GLOBAL HEALTH CENTRE | 2021

A GUIDE TO GLOBAL HEALTH DIPLOMACY

Better health – improved global solidarity – more equity

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PREFACE

The year 2020 marks two important anniversaries: 100 years of multilateralism in Geneva and 75 years of the United Nations. For almost all of that time, Geneva has been the seat of the World Health Organization (WHO) and the hub of global health diplomacy.

Since then, global health challenges have moved increasingly centre-stage, and the COVID-19 pandemic has only underscored the centrality of health to social, economic and political stability, and to the 2030 Agenda for Sustainable Development. The growing awareness of social, environmental, commercial, and political determinants of health has also made international health negotiations increasingly political, diverse, and multi-sectoral.

The COVID-19 pandemic has demonstrated the vital importance of global solidarity to confront shared public health threats. WHO plays a central role in supporting countries to respond in a coordinated way and to bring together many actors to jointly address the pandemic and its enormous global impact.

Global health diplomacy is a defining feature of the health "ecosystem" in Geneva, and plays a vital role in shaping the global health architecture and agenda. Successful global health diplomacy relies on political and diplomatic experience and practice, which must be combined with public health knowledge and evidence.

This Guide to Global Health Diplomacy is a valuable and practical tool for enabling health diplomats to be both professional and effective in their work. I am grateful to the authors, the Global Health Centre at The Graduate Institute of International and Development Studies for its pioneering work, and the Swiss government for its generous support.

Tedros Adhanom Ghebreyesus
Director-General, World Health Organization
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Abbreviations	
ACT Accelerator	Access to COVID-19 Tools Accelerator
AMR	antimicrobial resistance
APEC	Asia–Pacific Economic Cooperation
ASEAN	Association of Southeast Asian Nations
AU	African Union
BMGF	Bill and Melinda Gates Foundation
BRICS	Brazil, Russian Federation, India, China and South Africa
CARICOM	Caribbean Community
CEPI	Coalition for Epidemic Preparedness Innovations
COMESA	Common Market for Eastern and Southern Africa
COVAX	COVID-19 Vaccines Global Access Facility
COVID-19	Coronavirus disease 2019
EAC	East African Community
EAEU	Eurasian Economic Union
ECOWAS	Economic Community of West African States
EFTA	European Free Trade Association
EMA	European Medicines Agency
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
FCTC	WHO Framework Convention on Tobacco Control
FENSA	Framework of Engagement with Non-State Actors [WHO]
G7	Group of Seven
G20	Group of 20

Abbreviations	
GDP	gross domestic product
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
Graduate Institute	Graduate Institute of International and Development Studies, Geneva
ICRC	International Committee of the Red Cross
IFPMA	International Federation of Pharmaceutical Manufacturers and Associations
IHR	International Health Regulations [WHO]
ILO	International Labour Organization
IOM	International Organization for Migration
MDG	Millennium Development Goal
MERCOSUR	Southern Common Market
MERS	Middle East respiratory syndrome
NCD	noncommunicable disease
NGO	nongovernmental organization
ODA	official development assistance
OECD	Organisation for Economic Co-operation and Development
OIE	World Organisation for Animal Health
PAHO	Pan American Health Organization
PEPFAR	United States President's Emergency Plan for AIDS Relief
R&D	research and development
SAARC	South Asian Association for Regional Cooperation
SADC	Southern African Development Community
SARS	severe acute respiratory syndrome
SDG	Sustainable Development Goal

Abbreviations	
SEEHN	South-Eastern Europe Health Network
SICA	Central American Integration System
TRIPS Agreement	Agreement on Trade-Related Aspects of Intellectual Property Rights
UHC2030	International Health Partnership for Universal Health Coverage 2030
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNASUR	Union of South American Nations
UNDP	United Nations Development Programme
UNECE	United Nations Economic Commission for Europe
UNEP	United Nations Environment Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFCCC	United Nations Framework Convention on Climate Change
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UN-Women	United Nations Entity for Gender Equality and the Empowerment of Women
V3P Project	Vaccine Product, Price and Procurement Project [WHO]
WAHO	West African Health Organization
WHO	World Health Organization
WIPO	World Intellectual Property Organization
WTO	World Trade Organization

INTRODUCTION

This Guide builds on the extensive experience of all four of its authors in both practising and teaching global health diplomacy. We have conducted courses at the Graduate Institute of International and Development Studies (hereafter the "Graduate Institute") in Geneva, Switzerland, and at similar institutions in many other countries over the past decade. During this period, the world experienced many changes and disruptions, all of which have come to be reflected in the underlying values, approaches and mechanisms of global health diplomacy. At the time of writing, the COVID-19 pandemic is having a significant impact on the multilateral system and expanding the range of actors and venues in global health diplomacy.

In 2013, the Global Health Centre at the Graduate Institute published the first systematic introduction to the field of global health diplomacy, outlining key concepts, issues, actors, instruments, forums and cases.[1] The present publication takes the process further, focusing on practical aspects of global health diplomacy and taking into account new experience and developments in this field. Case studies are available in the online version of the Guide, which will be updated with additional ones in due course.

A special focus of this Guide lies on the World Health Organization and negotiations in the Geneva global health "ecosystem". In view of the many relevant actors, processes and institutions that continuously interface with the health sphere, the Guide argues that health diplomats need to consider carefully the larger ecosystem within which they negotiate – also at the national level, including the various ministries and groups that are stakeholders. To reinforce this message, we have included a number of text boxes describing other organizations and the negotiation processes they follow. We hope that this Guide will soon be joined by other publications providing complementary perspectives.

Diplomacy is facing immense challenges at a point in time when it is more necessary than ever. Many analysts of international politics agree that multilateralism has entered a period of crisis. New political and economic realities, notably geopolitical power shifts, are leading to a questioning

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1   Kickbusch I, Lister G, Told M, Drager N, editors. Global health diplomacy: concepts, issues, actors, instruments, fora and cases. New York: Springer; 2013.

not only of existing institutions but also of the basic tenets on which those institutions were originally built. The very system of diplomacy is threatened by this "new disorder", while its methods are challenged by the ongoing digital transformation. Especially during the COVID-19 pandemic, complicated negotiations could not be conducted face to face, hampering the informal contacts that in the past have been so essential for reaching compromises.

As the authors we are convinced that global health diplomacy has never been as important as it is at present. This already became clear when negotiating the role of health in the Sustainable Development Goals, which were adopted in 2015. Now, during the second major pandemic after the influenza pandemic of 1918–1919, in a climate of growing suspicion, rivalry and infighting among nations, the need to work together at a multilateral level to ensure health for all countries is at its most acute. On the other hand, the above-mentioned challenges to multilateralism are making it more difficult to achieve global cooperation.

No country is safe unless all are safe. Global solidarity – the spirit in which the Constitution of the World Health Organization was drafted and adopted after the ravages of the Second World War – must be reinforced repeatedly through the kind of relationship-building and negotiating processes that are at the heart of global health diplomacy. Health challenges transcend not only borders but also North–South, East–West and public–private divides, exposing the limitations of segmented approaches. A more holistic, inclusive, comprehensive and coordinated strategy is required to tackle these truly global challenges.

Global health diplomacy is an important component of a multilateral system that seeks to contribute to a well-functioning global order. It requires the recognition that both science and politics are essential to inform negotiations. The goal of global health diplomacy is to bring about agreements that are scientifically credible and politically achievable.

Global health rests on the three pillars explored in this Guide: governance, instruments and diplomacy. The growing interconnectedness between these three pillars is an essential driving force of global health in the 21st century.

The present publication is intended to provide an entry point for readers wishing to gain a better understanding of the fundamentals of global health diplomacy and the various approaches involved. We hope that it will be useful for those preparing to work in this area for the first time, and that it will motivate them to undertake further studies and, above all, to acquire further practical experience. Those already engaged in global health diplomacy should find some useful indications for their work in this Guide. We also hope that it will be used as a support tool in the teaching of global health diplomacy at both national and international institutions.

NOTE TO READERS

The Guide focuses on basic concepts and practical aspects of conducting global health diplomacy. We hope that it will help individuals coming to the subject for the first time to better understand the context and system of global health diplomacy, and to familiarize themselves with relevant practical approaches.

The text is structured into three parts dealing with: (a) the basics in this field; (b) the features of negotiating health in a multilateral space; and (c) what makes for successful global health diplomacy. Key information is provided in the various chapters under each part. The chapters do not necessarily have to be read consecutively, even though the text's structure does follow such a logic. As some aspects (instruments, coherence, the role of key organizations etc.) are relevant to several parts of the Guide, we have deliberately left certain overlaps in the text and added cross references where applicable. We have also included text boxes on special topics written by invited contributors. For those who wish to delve deeper, we provide an annex listing various publications and other resources (the citations in the main text, presented using the Harvard system, refer to this annex).

We also hope that the Guide and the way it is structured will make it a useful resource for those engaged in teaching global health diplomacy. We have drawn on our own experience in teaching this subject for over a decade in many different contexts and settings and have been able to include many insightful comments provided by the reviewers. It should be possible to cover all of the subject matter in a one-week course while allowing enough time for students to look at specific case studies in greater depth, especially those relevant to the context in which the course is taking place. One day of the course could usefully be dedicated to the simulation of a global health negotiation by students.

PART A:
THE BASICS

CHAPTER 1 | GLOBAL HEALTH DIPLOMACY IN A CHANGING MULTILATERAL SYSTEM

1.1 Diplomacy in a changing world

Diplomacy has been practised for centuries, during which it has undergone many significant changes, some concerning its very nature. Over the past decade in particular, diplomacy has become a constitutive part of the system of global governance, which involves many different venues and actors. This development has been reinforced by the fundamental changes arising from the negotiation of the Sustainable Development Goals (SDGs) and by the increasing need for global crisis diplomacy. The most important shift has been that away from a mindset centred on development assistance towards acknowledgement of common global goals that can only be achieved if all countries work together – the COVID-19 pandemic has made that even clearer.

Despite these changes, three key defining features of diplomacy remain intact: representation, communication and negotiation.

Multilateral diplomacy as we know it began with the ad hoc congresses convened in Europe in the 17th century to negotiate war and peace between sovereign States. In 1919 it led to the creation of the first collective security organization: the League of Nations. At the end of the Second World War, multilateral diplomacy was institutionalized more robustly with the establishment of the United Nations (UN). One of the UN system organizations created shortly afterwards was the **World Health Organization (WHO)**, which took up its work in 1948 in Geneva, Switzerland. Over time, many other multilateral venues for health were established but WHO remains the norm-setting organization for health. The WHO Constitution defines health as a human right and this is a guiding principle for all other health organizations (see Box 7).

The significant cross-border economic and security impact of developments in such areas as the natural environment and human health made it clear that the issues in question could no longer be resolved at the national level only. As these areas, previously treated under "soft policy" in foreign affairs and diplomacy, gained in importance, new types of international agreements, instruments and organizations were created in response – for example, the Paris Agreement on Climate Change (2015), the revised International Health Regulations (2005), the Global Fund to Fight AIDS, Tuberculosis and Malaria (2002) and, most recently in 2020, the COVAX Facility, a global risk-sharing mech-

anism for pooled procurement and equitable distribution of eventual COVID-19 vaccines.

Multilateralism has many definitions – in essence it is governance by the many to address shared problems. It rests on a set of common principles guiding relations among the parties, including agreed rules of behaviour. Multilateralism often takes the form of membership in international organizations, but that is not the only form. Among the various types of multilateralism are universal multilateralism including all States, for example as members of the UN; regional multilateralism, which brings together States in specific geographical regions; values-based multilateralism as exemplified by organizations such as NATO or the European Union and the suggestions to create new bodies that include democracies only; and "minilateralism", which brings together small groups of States (or "clubs" such as the G20 and the BRICS countries) to tackle specific problems. Multilateralism stands in contrast to bilateralism and unilateralism, and governments have to decide which of these strategies they will adopt in their foreign policy to deal with a particular challenge. Bilateralism means engaging with just one other country, while unilateralism implies acting on one's own without regard for other countries.

Other terms are also in use. In trade negotiations, plurilateral agreements – meaning, for example, a treaty between a limited number of States with a particular interest in the subject of the treaty – have become more prominent. Finally, "polylateral diplomacy" refers to the involvement of many non-State actors in diplomatic processes – something that makes the contemporary diplomatic arena pluralistic, dynamic and complex. This is also referred to as multi-stakeholder diplomacy – the term used in this Guide.

This Guide focuses on the global health diplomacy practised at international organizations and in other multilateral venues that aim to resolve global health challenges. However, multilateralism also denotes what is often referred to as the liberal international order, enshrined in the Charter of the United Nations, which was signed by 50 States in 1945. The values, norms and principles underpinning this order have been defined as: economic openness, rule-based international relations, security cooperation, openness to reform and change, and solidarity based on the model of liberal democracy (Ikenberry, 2018).

The UN today encompasses 193 countries. A new and growing set of actors at the national, regional and global level have emerged and are now part of global decision-making. The past decade in particular has seen major geopolitical power shifts, while new parallel multilateral institutions have been created. Another important development is that new communication technologies are now omnipresent across the globe and significantly influence negotiations.

While there is an increasing number of interrelated global challenges that need to be resolved, the present multilateral system is in flux. Some criticize its ideological premises, its power imbalances and lack of inclusiveness; others demand greater transparency and accountability to the general public; while yet others decry the system's failure to deliver decisive action in response to such major crises as poverty, migration and climate change. Most alarmingly, though, a new wave of nationalism is challenging its very nature and necessity. The United States of America, which contributed so much to establishing the multilateral system after the Second World War, has during the Trump administration distanced itself from a number of organizations in the UN family, multilateral processes and international agreements. Possibly this will be reversed by the new Biden administration. All these developments have had an impact on the system of multilateral diplomacy, on relations between the actors involved and on the role of diplomats. The COVID-19 pandemic has highlighted both the mounting challenges faced by multilateral institutions and the central role of these institutions in finding joint solutions to shared problems.

1.2 The increasing politicization of global health

In 2007, a group of foreign ministers from seven countries 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".[2]

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2   The Oslo Ministerial Declaration, entitled "Global health: a pressing foreign policy issue of our time", was issued on 20 March 2007 by the Ministers for Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand.

More than 10 years later, the interface between global health and foreign policy has become increasingly dynamic, with both positive and negative implications for health. Global health is now integral to the foreign policy agendas of many countries, notably in relation to economic and social development, security, humanitarian affairs, social justice and human rights, and global crisis management. The number of multilateral health negotiations, instruments, organizations, and venues has increased significantly. Health is now part and parcel of global negotiations related to food, climate, energy and water, and is discussed at major global and regional summits. This is largely thanks to the adoption of the SDGs in September 2015 and to the inclusion of health in the deliberations of both the Group of Seven (G7) and the Group of 20 (G20). Health diplomats must therefore be able to negotiate in contexts and institutions that are very diverse and require quite different approaches. These developments have highlighted that global health diplomacy, like all diplomacy, is always political. Global health professionals are wary of what they consider a **politicization of global health**, but it is an illusion to think it can be avoided. The increasing involvement of political leaders and actors in health matters can indeed work in two directions: it can be the decisive factor in rallying political support for global health, or it can undermine global health if narrow geopolitical or ideological agendas prevail. Both types of effect could be observed during the COVID-19 pandemic. The erosion of shared norms can also lead to very difficult negotiations, and disagreement on other areas of national policy – for example, a liberal versus a restrictive position on immigration or on women's rights – often has a strong impact on health negotiations at the global level and makes it difficult to reach consensus.

Recent examples that serve to illustrate both the positive and the negative impact of the politicization of health include a series of recent G20 and G7 meetings (see Box 2); the negotiations on primary health care at WHO,[3] on universal health coverage at the UN,[4] and on the health rights of refugees at the International Organization for Migration; and, more recently, the negotiations at the UN Security Council leading to the adoption of a new resolution on sexual violence in conflict.[5] In all these cases, health objectives were diluted because of national political positions.

The specific national and geopolitical context has always been important in global health diplomacy. During the Cold War between the former Soviet Union and the United States (and their allies), ideological conflict was inseparable from the negotiations conducted at the UN and WHO, especially negotiations concerning the role of the State or the private sector in the provision of health care. Since the 1990s, positions detrimental to the advancement of global health have been closely tied to

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3   Specifically, the negotiations that resulted in the adoption of the Declaration of Astana in October 2018 (WHO & UNICEF, 2018).

4   Specifically, the negotiations during the High-Level Meeting on Universal Health Coverage held at the General Assembly on 23 September 2019, which resulted in the adoption of a political declaration (UN, 2019).

5   Resolution 2467 (2019), adopted by the Security Council on 23 April 2019.

the protection of economic interests and industries (for example, tobacco and pharmaceuticals), including patents and intellectual property rights. Almost all Member States use health negotiations to promote their industrial policy or their perceived economic interests, but they rarely do so openly in the context of health organisations, preferring instead to invoke health or humanitarian arguments.

Since early 2020, the geopolitical tensions between China and the United States have become a determining factor in global health diplomacy, with wide-ranging implications. These tensions came to a head during the COVID-19 pandemic, when the United States declared its intention to withdraw from WHO. On the other hand, the threat posed by COVID-19 has generally accelerated multilateralism and cooperation in Europe – even though the closing of borders, protectionist policies and trade restrictions dominated the early response to the pandemic. New opportunities emerge to strengthen multilateralism now that the USA has rescinded its withdrawal and conformed its commitment to a strong WHO.

It is clear that because of shifts in ideology and geopolitical power, the agreements, declarations, positions and approaches adopted through multilateral negotiations in the past can no longer be taken for granted. The constant conflicts on human rights matters are a case in point. Representatives of civil society and local communities expect their positions and concerns to be taken into account in formal negotiations. Social media have also encouraged a wider debate on, and greater public involvement in, global affairs, but in some cases, they have contributed to an erosion of trust in the international system or reinforced conspiracy theories about who sets global priorities. This can create considerable difficulties for the technical and evidence-based work of health organizations and for the consensus-oriented approach to global health diplomacy in the governing bodies of the UN and WHO. Social media therefore need to be factored in as a potentially critical new element in both diplomacy and policy-making.

The challenges for global health diplomacy in a divided world are intensifying because, as a result of the COVID-19 crisis, it is very unlikely that the health-related SDGs can be achieved by 2030. Indeed, the main task for the near future is to make up for the development losses caused by the devastating impact of COVID-19 and by some of the measures taken to combat the pandemic.

1.3 The move towards multi-stakeholder diplomacy

The SDG negotiation process was a conceptual and political breakthrough, leading to a significant expansion in multilateral diplomacy focused on global challenges within the UN framework. In adopting the 2030 Agenda for Sustainable Development in September 2015, the UN Member States agreed on a set of 17 interdependent goals that would apply to the entire world community.

Goal 17 in particular highlighted the need for strong global partnerships to achieve the SDGs.

Health has proved to be an integral component and outcome of every SDG that was negotiated. This explains the continuing central role of global health diplomacy in practically every subsequent round of SDG-related negotiations, a recent example being the negotiations at the UN Climate Change Conference in December 2019 or the annual meetings of the High-level Political Forum on Sustainable Development, which assesses progress on the SDGs. As a result, the global health agenda is now approached as a common challenge for all countries – not simply as a matter of development cooperation.

The dynamics of the SDG negotiations were quite different from the closed decision-making process conducted in the late 1990s that resulted in the adoption of the Millennium Development Goals (MDGs) in 2000. From the very start, the SDG negotiations transformed the role of diplomats at the UN. A novel negotiation process based on open working groups was established; seats were assigned on the basis of regions and had to be shared among several countries; a group of co facilitators was established. All this fundamentally changed the power dynamics and gave the developing countries a much stronger voice: they were able to lead the way in shaping agendas for the future (Dodds, Donoghue & Roesch, 2016).

Civil society, academia, policy networks, think tanks, the private sector and many newly formed alliances participated in an inclusive process entirely without precedent, which has been referred to as the "new multilateralism", or **multi-stakeholder diplomacy**. This move towards multi-stakeholder diplomacy within a multilateral system that was at first geared almost exclusively towards countries has accelerated in most areas of international policy-making, including global health. The accompanying changes in the power balance and in the roles of diplomats and other players have been reinforced by the multiplicity of outreach processes made possible by new technologies.

The UN Charter from 1945 had already recognized that the Economic and Social Council should consider consulting with nongovernmental organizations (NGOs). The number of such actors and the degree of their involvement have increased with the years. The involvement of non-State actors now extends far beyond consultation – as originally envisaged in the UN Charter – and includes the setting of agendas, participation in negotiations and collaboration in the development of standards. The inclusive and comprehensive SDG negotiation process has become the yardstick of multi-stakeholder involvement and continues to be emulated throughout the UN system. Indeed, such broad inclusivity is now expected of all multilateral processes – also in global health diplomacy. The SDGs have, moreover, introduced a new strong interface between multilateral objectives and processes on the one hand, and national implementation on the other. They have underlined – especially through Goal 17 – that **partnerships** need to drive implementation at all levels of governance. Pub-

lic engagement and innovative partnerships, facilitated by a whole-of-government and whole-of-society approach and supported by the enhancement of digital means of communication, continue to be an essential component of multi-stakeholder diplomacy as established through the SDGs.

All major UN high-level meetings now include multi-stakeholder forums in the preparatory process to provide input for the subsequent negotiations between governments. Civil society and community representatives have been provided with many new opportunities to participate and be heard. Despite some attempts at improvement, WHO still lags behind most of the rest of the UN system in terms of civil society involvement in its governing body processes. Even so, some Member States now include civil society representatives and youth delegates in their WHO delegations. In some instances, though, State–civil society relations have worsened, prompting some commentators to speak of a "shrinking space" for civil society organizations. The pressure exerted on such organizations includes restrictions on foreign funding, barriers to registration, intervention in their internal affairs, and other forms of harassment.

The multi-stakeholder approach to diplomacy supported by the UN has given the private sector unprecedented access to the UN and its deliberations. This is viewed with certain suspicion among some members of civil society, who are concerned about the possibility of undue influence by business and commercial interests. Yet, in global health the private sector has also become part of the new governance mechanisms of international organizations such as Gavi, the Vaccine Alliance or the Global Fund to Fight AIDS, Tuberculosis and Malaria (hereafter "the Global Fund") (see **Box 10** and **Box 11**).

A new development is the expansion in the global activity of cities and their authorities (see **Box 16**). Mayors are increasingly representing their cities on the world stage, and international organizations are reaching out to them. While city diplomacy was initially about the promotion of cities, it now includes involvement in the shaping and implementation of international agreements, the most important being the Paris Agreement to Combat Climate Change. Municipal authorities now also engage with WHO on health matters – for example, in combating tobacco use. The role of cities as global hubs was highlighted further by the COVID-19 pandemic.

1.4 Governance spaces for global health diplomacy

The World Health Organization plays a central role in the governance of global health: it is the leading authority for international health work. However, in recent decades, other organizations and bodies have begun to engage substantially – either directly or indirectly – in global health matters, resulting in greater complexity and even competition. The venue for negotiations may influence the composition of national delegations and, to some extent, also their position. At WHO, health ministries are at the forefront of most countries' delegations, at the UN it is foreign ministries, at development organizations it is development ministries and agencies (where these exist) and at the World Trade Organization (WTO) it is trade ministries. At the same time, WHO has itself expanded its participation in a wide range of venues for health negotiations and increased the number of actors it works with and the issues it addresses. This complex field can be broken down into three overlapping "governance spaces":

The global health system: the governance interface

Global Governance for Health
Health in the context of global organizations in other sectors

Global Health Governance
Governance of the dedicaced health organizations and their interface

Governance for Global Health
Governance at national and regional level in support of global health agendas

Network and Negotiation hubs

Governance for Global Health

Global Heath Governance

Global Governance for Heath
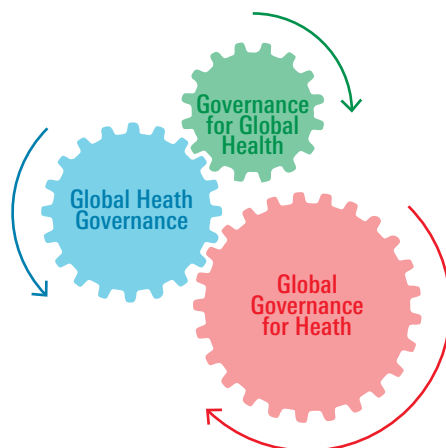
Global health governance refers mainly to those institutions and governance processes that are based on an explicit health mandate: WHO first and foremost, along with a few others with narrower – though still explicit – health mandates, such as the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Global Fund and the Gavi Alliance. An often-neglected aspect is the key role played by the secretariats of these organizations, whose staff members are part of a well-established international civil service system. A wide range of other global health actors are active, many of them working from Geneva, which is generally considered to be the global health capital. Additionally, in response to emerging challenges, several new research-based organizations have been created, such as the Coalition for Epidemic Preparedness Innovations, a global partnership launched in 2017 to develop vaccines aimed at preventing future epidemics. New governance structures have similarly been set up in response to the COVID-19 pandemic, such as the Access to COVID-19 Tools Accelerator, a G20 initiative that brings together many of the actors in the global health governance space with a view to overcoming the pandemic more quickly by supporting the development and equitable distribution of testing facilities, treatments and vaccines.

Box 1: Negotiating at the World Health Organization

Negotiations and decision-making at the World Health Organization (WHO) continue very much to be intergovernmental processes complemented by multi-stakeholder diplomacy. While the Sustainable Development Goals call for broader participation by non State actors, the majority of Member States support the exclusive role of nation States in WHO decision making, especially in view of the Organization's normative and treaty-making powers.

What are the core functions of WHO?

The main negotiating forum for health diplomats at WHO comprises the two governing bodies – the World Health Assembly and the Executive Board – and the many formal and informal platforms that provide inputs to their work. Since WHO deals with many different areas, it is important to be aware of the Organization's core functions. Article 2 of the WHO Constitution lists 22 functions, which may be summarized as follows:

→ Providing leadership on matters critical to health, and engaging in partnerships when joint action is needed;
→ Proposing conventions, agreements and regulations, and making recommendations on international health matters;
→ Setting norms and standards, and promoting and monitoring their implementation;
→ Shaping the research agenda and stimulating the generation, transfer and dissemination of valuable knowledge;
→ Articulating ethical and evidence-based policy options;
→ Providing technical support, catalysing change and building sustainable institutional capacity;
→ Monitoring the global health situation and assessing health trends; and
→ Responding to health emergencies.

Decision-making at WHO

Decision-making is formally governed by the principle of one vote per Member State. The Rules of Procedure of the World Health Assembly and those of the Executive Board provide for decision making by a simple majority except for decisions on important questions, such as the adoption of conventions or agreements, amendments to the Constitution and suspension of the voting privileges of Member States, for which a two-thirds majority of the Member States present and voting is required. However, virtually all negotiations are conducted with the goal of reaching consensus, and almost all decisions are indeed adopted by consensus. In WHO practice this means the adoption of decisions without a formal vote. Consensus does not imply unanimity, that is, a situation in which all Member States have formally accepted a decision, but, rather, that no Member State actively opposes the decision.

The adoption of new policies often requires a difficult and long process of consensus building. It may be necessary to drop strong wording from the draft text or to abandon certain policy options in order to secure the adoption of a resolution that proves acceptable to all 194 Member States. Briefings and consultation sessions are held to support the consensus-building process – these are often for Member States only.

Organizational Structure

- World Health Assembly
- Executive Board
- Secretariat
- Regions (6)
- Members Countries (193)
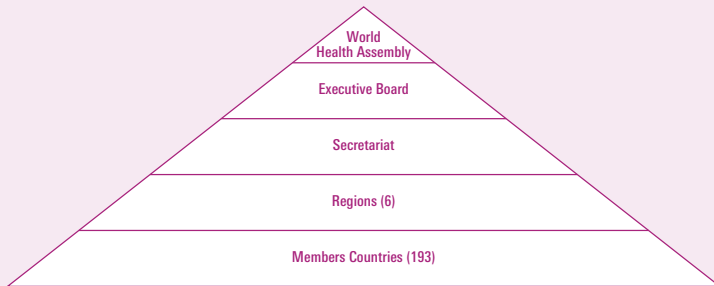
Negotiations take time. In that respect, setting priorities when drawing up the agenda for meetings of the governing bodies has been a major challenge because of the growing number of items to be covered, reluctance to allow issues to be taken off the agenda even if no new action is needed, and the limited time available for discussion. In recent years, more and more resolutions have been negotiated informally at intersessional meetings conducted mostly among the Geneva based missions.

Where are the WHO negotiating rules to be found?

The most important statutes can be found in the WHO book entitled *Basic documents* (the latest version was published in 2020). This regularly updated compendium contains all the statutory documents of the Organization, such as the WHO Constitution, agreements with other intergovernmental organizations, the Financial Regulations, the Framework of Engagement with Non-State Actors and, most importantly, the Rules of Procedure of the World Health Assembly and the Executive Board, whose regular sessions are the main venues for negotiations at WHO. The two sets of Rules of Procedure lay down, among other things:

→   how the agenda is set;
→   the role of officers;
→   the functions of the WHO Secretariat;
→   the conduct of business at plenary meetings and in committees; and
→   the voting regulations.

These statutory documents are difficult to amend, especially the Constitution, because Member States, for various reasons, are reluctant to forsake the status quo – in particular, the intergovernmental nature of WHO governance. New challenges have emerged in the context of the COVID-19 pandemic, as an increasing number of meetings – including meetings of the World Health Assembly and the Executive Board – have had to be conducted remotely.

What do the WHO negotiating rules reflect?

The operating rules of the WHO governing bodies establish the Organization's room for manoeuvre in complying with its constitutional obligation, namely, "to act as the directing and coordinating authority on international health work" (Article 2(a)).

Examples of unresolved issues

The founding fathers' vision was for WHO to be an organization embodying excellence in public health. They therefore wanted the members of the Executive Board to serve in their personal capacity, despite being designated by a Member State. The increasing politicization of debates within and around WHO finally led to a motion at the Fifty-first session of the World Health Assembly in 1998 calling for Article 24 of the Constitution to be interpreted (though not amended as such) to mean that members of the Executive Board act as government representatives.

The above development illustrates the fluctuation between political (social-medical) and technical aspirations that has characterized the Organization's history. WHO is torn between different demands by Member States, which expect it to be normative, technical and operational – as well as politically astute. These often-conflicting demands are particularly noticeable when the Organization seeks to address the root causes of health problems, such as the social and commercial determinants of health. It must also take extreme care not to become embroiled in conflicts between member states as – for example – during the COVID19 crisis.

The Framework of Engagement with Non-State Actors (FENSA), adopted by the World Health Assembly at its Sixty-sixth session in May 2016, is the first such framework to have been negotiated intergovernmentally within the United Nations (UN) system. FENSA codified and adjusted the observer status of non State actors in official relations, though without fundamentally changing the rules applied since the Third World Health Assembly, which have allowed nongovernmental organizations to participate as observers and deliver statements at meetings of the WHO governing bodies. A dedicated manual providing guidance on the application of FENSA is available (WHO, 2018a). A number of non-State actors are not satisfied with the Framework and wish to see it reformed.

There are a number of problems with the existing decision-making process. For example, there have been calls for meetings of the governing bodies to be scheduled for different periods of the year, mainly so as to separate meetings of the Executive Board's Programme, Budget and Administration Committee from meetings of the Board proper. This would give the Executive Board more time to react to issues arising at the Committee's meetings. However, this proposal has yet to be put into practice.

The effectiveness of decision-making at WHO depends on the political will of Member States to find a common solution. Fundamental disagreements between Member States, especially between powerful ones, can block political decision-making at WHO, although the Organization is often able to preserve its normative function (that is, the setting of technical norms and standards). When WHO was set up, it was necessary to find a way of integrating the existing Pan American Health Organization (PAHO) into the new entity. This resulted in WHO having the most federalistic structure of any UN agency, with the regional directors being selected directly by the Member States in the respective regions. The six regional committees are therefore also important decision making bodies. During periods in the Organization's history when WHO headquarters was perceived as weak, this proved to be an asset. However, concerns have been raised over the inefficiency of WHO's regional structure, particularly with regard to emergency response. Following the Ebola outbreak in 2014–2016, the Director-General's leadership was reasserted in some areas, such as preparing for and responding to outbreaks and emergencies, but in many others the decision making process remains highly complicated.

Global governance for health refers to those institutions and processes of global governance that do not necessarily have an exclusive or explicit health mandate but nevertheless influence health through the work carried out under their core mandates. They include – but are not limited to – the Bretton Woods institutions, the WTO (see **Box 9**), the Food and Agriculture Organization of the United Nations (FAO), the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Environment Programme (UNEP), the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) and the United Nations Office on Drugs and Crime (UNODC). In 2018, many of these organizations came together to implement the Global Action Plan for Healthy Lives and Well-being for All, which seeks to remedy the fragmentation in global health. In recent years, several important health topics have been promoted to the UN stage by being addressed at high-level meetings of the General Assembly and at the Security Council. Moreover, the centrality of health to the 2030 Agenda means that health matters feature prominently in the regular discussions at the Economic and Social Council on progress on the SDGs. Health is also a recurring subject of discussion at the Human Rights Council. (For further information, see **Chapter 12**.)

Governance for global health refers to institutions and mechanisms that contribute to global health established at the national level (that is, strategies on global health and health in foreign policy adopted by some national governments) and the regional level (for example, the European Union, the West African Health Organization (WAHO) and the Association of Southeast Asian Nations (ASEAN)). This governance space also includes political clubs and cross-regional actors, such

as the G7, the G20 and the BRICS grouping of countries. Moreover, through the Inter Parliamentary Union, the role of parliamentarians in global health has increased in recent years. (Chapter 7 explains in more detail how regional organizations are engaged in global health diplomacy.)

This increase in the number and diversity of venues means that significant administrative and human resources are necessary to be able to deal continuously with existing and emerging multilateral diplomacy challenges. Among the resources required are dedicated departments within national ministries and regional organizations, along with representations (referred to as permanent missions) and specialized staff at the main offices of international organizations. This inevitably gives rise to inequalities between the countries that have such resources in abundance and those that do not. Such inequalities are a major challenge and can themselves act as a barrier to consensus at times.

Dedicated resources to manage multilateral affairs – not only donor relations – are also increasingly required within the international organizations themselves.

In line with the **growth of multi-stakeholder diplomacy**, a wide range of civil society and private sector non-State actors (global, regional and national) participate in, and exert their influence on, all three governance spaces. Cities and local governments are also playing an increasingly prominent role.

Box 2: Negotiating health at the G7 and G20

Introduction
The Group of Seven (G7) and the Group of 20 (G20) are multi-stakeholder summit institutions that are playing an increasingly prominent role in the governance of global health.

The Group of Seven
The G7 – which comprises Canada, France, Germany, Italy, Japan, the United Kingdom and the United States (and the European Union as a non-enumerated member) – began convening at annual summits in 1975 for the stated purpose of promoting democracy and individual liberty worldwide.

How does the G7 contribute to global health governance?
As an informal international institution, with no charter or permanent secretariat, the G7 has mainly a deliberative role. Discussions among its members are conducted at the Group's annual summits, which are usually held in late spring or early summer. Its key functions in relation to health are:

→ Discussing key health issues and publicly recording conclusions in the summit communiqués. The health agenda of the G7 has expanded over the years. From 1979 to 1995 the Group dealt with a few selective issues. From 1996 to 2009 it focused on HIV/AIDS, tuberculosis and malaria, and then on severe acute respiratory syndrome and avian flu. Maternal, newborn and child health dominated the agenda in 2010 and a few years later Ebola was the principal item. Most recently, on 16 March 2020, the G7 held an emergency summit (via videoconference) on COVID-19.

→ Direction-setting by affirming principles and norms to guide members and others in their approach to health policy and its determinants. Thus, the G7 upheld the importance of human rights from 1985 to 1987, and it has been standing up for democracy from 1997 onwards. The Group focused on women's health rights in 2016 and 2017. There were no references to democracy in the summit communiqués of 2018 and 2019, but the G7 once again upheld that concept at the emergency summit of 16 March 2020. The Group has increasingly addressed health matters in connection with hunger, poverty, nuclear safety and proliferation, biotechnology, the natural environment, drugs, ethics, gender equality and climate change. There are now plans to expand the G7 into a D10.

→ Decision-making through specific, future-oriented and politically binding public commitments that oblige all or some members to act at home and abroad by changing or introducing policies, supporting outside actors and mobilizing funds to achieve key health goals. From 1979 to 2020 the G7 adopted 435 core health commitments, averaging 10 a year, with peaks of 69 at St. Petersburg, Russian Federation, in 2006; 61 at Schloss Elmau, Germany, in 2015; 85 at Ise Shima, Japan, in 2016; and 21 out of a total of 33 commitments at the emergency summit on COVID-19 on 16 March 2020.

→ Developing global health governance by shaping the evolution and work of international institutions. From 1987 to 2020, G7 summits made 330 references to such institutions, led by the World Health Organization (WHO) with 110 references, the United Nations with 65 and the Global Fund to Fight AIDS, Tuberculosis and Malaria with 61.

Decision-making at the G7

Decision-making at the G7 depends largely on the outcomes that the summit's host and the other members wish to see emerging from the annual summit. Up to two years in advance, the designated host country privately shares with the other members its priorities for the year of its G7 presidency. Every year, from 1 January, the leaders' personal representatives, called "sherpas", meet several times. The first meeting is often held to discuss a thematic paper from the host, which gradually develops into a draft communiqué that can be agreed on by the eve of the sum-

mit. During the summit itself, the sherpas assist their leaders in resolving any outstanding issues and working out the definitive text of the communiqué. The G7 leaders discuss and negotiate over two or three days; there are also some sessions at which they meet alone without the sherpas and other advisers. At the end of the summit, the agreed communiqué is released and each leader gives a news conference to explain what has been achieved.

Decisions are reached by consensus, with no formal votes. While the host country's preferences and the ability of its leader obviously influence the final result, the norms of equality and collegial consensus prevail throughout. The host country's leader will not propose an agenda item or text that he or she knows will be adamantly opposed by another G7 member. Moreover, the host will withdraw proposals at the end if two or more members are in opposition. If only one leader is opposed, he or she will usually acquiesce, though in recent years leaders in such a situation have explicitly not agreed to the commitment in question. The necessity, born out of domestic political considerations, to display leadership on a particular initiative often results in lengthy and multiple communiqués. At the summit itself, leaders often introduce new issues and initiatives spontaneously. In the case of controversial texts, they usually adopt the alternative wording presented by their sherpas, political directors and finance deputies.

Throughout the year, an increasing number of G7 ministerial meetings are held to iron out differences among countries and ease the leaders' task, or to decide on specialized, non contentious issues. The G7 health ministers, for instance, first met in this format in 2006, when they made 14 commitments, to which were added 36 in 2015, 40 in 2016, 101 in 2017 and 13 in 2019.

Outstanding issues

The G7 faces several outstanding issues or questions. For example, how can the Group return to the continuously high level of performance that it showed from 2000 to 2010? How should it relate to civil society, WHO and the G20? Should it focus on mobilizing funds for poor countries (first and foremost in Africa), as it has done in the case of the Global Fund, or should it move to a broader array of instruments and also deal with issues that affect developed countries, such as road accidents, "diseases of despair" and universal health coverage? Finally, taking its cue from the Sustainable Development Goals, should the G7 explicitly address the determinants of health, including health as a cause and consequence of gender equality; the natural environment; and climate change?

The Group of 20

The G20 is made up of the G7 member countries, the BRICS countries (Brazil, Russian Federation, India, China, South Africa), the MIKTA countries (Mexico, Indonesia, Republic of Korea, Turkey, Australia), Argentina, Saudi Arabia and the European Union. The International Monetary Fund

and the World Bank Group participate in the G20's deliberations but are not members. Since it started convening as a meeting of finance ministers and central bank governors in 1999, and as a leaders' summit in 2008, the Group's main objective has been to promote financial stability and make globalization work for all.

The G20 countries, drawn from a diverse array of developed, emerging and developing economies, represent a large majority of the global population, economy and health-generating capabilities. Their leaders are now supported by many ministerial meetings, international organizations and civil society engagement groups. They can thus shape the health agenda in a uniquely inclusive, comprehensive and synergistic manner.
As an informal international institution, the G20's functions are similar to those of the G7.

The scope of G20 summit deliberations on health has expanded considerably since 2008, in particular in 2013 and 2014, and then in 2017 and 2019 and at the emergency summit on COVID-19 held (via videoconference) on 26 March 2020.

From 2011 to 2019, the G20 leaders adopted a total of 75 commitments on health, with peaks of 33 (all on the Ebola outbreak) at Brisbane, Australia, in 2014, and 19 (on antimicrobial resistance, strengthening of health systems and polio) at Hamburg, Germany, in 2017. In March 2020, 22 further commitments were added (all on COVID-19).
From 2008 to 2019, the G20 leaders made 11 health-related references to entities within the G20 countries and 56 to external actors. The latter were led by WHO with 17 references and the United Nations with 15, the remaining entities receiving far fewer mentions.

Decision-making at the G20
Decision-making at the G20 is much like that at the G7. However, members must choose which of the 19 country members is to host the annual summit. Each country thus hosts summits far less frequently than at the G7. The leaders' G20 sherpas are sometimes the same as their G7 ones. Since 2017, annual meetings of the G20 health ministers have helped to prepare and implement their leaders' decisions. The inherited agenda, which has branched out from economics to cover social, environmental and security issues as well, gives hosts less flexibility to discard old agenda items in favour of new ones that they may consider to be more relevant.

1.5   The changing role of diplomats

Bilateral and multilateral diplomatic structures are embedded in the international order, but the negotiation and subsequent adoption of the SDGs have led to important changes in how multilateral diplomacy is practised. Instead of being concerned mainly with representation, diplomacy has now become, together with communication, a key tool for the management of transformational global change and social engagement, including the handling of complex relationships.

Diplomacy is now a critical element of global governance. Diplomats must connect both issues and actors, at the national and global level alike. The function of a foreign ministry has shifted from that of a gatekeeper overseeing all official contacts at the international level towards being the coordinator and enabler of a **whole-of-government and whole-of-society approach**, as more and more of a country's ministries engage in international affairs and its civil society organizations become ever more internationally minded. This also means that many more individuals are engaged in diplomacy outside the circle of professional diplomats. As one saying puts it, "Nowadays everyone is a diplomat".

Embassies and other diplomatic missions engage to a much greater extent than before in outreach, dialogue and relationship building, and diplomats must be able to interact with a wide range of traditionally non diplomatic actors at home and abroad, practising bilateral, multilateral and multi-stakeholder diplomacy – often at the same time and on the same issues. Foreign ministry officials must keep abreast with national policy developments and with the increasingly global activities of other ministries, many of which now have their own international departments and are expanding the scope of their activities – for example, to participate in the SDG implementation process. In many cases, the health ministries have had to expand their departments for international or global health. In the Geneva context, it is worth noting that governments may send different types of representatives to WHO and for the conduct of health negotiations: foreign ministry representatives in some cases, health ministry representatives in others, or from both ministries in yet other cases. The composition of a Member State's delegation ultimately determines whether diplomacy is being practised to advance health objectives, or vice versa. Finding the right balance is essential for national delegations and institutions such as WHO.

A further important representation and negotiation mechanism has emerged through the establishment of the G7 and the G20, namely the "sherpa" system. Sherpas are the personal representatives of the Heads of State or Government of the countries in these two groupings — career diplomats or senior government officials appointed by each leader to represent their country's interests and participate in the extensive series of consultations needed to prepare all summits. There is only one sherpa per G7 or G20 member. Sherpas are in turn supported by "sous sherpas": diplomats and experts from the same country who have been assigned to work on specific agenda items (now also

including health) as part of the working groups established for the various preparatory meetings.

The SDG process and the global challenges of our times require diplomats to assume a dual responsibility: to promote their country's interest and to advance the interests of the global community. As has repeatedly become clear in such areas as health and the environment, there is a need to develop an approach that safeguards certain "global public goods", or "global commons". This applies, for example, to the climate agenda or to the call for COVID-19 vaccines to be available to all people. Such common goods need to be protected jointly and managed in a manner that enables them to benefit everyone and make sustainable development a reality, despite the unilateral approaches chosen by some States. During the COVID-19 pandemic, this has been exemplified by what is often referred to as "vaccine diplomacy", which seeks to establish a mechanism that will ensure equitable access to a COVID-19 vaccine on a global scale, as opposed to "vaccine nationalism". (See Chapter 13 for further examples of global health diplomacy.)

Heads of State and Government are acquiring higher visibility in relation to key global issues. Increasingly, they are using **summitry** to shape agendas and **prestige diplomacy** to underscore their engagement. For example, the Chancellor of Germany, Angela Merkel, and the former Prime Minister of Japan, Shinzo Abe, have both distinguished themselves by raising global health issues at many high-level political forums, such as G20 and G7 summits. Japan played a key role in this respect by using its G20 presidency in 2019 to promote universal health coverage.

Diplomacy is increasingly expected to be more citizen-centric and to deliver value not only to a country's citizens at home but also to the global community through the country's efforts abroad and in international organizations. Heads of State and Government are more frequently making use of **social media** for outreach purposes, with some relying on "Twitter diplomacy" not only to position themselves vis-à-vis their electorate but also to secure an international audience and be able to move agendas forward. More recently, the President of China, Xi Jinping, the President of the Islamic Republic of Iran, Hassan Rouhani, The President of the Russian Federation, Vladimir Putin and the President of the Republic of Korea, Moon Jae in, have all practised "corona diplomacy", reaching out to a wide range of countries by providing them with support in the form of medical supplies. They have effectively been engaging in what has been termed a "soft-power race".

All this implies a changing role – indeed sometimes a weaker role – for foreign ministries and diplomats. At the same time, most foreign ministers, ambassadors and representations (missions to the UN in New York or Geneva) now have their own social media accounts and are thereby able to communicate their intentions, policies and outcomes more widely. This type of engagement is a new form of **public diplomacy**.

CHAPTER 2 | GLOBAL HEALTH DIPLOMACY: SYSTEM AND METHODS

2.1 Defining global health diplomacy

Global Health Diplomacy refers to the multi-level and multi-actor negotiation processes that shape and manage the global policy environment for health in health and non-health fora. Diplomacy is both a system of organization and a method of work. It is always political and is carried out through many different channels. Diplomats seek to achieve the objectives of their country's foreign policy and, more generally, to protect its interests abroad. Nowadays diplomacy is no longer conducted exclusively by accredited diplomats but by an increasingly wide array of actors, often through multi-stakeholder diplomacy. All this is also true of global health diplomacy.

