

Global Health Diplomacy



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Global Health Diplomacy is a complex, multifaceted field, in which we are still discovering new questions and sometimes new answers. Teaching and learning about this topic with WHO Heads of Country Offices, over a series of 10 week courses*, has continued to reveal new insights into the combination of technical knowledge “the science of public health” and the “art and practice” of diplomacy. In this brief introduction I have tried to share some of the ideas that I have found most helpful and which lead me to believe that this is one of the most important issues we must address not only for our future health but for the future of global governance.

As a starting point for this topic I suggest you should try to answer five basic questions:

- What do you mean by “Global Health”, does this differ from International Health?
- Does global health affect you and can you affect global health?
- What are the most common causes of poor health in low and middle income countries?
- If poverty is a key determinant of health; where do most poor people live?
- How is the world run; how do we address issues that affect all our futures?

The answers to these questions explain the importance of global health diplomacy for our future.

*These courses, which I tutored, were developed and delivered with colleagues at the Global Health Programme of the Graduate Institute, Geneva, led by Ilona Kickbusch, supported by Michaela Told and Pascale Wyss, we are grateful to course participants from whom we learnt a great deal.

International and Global Health

International Health

Study and actions to improve health conditions and systems in different countries, by sharing knowledge, often (but not always) focussed on low income countries.

See for example Kathryn H Jacobsen "Introduction to Global Health"



John Wyn Owen



Ilona Kickbusch

Global Health

Global health refers to those health issues which transcend national boundaries and governments and call for actions on the global forces that determine the health of people. It requires new forms of governance at national and international level which seek to include a wide range of actors.

Kickbusch and Lister eds European perspectives on global health: A policy glossary. Brussels: European Foundation Center. 2006

See www.globalhealthurope.org

In 1997 the US Institute of Medicine published a report called "America's Vital Interest in Global Health: Protecting Our People, Enhancing Our Economy, and Advancing Our International Interests".

Hillary Clinton hosted an event to introduce the paper to an international audience, including John Wyn Owen the Secretary of the Nuffield Trust. He brought the idea to England and, knowing my background in International Health reform he asked me to coordinate a programme with Kelly Lee of the London School of Hygiene and Tropical Medicine comprising 17 papers and a national symposium entitled "Global Health: a local Issue". Recognising the link between global health and foreign policy, we also hosted the first international symposium on this topic, chaired by Gro Brundtland (Director of WHO) and John persuaded Liam Donaldson (the UK Chief Medical Officer) to initiate the programme that led to "Health is Global" the UK strategy for global health.

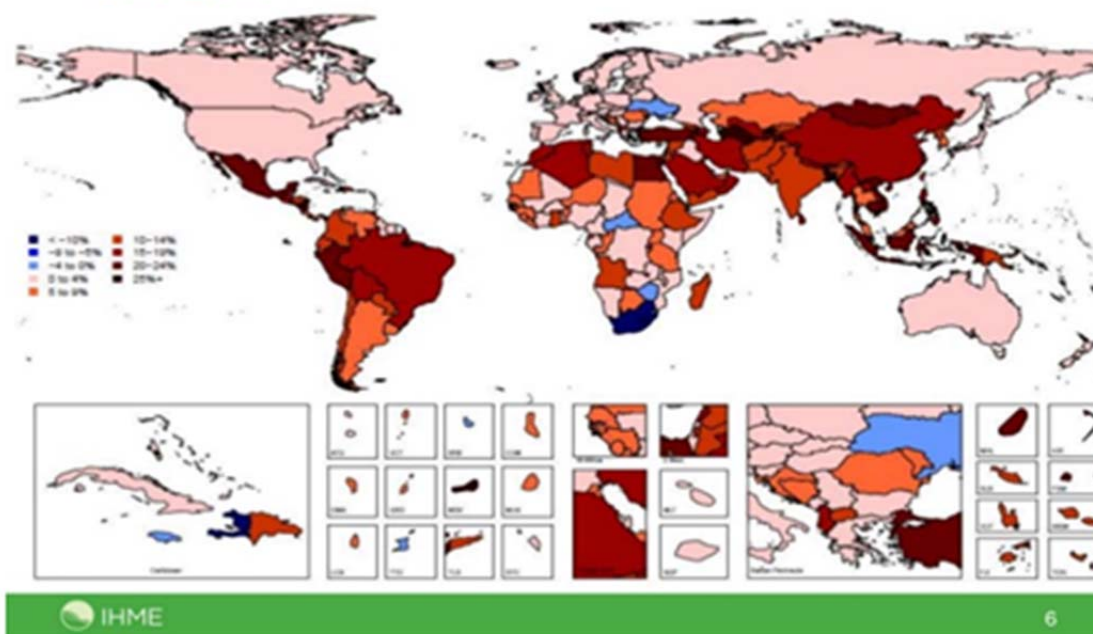
Meanwhile Ilona Kickbusch had moved from WHO to Yale to become the first Professor of Global Health. In 2004 she moved back to Geneva, there I helped her edit an influential paper called "European Perspectives on Global Health: a policy glossary" (available from http://www.globalhealthurope.org/images/stories/PDF_Links/EFC_EPGH_GlobalHealthGlossary-1.pdf . Later we worked with her to establish Global Health Europe - a think tank that had a great influence on the EU policy set out in "The EU Role in Global Health" (2010).

This does not mean "global health" has superseded international health (indeed I still work in international health system reform and leadership). **But these are different from the issues of global health policy addressed by the Global Health Programme of the Graduate Institute Geneva, which works with WHO, GF, NGOs and Government officials to improve skills in global health diplomacy.**

Rapid changes in disease patterns

(GBD report Lancet 2012)

Change in Percent of DALYs Due to NCDs 1990-2010



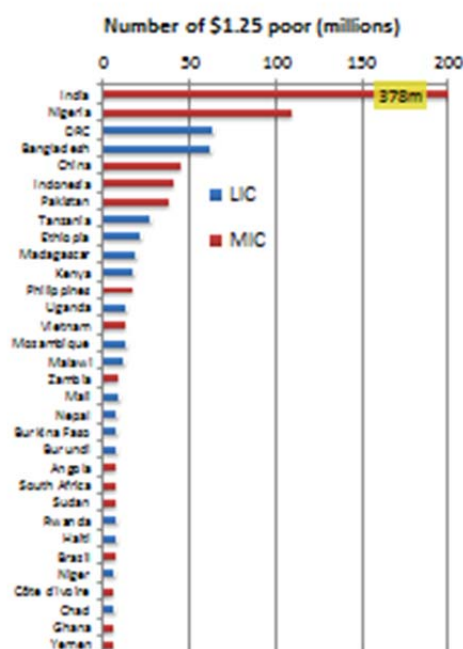
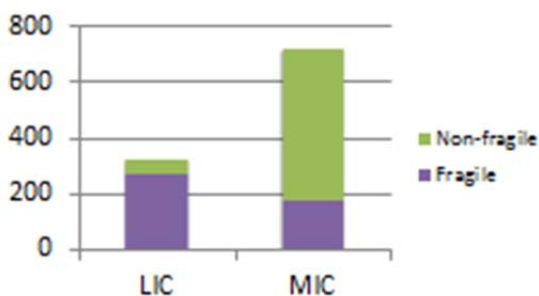
This slide is taken from a presentation given by Sir Andy Haines of the London School of Hygiene and Tropical Medicine. While it was true in the 1980s that Non Communicable Lifestyle diseases were more prevalent in high income countries and that infectious diseases were more prevalent in middle and low income countries, patterns of disease are changing rapidly. The WHO Noncommunicable diseases country profiles 2011 report notes: “Low- and lower-middle-income countries have the highest proportion of deaths under 60 years from NCDs. Premature deaths under 60 years for high-income countries were 13% and 25% for upper-middle-income countries. In lower-middle-income countries the proportion of premature NCD deaths under 60 years rose to 28%, more than double the proportion in high-income countries. In low-income countries the proportion of premature NCD deaths under 60 years was 41%, three times the proportion in high-income countries”.

