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## Meeting Summary: Centre on Global Health Security

# Global Health Diplomacy: A Way Forward in International Affairs

## Inaugural conference of the Global Health Diplomacy Network

28 - 29 June 2011

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## INTRODUCTION

The inaugural conference of the Global Health Diplomacy Network, of which Chatham House is a member, was held on 28 June, 2011 at Chatham House. More than 190 diplomats (including 6 current or former ambassadors), health professionals, senior government officials, academics, and representatives of business and non-governmental organizations gathered to discuss contemporary issues in global health diplomacy and outlooks for the future of the Network.

After a brief introduction to the Network and its recent activities, the conference opened with a debate on the 5-year legacy, current influence and future of the Foreign Policy and Global Health Initiative (FPGHI), one of the most high-profile efforts aimed at increasing health's importance in foreign policy. This debate was followed by an in-depth discussion of a key issue in global health diplomacy – intellectual property and access to medicines – before proffered papers exploring new players and partnerships in global health diplomacy were presented and discussed. The first day of the conference concluded with an open forum to generate ideas for the further development of the Global Health Diplomacy Network. The second day of the conference discussed the findings of the first set of studies to be produced through the Network's research stream and stimulated ideas for refining priorities for the research stream's future.

## DAY ONE, SESSION ONE

### **The Global Health Diplomacy Network: Background and recent activities**

The Global Health Diplomacy Network was formed as a result of a series of dialogues convened by the World Health Organization and the Rockefeller Foundation in 2009 in response to increasing interest in, and demand for, research, training and advisory expertise concerning diplomatic negotiations affecting health. It brings together practitioners and researchers in order to improve capacity in health diplomacy, and ultimately, to improve global health. It has 16 institutional members, including research institutions, universities and business schools in Europe, Africa, North America and Asia.

The Network divides its activities into three streams - training of health negotiators, information sharing, and research relevant to practitioners seeking to understand better the policy issues and process.

The Network secretariat outlined a range of activities undertaken under the three streams, including training workshops in Thailand and Kenya, a new textbook on global health diplomacy, the launch of the Health Diplomacy Monitor, an online publication that reports on current diplomatic negotiations that have direct or indirect impacts on health policy and health, a resource centre for current negotiations relevant to global health, and several studies exploring Asia's role in global health diplomacy.

### **The Legacy of the Oslo Ministerial Declaration on Foreign Policy and Global Health**

The Foreign Policy and Global Health Initiative, launched by the foreign ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand in 2006 and articulated in the Oslo Ministerial Declaration in 2007, is one of the most well known efforts to integrate health issues into foreign policy. This session aimed to review the impact of the Initiative - also known as the Oslo Group - and discuss its prospects for the future.

Ambassador Farani Azevedo, the Permanent Representative of Brazil to the United Nations and other International Organizations in Geneva, opened the debate, outlining the group's activities over the last five years and the challenges and perspective the group envisions going forward. Her presentation was followed by a panel discussion involving senior government advisors: Suwit Wibulpolprasert from the Thai Ministry of Public Health; Vijay Trivedi from India's Ministry of Foreign Affairs; and Benedikte Louise Alveberg from the Norwegian Ministry of Health.

Azevedo discussed the Oslo Group's activities at the UN General Assembly, the World Health Organization, and the Human Rights Council, and its work on NCDs and in humanitarian disasters such as the Haiti earthquake. She argued that the value of the Oslo Group is its diversity of needs, perspectives and visions of foreign policy and of global health, saying that the group's messages carry legitimacy because it speaks with one voice despite its diversity. However, she acknowledged that while this diversity is a strength, it also presents challenges because priorities differ across the membership.

Several Group members and conference participants remarked that the informal nature of the group, in part afforded by its small size, is a great strength. Azevedo noted that expansion has been debated within the Group and that other countries have sought membership, but in the interest of balance, the group has not sought to grow. The informality of the group was credited with fostering trust among its members.

Vijay Trivedi of the Indian Ministry of Foreign Affairs argued that the political class has realized that responding to health needs is today one of the best assurances for retaining power and predicted the initiative would go from strength to strength.