Over the past decades, a very complex, dynamic and diversified "ecosystem" of global health has emerged, which global health diplomats have to be able to navigate. It is based on rules, processes and institutions that operate at the global level but remain highly dependent on the willingness of States to cooperate with one another, despite the fact that other strong actors have entered the diplomatic health arena. In the context of multilateralism, global health diplomacy can both enhance and restrain the power of the players involved. Leadership in global health is always influenced by the prevailing power relations, as witnessed, for example, by the rules on intellectual property or by vaccine nationalism during the COVID-19 pandemic.

Power not only shapes relations between countries within WHO: it is also wielded by other key actors, such as large foundations, which are able to set global health agendas because of the significant funding that they provide for global health programmes and by virtue of their ready access to decision makers around the world.

Diplomacy is often defined as the art and practice of conducting negotiations – within a range of settings and on many different subjects. This is no less true of global health diplomacy, which is concerned with a very wide spectrum of issues and conducted within the governance spaces described in Section 1.4 However, it is much more than just negotiations, as will be explained in Chapter 3, which discusses global health diplomacy in terms of seven dimensions. It includes the building and maintaining of relationships, the gathering of information, the establishment of goodwill and the use of health as "soft power". The latter refers to influencing public opinion through

health, for example by establishing major health programmes such as the United States President's Emergency Plan for AIDS Relief (PEPFAR), launched in 2003, or through the "mask diplomacy" practised by China during the COVID-19 pandemic in 2020. These actions are often bilateral, but they are fully calculated to influence global opinion.

Global health diplomacy is a manifestation of the increased importance of **issue diplomacy**. It refers first and foremost to the negotiation processes in the multilateral system that address collective challenges relating to health. At the core of global health diplomacy are health issues that transcend national boundaries and require global agreements, instruments and alliances if they are to be tackled successfully and sustainably through joint action. However, as indicated above, it also covers many other diplomatic processes: for example, bilateral health diplomacy as manifested in donor relations (though these are not the focus of this Guide). There are also bilateral negotiation processes between agencies and countries, for example between the Global Fund or the World Bank and low- and middle-income countries. In some cases, WHO has special agreements with individual countries.

Global health diplomacy is not only conducted between accredited diplomats and health officials representing nation States but also involves many other major actors in the global arena, as is always the case with multi-stakeholder diplomacy. With health moving beyond the purely medical and technical realm to become an ever more critical element in foreign, security and trade policy, new skills are required to negotiate global regimes and international agreements and treaties, and to maintain good relations with a wide range of actors from other sectors in order to advance global health.

Most diplomats are generalists. When engaging in global health diplomacy, their familiarity with the international context and diplomatic processes is critical to the negotiations, but because of the special nature of the field of health, their general knowledge and experience often need to be complemented by the specific medical and scientific expertise of health professionals, usually from the health ministries. Tensions can arise – also within national delegations – between the national interest that diplomats are expected to uphold and the solidarity at the heart of the concept of "common goods for health", which should be the prime concern of global public health action.

With WHO as the directing and coordinating agency for global health, the bulk of global health diplomacy still consists of formal negotiations between States within its governing bodies, especially when the goal is to reach agreement on international instruments. Yet, as indicated in Section 1.4, all three governance spaces contain critical venues where global health diplomacy is practised. This proliferation of venues is proving to be a great strain on the departments responsible for international and global health within health ministries, which are often not equipped to deal with the growing number of negotiations and negotiating partners or with the increasing need for coordina-

tion between ministries. This is especially the case in small States and in low- and middle-income countries. Because of the ever-greater complexity of health negotiations, many permanent missions in Geneva now have dedicated "health attachés". There has also been a tendency in some foreign ministries to increase the number of subject-matter experts among their staff as issue diplomacy – such as on health – continues to gain in prominence.

However, it is important not to underestimate the role of informal health diplomacy, conducted between health diplomats but also with non-State actors, such as NGOs, academia, foundations and the private sector. Informal multi-stakeholder diplomacy can – and often does – influence the outcomes of formal global health diplomacy. Relationship-building is a critical skill in multi-stakeholder diplomacy. It plays a particularly important role in negotiation hubs such as Geneva and New York, where a large number of events and diplomatic receptions provide plenty of opportunities for informal diplomacy and information-gathering. Chapter 6 examines the role of non-State actors in more detail.

Example: The COVID-19 pandemic has posed a number of challenges to global health diplomacy, as outlined below:

The challenges faced by global health diplomacy during the COVID-19 pandemic reflect to a great extent the difficulties that the multilateral system has experienced over the past decade. Thus, the system's fragility manifested itself in the initial lack of global cooperation on the response to the pandemic. In particular, the geopolitical stand-off between China and the United States has hampered progress on multilateral approaches not only at WHO but also at the G7, the G20 and the United Nations Security Council. This negative trend was reinforced by the announcement of the United States that it intended to withdraw from WHO.

The challenges in question are considerable even as a new US President takes office: they include the future of WHO, the development of a new legal basis for pandemic preparedness and response, possibly a further revision of the International Health Regulations, and identifying new approaches to financing common goods in order to keep the world safe and to make a potential COVID-19 vaccine available to all.

New mechanisms have been created to address these challenges – a WHO committee to review the functioning of the International Health Regulations during the COVID-19 response; the Access to COVID-19 Tools Accelerator, a new type of global collaboration to speed up development, production and equitable access to COVID-19 tests, treatments and vaccines; the COVAX Facility, a global risk-sharing mechanism for pooled procurement and equitable distribution of eventual

COVID-19 vaccines; and new political alliances and fundraising initiatives. The European Union in particular has played an important role in promoting solidarity.

2.2 Foundations of the modern understanding of global health diplomacy

The global health architecture, institutions and processes rest on three key pillars: governance, instruments and diplomacy. The growing interconnectedness between these three pillars is an essential driving force of global health in the 21st century.

The historical foundations of global health lie in the second half of the 19th century, with the first of a series of international sanitary conferences taking place in Paris in 1851. The very first humanitarian health organization – the International Committee of the Red Cross (ICRC) – was founded in 1863, while international health conventions began to be adopted from 1892 onwards.

Two pioneering institutions in the field of international health were established in the first half of the 20th century: the International Office of Public Health (1907) and the League of Nations Health Organization (1923). Just over a year after the conclusion of the Second World War, the WHO Consti-

tution was adopted in New York on 22 July 1946, the first statutory function of the new Organization being **"to act as the directing and co-ordinating authority on international health work"**. The Constitution came into force in 1948, when WHO was able to take up its work in Geneva.

However, it was during the latter decades of the 20th century that the present understanding of global health began to take shape. Heightened demand and expectations for global cooperation on health were triggered by several external factors, including globalization; transnational commercial interests; the cross-border nature of health determinants; global epidemics such as HIV/AIDS and tobacco use; the rising political profile of health; and the multiplication of international actors engaged in health issues.

The end of the 20th and the beginning of the 21st centuries saw a new two-way dynamic emerge in global health. On the one hand, the world witnessed a rapid rise in the number and intensity of transnational factors influencing health. Growing international trade, transnational companies, global tourism, transport and communications have significantly accelerated the cross-border movement of people, goods, services, information and lifestyles. New global threats, such as inequality, climate change, food insecurity, resurging infectious diseases and mass migration, are having a significant impact on health and well-being. The benefits of globalization have not been equally distributed, and inequality has increased in the wake of the 2008 financial crisis and the austerity policies subsequently adopted by many countries.

On the other hand, it is now understood more clearly that health makes a considerable direct and indirect contribution to economic growth and sustainable development, and to international security, stability and peace. The wide-ranging economic impact of the COVID-19 crisis has highlighted this once again. Furthermore, the health sector has now become one of the largest industries. Global annual health spending reached US\$ 7.1 trillion in 2015 – a figure that was expected to balloon to US\$ 8.7 trillion by 2020. Health is also a key sector in public finance and a major area of household spending (Deloitte, 2019a). Accordingly, health has acquired a prominent place on both the domestic and foreign policy agendas of most countries.

At the same time, two distinct approaches to global health have emerged. One is more focused on improving health in developing countries; it is based on the SDGs, financed by development aid and increasingly supported by large philanthropic organizations. The other – reinforced by the COVID-19 pandemic – is concerned with all countries, the health inequalities within and between these, and with health issues that transcend national boundaries and call for responses taking into account the global forces that determine the health of people. This dynamic interface between health and economic and societal factors cannot be tackled within national or regional boundaries alone: the challenges it poses require global solutions based on both multilateral and multi-stakeholder coor-

dination and action, especially during global health crises and outbreaks.

Today there is a lively ongoing debate on how global health should be understood. Governments and communities in the Global South, in particular, are no longer willing to accept approaches to global health in which they have not been involved from the start, or to adopt programmes developed "for" them by others. Many global health professionals and organizations are still concentrated in the Global North: there have consequently been calls for a "decolonization" of global health (see **Box 3**).

Box 3: Decolonizing global health diplomacy

In recent years, there have been calls to "decolonize" global health, which some have described as an inherently "colonialist" field. University students have organized conferences to question the ahistorical and depoliticized teaching of global health. Journal articles have criticized the lack of inclusivity in the conduct and publication of research; for instance, African researchers were found to be grossly underrepresented in scientific papers about health issues in Africa. Some commentators have discerned "colonial" attitudes and practices in the global response to the COVID-19 pandemic – from early suggestions to use Africa as a "testing ground" for a potential vaccine to expert recommendations on handwashing and social distancing that do not take into account the local context in poor countries.

But what does it mean to decolonize? There are at least two major interpretations of the term "decolonization". The traditional view is that it refers to the end of one country's territorial domination of another. In this regard, most countries – especially in the "Global South"* – would already count as "decolonized". In an influential paper, however, the term was defined as "the reversal of the process of European imperial expansion with all its political, economic, social, cultural and linguistic consequences" (Bismarck, 2012) – in short, a return to a people's indigenous roots. While many remnants of the colonial past, such as language and culture, are difficult, if not impossible, to purge, this does not mean that the legacy of colonialism as reflected in modern-day capitalism, sexism, racism and globalization cannot be explicitly acknowledged and constantly challenged.

When examining the field of global health, the related concept of "decoloniality" is also important. Originating in Latin American scholarship, it refers to questioning the perceived universality and superiority of Western knowledge and culture. Much of centuries-old human medicine and contemporary global health has been shaped by Western thought, which largely ignored other systems of knowledge production. Therefore, decoloniality in global health is an invitation to a

more pluralistic vision of health that also considers non-Western and indigenous perspectives. It is hoped that such a dismantling of Eurocentric notions will give rise to health interventions, policies, practices and research arrangements that are inclusive and respectful of different peoples and their cultures. Some have argued, for example, that a lack of such respect led to a "narrative of mistrust" in the international response to the Ebola outbreak in West Africa in 2014 (Richardson, McGinnis & Frankfurter, 2019).

How, then, is global health diplomacy to be "decolonized"? While the geopolitical colonization of the Global South by Western countries is largely over, colonial legacies still very much prevail in the form of neoliberal policies, gender discrimination, white supremacy and ecological destruction, all of which to this day continue to drive health inequalities within and between countries. If pressing global health issues, such as noncommunicable diseases, sexual and reproductive health, and the long-term health impacts of climate change, are to be seriously addressed, multilateral and bilateral negotiations for health among countries must acknowledge and actively challenge these long-standing causes of power imbalances.

In addition, the platforms for health diplomacy must be made more inclusive and egalitarian. Developing countries are still generally unable to transition from unequal relationships with their former colonizers (and now development aid donors), which dominate decision-making on global health (whether in United Nations agencies or public–private partnerships, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria). Much-needed reforms must therefore be instituted to give equal voice to all countries – rich and poor. The shift in 2017 to having the WHO Director-General elected by the World Health Assembly (that is, by all countries), rather than by the Executive Board, was an essential step in that direction. However, additional measures will need to be adopted to accelerate progress towards greater inclusivity and diversity in global health leadership, governance and diplomacy.

Finally, applying the decolonial lens to health diplomacy helps in uncovering voices that are either "too loud" or "not heard at all" at the negotiating table. Beyond national governments, there are myriad actors who can be seen to be engaging in "neocolonial" behaviour and are exerting undue and disproportionate influence in global health policy – from multilateral banks and transnational corporations to philanthropic foundations and elite think tanks. On the other hand, there are the "silenced voices" in global health – women, members of the LGBT community, ethnic minorities and indigenous communities, social movements from the Global South, among others. In order to decolonize global health diplomacy, it has been argued that it is necessary to protect the negotiating space against "neocolonizers" and create more opportunities for the "colonized" and oppressed to become involved in negotiations – an important first step towards making global health truly global.

Resources

See the section entitled "Publications on decolonizing global health diplomacy" in Annex 2

2.3 The global health diplomacy system

The unique institutional mechanisms and instruments of global health diplomacy are part of a larger system of diplomacy, with which they intersect and on which they are partly dependent. Section 1.4 described three governance spaces within which actors negotiate and take decisions, and sought to give a general idea of the complex and dynamic ecosystem of global health.

Despite a weakening of multilateralism in recent years, the primary channel of global health diplomacy remains negotiation between States within the framework of the UN system. WHO remains the key conduit for global health diplomacy by virtue of its constitutional mandate to coordinate international health work and to establish norms and standards, its high level of legitimacy stemming from the representation of States, and its treaty making power. However, it has also become an indispensable platform for multi-stakeholder health diplomacy. The annual World Health Assembly, for example, brings together up to 4000 participants from all around the world: on such occasions one can truly say that "everyone is a health diplomat".

Global health diplomacy at WHO follows the general system of diplomatic representation and communication practices. The Organization currently has 194 Member States and works according to the UN principle of universal representation with one vote for each country, irrespective of size or level of development. Unlike many other venues for diplomacy, the **negotiations at WHO are aimed at reaching consensus**, even though in principle it is possible to call for a vote.

Tensions can often emerge at WHO between the value-driven and evidence-based proposals made by the Secretariat, the foreign policy interests of Member States and the specific national interests of the health ministries representing their countries in the WHO governing bodies. In most cases, the day-to-day negotiations are conducted by health attachés, who are based at the diplomatic representations in Geneva, with higher-level representatives such as ambassadors or ministers joining them at major meetings or when key decisions are to be adopted. The permanent mission of a State – for example in Geneva – or the negotiators from the capital receive instructions from the national government and seek to ensure that the State's national position and interests are

reflected in the outcome of the negotiations. The effectiveness of smaller missions may depend to a great extent on the personality and contacts of the health attaché, while larger missions operate more through their diplomatic machinery.

Responsibility for the success of negotiations also lies with the secretariats of organizations such as WHO. The way in which proposals are developed does make a difference: if they are handled in a transparent way that elicits support and includes dialogue and consultations with Member States, civil society and the private sector, the proposals are likely to make swifter progress within the governing bodies. Knowing when and how to put forward proposals is an important skill that needs to be honed within the secretariats of such organizations so as to ensure success in health diplomacy.

Appropriate mechanisms, procedures and strategies developed at the **national level** are critical for the success of global negotiations. Good global health begins at home. National policy frameworks on global health can serve as a compass for negotiations at other levels and can be supported through strong departments and focal points responsible for global health within national ministries (see Section 8.4).

These policy frameworks can deal with global health generally, or they may be national strategies on specific issues such as antimicrobial resistance which underline the need for both domestic and international cooperation. The success of international negotiations also depends on the trust that countries have in individual organizations, the level of such trust often being informed by the findings of official reviews. Examples include the Multilateral Aid Review in the United Kingdom of

Great Britain and Northern Ireland, and the Multilateral Organisation Performance Assessment Network, both of which review the performance of multilateral organizations and assess national plans and strategies.

Since health negotiations often require interaction between health and foreign policy (and other policy areas), the role of **health attachés** has become increasingly important. These diplomats are expected to brief officials in the capitals, prepare negotiations and in many cases to conduct them directly, both in Geneva and New York.

Geneva, the headquarters of many global health organizations, is considered to be the global health capital, and most countries and many other key global health actors are represented there. The city provides an environment in which it is easy to establish relations and use both formal and informal channels to prepare for negotiations. However, global health negotiations are increasingly also taking place at the **United Nations in New York**, especially given that health is an essential component of the SDGs (notably Goal 3). In some cases, health issues acquire such relevance that they are discussed at the General Assembly, the Security Council or at special high-level summits. Other important venues are the regular G7 and G20 meetings and special summits. Some commentators have criticized the fact that most major health organizations are based in Geneva, that is, in the Global North, whereas many of the challenges they are called upon to tackle are in low- and middle-income countries in the Global South. It should also be noted that some low income countries do not have their own representation in Geneva.[6]

Like other areas of diplomacy, the system of global health diplomacy has evolved to manage not only the relations between States (bilateral and multilateral) but also those between States and other actors. The importance of multi-stakeholder diplomacy has increased exponentially. Civil society organizations, in particular, expect a high level of involvement, transparency and accountability. This is not always forthcoming from large donors and foundations. Many of the more recently established global health organizations in Geneva are defined by a multi-stakeholder and constituency-based governance. For example, the Board of the Global Fund comprises 28 seats, of which 10 represent donor constituencies and 10 represent implementer constituencies; the remaining eight seats are for non voting members of the Board, including a broad range of global health actors, also from among civil society.

While there is often competition between global health actors, including WHO, for scarce donor resources, all of them rely on WHO for key aspects of their successful mission delivery, be it the

6   The Swiss Federation provides a regularly updated overview of all organizations and representations in Geneva: https://www. eda.admin.ch/dam/mission-onu-omc-aele-geneve/en/documents/GI--en-chiffres_EN.pdf

norms and standards underpinning their work, technical support at the national level through the numerous WHO country offices, or even just the legitimacy conveyed by WHO's support and its universal membership and consensus-based approach. As the directing and coordinating authority in global health, WHO has responded to the increase in the number of players in the global health arena: it engages with non-State actors by recognizing their contributions to global health and by encouraging them to develop their own activities to protect and promote public health at home and abroad. Their relations with WHO are governed by the Framework of Engagement with Non-State Actors. The Framework is intended to strengthen WHO engagement with non-State actors (NGOs, private sector entities, philanthropic foundations and academic institutions) while protecting the Organization's work from potential conflicts of interest, reputational risks and undue influence. (More details on the venues and actors in global health diplomacy can be found in Chapter 6.)

2.4 Relationships in the global health diplomacy system

Countries engage in both formal and informal global health diplomacy in a variety of ways. Indeed, the many different forms of conducting diplomacy in general also apply to health diplomacy. The uneven power dynamics among States, and between States and other actors that want to influence negotiations, always have an impact on and often even decide the outcome of negotiations. Despite the many difficulties over the past decades, a willingness to engage in negotiations and reach an outcome has generally always been forthcoming. However, the weakening commitment to multilateralism is now making it more difficult to use different forms of diplomacy to move agendas forward. One telling sign is that major meetings are increasingly unable to reach an agreed conclusion. The well-established system of global health diplomacy has been disrupted, with the leadership void recently created by the United States not yet filled, even though new alliances of States are forming.

In the majority of cases, different channels of diplomacy are used simultaneously to move an agenda forward. As already indicated, formal and informal negotiations (**"track-one" and "track-two" diplomacy**) will usually take place in parallel. In order to advance their positions and test possible alliances, countries (and other stakeholders) sometimes engage in **"forum-shopping"** – that is, launching an issue of importance to them in different negotiation venues and at different levels. (This process of course depends on the influence they have in the various venues.) If well conducted, the negotiations can reinforce one another and may even facilitate diplomatic breakthroughs, but they can also fail, as was the case with the global health negotiations at the G7 and G20 in 2020.

Most countries are engaged at the **multilateral level** with UN system entities (see the chart in Section 6.3).

The World Health Organization is the key entity when it comes to negotiations on global health norms and standards. The priorities for such negotiations are usually set by governments, which participate as nominal equals (according to the principle of one vote per country) within the UN framework. Before proceeding to the WHO stage there are normally preparatory negotiations at the bilateral and regional level. Alliances are created at all these levels to move an agenda forward. Global health diplomacy is also conducted at the Bretton Woods institutions, such as the World Bank, especially on matters of health financing, and at specific health organizations such as the Gavi Alliance, the Global Fund and the International Drug Purchase Facility (UNITAID).

The Joint United Nations Programme on HIV/AIDS (UNAIDS) was established by the United Nations Economic and Social Council and remains the only co-sponsored joint programme in the UN system. UNAIDS is steered by its Programme Coordinating Board, a governance structure unique in its small size and level of inclusiveness: it comprises Member States, Cosponsors, civil society representatives and specifically also people living with and affected by HIV. Significantly, the NGO delegation to the Programme Coordinating Board has co-equal status with Member States and UNAIDS sponsors. Such arrangements could help to promote the decolonization of global health governance.

The Global Fund is a private foundation under Swiss law, albeit with quasi-intergovernmental status conferred by the Swiss Government. Set up to accelerate the end of AIDS, tuberculosis and malaria as epidemics, the Global Fund works in partnership with governments, civil society, technical agencies, the private sector and people affected by these diseases, who are represented in its governing bodies.

In such settings as negotiations at the Global Fund or the Gavi Alliance, a country's level of development can determine whether it takes part in the negotiations as a donor, a recipient or as an implementer. A constituency model of representation is frequently chosen (see Box 10 and Box 11). **Multi-stakeholder diplomacy** in all organizations and negotiating venues increasingly involves bringing in other stakeholders: large foundations, academia, the private sector and NGOs. Such engagement comprises a wide range of interfaces and is often an essential factor in successful negotiations, even if the final decisions are taken by States. Multi-stakeholder diplomacy is also conducted through **public–private partnerships and alliances**, including new mechanisms such as the Access to COVID-19 Tools Accelerator, that brings together governments, scientists, businesses, civil society, philanthropists and global health organizations.

Summits of country groupings, such as the G7, the G20, the BRICS countries and the Commonwealth, now play a very important role in global health diplomacy. An increasing amount of multilateral negotiations on health issues takes place at the level of Heads of State and Government. This is often referred to as **"club diplomacy"**, with membership restricted to a select group of

countries and with the rotating presidencies deciding on which other countries should be invited to join the negotiations. Recent G7 summits have paid considerable attention to health (especially thanks to the presidencies of France, Germany and Japan). Similarly, meetings of the health ministers of the G20 countries have been taking place regularly since the first such meeting in Berlin in May 2017. There have also been joint meetings of health and finance ministers. In recent years, the final communiqués of both G7 and G20 summits have increasingly referred to health issues. Reaching agreement on global health issues at such summits, however, is now more difficult to achieve because of the politicization of the COVID-19 pandemic.

Most countries are likely to be engaged in negotiating **bilateral agreements** on health. Bilateral negotiations are frequently about securing financial support from donors or large funding agencies such as the World Bank or the International Monetary Fund. However, they may also have to do with people's access to health services or issues related to the safety of health products as these cross-borders. Myriad constellations are possible in such negotiations: not just South–North but also North–North and South–South. China has developed a new mixed approach, using the Belt and Road Initiative to build a "Health Silk Road" (see Box 5).

Countries may also be engaged in negotiating **regional agreements** – for example, within the European Union (EU), where such agreements are often binding, or between regions, as between the EU and the African Union. The countries in a regional bloc will frequently need to negotiate and agree on their positions in a multilateral negotiation, but bilateral trade agreements (often including health-related provisions) are on the rise. Since regional trade agreements can have significant positive and negative health impacts, they often prove difficult to negotiate. Regional groupings can play a key role in advancing global health, as the Caribbean Community (CARICOM) did with the noncommunicable diseases agenda or, more recently, as the EU has done with the response to the COVID-19 pandemic. (See Chapter 7)

All this testifies to the ever more important overlap between health diplomacy and **economic and commercial diplomacy**. Economic diplomacy is concerned with many transborder determinants of health – for example, with how to stimulate economic growth, particularly in the poorest countries. Commercial diplomacy, on the other hand, consists mainly of assistance with the promotion of exports, securing foreign direct investment, and access to raw materials. It has become increasingly relevant to the field of health as access to medicines and global supply chains for health gain in importance. Analysts have noted how modern diplomacy was influenced by commerce from its earliest days, and that the priority given to economic as well as commercial diplomacy has risen more in recent years (Berridge, 2015). Health diplomacy is also strongly integrated with economic and commercial diplomacy in such diverse areas as intellectual property protection, antimicrobial resistance, noncommunicable diseases, and nutrition policies and labels. More needs to be done to

proactively bring these work streams together, both within national delegations and among international organizations, as exemplified by the trilateral cooperation on access to medicines undertaken by WHO, the WTO and the World Intellectual Property Organization (WIPO).

The trend towards greater integration has been reinforced by increasing calls (for example, at the G7 and the G20) for joint meetings of health and finance ministers to secure financing for universal health coverage or for pandemic preparedness and response. Most countries integrate economic and commercial diplomacy into their health diplomacy at least to a certain extent, but this should not necessarily be seen as something negative. The issue of global supply chains in the face of COVID-19 is a case in point. For example, a recent EU veterinary directive has potential far-reaching implications for the fight against antimicrobial resistance, but it is also creating significant disruption throughout the Americas and Oceania, since trading partners in those regions do not necessarily categorize some feed additives as antibiotics, while the new EU directive does. In this case a range of commercial factors come into play, including the protection of domestic producers at the expense of imports.

Health diplomacy – especially if accompanied by science diplomacy – is a helpful channel for interaction between countries that have no or very strained foreign policy relations with one another. In the United States, the term **"track-three diplomacy"** is frequently used to refer to approaches that bring experts, scientists and citizens together; it is also referred to as "people to people diplomacy". Operating at the grassroots level, such approaches seek to facilitate a better understanding of others' positions. Many global health conferences make space for this kind of diplomacy, which, like the other types, has also become more difficult in the wake of the COVID-19 pandemic. In crisis situations and in humanitarian diplomacy, the use of **third party diplomacy**, where a neutral and independent actor serves as an intermediary, can be critical.

As already indicated, other types of diplomacy can be greatly relevant for the advancement of global health: crisis and emergency diplomacy; humanitarian diplomacy; science diplomacy; and climate diplomacy. It is important to keep in mind that diplomats are on rotation and gain experience in many settings. For example, many diplomats serve in Geneva after having been based with their national delegations to the UN in New York. Many different constellations of experience are possible and this can be an asset in health negotiations.

2.5 Digital diplomacy

Digital diplomacy is increasingly being used to publicize a country's position to a broader audience (a function previously fulfilled by **public diplomacy**) and to influence negotiations. This includes the

use of electronic media (such as websites, podcasts and blogs) and social media (particularly Facebook and Twitter) to reach out to other negotiators, the public and journalists. Digital diplomacy comprises such channels as "cyberdiplomacy"[7], which has mainly to do with security issues; "tech and science diplomacy"[8], which covers States' interactions through innovation hubs; "data diplomacy"[9], which refers to the use and impact of "big data"[10] on diplomacy and international affairs; and "e-commerce"[11], which is about economic issues.

Digital diplomacy through social media is often used by non-State actors to persuade or even pressure diplomats into adopting a particular position in negotiations. For example, social media featured prominently in the "Hands off our medicine!" campaign launched by Médecins sans Frontières in 2010 to dissuade the EU from concluding a trade agreement with India that would have limited the generic production of medicines for the treatment of tuberculosis and other diseases. Social media also played an important role in the negotiation of the "transparency resolution" at the Seventy-second World Health Assembly in 2019 (see Case Study 1). The increased use of new web-based tools in the practice of diplomacy is set to continue.

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7   DiploFoundation on Cyberdiplomacy: https://www.diplomacy.edu/blog/web-discussion-summary-applicability-international-law-cyberspace-do-we-know-rules-road

8   DiploFoundation on Tech and Science Diplomacy: https://www.diplomacy.edu/innovationhubs

9   DiploFoundation on Data Diplomacy: https://www.diplomacy.edu/datadiplomacy/policyresearch

10   DiploFoundation Website on Data Diplomacy: https://www.diplomacy.edu/blog/impact-big-data-geopolitics-negotiations-and-diplomatic-modus-operandi

11   DiploFoundation Website on E-Commerce: https://www.diplomacy.edu/e-commerce

Twitter diplomacy played a key role in the recent elections of the directors general of WHO and the United Nations Educational, Scientific and Cultural Organization (UNESCO). Most of the candidates for high-level UN positions now actively campaign on Twitter. This platform is also used increasingly by Heads of State and Government and by ministers and diplomats to share their views and positions with a wide audience. Similarly, the heads of international organizations use social media to present their work and policies – something that the WHO Director-General in particular has frequently done during the COVID-19 pandemic.

Social media are particularly prominent in what has come to be called **"global issue diplomacy"**. In the context of global health diplomacy, this refers to efforts to promote a specific health issue – for example, a certain disease (AIDS) or group of diseases (noncommunicable or neglected tropical diseases) – to the top of the agenda, to gain acceptance for a specific approach ("One Health", universal health coverage), or to draw attention to discrimination (the Women in Global Health campaign). Social media are also critical for new fundraising approaches, as illustrated by the "One World: Together At Home" campaign in support of the response to the COVID-19 pandemic.

Global health is an area in which broad societal involvement is clearly meaningful. Civil society organizations focused on development agendas expect governments to support initiatives on global health, human development and human rights. The number of NGOs active in the field of global health has grown significantly over the past few years, and they too now use social media to demand investment, action and accountability. They have also begun to organize novel types of **global fundraising campaigns**, such as the "One World: Together At Home" and "Global Citizen" campaigns, which helped to raise over US$ 230 million for the COVID-19 Solidarity Response Fund set up by WHO together with several philanthropic foundations around the world.

While social media provide a wide cross-section of the public with an opportunity to comment on foreign policy action (or neglect), they can also result in negotiators being subjected to great moral pressure, highly emotional responses and even vicious personal attacks. WHO has warned of the negative health impacts of **"infodemics"**, that is, where the volume of information associated with a specific topic grows exponentially in a short period of time. The COVID-19 outbreak and the ensuing response measures were accompanied by a massive infodemic: an overabundance of information – some accurate, some not – that made it hard for people to find trustworthy sources and reliable guidance when they most needed it. This new information environment poses an increasing challenge to diplomats. Accordingly, WHO took the critical decision to hold press conferences on the COVID-19 response three times a week – something that it still continues to do – and combined these with a strong social media presence and outreach efforts.

CHAPTER 3 | THE DIMENSIONS OF GLOBAL HEALTH DIPLOMACY

Efforts in global health diplomacy can be better understood by breaking this field down into seven dimensions:

Seven dimensions of global health diplomacy

- negotiating to promote health and well-being in the face of other interests
- establishing new governance mechanisms in support of health and well-being
- creating alliances in support of health and well-being outcomes
- building and managing donor and stakeholder relations
- responding to public health crises
- improving relations between countries through health and well-being
- contributing to peace and security
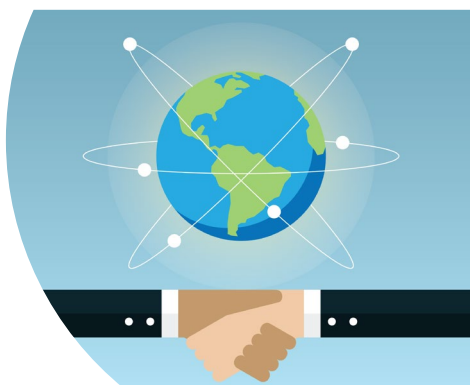
3.1 Negotiating to promote health and well-being in the face of other interests

Global health diplomacy at WHO has particular relevance because it is the only global health organization that sets norms and standards and can adopt treaties. Upholding health interests in the face of other interests – as was the case, for example, when negotiating the WHO Framework Convention on Tobacco Control (adopted in 2003) – is a highly political and sensitive matter requiring thorough preparation. It is important to apply evidence, foresight and judiciousness so as to ensure that short term political considerations and commercial interests do not endanger the prioritization of health aspects in sustainable development. The COVID-19 pandemic has demonstrated that, in addition to a strong mandate, global institutions such as WHO must also have strong tools to respond to health crises. Otherwise, geopolitical and national interests may stand in the way of solutions that benefit all countries. Before any round of global health negotiations, it is vital that diplomats should assess the interests at stake and prepare well to be able to address these strategically.

Four examples of global health diplomacy negotiations that were challenging because of the interplay of political, economic and commercial interests are presented below:

Price transparency for medicines: The adoption, in May 2019, of the landmark World Health Assembly resolution WHA72.8 on improving the transparency of markets for medicines, vaccines and other health products was achieved only after a very controversial series of negotiations, with a group of Member States withdrawing from the final round for reasons of both substance and process. The resolution tasks Member States and WHO with creating systems to collect and share information about prices, sales, patents, public and private sector research and development (R&D) costs, R&D subsidies and other items (see Case Study 1 by Catherine Saez).

Health of refugees and migrants: Member States at the 72nd World Health Assembly took note of the document Promoting the health of refugees and migrants: Draft global action plan, 2019–2023. After lengthy debate, which reflected the changed political landscape and the often emotionally charged tone of current discussions on migration, the opposing views of the delegations could not be reconciled, although the original intention had been to achieve a resolution. This outcome was the sole acceptable one for some countries that did not feel ready to accept any obligations under the action plan had it been adopted.

Intellectual property: Much of global health diplomacy in relation to this field takes place in "non-health" forums such as the WTO, a notable example being those rounds of the negotiations leading to the 1995 Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) in which public health needs had to be upheld in the face of political, economic and commercial interests.

Response to the COVID-19 pandemic: It had become increasingly difficult to reach agreement on collective measures in response to the pandemic at political negotiation venues such as the G7 or G20, in particular because of the geopolitical stand-off between China and the United States, and also because of the critical attitude of the United States towards WHO.

Resources
Bernes TA. COVID-19: the failure of G20. In: Centre for International Governance Innovation [website]. Waterloo, Canada: Centre for International Governance Innovation; 2020 (https://www.cigionline.org/articles/covid-19-failure-g20, accessed 14 September 2020).

Severoni S, Kosinska M, Immordino P, Told M, Kökény M, editors. Health diplomacy: spotlight on refugees and migrants. Copenhagen: WHO Regional Office for Europe; 2019 (http://www.

euro.who.int/en/publications/abstracts/health-diplomacy-spotlight-on-refugees-and-migrants-2019, accessed 14 September 2020).

Watal J, Taubman A, editors. The making of the TRIPS Agreement: personal insights from the Uruguay Round negotiations. Geneva: World Trade Organization; 2015 (https://www.wto.org/english/res_e/publications_e/trips_agree_e.htm, accessed 14 September 2020).

3.2 Establishing new governance mechanisms in support of health and well-being

At the turn of the 21st century, new organizations were created in the field of global health, such as UNAIDS, the Global Fund and the Gavi Alliance, which now enjoy a considerable standing. This was made possible by negotiations between countries and other partners at WHO, the UN, the G7 and the G20, which led to agreement on the establishment of these organizations and on the financing and governance mechanisms. They were often set up because WHO was at the time unable or unwilling to fulfil the relevant functions. Yet this has also led inadvertently to the fragmentation of global health governance. For that reason, many in the international community are now very hesitant about creating additional global health organizations.

Two megatrends have emerged in recent years. First, there has been a shift from the traditional global health architecture towards new political spaces and mechanisms, such as UN forums, regional economic and political blocs, major conferences on other global priorities (climate, urbanization, humanitarian action), initiatives by the Global South and agenda-setting by global health journals (see Chapter 2). Secondly, the processes of governance have changed: negotiations on a dynamic range of political and other issues are conducted by an increasingly flexible network of partnerships, alliances and coalitions (such as dedicated public–private partnerships and umbrella NGOs).

Within intergovernmental organizations, new governance models are being negotiated by the member countries. For example, the WHO Member States changed the Rules of Procedure of the Executive Board and the modalities for the election of the Director General. They also strengthened the Organization's operational role through the establishment of a new Health Emergencies Programme. These are important global health diplomacy processes on account of their impact on long term decision making.

Indeed, there have already been many calls for a complete overhaul of the governance mechanisms

in global health to ensure more effective cooperation and use of funds. Some proposals imply a strengthening, others a weakening of WHO and of its mandate. Reconciling these often-opposing tendencies will be a key area of global health diplomacy in the coming years.

3.3 Creating alliances in support of health and well-being outcomes

Alliances are formed for mutual benefit or to achieve some common purpose, whether or not an explicit agreement has been reached among the individual members. Alliances for global health may include political alliances. For example, in 2019, France and Germany established the Alliance for Multilateralism, which seeks to bring together all those who believe that strong and effective multilateral cooperation, based on the objectives and principles of the UN Charter, international law and justice, is indispensable to secure peace, stability and prosperity. The Alliance issued a strong statement in support of WHO in the context of the COVID-19 pandemic. Older alliances can also help to advance agendas: for example, the Non-Aligned Movement, a group established in 1961 that now consists of over 120 developing countries not formally aligned with or against any major geopolitical bloc, played a significant role in the negotiations leading to the adoption of the Pandemic Influenza Preparedness Framework in 2011.

Countries with common interests have used a system of **"bloc politics"** to organize their efforts under the UN framework. Member States often come together as a regional group within which there is consensus on defending a common position when voting at the World Health Assembly or the UN General Assembly. There are five regional groups at the UN: the Group of African States, the Group of Asia-Pacific States, the Group of Eastern European States, the Group of Latin American

and Caribbean States (GRULAC) and the Group of Western European and Other States. The voting correlation varies between regions and depends on the type of resolution that comes to a vote. The EU usually acts as a unified bloc during voting at the World Health Assembly or the General Assembly. Although the EU has no voting right as such, its delegation is authorized to speak on behalf of the whole bloc at the UN. EU member countries may express their individual views but they strongly align their vote with the consensus EU position.

Health alliances taking many different forms have been set up over the past two decades – often linked to specific diseases, as in the case of the Global Polio Eradication Initiative launched in 1988, which currently has six core partners. Alliances offer distinct advantages in terms of the pooling of resources and capabilities. One of the best known is the Gavi Alliance, established in 2000. Gavi today helps to vaccinate almost half of the world's children, which gives it vast power to negotiate prices for vaccines that are affordable for the poorest countries and to remove the commercial risks that previously deterred manufacturers from serving those countries.

Alliances are necessary to address public health problems that organizations working alone find it difficult to tackle. Moreover, the health-related targets under the SDGs offer a unique opportunity to create alliances that can influence the determinants of health. In particular, the interface between climate change and health has emerged as a priority area. The Global Climate and Health Alliance was launched in Durban, South Africa, in 2011 to tackle climate change and protect and promote public health. It comprises health and development organizations from around the world that are united by a shared vision of an equitable and sustainable future.

The Global Health Workforce Alliance was created in 2006 to coordinate the engagement of multisectoral stakeholders seeking to tackle the crisis in human resources for health. Bringing together national governments, civil society, international agencies, finance institutions, researchers, educators and professional associations, the Alliance was able, over the 10 years of its mandate, to generate significant political will and action for positive change in this area. After the conclusion of its mandate in 2016 it transitioned into the Global Health Workforce Network.

Groups of countries or health advocates at the country level have also come together to launch initiatives such as Friends of WHO or Friends of the Global Fund in order to support the relevant entities in a variety of ways. An example of an alliance for global health created at the national level is the German Health Alliance, which consists of more than 100 partners from virtually all sectors: the private sector and industry, NGOs, civil society and foundations, science and academia. A recent analysis showed that 80% of global health alliances are successful in their work. A key factor in this respect is achieving a good balance between participation and effectiveness. Successful alliances tend to encourage input from, and consultation with, all parties, without necessarily

involving them all in lengthy decision-making processes. Many alliances are created for a short period of time in order to work towards a specific goal; others take the form of loose networks – for example, the Geneva Global Health Hub was set up in 2016 by a group of international NGOs seeking to achieve a stronger voice by working together.

Box 4: Science diplomacy meets health diplomacy: recent examples

Science plays a critical role in health diplomacy. The close interface between **science diplomacy** and health diplomacy is proving ever more important in the promotion of global health. In broad terms, "science diplomacy" refers to the use of science, including its methods and results, for bilateral or multilateral diplomacy. It means putting science at the centre of diplomatic efforts aimed at building or maintaining relations and at establishing or achieving foreign or multilateral policy goals. Science diplomacy should ideally be part of the wider interface between policy, society and science. This type of diplomacy has gained traction in the past two decades owing to the speed of technological progress and the importance of science for tackling global challenges such as climate change, the digital divide or pandemics. The recent COVID-19 outbreak and the ensuing pressure to develop a vaccine have very much led to science taking centre stage in global affairs.

Foreign policy and science policy have become increasingly intertwined, particularly in connection with advances in the health and medical sciences. However, other scientific fields, such as climate change or artificial intelligence, also require attention on the part of those responsible for foreign policy. Diplomatic skills and scientific literacy (in some cases also expertise) have both become essential to the design and execution of foreign policy.

The definition of science diplomacy proposed by the American Association for the Advancement of Science acknowledges the fact that while foreign policy decisions may be informed by scientific evidence, they are also or even more so driven by values, ethics, economics and aspirations for leadership. Given the growing diversity of (non-State) actors and the opportunities opened up by digitalization and social media, the playing field for science diplomacy has become increasingly complex – just as with global health diplomacy. In view of rising geopolitical tensions and nationalistic tendencies, a robust set of overarching values, principles and standards is required if the full potential of science diplomacy is to be harnessed. The Madrid Declaration on Science Diplomacy issued in 2019 is an ambitious response to that need.

A relatively recent development in science diplomacy is the growing number of alliances established to promote science and innovation for global health. Two recent examples illustrate the new types of alliances that are emerging to help the scientific community respond to major

health challenges. The premise is that science (like health) should be regarded as a **global public good**, with fair and equitable access ensured for everyone. In order to enable all people to share in scientific advances and their benefits, the concept of **open science** (open methods, open source, open access, open data and so on) should be at the centre of diplomacy. Diplomats engaged in negotiations must also respect and uphold the freedom and independence of scientists.

COVID-19: Many new alliances have been created in the wake of the COVID-19 pandemic, especially to facilitate the development of a vaccine. The Access to COVID-19 Tools (ACT) Accelerator, for instance, is a global collaboration of organizations and governments working to speed up the development and production of, and equitable access to, COVID-19 tests, treatments and possible vaccines. The vaccines pillar of the ACT Accelerator, referred to as COVAX, is jointly led by Gavi, the Vaccine Alliance; the Coalition for Epidemic Preparedness Innovations (CEPI) and the World Health Organization (WHO). The aim of COVAX is to speed up the development and manufacture of COVID-19 vaccines, and to ensure fair and equitable access for every country in the world. It is a key example of multi-stakeholder diplomacy in which the Gavi Alliance, CEPI and WHO are working together with industrial manufacturers, including those based in developing countries.

Antimicrobial resistance (AMR): In 2020, more than 20 leading pharmaceutical companies launched the AMR Action Fund to bridge the current gap in funding for the development of new antibiotics. The concept for the Fund was developed by the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA), the Biopharmaceutical CEOs Roundtable, and several major biopharmaceutical companies and foundations, in collaboration with WHO, the European Investment Bank and the Wellcome Trust. The Fund seeks to forge partnerships with institutions and philanthropic organizations in order to enhance and accelerate the development of antibiotics. It will also work with governments to ensure that there is a sustainable supply of new antibiotics.

Resources
Gavi, the Vaccine Alliance (2020). What is the COVAX pillar, why do we need it and how will it work? [website]. (https://www.gavi.org/vaccineswork/gavi-ceo-dr-seth-berkley-explains-covax-pillar, accessed 12 October 2020).

IFPMA (2020). The AMR Action Fund [website]. (https://www.ifpma.org/partners-2/the-amr-action-fund/, accessed 12 October 2020).

3.4 Building and managing donor and stakeholder relations

As explained in Chapter 2, much of global health diplomacy is now multi-stakeholder diplomacy. This means that relationships must be established and maintained with a wide array of different actors in the global health arena. Many global health organizations have special rules and requirements for such relationship-building: WHO, for example, has the Framework of Engagement with Non-State Actors. **Multi-stakeholder diplomacy** is evolving rapidly, not only as a cross-cutting strategic component in international relations, but also in terms of the number of actors involved in global health. Stakeholders ranging from governments, through civil society organizations and foundations, to the private sector play an influential part at various stages and levels of global health diplomacy.

This complexity calls for a thorough analysis and assessment of the interests and needs of each stakeholder, so that diplomats can act effectively in such diverse environments. Attention should be paid to how the numerous stakeholders interact and manage their roles and responsibilities at the various stages of the negotiation processes, and how they balance requirements, expectations and accountability. Conflicts of interest must always be taken into consideration and made transparent.

All global health organizations have a special relationship with key **donors**, which may be countries, other organizations or private foundations. Donors increasingly expect a coherent, accountable and transparent collaboration between the various stakeholders before they are willing to commit any funding. One key challenge in global health diplomacy is, therefore, explaining the rationale for potential investments and clarifying the nature and duration of the returns on investment that are to be expected. Investment cases are increasingly at the start of a funding negotiation. Donors can of course also attempt to exert pressure on organizations and seek to influence their programmes or policies. WHO in particular, because of its uneven financing (only 20% of its budget comes from regular assessed contributions), must be careful to protect its independence. The risk of undue influence by donors (be they countries or large philanthropic organizations), along with the unpredictability that overreliance can create, remains a major concern in global health.

Negotiations at a series of high-profile international conferences in the first decade of the 21st century resulted in a significant increase in official development assistance (ODA) flows, which benefited health funding in particular. In 2002, the International Conference on Financing for Development, held in Monterrey, Mexico, set firm targets for each donor and heralded an upturn in ODA flows after a decade of decline. In 2005, at the Group of Eight summit held in Gleneagles, Scotland (United Kingdom), and the Millennium + 5 Summit held at UN Headquarters, donors made further commitments to increase the level of assistance provided. Fifteen years on, the weakening of multilateralism is reflected in the greater reluctance of some developed countries to provide foreign aid (ODA) for health. While there has been a short-term resurgence in response to

developing countries' needs with regard to tackling the COVID-19 pandemic, and also in connection with the quest for a vaccine, many other areas of health development have suffered a dwindling of support.