In many middle and low income countries high rates of NCDs associated with smoking, alcohol and other drug consumption and obesity are found alongside high rates of under-nutrition. Highest rates of obesity are found amongst urban populations. Slum areas have the highest rates of all forms of disease. While a total 227 million people in the world have moved out of slum conditions since 2000 the absolute number of slum dwellers has increased from 777 million in 2000 to 828 million in 2010.

This points to the fact that both access to health systems and action to enable people to live healthy lives is required in both low and middle income countries. It is also essential to address the global diplomatic, economic and trade systems that fail to protect citizens from conflict and violence and trap people in poverty, while supporting the promotion of grossly unhealthy products and lifestyles. This requires national, regional and global political action. **Health is a product of a political process.**

Most Poor people live in MICs

- Most poor people live in MICs (2/3rd of people living under \$1.25 a day).
- LIC poverty is concentrated in fragile states (83% of LIC poor)



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This slide is taken from a presentation by Dr Neil Squires, Head of Profession Health at the Department for International Development. It shows that most poor people living on less than \$1.25 a day live in middle income countries. Out of some 1.1 billion people (2011) living on less than \$1.25 a day about 700 million live in middle income countries, including India (378 m), Nigeria (110 m) China (45 m but falling rapidly), Indonesia (40m) and Pakistan (35m).

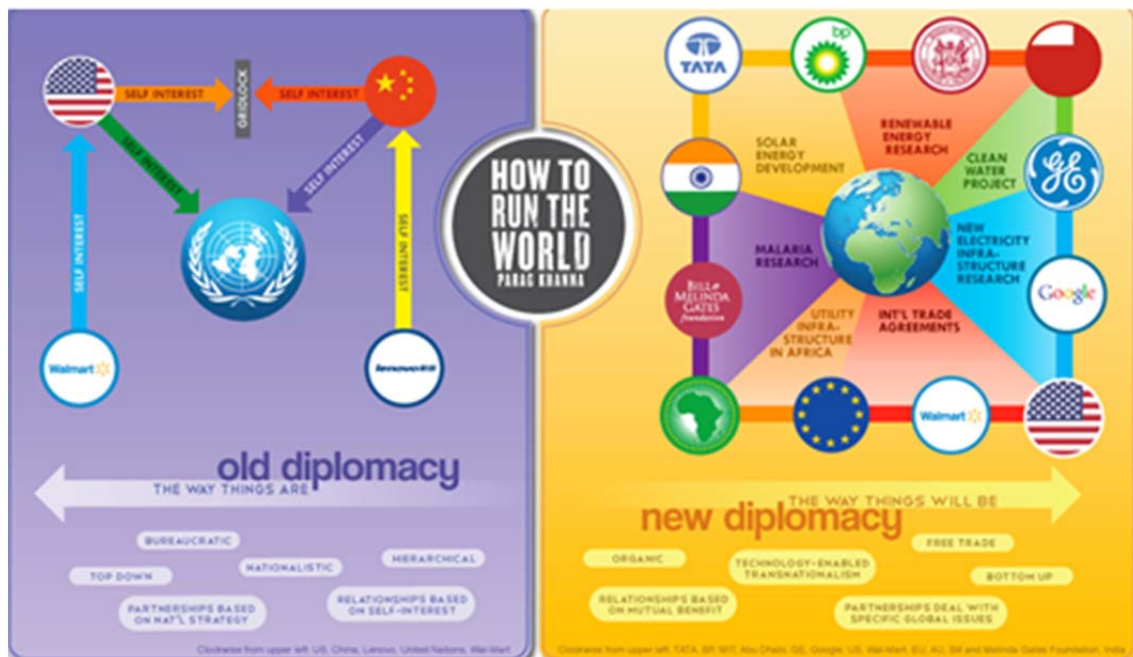
Most poor people in low income countries (83%) and many in middle income countries (25%) live in fragile states, which the OECD defines as “Those failing to provide basic services to poor people because they are unwilling or unable to do so”. This often reflects a lack of trust between government and people, possibly as a result of conflict or lack of legitimacy because of corruption.

Protecting the health security of its people may be seen as the first duty of a state, providing health security builds trust and legitimacy, failure to provide for health is conversely a sign of a failing state. At national level it is again apparent that health is always an intensely political issue. For international aid cooperation this poses difficult questions, can aid be provided to the poorest countries, without addressing the political conditions that create fragility and poor health?

The Abuja Declaration of 2001 committed member states of the African Union to increase spending on health to 15% of government budgets, but only one country has met this target and many have reduced the proportion, (OECD countries provide only 0.32% of GDP as aid against a target of 0.7%).

And can aid to the poorest people in middle income countries be justified in the light of income disparity and government budgets that may include high military expenditure and, in the case of China and India, space exploration? **This is another reason why diplomacy is a necessary component of global health cooperation.**

How is the world run?



Source Parag Khanna 2011

This diagram was produced by Rahul Kamath to illustrate Parag Khanna’s ideas set out in his book “How to run the world”. His view of modern diplomacy moves beyond the state centric world of the 1944 Bretton Woods system, to what he describes as mega diplomacy. This takes place in a “multi-polar” world, in which shifting coalitions of states, international NGOs, philanthropic foundations, multi-national businesses, cities, civil society groups and others influence the formation and application of partnership agreements to address issues of national, regional and global concern – such as global health.

This view is to some extent echoed by Stewart Patrick of the US Council on Foreign Relations in his article “The Unruled World”(see <http://www.foreignaffairs.com/articles/140343/stewart-patrick/the-unruled-world>). Stewart argues for “good enough” global governance, accepting the reality of a weak UN system, stymied by the diffusion of power across states and other actors with widely different interests that may (or may not) coalesce to address specific issues, increasingly at regional and sub-regional levels but also at global meetings.

Both Parag Khanna and Stewart Patrick present views of diplomacy in a world in which “global governance” is complex and difficult, involving many different actors at national, regional and global levels. You may wish to view some of the You Tube videos, in which Parag Khanna explains his view of the world, see for example:

http://link.brightcove.com/services/player/bcpid651017566001?bckey=AQ~~,AAAAGuNzXFE~_qu1BWJRJ7c26MMkBB19ukwmFB5ysvYz5&bctid=760202258001

In the following sessions we will explore this world of diplomacy and its relevance not only to public health but also to our foreign policy and to global governance.

Why is this Relevant to You?

- I want to study International & Global Health
- I want to improve health in poor countries
- I want to improve health in my country
- I want to create better health for all
- I want to protect our future health
- I want to save the world



When John Wyn Owen, Kelley Lee and I first introduced the concepts of global health to the UK we could not imagine that it would become such an important stimulus for research and policy. We supported others to develop programmes at UCL, London, in Medsin (Medical Students International) and in Dublin, Amsterdam, Canberra, Sydney and elsewhere. We helped organise a programme at the European Healthcare Forum in Gastein in 2004 with David Byrne, (European Commissioner for Health) as a starting point for EU policy for global health.

There is still a need for more research on international health issues and systems but I suggest that in many cases research evidence is not enough. You also need to consider the political dimension, if your findings are to be accepted and delivered, either in other countries or in your own country. This will mean working with many different partners, including the private sector and it won't be easy. You will need skills in global health diplomacy and in public diplomacy – or as we call it social marketing to promote public action for health.

