Chapter 3
Current and Future Issues in Global Health Diplomacy

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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

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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