Siloed approaches are very attractive to donors, but they can hamper efforts to achieve systemic goals such as universal health coverage or improved preparedness and response capacities. Parliaments in donor countries prefer to approve funds for aid programmes that pursue very specific objectives. That is why working with the Inter-Parliamentary Union to alert national parliaments to global health priorities is a very important new development in global health diplomacy.

The Organisation for Economic Co-operation and Development (OECD) regularly provides an overview of government aid that promotes and specifically targets the economic development and welfare of developing countries. The OECD Development Assistance Committee adopted ODA as the "gold standard" of foreign aid in 1969, and to this day it remains the main source of financing for development. The aid provided includes grants, "soft" loans and technical assistance. Soft loans are those in which the grant element makes up at least 25% of the total. In **development cooperation**, most ODA negotiations are concerned with bilateral aid, though countries are steadily increasing their contributions to **multilateral aid** by providing assistance to UN system organizations, the World Bank and specialized health agencies, such as the Gavi Alliance and the Global Fund. Certain shifts have occurred in funding priorities: for example, Norway launched a global strategy in November 2019 to help combat noncommunicable diseases in low-income countries, thereby reinvigorating a neglected area of funding.

The members of the OECD Development Assistance Committee have generally accepted the target of 0.7% of a donor's gross national income being earmarked for ODA, even though very few have actually achieved that target. The United Kingdom was the only large donor country to have reached the recommended level of spending alongside a group of smaller countries such as Denmark, Luxembourg, Norway and Sweden, which are all fulfilling their obligations. It has though recently decided to not exceed 0.5. The United States has recently rescinded its decision to withhold funding from WHO, it remains to be seen how this is reflected in ODA for health. Germany has significantly increased its contributions to WHO. Negotiating the funding of WHO is a key area of global health diplomacy in the years to come.

Negotiations on the funding of global health increasingly cover debt relief, loans and foreign direct investment. That is one reason why joint meetings of health and finance ministers are critical for global health diplomacy.

Partnerships are also negotiated with the private sector – for example, by the Gavi Alliance to en-

sure that vaccines are affordable. Gavi's predictable funding and pooling of demand have created an incentive for the pharmaceutical industry to set up a tiered pricing policy, whereby low-income countries are charged less than higher-income ones for the same product. Through COVAX, the new vaccine pooling mechanism for COVID-19, the Gavi Alliance is now striving to negotiate a new financial mechanism.

Two areas in which global health diplomacy plays a crucial role in securing funding are described below:

Universal health coverage: Investment on a vast scale is required from the public and private sectors to ensure equitable access to health services. On the other hand, "digital health" presents a major economic opportunity for both sectors. Dealing with the multi-stakeholder opportunities and risks arising from the attempt to balance economic interests and social (and global) solidarity is a key challenge in global health diplomacy. The multi-stakeholder hearings at the UN in preparation for the High-Level Meeting on Universal Health Coverage in 2019 – modelled on the multi-stakeholder SDG negotiations – are one example. The first-ever meeting between G20 health and finance ministers, which took place on the margins of the G20 summit in Osaka, Japan, in June 2019, was another significant milestone (see **Case Study 2** by Satoshi Ezoe, Tamar Tchelidze, Nathita Premabhuti, Marcelo A.C. Costa).

Replenishment of global health funds: Another significant challenge in global health diplomacy is the replenishment of the funds of four major financing platforms: the Global Fund to Fight AIDS, Tuberculosis and Malaria; Gavi, the Vaccine Alliance; the Global Financing Facility for Women, Children and Adolescents; and the Global Polio Eradication Initiative. Negotiating the replenishment model for financing is a particularly attractive opportunity for Heads of State and Government to engage in prestige diplomacy. A notable example is the French campaign to secure the replenishment of the Global Fund in 2018 and 2019. Becoming involved in such negotiations also appeals to donors, as it gives them high visibility and enables them to reach out to many different global health actors, such as governments, foundations, civil society and the private sector.

Resources
Health: launch of the campaign to replenish the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. In: France, Ministry of Europe and Foreign Affairs [website]. Paris: Ministry of Europe and Foreign Affairs; 2018 (https://www.diplomatie.gouv.fr/en/french-foreign-policy/development-assistance/news/2018/article/health-launch-of-the-campaign-to-replenish-the-global-fund-to-fight-hiv-aids, accessed 14 September 2020).

3.5 Responding to public health crises

Crisis diplomacy has been defined as the interactions between States (and other actors) under a heightened threat of systemic change. As global interdependence and integration increase, health diplomacy is used more and more often in dealing with local, regional and global health crises. In recent years the international system has been experiencing a range of crises arising mainly from power politics, economic and strategic interests, and globalization. Global public health crises belong to the latter category.

Multilateral health diplomacy has been practised since the 19th century, notably during major cholera pandemics. However, "modern" health crisis diplomacy emerged in the early 2000s, when the HIV epidemic, a global cross-border health threat, was placed on the agenda of the UN General Assembly and Security Council, notably in the Declaration of Commitment on HIV/AIDS "Global Crisis – Global Action", adopted on 27 June 2001 at the special session of the General Assembly on HIV/AIDS. Multilateral cooperation and diplomacy have further helped in responding effectively to tuberculosis and malaria, and they have paved the way for large-scale vaccination campaigns in fragile settings. Over the past 20 years, outbreaks of avian influenza, severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS), Ebola and COVID-19 have posed further challenges to the international multilateral order, international organizations and to crisis diplomacy in general.

The SARS epidemic that affected over 25 countries in 2003 served as a wake-up call for the international system. In view of that epidemic, the revised International Health Regulations (IHR) were negotiated and finally endorsed in 2005 as an international legally binding framework by all WHO Member States (see also **Chapter 5**). In adopting the revised IHR, Member States committed to reporting to WHO any disease outbreaks that had the potential to become global public health threats.

Within less than 10 years, health diplomacy was confronted with the failure of countries and international agencies to respond effectively to the first outbreak of Ebola, which began in West Africa in early 2014. Among the salient features of that crisis were: the long delay before it was recognized as a public health emergency of international concern and the IHR Emergency Committee was accordingly convened; the key role played by Médecins Sans Frontières, an NGO, in calling the world's attention to the crisis and organizing early interventions in the countries affected by the epidemic; and the lack of coordination between the affected countries when taking decisions with economic and political implications, such as the closure of national borders.

Bilateral and multilateral efforts were undertaken to support countries in their fight against the epidemic in Africa and to prevent it from escalating into a global pandemic. The UN Secretary General appointed a Special Envoy on Ebola, while ad hoc ambassadors were designated by a

number of countries and the EU to conduct the crisis diplomacy required. The UN Security Council adopted resolution 2177 (2014) on the Ebola outbreak and its impact in Africa and beyond. Crisis diplomacy covered issues as diverse as multilateral and bilateral aid, border closures, the pooling of scientific information, and the design and development of medicines and vaccines. Once the outbreak was over, health diplomats called for a reinforcement of the IHR, the creation of a contingency fund and the establishment of a global health emergency workforce (World Health Assembly resolutions A68/22, A68/24, A68/26 and A68/27). A WHO Health Emergencies Programme was established in 2016 at the request of the World Health Assembly. The most important lessons from the Ebola epidemic for health crisis management were the need for countries to fulfil their obligations under the IHR effectively and the urgent necessity of empowering WHO to monitor implementation of the IHR and promoting health-related data transparency. The recent COVID-19 crisis has made it clear that these lessons were not fully heeded.

The essential role of global health diplomacy in addressing crises
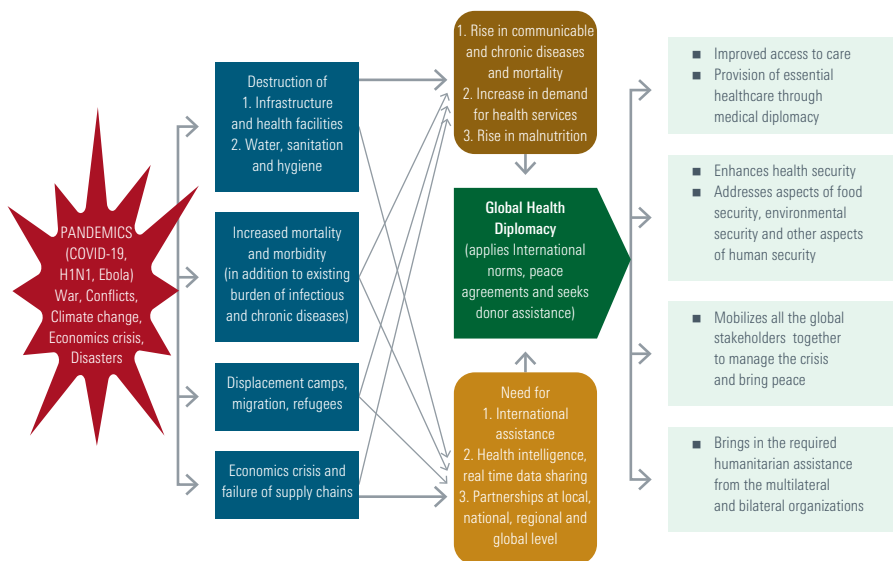
Source: Chattu & Chami (2020)

3.6 Improving relations between countries through health and well-being

Soft power refers to a country's ability to influence the actions of others without the use of force or coercion. The use of health aid in foreign policy is a widely used soft-power strategy through which the donor country can assert its influence. Thus, Tommy G. Thompson, former US Secretary of Health and Human Services, argued over 15 years ago that medical diplomacy was "a way to further America's causes around the world" that could accomplish a lot more than the use or projection of military power (Iglehart, 2004).

Earlier initiatives such as the launching of vaccination programmes (**"vaccine diplomacy"**) to tackle childhood mortality in Central American and African countries won the United States a great deal of trust and respect worldwide (see also Section 13.2). The United States President's Emergency Plan for AIDS Relief (PEPFAR) has invested over US$ 85 billion in the global response to HIV/AIDS since its launch in 2003, the largest financial commitment by any country to tackle a single disease in all of history. Similarly, Cuba and China have over many decades strengthened their international standing through **"medical diplomacy"** by sending medical personnel to developing countries and supporting medical education. Under the Belt and Road Initiative, officially launched in 2013, China is developing an approach referred to as the Health Silk Road (see Box 5). More recently, China's "mask diplomacy" in the early period of the COVID-19 pandemic attracted much attention, especially in Europe and Latin America.

Box 5: China's Belt and Road Initiative and its relevance to health

The Chinese Belt and Road Initiative (BRI), often also referred to as "the new Silk Road", has hitherto been discussed mainly in political and economic terms. Health, however, is an important additional dimension because of the way it underlies economic development, cross-border determinants and international cooperation. From the viewpoint of health diplomacy and governance, several aspects of the BRI are noteworthy.

The projects launched under the Initiative are at the intersection of trade, economic, transport and environmental policies. Furthermore, the overall BRI concept is strongly embedded in the foreign, development and investment policies of the participating countries. Health has its own interface with all the above sectors – it may thus potentially serve as a soft-power catalyst for connecting and engaging countries.

Such important areas as communicable diseases, health security, healthy lifestyles, illegal sub-

stances and road safety are bound to be affected by the increased flow of people, information, goods and services along the Road. There will also be opportunities for expanding trade in health products, services and technologies, establishing cross-border laboratories to enhance health security, and founding health care hubs to attract medical tourism. Increased international cooperation, negotiations and diplomacy will be required to manage such emerging pressures on, and opportunities for, cross-border health and public health in general.

Additionally, new forms of dialogue and cooperation in research and knowledge sharing are being developed. Cooperation networks for health policy research, public health and human resources have been launched, as have Belt and Road hospital and university alliances. A whole new "Health Silk Road" concept was introduced in 2017 at a high-level international meeting with the participation of WHO – a concept that is now even more important because of the COVID-19 pandemic. Health communication and dialogue are also likely to be enhanced by the Digital Silk Road strategy that was launched in parallel.

Regional institutions and mechanisms supporting the BRI serve as a further key channel of health diplomacy. This manifests itself in the public health stance adopted by political and economic organizations that have overlapping membership with the BRI, such as the Asia Pacific Economic Cooperation, the Shanghai Cooperation Organisation and the Eurasian Economic Union. Meetings of the health ministers of China and Central and Eastern European countries, along with the annual high-level Forums on China-Africa Health Cooperation, have further contributed to the strengthening of health diplomacy.

Diplomacy will also be critical in managing the associated risks. Countries with weaker health systems may find it difficult to cope with the health effects of a surge in infrastructure projects, cross-border movement and trade – notably the spread of infectious diseases in areas with low vaccination rates, readier supply of tobacco and unhealthy food, environmental and road safety concerns – unless these issues are discussed properly beforehand.

The world's changing realities – global power shifts, rising geopolitical tensions, weakening of traditional channels of multilateralism and the COVID-19 crisis – are further accentuating the role of health diplomacy in connection with major transnational movements such as BRI. The "vaccine diplomacy" practised by China and other countries is a recent case in point.

Although not at the heart of the BRI, health is nevertheless an important domain that needs to be taken into account as the Initiative advances. Health diplomacy will therefore be an integral part of the overall diplomatic framework of the Initiative. A Health Silk Road vision may even help to reconfigure the BRI as a whole – as may prove necessary because of the significant damage to

economies and to the multilateral climate caused by the COVID-19 pandemic. Vaccine availability and distribution might play a major role.

Countries were in the past often able to work together on global health challenges within the framework of multilateral organizations, a case in point being the eradication of smallpox, jointly achieved by the Soviet Union and the United States. Similarly, China and the United States both helped, together with WHO, to combat the Ebola outbreak in western Africa in 2014–2015. To cite an example from the Middle East: the human stampede resulting in the deaths of over 2000 pilgrims during the annual hajj to Mecca in 2015 could have escalated into a major political crisis between the Islamic Republic of Iran and Saudi Arabia had the health ministers of both countries not successfully used a range of soft power options. Geopolitical tensions are at present making it very difficult to tackle common challenges through global health diplomacy, as illustrated by the COVID-19 crisis. Moreover, there is growing concern that development aid will no longer be distributed on the basis of the SDG priorities – especially with regard to eradicating poverty and leaving no one behind – but according to foreign policy and economic priorities, as was the case during the Cold War.

3.7 Contributing to peace and security

At the intersection of health and peace, efforts to mitigate the effects of armed conflict on health include humanitarian ceasefires – for example, to allow immunization campaigns or other health interventions to take place. A good example is the collaboration of UNICEF, WHO and the Roman Catholic Church (later joined by Rotary International and the ICRC) to negotiate various ceasefires in El Salvador from 1985 onwards, which made it possible to immunize around 300 000 children every year. This example has often been cited in the context of "vaccine diplomacy".

The work of WHO on health security has expanded, especially of late in the wake of the COVID-19 pandemic. The Organization's successful efforts to tackle the Ebola epidemic in the Democratic Republic of the Congo, which began in August 2018, were long hampered by the fact that the outbreak occurred in a war zone. Several health workers have been killed by rebels in that region, and health facilities and medical personnel are increasingly subject to attack in other areas of the country affected by military conflict. Although no sustainable solutions have been found yet, it is becoming clearer to the global health community that, in some crisis situations, cooperation with the military can be as important as cooperation with the humanitarian sector. Armed conflicts and the accompanying human rights abuses pose a significant challenge to both health and humanitarian diplomacy (see **Box 6**).

A highly contentious issue in global health diplomacy is the use of **embargoes and economic sanctions**, which are tools of foreign policy. They not only lead to a decline in economic activity but often also have a significant health impact, especially on vulnerable population groups and innocent civilians. Proposals have been made to find ways of ensuring that such "economic warfare" is guided by the principles of humanitarian international law so as to mitigate the effects on civilians. This involves monitoring the impact of sanctions, particularly with regard to water purity, food availability and the control of infectious diseases.

Box 6: Humanitarian diplomacy and health

Humanitarian diplomacy aims to mobilize public and governmental support and resources for humanitarian operations and programmes, and to facilitate effective partnerships for responding to challenges and meeting the needs of communities in fragile settings.

The International Federation of Red Cross and Red Crescent Societies (IFRC) is the world's largest humanitarian network; it helps communities worldwide to be safer and healthier and to respond to and recover from crises more effectively. Founded in 1919, the IFRC comprises 192 National Red Cross and Red Crescent Societies and is guided by seven **Fundamental Principles**: humanity, impartiality, neutrality, independence, voluntary service, unity and universality. These principles underpin the IFRC's humanitarian diplomacy at all levels.

By engaging in humanitarian diplomacy, the IFRC is living up to a responsibility emanating from the important role of Red Cross and Red Crescent National Societies as auxiliaries to the public authorities in the humanitarian field. This responsibility further reflects the international status of the IFRC and the global reach of its members' humanitarian and development activities, carried out at the community level by over 14 million volunteers.

Humanitarian diplomacy consists of a range of activities designed to change mindsets and ultimately to improve the well-being and resilience of individuals and communities, particularly the most vulnerable living in humanitarian settings. These activities include:

Profile-building: achieving widespread understanding of, and gaining the appreciation and trust of policy-makers, partners and the public for, the role, achievements and working methods of Red Cross and Red Crescent National Societies and of the IFRC network as principled humanitarian actors;

Public diplomacy: influencing public behaviour so that individuals and communities take the

steps that are available to them to safeguard their health, strengthen their resilience to crises, and build peaceful, caring and inclusive communities free from any sort of discrimination; and

Influencing States and other actors: influencing policy-makers at the domestic, regional and global levels to uphold, adopt or enforce new or updated decisions, laws, policies and practices that promote the safety, well-being and resilience of vulnerable persons and enable the work of National Societies, particularly in humanitarian settings.

Humanitarian and health diplomacy often intersect in the work of IFRC at various levels. While diplomacy at the global level (for example, in multilateral institutions) addresses issues of global concern (such as advocating universal health coverage), humanitarian diplomacy and health diplomacy at the national level are critical to the delivery of health programmes for the most vulnerable through complex partnerships.

Response to the Ebola outbreak in the Democratic Republic of the Congo

Throughout the Ebola crisis in the North Kivu and Ituri provinces of the Democratic Republic of the Congo from 2018 to 2020, the Red Cross was operating in a highly volatile environment characterized by mistrust towards health personnel, frequent violence and targeted attacks against front-line responders, including Red Cross volunteers.

Gaining access to and trust within various communities affected by Ebola was a long-term effort that involved regular consultations and negotiations with public authorities, local armed groups, partners and communities.

The Red Cross of the Democratic Republic of the Congo was able to educate communities, isolate Ebola patients, trace and monitor anyone who had come into contact with an infected person, and provide safe and dignified burials for those killed by the disease. Many volunteers risked their lives in the front-line response and faced violence and discrimination within their communities. It was the trust of local communities, obtained through a combination of humanitarian and health diplomacy, that ultimately led to the chain of transmission being broken.

PART B: NEGOTIATING HEALTH IN A MULTILATERAL SPACE

CHAPTER 4 | MANDATES AND LEGITIMACY IN GLOBAL HEALTH DIPLOMACY

4.1 Multilateralism and the legitimacy of international organizations

"Multilateralism" is the term used to describe cooperation among States: it is an approach based on the premise that, by working together, countries can find solutions to common problems without renouncing their sovereignty.

It was during the Paris Peace Conference of 1919–1920 that a new type of institutionalized mechanism was established for States to interact with one another: the **universal membership organization**. The first such organization was the League of Nations (founded in 1920), which was replaced in 1945 by the UN. After the Second World War, **multilateralism** became synonymous with the liberal international order based on Western concepts of international relations – an order that is now being increasingly challenged. Multilateralism operates through global and regional institutions, norms, frameworks, summits, self-defined blocs and alliances. The rules and procedures determining which actors have the mandate and legitimacy to conduct negotiations are well established. The multilateral system is also shaped by differences between States, which have to do with power, status, wealth and other characteristics; certain Member States exert greater influence than others on decision-making.

As the UN celebrated its 75th anniversary in 2020, it could look back on a dramatic increase in membership and expansion of global diplomacy institutions and activities. Membership has been stable since 2011 at 193 sovereign States, which have equal representation in the **United Nations General Assembly**.

Number of UN Members States

UN Member States nearly quadrupled while the number of Securit Council selats remains almost the same.

	1945	1965	2010
Permanent Members	5	5	5
Security Council Seats	11	15	15
UN Member States	51	118	193

■ Permanent Members   ■ Security Council Seats   ■ UN Member States
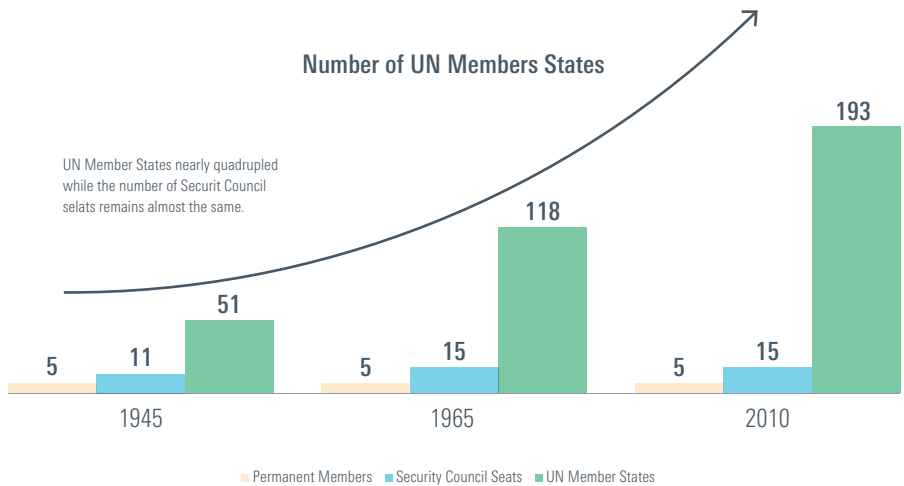
As of September 2011

The World Health Organization is also a universal membership organization, which, as of November 2020, has 194 Member States. All of the UN Member States except Liechtenstein are WHO members, as are the Cook Islands and Niue. A State becomes a full member of WHO by ratifying the treaty entitled the Constitution of the World Health Organization. Membership is based on the principle of one vote per country irrespective of a country's size or wealth. Despite this principle, significant power differentials do of course exist between countries in universal membership organizations, with the power balance within these being shaped by geopolitical realities. For example, WHO's governance and activities in the field of global health diplomacy were greatly influenced by the long stand-off between the Soviet Union and the United States during the Cold War; the decolonization processes that began in the 1960s and led to the accession of many new Member States from the Global South; the strengthening of neoliberal globalization after the Berlin Wall fell in 1989; and, most recently, by the geopolitical competition between China and the United States that has been intensifying over the past decade.

The role played by international organizations depends on the interests and the commitment of their Member States. However, international organizations have increasingly become actors in their own right and begun to take the initiative in setting agendas – the MDGs and SDGs being a prime example. Significantly, the UN's history as an agent of multilateralism, now spanning more than 70 years, has been accompanied by an **expansion of the global diplomacy agenda** beyond peace and security to cover economic development, trade and a wide range of social issues. Multilateral action has changed dramatically to include tackling poverty reduction, defending human rights, protecting the environment and promoting health.

Such areas as human rights, the environment and health were at first seen as so-called low politics (in comparison with peace and security), but they and their economic impact are now increasingly at the forefront of concerns. The prominence of health on the political agenda and in the SDGs rests on the legitimacy with which it has been invested by key decision-makers – a legitimacy that drives much of global health action nowadays. This development is part of a long process of transformation of multilateralism that affects both States and international organizations – even to the extent of reshaping them – and that has an impact on all other stakeholders, too.

Many analysts agree that the "crisis of the liberal order" has eroded the authority and legitimacy of international organizations, leading even to outright rejection of international cooperation by some countries. This is partly the reason why multi-stakeholder diplomacy has so gained in strength: as States withdraw from the global arena, it becomes important for international organizations to serve as a platform for a wide range of actors and to no longer presume that a particular area is more important than others. International organizations are themselves fulfilling multiple functions as actors in their own right, as platforms and as brokers. In many areas of global policy making, including global health, diplomats need to be aware of this complex "force field" around international organizations.

Box 7: Health and human rights

The right to health is essential to a life in dignity and the enjoyment of all other rights.

The right to health was first enunciated as such in the preamble to the Constitution of the World Health Organization (WHO), adopted in 1946, which states that "[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". The Universal Declaration of Human Rights (1948) mentions health as part of the right to an adequate standard of living. Moreover, the right to health was recognized as a human right in the International Covenant on Economic, Social and Cultural Rights (1966).

The right to health is inclusive in that it extends to key determinants of health such as access to safe drinking water, adequate nutrition and housing, and gender equality. It includes entitlements such as the right to a system of health protection, the right to disease prevention and treatment, and the right to access essential medicines. It also includes freedoms, such as the right to be free from non-consensual treatment and to be free from torture and other cruel, inhuman or degrading treatment or punishment.

The right to health and decent care is closely linked to the rights to equality before the law, privacy, work and education; to the right to live in a society that upholds rights; and to the right to benefit from the advances of science. Human rights are universal, indivisible and interrelated.

The right to health is also intimately linked to freedom from discrimination. Non-discrimination is a key principle in human rights. Across the globe, discriminated and marginalized groups are more likely to suffer from poor health. Discrimination on the grounds of race and ethnicity translates into people receiving less health information and accessing fewer health services. Women are more negatively impacted by disease in many societies, because they lack influence on decision-making, including policy decisions that affect their sexual and reproductive lives, and because of gender violence and gender biases in the health system.

Stigma and discrimination remain major barriers to achieving universal access to prevention and treatment. The American physician and WHO official Jonathan Mann (1947–1998) was among the first to highlight the critical links between human rights and public health in the early years of the AIDS crisis, demonstrating how gender-based violence puts women and girls at risk of HIV infection, and how punitive laws deter sex workers, men who have sex with men, people who use drugs and certain other population groups from accessing the services they need.

In recent years, human rights approaches and voices have become less effective in influencing many critical debates in health. The fulfilment of the right to health is based on equitable health systems, which are in turn embedded in social orders that ensure the protection of basic rights and liberties for all. Such social orders have come under threat recently as there has been a sharp rise in the manipulation of national, racial and religious identity by those wielding or seeking political power. At the same time, medical innovation (including the development of vaccines) and disease prevention and treatment are being increasingly determined by economic, security and trade agendas in which the public have hardly any say. The right to truth has also been challenged by the rise of social media platforms and the spread of disinformation. The distortion of scientific evidence is having a direct impact on health, as may be seen, for example, in the anti-vaccine movement.

The right to health and other health-related human rights have been enshrined in a number of international treaties, regional instruments and national constitutions and laws. The legal empowerment of people, even the most marginalized, has been increasingly adopted as a strategy to combat human rights abuses, to use the law to find concrete solutions, and to hold authorities to account. The Global Fund to Fight AIDS, Tuberculosis and Malaria is one of several donors that currently support specific human rights programmes aimed at advancing the sexual and reproductive health and rights of women and girls, removing barriers to access to treatment and services, promoting

the meaningful engagement of vulnerable population groups in decision making, and taking human rights into account throughout the grant cycle and in policies and policy-making processes.

The most emphatic recent reassertion of the right to a minimum achievable standard of health care is the global push for universal health coverage. But this must go hand in hand with the human rights imperative to leave no one behind (that is, focusing on those most likely to be excluded) – a principle that was echoed in the United Nations 2030 Agenda for Sustainable Development.

A notable recent success of global health diplomacy was the Political Declaration adopted at the 2019 United Nations High-Level Meeting on Universal Health Coverage, in which Member States committed themselves to the implementation of universal health coverage. The Political Declaration mentions sexual and reproductive rights and various vulnerable groups that should enjoy the right to health care, namely persons with disabilities, people living with HIV/AIDS, older people, indigenous people, refugees, internally displaced persons and migrants. The quest for universal health coverage is a recurring topic of health diplomacy discussions at WHO.

To achieve universal health coverage and win the fight against disease, it is also necessary to win the fight for human rights.

Resources

United Nations General Assembly (2015). Transforming our world: the 2030 Agenda for Sustainable Development (A/RES/70/1; https://undocs.org/en/A/RES/70/1, accessed 13 November 2020).

United Nations General Assembly (2019). Political declaration of the high-level meeting on universal health coverage (A/RES/74/2; https://undocs.org/en/A/RES/74/2, accessed 13 November 2020).

4.2 The importance of legitimacy

Former US Secretary of State Henry Kissinger once defined diplomacy as "a specific method for compromise and consensus, and a system of organization – within a legitimate international order". In both international affairs and domestic politics, a **mandate** is the authority granted by a constituency to an organization to act as its representative. For example, Member States provide WHO with the authority to act on their behalf. It is from this mandate that WHO in the first instance de-

rives its **legitimacy**. However, legitimacy also depends on the perception among both constituents and observers that this authority is being exercised appropriately. Ever since its inception, multilateral diplomacy has set itself apart from the often-secretive diplomacy of the past through a **commitment to transparency, modelled on parliamentary practice**.

Formal legitimacy no longer tends to be sufficient to justify a system of governance: moral legitimacy and results-based legitimacy are playing an ever more important role, especially in global health. For multilateral organizations, legitimacy is critical because it:

→   determines whether they continue to be the main platform for States' efforts to coordinate policies and solve problems;
→   affects their capability to develop new rules and norms that are accepted broadly; and
→   has a bearing on their ability to ensure compliance with international rules and norms.

Legitimacy is also related to fundamental **normative concerns**: if international organizations and their processes lack legitimacy in society, this contributes to a sense of democratic deficit and a lack of trust in global governance. It is necessary to think about what actually constitutes legitimacy, especially in the age of social media, in which moral legitimacy is so important. In this context, a new type of legitimacy is derived from the representation and involvement of a large number of stakeholders. Legitimacy is undermined if an organization does not reflect the diversity of its constituency – for example, if it fails to recruit more women and professionals from the Global South, also for senior positions. Because of the ongoing shifts in global power, fair and just negotiations are now prerequisites for reaching international agreement and ensuring effective follow-up on commitments.

Another key issue is the level of independence and authority granted to an organization by its members. For example, there are increasing calls for WHO to be granted a stronger mandate by its Member States, especially in relation to health security. The decision-making procedures of international organizations – including those active in global health diplomacy – are continually being questioned, as are their transparency and representativeness. While such questioning is necessary, it can also have a corrosive effect on the legitimacy of organizations and thwart processes seeking to put multi-stakeholder diplomacy into practice.

Finally, it is important to keep in mind that organizations themselves confer legitimacy: working with highly respected organizations results in a bonus in trust for their partners, which is why close attention needs to be paid to the building of partnerships.

4.3 Legitimacy and sovereignty of States

Diplomacy existed long before the present understanding of sovereign States emerged. The practice of diplomacy in the modern international system, however, builds on the concept of **State sovereignty** that was promoted in Europe in the 17th century (also referred to as Westphalian sovereignty, from the Peace of Westphalia, which ended the Thirty Years' War in 1648). According to this principle of international law, which is enshrined in the **Charter of the United Nations**, each State has exclusive sovereignty over its territory. Moreover, every State, no matter how large or small, has an equal right to sovereignty. The UN Charter also lays down the principle of non intervention (exclusive sovereignty).

These two principles have been challenged in recent years by the UN's promotion of a further principle of international law, namely, the "responsibility to protect", which provides for humanitarian interventions by the international community. The extent to which public health crises fall under the scope of the principle of responsibility to protect has yet to be clarified. This principle has proved powerless in the face of prolonged conflict and geopolitical stand-offs. Its weakness also reflects the ever-greater difficulties in reaching agreement at the UN Security Council and the urgent need for reform of the Security Council.

Globalization processes have led to transformations that weaken sovereignty. For example, the activities of transnational companies and global capital flows, but also development strategies, have made poorer countries dependent on donors and caused them to incur significant levels of debt. Of particular relevance for global health diplomacy is the fact that successive waves of globalization have shown that States cannot cope on their own with emerging global threats, such as environmental pollution or pandemics. This has led to new forms of diplomacy, with countries sharing a common interest coming together to engage in issue diplomacy. Indeed, issue diplomacy was at the origin of multilateral health negotiations in the 19th century during the first major wave of globalization. Thus, the first two international sanitary conferences in the 1850s were concerned with standardizing international quarantine regulations so as to combat the spread of cholera, plague and yellow fever.

The tension between national sovereignty and global welfare continues to characterize many global health negotiations and has proven to be one of the reasons for key shortcomings of the International Health Regulations and the Paris Agreement on Climate Change. Analysts argue that there are no real grounds for such tension: the concept of "smart sovereignty" implies that in policy areas where interdependence features prominently it is in countries' enlightened self-interest to cooperate.

Growing concerns have been raised over the unequal power relations in global health and global

health diplomacy, in particular over the lack of influence of countries and other actors from the Global South. Considerable power is wielded by the wealthier countries that provide large part of the funds for the global health system and are therefore able to influence negotiation outcomes to their own advantage and to the detriment of poorer countries. This has been observed in studies of the impact of trade negotiations on health.

The influence of large philanthropic organizations – often termed "philantrocapitalism" – has likewise attracted criticism, as these often borrow such concepts from for-profit organizations as "investors", "investment cases" and "social returns". Criticisms are also levelled against the model of economic growth that has made possible their extraordinary wealth.

Recent critiques of power structures and relations in global health have invoked the concept of neocolonialism and called for a "decolonialization" of global health (see **Box 3** in **Chapter 2**). The proponents of such arguments point to the "Washington Consensus" era of the 1990s, when the International Monetary Fund and the World Bank were making loan agreements subject to unnecessarily strict criteria, leading to a drastic reduction in health and social spending in debtor countries and, thereby, exacerbating social and economic inequalities. Offering aid to countries in exchange for their agreeing to introduce austerity measures, it is argued, is simply a manifestation of colonialism in a new guise. It is also pointed out how market- and target-driven family planning policies have infringed on the sexual and reproductive health rights of vulnerable women. Accordingly, such commentators call for a decolonization process based on reclaiming space and advancing alternative visions. Another focus of criticism is the underrepresentation of women in global health and global health diplomacy (see **Box 8**).

Box 8: Women as global health diplomats

At the start of 2020, only 6% of Heads of Government worldwide (12 countries) were led by women and only 25% of parliamentarians were female. There were only 47 female ministers of health (representing 25% of 190 countries). Although women make up half of the world's population, they do not have an equal say in political decisions on the development and financing of health systems in the vast majority of countries.

Much the same picture may be observed in global health diplomacy. Since invitations to special sessions of the United Nations General Assembly and United Nations high-level meetings are made to Heads of State and Government, women are necessarily in a small minority during negotiations on health at the highest level. Similarly, analysis shows that the share of heads of delegation to the annual World Health Assembly who are women has remained persistently low. Af-

ter peaking at 31% in 2017, it fell to 23% in 2020. Women make up just 25% of the heads of global health organizations and 25% of the chairs of the boards of those organizations. Women from low-and middle-income countries are particularly underrepresented in health diplomacy at the global level.

These trends are striking, particularly when contrasted with the fact that women make up 75% of the health workforce and, globally, account for 90% of nurses and midwives – the biggest single health worker cadre. Women are the experts in the areas of health they know best, but their skills and knowledge have not guaranteed them equality in global health diplomacy.

This pattern also manifested itself in 2020 with regard to decision-making during the COVID-19 pandemic. Although women work at all levels in health security—from the front lines of health services to research facilities and health policy-making – they have not been represented equally in global or national decision-making bodies dealing with the pandemic. In January 2020, just five women were invited to join the 21-member emergency committee on the novel coronavirus established by the World Health Organization. Only two of the 27 members of the White House Coronavirus Task Force in the United States are women. In over 80% of national task forces on COVID-19, men are in the majority. Even in health emergencies, women are expected to deliver front-line services, while it is men who generally make the decisions.

Including women in equal numbers in health leadership and diplomacy – and, in particular, women from diverse social groups and geographical regions – is about effectiveness and saving lives, as well as representation. The invaluable perspectives that women are able to bring, drawing on their expertise and experience, are currently being lost; decision-makers are not being selected from the whole talent pool. Diverse leadership groups make better-informed decisions, and it cannot be denied that global health diplomacy is undermined by the underrepresentation of women.

Resources
See the section entitled "**Publications on Women as global health diplomats**" in Annex 2

CHAPTER 5 | KEY GLOBAL HEALTH INSTRUMENTS

5.1 Introduction to global health instruments

Global health instruments make up a key domain of global health. Indeed, setting up institutions and mechanisms to promote global health cooperation is not enough: collectively agreed instruments are necessary so that such cooperation can be carried out in practice. These instruments derive from multilateral diplomacy and negotiations taking place on various political platforms.

Internationally agreed instruments are not a new phenomenon in public health. The first international sanitary conventions were adopted as early as the 1890s, and they were revised and updated throughout the first half of the 20th century.

The establishment of WHO in 1948 further accelerated the adoption of multilateral health instruments: their scope was extended, and they achieved truly global coverage. As part of this process, the earlier international sanitary conventions were replaced by the WHO International Health Regulations, the first version of which was issued in 1969.

Moreover, several international instruments adopted under the aegis of other multilateral institutions – for example, trade and environmental treaties – have a significant impact on health, even though health is not their primary objective.

Multilateral instruments for health can be grouped into the following broad categories:

→   pre-WHO, **WHO** or **external to WHO**
→   regional or **global**

In view of its scope, this Guide focuses on the categories shown in bold above.

5.2 Instruments adopted by the World Health Organization

The World Health Assembly, which is the principal governing body of WHO, can adopt the following

types of normative instrument: recommendations (in line with Article 23 of the WHO Constitution), regulations (in line with Article 21) and conventions or agreements (in line with Article 19).

Recommendations can be on any matter within the competence of WHO. They are normally drawn up as, or approved through, resolutions and decisions of the World Health Assembly and take various forms, including codes of practice, strategies, frameworks and action plans. Some notable examples are the Global Code of Practice on the International Recruitment of Health Personnel (2010); the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (2008); the Recommendations on the Marketing of Foods and Non-Alcoholic Beverages to Children (2010); the Framework on Integrated People-Centred Health Services (2016); and the Global Action Plan on Physical Activity (2018).

Regulations, in contrast, can be adopted on certain matters only, as listed in Article 21 of the WHO Constitution (namely, on sanitary and quarantine requirements, nomenclatures, standards and procedures). Indeed, WHO has adopted only two sets of regulations so far: the International Health Regulations (1969; most recently revised in 2005), which are aimed at preventing, controlling and providing a public health response to the international spread of disease; and the less well-known Nomenclature Regulations (1967), which require countries to compile mortality and morbidity statistics in line with the International Statistical Classification of Diseases, Injuries and Causes of Death.

Conventions and **agreements** (often also referred to as treaties) can be adopted on any matter falling under the competence of WHO. However, WHO has so far used its constitutional power to adopt a global health treaty only once, namely when the Framework Convention on Tobacco Control was adopted in 2003 (it entered into force in 2005). The Parties to the Convention subsequently negotiated and adopted the Protocol to Eliminate Illicit Trade in Tobacco Products, a new treaty in its own right, which entered into force in 2018.

Article 19 of the WHO Constitution
The Health Assembly shall have authority to adopt conventions or agreements with respect to any matter within the competence of the Organization. A two-thirds vote of the Health Assembly shall be required for the adoption of such conventions or agreements, which shall come into force for each Member when accepted by it in accordance with its constitutional processes.

5.3 The legal status of WHO instruments

Only regulations and conventions are legally binding. Accordingly, they are often referred to as "hard law". They create binding obligations under international law and are thus generally considered to be the strongest instruments in terms of global application and impact.

Recommendations, in contrast, are legally non-binding; they are often referred to as "soft law". However, soft instruments do generally also carry significant normative and political weight and can have a substantial impact on public health. Despite not having binding legal force, they are expected to be universally respected and implemented because countries are interdependent and have to work together to tackle global health challenges. In addition, recommendations usually enable a quicker response to evolving challenges than legally binding instruments, which are more laborious to negotiate, adopt and bring into force. In a few rare cases recommendations may also contain some compulsory measures, such as the Pandemic Influenza Preparedness Framework adopted in 2011.

5.4 Entry into force of WHO instruments

Recommendations do not require a formal process or a specific timeline for entry into force: they become effective once adopted.

Regulations come into force for all WHO Member States after a jointly agreed period of time – it was, for example, 24 months in the case of the International Health Regulations (2005) – although Member States are entitled to notify the WHO Secretariat of their rejection of the new regulations or to submit their reservations, as long as they do so by an agreed deadline. In other words, regulations come into force simultaneously for all WHO Member States (except those opting out); it is not necessary for each Member State to ratify them individually.

Conventions, in contrast, do require formal ratification by individual countries. Accordingly, they enter into force after an agreed number of ratifications has been reached: for example, 40 ratifications were required in the case of the Framework Convention on Tobacco Control. As far as the remaining countries (and regional economic integration organizations where applicable) are concerned, the convention enters into force separately for each country following that country's ratification (or acceptance, approval or accession in some legal systems).

5.5 Proposals for new WHO conventions

The Framework Convention on Tobacco Control (FCTC) to this day remains the only convention adopted under the auspices of WHO. The question as to why no further conventions have followed – or at least been attempted – has often been discussed among policy makers and experts. One common explanation is that the negotiations for and adoption of the FCTC coincided with the so called golden era of global health in the late 20th and early 21st centuries, and that multilateralism has generally been in decline since then. Some experts have also argued that, given the overwhelming evidence of the devastating effects of tobacco and growing awareness of the inadequacy of national measures to tackle a major global epidemic – which had been aggravated by globalization, trade liberalization and the aggressive tactics of the transnational tobacco industry – there was no choice other than to agree on a legally binding treaty.

Over the years, proposals have been made for new WHO conventions covering such areas as noncommunicable diseases, nutrition, alcohol, air pollution, antimicrobial resistance, falsified/substandard medicines, and R&D, and pandemics. The idea of a more general "framework convention on global health" has also been mooted. However, no formal processes or negotiations on a new convention covering any of these areas have been initiated yet. Among the reasons for this state of affairs are the potential duration and costs of treaty negotiations; concerns about enforceability; sensitivities regarding the sovereignty of national decisions vis-à-vis international obligations; the more nuanced nature of some health determinants, such as diet, compared with the black and white case of tobacco; the potential divergence of national health and economic interests; issues of compatibility with other international agreements; and trade-offs between the legal power of treaties and the pragmatism of "softer" instruments. It remains to be seen whether WHO will embark on a new treaty-making process at some point in the future – possibly in the area of health security, as some have called for in the light of the COVID-19 pandemic.

The following general criteria should be applied when deciding whether a specific problem could be covered by a future global health treaty: (a) the problem should be of a global and growing magnitude; (b) transnational factors play a dominant role; and (c) the existing instruments have proved inadequate to tackle the problem.

5.6 Instruments adopted outside WHO

Several conventions adopted outside WHO have a significant influence on health, although their main objectives are not related to health. Most of them were negotiated and adopted within the UN system; some by other international organizations (such as the WTO).

Examples in the area of the environment include the Basel, Rotterdam and Stockholm Conventions,[12] the United Nations Framework Convention on Climate Change (UNFCCC) (entered into force in 1994) and the more recent Minamata Convention on Mercury (2017); in international trade, the WTO Agreement on Technical Barriers to Trade (1995), the TRIPS Agreement (1995) and the WTO Agreement on the Application of Sanitary and Phytosanitary Measures (1995); and in human rights, the International Covenant on Economic, Social and Cultural Rights (1976) and the Convention on the Rights of Persons with Disabilities (2008). Other relevant examples are the conventions covering biological and chemical weapons[13] and the Single Convention on Narcotic Drugs of 1961 (entered into force in 1964). The Single Convention is particularly notable for enshrining a statutory review role for WHO as part of its implementation.

However, conventions are not the only form of non-WHO instruments that may have a health impact. States often adopt other prominent instruments covering global health issues, such as declarations and agreed goals and mechanisms. Despite being legally non-binding, these instruments do carry political weight and are in general widely implemented. The Sustainable Development Goals (2015), in which health occupies a key role, are a case in point. Another notable example is the series of political declarations and resolutions adopted by the UN General Assembly on global health and foreign policy (from 2008 onwards), noncommunicable diseases (2011, 2018), antimicrobial resistance (2016), tuberculosis (2018) and universal health coverage (2019). In 2006 and 2008 there were high-level meetings of the General Assembly on HIV/AIDS. In a few cases, issues with immediate relevance for international security (such as HIV/AIDS, polio and Ebola) have been considered by the UN Security Council. Similarly, political declarations by the Heads of State and Government of the G7 and the G20 have proved to exercise significant influence over the global health agenda.

Another category of instruments that are not exclusively WHO instruments are those issued jointly by WHO and other international agencies. Notable examples include the Codex Alimentarius compendium of food standards, guidelines and codes issued under the Joint WHO/FAO Food Standards Programme; the WHO–FAO–OIE tripartite framework on antimicrobial resistance;[14] and, most recently, the Global Action Plan for Healthy Lives and Well-being for All, which was launched by 12 multilateral agencies in 2018, led by WHO. Such instruments represent an additional layer in glob-

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12 Basel Convention on the Control of Transboundary Movements of Hazardous Waste and Their Disposal (entered into force in 1992); Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade (2004); Stockholm Convention on Persistent Organic Pollutants (2004).

13 Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological (Biological) and Toxin Weapons and on Their Destruction (entered into force in 1975); Convention on the Prohibition of the Development, Production, Stockpiling and Use of Chemical Weapons and on Their Destruction (1997).

14 Global Framework for Development and Stewardship to Combat Antimicrobial Resistance initiated in 2017 by WHO, FAO and the World Organisation for Animal Health (OIE).

al health negotiations – specifically, they are the fruit of negotiations where the cultures and engagement strategies of sometimes very different organizations have been reconciled in order to achieve a common goal.

Box 9: Negotiating health at the World Trade Organization

The overriding objective of the World Trade Organization (WTO) is to help trade to flow smoothly, freely and predictably, supported by a rules-based, inclusive international trading system that benefits all its members. The WTO provides a common institutional framework for the conduct of trade relations among its members in matters related to trade in goods and services and to trade-related intellectual property rights. In addition to operating a global system of trade rules, the WTO serves as a forum for negotiating trade agreements, settles trade disputes between its members, and it supports the needs of developing countries.

