health is Global" was the most detailed GHS to be launched by a nation state, reflecting a broad participatory process.

In recognition of the opportunities and challenges of globalization to health and health care, the permanent secretaries of UK government departments asked the Department of Health (DH) during the last Labour government to consider leading the development of a cross-government strategy for global health. In response to this, the Chief Medical Advisor developed a discussion paper in 2007 that set out the rationale for such a strategy and the areas that it might cover. The discussion paper was presented to the Prime Minister and his Cabinet by the Secretary for State for Health, and it was subsequently published. The Minister for Public Health chaired an inter-ministerial group that led the development of the strategy.

A series of consultation events held throughout the UK helped shape the strategy and these were jointly run by government departments, the Lancet, the Royal Colleges and the London School of Hygiene and Tropical Medicine. Evidence from these events and written responses were collated by a cross-government officials group leading the day-to-day development of the strategy.

Since nearly any area of public policy can be argued to affect global health, setting boundaries for the strategy was an important early step. Criteria were therefore developed as to what should be included in the strategy. These were:

- That the area had a direct link to an important global health issue.
- That the UK had particular expertise and experience of working in the area and/or the ability to influence others.

- That delivery required effective cross-government working.
- That the government could identify what they could deliver with specific and timetabled measurable results.
- Whether the UK stood to benefit directly from engaging in the issue, for example where there are clear links to the health of the UK population.

The central aim of the strategy was to ensure a consistent and joined-up approach across all government departments. Many UK government departments and agencies work on issues that directly or indirectly affect the health of the world's population. To be most effective, and to make the most of opportunities to improve UK health, the strategy argued for the need for a consistent and joined-up approach to global health across government. A more coherent approach could also raise awareness of any unintended adverse effects of UK government policy and highlight policies that conflict with efforts to improve global health.

The strategy's goal was to improve the health of the populations of the UK and of the world: a clear recognition of the inextricable links between health at home and health abroad. The strategy, known as the UK's GHS included a set of principles, action areas and commitments.

"Health Is Global": What the Strategy Covered

The strategy was underpinned by ten principles (Box 1).

Box 1 The Principles That Underpinned the 2008 UK Strategy, Health is Global

We will:

1. Set out to do no harm and, as far as feasible, evaluate the impact of our domestic and foreign policies on global health to ensure that our intention is fulfilled.
2. Base our global health policies and practice on sound evidence, especially public health evidence, and work with others to develop evidence where it does not exist.
3. Use health as an agent for good in foreign policy, recognizing that improving the health of the world's population can make a strong contribution towards promoting a low-carbon, high-growth global economy.
4. Promote outcomes on global health that support the achievement of the Millennium Development Goals (MDGs) and the MDG Call for Action.
5. Promote health equity within and between countries through our foreign and domestic policies.
6. Ensure that the effects of foreign and domestic policies on global health are much more explicit and that we are transparent about where the objectives of different policies may conflict.

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Box 1 (continued)

7. Work for strong and effective leadership on global health through strengthened and reformed international institutions.
8. Learn from other countries' policies and experience in order to improve the health and well-being of the UK population and the way we deliver health care.
9. Protect the health of the UK proactively, by tackling health challenges that begin outside our borders.
10. Work in partnership with other governments, multilateral agencies, civil society and business in pursuit of our objectives.

These ambitious principles were important in highlighting the strong relationship between health and foreign policy. They were recognized the impact that domestic policy can have on global health. They were also recognized that there are potential conflicts between domestic and foreign policy. One of the questions often raised was whether Principle 1 was essentially the same as the so-called "ethical foreign policy" that was attributed to the former Foreign Secretary, Robin Cook. Mark Malloch-Brown, the then Foreign and Commonwealth Office (FCO) Minister at the time was clear that it was not. He said that the GHS promoted a "health foreign policy"—one that recognized that a healthy global population was necessary for a safer, secure and economically productive world.
The GHS set out five areas in which the UK government intended to act. These were:

- Better global health security
- Stronger, fairer and safer systems to deliver health
- More effective international health organizations
- Stronger, **freer and fairer trade for better health**
- Strengthening the development and use of evidence to improve policy and practice

Better Global Health Security

Global health security is crucial to economic and political stability and the strategy focused on improving global health security by tackling:

- Global poverty and health inequalities
- Climate change and environmental factors
- The effects of conflict on health and health care
- Reducing the threat from infectious disease
- Human trafficking and the health of migrants

Stronger, Fairer and Safer Systems to Deliver Health

One of the main reasons achieving the MDGs is so difficult is that strong, fair and accountable systems for delivering good health are absent in many countries. *Health is Global* set out an approach that committed the Labour government to work to:

- Increase finance for health systems with universal health-care coverage.
- Support stronger health systems through the International Health Partnership.
- Address the global shortage of healthcare workers.
- Increase fairer and safer access to medicines, technologies and innovations and continue to work for improved patient safety worldwide.
- Emphasize the importance of sexual, reproductive and maternal health.
- Increase the focus of health systems on preventing and treating non-communicable diseases and injuries, and supporting policies that help people be active and well.

More Effective International Health Organizations

The strategy set out an approach for promoting effective international institutions for improving global health. The strategy highlighted:

- Working towards a reformed UN system with an ever more effective WHO.
- Supporting the European Union (EU) to play an even more effective role in global health.
- Fostering a coherent approach to resourcing health programmes and projects in low- and middle-income countries, and to resourcing international agencies.

Stronger, Freer and Fairer Trade for Better Health

Worldwide, the health-care industry is worth more than US$5 trillion a year. Trade in health services, drugs and medical devices contributes significantly to the UK and global economies. In 2008, the NHS spent an estimated £20 billion on goods and services. The marketplace for these commodities means that the UK and other economies can benefit from the opportunities that come from freer and fairer global trade in health services and commodities. The strategy highlighted the UK government's commitment to work for:

- Stronger, fairer and more ethical trade in the health sector.
- A robust system of intellectual property rights, used innovatively and flexibly to promote access to medicines.
- Enhancement of the UK as a market leader in well-being, health services and medical products.

Strengthening the Development and Use of Evidence to Improve Policy and Practice

Health policy, public health and service delivery should use reliable evidence drawn from high-quality research. At present, research on global health problems worldwide is under-funded, inadequately coordinated and does little to benefit the poorest 90% of the world's population. Therefore, the UK government aimed to:

- Identify and support research and innovation that tackle global health priorities.
- Use evidence and innovation to strengthen policy and practice.
- Maintain the UK as a global leader in research and innovation for health, well-being and development.

Working in Partnership

A key aspect of the strategy—and one that came out of the workshops in particular—was the opportunity for government to work ever more effectively with non-governmental partners, especially when developing and implementing government policy and to foster greater coherence and consistency of policy and action. An increased commitment to be more transparent with non-governmental partners was a constant theme in the GHS.

The activities of our non-governmental partners were described in detail in *Health is Global*. This was because partners saw the GHS in part as an enabling mechanism for their work. Many encouraged reference to their involvement in global health and found this a useful way of adding legitimacy to the work they were taking forward. The GHS described work of non-governmental partners, research and development partners, foundations, professional organizations, the NHS, the private sector and the media. The importance of working with multilateral institutions such as the United Nations (UN) and the EU were highlighted. *Health is Global* also recognized that in many parts of the world the private sector and NGOs may be able to deliver health care better and more innovatively than government.

Resourcing the Strategy

One of the key issues that were discussed during the development of the strategy was how to describe financial resources for driving forward the strategy. Most of the UK government's resources for global health are channelled through the Department for International Development (DFID) and their resource commitments at the time of publication were described. Resources from other government departments, such

as DH, FCO and Ministry of Defence (MoD) also finance programmes that contribute to improving global health and these too were described. *Health is Global* was clear; however, the strategy was less about new resources—it was more about using available resources most efficiently.

Impacts of "Health Is Global"

In this last section we look at a series of case studies. These illustrate some of the successes and challenges of policy coherence and working in partnership. This involves communicating and translating objectives for a wide range of potential "global health diplomats". The case studies are: (1) working with WHO; (2) human resources in health; (3) unlocking the global potential of the NHS; (4) conflict and health; and (5) developing **evidence for policy** in health and international relations. Further insight is provided from the findings from the first independent annual review of the strategy. The chapter ends with a discussion of the challenges and opportunities for global health diplomacy given this experience and the election of a new government.

After 24 months, *Health is Global* achieved significant results. Its principles, influence, partnerships and actions reflected in concrete outcomes despite unprecedented and unexpected domestic and global challenges. At the launch of the strategy, sub-prime mortgages were little known financial instruments. Domestically, the timing and outcomes of elections were uncertain. Multilateral and bilateral relationships had markedly different political influences and content. Meanwhile global health was not a high-level approach for many governments. Perhaps most telling, some viewed bird flu as the most pressing concern for global health security.

Right from the start, ambitions to ensure coherence and consistency across UK policy were put to the test. Despite limited financial and human resources, joint positions between ministries were established in several areas. Small budgets were used strategically and partners worked alongside government, across the five themes of the strategy. As the action plans rolled out, the strategy had to adapt to new challenges.

Working with WHO

The strategy provided the DFID, FCO and DH with a clear framework for the UK's engagement with key fora for diplomacy such as the European Commission and WHO. Shortly after *Health is Global* was launched, a joint UK-WHO strategy was published. This was the first time that the UK had published a cross-government strategy for working with WHO and the strategy has been important in dialogue within government and between the UK and WHO.

Box 2 A Joint Institutional Strategy for Working with WHO

The UK looks to WHO to help protect and improve the health of the UK population and to help improve global health, with a focus on achieving the health-related MDGs. In order to do so, the government wished WHO continuously to strengthen its own organizational effectiveness, and help build a strong and effective reformed UN system. The Institutional Strategy (IS) highlighted a number of key challenges for WHO and its partners and described commitment to work together to tackle them.

The IS described UK political, financial and technical commitment to assist WHO progress against its 10-year General Programme of Work and its 6-year Medium Term Strategic Plan (MTSP). At a political level, the IS described support to WHO: to promote the highest standards of ethical and evidence-based public health policy; support WHO's commitment to policy coherence across and between its regional offices, country offices and its headquarters; and stepping up UK engagement with WHO's Regional Office for Africa to support the Regional Director's reforms.

The IS recognized the importance of increasing levels of coordinated, predictable, multiyear, unearmarked funding. The strategy also highlighted a set of priority areas taken from the MTSP where the UK and WHO was able to work together most usefully. They included WHO's contribution to: achieving the MDGs, particularly those most off track such as maternal health; tackling global health security threats like pandemic influenza; working effectively with governments and key development partners to promote universal access to safe and effective health care through adequately resourced health systems; championing harmonization and alignment at global, regional and country level; wider UN reform; and continuing to improve WHO performance at regional and country level.

The IS included a performance framework using a subset of MTSP indicators, which was designed to increase unearmarked funding and access to additional performance-based finance.

In terms of technical support, the UK continues to support WHO by sharing its professional, clinical, academic and governmental expertise. Over 60 UK institutes currently work with WHO as collaborating centres. These provide support to WHO in fulfilling its mandate and implementing programmes, as well as in developing and strengthening institutional capacity in regions and countries.

Human Resources for Health

The strategy has been especially useful in taking forward a whole of government approach to human resources for health. This was important in building on a UK Code of Conduct and working with the Global Health Workforce Alliance and playing a strong role in supporting WHO develop the Global Code of Practice on International Recruitment of Health Personnel.

Workforce planning, ensuring training, retention and recruitment, and responding to the pros and cons of migration of health workers are long-standing challenges. The GHS approach was used to promote coherence between potentially competing UK interests and policies on human rights, the UK health system, trade in services, immigration policy and development. DFID has given substantial technical and financial support for sustainable workforce provision in low-income countries. Working closely with DH, the NHS and non-governmental bodies, a health partnership centre and funding scheme was created to support links between the UK and other health systems. An NHS Framework for International Development was developed to support the effectiveness, sustainability and growth of these links.

Unlocking the Global Potential of the NHS

One of the outcomes of the strategy has been greater recognition of the opportunities for the NHS to maximize the commercial value of its technologies, products and knowledge and to build its brand and reputation overseas. The Coalition Government wants to develop this thinking so that NHS agencies are establishing themselves not just as international leaders in clinical results and research but international leaders in managing health-care systems, with financial benefits flowing back to the NHS. Examples of NHS organizations that are working overseas in a commercial capacity include Moorfields Eye Hospital's facility in Dubai and Imperial College's diabetes clinic in Abu Dhabi. Hospitals with well-developed international reputations, such as Great Ormond Street, treat international private patients at their domestic facilities.

The strategy has also helped drive collaboration between DFID and other development partners and the UK health system. A second outcome has therefore been more strategic alignment between DFID and the UK health system (see Box 3).

Box 3 Unlocking the Potential of the UK Health System to Support the International Development Activities of DFID

Since 2008, the Health Protection Agency, the National Institute for Health and Clinical Excellence, a range of UK hospitals and primary care organizations have developed international strategies to drive forward work on global development and health protection. The Health Protection Agency has, for example, identified a series of strategic international secondments. The National Institute for Health and Clinical Excellence has, for example, been undertaking work in India and China where government partners have been eager to learn from their experience. The NHS Strategic Health Authority Chief Executives set up an international group to respond ever more effectively to the development opportunities of overseas work. To assist them in

(continued)

Box 3 (continued)

this work an International Health Partnerships Centre was launched in Liverpool and a fund for NHS work overseas was provided by the Labour Government.

The new Coalition Government has been clear that it wants to see the NHS and UK health system respond to the MDGs—especially maternal health—and in 2010 it announced plans for a Health Systems Partnership Fund for NHS staff that are able to make a contribution to support developing countries tackle the MDGs.

Security in Action

Security has played a significant part in the rationale for global health approaches. Not only is health affected by conflict in direct terms, but health has been proposed as a form of "soft power" to promote stability and security. The GHS recognized that the UK population could be offered protection by investing in health, health systems and international and development institutions in other parts of the world and in 2009, the Labour government published the UK International Influenza Preparedness strategy. The principles set out in *Health is Global* were an important reference point in helping government departments work together effectively during the subsequent H1N1 pandemic. Officials across government worked closely with public health services, multilateral organizations and industry to review preparedness plans and to insure the public was protected against the most significant risks. Ensuring coherence was challenging, given the need to take into account public health, financial and diplomatic considerations. Close surveillance, regular sharing of technical expertise and frequent negotiation were required. Concrete financial and technical support was given to the WHO and International Federation of the Red Cross amongst others to insure the UK and others against the potential effects. Equity in global public goods was an important principle used when considering international objectives.

A security lens has also been used to encourage a multidisciplinary, global health approach in other areas, while maintaining the broader principles of the GHS. For example, the strategy enabled the UK government to provide finance and technical assistance to WHO in tackling climate change and work together more coherently on the health components of global events, such as Copenhagen. Another commitment was for Government to develop more coherent and consistent policy on health, stabilization and conflict. As a result a cross-government working group was established (see Box 4).

Box 4 Health, Stabilization and Conflict: Greater Coherence and Consistency Across Government

A new group was set up in 2009 consisting of officials from The MoD, the DFID, the joint government Stabilization Unit and the Department of Health (DH). To date, the group has facilitated a greater understanding on health and conflict across government on the determinants of policy making in practice through discussion and shared understanding. In addition, the group has discussed a range of issues and received evidence from a range of external stakeholders. The group has also commissioned research looking primarily at the links between health service delivery and stabilization to inform policy making. Finally, the group co-hosted a workshop at Chatham House to further explore policy and explore the roles that different stakeholders play. Participants included government officials, NGOs, academia and think tanks. To support the group and provide some independent thinking, a Department of Health member of staff was seconded to the NGO, Merlin and the London School of Hygiene and Tropical Medicine.

By gathering evidence from a variety of sources, the group improved the government's collective understanding on how respective departments work on health and conflict, which coupled with evidence from internal and external stakeholders, helped the group to understand the determinants of policy making in practice, and make recommendations, with specific actions, on how to improve the future joint policy work relating to health and conflict. The group plans to focus on working through the recommendations that have come out of this work. A particular focus will be working with external stakeholders such as Chatham House and initiating work with other governments working in this area. Overall, the group provides an important focal point for new and emerging issues in health and stabilization that can discussed across government.

Developing Evidence for Health and International Relations

Issues of aid, trade, security and diplomacy are key intersections that require collaboration between global health and foreign policy approaches. The GHS recognized that such collaboration should be evidence-based to ensure effective and efficient actions and concrete outcomes. Key institutions that have accelerated their work through GHS support include Chatham House, focusing on challenges for international affairs such as economics and security (Chatham House 2010), and Global Health Europe, addressing global health diplomacy.

The Centre on Global Health Security at Chatham House is working to analyse how improved international relations can more effectively address global health challenges. The Centre emerged from the recognition that an independent source of information and advice was required to provide global goods for governments and other actors in this area. The Centre has paid particular attention to global health issues that have encountered difficulties in bilateral relations, international organizations and diplomatic negotiations because of a perceived divergence of political, economic or social interests among states and between states and non-state actors. The Centre has gone on to develop its own research agenda that focuses on timely, evidence-based and politically feasible policy options. Themes include the prevention and control of disease threats and their determinants; access to health-related products, technologies and services; governance issues in health that present challenges and opportunities in international relations.

Evaluation and a New Outcomes Framework

The 2010 Independent Review of the Strategy

The strategy committed the government to independent reviews on progress. The first review of the strategy was done in 2010 and focused on the coherence and consistency of cross-government working with key emerging economies on global health Mott Macdonald for the Department of Health (2010). The GHS secretariat commissioned an independent review to on an area that crossed the themes of the strategy, but also was one of commitments in the action plan. The researchers reviewed grey literature and collated views from a series of interviews across government, non-governmental bodies, and officials from countries in Brazil, Russia, India, China and South Africa (BRICS).

Overall, the review concluded that there were good examples of UK government working in the BRICS countries, which they considered impressive given the short time frame that the strategy has been operational. There was a good level of awareness of the strategy among UK-based staff working with and in the BRICS countries with most of those who are aware of the strategy reporting positively regarding the potential of the strategy to bring a more coherent approach. They found several examples of successful joint working across government departments; a degree of shared language on global health; some high level commitment to global health thinking and a number of examples of a coordinated approach. In China and India, cross-government programmes are emerging that bring together the different dimensions in security, health systems, trade and **evidence for policy**. From this perspective there are several successful examples of global health diplomacy in action.

However, there were several areas where UK government departments could better coordinate and plan their approach in the countries that were reviewed. Much of the activity appeared to be ad hoc and opportunistic. Activities were unevenly clustered in certain areas of the GHS, and other areas were not addressed. Overall, better cross government coherence on global health was needed. The key recommenda-

tions were themed around prioritization, the generation of strategic leadership, improved communication and the organization of resources. These issues illustrate that global health diplomacy is in part reliant on the supporting systems and structures in the policy process. In effect, they act to reduce the multiplying effect of working towards global health in sectors beyond health care.

The first review has made clear that achieving meaningful partnership and realizing change is complex and challenging. However, the UK has received great interest from around the world regarding its global health experience. The GHA has been enthusiastically shared and it has been encouraging that countries such as USA and China, and organizations such as the European Commission and the United Nations, have in parallel developed their own concepts of global health—with multidisciplinary cooperation taking centre stage in their interpretations.

A new Government at a Time of Fiscal Constraint

At the heart of *Heath is Global* was a commitment for the government to work with greater coherence and consistency. Since its launch the UK government published the first ever cross-government strategy for working with WHO, and this has improved the way it works as a multilateral leader in global health. We have also seen government departments work closely to ensure a consistent approach in how we utilize the UK's considerable human resources. This technical, professional and social capital is being used to greater effect in humanitarian emergencies earthquake such as Haiti, as well as development challenges elsewhere. Learning lessons from these activities is a key objective.

While the aspirations and broad trajectory of the strategy remain as relevant as ever, the changing fiscal and political environment mean that the UK must take a hard look at future priorities. A key challenge is to ensure that GHS activities are effective, efficient and produce concrete outcomes. Pandemic influenza showed the importance of systems that can adapt rapidly when facing an acute threat, with key uncertainties over the nature of that threat and the best way to face it. It will be important to review the experience to ensure that actors find new and better ways of doing things where possible. The financial crisis also highlights the importance of ensuring government and others do all they can to promote freer, fairer trade, while recognizing UK industry as an even more influential partner in health and health care at home and abroad.

Partners in the strategy have all been stepping up their response to the challenges. The National Institute for Health and Clinical Excellence (NICE) offers services in India, China and elsewhere. The MRC and Wellcome Trust both have new strategies that highlight the importance of global health, while the UK Collaborative for Development Sciences is supporting funders to work better collectively for global health research. And in the NHS, a new Health Partnerships Fund is accelerating the domestic and international benefits of links between the UK health system and its international counterparts. This perhaps illustrates the challenge that those doing global health diplomacy must also prioritize their efforts yet work with a wide range of actors.

A New Outcomes Framework in a Time of Economic Challenge

The new UK government remains committed to reaching 0.7% on development spent by 2013, with £7 billion for health despite wider austerity measures. On March 30, 2011, the Coalition Government published Health is Global: an outcomes framework for global health 2011–2015. Starting with the previous Government's publication and the recommendations from the independent review, the new government developed an outcomes framework to support the next phase of the strategy. The framework reaffirms a set of guiding principles, focuses efforts towards achieving a set of 12 high-level global health outcomes by 2015 and will be underpinned across Government by departments' own delivery plans.

In the new framework, the five areas were narrowed to three: global health security, international development, and trade for better health. The new outcomes framework reduces 41 process indicators and 31 outcome indicators to 12 outcomes. Box 5 shows the three areas and the 12 outcome areas (see Box 5).