For me global health diplomacy has a wider significance, I see it as an example of the development of global governance in a complex, multi polar world. Diplomacy is not simply a means of defending national interests - it must also encompass the management of global public goods (from which all benefit and none can be excluded). At a time of increasing competition for resources such as food and water, pollution of our air and oceans, climate disruption and growing inequality between and within countries; **better global governance is essential not only for our future health but for our survival.**

So What is Diplomacy?



- Diplomacy is the art and practice of creating relationships, sharing values, and negotiating alliances, treaties, and agreements between representatives of different countries and agencies to achieve their policy objectives through mutual agreement.
- Edmund Burke coined the term diplomacy in 1775
“All government, indeed every human benefit and enjoyment, every virtue and every prudent act, is founded on compromise and barter.”

Diplomacy refers to both specific methods for reaching compromise and consensus, as well as a system of organisation for the negotiating process. It is essentially a political activity for the adjustment of differences, through negotiation in a legitimate international order (Kissinger H (1994) The New World Order. Chapter 1. In: Diplomacy. New York: Simon and Schuster).

Diplomacy starts by building relationships, developing shared values and mutual understanding and establishing coalitions of the willing. Moreover, it does not end once an agreement is signed, diplomatic negotiations continue throughout the implementation of agreements.

Over time, as the environment within which diplomacy functions has changed, both the methods and the system of diplomacy have evolved to reflect:

- The increase in both summit diplomacy and technical diplomacy, both of which require diplomatic support of a different nature to conventional “embassy representation”.
- Changing power balance from the cold war to the current multipolar world in which alliances of interest groups of nations and other actors coalesce on specific issues of interest to them.
- The rise of regional and sub-regional organisations including the EU, AU, ASEAN, UNASUR, but also many sub regional groups within regions and cross regional groups such as OIC.
- The engagement of new actors including, for health: Public Private Partnerships (~300), International Non-Government Organisations (~ 1,000), and Civil Society Groups (~ 250,000).
- Multinational Corporations, (there are more than 40,000 MNCs, in 1995 the top 200 MNCs had a turnover of \$7.1 trillion, 28.3 percent of the world's gross domestic product).
- Internet Communications and Social Media (and its vulnerability to hacking).
- Increasing recognition of the need to address global threats and to manage global public goods, as well as maintaining national interests.

Diplomacy is the process of global governance it must engage all these actors.



History of Diplomacy

- Foreign relations amongst Italian city-states: 1350+
- First modern foreign ministry created in France: 1626.
- Peace of Westphalia treaties - state's sovereignty: 1648
- Congress of Vienna - multilateral diplomacy: 1815
- Multilateral conferences 1830 +
- The League of Nations: 1919.
- The United Nations system: 1945



Fourteenth-sixteenth century: The first ministries of foreign relations were developed by Italian city-states. The political works, of Niccolò Machiavelli - "The Prince" and "Discourses" provide fascinating and sometimes surprisingly relevant reflections.

Seventeenth century: The Peace of Westphalia treaties introduced a new political order in central Europe based on the concept of each state's exclusive sovereignty over its lands, its people, and its agents abroad. Thomas Hobbes, "Leviathan" sets out a philosophical case for the all powerful state.

Eighteenth century: As a response to threats from other States, European Great Powers constantly shifted alliances to maintain a balance of power. Adam Smith "The Wealth of Nations" reflects this.

Nineteenth century: After the Congress of Vienna, the Concert of Europe introduced a new multilateral system of diplomacy. Multilateral conferences on a range of topics allowed for simultaneous negotiation among states. Jeremy Bentham's utilitarianism has resonance with this.

Twentieth century: The diplomatic system was rapidly weakened due to political and economic rivalries leading to the First World War. The League of Nations, in 1919, was the first universal membership organisation. The idea was to move to a 'parliament of man' with negotiations run by an international secretariat. Bertrand Russell and logical positivism was a hopeful undercurrent.

The United Nations system was established following the Bretton Woods Conference of 1944, many international agencies, including the World Health Organization, were established. The Charter for Human Rights (1948) established for the first time that other governments could be concerned with how a state treats its people. While the Charter for Human Right may be said to be informed by Immanuel Kant's Categorical Imperative and its implications (1785), UN diplomacy reflects John Rawls "A Theory of Justice" balancing freedom and equity but stressing state freedom to act.

The role of the UN has diminished but it is still a central to global governance.



Modern Diplomacy

- Bilateral Diplomacy – Trade/Aid/Soft/Hard/Smart power
- UN Diplomacy – Leadership/Framing Issues/ECOSOC
- Global Public Goods Diplomacy – SDGs/WwW
- Responsibility to Protect – R2P Alliance
- Summit Diplomacy – G7/8 Club Diplomacy
- Multipolar diplomacy – G20/G77
- Regional Diplomacy – EU/ AU/ ASEAN/UNASUR
- Public Diplomacy – People’s Diplomacy
- People’s Diplomacy – Arab Spring
- Mega Diplomacy – Network Diplomacy



Bilateralism is the prevalent form of relationship, for example 70% of aid is provided through bilateral agreements. Smart power refers to the use of persuasion backed by possible sanctions.

More than 50 informal groups of nations act as coalitions at the UN. Despite many efforts it has remained largely unreformed in its structure or the membership of the Security Council. However, it has made some tentative advances. At national level UN Agencies are asked to improve coherence, to “Deliver as One”. There have also been small steps to engage with the private sector through the “Global Compact”. The UN is increasingly focussing on global public goods for sustainable development and have been engaging Civil Society organisations, through ECOSOC, “The World we Want”(WwW) debate leading to post 2015 goals and in the Responsibility to Protect (R2P) Alliance.

‘Summit diplomacy’ was initially dominated by the G7 /G8 meetings, but, when faced with the global economic crisis of 2008, the locus of discussion moved to the G20 meeting of the Finance Ministers of the 20 leading economies, representing 80% of the global economy (the economies of China, India, and Brazil are now the second, third, and seventh largest by GDP). It was thought that G20 would take on some of the roles of G8, for example, in relation to the MDGs but this has not so far been evident, perhaps because the sense of “club” responsibility has not emerged.

Regional Organisations and sub-regional co-operations have greatly increased in recent years and South-South and Triangular Co-operation has also grown.

Soft power(described by Joseph Nye as” getting people to want the things you want”) influences the population of another country through Public Diplomacy. Peoples Diplomacy is expression of public aims and often rage, via social media – as during the Arab Spring.

All are elements of mega-diplomacy.

Global Health Diplomacy History

Global health diplomacy, developed in 5 stages:

- The first International Sanitary Conferences.
- The first international health organisations.
- Creation of the World Health Organization.
- Alma Ata Declaration / Primary Healthcare for all.
- 2000 -2004: toward a multi-polar world with.
 - The Millennium Development Goals , greatly increase health aid
 - 280 Public-Private Partnerships such as GAVI and the Global Fund
 - NGOs such as Oxfam and Médecins sans Frontières take a larger role
 - Civil Society Organisations and Faith Based Organisations are engaged



The first international body to control health was the 1839 Constantinople Supreme Council for Healthcare. The 1851 International Sanitary Conference held in Paris, was the first of 10 to consider the problems of infectious diseases and their impact on trade and shipping, bringing together diplomats and doctors from at first 7 and then 12 countries.

There were no inter-governmental health agencies until the first half of the twentieth century. The Pan American Sanitary Bureau (PASB) was created in 1902, the International Office of Public Hygiene (OIHP) in 1903, and the League of Nations Health Organization (LNHO) in 1920.