The WTO has 164 members, which together account for 98% of world trade. A total of 23 countries are in the process of acceding to the Organization. Both negotiations and decision-making at the WTO are member-driven processes. The WTO Secretariat conducts activities that are instrumental to the functioning of the system, including maintaining regular dialogue with non-governmental organizations and other international organizations, coordinating activities and preparing reports such as the Trade Policy Reviews.

What are the core functions of the WTO?
Article III of the Marrakesh Agreement Establishing the World Trade Organization lists five core functions:

→   Facilitating the implementation, administration and operation of WTO trade agreements;
→   Providing a forum for trade negotiations;
→   Handling trade disputes;
→   Monitoring members' trade policies; and
→   Cooperating with other international organizations.

In addition, the WTO supports developing and least developed countries through technical assistance and training so that they are able to build their capacity to engage in trade, to handle disputes and to implement technical standards.

Decision-making at the WTO
Decisions are made by the entire membership by consensus. A majority vote is also possible on

the basis of one vote per member, but such a procedure has never been used at the WTO as yet; it was extremely rare under the Organization's predecessor, the General Agreement on Tariffs and Trade (GATT).

The WTO's top-level decision-making body is the Ministerial Conference, which meets usually every two years. The Ministerial Conference can take decisions on all matters under any of the multilateral trade agreements. The General Council acts on behalf of the Ministerial Conference on all WTO affairs. It meets as the Dispute Settlement Body and the Trade Policy Review Body to oversee procedures for settling disputes between members and to analyse members' trade policies, respectively. All WTO members are represented in three councils, the Council for Trade in Goods, the Council for Trade in Services and the Council for Trade-Related Aspects of Intellectual Property Rights (TRIPS Council), which are responsible for facilitating the operation of the WTO agreements covering their respective areas of trade.

Numerous specialized WTO bodies (committees, working groups and working parties) deal with the individual agreements and other areas, such as the environment, development, accessions and regional trade agreements. Subsidiary bodies dealing with the plurilateral multi-stakeholder agreements (not signed by all WTO members) on trade in civil aircraft and government procurement also report regularly to the General Council on their activities.

Where are the WTO negotiating rules to be found?

Most of the WTO agreements are the result of the 1986–1994 Uruguay Round negotiations and were signed at the Marrakesh Ministerial Meeting in April 1994. These agreements are not static: they can be renegotiated from time to time. New agreements can also be added, and WTO bodies may adopt decisions or guidelines. Accordingly, negotiations have led to the adoption of a number of additional legal texts since 1994, including the 2005 Protocol amending the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), intended to enable the manufacture of affordable generic medicines under compulsory licence for export to countries with insufficient or no manufacturing capacities; and the 2013 Agreement on Trade Facilitation, which aims to reduce border delays by slashing red tape. New negotiations were launched at the Doha Ministerial Conference in November 2001. They are taking place at the Trade Negotiations Committee and within specific negotiating groups.

Health-related issues at the WTO

Health-related work at the WTO covers numerous areas, such as tariffs, import licensing procedures, regulatory issues, intellectual property rights, government procurement, trade in services and trade facilitation, to name but a few. While WTO disciplines influence the public health-related policies, strategies and laws of WTO members, the rules were designed to take into account

WTO members' obligation to protect public health. WTO members have stressed the need for a positive, mutually reinforcing link between public health and the global trading system. Thus, the 2001 Doha Declaration on the TRIPS Agreement and Public Health recognized the gravity of the public health problems faced by many developing countries and least developed countries – in particular those arising from HIV/AIDS, tuberculosis, malaria and other epidemics – and called for the TRIPS Agreement to be part of national and international efforts to tackle these problems.

Various aspects of trade that may have an impact on health policies are regularly considered by the competent WTO bodies. At the TRIPS Council, for example, members have discussed the importance of intellectual property rights for the development of new pharmaceutical products and the role of TRIPS flexibilities in facilitating access to affordable medicines. Moreover, members regularly review the functioning of the system that permits the granting of special compulsory licences exclusively for the export of medicines (Article 31bis of the amended TRIPS Agreement). They also review health-related intellectual property laws or regulations that have been notified to the TRIPS Council.

The Committee on Technical Barriers to Trade (TBT Committee) and the Committee on Sanitary and Phytosanitary Measures (SPS Committee) are key WTO bodies in the context of health policies that affect trade. A wide range of domestic health-related policies, standards and regulations prepared and adopted by governments are collectively discussed at these committees. Both the Agreement on Technical Barriers to Trade (TBT Agreement) and the Agreement on the Application of Sanitary and Phytosanitary Measures (SPS Agreement) encourage members to base their measures on international standards. The TBT and SPS Committees receive for consideration many of the health-related trade measures notified by members to the WTO. Both committees frequently negotiate and adopt general guidance for members on how to enhance implementation of the TBT and SPS Agreements. Much of this guidance, in particular that adopted by the SPS Committee, has a direct bearing on some human health-related issues as well as on animal and plant health.

Import licensing procedures (such as licences, permits, authorizations and other procedures requiring the submission of an application to a competent authority as a prior condition for importation) are used by many members for health policy reasons and are reviewed by the Committee on Import Licensing. In addition, two sectoral initiatives have provided for the elimination of import duties on certain health products. The Agreement on Trade in Pharmaceutical Products (Pharmaceutical Agreement) covers pharmaceutical products, including the chemical components and active ingredients used in their production. Negotiated during the Uruguay Round by a number of members, it eliminated tariffs on these products. The product coverage of the Pharmaceutical Agreement is subject to periodic reviews in order to ensure that it remains up to date. In 2015, 24

participants (including the European Union) agreed on an expansion of the Information Technology Agreement (ITA) to provide for the elimination of tariffs on a number of high-technology products, including medical equipment, such as scanners, machines for magnetic resonance imaging, tomography, dental care and ophthalmology. By 2020 the ITA Expansion Agreement had 26 participants covering 55 WTO members that together account for approximately 90% of world trade in these products. In addition to the elimination of import duties, the ITA Committee is also engaged in efforts to eliminate non-tariff barriers to international trade in those products.

Although only a few market access commitments have been made by WTO members in the area of health to date, trade in health-related services is covered by the General Agreement on Trade in Services. During discussions at the Council for Trade in Services, members have considered the various ways in which health services are delivered, such as e-health, the provision of medical treatment abroad, foreign investment in the health sector, and certain aspects of the cross-border movement of health professionals.

Health-related discussions at council and committee meetings can be complementary. For instance, proposals on plain packaging measures for tobacco were initially discussed at both the TRIPS Council and TBT Committee before they were moved on to the dispute settlement stage.

Furthermore, a number of international bodies (including those in charge of setting health related international standards) and intergovernmental organizations (such as the World Health Organization (WHO)) regularly participate in health-related discussions at meetings of various WTO entities.

The WTO and other organizations
The WTO works with other intergovernmental organizations under the banner of "coherence", a term originating in the Ministerial Declaration on the Contribution of the World Trade Organization to Achieving Greater Coherence in Global Economic Policymaking, adopted in Marrakesh in April 1994. Indeed, it is now recognized that the WTO system is just one part of a much broader framework of international rights and obligations that WTO members must uphold and fulfil.

The WTO's work on issues relating to public health, trade and intellectual property rights is complementary to that of WHO and the World Intellectual Property Organization, in particular. Together, these organizations share a responsibility to strengthen dialogue on practical matters – both among themselves and with other partners – in order to fulfil their mandates more effectively, to ensure the efficient use of resources for technical cooperation and to avoid the duplication of efforts. In particular, the Doha Declaration on the TRIPS Agreement and Public Health has served as a catalyst for intensifying collaboration and developing coherence at the international level.

The WTO also cooperates on health-related topics with a number of other intergovernmental organizations, including the World Organisation for Animal Health, the FAO/WHO Codex Alimentarius Commission, the United Nations Conference on Trade and Development, and the World Customs Organization.

5.7 Steps after the adoption of instruments

Instruments, once adopted, often require further negotiations, diplomacy and governance decisions if they are to be implemented effectively. This is particularly true of conventions. They normally require a great deal of multisectoral diplomacy and political compromises in the process culminating in ratification by a State party's national parliament; they often also require new types of governance body (such as a conference of the parties) and mechanisms (such as intergovernmentally agreed guidelines on the implementation of specific legal provisions) to be established, leading to further multilateral diplomacy and negotiations once the treaty is in force.

The process for amending adopted instruments may also involve a fresh round of multilateral negotiations. Legal instruments do usually provide for revisions and amendments to be made under certain conditions. The FCTC, for example, allows for amendments to be adopted by a three quarters majority vote in the Conference of the Parties, further subject to ratification or acceptance by each individual Party. The International Health Regulations, first adopted in 1969, were later revised and amended in 1973, 1981 and 2005. Global health crises of particular magnitude may often trigger such changes. The last revision of the IHR, for example, although already in progress in the late 1990s, gained in momentum following the SARS outbreak in 2002–2004, the first global public health emergency of the 21st century. Some 15 years later, the COVID-19 pandemic has sparked worldwide discussions on whether the IHR in their 2005 version are adequate for dealing with global crises of such magnitude. A World Health Assembly resolution adopted in 2020 called for an independent evaluation of the functioning of the IHR as part of a broader review of the global response to the pandemic.

CHAPTER 6 | KEY GLOBAL VENUES AND ACTORS

6.1 The World Health Organization and the changing field of global health

The World Health Organization is the key venue for global health negotiations. An intergovernmental organization in which all decision-making power is vested in its Member States, WHO is the United Nations specialized agency tasked with coordinating and steering global health efforts. In its early years, WHO dealt mainly with State actors, that is the ministries of health and ministries of foreign affairs, often through States' diplomatic representations in Geneva and, especially in later years, the health attachés based there. The latter are a mixture of representatives of States' foreign and health ministries. The Member States are the key actors at WHO: it is they that govern the Organization and negotiate major agreements. However, as the global health landscape has become more and more complex, WHO has had to reconsider its relationship with a wide range of actors.

Accordingly, WHO has adopted a policy on its relationship with non-State actors in line with its constitutional mandate: the Framework of Engagement with Non-State Actors (FENSA), which was approved at the Sixty-ninth session of the World Health Assembly in May 2016. The Framework seeks to strengthen WHO's engagement with non-State actors, including NGOs, private sector entities, philanthropic foundations and academic institutions. At the same time, the Framework is meant to protect WHO and its work from potential risks, such as conflicts of interest, reputational risks and undue influence.

Non-State actors are not involved formally in global health negotiations at the WHO governing bodies, but they attend consultations and are often asked to provide input and comments. They come to Geneva on occasion of the meetings of the WHO governing bodies (that is, the World Health Assembly and the Executive Board) in order to engage in advocacy, hold informal discussions with negotiators and – if in official relations with WHO – to give statements at the meetings of the governing bodies. Such participation can seem like a pro forma gesture at best, particularly in comparison to other parts of the UN system. The WHO Constitution, FENSA and the Rules of Procedure of the World Health Assembly lay down the type of engagement which the various actors may have. The WHO leadership is committed to a more open approach, and the present Director-General reaches out to civil society more extensively than many of his predecessors. Yet, the Organization's culture as a whole often seems somewhat "closed" and risk-averse. Creative think-

ing should be applied by all the stakeholders so that they can make the most of the opportunities that arise and develop new mechanisms for interaction where possible.

There is a special category of actors with which WHO works together more closely: the **non State actors in official relations with WHO**. Official relations are a privilege that the Executive Board may grant to NGOs, international business associations and philanthropic foundations that have had and continue to have "a sustained and systematic engagement in the interest of the Organization". The aims and activities of these entities must be in conformity with the spirit, purpose and principles of the WHO Constitution, and they are expected to contribute significantly to the advancement of public health. WHO is in the process of compiling a register of non-State actors detailing, among other things, their type of engagement with the Organization. There is considerable scope for further increasing the engagement and involvement of non-State actors in WHO's work. During the COVID-19 pandemic it became clear that new forms of cooperation must be found, in particular with the science and digital technology sectors.

Global health is now one of the most prominent areas of multi-stakeholder diplomacy. This type of diplomacy encompasses a remarkably wide range of initiatives and institutions: international organizations, national sectors and agencies, development banks, civil society, private industry, philanthropic and academic institutions, professional associations, and dedicated – and sometimes also very powerful – individuals. By including many stakeholders in the SDG negotiations and adopting Goal 17 on partnerships, the UN gave multi-stakeholder diplomacy a high degree of legitimacy. In the field of global health, in particular, many hybrid organizations have been created, along with alliances and initiatives that derive their legitimacy from the representation and involvement of a large number of stakeholders, on the one hand, and from a focus on results, on the other.

HANDBOOK FOR NON-STATE ACTORS ON ENGAGEMENT WITH THE WORLD HEALTH ORGANIZATION

World Health Organization

It is important to note that the decision-making processes in the World Health Assembly and the UN General Assembly are quite different. While voting is not used that much at the former, it is employed in the latter for agenda items that are highly political or sensitive, such as nuclear weapons. In the past, health-related General Assembly resolutions have usually been adopted without a vote, yet, significantly, a vote had to be called on the most recent resolutions in September 2020 on the response to the COVID-19 pandemic (A/RES/74/306 and A/RES/74/307). Moreover, Member States are increasingly "disassociating" themselves from sections of a resolution or declaration. An example is the US Government's disassociation from World Health Assembly resolution WHA73/1 on the COVID-19 response.[15]

6.2 Other international health organizations and entities

Global health diplomacy is characterized by the many innovative features and approaches that have been developed throughout its history. About 20 years ago, a new set of health organizations with very different governing structures began to emerge. The first was **UNAIDS** – the only co-sponsored joint programme in the UN system – whose work is steered by a multi-stakeholder Programme Coordinating Board comprising representatives of 22 governments from all geographical regions; the UNAIDS Cosponsors; and five representatives of NGOs, including associations of people living with HIV.

Similarly, **Gavi, the Vaccine Alliance** (a foundation) and the **Global Fund to Fight AIDS, Tuberculosis and Malaria** (a partnership) are both governed by boards featuring representatives from countries, the private sector, civil society and other international organizations. The Gavi Board also includes independent, or "unaffiliated", individuals. The Board of the Global Fund has 20 voting seats, with equal representation for implementers and donors, including NGOs; communities affected by HIV, tuberculosis and malaria; the private sector; and private foundations. In addition, there are eight non-voting members, including the Chair and Vice-Chair of the Board; representatives of partner organizations such as WHO and the World Bank; and the Additional Public Donors constituency (see **Box 10** and **Box 11**).

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15   See: https://geneva.usmission.gov/2020/05/19/explanation-of-position-covid-19-response-resolution/

Box 10: The governance model of Gavi, the Vaccine Alliance

Gavi, the Vaccine Alliance (formerly the Global Alliance for Vaccine and Immunization, hence the acronym), is an international organization established in 2000 to provide affordable and accessible vaccines for children in the developing world. Today, the Gavi Alliance is one of the most important actors in global health governance.

The Gavi Board has 28 seats in total; there are both permanent and time-limited seats. Board members are appointed in accordance with the Gavi statutes and operating procedures. Representatives of key partners of the Gavi Alliance hold 18 seats; independent or unaffiliated individuals have nine; the Chief Executive Officer of the Alliance holds one. While the Bill and Melinda Gates Foundation, the World Bank, the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) hold permanent seats at the Board, other Gavi partners' representatives serve on a time-limited basis.

The members on "representative" seats are responsible for ensuring that their governments or institutions provide formal inputs to the development of Gavi's policies and to the management of its operations. Independent or unaffiliated individuals do not have any professional connection to Gavi's work, but they provide expertise in critical areas such as investment, auditing, and fundraising. They also bring independent and balanced scrutiny to all of the Board's deliberations. These members are appointed in their personal capacity on the basis of their skills and networks.

Other types of representatives are alternate Board members and observers. Each eligible organization and constituency may designate one person per Board member as an alternate, who is entitled to act in lieu of the representative Board member. Both Board members and alternates are invited to attend the Board meetings; at least one of them should attend to ensure representation of their constituency. With the Chair's permission, observers may also participate in the Alliance's Board or Committee meetings.

Governance structure
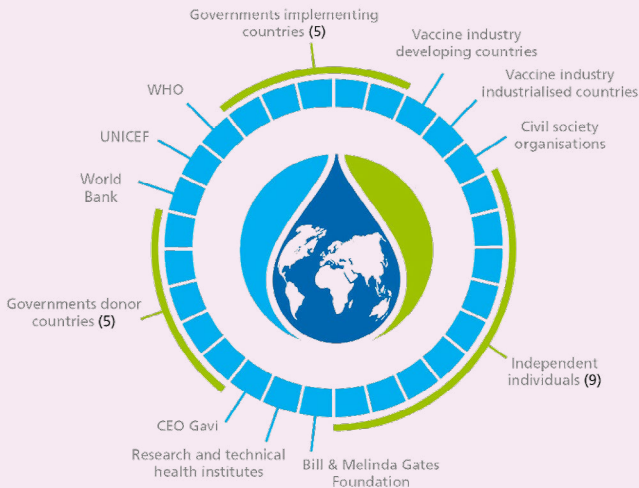
The partners of the Gavi Alliance
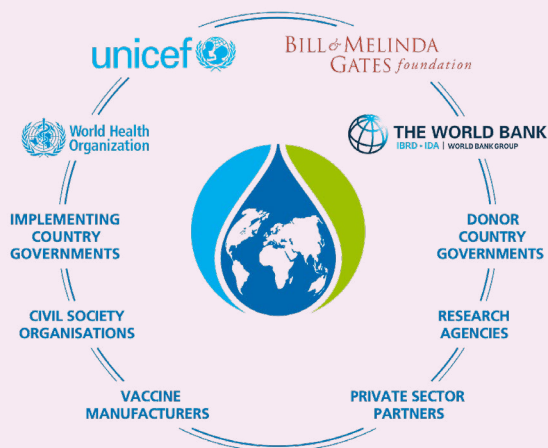
→ The **governments of implementing countries** identify their immunization needs and co finance and implement vaccine programmes.

→ **Vaccine manufacturers** make affordable, quality vaccines and cold chain equipment available to implementing countries.

→ **Civil society organizations** help to ensure that vaccines reach every child.

→ **Private sector partners** contribute resources, expertise and innovation to help achieve the Gavi Alliance's mission.

→ **The Bill and Melinda Gates Foundation** provides funding and expertise, pioneers innovative approaches, and supports research and development work on new vaccines.

→ **Research and technical health institutions** help to generate the evidence base and communicate the value of vaccines.

→ The **governments of donor countries** make long-term funding commitments and collaborate with Gavi on the ground.

→ The **World Bank** helps to support innovative financing mechanisms such as the International Finance Facility for Immunisation and advance market commitments.

→ **UNICEF** procures vaccines and supports countries in maintaining their cold chain systems, improving access and collecting data.

→ **WHO** regulates vaccines and supports their introduction in individual countries, with a focus on increasing immunization coverage and improving data quality.

Adapted from: Gavi, the Vaccine Alliance website (https://www.gavi.org, accessed 12 October 2020).

Box 11: The governance model of the Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund to Fight AIDS, Tuberculosis and Malaria (hereafter referred to as the Global Fund) is an international financing organization founded in 2002, its mission being "[t]o attract, leverage and invest additional resources to end the epidemics of HIV, tuberculosis and malaria and to support attainment of the Sustainable Development Goals". The Global Fund mobilizes and invests more than US$ 4 billion a year to support programmes in over 100 countries. It is a partnership between governments, civil society, technical agencies, the private sector and people affected by those diseases.

The composition of the Board of the Global Fund is illustrative of the concept of plurilateral health diplomacy. The Board includes 20 voting members, with equal representation by implementers and donors, and an additional eight non-voting members. The Chair and Vice-Chair chair Board meetings and play roles in advocacy, partnership and fundraising. The 20 voting members represent the constituencies, with an equal number of seats (10) representing donor constituencies and implementer constituencies. One Board member heads each constituency and is seconded by an alternate Board member.

The 20 constituencies (groups of voting members) are as follows: Australia, Canada and Switzerland; communities of people affected by the diseases; nongovernmental organizations (NGOs) from developed countries; NGOs from developing countries; Eastern Europe and Central Asia; Eastern Mediterranean Region; Eastern and Southern Africa; European Commission, Belgium, Italy, Portugal, Spain; France; Germany; Japan; Latin America and the Caribbean; "Point Seven" (Denmark, Ireland, Luxembourg, Netherlands, Norway, Sweden); private foundations; private sector; South-East Asia; United Kingdom; United States; West and Central Africa; and the Western Pacific region.

The remaining eight of the Board's 28 seats are non-voting members: the Board Chair; the Board Vice Chair; the Executive Director; Partners; the Joint United Nations Programme on HIV/AIDS (UNAIDS); the World Health Organization; the World Bank; and "Additional Public Donors", a constituency created by the Board to accommodate public donors that are not already represented by a voting constituency.

Partnership Approach to Governance
The Global Fund Board

- Donors
- Recipient Countries

Public Sector (Governments and Agencies)

Civil Society

- NGOs from Global North
- NGOs from Global South
- Communities living with, and affected by, the diseases

- Private Sector
- Private Foundations

Private Sector

Technical Agencies and Partnerships

- WHO
- UNAIDS
- World Bank
- UNITAID
- RBM
- Stop TB Partnership…
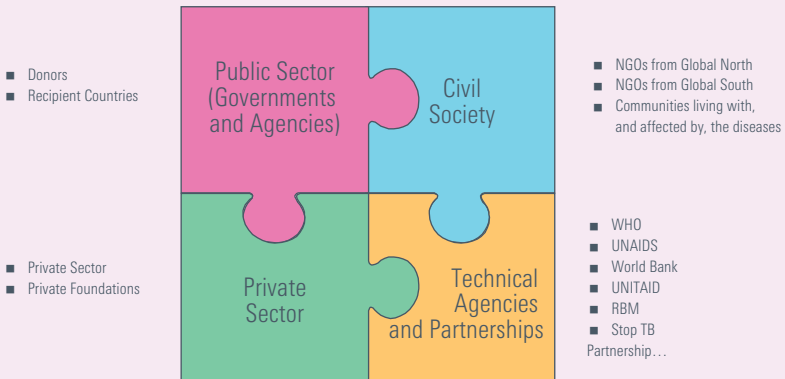
Adapted from: Global Fund website (https://www.theglobalfund.org/en/).

The Framework Convention on Tobacco Control, WHO's first global health treaty which entered into force in 2005, is another newcomer to the global health architecture. It has its own governing body (Conference of the Parties) and a Secretariat hosted by WHO (more details on the FCTC can be found in Chapter 5). In addition, several health partnerships, with their own specific governance structures and operating modes, are hosted by WHO (for example, the Partnership for Maternal, Newborn and Child Health) or other UN system organizations (such as the RBM Partnership to End Malaria, which is hosted by the United Nations Office for Project Services (see **Chapter 5**).

Countries, like other actors, are involved in negotiations and decision-making at many of the health organizations, but they do not always adopt the same national position in each of these organizations. This is partly because the ministries represented are different: in WHO it is mainly the health ministries, while in the other health organizations it is mainly the development ministries (or the foreign ministries through their development agencies). In many cases, there is a lack of cooperation between the various national authorities, which sometimes even compete with one another.

6.3 Health diplomacy at the United Nations

By the turn of the millennium it had become apparent that tackling global health problems requires a high level of political commitment and a concentration of resources. Greater attention has therefore started to be paid to the decision-making bodies of the UN in New York.

In principle, health can appear on the agenda of four UN forums, namely:

→ The General Assembly, under the Charter of the United Nations, may make recommendations on any matters within the scope of the UN, including global health.

→ The Security Council, which, as its name implies, watches over peace and security, rarely puts health issues on its agenda: this has happened so far only with AIDS and Ebola, which were declared a threat to international stability in 2000 and 2014, respectively. Additionally, in 2013 the Security Council issued a press statement on polio vaccination in the Sudan.

→ The Human Rights Council and the Economic and Social Council are involved, together with other bodies, in preparing the deliberations of the General Assembly. The Economic and Social Council is the central platform for fostering debate and innovative thinking on the three dimensions of sustainable development – economic, social and environmental. These two bodies also employ special mechanisms in relation to health, such as establishing UN inter-agency task forces – for example on noncommunicable diseases – under the auspices of the Economic and Social Council, or the appointment of a Special Rapporteur on the right to health under the auspices of the Human Rights Council.

The UN's interest in health was strengthened by the Oslo Declaration of 2007, in which the foreign ministers of seven countries identified global health as a pressing foreign policy issue of modern times. Since 2008, the General Assembly has every year discussed the links between foreign policy and health, drawing attention to the broader context of topics on the WHO agenda (see **Box 12**).

The negotiations on and subsequent adoption of the 2030 Agenda for Sustainable Development with its 17 SDGs in 2015 created even more favourable conditions for devoting greater attention to global health issues. The UN recognized that, in an interconnected world, infectious diseases can spread across continents in a matter of days; the lifestyle factors spread by media and advertising can influence global populations within months (such as smoking, alcohol and junk-food consumption); and knowledge can be shared instantly. Determinants of health are therefore embedded in each of the SDGs, and health diplomats too have become involved in ensuring that these are addressed as part of countries' comprehensive sustainable development plans. A new mechanism launched in 2019 – the Global Action Plan for Healthy Lives and Well-being for All – brings together 12 international organizations with a view to providing more effective support to countries in their efforts to achieve the health-related SDGs.

These developments have made possible an increasing number of high-level meetings of the General Assembly on specific health matters. The political declarations adopted by these meetings (such as those on noncommunicable diseases, tuberculosis, antimicrobial resistance and universal health coverage) were subsequently endorsed by the General Assembly, which has provided strategic guidance for international cooperation in the areas in question.

Global treaties with a health impact, negotiated under the auspices of different UN bodies and agencies, are another "centre of attraction" for health issues at the UN. Prominent examples include the Minamata Convention on Mercury (under the auspices of UNEP), the Convention on the Rights of Persons with Disabilities (under the auspices of the Human Rights Council) and the United Nations Framework Convention on Climate Change.

When the COVID-19 pandemic broke out, the UN was mired in various conflicts. The General Assembly could only agree on a symbolic resolution on solidarity. Interestingly, the Security Council did not put the consequences of the pandemic on its agenda, although that is what it had done during the more limited Ebola epidemic. The Council has been unable to back a resolution that would endorse the Secretary-General's call for pandemic-related ceasefires in war zones, including the Syrian Arab Republic, Yemen, Libya and Afghanistan, because of a dispute between the United States and China over whether or not to include a reference to WHO in the text of the resolution. In the first six months of the COVID-19 response, political commitments to roll back the pandemic were being made at the WHO, the G20 and at the regional level.

The United Nations System

UN PRINCIPAL ORGANS

- GENERAL ASSEMBLY
- SECURITY COUNCIL
- ECONOMIC AND SOCIAL COUNCIL
- SECRETARIAT
- INTERNATIONAL COURT OF JUSTICE
- TRUSTEESHIP COUNCIL[6]

Research and Training
- **UNIDIR** United Nations Institute for Disarmament Research
- **UNITAR** United Nations Institute for Training and Research
- **UNSSC** United Nations System Staff College
- **UNU** United Nations University

Subsidiary Organs
- Disarmament Commission
- Human Rights Council
- International Law Commission
- Joint Inspection Unit (JIU)
- Main Committees
- Standing committees and ad hoc bodies

Funds and Programmes[1]
- **UNDP** United Nations Development Programme
  - **UNCDF** United Nations Capital Development Fund
  - **UNV** United Nations Volunteers
- **UNEP**[8] United Nations Environment Programme
- **UNFPA** United Nations Population Fund
- **UN-HABITAT**[8] United Nations Human Settlements Programme
- **UNICEF** United Nations Children's Fund
- **WFP** World Food Programme (UN/FAO)

Other Entities
- **ITC** International Trade Centre (UN/WTO)
- **UNCTAD**[1,8] United Nations Conference on Trade and Development
- **UNHCR**[1] Office of the United Nations High Commissioner for Refugees
- **UNOPS**[1] United Nations Office for Project Services
- **UNRWA**[1] United Nations Relief and Works Agency for Palestine Refugees in the Near East
- **UN-WOMEN**[1] United Nations Entity for Gender Equality and the Empowerment of Women

Related Organizations
- **CTBTO PREPARATORY COMMISSION** Preparatory Commission for the Comprehensive Nuclear-Test-Ban Treaty Organization
- **IAEA**[1,3] International Atomic Energy Agency
- **ICC** International Criminal Court
- **IOM**[1] International Organization for Migration
- **ISA** International Seabed Authority
- **ITLOS** International Tribunal for the Law of the Sea
- **OPCW**[3] Organization for the Prohibition of Chemical Weapons
- **WTO**[1,4] World Trade Organization

Peacebuilding Commission

HLPF
High-level Political Forum on Sustainable Development

Subsidiary Organs
- Counter-Terrorism Committee
- International Residual Mechanism for Criminal Tribunals
- Military Staff Committee
- Peacekeeping operations and political missions
- Sanctions committees (ad hoc)
- Standing committees and ad hoc bodies

Specialized Agencies[1,5]
- **FAO** Food and Agriculture Organization of the United Nations
- **ICAO** International Civil Aviation Organization
- **IFAD** International Fund for Agricultural Development
- **ILO** International Labour Organization
- **IMF** International Monetary Fund
- **IMO** International Maritime Organization
- **ITU** International Telecommunication Union
- **UNESCO** United Nations Educational, Scientific and Cultural Organization
- **UNIDO** United Nations Industrial Development Organization
- **UNWTO** World Tourism Organization
- **UPU** Universal Postal Union
- **WHO** World Health Organization
- **WIPO** World Intellectual Property Organization
- **WMO** World Meteorological Organization
- **WORLD BANK GROUP**[7]
  - **IBRD** International Bank for Reconstruction and Development
  - **IDA** International Development Association
  - **IFC** International Finance Corporation

Functional Commissions
- Crime Prevention and Criminal Justice
- Narcotic Drugs
- Population and Development
- Science and Technology for Development
- Social Development
- Statistics
- Status of Women
- United Nations Forum on Forests

Regional Commissions[8]
- **ECA** Economic Commission for Africa
- **ECE** Economic Commission for Europe
- **ECLAC** Economic Commission for Latin America and the Caribbean
- **ESCAP** Economic and Social Commission for Asia and the Pacific
- **ESCWA** Economic and Social Commission for Western Asia

Other Bodies[10]
- Committee for Development Policy
- Committee of Experts on Public Administration
- Committee on Non-Governmental Organizations
- Permanent Forum on Indigenous Issues
- **UNAIDS** Joint United Nations Programme on HIV/AIDS
- **UNGEGN** United Nations Group of Experts on Geographical Names
- **UNGGIM** Committee of Experts on Global Geospatial Information Management

Research and Training
- **UNICRI** United Nations Interregional Crime and Justice Research Institute
- **UNRISD** United Nations Research Institute for Social Development

Departments and Offices[9]
- **EOSG** Executive Office of the Secretary-General
- **DCO** Development Coordination Office
- **DESA** Department of Economic and Social Affairs
- **DGACM** Department for General Assembly and Conference Management
- **DGC** Department of Global Communications
- **DMSPC** Department of Management Strategy, Policy and Compliance
- **DOS** Department of Operational Support
- **DPO** Department of Peace Operations
- **DPPA** Department of Political and Peacebuilding Affairs
- **DSS** Department of Safety and Security
- **OCHA** Office for the Coordination of Humanitarian Affairs
- **OCT** Office of Counter-Terrorism
- **ODA** Office for Disarmament Affairs
- **OHCHR** Office of the United Nations High Commissioner for Human Rights
- **OIOS** Office of Internal Oversight Services
- **OLA** Office of Legal Affairs
- **OSAA** Office of the Special Adviser on Africa
- **SRSG/CAAC** Office of the Special Representative of the Secretary-General for Children and Armed Conflict
- **SRSG/SVC** Office of the Special Representative of the Secretary-General on Sexual Violence in Conflict
- **SRSG/VAC** Office of the Special Representative of the Secretary-General on Violence Against Children
- **UNDRR** United Nations Office for Disaster Risk Reduction
- **UNODC**[1] United Nations Office on Drugs and Crime
- **UNOG** United Nations Office at Geneva
- **UN-OHRLLS** Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States
- **UNON** United Nations Office at Nairobi
- **UNOP**[2] United Nations Office for Partnerships
- **UNOV** United Nations Office at Vienna

Notes:
1 Members of the United Nations System Chief Executives Board for Coordination (CEB).
2 UN Office for Partnerships (UNOP) is the UN's focal point vis-a-vis the United Nations Foundation, Inc.
3 IAEA and OPCW report to the Security Council and the General Assembly (GA).
4 WTO has no reporting obligation to the GA, but contributes on an ad hoc basis to GA and Economic and Social Council (ECOSOC) work on, inter alia, finance and development issues.
5 Specialized agencies are autonomous organizations whose work is coordinated through ECOSOC (intergovernmental level) and CEB (inter-secretariat level).
6 The Trusteeship Council suspended operation on 1 November 1994, as on 1 October 1994 Palau, the last United Nations Trust Territory, became independent.
7 International Centre for Settlement of Investment Disputes (ICSID) and Multilateral Investment Guarantee Agency (MIGA) are not specialized agencies in accordance with Articles 57 and 63 of the Charter, but are part of the World Bank Group.
8 The secretariats of these organs are part of the UN Secretariat.
9 The Secretariat also includes the following offices: The Ethics Office, United Nations Ombudsman and Mediation Services, and the Office of Administration of Justice.
10 For a complete list of ECOSOC Subsidiary Bodies see un.org/ecosoc.

This Chart is a reflection of the functional organization of the United Nations System and for informational purposes only. It does not include all offices or entities of the United Nations System.

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Source: https://www.un.org/en/pdfs/18-00159e_un_system_chart_17x11_4c_en_web.pdf

Box 12: What are the characteristics of health negotiations at the United Nations?

In negotiations at the United Nations (UN), health is viewed through the lens of global politics. Public health arguments and evidence have an indirect (sometimes subordinated) effect, while geopolitical aspirations, power considerations and interests have a stronger impact. There are three aspects to setting and debating health-related agenda items: the world economy; the security environment; and the humanitarian, human rights and social justice arenas.

The complexity of global health challenges and their economic and development policy contexts call for more thorough and organized preparation of the diplomats involved in the negotiations. It is no longer sufficient for diplomats to have foreign policy experience: background support based on cooperation between experts from various sectors in their home countries is essential if they are to succeed at the negotiating table.

Although professional diplomats play a key role in UN health deliberations, they are increasingly relying on experts, notably the health attachés at Geneva-based missions. The link between Geneva and New York is becoming stronger, since high-level health conferences at UN Headquarters are often prepared at the World Health Organization, together with representatives of the Member States. At the same time, there has been a growing demand for health diplomats to be based in New York. Ensuring that diplomats possess or can call on specialist knowledge is less affordable for countries from the Global South, yet it is important that these countries' interests should be represented strongly during health negotiations. Coordinated action and the pooling of expertise by regional organizations such as the African Union or the Caribbean Community can help in that respect.

The influence of non-State actors commanding large amounts of resources, particularly financial resources, is growing in the UN. They can exert political pressure on governments that is difficult to resist and may be at odds with the public good. A prime example is noncommunicable diseases, where the market power of large companies can counteract the public health objectives of governments. Indeed, some countries seem to be less assiduous in their efforts to regulate big business (pharmaceuticals, food and drink, tobacco and alcohol and so on) than in the past. This could have a significant impact on efforts to find policy solutions for improving global health. On the other hand, space is increasingly being provided at the UN for the views and positions of international nongovernmental organizations, philanthropic foundations, academic institutions, advocacy groups, religious groups and humanitarian organizations.

There is a risk that the rules-based multilateral system that governs global political and trade relations could suffer further fragmentation as more self-assured emerging nations assert their own values and rules. The COVID-19 pandemic has shown that the rise in nationalist sentiment throughout the world poses yet another threat to the multilateral system, with multilateral institutions and the very notion of global governance being rejected outright.

6.4 The central role of States in global health diplomacy

States remain critical actors in old and new international health organizations. Indeed, in many cases it was at the initiative of States that new organizations were created to address common challenges. In their foreign policy, States have to strike a balance between various goals: serving the national interest, providing development assistance and supporting collective action. Their positions reflect geopolitical realties. Significant shifts occurred in the power balance between States in the course of the 20th century. The first decades after the Second World War were defined by the conflict between the former Soviet Union and the United States, often referred to as the Cold War. From the 1960s onwards, the nations of the developing world began playing a more prominent role, and membership of the various UN bodies increased significantly. However, the most powerful countries have, by and large, preserved to this day their disproportionate influence on decision making at global institutions. Some newer health organizations have tried to address this issue by giving donor and recipient nations an equal number of votes.

The current geopolitical power conflict between China and the United States is reflected in the deliberations of the UN and those of many other multilateral bodies and political clubs. New alliances have become possible, especially between "middle powers". Nations from the Global South now have greater influence on global health policy, as reflected, for instance, in the election of the first African WHO Director General in 2017. This increase in the influence of Africa is related both to the impact that most health issues have on that region and to the cumulative weight of the votes of its countries in a voting scenario. Similarly, regional bodies, such as the EU, are gaining in relevance. The COVID-19 crisis has shown just how political the field of global health is. It has also highlighted the crucial role of global health diplomacy in ensuring that collective action can be taken.

Experience shows that States will continue to establish and develop international organizations in order to achieve objectives that they cannot attain on their own, or if they consider that an existing organization is not delivering on its mandate or if they are not satisfied with the role that they are playing in it. However, the very different mandates and (perceived) legitimacy bases of existing in-

ternational organizations and their different organizational cultures are often not fully understood by political actors. This can have significant implications for judging their effectiveness.

New organizations may be created because countries and other actors consider existing organizations to have lost their legitimacy or because they wish to try a new, more promising funding mechanism. Organizations are also created to give donors a greater say in how the money they donate is spent. Sometimes, parallel entities and mechanisms are set up by countries that fail to secure sufficient influence within existing multilateral organizations – a phenomenon referred to as **parallel** or **competitive multilateralism**. The Belt and Road Initiative launched by China is an example of such multilateralism.

One striking feature of 21st-century diplomacy is the **expansion of both club diplomacy and network diplomacy**, which reflects the way international politics is moving towards multipolarity. Influence is no longer solely exerted along the channels traditionally associated with developed and developing countries. The BRICS countries, in particular, are playing a more important role in global affairs by taking the lead on certain issues and by acting as regional power brokers. For example, China is now the second-largest economy in the world and the second-largest contributor to the UN budget. In the field of global health, too, China has become both a major donor and a major investor. Similarly, India is currently at the forefront of discussions on digital health.

As they seek to become regional leaders, the BRICS countries, along with certain other countries in Asia and Africa, are building broad alliances and strengthening their regional cooperation (see **Box 13**). For example, Indonesia is currently promoting cooperation between Indo-Pacific States, which has the potential to be used by key policy-makers to draw attention to the urgency of collective action on transnational health issues. The shift in power relations has opened new spaces for international political engagement, notably also for global health diplomacy. In the coming years it is likely that many more new types of alliance will spring up.

Small groups of countries can exercise considerable influence if they build alliances based on the UN principle of one vote per country. Such alliances are increasingly conducting group and network diplomacy – with considerable success, as shown by the way in which the CARICOM countries managed to put noncommunicable diseases on the UN agenda. In general, the influence of regional integration blocs on health matters is steadily rising, as discussed in **Chapter 7**.

A key development has been the incorporation of global health challenges – at first mainly related to health security – into the agendas of high-level political meetings, such as the G7 and G20 summits, and of political clubs such as the BRICS countries. This widening of the political space for health negotiations has increased the likelihood of health matters being taken up in other venues

such as the World Bank or the WTO. For example, during the G20 summit in Osaka, Japan, in June 2019 a joint session of the health and finance ministers was organized for the first time; the ministers discussed some of the financial issues that had been raised at the 2019 Spring Meetings of the World Bank Group and the International Monetary Fund.

6.5 The role of non-State actors in global health diplomacy

The global health diplomacy space features a wide range of non-State actors that interact mainly through network diplomacy. The WHO Register of Non-State Actors (in the process of compilation) reflects the diversity of these actors – including global health alliances, initiatives, public–private partnerships and foundations – and of their interests. Many of them seek to combine global agenda setting with on-the-ground action.

Given the variety and diversity of actors in global health diplomacy, in-depth **stakeholder analysis** should be performed before any negotiations are undertaken. This involves seeking to understand not only the various stakeholders' interests but also how they operate (for example, their social media strategies).

The activities of civil society organizations are critical to the success of global health negotiations. Examples include the negotiations that led to the adoption of the Framework Convention on Tobacco Control (FCTC) in 2003 and the International Code of Marketing of Breast-milk Substitutes in 1981, or the many negotiations dealing with access to medicines and with the commercial determinants of health. As outlined in Section 1.3, it is now standard practice to include NGOs in the global health diplomacy process. NGO diplomats represent the interests of the wider public and demand transparency, especially on attempts by the private sector to exert undue influence. A study of the negotiation of the FCTC revealed that NGOs played five key roles during that process: monitoring, lobbying, brokering knowledge, offering technical expertise and fostering inclusion (Lencucha, Kothari & Labonté, 2011).

Philanthropic foundations have acquired a significant level of influence on the global health agenda. Many foundations are active in global health, the most influential being the Bill and Melinda Gates Foundation (BMGF). Since its creation in 2000 it has channelled significant resources into global health and helped to set up many new health organizations, alliances and programmes. The BMGF seeks to support innovative, ambitious and scalable solutions to health problems that have a major impact in developing countries. Moreover, it is the leading donor among the non State actors contributing voluntarily to the financing of global health. While the BMGF has no formal decision making power at WHO, its decisions to fund major programmes, such as those on polio eradication

or management innovation, do have a significant impact on the Organization's work. The BMGF's intensive interactions with both donor and recipient countries, as well as with the WHO leadership, clearly give the Foundation considerable influence in the field of global health diplomacy – something that is severely criticized by many civil society actors.

The overt role of the private sector in global health diplomacy has increased significantly in recent years. In this respect, a great deal of attention has been paid to pharmaceutical companies and their role in determining access to medicines, and also to large multinational companies that have contributed to the staggering increase in the prevalence of noncommunicable diseases. Accountability clearly needs to be strengthened in these areas. Yet, at the same time, many private companies are contributing to the advancement of global health goals, a case in point being the ARM Industry Alliance launched in 2017 to help combat antimicrobial resistance. In many countries beyond OECD economies, notably India, the private health sector plays a crucial role. A wide range of new partnerships have emerged, as have initiatives by the companies themselves in relation to their employees. The World Economic Forum increasingly brings together governments and major companies to promote innovative approaches and build new alliances. New challenges have arisen as information technology becomes more and more important for the development of global health. WHO recently reached out to major technology companies and platforms, enlisting their help both in tackling the infodemic associated with COVID-19 (see Section 2.5) and in promoting digital health innovation.

Multi-stakeholder diplomacy in action

Microsoft has opened a representation office to the United Nations (UN) in New York. Its task is to intensify the company's support for the UN's mission and work. This includes promoting global multi-stakeholder action on key technology, environmental, humanitarian, development and security issues, and helping to achieve the Sustainable Development Goals. Microsoft has initiated numerous projects focusing on Goal 4 (quality education), Goal 8 (decent work and economic growth), Goal 13 (climate action) and Goal 16 (peace, justice and strong institutions).

The new representation office will concentrate on developing Microsoft's partnerships with the UN and UN system agencies, building relationships with UN representatives, identifying new opportunities for partnerships, building stronger connections between Microsoft and UN teams, lobbying for the UN's priorities within Microsoft, and working across the company to support Microsoft teams in their collaboration with the UN community.

6.6 Maintaining a balance

Civil society organizations, in particular, have expressed concerns over the possibility of SDG based multi-stakeholder diplomacy giving the private sector excessive influence on negotiation processes that should be about safeguarding global public goods. The private sector is invited – as are civil society organizations – to share their views and provide inputs during regional or global consultations on a particular topic but not during the negotiation process itself, in which only Member States may participate. In preparation for a number of high-level meetings of stakeholders on non-communicable diseases in 2011, WHO invited relevant private sector entities to a stakeholder hearing and a web-based consultation, where they could share their views with the Organization. These views served as an input for the preparation of Member State negotiations.

Civil society organizations continue to fear that if the private sector is given access to the prestigious platform of multi-stakeholder diplomacy, its lobbying power, which has long made itself felt in economic and commercial diplomacy, will increase further and lead to less attention being devoted to development, equity and human rights concerns. It would also become harder to challenge companies on their health, environmental and human rights records.

In this respect, it is important to note that the UN system not only thrives on its own legitimacy but can itself also confer a high degree of legitimacy on the various actors involved in its work. A strong tendency may currently be observed among private sector entities to seek to conclude memoranda of understanding with UN system organizations. This applies to such diverse entities as the International Federation of Association Football (FIFA), the World Economic Forum and the new "big tech" companies. In conjunction with the increasing number of public–private partnerships, this tendency means that multi-stakeholder diplomacy faces the challenge of maintaining a delicate balance so that trust in the multilateral system is not undermined. This also includes a recurring concern that some civil society organizations may have undisclosed business links. With regard to WHO, the FENSA framework and transparency measures are meant to allay such concerns, but constant vigilance is still required. Other organizations without such a robust system are more vulnerable.

To manage this complexity, one must navigate the interface between diplomacy and science, conduct multilevel, multi-factor and multi-actor negotiations, and take into account existing power relations. The value base of global health – equity and human rights – has repeatedly been challenged by some States and defended by civil society actors. In principle though the field of health provides diplomats with a range of opportunities to both advance national interests and to strengthen multilateral institutions.

Geneva Global Health Ecosystem Map

CHAPTER 7 | THE ROLE OF REGIONAL ORGANIZATIONS

7.1 The interface between regional bodies, diplomacy and global health

Regional diplomacy is an increasingly important factor in multilevel global health diplomacy. As well as complementing processes taking place at the global level, regional diplomacy strengthens national contributions to global health. However, its role in global health has not been sufficiently analysed.

WHO regional bodies and offices provide a key platform for regional health diplomacy – often supported by regional civil society organizations and professional networks engaged in promoting international cooperation on health. Meanwhile, regional integration organizations and processes have acquired greater prominence in recent years.