Box 5 Current UK Global Health Outcomes. Adapted from Health is Global: An Outcomes Framework for Global Health 2011–2015

Global Health Security

1. MDGs—food and water security
   - Greater proportion of the world enjoy improved food and water security. Coordinated international efforts raising food security for the most vulnerable.
2. Climate change
   - Low and middle-income countries supported to assess and address health vulnerability in relation to climate change.
3. Health and conflict
   - Reduced humanitarian and health impact of conflict.
4. Emergency preparedness
   - UK and rest of the world better able to predict, avoid and respond to emerging global health threats.
5. Research
   - Deeper scientific understanding of the effects on health of changes in climate and water and food resources, and we will use this to inform options for action.

(continued)

Box 5 (continued)

International Development

6. MDGs—health systems and delivery
   - To combat HIV/AIDS, tuberculosis (TB), malaria and improve reproductive, maternal, newborn and child health through health systems strengthening.
   - Balance of health-care workers in individual countries (losses and gains) should have a net positive effect on developing countries and economies in transition.
7. Non-communicable diseases
   - Stronger integrated strategies and actions, and effective support from international agencies in low- and middle-income countries.
8. Learning from other countries
   - Improving the UK's population health outcomes to be amongst the best in the world through learning from international experience.
9. Research
   - Better coordination of UK and European Union (EU) global health research.
   - Enhanced, low-cost access to research knowledge for researchers and policy makers in developing countries.

Trade for Better Health

10. MDGs—access to medicines
    - Increased access to safe, high-quality and affordable treatments and medicines.
11. Trade and investment
    - UK life sciences and health-care sectors make the most of global trade opportunities, particularly in key emerging markets.
12. Research
    - Investment and operational partnerships to address critical challenges in scaling up innovation and evidence-based interventions for the poor.

The outcomes framework reaffirms the breadth and complexity of global health and the importance of maintaining effective relationships with external partners and networks. A particular challenge will be to maintain the priority for global health in the economic environment.

The views expressed in this article are the personal views of the authors and do in no way constitute the official view of any institution.

Questions

1. Why did the UK develop a GHS, and the subsequent outcomes framework?
2. Which areas were identified that required further cross-government collaboration?
3. How does this strategy compare with other attempts to create policy coherence in other states?
4. How do policy negotiations at the national level impact on diplomacy elsewhere?
5. How does policy coherence relate to implementation and outcomes?

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Further Reading

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Chapter 20
National Strategies for Global Health

Priyanka Kanth, David Gleicher, and Yan Guo

Readers' Guide

This chapter brings together a review of the global health diplomacy strategies of the USA and Switzerland by Priyanka Kanth and David Gleicher with a review of the development of China's approach to health and diplomacy by Yan Guo. It explores the difficulties of achieving agreement between different stakeholders on a common definition of global health and the actions required to address it at national level. It suggests that the concept of global public goods is an important key to global health governance issues. National strategies or approaches to global health reveal the way in which different countries have resolved cross sector issues raised by the determinants of global health. The examples explored here of the approaches taken by the USA, Switzerland, and China provide insights into the way national interests in global health are defined in practice and the light they cast on the difficulties of strengthening global governance for health.

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Learning Points

- National goals for global health are interpreted in different ways depending on the perspective of the ministry or other stakeholders engaged.
- Resolving such differences and achieving a balanced approach to the many different aspects of global health is difficult but worthwhile.
- The concept of global public goods for health can play an important role in achieving a consensus on national and international action.
- Different national strategies and approaches to global health issues reflect the way conflicting perspectives are reconciled in each country—in this case the USA and Switzerland.
- The development of national and regional strategies highlights the need to achieve international agreement and action on such issues at regional and global levels.
- The review of health and diplomacy in the People's Republic of China illustrates how changing political, economic and social conditions have both shaped and been shaped by global health diplomacy.

Introduction: Contested National Goals for Global Health

Global health is at its heyday. Yet, despite a decade of publications and conferences, projects and programmes, the establishment of committees, councils, centers, and institutes, and even a TV channel—all with "global health" in their titles—it is still unclear what global health means for national policies. It is described in many different ways; by focussing on specific health topics—(e.g., infectious and non-communicable disease, medicines, and professional migration) or focussing on the nature of the issue—(e.g., health, security, trade, or aid agencies), while some see global health in terms of goal to be achieved—(e.g., human rights to health and access to medicine or eradication of polio). On the other hand, there are also those that think of global health as an instrument of foreign policy to serve a country's interest in achieving other goals—(e.g., as a source of influence or soft power).

As the application of global health in national policies is contested at every turn, in its definition, purpose or outcome, what all too often happens is that stakeholders from different government departments or interest groups each define global health in a way that reflects their perspectives with regards to how they wish global health to be perceived or applied and what global health should produce in terms of outcomes.

The concepts applied by a ministry of health to set out and operationalize a policy designed to address health issues that cross borders and therefore also threaten the

health of the population they serve, are not necessarily the same as those applied by the ministry of trade, which may emphasize opportunities and constraints to national business interests in health-related trade. Foreign affairs interests may focus on threats to peace and security and the use of soft power. A development aid perspective may focus on the needs and human rights of poor people in developing countries and the importance of strengthening civil society to address their health issues. Indeed, too often, interdepartmental discussions refer to global health, but mean different things—with the consequential risk of undermining the ultimate goals of a national strategy for global health that may seek to apply a balance of all of these goals, as illustrated by the UK strategy for global health discussed in Chap. 19.

Thus global health is a field of action where there is often no common sense of purpose or direction. When publications or discussions do achieve a sense of common purpose it is by the exclusion of alternative perspectives. The global health debate is at present dominated by development interests; fighting disease and poverty in low- and middle-income countries is an important part of global health, but to focus mainly on the contribution of wealthy "donor" nations to low-income settings is misguided and often distracts from the larger challenges. Global health must be seen as a domain that is relevant at the global, regional, and national levels and cuts across the traditional development paradigm to include governance issues that have so far remained aloof from development policies, for example, areas, such as security, trade, and intellectual property, to mention but a few. The EU strategy for global health as described in Chap. 16 begins to address some of these issues.

All nations, whether rich or poor, are increasingly beset by common health challenges. These include: anti-microbial resistance, infectious disease outbreaks, natural disasters, health systems financing and managing the growing burden of chronic disease. These and other issues are global health challenges because their underlying causes transcend national boundaries and can only be addressed by concerted cross sector, international action. An increasing number of health problems have become dependent on action in other sectors and on collective action at a global level, changing the way governments "do business" individually and collectively. Governments need to rid themselves of their long-standing silo-thinking, not only in linking different ministries and government agencies whose actions are relevant to global health but also reaching out to non-state civil society actors for collaborative global health action. It becomes evident that, as a result, governments' approaches to fulfill their mandates to their citizens have to change and in fact are already changing to recognize that they are also global citizens. At international level global health governance needs to be developed to ensure effective collective action on the global factors that determine health.

Early in the first decade of the twenty-first century the economic theory of *global public goods* gained traction in academia and in policy circles wishing to find ways to conceptualize and cope with new challenges brought on by globalization. A debate was waged in academia over whether health could be classified as a global public good, or rather if the discussion could be shifted to the notion of global public goods *for* health. This intriguing dialogue has unfortunately tapered off in recent years and merits fresh discussion (see Chap. 9). A global public goods approach to

global health has the potential to bridge the disparate strands of global health policy and action and provide a coherent understanding of the relevant global health stakeholders. For governments, approaching global health through a global public goods lens is of unique relevance as they start provide a consolidated basis to address the interdependencies of global health at the national–global interface.

Public goods are commodities or services provided by governments or wealthy donors for the use and enjoyment of all. Providing goods in this way, whether in education, national defense, waste management or street-lighting (understanding the outcomes of these areas of activity as commodities), reflects a policy choice—as a society we decide that a commodity or service is too important to be provided privately due to the risk that it might be underprovided or that some citizens could be excluded from accessing these goods. It is also usually the case that the free availability of such a good creates a net benefit for society. Goods whose benefits and costs spread worldwide, potentially affecting all people, perhaps even several generations, can be conceptualized as challenges to the provision of global public goods, of course such goods can only be provided by international agreement.

In response to global challenges like climate change, food security or financial stability—there has been an increasing awareness of the need for global public goods. At present governments tasked with mandates to protect the environment, their citizens enjoy, prevent famines, or provide dependable market regulations and stable currencies are finding they can no longer achieve this by acting alone at national and local levels of government. More and more they must seek solutions through cooperation at the international level, and contrary to the view of many domestic policymakers—cooperating globally does not mean losing sovereignty. As Kaul (2010) noted, nations must realize that their inability to provide key public goods means their sovereignty has already been weakened and can only be regained by acting together.

A global public goods approach to health implies a strong commitment to addressing the globalized determinants of health—such as agriculture policy—and strengthening the rule of law in the global health arena through international agreements on issues like intellectual property or the movement of health professionals. Reliable mechanisms for health security also need to be ensured through global surveillance systems, while strong and inclusive institutions of global health governance need to be further developed through strengthening and reforming the World Health Organisation (WHO).

All this requires a new perspective on health governance that can be provided by a global public goods approach. For many years health policies have been considered domestic issues reflecting national priorities. With a global public goods perspective it becomes clear that today's national health ministers have the dual responsibility of promoting their country's health and advancing the health interests of the global community. Such a perspective links internal and external policies in new ways and requires mechanisms for policy coherence. It reflects the fundamental shift in thinking that is necessary within health ministries and also provides for an entry of governments' ministries of foreign affairs that need to become actively engaged in global health matters.

Global health is about more than development assistance—and this inevitably requires concerted action not only from the ministry of health but also in collective efforts with other ministries that have traditionally only been marginally (or not at all) involved in health matters. It is also about the policies and strategies that are being developed to address health in all its manifestations in Europe, the USA, China, or any number of rising states and by global institutions. Adopting a broader understanding of the determinants and consequences of global health challenges, including but not limited to efforts to eliminate poverty and corruption, fundamentally changes the argument for spending on aid and assistance. Global health must be understood not only through the moral and equity concerns about the plight of less fortunate, poor nations and people, but actually as a mode of international cooperation driven by national enlightened self-interest where countries engage in international cooperation, such as strengthening health systems abroad, not simply out of charity or altruism, but because it is in the best interest of the "donor" electorate or society to do so.

When global health governance is discussed there is usually reference made to the multitude of diverse actors from civil society and the private sector that increasingly shape events in the global health arena. But the fact remains that while intergovernmental health institutions and global civil society movements and organizations are influential, there is still no supranational authority that can ensure that nation states deliver on their health obligations to citizens other than the WHO. As such, nation states remain the central actors that set the pace of reforms that favor better global health outcomes.

In response to this need, a number of countries including the USA, China, and Switzerland as discussed below have started focusing on creating policy coherence on global health at the national level within the different ministries and other parties through the national global health strategies, integrating interests, agendas, workplans and aims of different policy sectors.

The USA and Global Health

The US Government's current Global Health Initiative (US GHI) is a commitment to spend US$ 63 billion over 6 years to help US development aid partner countries improve health outcomes and strengthen health systems. By far the largest single country financial commitment (in absolute terms), the initiative prioritizes action on HIV/AIDS, malaria, tuberculosis, non-communicable disease, family planning, and nutrition, but places its central focus on improving the health of women, newborns, and children. In the formation of this new policy the US government recognizes health as intimately connected with economic development, job creation, education, agricultural development, gender equity, and political stability; and as a key facet in its diplomacy and development work around the world. The USA sees investments in global health as catalysts for progress in all the mentioned areas. In return the global impacts of achieving (or failing to achieve) these goals are seen as having direct consequences on the security and prosperity of the USA.

For the US government global health is presented as both an end in itself and a strategic means to address foreign policy challenges. Despite this, there is an obvious lack of congruence between the enlightened systems thinking of this justification and the narrow development cooperation focus of the US GHI. Despite the Obama administration's incorporation of the notions of soft and smart power into its dialogue on the GHI, and despite attention given to global health from Secretary of State Hillary Clinton, the US GHI nevertheless maintains global health as a subfield of action packed within the box of development assistance. The policy is called "global" but it is clearly focused on improving health programming in US development aid partner countries. The USA states that the GHI is closely linked to US foreign policy, but current analysis suggests it is strongly linked to foreign policy in only one way. It is a tool to reshape America's image abroad; a tool to win the hearts and minds of foreign populations.

Secretary Clinton (2010) was exceptionally accurate in her explanation of the GHI, "we invest in global health as a tool of public diplomacy." What is public diplomacy? Like global health, public diplomacy is difficult to define. Having evolved from a 1960s euphemism for propaganda, today public diplomacy carries the notion of direct diplomatic engagement between a government and a foreign population outside the traditional diplomatic channels.

> It is important to distinguish public diplomacy from traditional diplomacy. Traditional diplomacy occurs between governments, i.e., from a US embassy to the foreign ministry of another country. Public diplomacy maintains a different and more transparent target audience, namely the wider international public. Public diplomacy concerns itself not with the comportment or policies of foreign governments, but rather with attitudes and behaviours of publics (Syracuse University Maxwell School Public Diplomacy Web Page).

Early indications statements suggested that the GHI would be largely a public diplomacy tool with undefined real applications in the arenas of multilateral diplomacy and global health governance. The discussion around the GHI made only passing reference to issues such providing global public goods for health, like a global surveillance system for emerging pandemics, or how the USA will work with the WHO and other partners in global health. Much more detail is given to the plight of the poor and grandiose rhetoric of America's quest to save the lives of millions. Make no mistake; US global health assistance is desperately needed and is in some ways so commendable that it is almost beyond criticism. However, in its current form the US GHI represents only one of various potential perspectives on what global health means. The US GHI focuses major attention on the amelioration of preventable suffering around the world, but the policy does seemingly little to address the global forces which fuel the suffering. Nowhere in the GHI consultation document, or in subsequent US government speeches on the GHI, is there mention of issues such as trade, migration, climate change, clean energy, corruption, war and reconstruction, or fragile and failed states. Nor is there mention of global commodity prices, natural disasters and humanitarian response, demographic change and population aging, or the globalization of unhealthy diets and lifestyles. Judging by the text of the US GHI equity appears to be an issue related to gender alone; global health is associated with economic development, but not economic integration; and

access to essential medicines seems to only be an issue related to antiretroviral treatments.

The US approach to global health has evolved greatly in recent years. Its initial focus was made clear by "America's Vital Interests in Global Health" the 1997 book from the US Institute of Medicine (1997) that was subtitled "Protecting our people, enhancing our economy and advancing our international interests." Global health issues featured in the US State Department's objectives from this perspective and funding programmes such as the President's Emergency Plan for AIDS Relief proposed in 2003 were targeted at health concerns and countries reflecting US interests and beliefs US Institute of Medicine (1997).

A new emphasis on funding for programmes that target primary health-care delivery and less funding for providing antiretroviral therapy should be understood as more than a response to counterbalance the unintended negative side effects of a decade's focused investment on "vertical" disease-specific programs. This new emphasis also marks a change in philosophy from earlier generations of American leadership who upset the implementation of the WHO Alma Ata Declaration with their preference for the World Bank and its cost–benefit rationalization of health services. Global health is a dynamic field in which policies can be fine-tuned to serve specific domestic needs that change over time. As such there is the potential for the USA to broaden its approach and to link global health more strongly with issues more closely associated with "traditional" diplomatic arena. However, the US GHI was focused on health development assistance as public diplomacy.

In line with this the US Department of Health and Human Services published its Global Health Strategy 2011–2015 (2011). This set out three strategic goals: to protect the health and well-being of Americans through global health action, to provide leadership and technical expertise in science policy, programs and practice to improve global health, and to advance US interests in international diplomacy development and security through global health action. These goals are unequivocally expressions of US diplomatic and human security aims; however, the expression of these goals in the operational principles of the strategy reflects a more nuanced approach to development aid. They include working through partnership and coordination, responding to local needs, building local capacity and improving the equity of health. Perhaps this last principle reflects changes in US national policy with the introduction of the Affordable Healthcare for America Act in 2009. US Department of Health and Human Services (2011).

Switzerland's Health and Foreign Policy

Historically in the late twentieth century health issues were managed by two ministries in Switzerland: health in the development context fell within the remit of the Swiss Development Cooperation (SDC) of the Ministry of Foreign Affairs and all other health issues were the responsibility of the Federal Office of Public Health, within the Ministry of Home Affairs. Often, even if the various aspects of health were dealt in one and the same meeting, for example the World Health

Assembly, the two ministries acted completely independently—and ministries limited their engagement in health issues often due to a lack of competence in the technicalities of health.

Challenges in coherence first arose with the "Nestle kills baby" affair (1973–1974), when a third ministry got interested in health (the Ministry of Economics and Trade). Such challenges were compounded with rising debates on intellectual property and access to medicines, which fired up with the launch of a Campaign for Access to Essential Medicines by the Medecins Sans Froniteres in 1999, when a fourth ministry—of Justice—felt the need to engage with health-related issues.

Conflicts of interest, amongst the different government ministries, became evident, especially in settings of multilateral negotiations, where Switzerland's position on issues fluctuated depending on who was representing the country. The lenses adopted in multilateral negotiations were significantly different based on which ministry sent a representative. The positions fluctuated from considerations of economic growth and trade—especially in view of Switzerland's booming health-care sector and pharmaceutical industry; considerations of public health and human rights; considerations of international development—given that Switzerland has a very old humanitarian tradition, and so on.

With the growing importance of health and other consideration of large economic sectors linked to health, tradition and legacy of humanitarian work, being the host nation to various international organizations, including the World Health Organization, the need for coherence in policies and actions was paramount.

To this effect, Switzerland was the first country to formally adopt a national strategy, entitled *Swiss Health Foreign Policy* in 2006. It constitutes an "internal agreement between the relevant services of the Swiss federal administration." Its primary purpose is to improve the "instruments of internal cooperation." The policy paper was drafted following the Federal Council's decision to "improve coordination and coherence of Swiss foreign policy." The decision was passed on the 18th May 2005. The agreement is between the Federal Department of Foreign Affairs (FDFA) and the Federal Department of Home Affairs' (FDHA)'s Federal Office of Public Health (FOPH). The policy paper was prepared in consultation with other Federal departments concerned.

The rationale behind the decision to prepare this policy paper was the realization and acknowledgement of the extent of global interdependence and need for stronger and consorted responses from countries. Until the preparation of this policy paper, the Swiss addressed health issues primarily through a public health or development lens.

In the document, there is a clear focus and will on wanting to strengthen international collaboration on health matters, the place of health as a fundamental component of sustainable development and global security. The document highlights the role of the individual federal departments and offices, whose work may touch upon health matters.

The policy paper clearly sets out five main areas of interest. The first relates to *protect(ing) the health interests of Swiss population*, through measures against the spread of communicable and non-communicable diseases and ensuring consumer protection. This would be done through heightened cooperation with international

organizations and immediate neighbors, essentially the EU. The second area of interest is to *harmonize national and international health policies*, which focus on protecting and addressing the concerns of industry that are affected by health protection measures, namely, pharmaceutical and food industry. This would not be exclusive as the attempt would be made to match the needs of various stakeholders, industry, as well as the World Bank, the EU, the OECD, and the WHO. The third area of interest seeks to *improve the effectiveness of international collaboration in the area of health*, which would be achieved by aid in strengthening the WHO's normative role, supporting the coordination between WHO, OECD, and EU on normative health issues and "promote synergies," improving efficiency of multilateral players in the fields of health, development cooperation and humanitarian aid, amongst other measures. The fourth area of interest looks to *improve the global health situation*, by developing and strengthening health systems in developing countries; fighting in eliminating HIV/AIDS, TB, and Malaria; aiding in combating non-communicable diseases by emphasizing prevention, health promotion and reproductive health; and finally by devoting aid and support to health-care needs in areas in conflict. Finally, the fifth area of interest states the desire to safeguard *Switzerland as a host country to international organizations and as an industrial location*, by consolidating Geneva's position as an international center of excellence for public and humanitarian health and ensuring incentives for R&D of new drugs and vaccines, through protection of intellectual property.

Various measures have already been undertaken to ensure sound implementation of the various goals that have been set. The FDFA is undertaking the *establishment of a coordinating office for health foreign policy*, in-charge of ensuring overall policy coherence and perfecting intelligence gathering. The FDFA has, additionally, undertaken the *creation of an information platform for health foreign policy*, an accessible platform to store all necessary and relevant information.

In support of this approach, the FDHA undertook measures including *producing policy papers on subjects arising in health foreign policy and strengthening academic competence; and Harmonization with general foreign policy and other sectoral policies.*

Finally, joint measures with the two departments include *creation of an Interdepartmental Conference of Health Foreign Policy; and Staff exchange and foreign missions*, to ensure policy coherence and a common understanding of the issues in all offices of the government.

China and Global Health

Country Brief

The People's Republic of China covers an area of about 9.6 million square kilometers, which is the third largest in the world and is the most populous country in the

world, with a population of 1.338 billion by the end of the year 2008. Since the reform and adoption of the "opening-up policy," China has applied successful family planning policies which led to a decline in its percentage in world's population, from 22.2 % in 1980 to 20.1 % in 2007.

The Chinese population is composed of 56 nations, in which Han takes up the majority, whereas the other 55 nations, with much less population, are usually referred to as "minority nations." Meanwhile, China respects different religions, people can choose their belief and express their religious identity freely; religions like Buddhism, Taoism, Islam, Catholicism, and other forms of Christianity are all widespread with large number of believers.

