

Chapter 2

The History and Evolution of Global Health Diplomacy

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Reader's Guide

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

Learning Points

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Creation of WHO and Its Role in Global Health Diplomacy

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

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

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

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

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

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

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

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

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

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

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

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

Beyond Traditional Health Fora: The Emergence of Market Multilateralism

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Box 2 Swiss Health Foreign Policy

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

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

Box 3 UK “Health Is Global”

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

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

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

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

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

Box 4 G8 Involvement in Health

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

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

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

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

Conclusion: Diplomacy Persistent in Change

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

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

Questions

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

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