Although regional integration processes pursue mainly trade, economic and security objectives, health does come into the picture because of its interface with each of those domains. Thus, trade can both improve and undermine health, while a low level of health of the general population prevents economic gains. The transborder spread of infectious diseases, on the other hand, threatens security. In addition, human rights and social justice – two important elements of the interface between health and foreign policy – are treated as cross-cutting issues in most regional integration processes. Health and well-being, therefore, inevitably feature on regional integration agendas. Indeed, the level of health among a region's population may be used as a gauge of the social benefits of integration.

Another aspect of regional diplomacy is the pooling of knowledge and capacities to tackle common challenges, including health-related ones. In many cases – particularly where region-specific issues are concerned – regional negotiations are the first to be conducted; they may then prompt global negotiations and feed into these.

Health is often seen as an area for the exercise of soft power whereby regional organizations are able to strengthen ties, cooperation and trust among their member countries, and to promote regional stability in general. Since health now receives more attention in global governance, health diplomacy often helps regional organizations and their members, particularly smaller States, to be heard on the global stage. Moreover, they can draw on their shared expertise when conducting

negotiations on health issues in global forums.

7.2   An overview of regional integration

Regional integration processes vary in terms of the specific forms they take and in the level of integration pursued or achieved. They range from free trade areas as the most basic form of integration to customs unions, common markets and fully fledged political and economic unions. Regional organizations operate mainly on the basis of intergovernmental decision-making, buttressed by supranational institutions in some cases. Several organizations even have their corresponding parliaments, parliamentary assemblies or unions with a distinct legal authority.

In economic terms, the European Union (EU) is the largest regional bloc; it also exemplifies the most advanced form of regional integration. In addition, the EU's single market extends to the area of the European Free Trade Association (EFTA), a smaller bloc of four countries. Straddling parts of Eastern Europe and Central Asia, the Eurasian Economic Union (EAEU) is the world's newest regional economic organization. Three other regional organizations also span parts of Europe and Asia.[16]

Several regional organizations exist in Asia and the Pacific.[17] Additionally, one organization straddles parts of Asia and Africa and one intergovernmental forum links economies in the Pacific Rim.[18]

The integration architecture is more complex in Africa and the Americas, where in some cases it has multiple layers (subregional, cross-regional, continental) and overlapping membership. In addition, some of the organizations contain smaller subgroups that have a higher degree of integration (for example, customs and/or monetary unions).

In Africa, there are eight regional organizations covering different subregions:[19] these regional economic communities are the pillars of the African Economic Community, which is in the process of being created by the African Union (AU).

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16   Organization of the Black Sea Economic Cooperation (BSEC), Shanghai Cooperation Organisation (SCO), Economic Cooperation Organization (ECO).

17   South Asian Association for Regional Cooperation (SAARC), Association of Southeast Asian Nations (ASEAN), Gulf Cooperation Council (GCC), Pacific Islands Forum (PIF), Pacific Community.

18   The League of Arab States (LAS) and the Asia–Pacific Economic Cooperation (APEC), respectively.

19   Arab Maghreb Union (AMU), Common Market for Eastern and Southern Africa (COMESA), Community of Sahel-Saharan States (CEN-SAD), East African Community (EAC), Economic Community of Central African States (ECCAS), Economic Community of West African States (ECOWAS), Intergovernmental Authority on Development (IGAD), Southern African Development Community (SADC).

In the Americas, there are six organizations covering different subregions.[20] This integration architecture was recently complemented by organizations with wider regional coverage: the Union of South American Nations (UNASUR) and the Community of Latin American and Caribbean States (CELAC).

7.3 Regional integration and health

The integration of health agendas into the work of regional organizations generally takes place at four different levels, as shown below:
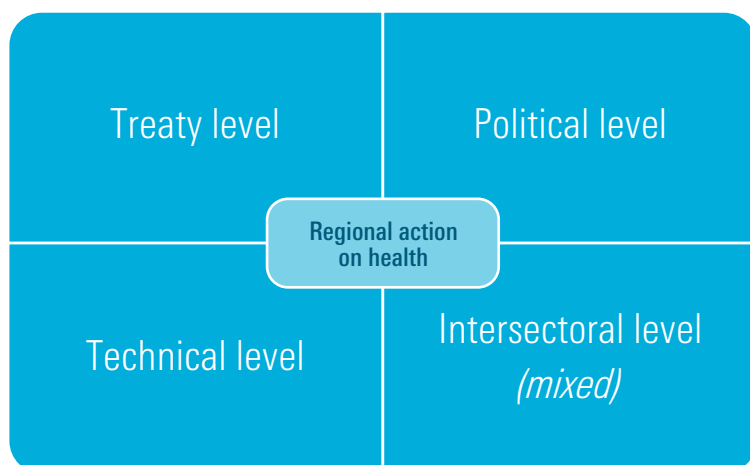
At the **treaty level**: The founding (constitutive) treaties of most regional organizations address health indirectly, through overarching goals (for example, social and human development, internal market, human and labour rights, free movement of goods and services, technical regulations) and sectoral policies (for example, on food safety, consumer protection, agriculture, medical products, migration and the environment).

In some cases, however, health is explicitly referred to in the founding (or complementary) treaties of regional organizations, usually with an emphasis on specific areas or aspects: public health and health in other policies (EU); action on preventable diseases and promotion of good health (AU); universal access to health services (UNASUR), health systems and harmonization of policies (EAC);

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20   Amazon Cooperation Treaty Organization (ACTO), Andean Community (CAN), Caribbean Community (CARICOM), Central American Integration System (SICA), Pacific Alliance, Southern Common Market (MERCOSUR).

sanitary and veterinary measures (EAEU); health as a prerequisite for development (SADC); and health as an essential ingredient of social integration (SICA).

At the **political level**: High-level declarations, strategies and action plans on health have been adopted at summits and by the highest governing bodies of several regional organizations. Examples of such documents include the Africa Health Strategy 2016–2030 (AU), the ASEAN Post-2015 Health Development Agenda and the Strategic Plan on Health (Andean Community). In the EU, some normative acts (directives and regulations) have higher legal status than others (recommendations).

Several regional organizations have initiated regular meetings of their member countries' health ministers, including the Andean Community, MERCOSUR and SAARC. Others have established councils, committees or assemblies as political bodies with responsibility for the health sector, including ECOWAS, SICA and UNASUR. In the EU, the member countries' health ministers meet regularly as part of the Employment, Social Policy, Health and Consumer Affairs Council configuration – one of the 10 configurations of the Council of the EU, which is the Union's main legislative body alongside the European Parliament. In large organizations with an executive commission such as the AU and the EU there is a designated commissioner who is responsible for health and is supported by a specialized department of the commission.

Health objectives are often supported by other regional bodies and institutions, such as: regional parliaments and legislative assemblies (which endorse relevant legislation); regional development and investment banks (which may fund health, medical and biotechnology projects); and regional courts of justice (which may be called upon to interpret relevant regional legislation or settle legal disputes concerning, for example, citizens' rights to cross-border care).

At the **technical level**: Some regional organizations have established specialized health agencies, which are probably the most advanced mechanism for technical cooperation. Examples of such health agencies, with the parent organization indicated inside square brackets, are:

→   Africa Centres for Disease Control and Prevention [AU];
→   Andean Health Organization [Andean Community];
→   Caribbean Public Health Agency [CARICOM];
→   East African Health Research Commission [EAC];
→   West African Health Organization [ECOWAS];
→   European Centre for Disease Prevention and Control, European Medicines Agency, European Monitoring Centre for Drugs and Drug Addiction [EU]; and
→   South American Institute of Governance in Health [UNASUR].

Other mechanisms employed by various organizations include regional reference and regulatory networks, registries, databases, initiatives and partnerships. In some cases, these mechanisms have resulted in public health goods that are of particular importance for the region as a whole, such as MERCOSUR's database of pictorial warnings on the dangers of tobacco, SAARC's telemedicine network, the EU's eHealth Digital Service Infrastructure and UNASUR's medicines price bank.

At the **intersectoral level**: In addition to traditional multisectoral approaches to health, some special mechanisms have been used at both the technical and political level. Examples include APEC's joint annual meeting of the ministers for health and the economy; SICA's joint meetings of its bodies responsible for health and economic integration; the Pacific Community's High-Level Dialogue on Water and Sanitation; and SADC's cross-cutting policy on HIV/AIDS and sexually transmitted diseases. Furthermore, international health emergencies often trigger urgent regional diplomacy and coordination in closely related sectors, as for example in the case of ASEAN, where the member countries' ministers of the economy, agriculture, labour, social welfare and transport convened their respective coordination meetings during the early phase of the response to the COVID-19 pandemic.

7.4   Regional integration and global health diplomacy

A considerable amount of negotiation and consensus-building is necessary – at both the intergovernmental and intersectoral level – to ensure that health is not crowded out by the various political, trade, economic and security agendas that primarily drive the processes of regional integration. In addition to strengthening the health dimension of regional integration, such negotiations help to lay the foundations for a region's engagement in global diplomacy for health.

There are three different types of mechanism for the interaction between regional integration and global health diplomacy: internal, horizontal and vertical.

Internal: Some organizations have formally set out their region's role in global health (EU) or have promoted global treaties that are of particular relevance to their region (as in the case of the Amazon Cooperation Treaty Organization with its strong support for the Minamata Convention on Mercury).

Horizontal: Regional organizations cooperate with one another in order to achieve improved collective outcomes, including health outcomes. Such cooperation may occur both within a continent (for example, the COMESA–EAC–SADC Tripartite, which seeks to accelerate economic integration in eastern and southern Africa), or intercontinentally (for example, the EU's cooperation on communicable diseases with the AU and ASEAN, or the recent EU–MERCOSUR free trade agreement, which

may have an impact on health). A related horizontal mechanism is the way in which major cross-regional political clubs (G7, G20, BRICS) are paying ever greater attention to global health issues.

Vertical: Several such mechanisms have emerged over the years. First, the members of some regional organizations adopt a coordinated stance at WHO – a mechanism that supplements the well established coordination between Member States within the WHO regions. In that case, a regional organization/grouping acts as a voting bloc. This has long been the case with the EU, but there are more recent examples, such as UNASUR's call for action against counterfeit medicines. Secondly, the political stance of some regional organizations has proved instrumental in pushing certain issues to the top of the global agenda. Two examples are CARICOM's catalytic role in raising the profile of noncommunicable diseases at the UN and the Pacific island States' powerful statements on climate change at WHO and other global forums. Thirdly, regional integration organizations can directly support global health treaties, as demonstrated by the EU's support for the negotiations on the FCTC and its Protocol to Eliminate Illicit Trade in Tobacco Products, followed by its accession to the both instruments. Given the dominance of cross cutting agendas in most integration processes, regional multisectoral diplomacy is important to ensure that health objectives are achieved when negotiating future global health treaties (or treaties with a health impact) and when implementing the existing treaties.

Global health crises often trigger demand for the above mechanisms – internal, horizontal and vertical – to be rolled out in a pooled manner or simultaneously. This could be seen, for example, during the global crisis caused by the COVID-19 pandemic. The EU, while slow in its initial response to the pandemic, later nevertheless undertook substantial coordinating efforts. It also spearheaded the difficult negotiations for a recovery fund totalling an unprecedented €750 billion, which was eventually approved in July 2020. In parallel, at the global level, the EU proposed and facilitated adoption of the crucial World Health Assembly resolution on the COVID-19 response; provided substantial resources to the Gavi Alliance; and championed the Coronavirus Global Response initiative, for which pledges worth nearly €16 billion were secured over a few months. Similarly, the AU established the Africa Joint Continental Strategy for COVID-19, the African Union COVID-19 Response Fund and a joint medical supplies platform. At the global level, the AU appointed a special envoy to mobilize international economic support for the continent's fight against the pandemic and actively supported WHO's global response to the pandemic. As for interregional (horizontal) mechanisms, notable examples include the EU's promptly activated COVID-19 response dialogue with ASEAN and the AU, and various response measures under the Tripartite Transport and Transit Facilitation Programme in eastern and southern Africa. However, the pandemic also showed that existing divisions between member countries may seriously hamper an organization-wide coordinated response, as for example in the case of MERCOSUR.

In summary, regional health diplomacy acts as a complement to – and intermediary between – diplomacy at the national (in some cases also subregional) and global levels. Regional integration helps to harness the collective will and knowledge of States, particularly smaller ones, when it comes to tackling shared health challenges at global forums. An important conclusion is that the three levels of health diplomacy are interrelated and complementary.

Box 13: Global health diplomacy in Africa

The spread of diseases increasingly threatens national security, trade, economic and development agendas in Africa. These agendas are the building blocks of the Agenda 2063 of the African Union (AU). Recognizing the importance of the nexus between global health threats and broader goals in diplomatic efforts towards realizing Agenda 2063, the AU decided to establish the Africa Centres for Disease Control and Prevention (Africa CDC). Its mandate is to support the public health initiatives of AU Member States, and to strengthen the capacity of their public health institutions to detect, prevent, control and respond quickly and effectively to disease threats. The fact that Africa CDC is based at the AU is a reflection of the diplomatic implications of its work, particularly in a global health context. Health diplomacy is an important dimension of Africa's wider diplomatic engagement. Africa's high disease burden, its difficulties with health financing and consequent reliance on external funding call for effective health diplomacy and concerted steps by both African and international stakeholders to prompt global health policies and action that are relevant to the continent's needs with regard to improving the health of all its citizens.

Health has become an important bargaining chip in diplomatic negotiations, as most recently demonstrated in global efforts on the COVID-19 pandemic. Before the pandemic, the political and economic interests of donors (bilateral and multilateral organizations, the private sector and so on) were often facilitated through donor health packages. These packages were geared towards leveraging soft power and gaining relevance in negotiations on security, trade agreements and development policies. African countries on the whole benefited from donor packages, and donor countries built on this to consolidate their influence and promote their own interests. Conversely, health diplomacy has been relatively underused to advance African countries' interests. However, during the pandemic, governments adopted drastic policies and took bold action to mitigate the human and socio-economic toll of COVID-19, especially on the informal sector, which employs over 85% of Africans. Public health measures have informed policy- and decision-making to mitigate the spread of the pandemic – for example, curfews and lockdowns, safe border initiatives and negotiations to safeguard trade between countries.

In an effort to mitigate the pandemic's impact, the Bureau of the AU Assembly of Heads of State

and Government issued a joint statement at its onset requesting debt forgiveness. This highlights the critical need for political and diplomatic action informed by health goals.

However, there is untapped potential for health diplomacy in Africa to become more systematic than previously. Despite the development of the Africa Health Strategy 2016–2030 and the establishment of Africa CDC, public health is not treated as a core priority in key agenda setting documents such as Agenda 2063. Moreover, before the inception of Africa CDC, a unified African voice on health matters was not discernible, leaving countries vulnerable to different positions and influences. Two events may be cited as an illustration of the effect of not having such a unified voice:

→   The African region, as a regional bloc, did not collectively support the Political Declaration of the high level meeting on universal health coverage in 2019. Since countries signed separately, Africa's collective negotiating power was weakened. This resulted in some countries signing an alternative statement on universal health coverage initiated by the United States of America, which excluded sexual and reproductive health rights.

→   At the 2019 World Health Assembly, 20 countries (five of which were African) sponsored a resolution to improve the transparency of markets for medicines, vaccines and other health products. The resolution provides governments with useful information to negotiate fairly. However, some critical elements of transparency were omitted. This was the result of objections raised by Germany, Japan, the United Kingdom and the United States on publishing data relating to production and other relevant costs, and to subsidies from governments and other groups. Despite the fact that the lack of access to and availability of vaccines, drugs and commodities is a public health crisis in African countries, there was no objection from the region as a whole to those omissions in the final text of World Health Assembly resolution WHA72.8.

The COVID-19 pandemic offers exceptional scope for health diplomacy to come into its own in Africa. Africa's joint response to the pandemic has created the policy space for global health processes. Governments, through the Africa CDC or regional economic communities, such as the East African Community (EAC), the Southern African Development Community (SADC) and the Economic Community of West African States (ECOWAS), have coordinated their pandemic responses, policies and guidelines. The President of South Africa, in his role as AU Chairperson, appointed four Special Envoys of the AU to mobilize support for Africa's COVID-19 response. In addition to the health implications, the support being sought is also intended to help address the economic challenges faced by African countries as a result of the COVID-19 crisis. Through concerted engagement, certain regional economic communities and designated envoys have emerged as negotiators for Africa's response to the pandemic. This consensus on the response

framework has promoted the adoption of shared goals in pandemic response and made it possible to raise more funds from both traditional donors and African philanthropists. Such coordinated and strategic health diplomacy is likely to have a positive impact on health and other socio-economic factors.

In developing strategic health diplomacy in Africa further, African policy-makers may like to consider the following actions:

→ Institutionalize the integration of health into foreign policy. Governments should collaborate to develop common positions that will enable them to influence resolutions adopted at the global level. Broader engagement within the region will strengthen the ability to achieve coordinated positions and responses on health matters, such as joint guidelines, the pooling of resources (for the financing and deployment of first responders, for procurement and so on) and exchange of best practices.

→ Negotiate as a regional bloc in order to manage complex partnerships and protect Africa's interests. By advancing its own health agenda, Africa can increase its purchasing power and ability to access innovative technologies, medicines, vaccines and other health commodities. Strengthening the dialogue between diplomats and health experts will ensure that health impacts are a key consideration in all negotiations. This requires inclusive and transparent decision-making processes not only during programme implementation but also in research and development.

→ Build capacity to develop and proactively engage in health diplomacy, that is in the interface between health and foreign policy. With African governments recognizing that health security is not only a national concern, the pandemic is demonstrating the growing link between domestic and foreign policy. Policy-makers need to be aware of international health agreements and to anticipate attendant risks or threats. Special technical skills are also required to negotiate health agendas within foreign policy and development agreements (including trade and commerce). To that end, a cohort of key officials should be trained in these skills. Such capacity-building can be enhanced by offering placements to these officials at the diplomacy hubs of Addis Ababa, Geneva and New York and within ministries of foreign affairs. Governments should also cooperate with academic institutions to build capacity in health diplomacy and, specifically, to enable the officials to familiarize themselves with the latest public health trends. Governments could go even further by establishing global health diplomacy units within their foreign ministries, which would interact with health attachés at diplomatic missions, relevant AU entities (Department of Social Affairs, Africa CDC, African Continental Free Trade Area), parliamentarians and WHO country and regional offices.

In view of the critical role of global health diplomacy in improving health indicators across Africa, it is imperative to restructure and systematize the way such diplomacy is conducted in the region. This is necessary in order both to increase Africa's negotiating power and to build better institutions that can promote positive health diplomacy and public health outcomes.

CHAPTER 8 | POLICY COHERENCE FOR GLOBAL HEALTH

8.1 Creating synergies

In the SDGs era, strategies for health equity and sustainable development should be integrated, taking into account the links between social, environmental and economic policies. However, different sectors have their own objectives and tend to operate in "silos". Introducing health issues into the policy space of non-health sectors is often perceived as interference unless the potential co-benefits are clearly pointed out.

Sectors other than health have always made a fundamental contribution to health promotion and disease prevention, as exemplified by the social medicine movements of the first half of the 20th century and by such milestones in the second half as the Alma-Ata Declaration on primary health care (1978), the Health for All Strategy (1981) and the Ottawa Charter for Health Promotion (1986). More recently, the intersectoral approach to health was reinforced by the Health in All Policies Framework (2006), the final report (2008) of the WHO Commission on Social Determinants of Health, and the emphasis on health as a cross-cutting dimension in the SDGs (2015). International legal instruments such as the revised International Health Regulations (2005) and the WHO Framework Convention on Tobacco Control (FCTC), which also entered into force in 2005, have resulted in

binding obligations for different sectors (and for governments as a whole) with regard to protecting and promoting public health.

Because of the influence of different sectors on health – an influence that may be either positive or negative – it is necessary to achieve effective intersectoral engagement and coordination. Both at the domestic level and in the international arena, such **integrative diplomacy** has become increasingly important for the promotion of health. The adoption of the SDGs has accelerated this shift towards policy coherence and integrative diplomacy. However, governments often find it difficult to align, for example, their trade and economic policies with their national and global health objectives.

Policy coherence is particularly important – and difficult to achieve – when cross-sectoral interaction is tightly embedded in multilateral processes and negotiations. Notable examples illustrating the need for policy coherence through integrative diplomacy are the negotiations and processes in the framework of international legal regimes such as the FCTC and the revised IHR; multidisciplinary negotiations on how to tackle the mounting global challenges of health security and antimicrobial resistance; and efforts to place more emphasis on health in the global dialogue on climate change.

Negotiations on issues of high priority at the global level are conducted not only at regular multilateral forums and summits, but increasingly also at ad hoc high-level conferences. The more relevant such negotiations are to certain States, the more these will strive for the synergistic interaction of diplomacy efforts at various levels and within the framework of different organizations, processes and meetings – a strategy sometimes referred to as **"forum shopping"**.

8.2   Using existing mechanisms more effectively for policy coherence

Policy coherence is about upholding shared values and achieving common goals. By **using universally accepted platforms**, such as the 2030 Agenda for Sustainable Development, more effectively, cross-sectoral coherence in support of health and agreed values – such as human rights – can be achieved through integrative diplomacy.

By virtue of their binding force, **international legal instruments** in the field of health can contribute greatly to cross-sectoral coherence. For example, the FCTC requires countries to establish a national coordination mechanism for tobacco control. Similarly, the revised International Health Regulations (2005) stipulate that a public health response to the international spread of disease should "avoid unnecessary interference with international traffic and trade". Moreover, several environmental, labour, trade and other sectoral treaties contain binding provisions that support health objectives. All these legal regimes can help to foster cross-sectoral synergies.

While the contribution of such sectors as education, social protection, agriculture, trade and transport to health has long been recognized, in recent years there has been increasing involvement by **other sectors that were not previously regarded as partners** for the health sector's day-to-day work. Examples of such sectors are customs (in relation to the Protocol to Eliminate Illicit Trade in Tobacco Products, which entered into force in 2018), migration (in connection with the rising interest in migration and health) and telecommunications (as a result of the rapid expansion of digital health). Keeping experts and authorities aware of new and emerging issues at the interface of health with other sectors is important to ensure effective policy dialogue and coherence. **Policy networks** play an increasingly important role in this regard.

In some cases, opportunities arise when all **relevant sectors are brought together by a major health crisis**, such as a disease outbreak or a heatwave. The ensuing intense interactions improve these sectors' mutual understanding and trust, which can help to sustain regular dialogue afterwards.

8.3 The domestic groundwork for global policy coherence

Health and health-related issues are frequently on the table during multilateral negotiations, both within and outside WHO. Because of the cross-sectoral nature of health matters, front-line negotiators are often under pressure to reconcile the views – often conflicting ones – of different sectors. Achieving a coherent government stand on the various issues, before or between negotiating sessions, is an important factor in determining the success of negotiations. Governments therefore frequently set up national multi-stakeholder coordination mechanisms to support multilateral negotiations. Some countries have developed national global health strategies to support coherence and clarify the objectives of such efforts (more on this in **Section 8.4**).

National coordination mechanisms vary depending on the issues and actors involved. There are, however, some common features, as follows:

A proactive approach by the health ministry is essential. This is above all because other sectors may not be aware of the health implications (often hidden or largely technical) of issues discussed in non-health forums. Moreover, it is the health sector that has to deal with the consequences, should the protection of public health fail.

Cross-sectoral coordination within a country involves both technical and political debate. The technical exchange of rules, norms and evidence across sectors is usually not sufficient. Higher-level political consensus, often involving compromise and trade-offs, is normally required when developing the mandate for subsequent negotiations.

Foreign ministries need to be involved in order to ensure coherence with a country's relevant multilateral commitments and priorities. Such umbrella involvement may not be as intense as the exchange between sectoral ministries, but it is still essential from a political and foreign policy perspective. In many negotiations, particularly those taking place in the principal international forums and hubs, foreign ministry representatives are members of the national delegation, or they may actually lead it. This makes prior coordination even more important.

National intersectoral coordination can be promoted by coherence between the approaches of relevant international organizations. Intersectoral arguments presented by WHO that are harmonized with those of other organizations – such as the World Bank, FAO, the International Labour Organization (ILO) and UNEP – help to increase the various sectors' understanding of and confidence in one another.

Achieving convergence on key intersectoral issues during, rather than before, multilateral negotiations is usually difficult because of the intensity and changing dynamics of negotiations and the lack of time to consult with relevant ministries in the capital. Unless sufficient preparatory work has been carried out at home, seeking convergence within a national intersectoral delegation can often be as demanding as negotiating with other delegations. Chapter 11 explains in more detail how coordination with different non-health sectors works, including the role of the health sector in such coordination.

While preparing a coherent negotiating platform is the responsibility of governments, these will frequently involve relevant non-State actors in the process – for example, through open multi-stakeholder dialogue to provide input for the formal preparations. It is particularly helpful to draw on the knowledge of civil society and professional organizations that are members of international alliances with observer status at the multilateral negotiations on the issues at stake.

8.4 The importance of a national global health strategy

Global health is one of the few areas of diplomacy in which countries have drawn up national strategies to address a global issue. Switzerland was the first country to adopt a health-related foreign policy in 2006. Since then, a number of countries have adopted national strategies on global health, enabling them to align their commitments to global health with national health and foreign policies. These include France, Germany, Japan, Thailand, the United Kingdom and the United States. Many other countries – including Brazil, Cameroon, Canada, China, Norway, South Africa and Sweden – have identified specific priority areas for engaging more proactively in global health diplomacy.

Most of the countries that have so far adopted national strategies on global health are donor coun-

tries, high-income countries and emerging economies. They are often pursuing specific geopolitical interests and striving for influence. However, all countries should consider such strategies, since national health issues are tightly interlinked with global health ones. Additionally, in the case of low- and middle-income countries, ensuring that the national health strategy meets donors' expectations and engaging as a country (or regional group) in international forums are both essential to optimize the impact of donor funding on health at the national level.

The health ministry is normally the ministry responsible for liaison with WHO, and it usually has a department dealing with international health. However, on political matters, the positions adopted by the foreign ministry will overrule those of the health ministry. In some cases, there is a focal point for global health within the foreign ministry, while some countries have even appointed global health ambassadors. In high-income countries, the ministry of development and development agencies are often the focal points for health organizations, such as the Global Fund, that receive significant financial contributions from donors. These various players will interact with the network of diplomatic representations in Geneva or New York to give instructions or develop positions. The first point of contact will usually be a health attaché in the diplomatic mission – normally a diplomat who has been assigned the health portfolio (often together with a few other portfolios), though sometimes it is a health professional seconded from the health ministry.

It can be very difficult to achieve coherence at the national level between global health efforts, since this requires working with different agencies and actors at various levels of governance both at home and abroad. There is inevitably competition – sometimes even conflict – between ministries and agencies. This means that diplomatic representations often have to contend with and reconcile the divergent positions of different ministries. In donor countries, it is the national parliament that ultimately decides the level of global health funding. Parliaments also decide the amounts that are to be spent bilaterally and multilaterally, and which ministries are to have control of the budget.

In many countries the international health departments in the health ministry are weak and understaffed. Yet, they are expected to be able to provide sound technical advice on the many proposals emerging out of different multilateral processes. In some cases, they are also expected to take the initiative and develop resolutions on behalf of their country.

The agendas of the WHO Executive Board and of the World Health Assembly have expanded significantly, and their implications are more complex and political than in the past. Engaging fully with these agendas requires knowledge of other multilateral processes that are under way – for example, in order to understand the positions taken by Member States on antimicrobial resistance it is necessary to be aware of relevant negotiations at FAO. Similarly, a donor country's decision to be-

come involved in funding health systems requires coordination between the ministry (health or foreign affairs) overseeing Global Fund investments and the finance ministry, which represents the country at the World Bank.

Low- and middle-income countries often lack sufficient capacity in their various ministries and the diplomatic service to be able to engage properly in complex negotiations. Moreover, smaller delegations at global health negotiations find it difficult to participate fully and influence the outcome of these. Sharing the burden between different country representations from the same region or between countries with shared interests in Geneva and New York is becoming an essential part of successful global health diplomacy. Regional entities, such as the AU and EU, are increasingly making such arrangements.

As far as their global health strategies are concerned, a priority for low- and middle-income countries is to be well prepared to engage with the various global health actors, including international organizations. Many such countries, for example, have a cooperation strategy with WHO. Several ministries and government bodies other than the health ministry play a key role in this respect, especially when the focus is on donor coordination and securing foreign investment to build up the health system. African countries have for a long time been calling for greater donor coordination and accountability. Despite agreements negotiated at major conferences – such as the International Conference on Financing for Development held in Monterrey, Mexico, in 2002, which brought together more than 50 Heads of State and Government and over 200 ministers of foreign affairs, trade, development and finance – the reality on the ground leaves much to be desired. A key objective of global health negotiations at the country level is to make the delivery of aid more efficient by aligning donor programmes with national plans. A good example is the way in which Ethiopia has aligned Global Fund and PEPFAR investments with its national priorities to establish a primary health care system capable not only of combating HIV but also of dealing with child vaccination, maternal health care, tuberculosis and hypertension treatment, and the promotion of hygiene.

Middle-income countries and emerging economies are often at a halfway point between focusing on bringing coherence to national efforts supported by international donor funding, on the one hand, and being an active player in global health forums, on the other. For example, Brazil has long advocated universal access to medicines, India has been a driving force in mobilizing global efforts to combat tuberculosis, and the Russian Federation has been instrumental in putting noncommunicable diseases on the global agenda.

Box 14 below provides brief guidance on negotiating a national strategy on global health.

Box 14: Preparing a national strategy on global health

Preparing a national strategy on global health starts with information-sharing, capacity-building and internal negotiations among diplomats and civil servants at the national level to promote the concept of a global health strategy and raise awareness of its expected positive impacts. The rationale for developing such a strategy is based on the notion, enshrined in the SDGs, that global health issues are relevant to all countries, regardless of their economic status and political influence, and can only be tackled by a joint global effort. The concept is not yet universally accepted, though. Moreover, securing political acceptance for such a strategy has become harder lately, because of growing nationalism and questioning of the multilateral system. The adoption, in October 2020, by the German Government of a global health strategy for 2020–2030 is therefore a very important signal.

Moving towards a global health agenda at the national level implies a strong national commitment to the strengthening of multilateral institutions in health and to multilateral governance. In donor countries, a focus on multilateral engagement may be interpreted by some as a weakening of bilateral development aid that has the potential to reduce the country's visibility and political influence on the global stage.

One of the main challenges in the design of a national global health strategy is to achieve coherence between national policies in various areas. The multisectoral nature of global health should be a key element in its governance both at the national and international level. This is something that diplomats need to understand and take into account. Global health strategies encompass common goods, development and peace, ethical values and multilateralism, and primary responsibility for them rests with the whole of the government, rather than with the ministry of health alone.

The key preparatory step is conducting consultations with a large number of stakeholders. Such consultations may be overseen by a steering committee with, ideally, joint leadership provided by the health and foreign ministries (or the development ministry). In countries with a formally designated ambassador for global health, he or she may be the most appropriate person to chair the steering committee. In addition to a steering committee, an international advisory board on global health can provide helpful input, as recently pioneered by Germany. Consultations should start by undertaking a comprehensive review of national health and foreign policies, and also of the country's international and multilateral commitments. Experience has shown that it is often more effective to share a so-called zero draft and ask stakeholders for comments and additions, rather than holding open ended consultations. The selection of stakeholders for the consultations will inevitably have an impact on their outcome.

The next step is setting priorities. Strategies are national, which means that their specific priorities will vary from country to country. A common feature of all strategies, however, is that they deal with all or some of the issues generally regarded as key global health issues, such as combating epidemics or tackling antimicrobial resistance. National strategies will also have in common several underlying values, such as a commitment to defending human rights, reducing health inequalities and achieving universal health coverage. Taking decisions on the priorities in a national strategy on global health may prove to be quite challenging. Tensions may arise, for example, between a political discourse in favour of universal access on the one hand, and the protection of national commercial interests on the other.

A successful national strategy not only sets the policy priorities, but also outlines the interministerial process for defining negotiation positions. This can be done through regular interministerial coordination meetings or through a specific process for global health, and should combine incentives for collaboration at ministerial, senior official and desk officer level.

Ultimately, decisions are taken by the executive branch of government and are not usually debated by the legislative branch.

The Swiss national strategy on global health, for instance, sets out six priority areas to which a common approach has been agreed on by government bodies as diverse as the Federal Office of Public Health, the Federal Department of Foreign Affairs, the State Secretariat for Economic Affairs and the Federal Institute of Intellectual Property. The six areas were identified through consultations with central and local government bodies, the research community, civil society, the private sector and patients' organizations. Officially entitled Swiss Health Foreign Policy 2019–2024, the strategy is intended to enable Switzerland to develop a coordinated, coherent public health policy at both the national and international level. Given the rapidly changing international environment, it will be reviewed periodically.

The six priority areas of the Swiss Health Foreign Policy 2019–2024

1. Health protection and humanitarian crises
2. Access to medicines
3. Sustainable health care and digitalization
4. Health determinants
5. Governance of the global health regime
6. Addiction policy

The five priorities of the German global health strategy for 2020–2030

1. Promoting good health, preventing diseases and developing adequate responses
2. Holistic approaches to the environment, the climate change and public health
3. Strengthening health systems
4. Protecting health by addressing cross-border health threats
5. Advancing research and innovation for global health

PART C:
THE ELEMENTS OF SUCCESSFUL GLOBAL HEALTH DIPLOMACY

CHAPTER 9 | ACHIEVEMENTS IN GLOBAL HEALTH DIPLOMACY

9.1 Defining success in global health diplomacy

Judging success or failure in global health diplomacy always depends on the context and the actor. Success should arguably be measured in terms of the extent to which opportunities have been created to change the direction of events – in this case the benefit to health and well being. However, agreements reached at the global level have to be enacted at the national – in some cases also subnational – level. This means that success depends very much on States' implementation of global agreements and resolutions, not just on achieving certain outcomes in global venues. In part such implementation is further influenced by the type of agreement reached – for example, if it is hard or soft law.

It is important to note that success in global health diplomacy is at times also linked to extraordinary individuals and negotiators. Because of the diversity and complexity of the issues involved, a strong personality and passionate commitment can make a big difference in many global health negotiations.

Success depends of course on what a country or other interested party had set out to achieve in the first place. What one negotiator considers to be success may represent failure for another, which is why WHO strives for decision-making by consensus, trying to ensure that all countries are on board. However, this can sometimes result in outcomes based on the lowest common denominator.

Member States may occasionally try to push specific issues that do not merit global attention at the time (such as a control plan for a single disease) on to the agenda of the WHO governing bodies just to please domestic audiences or, in some cases, to promote vested business interests. Furthermore, certain agenda items keep recurring at WHO on which progress has yet to be achieved, such as tackling substandard and falsified medical products (a topic which has occupied a WHO working group for many years), or the destruction of any remaining stocks of smallpox virus. In these cases, public health interests are overshadowed by political agendas.

The COVID-19 pandemic posed new challenges for WHO, whose work was made harder by the political tensions between China and the United States, and which had to coordinate a response using limited resources. Multilateral response has not worked well at the UN level either. The Security

Council was unable, because of disagreements between permanent members, to adopt a resolution endorsing the Secretary-General's call for ceasefires during the pandemic in conflict zones.

Nevertheless, the Seventy-third World Health Assembly in May 2020 – the first Health Assembly to be conducted in virtual format – achieved a relative success by adopting a balanced, albeit cautiously worded resolution on the COVID-19 response (WHA73.1). This EU-initiated resolution covers many aspects of the pandemic and calls for an independent evaluation of the international response, including, but not limited to, WHO's role. It recognizes extensive immunization against COVID-19 as a global public good. The resolution also makes several references to the right of countries to legally override international patent rules during a health emergency, making use of the "flexibilities" under the TRIPS Agreement – an issue that was central to advocacy efforts by civil society.

Well-conducted global health diplomacy can lead to the following key results:

→   Better health: better population health outcomes for each and every one of the countries involved, along with an improved global health situation in achievement of the SDGs;

→   Improved global solidarity: improved relations between States and a commitment of a wide range of actors to working together to advance health, common goods for health and support multilateralism; and

→   More equity: outcomes that are deemed fair and support the goals of promoting human rights, reducing poverty and increasing social justice.

9.2 Examining success

The 10 examples presented briefly below can serve as an entry point for closer examination and an assessment of lessons learned from successful past negotiations in global health diplomacy.

→ The SDGs, which were negotiated by the UN Member States with significant input from other actors, include almost 50 health-related targets, many of which require constant vigilance and negotiations at several different venues. Health, as a result, is widely seen both as a beneficiary of and contributor to almost all of the SDGs, not just the health-specific Goal 3. A key measure of successful global health diplomacy is its contribution to progress towards the SDGs. Several high-level meetings have helped to move this agenda forward.

→ A major success in global health diplomacy over the past decade has been the way in which health issues were taken up by non-health forums at the UN, that is, by the General Assembly (noncommunicable diseases, tuberculosis, antimicrobial resistance, universal health coverage) and the Security Council (HIV/AIDS, health in conflict areas, Ebola). This success was facilitated to a great extent by pro-health statements by the G7 and the G20.

→ At the UN General Assembly in September 2019, 12 multilateral health, development and humanitarian agencies launched a joint plan to support countries in making swifter progress towards the health-related SDG targets. The Global Action Plan for Healthy Lives and Well being for All, as it is entitled, is designed to help countries to identify their priorities and to plan and implement their work; it will also support efforts in key areas, such as primary health care.

→ A UN high level meeting on 23 September 2019 resulted in the adoption of a landmark declaration on universal health coverage, which recognizes that it is not only access to health care services that matters but also access to a healthy lifestyle, information allowing one to make the right choices, health literacy, healthy food, transport, a healthier environment and other determinants of health.

More details of the negotiations leading to the Political declaration of the high-level meeting on universal health coverage (2019) are provided in Case Study 2.

→ The world's first-ever summit of Heads of State and Government on the prevention and control of noncommunicable diseases (NCDs) was convened by the Caribbean Community (CARICOM) in 2007, resulting in the Declaration of Port of Spain entitled "Uniting to stop the epidemic of chronic non communicable diseases". The English-speaking Caribbean once had the highest per capita burden of chronic NCDs in the Americas region. Building on a long history of cooper-

ation in health among its member countries and on past successes in eliminating or reducing communicable diseases through collective action, CARICOM therefore decided to target NCDs and subsequently turned this approach into a global one by successfully campaigning for a first UN high-level meeting on NCDs.

After nearly a decade of global health diplomacy, NGOs and professional organizations, supported by a group of Member States, succeeded in ensuring that the third UN high-level meeting on NCDs (2018) expanded the earlier meetings' focus on four major NCDs (cardiovascular diseases, cancer, diabetes and respiratory diseases) and four risk factors (tobacco use, physical inactivity, the harmful use of alcohol and unhealthy diets). The result was the adoption of a "five-by-five" approach, with mental health conditions now included as an NCD and air pollution as a risk factor.

Successes in this area (political commitments) are overshadowed by the impact of commercial determinants. The Political Declaration of the United Nations General Assembly on the Prevention and Control of NCDs in 2011 included a commitment from governments to explore the provision of adequate resources through, inter alia, domestic and bilateral channels. However, this goal has not been fulfilled. NCDs remain the largest, most internationally underfunded public health issue globally, where most lives could be saved or improved, because the political momentum was offset by the interference in international health policy-making of vested economic, market and commercial interest groups in donor countries. Unfortunately, most developed countries show limited interest in pursuing policy coherence and recognizing the interconnectedness of promoting a multilateral trading system under the WTO with promoting health in their international development policies as two sides of the same coin in terms of achieving the indivisible SDGs.

→ The 2014 outbreak of Ebola in western Africa posed a severe threat to human life in a globalized world in which pathogens are able to spread quickly. In the countries most affected, however, national capacities were inadequate to deal with the epidemic and leaders were reluctant to acknowledge its full implications. WHO declared a Public Health Emergency of International Concern in August 2014 to alert countries and trigger action. The epidemic was subsequently declared by the UN Security Council to be a global threat, which made it possible for the international community to further bolster direct support to the countries concerned.

→ The Seventy-second World Health Assembly in May 2019 adopted a landmark resolution urging Member States to introduce transparency policies and the Human Rights Council adopted a resolution on improving access to medicines in July 2019.

See Case Study 1 on the above mentioned World Health Assembly resolution.

→ The adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel in May 2010, which created a global framework, including ethical norms and institutional and legal arrangements, to guide international cooperation on the critical problem of health worker migration. Mandated in 2004, it took six years in all to draw up the Code of Practice. The art of compromise proved to be essential during the long and tortuous negotiations in order to reach a satisfactory but non-binding agreement for both countries of origin of health worker migration and destination countries (Taylor & Dhillon, 2011). More on global health instruments can be found in Chapter 5.

→ Since the entry into force of the FCTC in 2005, the biennial global progress reports prepared by the Convention Secretariat have provided a good overview of its implementation by the Parties. Although the rate of progress differs considerably from country to country, it is a tremendous achievement that, despite the tobacco industry's resistance, so many effective measures have already been taken to reduce the use of tobacco. Implementation has been most successful in the following three areas: the creation of smoke-free environments; the banning of misleading tobacco packaging and labelling; and education, communications and public awareness programmes. In general, though the implementation of the Convention's provisions has been quite uneven in many countries.

→ The International Health Regulations, in their revised version from 2005, are the key international legal instrument regulating the public health preparedness and response of countries to the international spread of disease. However, both the Ebola epidemic and the COVID-19 pandemic have highlighted a lack of preparedness. Many Member States have failed, for financial or political reasons, to build up adequate capacity and to honour their obligations to implement all the measures provided for in the IHR.

CHAPTER 10 | ANALYSING NATIONAL AND GEOPOLITICAL INTERESTS

10.1 Understanding the complexity of global health issues

Global health diplomacy has to deal with several complexities at the same time: the new complexity of the international system, the complexity of the organizations and actors operating in the field of global health, and the complexity of global health issues, which have strongly interlinked social, political and economic determinants. These complexities require upstream political responses at the national and supranational level. However, experience shows that negotiations in Geneva tend to follow a technical and segmented approach. Such an approach should be resisted because global health diplomacy cannot be dissociated from geopolitics.

A global health diplomat needs to be able to understand the national and geopolitical interests that may lie behind negotiations on a resolution or decision. There are several aspects to consider.

The world is going through a period of transition and geopolitical instability. Globalization continues to advance, which means that domestic conditions in a country are increasingly shaped by events and processes taking place elsewhere. At the same time, and somewhat paradoxically, confidence in and commitment to multilateralism are decreasing, which is leading to the rise of regionalism, nationalism and protectionism. In some parts of the world, the international order based on the rule of law has been openly challenged. In this tense atmosphere, health was until recently one of the few areas in which multilateral governance continued to be fully accepted and active. This changed during the COVID-19 pandemic, with the geopolitical stand-off between China and the United States leaving its mark on global health. Moreover, a new "vaccine nationalism" has emerged in several countries.

As members of a larger diplomatic network, health diplomats can benefit from the regular analyses of the state of the world and of specific regions, countries and issues conducted by specialized departments of their foreign ministry. A diplomat must make every effort to understand geopolitical changes. Similarly, it is important to understand different mindsets. In global health diplomacy – as in other areas of diplomacy – much of the academic analysis has been conducted from a Western perspective on international relations. Other perspectives and diplomatic cultures need to be taken into account, too.

10.2 Building relationships in Geneva and other negotiating hubs

Since global health issues are highly interconnected, they may come up for discussion concurrently or separately at different forums in Geneva, the main negotiation hub for global health diplomacy. Access to medicines, for example, has been and is being debated at the WTO, WIPO, the Human Rights Council, the ICRC, the UNAIDS Programme Coordinating Board and the Board of the Global Fund, as well as at WHO.

It is essential for diplomats to liaise regularly with fellow diplomats and with technical experts within the mission who are in charge of following up on the work of the various Geneva-based organizations. This may be easier in a small mission. In a larger one, it will require coordination – something that is done remarkably well in some of the largest missions in Geneva – and, most importantly, initiative, talent and energy.

Communicating with the non-health sectors and with colleagues in the mission who are responsible for those other areas will enable awareness of important issues that may first come up outside the health context. It will also contribute to coherence in the positions and language adopted by a country's delegation at different forums.

Communication with fellow diplomats from other missions in Geneva should take place both on a personal basis and within the framework of formal and informal groups, which may include groups such as the AU, the EU, constituents of the WHO regional groups, subregions (for example, West Africa) and gatherings of like-minded or donor countries.

10.3 Gathering available information

Studying documents and other information material from previous negotiations at WHO or other organizations helps in understanding better the subject matter and the national and geopolitical complexities behind an issue that is to be discussed.

Moreover, such information-gathering will shed light on the positions previously taken by negotiating countries. It also enables the compilation of examples of previously agreed language on the issue under debate or on other issues or processes relevant to the current negotiation. Resolutions and declarations adopted by consensus at the UN are the most promising in that respect. In negotiations on a controversial global health issue, referring to the language adopted at the General Assembly during the SDG negotiations in 2015 can serve as a good starting point for building consensus.

In contrast, drawing on the language used in conclusions and reports that were not approved by consensus is less useful for the above purpose. For example, the final report of the UN Secretary General's High-Level Panel on Access to Medicines, issued in 2016, anticipated to a great extent the resolution on transparency in the pricing of medicines that was adopted at WHO in 2019. However, the impact of that UN report was impaired by the disagreement between Panel members on a number of other issues in the document.

The importance of agreed language should not be underestimated. One particular UN forum may be more suited than another to endorse language or terminology on a sensitive issue. Language on sexual and reproductive rights and vulnerable populations at high risk of HIV infection has been adopted, for example in the UN General Assembly resolutions on HIV/AIDS and can be used as a precedent to support such language in other resolutions in other organizations.

10.4 Understanding positions

Understanding how Member States develop their positions for negotiations comes with experience. A senior diplomat in Geneva once remarked that she had spent most of her first year at WHO listening to debates and observing negotiations in order to understand better how geopolitics and national interests determine the issues taken up by Member States and are reflected in the positions they try to defend and promote. Countries normally take positions informed by their specific needs. To start with, these positions are often more radical than the interests they are seeking to defend, which creates some leeway for negotiation.