Health systems in China have progressed substantially from widespread shortages medicine and health care to an improving health-care service system. The Three-tier Network of Health-care, Barefoot Doctors, and Cooperative Medical Scheme plays an important role in safeguarding the health of the Chinese population. Over the past 60 years, China successfully eliminated smallpox and filariasis accomplished the goal of "Perishing Poliomyelitis" put forward by the WHO, and there has been no report of diphtheria in the past 20 years.

After the adoption of the reform and opening-up policy, the health condition of residents in both urban and rural areas is improving. Life expectancy increased from 68.2 years in 1978 to 73 years in 2005, infant mortality rate decreased from 34.7‰ in 1981 to 15.3‰ in 2007, maternal mortality rate decreased from 88.9/100,000 in 1990 to 36.6/100,000 in 2007, all these figures are lead the majority of developing countries, approaching the average level of high- and middle-income countries, thus paving the way for realizing government's commitment on Millennium Development Goals and constructing a socialist society with moderate nation income and health level. However, the imperfect medical insurance system and the widespread health inequities are constraints in the development of health-care services in China and need to be addressed with priority.

Development of Health Diplomacy in China

Cooperation in the health-care sector is crucial for economic and social interchanges between countries and is also a fundamental tool for accumulating "soft power." China has been actively involved in health diplomacy since its foundation, and fully utilizing bilateral and multilateral as well as other effective channels in a pragmatic and cooperative way, which is both fruitful and productive. In line with the changing international environment, dominant ideologies and diplomatic situations over the past 60 years, health diplomacy in China also demonstrated strategic shifts:

From the foundation of the People's Republic of China to the end of 1950s: "Leaning to one side" diplomacy and health cooperation between China and Soviet Union

Shortly after its foundation, in face of the blockage by America and the western world, China leaned to Soviet Union in its foreign policy. Not only did it join the

socialist allies led by the Soviet Union, but it also kept in step with the Soviet Russia and other socialist countries in diplomatic issues. They have been mutually supportive in politics, and also shared frequent exchanges in health arena. During the first 5-year plan, the Soviet Union offered help in developing 156 large-scale plants and factories in China, including two pharmaceutical factories in north China and Taiyuan, capital of Shanxi Province. Meanwhile, a large group of Chinese students and health technicians were sent to Soviet Union for further study and training, providing a reservoir of health professionals for future development. Many of those who come back after studying there became the main force in health sector in China, the former Health Minister, Dr. Qian Xinzhong, obtained his doctoral degree in Soviet Union.

From the beginning of 1960s to the end of 1960s: "Anti-America and Combating Soviet Union" and the initiation of medical teams to Africa

The honeymoon between China and Soviet Union didn't last long. By the end of 1950s, the two sides fell apart over many issues, including: diplomatic direction, ideology and the construction of a socialist country. Though still isolated from the capitalist world, China enhanced its diplomatic relations with countries in Asia, Africa, and Latin America. Apart from supporting these countries in their efforts to win and sustain independence, China also offered political and material assistance to them, notably the assignment of medical teams. On April 6th, 1963, China sent its very first medical team to Algeria as directed by the former Premier Zhou Enlai. Over the past 40 years, Chinese medical teams sent to the underdeveloped world experienced enormous hardships yet achieved remarkable results, exerting a positive influence, establishing a favorable image of China in international community and promoting the development of Chinese diplomatic relations.

From the end of 1960s to the end of 1970s: "Unite with America to contain Soviet Union" and the beginning of multilateral health diplomacy

The Sino-American relationship emerged as a historical reconciliation right after the conflict over Zhenbao Island between China and the Soviet Union in March 1969, which was also the time when the USA. was deeply enmeshed in the Vietnam War. This process reached its climax in February 1972, when former President Nixon visited China in public. China began to break the ice with the Capitalist world and became more involved with the international community, especially with the regaining of country identity as a U.N. member. The relaxation of tension in diplomatic relations has also facilitated the exchanges in the health arena. This period witnessed a booming of China's health assistance to other countries, as well as very frequent visits by country health delegations from Asia, Africa, and Latin America.

On May 12, 1972, the 25th World Health Assembly passed a resolution to resume the rightful identity of China in World Health Organization. Since then, China, as a member country, has participated every assembly and regional committee conference in the WHO and was elected as member in executive committee many times. In October 1978, the former health minister Dr. Jiang Yizhen signed

the *Memorandum of Technical Cooperation Between the People's Republic of China and the World Health Organization* (hereinafter referred to as the *Memorandum*) with the former Direct-General of the WHO, Dr. Halfdan Mahler, in Beijing, a milestone that marked the initiation of multilateral health cooperation in China.

From the end of 1970s to the end of 1990s: "Pragmatism" and advance of comprehensive health diplomacy

With the implementation of the reforming and opening-up policy, proposed by the 3rd Conference of 11th Congress of the Communist Party in 1978, China decided to shift its priority to economic development and orient its foreign policy towards the direction of independence, peaceful coexistence, as well as comprehensive diplomatic relations, thus adding momentum to economic modernization in China. At the same time social institutions and ideologies are no longer the reference for foreign policies; rather, foreign policies are seen as supporting economic development.

Such shifts also promoted comprehensive diplomatic relations in the health arena, mainly embodied in four aspects: co-development of bilateral and multilateral cooperation, co-investment of technologies and capital in health, mutual complementarity of official and nonofficial approaches, and a bidirectional flow of health assistance both inwards to China and outwards from China. It was during this period that many agreements on health cooperation with strategic importance have been signed between China and other countries, such as *Protocol of Scientific Cooperation on Health Between the People's Republic of China and the United States of America* on 22 June 1979; *Agreement of Scientific Cooperation on Health and Medical Science* signed between China and the Soviet Union on 16 May 1990; *Memorandum of Understanding on Health Cooperation* signed between health ministries in China and Australia, etc. Apart from booming of bilateral health cooperation, China has also been extending its influence in international health affairs both in breadth and depth, and has further enhanced cooperation with international health organization like the WHO.

Features of China's Health Diplomacy in the New Century

During the 60th anniversary of the founding of the United Nations in September, 2005, the Chinese President Hu Jintao proposed a democratization of international relations and construction of a harmonious world where all civilizations coexist and accommodate each other. This new diplomatic thinking has thus influenced health diplomatic activities in the twenty-first century China, giving them new characteristics, as listed below, while maintaining the strategy of "comprehensive health diplomacy" in the last period:

Active involvement in international health affairs

In the twenty-first century, the development of globalization facilitated the cross-border transmission of health hazards, making it an issue that requires countries to work together. The international organizations thus became an ideal platform for countries to sit together and discuss solutions to these transnational health issues. In this regard, China enhanced its cooperation with international organizations such as the WHO and participated in the international health decision-making more actively to promote its influence in international health affairs.

Cooperation with the WHO

With the regaining of its lawful seat in 1972, China has been cooperating with the WHO with great enthusiasm, which has become even more active in the new century as China aggregates its national power. Such cooperation activities are conducted mainly through the following three approaches:

Supporting activities of the WHO in the world, and coordinating conferences as host country: in December 2006, the former Director of Health Department in Hong Kong, Dr. Margret Chan, was elected Director-General of the WHO under the nominating by People's Republic of China, an event that symbolized China's increasing influence in the WHO. Meanwhile, China plays its role in the formulating and revising of policy tools of the WHO, such as the revision of International Health Regulations (hereinafter referred to as "IHR") in 2005. Not only did China participate in the whole process, but it also made an official announcement during the 60th World Health Assembly in June 2006 that the revised IHR 2005 will be applicable to the whole China, including Hong Kong, Macao and Taiwan area, and establishing a special coordinating team composed of ministries of health, foreign affairs and quarantine departments.

Establishing WHO cooperating centers (CC) in China: at present, there are altogether 60 WHO CCs in China, accounting for about 8 % of the total, 13 of them were established after the year 2000. The major fields include prevention of communicable and non-communicable diseases, traditional medicine, reproductive health, mental health, primary health care, and maternal care.

Conducting WHO cooperation programs: these programs are composed mainly of biennial regular budget programs and extra-budget supporting programs. From the year 1982 to 2009, China received in total $86.53 million dollars of regular budget from the WHO, of which $33.3 million were agreed in the new century till the year 2009. The budget for each biennial program remains around $6.8 million, indicating that this cooperation has stabilized. Four major fields include disease control and prevention, health sector development, health promotion and extension activities. These programs have been very conducive to the cultivation of health personnel and enhancement of health system in China.

Cooperation with other international organizations

Cooperation with UNICEF: from 1980 to 2005, UNICEF has provided in total $140 million dollars to the health sector in China, supporting seven rounds of cooperation projects, and established a dozen cooperative programs in fields like maternal and child health, immunization, elimination of iodine deficiency, health

education, and nutrition, etc. In the 8th round, which is from the year 2006 to 2010, UNICEF has committed another $50 million dollars to health in China, and taking into consideration China's national development strategies for the health sector, it reoriented its priorities to fields more related with maternal and child health, i.e., maternal and child hygiene, child nutrition, disease prevention and immunization, as well as avoidance of unexpected injury.

Cooperation with Global Fund to Fight AIDS, Tuberculosis and Malaria (hereinafter referred to as the "Global Fund"): The Global Fund was established in January 2002, initiated by G8. China has also been active in the whole process since June 2001 and has been a member of the council for developing countries in Western Pacific region. Bty June 2008, China has successfully secured 11 programs from the Global Fund, the amount totaling $550 million.

Cooperation with UNAIDS: UNAIDS is a major advocate and leader in the fight against HIV/AIDS worldwide. In June 1996, UNAIDS set up an office in Beijing, China, to advance its cooperation with this emerging economy. China has been supporting UNAIDS since 1996 by making annual donation of about $100,000 dollars; while by the end of 2007, it received more than 3 million dollars of assistance, from UNAIDS with a focus in policy, guidance and leadership training, engagement of HIV/AIDS patients, management of migrants and gender issues.

Cooperation with the World Bank: since the first loan program in 1982, China has cooperated with World Bank in carrying out 15 health projects, utilizing loans of 1.26 billion dollars and donations of 112 million dollars, prioritized fields are regional health planning, rural human resource preparing, DOTS strategy in tuberculosis, medical aid for maternal and child health in poor areas, as well as HIV/AIDS prevention and control.

Expanding intergovernmental health cooperation

Health cooperation and exchanges between China and other countries include signing health cooperation agreements, establishing regular dialogue mechanisms, high profile visits, and conducting joint health programs.

Cooperation with developed countries

Cooperation with the Britain: Britain is the country that provided most funds, more than 100 million pounds, to China's health sector through Official Development Assistance. Since 2000, DFID has been engaged in active and comprehensive cooperation with Ministry of Health in China, supporting the government's efforts in tuberculosis, HIV/AIDS, community health and medical aid, as well as research on health policy. The two major programs are HIV/AIDS Prevention & Care Project (HAPAC) and China AIDS Roadmap Tactical Support Project (CHARTS). The next round of cooperation on AIDS prevention between China and the Britain is expected to operate from 2006 to 2011, with a committed input of 30 million pounds from Britain to further enhance the AIDS prevention in China.

Cooperation with the European Union: China established a comprehensive strategic partnership with the European Union in 2003. From 1994 to 2001, the EU made a contribution totaling 4.5 million Euros to HIV/AIDS prevention in China, setting

up six provincial level regional training centers to provide technical assistance to medical personnel in HIV/AIDS prevention, which is in support of capacity building in dealing with HIV/AIDS and of medical institutions at all levels.

Cooperation with the USA: the new century witnessed closer ties on health cooperation between governments of China and the USA. In 2005, a mechanism of biennial ministerial-level dialogue was established between the two sides; in 2006, Sino-U.S. Strategic Dialogue was initiated jointly by the leaders of the two countries, in which health is an important topic. The personal participation and direct dialogue of high profile leaders have significantly promoted the exchange and cooperation in health sector. In recent years, the cooperation between China and the States have mainly focuses on emerging and reemerging infectious diseases, HIV/AIDS, and influenza. In June 2002, the health ministries of both sides reached agreement on *Memorandum of Understanding on AIDS Cooperation*, which served as policy foundation for enhancing AIDS prevention and treatment. On November 20, 2005, the leaders of two countries officially signed the *Conceptual Paper on China-US Joint Actions on Avian Influenza*, and the two health ministries signed *Memorandum of Understanding on Establishment of Cooperation on Emerging and Re-emerging Infectious Disease*.

Cooperation with Australia: China and Australia share broad cooperation and exchanges in infectious disease prevention, public health emergency response, health system and financing as well as medical research. In September 2005, the two sides set up regular ministerial-level meeting on health. Since 2000, altogether 7 health projects have been successfully carried out between AusAID and Chinese government, reaching a total amount of 82.84 million Australian dollars, which includes project on elimination of Iodine deficiency in Tibet, May 2005; project on prevention and care for HIV/AIDS in Xinjiang Uyghur Autonomous Region, 2002–2009; HIV/AIDS project in Asia, covering Yunnan province and Guangxi Zhuang Autonomous Region, 2002–2007.

Cooperation with East European countries and Russia

East European countries, notably Russia: share a close and stable tie with China. Over the past 30 years, Ministry of Health in China has signed altogether 92 health cooperation agreements with 24 countries in this region, and secured and maintained frequent high profile exchanges. From the formation of Sino-Russian Cooperation Committee on Humanity in the year 2000 (previously known as Sino-Russian Committee of Education, Culture, Health and Sports), the vice premiers of both countries have already called for a number of meetings, in which both health departments and health issues are inseparable components. Inside this Committee, a health branch was established at the beginning of the year 2001, with officials in health departments at vice-ministerial level served as chairmen, thus adds momentum to the health cooperation between two countries.

The Shanghai Cooperation Organization (SCO): is yet another effective channel for China to enhance its cooperation within this region. At the end of November 2008, the first ministerial meeting of health ministers of SCO members was held in Beijing, issues like health emergency response, cross-border infectious disease

prevention and control, medical assistance and disaster relief, as well as R&D for traditional medicine are shared priorities that call for regional cooperation.

Cooperation with ASEAN

China started its official cooperation with ASEAN in 2003; to date it has established a series of health ministerial-level dialogues and other regular high profile meetings. In April 2003, China contributed 10 million RMB to set up a Sino-ASEAN Foundation on Public Health Cooperation. Also, the Sino-ASEAN Cooperative Foundation and other special funds for cooperation with Asia countries set public health as their priority. In March 2008, ASEAN, together with China, Japan and Korea, began its operation on information notification for emerging infectious diseases, making the information sharing among China and ASEAN countries a reality, thus guaranteeing effective response to disease outbreak in advance.

Cooperation with GMS countries

GMS (Great Mekong Sub-region) countries: are pivotal for China to carry out its strategic policies and promote regional cooperation. China began its cooperation in health with GMS in 2005, with a focus on malaria, HIV/AIDS, and tuberculosis prevention in bordering areas at Yunnan Province and Guangxi Zhuang Autonomous Region. To date China has donated more than 5.08 million RMB for these courses and provided training to some 220 person-time. Such cooperation facilitates exchanges among health departments of different countries and benefits capacity building in bordering areas.

Cooperation with African countries

In 1963, China sent its very first medical team to Africa. Over the past 30 years, the number of medical teams sent to Africa has been growing very fast. By the end of 2007, China has sent medical teams to 67 countries and regions in Asia, Africa, Latin America, Europe and Oceania, comprising a total of 21,238 medical professionals, providing treatment to about 200 million persons. Africa has received the majority of medical teams. China has sent 40 medical teams of 980 medical personnel to 39 African countries, and all of them are highly valued by local governments and people for their devotion to work and willingness to help.

Meanwhile, as proposed by China, the Forum on China-Africa Cooperation was started in October 2000. During the Beijing Summit of this Forum in 2006, Chinese President Hu Jintao put forward 8 measures to advance assistance to Africa, which included setting up 30 hospitals and 30 centers for malaria prevention and treatment, both are now underway.

Pioneering non-governmental health diplomacy

Globalization has brought an influx of players and actors in health arena, notably the non-governmental organizations, who are shouldering an ever more important role. In the new century, China stepped up its efforts in cooperating with these organizations and institutions, and has attracted funding, technology and pharmaceuticals of more than 80 million dollars for health sector.

In 2004, Ministry of Health signed memorandum of understanding with Clinton Foundation in the USA, initiating AIDS cooperation projects. In 2005 the Ministry of Health signed a memorandum of understanding on AIDS prevention and control in Sichuan Province with the Merck Company of the USA, totaling 30.5 million dollars for a period of 5 years. In 2006 a memorandum of understanding on AIDS prevention was signed between the Ministry of Health and the Gates Foundation, amounting 50 million dollars for 5 years. In 2007 a memorandum of understanding on philanthropic surgery of cleft lip and palate was reached by the Ministry of Health and the Smile Train foundation of the USA, in which the latter committed funding and technical assistance to patients with cleft lip and palate. What's more, China maintains favorable cooperative ties with many NGOs in the world, like Rockefeller Foundation and China Medical Board, Ford Foundation, and Open Society Institute.

Trends and Challenges for Health Diplomacy in China

During the past 60 years since the founding of the People's Republic of China, health has always functioned as a tool in foreign policy, taking different roles in different times. At the beginning of 1960s, the decision to discontinuing health cooperation with Soviet Union and East European countries was made against a special historical background; the dispatching of medical teams to Africa in the middle of 1960s opened a new chapter in Sino-African health cooperation; health diplomacy in the 1970s melted the ice between China and the USA; the Taiwan issue in WHO beginning 1990s is testing the wisdom of Chinese health diplomats; yet in 2006, with Dr. Margret Chan successfully elected as Director-General of WHO, China is poised to have more say in international health affairs.

Though a tool for diplomatic reasons, we can still summarize the changes in health diplomacy itself. In the first 30 years after the founding of the PRC, the primary function of health diplomacy was to maintain national security, which was our primary political concern. However, ideological differences and domestic "left" leaning mentality interfered with health foreign policies and politicized many insensitive health issues unnecessarily, such as refusing to participating in Alma-Ata conference, exaggerating economic strength, and rejecting WHO technical assistance. A major transition occurred from 1978, when foreign policy became more "pragmatic," when the main function of health diplomacy turned to facilitating national economic development. In this regard, the orientation of health policy was readjusted to both political and the modernization needs, making it stronger and more productive.

The new century is a century influenced by the mentality of the "harmonious world." Health, in this context, while continuing to serve foreign policy, becomes more and more mutually dependent on diplomacy. Over the past decade, high profile health meetings are more frequent and foreign policy tools like negotiation and consultation are employed in health sector to facilitate the development of health.

China needs to be more active in the new era of interdependent health and diplomacy. As an emerging power, China still lacks voice in health diplomacy and is lagging behind in formulating its country strategy on health diplomacy. As the development of globalization has brought non-traditional security threats like climate change, public health, security and biological terrorism to the fore, it is essential now for countries to join hands in dealing with such issues, most of them respecting no country border. Diplomacy, with its negotiation power, will become an indispensable component in this process. Apart from the requirement of the changing global context, China's larger role in health diplomacy also arises from its own leap forward in national strength. "With greater power, there comes greater responsibility." This is the expectation of the international community, but it will also improve China's own image if it can shoulder more responsibility and be more responsive.

China is also taking a leading role amongst emergent countries, such as Brazil, India, Russia, and India in health diplomacy. The first meeting of the Health Ministers of these five countries took place I July 2011 and the Beijing Declaration, they signed pledging greater technology transfer between their countries to increase the capacity to produce affordable medicine which was hailed as bringing new leadership to global health (UNAIDS 2011).

However, there are challenges ahead. As an emergent country, which is increasingly involved in the world system, China may share more similarities with the international community, especially western countries, than before, but as a developing country it also shares issues and perspectives with many other countries. How to adjust its position to strike an appropriate balance between China's own interest and the interests of the majority of developing countries, how can health diplomacy better serve this balance and maximize both interests, these are issues that China needs to address in the coming years.

Conclusions: Beyond National Interests

It is perhaps inevitable that national strategies for global health should reflect national interests, indeed it could be thought hypocritical if they did not. But achieving agreement and coordination between different government ministries on how national interests in global health should be defined and pursued is difficult in practice and becomes even more complex when other stakeholders are engaged. Nevertheless this process of obtaining cross sector commitment between groups with different perspectives and interests provides valuable lessons for global health governance. It serves to focus attention on the determinants of global health, the actions that can be taken at national level and those that require more concerted global action by nations and international agencies working together. It also provides a practical test bed for applying the concept of global public goods and considering their governance. Thus national strategies for global health can be seen as an important first step in developing national and global commitment to action on global health and its determinants.

Questions

1. Why is it difficult to elucidate national goals for global health?
2. How can the concept of global public goods clarify the debate on global health actions?
3. How are different aims and objectives reconciled in national strategies or plans?
4. Compare the approaches to global health of the EU (Chap. 16), UK (Chap. 19) with that of the USA, China, and Switzerland?
5. What do you think should be the next step for your government in global health policy?

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Chapter 21
Power Shifts in Global Health Diplomacy and New Models of Development: South–South Cooperation

Paulo Marchiori Buss and Miriam Faid

Readers' Guide

South–South cooperation represents an alternative ideal to the model of rich northern countries providing aid to the poor countries of the southern hemisphere. It offers the prospect of mutual advantages for developing and emerging countries as well as a stronger voice in global diplomacy on social and economic issues. This chapter sets out to provide a balanced view of opportunities and challenges of **South–South cooperation**, outlining pertinent questions that emerge from this new dynamic of global governance. In the following sections, we briefly outline the history of **South–South cooperation** and describe its main mechanism and its application to health. We then discuss the paradigm shift from the former bipolar system during the Cold War to today's global multipolar system. We demonstrate how the consolidation of multipolarity is particularly reflected in the (re)formation of regional blocks, notably in terms of their spheres of coordination and their engagement in different **South–South cooperation** mechanisms. The African Union (AU), the Association of Southeast Asian Nations (ASEAN), and the Union of South American Nations (UNASUR in its official Spanish acronym) serve as key examples to illustrate both the current state of **South–South cooperation** and emerging challenges that need to be addressed if **South–South cooperation** is to be effective and viable in the long term.