The WHO was established in Geneva in June 1948. It resulted from the unification of the OIHP, the LNHO, PAHO and other regional bodies. By that time the regional PASB had been very active since its inception in 1902 and had become the Pan American Health Organization (PAHO). The diplomacy that led to the creation of the WHO was led by a Chinese health diplomat Dr Szeming Sze, read his story at [http://whqlibdoc.who.int/analytics/WHForum_1988_9\(1\)_29-34.pdf](http://whqlibdoc.who.int/analytics/WHForum_1988_9(1)_29-34.pdf) .

In 1978, the international health agenda and diplomacy in general were taken a step further by an international conference on primary healthcare held in Alma Ata, Kazakhstan, bringing together countries across the divides of a world polarised by the Cold War. The success of this conference also paved the way for health to become a focus for international agreement and action, for example, at subsequent G7/8 meetings, at the UN and in the Millennium Development Goals.

With the end of the cold war, a more complex diplomatic environment has emerged, this has introduced many more actors in global health diplomacy.

A major milestone emerging from Alma Ata was a declaration reaffirming health as fundamental right, bringing forward the importance of primary healthcare and emphasising the role of the state government in providing health for all.



Modern Global Health Diplomacy



- Millennium Development Goals: 4,5,6 + I and 8
 - Child mortality, Maternal Health, HIV/AIDS, Malaria and TB
 - Plus reducing hunger and partnership towards the 0.7% GDP target
- International Laws
 - Framework Convention on Tobacco Control (FCTC)
 - International Health Regulations (IHR)
 - Trade Related Aspects of Intellectual Property Rights (TRIPS)
- WHO as a normative leader of health diplomacy
- Multiple agencies and channels for health diplomacy
- The Oslo Declaration and Subsequent UN Resolutions
 - Health and Foreign Policy



The MDGS were preceded by a consultation with representatives of over 1,000 non-governmental and civil society organizations from more than 100 countries. However, decision making at the Mexico Summit was dominated by G8 leaders. The MDGs introduced a new pattern of diplomacy for global development goals, with clear targets and commitments followed up by monitored results.

The FCTC adopted in 2005 represented a watershed for global public health; not only was the treaty the first to be adopted under WHO's Article 19, but it the first multilateral, binding agreements regarding a chronic, non-communicable disease (see the WHO constitution, a remarkable document, at http://www.who.int/governance/eb/who_constitution_en.pdf)

IHR was another step towards an international legal framework for global health. Diplomacy regarding the WTO TRIPS agreement is aimed at enabling low income countries to challenge the pricing of essential medicines, while still ensuring that there are incentives for research and development. This has been a longstanding dispute since the 2001 Doha Trade round began.

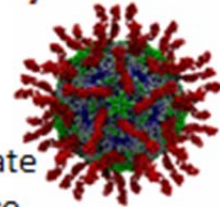
The six core functions defined in the WHO 11th General Programme of Work underline WHO's role in health diplomacy:

1. Provide leadership on matters critical to health and engage in partnerships.
2. Shape the research agenda, and stimulate knowledge.
3. Set norms and standards, and promote and monitor their implementation.
4. Articulate ethical and evidence-based policy options.
5. Provide technical support, catalyse change and build institutional capacity.
6. Monitor the health situation and assess health trends.

United Nations Resolutions on Global Health and Foreign Policy (UNGA, 2008, 2009 and 2010) stress the need to train diplomats and health officials in global health diplomacy. **In response the Global Health Programme of the Graduate Institute Geneva has developed a range of courses, books, case studies and other resources to support global health diplomacy see <http://graduateinstitute.ch/globalhealth> .**

The Future of Health Diplomacy

- Post 2015 goals
 - The World we Want debate –wider engagement
 - Sustainable development: poverty, food, water, climate
 - Universal Health Coverage plus cross cutting influence
 - Continuation of the MDG agenda
- Other major global health issues
 - Action on NCDs – another framework convention?
 - Antimicrobial resistance – a major concern/ Pharma cos
 - Emergent diseases – implementation of IHR
 - Neglected Tropical Diseases – working with Pharma Cos
 - Maternal and child health – still a major focus



The next phase of development will require an intensification of diplomatic efforts for global health as a new set of global development goals is agreed. It is notable that the debate on post 2015 goals has been characterized by wider cross sector engagement. The goals must be sustainable in terms of their costs but also for impacts on climate, food and water access, all deeply political issues.

For health the focus of the proposed new post 2015 goal is Universal Health Cover and most people without access to health services live in middle income and low income countries, which are mostly categorised as fragile states, so again political issues will need to be addressed.

In other health fields there will be an increasing focus on NCDs, with the possibility of the WHO “Global action plan for the prevention and control of NCDs 2013-2020” leading to a Framework Convention – this time taking on “Big Sugar”.

The increasing development of resistant strains of diseases due to misuse of antibiotics for treating cattle and coughs in rich countries and uncontrolled sale in poor countries is an urgent issue to be addressed. To illustrate this I bought a single dose of Rocephin, a fourth generation antibiotic, in a wayside shack in Cambodia.

Emergent and re-emergent diseases (particular zoonotic) - 30 in the last 20 years, pose a continuing threat to global health. The SARs epidemic of 2001/3, though it caused the death of less than 800 people, produced major economic disruption. This was a stimulus for agreement of the International Health Regulations of 2005. However, there has been a political dispute over virus sharing in Indonesia and the question of how implementation will be funded is still not resolved. Other issues include working with pharmaceutical companies and NGO/CSO to improve Access to Medicines (including those for HIV/AIDS and Neglected Tropical Diseases) and Maternal & Child Health – a soft power focus.

Global health diplomacy will be even more critical in future.

Where does diplomacy happen?

- **Governance for Global Health**
 - Between government departments
 - With international aid agencies
 - With NGOs and CSOs
 - With business interests
- **Global Health Governance**
 - Within regions – EU
 - Sub regions - SEEHN
 - At WHA and UNGA
- **Global Governance for Health**
 - At WTO, WEF
 - Across Regions – G77
 - At UN: ECOSOC, ILO, UNEP



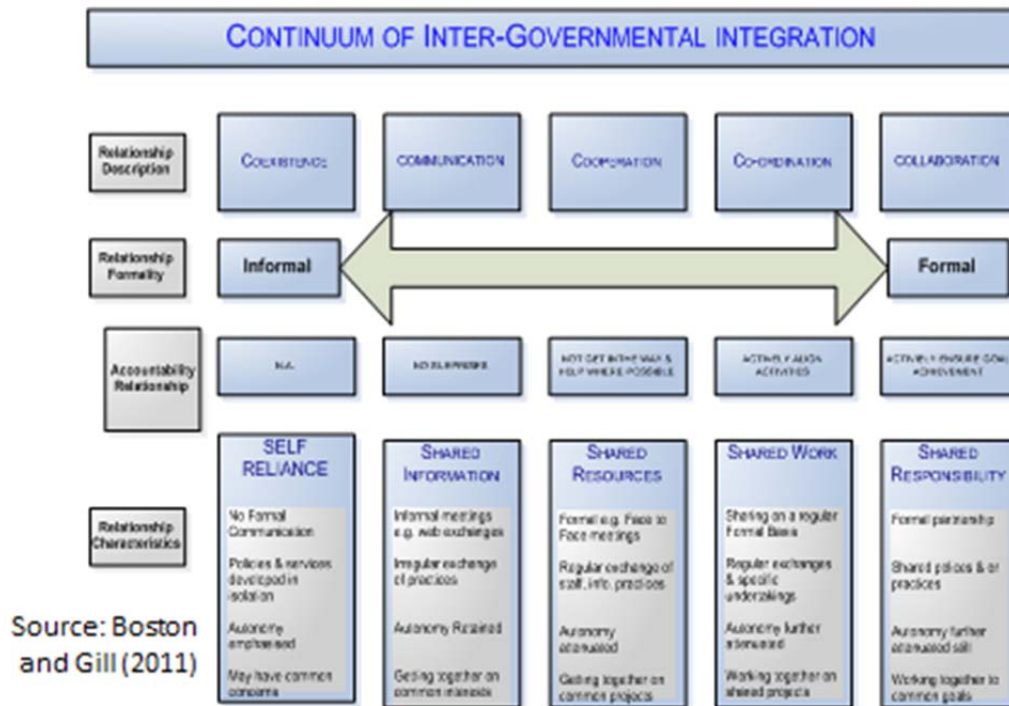
At national level **Governance for Global Health** requires cross sector engagement to address global health issues. For example a programme to address child obesity might engage agencies responsible for: health, education, parks and recreation, sports, food sales, taxation and wellbeing. These could include national and local government, international, national and local NGOs and CSOs as well as food and retail business interests.