There are a number of issues that some countries will constantly raise or take a strong position on in a debate or during negotiations, for example NCDs (Russian Federation), primary health care (Kazakhstan), drug policy (Switzerland), substandard medicines (India), tuberculosis (South Africa) and sexual and reproductive rights (United States and the Nordic countries). The positions of some countries on these issues are often predictable over longer time periods – for example, the Nordic countries' support for sexual and reproductive health. In the case of the United States, it may depend on the administration in power.

While a common line is normally to be expected from EU Member States, some dissent may appear on issues such as sexual and reproductive rights or the prevention of NCDs. Similarly, the BRICS countries now constitute a less cohesive bloc than a few years ago.

China shows relative restraint at WHO but remains highly influential. Thus, China may ally itself with different countries on different issues – for example, with the Russian Federation on security
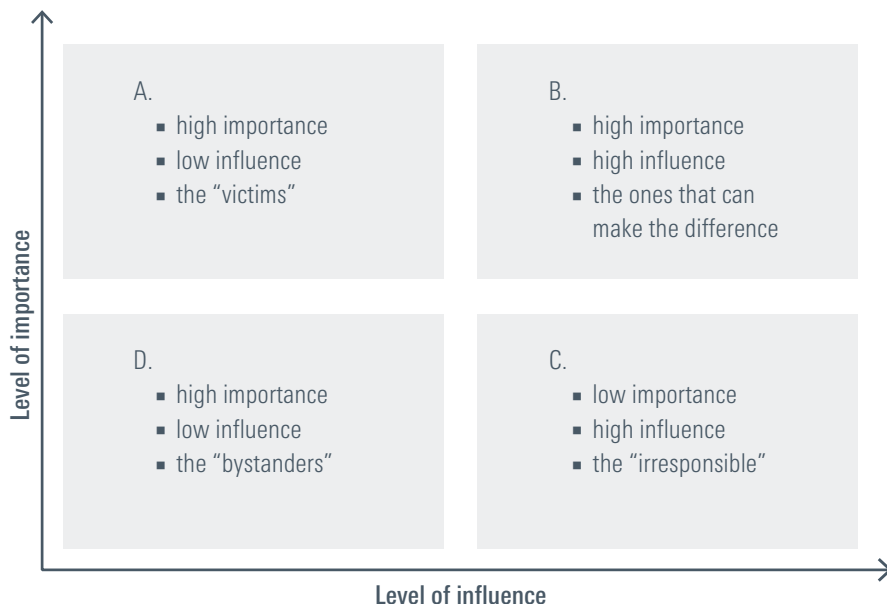
issues and with India and South Africa on medicines policy and transparency in the pricing of medicines. A global game changer was South Africa's historic legal challenge on access to cheaper drug treatment for HIV/AIDS. Usually in each region there are countries that are more vocal than others in global health forums.

As part of their stakeholder analysis, global health diplomats have to be able to recognize situations in which hidden interests, be they political or economic, determine a country's position or in which a smaller country is serving as a vehicle for the agenda of a larger country or entity.

10.5 Examining negotiation blocs and alliances

Health negotiations often see the long-standing blocs come together, although the geopolitical landscape has changed considerably since the first decade of the 21st century. The United States still often leads the way, entering into shifting and sometimes surprising alliances, though its once hegemonic position is weakening. The EU is a bloc that adopts a common position in negotiations, although countries such as Hungary and Poland tend to dissociate themselves from the EU consensus on such sensitive issues as lesbian, gay, bisexual and transgender persons, sexual and reproductive rights, or health and migration. The AU is another bloc, often strongly united when the issue under discussion is more political than technical – for example, an election within an international organization. There are of course several other regional blocs; they are described in more detail in Chapter 7.

When preparing for a negotiation it may be useful to analyse negotiation blocs, their members and other stakeholders with reference to the following diagram:

Source: Multi-Stakeholder Partnerships (http://www.mspguide.org/tool/stakeholder-analysis-importanceinfluence-matrix)

While a bloc may adopt a common position on the text to be negotiated, countries within that bloc may still express their own specific views once the negotiations have started. Any red lines decided on by the bloc will, however, be respected by the countries belonging to it.

A country's diplomatic representation will regularly study political groups and voting blocs in the UN context and how those operate. Some countries, such as the United States, are using publicly available UN records to track "voting coincidence" with their positions, while some researchers and think tanks have conducted analysis of voting patterns, which can be useful for diplomats.

An asset of being the member of a bloc, such as the AU or EU, is that the detailed preparatory work for negotiations may be undertaken by a member that has a particular interest in the issue at stake (referred to as the "penholder"). The other members can benefit from that work thanks to the relationship of mutual trust that exists within the bloc. Special groups – such as the Geneva Group, an informal group (established in 1964) of UN Member States each of which pays more than 1% of the UN's regular budget – also play an important role. Those blocs and individual countries that wield

great influence in global health – such as the EU, the AU, the United States, the United Kingdom, France, Germany, Japan or Brazil – tend to have a position on all the topics that may come up during negotiations. Many other national delegations will listen attentively to the debates but will intervene only on specific topics. The Russian Federation, for example, always participates vigorously in any discussion on NCDs and health security. Smaller countries with small Geneva-based missions – whose diplomats have to deal simultaneously with health, human rights and labour issues, and which have less expertise in global health to draw on in their capitals – will often participate less actively in the negotiations, unless the topic is essential to them. Some of these countries may be part of geographical groups (for example, the Middle East and North Africa) or of ad hoc alliances with larger countries or blocs that will defend their positions on their own and in conjunction with their allies.

An example of a permanent alliance is the South-Eastern Europe Health Network (SEEHN), which brings together nine countries, mostly from the Balkans. Established in 2001, SEEHN aims to strengthen national health systems, promote stability and help to prepare the region for EU integration. This cross-country cooperation now takes the form of health diplomacy, reflecting the weight of concerted actions, primarily in the WHO governing bodies. The lessons learned from engaging in health policy negotiations at the European level mean that SEEHN member countries have the potential to speak with an influential voice in global WHO negotiations as well.

CHAPTER 11 | COORDINATION WITH NON-HEALTH SECTORS

11.1 The interface between health and other sectors at the national level

The role of different sectors in advancing global health has not always been properly acknowledged. There is a long history of cooperation with some sectors, while cooperation with others has only recently increased or begun in the first place. Very frequently, opportunities are lost to promote health by addressing the health determinants in other negotiations. The sectors that can play an important role when it comes to taking a global health agenda forward are discussed below.

Foreign policy has a fast-growing interface with health. This is the result of multiple factors: the growing prominence of health in key global agendas (economic, security and social justice); the mounting pressure of global health challenges that call for global solutions; the proliferation of international actors and negotiations in the field of health; the rising profile of global health issues in the UN and influential political blocs; and the complex mix of synergies and asymmetries (often conflicts) between countries' health-related commitments and their other international commitments. The interaction of foreign policy and health is multifaceted: health can be an integral part of foreign policy; foreign policy and diplomacy can be used to promote – and often protect – health in multilateral forums; and health in turn can be used as a foreign policy instrument to achieve other goals. Because of its wide scope, the interface between health and foreign policy manifests itself in most health-related intersectoral relations in the multilateral arena.

Fiscal and budgetary matters have long been important factors in health policy in general and in making progress towards universal health coverage in particular. Relevant issues in intersectoral diplomacy for health include: bridging governments' approaches to health and finance; assessing political and institutional risks to the fiscal sustainability of health systems; creating mechanisms for cooperation between health and finance ministries (though this is difficult and not always effective in practice); cost-effectiveness analysis and price containment strategies for medicines and health technologies; and exploring innovative approaches to the financing of health (albeit with caution because of the economic distortion often brought by higher or new taxes).

International trade can both promote and impede health. Key issues related to the interface between trade and health include the cross-border spread of communicable diseases and food safety, which are linked to trade restrictions introduced on grounds of health; access to medicines and medical technologies, which is linked to import duties and intellectual property rights; trade in health-related services, which has to do with cross-country health insurance and care, telemedicine and medical tourism; and concerns over trade in unhealthy products such as soft drinks and tobacco. Several WTO global trade agreements – the TRIPS Agreement, the Agreement on Technical Barriers to Trade, the Agreement on the Application of Sanitary and Phytosanitary Measures and the General Agreement on Trade in Services – have substantial linkages to health. Moreover, there are a large number of trade agreements at the regional (often also bilateral) level.

Health, therefore, often comes to the fore in international trade negotiations – particularly the challenge of protecting public health interests vis à vis trade and economic interests. In recent years, the potential impact of international investment agreements on health has also become clear. Such agreements can, for example, be used to challenge strong national tobacco control measures. Vigilance and diplomacy are essential to protect public health interests in trade and investment negotiations.

Environment has a profound impact on health. WHO estimates that 23% of all deaths worldwide could be prevented through better management of the environment. The environmental determinants of health are manifold: they include, in particular, air pollution (both ambient and household), water and sanitation, chemical safety and radiation. Climate change is another global concern because of the health risks associated with extreme heat and water events, increased air pollution, food and water insecurity, and vector- and water-borne diseases. Consequently, it is important to coordinate efforts with a wide range of non-health sectors, including transport, housing, energy, agriculture, land planning, water management and industry. Global mechanisms and processes can facilitate national multisectoral dialogue. Examples of this include the International Decade for Action, "Water for Sustainable Development", 2018–2028; processes under several environmental treaties; and the ongoing global dialogue on climate change.

Education has a positive effect on health by improving people's employment prospects, income, living conditions, literacy, access to information and general life skills. Investing in education is synonymous with investing in health. Better health in turn promotes learning environments, opportunities and achievements. From a health diplomacy perspective, dialogue between the two sectors can be expected to take place in both intersectoral and multisectoral settings, since health and educational challenges often co-exist with other social challenges, such as housing conditions and unemployment. It is also worth taking into account the potential of relevant multilateral forums – that is, processes within the framework of UN human rights treaties and UNESCO treaties and

recommendations – to promote health and education at the same time.

Social and labour protection play a key role in health. Employment policies contribute to health by helping to generate sufficient income for households, promoting active lifestyles and access to health services, providing social benefits, fostering health-friendly working conditions and occupational safety, and preventing job insecurity. Good health in turn enables workers to work for longer and be more productive. Housing policies are vital in improving social and living conditions and preventing injuries and disease. The synergies between labour market and social policy, on the one hand, and the health sector, on the other, can help to reduce social exclusion and inequalities. Cross-sectoral diplomacy can tap into these synergies, both within a country and in multilateral forums such as the ILO.

Food and agriculture have traditionally been linked to population health. Effective agricultural policies can increase the supply and affordability of healthier and safer food, which is key in tackling the challenges posed by malnutrition, unhealthy diets, obesity, NCDs and foodborne diseases. Collaboration between the human and animal health sectors is critical in the fight against antimicrobial resistance. Coordination to ensure the production of healthier and safer food is required across the entire food supply chain from better and more sustainable production and processing models to accurate and informed nutrition labelling systems. There are also important linkages with other sectors, such as trade, environment, consumer protection and education.

From a global health diplomacy perspective, several existing multilateral mechanisms provide opportunities for cross-sectoral dialogue and cooperation, including the FAO/WHO Codex Alimentarius Commission, the FAO/WHO International Conferences on Nutrition, mechanisms under relevant WTO treaties such as the Agreement on the Application of Sanitary and Phytosanitary Measures and the Agreement on Technical Barriers to Trade, and the FAO–OIE–WHO tripartite collaboration on antimicrobial resistance.

Water is critically important for health. Access to clean water and sanitation facilities is a basic human right, and improving such access is an important target in the SDGs. Key issues related to water include quality standards, water supply, safety, access, storage and wastewater treatment. Cooperation between the health and water management sectors at the national and local level is fundamental to public health.

At the international level, health is often promoted through so-called water diplomacy, which is about resolving disagreements and conflicts over shared – and often scarce – water resources in the interests of cooperation, stability and peace. Several regional mechanisms support water diplomacy, including its interface with health. The Protocol on Water and Health (to the Water Conven-

tion[21]) is a good example of a targeted multilateral response in the pan-European domain. Other regional mechanisms have an impact on health by enabling broader cooperation on water management. Examples include the Mekong River Commission in Asia, the Water Charter of the Lake Chad Basin in Africa, the EU Water Framework Directive, and the Guarani Aquifer Agreement in South America. National intersectoral dialogue contributes significantly to such cooperation.

Transport is linked to health in many ways. Key concerns related to transport include road safety, air pollution, noise, congestion, greenhouse gas emissions, mobility constraints and sedentary lifestyles. Promoting safe, accessible and affordable public transport, along with walking and cycling, can significantly improve population health. The interface between transport and health is also linked to environmental and urban planning policies, and, more generally, to sustainable development. Intersectoral and multisectoral dialogue within countries is essential to improve transport-related health outcomes. Such dialogue frequently also occurs in multilateral forums – for example, the Global Ministerial Conferences on Road Safety, the UN Decade of Action for Road Safety 2021–2030, the Transport, Health and Environment Pan-European Programme conducted jointly by WHO and the United Nations Economic Commission for Europe (UNECE), and various multilateral forums dealing with air pollution, physical activity and NCDs.

11.2 Emerging linkages to other sectors

The health impacts of the sectors discussed in the preceding section have long been acknowledged. However, globalization and the greater influence of transnational factors on health have led to certain other sectors becoming more prominent in this context.

Law enforcement plays a growing role in public health. The areas of interaction between the two sectors include violence prevention, misuse of alcohol and drugs, road safety, catastrophes, sex work, mental health management, human trafficking and, most recently, illicit trade in tobacco products (along with **customs**, another sector with an emerging interface with health). More broadly, the interface also extends to community safety, public protection, migration, the management of disease outbreaks, and health in prisons. Cooperation between the health and law enforcement sectors can lead to improved health outcomes in countries. Such cooperation also helps to strengthen cross-sectoral diplomacy in the relevant international forums – for example, processes and mechanisms under the aegis of UNODC, negotiations to operationalize the Protocol to Eliminate Illicit Trade in Tobacco Products, and global debates on road safety and violence.

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21   Convention on the Protection and Use of Transboundary Watercourses and International Lakes (adopted in 1992).

The interface between **migration** and health is not new, but it has attracted particular attention in the 21st century. It is an area in which multisectoral, and multilateral diplomacy should reinforce each other. Action is needed both within and outside the health sector to meet the health needs of refugees and migrants and to alleviate the pressure that they put on the health-care systems of both transit and destination countries. Several non-health sectors are closely involved in this interface, including education, employment, social security, housing, law enforcement and foreign policy. In wider terms, the health–migration interface is directly related to the fundamental values of equity, solidarity and human rights. The recently adopted Global Compact for Safe, Orderly and Regular Migration and Global Compact on Refugees (both under the aegis of the UN) – along with relevant forums at WHO, the International Organization for Migration (IOM) and the Office of the United Nations High Commissioner for Refugees (UNHCR) – have created greater opportunities for multisectoral and multilateral dialogue.

Another emerging interface is that between health and the **information technology and telecommunications** sector, as testified by the growing interest in digital health worldwide. Thus, WHO has initiated cooperation with the International Telecommunication Union, established a multidisciplinary platform and issued its first set of guidelines on digital health interventions (2019). All of these developments have created new opportunities for strengthening cross-sectoral dialogue.

11.3 The health sector's role in cross-sectoral cooperation

The health sector plays a central role in cross-sectoral dialogue and coordination. Health ministries are expected to initiate such coordination, advocate joint solutions, provide evidence, negotiate responses and lead by example. Significantly, health ministries in most countries are not so adept at representing health interests in other sectors. This often proves to be a liability in global health diplomacy.

From a health diplomacy perspective, it is important that health ministries should persevere in putting health issues higher on their countries' political and foreign policy agendas. This strengthens the health sector's influence and convening power with regard to multisectoral dialogue in both the domestic and international arenas.

There are also other approaches that the health sector should consider in dealing with cross-sectoral issues. For example, it is advisable to strive for a whole-of-government decision on issues that have a significant multisectoral impact, rather than pressing ahead with a decision taken solely by the health ministry. Similarly, dialogue with and feedback from parliaments on major multisectoral issues can strengthen the political – and often legislative – support that parliaments are able to provide.
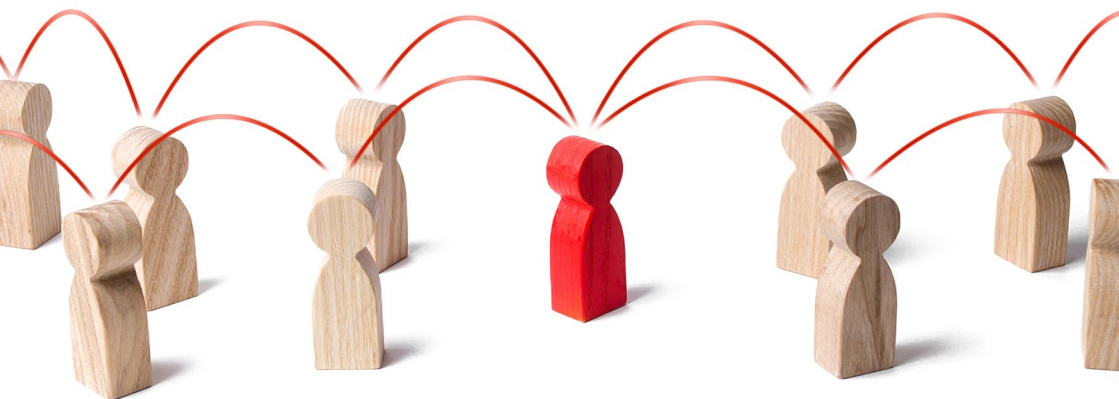
Conducting a health impact assessment of major economic legislation and initiatives at an early stage is another tool that health ministries can and often do use effectively. Finally, the health sector should harness the potential of relevant international legal instruments to achieve better intersectoral responses. For example, the FCTC contains binding obligations that impinge on several non-health sectors. Similarly, the comprehensive implementation of various non-health treaties (covering areas such as human rights, labour and the environment), to which most countries are party, can help to improve national health outcomes.

CHAPTER 12 | CONDUCTING GLOBAL HEALTH NEGOTIATIONS

Twelve tips for successful global health negotiations

1. Be prepared for all scenarios
2. Start by offering a clear road map, schedule and deadlines
3. Build trust with secretariat (WHO staff)
4. Understand the subject: read up on it and consult the experts
5. Know your partners and their strengths and weaknesses; identify how far they are willing to compromise (their red lines); consider how flexible they may be in their positions
6. Identify any vested interests: personal ambitions, geopolitical agendas and so on
7. Create alliances with key Member States, like-minded groups in the negotiation hubs, fellow diplomats and so on
8. Know and apply the rules of procedure
9. Adapt to the cultural context
10. Be aware of tactics: ask for time; introduce constructive compromises, package deals, face saving solutions and so on
11. Consider options outside the conference room: informal side meetings, coffee breaks
12. Remember that nothing is agreed until everything is agreed

12.1 Competencies for global health diplomacy

Competency can be defined as a set of skills, knowledge and attitudes that enable people to perform well at work. A recent qualitative study has explored the state of competency management in the Finnish diplomatic service, seeking to identify the main characteristics of a competent diplomat (Kallinen, 2016). The OECD has developed a competency framework for employees at the various levels of the Organisation (OECD, 2014). Many of the elements of this checklist-type framework also apply to global health diplomacy (see **Box 15**). WHO also has a competency model of its own.[22]

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22 See: https://www.who.int/employment/competencies/WHO_competencies_EN.pdf.

Effective global health diplomacy requires coordinated work by experts from various disciplines who have different sets of skills, especially experts from the fields of foreign policy and public health. Global health diplomats may come from the most diverse backgrounds and, consequently, the extent of their knowledge of global public health and health policy varies greatly. Experience suggests that the foreign affairs institutions tasked with training diplomats need to equip these with additional knowledge, skills and abilities in health communication, analysis and public health ethics so that they are able to promote global health more effectively. Similarly, public health institutions that train health professionals need to ensure that these acquire diplomatic skills and a good knowledge of foreign languages and foreign policy matters.

Negotiations at the World Health Assembly require Member States' diplomats and experts to wear several hats, so to speak: in addition to participating in the formal structure of the World Health Assembly (with plenary meetings and meetings of two committees), they also take part in meetings of drafting groups, and they are involved in regional consultations and informal meetings with counterparts from countries with similar interests and with non-State actors. Further informal interaction takes place at coordination meetings, side events and technical briefings. Informal meetings over coffee breaks and at receptions should not be underestimated either. Most of the substantial negotiations take place within the drafting groups, outside of the committees. NGOs are typically not allowed to attend meetings of drafting groups, which are reserved for Member States and essential WHO staff.

Ensuring that diplomats have a combination of different skills increases the professionalism of global health diplomacy negotiations and the likelihood of achieving successful outcomes. Thailand has systematically built national mechanisms and capacity for preparing young professionals for global health diplomacy. The authorities there have recognized the importance of training, developing skills and practising these in real-life situations such as the World Health Assembly.

12.2 Understanding values

Values are fundamental pillars in global health negotiations. Global health is about delivering global public goods. Human dignity and rights, equity and universal access are key principles that must be taken into account when seeking to achieve global health objectives. Since some countries may express their own values and preferences or insist on their own way of interpreting universal values, this may generate friction during negotiations on global health issues. Countries may even draw red lines, making it harder to reach an acceptable compromise. This is happening more frequently – not least in global health negotiations.

For example, the negotiations in New York in 2016 on the outcome document of the UN General

Assembly Special Session on the World Drug Problem could not overcome the red line drawn by countries opposed to abolishing the death penalty for drug-related offences. Those countries that consider capital punishment for such offences to be a violation of human rights finally agreed to relinquish their position and to sign a declaration that did not mention abolition of the death penalty. However, within minutes of the declaration having been adopted, these countries presented their opposing views at the General Assembly and expressed their reservations on the text of the declaration. They clearly felt that having no approved declaration as the outcome of the Special Session would have posed a higher risk to global health and human rights in the future than reluctantly agreeing to leave that matter out of the text.

There are a number of topics in global health negotiations with regard to which countries perceive universal values to be at odds with their own values or interests. Among these topics are equitable access to medicines (which poses a challenge to intellectual property frameworks and the interests of national pharmaceutical industries); sexual and reproductive rights; the rights of sexual minorities; out-of-pocket financing of health by citizens (an unacceptable concept for some countries); and harm reduction (despite having been recommended by WHO, such medical interventions remain unacceptable to a number of Member States).

Countries may sometimes draw their red lines on the strength of empirical considerations, rather than value-based arguments. For example, Finland's opposition to vaccinating everyone against hepatitis B is based on national epidemiological studies and considerations of cost-effectiveness. Yet, that stance is at variance with the notion of universal vaccination coverage aimed at achieving ultimate eradication of the disease.

12.3 Negotiation tactics and conflict resolution

What are the main negotiation tactics and why does WHO prefer decision-making by consensus?

In negotiation, "tactics" refer to the skilful use of the available means in order to reach a desired outcome. Two different types of negotiation tactics may be distinguished in global health diplomacy: **policy type tactics** (integrative bargaining) and **transaction-type tactics** (distributive bargaining).

In policy-type tactics, the parties share their views and values, and strive for reasonable compromises (or a win–win situation), as is usually the case during negotiations of the WHO governing bodies. In transaction-type tactics, power aspects are prevalent: one side usually wins at the expense of another, for instance when negotiating a commercial contract for the supply of medicines. The UN system prefers decision-making by consensus as it confers legitimacy on the outcomes of

negotiations: they are then more likely to be implemented and less costly in political terms. However, this approach is often time-consuming, masks political and ideological divisions, and can hinder rapid action in an emergency.

Integrative, or win–win, bargaining means that the parties seek to find a solution that leaves everyone better off. This approach requires the parties to collaborate and arrive at a compromise by making some concessions. It is the preferred negotiation strategy in global health diplomacy.

The essential elements of integrative bargaining in negotiations are:

→ Identifying interests – trying to understand the interests of each party and how these could be satisfied through a win–win solution.

→ People – separating the people from the problem. The better the relationship between fellow negotiators, the more likely it is that the best win–win solution will be achieved.

→ Alternatives – it is crucial to think about alternatives even before the negotiations start. If the negotiations do not result in an agreement, having alternatives means that the discussions can be resumed at a later point.

→ Options – proposing realistic options together with the other parties helps in attaining a win–win solution. This can be done through collective brainstorming.

→ Criteria/legitimacy – it may sometimes happen that two (or more) parties propose incompatible solutions. In such cases, opting for one solution, even if it seems fair, could lead to resentment. Instead, joint decision-making may help to reach an agreement.

→ Commitments – negotiations can only succeed if all parties honour the outcome and keep their promises.

→ Communication – good communication skills are important to achieve the best solution and may help to overcome the scepticism or hostility of other parties.

Distributive, or win–lose, bargaining is a competitive bargaining strategy in which one party gains only if the other party loses something. Global health negotiations try to avoid such a situation. The ultimate aim, in a distributive bargaining approach, is not to attain a win–win kind of situation but for one side to win as much as it can. Both parties will try to get the maximum share from the asset or resource which needs to be distributed.

Distributive Negotiation Strategy	Integrative Negotiation Strategy
Distributive negotiation connotes a negotiation technique wherein the parties try to gain maximum value for themselves, from definite resources.	Integrative negotiation can be described as negotiation strategy which attempts to settle the dispute, with a mutually acceptable solution.
Distributive negotiation is a competitive strategy.	Integrative negotiation uses a collaborative approach.
Distributive negotiation has a win-lose orientation.	Integrative negotiation is based on win-win orientation.
When the resources are limited, distributive negotiation is better.	Integrative negotiation is used when the resources are in abundance.
In distributive negotiation, the parties' self-interest and individual profit motivate the parties.	In integrative negotiation mutual interest and gain act as a motivation for the parties involved.
Distributive negotiation discusses only one issue at a time.	Multiple issues are taken into account in an integrative negotiation.
Controlled and the selective environment is there in a distributive negotiation.	The communication climate is open and constructive in an integrative negotiation.

Source: Vskills (2019).

How to handle conflicts?

Conflicts may arise at any point during a negotiation. The most common cause of conflict is opposing interests. Conflict resolution depends largely on using the following tactics:

→ It is important to develop good personal relations and mutual trust with the other negotiating parties, and to understand their perspective, cultural background, interests and constraints. An informal dinner early on during the negotiations can achieve a lot in that respect. The use of humour can sometimes help to lessen tensions; taking time out can also calm the atmosphere.

→ Understanding the background of the negotiation itself and of the various parties, as well as identifying the issues that matter, is essential. If it seems likely that a certain party will not make concessions, approaching other key actors with similar opinions to those of that party can be useful in terms of identifying ways of achieving a compromise.

→ Opening statements are vital in negotiations because they set a benchmark for the expectations of all the parties concerned. An optimistic opening statement sets high expectations, but the danger is that if the agreement reached falls short of those expectations, it may be per-

ceived as a failure, even though it is in fact a good outcome.

→ Restating core shared objectives including the basic principles that underpin global health and human rights helps to remind participants of their common values.

→ It can be very helpful to agree on objective measures of the outcomes that are to be achieved, as there is then a practical way of assessing the various solutions proposed.

→ Creative problem-solving to come up with new solutions is possible even during formal negotiations, but it requires the chairperson to demonstrate leadership and the parties to trust one another.

→ Generally, negotiators begin from a conservative position reflecting their own interests; they then make concessions, starting often with larger gestures and proceeding to small-scale adjustments in response to concessions made by other parties.

→ While it may seem important to achieve a particular outcome, if this can only be done by jeopardizing the later ratification or implementation of the agreement by other parties, the victory scored during the negotiations would be meaningless. It is therefore vital that as many parties as possible should be satisfied with the outcome.

→ Negotiating parties must remember that nothing is agreed until everything is agreed. This often means shuffling back and forth between different parts of the document and agreeing on several issues at the same time.

→ There are often late-night sessions especially on the final day, with the looming deadline for conclusion of the negotiations creating additional pressure on the parties to reach agreement. This means that diplomats have to be prepared for long hours.

12.4 Understanding the rules and procedures

A good understanding of the relevant rules and procedures is crucial in multilateral negotiations. In WHO, the rules of procedure of the governing bodies determine the course of the proceedings, dictating who may speak when and under which circumstances. The rules of procedure can also be used by delegations to gain tactical advantages.

Some key terms are defined below:

→ **Procedure** refers to the way in which the conference is conducted; it is set out in the rules of procedure.

→ **Rules of procedure** refer to a document describing in detail how a conference is meant to operate. The rules define the chairperson's responsibilities, and explain, among other things, how to deal with a procedural motion or what the consequences are of violating the rules. In the case of established conferences, the rules of procedure will typically have been agreed for previous sessions. For a new conference, the rules of procedure need to be agreed on by all parties before the session begins.

→ **Process** refers to the way in which a proposal is handled, in particular the sequence of steps involved. All relevant formal processes are also described in the rules of procedure.

12.5 Understanding global health actors and partners at home

Diplomatic skills begin with developing an ability to listen to and understand the views of others. The players in the field of global health are remarkably diverse, ranging from government, academia and the private sector to local communities and civil society. To succeed in global health diplomacy it is necessary first of all to enlist the support of national authorities. Moreover, it requires building a strong negotiating base in Geneva (and other international hubs) being familiar with the issues at stake and drawing on comprehensive analyses undertaken by experts, civil society and other relevant stakeholders. A carefully prepared position needs to be agreed on by the government. Several skills are necessary for these tasks, not least the ability to build a good work-

ing relationship with officials in capitals and with fellow diplomats in the forum at which the negotiations are taking place.

The first port of call in the government will be diplomats from the ministries of foreign affairs and development, and policy-makers in health. At the foreign ministry, one should consult the political advisers to the minister, the diplomats who manage relations with the UN and other multilateral organizations, and the diplomats dealing with continental/regional entities and with agencies that provide bilateral international development aid.

Understanding the role and strategic objectives of the health ministry, along with identifying key players in policy-making inside the ministry, is likewise essential. The health ministry is often focused on public health and public safety within national borders, and generally takes less interest in global issues, except for transmissible diseases, emergency preparedness and implementation of the International Health Regulations.

Within-country dialogue with the government should extend to other ministries – including those responsible not only for finance, trade and agriculture (that is, issues falling under the "One Health" approach), but also for education, gender equality and family – and to specialized entities, such as the national agency tasked with evaluating and supervising medicinal products. The linkages between health and other sectors are described in detail in Chapter 11.

12.6 Understanding the positions of other actors

Negotiations with other governments will be conducted in various capitals, but mostly they will take place as **"front-line diplomacy"** in Geneva and New York, and also in ad hoc multilateral forums. In Geneva, the negotiations primarily involve fellow diplomats from missions. At other negotiation forums such as the G7 or the G20, the front-line diplomats involved in the negotiation are called "sherpas".

In that respect, establishing and expanding **personal contacts** and **building networks** are an important asset for future negotiations. Networks may take the form of formal structures or alliances. However, the most effective networks are informal and based on interpersonal relationships.

Establishing a good relationship with like-minded delegations and building alliances are essential to secure a favourable outcome in negotiations. Alliances may be forged with natural partner countries – for example, within a regional or political bloc – or on an ad hoc basis, depending on the issue that is being debated. Although a partner government may have different views, this should not rule out seeking to build a personal relationship with its representatives.

Respecting other people's views and being sensitive to cultural differences are vital. In addition to skills, empathy (that is, the ability to see the world from someone else's perspective) and emotional intelligence (that is, the capacity to understand one's own emotions and those of others) can be critical. Always remaining courteous helps to keep the discussion going, even in a tense and difficult context.

Understanding a partner's position requires patience and the ability to put one's own convictions and opinions to one side for a while. It may be more difficult, though, to understand the reasons behind the position of other parties. Sometimes the reasons are immediately apparent – for example, if the negotiation is about a topic on which the other delegation has consistently taken a strong public stand (say, the United States on sexual and reproductive health, or the Russian Federation on harm reduction). Sometimes the reasons are less obvious, especially if they are linked to another item on the political or trade agenda of the country concerned. Thus, health may be used as a means of achieving other goals, such as promoting exports of medicines and medical infrastructure. In other instances, it may well be that the position adopted by a negotiating country is deliberately furthering the political objectives of a third party. It is critical not only to listen to what is being said but also to how it is said so that one can respond in the most appropriate way.

Finally, **assertiveness** is a prerequisite for being able to influence others and for moving towards a compromise solution in the negotiations. Assertiveness should be seen not simply as a personal skill: it is also influenced by how thoroughly one has prepared for the negotiations.

Engaging with nongovernmental organizations

Communities of various kinds and civil society as a whole are key stakeholders in global health. It is essential that civil society representatives should be meaningfully engaged in the preparatory work for negotiations on global health issues.

NGOs operating in the field of health are able to bring the perspectives of patients to the negotiating table. They are often able to reach vulnerable and stigmatized communities more readily than governments and health-care providers. The engagement of civil society and local communities ensures that health-care programming is more responsive to people's needs.

Civil society plays a further important role by gathering and analysing data that public entities cannot easily access. Networks of civil society organizations in Eurasia and other parts of the world, for example, have gathered most of the epidemiological data on HIV relating to sex workers and men having sex with men in countries where those groups are stigmatized and criminalized.

Engaging with civil society usually means getting in touch with umbrella organizations and networks, rather than individual NGOs. Networks and umbrella organizations can offer the perspec-

tives of their many member organizations and have often acquired considerable expertise in global health and global health diplomacy.

The Global Fund, the Gavi Alliance and UNAIDS are three multilateral decision-making bodies in global health in which communities and civil society are represented as negotiating partners in their own right, not simply as the providers of input for other negotiators.

Engaging with the private sector

The views of the for-profit private sector are not collected so frequently by diplomats when preparing for multilateral negotiations. Diplomats tend to sound out the pharmaceutical industry, for example, on specific issues, such as influenza preparedness measures.

The private sector's views are, however, clearly discernible in the forums at which negotiations take place. A number of umbrella organizations – for example, the International Federation of Pharmaceutical Manufacturers and Associations – are present in Geneva and other centres of global health diplomacy, and they engage very actively.

Engaging academic expertise

Preparing for negotiations requires a comprehensive understanding of the issue at stake and of the implications of the resolution or other document to be negotiated. This is the kind of information that a diplomat should be seeking from experts, usually those based in his or her country, though it is also possible to consult national experts working for a relevant international organization in Geneva. Within a constituency or alliance – for example, among EU or AU countries in Geneva – member countries may decide to delegate the task of collecting experts' perspectives to one particular coun-

try ("burden-sharing") with experience of the matter in hand so as to avoid duplication of efforts.

In a complex and interconnected world, there is a growing need for evidence and expertise to inform policy making. Expert analysis by scientists and academics can greatly support policy design. Scientists should share the best available evidence, but at the same time acknowledge the limits of what science can do. Policy-makers should be receptive to independent scientific advice, even when that advice is not what they expected or wanted to hear.

However, scientific evidence is only one of the many types of information that will feed into the decision-making process. The other inputs include ethical values, culture, politics and consideration of the impact that any negotiated decision or resolution could have on other policy areas. Thus, expert opinions should not be obtained solely from academia; it is important also to gather the views of relevant government entities, the private sector and NGOs.

Box 15: Competencies required to conduct global health negotiations

> → Ability to represent and combine two professional cultures (public health and diplomacy)
> → Knowledge of diplomatic relations and a multidisciplinary understanding of how issues such as security, trade, social justice and development impinge on global health
> → Awareness of new and emerging players in the field of global health
> → Knowledge of the evolution of global health diplomacy and an understanding of its key concepts and mechanisms, including governance in global health, global public goods and major shifts in the global political environment
> → Awareness of the determinants of global health and an understanding of their links to other aspects of foreign policy
> → Understanding of the moral and ethical value basis of global health, and of how such values are interpreted from different cultural perspectives
> → Familiarity with negotiation processes and skills in the practice of negotiation
> → Appreciation of the multinational and multilateral nature of global health diplomacy, including:
>> → the roles of key venues and actors and an understanding of their perspectives and how to engage with them;
>> → the instruments of global health diplomacy: international law, treaties, agreements, conventions, protocols, declarations, strategies and codes;
>> → the key mechanisms of global health diplomacy: advocacy, consultation, conciliation and arbitration.

12.7 Chairing negotiations

What is the role of the chairperson in (global health) negotiations?
The chairperson's role is to ensure that the negotiation process is conducted in an efficient and orderly manner, in accordance with the rules of procedure and to steer the process to conclusion. Before the negotiations start, a chairperson who is agreeable to all parties is elected to preside over the proceedings, assisted by a secretariat. The chairperson must remain neutral in the negotiations. This core principle of successful negotiations must be upheld consistently and not allowed to erode in a difficult geopolitical context.

The chairperson is critical to success in global health negotiations. In addition to ensuring that the rules and customary processes are being observed, he or she has considerable influence on the atmosphere prevailing during the negotiations. If the negotiations are not managed well, the desired outcomes are much harder to achieve.

What are the duties of the chairperson?
The chairperson's role is essential at all stages of the negotiation process. Before the negotiations start, the chairperson needs to prepare extensively, think about possible and desirable outcomes and consider how they can best be achieved. During the negotiations, if they proceed according to plan and towards achieving the goals that were set, the chairperson acts as a facilitator. However, if the negotiations move in a direction that could lead to unsuccessful outcomes, the chairperson needs to take a more active role and find creative solutions to attain the goals being pursued.

What kinds of challenges may the chairperson face during negotiations?
The chairperson is expected to act as a broker or facilitator, not as an interested party. In chairing meetings, health diplomats can face many challenges, including the following:

→ On the one hand, consensus-building takes time (this is often emphasized by low-income countries, which are concerned about the inordinate influence that rich countries may exercise); on the other, key donor countries are anxious for swift solutions to be found. Behind this antagonism one may detect the perennial dilemma at WHO between being strictly technical and aspiring to a political role. However, the international community actually expects both, namely evidence based policy solutions.

→ Geneva-based diplomats can be given too much weight in the discussions. Not so many missions have a well-prepared health attaché or sometimes even just a specialist in health. This leads to time-consuming consultations with the national authorities in the capital.

Which qualities are essential in order to lead negotiations successfully?
The chairperson needs to possess certain qualities if he or she is to lead the negotiation process successfully:

→   an encompassing vision of the values of global health and awareness of the political context and of the situation as seen from all perspectives, so that he or she can frame the issue in a way that can be accepted by all participants;

→   the emotional intelligence to understand and empathize with different perspectives and the ability to influence thinking and action across national, cultural and institutional boundaries by fostering shared understanding and a sense of common purpose;

→   the ability to encourage and draw on shared leadership by other individuals, institutions and organizations with different skills and perspectives, encouraging these to act together to achieve common goals;

→   the personal integrity, self-awareness, patience and self-control required to lead the negotiations in an impartial manner and to speak truth to power where necessary, thereby earning the trust of people from different countries and organizations; and

→   the courage to step beyond the conventional, to take the initiative and to lead.

How can the chairperson influence the negotiation process?
There are certain resources through which the chairperson is able to influence the negotiation process:

→   the rules of procedure and customary processes: these define the chairperson's powers, and process options that can be used judiciously to steer the negotiations in a productive direction (for example, proposals of the "Chair's text" type);

→   atmosphere: the chairperson plays a major part in ensuring that the atmosphere remains positive and constructive;

→   time: the available time depends to a great extent on the chairperson, who may allow more time for certain agenda items or restrict the time available for interventions that do not serve the desired outcome;

→   control over opportunities to speak: the chairperson determines who has the right to speak at any given point of the proceedings. He or she may thus give the floor to underrepresented

groups and encourage constructive interventions, and, conversely, restrict speaking opportunities for those whose interventions are unhelpful;

→ information: the chairperson closely monitors the negotiation process and usually has the most information thanks to his or her discussions with the parties;

→ support: the parties understand that in order to achieve an outcome that is satisfactory to everyone, they need to support the chairperson throughout the process; and

→ prestige: the chairperson has been agreed on by all the parties and is the acknowledged leader of the negotiations.

Two examples of memorable achievements in the chairing of WHO negotiations are given below:

→ The final deliberations on the **WHO Global Code of Practice on the International Recruitment of Health Personnel (2010)**: the World Health Assembly at its Sixty-third session immediately sent the technically well-elaborated draft to a closed-door drafting group with an experienced chairperson from Thailand to focus on the text, rather than ideology. The chairperson did not allow any political debates and went through the text of the draft Code, provision by provision, until consensus was achieved. However, many compromises were necessary. For example, the prescriptive nature was toned down by dropping terms such as "standards" or "comply" and by changing "should" to "should consider": without these changes, the target countries would have rejected the Code. It became clear later that the price of the much-lauded consensus was further deficiencies in implementation owing to the softened text.

→ Negotiations on the **Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and Access to Vaccines and Other Benefits (2006–2011)**: after four years of bitter acrimony, agreement on the Framework was reached in an open-ended working group chaired by the Mexican and Norwegian ambassadors at the time, who were able to secure Member States' approval after a special understanding with the chief executive officers of major companies had been drawn up outside the formal negotiations.

CHAPTER 13 | EXAMPLES OF GLOBAL HEALTH DIPLOMACY

This chapter presents some recent examples of global health diplomacy. They were selected to reflect the wide spectrum and complexity of negotiating health issues multilaterally in the 21st century, and also to illustrate the various features and types of relations in global health diplomacy described in the previous chapters.

13.1 Access to medicines

One of the most long-standing and controversial issues in global health diplomacy is access to medicines. This topic must be considered in relation to the broader questions as to who will benefit from scientific and technological progress, and to what extent is knowledge a global public good. The costs of medicines are no longer a burden solely for developing countries: progress in areas such as the development of cancer medicines has created a financing challenge for high-income countries as well.

The WTO's globalized system of intellectual property rights has led to a new generation of multilateral, regional and bilateral negotiation processes and arrangements in areas of intersection between trade, intellectual property and health. The WTO agreements count as hard law and are underpinned by a binding dispute settlement mechanism, which provides for the imposition of sanctions for non-compliance. A central pillar of the international patent regime is the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), an international legal agreement between all the WTO member countries that lays down minimum standards for national governments' regulation of many forms of intellectual property. The TRIPS Agreement was negotiated between 1989 and 1990 and is administered by the WTO. Developing countries were opposed to many elements of the Agreement. As far as health is concerned, they were able to secure a number of "flexibilities", which were reiterated in the Doha round of trade negotiations launched in 2001 but still left much to be desired. The negotiations on intellectual property, in particular, illustrate both the lobbying power of pharmaceutical companies and the advocacy power of civil society. Although neither pharmaceutical companies nor civil society organizations are involved directly in the negotiations, they do exert significant influence on national positions and on public opinion in the WTO member countries.

Access to medicines is also a perennial subject of debate at WHO. After some unusually controversial and heated negotiations, the Seventy-second World Health Assembly in May 2019 adopted a landmark resolution (WHA72.8) to support greater public disclosure of prices for medicines and other health products (see **Case Study 1**). Even though WHO resolutions count as soft law, the Member States departed on this occasion from their usual consensus-based approach to health diplomacy: several of them openly expressed their disagreement with both the content of the proposed resolution and the negotiation process. It was also the first time that a concerted Twitter campaign was launched by civil society, in which ministers and officials from countries opposing the resolution were subjected to personal attacks.

The process and methods used in the above-mentioned negotiations suggest that the consensus based approach to global health diplomacy may no longer be the sole modus operandi at WHO.

13.2 Vaccine diplomacy

The COVID-19 crisis has forcefully revived the field of vaccine diplomacy by re-opening the debate on how to ensure affordable and equitable access to vaccines of global public interest.

At the time of publication of this guide and as vaccines begin to be rolled-out, significant gaps exist between countries in the level of access to vaccines, diagnostics and essential supplies. It is anticipated that most upper-income countries will see coronavirus vaccines widely available between September 2021 and March 2022, large middle-income countries and emerging economies – between September 2021 and summer of 2022; a number of other middle-income countries in 2022 and low-income countries between spring of 2022 and 2023.

Vaccine diplomacy refers to all aspects of global health diplomacy pertaining to the development, manufacture and delivery of vaccines as public health goods. Among the key features of vaccine diplomacy are its potential as a humanitarian intervention and its proven role in helping to mediate the cessation of hostilities and ceasefires during vaccination campaigns.

Modern vaccine diplomacy starts with the creation of Gavi, the Vaccine Alliance in 2000 after it was recognized in the late 1990s that coverage of the six basic vaccines under the WHO Expanded Programme on Immunization had been stagnating or declining, and that other vaccines, including new potentially life-saving ones, were too expensive for developing countries.

The Gavi Alliance was established to bring UN agencies, governments, the vaccine industry and other branches of the private sector, and civil society together with a view to improving childhood

immunization coverage in poor countries and providing future purchase guarantees for new vaccines. By 2018, Gavi-funded programmes had reached over 700 million children. Many countries gained access to vaccines against rotavirus and *Haemophilus influenzae* type B. The Gavi Alliance also facilitated the development of a new vaccine against *Streptococcus pneumoniae*.

The outbreaks of SARS, H1N1 influenza, Ebola, MERS and Zika, along with the growing problem of antimicrobial resistance, have made the production, financing and availability of adequate and effective vaccines an even more sensitive political issue. Geopolitical and national interests have hampered negotiations on vaccination. A "securitization" of the public health agenda made itself felt in these negotiations, as did lobbying by health and pharmaceutical industries. Increasing insistence on national sovereignty has slowed down global talks. Notably, during the long process of the WHO-convened Intergovernmental Meeting on Pandemic Influenza Preparedness: Sharing of Influenza Viruses and Access to Vaccines and Other Benefits (2007–2010), Member States failed to come to an understanding for years because they could not agree on the assets to be provided to developing countries. Indonesia, for example, was reluctant to share viral sequences. A compromise was eventually reached whereby pharmaceutical manufacturers were no longer permitted to access data on and samples of circulating viral strains for the development of influenza vaccines unless they committed to benefit-sharing arrangements, including the provision of a certain percentage of influenza vaccines at heavily discounted prices. Other benefits included such measures as technology transfers and improved access to diagnostic reagents and influenza test kits – resources that many low-income countries had previously been struggling to obtain.