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Learning Points

- While **North–South cooperation** was characterized by an unequal relationship between donors and recipients, **South–South cooperation** is built on relationships between more equal partners with the objective of mutual exchange and development.
- The principles of **South–South cooperation** were forged at the first Asian-African Conference also known as the Bandung Conference in 1955.
- **South–South cooperation** in health is now seen by some commentators as a viable alternative model to the often highlighted difficulties of **North–South cooperation**.
- New regional platforms have begun to provide increasing opportunities to promote **South–South cooperation**; these include the ASEAN, the AU, and the UNASUR.

Introduction: The History of South–South Cooperation

According to the United Nations Economic and Social Council's recent and most comprehensive report on **South–South cooperation**, Southern contributors are estimated to have disbursed between US$9.5 billion and US$12.1 billion in 2006, representing 7.8–9.8 % of total aid (United Nations Economic and Social Council 2008). While attention is increasingly paid to this model, the origins of development cooperation among developing countries can be traced back to the 1950s. At that time, **South–South cooperation** was an innovative practice established to foster economic cooperation among developing countries; it was influenced by an international system whose structures were shaped by the logic of the Cold War and growing independence movements in colonized developing countries. The two dynamics had a profound impact on the key rationale of **South–South cooperation**, primarily founded on the concepts and practices of "internationalist solidarity" of socialist countries. These countries portrayed **South–South cooperation** as "a mechanism through which countries of the (developing world) would be enabled to overcome dependence on the industrialized nations" (De la Fontaine and Seifert 2010, p. 2). Whereas **South–South cooperation** has a long history, it is only in this new millennium that we see an unprecedented upsurge of **South–South cooperation** on national, regional and global levels, and especially in the realm of global health governance (United Nations Economic and Social Council 2008).

While **North–South cooperation** was characterized by an unequal relationship between donors and recipients, **South–South cooperation** is meant to be different. It is built on relationships between more equal partners with the objective of mutual exchange and development (de Sousa 2010). It therefore presents a viable alternative to the dominant cooperation model that seeks to avoid the same historical mistakes in developing countries and to foster development and thus benefits for all countries

involved. Whereas **North–South cooperation** was primarily founded on the notion of "technical assistance", **South–South cooperation** is based on the concept of "technical cooperation" to emphasize the joint effort of integrating partners in a genuine joint operation in which know-how and strategic orientations are shared in order to improve the work capacity and to foster equitable development (Buss 2009).

The political concept of **South–South cooperation** dates back into the 1950s, when the developing countries united for protection from the practices of the developed countries that were regarded as continuous exploiters and hegemons of the South. At the height of the Cold War, the core principles of **South–South cooperation** were forged at the first Asian-African Conference also known as the Bandung Conference hosted by Indonesia in 1955 (see Bandung, 24 April 1955). These ten principles are set out in Box 1.

Box 1 The Ten Principles of Bandung (the Asian-African Conference, Bandung, 18–24 April 1955)

1. Respect for fundamental human rights and for the purposes and principles of the charter of the United Nations.
2. Respect for the sovereignty and territorial integrity of all nations.
3. Recognition of the equality of all races and of the equality of all nations large and small.
4. Abstention from intervention or interference in the internal affairs of another country.
5. Respect for the right of each nation to defend itself singly or collectively, in conformity with the Charter of the United Nations.
6. (a) Abstention from the use of arrangements of collective defence to serve any particular interests of the big powers. (b) Abstention by any country form exerting pressures on other countries.
7. Refraining from acts or threats of aggression of the use of force against the territorial integrity or political independence of any country.
8. Settlement of all international disputes by peaceful means, such as negotiation, conciliation, arbitration or judicial settlement as well as other peaceful means of the parties own choice, in conformity with the Charter of the United Nations.
9. Promotion of mutual interest and cooperation.
10. Respect for justice and international obligations.

The milestone Bandung conference of 1955 triggered talks between Indonesia, India, Egypt and then-Yugoslavia. The same group agreed to establish the Non-Aligned Movement (NAM) at the Belgrade Conference in 1961. Most of the NAM members also formed part of the Group 77 (G77), which was subsequently established in 1964, that actively sought to integrate **South–South cooperation** into its agenda to "promote developing countries' interests in support of a proposed New International Economic Order" (Cabral and Weinstock 2010, p. 24). The call for the

revision of the dominant international economic system represented a culmination of the joint efforts of developing countries to overcome economic dependency and inequality that were—in the view of the developing countries—manifested in the Bretton Woods System. With these different Southern alliances, the basic framework for the development of political consensuses between developing countries was established (Buss and Ferreira 2010). Their agglomerated influence played a critical role in the establishment of the United Nations Conference on Trade and Development (UNCTAD) in 1964. Following these developments, the United Nations General Assembly in 1972 initiated a Working Group on Technical Cooperation among Developing Countries (TCDC). In 1978, the United Nations Conference on TCDC, held in Buenos Aires, set another essential landmark in recognizing TCDC as an essential part of **South–South cooperation**. The Plan provided the conceptual basis and a practical guide for realizing the objectives that TCDC aimed to achieve (SU-SSC-UNDP 2010). Six years later it was institutionally supported by the UN Special Unit for **South–South cooperation**, whose mandate to this day is "to promote, coordinate and support South–South and triangular cooperation on a Global and United Nations systems-wide basis" (SSC-UNDP 2010). The establishment of this UN division reflected the increasing importance the UN gave to **South–South cooperation**. In 1987, the NAM convened a summit at which the **South Commission** was launched and which was later to become famous for its 1990 report "The Challenge to the South". This highly cited work assessed the South's achievements and failings in development and suggested directions for action, in particular with regards to how exactly developing countries could benefit from globalization. The report was critical in trying to establish a more pragmatic view on fostering more development within the South, elaborating how developing countries could in practice benefit from emerging global interdependencies.

The Emergence of South–South Cooperation in Health

The establishment of the South–South institutions noted in the previous section often dates back decades into the past, but many of these organizations are still actively shaping today's global policy-making processes. The bulk of Southern actors—particularly a large number of **rising states**—still claim to respect and apply the Bandung Principles. What has changed is that the early period of **South–South cooperation** primarily focused on the promotion of economic development, while the policy area of health was at best considered at the margins of Southern development cooperation. However, in but more recent years, approaches to international cooperation in health have evolved. This subsequent integration of policy issues that went beyond the initial primary objective of furthering economic development occurred gradually over time and through the evolutionary establishment of new institutions and/or strategies focusing on specific aspects of **South–South cooperation**.

Thus, while **South–South cooperation** had been increasingly pursued since the 1950s, it was only since the mid-1970s that the Southern countries started to pay more attention

to the component of health in their development cooperation schemes. By 1976, health representatives and coordinators from the non-aligned and developing countries met regularly to develop and discuss their activities in the field of health cooperation (Research Centre for Cooperation with Developing Countries 1987, p. 11).

The end of the Cold War marked a turning point, not only for collective action in the area of health, but also for **South–South cooperation** in general. Developing countries' movements suffered a serious political setback in the context of the end of the bipolar world. A number of developing countries were dealing with financial crises that forced them to approach the Bretton Woods institutions for assistance, "which generally came with the conditionality of binding them firmly with the Washington Consensus" (Kumar 2008, p. 2). Developing countries became progressively interwoven into an increasingly complex international system, but in heterogeneous ways. The consequence for the formerly rather united stance of Southern countries, based on common objectives critical of the developed world, was suddenly no longer shared by all developing countries. Yet, despite these substantial changes, the interest of developing countries in engaging in new ways in **South–South cooperation** was not extinct and was revived with an unprecedented enthusiasm as the dynamics of globalization became apparent in the twenty-first century. The new zeal of Southern countries also captured a vivid interest in development cooperation in areas that previously had been of less interest to these countries. Health now received unprecedented levels of attention in Southern development agendas, a trend that also reflects the **power shift** of health as it gained recognition as an issue of global concern (Alcazar 2008). **Global health**, due to its complex character that touches many governance levels and policy fields (e.g. trade, security, development), has been the focus of a plethora of development initiatives. Many of these still follow the traditional logic of the "rich" industrialized countries seeking to help the "poor" developing countries. But this long-standing dichotomy is changing remarkably in today's world where a considerable number of those countries formerly regarded as "poor" or "third world" have become new regional and global centres of power and influence, both economically and politically (see Khanna 2008; Kickbusch 2009; Alexandroff and Cooper 2010). **South–South cooperation** is reviving to match these geopolitical **power shift**s, to generate better development outcomes for all the partners involved.

The factors leading to an increasing focus on South–South health cooperation were manifold. Economic crisis, debt payment, implementation of structural adjustment programmes and significant political shifts worsened the situation of poverty and inequality for many people in the Southern countries (Almeida et al. 2010). Additionally, the health systems of many developing countries were disproportionately burdened as they struggled with the emerging HIV/AIDS epidemic as well as other fatal diseases (Almeida et al. 2010, p. 25).

Many academics and policy makers have praised today's model of **South–South cooperation** in health, portraying it as a viable alternative model in contrast to the often highlighted difficulties of **North–South cooperation**. This long-time dominant model of international health cooperation has been exclusively provided by multilateral organizations and national agencies from developed countries, and

more recently has been increasingly influenced by philanthropic foundations, celebrity opinion leaders and a myriad of other nongovernmental organizations. All these actors from the industrialized countries have been keen to help poor people in "recipient" countries; despite having the best intentions to help poor populations in the poorest countries in the world, very often these actors impose their own world views, agendas and predefined objectives. On the other hand, some developing countries are frequently seen as unable to organize their national demands, given the lack of coordination between Ministries of Health, Foreign Affairs and other key public and private institutions. As a result of both situations, developing countries often suffer from the highly fragmented and ineffective use of the limited resources available (Buss 2007, 2008a, b).

South–South cooperation in health now aims to achieve four clear objectives, all of them representing a substantial move away from the traditional features of the dominant North–South model, highlighting (Buss and Ferreira 2010):

- A move away from vertical (disease-focused interventions) to the comprehensive development and thus strengthening of the health system.
- An emphasis on long-term instead of short-term needs, i.e. by strengthening key institutions to acquire true leadership, promoting the development of a future-oriented agenda and balancing specific actions with the generation of knowledge.
- A move away from programmes based on a single global orientation towards strategic planning centred on the reality of the "recipient" country by broadly incorporating the social determinants of health.
- A prioritization of population-based (public health-oriented) programmes and activities strictly focused on individuals.

The fourth ministerial meeting of the NAM ministers of health during the 64th World Health Assembly in Geneva in 2011 represents a further step forward. Together, the NAM member states issued a declaration on "Strengthening the International Health System": "Reinforcing global solidarity against pandemics, addressing health systems financing and universal coverage and combating non-communicable diseases" (Non-Aligned Movement 2011). A fifth meeting of NAM Ministers of Health took place during the 65th World Health Assembly in Geneva in May 2012.

Today, South–South development cooperation activities in health have a large portfolio of different mechanisms, including, for example, institution-building, capacity-building, the dispatch of human resources and technology, foreign aid or foreign direct investments. This range of cooperative tools stands in contrast to traditional **South–South cooperation** projects in health, which had been mainly driven by ideological reasons (e.g. China, Cuba, Soviet Republic), whose main **South–South cooperation** activities consisted of the dispatch of medical personnel to developing countries or graduate training of thousands of health professionals (Feinsilver 2008; see Huang 2010). Today we can observe an enlarged scope of development cooperation mechanisms reflecting **South–South cooperation** of a pragmatic nature, with partners seeking to foster economic, political and social objectives. Currently about 20 % of development assistance from Southern

contributors—especially from **rising states**, such as Brazil, China, India, Indonesia or South Africa—has been allocated to the health and education sectors in developing countries (Chahoud 2008; United Nations Economic and Social Council 2008). And yet, although a growth can be observed in the acknowledgement of health within **South–South cooperation**, it is striking that relatively little literature has been published that specifically focuses on South–South health cooperation. While Brazil has recently published academic articles that sketch out how the country understands and implements its guiding concept of "structuring cooperation for health" (Buss 2011; Almeida et al. 2010), only a few historical and mostly descriptive narratives have been published that broach the issue of South–South health cooperation (see: Ruger and Ny 2010; Bliss 2010; Huang 2010).

Multipolarity, Rising States and Its Implications for South–South Health Cooperation

The recent increase in **South–South cooperation** reflects the changing dynamics of today's multipolar global system. This multipolarity can be seen in the substantial redistribution of power that is taking place among different centres of power, with many of them being geographically located in the Southern hemisphere (Khanna 2008; Fidler 2010; Lesage and Vercauteren 2009). As portrayed in the report "Global Trends 2025" of the U.S. National Intelligence Council, the world's environment is characterized by a gradual diffusion of power away from the West, a decay in multilateral institutional governance and the growing influence of new power centres that are increasingly orchestrating global affairs (National Intelligence Council 2008).

It has become common practice to denominate these new power centres as "emerging countries" or "emerging economies", alluding to these countries' accelerated economic growth that is increasingly overtaking many OECD countries. On the other hand, the academic disciplines with a less emphasis on economics find it hard to work with such confined terms. In the social sciences, the most popular attempt so far has been to define these countries as "**rising states**". As Alexandroff and Cooper (2010) suggest, the term "rising state" does not deny the distinctive economic characteristics of these countries but specifically focuses on socio-economic and political features. Khanna (2008) has offered to define these states as second world countries. This term was formerly used to describe socialist countries during the Cold War, but today's second world countries are defined by their common hybrid nature, in that they are both, rich and poor, developed and underdeveloped, post-modern and pre-modern, cosmopolitan and tribal, all at the same time. Such conceptualizations account more accurately for the hybrid realities and the countries' individual experience of self-development, which, these countries suggest, gives them greater insight and legitimacy as partners than countries from the industrialized world.

The rise of **South–South cooperation** has also to be seen in the context of the traditional donors of **North–South cooperation** who welcome this trend, perceiving

the increasing number of Southern development initiatives as acknowledgment from **rising states** of the need to take more global responsibility. The United Nations target is for countries to give at least 0.7 % of their gross national income to official development assistance projects. However, this only applies to states that are full members of the OECD's Development Assistance Committee (DAC) and of these only five countries meet the target.

rising states such as Argentina, Brazil, India, Malaysia, South Africa, Thailand and recently also China have concluded trilateral agreements with traditional donors belonging to the DAC. This is the first example of DAC and non-DAC partners jointly implementing development projects in developing countries. The Development Assistance Committee (OECD) has increasingly sought to strengthen its relations with emerging donors, generating a number of occasions to increase communication and collective action by both traditional and emerging partners. In 2005, a Forum organized jointly by the DAC of the Organization for Economic Cooperation and Development (OECD) and the UNDP brought together for the first time members of OECD/DAC and a wide range of non-OECD governments involved in South–South initiatives, seeking to promote greater dialogue and mutual understanding among the world's principal providers of development cooperation. In addition, in 2009, a Task Team on **South–South cooperation** (TT-SSC), a Southern-led multi-sectoral platform hosted at the Working Party on Aid Effectiveness (WPAEFF) at the OECD/DAC, was created to bring partner countries together with the aim of mapping, documenting, analysing and discussing evidence on the synergies between the principles of aid effectiveness and the practice of SSC (Cabral and Weinstock 2010).

Despite all these developments, we still lack data showing the concrete results of Southern countries' engagement in such development partnerships. Greater documentation of successful development cooperation outcomes could help to answer criticisms of **South–South cooperation** that have recently emerged. For example, critics have noted that the world is experiencing a rising Global North within the Global South (Sotero 2009), speculating that **South–South cooperation** would primarily be guided by **rising states** and their interests. While it is important to respond to such emerging critics, it is also important to note that the different **South–South cooperation** models are very diverse. This is the case not only for the engagement of individual **Rising states**, for example, but also for the various regional blocks worldwide, where integration processes now go beyond the traditional regional cooperation areas of security and economics, to increasingly include other sectors, such as health.

Regional institutions have developed as a response to global challenges that nation-states are no longer capable of addressing on their own. This has led to new modes of regional governance. Such regional platforms have also begun to provide increasing opportunities to promote **South–South cooperation** (Sridhar et al. 2008/2009). The ASEAN, the AU and the UNASUR are illustrative examples; and especially with regards to the latter two institutions, it can be observed that **rising states**, such as Brazil or South Africa, have been particularly active in strengthening regional integration and development through **South–South cooperation** initiatives.

The Association of South East Asian Nations

The ASEAN was founded in 1967 by Indonesia, Singapore, Philippines, Malaysia and Thailand signing the Bangkok Declaration (ASEAN Declaration). The organization was constructed as a political regional organization with an overall aim of ensuring their member states' security and political stability (see Stevenson and Cooper 2009). Since then, ASEAN has expanded to include the countries of Brunei, Burma (Myanmar), Cambodia, Laos and Vietnam. Together, the ten countries have committed themselves to accelerate economic growth, social progress and cultural development and to promote regional peace and stability, to mention but a few primary objectives outlined in the ASEAN Declaration.

Although not explicitly referred to, ASEAN's objectives—especially its aim of maintaining regional security—provided the basis for health to emerge on the organization's agenda first in response to the HIV/AIDS and then in 2003, in response to the immediate public health threat of the SARS pandemic. ASEAN's health security agenda also had a significant impact on what Curley and Thomas (2004) describe as an unprecedented change of the "ASEAN Way". While the traditional regional approach was governed by the belief in non-interference and consensual decision making, there has been a growing recognition in the more recent past that non-traditional security issues can also threaten the stability and prosperity of the ASEAN region. ASEAN member states suddenly had to go beyond their traditional security concepts and consider their response to human security issues (Curley and Thomas 2004). ASEAN responded to the daunting SARS epidemic through a number of high-level meetings and several action points to confront the global public health threat, including the ASEAN + 3 (ASEAN plus China, Japan, South Korea) Ministers of Health Special Meeting on SARS, or the Special ASEAN Leader's Meeting on SARS, which also included the non-member states China, Japan and South Korea, as well as the Hong Kong region of China.

While health security has been an important focus, this approach is too narrow and fails to capture the region's health threats that are not directly linked to the security of state and society. As The Lancet recently noted "Southeast Asia is a microcosm of global health" (Health in South East Asia 2011), with the region "hosting complex animal–human interactions, which has borne the brunt of several emerging and re-emerging infections, coupled with several strains of multi-drug resistant microbes that not only threaten health in the region, but also globally" (Acuin et al. 2011). All these challenges are linked to the need to strengthen the countries' health systems and to formulate and implement cooperation agreements that cover the health-related challenges that are of a cross-border and often regional nature.

The region's growing awareness of the need to include health issues in their cooperation frameworks also reflects the dynamic interface of global health and foreign policy. Several ASEAN countries have become active in global health governance applying sophisticated diplomatic strategies in what has been coined global health diplomacy. Illustrative examples include Thailand's brave declaration on compulsory licensing to produce and import essential medicines and Indonesia's refusal to share samples of H5N1 influenza viruses with WHO, which sparked

heated diplomatic debates about how to balance national with global interests (Pitsuwan 2011; Kuek et al. 2010; Sedyaningsih et al. 2008).

Looking at ASEAN's engagement in regional health cooperation today, the main document that guides its member states is the ASEAN Socio-cultural Community Blueprint (ASCC), which was approved at the 14th ASEAN Summit held in March 2009 in Thailand (Association of South-East Nations 2011). To guide the achievement of the strategic objectives set out in the Blueprint, the member states agreed to establish the ASEAN Strategic Framework on Health and Development (2010–2015) (Association of South-East Nations 2011). This policy reaffirms ASEAN's vision of "Healthy ASEAN 2020" adopted at the 5th ASEAN Health Ministers Meeting, which was held in April 2000 in Yogyakarta, Indonesia. It promoted the vision that by 2020 "health shall be at the centre of development and ASEAN cooperation in health shall be strengthened to ensure that our peoples are healthy in mind and body, and living in harmony in safe environments" (ASEAN 2010). In addition, various ASEAN Working Groups on Health Cooperation have been set up and tailored ASEAN Health Programmes are planned that focus on capacity-building activities, including institutional capacity, laboratories, surveillance, preparedness and rapid response. All these actions are in pursuance of the strategic objectives of health development in ASEAN, including the enhancement of food security and safety, and ensuring access to adequate and affordable healthcare, medical services and medicine, and to promote healthy lifestyles (ASCC Blueprint, 2009: B3, B4).

While ASEAN's attempts to further health in its region are undoubtedly laudable, it is hard to obtain objective and systematic information about implementation cycles of ASEAN's **South–South cooperation** projects, their outputs and their impacts on health development in the region. Scholarly literature has so far been rather loath to identify and analyse ASEAN's different policies and instruments of health cooperation. In an academic account on challenges emerging from state sovereignty and its implications for global health governance in Asia, scholars have suggested that "ASEAN's historic strength as a regional organisation lies in its commitment to political stability, which has been informed by the norm of non-interference by member states. Yet this norm is also its inherent weakness when forced to confront threats to public health rooted in poor governance by the organisation's members" (Stevenson and Cooper 2009, p. 1390). Against this background, it remains to be seen to what extent present and future aspirations for ASEAN's health cooperation policies can be realized.