Global health governance is focussed on regional and sub regional action as well as global agreements (for example agreement on regional action on food labelling at the EU). At global level the "Global action plan for the prevention and control of NCDs 2013-2020", agreed at the World Health Assembly, provides a framework of norms and measures to guide national and regional action" (see <http://www.who.int/nmh/en/>). The 2011 UN "Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases" provides political backing for international action (see <http://www.ncdalliance.org/node/3521>). But as you will see, if you follow the link, it also provides a forum for NGOs and CSOs. The NCD Alliance unites a network of over 2,000 civil society organizations in more than 170 countries.

Governance for global health refers to the need to exercise global health diplomacy with the many other international agencies and agreements that influence global health. The World Trade Organisation influences the determinants of health to promote free trade. Note that WTO is not a UN organisation but a multilateral agreement between states. The USA, where 28% of the largest MNCs are headquartered, has resisted the engagement of the UN with the regulation of trade or the actions of MNCs. However, there is increasing anger at the way MNCs manipulate their internal pricing to avoid tax and encourage a "race to the bottom" for health and environmental standards.

The UN has a system for negotiating food safety standards (Codex Alimentarius) but no system for regulating impacts of global companies on determinants of health or other global public goods.

Coherent Policies for Global Health



While it may seem obvious that different parts of government should work together to achieve national goals in fields such as: health, education, trade and welfare, it is also apparent that different departments and agencies have different objectives and approaches. They therefore tend to drift apart and coordinate their efforts only partially as indicated by the diagram from Boston and Gill 2001 “Joint or Shared Accountability: Issues and Options”. For this reason policy coherence in fields such as global health, require a collective effort and a mechanism for coordination.

One mechanism for coordination is a national strategy for global health, such as the UK “Health is Global” and its subsequent “Outcomes Framework”. The strategy provides a way of linking domestic and global health concerns to foreign policy, aid and trade interests. It also provides a forum to engage UK based NGOs and academic partners. Other countries that have developed different ways to improve policy coherence for global health as it affects national interests and foreign policy include:

- Switzerland, Brazil, Cuba, USA, Japan, Norway, and Sweden all of which have mechanisms linking health and foreign policy including aid.
- China and India, which link global health with foreign policy, aid and trade.
- Indonesia and Thailand have agencies ensuring coherence both with respect to national health and their contribution to global health.
- The European Union, The African Union, The Association of Southeast Asian Nations and the Union of South American Countries all have mechanisms for ensuring coherent cross border approaches to global health.

These are all mechanisms to establish the policy coherence necessary for global health diplomacy.



Working Across Borders

- Health Aid has grown rapidly in recent years
 - \$15b to \$30b, but for health in low income countries
 - aid = 15-30%, Govt = 15-30%, People = 30-70%
- Trends in Aid
 - Increase Public Private Partnership/Foundation aid
 - Growth of South-South Aid /Triangular cooperation
 - Development of Regional/Sub Regional cooperation
 - Growing awareness of need to address MNCs
 - And other corruption



Total Official Development Aid (ODA) amounted to some \$140 billion in 2010, OECD countries provide more than 90% of this, 70% of which is managed through bilateral agreements. In addition about \$55 billion of aid is donated through non-governmental and private philanthropy. This is still less than half of the commitment of 1 % of Gross Domestic Product (now measures as Gross National Income (GNI)) made at the UN in 1970 (0.7% ODA plus 0.3% from private sources). Current ODA is 0.33% of the GNI of OECD countries and 0.13% of GNI from other sources). In 2013 the UK became one of the six countries meeting its commitment to the ODA target of 0.7% of GNI and is also a major source of NGO philanthropy. Total global aid flow of some \$195 billion, can be compared with worker remittances to low and middle income countries of some \$326 billion.

Health aid has doubled from 2002 to 2012 and now amounts to some \$27–30 billion (11% of ODA and 22% of Foundation and other civil society aid), this is about a third of the agriculture subsidies paid by rich OECD countries to their farmers.

Health aid is made up of: bilateral and EU aid, \$12.5 billion; development banks \$2 billion; UN agencies, \$4 billion; global partnerships and programmes \$5 billion; foundations about \$2 billion; and NGOs about \$2 billion.

But in low-income countries, health aid only accounts for about 15–30% of health expenditure, government expenditure making up a further 15–30%; out-of-pocket expenditure including co-payments, purchase of medicines, and informal payments make up 30–70% (Hsiao and Shaw, 2007). In total, low-income countries, which experience 56% of the burden of disease, take up less than 2% of total global health expenditure, \$120 billion out of a total of \$6.5 trillion (WHO 2012).

South-South Aid is growing but constitutes less than 5% of aid. It is claimed South-South aid is more empowering and less conditional, but does this mean more corruption? Triangular aid is low income countries sharing expertise, with funding from a rich one. **These are further manifestations of global health diplomacy.**

Working together for Global Health

Just as the different aims and objectives of Government Departments lead to loss of policy coherence, the many different agencies working in health in low and middle income countries create problems. There have been many different attempts to fix this:

- Sector-wide approach (SWAp) 1990s
- Paris Declaration on Aid Effectiveness 2005
- International Health Partnership IHP+ 2007
- Accra Agenda for Action on Aid Effectiveness 2008
- Health 8 (H8)
- Busan Partnership for Effective Development Cooperation 2011



Working together depends upon the skill and commitment of those engaged in negotiating their working relationships.

Sector-wide approaches (SWAps) require leadership from the host country Ministry of Health, improved planning and management and greater discipline on the part of donors, to fund only those areas identified in a national health sector plan.

The Paris Declaration on Aid Effectiveness of 2005 established five principles: country ownership, alignment of goals, harmonisation of efforts, results orientation and mutual accountability.

IHP+ was launched in 2007 (initiated by UK as IHP). It is a Global Compact to deliver the Paris principles through a systematic process for engaging all partners including NGOs and Civil Society Groups, managing and reporting on aid projects. It currently comprises 59 donor and recipient countries administered by the WHO and World Bank.

The Accra Agenda for Action on Aid Effectiveness of 2008 built on the Paris Declaration and provided concrete commitments to reduce duplication and improve the value for money of aid. It placed particular stress on wider engagement with civil society organisations in planning and implementing aid projects.

Health 8 (H8) created in 2007 as an informal coordination meeting of: WHO, UNICEF, UNFPA, UNAIDS, GFATM, GAVI, the Bill and Melinda Gates Foundation and the World Bank.