The COVID-19 pandemic has abruptly brought back the question of how a vaccine – if an effective one can ultimately be developed – will reach everyone who needs it.
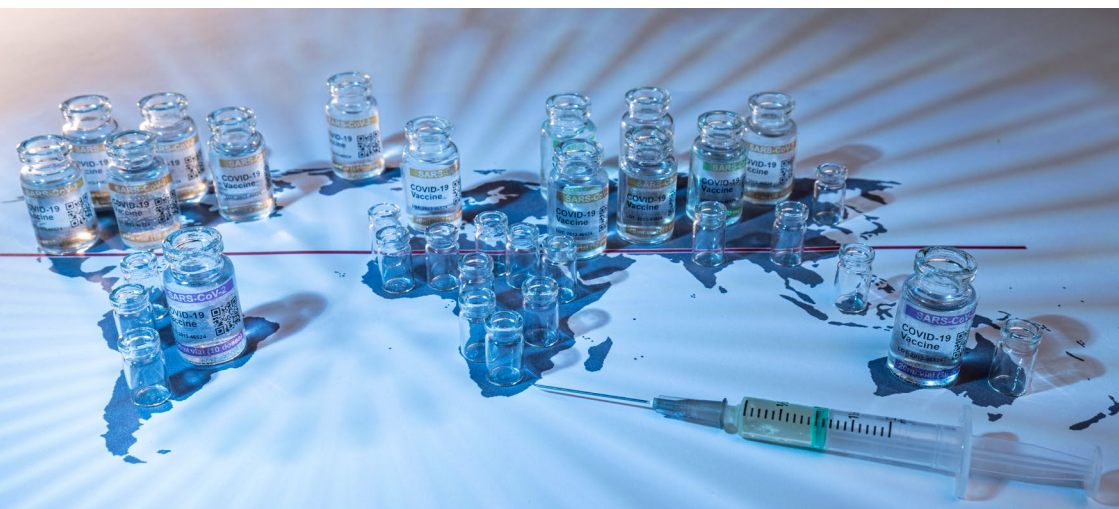
Political and global leaders have called for a COVID-19 vaccine to be treated as a global public good that should be available to all.[23] The full potential of vaccines cannot be realized if national interests and economic power determine who gets access, instead of basic principles of fairness and ensuring that allocation will optimize their public health impact. Nevertheless, rich countries have rushed to place advance orders in order to ensure vaccine access for their citizens, since it is expected that supply will be limited. This raises important questions concerning vaccine access for people in developing countries, particularly in middle-income countries that are not eligible for support from the Gavi Alliance or other international aid mechanisms.

The task of addressing the key questions of how to develop effective global cooperation and who should be given priority access has been pushed aside by the current disarray of multilateral health governance and by the nationalistic and free-market-driven, competitive approaches taken by some countries.

On the other hand, there are several vaccine diplomacy initiatives that point in the right direction. The alliance between several EU countries for pooled advanced purchase of vaccines, for example, requires the pharmaceutical companies with which the EU contracts to make a portion of vaccine supplies available to low-income countries. The COVAX Facility – which brings together WHO, the Gavi Alliance, the Coalition for Epidemic Preparedness Innovations (CEPI) and industry – allows the participating countries to pool their resources so that they can back the development of a larger number of candidate vaccines than any single country could do on its own. This initiative further uses "push" investments in manufacturing facilities and "pull" mechanisms (advance purchase commitments) to encourage manufacturers to invest in scaling up vaccine production and help share the risks. If a vaccine is successful, doses as they become available will be distributed equitably through the COVAX Facility between self-financing countries (there are currently 75), which will pay for their doses, and developing countries (currently 90) that would otherwise be unable to afford the vaccine.

Massive resources have been channelled into R&D work on a COVID-19 vaccine. Ensuring equitable access to such a vaccine will require strong global governance and the use of vaccine diplomacy.

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23   UNAIDS. Uniting behind a people's vaccine against COVID-19. Geneva: Joint United Nations Programme on HIV/AIDS; 14 May 2020 (https://www.unaids.org/en/resources/presscentre/featurestories/2020/may/20200514_covid19-vaccine-open-letter, accessed 16 November 2020).

13.3 Air pollution

Scientific evidence can play an important role in negotiating major agreements. Over the past decade, WHO has become increasingly involved in tackling the problem of air pollution. One major milestone was the adoption of a World Health Assembly resolution and an associated road map in 2015 to address this mounting global health challenge. In terms of health diplomacy, the resolution and road map paved the way for a broad inter-agency collaboration with the UN and other international organizations. They have also strengthened cooperation between WHO and urban health networks – a significant development given that city health diplomacy (see **Box 16**) is rapidly becoming an important element of global health diplomacy in the 21st century.

Air pollution moved further up the global health agenda in 2018, when it was recognized, at the third UN High-Level Meeting on the Prevention and Control of Noncommunicable Diseases, as a fifth key risk factor for NCDs alongside the established "quartet" of tobacco, alcohol, unhealthy diet and physical inactivity.

Many of the drivers of air pollution, such as the combustion of fossil fuels, lead to the emission of carbon dioxide and other short-lived climate pollutants, including ozone and black carbon, which greatly contribute to climate change and affect human health. Accordingly, WHO has stepped up its knowledge-based activities during major negotiations on climate change within the UN framework, notably at the UN Climate Action Summit held in New York on 23 September 2019 and during the 25th session of the Conference of the Parties to the UNFCCC, which took place in Madrid from 2 to 13 December 2019. WHO had been mandated by the UN Secretary-General to help develop two health-related commitments for the Climate Action Summit, namely (a) to save lives by cutting carbon emissions and cleaning the air; and (b) to boost investment in climate action, public health and sustainable development. WHO provides negotiators with evidence on the health impact of climate change by quantifying and monitoring the effects of exposure to air pollution.

At the regional level, multilateral cooperation on air pollution has an even longer history. One notable achievement was the adoption of the Convention on Long-range Transboundary Air Pollution in 1979 under the auspices of UNECE. As the first international treaty in this area, it provided legal and policy space for measures to protect both human health and the environment against transboundary air pollution. The Convention is an example of what multisectoral, and science-driven diplomacy can achieve at the international level.

Box 16: City diplomacy for global health

A guide to global health diplomacy cannot prescind from acknowledging the now well-established role that subnational entities play in global governance. Among the many actors at this level, cities have arguably been some of the most proactive on the world stage for the better part of the past three decades. This box gives a brief overview of the recent rise of "city diplomacy" and the current challenges in the intersection of such diplomacy with global health.

Cities have been in the spotlight across many global agendas, not just as an issue or as places, but more and more formally called upon by multilateral initiatives and frameworks as **international actors in their own right**. In turn, many local governments no longer defer to national governments when developing strategies and terms for international engagement on key issues.

Mayors, city councils, metropolitan commissioners and representatives of local authorities are reaching out directly to one another and more broadly to international actors, including corporations, United Nations (UN) system agencies, and overseas nongovernmental organizations. There are now hundreds of formalized international cooperation mechanisms that have been established by cities (**city networks**), giving cities a voice in discussion on many global issues, such as the climate change agenda and the Paris Agreement or the Sustainable Development Goals (SDGs). This means that cities have been accorded a key role in responding to major transnational challenges. The COVID-19 crisis has further accentuated the front-line role of cities: as of September 2020, approximately 95% of COVID-19 infections had occurred in urban settings, with over 1500 cities affected worldwide. Accordingly, the UN Secretary-General has called for a clearer understanding of how the pandemic, like other health challenges, is unfolding in an urban world. For their part, numerous cities and city networks have quickly activated their city diplomacy connections to form COVID-19 task forces, repositories of policy actions and mechanisms for the exchange of best practices. Yet, city diplomacy should be understood in the context of a nascent **global urban governance**, not simply as city-to-city exchange.

A brief history of city diplomacy is telling in that respect. The modern evolution of cities' international engagement comprises at least three different "generations". City diplomacy has gone from more culture-based city-to-city relationships to a complex mechanism and circuit for international coalition-building and policy exchange, even in the wake of the considerable COVID-19-related impacts on international travel and cooperation. While the first modern generation (early 20th century) of city diplomacy was based on formalized, bilateral **"sister cities"**, a second (mid to late 20th century) generation has scaled up these twinning networks to more formalized **city network coalitions for advocacy and exchange**, often backed by UN specialized

agencies. The mid-1990s were the heyday of efforts towards more formalized city health diplomacy through the work of the European Healthy Cities Network under the aegis of the World Health Organization (WHO) and other regional efforts such as the Alliance for Healthy Cities (in the Western Pacific). Nowadays there are other similar, albeit more specialized, networks such as the WHO Age-Friendly Cities project.

The 21st century has, however, seen the emergence of a more complex realm of urban diplomacy, not least in health. This has led to even more specialized and often purpose-built networks that are closely intertwined with private and major philanthropic investments. City diplomacy is engaged directly in **localizing major global agendas** such as the 2030 Agenda on Sustainable Development. In health this includes the launch of initiatives such as the Bloomberg Philanthropies-backed Partnership for Healthy Cities within WHO, or the localization of the health-related SDGs via the WHO Shanghai Consensus on Healthy Cities. Understanding city diplomacy from this angle allows greater room for manoeuvre beyond twinning and city-to-city cooperation, and gives a clearer idea of the intersections between cities and global governance.

Although potentially paradigm-changing, the COVID-19 crisis has not affected the impetus for city diplomacy. City governments still recognize the importance of engaging internationally but lack the necessary formal diplomatic training and resources for doing so to maximum effect. Nevertheless, cities' commitment to global agendas such as the SDGs (and not least their health related premises) remains strong, and international frameworks are increasingly influential in municipal affairs. Cities remain confident in their capacity to tackle global challenges. The crisis has also prompted **attention for global health beyond the health sector**: thus, health and well being are now covered by city diplomacy efforts originally focused on other sectors (for example, the environment in the case of the C40 Cities Climate Leadership Group, or migration in the case of the Mayors Migration Council).

Nevertheless, the role of city diplomacy in global health remains relatively limited compared with its role in other areas such as migration, climate or resilience. Cities and urban issues continue to occupy very modest positions on the global health agenda. Apart from the self-organized initiative of city networks, cities are at present still very much on the sidelines of official multilateralism. WHO, for instance, still does not have a major unit for cities and has relegated the topic of urban health to relatively few, often regional, conversations. More broadly, as in many other global policy areas, **capacity-building and investment remain critical** at the local level, where there are significant constraints on budgets and training opportunities for "city diplomats". Recognition and institutionalization of an urban voice are still a key challenge.

13.4 Trade, intellectual property and health

Following the Doha Declaration on the TRIPS Agreement and Public Health of 2001, the interface between trade, intellectual property and health has become one of the main focuses of global health diplomacy in the 21st century. This interface is also one in which the multilateral and multi-sectoral dimensions of health diplomacy are most closely interconnected. The present Guide accordingly deals with it in various places, notably Chapter 11 (covering intersectoral aspects), Chapter 8 (policy coherence), Chapter 7 (regional health diplomacy), Section 13.1 (access to medicines) and Case Study 1 (on price transparency). Dialogue on health and trade (and on intellectual property in most cases) is taking place in national, multilateral and inter-agency settings alike.

Dialogue in national settings typically occurs in multisectoral committees covering a wide range of issues affected by trade. In some cases, however, when health arguments are strongly articulated by stakeholders, governments have established a dedicated mechanism (ad hoc or standing) to assess the health impact of international trade. As the trade and health sectors are rarely involved in each other's respective spheres, such intense interaction increases mutual understanding of the issues at stake.

International health-related trade disputes, too, foster closer intersectoral cooperation. Australia, Norway and Uruguay, for example, successfully defended – at, respectively, the WTO, the EFTA Court and the International Centre for Settlement of Investment Disputes – the tobacco control measures they had introduced as part of their implementation of the FCTC. These cases highlighted an emerging phenomenon, namely how a new international legal regime in health (the FCTC) can help to balance the legal arguments on both sides of the trade and health interface, which in the past was overwhelmingly dominated by the legal power of trade and investment agreements. In a contrasting trend, regional and bilateral trade and investment agreements provide generally lower protection for health than the flexibilities contained in the WTO's global regimes. It is therefore important for the health sector to become proactively involved in the negotiation of such agreements.

In the inter-agency arena, a recent notable example of dialogue and cooperation is the second edition (2020) of the trilateral WHO–WIPO–WTO study on promoting access to medical technologies and innovation. Building on the first edition (2013), the new publication is meant to support dialogue and decision-making in this highly complex policy interface, thus serving as an invaluable resource at a critical time for global health.

13.5 Antimicrobial resistance

The problem of antimicrobial resistance (AMR) is attracting growing attention in the 21st century, and there is a need for more effective coordination of national intersectoral efforts to tackle it. In terms of health diplomacy, several factors and processes lie behind a steep increase in multisectoral and multilateral dialogue on AMR.

First, multisectoral action involving the health, agriculture and veterinary sectors – something that is not easy because of their frequently diverging approaches – has truly become a matter of urgency in view of the scale of the problem.

Secondly, several international initiatives and platforms have been launched within a short period, including the WHO Global Action Plan on Antimicrobial Resistance (2015), the Political Declaration of the High-Level Meeting of the UN General Assembly on Antimicrobial Resistance (2016), the G20 Osaka Leaders' Declaration (2019), the FAO–OIE–WHO tripartite collaboration, the UN ad hoc Inter-agency Coordination Group on Antimicrobial Resistance, several regional and bilateral platforms, and the Global Antibiotic Resistance Partnership (which focuses on low- and middle-income countries). A further mechanism, the AMR Multi-Partner Trust Fund, was established under the auspices of the FAO–OIE–WHO tripartite partnership. This proliferation of international mechanisms has required concerted multisectoral input from governments, thereby also encouraging the development of national multisectoral strategies within a relatively short period.

Thirdly, the international and inter-agency cooperation on AMR arose against the backdrop of existing collaborative arrangements in some closely related fields, such as the Codex Alimentarius Commission and the International Food Safety Authorities Network, both under the dual auspices of WHO and the FAO. These were important institutional foundations to learn from.

Fourthly, solutions in the fight against AMR are linked to broader ("One Health") and parallel (pharmaceutical innovation and R&D) concepts and processes. This is reflected in some global mechanisms,[24] and also in the One Health Global Leaders Group on Antimicrobial Resistance that is to be convened by the FAO–OIE–WHO tripartite partnership on behalf of the UN Secretary-General. Other sectors of relevance for these efforts are the environment, industry, economy, trade and intellectual property rights.

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24   For example, the Global Antibiotic Research and Development Partnership (launched jointly by WHO and the Drugs for Neglected Diseases Initiative) and the World Bank's One Health Operational Framework for Strengthening Human, Animal and Environmental Public Health Systems.

On the whole, AMR is one of the main items on the global health agenda of the 21st century. It is closely linked to other politically and technically complex areas, such as the One Health approach, R&D and innovation, and therefore requires increasing international (and intersectoral) diplomacy and negotiations so that global solutions can be found.

13.6 Migration and health

One important lesson from the global dialogue on migration and health is that coherent inter-agency work and national intersectoral convergence can be mutually supportive when applied to a relatively new – and acute – global health challenge. This is exemplified by the process leading to the World Health Assembly's adoption, in May 2017, of the landmark resolution WHA70.15 on promoting the health of refuges and migrants and of the corresponding Framework,[25] which was subsequently cited in the UN Global Compact for Safe, Orderly and Regular Migration (hereafter the "Global Compact"). Synergetic work by WHO, the IOM and the UNHCR during the preparatory work and negotiations on resolution WHA70.15 went hand in hand with political leadership by a group of core countries. That inter-agency work also provided evidence for and impetus to the pursuit of national intersectoral convergence in support of the multilateral process – particularly in countries with less technical and diplomatic resources. This is important because of the limited knowledge of this area of public health and the many misconceptions and divergent views that have arisen.

The incorporation of health into the Global Compact – itself a complex political document of a highly intersectoral nature – posed a number of challenges for health diplomacy. First, one must bear in mind that negotiations at UN Headquarters in New York are led by foreign ministries and diplomats and are highly political, offering fewer opportunities for day-to-day specialized input than negotiations in Geneva, where WHO, other relevant specialized agencies and the health focal points of countries' permanent missions are based (see also Chapter 6). Significantly, the health sector was very poorly represented at the crucial Intergovernmental Conference to Adopt the Global Compact held in Marrakesh, Morocco, in December 2018, in contrast to ministries of the interior, labour, social welfare and foreign affairs. This goes to show that when negotiations on a major international instrument with implications for health are taking place in highly political settings outside Geneva, it is essential, on the one hand, for WHO to work together with Member States and like-minded international agencies, and on the other, for health ministries to engage actively with their national delegations, so as to ensure that health aspects are adequately reflected in the outcome of the negotiations.

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25   WHO Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants (2017).

Secondly, health had not been identified as a specific topic for thematic sessions at the start of the negotiation process for the Global Compact. It thus proved necessary to make use of other relevant platforms, such as side events at high-profile events and the WHO–IOM global consultations on migrant health, in addition to advancing priorities and principles already adopted by WHO and promoting linkages to major international instruments, such as the Universal Declaration of Human Rights, the relevant International Covenants[26] and the SDGs. Another key lesson from the process of including health in the Global Compact is, therefore, that using parallel platforms and harnessing the power of universally recognized existing instruments can play a critical role when promoting health interests during negotiations at the UN on a document of broader scope.

13.7 Concluding remarks

All of the examples presented in this chapter demonstrate that tackling complex global health challenges calls for **multilevel diplomacy** (that is, involvement in negotiations in different forums) combined with **multi-stakeholder diplomacy** (involving different types of actors), usually over a significant time period. Global health diplomacy efforts on complex issues have become more difficult owing to the large number of actors and the diversity of cultures and diplomatic styles. Together with a weakening commitment to multilateralism, this is making it **harder to reach agreement** (as reflected in the failure of the 25th session of the Conference of the Parties to the UNFCCC to agree on global carbon markets) and leads to **increasingly unpredictable outcomes**.

These examples also illustrate another significant new development in international relations: the way in which **international organizations are becoming important players** in multi-stakeholder diplomacy, as shown by the involvement of WHO in G7 and G20 summits and various inter-agency arrangements in the above areas. International civil servants are increasingly perceived to be **defending supranational interests**, namely the production and supply of global public goods. This is very much the case with diplomatic efforts on, for example, environmental protection and health.

The examples further serve to illustrate **synergistic health diplomacy**, which is yet another feature of contemporary global health diplomacy – namely, where States strive for the synergistic interaction of diplomatic efforts at various levels and within the framework of different organizations, processes and meetings.

26 The International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (both adopted in 1966).

Finally, some of the examples of global health diplomacy discussed in the preceding sections – particularly those related to trade, migration and antimicrobial resistance – highlight, from various angles, the importance (and complexity) of achieving national intersectoral coordination and policy coherence in multilateral processes and negotiations.

Box 17: Preparing for negotiations in Geneva

Preparing comprehensively for negotiations involves several key actions and the judicious engagement of relevant stakeholders and partners at the country level and in Geneva (or wherever the negotiations take place). All the actions are useful (to varying levels depending on the negotiation in question) but are not necessarily sequential – often all are done simultaneously, or in a different order depending on the issue and level of negotiation.

Action 1
The first step is to study the history of the matter under discussion. You should consult documents that will help you to understand the background to the resolution or other text to be negotiated.

It is also important to be aware of (a) the positions adopted by your country on the matter in previous negotiations; and (b) the positions adopted both by like-minded countries and by countries known to have different views.

Action 2
The second step is to identify the issues or language in the text under discussion that are likely to provoke controversy during the negotiation process.

Again, looking back at earlier negotiations on the topic is essential. For example, referring to sexual and reproductive rights has always sparked concerns among a specific group of countries across the world while receiving strong support from another group.

Action 3
The third step is to mobilize experts so that you can achieve a comprehensive understanding of the matter under discussion.

The experts may be based in a country's capital, either within or outside the health ministry, foreign ministry or another relevant ministry. Further considerations on the role of different sectors are to be found in Chapter 11.

Requests may also be received by a country's mission in Geneva to supply the national authorities in the capital with additional expertise. This is because on some issues – as was the case with the outbreak in early 2020 of a poorly understood influenza-like disease in Asia (later named COVID-19) – the most relevant information may reside in Geneva at the World Health Organization (WHO), rather than in the country's capital.

Expertise may be national – this includes the expertise of nationals who are working for international organizations in Geneva – or international. There is a large pool of experts in global health in Geneva in particular, but also in New York, other international hubs and in universities around the world. Great care should be taken to include experts from the Global South.

An important point worth stressing is that it is often best to seek expertise by contacting people from an existing personal network. To continue with the example cited above, an expert opinion on the influenza-like outbreak in Asia (later named COVID-19) would possibly be obtained more readily from an expert known to you personally than by contacting a research institute.

The above recommendation may not be relevant where countries have a strong team of experts based at – or associated with – the ministries concerned. This was the case, for example, with the former Department for International Development in the United Kingdom (now part of the new Foreign, Commonwealth and Development Office). Nor is the recommendation relevant where countries have high-level research institutes that can provide information. It can be much more difficult for low- and middle-income countries to gain access to such information.

Action 4

The fourth step is to mobilize stakeholders and partners in your country and in Geneva so that you can prepare effectively for the forthcoming negotiations.

First, you should get in touch with the diplomats and civil servants who are your contact persons (focal points) in the foreign ministry and the health ministry. They need to be informed about the forthcoming negotiations and be given enough time to gather information, consult others, receive relevant approvals from their immediate superior or from the minister, and, eventually, send you instructions on the position you are to defend.

Typically, instructions from the capital will be developed through coordination among representatives from relevant ministries after consultation with experts if needed, and, as is increasingly the case in the field of global health, also with civil society. The instructions will ultimately be approved at the senior level in the lead ministry before being sent to the mission in Geneva. Often coordination is via written exchange. The necessary approval level depends on the negotiation.

As you engage with the national authorities in your capital, you may find them to be helpful or less so, depending on a number of factors: the extent to which the matter under discussion is of interest to the ministries and the government; the ability of focal points in the ministries to mobilize expertise and opinions in the capital; and – equally important – your personal relationship with, and style in relating to, the focal points and ministries.

Secondly, you should approach your contacts at WHO and other global health organizations in order to understand, from their perspective, what is at stake in the forthcoming negotiations. Here again, personal relationships and networks will give better results than addressing requests to an institution in general.

Thirdly, you should contact your counterparts in diplomatic missions in Geneva to gather information on the positions that their countries will adopt in the negotiations and, in some cases, gather support and build alliances. Again, personal relationships, legitimacy and communication skills are essential. Engaging with counterparts is crucial so that you can find out how others are preparing for the negotiations. It is also a necessary step in developing a common position with partner countries within a political entity, such as the European Union or the African Union, or within more informal groupings, such as the Nordic countries.

In Geneva there exists a very important regional coordinator system of health attachés. Each of the six WHO regions has an informal coordinator who usually rotates on an annual basis. These coordinators' activities range from routine communication between WHO governing bodies, the WHO Secretariat and Member State missions to the extraordinary challenge of selecting chairs and vice-chairs for intergovernmental negotiations.

Action 5

At the end of the process you will receive a set of instructions from your capital. The strong engagement of specific stakeholders and partners at each step of the process described above is the best guarantee of the instructions being clear and enabling you to defend a coherent national position during the negotiations.

ANNEX 1 | GLOSSARY

Global health diplomacy is a burgeoning field that combines the priorities of global health with those of foreign affairs. Health challenges of various kinds have acquired an urgency that is unprecedented in the long history of international health activities. Developments in the field of health are affecting the way in which normative concepts and international legal rules are applied in diplomatic negotiations. Global health diplomacy involves a number of disciplines, ranging from public health, law and international affairs to management and economics. Understanding and using concepts from different disciplines consistently is therefore essential.

The ABC of Diplomacy is a glossary of alphabetically ordered keywords produced by the Swiss Federal Department of Foreign Affairs. It explains frequently used terms, and provides information about the laws and customs governing international relations:

https://www.eda.admin.ch/dam/eda/en/documents/publications/GlossarezurAussenpolitik/ABC-Diplomatie_en.pdf

The institutional repository of the Global Health Centre at the Graduate Institute of International and Development Studies contains two resources that explain commonly used concepts:

→ A glossary of terms used in global health negotiation: a working tool (2013), by Martin Jacques, Ilona Kickbusch and Michaela Told
https://repository.graduateinstitute.ch/record/296833?ln=en

→ Discussing a definition of global health (2013) by Samantha Battams and Stephen A. Matlin
https://repository.graduateinstitute.ch/record/288069?ln=en

A few years ago, the online portal Middle East Medical published an article outlining a former American ambassador's views on global health diplomacy, from which it is worth quoting the following excerpts:

> *Scientists and diplomats approach problems differently. Scientists see a problem, a pattern or an anomaly, do research to collect data and evidence, and, if the evidence is strong enough, publish the results – the solution to the problem — in a peer-reviewed journal.*
>
> *For diplomats, who don't read peer-reviewed medical or scientific journals in the first place, even an elegant proof is merely the beginning of a solution. Diplomats, if we are good at our jobs, put our priorities onto other people's agendas. This means making a judgment about whether the problem the scientist's research has set out to solve is genuinely a priority for our own program or for the policy maker we are trying to influence. It also implies understanding the context in which the policy-maker is operating and how to present or explain our health priority so that it fits into his or her wider agenda.[27]*

Below we present a compilation of key terms, based on the glossary prepared for the participants in an online course on global health diplomacy organized by the Global Health Centre at the Graduate Institute of International and Development Studies:

Civil society: Refers to the process through which individuals negotiate, argue, struggle against or agree with one another and with the centres of political and economic authority, and through which voluntary associations, movements, parties, unions and individuals are able to act publicly. The precise scope of the term varies but most common usage excludes private sector businesses and formal local government organizations. (Kickbusch et al., 2013)

Club-type health diplomacy: Refers to diplomatic relations and negotiations among a group of leaders who know one another well and can employ personal charm and persuasion.

COVID-19 diplomacy / pandemic diplomacy: Multi-stakeholder and multilevel negotiations to end the COVID-19 pandemic more quickly by shaping and managing the global policy environment at many venues.

Crisis diplomacy: Interactions between States (and other actors) under a heightened threat of systemic change.

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27   Kolker J, Abdelghany A (2018). The role of diplomacy in global health. In: Middle East Medical [website] (https://www. middleeastmedicalportal.com/the-role-of-diplomacy-in-global-health/, accessed 11 February 2020).

Determinants of health: Determinants of health refer to the social, economic and physical environment and to individual characteristics and behaviours, all of which can affect people's well being and health. Whether people are healthy or not is determined largely by their circumstances and environment. Access to health care and the quality of the services provided are also considered to be determinants of health. Trends in recent years warrant a distinction to be made between commercial and political determinants. Commercial determinants include "strategies and approaches used by the private sector to promote products and choices that are detrimental to health" (Kickbusch, Allen & Franz, 2016). Looking at health through the lens of political determinants means analysing how different power constellations, institutions, processes, interests and ideological positions affect health within different political systems and cultures and at different levels of governance. In addition, other health determinants are dependent on political action (Kickbusch, 2015).

Digital health diplomacy / Twitter health diplomacy: The use of the Internet and new information and communication technologies to help achieve diplomatic objectives. (However, other definitions have also been proposed.) The above definition focuses on the interplay between Internet and diplomacy, ranging from Internet-driven changes in the environment in which diplomacy is conducted to the emergence of new topics on diplomatic agendas such as cybersecurity and privacy, along with the use of Internet tools to practise diplomacy. Digital diplomacy is part of public diplomacy; it is still mostly centred on the use of social media tools such as Twitter, Facebook, Instagram and Snapchat, but it is also about creating engaging online content that stimulates people to participate in complex conversations about foreign policy, the role of governments and the common good.

Global governance for health: Global institutions and processes of governance that have a direct and indirect impact on global health. It also includes other institutions associated with global health that may not necessarily have health as part of their explicit agendas: for example, organizations working in the areas of climate change, intellectual property rights, trade and education.

Global health: Health issues that transcend national boundaries and call for action on the global factors that determine the health of people (Kickbusch, 2006).

Global health diplomacy: The multilevel and multi-stakeholder negotiation processes that shape and manage the global policy environment for health in both health and non-health forums. Such diplomacy deals in particular with health issues and determinants that cross national boundaries and need to be tackled through global agreements. It brings together the disciplines of public health, international affairs, management, law and economics (Kickbusch et al., 2007).

Global health governance: The conscious creation, shaping, steering, strengthening and use of international and transnational institutions and regimes (of principles, norms, rules and deci-

sion-making procedures) to organize the promotion and protection of health on a global scale. Such governance is about institutions focused on global health, including conventional structures involved in such work at the multilateral and bilateral level, and also innovative bodies, such as public–private partnerships with representatives from different stakeholders.

Global health security: Reducing collective vulnerability to global public health threats, both immediate and gradual. These threats transcend borders and may be caused by infectious agents that emerge naturally at the human–animal interface, but they may also be caused by chemicals, toxins and radiation, or be deliberately caused by acts of terrorism. At the individual level, health security must include protection and provision measures such as access to safe and effective medicines, vaccines and medical care. Increasing personal health security thus means providing individuals with more sustained – and therefore secure – access to quality medical goods and services.

Global public goods of health: In an increasingly interconnected world, many public goods (that is, goods which generate benefits shared by all and from which no one can be excluded) can no longer be defined in exclusively national terms. Global public goods generate benefits – such as a safer world, protection against the impacts of climate change, and improved health – that are vital to the well-being of those living now and to the survival of future generations. Examples of global public goods for health include shared scientific knowledge (such as the sequencing of the human genome), the eradication of smallpox, global surveillance systems for influenza and other diseases, the WHO International Health Regulations and support for the development of new vaccines.

Governance for global health: The institutions and mechanisms established at the national and regional level to contribute to global health governance and/or to governance for global health, such as national or regional strategies on global health. It may also cover governance at the level of local communities.

Humanitarian diplomacy: The International Federation of Red Cross and Red Crescent Societies defines humanitarian diplomacy as "persuading decision-makers and opinion leaders to act, at all times, in the interests of vulnerable people, and with full respect for fundamental humanitarian principles".

Instruments of global health: International law, treaties, agreements, conventions, protocols, declarations, strategies, action plans and codes that concern global health.

Multilateralism in global health diplomacy: "Multilateralism" is the term used to describe cooperation among States: multilateralism in global health diplomacy is an approach based on the premise that, by working together, countries can find solutions to global health problems without renouncing their sovereignty.

Private sector: The private sector is the part of the economy that is owned by private groups, usually as a means of enterprise for profit, rather than being owned by the State.

Science diplomacy: The use of scientific collaboration among nations to address the common problems facing humanity and to build constructive international partnerships. It is both a component of health and environmental diplomacy and a field in its own right.

Vaccine diplomacy: All aspects of global health diplomacy that relate to the development, manufacture and delivery of vaccines as public health goods. Among the key features of vaccine diplomacy are its potential as a humanitarian intervention and its proven role in helping to mediate the cessation of hostilities and ceasefires during vaccination campaigns.

Whole-of -government / whole-of-society approach: These approaches call for collaboration, planning and dialogue across the entire government and society. They involve working together on public health issues with non-traditional partners, including NGOs, the private sector and civil society.

ANNEX 2 | RESOURCES

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Gavi, the Vaccine Alliance:
→ Homepage: https://www.gavi.org/

Global Financing Facility for Women, Children and Adolescents
→ Homepage: https://www.globalfinancingfacility.org/ [The Global Financing Facility is helping governments in low- and lower-middle-income countries to transform the way in which they prioritize and finance health and nutrition.]

Global Fund to Fight AIDS, Tuberculosis and Malaria
→ Homepage: https://www.theglobalfund.org/en/

Global Health Council
→ Homepage: https://globalhealth.org/

Graduate Institute of International and Development Studies
→ Global Health Centre: https://graduateinstitute.ch/globalhealth

Henry J. Kaiser Family Foundation
→ Global health policy: https://www.kff.org/global-health-policy/ [This covers mainly the role of the United States.]

Institute for Health Metrics and Evaluation
→ Homepage: http://www.healthdata.org/ [See in particular the report Financing global health 2018: countries and programs in transition (2019).]

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→ Homepage: https://www.unaids.org/en

Organisation for Economic Co-operation and Development
→ Health: https://www.oecd.org/health/

UHC2030
→ Homepage: https://www.uhc2030.org/ [This multi-stakeholder platform promotes collaboration on the strengthening of health systems and on achieving universal health coverage.]

United Nations
→ Health: https://www.un.org/en/sections/issues-depth/health/
→ Sustainable Development Goals Knowledge Platform: https://sustainabledevelopment.un.org/

Women in Global Health
→ Homepage: https://www.womeningh.org/

World Bank
→ Health: http://www.worldbank.org/en/topic/health

World Health Organization
→ Homepage: https://www.who.int/en/ [This includes links to all six WHO regional offices.]
→ Governance: http://apps.who.int/gb/gov/ [This gives an overview of all governance-related processes at WHO, including documentation, records and the rules of procedure of the governing bodies.]
→ WHO Framework Convention on Tobacco Control: https://www.who.int/fctc/en/

ANNEX 3 | LIST OF BOXES

CASE STUDIES

CASE STUDY 1 | NEGOTIATIONS FOR THE WORLD HEALTH ASSEMBLY RESOLUTION ON PRICE TRANSPARENCY (2019)

Full title: Negotiations leading to the adoption of World Health Assembly resolution WHA72.8 on improving the transparency of markets for medicines, vaccines and other health products

Author: Catherine Saez

Introduction

On 28 May 2019, Member States at the Seventy-second World Health Assembly adopted a resolution aimed at improving the transparency of markets for medicines, vaccines and other health products, including medical devices, diagnostics, assistive products, cell-and-gene-based therapies and other health technologies (WHO, 2019a).[28]

Described by many as a landmark decision, this resolution was agreed on after intense negotiations that included several night sessions. The language of the final version was slightly less ambitious than that of the original proposal submitted in February 2019 by Italy, which was joined by nine co sponsors at the opening of the Seventy-second World Health Assembly in May. Nevertheless, for the first time a WHO resolution was adopted that explicitly urges countries to publicly share information on the net prices of health products.

Only three countries dissociated themselves from the resolution: Germany, Hungary and the United Kingdom (Fletcher, 2019).

The resolution called for transparency on the prices actually paid for health products in national and global markets, and for more data on the R&D cost for medicines, the cost of clinical trials and the patent status of medicines. It was prompted by the need to tackle the huge disparity in medicine prices between countries. As pointed out by proponents of the resolution, some medicines are, paradoxically, more expensive in low-income countries than in high-income ones (Saez, 2019a).

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28   Citations in the text of this case study are to the references in the list at the end of the case study, not to those in **Annex 2**.

The issues at stake: high prices, disparities and lack of transparency

Access to medicines and health products is to a great extent conditioned by pricing. The 2019 Medicine Price Index noted that "one of the biggest disparities across the world when it comes to access to care is the price of medicine" (Medbelle, 2019). With the rise of noncommunicable diseases, particularly in low- and middle-income countries, and the ageing of the world's population, the global health burden is increasing. New life-saving therapies, often protected by patents, are marketed at prices that put a great strain on the resources of health-care systems, even in affluent countries.

The problem of medicines being unaffordable is not a new one for low- and middle-income countries. It was first brought to international attention by the HIV/AIDS epidemic, in which millions of people in such countries were left without access to medicines. A new factor, however, is the rising discomfort felt in high income countries over the prices of new medicines, triggered by the high cost of the novel life saving treatment for hepatitis C marketed by Gilead in 2014. Some high income countries began to question the high prices charged for new drugs and the transparency of pricing negotiations with the pharmaceutical industry.

DISPARITIES IN MEDICINE PRICES BETWEEN COUNTRIES

Many low-income countries are expected to increase their gross domestic product (GDP) in the coming years, thereby losing their eligibility for aid from donor agencies. These countries will have to negotiate the prices of medicines directly with pharmaceutical companies.

The lack of transparency in the prices paid to the pharmaceutical industry for medicines, both branded and generic, leads to significant pricing disparities between countries. In its 13th General Programme of Work, WHO (2019b) noted, "In many contexts, the principal cause of financial hardship is out-of-pocket payments for the purchase of medicines." As pointed out in the WHO Guideline on Country Pharmaceutical Pricing Policies, "[u]p to 90% of the population in developing countries purchase medicines through out-of-pocket payments, making medicines the largest family expenditure item after food" (WHO, 2015).

According to the Global Health Observatory (WHO, 2020), out-of-pocket spending accounted for around 32% of global health expenditure in 2015.
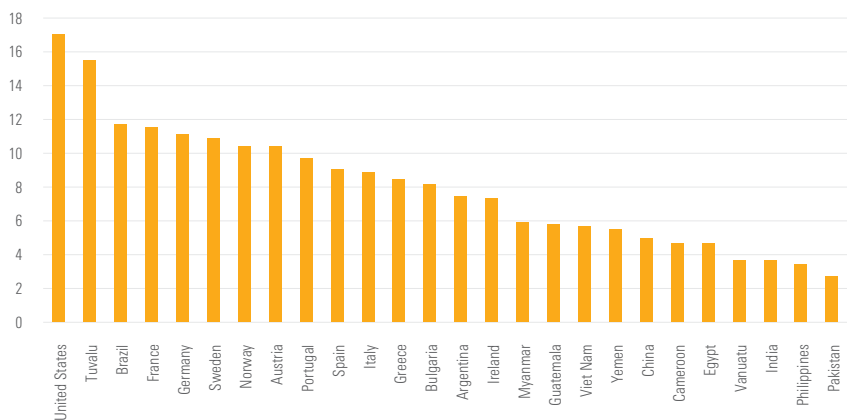
However, there are substantial disparities between countries, as may be seen in the figure below:

Out-of-pocket expenditure (%) in 2015
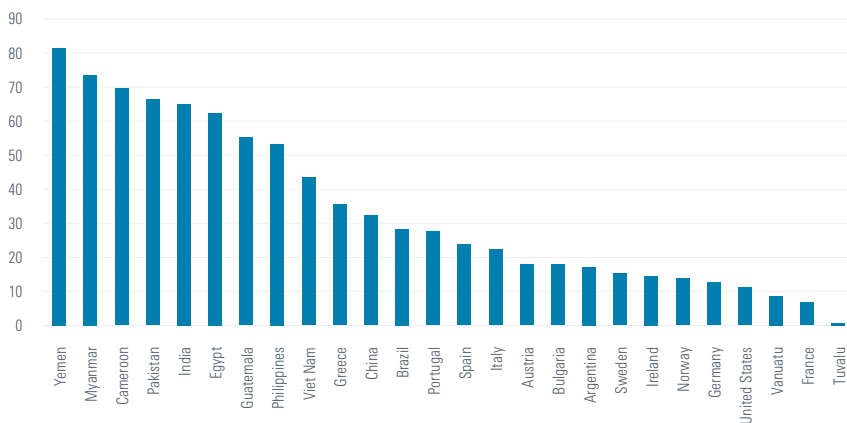
Similarly, data from the World Bank (2016) point to large disparities in health expenditure between countries, as shown in the next figure:

**Health expenditure in 2016 (% of GDP)**

A study carried out by Health Action International (Hawlik & Delavière, 2016) found that the hospital prices of medicines in four EU Member States (Austria, France, Latvia and Spain) did not correlate with GDP per capita: the prices of the five medicines examined (for cancer, rheumatic diseases and hepatitis C) were higher in Latvia and Spain than in Austria and France, despite the first two countries having a lower GDP per capita.

Such disparities have been noted by numerous studies, including one by Iyengar et al. (2016), who found great variations between countries in the prices of two novel hepatitis C medicines and concluded, "Poorer countries may be paying higher adjusted prices than richer countries."

The 2019 Medicine Price Index (Medbelle, 2019) compared the prices of 13 prevalent pharmaceutical compounds across 50 countries, regardless of whether the medicines were covered by a healthcare system or paid for by patients out of their pocket. Both brand-name and generic versions of medicines for common conditions were included in the study, which found that the deviation from the median price ranged from +306.82% in the United States to −93.93% in Thailand.

The OECD has determined an indicator of pharmaceutical spending as a share of total health spending – expressed in both US dollars per capita and as a share of GDP – for a number of countries (OECD, 2020), as may be seen in the figure below:

Pharmaceutical spending
Total, % of health spending, 2018 or latest available
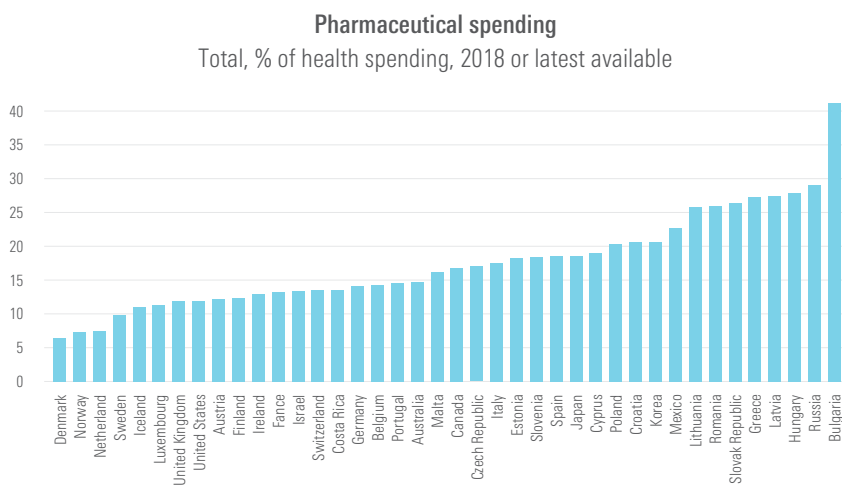
DISPARITIES DRIVEN BY A LACK OF TRANSPARENCY

The authors of a 2019 study on confidentiality agreements in the pharmaceutical industry observed how the significant increase in health spending associated with very expensive novel treatments was prompting countries to negotiate discounts with manufacturing companies. The lack of transparency arising from such confidentiality agreements prevented fair access to essential health products and made the pharmaceuticals market difficult to regulate (Iunes et al., 2019).

A number of countries set reference prices for prescription drugs on the basis of official list prices, which are higher than the actual prices paid after negotiations with manufacturers.

As observed in the above-mentioned study by Health Action International (Hawlik & Devalière, 2016), "Opacity of the actual prices of medicines across the EU makes it challenging to assess price equity and affordability. It is impossible to access data on the true prices of medicines after negotiation with the manufacturer."

Efforts to tackle high medicine prices before the Seventy-second World Health Assembly

The problem of high medicine prices has been discussed in various international forums over the years. However, the lack of transparency in price negotiations with manufacturers has attracted the most attention recently as studies such as those cited above have found large disparities worldwide. High income countries have had to start rationing treatments because of their cost, with some of them even considering using the flexibilities under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), which were originally designed to help developing and least developed countries access lower-priced generic versions of pharmaceuticals.

GLOBAL INITIATIVES HIGHLIGHTING THE NEED FOR TRANSPARENCY

A number of global initiatives have been launched to seek ways of facilitating access to medicines and increasing transparency in their pricing. For example, the WHO Roadmap for Access to Medicines, Vaccines and Other Health Products 2019–2023, presented at the Seventy-second World Health Assembly in May 2019, stresses the importance of transparency, whether on the results of clinical trials, the patent status of medicines and health technologies, the research and development costs, or on pricing, procurement and reimbursement (WHO, 2019c).

In May 2017, WHO held its first Fair Pricing Forum, during which it was pointed out that "in many countries the published prices for medicines are not the actual prices paid". Moreover, governments generally did not realize the bargaining power they had. They "could negotiate more effectively if they shared information on prices and joined together to reduce transactional costs and place more emphasis on price–volume negotiations". It was suggested that governments should agree to acknowledge where the published price was not the actual price paid in order to ensure greater transparency on prices (WHO, 2017).

A second Fair Pricing Forum was held by WHO in April 2019. The participants again stressed the importance of transparency on prices and explored ways of improving it. By that time, the draft resolution on the transparency of markets for health products had been put forward by Italy, and the then Director General of the Italian Medicines Agency, Luca Li Bassi, discussed the draft at the Forum (WHO, 2019d).

Before that, in 2016, the report of the United Nations Secretary-General High-Level Panel on Access to Medicines had similarly underlined the need for transparency in the cost of R&D, marketing, production and distribution. In particular, the report noted, "Existing public databases of health technology prices managed by international organizations and civil society groups, while laudable, tend to be limited in scope and accuracy, in part because of discounts, mark-ups, taxes and regional pricing differences" (UN High-Level Panel on Access to Medicines, 2016).

Launched in 2014, the WHO Vaccine Product, Price and Procurement (V3P) Project aims to facilitate the comparison of price information by providing countries with accurate and useful data on vaccine products and prices (WHO, n.d.). International organizations acting as procurement agencies, such as UNICEF and PAHO, provide price and procurement resources for the V3P Project, as do a number of countries including France, the Netherlands, Portugal, South Africa, Sweden and the United States.

In 2017 the OECD proposed multi-country joint procurement as a way of tackling high prices and information asymmetry between countries and global companies. The OECD recommends "ensur[ing] an adequate degree of transparency of the public procurement system in all stages of the procurement cycle" and allowing free access for all stakeholders, including "potential domestic and foreign suppliers, civil society and the general public" (OECD, n.d.).

REGIONAL EFFORTS TO INCREASE TRANSPARENCY

A well-known and widely cited example of regional efforts to increase pricing transparency for medicines is the PAHO Strategic Fund, a regional technical cooperation mechanism that supports

the pooled procurement of essential medicines and strategic health supplies (PAHO, n.d.).
Some EU countries, such as the Netherlands, have voiced strong concerns about the prices of medicines, and attempts have been made to organize joint negotiations with the pharmaceutical sector on the prices of medicines.

Thus, in 2015, the Belgian and Dutch health ministers signed a declaration of intent to negotiate prices jointly with the pharmaceutical sector. Belgium and the Netherlands were later joined by Austria, Ireland and Luxembourg in what is now known as the Beneluxa Initiative. The Initiative seeks to facilitate access to medicines, in particular newer expensive medicine, and achieve greater transparency on the cost build-up of pharmaceutical products and on pricing in different countries (Beneluxa Initiative, 2015).

Separately, the Valletta Declaration Group – established in 2017 by Cyprus, Greece, Italy, Malta, Portugal and Spain, and later joined by Croatia, Ireland, Romania and Slovenia – is seeking to increase the transparency of medicine prices and to facilitate joint procurement initiatives. France has been granted observer status at the Group's meetings.