## **DAY ONE, SESSION TWO:**

### **Diplomacy in action: Intellectual property and access to medicines**

The discussion began with a presentation by Suerie Moon of the Sustainability Science Program at the Center for International Development, Harvard Kennedy School of Government, on the implications of multipolarity for intellectual property rules, access to medicines and global health.

Intellectual property is one of the most difficult issues facing health practitioners and one of the main issues where health and foreign policy intersect. It is also the area where health concerns have been most successfully integrated into economic policymaking. The presentation outlined how middle-income countries have shaped the intellectual property debate around medicines and explored what impact their rising power will have on the global intellectual property regime and diplomacy around access to medicines.

The presentation argued that over the last decade, middle-income countries have increasingly gained and exercised power in shaping global rules governing intellectual property and access to medicines, in part by reframing intellectual property from an economic to a social issue.

It remains to be seen whether middle-income countries will pursue a more stringent intellectual property regime or a more flexible one in the future, but ongoing political conflict between the North and middle-income countries can be expected. Middle-income countries - including but not only BRICS countries - will increasingly challenge intellectual property rules that are perceived to favour industrialized countries, and can shape alternative global institutions to meet their domestic health needs. However, they will simultaneously face growing expectations to contribute to research and development that meets the needs of all countries.

## **DAY ONE, SESSION THREE:**

### **New players and partnerships in global health diplomacy**

This session focused on five proffered papers that explored who the new and emerging players in global health diplomacy are and what issues they are tackling.

Kristin Sandberg, of the Center for Development and the Environment/Institute for Health and Society at the University of Oslo, described an ongoing research project that involves reviewing cross-sectoral experiences in international relations to yield lessons for the health sector. Questions being explored include what factors are associated with successful mainstreaming and issue-linkage, and what outcomes can and should be measured.

Rene Loewenson of EQUINET/TARSC, the Regional Network on Equity and Health in Southern Africa, outlined a study highlighting that bringing local experiences in public health to global diplomatic processes is important for strengthening the African voice in global health diplomacy. She argued that health advocates seem to have lost the ability to articulate the basis of public health - what population health is as distinct from treatment for individuals. She concluded that beyond fostering relationships and understanding the dynamics of the process, there is a need in global health diplomacy for a clear understanding of what is meant by public health impact. In discussing the paper, Ambassador John Lange of the Bill & Melinda Gates Foundation noted that his organization measures the success of global health diplomacy efforts by improvements in disability-adjusted life years (DALYs) and by the number of lives saved.

William Onzivu, lecturer in law at the University of Bradford presented a paper outlining how African regional institutions are engaging in global health diplomacy. Challenges to regional health diplomacy through these groups include regional priorities competing with health, capture by commercial interests, governance challenges due to language, and a limited role for civil society. His research concluded there is a need for capacity building in health diplomacy, and the challenge for all actors is to embed global health into the foreign, trade, and other sectors addressed in regional negotiations.

John Kirton, from the G20 research group and the G8 research group, outlined a study examining what insights can be gleaned from the 2007 Caribbean Community (CARICOM) special summit on non-communicable diseases for the September 2011 UN High-Level Meeting on Non-

communicable Diseases. The analysis revealed there was great variation in which countries implemented the summit recommendations and in which recommendations were implemented. Higher disease burden, and to a lesser extent national capability, influenced compliance. Other factors included whether a country had a leadership role in the summit; whether the head of state attended; whether the commitment was placed prominently in the communiqué; and whether the recommendation was tied to a relevant international organization. Attaching money to a commitment, references to international law or past promises did not increase compliance.

Valerie Percival of Carleton University presented research findings on factors facilitating or impeding cooperation with health efforts in humanitarian assistance settings, using four case studies involving natural disasters and/or conflict. The study found that health issues do not have a unique ability to engender cooperation, with vaccines being an exception. It concluded that international organizations are important as forums and actors, that civil society is critical actor, diplomatic skills help, and that instrumentalising health impedes cooperation. Percival argued that whether or not it is appropriate or cost-effective for military personnel to be delivering health aid, governments want to use the military for that purpose and the military want to engage in this kind of work, so they cannot now be taken out of the equation. The issue is how best to manage their input.

## **DAY ONE, CLOSING SESSION:**

### **A Challenge to the Global health diplomacy network**

The final session was designed to reflect on the day's discussions and discuss how the Global Health Diplomacy Network can contribute to the issues raised.