The Busan Partnership for Effective Development Cooperation of 2011 takes further steps along the path set by the Paris Declaration and the Accra Agenda. It recognises the importance of addressing the needs of fragile states, of recognising the potential of south-south cooperation, and of engaging with private sector and civil society partners. These are seen as steps to improve aid effectiveness and to extend partnership for development.

All depend on improved capacity for global health diplomacy in host countries.

Agreements for Health

- Diplomatic negotiations build agreements working together
 - At local, national and bilateral levels
 - At regional and sub regional organisations
 - At cross cutting organisations e.g. OIC and Commonwealth
 - At summits and conferences
 - At WHA, WTO, UN
 - These agreements may be
 - Hard Law or
 - Soft Law
- Effectiveness depends on win-win



Agreements to collective action for health may be reached at many different levels, as examples: “Health is Global” provides a basis for national agreement, the European Union has established a Strategy for Global Health, agreements at sub regional level include those of the South-eastern European Health Network and amongst members of the Organisation of Islamic Cooperation.

International agreements strengthen the position of countries, for example, in the face of threats of legal action from MNCs (a consortium of tobacco companies is currently suing various countries to remove warning pictures from cigarette packages).

In international law a distinction is sometimes made between hard law and soft law agreements. The distinction indicates the extent to which agreements commit the parties involved and the recourse to agreed sanctions in international law if they are not complied with. Hard-law agreements are expressed in different forms including: Constitutions, Conventions, Framework conventions, Regulations and Protocols.

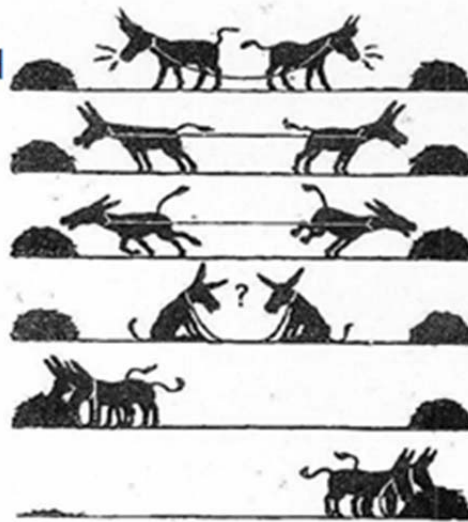
There is no rigid classification but soft law implies a general agreement with perhaps some mutually understood consequences in case of non-compliance but not a recourse to international courts. Soft law instruments are usually identified as: recommendations, including codes of conduct, strategies, nomenclatures, and standards; advisory mechanisms, including advisory groups, impact assessment methods and commissions; and collaborative, operative, and normative instruments. These include memoranda of understanding (MoU) which are often used to express commitments to bilateral aid collaboration and agreements (or contracts) with NGOs and CSOs involved in implementing health projects.

These instruments may be formulated as resolutions, decisions, declarations, guidelines, or statements of the World Health Assembly or other bodies. Their binding nature varies according to the type and content of the instrument. International affairs and laws rely greatly on precedents. The systematic adoption of soft-law instruments on a given issue may create the momentum to create a more binding instrument.

A state may feel as much pressure to abide by a soft law agreement, because of the force of public diplomacy as to abide by unpopular hard laws.

Why negotiate health

- Health is a global good but different interpretations and different interests must be reconciled.
- In health we are nearly always trying to achieve win-win outcomes.
- Because what good is an agreement that is not followed in practice.



Negotiation is a key process of global health diplomacy. Negotiations can be formal or informal, local, national, international or global in scope. In some cases they will be of a win-lose nature, for example, in negotiating a commercial contract for the supply of medicines.

But where the parties to an agreement must implement the measures agreed upon themselves, there will be little point in negotiating an agreement that the parties have no intention of observing. In such cases a win-win approach is required so that all the parties are motivated to work together.

This applies to local agreements; for example, the owners of a new factory may agree with local community groups to ensure the environmental and health impacts of their plant will be minimised and that local people will have opportunities for employment and factory provided health facilities. A public health role may be to assist in both the negotiation and subsequent implementation of the terms agreed.

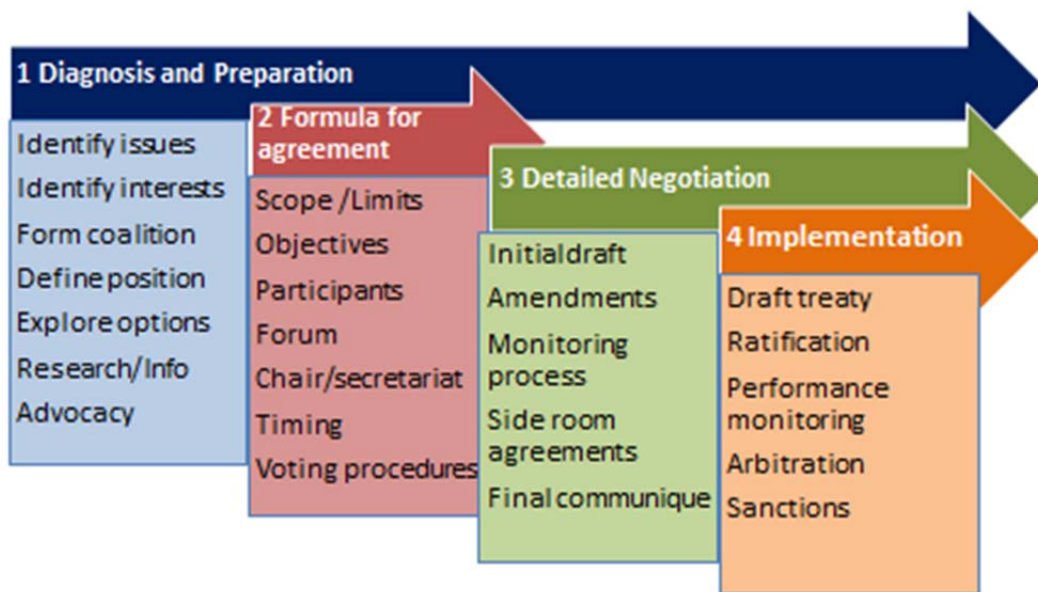
At national level agreements will be negotiated with aid organisations and NGOs and CSOs involved in a health improvement. A public health role may be to support negotiations and monitor implementation based on the national health strategy.

At regional and sub-regional level states and other organisations may agree to joint action, for example, to monitor water quality in a river basin area. They may also agree to adopt a common regional approach to global health negotiations, whether at the WHA or WTO, a public health role may help to develop a common understanding of long term interests in global health.

Global health diplomacy is not confined to international treaties it occurs at every level and in every situation in which joint action is required, this applies to all actions for global public health.

Achieving win-win outcomes requires diplomacy skills.

The negotiation process



The process (based on Lister and Lee, (2013) “The process and practice of negotiation”, in Kickbusch, Lister et al. [eds] Textbook on Global Health Diplomacy. New York: Springer.) can be discerned in all negotiations, whether at local or global level, but clearly you need to interpret the stages in somewhat different ways.

Diagnosis and preparation is the most important phase; careful timing and selection of the issues to be addressed, identifying the interested parties and their interests, creation of “coalitions of the willing”, defining the coalition’s position, exploring the options for agreement and undertaking research and advocacy to build a case and create the conditions in which parties are open to negotiation are essential.

The formula for agreement phase defines the scope and limits of the agreement it is hoped to achieve and its legal form, the aims and objectives, who will participate and how negotiations will be conducted.