The African Union

The AU was founded in 1999 by the Agreement of the Sirte Declaration with the objective of accelerating the process of integration on the African continent, to enable Africa to play its rightful role in the global economy, while addressing multifaceted social, economic and political problems (African Union 2009; 2011). As a result, the organization covers health amongst a vast range of other issues that fall

under these broad objectives. AU-agreements on health include: the Abuja Declaration (2001) calling for its 53 Member States to allocate 15 % their national budgets to health; the Abuja Summit on HIV/AIDS in 2005 to reaffirm that commitment; the AUC Strategic Framework 2005–2007, or the Maputo Declaration on Strengthening of Laboratory Systems (2008). One of the recent health milestones has been the Africa Health Strategy 2007–2015 that addresses the main challenges faced by African health systems and outlines a broad strategic framework for African nations to achieve the health Millennium Development Goals. It thereby complements existing national and sub-regional strategic documents (African Union 2007). The broader goal of this strategic document is to contribute to Africa's socio-economic development by improving the health of its people and by ensuring access to essential health care for all Africans, especially the poorest and most marginalized, by 2015. Strengthening the health systems of the African countries is particularly necessitated by the fact that many of their health systems are overwhelmed by the high disease burden and confronted with inadequate human and financial resources. Funding targets both from international assistance and from AU countries themselves are being missed and reflect a long-time priority challenge that was already recognized in the Abuja Declaration 10 years ago, when the importance for AU member states was highlighted to give greater weight to health in the allocation of government revenues (World Health Organization 2010).

Besides the numerous declarations and commitments of the AU member states to improve the state of health in their countries, one remarkable institutional development that has steadily embraced health as a key point of action stands out: the New Partnership for Africa's Development (NEPAD). A development strategy established by Africans for Africans in 2001, the initiative represents a pledge by African leaders to eliminate poverty and to achieve a sustainable path of economic growth and development. Set out as an explicit development strategy, health was initially not a primary focus of NEPAD. The AU/NEPAD strategy entitled "Strengthening of Health Systems for Equity in Development in Africa: Africa Health Strategy 2007–2015" represents a milestone in recognizing the importance of health and its essential links with NEPAD's paramount objective on economic growth and development. This strategic document highlights what is known as the "triple burden" of communicable and non-communicable diseases as well as violence and traumatic injuries and their social consequences in retarding Africa's development (Iluyemi and Briggs 2008). The strategy is formulated as a comprehensive health systems approach, through which improvements in health care and health status are expected to be delivered largely at the country level (Buch 2003).

Africa's poor state of health continues to represent one of the most pressing challenges of the continent to reach NEPAD's overall objective of accelerated economic growth and sustainable development. Whereas NEPAD initially recognized the importance of health improvement only marginally in its development approach, this philosophy has certainly changed. NEPAD has given unprecedented recognition to the state of health in general and health systems strengthening in particular in relation to overall goals of social and economic development. While this strategic development is admirable, it remains uncertain whether and how the causes of

poverty and inequity will be addressed by the AU/NEPAD members in the future (see Labonté et al. 2004). Despite the numerous pledges and discourses that have emerged around health as a prerequisite to the achievement of sustainable development for Africa, tangible evidence of results is still lacking. Academic research and review is required to examine whether and how AU/NEPAD's health strategies have produced measurable improvements in health care and health status at country level.

The Union of South American Nations

The UNASUR represents the most recent regional organization of the South American continent resulting from the merger of the previously separate regional blocks Mercosur and the Andean Community of Nations. In a way, UNASUR can be seen as the result of an incremental process dating back to the initial proposals of a South American Free Trade Organization (SAFTA) and the South American Community of Nations (SACN) in 2000 (Briceño-Ruiz 2010). UNASUR's formal establishment traces back to December 8, 2004, when the Heads of State of 12 South American nations gathered in Cusco, Peru to promote further integration of the continent (Union de Naciones Suramericanas 2011). Two years later, in 2006, this goal was further elaborated in the Cochabamba Declaration, in which the member states pledged to establish solidarity and cooperation in their common search for greater equity, reduction of poverty, curtailed asymmetries and strengthened multilateralism to better assert themselves in international relations (UNASUR Health 2010). At that time, the group was known as the South American Community of Nations (CSN), but renamed on April 17, 2007, as UNASUR—the Union of South American Nations.

The aim of UNASUR is to build, in a participatory and consensual manner, an integration and union among its peoples in the cultural, social, economic and political fields. It prioritizes political dialogue, social policies, health, education, energy, infrastructure, financing and the environment, among other objectives, with a view to eliminating socio-economic inequality, achieving social inclusion and participation of civil society, strengthening democracy and reducing asymmetries within a framework of strengthened sovereign and independent states (Buss and Ferreira 2010). Some analysts consider this regional political bloc the first true balance to the political power of the USA in the hemisphere (Buss and Ferreira 2010, p. 104).

A milestone in establishing health as a focus for UNASUR was achieved on December 16, 2008, when the Heads of State gathered in Salvador de Bahía and created the South American Health Council. Its purpose was to build a common platform for integration on matters of public health, incorporating the efforts and achievements of other regional integration mechanisms, and promoting common policies and coordinated activities among UNASUR member states (UNASUR Health 2010). One year later, their Health Ministers successfully formulated a Five Year Plan (2010–2015) for the South American Health Council, which is composed by the Health Ministers of the twelve UNASUR

member states. The Council's health agenda prioritizes five work areas of common action, consisting of the establishment of a South American Health Vigilance & Response Network, the development of universal health systems, the provision of universal access to medication, the promotion of health and to tackle its social determinants, as well as the development and management of human resources in the field of health.

Another essential initiative aimed at fostering **South–South cooperation** in health was the agreement of the UNASUR member states to establish the first South American Institute of Health Governance (ISAGS in its Spanish acronym). Since all initiatives outlined in the UNASUR Health Agenda depend on management capacities, leadership skills, the quality of advanced training, knowledge production capabilities and health and intersectoral policies, ISAGS was developed to help South American countries train the future heads of health systems (Buss and Ferreira 2010, p. 107; Instituto Suramericano de Gobierno en Salud 2012). Another important mission of the new institution is to manage the existing knowledge, as well as to produce the new knowledge necessary to fulfil its goals, jointly with relevant social and political actors of the social and health spheres of the region (Buss and Ferreira 2010). The Institute is owned by all UNASUR member states and is headquartered in Rio de Janeiro, Brazil (see www.isags-unasul.org).

The UNASUR Health agenda and structures present unprecedented opportunities to improve health and health systems in the Latin American region. Most UNASUR countries have been exposed to a new approach to health that sees it as a product of local and global social determinants and locates health at the interface of domestic and foreign policy. Brazil has been particularly active in the field of global health and foreign policy through other **South–South cooperation** mechanisms (e.g. IBSA, CPLP, see Buss and do Carmo 2009; Almeida et al. 2010), alliances (Oslo Declaration Group 2007) and in global health negotiations (e.g. FCTC, see Alcazar 2008; Lee et al. 2010). These experiences have reinforced Brazil's understanding of health as a complex, intersectoral good that transcends the traditional concept of public health, being seen as increasingly relevant in former non-health governance areas such as: security, trade and development. Such perspectives and experience can be shared with other UNASUR members to eventually consolidate a shared South American understanding of public health as contributing to everyone's well-being and development.

With the establishment of ISAGS, UNASUR has achieved one of its most promising institutional initiatives for South–South health cooperation. In order for health development to flourish within and between its member states, current challenges in the UNASUR region, particularly on country level, still need to be addressed. For example, one challenge that has been highlighted in a recent publication is: "(t)o further improve Brazilian international cooperation in health, many of its institutions need to be harmonized and a law is needed for international cooperation by the National Congress that can define new concepts and provide mechanisms to improve the country's international efforts" (Buss 2011). National efforts to address similar barriers in other countries of the region are therefore more important than ever if South–South health cooperation is to succeed in the UNASUR region.

Conclusions: Opportunities and Challenges in South–South Health Cooperation

Over the last decades, and most notably in this twenty-first century, **South–South cooperation** has evolved into a more comprehensive development structure that not only seeks to foster economic benefits within the South but also contributes to social and political development. While a number of **rising states** are increasingly becoming engaged in South–South development cooperation projects in developing countries, regional integration processes have also provided support for **South–South cooperation** to flourish in defined regional spaces. Countries have adopted more integrated policy approaches to health and development in response to emerging concepts and as a product of **South–South cooperation**. Cross-country collaboration and regional structures usually emerged with the aim of addressing high disease burdens or to improve inadequate health systems.

The recent increasing attention the international community has allocated to health especially on the global level due to its cross-sectoral character has also positively influenced countries to promote health integration through institutions at the regional level. **Rising states** such as Brazil, Indonesia or South Africa have been notably active in this trend, while even countries without a current membership status in the most prominent regional organizations have approached such institutions in order to ensure health for its citizens, as the case of China in its closer engagement with ASEAN demonstrates. Many regional institutions have expanded their health agenda to embrace initiatives that go beyond immediate threats to health, promoting for example, structural cooperation for health through better health infrastructures. But many commitments to such initiatives still need to be implemented, so it remains difficult to analyse their impact. While these developments are potentially fundamental to improving health for all, we also observe that to date there has been a lack of active civil society involvement in such initiatives (see Buss and Ferreira 2010).

While **South–South cooperation** is thriving in international development practice, it is a concept that most scholars find difficult to grasp. Most recently, scholars have pointed out that the contemporary South–South geography includes asymmetries of economic and political power that have so far not been adequately taken into consideration when discussing the respective collaboration between **rising states** and developing countries (De la Fontaine and Seifert 2010). Such a discussion must be avoided as **South–South cooperation** undoubtedly represents a foreign policy instrument (Betancourt and Schulz 2009).

As signatories to the Oslo Ministerial Declaration, **rising states** such as Brazil, Indonesia, South Africa and Thailand joined with other developed country partners to stress the essential links between health and foreign policy. These countries commit themselves to ensure that foreign policy serves health objectives (Oslo Declaration Group 2007). According to its signatory states, foreign policy should actively seek to further health for all. **South–South cooperation** is undergoing an exciting revival among **rising states** and developing countries; it represents a new

way of integrating foreign policy with health goals that promises to generate considerable socio-economic benefits for the all partner countries involved. This provided the basis for several consecutive UN General Assembly Resolutions on Global Health and Foreign Policy (http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N08/472/77/PDF/N0847277.pdf?OpenElement; http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N09/468/31/PDF/N0946831.pdf?OpenElement; http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N10/518/24/PDF/N1051824.pdf?OpenElement; http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N11/465/72/PDF/N1146572.pdf?OpenElement) which were adopted during the last four years. This represents a significant step forward in the field of global health governance and raises expectations for increasingly concrete achievements in the future.

Questions

1. What is the connection between foreign policy and health in **South–South cooperation**? What consequences does it have?
2. Is it useful to make a distinction between developing countries and **rising states** when discussing the topic of **South–South cooperation**? Why?
3. What factors can explain the re-emergence **South–South cooperation**?
4. What impact will **South–South cooperation** have on **North–South cooperation**?
5. Do you think that the increasing importance **South–South cooperation** represents only a passing phase that is bound to diminish eventually?

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Chapter 22
The Copernican Revolution: The Changing Nature of the Relationship Between Foreign Policy and Health

Santiago Alcázar

Readers' Guide

This chapter reflects on some basic questions about the relationship between health and foreign policy. The focus is on how our understanding of these issues has evolved. Conceptions of foreign policy in the period between the two World Wars were very different from current thinking. The same can be said of health: the biological conception of health that prevailed at the beginning of the twentieth century is far removed from the modern view, with its focus on the social determinants of health. The purpose of this chapter is to show that the insertion of health in foreign policy, as an independent non-subordinated object of negotiation produces a radical shift that has to be taken into account. This constitutes a change in perspective in the way of thinking about foreign policy. The change in perspective may be called a ***Copernican Revolution***.

Learning Points

- "Copernican Revolution" and "paradigm shift" are sometimes used interchangeably, although the former may suggest a simple change in perspective whereas the latter seems to imply a profound change in the conceptual framework.
- The **Copernican Revolution** in multilateral conceptions of global health is demonstrated by the Global Strategy on Public Health, Innovation and Intellectual Property, adopted by the World Health Assembly.

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- There is a fundamental difference between the perspective of health seen as a fragmented, **attached** and subordinated issue to the view of health now adopted in the field of foreign policy, as an objective to which other policies have to adjust and address.

Introduction: Copernican Revolution and Paradigm Shifts

The expression **Copernican Revolution** comes from the sixteenth century work *De Revolutionibus Orbitum Coelestium* (Of the Revolution of Celestial Spheres), by the Polish astronomer Nicolaus Copernicus. In it, the heliocentric view of the cosmos replaces the traditional geocentric system that had prevailed since the time of Aristotle and was further developed by Claudius Ptolemy.

The change in perspective may seem merely diametrical and interchangeable, as when one switches the colours in a chessboard, with no further consequence. But it is not. It can be shown, for example, that in the Ptolemaic system the phases of the planet Venus vary from new to half, it being impossible to see more than that, whereas in the Copernican system the full range of phases, from new to full, can be observed. It was only in the early seventeenth century that Galileo saw this with his newly constructed telescope. The change in perspective reveals new insights and discoveries.

Thomas Kuhn, in his influential work *The Structure of Scientific Revolution*, explains the nature of scientific revolution as a paradigm shift. When something cannot be explained by the standard scientific view, there is an anomaly. The growing number of anomalies throws the standard theoretical framework model into a crisis—or a turning point—from where it can continue on a different path only if one accepts a paradigm shift, a new way of thinking that enriches the set of acceptable explanations and smooths away the anomalies.

The transition from Newton's worldview to that of Einstein's relativity worldview and the transition from classical mechanics to that of quantum mechanics are examples of what Thomas Kuhn called paradigm shifts in science. What is involved here is more profound than what may be suggested by an interchangeable perspective, as in the colour switching on a chessboard, or to the shift from the Earth-centred to the Sun-centred system. It is an entire theoretical framework—a paradigm—that is changed and carries with it the fundamental concepts of understanding.

Copernican Revolution and *paradigm shift* are sometimes used interchangeably; the former may suggest a simple change in perspective, whereas the latter seems to imply a profound change in the conceptual framework. It is the simpler change in perspective that is brought about by the insertion of health in foreign policy that we will try to follow.

Foreign Policy and National Interest

In simple terms, foreign policy may be conceived of as a set of strategies adopted to safeguard national interests. The problem with this definition, however, is that it leaves one in the dark with respect to the meaning of national interests. What is meant by national interests may vary from one country to another. Geography and history are some of the factors that determine what is meant by national interest at a certain place and at a certain time. The need to defend itself from warring neighbours may at one point in time determine what is most important for a given community. At a later stage, the dominant factors may need to foster its trading advantages and to protect its merchant ships. At still another time, education may become a national priority. Geographical proximity to thoroughfares changes, for example as the importance of the Mediterranean in global trade, was overtaken by the Atlantic and later by the Pacific. Scarcity of natural resources at one time can be overturned by abundance in the next, as demonstrated by the discovery of petroleum in Saudi Arabia. Switzerland's landlocked isolation in the nineteenth century is hardly recognizable from today's Geneva, hosting a plethora of international organizations that help define world politics. The fluid changes of circumstances, both geographical and historical, suggest that it is not possible to define national interest once and for all. It is perhaps better to group in a cluster all the different policies that may be considered of central importance for a nation at one time.

General Charles de Gaulle once said that *no country without an atom bomb could properly consider itself independent.* This quote is useful because it puts in a nutshell what, from De Gaulle's perspective, is the national interest—the pursuance of independence—and how it is to be achieved—through the production of atom bombs. In that context, foreign policy is given a definite direction. The search for economic prosperity, trade and development, security, stability, ideological goals, language and cultural values, among others, may all be seen as part of the objective of assuring and sustaining that concept of independence, and, as such, may be included in De Gaulle's cluster of France's national interest at that time. Those same elements are generally to be found in any national interest cluster, although with different objectives and orientations. Thus for France at that time achieving nuclear capacity may have galvanized a nation's energy in a way that orients all the elements of the **national interest cluster** to work towards that defined objective.

The health of its own people should be among a nation's highest priorities and may be therefore considered an important element in the national interest cluster. But is it a foreign policy priority? It is interesting to observe that in examining foreign policy, security, stability, economic prosperity, trade and development, ideological goals, language and cultural values may all be considered priorities, but seldom, if ever, is this the case with health, at least not until very recently. Why is this? The reason may lie in the way health is perceived.

A Fragmented Perception of Health

There are many ways to understand the concept of health. One of the simplest and most common perspectives is in relation to communicable or infectious diseases. The WHO defines infectious diseases as those that are caused by "pathogenic micro-organisms, such as bacteria, viruses, parasites or fungi". In most developing countries, at the beginning of the twentieth century, health services were organized to control each of the many infectious diseases in a specific manner. The result called to mind a vertical structure as opposed to a horizontal one. The obvious flaw of a health system organized in a vertical manner is that the concept of health becomes fragmented, meaning that it lacks a transversal character.

What are the consequences of such a system in relation to the inclusion of health among the priorities of foreign policy?

One answer to this question relates to the WHO definition of infectious disease and the appreciation that those diseases "can spread, directly or indirectly, from one person to another". Why is this important for foreign policy? In case of an outbreak, the first logical sanitary measure is to contain the disease and the second to control its spread. Both sanitary measures require foreign policy decisions and actions. On one hand, disease containment is important for foreign policy in its relation to trade as its purpose is to minimize interference with the normal flow of goods. On the other hand, disease control is also important for foreign policy in its relation to national security as its purpose is to avoid the breakdown of government structures that could eventually result from the uncontained spread of an infectious disease. Therefore, the inclusion of both sanitary measures into foreign policy derives their importance from the clusters of trade and national security. In each case, it is not health per se that is the focus, but the impact of health on trade and to security.

As long as the health system retains its vertical character, it remains fragmented; and as long as it remains fragmented, it cannot hold its ground autonomously and be on par with the other priorities of foreign policy. Health has to be detached, from trade and national security, among others, so that it can become a vector for foreign policy.

In addition, fragmentation does not allow for a foreign policy that has health as its point of departure. The sanitary measures of disease containment and disease control must associate themselves with the foreign policy priorities of trade and national security of the developed country, not of the developing country. It is not that disease containment and disease control are not important for developing countries, only that they do not find a natural place in their respective foreign policy. This is one aspect of the asymmetry in north–south relations.

From the point of view of a developed country the fragmented concept of health may be useful for foreign policy purposes. The reason is that it is much simpler and less costly for them to search for solutions to specific health problems, and in finding them, to benefit from the recognition, rather than to engage in development.

Malaria is a good example to demonstrate this. It is a life-threatening disease. According to the WHO, malaria caused an estimated 655,000 deaths in 2010, mostly among African children. A cooperation program to address malaria in an African country is designed by a developed country in view of its foreign policy. Mosquito

nets and a set of medicines may be donated through the cooperation program. In the meantime, pharmaceutical companies in the developed country may be in the process of finding and marketing a vaccine for malaria. If such a vaccine is found, malaria would cease to be a source of major concern for African health authorities. But, would this be a satisfactory solution to the malaria problem in the African country? Certainly not, because the suggested solution would only partially solve a more complex situation: Only the biological causes of the disease would have been addressed, leaving untouched all its social determinant roots. The same sordid conditions that fostered malaria would still exist, probably leading to other diseases. The only difference being that the targeted population would be free from the specific pathogenic effects. From the developed country's foreign policy perspective, there may be a sense of mission accomplished, but the health inequalities of the north–south divide would still remain.

The fragmented notion of health also means that health needs to be attached to foreign policy objectives, which has not been done until recently. Health is, therefore, subordinated to the national interest cluster as defined earlier. From this perspective, health is a subordinated objective that leaves the policy-making process untouched.

It is for that reason that the fragmented notion of health is so useful for foreign policy. An example of how fragmentation and attachment can affect health policies may be seen in the neoliberal reforms that swept away entire public health systems in developing countries (see for example the recommendations of the 1993 World Bank Report). The Burkinabe historian, Joseph Ki-Zerbo, in an interview with René Holenstein, gives a vivid picture of this situation as he experienced it in Burkina Faso:

Box 1 The Impact of Neoliberalism in Burkina Faso

La Banque Mondiale et le FMI poussent les pays africains à des privatisations qui sont basées sur le principe du profit individuel. La politique de privatisations a totalement bouleversé notre système de santé. Je prends le cas des médecins de l'hôpital principal de Ouagadougou. Tant que le système était étatique, les médecins consacraient tout leur temps aux malades. L'État mettait suffisamment de moyens dans le budget social pour créer les conditions de travail susceptibles d'intéresser les médecins. Mais à partir du moment où la Banque Mondiale a proposé au gouvernement de privatiser le système de santé, il fallait la rentabiliser. Le gouvernement a comprimé les budgets de la santé sur ordre de la Banque mondiale. La privatisation consistait à s'orienter vers un transfert des hôpitaux publics à l'hospitalisation privé, si bien qu'il y a eu un rush pour constituer des cliniques. Aujourd'hui, les médecins renvoient purement et simplement les malades à leurs propres cliniques quand ils viennent les voir à l'hôpital. Mais les cliniques sont absolument inaccessibles aux pauvres, les frais des soins y étant beaucoup plus élevés. Si vous entrez à l'hôpital, tout est payant, pour y entrer comme pour en sortir d'ailleurs. Les soins terminés, si vous ne payez pas, vous ne sortez pas de l'hôpital. Bientôt, la santé sera un bien réservé aux seuls riches: un bien privatisé (Ki-Zerbo 2003).

Fragmented and attached to the economic principles of neoliberalism, health follows the logic of that to which it is attached, not its own logic. The same would happen if health was attached to any other policy field, to security or to trade, for example.