Key points included:

- The Network should help the health sector understand that the top priorities of foreign policy are national security and economic growth, not health. It must not view the link between health and foreign policy as an opportunity to exploit the foreign policy sector to reach health goals. The health sector must think how it can advance foreign policy goals and be aware and acknowledge that health policy can have a negative impact on foreign policy and its goals, just as foreign policy can have a negative impact on health. The most important thing is to build trust between the

two sectors. Both need to think about the implications for the other and work to minimize the negative impacts.

- The Network should remain informal and knowledge-based, and meet regularly.
- Evaluating the impact of global health diplomacy processes will be crucial for the future of the Network. It must establish a role beyond one of a negotiation improvement organization to one that can make a statement about the impact these processes have on global health.
- One lesson from successful business engagement is to not try to reconcile philosophical divides, as that is futile. The better approach is to define concretely what can be achieved together, set a timeframe, and ensure specific roles and responsibilities are clearly assigned.
- Most of the time in Geneva, health diplomacy is about trade and about intellectual property.
- One problem facing global health diplomacy is a lack of coherence in the relationship between global institutions and their goals, and the problem has been exacerbated by the proliferation of actors. For instance, one initiative seeks to stem the migration of health workers and increase their ranks, while another seeks to cut public sector spending. This kind of dissonance must be addressed.

## **DAY TWO: ASIA'S ROLE IN GLOBAL HEALTH DIPLOMACY**

### **Overview**

This part of the conference outlined the first set of studies to be produced through the Network's research stream, discussed lessons learned from the findings and process, and stimulated ideas for refining priorities for the research stream's future.

The mission of the Network's research stream is to engage in and disseminate research on all facets of global health diplomacy in order to deepen understanding of the problems to which global health diplomacy is applied, the players involved, the processes used and the outcomes.

The studies, which represent the initial stage of a longer-term research programme, comprise six case studies focused on Asia, the world's largest and most populous continent, which has undergone rapid integration in the global economy and has emerged as a key actor in global health. Case studies presented include:

- ASEAN's role in global health diplomacy
- Lessons from building Thailand's capacity in global health diplomacy
- The emerging role of China in health aid to Africa
- Chronic diseases and marketing to children in India
- The role of global health diplomacy in Taiwan's bid for observer status at the World Health Assembly (WHA)
- The role of global health diplomacy in the Indonesian virus sharing issue

For each case study, the issue, actors, process and outcome were examined. The methodology was largely the same for each – systematic literature reviews; semi-structured in-depth interviews with key informants at the domestic and international levels; and review of available official negotiating documents.

### **Case studies: Key Lessons**

Details of the case studies are included as Annex 1. The researchers concluded that key lessons emerging from the studies were:

- Domestic politics may matter more and trump processes of global health diplomacy;
- The “global” in global health diplomacy may distract from the need to address domestic interests, aspirations and perceptions that shape strategies, suggesting a need to align global and local concerns;
- Domestic institutional capacity of the health community, and the non-health community across countries to engage with health issues can vary considerably, shaping the conduct of global health diplomacy;
- Institutionalising some aspects of GHD within the Ministry of Health, as well as integrating health concerns into the wider governmental system, is important to its effectiveness;

- Despite the state-centric nature of formal diplomatic processes, non-state actors can play an important role in influencing global health diplomacy processes;
- There are opportunities, and risks, in linking health to other issues on the international agenda, such as security;
- Analysis of global health diplomacy has to be undertaken over time, to understand often slow moving processes and institutional and policy shifts;
- Health officials and their counterparts in other departments have important opportunities to identify synergies that help each other make their arguments more persuasively in international negotiations.

## Defining a Follow-up Research Agenda for the Network

### ***Network Research Stream ideas***

On the basis of the case study findings, the Network proposed follow-up research in the following areas:

- What are the most important domestic drivers of global health diplomacy? For instance, what is the role of global health diplomacy in international image building; and the role of institutions in developing the international agenda and in engagement in global health diplomacy?
- How do domestic politics shape global health negotiations?
- What factors influence the positioning of an issue as one for global health diplomacy, including how influential are national security, trade, economic impact or the scale of morbidity and mortality?
- How do global health issues relate to other “new diplomacy” issue areas?
- To what extent is there a set of global health diplomacy actors distinct from global health, and what is the relative and type of power and influence of specific actors?
- Are the actors and processes in Asia different from those in other regions? In what way, and what impact does any difference have?