Detailed negotiation may involve different participants setting out their opening positions or may use an initial draft with points at which disagreement must be resolved identified. Parties to the negotiation then propose amendments and address issues such as: how the outcome is to be monitored and what should happen in case of default from the agreement. The main agreement may be encouraged by “side room” agreements to overcome obstacles.

But the final communiqué or written agreement is not the end of negotiation, it is the start of the implementation phase, which itself will often involve continuing negotiation of the acceptance, interpretation and performance of the agreement.

Negotiation of diplomatic agreements is the basic process of global governance.

Mega Diplomacy: Power and Interests

- To negotiate with many different groups you need to
- Support self organisation (coalitions) and
- Understand what underlies their positions.
 - Power:
 - Discursive, decision making, legal, economic, influence
 - Legitimacy
 - State, moral, democratic, experience, knowledge,
 - Interests
 - Political, financial, reputational, association
- This is a basis for negotiation and win-win outcomes



The modern world of mega diplomacy for health requires public health leaders to work with many different partners and sometimes opponents. A key starting point is to gain an understanding of the factors that underlie the position taken by each of the parties involved. It is important to understand the basis of their power, which may derive from: discursive power - being able to define the situation and set norms, decision making power – ability to take decisions without deferring to others, legal power – based on rights established by international and national laws, economic power – controlling the financial or other resources required, or influence – the ability to sway the behaviour and choices of others (the public or perhaps health professionals).

In practice it is often important to distinguish between the position and power of the organisations represented in a negotiation and the personal position and power of the individual in the room. Negotiators can be limited or empowered by the instructions they receive, understanding this is key.

It is also essential to understand the factors that support the legitimacy of each party. These include: state legitimacy – the authority vested in a state institution to act on behalf of citizens, moral legitimacy – based on human rights and equity, democratic legitimacy – established through election, experience – patient groups may derive legitimacy because their members share direct experience of a condition, knowledge – the expertise derived from research or skills in providing treatment.

Individuals will also build personal legitimacy, earning the trust and respect of others at the negotiation, though in some cases the reverse may happen.

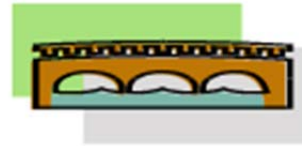
All these factors may reflect, or sometimes hide, underlying interests. These may include: political interests – reflecting a national or local party position, financial interests – receiving income for service or from a private sector sponsor and sometimes receiving corrupt payments, reputational interests – protecting their good name and associational interests – their relationship with other parties.

Interests and power are complex in global health mega diplomacy.

Tips for health negotiators



- Reframe the issues
 - To provide negotiating space
- Cross the golden bridge
 - Help them remove obstacles
- Go to your balcony
 - Stand back from the issue
- Bring the extra dimension
 - Add new element to solve issue
- The single text method
 - A creative new approach
- Look for Win-Wins
 - Celebrate success



In negotiating for win-win outcomes for health we can learn from experience, most of these tips are taken from William Ury, the world leader in negotiation skills (you can find talks by him at http://www.ted.com/talks/william_ury.html .)

Reframing the issue means setting the issue in a different policy context, helping people to address the issue in a different way. Thus while you may see an issue solely in health terms, it may be helpful to reframe it as a question of community solidarity. For example smoking is a health issue but it can also be represented as exploitation by multinational companies, or an attack on family life and livelihood.

“Crossing the golden bridge” refers to the importance of helping your opponent to overcome the barriers that face them, to do this you need to accept and work with “where they are coming from” and talk them through the obstacles they face.

“Going to your balcony” means not getting sucked into arguments, keeping a clear perspectives on the aims of the negotiation and discussing issues not personalities.

In some negotiations it can be helpful to introduce an additional element so that everyone wins from the outcome. The story of the 17 camels illustrates this.

The single text method was used to develop the road map for peace in the Middle East, both sides started from hard line positions and would not give way, so the American chair of negotiations started afresh with a single text both sides could take or leave.

Looking for win-wins has been stressed throughout, because if one side feels they “lost” they are unlikely to be enthusiastic about implementing the agreement. One way of reinforcing this is to encourage everyone to cheer at each sign of progress.

Diplomacy and negotiation are difficult arts best learnt from experience.

Leading global health diplomacy

- An encompassing vision, seeing all perspectives
- Emotional intelligence and the ability to listen
- Shared leadership across different actors and countries
- Personal integrity and moral values to earn the trust of others
- Courage to speak truth to power



Leadership of global health diplomacy may be described as the art of “meta leadership” (see <http://npli.sph.harvard.edu/meta-leadership/>). This requires: an encompassing vision - understanding the perspectives that all the parties bring to an issue, but with a vision that transcends the differences they bring. It requires emotional intelligence and the ability to listen to others, which is a much underrated skill in a world obsessed with gesture politics and grandstanding leadership. Global health leaders need to be able to prompt others to take the lead, recognising their skills and strengths and giving them support and encouragement rather than competing with them. Underlying these skills, global health leaders need personal integrity and moral values that earn respect and trust. Most of all a meta leader of health diplomacy must have the courage to speak truth to power and to act on their values.

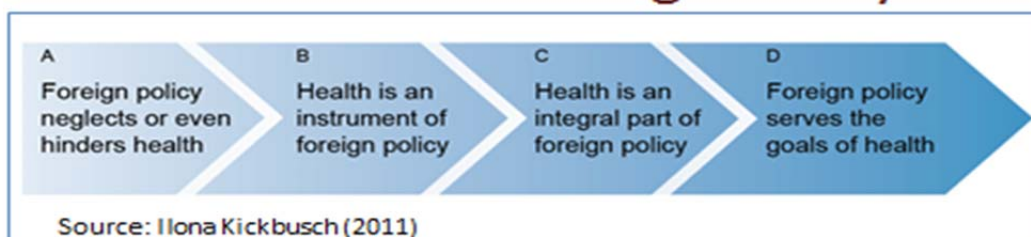
These qualities combine and go beyond elements of “servant leadership”, “leadership through constructive conversations” and “distributed leadership” (if you Google around these phrases you will find examples of the application of these ideas to health leadership). For me these values are best illustrated by a quotation from Nelson Mandela’s book “Long Walk to Freedom” (1995).

As a leader... I have always endeavoured to listen to what each and every person in a discussion had to say before venturing my own opinion. Oftentimes, my own opinion will simply represent a consensus of what I heard in the discussion. I always remember the axiom: a leader is like a shepherd. He stays behind the flock, letting the most nimble go out ahead, whereupon the others follow, not realizing that all along they are being directed from behind.

This quotation illustrates the importance of listening to others, summarizing – often framing issues in terms of underlying values and guiding the direction of others – all key attributes of diplomacy.

His values, vision and iron will show what is needed to lead global diplomacy.

Health and Foreign Policy



As examples :

A Iraq War – Shock and Awe

B Health as a bridge to peace and Ukraine Crisis

C Women’s health and development

D Developing global governance for health

The illustration taken from Kickbusch I (2011) “Global health diplomacy: How foreign policy can influence health”. British Medical Journal, Vol. 342, suggests there is a continuum of interactions between health and foreign policy. In practice we hear from WHO heads of country offices that different countries and issues are at different stages in this spectrum. Moreover it is not always apparent that there is progress from left to right.

The examples include the “shock and awe” tactics of the Iraq war, that may have been a way of ensuring victory, but paid little heed to the medical facilities or water supplies necessary to protect health and win the peace.

The idea of health as a bridge to peace has emerged as a practical strategy for the UK Ministry of Defence, to “win hearts and minds”. Opponents recognise this and now target health personnel and provide their own health services in some cases.