World Health Assembly resolution WHA72.8

CONTENT

Although not legally binding, the resolution adopted by the Seventy-second World Health Assembly in May 2019 was immediately hailed as a major success. Resolution WHA72.8 is the first international agreement on increasing the transparency of markets for medicines. Spearheaded by Italy, it gained overwhelming support from delegations, after long negotiations that removed the most contentious provisions.

The resolution urges Member States in particular to:

→   Take measures to publicly share information on the net prices[29] of health products;

→   Take steps to support the dissemination of, and access to, information on the costs arising from clinical trials on human subjects, regardless of their outcomes or whether the results will support an application for marketing approval; and

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29   Net prices are the amount received by manufacturers after subtraction of all rebates, discounts and other incentives.

→ Work collaboratively to improve the reporting of information by suppliers on registered health products, such as reports on sales revenues, prices, units sold, marketing costs, and subsidies and incentives.

The resolution, moreover, requests WHO in particular to:

→ Support Member States in collecting and analysing information on economic data across the value chain for health products;

→ Support Member States, especially low- and middle-income countries, in developing and implementing their national policies relevant to the transparency of markets for health products;

→ Support research on and monitor the impact of price transparency on the affordability and availability of health products, including its effect on differential pricing;

→ Analyse the availability of data on inputs throughout the value chain, including data on clinical trials and price information;

→ Continue convening the Fair Pricing Forum every second year; and

→ Continue supporting efforts to determine the patent status of health products.

A report on the progress made in implementation of the resolution is expected to be delivered to the Seventy-fourth World Health Assembly, through the Executive Board at its 148th session in 2021.

COSTS RELATED TO RESEARCH AND DEVELOPMENT, MARKETING AND CLINICAL TRIALS EXCLUDED FROM TRANSPARENCY OBLIGATIONS

Several versions of the draft resolution were in circulation among Member States, both before and during the Seventy-second World Health Assembly in May 2019, because numerous informal meetings and negotiating sessions were convened by proponents to try to find common ground in advance of the Health Assembly.

The NGO Knowledge Ecology International, which followed the discussions closely, published six preliminary versions of the draft proposal.

A number of compromises were made after consideration of the original proposal: elements of the text had to be removed or tweaked as delegates sought to find language on which most of them

could agree. For example, the original proposal submitted by Italy in February 2019 (KEI, 2019a):

→ Made the information on R&D and clinical trial costs, marketing, grants, tax credits, sales revenues, prices and quantities a condition of registration for drugs and vaccines;

→ Urged Member States to establish minimum standards for transparency regarding information from clinical trials;

→ Requested WHO to collect and analyse data on health technologies of public health importance, including the actual manufacturing costs of specific drugs, vaccines and health technologies; and

→ Urged Member States to avoid measures in trade agreements that could limit the transparency of information from clinical trials, legitimate disclosures of manufacturing know how for drugs and vaccines, or the reporting of data on pharmaceutical, vaccine and health technology prices, revenues and other relevant medical or economic information.

The draft resolution put forward by Italy, Greece, Egypt, Malaysia, Portugal, Serbia, Slovenia, South Africa, Spain, Turkey and Uganda (KEI, 2019b):

→ Urged Member States to undertake measures to publicly share information on prices and the reimbursement cost of medicines, vaccines, cell and gene-based therapies and other health technologies;

→ Urged Member States to require that all the results from clinical trials on human subjects be reported publicly, including the costs incurred in undertaking each trial and the direct funding, tax credits or other subsidies received from governments; and

→ Urged Member States to require that the following information be made public for medicines, vaccines, cell and gene-based therapies: annual reports on sales revenues, prices and units sold; annual reports on marketing costs incurred for each registered product or procedure; the R&D cost directly associated with each clinical trial used to support the registration of a product or procedure; and all grants, tax credits or any other public sector subsidies and incentives relating to the initial regulatory approval.

The adopted resolution (WHA72.8):

→ Does not request the disclosure of R&D costs;

→ Only asks that the costs arising from clinical trials on human subjects be disseminated if already publicly available or voluntarily provided;

→ Does, however, request enhanced availability of the results of clinical trials regardless of outcomes or whether the results will support an application for marketing approval;

→ Does not request the disclosure of manufacturing costs; and

→ Does not seek to prevent measures in trade agreements that limit the transparency of information from clinical trials, legitimate disclosures of manufacturing know-how for drugs and vaccines, or the reporting of data on pharmaceutical, vaccine and health technology prices, as envisaged in the original Italian proposal.

NEGOTIATIONS

As the heavy financial burden of new medicines started to be felt by high-income countries, they became more vocal and joined developing countries in the quest for solutions to bring prices down.

At the meeting of the WHO Executive Board in January 2019, Romania, on behalf of the EU Member States, advocated a holistic approach, including fair pricing and transparency. Portugal mentioned in particular the price of hepatitis C and cancer medicines and emphasized how a lack of transparency "prevail[ed] throughout the pharmaceutical chain". Italy called for an instrument to tackle the problem of access to health products, and expressed interest in a WHO resolution on transparent pricing of medicines at the forthcoming World Health Assembly – the first time that such a resolution was proposed. There were calls for price transparency from a number of other countries too, including Bangladesh, the Plurinational State of Bolivia and Chile (Saez, 2019b).

In early February 2019, Italy submitted a draft proposal to improve the transparency of markets for medicines, vaccines and other health-related technologies. On 29 April, a draft resolution on the same topic was put forward by 10 Member States for discussion at the Seventy-second World Health Assembly to be held between 20 and 28 May; those Member States were Italy, Greece, Malaysia, Portugal, Serbia, Slovenia, South Africa, Spain, Turkey and Uganda. There followed intense negotiations with other Member States before the opening of the World Health Assembly.

On 20 May 2019, the first day of the Seventy-second World Health Assembly, a side event on access to medicines, vaccines and health products (focusing on how to ensure transparency of markets and affordable and quality products with a view to achieving universal health coverage) was organized by Italy and the Republic of Korea, with the co-sponsorship of Costa Rica, Greece, Indonesia,

Mexico, Mongolia, the Netherlands, Portugal, Saudi Arabia, Spain and Viet Nam (Saez, 2019c).

The draft resolution had not yet been presented at the World Health Assembly, and the room at this side event was overflowing, with many health ministers attending. The speakers emphasized the high prices of medicines, the secrecy surrounding R&D costs, and the negotiated prices obtained by some countries.

In particular, a representative of the Cypriot Ministry of Health referred to "unethical practices" by the pharmaceutical industry. Cyprus had a small population and no negotiating power and was being asked to pay prices much higher than those granted to other countries. A study conducted in Cyprus had examined all the products approved by the European Medicines Agency (EMA) since 2011, finding that the industry tended to wait about four years before releasing newly EMA-approved products in Cyprus, reserving those products for richer northern European countries first.

The then Director General of the Italian Medicines Agency, Luca Li Bassi, observed that it would be interesting to see whether differential pricing was actually occurring according to countries' GDP, citing the example of a pneumococcal vaccine that cost twice as much in Lebanon as in Greece. He called for more comprehensive information to be made available to support better-informed policy decisions. Countries were the biggest investors in the pharmaceutical industry and should be able to shape the market.

Armando Bartolazzi, Italy's Undersecretary of State for Health at the time, noted that transparency was recognized as a solution to the problem of there being an increasing number of highly effective but unaffordable medicines.

Bruno Bruins, Minister for Medical Care of the Netherlands, argued that countries should be more transparent on the price they were willing to pay, while Sarangerel Davaajantsan, Minister of Health of Mongolia, said that the price of medicines would decrease if transparency were to be legalized, as it might create competition between suppliers.

Confidential rebates and discounts kept the list prices high, impairing the effectiveness of external reference pricing, said Soonman Kwon from the Graduate School of Public Health at Seoul National University, while Nikos Raptis, Special Adviser to the Greek Minister of Health, added that the non disclosure clauses which countries had to sign were a way for the pharmaceutical industry to "divide and conquer".

In the audience, Anban Pillay, Deputy Director-General for National Health Insurance at the National Department of Health of South Africa, called upon countries to follow his country's example.

South Africa had enacted a law preventing non-disclosure contracts and requiring information from pharmaceutical companies, such as the price of the active ingredients in their products.

The side event was followed by intense rounds of negotiations between Member States over the next few days. By 23 May, the discussions had not resulted in consensus, and a drafting group was set up in view of the fact that the draft resolution was rapidly being riddled with comments and caveats: there had been almost 100 proposed additions, deletions and amendments. As the plenary discussion, scheduled for 24 May, drew closer, it remained uncertain whether consensus would ever be reached (Saez, 2019d).

Countries with a strong pharmaceutical industry proposed revisions and amendments to the draft text. While Germany and the United Kingdom continuously requested revisions, other countries, including Japan, Switzerland and the United States, sought amendments to specific sections, in particular those dealing with the disclosure of R&D and clinical trial costs.

The EU Member States were divided, with some co-sponsoring the draft resolution but others openly making known their opposition to it. Some countries, such as Germany and the United Kingdom, argued that the draft text had been prepared too hastily and that it should have gone through the WHO Executive Board in January before being submitted for consideration to the World Health Assembly.

Little progress had been achieved by 24 May. Further negotiations were conducted behind closed doors, and the formal plenary session that had been scheduled for that date, a Friday, was delayed until the following Monday (27 May). During the session of 24 May, some Nordic countries, notably Finland and Norway, expressed their support for the resolution. Similarly, the United States and Switzerland spoke out in favour of the proposed provisions calling for the publication of list prices of medicines sold and purchased in national markets. They were, however, against the disclosure of R&D and clinical trial costs for drugs at the time of regulatory approval, even if the funding came from public sources (Saez, 2019a).

On 27 May, after a full day of negotiations and yet another postponement of the plenary session tasked with examining the draft resolution (now postponed to the final day of the World Health Assembly), the prospect of agreement was brought closer as the number of co-sponsors increased to 19. The newcomers included the Republic of Korea and Malta. Moreover, Brazil, Ecuador, Norway, the Netherlands, Switzerland and Thailand expressed their support in principle for the resolution (Saez, 2019e).

While a dedicated core team of some 30 delegates – led by Italy and drawn from, among others, Brazil, Japan, Norway, Spain, Sweden, Switzerland, Thailand, the United Kingdom and the United

States – continued working late into the night on Monday, 27 May, some countries, such as Germany, had by then left the negotiating table. Turkey was reported to have withdrawn its previous co-sponsorship of the draft resolution – a move linked by some observers to the objections raised by Germany.

According to sources inside the room, a critical moment occurred when France changed its position and, breaking ranks with Germany, the United Kingdom and the United States, decided to support the inclusion of a reference to the costs of clinical trials.

The opening of the last session of Committee A on 28 May, the last day of the World Health Assembly, during which the draft resolution was to be discussed, was delayed slightly as the United Kingdom tried in vain to gain support for postponing the discussion until the next meeting of the WHO Executive Board in January 2020 (Fletcher, 2019).

The draft resolution was approved by Committee A with overwhelming support. However, Germany, Hungary and the United Kingdom, though not blocking the adoption as such, chose to "dissociate" themselves from the resolution. The United Kingdom complained mainly about the resolution not having been reviewed by the WHO Executive Board. Julian Braithwaite, the British Permanent Representative to the UN and other international organizations in Geneva, noted that the United Kingdom was concerned about the disruptive effect which price transparency could have on differential pricing agreements granted to low- and middle-income countries. He criticized the process as having been rushed through, without sufficient time given for careful consideration of potentially far-reaching implications.

Those concerns were echoed by the German delegate, who pointed out that the transparency of prices was a very complex issue and that the potential implications for health-care systems should have been better assessed.

Other actors: The World Health Organization, civil society and public–private partnerships

WORLD HEALTH ORGANIZATION

At the close of the Seventy-second World Health Assembly, WHO Director-General Tedros Adhanom Ghebreyesus described the resolution as a "landmark agreement to enhance the transparency of pricing for medicines, vaccines and other health products".

WHO has long been advocating greater transparency in the pricing of pharmaceuticals. The Organization is currently working on updating the 2015 WHO Guideline on Country Pharmaceutical Pricing Policies, with the new version expected to be published in 2020. The updated version will include "evidence-informed recommendations for the promotion of price transparency of pharmaceutical products" (WHO, 2019e).

The WHO Roadmap for Access to Medicines, Vaccines and Other Health Products 2019–2023 calls for global and regional collaboration to increase price transparency, facilitate dialogue between public payers, government decision-makers and industry, and improve capacity for price negotiation. It also suggests measures to assist countries with the selection of appropriate medicines, vaccines, diagnostics and other health products; with transparent and fair pricing; and with the implementation of policies to reduce costs for both governments and individuals while ensuring quality, safety and efficacy and sustainable supply (WHO, 2019c).

In 2018, World Health Assembly decision WHA71(9) on the WHO global strategy and plan of action on public health, innovation and intellectual property urged Member States to implement and take into account the recommendations made by the expert panel that had reviewed the strategy. One of the recommendations flagged as high priority was that Member States should support the WHO Secretariat in promoting transparency in, and understanding of, R&D costs. Another high-priority recommendation was that the WHO Secretariat should provide guidance to Member States on promoting and monitoring transparency in medicine prices and on the implementation of pricing and reimbursement policies.

In 2017, WHO held its first Fair Pricing Forum, which was followed by a second in 2019. Both events provided a platform for discussing transparency as one of the means of achieving fair pricing.

CIVIL SOCIETY

Civil society was closely involved from the very start and strongly supported the draft resolution put forward by Italy. Access to medicines and, in particular, the need to tackle high prices have been long standing concerns for many civil society organizations, such as Médecins Sans Frontières, Health Action International, Knowledge Ecology International, Oxfam and Medicus Mundi International.

Intense lobbying by civil society raised awareness of what was at stake in the discussions, before and during the World Health Assembly. This lobbying, which was carried out either during the World Health Assembly or at the national level, clearly influenced the negotiations.

On 9 May 2019, a group made up of 77 NGOs and 49 individuals, including prominent academics, signed an open letter denouncing the profusion of brackets and proposed changes to the draft text that had been made during informal negotiations. The open letter argued that a group of high income countries was seeking to derail the initiative. Australia, Denmark, Germany, Sweden and the United Kingdom were singled out as the main opponents of the draft resolution, but Austria and the United States were also cited as seeking to dilute key parts of the text (Branigan, 2019).

On 23 May, in view of how little progress had apparently been made, Knowledge Ecology International and Médecins Sans Frontières, together with 44 other NGOs and 10 individuals, published an open letter to delegates, urging them "to reach consensus on a strong WHO transparency resolution that addresses every topic in the original proposal, including prices, revenues, units sold, marketing costs, clinical trial enrollment and outcomes, clinical trial costs, government R&D subsidies, patent landscapes, manufacturing know-how, and future meetings, forums and activities that collectively are designed to progressively expand and implement norms on transparency" (KEI, 2019c).

The open letter further called for the negotiating text to be released after every negotiating session, with Member States' positions identified for any brackets or alternative texts proposed.

France's initial opposition to the draft resolution stirred a group of prominent civil society leaders, including Nobel Prize laureate Françoise Barré-Sinoussi, into action. The group published an op-ed in the leftist newspaper *Libération* calling on the French Government to support the resolution without any reservations or ambiguities. The group noted that, in the United Kingdom, treatments costing above £30,000 per quality-adjusted life year gained were not covered by the National Health System. In France, unprecedented rationing had had to be introduced for medicines used to treat hepatitis C, and cancer treatments had been delayed.

A group of German NGOs issued a similar petition to protest against Germany's position during the negotiations on the draft resolution. They called on the German Government to reconsider its stance.

In a separate development, 66 African NGOs based in South Africa, Uganda and Zimbabwe sought to influence Germany's negotiating position by addressing an open letter to Jens Spahn, the German Minister of Health. They urged the German Government to display solidarity with the people most at risk of acute suffering and even death because of lack of access to medicines. The same letter was addressed to French Health Minister Agnès Buzyn and to Matthew Hancock, Secretary of State for Health and Social Care of the United Kingdom.

PUBLIC–PRIVATE PARTNERSHIPS

During the discussions on the draft Roadmap for Access to Medicines, Vaccines and Other Health Products 2019–2023 at the Seventy-second World Health Assembly, the Drugs for Neglected Diseases Initiative, which works with private sector partners, emphasized that transparency on the costs of R&D was a central element of its policy: "We put as much information into the public domain as possible, including all clinical trial data, our actual R&D costs and related financing flows, including the in-kind contributions from our partners where they provide them."

PHARMACEUTICAL INDUSTRY

The pharmaceutical industry did not express its views openly during the negotiations at the Seventy second World Health Assembly. The industry has traditionally been against the disclosure of R&D and clinical trial costs, arguing that such figures are difficult to compile. Moreover, so it is argued further, such costs are influenced by multiple factors, and prices are only one aspect of access to medicines.

As the industry came under pressure from high-income countries protesting about the unprecedentedly high prices of new medicines, some companies defended themselves by pointing out that medicines such as the new hepatitis C drugs offered a cure for life, thereby saving health-care systems a lot of money.

Commenting on the draft Roadmap for Access to Medicines, Vaccines and Other Health Products at the meeting of the WHO Executive Board in January 2019, the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) voiced concerns about what it described as a narrow approach to pricing that focused on price transparency, rather than taking into account the broader context. The IFPMA also warned about possible unintended consequences of price transparency on pharmaceutical companies' ability to offer preferential pricing to developing countries and argued that those consequences should be examined before embarking on discussions on transparency.

Speaking on the same topic at the Seventy-second World Health Assembly, the IFPMA pointed out that sharing information on the prices of medicines could drive prices up in less developed countries – namely, if developed countries were to see what the latter were paying and demand greater price parity.

With regard to reporting on R&D costs, the IFPMA argued that medicine prices should reflect the therapeutic value of medicines and the positive outcomes experienced by patients and society, rather than considering the "cost input" of individual medicines. However, the Federation acknowledged the need for more information to be made available.

At the close of the World Health Assembly, the IFPMA concluded that improving the affordability of, and access to, medicines and vaccines was a multidimensional challenge requiring collaborative and holistic solutions from all stakeholders, including the pharmaceutical industry. In particular, it was important to reduce the out-of-pocket payments that patients had to make; tackle inefficiencies in supply chains; combat counterfeit medicines; improve procurement practices; and make differential pricing possible for low- and middle-income countries.

Lessons learned – What now?

The negotiations leading to the adoption of the resolution on improving the transparency of pharmaceutical markets were tortuous, but their successful conclusion was aided by the strong support of some high-income countries, whose interests are now divided between protecting their pharmaceutical industries and ensuring the sustainability of their health systems.

Eventually only Germany, Hungary and the United Kingdom dissociated themselves from the resolution. According to observers, a number of high-income countries, including Australia, Belgium, Bulgaria, Canada, Denmark, the Netherlands, Poland, Sweden and Switzerland, objected to certain passages of the draft, leading to a weakened text in the final version.

Once the transparency of R&D costs had been removed from consideration, Japan, the Netherlands, Switzerland and the United States were able to rally the resolution's other proponents. Only a small number of countries were opposed to the disclosure of clinical trial costs.

Both Germany and the United Kingdom have a strong pharmaceutical industry (notably GlaxoSmith-Kline and AstraZeneca in the latter), but they also depend on negotiations with the industry to maintain their health-care systems. Germany was recently dubbed the leader of the European pharmaceutical industry.

The strong lobbying by civil society also helped tilt the balance of the negotiations. During the Seventy second World Health Assembly, Germany complained about the campaign mounted by civil society – in particular, that negotiators were being put under pressure by the publication of leaked information on their perceived positions.

Following the resolution's adoption, France and Italy approved new regulations requiring pharmaceutical companies to disclose public contributions received for R&D on new drugs. However, by the end of 2019 those initiatives had stalled owing to procedural issues in France and to the formation of a new government in Italy.

The WHO report to be presented at the 148th session of the Executive Board in January 2021 is expected to shed some light on the implementation of the resolution at the national level.

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CASE STUDY 2 | THE POLITICAL DECLARATION OF THE HIGH-LEVEL MEETING ON UNIVERSAL HEALTH COVERAGE (2019)

Full title: The Political Declaration of the High-Level Meeting on Universal Health Coverage (2019): Negotiating the most comprehensive agreement ever reached on global health*

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*_This case study was written by the authors in their personal capacity; it does not reflect their respective organizations' views and positions._

Introduction

On 23 September 2019, world leaders at the United Nations General Assembly High-Level Meeting on Universal Health Coverage unanimously approved the Political Declaration of the High-Level Meeting on Universal Health Coverage (UN, 2019a),[30] described by UN Secretary-General António Guterres as "the most comprehensive agreement ever reached on global health" (UN, 2019b). This historic agreement reiterates a number of key principles, including the importance of health for implementation of all the goals and targets of the 2030 Agenda for Sustainable Development. World leaders recommitted themselves to achieving universal health coverage by 2030 and to scaling up global efforts to build a healthier world for all.

The high-level meeting and its political declaration were the result of a series of concerted multi-stakeholder efforts. This case study looks at the relevant processes from the point of view of health diplomats in New York who were closely involved in the planning and negotiations that led to this landmark agreement.

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30   Citations in the text of this case study are to the references in the list at the end of the case study, not to those in **Annex 2**.

The problem

As defined by WHO, universal health coverage is when "all people receive the health services they need, including public health services designed to promote better health …, prevent illness …, and to provide treatment, rehabilitation and palliative care … of sufficient quality to be effective, while at the same time ensuring that the use of these services does not expose the user to financial hardship" (WHO, 2019a).

As a result of several advocacy campaigns and intergovernmental negotiations, universal health coverage was included in the Sustainable Development Goals (SDGs) adopted at the UN General Assembly in 2015, specifically as SDG target 3.8, "Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (UN, 2015).[31]

However, according to the 2019 global monitoring report on universal health coverage, global progress since the previous report in 2017 has been less than satisfactory. Alarmingly, at least half of the world's population still lack access to essential health services. Every year, more than 900 million people spend at least 10% of their household income on health care, and out-of-pocket expenses on health drive some 100 million people into poverty. If the current trend continues, at least one-third of the world's population will still have no access to essential health services in 2030 (WHO, 2019a).

The context

Global health matters are discussed mainly at the governing bodies of WHO, particularly the World Health Assembly, which is convened under the auspices of Member States' health ministers. However, there has been an increasing tendency for the Heads of State and Government to discuss prominent health issues at the UN General Assembly, the primary role of which is to tackle matters related to peace and security, human rights and development. The first example of this trend was the General Assembly Special Session on HIV/AIDS held in 2001, which was a watershed in the sense that the global response to AIDS was now put on the political agenda of the Heads of State

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31   The associated indicators were defined in 2017 as shown below:

→   SDG indicator 3.8.1: "Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non communicable diseases and service capacity and access, among the general and the most disadvantaged population)"; and

→   SDG indicator 3.8.2: "Proportion of population with large household expenditures on health as a share of total household expenditure or income" (UN, 2017).

and Government (UN, 2001). That special session has been followed by high-level meetings at the General Assembly on noncommunicable diseases (2011, 2014 and 2018), antimicrobial resistance (2016) and tuberculosis (2018).

While these meetings – and the declarations endorsed at them – helped to draw policy-makers' attention to a number of major health issues, it was recognized increasingly that health-related discussions in New York, particularly those on universal health coverage, required a more coherent and integrated approach for the following reasons:

→ The 2030 Agenda for Sustainable Development emphasized the integrated, indivisible and interlinked nature of the SDGs, and called for a holistic rather than piecemeal approach;

→ The international community's renewed commitment to primary health care and to the strengthening of health systems in order to ensure health for all put the focus on universal health coverage as an umbrella concept under which all health issues related to SDG 3 could be tackled (WHO, 2019b); and

→ The interrelated and increasingly complex topics dealt with at the UN, such as climate change, financing for development and nuclear disarmament, required a more focused approach to health as opposed to holding high-level meetings on individual health issues about once a year.

Accordingly, the General Assembly decided, in 2017, to convene a high-level meeting in 2019 on universal health coverage and to proclaim 12 December as International Universal Health Coverage Day (UN, 2018a, 2018b). The two resolutions, both adopted on 12 December 2017, were put forward by Thailand, which was then chairing the Foreign Policy and Global Health Initiative.

On 13 and 14 December 2017, the first Universal Health Coverage Forum was held in Tokyo, bringing together high-level representatives of various countries and international agencies – including the UN Secretary-General and the heads of WHO, the World Bank and UNICEF – to generate momentum for the promotion of universal health coverage (MoFA Japan, 2017). The outcome document (MoFA Japan et al., 2017), which included such aspirations as extending essential health coverage to an additional 1 billion people by 2023, was to feed into the Political Declaration of the High-Level Meeting on Universal Health Coverage in 2019.

In December 2018, the General Assembly unanimously adopted a resolution setting out the scope, modalities, format and organization of the high-level meeting on universal health coverage, which was to be convened on Monday, 23 September 2019, the first day of the high-level week (UN, 2019c). The resolution, co-facilitated by Thailand and Hungary, called upon all Member States to

participate in the meeting at the highest level and to commit to achieving universal health coverage by 2030. Moreover, the General Assembly in the same resolution decided that the meeting should approve "a concise and action-oriented political declaration, agreed in advance by consensus through intergovernmental negotiations". At this point, the stage was set for the meeting in September and the Member States had to start negotiating a political declaration that would merit endorsement by world leaders.

The players and their roles

PRESIDENT OF THE GENERAL ASSEMBLY

The President of the General Assembly was tasked with organizing the high-level meeting and with submitting to the General Assembly the political declaration to be approved at the meeting as mandated by the General Assembly (UN, 2019c). The President was also tasked with organizing an interactive multi-stakeholder hearing as part of the preparations for the meeting. In her capacity as President of the 73rd session of the General Assembly, H.E. Ms María Fernanda Espinosa Garcés demonstrated strong commitment and led the preparatory arrangements, including the appointment of the Permanent Representatives of Thailand and Georgia as co facilitators for the negotiations on the political declaration. The actual convening of the high-level meeting was taken on by the President of the 74th session of the General Assembly, H.E. Mr Tijjani Muhammad-Bande.

CO-FACILITATORS

H.E. Mr Vitavas Srivihok and H.E. Mr Kaha Imnadze, the Permanent Representatives of, respectively, Thailand and Georgia to the UN, were appointed by the President of the General Assembly as co facilitators to conduct informal consultations with the Member States aimed at producing the political declaration that was to be approved at the high-level meeting (PGA, 2019a). They led the drafting of the political declaration, incorporating inputs from various stakeholders, and steered the negotiations between the Member States.

GROUP OF FRIENDS OF UNIVERSAL HEALTH COVERAGE AND GLOBAL HEALTH

On International Universal Health Coverage Day in 2018, the Group of Friends of Universal Health Coverage and Global Health was launched. H.E. Mr Koro Bessho, Permanent Representative of Japan to the UN, was appointed its Chair (UHC2030, 2019a). The Group was established as an open platform that Member States could use to build momentum towards the high-level meeting in September 2019, and to raise awareness of the importance of universal health coverage among

diplomats in New York, most of whom have expertise not in health matters but in security, human rights or development. The Group started off with just a few members (including Brazil, France, Ghana, Hungary, Japan, South Africa and Thailand), but by the start of the negotiations on the political declaration its membership had grown to more than 50.

FOREIGN POLICY AND GLOBAL HEALTH INITIATIVE

A group of Member States under the Foreign Policy and Global Health Initiative, which was launched by the Oslo Ministerial Declaration of 2007 (MoFA Brazil et al., 2007), has been proposing draft resolutions on global health and foreign policy to the General Assembly since 2008.[32] It was thanks to the 2012 version of the "Global health and foreign policy" resolution, presented by France, that universal health coverage was first discussed at the General Assembly (UN, 2013). In 2017, Japan, a long-standing proponent of universal health coverage, suggested to Thailand, which then held the chairmanship of the Foreign Policy and Global Health Initiative, that the forthcoming "Global health and foreign policy" resolution should, among other things, call for a high level meeting on universal health coverage. After negotiations led by Thailand and supported by other proponents of universal health coverage, it was unanimously decided through the new resolution to hold such a high-level meeting in 2019 (UN, 2018a).

MEMBER STATES

During the negotiations on the political declaration, Member States negotiated either individually or coordinated their positions as part of groups. The main groups in these negotiations were the Group of African States, the European Union and the CANZ (Canada, Australia and New Zealand) group. The Group of 77, which is the largest coalition of developing countries in the UN, did not negotiate as a group at the time, although it had done so during the negotiations leading to the two high-level meetings on tuberculosis and noncommunicable diseases in 2018. It appears that the Group of 77 countries were unable to agree on a common position because of the broader scope of the political declaration on universal health coverage. Two other groups worth mentioning in this connection are the Group of Seven[33] and the Group of 20[34], both of which have taken up universal health coverage in recent years (G7, 2016, 2019; G20, 2019). Other groups and individual Member States also contributed significantly to the negotiations, forming coalitions on an ad hoc basis.

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32   The Member States taking part in the Foreign Policy and Global Health Initiative are Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand.

33   The G7 consists of Canada, France, Germany, Italy, Japan, the United Kingdom, and the United States of America. The EU is regularly represented at G7 summits.

34   The G20 consists of the G7 countries (plus the EU), along with Argentina, Australia, Brazil, China, India, Indonesia, Mexico, the Republic of Korea, the Russian Federation, Saudi Arabia, South Africa and Turkey.

WORLD HEALTH ORGANIZATION

Ever since his inauguration, WHO Director-General Tedros Adhanom Ghebreyesus (2017) has made it clear that universal health coverage is a "top priority" for the Organization. As the UN technical agency on health, WHO played a central role in providing technical support throughout the negotiations, as it had already done for previous high-level meetings on health topics at the General Assembly. WHO served as a technical secretariat during the negotiations: its tasks included replying to Member States' requests for technical clarification and ensuring the technical integrity of the political declaration. Moreover, WHO assisted the President of the General Assembly in organizing the multi-stakeholder hearing in April 2019 as well as the high-level meeting itself.

INTERNATIONAL HEALTH PARTNERSHIP FOR UNIVERSAL HEALTH COVERAGE 2030

The International Health Partnership for Universal Health Coverage 2030 (UHC2030) is a multi-stakeholder partnership established in 2017 to facilitate equitable and sustainable progress towards universal health coverage.[35] It played an instrumental role in the preparations for the high level meeting by bringing together multiple stakeholders (including civil society, the private sector, philanthropic institutions and academia) through a series of consultations. These resulted in the compilation of a set of "Key Asks" that were presented to the co-facilitators of the negotiations and to Member States through briefings given by the Group of Friends of Universal Health Coverage and Global Health, and also through the multi-stakeholder hearing in April (UHC2030, 2019b). There are seven Key Asks in all: (1) "Ensure political leadership beyond health"; (2) "Leave no one behind"; (3) "Regulate and legislate"; (4) "Uphold quality of care"; (5) "Invest more, invest better"; (6) "Move together"; and (7) "Gender equality and women's rights as drivers of health".

Tools and approaches

The drafting of the political declaration was led by the co-facilitators and involved broad and inclusive consultations with the UN Member States, WHO, civil society, academia, the private sector and other stakeholders. The main approaches employed to ensure an inclusive and effective process leading to a meaningful consensus-based declaration were as follows:

MULTI-STAKEHOLDER ENGAGEMENT

One important input for the declaration was the Key Asks presented by the multi-stakeholder plat-

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35   See https://www.uhc2030.org/.

form UHC2030 (2019b). Stakeholders were given the opportunity to contribute to the six Key Asks before these were submitted for the co-facilitator's consideration as part of the development of the zero draft of the declaration. Stakeholders were also able to voice their views during the briefings of the Group of Friends of Universal Health Coverage and Global Health, and at the interactive multi-stakeholder hearing convened by the President of the General Assembly on 29 April 2019. At the hearing, it was proposed to include the area of gender equality and women's rights as the seventh Key Ask; this proposal was duly accepted.

GROUP OF FRIENDS OF UNIVERSAL HEALTH COVERAGE AND GLOBAL HEALTH ESTABLISHED AS A PLATFORM IN NEW YORK

The Group of Friends convened a series of briefings in New York that brought together UN agencies (including WHO, which gave a briefing on the relevant resolutions and discussions in Geneva), experts and civil society organizations. The Group also organized a briefing to launch the Key Asks prepared by UHC2030. These briefings were instrumental in helping diplomats in New York to play an informed and constructive role in the negotiations on the political declaration.

LIAISON BETWEEN GENEVA AND NEW YORK

At WHO headquarters in Geneva, as a basis for formulating a draft declaration, Thailand and Japan jointly led the development of a resolution entitled "Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage", which was adopted by the Executive Board in January 2019 (WHO, 2019c) and by the World Health Assembly in May 2019 (WHO, 2019d). The Permanent Representatives of Thailand and Georgia to the UN in New York, who had been appointed co-facilitators of the negotiations on the political declaration, paid a visit to Geneva in May 2019 to brief WHO Member States on the status of the negotiations in New York and to consult technical experts at WHO headquarters with a view to ensuring coherence between the negotiation processes in the two cities.

ALIGNING THE DECLARATION WITH RELEVANT INITIATIVES

During the drafting of, and the negotiations on, the political declaration, the co-facilitators sought to ensure that the declaration was aligned with relevant initiatives and outcomes. These included: (a) the Astana Declaration, endorsed at the Global Conference on Primary Health Care that was held in Astana (now Nur Sultan), Kazakhstan, in October 2018 (WHO, 2019b); (b) the Global Action Plan for Healthy Lives and Well-being for All, launched at the UN General Assembly in September 2019 to strengthen collaboration among multilateral organizations with a view to helping countries

achieve swifter progress on the health-related SDGs;[36] and (c) the G20 Osaka Leaders' Declaration (adopted at the G20 Summit held in Osaka, Japan, in June 2019), which includes commitments on universal health coverage. The Astana Declaration was invoked in paragraph 13 of the political declaration, which states that "primary health care is the cornerstone of a sustainable health system for universal health coverage and health-related Sustainable Development Goals". The proposal to include a reference to the Global Action Plan for Healthy Lives and Well-being for All was initially not supported by some Member States, but such a reference did finally appear in paragraph 77, where the agreed wording from the G20 Osaka Leaders' Declaration was used. Some concepts from the G20 Osaka Leaders' Declaration were also incorporated into the political declaration – for example, "healthy and active ageing" (paragraph 30) and collaboration between finance and health authorities (paragraph 39).

Outcomes and challenges

Drawing on the inclusive and carefully sequenced processes in both Geneva and New York that had brought together a range of multi-stakeholder views, the co-facilitators developed a zero draft of the political declaration, which was circulated among Member States in late May 2019, initiating a series of negotiations. More than 10 informal consultations had been held by the end of July; these were supplemented by small-group and bilateral meetings to deal with specific concerns. Following the negotiations, the final draft was placed under silence procedure on 24 July.[37] The silence was broken twice over contentious issues in early August (PGA, 2019b, 2019c, 2019d). However, thanks to the skill and perseverance of the two co-facilitators – who organized a final ambassadorial meeting on 4 September as well as several informal bilateral discussions – the final draft of the political declaration could be placed under silence procedure again on 10 September (PGA, 2019e). By the end of the silence period two days later, the political declaration had been agreed upon by consensus.

The Political Declaration of the High-Level Meeting on Universal Health Coverage reaffirms various relevant agreements and stresses the central role of universal health coverage for implementation of the 2030 Agenda for Sustainable Development. Moreover, it lays down the commitment by world leaders to achieve universal health coverage by 2030. The main points of the declaration were summarized by the International Health Partnership for UHC2030 as "Key targets, commitments and actions" (UHC2030, 2019c) with reference to the "Key Asks" that the Partnership had compiled

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36   See https://www.who.int/sdg/global-action-plan.

37   The silence procedure is used in most intergovernmental negotiations at the UN to agree upon a proposal by consensus. A draft version of the text of the proposal is circulated among participants and if no amendments or objections are proposed – that is, if no one breaks the silence – before a specified deadline, the text is considered to have been agreed upon by all participants.

in advance of the high-level meeting. Some of the highlights of the political declaration are outlined below:

1. KEY TARGETS

Among the most important targets of the political declaration – targets that were intensely debated during the negotiations – are: providing all people with quality essential health services by 2030; reversing the trend that is seeing out-of-pocket health expenditure rise to catastrophic levels; and eliminating impoverishment due to health related expenses by 2030. Achieving agreement on those targets became possible thanks to a technical briefing given by experts from WHO headquarters, convened by the co-facilitators. Those Member States, including Japan, that were keen on setting meaningful and ambitious numerical targets had asked for various technical clarifications, including trends and estimates. Other key targets are summarized in **Figure 1**.

Figure 1: Political declaration: outcome targets

Global targets	National targets
[24] Accelerate efforts towards the achievement of UHC by 2030 → Progressively cover 1 billion additional people by 2023 and all people by 2030 → Reverse the trend of catastrophic out- of-pocket health expenditure and eliminate impoverishment due to expenses by 2030 [42] Expand services, strengthen health systems, and mobilize resources, noting that an additional 3.9 trillion USD in by 2030 could prevent 97 million premature deaths and add 3.1 and 8.4 years of life expectancy in low- and middle- income countries [60] Address the shortfall of 18 million health workers and the call for the creation of 40 million health worker jobs by 2030.	[40] Optimize budgetary allocations on health, broaden fiscal space, and prioritize health in public spending, with emphasis on primary health care, and note the World Health Organization recommended target of an **additional 1% of GDP or more**.

Source: Political Declaration of the Hight-Level Meeting on Universal Health Coverage

2. KEY COMMITMENTS

The political declaration incorporates all seven "Key Asks" compiled by the International Health Partnership for UHC2030, with a strong emphasis on: the importance of political commitment; developing and implementing evidence-based policies and programmes; national ownership; tackling

health inequities so as to leave no one behind; engaging stakeholders; and increasing investment, notably through enhanced collaboration between health and finance authorities. The declaration recognizes the urgent need for health systems to be strengthened, and the pivotal role of primary health care in achieving universal health coverage. Moreover, the declaration calls for social justice and social protection mechanisms to be upheld so that health-care systems are truly comprehensive and people-centred.

3. CONTROVERSIAL AREAS

There were three main controversial areas that required focused attention and consultations during the negotiation process:

Sexual and reproductive health and rights

One of the most contentious topics during the negotiations was sexual and reproductive health and rights, which many Member States felt strongly about in different ways, as has happened before in other UN forums. When a difficult issue comes up during negotiations at the UN, a well-tried approach is to use agreed language from earlier documents adopted unanimously by the Member States. In this case, however, it proved difficult to agree on which agreed language to use. One possible approach was to use the outcome document of the 2019 session of the UN Commission on the Status of Women (UN-Women, 2019). Wording from that document appeared in the zero draft of the political declaration, but it was contested by some Member States on the grounds that the source text might not be a consensus-based document and that the context was different. Another possible approach was to use the language from the World Health Assembly resolution on preparation for the high-level meeting (resolution WHA72.4), which referred to "sexual and reproductive health"; however, some Member States felt that this was insufficient, as there was no mention of rights. Either approach would have been equally valid, but after extensive consultations and attempts at persuasion that went on until the very last minute, the Member States, as suggested by the co-facilitators, finally agreed to settle the matter by using agreed language from the SDGs – specifically from SDG targets 3.7 and 5.6 (UN, 2015) – in paragraph 68 of the political declaration.

Migrants

The issue of migrants was another controversial area that required extensive consultations, as in some other UN forums. Some Member States felt that there was no need to refer to migrants in the political declaration, while others considered this to be essential. Similarly, some Member States felt it was necessary and relevant to invoke the Global Compact for Safe, Orderly and Regular Migration, while others disagreed, pointing out that the Global Compact had not been universally

agreed upon by the UN Member States. Finally, as suggested by the co facilitators, Member States agreed to base paragraph 70 of the political declaration on agreed language from the "Global health and foreign policy" resolution adopted by the General Assembly in December 2017 (UN, 2018a). The final text of that paragraph refers generally to leaving no one behind, including migrants among other vulnerable groups of people.

Intellectual property and price transparency

The question of how to strike a balance between ensuring that medical products are affordable and protecting intellectual property in order to incentivize innovation is a perennial subject of debate in health-related negotiations, not least in the negotiations on the political declaration. Furthermore, the issue of increasing transparency in the pricing of high-priced medical products, which was discussed at great length during the Seventy-second World Health Assembly in May 2019, was taken up in these negotiations. With regard to intellectual property, the co-facilitators decided to incorporate into paragraph 51 of the declaration the language agreed on during the negotiations for the Political Declaration of the High-Level Meeting of the General Assembly on the Fight against Tuberculosis in 2018 (UN, 2018c). As for price transparency, Member States finally chose to use the agreed language from World Health Assembly resolution WHA72.8 (WHO, 2019e) in paragraph 50 of the political declaration, rather than reopening in New York the technical discussions on that topic that had taken place in Geneva.

4. ACCOUNTABILITY AND FOLLOW-UP

The political declaration further focuses on identifying priority tasks for action, follow-up and accountability at the national and global level, such as: setting national targets and strengthening national monitoring and evaluation platforms; monitoring and enhancing the initiatives undertaken to achieve universal health coverage through progress reports prepared by the Secretary-General; and organizing a high-level review meeting on universal health coverage in 2023, intended to consolidate all health-related efforts. Relevant commitments on accountability and follow-up are summarized in Figure 2.

Figure 2: Political declaration: follow-up, accountability

Global follow-up	National follow-up
[82] SG progress report in 75th session of General Assembly (2020/21) [82] SG report with recommandations on political declaration implementation in 77th session og General Assembly (2022/23) [83] HLM on UHC in 2023 – scope and modalities to be decided by 75th session of the General Assembly (by September 2021)	[55] Strengthen the capacity of national government authorities for strategic leadership and coordination, focusing on intersectoral interventions, as well as strengthen the capacity of local authorities [79] Set measurable national targets and strengthen national monitoring and evaluation platforms [80] Upon Member State request, leverage the full potential of the multilateral system, including WHO, the UN development system, RCs and UN country teams, and other relevant actors, to assist and support countries at the national level to achieve UHC

Source: Political Declaration of the Hight-Level Meeting on Universal Health Coverage

Lessons learned and next steps

The key lessons learned throughout the planning and preparations for, negotiations on, and convening of the high-level meeting are outlined below:

1. THE RIGHT AGENDA AT THE RIGHT TIME

Following the adoption of the SDGs in 2015 and a series of high-level meetings at the UN that focused on specific health issues (2001, 2006, 2011, 2014, 2016 and 2018), there was increasing momentum for a comprehensive approach towards health to be discussed at the level of Heads of State. The fact that the representatives of 165 Member States, including 57 Heads of State and Government, registered in advance of the High-Level Meeting on Universal Health Coverage suggests that the topic was very much seen as worthy of the international community's attention. Scheduling the meeting to take place on the first day of the UN General Assembly's high-level week also helped to ensure the participation of many senior State representatives.

2. LEADERSHIP AND COMMITMENT BY CHAMPIONS OF UNIVERSAL HEALTH COVERAGE

The leadership and commitment of champions of universal health coverage were essential to the successful outcome of the high-level meeting. Thailand and Georgia, the co-facilitators, and their

teams demonstrated great perseverance and skill throughout the negotiations. The UN Secretary-General, the WHO Director-General and the President of the General Assembly made clear their support for the agenda early on through their statements and actions, such as convening preparatory meetings. Member States – including such champions of universal health coverage as Brazil, Georgia, Japan and Thailand, and also the members of the Group of Friends of Universal Health Coverage and Global Health – helped to steer the negotiations and convene the high-level meeting. Experts from Thailand and Georgia (as the co-facilitators), the Office of the President of the General Assembly, the Chair of the Group of Friends, and WHO (as the technical secretariat for the negotiations) communicated daily on practical matters, which helped to move the process forward.

3. MULTI-STAKEHOLDER ENGAGEMENT

The "Key Asks", compiled by the International Health Partnership for UHC2030 and based on extensive consultations with civil society, the private sector, philanthropic institutions and academia, were instrumental in ensuring that the views of a wide range of stakeholders were reflected in the political declaration. In addition, the multi-stakeholder hearing convened by the President of the General Assembly and the briefing held by the Group of Friends of Universal Health Coverage and Global Health to invite the International Health Partnership for UHC2030 to present the "Key Asks" helped to channel the voices of these stakeholders into the final negotiations.

4. PREPARING THE DIPLOMATS IN NEW YORK FOR THE NEGOTIATIONS

As the diplomats in New York are not necessarily experts in health matters, the Group of Friends of Universal Health Coverage and Global Health was created as a platform for Member States to deepen their understanding of universal health coverage and of the views of different stakeholders. Briefings on relevant discussions at WHO headquarters and governing bodies in Geneva and on multi-stakeholder consultations helped diplomats to prepare for, and constructively engage in, the negotiations. There were also briefings, jointly convened by interested Member States and partners, on such topics as the private sector's role in health care, the funding of universal health coverage and population ageing.

5. LIAISON BETWEEN GENEVA AND NEW YORK

Every effort was made to ensure coherence between the discussions in Geneva and New York, which had different dynamics and priorities. This was achieved mainly through the preparatory World Health Assembly resolution (WHA72.4; WHO, 2019d), the co-facilitators' briefing in Geneva and the engagement of experts from WHO headquarters. The technical foundations for the negotiations were thereby laid, and it was possible to tackle some controversial issues such as price

transparency. However, some topics – notably sexual and reproductive health and rights, and migrants – proved more controversial in New York than in Geneva; these required focused mediation and persuasion as described above. Diplomats taking part in future health negotiations in New York should bear in mind their political nature, which is closely linked to broader developments at the General Assembly.

> The Political Declaration of the High-Level Meeting on Universal Health Coverage endorsed by world leaders on 23 September 2019 reaffirmed the role of universal health coverage as an umbrella concept for all health related goals and targets contained in the 2030 Agenda for Sustainable Development. The declaration amounts to a global call for health for all by 2030, backed by bold targets, commitments and follow-up processes. This landmark agreement was made possible by a series of concerted multi-stakeholder efforts, which built on earlier and ongoing initiatives on global health. Whether the various specific objectives for 2023 and 2030 set out in the declaration will be achieved depends on the commitment of all those engaged in the field of global health.

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