- What is the relative importance of different venues, such as the World Health Assembly, the G8 or the World Economic Forum; and the relative importance of formal versus informal settings? Does GHD differ across these venues?
- To what extent is global health diplomacy integrated with other topics of diplomacy; and how does the shifting balance of power in world politics affect global health diplomacy?
- What are the criteria for judging the success of global health diplomacy?

### ***Participant recommendations for the Network's research stream***

Meeting participants were divided into four workshop groups to discuss suggestions for guiding the Network's research priorities going forward. The groups were assigned three questions each. Much of the feedback reflected priorities already identified by the Network, as described above.

Participants were asked to discuss the following questions:

1. What remains to be understood about global health diplomacy?
2. What should the goals of further global health diplomacy research be?
3. Who should the target audience for global health diplomacy research be?
4. Should research be focused on geographical regions, issues or types of actors and processes?
5. What three research questions should be pursued as a priority?
6. How should the network go about building global health diplomacy research capacity, and which groups should it target?

### ***Key recommendations***

Details of the participant feedback for each question above can be found in Annex 2. The following recommendations emerged repeatedly throughout the discussion as core issues.

- Define more concisely what global health diplomacy is and how it is distinct.
- Define what 'success' means when it comes to global health diplomacy.

- Measure what impact global health diplomacy has – both positive and negative - on health and other goals.

## **ANNEX 1: RESEARCH CASE STUDIES**

### **ASEAN's role in global health diplomacy**

ASEAN's primary focus is regional security ties and economic integration, but it has been engaged to some extent since the 1970s in improving regional health. Its interest in health has increased since 2003, when the SARS outbreak emerged from the region. For instance, the group addresses pandemic preparedness and response, but also aspects of food security and food safety, and regional health worker migration. Most of ASEAN's interest in health has revolved around communicable disease control, reflecting traditional security and economic concerns.

The research found that the workings of the institution demonstrate that domestic political considerations and a lack of trust in many cases affects regional cooperation, resulting in silo-style nationally focused activities.

The study identified two key strengths of ASEAN as a global health diplomacy institution: It is a forum that accommodates discussion at both the technical and bureaucratic level and among high-level political leaders, and it bridges high-, middle- and low-income countries that are spread across two World Health Organization regions. Key challenges identified for global health diplomacy within ASEAN were a pervasive lack of trust between the countries, and a lack of expertise and capacity to tackle global health issues.

### **Lessons from building Thailand's capacity for global health diplomacy**

Global health diplomacy requires capacity not only at the international level, but also at the national level. Thailand was selected as a national case study because its experiences with 'TRIPS-plus' negotiations with the USA, as well as some other issues in the 1990s, led the Ministry of Public Health to forge greater engagement in trade and diplomatic negotiation processes to address health concerns. In doing so, the Ministry has been seeking to achieve integration of Thailand's various national interests.

The study determined that lessons for other nations include:

- Capacity should be built in a strategic, systematic and formalised manner.
- Mechanisms of collaboration among agencies should be institutionalised rather than ad-hoc and informal. In Thailand, this includes interagency cooperation via committees and a new multi-stakeholder form in the form of a National Health Assembly.
- Personal informal relationships between individuals involved in health, trade, foreign policy, are an important and necessary addition to institutionalised collaboration.

## **The emerging role of China in health aid to Africa as global health diplomacy**

Since 1994, China has greatly expanded its programme of aid to Africa. The general aid programme has been principally focused around natural resources and follows the traditional model of being heavily tied (natural resource-backed concessional loans to fund infrastructure built by Chinese construction firms). In parallel to this, there is a longer history, dating back to the 1960s, of Chinese health diplomacy in Africa focused on building solidarity with the developing world. Examples of Chinese endeavours in various African countries include 20,000 medical staff treating 250 million patients by 2009; construction of health infrastructure; a programme that has sent Chinese youth volunteers to Africa since 2007; and a Chinese Navy medical ship launched in 2010 with 500 beds and 8 operating theatres.