Box 2 Negotiation of the IHR: Risk to Health or Threat to Health?

In the negotiations of the International Health Regulations (IHR) an attempt was made to adopt the expression "threat to health" instead of the usual "risk to health". While the latter is akin to public health and to the WHO, as it expresses a possibility of loss or harm, the former conveys, in addition to possible loss and harm, the idea of intentionality, which is foreign to both public health and to the WHO. If successful, that attempt would logically result in an eventual translation of the IHR from the WHO to the UN Security Council, which would be the height of folly.

To be attached to something, in this sense, means the same as to be subordinated to something. To be attached to the economic principles of neoliberalism means the same as to be subordinated to it. To be attached to security or to trade means the same as to be subordinated to security or to trade, and so on. If we consider the fragmented notion of health in Brazil in the early part of the twentieth century, the main concern was with the containment and control of, say, yellow fever, in order to prevent disruption of commerce and the spread of that disease. In that case, health was subordinated to commerce and security, and the other elements contained in the national interest cluster that demanded action from the health sector to curb that specific public health risk. Health therefore took its orders from commerce.

The Copernican Revolution in Health and Foreign Policy

A restricted Copernican Revolution in the conception of global health would invert the relation between health and commerce; as a consequence, commerce would have to take its orders from health. A general Copernican Revolution or paradigm shift would invert the order of the relation of health to, say, the economy, or to security or to any other element contained in the national interests cluster.

Box 3 A Copernican Revolution: Who Gives the Orders?

The expression "to take its orders from" must be understood here in the sense that may be applied in General Relativity to depict the idea that "spacetime tells matter how to move" and that "matter tells spacetime how to curve". In that sense, commerce, at the centre, as a sun, tells fragmented and attached health to move round it. In the Copernican Revolution an inversion is proposed by which the full significance of health, as a sun, tells the economy, trade, security and whatever else how to move.

In August 2008, the WHO Commission on Social Determinants of Health issued its first report. In it we learn that:

> the social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.

It is interesting to note that this concept is incompatible with the fragmented notion of health. It is not sufficient to attack the biological causes of infectious diseases and develop life-saving vaccines. It is necessary to search for the set of conditions that define the social determinants, and, by modifying them, attain the WHO definition of health: "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This makes it clear that health can never be attained by a fragmented approach that does not take into consideration the full concept of sustainable development in all its ramifications. It is in this sense that health cannot be fragmented and **attached** and subordinated to other interests. It is in this sense that a Copernican Revolution becomes necessary.

A sense of that necessity was already building when, at the end of 2008, a financial crisis of epic dimension swept away faith and confidence in the ability of market-oriented decision makers, sending in its wake shockwaves that swept through the conditions that shape the social determinants of health. As a reaction, Dr Margaret Chan, Director-General of the WHO, delivered a speech at the United Nations General Assembly Panel on globalization and health in 2008 highlighting the impact on health of blind one-sided policies:

> We meet at a time of crisis. We face a fuel crisis, a food crisis, a severe financial crisis, and a climate that has begun to change in ominous ways. All of these crises have global causes and global consequences. All have profound and profoundly unfair consequences for health. Let me very clear at the start. The health sector had no say when the policies responsible for these crises were made. But health bears the brunt.

What was set out here was that health should have a say when policies are decided and executed, or, more forcefully, impact on health should be the point of departure in the making of policies, not a point of arrival at which it has nothing to say but still bears the brunt. A group of foreign affairs ministers had already taken that view when they adopted, in 2007, the Oslo Declaration on Global Health. Recognizing

global health as a pressing foreign policy of the time, they agreed to make impact on health a point of departure and a defining lens to examine their respective foreign policy and development strategies. Although the Oslo Declaration focuses on foreign policy, the concept of impact on health, in its Copernican revolutionary meaning, applies to any policy that may have an impact on health, domestic or foreign, or multilateral.

An example of the Copernican Revolution in domestic legislation is Brazil's Constitution which states that health is a universal right and a duty of the State that shall be guaranteed by social and economic policies. A universal right to health means that all levels of health must be assured by the State, from low-complexity interventions, such as the ones found in primary health care, to medium-complexity treatments and elective surgery, to highly complex treatments. Approximately 25 % of the Brazilian population are privately insured and may also make use of the public health system, especially in cases where the private insurance does not cover highly complex treatment and emergency surgery. The duty of the State is to guarantee that universal right by the adoption of policies that are tuned to the needs of health. In this context, policies take their orders from health.

The Copernican Revolution in multilateral conceptions of global health is demonstrated by the Global Strategy on Public Health, Innovation and Intellectual Property, adopted by Resolution WHA61.21 of the World Health Assembly. This espouses the principle that "WHO shall play a strategic and central role in the relationship between public health and intellectual property and the one that establishes that intellectual property has to be managed and applied in a manner oriented to the needs of public health". The cited words are similar to orders that must be observed in the Copernican Revolution. Health tells trade how to bend.

Another example in multilateralism is: Resolution 63/33—Global health and foreign policy—which the United Nations General Assembly adopted by consensus in January 2009. The first two operative paragraphs recognize "the close relationship between foreign policy and global health and their interdependence (…)" and urge "Member States to consider health issues in the formulation of foreign policy". It is quite extraordinary, for, in a sense, that Resolution recognizes the Copernican Revolution as it embraces the spirit of the Oslo Declaration and, in so doing, adopts its health lens concept through which one has to measure the appropriateness, from the health perspective, of political decisions in other fields.

A further example of the Copernican Revolution in multilateralism is demonstrated by the Doha Declaration on the TRIPS Agreement and Public Health (Box 4).

Box 4 The Doha Declaration the Detachment of Health from Trade

The Doha Declaration on the TRIPS Agreement and Public Health responds to the concern of developing countries that "nothing in the Agreement can prevent a member State to take measures to protect public health". That principle was incorporated in the TRIPS Agreement after a lengthy negotiation. It is in that context that is legitimate to say that the Declaration detaches health from trade.

Health as an Objective and Point of Departure

There is a fundamental difference in perspective when one takes health from its fragmented, attached and subordinated position to the one it now occupies in the field of foreign policy, as an objective to which other policies have to adjust and orbit. How different this is from when economists, from their ivory towers of illusions, would advise governments to invest in growth before addressing the social agenda, and in the process still sacrifice the subordinated objective of health.

It is important to realize at this point that if health is going to have a say in the formulation and execution of foreign policy; if it is also going to be a point of departure and a defining lens to examine foreign policy and development strategies; if it is going to be part of foreign policy, not as something fragmented, attached and subordinated, but as an independent object capable of influencing and orienting the other objects in that cluster, as required by the Copernican Revolution, then there has to be a fundamental change in the nature of foreign policy. In other words, the insertion of health in foreign policy, in this sense, changes foreign policy. Health detached would have attached to it the other elements of the foreign policy cluster. Is this possible?

Take the case of security—perhaps the most recognized element of the national interest cluster. In the 1994 UNDP Report on Human Development, Mahbub Ul Haq and Amartya Sen expressed the view that "for too long security has been interpreted narrowly: as security of territory from external aggression, or as protection of national interests in foreign policy or as global security from a nuclear holocaust. It has been related more to nation states than to the people" The two great economists then propose that the notion of security may be extended to other areas, thereby producing economic security, food security, health security, environmental security, personal security, community security and political security. With the sole exception of food security, none of the others have a consensually adopted definition. The 1996 World Food Summit adopted the Rome Declaration on World Food Security, later embraced by the United Nations and the WHO. In it, food security is defined as the state when "all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life" (FAO 2010). If one uses that definition to adapt it to health, one may come up with something along the following lines: "health security" would be attained when all people, at all times, have physical and economic access to health, meaning everything from health promotion, to health protection and to health recovery, in any level of complexity. It should be accepted that obstacles to health, whether physical or economic or of any other nature, have to be addressed and overcome. This definition was indeed circulated by the delegation of Brazil during the WHO 122nd Session of the Executive Board in preparation for an informal discussion on the use, by the WHO, of a loosely defined concept of "global health security". However, that informal discussion never took place. The definition of "health security" makes perfect sense from a health perspective and it is one that should be adopted by the WHO if the references to health it contains are to be understood in light of that Organization's definition of health.

The definition of health security encompasses the idea of food security, since there can be no health security without food security. In this context, health security is a central concept, a point of departure and a defining lens, which takes on board the social determinants of health and lays out the road map for the attainment, in particular, of the Millennium Development Goals, as stated by the Ministerial Declaration of the Economic and Social Council (ECOSOC) high level segment of July 2009 or, in a more general way, the development strategies aimed at eradicating poverty.

If health security can be seen as an example of a fundamental change in the making of foreign policy, it is not the only one. Another example of attachment to health comes from economy and trade, specifically through the Framework Convention on Tobacco Control (FCTC). Tobacco is big business, or used to be. In many countries it was deeply interwoven into national economies, providing employment and important revenues for investors, as well as for national governments in the form of taxation. We know today, indisputably, that tobacco kills, but, back when it reigned undisputed, it would be unthinkable that an industry with such impressive credentials could be the object of governmental measures to reduce supply. On the contrary, governments would naturally support advertising of its products to increase demand as an important part of a commercial strategy aimed at strengthening the economy. To speak up against the supply of tobacco products could be rightly interpreted as counter-propaganda aimed at sabotaging the economy and a threat to a government's stability. This was natural in an environment dominated by the economy, where health, at best, could be attached to something other than itself. It had to be different if it was the other way round; if the economy was attached to health on the principle that tobacco use constitutes a public health risk. Unlike the UN drug control agreements—designed to control the supply of drugs—the FCTC would be demand reduction-oriented. To treat a public health risk in this way requires a mindset change in the relation between the economy and health, which is exactly what the Copernican Revolution, through the workings of health promotion, is all about. And health promotion, in turn, is part of an "unfragmented" and **unattached** notion of health. In other words, the FCTC would be impossible under a fragmented, attached and subordinated notion of health, and this may be interpreted as a change in the nature and the making of foreign policy.

There is yet another aspect of the change brought about by the insertion of health in foreign policy, which is perhaps more profound although perhaps less noticeable. The concept of health alluded to here is not merely as a biological condition but the result of a complex maze of interrelated policies supporting to the general well-being of human beings. It is essentially an irradiation of human values: saving lives from the medical standpoint, of course, but also, and most important, dignify the human condition through the adoption of policies that take health as their point of departure. But at this point it is important to realize that reference to health only makes sense when it is implied that what is meant is the health *of*, of someone or of a population, as is conveyed by the meaning of public health. In this context, it is the people, not health, which should be the point of departure and the defining lens

for the making of policies and development strategies that impact upon the lives of people. Health, in that context, is only the instrument that brings about the Copernican Revolution that echoes the much stronger words that "the Sabbath was made for man, not man for the Sabbath". It is in that sense, placing people at the centre, that health can be seen as a celebration of human values present in the human rights provisions that ensure universal right to social security, to work, to a standard of living adequate for health and well-being and to education, which is really the flame needed to illuminate the WHO's health definition; or to highlight the structural transformations suggested by the concept of the social determinants of health or; again, to meet the Millennium Development Goals.

There is no denying that the insertion of health in foreign policy has produced a change, from the perception of the economy and security as the central *raisons d'Etat* to the perspective of human solidarity brought about by health and also by a host of other issues and policies associated with it, such as the fight to end poverty, the movements to arrest social exclusion, discrimination and alienation, and the growing empowerment of women. It would be hard to justify any of these in a foreign policy not influenced by the moral arguments brought about, although perhaps not exclusively, by the insertion of health in foreign policy.

Box 5 Human Values in Foreign Policy

The recognition by States of past wrongdoings may have nothing to do with health or with foreign policy. The 1990 acknowledgement by Mikhail Gorbachev of the Katyn killings of the Poles by the Soviets was a foreign policy act. It was a decision made possible by *Glasnost*, which opened the possibilities for the recognition of human values. Contrast this with the 1992 acceptance by Pope John Paul II that Galileo's view on the heliocentric system is correct. Discours du Pape Jean-Paul II aux participants à la session plénière de l'Académie Pontificale des Sciences, 31 October, 1992, in http://www.vatican.va/holy_father/john_paul_ii/speeches/index.htm. Note that in that speech, however, the Pope does not apologize for any wrongdoing committed by the Church. Is this a foreign policy decision? Is it a recognition of human values? In the wake of the financial crisis that hit the world at the end of 2008, President Barack Obama referred to the "sense of irresponsibility that prevailed from Wall Street to Washington". Can you think of any other example similar to this one? It may be that today's widely accepted disposition to effectively control the shadowy banking and financial systems that seems to signal a salutary departure from the unsustainable credo that all that matters is how much is there to win is also a broadening of the perspective from where policies in general, and foreign policy in particular, are made.

Conclusion: Health in Foreign Policy Has Achieved a Copernican Revolution

A distinctive characteristic of the change illustrated by the acceptance of health in foreign policy is the common use of moral arguments in developing countries' recent foreign policy discourse. If it is true that, in the past, there was no arguing against hard power, it has become true today that there is no arguing against the soft power of a sound moral argument. The moral argument was used to take forward the Doha Declaration on the TRIPS Agreement and Public Health at the WTO, which is a forum not exactly prone to that line of reasoning, and it may even have been used in the formation of the G-20 developing nations in the 5th WTO Ministerial Conference. Strangely enough, moral arguments had to be used in the negotiations that lead to the adoption of the FCTC and to the Global Strategy on Public Health, Innovation and Intellectual Property, in a forum where that line of reasoning should be common currency.

It may be arguable that the insertion of health in foreign policy is the key factor that has to be considered in examining the change in nature of foreign policy, but it is certain that health, in the sense suggested here, instructs foreign policy to broaden its perspective and to seriously consider issues and policies in the light of a discourse on human values previously unconsidered, ignored or simply not heard of.

A Copernican Revolution in the relationship between health and foreign policy has seen health transformed from an attached, fragmented and subordinated condition among the elements that comprise the national interest cluster, to an unattached objective to which all the other elements of that cluster are subordinated. Indeed, health brought about a Copernican Revolution in the relationship between health and foreign policy.

Questions

1. What is foreign policy?
2. What is health?
3. Is it legitimate to say that there is a relation between foreign policy and health?
4. Has health always been a part of foreign policy?
5. If this is not the case, what historical circumstances favoured the entry of health into foreign policy?
6. What is the nature of the relationship between foreign policy and health?
7. How has it changed, if at all?

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Glossary

Introduction

This glossary provides a brief working definition of key terms used in the book. Some of these terms are subject to different interpretation and elaboration depending upon the context. Links to further glossaries on related topic are included at the end of this section.

Academic and professional networks These may be formal or informal groups of members usually established at national and international levels that recognize the special expertise of members to contribute to the development of knowledge and sharing of good practice in a particular field. Professional associations claim the right to participate in the regulation of their own members' practice due to their shared knowledge and ethics (see Chap. 18).

Accountability Refers to the obligation of an individual or organization to account for their activities and accept responsibility for them by disclosing the outcomes to the public in a transparent manner. It a key aspect of public governance, requiring the acknowledgment of responsibility for actions and disclosure of their impacts, it applies to international and governmental agencies and officials as well as civil society and private sector organizations. International civil society organizations and networks may be crucial in holding other agencies to account (see Chap. 5).

Advocacy Is the active support of a cause or policy, perhaps reflecting the human rights of a particular group, e.g. people infected with HIV. This may include the formulation of moral and ethical arguments as well as gathering factual evidence to support a particular course of action. Advocacy may also include empowering the group in question to voice their needs and public diplomacy (see later) to engage public support for the particular cause as well as targeted approaches to key actors (see Chap. 6).

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Aid effectiveness Is effectiveness in achieving development and/or health targets, which should be set out prior to the disbursement of aid. Aid effectiveness is not just about how much aid is disbursed, but how it is done, avoiding corruption, duplication of effort or other negative impacts and achieving outcomes as effectively as possible. This is recognized by OECD's Working Party on Aid Effectiveness and has become a critical issue for global governance in response to the increasingly fragmented development aid landscape. It addresses of issues such as aid transparency and mutual accountability of donors and recipients (see Chap. 5).

Alignment of interests In diplomacy it is often useful to identify the actors whose interests most closely coincide. Then at an early stage a preliminary discussions can find a way of expressing the position that these parties share, this process is referred to as the alignment of interests. This may be done by advocates for a particular policy, e.g. the Framework Convention on Tobacco Control. Conversely it may also help to identify the factors which cause other actors to adopt different positions, for example tobacco-producing countries and cigarette manufacturers may object to actions to limit smoking. This process may simplify subsequent negotiations by identifying interest groups and issues to be addressed (see Chap. 6).

Attached and unattached objectives Santiago Alcázar uses these terms to refer to objectives such as improvement of global health that in the past have been seen as attached and therefore subordinate to or dependent upon national interests. Thus global health seen as an attached objective would be seen as one aspect of national interests that may be overridden by other concerns. When the same objectives are seen as unattached and therefore independent of other objectives they may be seen as ends in themselves (see Chap. 23).

Binding and non-binding instruments International treaties and agreements may specify sanctions in international law in the case of a breach of the agreement. In this case the agreement or those parts referring to such sanctions may be regarded as binding. Other agreements may be less explicit with regard to international legal sanction but may imply a moral obligation to the observance of the agreement, this may be said to apply a non-binding instrument. While this may imply that a binding instrument is stronger or "harder" than a "soft" non-binding instrument in practice the distinction is not so clear (see Chap. 4).

Biomedical model Is a model of medicine, which is predominantly used by physicians since nineteenth century. It focusses on physical causes and processes of disease, based heavily in the study of pathology and biochemistry. It therefore ignores social factors such as poverty, ignorance and social exclusion as determinants of health (see Chap. 10).

Civil society Refers to the process through which individuals negotiate, argue, struggle against or agree with each other and with the centres of political and economic authority and through which voluntary associations, movements, parties, unions, the individual is able to act publicly. The precise scope of the

term civil society varies but most common usage excludes private sector businesses and formal local government organizations (see Chap. 18).

Civil society organizations Civil Society is supported by a wide range of different types of organizations including: Faith-Based Organisations (FBOs), Health NGOs, Patient and Community Health Organisations, Academic and Professional Networks and Foundations. Their scope can range from local to global. At the local end of the spectrum Civil Society groups may be more informal in nature, based in local communities, such as youth groups or women's groups or groups bound by common interests such as child health, cooking or religion. At the other end of the spectrum global Civil Society Organisations are not only major funders of health, as for instance the Gates foundation but often major provider of grass root health services, such as FBOs in rural Africa (see Chap. 18).

Codex Alimentarius Commission Established by FAO and WHO in 1963 this body develops harmonized international food standards, guidelines and codes of practice to protect the health of the consumers and ensure fair trade practices in the food trade. The Commission also promotes coordination of all food standards work undertaken by international governmental and non-governmental organizations (see Chap. 11).

Complex adaptive systems Are processes in which many different factors interact in multiple ways so that the connection between causes and effects is difficult if not impossible to predict. Moreover the relationships between factors may be changed by the interaction, so that the systems adapts to successive stimuli. Examples of complex adaptive systems include the global ecosystem (see Chap. 10).

Conventional international law Is the set of rules generally regarded and accepted as binding in relations between states and nations it derives from international agreements and may take any form that the contracting nations agree upon (see Chap. 4).

Copernican revolution This term and "paradigm shift" are sometimes used interchangeably, although the former may suggest a simple change in perspective, whereas the latter seems to imply a profound change in the conceptual framework. Thus a Copernican revolution in our view of global health and diplomacy as applied by Santiago Alcázar refers to a change of perspective rather than a reimagining of the process (see Chap. 23).

Council of the European Union Is the body representing the executives of member states participating in the treaties of the EU. The Council is composed of 27 national ministers (one per state). The Presidency of the Council rotates every 6 months between the governments of EU member states, with the relevant minister of the respective country holding the Presidency at any given time ensuring the smooth running of the meetings and setting the daily agenda. The Council is administered by the Council's Secretary General. Its decisions are made by qualified majority voting in most areas, unanimity in others. Usually where it operates unanimously, it need only consult the Parliament. However, in most areas the ordinary legislative procedure applies meaning both Council and Parliament share legislative and budgetary powers equally. In a few limited areas the Council may initiate new EU law itself (see Chap. 16).

Customary international law Is a source of binding international law, along with general principles of law and treaties and is considered to be so by the International Court of Justice and the UN. It is based on the concept that widespread international practice undertaken by custom, out of a sense of legal duty, and creates reasonable expectations of future observances and constitutes implicit consent to the creation of legal rules (see Chap. 4).

Determinants of global health Refers to those factors that transcend national boundaries and governments to determine the health and human security of people across rich and poor countries and of future generations. They include a complex range of biological, social, economic environmental, political and other factors. These include new and re-emergent communicable diseases spread by humans or animals, and non-communicable diseases resulting from trends in lifestyle and diet influenced by global advertising and media. Factors such as the misuse of antibiotics in both rich and poor countries, which leads to drug resistance and makes treatment ineffective, restrictions on access to affordable medicines and failure to support research into diseases affecting poor people are examples of the economic determinants of global health. Pollution of oceans and global warming are examples of environmental factors that not only have a global impact but may also affect the health of future generations. Trade systems that trap some poor country producers in poverty, and consequently poor health and investment that fails to take into account the impact on health and well-being, are examples of the political determinants of global health. Biological terrorism and other threats to human security may also be considered as threats to global health (see Chap. 2).

Diplomacy Is the art and practice of conducting international relations, as in negotiating alliances, treaties, and agreements between officials of different countries to achieve their policy objectives without recourse to war (see Chap. 1).