The current crisis in Central Europe suggests a dilemma, should more EU health and other aide be directed to countries like Moldova, Georgia and Ukraine, for political as well as health reasons?

Women’s health and development is the clearest example of a win-win, for both health and foreign policy. Countries that suffer the worst levels of women’s health and development through conflict or male domination, excused by cultural reference, are crucial to global peace and stability. The potential for economic and social progress released by improving women’s health is immense and equally social advancement is a necessary condition for women’s health.

Foreign policy is no longer simply about advancing a narrow view of national interests, it also recognises that our sustainable future depends upon the creation of an adequate system of global governance. This point is made by the Clingendael report “Futures for Diplomacy” (see http://www.clingendael.nl/sites/default/files/20121030_research_melissen.pdf.) This recognises a fundamental shift in the nature of future diplomacy. **Global governance for health is leading example of the potential for creating this future.**

The Canada-UK Colloquium:

New Realities for Global Health 2013



- Health and Diplomacy experts from UK Canada agreed:
 - Global Health is central to Foreign Policy in the 21st Cent
 - Key to: soft power, sustainable development, global security
 - And to global governance for global public goods
- Key recommendations:
 - Renewal /extension of Maternal Child Health Programme
 - Partnerships action on non-communicable chronic diseases
 - Research cooperation on whole society health solutions
 - Measures to strengthen global governance for health:
 - Renewal of global health protection collaboration
 - Renewal of the Neglected Tropical Diseases programme,

The 2013 Canada -UK Colloquium brought together 50 leading experts in global health and foreign policy, from the two countries and participants from Africa, India and East Asia. The meeting was chaired by John Wyn Owen and I was rapporteur. Our meeting in London and at Cumberland Lodge in Windsor Great Park provided the opportunity to reflect on the new realities of global health and foreign policy, share lessons and identify policy action to build on UK-Canadian successful collaborations in global health and our common interests and concerns.

Canada and the UK governments recognise global health as a foreign policy objective, to protect health in our own countries, to enable sustainable development, build relationships with other peoples and enhance the governance of global public goods. Specific proposals for action included:

1. Investment to build on Canada and Britain's cooperation for the health of mothers, newborn and children, by action to protect children over the first 100 days and to protect girls from violence including rape, abuse and female genital mutilation (global health issues affecting the UK).
2. Partnerships with civil society and the private sector for action on non-communicable chronic diseases such as mental illness, and the diseases associated with tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity:
3. Research cooperation between our countries and with partner countries to develop the science of implementing whole society health engagement and health solutions.
4. Measures to strengthen global governance for health and other global public goods, first by building communities of practice bringing together diplomacy and health knowledge.
5. Renewal and extension of global health protection collaboration programmes.
6. Renewal of support for the Neglected Tropical Diseases (NTDs) programme, which supplies drugs donated by pharmaceutical firms through CSOs and the Queen Elizabeth Diamond Jubilee Trust work against trachoma.

The meeting demonstrated the practical benefits of bringing diplomats (including politicians) and health experts together. While arguments for action on health issues based on needs and equity are paramount, **diplomacy adds an important understanding of how to address the underlying political context of health.**

What should we do now?

Health is Global:
An action framework for
global health 2013-2017



- Health is Global renewal 2015
 - Platform for Health and Foreign Policy
 - Communities of Practice: health and diplomacy
 - Extend cross Govt + NGOs and business
- Post 2015 Goals
 - Develop realistic approach to global governance
 - Identify UK FP interests in Global Public Goods
 - Build Communities of Practice for GPGs
 - Extend to Partner Countries

The leading position established by the UK by developing the “Health is Global” strategy and in leading the debate on post 2015 goals (David Cameron is Joint Chair of the UN Panel considering the post 2015 goals), provides a unique opportunity to lead the next phase of global health diplomacy.

The renewal of “Health is Global” provides a basis for building a UK “community of practice” to share knowledge and experience between diplomats and health experts. The power of such networks was underlined by the 2006 WHO Knowledge Management for Public Health initiative (for which I was rapporteur). The training of WHO Heads of Country Office in Global Health Diplomacy was also designed to foster similar horizontal communities of practice to address common challenges faced at country level as an element of Margaret Chan’s reform of the WHO’s methods of work.

For the UK, communities of practice for health diplomacy can build networks and links across professional and organisational boundaries across government departments, starting with DH, FCO and DfID, as well as strengthening links with NGOs and business. It can improve the assimilation of research findings into practical agreements for action and that conversely can help ensure that research findings reflect country needs and priorities. It can also improve the ability of both health and diplomatic experts to work together for global goals that are also in the UK’s interest

This can stimulate a re-examination of UK’s approach to global governance, which has tended to examine each international agency and goal in isolation, a total systems approach at this level would facilitate a more complex understanding of global governance, building on the DfID “ Multilateral Aid Review 2011”. This would support the development of UK strategy with respect to the Global Public Goods relevant to the post 2015 goals. This could also help FCO to diplomats to respond to the challenge of working with colleagues in areas of technical cooperation and global public goods.

Sharing knowledge and understanding is of course a two way process, diplomats need to understand the technical issues but equally technical experts need to understand diplomacy. This could be enabled by building communities of practice first for the UK, then extended to partner countries.

This would recognise that in the modern world diplomacy has both national and global aims.

Reading

- “Global Health Diplomacy”
 - Ilona Kickbusch, Graham Lister et al Springer Books 2013
- “How to Run the World”
 - Parag Khanna, Random House 2013
- “Getting Past No”
 - William Ury, Random House 1991
- “The Lancet—University of Oslo Commission on Global Governance for Health”
 - The Lancet 2014 or watch the launch online at
 - <http://www.thelancet.com/commissions/global-governance-for-health>
- For news, views and a full glossary visit the Global Health Europe web site
 - <http://globalhealth europe.org/>
- I also urge you to join Medsin a student network tackling global and local health inequalities through education, advocacy and action.

Graham Lister MSc PhD

I am a sociologist and economist working for better health. From 2005 I have worked with the Global Health programme of the Graduate Institute Geneva to develop their Global Health Europe web site co-author “European Perspectives on Global Health” and edit their textbook book “Global Health Diplomacy”. I also helped develop training materials and tutored 120 WHO Heads of Country Office on a 10 week online development programme in global health diplomacy, I also helped develop and taught a course for Global Fund staff and delivered a course in Moldova for health and other ministry officials and partners with my colleagues Michel Kazatchkine and Mihály Kökény.

From 1999 - 2004 I worked with Nuffield Trust, leading their programme “Global Health: a local issue”, that introduced this topic to the UK and Europe. We also ran programmes on globalisation and women’s health, and the first international conference on Health and Foreign Policy at Ditchley Park in 2004. I prepared the health input to the White Paper “Making Globalisation Work for the Poor” and assisted in early drafting of UK strategy for global health “Health is Global”.

I have worked with the WHO and EU on leadership, management and reform in Geneva, Copenhagen, Beijing, Muscat, Moscow, Nairobi, Kampala, Dar Es Salaam and as an advisor on the future role of WHO Euro. I was also rapporteur for the WHO Knowledge Management for Public Health Initiative and advised on WHO’s leadership development programme.

I also work in international health including reviews of the public health systems of Hungary, the Czech Republic and Lithuania to prepare for EU Accession, nurse leadership in East Africa and reviews of major hospitals in Kenya and Cambodia. In the UK I work with the National Social Marketing Centre to develop tools for evaluating health and well being interventions.

Prior to this I was the healthcare partner for a major international consulting group, engaged in the reform of the UK NHS and action to improve health systems and policies in many other countries.

Please see my web site: <http://www.building-leadership-for-health.org.uk/>

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