China had an early recognition of the importance of so-called 'soft power' in foreign policy, characterized by a bottom-up approach that aims to build solidarity with the local population.

The study concluded that there is an opportunity for China, as a developing country, to create a new system or modality of aid. However, it also concluded that there is complexity in the aid bureaucracy, that health is firmly seen as a tool of foreign policy; and that there are risks to scaling up Chinese presence in Africa. A heavy emphasis on bilateral rather than multilateral channels adds to existing problems relating to aid coordination, and the founding principles of non-conditionality and self-reliance are at risk if health diplomacy is too closely tied to economic policies and health as a tool of foreign policy.

## **Chronic diseases and marketing to children in India**

This study examined India's implementation of the 2010 World Health Assembly (WHA) adoption of a set of recommendations on the marketing of food and non-alcoholic beverages to children. The agreement, part of a global strategy to combat obesity, relies on urging countries to develop policies to reduce the marketing of fatty, sugary, salty foods to children. This agreement can be seen as an example of successful global health diplomacy, with health interests being put at the forefront, and potentially over trade interests. However, what is important is national implementation.

The study observed a gap between the global and the national context. For instance, In India, obesity is not seen necessarily to be a significant priority, with only two percent of children overweight while 43 percent are underweight. In addition, a set of issues around cultural factors made the WHA recommendations appear irrelevant or reflective of a 'western' view of the problem and how to address it, for example through regulation. The study also found that the role of the private sector was felt to be under-appreciated. India has recently set up a system called the India Pledge, whereby a number of companies have volunteered to market appropriately. Such initiatives raise the issue of the role of industry,

the use of voluntary guidelines and whether they are followed, and what that means for the process of global health diplomacy enacted at a national level.

Implementation in India of the WHA marketing recommendations suffered from a lack of coordination among national agencies - there are six that deal with food and children. However, the recommendations do not address such complications. Non-communicable diseases have only recently been put on the health agenda in India and even if they were recognised as being important, there is a lack of experience and resources to address the problem. The study showed that although the production of recommendations at a global level can appear to be a success of global health diplomacy, national implementation can be beset by fundamental problems.

### **Taiwan's bid to be an observer to the World Health Assembly**

The People's Republic of China has occupied its United Nations seat since 1972. Taiwan has since then sought access to the WHA by turns as a member and as an observer, over the objections of Beijing, which considers Taiwan a province of China. In 1997, Taiwan stepped up its efforts, applying for observer status to the WHA every year under a variety of names. The SARS outbreak in 2003 and the implementation of the International Health Regulations (IHR 2005) highlighted problems caused by Taiwan's inability to benefit from access to WHO technical expertise and the inability of the IHR to be applied to Taiwan, and in 2009, Taiwanese health authorities attended the WHA - under the compromise name 'Chinese Taipei' - for the first time since 1971.

The study examined whether this outcome was an example of health diplomacy overcoming foreign policy goals - whether there was something unique about global health diplomacy, or whether it was a case of straightforward traditional diplomacy.

It concluded that although there were some health aspects, this was in essence a story of traditional diplomacy and foreign policy between China and Taiwan. On the one hand, the health officials were able to move around more freely than the officials involved in foreign policy; they could, among themselves and within the international community, galvanise indirect support for the wider diplomatic goals of Taiwan. It helped that health had become a focus of political concern around SARS, pandemics and the IHR and that Taiwan is located geographically in an area that is important for those issues. However, the study revealed that health arguments remained subordinate to the traditional diplomatic concerns, with the result being observer rather than membership status, a compromise name and a status that is renewable annually and is enabled by the state of, and dependent on, the relations between Taipei and Beijing. The study illuminated the need to acknowledge the role of global health diplomacy in this instance, but also its limitations and subordination to diplomatic processes and interests.

## **The role of global health diplomacy in the Indonesian virus sharing issue**

The Global Influenza Surveillance Network, in which countries share virus samples by sending them to WHO collaborating laboratories so that WHO can assess which strains pose the greatest threat and plan vaccine production, has been operating for more than 50 years. In 2007, in the midst of the H5N1 avian influenza outbreak, Indonesia ceased sharing virus samples, citing concerns over equitable access and affordability of the vaccines that would be produced from the samples. Critics accused Indonesia of threatening global health security. The issue became one of global health diplomacy, with an intergovernmental working group launching into negotiations. The negotiations resulted in a “framework”, which was adopted at the 2011 World Health Assembly.