Ethics The moral principles agreed to define the rules of conduct recognized in respect to a particular class of human actions or a particular group or culture. In relation to global health the ethical basis for discussion of global health may take as a starting point the principles set out in the Constitution of the WHO (see Chaps. 1 and 7).

European Commission Is the EU's executive organ. It represents and upholds the interests of Europe as a whole. It drafts proposals for new European laws, which it presents to the European Parliament and the Council. It manages the day-to-day business of implementing EU policies and spending EU funds. The Commission also polices European treaties and laws. It can act against rule-breakers, taking them to the European Court of Justice if necessary. It is led by 27 men and women—one from each EU country assisted by about 24,000 civil servants, most of whom work in Brussels. The president of the Commission is chosen by EU governments and endorsed by the European Parliament (see Chap. 16).

European Parliament Is the legislative assembly of the EU. Members of the Parliament, who now number more than 700, are elected by direct universal suffrage to terms of 5 years. The number of members per country varies depending on population. The Parliament's leadership is shared by a president and 14 vice

presidents, elected for 30-month terms. The EU Council of Ministers, which represents the member states, consults the Parliament, which is free to discuss whatever matters it wishes. Although it has veto power in most areas relating to economic integration and budgetary policy, it is subordinate to the Council of Ministers. It may pass motions by simple majority vote (see Chap. 16).

European social model Jacques Delors coined the term "European Social Model" in the mid-1990s to designate an alternative to the American form of pure-market capitalism. It applies both to the common character of the different European States' approaches to economic and social progress and to the idea of an emerging pan EU economic and social values. It was first defined in the European Commission 1994 "White paper on social policy" as a set of common values, namely the commitment to democracy, personal freedom, social dialogue, equal opportunities for all, adequate social security and solidarity towards the weaker individuals in society. This definition has been successively updated to include reference to sustainable health and social care systems, supported by a sound economy (see Chap. 16).

European Union Is an intergovernmental economic and political union formed by treaty (currently the Treaty of Lisbon) between 27 member states who agree to work together and recognize common laws, regulations and decision-making processes. The main source of authority for the EU arises from agreements between its 27 member states. The Council of Ministers is the primary meeting place of the EU member state national governments. The principle responsibility of the Council of Ministers is to take policy and legislative decisions. These powers are shared with the European Parliament and the European Commission, but both these institutions are superseded by the authority of the Council. The extent to which the Council must work with the Commission or the European Parliament depends on the policy area as defined by treaty (see Chap. 16).

Evidence for policy Evaluation of the success and failure of policies, in this case for the development of health systems and improvement of health. Greater sharing of the success and failures of health solutions including more openness by policy makers and pharmaceutical companies would be an important global good for health (see Chap. 19).

Externalities Are the consequences of economic activity whose costs and benefits are not reflected in market prices. Thus a product that results in long-term damage to the environment or a spillover effect on another country may have no immediate costs to its producers or users but great harm to future generations. It is argued that one of the key tasks of national or global governance is to ensure that the cost or benefits to society are reflected in the market, through measures such as taxing polluters or rewarding research to reflect the costs and benefits to society (see Chap. 8).

Faith-based organisation Draw their membership and support from members of a particular faith group. Charity is a major tenet of all main world religions including Christianity, Islam, Hinduism and Buddhism. A very high proportion of philanthropic giving from community to community is faith based particularly in the USA. This giving is often channelled directly to specific community partnership

projects through church, temple or mosque links. Faith provides a direct link between benefactors and recipients which is stronger than simply contributing to a good cause, it engages people and communities in a shared responsibility for health and well-being. FBOs are also direct providers of a great deal of health services in poor countries. Across most of sub-Saharan Africa, faith-based hospitals are generally estimated to provide 30–40% of health-care services, particularly in rural areas though some estimates are as high as 50% (see Chap. 18.

Financing of international cooperation Is dependent upon the voluntary contribution of States and some major international charitable foundations. Official Development Aid (ODA) reached some $135 billion in 2011 and charitable foundations, faith-based organisations and other sources increase this to about $170 billion. This does not include remittances by overseas workers, which are about twice the level of ODA. While the UN endorsed a resolution in 1970 calling for rich countries to contribute 0.7% of their GDP to official development aid, this target has never been achieved and currently only about 0.35% of global GDP is contributed as ODA. Current estimates suggest that a high proportion of ODA is either not directed at the poorest recipients or is wasted through ineffective coordination. And further the level of ODA is far less than subsidies given to agricultural produce that reduces the market for poor country producers. This demonstrates the lack of consistent or fair global governance or funding for global public goods (see Chap. 8).

Foreign policy and global health initiative Was an initiative to raise awareness and focus action on the connection between foreign policy and global health by passing a resolution at the UN General Assembly proposing a programme of actions. It was launched in 2007 by the Oslo Group (see Chap. 15).

Formula for agreement This is the mechanism established for the negotiation of an agreement usually established by the body hosting the negotiations. It defines the limits of negotiations within which agreement can be reached, the terms in which agreement will be reached and the process of negotiation. It is important for the formula to be kept relatively simple but with sufficient scope to allow all parties to benefit from the eventual agreement. The formula identifies the points of disagreement and the terms in which these will be negotiated. Thus for example in relation to tobacco control a study was carried out to determine the form of agreement that would be most appropriate and most likely to gain support from member states of the WHO (see Chap. 6).

Forum diplomacy Refers to a form of summit diplomacy, i.e. negotiations at a meeting of heads of state, in which those participating have well-developed personal relationships. Thus forum diplomacy combines personal social interaction with the negotiation of common interests and differences. In win–lose negotiations such personal interaction engaging personal hubris and charm might be considered a disadvantage. However, in global health and other areas where goals are shared forum diplomacy has achieved considerable progress (see Chap. 17).

Foundations Are Civil Society Organisation which are formed as charities benefiting from a major bequest or on-going income from assets. They are usually governed by a board of Trustees which follows the founding deed, setting

out the aims and obligations of the foundation. They often benefit from favourable tax regimes; however, this varies greatly between countries. Even within Europe many tax systems treat domestic philanthropy more favourably than international philanthropy, and there is still no legal definition of what constitutes a charitable aim (see Chap. 18).

Fragile state Is the term used for countries facing particularly severe development challenges: weak institutional capacity, poor governance, and political instability. Often these countries experience on-going violence as the residue of past severe conflict. Armed conflicts affect three out of four fragile states. In 2011 the World Bank harmonized list of fragile situations covered 33 states and territories (see Chap. 2).

Freer and fairer trade for better health Refers to UK government policy to increase its share in the global health-care industry, which is worth more than US$5 trillion a year and to benefit from opening market opportunities in rising states. The call for freer and fair trade is also relevant to developing countries where the cost of drugs is maintained at artificially high prices by patents. The solution often proposed is to match prices to market conditions and restrict the secondary movement of drugs from low price to high price markets. Fair trade rules also have a wider significance for health because agricultural subsidies to farmers in rich countries reduce the opportunities for farmers in poor countries and thereby impact on poverty and health in developing countries (see Chap. 19).

Free Trade Agreements (FTAs) Are treaties between two or more countries that do not impose tariffs for commerce conducted across their borders. This doesn't mean capital and labour moves freely between them, and tariffs are still imposed upon non-member countries. This is to open markets and provides opportunities for agricultural, industrial and service businesses to compete across borders (see Chap. 11).

G8 Or the Group of Eight countries is a forum initially created in France in 1975 and comprises of Canada, France, Germany, Italy, Japan, United Kingdom, the USA and Russia, which was added later in 1997. It was created to bring together the world's major industrialized democracies emerging following the 1973 oil crisis. The group is governed through an annually rotating presidency, sharing responsibility for organizing ministerial-level meetings and the head of state summit each year.

G20 Or the Group of Twenty is a group of finance ministers and central bank governors of the world's 20 biggest economies. It comprises of 19 individual countries and the European Union. It was initially summoned in 1999 to address the global financial regulation issues during the aftermath of the Asian financial crisis. Its role has been reaffirmed and the G20 gained an importance following the 2008 global financial crisis. Heads of states are occasionally present. The G20 nations together represent more than 80% of global GDP.

GATS Or General Agreement on Trade in Services is a treaty negotiated and agreed by all members of the World Trade Organization, during the Uruguay Round negotiations finalized in 1995, to extend the multilateral trading system

to services such as insurance and health-care provision. While GATS allows countries to open all service sectors to international competition, they are also free to choose which sectors to open and the nature of competition, for example whether to allow cross border trade, whether nationals can travel abroad for services, whether overseas companies can be established in their country or whether overseas specialists will be allowed to operate in their country. Once a country has signed up to the application of GATS in a particular sector at a given level of openness, disputes over the interpretation of the agreement are referred to the GATS Dispute Panel that takes precedence over national regulations and decisions (see Chap. 11).

Global environmental diplomacy Is the multi-level processes that support the negotiation of more effective agreements on action to address threats to the global environment in the short and long term. Multi-level processes include measure to engage the public and civil society organizations in direct action to lessen environmental damage and in support of international action by states and multi-national companies. While conventions and treaties are important, diplomacy is also required to ensure that international and local action is consistent with such agreements (see Chap. 10).

Global expert commissions Groups of international experts mandated by an international agency (usually a UN agency) to report on an issue and potential solutions. The selection of members of such a commission is in itself an act of diplomacy requiring a balance between different academic perspectives on a particular issue and the representation of the differing views of states and other agencies who may be engaged in agreeing and implementing the statement of the issues and solutions proposed (see Chap. 5).

Global governance Describes the system of ethical values, organizations and processes through which global society responds to its challenges and responsibilities. In the post-war period, most emphasis was placed on the resolution of conflicts between states, and reconstruction and development following the war. What emerged, therefore, was a system of global interstate organizations to resolve conflicts and support development collaboration. The United Nations System including the Universal Declaration of Human Rights, UN organizations such as WHO and procedures such as General Assembly and Security Council resolutions. These developed in response to the concerns and balance of power during this period. Since then, the international agenda has broadened and new interstate organizations have sprung up to reflect regional, trade, development and environmental concerns and changing influence structures. With increasing globalization and the ending of cold war tensions, it is also apparent that non-state international actors, including civil society and business interests, have a role to play in global governance. The emergence of global public–private partnerships to support the implementation and management of international initiatives has added a further significant element to the architecture of global governance. This now constitutes a complex web of relationships between nations, international agencies, civil society and international business expressed in treaties, conventions and agreements. Whether this web is sufficiently strong to

address the challenges of globalization, poverty, global climate change or threats to health is questionable (see Chap. 1).

Global health Global Health refers to those health issues which transcend national boundaries and governments and call for actions on the global forces and global flows that determine the health of people. The health of a population, in aggregate, will reflect the many different factors that determine health outcomes and their distribution in a population. These include efforts to prevent disease, prolong life and promote health through the organized efforts and informed choices of society, organizations, public and private; communities and individuals. Where such factors transcend national boundaries and require collective transboundary action they may be defined as global health issues (see Chap. 1).

Global health diplomacy Is the multi-level negotiation processes that shape and manage the global policy environment for health. Ideally these result in both better health security and population health outcomes for each of the countries involved (thus serving the national interest) as well as improving the relations between states and strengthening the commitment of a wide range of actors to work together to ensure health as a human right and a public good (see Chap. 1).

Global health governance and governance for global health Describes the system of ethical values, organizations and processes that address global health issues. Ethical values are expressed as human rights to health and well-being. In the past governance of global health has been seen as the responsibility of the UN and WHO as the main fora for establishing international legal agreements. But now a wider range of organizations including nation states, regional and other collective organizations of states, global interstate institutions and global public–private partnerships and civil society organizations are also involved discussions that affect global health. Governance for global health includes diplomacy at all levels for the agreement and subsequent implementation of treaties, conventions and agreements as well as informal understandings and recognition of the role and responsibilities of all of society to address global health issues (see Chaps. 1, 2, 5 and 12).

Global Health Governance Architecture Refers to the relationship between the many different actors engaged in global health governance and the processes through which they work together. Reference to architecture may seem to imply a designed structure in which roles and relationships are defined. But in practice the system is more chaotic and perhaps an analogy with the architecture of a computer system is more appropriate, with multiple, ever changing relationships (see Chap. 12).

Global health negotiations The discussions and exchanges between representatives of state and non-state actors leading to agreement on action to address global health issues. Negotiations can arise in many different ways in relation to threats posed by different diseases and determinants of health or as a consequence of other foreign policy issues such as security and trade. They often involve multiple stakeholders and interests, both because they deal with trans-border issues and because health and its determinants, including globalization, have impacts across all social and economic spheres. The health issues negotiated are often

uncertain in their long-term impact and capable of different interpretation, thus an agreed evidence base and effective presentation of information are essential during the negotiation of international agreements and in their implementation (see Chap. 6).

Global health partnerships Are a diverse group of organizations, networks and alliances focusing on discrete and measurable areas of action in relation to specific diseases or health issues and have been established over the past 25 years. They usually involve a partnership between public sector agencies and private and or civil society partner organizations. There are about 80 global public–private partnerships in the health sector, differing in terms of legal status, disease focus and area of activity, and ranging from small initiatives for single issues to large institutions for multiple diseases. They may act as channels for the disbursement and management of funding programmes or may directly undertake research and/or health service provision. They are mostly funded through official development assistance but, in some cases, they also combine income from philanthropic foundations or business partners. A focus on specific targets and diseases brings greater efficiency and makes it possible to transfer lessons and approaches from one country to another. However, this "vertical" programme approach can also create problems for the recipient country, because it does not readily respond to local conditions and priorities, it may lead to high coordination costs and may divert resources away from other elements of the health and care system (see Chap. 5).

Global public goods The main characteristics of public goods are that they are non-excludable and non-rival in consumption. Non-excludability means that, once the good is produced, its benefits accrue to all. Non-rivalry means that the consumption of a public good has no effects on the amount available to other people. Goods with both these properties are *pure public goods*.

Globalization Is defined as the widening, deepening and speeding up of worldwide interconnectedness in all aspects of contemporary social life. Its driving forces are the cultural, social, economic and technological movements that shape our world and their agents. Many of these transcend national boundaries and are beyond the reach of national governments acting alone. Their agents include the actions of multinational companies, financial institutions, international terrorists and criminals, advertisers and the media that shape international culture. Indeed even the concerted international efforts of governments may be insufficient to govern such forces unless supported by public and community efforts and new forms of global governance to harness the benefits of globalization and regulate its agents (see Chap. 2).

Health Is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (see Chap. 1).

Health acquis communautaire The entire body of European laws applicable to health. This includes all the treaties, regulations and directives passed by the European institutions as well as judgements laid down by the Court of Justice (see Chap. 16).

Health equity Implies equal rights to health as defined above, without unjust impediment to access, due to race, religion, income or place of residence. This is not the same as equality of health as people will have unequal health due to genetics and chance. In practice health equity is only partly achieved within states as health systems and entitlements differ, and even within states access to some health services may depend upon income and area of residence. Moreover, there are very considerable differences in access to health services and health outcomes for people in poor countries compared to those in rich. Thus global health equity is most evidently lacking but the concept may point out some of the most flagrant examples of unfair obstacles to health for the disadvantaged (see Chap. 7).

Health NGOs Are a form of Civil Society Organisation representing those subscribing to a particular cause, e.g. the needs of people with mental illness problems to better recognition and care or rights to universal access to health services (see Chap. 18).

Health security Has both a societal and an individual aspect. At the societal level, **global health security** means reducing collective vulnerability to global public health threats, both immediate and gradual. These threats often go beyond or transcend borders and may be caused by infectious agents that emerge naturally at the human/animal interface, but they may also be caused by chemicals, toxins and radiation, or be deliberately caused by acts of terrorism. The steady and increasing rise in non-communicable diseases also constitutes a threat to societal health security. Moreover, reducing vulnerability means, not only combating the disease threats themselves, but also addressing their determinants, some of which may also transcend borders, such as international trade and other economic policies that influence the emergence and spread of disease. At the individual level, health security must include protection and provision measures such as access to safe and effective medicines, vaccines and medical care. Increasing personal health security thus means providing individuals with more sustained—and therefore secure—access to quality medical goods and services (see Chap. 9).

Human rights Are the fundamental entitlements of every person simply because she or he is a human being. They are recognized in the Charter of the United Nations and in the constitution of the WHO. Human rights are applicable everywhere and are the same for everyone, they cannot be surrendered, transferred or taken away by any authority. These entitlements exist as natural rights that should be enshrined in legal rights and obligations, in both national and international law. The doctrine of human rights in international practice, within international law, global and regional institutions, in the policies of states and in the activities of non-governmental organizations, is the foundation for global governance (see Chap. 1).

Hypercollective action Characterizes a change from collective action, in response to proliferation—increase in number of actors—and fragmentation—scattering of activity and loss of coherence—of the development aid landscape. While it engages a broader range of agencies and resources it can also bring problems of

coordination and governance, demanding diplomacy at international and local levels to maximize the contributions of all agencies and minimize incoherence (see Chap. 5).

Infectious diseases Also known as communicable diseases, contagious diseases or transmissible diseases results from the infectious pathogens including some viruses, bacteria, fungi, protozoa, multicellular parasites, and aberrant proteins known as prions. These pathogens are transmitted from one person to another or in the case of zoonotic diseases may be transmitted by animals, they may also transmute and change as they are transmitted thus a disease outbreak may become more or less severe as pathogens develop (see Chap. 9).

Intergovernmental organizations Are organizations established by treaties, composed, primarily, of sovereign member states. They are an important part of international public law, as they often host the venue for the formation, implementation and governance of international legal instruments. They are responsible to and are accountable to their member-states. They include the UN and its agencies such as the WHO, groups of nations linked by economic and political interests such as the EU and the World Trade Organization and other international groups such as the G8 or G20 (see Chap. 5).

International agreements and conventions Are forms of agreement between nation states that may create binding obligations under international law (see Chap. 13).

International cooperation National states or other agencies working together across national boundaries to achieve common ends provide examples of international cooperation. While in the past nations cooperating together in stable and predictable ways representing the interests of defined power blocs, current patterns of cooperation are much more diverse and specific to the issues at hand. There are also examples of states working together across all spheres of political and economic interest, for example to monitor the spread of infectious diseases. This is another example of the multi-polar world of global diplomacy. See also North–South Cooperation and South–South cooperation (Chaps. 8 and 21).

International Covenant on Economic, Social and Cultural rights (ICESCR) Is a multilateral treaty adopted by the UN General Assembly on 16th December1966, committing its parties towards ensuring the fullest attainment of economic, social and cultural rights to individuals. These include labour rights, the right to health and the right to education and the right to an adequate standard of living. ICESCR is part of the International Bill of Human Rights along with the Universal Declaration of Human Rights (see Chap. 5).

International Health Organizations Are organizations focussing on international or global health issues they include UN organizations, Bilateral Aid organizations, Civil Society Organizations, Public/Private Partnerships for Health and some Private Sector organizations (see Chap. 19).

International law Is primarily, though not exclusively focused on the interactions of sovereign states and can broadly be defined as the rules that govern the conduct and relations of states. It is divided into public and private international

law, where the former is primarily based on relations of states and the latter on law of private transactions of individuals and corporations (see Chap. 4).

International legal sanctions Penalties as agreed in a treaty or other form of international law taken by one country or groups of countries against another, designed to bring a state into compliance with agreed rules of conduct. International sanctions may be either non-forceful or military. Non-forceful international sanctions include diplomatic measures such as the withdrawal of an ambassador, the severing of diplomatic relations, or the filing of a protest with the United Nations; financial sanctions such as denying aid or cutting off access to financial institutions; and economic sanctions such as partial or total trade embargoes. The U.N. Security Council has the authority to impose economic and military sanctions on nations that pose a threat to peace. However, these are extreme steps seldom taken. In the context of global health diplomacy, sanctions are more likely to be none-forceful and normative in nature (in other words pronounced judgements) (see Chap. 13).

International Office of Public Hygiene Was an international organization founded in1907 and based in Paris created to oversee international rules regarding the quarantining of ships and ports to prevent the spread of plague and cholera, and to administer other public health conventions. It was dissolved in 1946 and incorporated in the newly formed WHO (see Chap. 3).

International sanitary conferences and conventions Meetings of technical experts and diplomats first from leading trading nations and then from a wider number of states. They were firstly organized by France in 1851. In total 14 conferences took place from 1851 to 1938. The International Sanitary Conferences were the first international convention organized in Europe to deal with the arrival and spread of pestilent diseases, particularly cholera (see Chap. 3).

League of Nations An intergovernmental organization founded by treaty between 58 member states as a result of the Paris Peace Conference that ended the First World War. It was the first permanent international organization whose principal mission was to maintain world peace. Other issues in this and related treaties included labour conditions, just treatment of native inhabitants, human and drug trafficking, arms trade, global health, prisoners of war, and protection of minorities in Europe (see Chap. 3).

Legitimacy The accepted right to act or pronounce on a topic derived from the consent to the laws or customs which confer such rights. Thus we may speak of the legitimacy of UN to impose sanctions as derived from its member states' acceptance, even though the state that is sanctioned may deny the legitimacy of the action. Legitimacy refers to accepted moral authority, for example arising from the democratic a process that selected a government to represent their views. Civil society organization may have other bases for their legitimacy, e.g. arising from the perspective they provide of people with special needs, or as a result of their special knowledge or their practical contribution, for example in delivering health services in developing countries (see Chaps. 5 and 18).