Virus sharing became a subject of global health diplomacy because of a breakdown of trust between Indonesia and the system addressing virus sharing and vaccine production. However, as was the case for other studies in the project, the importance of the interplay between the national and global levels in determining why an issue gets on the global health diplomacy agenda emerged. Underlying the basic context of a lack of trust in the system were the role of individual personalities, domestic politics and wider foreign policy. From the individual perspective, the Indonesian health minister accused the USA of using the virus samples to create biological weapons, while a former US Ambassador to the United Nations stated that refusing to share samples was ‘morally reprehensible.’ In the domestic context, internal politics within Indonesia had an influence, as well as wider foreign policy around Indonesia’s role and visibility in the global community. The issue also highlighted gaps in the current system, namely the International Health Regulations and the Convention on Biological Diversity.

## ANNEX 2: PARTICIPANT FEEDBACK

### ***What remains to be understood about global health diplomacy?***

- What is global health diplomacy?

There was a consensus among participants around the need to better define what global health diplomacy is, in order to reach a shared understanding and basis for measuring success. There is a lack of clarity because global health professionals tend to see diplomacy as a way to achieve global health outcomes, while those in the foreign policy sector view global health diplomacy as a subset of traditional diplomacy, and therefore as a way to advance national interests, not as a way to improve global health. A career diplomat urged understanding that if the real goal of global health diplomacy is to improve health outcomes, that is not always consistent with the goal of traditional diplomacy, and that when judging the success of a given negotiation in global health diplomacy, it is important to note that even if health outcomes are not optimal, the process may have advanced national interests and would in that sense be seen as a success by the foreign policy community. For both definitions, there is a need for greater understanding of the landscape - who the actors are, what the processes, strategies and tactics are, and what motivations and interests are in play.

- How do domestic policies and politics influence global negotiations around global health issues?

### ***What should the goals of further global health diplomacy research be?***

- To clarify the definitions, principles and what should be measured.
- To measure the impact (both positive and negative) of global health diplomacy, on health and on other sectors.
- To establish and track qualitative and quantitative outcome measures.
- To increase understanding of the stages of getting to an outcome, and then how (and whether) the outcomes of diplomacy get implemented on the national level.
- To inform the global health and foreign policy sectors of each other's perspectives, in order to bridge the gap between two communities that come together in times of crisis but with different contexts - for one group, health is the issue, while for the other, health is just one of many issues that need to be pursued, and not always the central one.
- To better equip those engaged in global health diplomacy, in coherence with the Network's training stream. Research processes that include the participation of global

health diplomacy actors might yield more relevant information, forming a closer loop between research findings and practice.

- To learn lessons from diplomacy not related to health.
- To gain a better understanding of the role of WHO in global health diplomacy, relative to other processes, both bilateral and multilateral.

***Who should the target audience for global health diplomacy research be?***

- Academics, health professionals, health policymakers, traditional diplomats, international organizations.
- The ultimate audience is the diplomatic community, but care needs to be taken in how this audience is approached, given the demands on their time and attention.
- The individuals who can translate the findings into practice and insert or integrate the issues into negotiations.

***Should research be focused on geographical regions, issues or types of actors and processes?***

- Space should be given to all of these.
- Consult the diplomats on what they want/need.
- Food, agriculture and nutrition.

***What research questions should be pursued as a priority?***

- What is global health diplomacy?
- How successfully are global agreements implemented nationally?
- What is the impact of global health diplomacy on health outcomes?
- What are the most effective strategies for success in global health diplomacy? Investigate this aspect for agenda setting, policy development, decision-making and implementation/outcome.
- What is success in global health diplomacy? What are the appropriate indicators?
- Who influences what stage of the process, from agenda setting to implementation?

***How should the network go about building global health diplomacy research capacity, and which groups should it target?***

Students need to be involved in monitoring the implementation of global health diplomacy agreements or commitments. They should be engaged in mock summits, go to real ones, and report on the outcomes.