Major Economies Forum (MEF) The Major Economies Forum on Energy and Climate (MEF) was launched in 2009. It is intended to facilitate a candid dialogue among major developed and developing economies, help generate the political leadership necessary to achieve a successful outcome at the December UN climate change conference in Copenhagen, and advance the exploration of concrete initiatives and joint ventures that increase the supply of clean energy while cutting greenhouse gas emissions. The 17 major economies participating in the MEF are: Australia, Brazil, Canada, China, the European Union, France, Germany, India, Indonesia, Italy, Japan, Korea, Mexico, Russia, South Africa, the United Kingdom, and the USA. Denmark, in its capacity as the President of the December 2009 Conference of the Parties to the UN Framework Convention on Climate Change, and the United Nations have also been invited to participate in this dialogue (see Chap. 10).

Market failure Is a situation in which the operation of the conventional market competition for investment and the delivery of products or services fails to maximize social benefits. This may be due to market factors such as monopoly of supply or lack of information or demand factors that distort the market. With regard to health the inability of customers in poor countries to afford medicines may inhibit investment in health research and development even though as a global public good improvement of health and eradication of disease would generate global social benefits (see Chap. 8).

Meta-leadership The qualities required to influence and activate change well above and beyond established lines of their immediate decision-making and control, i.e. beyond the boundaries of a particular organization or role. Thus the vision and values of meta-leaders inspire people from different organizations to achieve underlying common goals. Their emotional intelligence enables them so understand and empathize with the different perspectives of participants and help establish a common understanding. Their willingness to share leadership and encourage others to take action empowers others to participate. And their personal integrity and self-control enable them to earn the trust of people from different countries and organizations (see Chap. 6).

National interest cluster The foundation for the development of valid national objectives that define national goals or purposes. Such interests were originally conceived in narrow terms of national military security but now a wider view is taken encompassing economic security, food security, health security, environmental security, personal security, community security and political security all of which may constitute linked or unlinked elements of national interest (see Chap. 23).

Neglected diseases Constitute a range of different diseases that are not the focus of commercial research because they are either very rare or largely affect poor populations and countries that would be unable to afford medicines or treatments once developed Thus market-forces have not created enough incentives to focus research and care to these diseases. Action to address this issue is mainly through development aid and non-market incentives for research and drug development, such as product development partnerships (see Chap. 5).

Negotiations Can be defined as a process of exchange between two or more interested parties for the purpose of reaching agreement on issues of mutual concern. It is possible to distinguish three main phases leading to agreement: the diagnostic phase, during which the issues are identified, stakeholders engaged and information is prepared, the formula phase, establishing a shared framework for agreement including the process of exchange and the detailed phase of negotiation and exchange. Negotiation is also crucial to the effective implementation of any international agreement, requiring on-going monitoring and possibly arbitration of disputes by an international body (see Chap. 6).

Nodal governance A system in which different agencies or centres of knowledge and influence, agreed by states and other actors take the lead on specific issues identified in treaties or agreements. It operates in a landscape of mixed social interactions and of conflicting or merging cultural and political perspectives and behaviours. It is an elaboration of contemporary network theory that explains how a variety of actors operating within social systems interact along networks to govern the systems they inhabit. In the context of global health it is characterized by issue-oriented treaties, agreements and organizations and processes beyond the WHO, but linked to it (see Chap. 5).

Non-Communicable diseases (NCDs) Are generally diseases of long duration and slow progression which are not caused by transmissible pathogens but are often linked to lifestyle factors such as stress, inactivity, smoking, poor diet, obesity and poverty as well as affluence. They include mental illness, heart disease, stroke, rickets, cancer, asthma, diabetes, chronic kidney disease, osteoporosis, Alzheimer's disease, cataracts, and more. NCDs are by far the leading cause of mortality in the world, representing over 60% of all deaths (see Chap. 14).

Non-state actors Refer to organizations with sufficient legitimate influence to affect international negotiations (in this case in the sphere of global health diplomacy) not belonging to or being an established institution of a state (see Chap. 18).

Normative instruments These are judgements of behaviour or outcomes in relation to an accepted standard, which may be derived from UN declarations of human rights, or other expected norms, or may be specified in specific treaties and agreements. The World Health Assembly applies three types of normative instruments: recommendations, international agreements and conventions and regulations. Recommendations do not bind Member States under international law and are, in this narrow sense, "soft" instruments; international agreements, conventions and regulations, on the other hand, create binding obligations under international law (see Chap. 13).

North–south cooperation Is largely conceived as development assistance flowing from rich northern countries to poor southern ones. This implies an unequal dependence relationship between donors and recipients. This may be intended to assist southern countries but is directed and governed by northern "partners" (see Chap. 21).

Open-source anarchy The confusion that arises when many different actors are able to redefine issues to suit their own agenda and interests (similar to the development of open source software). While there are advantages in bringing in many different perspectives, this may cause a problem in governing global health, because state and non-state actors resist governance reforms to increase cohesion that would restrict their freedom of action (see Chap. 5).

Oslo Ministerial Declaration Was issued in 2007 by the ministers of foreign affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand (**The Oslo Group**) who pledged to bring health issues more strongly into foreign policy discussions and decisions, recognized health as one of the most important, yet still broadly neglected, long-term foreign policy issues of our time, tying it to the environment, trade, economic growth, social development, national security, human rights and dignity (see Chaps. 9 and 15).

Pandemic Is the spread and increase of an infectious disease across continents and worldwide. A widespread but stable or declining disease is not a pandemic, and the pandemic status does not imply that the disease is more or less severe in its effect on those infected. Pandemic status is declared by the WHO with a six-level indication of the progress of an epidemic to pandemic level (see Chap. 9).

Paris declaration An agreement on measures to improve the effectiveness of aid, accepted by representatives of aid donors and recipients in 2005. It puts in place a series of specific implementation measures and establishes a monitoring system to assess progress and ensure that donors and recipients hold each other accountable for their commitments. The Paris Declaration outlines the following five fundamental principles for making aid more effective:

1. *Ownership*: Developing countries must set their own strategies for poverty reduction, institutional strengthening and tackling corruption.
2. *Alignment*: Donor countries should align with these strategies and use local systems.
3. *Harmonizsation*: Donors should coordinate resources and information with simplified procedures.
4. *Results*: Developing countries and donors should focus on measured results.
5. *Mutual accountability*: For the results of development strategies and aid (see Chap. 12).

Paris-Accra process Reviewed progress on the Paris Declaration in 2008 and developed the Accra Agenda for Action setting the agenda for accelerated advancement towards the Paris targets. It proposed steps to improve: ownership, with stronger leadership by developing countries, alignment, with inclusive partnership engaging all donors and civil society organizations in the developing country, results impact measurement, capacity building to strengthen the ability of developing countries to manage their own future (see Chap. 12).

Patient and community health organizations Civil society organizations that represent the interests of specific groups of patients (i.e. patient groups such

as people with mental illness or diabetes) or communities of health users (i.e. local community organizations or national groups representing health users in general) (see Chap. 18).

Plurilateral A plurilateral treaty is a special type of multilateral treaty between a limited number of states with a particular interest in the subject of the treaty. The primary difference between a plurilateral treaty and other multilateral treaties is that the availability of reservations is more limited under a plurilateral treaty. Due to the limited nature of a plurilateral treaty, the full cooperation of the parties to the treaty is required in order for the object of the treaty to be met. As a result, reservations to plurilateral treaties are not allowed without the consent of all other parties to the treaty. This principle is codified in international law by article 20(2) of the Vienna Convention on the Law of Treaties (see Chap. 11).

Policy frame The perspective adopted in setting out arguments on policy issue which defines the terms of debate. Thus for example, a health issue such as the spread of multi-drug resistant tuberculosis may be seen as a threat to the health of HIV/AIDS patients (who are currently most at risk) or it may be seen as an issue affecting health in developing countries, or a specific threat to health in prison populations in Russia, or as a coming threat to health in rich countries and an economic threat to their health systems or as an issue affecting immigrant health. Of course it is all of these and more but the perspective from which the issue is viewed will shape the subsequent debate and negotiations. It is therefore an important consideration in applying global health diplomacy (see Chap. 6).

Polylateral diplomacy As opposed to bilateral and multilateral diplomacy, which remain traditionally state-dominated, is viewed as a third conceptual layer, in which non-state actors are more closely incorporated into the global dialogue. Non-state actors such as CSO, NGO and private sector entities are able to exert lobbying pressures to advance their interests (see Chap. 3).

Power shift A change in the balance between the relative power and influence of different states and non-state actors, this is evident in both the extent of power and influence and the form it takes. In the past we have seen a contest of power between European states then an uneasy balance of military power between leading capitalist and communist regimes, then a hegemony (international dominance in many fields) by the USA. We now see the decline of the economic dominance of the USA and EU and the rise of the power and influence of countries such as China, Brazil, India and Russia. At the same time multinational companies are exerting economic power in the relatively ungoverned field of globalization. Access to all forms of media is changing rapidly resulting in diverse cultural influences ranging from celebrity culture to popular demands for democracy, or at least freedom from oppression. Differing religious movements are influencing, thought and behaviour and global civil society organizations are also able to exert more influence (see Chap. 21).

Precautionary principle States that if an action or policy has a suspected risk of causing harm to the public or public health or to the environment. Even in the absence of scientific consensus that the action or policy is harmful, but were reasonable doubt has been raised, the burden of proof that it is *not* harmful falls

on those taking the action. The principle implies that there is a social responsibility to protect the public from exposure to harm, when scientific investigation has found a plausible risk. These protections can be relaxed only if further scientific findings emerge that provide sound evidence that no harm will result. This principle is embodied in aspect of EU legislation (see Chap. 11).

Public diplomacy Is the communication with the public to establish a dialogue designed to inform and influence public sentiment and policy debate. This communication may apply to the public in other countries where public diplomacy may be applied to gain "soft power" (see below). It may also apply to appeals to the wider public as global citizens to engage people in mass movements in respect of issues such as global health or environmental policies. It is practiced through a variety of instruments and methods ranging from use of advertising and mass media to Internet and social networking applications. One particular form of contact is by celebrity endorsement of particular causes, for example UNESCO has established "good will ambassadors" (see Chaps. 10 and 18).

Ratification Here refers to the process of adopting an international treaty or other nationally binding document within the laws of a state, by the agreement of chambers of government or subunits such as regional states within a federation. Different countries have different rules for the ratification of treaties, and this may vary with the impact on the national constitution. Thus several European countries require a referendum to ratify agreements transferring powers from national governments. Apart from this the ratification of international treaties follows the same rules as the passing of laws in most democracies. An important exception is the USA, where treaty ratification requires a two-thirds majority in the U.S. Senate (and the United States House of Representatives does not vote on it at all). This makes it considerably more difficult in the USA than in other democracies to rally enough political support for international treaties. Governments may nevertheless observe an international agreement in practice without formal ratification (see Chap. 6).

Realpolitik (German for "politics of reality") is foreign policy based on practical concerns for the advancement of the national interests of a country rather than ethical or moral concerns (see Chap. 3).

Recommendations Of the WHO are normative instruments that do not bind Member States under international law and are, in this narrow sense, "soft" instruments (see Chap. 13).

Regulations Rules of conduct that may be set out in international treaties. Specifically the **International Health Regulations** 2005 are legally binding regulations to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade. The regulations place an obligation on all member states of the WHO to monitor, report and take action on threats to international health. They also require member states to cooperate and share information with regard to such threats (see Chap. 13).

Results orientation A focus on targeted specific measurable outcomes agrees at the planning stage. This can mean that the performance, for example of a given aid programme is more effective in achieving the targets it sets. But it can also lead to a narrow focus on the specified outcome without consideration of the wider needs of the communities served or the unintended consequences. Thus for example, an HIV/AIDS programme may be effective in meeting its goals for the delivery of drugs and treatment but may result the distortion of the local health system by drawing professionals and other resources away from other areas of community health (see Chap. 5).

Rising states Are states which are increasing in economic power and influence. Usually Brazil, Russia, India and China are seen as rising states referred to as BRIC or BRICS (with the addition of South Africa); however, this shorthand term is not well received by the countries concerned. Other countries such as South Korea and Malaysia are also increasing in wealth and influence (see Chap. 21).

Rockefeller Foundation A major charitable foundation founded by John D. Rockefeller in 1913. Its mission is "to promote the well-being of mankind throughout the world". It funded the creation of several prominent schools of public health as well as research into vaccines and agricultural improvement. It is still active in support of global health programmes (see Chap. 3).

SARS Severe acute respiratory syndrome is a serious form of pneumonia, caused by a virus, which was first identified in 2003. It is a zoonontic disease (one that can be transmitted from animals to humans) carried by polecats. It provided an example of the need for urgent international collaboration to halt its spread and also demonstrated the large-scale economic impact that could be caused by what turned out to be a limited epidemic (see Chap. 9).

Social justice Refers to the idea of creating a society or institution that is based on the principles of equity and solidarity that understands and values human rights and that recognizes the dignity of every human being. The application of social justice in national political and social systems led to the emergence of welfare state measures to provide more equitable access to health, education, employment and social care. Now that economic power and influence are increasingly disposed through the mechanisms of globalization it may be seen as time to apply ideals of social justice in governance and practice at the global level (see Chap. 7).

Soft power Soft power is the ability to achieve foreign policy objectives by making other people want the same things. This means co-opting the people or representatives of other countries so that they share one's goals. It can be contrasted with "hard power", that is the use of coercion and payment. Soft power can be wielded not just only by states but also by all actors in international politics, such as NGOs or international institutions. Public diplomacy may be seen as a tool of soft power to gain public support for a policy on a world-wide level or in a specific foreign country. So to personal charm, moral leadership and diplomacy exercised in forum diplomacy can be tools of soft power (see Chap. 2).

South Commission Was established in 1987 of distinguished individuals from the South chaired by Mwalimu Julius Nyerere, former President of Tanzania. It functioned as an independent body, with its members serving in their personal capacities. In 1990 it released its Report, The Challenge to the South, assessing the South's achievements and failings in the development field and suggesting directions for action. The Report makes a cogent case for self-reliant, people-centred development strategies. The Commission also shows how developing countries could gain strength—and bargaining power—through mutual co-operation (see Chap. 21).

South–South cooperation South–South cooperation is built on relationships between equal partners with the objective of mutual exchange and development. It is based on the concept of "technical cooperation" to emphasize the joint effort of integrating partners in a genuine joint operation in which know-how and strategic orientations are shared in order to improve the work capacity and to foster equitable development (see Chap. 21).

State failure The failure of states to act effectively. This may be due to lack of capability or lack of will, for example many states take ineffective action to curb corruption because the beneficiaries of corruption are themselves responsible for enforcing measures against it (see Chap. 8).

Structuring cooperation for health The model for South–South cooperation in health adopted by Brazil has been called "structuring cooperation for health". It is based fundamentally on capacity building for development. This new model is innovative in two ways—first, by integrating development of human resources with organizational and institutional development; and second, by breaking the traditional model of passive unidirectional transfer of knowledge and technology and mobilizing each country's existing endogenous capacities and resources (see Chap. 21).

Summit diplomacy Negotiations that take place at meetings of heads of state. These are usually preceded by lower-level meetings to set an agenda, but this is not always the case (see Chap. 17).

Trade rounds Are series of negotiations conducted by the World Trade Organization aimed at achieving agreement on measures to improve trade between member states. They may involve states that are members of the WTO and other actors who may be consulted. Often a round of trade talks will take several years and participants will meet many times. This is because trade rounds deal with whole packages of related matters and an issue affecting one component of the package may hold up the progress of the overall agreement. It is nevertheless considered more beneficial to address packages of measures than to try to handle-related issues one at a time (see Chap. 11).

Transnational Networks A positive feature of the globalization of communications is that it allows for the formation of connections between individuals and organizations regardless of national boundaries. This has led to the formation of transnational networks joining people with a common agenda or concern from democratic freedom to fair trade (see Chap. 5).

Treaty Is an instrument of international law, an agreement entered into by sovereign states with or without international organizations. It encompasses all written instruments concluded between states, by which they establish obligations by and among themselves. It functions essentially like a contract, whereby they create explicit rules to govern their own conduct and the conduct of their individual and corporate nationals. Treaties may identify sanctions to be invoked in the case of a breach of treaty obligations and may also establish procedures for the resolution of issues. The 1969 Vienna Convention on the Law of Treaties now ratified by 111 states and clarifies the nature of treaties and their obligations (see Chap. 4).

Treaty of Lisbon Is an international agreement signed by the EU member states in 2007 and entered into law in 2009 after ratification by member states that defines the duties, rights and obligations of member states of the EU. It amends the prior Maastricht Treaty and aspects of the Treaty of Rome. Changes include amendments to the decision-making processes of the EU to make them more appropriate for the enlarged EU of 27 member states. It established a long-term President of the European Council and a diplomatic presence for the EU in the form of the High Representative of the Union for Foreign Affairs and Security Policy. It also made the EU's bill of rights, the Charter of Fundamental Rights, legally binding (see Chap. 16).

TRIPS The Trade Related Intellectual Property Rights Agreement came into effect in 1995 following negotiations in the 1986–1994 Uruguay round of the World Trade Organization. It is the most comprehensive multilateral agreement for the protection of intellectual property rights. Members of the WTO agreed to enforce such rights and to submit disputes to the WFO resolution process. However, while the initial TRIPS agreement made note of the need to protect access to essential medicines in case of emergencies, this aspect of the agreement was renegotiated during the Doha round of trade talks. This trade round was started in 2001 and by 2003 agreement was reached on issues affecting access to essential medicines, reaffirming the flexibility of TRIPS and allowing member states to take action to ensure access to essential medicines. However, the trade round has still not been completed due to a failure to reach agreement on a range of issues particularly in respect of trade in agricultural products (see Chap. 11).

UN Economic and Social Council (ECOSOC) Is the primary UN forum to discuss international social, economic and humanitarian issues and coordinate UN agencies and bodies concerned with these issues. It has four main responsibilities

1. Promoting higher standards of living, full employment, and economic and social progress.
2. Identifying solutions to international economic, social and health problems.
3. Facilitating international cultural and educational cooperation.
4. Encouraging universal respect for human rights and fundamental freedoms.

Fifty-four Member States are elected by the General Assembly to sit on the Council. This includes a High-Level Segment involving representatives from national governments, international institutions, civil society and the private sector. It is an advisory and coordinating body rather than a decision-making or treaty-negotiating body (see Chap. 14).

United Nations General Assembly (UNGA) Is the main deliberative forum of the UN system, where representatives of its 192 member states can debate and resolve issues of common concern. The increasing focus on health issues at UNGA in recent years provides a good demonstration of the growing nexus between health and foreign policy. While the World Health Organization (WHO) is the directing and coordinating authority for health within the United Nations system, global health issues that raise concerns for foreign policy and human security may warrant consideration in the context provided by the UNGA, where Member States can raise, negotiate and adopt reports and resolutions in field of health that have a wider impact on foreign policy (see Chap. 15).

United Nations Human Rights Council (UNHRC) Is an inter-governmental body and is a subsidiary body of the United Nations General Assembly. The council works closely with the Office of the High Commissioner for Human Rights (OHCHR) and with the Special Rapporteurs, Special Representative of the Secretary-General or Independent Experts or working groups to investigate human rights issues and their violation (see Chap. 14).

UN Security Council Has primary responsibility for the maintenance of international peace and security. The Council is composed of five permanent members (China, France, Russia, United Kingdom and the USA) and ten non-permanent members, elected by Member States for two-year terms. The Security Council has a unique status among UN institutions. While other organs of the United Nations make recommendations to Governments, the Council alone has the power to take decisions related to Chap. 7 of the UN Charter that allows the Council to "determine the existence of any threat to the peace, breach of the peace, or act of aggression" and to take military and nonmilitary action to "restore international peace and security", which Member States are obligated to carry out (see Chap. 14).

UN Special Rapporteur Is a title given to individuals working on behalf of the UN or its agencies who bear specific mandates to investigate, monitor and recommend solutions to specific human rights problems (see Chap. 14).

Unstructured pluralism The existence of different laws and legal institution with different sources of authority and methods of resolution, which are not readily compatible one with another. Thus no overarching system of laws or legal authority can be discerned. This leads to complex and often unpredictable competition, between different groups, that is difficult to resolve by negotiation in the absence of common agreement to basic values (see Chap. 3).

Values Describes the beliefs of an individual or culture. A set of values may be placed into the notion of a value system. Values are considered subjective and vary across people and cultures. Types of values include ethical/moral values, doctrinal/ideological (political, religious) values, social values, and aesthetic values. The UN statement of human rights values takes the view that some basic values are innate stemming from the common humanity of people and the rights and obligations that follow from this (see Chap. 7).

Westphalian system Describes the system of nation states, in which national governments claim the right to rule and to freedom from external interference regardless of the basis of their authority (whether democratic or dictatorship) or their treatment of citizens. It also implies a rejection of international obligations or global governance. The concept refers to the treaties arising from the Peace of Westphalia in 1648, which establish a new system of political order in central Europe, based upon the concept of a sovereign state governed by a sovereign (see Chap. 3).

Further sources For a fuller examination of the terms and their meaning, please refer to the glossary at the Global Health Europe web site at www.globalhealtheurope.org or the European Foundation Centre Global Health Policy Glossary at http://www.globalhealtheurope.org/images/stories/PDF_Links/EFC_EPGH_GlobalHealthGlossary-1.pdf or the Kaiser Foundation US Global Health Policy Glossary at http://globalhealth.kff.org/Common/Glossary.aspx or the Action for Global Health Guide to Global Health in the EU at http://www.globalhealthguide.eu/ or the WHO Glossary of Globalization, Trade Foreign Policy and Health terms at http://www.who.int/trade/glossary/en/index.html or The United Nations Institute for Training and Research Glossary on Multilateral Conferences and Diplomacy at http://www.ghdnet.org/sites/default/files/UNITAR%20Glossary.pdf.

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